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# Table of Contents

<table>
<thead>
<tr>
<th>Acknowledgements</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table of Contents</td>
<td>ii</td>
</tr>
<tr>
<td>List of Tables</td>
<td>iii</td>
</tr>
<tr>
<td>List of Appendices</td>
<td>iv</td>
</tr>
</tbody>
</table>

## Chapter

I. Review of the Literature .................................. 1

II. Rationale and Hypotheses ................................ 31

III. Method                                           .................. 34

IV. Proposed Analyses                                  .................. 40
    References                                          .................. 42
    Appendices                                          .................. 55

V. Dissertation                                        .................. 68
    References                                          .................. 88
    Tables                                              .................. 96
    Appendices                                          .................. 102
    Summary                                             .................. 117
List of Tables

Chapter V

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total Sample Frequency Statistics for Help-Seeking Questionnaire Item One</td>
<td>96</td>
</tr>
<tr>
<td>2. Total Sample Frequency Statistics for Help-Seeking Questionnaire Item Two</td>
<td>97</td>
</tr>
<tr>
<td>3. Total Sample Frequency Statistics for Help-Seeking Questionnaire Item Three</td>
<td>98</td>
</tr>
<tr>
<td>4. Total Sample Frequency Statistics for Help-Seeking Questionnaire Item Four</td>
<td>99</td>
</tr>
<tr>
<td>5. Comparison of Rural and Urban Adolescents’ Perception of Treatment Barriers</td>
<td>100</td>
</tr>
<tr>
<td>6. Comparison of ATSMI-AV and ATSPPH-SF Normative Mean Scores to Obtained Mean Scores</td>
<td>101</td>
</tr>
</tbody>
</table>
## List of Appendices

<table>
<thead>
<tr>
<th>Proposal</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Attitudes Toward Seeking Professional Psychological Help Scale-Short Form</td>
<td>55</td>
</tr>
<tr>
<td>B. Attitudes Toward Serious Mental Illness Scale-Adolescent Version</td>
<td>56</td>
</tr>
<tr>
<td>C. Help-Seeking Questionnaire</td>
<td>57</td>
</tr>
<tr>
<td>D. Demographics Questionnaire</td>
<td>60</td>
</tr>
<tr>
<td>E. Raffle Information Card</td>
<td>61</td>
</tr>
<tr>
<td>F. Parental Consent Form</td>
<td>62</td>
</tr>
<tr>
<td>G. Student Consent Form</td>
<td>64</td>
</tr>
<tr>
<td>H. Student Assent Form</td>
<td>66</td>
</tr>
<tr>
<td>I. Study Protocol</td>
<td>67</td>
</tr>
</tbody>
</table>

### Chapter V

<table>
<thead>
<tr>
<th>Proposal</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Attitudes Toward Seeking Professional Psychological Help Scale-Short Form</td>
<td>102</td>
</tr>
<tr>
<td>B. Attitudes Toward Serious Mental Illness Scale-Adolescent Version</td>
<td>103</td>
</tr>
<tr>
<td>C. Help-Seeking Questionnaire</td>
<td>104</td>
</tr>
<tr>
<td>D. Demographics Questionnaire</td>
<td>107</td>
</tr>
<tr>
<td>E. Raffle Information Card</td>
<td>108</td>
</tr>
<tr>
<td>F. Parental Consent Form</td>
<td>109</td>
</tr>
<tr>
<td>G. Student Consent Form</td>
<td>111</td>
</tr>
<tr>
<td>H. Student Assent Form</td>
<td>113</td>
</tr>
<tr>
<td>I. Study Protocol</td>
<td>114</td>
</tr>
<tr>
<td>J. Xavier University Institutional Review Board Approval Letters</td>
<td>115</td>
</tr>
<tr>
<td>K. Summary</td>
<td>117</td>
</tr>
</tbody>
</table>
Chapter I

Review of the Literature

Research suggests that approximately one in five adolescents experiences the signs and symptoms of a mental illness over the course of one year, while even more youth experience general emotional and behavioral problems that interfere with their everyday lives during this time period (U.S. Surgeon General, 1999). Yet, it has been documented that nearly two-thirds of all people who meet diagnostic criteria for a mental illness do not seek treatment (Kessler et al., 1996). This is concerning since research reviews have concluded that receiving treatment for a mental illness, namely psychotherapy, is more beneficial for the majority of children and adolescents than going without treatment (Kazdin, 2000; Weisz, Donenberg, Han, & Weiss, 1995). The magnitude of the effect of psychotherapy treatment for children and adolescents, compared to no treatment, is quite large (meta-analytic effect sizes ranging from .71 to .84) (Weisz et al., 1995).

Mental health need is commonly defined as “clinically assessed psychiatric diagnosis and/or functional impairment,” whereas unmet mental health need is defined as “the difference between assessed need and service utilization” (Srebnik, Cauce, & Baydar, 1996, p. 211). Srebnik et al. (1996) suggested that there is a “critical distinction between clinically assessed mental health need and subjective perception of need” (p. 212). Personal discomfort or distress, as perceived by an individual, is often times different than more objectively assessed need, but it
is a strong predictor of mental health problem recognition and seeking help for mental health problems (Costello & Janiszewski, 1990; Srebnik et al., 1996).

Researchers have proposed various reasons why a high unmet mental health need among youth exists. Some of these reasons include: beliefs that stigma is associated with mental health services, perceptions that treatment is not relevant and/or too demanding, cost of treatment, and dissatisfaction with services (U.S. Surgeon General, 1999). There are additional barriers that contribute to unmet mental health need and underutilization of mental health services among youth. Many of these barriers are thought to be especially prevalent in rural areas (Hauenstein et al., 2007; Heflinger & Christens, 2006; Judd et al., 2006; Kelleher, Taylor, & Rickert, 1992; Wagenfeld, 2003). More specifically, differences between rural and urban areas may influence adolescents’ perceptions of mental illness and their attitudes toward seeking help for psychological problems, yet this area of research has largely been overlooked.

Attitudes

Hundreds of definitions exist of the construct “attitude”, many of which originated from the social psychology literature. A frequently cited definition of attitude was put forth by Eagly and Chaiken (1993), which states “an attitude is a psychological tendency that is expressed by evaluating a particular entity with some degree of favor or disfavor” (p. 1). Antonak and Livneth (1988) suggested that an attitude is a complex, relatively stable, learned construct that can ultimately influence an individual’s behavior. Attitude is comprised of affective, cognitive, and behavioral components (Ajzen & Fishbein, 2005).

Thurstone (1928) was one of the first researchers to suggest that attitudes can be measured. He originally argued that an attitude is a subjective construct that consists of feelings and inclinations, which can be measured by assessing one’s opinions (Thurstone, 1928). Various
methodologies currently exist to measure attitudes, including direct self-report through open questions, closed questions, and rating scales, as well as indirect attitude measures (Krosnick, Judd, & Wittenbrink, 2005). Due to the intricate nature of attitudes, some argue that research should not simply attempt to construct a "single best" attitude measure but try to measure attitudes "in all their complexity and all their manifestations" (Krosnick et al., 2005, p. 63).

A central question that arises when studying attitudes is whether or not attitudes can accurately predict behavior. When addressing this question, it is important to differentiate attitudes from behavioral intention. Behavioral intention is defined as one’s unstated commitment to behave in a particular manner that is consistent with her or his belief system and attitudes (Siperstein, 1980). Researchers have suggested that behavioral intention can be predicted reasonably well from the measurement of attitudes, as behavioral intention has been found to correlate well with attitudes (ranging from .45 to .60) (Ajzen & Fishbein, 2005). Also, behavioral intention is considered to be a good predictor of behavior, as correlations between behavioral intention and observed behavior have been reported to range from .45 to .62 (Ajzen & Fishbein, 2005). However, as Ajzen and Fishbein proposed, it is a difficult task to consistently and accurately predict behavior across all situations and populations by assessing attitudes and intentions since individuals sometimes say one thing and do another.

General attitudes are not considered to be good predictors of specific behaviors, but research has shown that specific behaviors can be predicted quite well from measuring attitudes toward the specific behavior in question (Ajzen & Fishbein, 2005). Studies investigating attitudes toward specific behaviors have reported attitude-behavior correlations of .45 (Godin, Valois, Shephard, & Desharnais, 1987), .53 (Terry & O’Leary, 1995), and .67 (Manstead, Proffitt, & Smart, 1983). The extent to which attitudes can accurately predict behavior depends
largely on the specificity of the attitude measurement being similar to the context and details of the particular situation in which the attitude is predicted to be expressed (Siperstein, 1980).

More specifically, attitudes toward mental illness have gained more research attention over the years. The general public has been found to endorse negative attitudes toward individuals described as having a mental illness (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999; U.S. Surgeon General, 1999). Negative attitudes can have a detrimental effect on those who suffer from mental illness and can influence how the general adult population treats these persons. For example, those who were diagnosed with a mental illness had a harder time leasing an apartment (Page, 1995) and finding employment (Link & Phelan, 2001) compared to individuals who did not have a mental illness diagnosis. Negative attitudes and stigmatization are also associated with reduced self-esteem (Wright, Gronfein, & Owens, 2000) and increased symptoms and stress (Markowitz, 1998) among individuals diagnosed with a mental illness.

**General Adult Attitudes Toward Mental Illness**

Outlined in the U.S. Surgeon General’s Report (1999), public attitudes about mental illness have changed somewhat over time. In the 1950’s, research demonstrated that the general public did not have a full understanding of what mental illness was, recognizing it mainly as an extreme form of behavior, namely psychosis. During this time period, research participants had difficulty distinguishing mental illness from general worry and unhappiness and tended to view mental illness as a dreaded condition that carried a great deal of social stigma (Star, 1955).

Research in the 1990’s demonstrated that individuals had a better scientific understanding of mental illness and were better able to distinguish mental illness from other conditions, namely general worry and unhappiness (U.S. Surgeon General, 1999). Research during this time period
also found that the general public's definition of mental illness was broadened to include other disorders besides psychosis, including anxiety and depression. However, negative attitudes toward mental illness persisted. Compared to studies conducted in the 1950's, research participants in the 1990's incorporated more violent behavior into their overall perceptions of mental illness (Phelan, Link, Stueve, & Pescosolido, 1997). Put another way, individuals described as having a psychosis were viewed as dangerous and unpredictable people who should be kept at a distance.

A more recent paper by Angermeyer and Dietrich (2006) reviewed over 60 population studies generated over a period of 15 years that investigated public beliefs about and attitudes towards individuals with mental illness. The studies they reviewed employed a wide variety of methodologies including descriptive comparisons, evaluations of antistigma interventions, cross-cultural comparisons, analyses of time trends, and theory-based models of stigmatization. Angermeyer and Dietrich explained that there is currently not a universally agreed upon methodology for investigating attitudes towards individuals with mental illness, which makes it difficult to reach firm conclusions.

Angermeyer and Dietrich (2006) suggested several broad conclusions after their review of the literature. First and foremost, they proposed that much more needs to be done in terms of providing an empirical basis for evidenced-based interventions to combat misconceptions about mental illness. The authors strongly advised that there needs to be more efforts to improve attitudes toward persons with mental illness. Angermeyer and Dietrich found that the general public tends to recognize that individuals suffering from mental illness are in need of help and may encourage them to seek treatment, perhaps exhibiting pro-social behaviors toward them. Yet, others tend to distance themselves from mentally ill persons and sometimes consider them
to be unpredictable, violent, and dangerous. More specifically, individuals suffering from alcoholism and schizophrenia were considered to be more violent and unpredictable compared to individuals with other mental health problems (e.g., anxiety disorder, depression).

Angermeyer and Dietrich (2006) reached several additional conclusions. As a whole, there was an inconsistent association between attitudes toward mental illness and gender. However, other studies have suggested that males have more negative attitudes toward mental illness compared to females (e.g., Lauber, Nordt, Falcato, & Rossler, 2004). According to Angermeyer and Dietrich, individuals with more education tended to express more positive attitudes toward mental illness and distanced themselves less from individuals suffering from a mental illness, and negative attitudes toward mental illness was found to be positively associated with age. Also, individuals consistently reported that they had more positive attitudes and were more accepting if they were more familiar with (including contact with mentally ill individuals) and knowledgeable about mental illness.

**Children’s and Adolescents’ Knowledge of and Attitudes Toward Mental Illness**

While there is a growing body of literature on adults’ attitudes toward mental illness, much less is known about how children and adolescents understand and view mental illness. Some have suggested that compared to adults, youth have more negative attitudes toward individuals diagnosed with a mental illness (Stuart & Arboleda-Florez, 2001). The relatively few studies that have investigated children’s and adolescents’ attitudes toward mental illness have used various methodologies including questionnaires, vignettes, storytelling, drawings, qualitative measures, differential rating scales, and interviews. There is not a universally agreed upon methodology to study children’s and adolescents’ attitudes toward mental illness. Similarly, psychometrically standardized measures of children’s and adolescents’ attitudes
toward mental illness are virtually nonexistent. There are a few measures that are commonly used for adults, such as the Community Attitudes Toward Mental Illness Scale (Taylor & Dear, 1981) and the Opinions About Mental Illness Scale (Cohen & Struening, 1962), but these measures were not designed to be used with children and adolescents. Due to varying methodologies and controversy surrounding how to measure youth attitudes, it is difficult to make comparisons between studies and reach firm conclusions.

In his 2002 paper, Wahl reviewed research generated since 1980 on children’s attitudes toward mental illness. Wahl explained that when attitudes toward mental illness are studied in adults, these attitudes are usually already firmly established. He stated that it is possible that “these ideas and attitudes are acquired gradually over a lifetime and that their roots are established in childhood” (pp. 135-136). To reduce stigmatizing attitudes before they are firmly established, Wahl suggested more attention needs to be given to younger populations and how they begin to conceptualize mental illness. Wahl stated, “shaping attitudes before they are well-formed may be easier than challenging and modifying attitudes that are already firmly entrenched” (p. 136).

Children do not seem to have the same understanding of mental illness as well-educated, mature adults (Wahl, 2002). Young children have been found to sometimes confuse mental illness with physical illness and mental retardation (Wahl, 2002). Yet, Wahl (2002) argued that even young children have a vague understanding that mental illness is a stigmatized condition, as children as young as five-years-old have been found to endorse negative attitudes toward mental illness. Older children tend to have a better understanding of mental illness, reflected in perceived disturbances in emotions and thoughts rather than just observed abnormal behaviors (Wahl, 2002). Also, compared to younger children, older children have shown a broader
knowledge of etiology and treatment of various psychological disorders (Wahl, 2002). At least by adolescence, individuals are able to differentiate between psychiatric disorders and general medical conditions (Arbanas, 2008). In general, as children mature and develop, their understanding of mental illness and how it can impact thoughts, emotions, and behaviors becomes more articulated, but these developing attitudes and perceptions may be negatively influenced by existing mental illness stereotypes (Wahl, 2002).

Wahl (2002) made several additional conclusions after his review of the literature. He proposed that youth generally tended to view individuals who had been diagnosed with a mental illness more negatively compared to those who had not been diagnosed with a mental illness, and these negative attitudes increased with age. Wahl also explained that several studies have demonstrated that children (varying in ages) viewed people with mental illness as less attractive, usually sought social distance from them, and rated them less positively in various stories and descriptions compared to those not diagnosed with a mental illness. Citing one of his previous co-authored studies (Adler & Wahl, 1998), Wahl suggested that even though younger children may not be able to fully articulate differences between mentally ill individuals, physically disabled individuals, and “regular gown-ups,” even third graders seemed to understand that those labeled mentally ill were somehow “worse” than the other groups (p. 142).

Relatively few studies have specifically devoted attention to adolescents’ attitudes toward mental illness. Whereas middle childhood is usually considered to last from six to twelve-years-old, adolescence is a developmental period lasting from twelve-years-old until around twenty-years-old (Feldman, 2008). Adolescence is characterized by rapid physical growth and maturation and continued cognitive and emotional development (Feldman, 2008). This is a crucial developmental period to study, as attitudes and belief systems are being shaped (Chandra
& Minkovitz, 2007). During adolescence, these young people are developing more independence from parents and evaluating their ideas separate from the values and beliefs that were imparted to them during their childhood years (Chandra & Minkovitz, 2007).

One study investigating adolescents’ attitudes toward mental illness was conducted by Corrigan et al. (2005). These researchers attempted to determine if several findings commonly cited in the adult stigma literature applied to an adolescent population. These findings include: people with a mental illness are stigmatized more than those with a physical health condition, those who drink alcohol in excess are viewed more harshly than individuals with a mental illness, mental illness stereotypes related to danger and responsibility tend to lead to discriminatory behaviors and negative emotional reactions, and familiarity with individuals who have been diagnosed with a mental illness tends to reduce negative attitudes.

