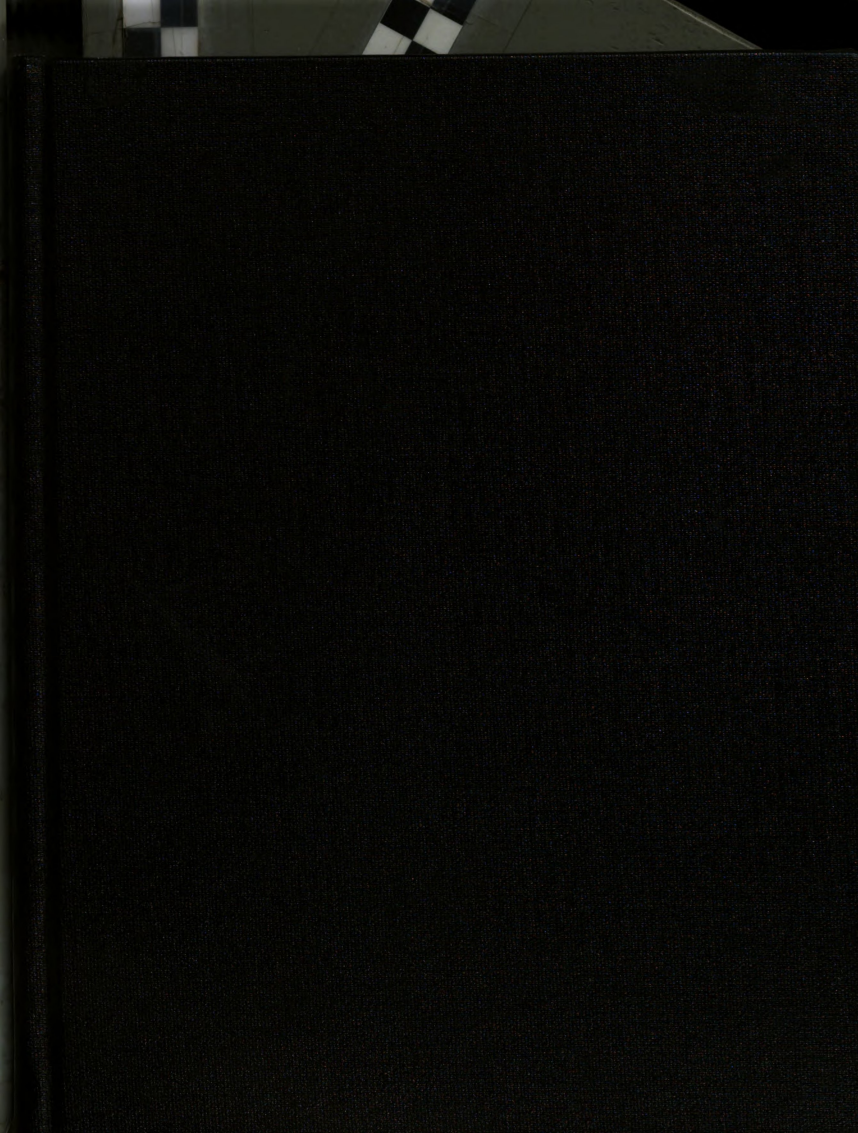




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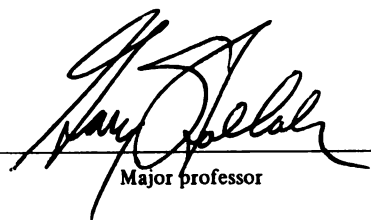
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PARENTAL HELP-SEEKING ATTITUDES AS GATEKEEPERS OF YOUNG
CHILDREN'S PATHWAYS INTO PROFESSIONAL MENTAL HEALTH
TREATMENT

By

Ioanna D. Kalogiros

A THESIS

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ABSTRACT

PARENTAL HELP-SEEKING ATTITUDES AS GATEKEEPERS OF YOUNG
CHILDREN'S PATHWAYS INTO PROFESSIONAL MENTAL HEALTH
TREATMENT

By

Ioanna D. Kalogiros

The role of self-concealment (tendency to conceal from others personal and often distressing information) and treatment fearfulness on parents' help-seeking attitudes were examined in a sample of 106 mothers of very young children. Results of multiple regression analysis showed that parents' concerns about meeting with mental health professionals about their child's possible problems in living predicted their help-seeking attitudes. Specifically, concerns about how one's image may change due to prospective help-seeking behavior uniquely predicted help-seeking attitudes. Parents' help-seeking attitudes were also predicted by parents' self-concealment. In addition, the tendency to self-conceal predicted parents' overall treatment fearfulness, and specifically predicted parents' image concerns and coercion concerns. These findings highlight the importance of considering such variables in the study of parents' help-seeking attitudes for their young child's mental health needs.

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INTRODUCTION

There is a significant risk for preschoolers with behavior problems to develop psychopathology later in life (Campbell, 1997). Methods to identify problematic behavior of children by parents and by other caregivers have received a great deal of attention (e.g., Martini, Strayhorn, & Puig-Antich, 1990; Achenbach, Verhulst, Edelbrock, Baron, et al., 1987; Kashani, Holcomb, & Orvaschel, 1986). However, we know much less concerning the variables involved in affecting a parent's decision to seek out and use mental health services.

The primary focus of this research was to examine the role parents' self-reported thoughts about mental health services and preference to conceal personal and often distressing information from others relate to their attitudes toward seeking professional mental health help for their young children if the need should arise. Specifically, parents' propensity to self-conceal was evaluated in relation to their concerns about meeting with a mental health professional regarding their child's possible problems in living as well as their attitudes toward seeking professional psychological help for their child. This study assessed the relation between these variables in a sample of parents of non-clinic referred young children.

More specifically, the study was designed to address the following questions:

- a) Are parents' concerns about meeting with mental health professionals regarding their child's potential problem(s) inversely related to their attitudes toward seeking formal mental health care for their child?

- b) Do parents who consciously conceal personal and often distressing information from others report unfavorable attitudes toward seeking professional help for their child?
- c) Do parents who consciously conceal personal and often distressing information from others report many concerns about meeting with mental health professionals regarding their child's potential problem(s)?

The Role of Parents

Approximately twenty percent of all preschool children show some type of behavioral or emotional problem (Pavuluri, Luk, & McGee, 1995; Luk, Leung, Bacon-Shone, et al., 1991). Research has found the existence of early child behavioral/emotional problems to be the best predictors of the presence of future mental health difficulties in children. For instance, a longitudinal 3-year reassessment of a nationally representative sample of American children found parents' ratings of their children's (4 – to 16- year-olds) behavioral/emotional problems at time 1 predicted the persistence of their children's deviance at time 2 (i.e., three years later; Stanger, McConaughy, & Achenbach, 1992). In addition, parents' time 1 ratings of the same data set predicted time 2 ratings for both teacher and self-reports (i.e., for 11 – 19 year olds only) of children's behavioral and emotional problems (McConaughy, Stanger, & Achenbach, 1992).

Parents hold a critical role in both communicating with mental health professionals concerning the history of their child's difficulties, and facilitating the delivery of mental health care to their child (e.g., with regard to the cost of services and

transportation to providers). The significance of their involvement increases exponentially throughout the assessment and treatment of their child's problem, and their active participation is essential in stimulating change in their child's problem behavior(s), and maintaining a climate within which their child can develop cognitively, emotionally, and socially to his/her maximum potential. In fact, the greatest amount of research concerning mental health treatment for preschool age children involves their parents in parent-child interaction or behavioral training programs (Eyberg, 1992). Treatment modalities such as filial therapy (FT; Guerney, 1964; Stollak, 1981) and parent management training (PMT; Barkley, 1987) incorporate parents as change agents and consider them to be irreplaceable figures in every session. In both FT and PMT, the mental health professional models and/or coaches parents in changing their style of interacting with their child during weekly sessions. Emphasis is placed upon mirroring the child's feelings, giving clear directions, verbally reinforcing good behavior, and consistently reinforcing age-appropriate consequences etc. In FT, parents also practice their new interaction styles with their child during play sessions they have at home.

Other types of parent training paradigms (Patterson, Reid, Jones, & Conger, 1975) exclude the child from weekly sessions during which parents meet alone with the mental health professional for parenting guidance. Parents are taught to react to their child's behavior in a contingent fashion based on the rules of behavior modification charts (e.g., point or token systems) that are created to outline various tangible behavioral reinforcers (i.e., rewards for good behavior and punishments for targeted problem behaviors). Children are often times involved in both the selection of tangible rewards and punishments and in the enforcement of chart rules (e.g., marking and tallying the

number of points they earn or lose due to undesirable behaviors, etc.). In addition, parents' roles in implementing behavioral plans (such as that in PT programs similar to Patterson et al.'s [1975]) further include parents' interfacing between their mental health professional(s), the family unit as a whole, the child's school system, and their child's child/day care provider(s).

Until recently, little was known about parental help-seeking for their young children's cognitive and/or behavior/emotional problems. The only study found specifically concerning help-seeking behavior of parents of preschoolers was a community study conducted in New Zealand by Pavuluri, Luk, and McGee (1996). The study recruited parents of young children who were enrolled in preschool centers, which included kindergarten, play centers, and day-care centers. Parents of preschoolers aged 30 – 60 months were asked to identify the types of perceived help-seeking barriers (using questions adapted from Hornblow, Bushnell, Wells, Joyce, & Oakley-Browne, 1990) they had encountered during a time when they perceived a need for help with their child's problem behavior but decided not to seek assistance. The majority of parents who reported one or more barrier(s) endorsed *attitudinal* barriers, such as the beliefs that their young child's problems would ameliorate by themselves over time (79.4% of parents) and that they, as parents, should be strong enough to handle their child's behavior problems on their own (58.8%), as the most salient influences on their decision. Additional barriers included a lack of knowledge of available services (38.2%), a belief that no one could help (35.3%), and that their child was too young for help (32.4%). Practical or physical barriers such as concerns about the cost (29.4%), lack of transportation (20.6%) or time (17.6%) and inconvenient hours of operation (2.9%) were

also endorsed as barriers. Prior disappointment in services (17.6%) and fear of the treatment that their child would receive (8.8%) were also reported. Lastly, parents' reported a fear of what their boss, friends, or family would think (2.9%), hating to answer personal questions (11.8%), and feeling too embarrassed to discuss their child's problem with anyone (5.8%) as having influenced them to not seek professional help for their child.

Another study concerning parental help-seeking for their children during childhood (ages 5-11) and adolescence (ages 12-15) for behavior and emotional problems was also conducted in New Zealand and involved a longitudinal study of the health of a birth cohort (Feehan, Stanton, McGee, & Silva, 1990). Results indicated a stable rate of parental help-seeking (approximately 1 in 5 parents) during later childhood and adolescence. It is important to note that a possible limitation of the study conducted by Feehan et al. (1990) includes their retrospective measurement of parental help-seeking behavior. That is, parents were contacted when their children were 9 years old to report on their help-seeking behavior from their child's fifth to 9th birthdays while parents of children of all other ages were asked to refer to the last two years of their help-seeking behavior (e.g., 12th to 14th birthdays for a parent of a 14 year old). Asking parents to report on their help-seeking behavior across a 4-year time frame may have decreased the accuracy of parental reports, thus increasing some margin of error.

McMiller and Weisz (1996) investigated parents' help-seeking behavior for children and adolescents (ages 7 to 17 years old) who had been referred to a community mental health clinic for outpatient treatment in the United States. More specifically, families of diverse ethnic backgrounds were interviewed after clinic intake but before the

onset of therapy concerning who they had sought help from, the perceived severity of their child's problem(s), as well as their perception of how beneficial the outpatient clinic would be for their child. Results indicated ethnic group differences in the number of pre-clinic professional contacts reported by parents with Caucasian parents (56%) seeking the most help from professionals preceding clinic intake followed by African American families (47%) and Latinos (42%). McMiller and Weisz further examined the correlation between parents' ratings of the severity of their child's problems and their decision to seek professional help based on their ethnicity to elucidate the relationship between ethnic origin and quantity of pre-clinic contacts. More specifically, higher correlations were found for minority than Caucasian families suggesting that minority parents' decisions to seek professional psychological care for their children may be contingent upon their children's problem severity (McMiller & Weisz, 1996) having reached if not surpassed the ceiling of their "distress threshold." That is, intercultural differences in the definition/identification of problem behaviors and their perceived prognosis in the absence of professional help may have shaped parents' decisions to seek formal assistance (Weisz and Weiss, 1991).

It is important to acknowledge that the use of clinical samples in help-seeking research may compromise the generalizability of research findings since those who are truly hindered by finances and other practical barriers to mental health care (e.g., transportation) may be underrepresented. Focusing on measuring help-seeking of both parents and youths *after* they have recognized a need and arrived for professional clinical treatment (e.g., McMiller & Weisz, 1996) may also inaccurately capture the process parents undergo in weighing the perceived cost and benefits of seeking

professional psychological help. That is, a majority may have tested and/or exhausted alternative forms of support (e.g., informal assistance from friends, family, coworkers, etc.), thereby defining assistance from mental health professionals as their last resort.

It is unclear how helpful downward extrapolation of parental help-seeking behavior from research involving a wide range of children's ages (i.e., from early elementary age children and adolescents) to young children (24 to 60 months old) may be, especially in retrospective studies using clinic populations or spanning help-seeking behavior over a number of years. Because attitudinal variables have been identified as playing a very influential part in shaping parents' decisions to *not* seek professional help for their preschoolers' behavior problems despite their identification of a need (Pavuluri, Luk, & McGee, 1996), it is logical to investigate personal factors that may influence parents' help-seeking attitudes from the perspective of their involvement. Put more simply, parents' involvement in fulfilling their child's mental health care needs, from recognizing the inception of a problem to playing an integral part in their child's treatment, may be influenced by a myriad of their *own* beliefs, fears, and barriers to seeking psychological help for themselves.

Adult Help-Seeking

Existing research has identified a number of barriers associated with adults' decision to seek mental health care assistance for their problems. In a prevalence study of psychiatric disorders in New Zealand, Hornblow et al., (1990) found adults reported two of the *major* reasons they did not seek assistance (from a health professional) for their mental health problems (when they themselves or their family thought they should) to be

attitudinal in nature. Moreover, adults indicated the same two beliefs that parents' of preschoolers (Pavuluri, Luk, & McGee, 1996) indicated as deterrents to seeking psychological assistance for their preschool child's problem. That is, adults indicated holding the beliefs that an individual should be able to handle his or her difficulties alone (83%), and that his/her issues were transient (e.g., problems would be resolved by themselves [65%]) as having influenced their help-seeking behavior to the greatest extent in comparison to other barriers. Cost (20%), low levels of awareness of sources for mental health care (18%), time (10%), inconvenient hours of service operation (8%), and a lack of transportation (2%) were reported to be among other reasons for which adults did not seek help. Other studies have also found accessibility, availability, and economic costs of mental health services to mediate the relationship between adults' recognition of a need for help and their enlisting such involvement (see Kushner & Sher, 1991; Leaf, Bruce, Tischler, & Holzer, 1987; Lorefice, Borus, & Keef, 1982; Sharfstein & Taube, 1982).

Prior research concerning adults' help-seeking attitudes reports a relation between individuals' help-seeking attitudes and their propensity to seek assistance. For example, favorable attitudes toward psychotherapy (i.e., formal sources of care) have been found to be associated with a greater willingness to seek help in adults (e.g., Deane & Todd, 1996; Deane & Chamberlain, 1994; Leaf & Bruce, 1987) regardless of the problem-type (e.g., psychological/interpersonal, academic, or drug use concerns; Cepeda-Benito & Short, 1998). Adults' attitudes toward mental health services have also been found to significantly affect not only the likelihood of their seeking assistance for their mental health difficulties (Leaf et al., 1987) but also the probable number of services they would

be willing to participate in (Leaf, Livingston, Tischler, Weissman, Holzer, & Myers, 1985).

Despite the persistence of young children's psychiatric problems to continue past their preschool years if left untreated (Prior, Smart, Sanson, & Pedlow et al., 1992; Campbell & Ewing, 1991; Stevenson, Richman, & Graham, 1985), approximately 19% of parents of preschoolers who were clinically diagnosed with a behavior disorder (assessed using a semi-structured clinical interview of the parent by a research interviewer; Pavuluri, Luk, & McGee, 1996) sought help for their child's difficulties in living. Investigating factors that affect parents' attitudes toward seeking psychological help for their young child may lend itself to future research examining their probability of seeking help from formal sources of care.

Thoughts/Concerns About Mental Health Services

Kushner and Sher (1989) define *treatment fearfulness* as a "subjective state of apprehension that arises from aversive expectations about the seeking and consumption of mental health services (p. 251)" which may act alone or in combination with other factors to affect an individual's propensity to seek help. In addition, their further proposition that individuals' fears about assessment and/or psychotherapy, ranging from fears of embarrassment, stigma, change, to stereotypes they may proscribe to mental health service providers and various types of assessment and treatment, may inhibit their use of mental health services (Kushner & Sher, 1991), has been supported by research. For example, research on adult help-seeking attitudes has found fears concerning stigmatization and receiving negative feedback from friends and family members to be

two attitudinal barriers adults report regarding their seeking help for their mental health needs (Farina, 1982). Similarly, adults reported concerns about their image changing as a consequence of seeking help for mental health problems (e.g., fears of what others would think) in addition to fears concerning the types of treatment they may receive (i.e., excluding hospitalization) as reasons they did not see a health professional for their mental health needs when they or someone in their family believed they should have (Hornblow et al., 1990). Hornblow et al. (1990) also found adults indicated that their decision to not seek help was influenced by their concerns about having to discuss interpersonally sensitive information with another person (e.g., “too embarrassed to discuss it with anyone;” “hated answering personal questions”) and their fear of being hospitalized.

Studies have also found adults’ confidence in the helpfulness of professional mental health care personnel/agencies to impact their use of formal support from mental health professionals; Takeuchi, Bui, & Kim, 1993; Broman, 1987; Staggers, 1987; Hall & Tucker, 1985; Neighbors, 1985; Viale-Val, Rosenthal, Curtiss, & Marohn, 1984). For instance, adults have reported their belief that no one could help them as a reason why they had not sought help for their problem despite the perception of a need (Hornblow et al., 1990).

Cash, Kehr, and Salzbach (1978) studied the relation between attitudes toward seeking help and perceptions of counselor behaviors in a college student population. Their findings revealed a positive relationship between help-seeking attitudes (Fischer & Turner, 1970) and perceptions of counselors’ expertise, trustworthiness, regard, empathy, genuineness, and helpfulness (i.e., after listening to a taped counseling interview).

Participants who espoused more positive help-seeking attitudes were also found to be more willing to return after a first interview and more optimistic in their expectations of improvement in personal problems. Similarly, research conducted by Kelly and Achter (1995) found a positive predictive relationship between individuals' help-seeking attitudes and their reported likelihood of seeking help from a university counseling center on a variety of psychological, interpersonal, and academic potential problems in living.

The topic of parents' thoughts/fears concerning *their* involvement with mental health services for their child has been largely unresearched. Research by Stagers (1987) suggests that parents may fear being blamed for inadequate parenting skills as well as the emotional or social effects their children may experience as a result of being labeled and/or medicated (e.g., experience stigma). Kushner and Sher (1991) called for research in the area of parents' fears toward mental health services and emphasized its importance with regard to the crucial role parents play in referring their children for treatment. While barriers to help-seeking such as fears about the type of treatment a child may receive and concerns about parents' images changing (both self and as perceived by others; see Pavuluri, Luk, & McGee, 1996) have been identified by parents of preschoolers, a review of the literature has not located a single study investigating the relation between parents' concerns about their involvement in their young child's mental health care delivery and their attitudes toward seeking professional help for their child if a need should arise.

Parents' thoughts about mental health services including their concerns about their contact with their child's mental health professional may influence the development and maintenance of their attitudes toward seeking professional psychological help. Taken

together with the adult literature on fears about psychotherapy (Kushner & Sher, 1989), parents may also be concerned about the professionalism and competence of their child's mental health professional. As such, parents' level of trust in the efficacy of professional psychological assessment and treatment regardless of the modality (e.g., individual child treatment and/or parenting management) may influence their help-seeking attitudes. For instance, parents may be concerned about mental health professionals' lack of competence in understanding and addressing their child's problem and/or their concerns about their child's problem. Consequently, parents' reservations about assessment and treatment, in general, may adversely influence their commitment to interventions contingent upon their consistent participation (e.g., filial therapy, parent management groups, etc.). That is, some parents may end their child's individual treatment (e.g., play therapy) early as a consequence of terminating their personal involvement in another treatment modality (e.g., parent training or filial therapy sessions) due to their fears regarding their contact with mental health professionals (e.g., how responsive the assessor/therapist will be/is to them). In this regard, parents with many concerns about their child's mental health care delivery may espouse unfavorable attitudes toward seeking help to a greater extent than parents with less reported fears.

Self-Concealment

Beliefs about the level of self-disclosure that a formal child assessment and/or treatment may require of parents may constitute another element that functions to influence parents' attitudes toward formal psychological assistance for their children. For instance, parents of preschoolers who perceived a need for help with their child's

behavior problem(s) reported their belief that seeking help for their child would have brought about sharing personally embarrassing information as a reason why they had decided to *not* seek formal assistance (Pavuluri, Luk, & McGee, 1996). Similarly, parents may fear that they will be coerced to discuss topics and/or change their *own* behavior in ways that may make them feel uncomfortable if not very distressed (e.g., by having to change their thoughts about parenting or their parenting behaviors).

Larson and Chastain (1990) define self-concealment as “a predisposition to actively conceal from others personal information that one perceives as distressing or negative (p. 440).” Research on the relation between self-concealment and attitudes toward help-seeking has revealed a statistically significant predictive effect (Kelly & Achter, 1995). Specifically, college students reporting higher self-concealment scores indicated having less positive attitudes toward seeking professional psychological help as compared to adults whom reported practicing self-concealment to a lesser extent. High self-concealers have also reported there being three times as many times in their lives when they perceived a need for help but did not seek it as compared to low self-concealers (i.e., 37% versus 12%, respectively; Cepeda-Benito & Short, 1998).

The effects of self-concealing personal and often distressing information have also been found to be negatively associated with adults’ physical health, and psychological adjustment (e.g., Ichiyama, Colbert, Laramore, Heim, Carone, & Schmidt, 1993; Pennebaker & Susman, 1988). For example, Pennebaker and Susman (1988) found adults’ current health problems (i.e., ranging from cancer to headaches) were significantly predicted to a greater extent for individuals who had not confided to anyone that they had experienced a trauma before the age of 17 (e.g., experiencing

divorce/separation, violence, sexual trauma, or the death of a friend or relative) than those who disclosed their experience. Furthermore, a laboratory study by Pennebaker and Susman (1988) reported the benefits of confiding traumatic experiences through written expression. Specifically, positive physiological effects in immune functioning were evidenced for undergraduate students who wrote about traumatic experiences (i.e., described the facts and their emotions) over the course of 4 days as compared to subjects who wrote about trivial experiences (i.e., control group). In fact, significant improvements in immune functioning were reported for individuals who wrote about traumatic occurrences both after the experiment was completed and 6 weeks later. In addition, a significant decrease in health center visits was found for individuals who wrote about traumas than trivialities.

Due to the important interface role that parents play in their child's mental health care delivery, investigating the degree to which parents' self-concealment affects their help-seeking is important because parents who actively conceal information may hinder the course of their child's assessment and/or treatment. For instance, research by Pavuluri, Luk, & McGee (1996) found parents of preschoolers identified components of self-concealment (namely, that they hated to answer personal questions and were too embarrassed to discuss their child's problems) as reasons why they did *not* seek help for their child despite their recognition of a need.

Extrapolating from the adult literature, parents' who tend to conceal personal information may report having negative attitudes to seeking help for their child. Further investigation into the relation between parents' degree of self-concealment and help-seeking attitudes is necessary because there exists potential that parents'

self-concealment may be doubly harmful in affecting their own as well as their child's mental and physical well-being. Moreover, the accuracy of high self-concealing parents' reports of their child's behavior may also be compromised as a result of parents' decisions to conceal information they may feel is necessary to withhold from a mental health professional. For example, parents may keep secrets from the mental health professional in regards to domestic violence for fear of losing their child to social services. In this regard, the commitment of parents who are high self-concealers in participatory interventions (e.g., filial therapy) may also be negatively influenced.

Conclusion

Previous research has identified attitudinal barriers as impeding parents' decisions to seek help for their preschoolers' problems in living (Pavuluri, Luk, & McGee, 1996). As of late, factors that may influence the development and maintenance of parents' attitudinal barriers have not been examined. The current investigation of parents' self-reported thoughts/concerns about mental health services, preferred level of self-concealment, and attitudes toward seeking professional help for their young children's potential mental health care needs may uncover a framework from which to better understand the role of such beliefs and attitudes as gatekeepers to children's viable pathways into mental health services.

An increased understanding of such influences could potentially assist in the development and delivery of attractive and useful programs (e.g., in pediatric, day care or preschool settings) aimed to help parents identify their young children's competencies and deficits, and facilitate their seeking and obtaining available professional assessment

and help, when such a need should arise. Effective outreach programs may also promote the removal of possible barriers to help-seeking such as the diminution of stigma potentially associated with enlisting the involvement of formal mental health care assistance on peer, familial, cultural, and religious levels. In addition, exploring the driving force behind parents' decision-making processes concerning seeking professional psychological help for their young children's potential problems may hold policy implications for the future with regard to state and government definitions of child abuse and neglect.

Hypotheses

Hypothesis 1A: Fears About Mental Health Services Will Predict Help-Seeking

Attitudes.

Consistent with prior research of the relationship between adults' fearfulness of psychotherapy and attitudes toward seeking professional psychological help (Cepeda-Benito & Short, 1998; Kelly & Achter, 1995), parents' fears about meeting with a mental health professional to discuss their child's potential problems in living were hypothesized to be negatively correlated to their help-seeking attitudes. Parents who endorsed more concerns on the TAMHS-MC (total score) were expected to report having less positive attitudes toward seeking professional psychological help on the HS survey than parents who report less concerns.

A speculation was also made that If Hypothesis 1A was supported, a negative relationship would be found between the types of fears parents may have about mental

health services (individual subscale scores) and attitudes toward seeking professional psychological help for their young child (total HS-MC scores).

Hypothesis 2: Self-Concealment Will Predict Attitudes Toward Help-Seeking.

Consistent with prior research on the negative relationship between adults' help-seeking attitudes and reported self-concealment scores (SCS; Kelly & Achter, 1995), parents who preferred to conceal personal and often distressing information about themselves were expected to report having less favorable attitudes toward help-seeking for their child than parents who indicated concealing such information to a lesser degree.

Hypothesis 3: Levels of Self-Concealment and Concerns about Mental Health Services Will Predict Parents' Help-Seeking Attitudes.

Combining previous research regarding the independent influence of SCS (Kelly & Achter, 1995) and TAMHS-MC (Cepeda-Benito & Short, 1998; Kelly & Achter, 1995) scores on predicting help-seeking attitudes, it was expected that SCS and TAMHS-MC would together predict parents' HS-MC scores.

Speculation: In addition, the relationship between parents' total self-concealment scores (as the predictor) and each of the TAMHS-MC components (dependent variables) that are found to predict parents' help-seeking attitudes was also explored.

Hypothesis 4: Self-Concealment Scores Will Predict Parents' Fears About Mental Health Services.