Corrigan et al. (2005) employed a sample of 303 adolescents from various races and ethnicities who ranged in age from thirteen to nineteen-years-old. Participants completed a revised version of the Attribution Questionnaire (rAQ), which presented four vignettes that described an adolescent peer with a mental illness, a peer with an alcohol problem, a peer with a mental illness caused by a brain tumor, and a peer suffering from leukemia. Results of this study revealed that, like adults, adolescents viewed peers who had an alcohol problem most negatively. Participants also exhibited negative attitudes toward peers described as having a mental illness, but did not endorse negative attitudes toward persons suffering from leukemia. Adolescents who reported that individuals suffering from a mental illness are dangerous and responsible for their own illness were also more likely to exhibit discriminatory attitudes toward these individuals. However, the researchers were surprised to find that those adolescents who reported familiarity with mental illness also reported negative attitudes toward mental illness. Corrigan et al.
concluded that more research is needed to better understand adolescents’ attitudes toward mental illness and suggested, “modifying negative attitudes among children and adolescents might stop them from developing into adults who stigmatize persons with mental illness, which can lead to full-blown social injustice” (p. 545).

Another study investing adolescents’ attitudes toward mental illness was conducted by Watson, Miller, and Lyons (2005). These researchers evaluated and described the Attitudes Toward Serious Mental Illness Scale-Adolescent Version (ATSMI-AV). This 21-item measure was structured around five attitudinal factors, which included: fear of being harmed by a mentally ill person or reputation for having a mental illness (factor 1=threat); worry about getting a mental illness as well as concern about mental illness labels being used to control people (factor 2=social control/concern); belief that individuals who suffer from mental illness can be cured with medication, convinced to get well, or can get well by trying hard enough or having enough love and kindness (factor 3=wishful thinking); belief that mentally ill persons are different and easy to spot (factor 4=categorical thinking); and the idea that mentally ill people do bad things and are out of control (factor 5=out of control).

Watson et al. (2005) employed a sample of 415 adolescents who resided in northern suburbs of Chicago, Illinois. The majority of participants were Caucasian (79.1%), ranging from grades nine through twelve. Independent sample t tests indicated that males scored significantly higher than females on both categorical thinking and threat factors. This finding suggested that males endorsed more negative attitudes toward mental illness compared to females, which was consistent with previous studies (Pinford et al., 2003; Watson et al., 2004). Also, younger students scored higher on the out of control, threat, and categorical thinking factors, but these differences did not meet the Bonferroni criteria for statistical significance. Ninth and tenth
graders scored significantly higher on the social control/concern factor compared to eleventh and twelfth graders. White students scored significantly lower on the wishful thinking and social control/concern factors compared to their nonwhite peers. White students were also less likely to endorse the threat, out of control, and categorical thinking factors compared to nonwhite students, but again, these differences did not meet the Bonferroni criteria for statistical significance. Finally, adolescents who stated they had a family member with a mental illness were less likely to endorse the categorical thinking factor but more likely to endorse the social control/concern factor.

Based on these data, Watson et al. (2005) concluded that adolescents’ attitudes are multidimensional, and there are improvements that can be made across all dimensions. The authors also suggested that adolescent antistigma programs may want to focus on diminishing categorical thinking about mental illness and perceptions of mentally ill people being out of control and violent. Furthermore, Watson et al. pointed out that results may have been different with samples of rural and urban adolescents.

Chandra and Minkovitz (2007) conducted a study that examined eighth graders’ mental health attitudes and how these attitudes are shaped. The research sample consisted of a total of 57 eighth grade students who resided in a suburban, mid-Atlantic community. Using a qualitative methodology of interviewing students, the researchers uncovered several themes. The various factors influencing these eighth graders’ attitudes toward mental health included: mental health knowledge, personal experience with mental health issues, perceived social consequences of using mental health services, family conversations about mental health issues, and peer conversations about mental health issues.
Chandra and Minkovitz (2007) suggested that adolescents who were less knowledgeable about mental health issues tended to exhibit more negative attitudes compared to those who knew more about mental health issues. Many of the students had personal experiences with mental health services. While some of these same students endorsed the potential benefits of talking with mental health professionals, the majority of adolescents reported having negative experiences and/or being dissatisfied with mental health services. The adolescents also explained they believed they would be viewed negatively by their peers and others if they sought mental health services for a mental health problem. Many stated they believed there is social stigma associated with admitting a mental health problem and seeking treatment for this problem. Finally, these students reported that family and peer conversations can have an impact on how they view mental illness and if they would ever seek mental health treatment. Those who engaged in open discussions about mental health issues with family and friends tended to express more benevolent attitudes toward mental illness and were more willing to seek mental health treatment compared to those who did not engage in these conversations.

A study by the Adolescent Risk Communication Institute of The University of Pennsylvania’s Annenberg Public Policy Center (APPC) in 2003 provided evidence for the presence of stigmatizing attitudes toward peers with mental illness (Penn et al., 2005; Romer, 2003). The National Annenberg Risk Survey of Youth (NARSY), a nation-wide telephone survey, asked 474 youth (ages 14-22) if they were aware of various mental disorders (e.g., bipolar disorder, major depression, schizophrenia, and eating disorders). Results indicated that awareness was highest for eating disorders (89%), followed by depression (86%), schizophrenia (81%), and bipolar disorder (73%).
Participants who were aware of at least one disorder were asked additional questions regarding the disorder(s) with which they were familiar. Participants were told to imagine that someone their age was suffering from one of the disorders, and participants were then asked if this person would be more likely, less likely, or about as likely as other people to be: (a) violent, (b) prone to committing suicide, and (c) good in school. Results indicated that participants identified mentally ill peers as different from others. Participants reported that schizophrenics were more likely to be violent (72%), followed by individuals with bipolar disorder (65.1%), major depression (55.7%), and an eating disorder (28.9%). These youth also reported that individuals with major depression were more likely to be suicidal (91.9%), followed by those with an eating disorder (80%), bipolar disorder (79.9%), and schizophrenia (75.9%). Finally, participants consistently reported that individuals with a mental illness were less likely to be good in school (76.5% for major depression, 69.7% for schizophrenia, 62.5% for bipolar disorder, and 56% for an eating disorder).

There are numerous limitations and shortcomings in this area of research. Several of these studies have consistently pointed out that children and adolescents commonly endorse negative attitudes toward mental illness. However, as previously mentioned, these studies used a variety of methodologies to arrive at this conclusion. The language used to define and describe the term “mental illness” varied between studies, and social desirability may have influenced how young people responded to attitude surveys. Also, studies have generally failed to account for possible differences in attitudes between adolescents residing in different parts of the country (e.g., geographic residence), which limits generalizability of findings. Controversy also surrounds how children’s understanding and view of mental illness develops and changes as they
get older. In general, there is more research needed to better understand young peoples’ attitudes toward mental illness and how these attitudes are shaped. Wahl (2002) concluded:

Continued research on these topics is a necessity for expanding our understanding of children’s conceptions of mental illness and for the establishment of a core of knowledge on which to base efforts to help children develop more accurate and sympathetic views of mental illness (p. 155).

A related area of research that has gained more widespread attention recently is help-seeking for mental health problems. Negative attitudes and stigma associated with mental illness are considered to be potential reasons why individuals are reluctant to seek help for mental health problems (Schomerus & Angermeyer, 2008). Other obstacles to receiving mental health treatment also exist. The still developing help-seeking literature and its relevance to the present study will now be discussed.

Help-Seeking Among Adults

Many adults do not seek help for mental health problems when they arise (Kessler et al., 1996), as various barriers prevent these individuals from seeking the treatment they need. Negative attitudes toward mental illness and mental health services have been cited as some of the most formidable obstacles to receiving mental health treatment (U.S. Surgeon General, 1999). This is concerning since researchers have suggested that negative attitudes are still common among the general public (Angermeyer and Dietrich, 2006). Negative attitudes have been thought to be a particularly important barrier to receiving mental health services in many rural areas (Fox, Blank, Rovnyak, & Barnett, 2001).

Jackson et al. (2007) differentiated between the terms service utilization and help-seeking. They defined service utilization as the “actual presentation to treatment and use of
services for mental health problems,” while help-seeking is a broader, more general term “that encompasses a range of indicators including attitudes to seeking help, planned behavior, and consultation with friends, help lines, the internet or professionals” (p. 148). Other definitions of help-seeking exist, including one that was put forth by Srebnik et al. (1996). These authors explained that “help-seeking can be defined as seeking assistance from mental health services, other formal services, or informal support sources for the purpose of resolving emotional or behavioral problems” (p. 211).

Help-seeking attitudes and behavior among adults have changed somewhat over time. Compared to studies conducted in the 1950’s, 1960’s, and 1970’s, research conducted in the 1990’s demonstrated that adults were more likely to deal with mental illness (e.g., seeking help) instead of avoiding the problem altogether (Phelan et al., 1997; U.S. Surgeon General, 1999). Research participants in the 1990’s who were willing to seek help tended to prefer informal social supports such as self-help groups (Phelan et al., 1997; U.S. Surgeon General, 1999). On the other hand, those who sought more formal help tended to rely on psychologists, counselors, and social workers (Swindle, Heller, & Pescosolido, 1997; U.S. Surgeon General, 1999).

Adults may seek help at different rates for different types of problems (discussed in Boldero & Fallon, 1995). Several older studies revealed that adults asked for help less often for problems that had some form of shame attached to them (e.g., mental illness) (Bergin & Garfield, 1971), problems that implied some type of personal inadequacy (e.g., cognitive deficits, low self-esteem) (Shapiro, 1980), and very personal problems (e.g., intimate relationship difficulties) (Greenley & Mechanic, 1976). Adults were more likely to seek help when their problem(s) could be attributed to external causes (Gross, Wallston, & Piliavin, 1979).
A more recent paper by Jackson et al. (2007) reviewed several general help-seeking studies (e.g., Bland, Newman, & Orn, 1997; Wells, Robins, Bushnell, Jarosz, & Oakley-Browne, 1994) that employed various adult samples from countries around the world. The studies they reviewed employed a variety of methodologies including various questionnaires, community and national health surveys, telephone surveys, general interviews, and clinical interviews. Differing methodologies made it difficult to make comparisons between studies, generalize findings, and reach firm conclusions.

After their review of the literature, Jackson et al. (2007) reached several broad conclusions. They listed several demographic variables that seemed to consistently predict help-seeking attitudes and actual help-seeking behavior among adults. These variables included female gender, being alone (e.g., single, divorced or widowed), and younger age. Jackson et al. also discussed several additional predictors of mental health service utilization, which included perceived general stress, having one or more medical conditions, long-term disability, history of suicide attempts, having a self-identified or diagnosed mental illness, comorbidity, and increased psychological distress. Finally, the authors listed various attitudinal factors that were predictive of help-seeking. These attitudinal factors included having a positive attitude towards seeking help, being positive and confident about mental health professionals being able to provide effective treatment, and being less likely to see chance as a factor.

Other demographic variables and how they relate to help-seeking have been investigated. Researchers have suggested that among adult college students, Western students (e.g., European and Latin) have reported more positive attitudes toward help-seeking compared to their non-Western counterparts (e.g., Asian and African) (Oliver, Reed, Katz, & Haugh, 1999). Another study found that Caucasian and African-American college students reported similar help-seeking
attitudes and behaviors (Delphin & Rollock, 1995). A less recent study reported that adult college students who were older and came from higher SES backgrounds were more likely to seek help (Pliner & Brown, 1985). Studies investigating religious beliefs and help-seeking have produced inconsistent findings. One study found that participants’ willingness to seek psychological help was strongly associated with their religious beliefs (Bhatt, 2002), whereas another study reported that religious beliefs were not associated with willingness to seek help (Singer, 1997).

Help-Seeking Among Youth

There is a growing literature on adults’ attitudes and behavior toward seeking help for psychological problems, but help-seeking among children and adolescents has been somewhat overlooked (Boldero & Fallon, 1995; Srebnik et al., 1996). Like adults, young people rarely seek professional help for psychological problems even when they are in a great deal of distress (Whitaker et al., 1990). Researchers have argued, “It is critical to identify factors that facilitate or deter adolescents’ help-seeking behavior” (Sears, 2004, p. 396).

Various methodologies have been employed to investigate children’s and adolescents’ attitudes and behavior toward seeking help for psychological problems. These methodologies have ranged from questionnaires, qualitative measures, interviews, health surveys, and comparisons of demographic information. Since this area of research has not generated a great deal of attention over the years, a universally agreed upon methodology for measuring youth help-seeking attitudes and behavior does not currently exist. Jackson et al. (2007) explained, “the existing literature on help-seeking for mental health problems is at an early stage of development and is limited by the absence of an agreed framework” (p. 159).
Researchers have suggested several factors that contributed to young peoples' decision to seek help or go without treatment. Youth were more inclined to seek help for psychological problems when they had at least some knowledge of mental health issues and were aware of the sources of help that were available (Rickwood, Deane, & Wilson, 2007). Young people were also more inclined to seek help if they felt competent to express their feelings, if they had positive attitudes toward the help-seeking process, and if they trusted their potential treatment providers (Rickwood et al., 2007). On the other hand, youth were less likely to seek help if they held negative attitudes toward seeking help, had bad previous experiences with mental health treatment providers, or believed they could or should be able to deal with their problems on their own (Rickwood et al., 2007).

Youth have sought help from a variety of service providers for a range of problems. Fewer than 20 percent of youth who sought help went to mental health service providers (Srebnik et al., 1996). More children and adolescents tended to seek help from friends, family members, and teachers (Boldero & Fallon, 1995). Those who decided to seek help from formal service providers often relied on medical personnel and school-based services (Barker & Adelman, 1994). Help-seeking can be a complicated process for youth, which involves "a series of decisions, rather than a single, planned choice" (Srebnik et al., 1996, p. 213). Therefore, young people have frequently relied on their parents for assistance and guidance when seeking help, and parents sometimes have made the ultimate decision to seek mental health treatment, especially for younger children (Srebnik et al., 1996). Problems that youth have commonly sought help for, often times with assistance and guidance from their parents, included interpersonal relationship difficulties, psychiatric symptoms (e.g., depression), school/education
problems, substance abuse, family problems (e.g., parents’ divorce), and general health concerns, among others (Boldero & Fallon, 1995; Srebnik et al., 1996).

Employing a wide range of methodologies, researchers have uncovered a couple of consistent findings in the child and adolescent help-seeking literature. One of these findings is that females sought help to a greater degree than males (Barnett et al., 1990; Garland & Zigler, 1994). This finding held up even after controlling for symptom severity (Rickwood & Braithwaite, 1994). Based on these results, researchers have hypothesized that gender differences in help-seeking are related to individuals’ willingness to identify problems and internal states as mental health concerns that require attention/help (Saunders, Resnick, Hoberman, & Blum, 1994). Another fairly consistent finding is that youth from very low and very high socioeconomic status (SES) backgrounds were the most likely to utilize mental health services (Cohen & Hesselbart, 1993).

Studies on help-seeking and mental health service utilization among different races and ethnicities have produced mixed results. Cohen and Hasselbart (1993) reported that compared to Caucasian youth, African American youth were more likely to receive mental health services. On the other hand, Asian American, Latino, and Native American youth have been reported to be less likely to receive mental health services compared to Caucasian youth (Bui & Takeuchi, 1992). However, other studies have found that Latino and African American young people received less mental health care compared to their Caucasian counterparts, especially in urban areas (Howell & McFeeters, 2008).

Few studies have specifically investigated adolescents’ help-seeking attitudes and behavior. Offer, Howard, Schonert, and Ostrov (1991) studied help-seeking among adolescents and employed a sample of 497 adolescents from the Midwest (mean age of 17-years-old). These
researchers administered a variety of measures to participants, including the Delinquency Checklist, the Offer Self-Image Questionnaire for Adolescents, a modified version of the SCL-90, a mental health utilization questionnaire, and a demographics questionnaire. Results of this study indicated that females tended to go to their friends for help more often, while males went to their parents more. Offer et al. (1991) also found that emotionally disturbed adolescents sought help more than nondisturbed adolescents. Adolescents who reported higher emotional distress tended to seek help from friends, while nondisturbed adolescents preferred to seek help from parents. Offer et al. did not inquire why some adolescents chose not to seek help, and this study also did not investigate adolescents’ perceptions of various barriers that prevented them from seeking help.

Schonert-Reichl and Muller (1996) examined psychological and demographic variables associated with seeking help among adolescents. Two hundred and twenty one adolescents, ranging in age from thirteen to eighteen-years-old, completed measures that assessed locus of control, self-consciousness, self-worth, and help-seeking behavior. The help-seeking behavior measure was a modified version of an instrument that was originally developed by Offer et al. (1991), which measured the extent to which adolescents felt the need to use professionals, friends, and/or parents for help for various psychological/emotional problems. Schonert-Reichl and Muller found that adolescents who reported seeking help for various psychological problems had lower self-worth, were older, and were less self-conscious compared to their counterparts who did not seek help.

Another study that investigated help-seeking among adolescents was conducted by Saunders et al. (1994). These researchers employed a sample of 17,193 adolescents in grades nine through twelve who completed a self-report, school-based survey. This survey consisted of
148 questions that addressed issues such as risk-taking behaviors, antisocial behaviors, substance use, sexual behavior, and emotional well-being. Roughly twenty five percent of participants reported that they felt they had a serious problem, as classified by Saunders et al. Results of this study also indicated that recognizing a need for help was associated with suicidal ideation, poor physical health, history of abuse, and female gender. Actually obtaining help was associated with lack of suicidal ideation, parental marital status (e.g., parents being married) and education, prior tendency to use informal support systems, having a physical checkup within the past year, and higher SES. Saunders et al. concluded that more research needs to be done to better understand help-seeking attitudes and behavior among adolescents as well as the barriers that prevent this population from seeking help.

The help-seeking literature among youth is still developing. To date, this body of research has largely ignored how geographic residence (e.g., rural and urban) may influence children's and adolescents' help-seeking attitudes and behaviors. Studies investigating how geographic residence might impact children's and adolescents' perceptions of mental illness are also virtually nonexistent. The rural-urban literature and how it relates to the present study will now be discussed.

**Rural vs. Urban**

Differences have been noted between rural and urban areas in regard to the availability of mental health services (Hauenstein et al., 2007; Jameson & Blank, 2007). Researchers have suggested that rural areas offer significantly fewer mental health services compared to more urban or metropolitan areas (Hauenstein et al., 2007; Jameson & Blank, 2007). Hauenstein et al. (2007) suggested that individuals residing in urban/metropolitan areas were approximately 47 percent more likely to receive general mental health treatment compared to those who lived in
rural/nonmetropolitan settings. Many rural areas are suffering from what some are calling an all out mental health “service crisis” (Jameson & Blank, 2007, p. 283). However, even though they have limited access to mental health services, many rural residents do not perceive a need for an increase in such services (Flaskerud & Kuiz, 1984).

Although research in this area is sparse, researchers have noted differences in help-seeking and service utilization between rural and urban adult residents. In general, help-seeking and service utilization rates are lower among rural residents compared to their urban counterparts (Jackson et al., 2007; Linn & Husaini, 1987; Lord-Flynn, 1989). Some have suggested that rural residents have a high regard for autonomy and believe they should cope with their problems, which may prevent them from seeking professional mental health services (Judd et al., 2006; Kelleher et al., 1992).

Additional barriers to receiving mental health treatment in rural areas have also been reported in the literature. Researchers have suggested that many rural dwellers simply do not recognize the need for mental health treatment (Fox et al., 1999). In one study, it was reported that approximately 90 percent of adults residing in a rural area who screened positive for a mental disorder (by way of the short form of the Composite International Diagnostic Interview or CIDI) did not seek professional treatment one month after receiving a diagnosis and an educational intervention (Fox et al., 1999). One of the most common reasons these individuals gave for not seeking help was “felt there was no need” (Fox et al., 1999, p. 181). Many other barriers to mental health treatment among rural populations have been cited in the literature, including transportation difficulties, communication problems, laws, trouble recruiting and retaining trained mental health professionals, funding difficulties, rampant poverty, unemployment, substance abuse problems, lack of insurance, insufficient population bases to
support services, stigma, stoicism, and agrarian values (Hauenstein et al., 2007; Hefflinger & Christens, 2006; Judd et al., 2006; Kelleher et al., 1992; Wagenfeld, 2003).

Although many rural residents do not recognize and seek help for mental health problems, some do. Jackson et al. (2007) reviewed several help-seeking studies conducted in rural areas that employed adult samples (e.g., Fox et al., 1999; Hoyt, Conger, Valde, & Weih, 1997; Smith, McGovern, & Peck, 2004). Based on the data from these studies, Jackson et al. listed several demographic variables that were predictive of help-seeking and service utilization for mental health problems in rural areas. These variables included female gender, younger age, being alone (e.g., widowed, divorced), having a mental illness diagnosis, having a disability, psychological distress, medical comorbidity, and past use of professional mental health services. Having a positive attitude toward help-seeking and mental health service providers was also predictive of actual help-seeking. Finally, lower levels of self-efficacy and stoicism were found to be predictive of help-seeking for various mental health problems.

Rural-urban attitude differences among adults have also been reported, which have been found to be a major barrier to mental health service utilization. Hoyt et al. (1997) reported that individuals residing in rural areas held more negative attitudes toward mental health care compared to those who did not reside in these rural areas. These researchers also reported that individuals' attitudes were predictive of willingness to seek help (e.g., individuals who endorsed more negative attitudes were less willing to seek mental health treatment). Another study by Rost, Smith, and Taylor (1993) found that individuals residing in rural areas who had a history of depression labeled people who sought help for depression more negatively compared to their urban counterparts. Results also revealed the more negative the labeling, the less likely rural
residents were to seek professional help for their depression. This association was not found among the urban population with a history of depression.

Although data are limited, other studies investigating adult attitude differences between rural and urban residents have produced somewhat mixed results. Stuart and Arboleda-Florez (2001) reported that compared to people residing in urban areas, rural residents endorsed a stronger desire to keep individuals described as mentally ill at a distance. On the other hand, a study conducted by Martin, Pescosolido, and Tuch (2000) found the opposite; people residing in urban areas were found to be significantly more likely than rural residents to avoid individuals who were described as having a mental illness. A study by Magliano, DeRosa, Fiorillo, Malangone, and Maj (2004) suggested that rural residents, compared to their urban counterparts, perceived individuals described as mentally ill to be more dangerous and unpredictable. However, studies by Phelan and Link (2004) and Pescosolido, Monahan, Link, Stueve, and Kikuzawa (1999) found no rural-urban differences in regard to mentally ill individuals being perceived as being dangerous and unpredictable. Earlier studies have suggested that rural residents often did not access mental health services due to a heightened perceived stigma associated with mental illness (Kenkel, 1986). Along this same line, others have suggested “rural Americans, perhaps more so than other groups, are susceptible to the effects of stigma associated with mental illness” (Estes, Cooker, & Ittenbach, 1998, p. 469).

Studies investigating rural-urban differences in children’s and adolescents’ attitudes are virtually nonexistent. One of the few studies of its kind, Chimonides and Frank (1998) specifically looked at rural-urban differences in adolescents’ perceptions of mental health and mental illness. Employing a questionnaire similar to the one developed by Flaskerud (1980), Chimonides and Frank presented 220 rural and urban adolescents (14-20 years old) from
northern Florida with a series of nine vignettes that depicted various mental health issues (e.g., one described a 42-year-old man who drank alcohol excessively). Chimonides and Frank reported significant rural-urban differences in how adolescents viewed mental health issues. Compared to urban adolescents, rural adolescents expressed less negative attitudes toward a scenario in which a man drank alcohol excessively. In general, adolescents residing in rural areas tended to be more accepting of alcohol abuse. On the other hand, compared to rural adolescents, urban adolescents expressed more accepting attitudes toward a vignette depicting manic behavior. In yet another vignette depicting a woman who was depressed, rural adolescents viewed the woman’s behavior as more unhealthy compared to urban adolescents. When asked what type of interventions they would recommend for the individuals depicted in the vignettes, rural adolescents were more likely to recommend punishment and violence for some behaviors (e.g., dealing with an abusive father by hitting him back or shooting him).

Other comparisons have been made between youth residing in rural and urban areas. Rates of mental illness between youth residing in rural areas and youth residing in urban areas were reported to be roughly the same (Kelleher et al., 1992). Similar rates of mental illness between rural and urban areas have also been found among adults (Kessler et al., 1994). However, some suggested that compared to rural male adolescents, urban male adolescents experienced more conflict (e.g., interpersonal disputes) and engaged in more externalizing behaviors (e.g., aggressive and disruptive behavior) (Elgar, Arlett, & Groves, 2003). Researchers have also noted that compared to adolescents residing in urban areas, rural adolescents tended to experience more loneliness, had smaller peer groups, and were more family-oriented (Elgar et al., 2003).
Rural residents have also been found to fare worse than urban residents on several indicators of general health. Eberhardt and Pamuk (2004) reported that there is a higher death rate in many rural areas due to cardiovascular disease, unintentional injuries (e.g., car accidents), suicide, cancer, and stroke, among other factors. Compared to urban residents, rural residents also have higher rates of arthritis, diabetes, obesity, and smoking (Eberhardt & Pamuk, 2004). Coupled with a general lack of health care access in many rural areas, these health conditions can have a negative impact on rural residents’ overall well-being (Eberhardt & Pamuk, 2004).

A crucial question that arises when making rural-urban comparisons for research purposes is how to operationalize the constructs rural and urban. Some argue that “it is doubtful that a consensus will ever be reached on a definition that fully captures the demographic, cultural, and economic aspects of rurality” (Jameson & Blank, 2007, p. 284). Hart, Larson, and Lishner (2005) outlined several commonly used taxonomies for defining the terms rural and urban for health policy and research. Hart et al. (2005) explained that these rural and urban taxonomies have been developed based on population size, proximity, density, adjacency and relationship to metropolitan areas, degree of urbanization, economic and trade relationships, work commutes, and principal economic activity. Hart et al. also discussed various strengths and weaknesses of each taxonomy.

The U.S. Federal Government’s Office of Management and Budget (OMB) uses the terms metropolitan (metro) and nonmetropolitan (nonmetro) instead of the terms urban and rural to classify individual counties within states (described in Hart et al., 2005). In 2003, metropolitan areas were defined as “central counties with one or more urbanized areas (cities with a population greater than or equal to 50,000) and outlying counties that are economically tied to the core” (Hart et al., 2005, p. 1151). Those counties that did not meet the metropolitan
definition were considered nonmetropolitan counties. Nonmetropolitan counties were further broken down into micropolitan counties, which were “those nonmetropolitan counties with a rural cluster with a population of 10,000 or more,” and noncore counties, which were those counties that did not fit any of the above definitions/criteria (Hart et al., 2005, p. 1151). The OMB’s definitions of metropolitan and nonmetropolitan counties are frequently used in federal policy. However, this taxonomy has been criticized because it only classifies entire counties instead of individual towns and cities, which can lead to inaccurate conclusions as to whether an individual area within a county is considered truly metropolitan or nonmetropolitan (Hart et al., 2005).

Another taxonomy was put forth by the U.S. Department of Agriculture Economic Research Service (ERS). This taxonomy, commonly referred to as the Urban Influence Codes (UIC), expanded on the OMB’s definitions of metropolitan and nonmetropolitan and classified counties on a continuum (Hart et al., 2005). As of 2003, counties were classified into one of twelve different groups (United States Department of Agriculture Economic Research Service [ERS], 2007). The ERS (2007) described this classification system by stating:

Metro counties are divided into two groups by the size of the metro area—those in ‘large’ areas with at least 1 million residents and those in ‘small’ areas with fewer than 1 million residents. Nonmetro micropolitan counties are divided into three groups by their adjacency to metro areas—adjacent to a large metro area, adjacent to a small metro area, and not adjacent to a metro area. Nonmetro noncore counties are divided into seven groups by their adjacency to metro or micro areas and whether or not they have their ‘own town’ of at least 2,500 residents.
This taxonomy has been used for research purposes, classifying counties on a continuum instead of only dichotomizing counties (Hart et al., 2005). However, since this taxonomy classifies entire counties instead of individual cities or towns, inaccuracies can occur when attempting to generalize a county’s classification number to a specific area within that county (Hart et al., 2005).

The ERS introduced a similar taxonomy called the Rural-Urban Continuum Codes. This taxonomy was updated in 2003 and is described as “a classification scheme that distinguishes metropolitan (metro) counties by the population size of their metro area, and nonmetropolitan (nonmetro) counties by degree of urbanization and adjacency to a metro area or areas” (United States Department of Agriculture Economic Research Service [ERS], 2004). Counties are subdivided into three metro categories (1-3) and six nonmetro categories (4-9), with number one signifying the most urban counties and number nine signifying the most rural counties (ERS, 2004). This taxonomy indicates how rural or urban a county is by assigning it a number on a continuum (Jameson & Blank, 2007). The Rural-Urban Continuum Codes taxonomy has been widely used, and some have suggested it is “probably the most popular method for defining rural among researchers” (Jameson & Blank, 2007, p. 284). Another advantage of this taxonomy is that it can:

- allow researchers working with county data to break such data into finer residual groups beyond a simple metro-nonmetro dichotomy, particularly for the analysis of trends in nonmetro areas that may be related to degree of rurality and metro proximity (ERS, 2004).

However, like other taxonomies that only classify counties, it is difficult to precisely categorize specific areas within counties (Jameson & Blank, 2007).
The United States Census Bureau put forth another taxonomy for classifying individual areas as either urban or rural. This widely used and cited taxonomy classifies individual areas within counties based on census tract data. As of 2000, an area was considered to be urban if it fell within an urbanized area or an urban cluster (Hart et al., 2005). Urbanized areas have core populations of 50,000 or more people while urban clusters have core populations that range from 2,500 to 49,999 people (Hart et al., 2005). Urbanized areas have core population densities of at least 1,000 people per square mile and may contain adjoining territory with at least 500 people per square mile (U.S. Census Bureau, 2000). All other areas that are not designated as urbanized areas or urban clusters are considered rural (Hart et al., 2005). Rural areas include open country and settlements with fewer than 2,500 residents (Hart et al., 2005). This taxonomy is widely used for both health policy and research purposes (Hart et al., 2005). Also, unlike county-based taxonomies, the United States Census Bureau’s taxonomy is able to identify specific areas within counties as either urban or rural (Hart et al., 2005). However, since the Census Bureau only collects data every ten years, populations can fluctuate over time, thus rendering an inaccurate classification (Hart et al., 2005).

Hart et al. (2005) discussed a few additional taxonomies for classifying rural and urban areas, including the Rural-Urban Commuting Area (RUCA) taxonomy, ERS’s Economic Typology of Nonmetropolitan Counties taxonomy, and the Frontier Area taxonomy. These researchers explained that “there is no perfect rural definition that meets all purposes” (Hart et al., 2005, p. 1154). Huge differences within and between the environment, culture, demography, and economics of rural and urban areas make it difficult to uniformly define the terms rural and urban (Hart et al., 2005). Hart et al. suggested that deciding which definition to use “depends on
the purpose at hand, the availability of data, and the appropriate and available taxonomy” (p. 1154).
Chapter II

Rationale and Hypotheses

Approximately one in five adolescents experiences the signs and symptoms of a mental illness over the course of one year (U.S. Surgeon General, 1999), but a majority of these individuals do not seek mental health treatment (Kessler et al., 1996; Whitaker et al., 1990). Chandra and Minkovitz (2007) explain “more than 70% of teens who require mental health care do not receive services” (p. 763). Research suggests that receiving treatment for a mental illness is more beneficial for the majority of children and adolescents than going without treatment (Kazdin, 2000; Weisz et al., 1995).

Barriers to receiving mental health treatment have been documented in the literature, and many of these barriers are present in rural areas (e.g., insufficient population bases to support services, trouble recruiting and retaining trained professionals, etc.) (Hauenstein et al., 2007; Kelleher et al., 1992). Negative attitudes toward mental illness and mental health services are cited as some of the most formidable barriers to receiving mental health treatment (Jackson et al., 2007; U.S. Surgeon General, 1999), and negative attitudes are thought to be particularly important barriers to receiving mental health treatment in rural areas (Fox, Blank, Rovnyak, & Barnett, 2001). Compared to their non-rural counterparts, researchers suggest rural dwellers endorse more negative attitudes toward mental health care (Hoyt et al., 1997). Rural dwellers have also been found to endorse more negative attitudes toward those who seek mental health treatment for a mental illness (Rost et al., 1993).
There is a growing literature on adults’ attitudes toward mental illness and help-seeking for psychological problems, but much less is known about youth attitudes. Researchers have noted that this area of research is “noticeably missing despite the recognition of negative attitudes towards mental health care as potential barriers to the receipt of care among teens” (Chandra & Minkovitz, 2007, p. 763). Furthermore, Penn et al. (2005) suggest:

Reluctance to seek psychological or psychiatric treatment is especially relevant to adolescents, because numerous disorders, such as major depression, bipolar disorder, anxiety disorders, anorexia and bulimia, and schizophrenia begin in late adolescence or early adulthood. Such delays in seeking treatment have important prognostic implications for individuals in this age group (p. 535).