Parents who preferred to conceal personal and often distressing information about themselves were expected to report having more fears (higher TAMHS-MC scores) about meeting with a mental health professional for their child possibly because of the kind of information they might expect the mental health professional to ask of them.

Speculation: In addition, the relationships between parents' total self-concealment scores (as the predictor) and all three of the TAMHS-MC components (dependent variables) was also explored. Because the concept of self-concealment reflects one's thoughts about his/her self-image, it was expected that parents who prefer to conceal personal and often distressing information about themselves would report more concerns about how their therapist and others may view them (i.e., Image Concerns). It was also expected that parents who prefer to conceal personal and often distressing information about themselves would also report more concerns about being pressured into doing things or speaking about distressing topics (Coercion Concerns) if they were to meet with a mental health professional.

METHOD

Study Sample.

Over a 1-month data-collection period, 518 parents whose young children were enrolled in four child development centers/schools in East Lansing, Michigan were invited to complete and return a research survey consisting of several parts; 125 parents did so. For the purposes of this thesis, analyses were restricted to include only mothers (n=106) due to the small sample size of fathers (n=18) and other guardians (n=1 grandmother). There were no other restrictions made on the final study sample. Demographic information collected from the one grandmother was not included in any Tables.

Demographic Characteristics

Respondents were first asked to answer a series of demographic questions (see last page of Appendix K) that ranged from respondents' classification of their relationship status, to both their own and/or significant other's occupation, education and income levels. The items were modified slightly from the Schedule of Recent Experience (Homes & Rahe, 1967). The final sample of mothers ranged in age from 20 to 48 years ($M\text{ age} = 34.41$, $SD = \pm 5.6$) and were homogeneous with respect to other demographic variables (see Table 1).

Additional response categories were created for ethnicity and occupation. Specifically, responses that could not be classified into any of the original ethnicity categories (n=2) were included in a new category called "other." Also, a new occupation

category for "student" was created because six respondents wrote on their surveys that their and/or their spouse/partner 's occupation was that of a student/graduate student.

Characteristics of Study Sample's Children.

The following characteristics of each respondent's child: age, gender, and number of siblings are also broken down by sex of the parent in Table 2. Two parents reported that their child was one of twins. One parent indicated that both of their twins were of the male gender, while another reported one twin of each sex. The child's gender variable for the parent whose twins were both boys was assigned as a male. The other parent with one twin of each sex was assigned a gender variable of missing.

The age of each child was computed by subtracting their date of birth from the date their parent indicated they had completed the survey. Parents' whose completion dates were missing were assigned the modal date of completion for their data collection trial (CDL vs. other). Children whose parent listed only the month and year of their date of birth (n=2) were assigned the first day of the month they were born in as their birthday in order to compute their age. Because the data distribution dates were part of a second group attempt at data collection (one to two days apart) for parents whose child attended either Spartan Village, Eastminster, or People's Church, their completion dates were analyzed together and their modal completion date was May 23, 2000. The children in the final sample ranged in age from 3.91 to 86.66 months (M age = 43.68, $SD = \pm 16.67$).

Procedures for Initial Data Collection Trial.

The Acting Director of the Child Development Laboratory (CDL) of Michigan State University supplied a list of classrooms (represented by teachers' initials) where children between the ages of 24 to 60 months were enrolled. Specifically, the total number of children meeting the age criteria, their enrollment status (morning or afternoon enrollment), and the name of each classroom's principal teacher were included. No additional information was obtained from the CDL.

Each identified teacher was informed that a study would be conducted but were not told about the study's purpose. On April 17, 2000 each principal teacher was given a specified number of research study packages for their student teachers to place in each of their eligible young children's backpacks before they left school that day. Research packets that were not distributed due to children's absence (n=36) were returned.

The study package parents received included a) a letter describing the present study and what was required of him/her (see Appendix G), b) a consent form indicating that by signing, either the child's mother or father was consenting to participate (see Appendix I), and c) the study survey (see Appendix K). Parents who volunteered to participate in this study were asked to spend approximately 20 minutes filling out a survey about their mental health attitudes/beliefs, use of mental health care services, and the degree to which they conceal information from others. The research letter specifically asked for 1 parent to independently complete the survey. In addition, parents/guardians were informed in the letter that their answers would be held strictly confidential. Lastly, the letter stated that each respondent would receive a chance to win a \$50 grocery gift-certificate as financial compensation for their participation.

Exactly one week after the survey distribution date, student teachers placed one page reminders (see Appendix J) printed on bright colored paper in the backpacks of all eligible young children (regardless of whether or not their parents had already returned their surveys). Faculty and/or staff of the CDL did not know the participation status of their students' parents. The reminders asked parents to please return their completed surveys as soon as possible in order to be eligible for the \$50 drawing.

On the same day that one-page reminders were placed in each eligible child's backpack, a short note appeared in the weekly newsletter of the Child Development Laboratories (CDL) that was distributed that day (see Appendix L). The note informed parents that a research survey was sent home in their child's backpack if their child was between the ages of 24-60 months. The note also stated that all participating parents would have a chance to win a \$50 Meijer's grocery gift-certificate as compensation for their time. No mention of the purpose of the study was made in order to avoid influencing parents' responses.

Because an insufficient number of surveys ($n = 46$; 37.1% of the total sample) were obtained from the data collection trial at the Child Development Laboratories of Michigan State University to conduct analyses, parents were recruited to participate from three additional child development centers/schools within the same vicinity (East Lansing, Michigan). The three centers consisted of Spartan Child Development Center, People's Church of East Lansing School, and Eastminster Child Development Center. The same research surveys were used throughout all four data collection trials. The inclusion of four child development centers/schools also helped reduce the risk that findings would reflect idiosyncratic characteristics of a single school.

Procedures for Additional Data Collection Trials.

First, the Director of the Spartan Child Development Center provided the number of enrolled children under the age of 60 months ($n=89$). On May 22, 2000, 89 research survey packets were placed by student teachers in the backpacks or file folders of all children enrolled at the Spartan Child Development Center. Principal teachers did not receive any correspondence from the principal investigators at the request of the Director of the school. Also, the director was asked to not inform the teachers of the purpose of the study. Children who were absent from school that day had their research packet taped to their locker. In addition, if a family had more than one eligible child enrolled at the same school, student teachers were instructed to place the research packet in the file folder of the oldest sibling. No additional information was obtained from or given to the Spartan Child Development Center.

Exactly one week after the survey distribution date, student teachers placed one-page reminders (see Appendix J) in the backpacks/file folders of all eligible young children (regardless of whether or not their parents had already returned their surveys). Once again, children who were absent from school that day had their reminder letter taped to their locker. Faculty and/or staff of the Spartan Child Development Center did not know the participation status of their students' parents. The reminders asked parents to please return their completed surveys as soon as possible in order to be eligible for the \$50 drawing. Twenty-seven surveys were returned in all (21.8% of the total sample).

Second, the Director of the People's Church of East Lansing provided the number of enrolled children under the age of 60 months ($n=115$). On May 23, 2000, all teachers were given a brief note informing them that a study was being conducted with their

director's approval. Attached to the note were a specified number of research study packages for their student teachers to place in each of their young children's backpacks before they left school that day. Teachers were not informed about the study's purpose. In addition, the director was asked to not inform the teachers of the purpose of the study. Lastly, if a family had more than one eligible child enrolled at the school, student teachers were instructed to place the research packet in the file folder of the oldest sibling. No additional information was obtained from or given to the People's Church of East Lansing.

Exactly one week after the survey distribution date, student teachers placed one page reminders (see Appendix J) printed on bright colored paper in the backpacks of all eligible young children (regardless of whether or not their parents had already returned their surveys). Faculty and/or staff of the People's Church of East Lansing did not know the participation status of their students' parents. The reminders asked parents to please return completed surveys as soon as possible in order to be eligible for the \$50 drawing. Twenty-three surveys were returned in all (18.5% of the total sample).

The last recruitment trial for data collection took place at the Eastminster Child Development Center. The Director of the Eastminster Child Development Center provided the number of enrolled children between the ages of 12 to 60 months old (n=130). Because parents are instructed by the school to check their child's file folder for events/homework every day upon picking up their child at the end of the day, research survey packets were placed in the file folders of every eligible child instead of their backpacks. Student teachers at the Eastminster Child Development Center placed the survey packets in all eligible children's file folders on May 24, 2000. Principal teachers

did not receive any correspondence from the principal investigators at the request of the Director of the school. In addition, the Director was asked to not inform the teachers of the purpose of the study. Lastly, if a family had more than one eligible child enrolled at the school, student teachers were instructed to place the research packet in the file folder of the oldest sibling. No additional information was obtained from or given to Eastminster.

Exactly one week after the survey distribution date, student teachers placed one-page reminders (see Appendix J) in the file folders of all eligible young children (regardless of whether or not their parents had already returned their surveys). Faculty and/or staff of the Eastminster Child Development Center did not know the participation status of their students' parents. The reminders asked parents to please return completed surveys as soon as possible in order to be eligible for the \$50 drawing. Twenty-eight surveys were returned in all (22.6% of the total sample). All surveys completed by parents were returned to the investigator.

Financial Compensation.

Lastly, two lottery drawings were held for two \$50 grocery gift-certificates that were donated from the Meijer's store in East Lansing. One winner was chosen from the original data collection trial at the Child Development Laboratories and the second winner was drawn from the pool of parents whose child attended one of the three additional child development centers. Both winning parents were sent a congratulation letter along with their Meijer's \$50 grocery gift-certificate.

Instruments.

Parental Help-Seeking Attitudes

Respondents were asked to rate on a 4-point scale the extent to which they agreed or disagreed with each of 11 items (ranging from 1 to 4; reverse keyed for negative items) of the “Help-Seeking” scale (HS; see Appendix A). Total scores could range from 1 to 44 on the HS scale, with higher numbers indicating more favorable attitudes toward seeking psychological help for their child. The HS scale is a modified version of the Attitudes Toward Seeking Professional Psychological Help (ATSPPH) scale first created by Fischer and Turner (1970; see Appendix C); and then revised and shortened by Fischer and Farina (1995; see Appendix B). Changes were made in the wording of the questions in order to evaluate parents' attitudes concerning seeking professional mental health assistance, and recognizing their children's potential mental health care needs. Typically, these changes included replacing the words *mental problems* with *cognitive/emotional/social problems, conflicts, or difficulties*, the terms *mental health clinic, psychiatric inpatient unit, and counseling center* with *help from a mental health professional*. Also, the term *person* was replaced with *a child*, and the term *my* was changed to *my child*. In addition, a new item was added (i.e., “*A parent should be able to work out his or her child’s cognitive/emotional/social problems; getting help from a mental health professional would be a last resort.*”) which was a modification of the Short Form’s last item. Lastly, the instrument's scale was changed to represent a 1 to 4 scale instead of the original 0 to 3 point scale used in both the ATSPPH (Fischer & Turner, 1970) and in Fischer and Farina's (1995) revised and shortened version.

Factor analysis of the unmodified short form (Fischer & Farina, 1995) revealed the best fit for a unidimensional solution. The internal consistency was reported to be .84 (Cronbach's alpha) with factor loadings above .50 for all ten items (Fischer & Farina, 1995). The original 29-item ATSPPH and its shortened form was reported to be correlated .87 which suggests that the short form could be used to substitute for the original version (Fischer & Farina, 1995). In addition, test-retest reliability after 4 weeks for the Short Form yielded an auto-correlation of .80 (Fischer & Farina, 1995). In comparison, the original ATSPPHS yielded a Cronbach's alpha of .83 and .86 (across two samples) and test-retest reliability estimates of $r = .73 - .89$ (e.g., $r = .82$ for 4 weeks; Fischer & Turner, 1970). Lastly, both the short and original forms of the ATSPPHS were found able to discriminate between individuals who have and have not sought psychological help.

Thoughts About Mental Health Services

Respondents were asked to rate each of 17 items of the "Thoughts about Mental Health Services-My Child" (TAMHS-MC; see Appendix D) on a 5-point scale indicating the extent to which they would be concerned about each item (ranging from 1 = *no concern* to 5 = *very concerned*) if they were to meet with a mental health professional regarding a potential cognitive/emotional/behavioral problem their child might have at some point in time. Total scores could range from 19 to 95, with higher numbers indicating a greater number of concerns.

TAMHS-MC is a modified version of the "Thoughts about Psychotherapy Survey" (TAPS; Kushner & Sher, 1989). The changes from the original scale included

replacing the word *therapist* with *mental health professional*, the term *in therapy* with *by the mental health professional*, and *my problem* with *the problem, my child's problem(s), or my concerns about my child's problem(s)*. Also, two items were modified from the original survey. The first item that was modified was changed from, "*Whether the therapist will think that I'm more disturbed than I am*" to "*Whether the therapist will think that I'm disturbed.*" The second item that was modified was changed from, "*Whether I will be pressured to do things in therapy I don't want to do*" to "*Whether I will be pressured to do things in assessment/counseling/psychotherapy I don't want to do.*"

Reliability analyses of the TAPS has yielded an alpha of .93 (Kushner and Sher, 1989) and .94 (Cepeda-Benito & Short, 1998). Factor analysis of the TAPS (see Appendix E) has reported a three factor solution model (i.e., Therapist Responsiveness (6 items), Image Concerns (8 items), and Coercion Concerns (3 items). Previous research reports satisfactory measures of internal consistency for each factor (coefficient $\alpha = .92$ for Therapist Responsiveness, .87 for Image Concerns, and .88 for Coercion Concerns; Kushner & Sher, 1989). In addition, Kushner and Sher (1989) found adults who had sought treatment reported a smaller number of concerns on the TAPS than individuals who had avoided psychotherapy.