More specifically, there are a lack of studies that investigate rural-urban differences in youth attitudes and how these attitudes might impact how and if these individuals receive mental health treatment. Due to various barriers to mental health treatment in rural areas, coupled with lower service utilization and help-seeking rates among rural residents (Jackson et al., 2007; Linn & Husaini, 1987; Lord-Flynn, 1989), negative attitudes among rural youth may make it even more difficult to provide these individuals with mental health treatment when needed. More data in this area may allow mental health treatment providers to structure services around the individual needs of rural and urban youth. Continued research may also aid anti-stigma programs (e.g., Schulze, Richter-Werling, Matschinger, & Angermeyer, 2003) in more specifically targeting the attitude and belief systems of adolescents residing in rural and urban areas to help dispel myths and reduce mental illness stigma.

Researchers suggest “direct comparisons between urban and rural settings are needed” (Jackson et al., 2007, p. 156). Jackson et al. (2007) also suggest “there are many unanswered
questions, but it is clear that psychological and attitudinal variables are worthy of much more exploration” (p. 159). Therefore, the purpose of the present study is to expand on previous research and investigate attitudes toward help-seeking and mental illness between adolescents residing in rural and urban areas in the United States. The following hypotheses are stated in directional form. Also, a series of additional research questions are posed, which will be addressed by the Help-Seeking Questionnaire.

**Hypothesis 1**

Rural adolescents will have more negative attitudes toward seeking help for a psychological problem(s) than urban adolescents, as measured by the Attitudes Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPH-SF) (Fischer & Farina, 1995).

**Hypothesis 2**

Rural adolescents will have more negative attitudes toward mental illness than urban adolescents, as measured by the Attitudes Toward Serious Mental Illness Scale-Adolescent Version (ATSMI-AV) (Watson et al., 2005).

**Additional Research Question 1**

What kind of problems would rural and urban adolescents seek help for?

**Additional Research Question 2**

Who would rural and urban adolescents seek help from if they thought they might be suffering from a psychological problem?

**Additional Research Question 3**

What might prevent rural and urban adolescents from seeking help for a psychological problem?
Chapter III
Method

Design

The present study compares two samples of adolescent high school students from rural and urban areas in the United States. Participants in each sample will be administered a series of questionnaires on a single occasion. The geographic residence of adolescents will serve as the independent variable (level 1=rural, level 2=urban). Participants' attitudes toward seeking help for a psychological problem(s), as measured by the Attitudes Toward Seeking Professional Psychological Help Scale-Short Form, and attitudes toward mental illness, as measured by the Attitudes Toward Serious Mental Illness Scale-Adolescent Version, will serve as the dependent variables.

Participants

Participants in this study will consist of 156 adolescent students from high schools in the Southeastern United States. Adolescent students from rural and urban high schools from the Southeast will serve as the rural and urban samples. A total of 78 participants will be in each sample.

Rural and urban high schools will be selected based on the ERS's Rural-Urban Continuum Code and U.S. Census Bureau's classification systems (ERS, 2004; Hart et al., 2005). Rural high schools will be in a nonmetropolitan (nonmetro) county (Rural-Urban Continuum Code of 4-9) and will not be located in an urbanized area or an urban cluster. On the
other hand, urban high schools will be in a metropolitan (metro) county (Rural-Urban Continuum Code of 1-3) and will be located in either an urbanized area or an urban cluster.

To ensure the study participants' confidentiality is protected, participants' responses will not be identified by their names. Instead, each questionnaire packet will be assigned a number. Participants' research materials will only be identified by questionnaire packet numbers.

A power analysis was conducted using the G Power 3 Program to determine sample size and effect size estimates (Faul, Erdfelder, Lang, & Buchner, 2007). Based on this analysis, to achieve standard statistical power of .80, 156 participants are needed (78 in each group). Also, based on statistical power of .80 and a total sample size of 156, medium effect sizes will be detected (.25 for ANCOVA and .5 for independent samples t-test).

Measures

**Attitudes Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPH-SF)** *(Appendix A).* Adolescents' attitudes toward seeking help for a psychological problem(s) will be measured by the Attitudes Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPH-SF) (Fischer & Farina, 1995). The ATSPPH-SF is a shortened version of the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH) (Fischer & Turner, 1970), which measures mental health treatment attitudes and has been psychometrically examined and used in a sizable number of studies (Elhai, Schweinle, & Anderson, 2008). Researchers suggest other measures, somewhat similar to the ATSPPH and ATSPPH-SF and limited in quantity, are “rarely used in research” (Elhai et al., 2008, p. 321).

The ATSPPH-SF is a 10-item measure that uses the same four-point Likert-type response format as the original ATSPPH (0=Disagree to 3=Agree). Five items are reverse scored (2, 4, 8, 9, and 10). Scores range from 0-30, and higher scores indicate more favorable mental health treatment
attitudes. Higher scores are also associated with decreased mental health treatment related stigma as well as increased emotional disclosure, patient satisfaction, and intentions to seek treatment in the future (Elhai et al., 2008). The ATSPPH-SF is comprised of two factors, including openness to seeking treatment for emotional problems (factor 1) and value and need in seeking treatment (factor 2). The ATSPPH-SF has demonstrated adequate internal consistency, ranging from .82 to .84 (Constantine, 2002; Fischer & Farina, 1995; Komiya, Good, & Sherrod, 2000), one month test-retest reliability of .80 (Fischer & Farina, 1995), and a correlation of .87 with the original ATSPPH (Fischer & Farina, 1995). Researchers suggest the ATSPPH-SF has adequate construct and criterion validity (Elhai et al., 2008). The ATSPPH-SF has been found to be negatively correlated (-.41) with the Stigma Scale For Receiving Psychological Help (SSRPH) (Komiya et al., 2000), which measures stigma-related concerns about mental health treatment (Elhai et al., 2008). Researchers have also found a relationship between higher ATSPPH-SF scores and actual mental healthcare use, which provides support for criterion validity (Elhai et al., 2008). The original ATSPPH (Fischer & Turner, 1970) was partially normed on a high school sample, but the short form was normed on a college sample (modal age of 18-years-old). The short form will be used for the present study due to its more contemporary language, succinctness, and updated factor structure.

**Attitudes Toward Serious Mental Illness Scale-Adolescent Version (ATSMI-AV)**

(Appendix B). Adolescents’ attitudes toward mental illness will be measured by the Attitudes Toward Serious Mental Illness Scale-Adolescent Version (ATSMI-AV) (Watson et al., 2005). This 21-item measure includes items about perceptions of violence, embarrassment if diagnosed as having a mental illness, social avoidance, and personal invulnerability to mental illness. Items of the ATSMI-AV were identified by “a review of existing stigma measures (primarily designed
for adults), a review of the adolescent development literature, and consultation with a group of clinicians who work with adolescents” (Watson et al., 2005, p. 770). The ATSMI-AV is comprised of five factors, including threat (factor 1), social construction/concern (factor 2), wishful thinking (factor 3), categorical thinking (factor 4), and out of control behaviors (factor 5). Items included in this measure were determined to load on a particular factor if its factor loading was less than .45 on other factors and greater than .45 on another factor. Employing a sample of 415 adolescents, Watson et al. (2005) reported factor loadings that ranged from .49 to .80. The ATSMI-AV is arranged on a five-point Likert-type scale (1=completely disagree to 5=completely agree). The scores of the items comprising each factor are summed and then divided by the number of items from the corresponding factor to produce a factor based scale score for each of the five factors (scores range from 1 to 5 for each factor). Higher scores indicate stronger endorsement of the construct and more negative attitudes. Reliability and validity statistics have not been generated for the ATSMI-AV, but this measure will be used for the present study because it is the only standardized scale located that specifically measures adolescent attitudes toward mental illness.

Help-Seeking Questionnaire (Appendix C). The Help-Seeking Questionnaire will assess what kind of problems rural and urban adolescents would seek help for (Question 1), who rural and urban adolescents would seek help from if they thought they might be suffering from a psychological problem (Questions 2 & 3), and what might prevent rural and urban adolescents from seeking help for a psychological problem (Question 4). This self-report questionnaire was developed by the researcher and consists of various multiple choice questions. Questions about preferred helping agents (Questions 2 & 3) are similar to the methodology employed by Schonert-Reichl and Muller (1996). The question about perceived barriers to seeking help for a
psychological problem (Question 4) is similar to the methodologies employed by Dubow, Lovko, and Kausch (1990) and Hornblow, Bushnell, Wells, Joyce, and Oakley-Browne (1990).

**Demographics Questionnaire (Appendix D).** A demographics questionnaire will be administered. This questionnaire will survey participants' age, grade level, gender, and race/ethnicity. Participants will be asked if they currently receive free or reduced price school lunches (Yes or No), which will assess participants' socioeconomic status (SES) (Question 5). Eligibility criteria for free or reduced price school lunches is not school or state specific; it is the same across the country (C.D. Grimes, personal communication, November 10, 2009).

Participants will also be asked if they have lived in their current county for at least three years (Yes or No) and if they have ever lived outside of their current county for at least three years (Yes or No). If participants have ever lived outside of their current county, they will be asked to report the county(ies) and state(s) in which they used to live. Data on participants' previous residence (if any) will help determine the influence (if any) that other geographic areas may have had on participants' attitudes toward help-seeking and mental illness (e.g., a participant who recently moved from Chicago, Illinois to a rural area). This will be discussed in the discussion section of the final dissertation document.

**Procedure**

Parental consent will be obtained via a form sent home with students (Appendix F). Only students who return a signed consent form will be eligible to participate in the study, except for students who are 18-years-old or older who are able to give their own consent to participate (Appendix G). After obtaining parental or student consent, students will be given the opportunity to assent to participate in the study (Appendix H). Students will be informed that their participation will be completely voluntary, that their confidentiality will be protected, and
that their choice to participate in the study will not affect their grades or eligibility to take part in school related activities. Students will also be informed that they can withdraw their participation at any time and ask questions about the study. Since participating in this study requires reading, only those students who are able to read will be invited to participate. Special education classrooms will not be sampled.

After obtaining consent and assent, questionnaire packets (containing the ATSPPH-SF, ATSMI-AV, Help-Seeking Questionnaire, Demographics Questionnaire, and Raffle Information Card; Appendices A-E) will be administered to participants in classroom settings. Participants will be informed that it should take them approximately 10-15 minutes to complete the packet of questionnaires. After participants complete their questionnaire packets, they will be thanked for participating in the study and dismissed.

Participants will be compensated for their time and participation with a chance to win a $15.00 Wal-Mart, Pizza Hut, or McDonald’s gift card. Three gift cards will be raffled off at each school. Each participant will be eligible to win only one gift card. Participants who wish to be included in the raffle will fill out an information card (Appendix E) attached to their questionnaire packet that will ask for their name, the name of the teacher whose classroom they are currently in, and the date/time. Following the completion of all questionnaire packets at a school, a raffle will be conducted. Raffle winners will be presented with their gift cards either by the researcher or a research assistant. Following the raffles, all information cards will be destroyed.
Chapter IV

Proposed Analyses

Before testing the two hypotheses, a chi square analysis will be conducted to determine if there is a difference between the rural and urban samples in regards to socioeconomic status (SES), as measured by item five on the Demographics Questionnaire. If a significant difference is detected at the .05 level, two ANCOVAs will be used to assess the dependent variables, while controlling for SES. If there is no significant difference between samples, two independent samples t-tests will be used to assess the dependent variables. In either case, the Bonferroni adjustment will be used (p value of .025 for each test). Descriptive statistics will be computed for the Demographics Questionnaire and Help-Seeking Questionnaire.

The first hypothesis states rural adolescents will have more negative attitudes toward seeking help for a psychological problem(s) than urban adolescents, as measured by the Attitudes Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPII-SF) (Fischer & Farina, 1995). Using the Attitudes Toward Seeking Professional Psychological Help Scale-Short Form scores as the dependent variable, and geographic residence of adolescents as the independent variable (level 1=rural, level 2=urban), an ANCOVA or independent samples t-test will be performed to determine if there is a significant difference between rural and urban adolescents' attitudes toward seeking help for a psychological problem(s).

The second hypothesis states rural adolescents will have more negative attitudes toward mental illness than urban adolescents, as measured by the Attitudes Toward Serious Mental
Illness Scale-Adolescent Version (ATSMI-AV) (Watson et al., 2005). Using the Attitudes Toward Serious Mental Illness Scale-Adolescent Version scores as the dependent variable, and geographic residence of adolescents as the independent variable (level 1=rural, level 2=urban), an ANCOVA or independent samples t-test will be performed to determine if there is a significant difference between rural and urban adolescents’ attitudes toward mental illness.

Additional research question one states, what kind of problems would rural and urban adolescents seek help for? Additional research question two states, who would rural and urban adolescents seek help from if they thought they might be suffering from a psychological problem? Additional research question three states, what might prevent rural and urban adolescents from seeking help for a psychological problem? These questions will be addressed by the Help-Seeking Questionnaire. Descriptive statistics will be computed for all of the items on the Help-Seeking Questionnaire.

Exploratory analyses (e.g., t-tests) will be conducted for the five factors of the Attitudes Toward Serious Mental Illness Scale-Adolescent Version (ATSMI-AV) (Watson et al., 2005) to determine if there are significant differences between factor scores. Exploratory analyses (e.g., t-tests) will also be conducted for question four of the Help-Seeking Questionnaire to determine if there are significant differences between rural and urban adolescents’ perceptions of treatment barriers.
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Appendix A

Attitudes Toward Seeking Professional Psychological Help Scale-Short Form

The Attitudes Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPH-SF) is not reproduced in this document. This measure can be found in the following journal article: Fischer, E.H., & Farina, A. (1995). Attitudes toward seeking professional psychological help: A shortened form and considerations for research. Journal of College Student Development, 36, 368-373.
Appendix B

Attitudes Toward Serious Mental Illness Scale-Adolescent Version

The Attitudes Toward Serious Mental Illness Scale-Adolescent Version (ATSMI-AV) is not reproduced in this document. This measure can be found in the following journal article: Watson, A., Miller, F., & Lyons, J. (2005). Adolescent attitudes toward serious mental illness. *Journal of Nervous and Mental Disease, 193*, 769-772. doi: 10.1097/01.nmd.0000185885.04349.99.
Appendix C
Help-Seeking Questionnaire

Instructions: Read and answer each of the following questions carefully.

(Note: A “psychological problem” is a pattern of behavioral and/or emotional difficulties that create distress in an individual’s life. Question 1 lists several types of psychological problems.)

1. What kind of problem(s) would you seek help for?
   (CHECK ALL THE BOXES THAT APPLY)
   - ☐ Anxiety (feeling nervous all the time or having panic attacks)
   - ☐ Depression (feeling sad for at least two weeks)
   - ☐ Being the Victim of Abuse/Violence (being hit by a boyfriend/girlfriend)
   - ☐ Behavior Problem (getting in trouble at school and/or home)
   - ☐ Eating Disorder (limited eating because of an intense fear of gaining weight or becoming fat)
   - ☐ Alcohol/Drug Problem
   - ☐ Problems Paying Attention (very easily distracted)
   - ☐ Academic Problems (low or failing grades)
   - ☐ Thoughts of Suicide
   - ☐ Self-Mutilation (cutting, scratching, or burning yourself)
   - ☐ Thoughts of Hurting/Killing Someone Else
   - ☐ Relationship Problem (friend, family, boyfriend/girlfriend)
   - ☐ Hearing Voices That Other People Don’t Hear
   - ☐ Seeing Things That Other People Don’t See
   - ☐ Death of a Loved One
   - ☐ Having Racing Thoughts (can’t slow down your thoughts)
   - ☐ Feeling Too Full of Energy (much more energy than you usually have)
   - ☐ Other(s): ____________________________________________
   - ☐ I would not seek help.
2. Who would you first seek help from if you thought you might be suffering from a psychological problem? (CHECK ONLY ONE BOX)

- [ ] School Counselor
- [ ] Psychiatrist
- [ ] Clergy (preacher, minister, priest)
- [ ] Friend
- [ ] Psychologist
- [ ] Principal/Vice Principal
- [ ] Family Member
- [ ] Teacher
- [ ] Social Worker
- [ ] Family Doctor
- [ ] Coach
- [ ] Other(s): __________________________
- [ ] Crisis Hotline
- [ ] Police
- [ ] I would not seek help.