Self-Concealment

Items from the "Self-Concealment Scale" (SCS; Larson & Chastain, 1990; see Appendix F) were also included in the survey. These items measure "the predisposition to actively conceal from others personal information that one perceives as distressing or

negative” (p. 440). Respondents were asked to rate each of the 10 SCS items on a 5-point scale indicating the extent to which they agreed or disagrees with each item (ranging from 1 = *strongly disagree* to 5 = *strongly agree*; no item reversals). An example item is “I have an important secret that I haven’t shared with anyone.” A total score was computed by summing participants’ responses to the 10 items. Total scores could range from 10 to 50 with higher scores indicating greater self-concealment. No modifications were made to this scale.

Test-retest reliability after 4 weeks ($r = .81$; Larson & Chastain, 1990) and 7 weeks ($r = .74$; Cramer & Barry, 1999) have been reported to be satisfactory. Internal consistency estimates of .83 (Larson & Chastain, 1990), .86 - .87 (across two studies by Cramer & Barry, 1999) and .88 (Cepeda-Benito & Short, 1998) have also been reported. In addition, Larson and Chastain reported that self-concealment significantly added to the prediction of self-reported depression, anxiety, and somatic complaints *after* controlling for trauma incidence, trauma distress, trauma disclosure, social support, and self-disclosure. Also, scores on the SCS were inversely related to a measure of general self-disclosure and trauma disclosure (Larson & Chastain, 1990). As such, Larson and Chastain reported self-concealment to be different from the construct of self-disclosure. For the purposes of this study, the unidimensional solution for the concept of self-concealment proposed by Larson and Chastain (1990) was used because it has demonstrated to be the most parsimonious (Cramer & Barry, 1999).

RESULTS

Prediction of Help-Seeking Attitudes

Hypothesis 1: The first hypothesis predicted that parents who endorsed more concerns about meeting with a mental health professional on the TAMHS-MC (total score) would have less positive attitudes toward seeking professional psychological help on the HS survey than parents who reported less concerns. First, for the purpose of this analysis, a principal components analysis of the HS-MC was conducted to compare the instruments' component structure with the 1-factor solution found for the ATSPPH-Short form (Fischer & Farina, 1995). To determine the factor structure of the HS-MC items, exploratory principal components analysis (PCA) was conducted with varimax rotation (Table 4 depicts the initial results from the PCA). While three components with eigenvalues greater than 1.0 were extracted based on Guttman's (1954) criteria on the use of eigenvalues for determining the number of factors to be extracted, the one component solution was retained because it was considered to be the most parsimonious (see Table 5). All items were retained in the one-component solution. In addition, the internal consistency of the Help-Seeking Survey was computed, judged to be satisfactory ($\alpha = .77$), and comparable to the alpha of the short form of the ATSPPH from which it was modified ($\alpha = .84$; Fischer & Farina, 1995).

To test Hypothesis 1, a simple regression was conducted. The findings supported the first hypothesis that parents' who reported having greater concerns about meeting with mental health professionals about their child had less favorable attitudes towards seeking help for their child's potential problems in living as compared to mothers who

reported having less concerns ($\beta = -.36$; $R^2 = .13$, $F(1, 104) = 15.21$, $p < .001$). The effect size for this regression analysis was small according to Cohen's (1992) criteria.

A speculation was also made that if Hypothesis 1 was supported, there would be a negative relationship between certain types of fears parents may have about mental health services and seeking professional psychological help for their young child. First, for the purpose of this analysis, a principal components analysis of the TAMHS-MC was conducted to compare the instruments' component structure with the 3-factor solution found for the TAPS (i.e., Therapist Responsiveness, Image Concerns, and Coercion Concerns; as derived from Kushner & Sher, 1989). To determine the factor structure of the TAMHS-MC items, exploratory principal components analysis (PCA) was conducted with varimax rotation. While four components with eigenvalues greater than 1.0 were extracted (Guttman's, 1954; see Table 4), the three-component solution was retained because it was the most parsimonious (see Table 6). All items were retained.

Previous research using the TAPS (see Appendix E) also reported a three-factor solution model similar to that of the TAMHS-MC. In fact, the component structure for the present sample was almost identical to the factor analysis conducted by Kushner and Sher (1989). For this reason, the original factor labels used in the TAPS (i.e., *Therapist Responsiveness*, *Image Concerns*, and *Coercion Concerns*, respectively) were retained. One difference that appeared between the current components and Kushner and Sher's factors included that Item #26 ("*Whether I will be pressured into talking about things I don't want to.*") loaded best on the Coercion Concerns component (component loading = .77) instead of the Image Concerns factor (component loading = .53) that Kushner and Sher found it to load on. It is worthy to note that two of the four items that loaded best on

the Coercion Concerns component for the current sample also began with the phrase "*Whether I will be pressured to....*" Because Item #26 appeared to reflect the conceptual meaningfulness of the Coercion Concerns component, it was retained in this component.

Reliability analyses of the TAMHS-MC yielded an alpha of .90 comparable to the alpha of the TAPS from which it was modified ($\alpha = .93$, Kushner and Sher, 1989; $\alpha = .94$, Cepeda-Benito & Short, 1998). Three scores were derived for each subject on the basis of the sum of the item scale responses they gave for each of the TAMHS-MC components. The internal consistency for each of its three components were also computed and judged to be satisfactory. Specifically, the Therapist Responsiveness component yielded an alpha of .89. The Image Concerns component yielded an internal consistency of .84, and the Coercion Concerns component yielded an alpha of .81. Previous research using the TAPS to measure adults' fears about psychological services in both clinical and nonclinical subjects reported higher measures of internal consistency for each factor ($\alpha = .92$ for Therapist Responsiveness, .87 for Image Concerns, and .88 for Coercion Concerns; Kushner & Sher, 1989).

The correlations among the three component scores were calculated for the sample. The intercorrelations were all significant and moderate—ranging from .32 (Therapist Responsiveness-Coercion) to .40 (Therapist Responsiveness-Image)—with the exception of Image and Coercion that correlated .61. Taken together, the three factors appear to be reasonably independent.

To test the speculation, a stepwise multiple regression was conducted on help-seeking attitudes to explore the relationship between Image Concerns, Coercion Concerns, and concerns about Therapist Responsiveness, and parents' attitudes toward

seeking professional psychological help for their child. The stepwise regression showed that only Image Concerns predicted parents' help-seeking attitudes ($\beta = -.40$, $R^2 = .16$, $F(1, 104) = 19.01$, $p < .001$). The effect size for this regression analyses was medium according to Cohen's (1992) criteria.

Hypothesis 2: The second hypothesis predicted parents who endorsed concealing personal and often distressing information about themselves (as evidenced by high scores on the SCS) would report having less favorable attitudes toward help-seeking for their child than parents who indicated concealing such information to a lesser degree. First, for the purpose of this analysis, a principal components analysis of the SCS was conducted to compare the instruments' component structure with the 1-factor solution found in past research (Larson & Chastain, 1990; Cramer & Barry, 1999). To determine the factor structure of the SCS items, exploratory principal components analysis (PCA) was conducted with a varimax rotation (Table 4 depicts the initial results from the PCA). While two components with eigenvalues greater than 1.0 were extracted (Guttman's, 1954), the one-component solution was the most parsimonious (see Table 7). All items were retained. The internal consistency of the SCS was computed and judged to be satisfactory ($\alpha = .85$). The internal consistency estimate for the current sample also was comparable to estimates found in previous research with adults ($\alpha = .83$, Larson & Chastain, 1990; .86 - .87 across two studies by Cramer & Barry, 1999; and .88, Cepeda-Benito & Short, 1998).

To test Hypothesis 2, a simple regression was conducted. The results supported Hypothesis 2 and showed that SCS scores predicted parents' help-seeking attitudes

($\beta = -.34$; $R^2 = .12$, $F(1, 105) = 13.74$, $p < .001$). The effect size for this regression analysis was small according to Cohen's (1992) criteria.

Hypothesis 3: The third hypothesis predicted that parents' SCS and TAMHS-MC scores would negatively predict their attitudes toward seeking professional psychological help on the HS survey. To test Hypothesis 3, a multiple regression analysis was conducted with the independent variables entered simultaneously.

Results of the multiple regression supported Hypothesis 3. The findings showed that the set of independent variables significantly predicted total help-seeking attitudes, $R^2 = .16$, $F(2, 104) = 9.52$, $p < .001$. Specifically, higher levels of self-concealment and greater concerns about meeting with a mental health professional, each uniquely contributed to the prediction of total help-seeking attitudes ($\beta = -.21$, $p < .05$ and $\beta = -.28$, $p < .01$, respectively). The effect size for this regression analysis was medium according to Cohen's (1992) criteria.

A speculation was also made that parents' degree of self-concealment and Image Concerns would predict parents' help-seeking attitudes. Image Concerns (IC) was included instead of any other concerns subscale because it was the only TAMHS-MC subscale to significantly predict parents' help-seeking attitudes. To test this speculation, SCS scores and IC scores were simultaneously entered into a multiple regression analysis.

The findings supported the speculation. Specifically, results of the multiple regression analysis showed that the set of independent variables predicted total help-seeking attitudes, $R^2 = .18$, $F(2, 104) = 10.95$, $p < .001$. However, only one variable,

Image Concerns, uniquely contributed to the prediction of help-seeking attitudes in this model, $\beta = -.33$, $p < .01$. The effect size for this regression analysis was medium according to Cohen's (1992) criteria.

Prediction of Parents' Thoughts about Mental Health Services

Hypothesis 4: The fourth hypothesis predicted that parents' SCS scores would predict their total TAMHS-MC scores. To test Hypothesis 4, a simple regression analysis was conducted. The findings supported Hypothesis 4 ($\beta = .29$; $R^2 = .09$, $F(1, 104) = 9.54$, $p < .01$). The effect size for this regression analysis was small according to Cohen's (1992) criteria.

A speculation was also made that self-concealment scores would predict different types of concerns parents might have about meeting with a mental health professional about their child. To test this speculation, three simple regression analyses were conducted to predict parents' scores on the Therapist Responsiveness (TR), Image Concerns (IC), and Coercion Concerns (CC) subscales. The simple regression analyses showed that self-concealment predicted parents' concerns about their image with regards to meeting with a mental health professional about their child's potential needs, ($\beta = .40$; $R^2 = .16$, $F(1, 104) = 19.82$, $p < .001$; medium effect size), and marginally predicted parents' concerns about being pressured to think or act differently, (CC; $\beta = .19$; $R^2 = .04$, $F(1, 104) = 3.99$, $p = .049$; small effect size). Self-concealment was not found to predict parents' concerns about Therapist Responsiveness.

DISCUSSION

A primary goal of the present study was to examine the relationship between parents' concerns about meeting with a mental health professional for their child and their help-seeking attitudes when their child's cognitive/emotional/social states would warrant it. Previously used surveys were modified to measure parents' attitudes toward help-seeking and concerns about seeking professional psychological care for their young child. A secondary goal of the study was to investigate the relationship between parents' self-concealment and help-seeking attitudes. In addition, the relationship between parents' self-concealment and concerns about meeting with a mental health professional was examined. These relations were examined in a community sample of mothers of young children enrolled in child-care development centers. While previous research has investigated parents' help-seeking attitudes, this is the first study to measure mothers' concerns about meeting with a mental health professional for their young child's possible (as compared to already existing) problems.

Prediction of Help-Seeking Attitudes by Treatment Fearfulness

As anticipated, mothers' who reported having greater concerns about meeting with a mental health professional for their child's potential problem(s) had less favorable attitudes towards seeking help as compared to mothers with less concerns. The current findings are in line with Kushner and Sher's (1991) research that college students' fears about assessment and/or psychotherapy, ranging from fears of embarrassment, stigma, change, to stereotypes they may proscribe to mental health service providers and various

types of assessment and treatment negatively predict their help-seeking attitudes. One possible explanation includes that parents' "subjective state of apprehension arising from aversive expectations surrounding the seeking and consuming of mental health services (p.251, definition of treatment fearfulness; Kushner & Sher, 1989)" influence their help-seeking attitudes to be unfavorable in order to possibly decrease the likelihood of their seeking help. For example, prior research has found that adults with unfavorable attitudes toward psychotherapy report a smaller willingness to seek help (e.g., Deane & Todd, 1996; Deane & Chamberlain, 1994; Leaf & Bruce, 1987). The current finding should be interpreted while keeping in mind that the research survey presented the participants with the help-seeking attitudes scale first, followed by the concerns about meeting with mental health professionals scale, and the self-concealment scale last. Moreover, given the high face validity of the help-seeking attitudes scale, and that parental help-seeking attitudes are quite difficult to measure due to the influence of social desirability, these results are significant with possible overestimates of mothers' favorable help-seeking attitudes.

The second regression analysis was conducted using separate subscales of the TAMHS-MC measure in an effort to determine which specific components may influence mothers' attitudes toward seeking help for their child's possible problems in living. Only the Image Concerns subscale predicted mothers' help-seeking attitudes. These items reflect mothers' concerns of being judged negatively by themselves and/or others (friends and/or mental health professionals) for seeking help (e.g., "Whether I will learn things about myself I don't really want to know," "Whether my friends will think I'm abnormal for coming," "Whether the mental health professional will think that I'm

disturbed."). The current finding is in line with Hornblow's (1990) research that found adults reported image concerns (e.g., fears of what others would think) as a reason why they did not see a health professional for their mental health needs even when they or someone in their family believed they should have. The study's results also correspond with Farina's (1982) research that found fears concerning stigmatization and receiving negative feedback from friends and family members to be two attitudinal barriers adults reported regarding their seeking help for their own mental health needs. Because of the personal involvement of parents in accessing and maintaining contact with formal mental health care for their children, it is not surprising that mothers' concerns about their image predicted their help-seeking attitudes in the current study.