3. Who else would you be willing to seek help from if you thought you might be suffering from a psychological problem? (CHECK ALL THE BOXES THAT APPLY)

- [ ] School Counselor
- [ ] Psychiatrist
- [ ] Clergy (preacher, minister, priest)
- [ ] Friend
- [ ] Psychologist
- [ ] Principal/Vice Principal
- [ ] Family Member
- [ ] Teacher
- [ ] Social Worker
- [ ] Family Doctor
- [ ] Coach
- [ ] Other(s): __________________________
- [ ] Crisis Hotline
- [ ] Police
- [ ] I would not seek help.

4. What might prevent you from seeking help for a psychological problem? (CHECK ALL THE BOXES THAT APPLY)

- [ ] Cost (too expensive)
- [ ] Don’t Think Help Is Necessary
- [ ] Lack Of Insurance
- [ ] Not Enough Time
- [ ] Not Knowing Where To Find Help
- [ ] Other People Finding Out (friends, mom, dad)
- [ ] Transportation (not having a ride)
- [ ] Don’t Like Answering Personal Questions
- [ ] Afraid You Would Be Put In The Hospital
- [ ] Too Embarrassed To Discuss The Problem With Anyone
- [ ] Afraid Of The Treatment You Might Receive
- [ ] A Family Member Would Not Let You (mom or dad)
- [ ] Believing That No One Could Help
- [ ] Lack of Mental Health Services Where You Live
- [ ] Believing The Problem Will Get Better By Itself
☐ Believing You Should Be Strong Enough To Handle The Problem Alone
☐ You Think You Can Take Care Of The Problem Yourself
☐ Other(s): _______________________________________________________
☐ I would not seek help.
Appendix D

Demographics Questionnaire

1. Age: __________

2. Grade: __________

3. Gender (circle one): Male Female

4. Ethnic/Racial Origin (circle one): American Indian/Alaskan Native Asian/Pacific Islander Black, Non-Hispanic Caucasian, Non-Hispanic Hispanic Other

5. Do you currently receive free or reduced price school lunches? (circle one) Yes No

6. Have you lived in your current county for at least 3 years? (circle one) Yes No

7. Have you ever lived outside of your current county for at least 3 years? (circle one) Yes No

8. If you answered No to Question 6 or Yes to Question 7, please list the county(ies) and state(s) in which you used to live.
Appendix E

Raffle Information Card

Name of Student: ____________________________

Name of Teacher: __________________________
(Classroom Where You Are Filling Out Questionnaires)

Date: ________________________________

Time: ________________________________
Appendix F

Parental Consent Form
(for students under 18-years-old)

Dear Parents and Guardians,

You are being asked to consent for your child to participate in a project conducted through Xavier University in Cincinnati, Ohio. The researcher will explain to your child what he or she will be doing during the project, and your child may ask him questions. Your child may choose not to participate without consequences. A basic explanation of the project is written below.

The Study About Attitudes Toward Help-Seeking and Mental Illness

Research suggests that approximately one in five adolescents experiences the signs and symptoms of a mental illness over the course of one year, but a majority of these individuals do not seek mental health treatment. There are various barriers to receiving mental health treatment. Negative attitudes toward mental illness and mental health services are cited as major barriers to receiving mental health treatment. Little is known about teenagers’ attitudes toward mental illness and seeking help for mental health problems. Therefore, the purpose of this study is to investigate attitudes toward help-seeking and mental illness between adolescents residing in rural and urban areas in the United States. More data in this area may allow mental health treatment providers to structure services around the individual needs of rural and urban teens.

The Classroom Visit

A researcher will be visiting your child’s classroom on one brief occasion. During this visit, students will complete a series of questionnaires about their attitudes toward mental illness and seeking help for mental health problems. It is estimated that this visit will last about 10-15 minutes.

The Study Data Will Be Anonymous

There are no anticipated risks of participation in this study. Data collected for this study will be anonymous. Participants’ data will be identified by a number on the front page of their questionnaire packet. These numbers will be assigned by the researcher. No names will be used. Participation in this study is completely voluntary. Students can withdraw their participation at any time.

A Raffle Will Be Conducted

Students who participate in this study will have a chance to win a $15.00 gift card from Walmart, Pizza Hut, or McDonald’s. The raffle will be conducted after all questionnaire packets are completed.
What To Do With This Form

Please check the line indicating your preference for your child to participate or not to participate, sign this form, and return it to your child’s teacher within the next week.

Questions

If you have questions at any time during this study, you may contact David Bull, M.A. at 276-698-5059, Dr. Janet Schultz at 513-745-3248, or the Chair of Xavier University’s Institutional Review Board at 513-745-3278.

Refusal to allow your child to participate in this study will have no effect on their grades or participation in other school activities.

_____ Yes, it’s okay if my child participates. _____ No, I don’t want my child to participate.

__________________________  __________________________
Child’s Name (please print)               Parent Signature

Expiration Date:__________________________
Appendix G

Student Consent Form
(for students 18-years-old or older)

Dear Student,

You are being asked to consent for your participation in a project conducted through Xavier University in Cincinnati, Ohio. The researcher will explain to you what you will be doing during the project, and you may ask him questions. You may choose not to participate without consequences. A basic explanation of the project is written below.

The Study About Attitudes Toward Help-Seeking and Mental Illness

Research suggests that approximately one in five adolescents experiences the signs and symptoms of a mental illness over the course of one year, but a majority of these individuals do not seek mental health treatment. There are various barriers to receiving mental health treatment. Negative attitudes toward mental illness and mental health services are cited as major barriers to receiving mental health treatment. Little is known about teenagers’ attitudes toward mental illness and seeking help for mental health problems. Therefore, the purpose of this study is to investigate attitudes toward help-seeking and mental illness between adolescents residing in rural and urban areas in the United States. More data in this area may allow mental health treatment providers to structure services around the individual needs of rural and urban teens.

The Classroom Visit

A researcher will be visiting your classroom on one brief occasion. During this visit, students will complete a series of questionnaires about their attitudes toward mental illness and seeking help for mental health problems. It is estimated that this visit will last about 10-15 minutes.

The Study Data Will Be Anonymous

There are no anticipated risks of participation in this study. Data collected for this study will be anonymous. Participants’ data will be identified by a number on the front page of their questionnaire packet. These numbers will be assigned by the researcher. No names will be used. Participation in this study is completely voluntary. Students can withdraw their participation at any time.

A Raffle Will Be Conducted

Students who participate in this study will have a chance to win a $15.00 gift card from Wal-Mart, Pizza Hut, or McDonald’s. The raffle will be conducted after all questionnaire packets are completed.
What To Do With This Form

Please check the line indicating your preference to participate or not to participate, sign this form, and return it to your teacher within the next week.

Questions

If you have questions at any time during this study, you may contact David Bull, M.A. at 276-698-5059, Dr. Janet Schultz at 513-745-3248, or the Chair of Xavier University’s Institutional Review Board at 513-745-3278.

Refusal to participate in this study will have no effect on your grades or participation in other school activities.

_____ Yes, I want to participate.           _____ No, I don’t want to participate.

_________________________________________          _________________________________
Name (please print)                              Signature

_________________________________________
Date of Birth

Expiration Date: ___________________________
Appendix H

Student Assent Form
(under 18-years-old)

I, _____________________________ understand that my parent or guardian has given permission for me to take part in a research project about attitudes toward mental illness and seeking help for mental health problems under the direction of David Bull, M.A. I agree to participate in this project.

I understand that I will be filling out a series of questionnaires, which will take about 10-15 minutes. I know that my participation in this study is completely voluntary, that my responses/information will be anonymous, and that my choice to participate in the study will not affect my grades or eligibility to take part in school related activities. I also know that I can withdraw my participation at any time and that I am able to ask questions. I understand that a raffle will be conducted following this project and that I will have a chance to win a gift card.

Student Assent Form
(18-years-old or older)

I, _____________________________ agree to participate in a research project about attitudes toward mental illness and seeking help for mental health problems under the direction of David Bull, M.A.

I understand that I will be filling out a series of questionnaires, which will take about 10-15 minutes. I know that my participation in this study is completely voluntary, that my responses/information will be anonymous, and that my choice to participate in the study will not affect my grades or eligibility to take part in school related activities. I also know that I can withdraw my participation at any time and that I am able to ask questions. I understand that a raffle will be conducted following this project and that I will have a chance to win a gift card.
Introduction and Assent:

“Hello. My name is ______________________ and I am here today to do an activity with you for some research I am conducting/helping to conduct through Xavier University, a school in Cincinnati, Ohio. If you are under 18-years-old, your mom, dad, or guardian has said it is okay for you to participate in this activity. If you are 18-years-old or older, you have given your own consent to participate in this activity. I am going to tell you a little about the activity and you can sign a paper to tell me if you want to participate. The activity involves filling out a series of four questionnaires about attitudes toward help-seeking and mental illness. It will take you about 10 to 15 minutes to complete the questionnaires. Your participation in this study is completely voluntary, your responses to questions will be anonymous, and your choice to participate in the activity will not affect your grades or eligibility to take part in school related activities. You can withdraw your participation at any time, and you can ask questions. If you participate in this study, you will have a chance to win a $15 gift card to Wal-Mart, Pizza Hut, or McDonald’s through a raffle that will be conducted at your school. If you want to be included in this raffle, please fill out the Raffle Information Card. Please read and answer all of the survey questions carefully.”

Then:
1. Distribute assent forms to students to read and sign and then collect the forms after completion.
2. Distribute questionnaire packets to students and then collect the packets after completion.
3. After all questionnaire packets are completed, state: “This concludes the activity. Thank you for participating in the study. Raffle winners will be notified and presented with their gift cards within the next couple of weeks.”

*Answer questions that students may have during this process.
Chapter V Dissertation

Abstract

The present study investigated attitudes toward help-seeking and mental illness between adolescents residing in rural and urban areas in the Southeastern United States. On a single occasion, a total of 182 students from grades nine through twelve (89 students in rural sample, 93 students in urban sample) completed a series of questionnaires that assessed their attitudes toward mental illness and seeking help for psychological problems. To make the samples more similar, this study controlled for an indicator of participants' socioeconomic status (SES). Results revealed that the rural adolescent sample endorsed significantly more negative attitudes toward seeking help for psychological problems compared to the urban adolescent sample. In contrast, results indicated no significant difference between rural and urban adolescents’ attitudes toward mental illness. Both rural and urban adolescents, however, endorsed somewhat negative attitudes toward mental illness. Results of additional research questions provide information regarding what kinds of problems rural and urban adolescents might seek help for, who rural and urban adolescents might seek help from, and what might prevent rural and urban adolescents from seeking help for a psychological problem. This study has implications for future mental health educational efforts and for addressing the unmet mental health needs of rural and urban youth.
Adolescent Attitudes Toward Help-Seeking and Mental Illness: A Rural-Urban Comparison

Approximately one in five adolescents experiences the signs and symptoms of a mental illness over the course of one year (U.S. Surgeon General, 1999), but a majority of these individuals do not seek mental health treatment (Kessler et al., 1996; Whitaker et al., 1990). Chandra and Minkovitz (2007) explain, “more than 70% of teens who require mental health care do not receive services” (p. 763). Research suggests that receiving treatment for a mental illness is more beneficial for the majority of children and adolescents than going without treatment (Kazdin, 2000; Weisz, Donenberg, Han, & Weiss, 1995).

There are various barriers that contribute to unmet mental health need and underutilization of mental health services among youth. Many of these barriers are thought to be more common in rural areas (Hauenstein et al., 2007; Heflinger & Christens, 2006; Judd et al., 2006; Kelleher, Taylor, & Rickert, 1992; Wagenfeld, 2003). More specifically, differences between rural and urban areas may influence adolescents’ attitudes toward mental illness and seeking help for psychological problems, yet this area of research has largely been overlooked.

Attitudes Toward Mental Illness

Researchers have focused on the relationship between attitudes and behaviors, noting hundreds of definitions of the construct attitude. General attitudes are not considered to be good predictors of specific behaviors, but research has demonstrated that specific behaviors can be predicted quite well from measuring attitudes toward the specific behavior in question (Ajzen & Fishbein, 2005). Studies investigating attitudes toward specific behaviors have reported attitude-behavior correlations of .45 (Godin, Valois, Shephard, & Desharnais, 1987), .53 (Terry & O’Leary, 1995), and .67 (Manstead, Proffitt, & Smart, 1983). More specifically, attitudes toward
mental illness and seeking help for psychological problems have gained more research attention over the years.

While there is a growing body of literature on adults’ attitudes toward mental illness (Angermeyer & Dietrich, 2006), much less is known about how children and adolescents view mental illness. Some researchers have suggested that compared to adults, youth have more negative attitudes toward individuals diagnosed with a mental illness (Stuart & Arboleda-Florez, 2001). The relatively few studies that have investigated children’s and adolescents’ attitudes toward mental illness have used a variety of methodologies including questionnaires, vignettes, storytelling, drawings, qualitative measures, differential rating scales, and interviews.

Wahl (2002) argued that even young children have a vague understanding that mental illness is a stigmatized condition, as children as young as five-years-old have been found to endorse negative attitudes toward mental illness. After his review of the literature, Wahl concluded that children (varying in ages) viewed people with mental illness as less attractive, usually sought social distance from them, and rated them less positively in various stories and descriptions compared to those not diagnosed with a mental illness.

Relatively few studies have specifically devoted attention to adolescents’ attitudes toward mental illness. These studies (e.g., Corrigan et al., 2005; Penn et al., 2005; Watson, Miller, & Lyons, 2005) demonstrated that adolescents commonly endorsed negative attitudes toward mental illness. Watson et al. (2005) concluded that adolescents’ attitudes are multidimensional and that there are improvements that can be made across all dimensions, particularly regarding the perception among some adolescents that mentally ill persons are violent and out of control. While research is limited, studies have consistently found that males endorsed more negative
attitudes toward mental illness compared to females (Pinfold et al., 2003; Watson et al., 2004; Watson et al., 2005).

**Help-Seeking**

There is a growing literature on adults’ attitudes and behavior regarding seeking help for psychological problems (Bland, Newman, & Orn, 1997; Jackson et al., 2007; Phelan, Link, Stueve, & Pescosolido, 1997; U.S. Surgeon General, 1999; Wells, Robins, Bushnell, Jarosz, & Oakley-Browne, 1994), but help-seeking among children and adolescents has been somewhat overlooked (Boldero & Fallon, 1995; Srebnik Cauce, & Baydar, 1996). Like adults, young people rarely seek professional help for psychological problems even when they are in a great deal of distress (Whitaker et al., 1990). Researchers have argued, “It is critical to identify factors that facilitate or deter adolescents’ help-seeking behavior” (Sears, 2004, p. 396).

Researchers have suggested several factors that contribute to young peoples’ decision to seek help or go without treatment. Youth were more inclined to seek help for psychological problems when they had at least some knowledge of mental health issues and were aware of the sources of help that were available (Rickwood, Deane, & Wilson, 2007). Young people were also more inclined to seek help if they felt competent to express their feelings, if they had positive attitudes toward the help-seeking process, and if they trusted their potential treatment providers (Rickwood et al., 2007). On the other hand, youth were less likely to seek help if they held negative attitudes toward seeking help, had unpleasant previous experiences with mental health treatment providers, or believed they could or should be able to deal with their problems on their own (Rickwood et al., 2007).

Youth have sought help from a variety of service providers for a range of mental health problems. Fewer than 20 percent of youth who sought help went to mental health service
providers (Srebnik et al., 1996). More children and adolescents tended to seek help from friends and family members (Boldero & Fallon, 1995). Those who decided to seek help from formal service providers often relied on medical personnel and school-based services (Barker & Adelman, 1994). Problems that have commonly prompted youth to seek help for included: interpersonal relationship difficulties, psychiatric conditions (e.g., depression), school/education problems, substance abuse, family problems (e.g., parents’ divorce), and general health concerns, among others (Boldero & Fallon, 1995; Srebnik et al., 1996).

Researchers have uncovered a couple of consistent findings in the child and adolescent help-seeking literature. One of these findings is that females sought help more frequently than males (Barnett et al., 1990; Garland & Zigler, 1994). Another fairly consistent finding is that youth from very low and very high socioeconomic status (SES) backgrounds were the most likely to utilize mental health services (Cohen & Hesselbart, 1993). However, studies on help-seeking and mental health service utilization among different races and ethnicities have produced mixed results (Cohen & Hesselbart, 1993; Howell & McFeeters, 2008).