A possible explanation for the significant predictive effect of mothers' image concerns includes that for some parents the belief that their parenting/mental health status may be called into question by their help-seeking behavior may result in their choosing to not take actions that would negatively alter their current self-image or desired presentation to others. On the other hand, a mother who is less concerned about the imagined and/or actual influence of others' perspectives on her image may find the same cognition to be less threatening to her SELF-regard. Moreover, a mother who is less occupied with her self-regard may be able to acknowledge feedback (i.e., negative information) from a mental health professional with less difficulty than mothers who report more concerns about their image.

It was thought that parents' concerns about the competence and professionalism of mental health professionals as well as parents' fear of having to change may negatively predict parents' help-seeking attitudes. The present findings did not support this

speculation for Coercion Concerns (i.e., fear of change) or Therapist Responsiveness (therapist competence and professionalism). An explanation for the non-significant findings may include the possibility that parents' concerns about the mental health professional and the process of mental health assistance (their active vs. passive involvement towards change) may play a role *after* parents have decided to seek help. That is, after they have already weighed the imagined effect their help-seeking behavior could have on their image. Because mental health professionals often offer parents alternative perspectives on parenting and recommend/require parents' involvement in their young child's treatment, a more intensive investigation of the role parents' perceptions of the process of mental health assistance play on their help-seeking attitudes is warranted.

The extent to which mothers' self-concealment influences their attitudes toward seeking help for their child's possible problems in living was examined. As hypothesized, mothers who reported a greater tendency to self-conceal rated themselves as having less favorable help-seeking attitudes than mothers who reported less of a tendency to self-conceal. Approximately 12% of the variance in attitudes was accounted for by mothers' self-concealment. These results are in line with previous reports (Kelly & Achter, 1995) that revealed a statistically significant negative predictive effect between self-concealment and attitudes toward help-seeking in college students. One possible explanation as suggested by Kelly and Achter (1995) is that individuals may fear that meeting with a mental health professional may require them to reveal "their innermost thoughts."

The present finding that parents' self-concealment negatively predicted their help-seeking attitudes also corresponds with research by Pavuluri, Luk, & McGee (1996) that found parents reported components of self-concealment (namely, that they hated to answer personal questions and were too embarrassed to discuss their child's problems) as reasons why they did *not* seek help for their young child despite their recognition of a need. Hornblow et al.'s (1990) research also found that adults indicated their decision to not seek help for their mental health needs was influenced by their concerns about having to discuss interpersonally sensitive information with another person (e.g., "too embarrassed to discuss it with anyone;" "hated answering personal questions"). Given these findings, more research is needed to understand the nature and content of the "secrets" mothers actively withhold.

As anticipated, parents' propensity to self-conceal along with their overall concerns about mental health services simultaneously predicted their help-seeking attitudes in an additive model. Together, parents' treatment fearfulness and self-concealment scores accounted for 16% of the variance in help-seeking attitudes. In addition, because image concerns was the only component of treatment fearfulness that independently predicted parents' help-seeking attitudes in the current sample, a follow-up analysis was conducted to determine the combined influence of self-concealment and image concerns in the prediction of help-seeking attitudes. Both independent variables were found to significantly predict parents' help-seeking attitudes.

Prediction of Parents' Thoughts about Mental Health Services

The relationship between parents' self-concealment and parents' treatment fearfulness was examined. As anticipated, parents' propensity to self-conceal positively

predicted their concerns about meeting with a mental health professional about their child's possible mental health needs. Specifically, mothers who indicated they had a high propensity to self-conceal also reported having greater overall concerns about meeting with a mental health professional about their child's possible mental health problems. This finding may reflect the role of self-concealment in increasing mothers' distrust about the process of seeking formal mental health care assistance for their child. In addition, the relationships between parents' self-concealment and concerns about their image, fear of coercion, and mental health professionals' competence were explored. As anticipated, parents who preferred to conceal personal and often distressing information about themselves reported more concerns about how their therapist and others may view them (i.e., Image Concerns). This was expected because the concept of self-concealment reflects one's concerns about protecting his/her self-image and mothers who actively withhold "secrets" would be more likely to be concerned about how others' perspectives may change about their regard due to their seeking help.

It was also expected that parents who preferred to actively withhold "secrets" would report more concerns about being pressured into doing things or speaking about distressing topics (Coercion Concerns) in a meeting with a mental health professional for their child. As hypothesized, mothers with greater tendencies to self-conceal reported having more fears about being pressured to talk about and/or act in ways that they would not want to. Mothers with high self-concealment may feel insecure about meeting with a mental health professional for fear that their tendency to withhold "secrets" will be challenged to such an extent that they will feel vulnerable and coerced. It is important to consider that the predictive significance of self-concealment on parents' treatment

fearfulness bordered on marginal ($p = .049$). This may be a result of a lack of variability in the current sample possibly due to the current sample size.

Self-concealment was not found to predict parents' concerns about therapist responsiveness/competence. One possible explanation is that the items that comprise therapist responsiveness (e.g., "Whether the mental health professional will be honest with me," "Whether the mental health professional will understand my child's or my concerns about my child's problem(s)," "Whether the mental health professional will be competent to address the problem.") do not reflect the construct of self-concealment. Another explanation may be that the current sample lacked adequate variability to comprehensively examine the predictive effect of self-concealment on parents' treatment fearfulness.

Limitations of This Research

Several weaknesses of the current study should be noted. A central limitation of this study was that self-report measures that are subject to the response sets of individuals completing the forms were used. It is important to note, however, that mothers with high concealment or many concerns about their self-regard may not have been truthful about their responses to the survey because of the items' personal focus and high face validity. That is, mothers' tendency to conceal personal information may have included their reporting more favorable beliefs about help-seeking for their child for fear that their responses could be judged negatively. In addition, the face validity of the help-seeking survey and the concerns about mental health services was very high and may have activated participants' tendency to conceal information.

The study measures were also limited in several ways. This was the first study where the HS-MC and the TAMHS-MC were used in measuring parents' help-seeking attitudes and concerns about meeting with a mental health professional for their very young child. Also, only the report of a single informant (the child's mother) was used. Questionnaires did not obtain information on insurance, which may determine access to mental health professionals and parents' views on the helpfulness of assessment/treatment. Parents' report of their children's current functioning and prior use of mental health services were also not assessed. Parents' own past or present experiences with mental health services as well as their mental health status were also not obtained, which may influence parents' reports of concerns about meeting with mental health professionals and their overall help-seeking attitudes. Both young children's and their parents' social network was not assessed, which may influence parents' attitudes about seeking informal support for their child's mental health needs instead of formal care. In addition, the current study was unable to adequately determine how many of the children of these parents had a cognitive/emotional/social/behavior problem, at least from the parent's perspective, at the time of the study.

Because the current sample was fairly homogenous in terms of its participants' demographics, it was impossible to explore more complex biases in parents' help-seeking attitudes and concerns about meeting with mental health professionals. It was thought that the little variability evident in the demographics may be partially explained by the location of the child development centers from which participants were recruited (all within a 5 mile radius of a large Midwestern university). With respect to the correlation analyses performed in this study, the interpretation of a significant result for any

individual variable should be made cautiously because no correction for error rate was made.

Directions for Future Research

The findings highlight the need to further address parents' help-seeking attitudes for their young children's needs in the context of their personal concerns about meeting with a mental health professional and their level of self-concealment. While research has suggested that parents fear their children may experience emotional or social effects as a result of being labeled with a diagnosis and/or medicated (e.g., experience stigma; Staggers, 1987), the impact of parents' fears of being labeled themselves on their help-seeking attitudes has not received the same attention in the research literature. Future research should further examine multiple possible contributors affecting parents' personal concerns about seeking help for their child. First, it is possible that a mother who is afraid of how others' perspective of her could change may be inclined to keep her concerns to herself until they worsen to a point of despair before consulting with a mental health professional. Consequently, the increased severity of her child's problems could warrant additional therapy, heightened costs, decreased parental empowerment, and damage to the mother-child relationship. Future research should address the question of whether young children's continuing symptomatology leads to escalating image concerns for parents.

The impact of contextual characteristics such as mothers' social support network and number of life events should also be examined with regard to mothers' help-seeking attitudes. Previous research has found that both variables are related to positive change

in the social-emotional and/or cognitive functioning of children between the ages of 4 and 13 years of age (at high risk for behavioral, adjustment, and psychiatric problems; Seifer, Sameroff, Baldwin, & Baldwin, 1992). A mother's social support network could also be severely limited if she were concerned about being judged differently for seeking help. As a result, mothers could feel lonely and hopeless about successfully dealing with their children's problems without the necessary or desired level of assistance.

Parents' image concerns coupled with the absence of others' help could adversely affect children's independent symptom reporting later in life. That is, children whose problem behavior or thoughts have not been attended to may learn to monitor their feelings/experiences less closely, and may disregard psychological and psychophysiological arousal/symptoms that may imply an increase in the risk of their problems worsening; thus, increasing their vulnerability. Parents who have not modeled a mind-body monitoring orientation for their children may subsequently fail to empower their children about their own mental health. Specifically, children may not learn how to identify, define, and respond appropriately to their internal feelings of psychological distress (e.g., seeking informal and/or formal help; Barnett et al., 1990).

Future research should examine the relationship between parents' help-seeking attitudes for their personal mental health needs and their attitudes toward seeking help for their child's difficulties in living. Parents who have favorable attitudes toward seeking help for their own problems in living may be more likely to view mental health professionals as sources of assistance for their children. Investigating parents' mental health status is also important from the standpoint that high rates of maternal depressed mood have been found to be risk factors associated with behavior disorder in children

(Pavuluri, Luk, Clarkson, & McGee, 1995; Seifer, Sameroff, Baldwin, & Baldwin, 1992; Egeland, Kalkoske, Gottesman, & Erikson, 1991). To assess if the current instruments can distinguish between clinical and non-referred parents, future research should include comparable numbers of both cases to examine each instrument's ability to discriminate based on parents' help-seeking attitudes and concerns about mental health services.

A future direction of research could involve the inclusion of low-income parents because low-income has been found to be associated with preschool behavior problems (Feehan et al., 1990; Jensen et al., 1990; Pavuluri et al., 1995). In addition, examining low-income parents' attitudes toward help-seeking may be even more important because their limited resources (e.g., financial constraints coupled with limited or no health insurance) may make them even less likely to seek formal mental health care for their child. There is also the fact that the largest number of young children in day care outside the home are in the homes of relatives and friends of the parents. A large majority of these parents may also be low-income and many may have differing attitudes about other's involvements in their own and their children's lives.

Further investigation of parents' concerns about their image should also be conducted in relation to parents' sharing their concerns about their child's mental health needs with their pediatricians. For example, parents may also fear that pediatricians will judge them negatively when their child has behavioral/emotional/cognitive problems. Investigating parents' concerns about consulting with their pediatrician about their child's difficulties is important because previous research has found that the likelihood of children's behavior problems being identified increased dramatically (i.e., thirteen times more) when parents consulted with their pediatricians (Dulcan et al., 1990). In addition,

consulting with a pediatrician about a child's difficulties in living before meeting with a mental health professional allows parents the opportunity to ask questions and obtain validation of their concerns. A close relationship between pediatricians and parents also affords pediatricians the chance to discuss with parents what some of their concerns may be about seeking formal mental health care.

In the current study, actual parent help-seeking behavior was not examined. Future researchers should include assessments of actual parent behaviors (retrospective) because the nature of the relationship between the measures used in this study and parents' actual help-seeking behavior has not been investigated. Future researchers should also attempt to replicate the findings with samples of parents from a variety of socio-cultural backgrounds in order to examine the modified instruments' factor structure, validity, and test-retest reliability.

The combined effect of assessing help-seeking attitudes of both parents or guardians as well as their mental health functioning rather than one in isolation may assist in a more effective identification of the process of help-seeking. It is important to study fathers to see if Fischer and Turner's (1970) finding that women have more positive attitudes toward seeking psychological help apply in the context of seeking help for one's child. Future research may also include each parent completing the instruments for themselves and for their significant other in order to examine how their partner's rating corresponds with their self-rating. Composite family scores on help-seeking attitudes and concerns about mental health professionals may also be interesting to research.

Due to the important interface role that parents play in their child's mental health care delivery, investigating the degree to which parents' self-concealment affects their

help-seeking is important because parents who actively conceal information may hinder the course of their child's assessment and/or treatment. For example, parents may keep secrets from the mental health professional in regards to physical/emotional/sexual abuse for fear of losing their child to social services. In this regard, the commitment of parents who are high self-concealers in participatory interventions (e.g., filial therapy) may also be negatively influenced. Moreover, the relationship between self-concealment and fathers' help-seeking attitudes as well as concerns about meeting with a mental health professional should be examined.

Future studies should also assess parents' levels of anxiety both before and after meeting with a mental health professional to examine the relationship between parents' reported concerns about meeting with a mental health professional and their levels of anxiety (state and trait). It may be possible that parents' who report many concerns about meeting with a mental health professional may report higher anxiety levels than their counterparts. These questions could be addressed in a naturalistic setting involving parents who are prescreened for their anxiety levels as well as their tendency to self-conceal. Mental health professionals could then use their knowledge of parents' pre-meeting anxiety and tendency to self-conceal in their assessment of young children's mental health problems.

Conclusion

The recognition of a child's problem does not in and of itself dictate that a parent will seek help (from formal or informal sources) despite an increase in their child's and/or their own distress. In order for parents to seek help for their child they must also view

mental health professionals as viable sources of support and assistance. Investigating factors that affect parents' attitudes toward seeking psychological help for their young child may lend itself to the creation of preventive services, and interventions that increase parents' help-seeking behavior from formal sources of care. In addition, such factors could aid in decreasing dropout rates among parents of young children. The present study significantly contributes to the dearth of research of parents' help-seeking attitudes for their young children's needs. Moreover, it highlights the importance of considering parents' self-concealment, and treatment fearfulness as important variables in the study of parental help-seeking.