Rural vs. Urban

Researchers have noted differences in help-seeking and mental health service utilization between rural and urban adult residents. In general, help-seeking and service utilization rates are lower among rural residents compared to their urban counterparts (Jackson et al., 2007; Linn & Husaini, 1987; Lord-Flynn, 1989). Some have suggested that rural residents have a high regard for autonomy and believe they should cope with their problems, which may prevent them from seeking professional mental health services (Judd et al., 2006; Kelleher et al., 1992).

Additional barriers to receiving mental health treatment in rural areas have been reported in the literature. Researchers have suggested that many rural dwellers simply do not recognize
the need for mental health treatment (Fox, Blank, Berman, & Rovnyak, 1999). Many other barriers to mental health treatment among rural populations have been cited in the literature, including: transportation difficulties, communication problems, trouble recruiting and retaining trained mental health professionals, funding difficulties, rampant poverty, unemployment, substance abuse problems, lack of insurance, insufficient population bases to support services, stigma, stoicism, and agrarian values (Hauenstein et al., 2007; Heffling & Christens, 2006; Judd et al., 2006; Kelleher et al., 1992; Wagenfeld, 2003).

Negative attitudes toward mental illness and mental health services are cited as some of the most formidable barriers to receiving mental health treatment (Jackson et al., 2007; U.S. Surgeon General, 1999), and negative attitudes are thought to be particularly important barriers to receiving mental health treatment in rural areas (Fox, Blank, Rovnyak, & Barnett, 2001). Compared to their non-rural counterparts, researchers discovered adult rural dwellers endorsed more negative attitudes toward mental health care (Hoyt, Conger, Valde, & Weihs, 1997). Adult rural dwellers have also been found to endorse more negative attitudes toward individuals who seek mental health treatment for a mental illness (Rost, Smith, & Taylor, 1993). Earlier studies have suggested that rural residents often did not access mental health services due to a heightened perceived stigma associated with mental illness (Kenkel, 1986). Other studies investigating adult attitude differences between rural and urban residents have produced somewhat mixed results (Martin, Pescosolido, & Tuch, 2000; Stuart & Arboleda-Florez, 2001).

There is a lack of studies that investigate rural-urban differences in youth attitudes and how these attitudes might impact how and if these individuals receive mental health treatment. Due to various barriers to mental health treatment in rural areas, coupled with lower service utilization and help-seeking rates among rural residents (Jackson et al., 2007; Linn & Husaini,
1987; Lord-Flynn, 1989), negative attitudes among rural youth may make it even more difficult to provide these individuals with mental health treatment when needed. Researchers have suggested, “direct comparisons between urban and rural settings are needed” (Jackson et al., 2007, p. 156).

Therefore, the purpose of the present study was to expand on previous research and investigate attitudes toward help-seeking and mental illness between adolescents residing in rural and urban areas in the Southeastern United States. The following hypotheses were tested: 1. Rural adolescents will have more negative attitudes toward seeking help for a psychological problem(s) than urban adolescents; 2. Rural adolescents will have more negative attitudes toward mental illness than urban adolescents. Additional research questions were: 1. What kind of problems would rural and urban adolescents seek help for; 2. Who would rural and urban adolescents seek help from if they thought they might be suffering from a psychological problem; 3. What might prevent rural and urban adolescents from seeking help for a psychological problem.

Method

Design

The present study compared two samples of adolescent high school students from rural and urban areas in the Southeastern United States. The geographic residence of adolescents served as the independent variable. Participants’ attitudes toward seeking help for a psychological problem(s), as measured by the Attitudes Toward Seeking Professional Psychological Help Scale-Short Form, and attitudes toward mental illness, as measured by the Attitudes Toward Serious Mental Illness Scale-Adolescent Version, served as the dependent variables.
Participants

A total of 182 students participated in the study. The rural sample consisted of 89 students, while the urban sample was comprised of 93 students. Students ranged in age from 14 to 19-years-old ($M_{\text{age}} = 16.83$). The total sample consisted of 39 freshmen, 8 sophomores, 53 juniors, and 82 seniors. Of the 182 participants, 73 (40.1%) were male, 109 (59.9%) were female, and 166 (91.2%) were Caucasian. A total of 94.5% of the total sample indicated that they had lived in their current county for at least three years, while 22% of participants reported they had lived outside of their current county at some point in their lives for at least three years.

The two rural high schools that were sampled had a combined total enrollment of approximately 1,054 students. Of these 1,054 rural high school students, eight percent (89 students) participated in the study. On the other hand, the two sampled urban high schools had a combined total enrollment of approximately 2,990 students. Of these 2,990 urban high school students, three percent (93 students) participated.

Rural and urban high schools were selected based on the U.S. Department of Agriculture Economic Research Service’s Rural-Urban Continuum Code and U.S. Census Bureau’s classification systems (Hart, Larson, & Lishner, 2005; United States Department of Agriculture Economic Research Service [ERS], 2004). Rural high schools were in a nonmetropolitan (nonmetro) county (Rural-Urban Continuum Code of 8) and were not located in an urbanized area or an urban cluster. In contrast, urban high schools were in a metropolitan (metro) county (Rural-Urban Continuum Code of 2) and were located in an urbanized area.

To ensure the study participants’ confidentiality was protected, responses were not identified by names. Instead, each questionnaire packet was assigned a number. Participants’ research materials were only identified by questionnaire packet numbers.
Measures

**Attitudes Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPH-SF)** *(Appendix A).* Adolescents’ attitudes toward seeking help for a psychological problem(s) were measured by the Attitudes Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPH-SF) *(Fischer & Farina, 1995).* This instrument is a shortened version of the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH) *(Fischer & Turner, 1970)*, which measures mental health treatment attitudes and has been psychometrically examined and used in a sizable number of studies *(Elhai, Schweinle, & Anderson, 2008)*. The ATSPPH-SF is a 10-item measure that uses the same four-point Likert-type response format as the original ATSPPH *(0=Disagree to 3=Agree).* Scores range from 0-30, and higher scores indicate more favorable mental health treatment attitudes. Normative data from a large college student sample has been reported for the ATSPPH-SF *(M = 17.45, SD = 5.97)* *(Fischer & Farina, 1995).* Table 6 provides a comparison of ATSPPH-SF normative mean scores to obtained mean scores. This measure has demonstrated adequate internal consistency, ranging from .82 to .84 *(Constantine, 2002; Fischer & Farina, 1995; Komiya, Good, & Sherrod, 2000)*, one month test-retest reliability of .80 *(Fischer & Farina, 1995)*, and a correlation of .87 with the original ATSPPH *(Fischer & Farina, 1995).* Researchers suggest the ATSPPH-SF has adequate construct and criterion validity *(Elhai et al., 2008)*. The original ATSPPH *(Fischer & Turner, 1970)* was partially normed on a high school sample, and the short form was normed on a college sample (modal age of 18-years-old). The short form was used for the present study due to its more contemporary language, succinctness, and updated factor structure.

**Attitudes Toward Serious Mental Illness Scale-Adolescent Version (ATSMI-AV)** *(Appendix B).* Adolescents’ attitudes toward mental illness were measured by the Attitudes
Toward Serious Mental Illness Scale-Adolescent Version (ATSMI-AV) (Watson et al., 2005). This 21-item measure includes items about perceptions of violence, embarrassment if diagnosed as having a mental illness, social avoidance, and personal invulnerability to mental illness. The ATSMI-AV is comprised of five factors, including threat (factor 1), social construction/concern (factor 2), wishful thinking (factor 3), categorical thinking (factor 4), and out of control behaviors (factor 5). The ATSMI-AV is arranged on a five-point Likert-type scale (1=completely disagree to 5=completely agree). The scores of the items comprising each factor are summed and then divided by the number of items from the corresponding factor to produce a factor-based scale score for each of the five factors (scores range from 1 to 5 for each factor). Higher scores indicate stronger endorsement of the construct and more negative attitudes.

Normative data for each of the five factor scores have been reported (factor 1 $M = 2.13$, $SD = 0.76$; factor 2 $M = 1.79$, $SD = 0.65$; factor 3 $M = 2.60$, $SD = 0.82$; factor 4 $M = 2.16$, $SD = 0.73$; factor 5 $M = 2.47$, $SD = 0.95$) (Watson et al., 2005). There is no overall mean available. Table 6 provides a comparison of ATSMI-AV normative mean scores to obtained mean scores. This measure was used for the present study because it specifically measures adolescent attitudes toward mental illness.

**Help-Seeking Questionnaire (Appendix C).** The Help-Seeking Questionnaire assessed what kind of problems rural and urban adolescents would seek help for (Question 1), who rural and urban adolescents would seek help from if they thought they might be suffering from a psychological problem (Questions 2 & 3), and what might prevent rural and urban adolescents from seeking help for a psychological problem (Question 4). This self-report questionnaire was developed by the researcher and consists of various multiple-choice questions. Questions about preferred helping agents (Questions 2 & 3) are similar to the questionnaire employed by
Schonert-Reichl and Muller (1996). The question about perceived barriers to seeking help for a psychological problem (Question 4) is similar to the questionnaires employed by Dubow, Lovko, and Kausch (1990) and Hornblow, Bushnell, Wells, Joyce, and Oakley-Browne (1990).

**Demographics Questionnaire (Appendix D).** This questionnaire surveyed participants’ age, grade level, gender, and race/ethnicity. Participants were asked if they were currently receiving free or reduced price school lunches (Yes or No), which was an indicator of participants’ socioeconomic status (SES) (Question 5). Participants were also asked if they had lived in their current county for at least three years (Yes or No) and if they had ever lived outside of their current county for at least three years (Yes or No). If participants had ever lived outside of their current county, they were asked to report the county(ies) and state(s) in which they used to live.

**Procedure**

This study was approved by the Xavier University Institutional Review Board (Appendix J). Students were first contacted by their school teachers/faculty about participating in this study, at which time the informed consent process was initiated. Parental consent was obtained via a form sent home with students (Appendix F). Only students who returned a signed consent form were eligible to participate in the study, except for students who were 18-years-old or older who were able to give their own consent to participate (Appendix G). After parental consent was obtained, students under 18-years-old were given the opportunity to assent to participate in the study (Appendix H). The only prerequisite to be able to participate in this study was the ability to read.

After obtaining consent and assent, questionnaire packets (containing the ATSPPH-SF, ATSMI-AV, Help-Seeking Questionnaire, Demographics Questionnaire, and Raffle Information
Card; Appendices A-E) were administered to participants in large group settings. Participants in the urban sample completed their questionnaire packets outside of instructional time. After participants completed their questionnaire packets, they were thanked for participating and dismissed.

Participants were compensated for their time and participation with a chance to win a $15.00 Wal-Mart, Pizza Hut, or McDonald’s gift card. Three gift cards were raffled off at each school. Each participant was eligible to win only one gift card. Participants filled out a raffle information card (Appendix E), which they detached from their questionnaire packets before completing the questionnaires. Raffle winners were presented with their gift cards by research assistants. Following the raffles, all raffle information cards were destroyed.

**Results**

Since a difference in socioeconomic status (SES) was initially expected between samples, this study attempted to make the samples more similar by controlling for an indicator of SES. To determine if there was a significant difference between the rural and urban samples in regards to an indicator of SES, as measured by item five on the Demographics Questionnaire, a preliminary chi-square analysis was conducted. This analysis indicated that the rural sample received significantly more free or reduced price school lunches ($n = 38$) compared to the urban sample ($n = 7$), $\chi^2(1, N = 182) = 28.36, p = .00, \phi = .41$. Since a significant difference was detected, two ANCOVAs were used to assess the dependent variables, while controlling for an indicator of SES. Because two ANCOVAs were conducted, a $p$ value of .025 was used for each ANCOVA.

**Attitudes Toward Seeking Help**

The first hypothesis stated rural adolescents would have more negative attitudes toward seeking help for a psychological problem(s) than urban adolescents, as measured by the Attitudes
Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPII-SF) (Fischer & Farina, 1995). A one-way ANCOVA was conducted to determine if there was a significant difference between rural and urban adolescents’ attitudes toward seeking help for a psychological problem, after controlling for an indicator of SES. Analyses revealed that the rural sample (unadjusted $M = 13.44$, $SD = 4.59$; adjusted $M = 13.16$, $SE = .55$) had significantly more negative attitudes toward seeking help for a psychological problem compared to the urban sample (unadjusted $M = 14.89$, $SD = 5.37$; adjusted $M = 15.16$, $SE = .54$), $F(1, 179) = 6.05$, $p = .015$, partial eta squared $= .03$.

**Attitudes Toward Mental Illness**

The second hypothesis stated rural adolescents would have more negative attitudes toward mental illness than urban adolescents, as measured by the Attitudes Toward Serious Mental Illness Scale-Adolescent Version (ATSMI-AV) (Watson et al., 2005). A one-way ANCOVA was conducted to determine if there was a significant difference between rural and urban adolescents’ attitudes toward mental illness, after controlling for an indicator of SES. There was no significant difference between the rural (unadjusted $M = 12.11$, $SD = 2.51$; adjusted $M = 11.99$, $SE = .28$) and urban (unadjusted $M = 12.16$, $SD = 2.59$; adjusted $M = 12.28$, $SE = .28$) samples on Attitudes Toward Serious Mental Illness Scale-Adolescent Version scores, $F(1, 179) = .48$, $p = .488$, partial eta squared $= .00$.

**Exploratory Analyses**

Analyses were conducted for the five factors of the Attitudes Toward Serious Mental Illness Scale-Adolescent Version (ATSMI-AV) to determine if there were significant differences between the samples’ factor scores. The first in a series of five independent-samples t-tests revealed no significant difference between the rural ($M = 2.33$, $SD = .83$) and urban ($M = 2.38$, $SD = .85$) samples. The second factor examined the belief that mental illness is something people can control, and the results indicated a significant difference between the rural ($M = 2.46$, $SD = .83$) and urban ($M = 2.50$, $SD = .85$) samples. The third factor assessed the extent to which mental illness is considered a normal part of life, with the rural ($M = 2.42$, $SD = .83$) and urban ($M = 2.46$, $SD = .85$) samples showing no significant difference. The fourth factor evaluated the belief that mental illness is a personal weakness, and the rural ($M = 2.50$, $SD = .85$) and urban ($M = 2.54$, $SD = .87$) samples did not differ significantly. The fifth factor explored the stigma associated with mental illness, and the rural ($M = 2.46$, $SD = .83$) and urban ($M = 2.48$, $SD = .85$) groups showed no significant difference.
samples on ATSMI-AV factor 1 (threat) scores, \( t(180) = -.41, p = .68 \). There was no significant difference between the rural \( (M = 1.97, SD = .71) \) and urban \( (M = 1.85, SD = .69) \) samples on ATSMI-AV factor 2 (social construction/concern) scores, \( t(180) = 1.16, p = .25 \). Analyses indicated no significant difference between the rural \( (M = 2.52, SD = .79) \) and urban \( (M = 2.52, SD = .74) \) samples on ATSMI-AV factor 3 (wishful thinking) scores, \( t(180) = .03, p = .97 \). Another independent-samples t-test revealed no significant difference between the rural \( (M = 2.27, SD = .81) \) and urban \( (M = 2.31, SD = .83) \) samples on ATSMI-AV factor 4 (categorical thinking) scores, \( t(180) = -.35, p = .73 \). The final independent-samples t-test in this series indicated no significant difference between the rural \( (M = 3.02, SD = 1.01) \) and urban \( (M = 3.10, SD = .82) \) samples on ATSMI-AV factor 5 (out of control behaviors) scores, \( t(180) = -.63, p = .53 \).

Exploratory chi-square analyses were computed for question four of the Help-Seeking Questionnaire to determine if there were significant differences between rural and urban adolescents' perception of treatment barriers (see Table 5). The only statistically significant difference noted in this series of analyses revealed that compared to the urban sample, the rural sample reported a lack of mental health services where they lived as a significant treatment barrier.

An additional exploratory chi-square analysis was conducted for question two of the Help-Seeking Questionnaire to determine if there was a significant difference between the total sample's preferences to first seek help from a family member or friend compared to all other helping agents. This analysis indicated a statistically significant difference, \( \chi^2 (1, N = 182) = 177.26, p = .00, \phi = .98 \).
Discussion

The present study investigated attitudes toward help-seeking and mental illness between adolescents residing in rural and urban areas in the Southeastern United States. Results indicated that the rural adolescent sample had significantly more negative attitudes toward seeking help for a psychological problem compared to the urban adolescent sample. This finding is generally consistent with previous studies that have employed adult samples. Previous research has indicated that adults residing in rural areas held more negative attitudes toward mental health care compared to those who did not reside in rural areas (Hoyt et al., 1997). Other studies have discovered that help-seeking and service utilization rates are lower among adult rural residents compared to their adult urban counterparts (Jackson et al., 2007; Linn & Husaini, 1987; Lord-Flynn, 1989) and that adult rural residents have a high regard for autonomy and believe they should cope with their problems, which may prevent them from seeking professional mental health services (Judd et al., 2006; Kelleher et al., 1992). The present finding suggests that rural and urban adolescents' attitudes toward seeking help for a psychological problem may be similar to those of rural and urban adults.