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TABLES

TABLE 1:
Sample Sociodemographic Characteristics

Table 1
Sample Sociodemographic Characteristics

Variable	Mothers (n = 106)	Fathers (n=18)
Parent's Age (Years)		
Mean (S.D.)	34.41 (5.57)	37.00 (5.65)
Parent's Ethnicity	% (n)	% (n)
Caucasian/Non-Hispanic	86.8 (92)	66.7 (12)
African-American/Non-Hispanic	1.9 (2)	33.3 (6)
Hispanic/Latino	1.9 (2)	0.0
Asian-American/Asian/Japanese	7.5 (8)	0.0
Other	1.9 (2)	0.0
Marital Status		
Single	3.8 (4)	0.0
Unmarried but Living with Partner	1.9 (2)	0.0
Married	87.7 (93)	88.9 (16)
Divorced, Not Married	.9 (1)	11.1 (2)
Divorced, Married Again	3.8 (4)	0.0
Divorced, Living w/Partner	1.9 (2)	0.0
Education		
Some High School or Less	0.0	0.0
High School Graduate	0.9 (1)	0.0
Some College or Technical School	15.1 (16)	11.1 (2)
College or Technical School Graduate	37.7 (40)	27.8 (5)
Professional/Graduate Degree	46.2 (49)	61.1 (11)
Spouse/Partner's Education		
Some High School or Less	0.0	0.0
High School Graduate	2.0 (2)	0.0
Some College or Technical School	11.9 (12)	12.5 (2)
College or Technical School Graduate	26.7 (27)	50.0 (8)
Professional/Graduate Degree	59.4 (60)	37.5 (6)
Income		
< \$10,000	4.8 (5)	11.1 (2)
\$10,000 to \$30,000	5.7 (6)	22.2 (4)
\$30,000 to \$60,000	29.5 (31)	5.6 (1)
\$60,000 to \$100,000	37.1 (39)	38.9 (7)
> \$100,000	22.9 (24)	22.2 (4)

Table 1 (cont'd).

Variable	Mothers (n = 106) % (n)	Fathers (n=18) % (n)
Current Occupation¹		
Corporate/Government/College Professors	18.1 (19)	56.3 (9)
Middle Managers/Independent Business	26.7 (28)	31.3 (5)
Teachers/Skilled Labor/Real Estate Sales	8.6 (9)	0.0
Factory/General Sales/Office Work	13.3 (14)	6.3 (1)
Homemaker	29.5 (31)	6.3 (1)
Student/Graduate Student	3.8 (4)	0.0
Spouse/Partner's Occupation¹		
Corporate/Government/College Professors	48.0 (47)	31.3% (5)
Middle Managers/Independent Business	37.8 (37)	31.3% (5)
Teachers/Skilled Labor/Real Estate Sales	7.1 (7)	0.0
Factory/General Sales/Office Work	5.1 (5)	0.0
Homemaker	0.0	31.3 (5)
Student/Graduate Student	2.0 (2)	6.3 (1)
Residence²		
Population > 120,000	23.6 (25)	27.8 (5)
Population > 50,000	43.4 (46)	50.0 (9)
10,000 - 20,000 people	24.5 (26)	22.2 (4)
2,000 - 8,000 people	8.5 (9)	0

¹ Occupation Scale.² Population Data Obtained from 1990 Census.

TABLE 2:
Demographic Characteristics of Children

Table 2
Demographic Characteristics of Children

Variable	Mothers (n = 106)	Fathers (n=18)
Age of Child (Months)		
Mean (S.D.)	43.68 (16.67)	51.22 (11.71)
Gender of Child	<u>% (n)</u>	<u>% (n)</u>
Female	50.5 (53)	29.4 (5)
Male	49.5 (52)	66.7 (12)
Number of Child's Siblings		
None	37.7 (40)	33.3 (6)
1	36.8 (39)	55.6 (10)
2	20.8 (22)	5.6 (1)
3	4.7 (5)	5.6 (1)

TABLE 3:

Inter-scale Correlations among Predictors, and Reliabilities for Mothers only

Table 3
Inter-scale Correlations among Predictors, and Reliabilities for Mothers only

Inter-scale correlations among TAMHS-MC and SCS, and Reliabilities

Variable	1	2	α
1. TAMHS-MC (total thoughts)	—	.29**	.90
2. Self-concealment (SCS scale)		—	.85

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

Note. TAMHS-MC = 17-item *Thoughts About Mental Health Services-My Child* Survey (Sum of scores on subscales: Therapist Responsiveness, Image Concerns, & Coercion Concerns).

Self-Concealment = 10-item Self-Concealment Survey.

Inter-scale correlations among TAMHS-MC Components and SCS, and Reliabilities

Variable	1	2	3	4	α
1. Therapist responsiveness (TAMHS subscale)	—	.40***	.32**	.11	.89
2. Image concerns (TAMHS subscale)		—	.61***	.40***	.84
3. Coercion concerns (TAMHS subscale)			—	.19* ($p = .049$)	.81
4. Self-concealment (SCS scale)				—	.85

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

Note. Therapist Responsiveness = 6-item subscale of TAMHS-MC.

Image Concerns = 7-item subscale of TAMHS-MC.

Coercion Concerns = 4-item subscale of TAMHS-MC.

Self-Concealment = 10-item Self-Concealment Survey.

TABLE 3b:

Means and Standard Deviations of Measures for Mothers only

Table 3b
Means and Standard Deviations of Measures for Mothers only

Variable	<i>M</i>	<i>SD</i>	n
1. Help-Seeking Attitudes	36.72	4.92	106
2. TAMHS-MC (total concerns)	42.27	13.20	105
3. Therapist responsiveness (TAMHS subscale)	19.54	7.23	105
4. Image concerns (TAMHS subscale)	14.10	5.78	105
5. Coercion concerns (TAMHS subscale)	8.62	3.61	105
6. Self-concealment (SCS scale)	21.24	7.14	106

Note. Help-Seeking Attitudes = 10-item *Help-Seeking Survey-My Child*.
TAMHS-MC = 17-item *Thoughts About Mental Health Services-My Child* Survey
(Sum of scores on subscales: Therapist Responsiveness, Image Concerns,
& Coercion Concerns).
Therapist Responsiveness = 6-item subscale of TAMHS-MC.
Image Concerns = 7-item subscale of TAMHS-MC.
Coercion Concerns = 4-item subscale of TAMHS-MC.
Self-Concealment = 10-item Self-Concealment Survey.

Table 4:

Initial Results from Unrotated Principal Components Analysis for each Measure

Table 4

Initial Results from Unrotated Principal Components Analysis for each Measure^a:

1. Help-Seeking Survey-My Child (HS-MC):

	Initial Eigenvalues		
Component	Total	% of Variance	Cumulative %
1	4.015	36.503	36.503
2	1.383	12.571	49.074
3	1.006	9.143	58.217
4	.904	8.222	66.439

2. Thoughts about Mental Health Services-My Child (TAMHS-MC):

	Initial Eigenvalues		
Component	Total	% of Variance	Cumulative %
1	6.609	38.876	38.876
2	2.719	15.992	54.868
3	1.263	7.430	62.298
4	1.067	6.275	68.573
5	.902	5.304	73.877

3. Self-Concealment Survey (SCS):

	Initial Eigenvalues		
Component	Total	% of Variance	Cumulative %
1	4.392	43.924	43.924
2	1.285	12.851	56.775
3	.912	9.116	65.891

^a Only Components with Eigenvalues $\geq .90$ are shown here.

Table 5:

Principal Components of the “Help-Seeking-My Child Survey (HS-MC)”

Table 5
Principal Components of the Help-Seeking-My Child (HS-MC)

Items Used to Form Component 1	Component 1
1. Considering the time and expense involved in getting help from a mental health professional, it would have doubtful value for a child of mine.	.82
2. A child's cognitive/emotional/social difficulties, like many things, tend to work out by themselves.	.80
3. If I believed my child was having a cognitive/emotional/social "breakdown," my first inclination would be to get help from a mental health professional.	.74
4. A child with a cognitive/emotional/social problem is not likely to solve it alone; he or she is likely to solve it with help from a mental health professional.	.69
5. I would want to get help from a mental health professional for my child if I were worried or upset about him or her for a long period of time.	.68
6. The idea of talking about my child's problems with a mental health Professional strikes me as a poor way to get rid of my child's cognitive/emotional/social conflicts.	.54
7. If my child were experiencing a serious cognitive/emotional/social crisis at this point in his or her life, I would be confident that he or she could find relief with help from a mental health professional.	.42
8. There is something admirable in the attitude of a parent who is willing to cope with his or her child's conflicts and fears <i>without</i> resorting to getting help from a mental health professional.	.41
9. I might want my child to have help from a mental health professional in the future.	.38
10. A child should work out his or her own cognitive/emotional/social problems; getting help from a mental health professional would be a last resort.	.37
11. A parent should be able to work out his or her child's cognitive/emotional/social problems; getting help from a mental health professional would be a last resort.	.30

Table 6:
Principal Components of the
“Thoughts About Mental Health Services - My Child (TAMHS-MC)”

Table 6

Principal Components of the *Thoughts About Mental Health Services - My Child* (TAMHS-MC)

Items Used to Form Component 1	Component 1	Component 2	Component 3
14. Whether the mental health professional will take my child's or my concerns about my child's problem(s) seriously.	.89	.20	.14
13. Whether the mental health professional will be honest with me.	.89	.13	.15
15. Whether everything I say to the mental health professional will be kept confidential.	.79	.27	.06
12. Whether I'll be treated as a person by the mental health professional.	.78	.06	.25
17. Whether the mental health professional will understand my child's or my concerns about my child's problem(s).	.73	.35	.06
23. Whether the mental health professional will be competent to address the problem.	.57	-.14	-.03
Items Used to Form Component 2	Component 1	Component 2	Component 3
19. Whether the mental health professional will think that I'm disturbed.	.26	.72	.28
16. Whether the mental health professional will think I'm a bad person if I talk about everything I have been thinking and feeling.	.37	.71	.13
20. Whether the mental health professional will find out things I don't want him/her to know about me and my life.	.17	.71	.40
18. Whether my friends will think I'm abnormal for coming.	-.02	.71	.38
28. The thought of seeing a mental health professional would cause me to worry, experience nervousness or feel fearful in general.	.06	.70	.03
22. Whether I'll lose control of my emotions while I'm with the mental health professional.	-.02	.50	.42
21. Whether I will learn things about myself I don't really want to know.	.11	.48	.43

Table 6 (cont'd).

Items Used to Form Component 3	Component 1	Component 2	Component 3
25. Whether I will be pressured to make changes in my lifestyle that I feel unwilling or unable to make right now.	.12	.14	.82
26. Whether I will be pressured into talking about things I don't want to.	.10	.30	.77
24. Whether I will be pressured to do things in assessment/counseling/psychotherapy I don't want to do.	.23	.18	.71
27. Whether I will end up changing the way I think or feel about things and the world in general.	.03	.20	.70

Note: Items 18, 21, and 25 through 27 were identical to their correlates in the TAPS instrument (Kushner & Sher, 1989). All other items were modified.

Table 7:
Principal Components of the “Self-Concealment Survey (SCS)”

Table 7
Principal Components of the *Self-Concealment Survey (SCS)*

Items Used to Form Component 1	Component 1
37. My secrets are too embarrassing to share with others.	.80
36. I have a secret that is so private I would lie if anybody asked me about it.	.76
29. I have an important secret that I haven't shared with anyone.	.75
30. If I shared all my secrets with my friends, they'd like me less.	.72
32. Some of my secrets have really tormented me.	.69
38. I have negative thoughts about myself that I never share with anyone.	.65
34. I'm often afraid I'll reveal something I don't want to.	.63
31. There are lots of things about me that I keep to myself.	.56
35. Telling a secret often backfires and I wish I hadn't told it.	.52
33. When something bad happens to me, I tend to keep it to myself.	.47

APPENDICES

APPENDIX A

Help-Seeking (HS)

Help-Seeking (HS)

Directions. Below are a number of statements pertaining to children's psychological and mental health issues. Some statements refer to your opinions about children in general, and others refer to your young child, specifically. Read each statement carefully and indicate your opinion about each. There are no "wrong" answers, and the only right ones are whatever you honestly feel or believe. It is important that you answer every item.

Please note the phrase "mental health professional" in some of the items below refers to the people who have a license from the state to practice including: **psychologists** (e.g., clinical, counseling, educational, or school), **psychiatrists**, **social workers** (e.g., clinical, psychiatric, or pediatric), **marriage and family therapists**, or **counselors** (school or vocational). Please also note that the phrase "help" in some of the items below refers to assessment, counseling or psychotherapy provided by a mental health professional.

Please indicate how much you agree with each of the following statements by choosing a number from the scale below and darkening its circle to the left of each item.