In contrast, results revealed no significant difference between rural and urban adolescents' attitudes toward mental illness, which is generally inconsistent with previous research. Several studies have demonstrated that compared to adult urban residents, adult rural residents expressed more negative attitudes toward mental illness (Magliano, DeRosa, Fiorillo, Malangone, & Maj, 2004; Rost et al., 1993; Stuart & Arboleda-Florez, 2001). The present finding is more in line with studies that discovered no rural-urban differences in regard to adult attitudes toward mental illness (Pescosolido, Monahan, Link, Stueve, & Kikuzawa, 1999; Phelan
& Link, 2004), which suggests the overall structure of rural and urban adolescents' attitudes toward mental illness may be more similar than different.

Nonetheless, both rural and urban adolescents in the present study endorsed somewhat negative attitudes toward mental illness, which is consistent with previous research that suggests negative attitudes toward mental illness among adolescents are common (Corrigan et al., 2005; Penn et al., 2005; Watson et al., 2005). In fact, both rural and urban samples expressed more negative attitudes toward mental illness (on four out of five factors of the ATSMI-AV) compared to a study conducted by Watson et al. (2005), which standardized the Attitudes Toward Serious Mental Illness Scale-Adolescent Version (ATSMI-AV). The present study supports the finding by Watson et al. (2005) that "there is certainly room for attitude improvement" regarding the perception among some adolescents that individuals diagnosed with a mental illness are violent and out of control, as both rural and urban samples scored highest on factor 5 (out of control behaviors) of the ATSMI-AV (p. 771). Perceptions that mentally ill people are violent has also been commonly reported in the adult literature (Angermeyer & Dietrich, 2006; Phelan et al., 1997).

Results of the additional research questions provide insight into what kinds of problems rural and urban adolescents might seek help for, who rural and urban adolescents might seek help from, and what might prevent rural and urban adolescents from seeking help for a psychological problem (see Tables 1-4 for total sample frequency statistics). Rural and urban adolescents reported they would most likely seek help for a drug/alcohol problem, suicidal ideation, and experiencing hallucinations, while they were least likely to seek help for described manic symptoms, general behavior problems, and relationship problems. These findings are generally in line with previous research (Boldero & Fallon, 1995; Srebnik et al., 1996). However, it is
surprising that participants were hesitant to seek help for relationship problems, as previous studies have demonstrated that youth have commonly sought help for interpersonal relationship difficulties (Boldero & Fallon, 1995; Srebnik et al., 1996). Participants in this study tended to be more willing to seek help for more extreme symptoms/problems, so they may have perceived relationship problems to be less problematic or issues that could be resolved without outside help.

Rural and urban youth reported they would be most likely to first seek help from family members and friends, whereas they were least likely to first seek help from crisis hotlines, police, teachers, and social workers. There was a statistically significant difference between family members/friends and all other helping agents on question two of the Help-Seeking Questionnaire. Several adolescents reported being open to seeking help from other sources and professionals, including: family doctors, psychologists, and clergy (see Table 3). These data are consistent with previous studies, which indicate children and adolescents usually seek help from friends and family members (Boldero & Fallon, 1995), and fewer than 20 percent of youth seek help from formal mental health service providers (Srebnik et al., 1996).

Participants reported several barriers that may prevent them from seeking help for a psychological problem. The most commonly reported barriers included: cost, thinking that one can take care of the problem alone, believing one should be strong enough to handle the problem alone, and believing the problem will get better by itself. These reported barriers are consistent with previous research (Rickwood et al., 2007; U.S. Surgeon General, 1999). There was only one significant difference found between rural and urban adolescents’ perception of treatment barriers. The rural sample reported a lack of mental health services where they lived as a
significant treatment barrier, which speaks to the harsh reality of the limited availability of mental health services in many rural areas (Jameson & Blank, 2007).

There are several implications of this study. First, there should be more concerted efforts, especially in rural areas, to educate youth about mental health issues and increase awareness of the sources of help available (Rickwood et al., 2007). The benefits of seeking help should be emphasized (Kazdin, 2000; Weisz et al., 1995). The stigma associated with seeking help and myths about mental health treatment should also be addressed through educational efforts. Moreover, mental health treatment agencies/providers should be cognizant of the hesitancy of some youth, especially in rural areas, to seek treatment, and since parents are typically involved in the help-seeking process (Srebnik et al., 1996), public mental health outreach programs should be actively involved with both youth and parents of youth.

This study indicates that some adolescents still have somewhat stigmatizing attitudes toward mental illness. Educational efforts via anti-stigma programs (e.g., Schulze, Richter-Werling, Matschinger, & Angermeyer, 2003) may help dispel myths and reduce mental illness stigma. Specifically, these programs should address the perception that mentally ill people are violent and out of control.

The present study demonstrates that there are unique concerns regarding seeking psychological help among a sample of rural youth. Results of this study also indicated youth in both rural and urban samples endorsed somewhat stigmatizing attitudes toward mental illness (both samples had higher factor scores on four out of five factors of the ATSMI-AV compared to study by Watson et al., 2005). Since negative attitudes toward mental illness and mental health services are thought to be some of the most formidable barriers to receiving mental health
ADOLESCENT ATTITUDES

treatment (Jackson et al., 2007; U.S. Surgeon General, 1999), these findings suggest the mental health needs of teenagers, especially in rural areas, may often go unaddressed.

Limitations, Strengths, and Suggestions for Future Research

There is variation among the operational definitions of rural and urban in the literature (Hart et al., 2005). Therefore, comparing the results of this study to other studies is difficult, and the results of this study may not be able to be generalized to other rural and urban areas. Also, it was not feasible to control for the myriad of demographic variables that could have influenced youth attitudes toward help-seeking and mental illness. As such, it is difficult to know for sure if geographic residence alone accounted for the significant difference discovered between participants' attitudes. However, the samples were chosen based on similar demographics (e.g., similar races/ethnicities among rural and urban students) in an attempt to isolate and detect any rural/urban differences. Also, results may have been influenced by the students who ultimately chose to participate in this study. In other words, sampling all students from the rural and urban high schools (1,054 total enrollment at rural high schools, 2,990 total enrollment at urban high schools) instead of a subset of students may have produced different results.

The present study has several strengths. It is one of the few empirical studies of its kind that directly compares samples of rural and urban teenagers in terms of their attitudes toward help-seeking and mental illness. This study also employed a quantitative research design and standardized instruments, which will hopefully allow researchers to replicate and expand on these findings, make comparisons between future studies, and eventually reach a more standardized methodology for measuring youth attitudes toward help-seeking and mental illness. The current study also employed stringent criteria when operationally defining the constructs rural and urban, as the sampled areas were classified at both the county (Rural-Urban Continuum
Codes, as discussed in United States Department of Agriculture Economic Research Service [ERS], 2004) and city/town (U.S. Census Bureau's Classification System, as discussed in Hart et al., 2005) levels.

Future research efforts should focus on developing statistically reliable and valid measures of youth attitudes toward help-seeking and mental illness and reaching a more universally agreed upon research methodology. A standardized, agreed upon methodology would allow researchers to make comparisons between studies, generalize findings, and reach firmer conclusions. Moreover, replicating the current study in other rural and urban areas of the United States is needed to test the generalizability of these results, and more research is necessary to tease out the inconsistent findings of rural and urban residents' attitudes toward mental illness. Studies employing more racially and ethnically diverse samples of teens are also needed. Finally, researchers should investigate if teenagers' attitudes toward help-seeking and mental illness actually affect their behavior in terms of personal help-seeking.

This study provides valuable insight into the unique attitudes of rural and urban adolescents. In an attempt to better meet the mental health needs of rural and urban youth, this research demonstrates the importance of considering youth attitudes toward help-seeking and mental illness and how these attitudes may play a role in facilitating or deterring adolescents from actually seeking help for psychological problems.
References


Constantine, M.G. (2002). Predictors of satisfaction with counseling: Racial and ethnic minority clients’ attitudes toward counseling and ratings of their counselors’ general and


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### Table 1

*Total Sample Frequency Statistics for Help-Seeking Questionnaire Item One: “What kind of problem(s) would you seek help for?”*

<table>
<thead>
<tr>
<th>Problem</th>
<th>Frequency Yes / No</th>
<th>Percent Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol/Drug Problem</td>
<td>125 / 57</td>
<td>68.7 / 31.3</td>
</tr>
<tr>
<td>Thoughts of Suicide</td>
<td>123 / 59</td>
<td>67.6 / 32.4</td>
</tr>
<tr>
<td>Seeing Things</td>
<td>121 / 61</td>
<td>66.5 / 33.5</td>
</tr>
<tr>
<td>Hearing Voices</td>
<td>116 / 66</td>
<td>63.7 / 36.3</td>
</tr>
<tr>
<td>Self-Mutilation</td>
<td>116 / 66</td>
<td>63.7 / 36.3</td>
</tr>
<tr>
<td>Thoughts of Hurting/Killing Someone Else</td>
<td>116 / 66</td>
<td>63.7 / 36.3</td>
</tr>
<tr>
<td>Victim of Abuse/Violence</td>
<td>112 / 70</td>
<td>61.5 / 38.5</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>106 / 76</td>
<td>58.2 / 41.8</td>
</tr>
<tr>
<td>Depression</td>
<td>105 / 77</td>
<td>57.7 / 42.3</td>
</tr>
<tr>
<td>Anxiety</td>
<td>87 / 95</td>
<td>47.8 / 52.2</td>
</tr>
<tr>
<td>Death of a Loved One</td>
<td>64 / 118</td>
<td>35.2 / 64.8</td>
</tr>
<tr>
<td>Problems Paying Attention</td>
<td>48 / 134</td>
<td>26.4 / 73.6</td>
</tr>
<tr>
<td>Racing Thoughts</td>
<td>47 / 135</td>
<td>25.8 / 74.2</td>
</tr>
<tr>
<td>Academic Problems</td>
<td>45 / 137</td>
<td>24.7 / 75.3</td>
</tr>
<tr>
<td>Relationship Problem</td>
<td>39 / 143</td>
<td>21.4 / 78.6</td>
</tr>
<tr>
<td>Behavior Problem</td>
<td>29 / 153</td>
<td>15.9 / 84.1</td>
</tr>
<tr>
<td>Feeling Too Full of Energy</td>
<td>23 / 159</td>
<td>12.6 / 87.4</td>
</tr>
<tr>
<td>I Would Not Seek Help</td>
<td>11 / 171</td>
<td>6.0 / 94.0</td>
</tr>
<tr>
<td>Other(s)</td>
<td>4 / 178</td>
<td>2.2 / 97.8</td>
</tr>
</tbody>
</table>
Table 2

_Total Sample Frequency Statistics for Help-Seeking Questionnaire Item Two: “Who would you first seek help from if you thought you might be suffering from a psychological problem?”_

<table>
<thead>
<tr>
<th>Helper</th>
<th>Frequency Yes</th>
<th>Percent Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Member</td>
<td>72</td>
<td>39.6</td>
</tr>
<tr>
<td>Friend</td>
<td>57</td>
<td>31.3</td>
</tr>
<tr>
<td>Other(s)</td>
<td>12</td>
<td>6.6</td>
</tr>
<tr>
<td>School Counselor</td>
<td>12</td>
<td>6.6</td>
</tr>
<tr>
<td>I Would Not Seek Help</td>
<td>8</td>
<td>4.4</td>
</tr>
<tr>
<td>Psychologist</td>
<td>7</td>
<td>3.8</td>
</tr>
<tr>
<td>Clergy</td>
<td>6</td>
<td>3.3</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>4</td>
<td>2.2</td>
</tr>
<tr>
<td>Family Doctor</td>
<td>2</td>
<td>1.1</td>
</tr>
<tr>
<td>Coach</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Principal/Vice Principal</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Crisis Hotline</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Police</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Social Worker</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Teacher</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>
Table 3

*Total Sample Frequency Statistics for Help-Seeking Questionnaire Item Three: “Who else would you be willing to seek help from if you thought you might be suffering from a psychological problem?”*

<table>
<thead>
<tr>
<th>Helper</th>
<th>Frequency Yes / No</th>
<th>Percent Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friend</td>
<td>81 / 101</td>
<td>44.5 / 55.5</td>
</tr>
<tr>
<td>Family Member</td>
<td>78 / 104</td>
<td>42.9 / 57.1</td>
</tr>
<tr>
<td>Family Doctor</td>
<td>49 / 133</td>
<td>26.9 / 73.1</td>
</tr>
<tr>
<td>Psychologist</td>
<td>45 / 137</td>
<td>24.7 / 75.3</td>
</tr>
<tr>
<td>Clergy</td>
<td>35 / 147</td>
<td>19.2 / 80.8</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>34 / 148</td>
<td>18.7 / 81.3</td>
</tr>
<tr>
<td>Teacher</td>
<td>33 / 149</td>
<td>18.1 / 81.9</td>
</tr>
<tr>
<td>School Counselor</td>
<td>32 / 150</td>
<td>17.6 / 82.4</td>
</tr>
<tr>
<td>Coach</td>
<td>27 / 155</td>
<td>14.8 / 85.2</td>
</tr>
<tr>
<td>I Would Not Seek Help</td>
<td>12 / 170</td>
<td>6.6 / 93.4</td>
</tr>
<tr>
<td>Crisis Hotline</td>
<td>7 / 175</td>
<td>3.8 / 96.2</td>
</tr>
<tr>
<td>Other(s)</td>
<td>7 / 175</td>
<td>3.8 / 96.2</td>
</tr>
<tr>
<td>Social Worker</td>
<td>5 / 177</td>
<td>2.7 / 97.3</td>
</tr>
<tr>
<td>Police</td>
<td>4 / 178</td>
<td>2.2 / 97.8</td>
</tr>
<tr>
<td>Principal/Vice Principal</td>
<td>4 / 178</td>
<td>2.2 / 97.8</td>
</tr>
</tbody>
</table>
### Table 4

*Total Sample Frequency Statistics for Help-Seeking Questionnaire Item Four: “What might prevent you from seeking help for a psychological problem?”*

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Frequency Yes / No</th>
<th>Percent Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost</td>
<td>109 / 73</td>
<td>59.9 / 40.1</td>
</tr>
<tr>
<td>Taking Care of Problem Yourself</td>
<td>105 / 77</td>
<td>57.7 / 42.3</td>
</tr>
<tr>
<td>Should Be Strong Enough To Handle Problem</td>
<td>100 / 82</td>
<td>54.9 / 45.1</td>
</tr>
<tr>
<td>Believing the Problem Will Get Better</td>
<td>94 / 88</td>
<td>51.6 / 48.4</td>
</tr>
<tr>
<td>Don’t Think Help Is Necessary</td>
<td>80 / 102</td>
<td>44.0 / 56.0</td>
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<tr>
<td>Not Enough Time</td>
<td>67 / 115</td>
<td>36.8 / 63.2</td>
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<tr>
<td>Not Knowing Where to Find Help</td>
<td>62 / 120</td>
<td>34.1 / 65.9</td>
</tr>
<tr>
<td>Too Embarrassed to Discuss Problem</td>
<td>61 / 121</td>
<td>33.5 / 66.5</td>
</tr>
<tr>
<td>Other People Finding Out</td>
<td>56 / 126</td>
<td>30.8 / 69.2</td>
</tr>
<tr>
<td>Lack of Insurance</td>
<td>55 / 127</td>
<td>30.2 / 69.8</td>
</tr>
<tr>
<td>Afraid of Treatment</td>
<td>52 / 130</td>
<td>28.6 / 71.4</td>
</tr>
<tr>
<td>Don’t Like Answering Personal Questions</td>
<td>50 / 132</td>
<td>27.5 / 72.5</td>
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<td>Afraid of Being Put in Hospital</td>
<td>49 / 133</td>
<td>26.9 / 73.1</td>
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<tr>
<td>Believing No One Could Help</td>
<td>41 / 141</td>
<td>22.5 / 77.5</td>
</tr>
<tr>
<td>Lack of Mental Health Services</td>
<td>29 / 153</td>
<td>15.9 / 84.1</td>
</tr>
<tr>
<td>Transportation</td>
<td>23 / 159</td>
<td>12.6 / 87.4</td>
</tr>
<tr>
<td>Family Member Not Letting You</td>
<td>22 / 160</td>
<td>12.1 / 87.9</td>
</tr>
<tr>
<td>I Would Not Seek Help</td>
<td>4 / 178</td>
<td>2.2 / 97.8</td>
</tr>
<tr>
<td>Other(s)</td>
<td>2 / 180</td>
<td>1.1 / 98.9</td>
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Table 5

*Comparison of Rural and Urban Adolescents' Perception of Treatment Barriers*

<table>
<thead>
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<th>Barrier</th>
<th>$\chi^2$</th>
<th>$p$</th>
<th>phi</th>
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<tr>
<td>Cost</td>
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<td>.40</td>
<td>-.07</td>
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<td>.03</td>
<td>.85</td>
<td>-.03</td>
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<tr>
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<td>.00</td>
<td>1.00</td>
<td>.00</td>
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<tr>
<td>Not Enough Time</td>
<td>.05</td>
<td>.82</td>
<td>.03</td>
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<tr>
<td>Not Knowing Where to Find Help</td>
<td>.14</td>
<td>.71</td>
<td>.04</td>
</tr>
<tr>
<td>Other People Finding Out</td>
<td>.13</td>
<td>.72</td>
<td>.04</td>
</tr>
<tr>
<td>Transportation</td>
<td>.11</td>
<td>.74</td>
<td>-.04</td>
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<tr>
<td>Don’t Like Answering Personal Questions</td>
<td>1.81</td>
<td>.18</td>
<td>.11</td>
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<td>1.00</td>
<td>.00</td>
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<td>3.17</td>
<td>.08</td>
<td>.14</td>
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<td>.12</td>
<td>.73</td>
<td>.04</td>
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<td>Family Member Not Letting You</td>
<td>.11</td>
<td>.74</td>
<td>.04</td>
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<tr>
<td>Believing No One Could Help</td>
<td>.27</td>
<td>.61</td>
<td>.05</td>
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<tr>
<td>Lack of Mental Health Services</td>
<td>4.64</td>
<td>.03*</td>
<td>.18</td>
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<td>Believing the Problem Will Get Better</td>
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<td>1.00</td>
<td>.00</td>
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<tr>
<td>Should Be Strong Enough To Handle Problem</td>
<td>.03</td>
<td>.86</td>
<td>.02</td>
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<tr>
<td>Taking Care of Problem Yourself</td>
<td>.12</td>
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<td>.04</td>
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* $p < .05$.  