1	2	3	4
Disagree	Partly Disagree	Partly Agree	Agree

Items:

- ① ② ③ ④ 1. Considering the time and expense involved in getting help from a mental health professional, it would have doubtful value for a child of mine. (*reverse scored*)
- ① ② ③ ④ 2. A child's cognitive/emotional/social difficulties, like many things, tend to work out by themselves. (*reverse scored*)
- ① ② ③ ④ 3. If I believed my child was having a cognitive/emotional/social "breakdown," my first inclination would be to get help from a mental health professional.
- ① ② ③ ④ 4. A child with a cognitive/emotional/social problem is not likely to solve it alone; he or she is likely to solve it with help from a mental health professional.
- ① ② ③ ④ 5. I would want to get help from a mental health professional for my child if I were worried or upset about him or her for a long period of time.
- ① ② ③ ④ 6. The idea of talking about my child's problems with a mental health professional strikes me as a poor way to get rid of my child's cognitive/emotional/social conflicts. (*reverse scored*)

- ① ② ③ ④ 7. If my child were experiencing a serious cognitive/emotional/social crisis at this point in his or her life, I would be confident that he or she could find relief with help from a mental health professional.
- ① ② ③ ④ 8. There is something admirable in the attitude of a parent who is willing to cope with his or her child's conflicts and fears *without* resorting to getting help from a mental health professional. (*reverse scored*)
- ① ② ③ ④ 9. I might want my child to have help from a mental health professional in the future.
- ① ② ③ ④ 10. A child should work out his or her own cognitive/emotional/social problems; getting help from a mental health professional would be a last resort. (*reverse scored*)
- ① ② ③ ④ 11. A parent should be able to work out his or her child's cognitive/emotional/social problems; getting help from a mental health professional would be a last resort. (*reverse scored*)

APPENDIX B

Attitudes Toward Seeking Professional Psychological Help (ATSPPH-Short Form; Fischer & Farina, 1995)

Attitudes Toward Seeking Professional Psychological Help (ATSPPH-Short Form)
(Fischer & Farina, 1995)

1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.
2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts. (*reverse scored*)
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.
4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help. (*reverse scored*)
5. I would want to get psychological help if I were worried or upset for a long period of time.
6. I might want to have psychological counseling in the future.
7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.
8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me. (*reverse scored*)
9. A person should work out his or her own problems; getting psychological counseling would be a last resort. (*reverse scored*)
10. Personal and emotional troubles, like many things, tend to work out by themselves. (*reverse scored*)

APPENDIX C

The Attitudes Toward Seeking Professional Psychological Help (ATSPPHS; Fischer and Turner, 1970)

The Attitudes Toward Seeking Professional Psychological Help
(ATSPPHS; Fischer & Turner 1970)

Below are a number of statements pertaining to psychology and mental health issues. Read each statement carefully and indicate your agreement, probable agreement, probable disagreement, or disagreement. Please express your frank opinion in rating the statements. There are no “wrong” answers, and the only right ones are whatever you honestly feel or believe. It is important that you answer every item.

1. Although there are clinics for people with mental troubles, I would not have much faith in them. (*reverse scored*)
2. If a good friend asked my advice about a mental problem, I might recommend that he see a psychiatrist.
3. I would feel uneasy going to a psychiatrist because of what some people would think. (*reverse scored*)
4. A person with a strong character can get over mental conflicts by himself, and would have little need of a psychiatrist. (*reverse scored*)
5. There are times when I have felt completely lost and would have welcomed professional advice for a personal or emotional problem.
6. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me. (*reverse scored*)
7. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.
8. I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric treatment. (*reverse scored*)
9. Emotional difficulties, like many things, tend to work out by themselves. (*reverse scored*)
10. There are certain problems which should not be discussed outside of one's immediate family. (*reverse scored*)
11. A person with a serious emotional disturbance would probably feel most secure in a good mental hospital.
12. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.

13. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns. (*reverse scored*)
14. Having been a psychiatric patient is a blot on a person's life. (*reverse scored*)
15. I would rather be advised by a close friend than by a psychologist, even for an emotional problem.
16. A person with an emotional problem is not likely to solve it alone; he *is* likely to solve it with professional help.
17. I resent a person--professionally trained or not--who wants to know about my personal difficulties. (*reverse scored*)
18. I would want to get psychiatric attention if I was worried or upset for a long period of time.
19. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.
20. Having been mentally ill carries with it a burden of shame. (*reverse scored*)
21. There are experiences in my life I would not discuss with anyone.
(*reverse scored*)
22. It is probably best not to know *everything* about oneself. (*reverse scored*)
23. 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.
24. There is something admirable in the attitude of a person who is willing to cope with his conflicts and fears *without* resorting to professional help.
(*reverse scored*)
25. At some future time I might want to have psychological counseling.
26. A person should work out his own problems; getting psychological counseling would be a last resort. (*reverse scored*)
27. Had I received treatment in a mental hospital, I would not feel that it ought to be "covered up."
28. If I thought I needed psychiatric help, I would get it no matter who knew about it.
29. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen. (*reverse scored*)

APPENDIX D

“Thoughts about Mental Health Services-My Child (TAMHS-MC)”

TAMHS-MC

Directions. Sometimes parents meet with mental health professionals about their child's problems both during assessment and/or as part of the treatment (e.g., parent guidance meetings with or without your child present). Please think about *how concerned you would be* about each of the following things if you were going to meet with a mental health professional at some point in time about a potential cognitive/emotional/behavioral problem your young child might be having.

Please indicate how concerned you would be with each of the following things by choosing a number from the scale below and darkening its circle to the left of each item.

1	2	3	4	5
No Concern	Somewhat Unconcerned	Neither Concerned Nor Unconcerned	Somewhat Concerned	Very Concerned

- ① ② ③ ④ ⑤ 1. Whether I'll be treated as a person by the mental health professional.
- ① ② ③ ④ ⑤ 2. Whether the mental health professional will be honest with me.
- ① ② ③ ④ ⑤ 3. Whether the mental health professional will take my child's or my concerns about my child's problem(s) seriously.
- ① ② ③ ④ ⑤ 4. Whether everything I say to the mental health professional will be kept confidential.
- ① ② ③ ④ ⑤ 5. Whether the mental health professional will think I'm a bad person if I talk about everything I have been thinking and feeling.
- ① ② ③ ④ ⑤ 6. Whether the mental health professional will understand my child's or my concerns about my child's problem(s).
- ① ② ③ ④ ⑤ 7. Whether my friends will think I'm abnormal for coming.
- ① ② ③ ④ ⑤ 8. Whether the mental health professional will think that I'm disturbed.
- ① ② ③ ④ ⑤ 9. Whether the mental health professional will find out things I don't want him/her to know about me and my life.
- ① ② ③ ④ ⑤ 10. Whether I will learn things about myself I don't really want to know.
- ① ② ③ ④ ⑤ 11. Whether I'll lose control of my emotions while I'm with the mental health professional.

- ① ② ③ ④ ⑤ 12. Whether the mental health professional will be competent to address the problem.
- ① ② ③ ④ ⑤ 13. Whether I will be pressured to do things in assessment/counseling/psychotherapy I don't want to do.
- ① ② ③ ④ ⑤ 14. Whether I will be pressured to make changes in my lifestyle that I feel unwilling or unable to make right now.
- ① ② ③ ④ ⑤ 15. Whether I will be pressured into talking about things I don't want to.
- ① ② ③ ④ ⑤ 16. Whether I will end up changing the way I think or feel about things and the world in general.
- ① ② ③ ④ ⑤ 17. The thought of seeing a mental health professional would cause me to worry, experience nervousness or feel fearful in general.

APPENDIX E

Factors of the Thoughts About Psychotherapy Survey (TAPS; Kushner & Sher, 1989)

Factors of the Thoughts About Psychotherapy Survey
(TAPS; Kushner & Sher, 1989)

<u>Factor 1: Therapist Responsiveness:</u>	<u>Loading</u>	<u>$\alpha = .92$</u>
Whether the therapist will take my problem seriously	.81	
Whether the therapist will be honest with me	.80	
Whether everything I say in therapy will be kept confidential	.71	
Whether the therapist will understand my problem	.71	
Whether I'll be treated as a person in therapy	.70	
Whether the therapist will be competent to address my problem	.70	
<u>Factor 2: Image Concerns:</u>	<u>Loading</u>	<u>$\alpha = .87$</u>
Whether the therapist will find out things I don't want him/her to know about me and my life	.70	
Whether the therapist will think that I'm more disturbed than I am	.64	
Whether I will learn things about myself I don't really want to know	.61	
Whether the therapist will think I'm a bad person if I talk about everything I have been thinking and feeling	.57	
Whether my friends will think I'm abnormal for coming	.57	
Whether I will be pressured into talking about things I don't want to	.53	
Whether I'll lose control of my emotions while in therapy	.51	
The thought of seeing a therapist would cause me to worry, experience nervousness or feel fearful in general	.51	
<u>Factor 3: Coercion Concerns:</u>	<u>Loading</u>	<u>$\alpha = .88$</u>
Whether I will be pressured to make changes in my lifestyle that I feel unwilling or unable to make right now	.71	
Whether I will be pressured to do things in therapy I don't want to do	.63	
Whether I will end up changing the way I think or feel about things and the world in general	.62	

APPENDIX F

Self-Concealment Scale (SCS) (Larson & Chastain, 1990)

Self-Concealment Scale (SCS; Larson & Chastain, 1990)

Directions. Please indicate how much you agree with each of the following statements by choosing a number from the scale below and darkening its circle to the left of each item.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

- ① ② ③ ④ ⑤ 1. I have an important secret that I haven't shared with anyone.
- ① ② ③ ④ ⑤ 2. If I shared all my secrets with my friends, they'd like me less.
- ① ② ③ ④ ⑤ 3. There are lots of things about me that I keep to myself.
- ① ② ③ ④ ⑤ 4. Some of my secrets have really tormented me.
- ① ② ③ ④ ⑤ 5. When something bad happens to me, I tend to keep it to myself.
- ① ② ③ ④ ⑤ 6. I'm often afraid I'll reveal something I don't want to.
- ① ② ③ ④ ⑤ 7. Telling a secret often backfires and I wish I hadn't told it.
- ① ② ③ ④ ⑤ 8. I have a secret that is so private I would lie if anybody asked me about it.
- ① ② ③ ④ ⑤ 9. My secrets are too embarrassing to share with others.
- ① ② ③ ④ ⑤ 10. I have negative thoughts about myself that I never share with anyone.

APPENDIX G

Research Letter to Parents

Dear Parent(s),

(Research Letter to Parents)

We are inviting you to take part in a study of parents' attitudes toward seeking help for their young children's *potential* psychological problems. Your young child, of course, may not now or ever have a mental health problem. Your participation will help us understand the many factors that may influence a parent's decision to seek mental health care/assistance/advice for their children's problems, *if and when* they arise.

After reading this letter, please read the attached *Parent Consent Form* (a signed consent form is necessary before beginning any research project at Michigan State University) and look over the items in the enclosed *HS survey* which we would appreciate your completing. We ask that only 1 parent complete (either the child's mother or father) both the *Consent Form* and then the *HS survey*. The total time required to complete these forms is approximately 20 minutes.

Please note that we *do not* ask for *any* information regarding your child's or your name in the survey; this will insure the confidentiality of your answers. We do ask that you write your complete name on the *Consent Form*. This sheet will be placed in a locked file cabinet and kept *separate* from your completed survey.

Your identity as a participant in this activity will be kept *strictly confidential*. Faculty and/or staff from the Child Development Laboratories will not know if you participated in this study and also will not have access to any of your research information. In addition, your answers to these questionnaires will remain anonymous in any report of research findings.

After you have completed the *Consent Form* and the *HS survey*, place *both* of them in the enclosed postage-paid and addressed envelope, and place them in the mail. All sealed envelopes will be opened and all questionnaires will be reviewed and scored by trained assistants, under the direction of Professor Stollak, who will not know or have access to anyone's name. **After we receive your packet, you will receive a thank you postcard indicating that we have entered you in the \$50 grocery-gift certificate random drawing to be held in late May. In addition, please note that if you would like us to send you a report of our findings please complete the bottom part of the *Consent Form*.**

The rules of conducting research at Michigan State University include communicating to participants that they can stop participating in any research activity at any time for any reason or drop out of this or any study at any time without penalty. Your participation is completely voluntary and you may discontinue answering the questions at any time without any loss of benefits or privileges.

If you have any questions at any time before, during, or after completing the survey please feel free to call Dr. Gary Stollak (517-353-8877) or Ioanna Kalogiros (517-353-6640). If you have other questions regarding participants' rights as human subjects in research, please call David E. Wright, Ph.D., Chair, University Committee on Research Involving Human Subjects (UCRIHS) at (517) 355-2180.

We hope you will help us by completing the survey as soon as possible. Thank you for your assistance.

APPENDIX H

Research Letter to Teachers

Dear Teacher(s):

(Letter to Teachers)

We are writing you for your help in conducting a research study regarding parents of young children. Your acting program supervisor at the Child Development Laboratories has consented to our recruiting parents of young children in your classes to respond to our surveys.

We kindly ask you to help us in placing two forms (one survey packet and a one-page reminder) in your young students' backpacks on two separate dates (1 week apart). First, on April 17, 2000, you will receive a specified number of research packets to place in your young students' schoolbags before they leave your class that day. If particular children are absent from school that day, please return their research packets to the main office where Ioanna Kalogiros will pick them up. It is important that all non-distributed packets be returned in order for us to accurately calculate our response rate. Second, we also are kindly asking you to place one-page reminders printed on bright colored paper in the backpacks of all the eligible young children in your class who are present on April 24, 2000. You may discard the remaining reminders if children are absent from your class on that day.

You will receive all materials in the early morning of each of the listed distribution dates. We would really appreciate your help in distributing our surveys. Parents will be asked to mail us their completed surveys.

We have stated in our letter to parents that faculty and staff at the Child Development Laboratories will not know of their participation status (whether or not they decided to participate in our study). In this regard, we also can not share with you the purpose of our study until after all surveys are collected in order to minimize the magnitude of parents' possible concern over your knowledge that they received our surveys.

We would be more than happy to send you a copy of our research findings upon completion of our study. If you would be interested in receiving a copy please email Ioanna Kalogiros at kalogiro@msu.edu.

If you should have any questions concerning the distribution of survey packets or reminders, please do not hesitate to call Ioanna Kalogiros at (517) 332-5530 or Professor Gary Stollak at (517) 353-8877.

Thank you very much for your time and assistance.

APPENDIX I

Research Consent Form

CONSENT FORM FOR PARENTS/GUARDIANS

1. You are being asked to consent to take part in a scientific study about parents' thoughts and attitudes toward seeking help from mental health services, being conducted by Dr. Gary Stollak, Professor of Psychology and Ioanna D. Kalogiros.
2. Your participation in this study will require that you read items included in a survey and respond to each item. Your participation is completely voluntary and you may choose not to participate at all. You can decline to respond to any item in the survey at any time without penalty.
3. This survey will take you approximately 20 minutes to complete.
4. All of your answers will be treated with strict confidentiality. Faculty and/or staff of the Child Development Laboratories will not have access to your data nor will they know of your participation status. Your privacy will be protected to the maximum extent by law. You will remain anonymous in all reports, and any report regarding information that you provide will be reported in the aggregate. On request, and within these restrictions, results may be available to you.
5. You will receive a chance to win a fifty-dollar grocery gift certificate (\$50) as financial compensation for the completion of the survey.
6. You can discuss any questions or concerns you might have about the study with Dr. Gary Stollak or Ioanna D. Kalogiros. You may call Ms. Kalogiros at (517) 353-6640 or email her at kalogiro@msu.edu, or you may contact Professor Stollak at (517) 353-8877 or email him at stollak@msu.edu. If you have questions about participants' rights as human subjects in research, please call David E. Wright, Ph.D., Chair, University Committee on Research Involving Human Subjects (UCRIHS) at (517) 355-2180.
7. You indicate your voluntary agreement to participate by signing this consent form and completing and returning this survey in the enclosed stamped self-addressed envelope.

Signature: _____ Today's Date: _____

Please print your name: _____

The address to which you would like your thank-you postcard and gift-certificate (if you are a winner) sent to:

Please print your address: _____

Your telephone number (optional): _____

If you would like the results of this study sent to you please place a check (✓) in the box to the right. ☐

APPENDIX J

Reminder Letter to Parents

Dear Parent(s):

(Reminder Letter to Parents)

PLEASE HELP US

LEARN HOW PARENTS THINK/FEEL ABOUT

YOUNG CHILDREN'S POSSIBLE DIFFICULTIES

IN

LIVING

And

Get a Chance to *WIN a \$50 Grocery-Gift Certificate!* ☺

One week ago we sent home in your child's backpack a packet of surveys that we would really appreciate you reading and completing. There is no cost to you to participate. A self-addressed postage paid envelope has been included in the packet for you to mail us your completed responses and consent form. Once we receive your packet, we will send you a thank you card verifying your *placement in our drawing for a \$50 grocery-gift certificate.*

All of your answers will be treated with strict confidentiality. In addition, faculty and/or staff of the Child Development Laboratories will NOT have access to your information NOR will they know whether or not you decided to participate.

If you should have any questions please feel free to call Ioanna Kalogiros at (517) 353-6640 or email her at kalogiro@msu.edu, or you may contact Professor Stollak at (517) 353-8877 or email him at stollak@msu.edu.

Thank you very much for your time and assistance.

If you have already mailed us your survey and signed consent form, please disregard this letter and thank you, once again, for your past help.

APPENDIX K

HS Survey

HS

Today's date _____

My relationship to my child: ___Mother ___Father ___Other (Please describe): _____

My child's date of birth: ___/___/___

My child is a: boy___ girl___

Part I

Directions. Below are a number of statements pertaining to children's psychological and mental health issues. Some statements refer to your opinions about children in general, and others refer to your young child, specifically. Read each statement carefully and indicate your opinion about each. There are no "wrong" answers, and the only right ones are whatever you honestly feel or believe. It is important that you answer every item.

Please note the phrase "mental health professional" in some of the items below refers to the people who have a license from the state to practice including: **psychologists** (e.g., clinical, counseling, educational, or school), **psychiatrists**, **social workers** (e.g., clinical, psychiatric, or pediatric), **marriage and family therapists**, or **counselors** (school or vocational). Please also note that the phrase "help" in some of the items below refers to assessment, counseling or psychotherapy provided by a mental health professional.

Please indicate how much you agree with each of the following statements by choosing a number from the scale below and darkening its circle to the left of each item.

1	2	3	4
Disagree	Partly Disagree	Partly Agree	Agree

Items:

- | | |
|---------|---|
| ① ② ③ ④ | 1. Considering the time and expense involved in getting help from a mental health professional, it would have doubtful value for a child of mine. |
| ① ② ③ ④ | 2. A child's cognitive/emotional/social difficulties, like many things, tend to work out by themselves. |
| ① ② ③ ④ | 3. If I believed my child was having a cognitive/emotional/social "breakdown," my first inclination would be to get help from a mental health professional. |
| ① ② ③ ④ | 4. A child with a cognitive/emotional/social problem is not likely to solve it alone; he or she is likely to solve it with help from a mental health professional. |
| ① ② ③ ④ | 5. I would want to get help from a mental health professional for my child if I were worried or upset about him or her for a long period of time. |
| ① ② ③ ④ | 6. The idea of talking about my child's problems with a mental health professional strikes me as a poor way to get rid of my child's cognitive/emotional/social conflicts. |
| ① ② ③ ④ | 7. If my child were experiencing a serious cognitive/emotional/social crisis at this point in his or her life, I would be confident that he or she could find relief with help from a mental health professional. |
| ① ② ③ ④ | 8. There is something admirable in the attitude of a parent who is willing to cope with his or her child's conflicts and fears <i>without</i> resorting to getting help from a mental health professional. |

- ① ② ③ ④ 9. I might want my child to have help from a mental health professional in the future.
- ① ② ③ ④ 10. A child should work out his or her own cognitive/emotional/social problems; getting help from a mental health professional would be a last resort.
- ① ② ③ ④ 11. A parent should be able to work out his or her child's cognitive/emotional/social problems; getting help from a mental health professional would be a last resort.

Part II

Directions. Sometimes parents meet with mental health professionals about their child's problems both during assessment and/or as part of the treatment (e.g., parent guidance meetings with or without your child present). Please think about how concerned you would be about each of the following things if you were going to meet with a mental health professional at some point in time about a potential cognitive/emotional/behavioral problem your young child might be having.

Please indicate how concerned you would be with each of the following things by choosing a number from the scale below and darkening its circle to the left of each item.

1	2	3	4	5
No Concern	Somewhat Unconcerned	Neither Concerned Nor Unconcerned	Somewhat Concerned	Very Concerned

- ① ② ③ ④ ⑤ 12. Whether I'll be treated as a person by the mental health professional.
- ① ② ③ ④ ⑤ 13. Whether the mental health professional will be honest with me.
- ① ② ③ ④ ⑤ 14. Whether the mental health professional will take my child's or my concerns about my child's problem(s) seriously.
- ① ② ③ ④ ⑤ 15. Whether everything I say to the mental health professional will be kept confidential.
- ① ② ③ ④ ⑤ 16. Whether the mental health professional will think I'm a bad person if I talk about everything I have been thinking and feeling.
- ① ② ③ ④ ⑤ 17. Whether the mental health professional will understand my child's or my concerns about my child's problem(s).
- ① ② ③ ④ ⑤ 18. Whether my friends will think I'm abnormal for coming.
- ① ② ③ ④ ⑤ 19. Whether the mental health professional will think that I'm disturbed.
- ① ② ③ ④ ⑤ 20. Whether the mental health professional will find out things I don't want him/her to know about me and my life.
- ① ② ③ ④ ⑤ 21. Whether I will learn things about myself I don't really want to know.
- ① ② ③ ④ ⑤ 22. Whether I'll lose control of my emotions while I'm with the mental health professional.
- ① ② ③ ④ ⑤ 23. Whether the mental health professional will be competent to address the problem.

- ① ② ③ ④ ⑤ 24. Whether I will be pressured to do things in assessment/counseling/psychotherapy I don't want to do.
- ① ② ③ ④ ⑤ 25. Whether I will be pressured to make changes in my lifestyle that I feel unwilling or unable to make right now.
- ① ② ③ ④ ⑤ 26. Whether I will be pressured into talking about things I don't want to.
- ① ② ③ ④ ⑤ 27. Whether I will end up changing the way I think or feel about things and the world in general.
- ① ② ③ ④ ⑤ 28. The thought of seeing a mental health professional would cause me to worry, experience nervousness or feel fearful in general.

Part III

Directions. Please indicate how much you agree with each of the following statements by choosing a number from the scale below and darkening its circle to the left of each item.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

- ① ② ③ ④ ⑤ 29. I have an important secret that I haven't shared with anyone.
- ① ② ③ ④ ⑤ 30. If I shared all my secrets with my friends, they'd like me less.
- ① ② ③ ④ ⑤ 31. There are lots of things about me that I keep to myself.
- ① ② ③ ④ ⑤ 32. Some of my secrets have really tormented me.
- ① ② ③ ④ ⑤ 33. When something bad happens to me, I tend to keep it to myself.
- ① ② ③ ④ ⑤ 34. I'm often afraid I'll reveal something I don't want to.
- ① ② ③ ④ ⑤ 35. Telling a secret often backfires and I wish I hadn't told it.
- ① ② ③ ④ ⑤ 36. I have a secret that is so private I would lie if anybody asked me about it.
- ① ② ③ ④ ⑤ 37. My secrets are too embarrassing to share with others.
- ① ② ③ ④ ⑤ 38. I have negative thoughts about myself that I never share with anyone.

Please continue on next page...

Part IV

Directions. The following statements concern your thoughts and experience with seeking help for yourself and/or your child.

Concerning yourself: Please check (✓) all of the statements that are true for you.

- _____ 39. Up until this present time in my life, neither I nor someone else (e.g., spouse, relative, friend, physician, religious advisor) believed that there was a need for me to consult with a mental health professional.
- _____ 40. Up until this present time in my life, I decided NOT to see a mental health professional for myself even when someone or I believed I should.
- _____ 41. I am currently in individual treatment with a mental health professional for my own cognitive/emotional/social problems.
- _____ 42. I currently meet with *my child's mental health professional* concerning his/her cognitive/emotional/social problems.
- _____ 43. *In the past*, I have sought help or assistance from a mental health professional for *my own* difficulties.

Concerning your child: Please check (✓) all of the statements that are true for your child.

- _____ 44. Up until this present time in *my child's life*, neither I nor someone else (e.g., spouse, relative, teacher, doctors, friends, religious advisor) believed there was a need for my child to consult with a mental health professional.
- _____ 45. Up until this present time in *my child's life*, I decided for *my child* to NOT see a mental health professional when someone or I believed he or she should.
- _____ 46. *My child* is currently in individual treatment with a mental health professional for his/her own cognitive/emotional/social problems.
- _____ 47. *In the past*, I have sought help or assistance from a mental health professional for difficulties *my child* had.

Please continue on next page...

General/Demographic Information

Directions. The following are items and questions concerning yourself and your family. The answers to these questions will help us understand more about families today. Please write in and/or darken the circle next to the right answer.

1. I am: _____ years old
2. My ethnicity/racial group:
 - ① 1. Caucasian/Non-Hispanic
 - ② 2. African American/Non-Hispanic
 - ③ 3. Hispanic/Latino
 - ④ 4. Asian American
 - ⑤ 5. Other (please describe your ethnicity/racial group) _____
3. My family and I live in:
 - ① 1. Lansing
 - ② 2. East Lansing
 - ③ 3. Okemos/Haslett
 - ④ 4. Williamston, Mason, Grand Ledge, Dewitt, Holt, or other
4. My current relationship status is:
 - ① 1. Married
 - ② 2. Divorced, not married
 - ③ 3. Divorced, married again
 - ④ 4. Unmarried but living together with a partner
 - ⑤ 5. Single
5. Does your child have brothers or sisters? ☐ YES ☐ NO
 If YES: My child has
 (how many?) _____ older brother(s),
 (how many?) _____ younger brother(s),
 (how many?) _____ older sister(s),
 (how many?) _____ younger sister(s)
6. Your current occupation (the major category of your own work during most of your adult life):
 - ① 1. Corporate managers and executives, highly skilled technical jobs, government officials, college professors
 - ② 2. Middle managers, other professional/technical workers independent business people
 - ③ 3. Public school and junior college teachers, skilled labor and trades, real estate sales
 - ④ 4. Factory workers, general sales, general service workers, office work, secretarial work
 - ⑤ 5. Homemaker
7. If you have a spouse/partner who lives with you: Your spouse/partner's occupation (the major category of your spouse/partner's work during most of his/her adult life):
 - ① 1. Corporate managers and executives, highly skilled technical jobs, government officials, college professors
 - ② 2. Middle managers, other professional/technical workers independent business people
 - ③ 3. Public school and junior college teachers, skilled labor and trades, real estate sales
 - ④ 4. Factory workers, general sales, general service workers, office work, secretarial work
 - ⑤ 5. Homemaker

8. Estimate of your *total* family income each year:

- ① 1. Less than \$10,000
- ② 2. \$10,000-\$30,000
- ③ 3. \$30,000-\$60,000
- ④ 4. \$60,000 - \$100,000
- ⑤ 5. Above \$100,000

9. Your education:

- ① 1. Some high school or less
- ② 2. High school graduate
- ③ 3. Some college or technical school
- ④ 4. College or technical school graduate
- ⑤ 5. Professional/graduate degree

10. Your spouse/partner's education (if you have a spouse/partner who *lives with you*):

- ① 1. Some high school or less
- ② 2. High school graduate
- ③ 3. Some college or technical school
- ④ 4. College or technical school graduate
- ⑤ 5. Professional/graduate degree

You are now finished. Thank you very much for your help. Please place the completed *Consent Form* and the completed *Survey* in the stamped and addressed envelope, and place the envelope in the U.S. mail

APPENDIX L

Notice for CDL Classroom Newsletters



ATTENTION ALL PARENTS: Please Check Your Child's Backpack. On April 17th a survey packet was sent home in the backpack of every child who is between the ages of 24 and 60 months of age. The developers of the survey (researchers at MSU) would really appreciate you reading and completing it. As compensation for your time and help, you will receive a chance to win a **\$50 grocery gift-certificate**. Thank you very much!

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