Table 6

*Comparison of ATSMI-AV and ATSPPH-SF Normative Mean Scores to Obtained Mean Scores*

<table>
<thead>
<tr>
<th></th>
<th>Normative Mean</th>
<th>Obtained Mean (Rural / Urban)</th>
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<td><strong>ATSMI-AV</strong></td>
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<td></td>
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<tr>
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<td>2.33 / 2.38</td>
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<td>Factor 2</td>
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<td>1.97 / 1.85</td>
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<td>Factor 3</td>
<td>2.60</td>
<td>2.52 / 2.52</td>
</tr>
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<td>Factor 4</td>
<td>2.16</td>
<td>2.27 / 2.31</td>
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<tr>
<td>Factor 5</td>
<td>2.47</td>
<td>3.02 / 3.10</td>
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<tr>
<td><strong>ATSPPH-SF</strong></td>
<td></td>
<td></td>
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<tr>
<td>Total Score</td>
<td>17.45</td>
<td>13.16 / 15.16</td>
</tr>
</tbody>
</table>
Appendix A

Attitudes Toward Seeking Professional Psychological Help Scale-Short Form

The Attitudes Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPHH-SF) is not reproduced in this document. This measure can be found in the following journal article: Fischer, E.H., & Farina, A. (1995). Attitudes toward seeking professional psychological help: A shortened form and considerations for research. Journal of College Student Development, 36, 368-373.
Appendix B

Attitudes Toward Serious Mental Illness Scale-Adolescent Version

The Attitudes Toward Serious Mental Illness Scale-Adolescent Version (ATSMI-AV) is not reproduced in this document. This measure can be found in the following journal article:
Appendix C

Help-Seeking Questionnaire

Instructions: Read and answer each of the following questions carefully.

(Note: A “psychological problem” is a pattern of behavioral and/or emotional difficulties that create distress in an individual’s life. Question 1 lists several types of psychological problems.)

1. What kind of problem(s) would you seek help for? (CHECK ALL THE BOXES THAT APPLY)
   - □ Anxiety (feeling nervous all the time or having panic attacks)
   - □ Depression (feeling sad for at least two weeks)
   - □ Being the Victim of Abuse/Violence (being hit by a boyfriend/girlfriend)
   - □ Behavior Problem (getting in trouble at school and/or home)
   - □ Eating Disorder (limited eating because of an intense fear of gaining weight or becoming fat)
   - □ Alcohol/Drug Problem
   - □ Problems Paying Attention (very easily distracted)
   - □ Academic Problems (low or failing grades)
   - □ Thoughts of Suicide
   - □ Self-Mutilation (cutting, scratching, or burning yourself)
   - □ Thoughts of Hurting/Killing Someone Else
   - □ Relationship Problem (friend, family, boyfriend/girlfriend)
   - □ Hearing Voices That Other People Don’t Hear
   - □ Seeing Things That Other People Don’t See
   - □ Death of a Loved One
   - □ Having Racing Thoughts (can’t slow down your thoughts)
   - □ Feeling Too Full of Energy (much more energy than you usually have)
   - □ Other(s): ____________________________________________
   - □ I would not seek help.
2. Who would you first seek help from if you thought you might be suffering from a psychological problem? (CHECK ONLY ONE BOX)

☐ School Counselor ☐ Psychiatrist ☐ Clergy (preacher, minister, priest)
☐ Friend ☐ Psychologist ☐ Principal/Vice Principal
☐ Family Member ☐ Teacher ☐ Social Worker
☐ Family Doctor ☐ Coach ☐ Other(s): __________________________
☐ Crisis Hotline ☐ Police ☐ I would not seek help.

3. Who else would you be willing to seek help from if you thought you might be suffering from a psychological problem? (CHECK ALL THE BOXES THAT APPLY)

☐ School Counselor ☐ Psychiatrist ☐ Clergy (preacher, minister, priest)
☐ Friend ☐ Psychologist ☐ Principal/Vice Principal
☐ Family Member ☐ Teacher ☐ Social Worker
☐ Family Doctor ☐ Coach ☐ Other(s): __________________________
☐ Crisis Hotline ☐ Police ☐ I would not seek help.

4. What might prevent you from seeking help for a psychological problem? (CHECK ALL THE BOXES THAT APPLY)

☐ Cost (too expensive)
☐ Don’t Think Help Is Necessary
☐ Lack Of Insurance
☐ Not Enough Time
☐ Not Knowing Where To Find Help
☐ Other People Finding Out (friends, mom, dad)
☐ Transportation (not having a ride)
☐ Don’t Like Answering Personal Questions
☐ Afraid You Would Be Put In The Hospital
☐ Too Embarrassed To Discuss The Problem With Anyone
☐ Afraid Of The Treatment You Might Receive
☐ A Family Member Would Not Let You (mom or dad)
☐ Believing That No One Could Help
☐ Lack of Mental Health Services Where You Live
☐ Believing The Problem Will Get Better By Itself
-believing you should be strong enough to handle the problem alone
-believe you can take care of the problem yourself
-other(s):
-i would not seek help.
Appendix D

Demographics Questionnaire

1. Age: ______________

2. Grade: ______________

3. Gender (circle one): Male  Female

4. Ethnic/Racial Origin (circle one): American Indian/Alaskan Native  Asian/Pacific Islander
   Black, Non-Hispanic  Caucasian, Non-Hispanic
   Hispanic  Other

5. Do you currently receive free or reduced price school lunches? (circle one) Yes  No

6. Have you lived in your current county for at least 3 years? (circle one) Yes  No

7. Have you ever lived outside of your current county for at least 3 years? (circle one) Yes  No

8. If you answered No to Question 6 or Yes to Question 7, please list the county(ies) and state(s) in which you used to live.
Appendix E

Raffle Information Card

Name of Student: ____________________________

Name of Teacher: ____________________________
(Classroom Where You Are Filling Out Questionnaires)

Date: ____________________________

Time: ____________________________
Appendix F

Parental Consent Form
(for students under 18-years-old)

Dear Parents and Guardians,

You are being asked to consent for your child to participate in a project conducted through Xavier University in Cincinnati, Ohio. The researcher will explain to your child what he or she will be doing during the project, and your child may ask him questions. Your child may choose not to participate without consequences. A basic explanation of the project is written below.

The Study About Attitudes Toward Help-Seeking and Mental Illness

Research suggests that teens sometimes experience mental illness (for example: depression), but many of these teens do not seek professional help for these problems. There are various things that can get in the way of teens receiving mental health treatment. Negative attitudes toward mental illness and mental health services can prevent teens from receiving mental health treatment. Not much is known about teenagers’ attitudes toward mental illness and seeking help for mental health problems. Therefore, the purpose of this project is to look at teens’ attitudes toward help-seeking and mental illness so that mental health treatment providers can better help teens if or when they need it.

The Classroom Visit

The researcher will be visiting your child’s school on one brief occasion. During this visit, students will complete paper and pencil surveys about their attitudes toward mental illness and seeking help for mental health problems. This visit will last about 10-15 minutes.

The Study Data Will Be Confidential

There are no expected risks of participation in this study. Data collected for this study will be confidential. Participants’ data will be identified by a number on the front page of their survey packet. These numbers will be assigned by the researcher. Names will not be used to identify data. Participation in this study is completely voluntary. Students can withdraw their participation at any time and ask the researcher questions.

A Raffle Will Be Conducted

Students who participate in this study will have a chance to win a $15.00 gift card from Walmart, Pizza Hut, or McDonald’s. The raffle will be conducted after all survey packets are completed.
What To Do With This Form

Please check the line indicating your preference for your child to participate or not to participate, sign this form, and return it to your child’s teacher as soon as possible. The other copy of this form is yours to keep.

Questions

If you have questions at any time during this study, you may contact David Bull, M.A. at 276-698-5059, Dr. Janet Schultz at 513-745-3248, or the Chair of Xavier University’s Institutional Review Board at 513-745-3278.

Your decision to allow or not to allow your child to participate in this project will have no effect on their grades or participation in other school activities.

_____ Yes, it’s okay if my child participates.   _____ No, I don’t want my child to participate.

_________________________________________  __________________________
Child’s Name (please print)  Parent Signature

Date:________________________
Appendix G

Student Consent Form
(for students 18-years-old or older)

Dear Student,

You are being asked to consent for your participation in a project conducted through Xavier University in Cincinnati, Ohio. The researcher will explain to you what you will be doing during the project, and you may ask him questions. You may choose not to participate without consequences. A basic explanation of the project is written below.

The Study About Attitudes Toward Help-Seeking and Mental Illness

Research suggests that teens sometimes experience mental illness (for example: depression), but many of these teens do not seek professional help for these problems. There are various things that can get in the way of teens receiving mental health treatment. Negative attitudes toward mental illness and mental health services can prevent teens from receiving mental health treatment. Not much is known about teenagers’ attitudes toward mental illness and seeking help for mental health problems. Therefore, the purpose of this project is to look at teens’ attitudes toward help-seeking and mental illness so that mental health treatment providers can better help teens if or when they need it.

The Classroom Visit

The researcher will be visiting your school on one brief occasion. During this visit, students will complete paper and pencil surveys about their attitudes toward mental illness and seeking help for mental health problems. This visit will last about 10-15 minutes.

The Study Data Will Be Confidential

There are no expected risks of participation in this study. Data collected for this study will be confidential. Participants’ data will be identified by a number on the front page of their survey packet. These numbers will be assigned by the researcher. Names will not be used to identify data. Participation in this study is completely voluntary. You can withdraw your participation at any time and ask the researcher questions.

A Raffle Will Be Conducted

Students who participate in this study will have a chance to win a $15.00 gift card from Walmart, Pizza Hut, or McDonald's. The raffle will be conducted after all survey packets are completed.
What To Do With This Form

Please check the line indicating your preference to participate or not to participate, sign this form, and return it to your teacher as soon as possible. The other copy of this form is yours to keep.

Questions

If you have questions at any time during this study, you may contact David Bull, M.A. at 276-698-5059, Dr. Janet Schultz at 513-745-3248, or the Chair of Xavier University’s Institutional Review Board at 513-745-3278.

Your decision to participate or not participate in this project will have no effect on your grades or participation in other school activities.

_____ Yes, I want to participate.  ____ No, I don’t want to participate.

Name (please print) ___________________________ Signature ___________________________

Date of Birth ___________________________

Date: ___________________________
Appendix H

Student Assent Form
(for students under 18-years-old)

I, ___________________________ understand that my parent or guardian has said it is okay for me to take part in a research project about attitudes toward mental illness and seeking help for mental health problems. I agree to participate in this project.

I understand that I will be filling out some paper and pencil surveys, which will take about 10-15 minutes. I know that my participation in this study is completely voluntary, that my responses/information will be kept confidential, and that my choice to participate in this project will not affect my grades or other school activities. I also know that I can quit participating in this project at any time and that I can ask questions. I understand that a raffle will be conducted after this project and that I will have a chance to win a gift card.

_____________________________  ___________________________
Signature                        Date
Appendix I

Study Protocol

Introduction and Assent:
"Hello. My name is ___________________ and I am here today to do an activity with you for some research I am conducting/helping to conduct through Xavier University, a school in Cincinnati, Ohio. If you are under 18-years-old, your mom, dad, or guardian has said it is okay for you to participate in this activity. I am going to tell you a little about the activity and you can sign a paper to tell me if you want to participate. If you are 18-years-old or older, you have given your own consent to participate in this activity. The activity involves filling out a series of four paper and pencil surveys about attitudes toward help-seeking and mental illness. It will take you about 10 to 15 minutes to complete the surveys. Your participation in this study is completely voluntary, your responses to questions will be confidential, and your choice to participate in the activity will not affect your grades or other school activities. You can stop participating at any time, and you can ask questions. If you participate in this study, you will have a chance to win a $15 gift card to Wal-Mart, Pizza Hut, or McDonald’s through a raffle that will be conducted at your school. If you want to be included in this raffle, please fill out the Raffle Information Card. Please read and answer all of the survey questions carefully."

Then:
1. Distribute assent forms to students under 18-years-old to read and sign and then collect the forms after completion.
2. Distribute questionnaire packets to students and then collect the packets after completion.
3. After all questionnaire packets are completed, state: "This concludes the activity. Thank you for participating in the study. Raffle winners will be notified and presented with their gift cards within the next couple of weeks."
   *Answer questions that students may have during this process."
March 4, 2010

Mr. David Bull
5323 Rolston Avenue
Cincinnati, OH 45211

RE: IRB Protocol Application #0635: “Adolescent Attitudes Toward Help-Seeking and Mental Illness: A Rural-Urban Comparison”

Dear Mr. Bull:

Thank you for your thorough and detailed protocol submission and response to the requests made by the IRB to clarify your study description and consent forms. The IRB reviewers have agreed that your study is approved under the expedited category of Federal Regulation 45CFR46. Approval expires on March 4, 2011 and a Progress Report is due by that date. The form can be found online at www.xavier.edu/irb/crms.

Please note that if you wish to further modify your study, it will be necessary to obtain IRB approval prior to implementing the modification. If any adverse events occur, please notify the IRB immediately.

We truly appreciate your efforts and attention to compliance within the spirit of human subject’s protection. Great success with your research!

Sincerely,

[Signature]

Kathleen J. Hart, Ph.D., ABPP
Interim Chair, Institutional Review Board
Xavier University

c: Janet Schultz, Advisor

KH/dm
February 23, 2011

Mr. David Bull
5323 Rolston Avenue
Cincinnati, OH 45211

RE: IRB Protocol Application #0635: “Adolescent Attitudes Toward Help-Seeking and Mental Illness: A Rural-Urban Comparison”

Dear Mr. Bull:

Thank you for your progress report. Given that you are continuing to follow established protocols and are not collecting any further data, your study continues to be approved under the expedited category of Federal Regulation 45CFR46. Approval expires on March 4, 2012 and a Progress Report is due by that date. The form can be found online at www.xavier.edu/research

We truly appreciate your efforts and attention to compliance within the spirit of human subject’s protection. Great success with your research!

Sincerely,

[Signature]

Morell E. Mullins, Jr., Ph.D.
Chair, Institutional Review Board
Xavier University

c: Janet Schultz, Advisor
Appendix K

Summary

Title: Adolescent Attitudes Toward Help-Seeking and Mental Illness: A Rural-Urban Comparison

Problem. Approximately one in five adolescents experiences the signs and symptoms of a mental illness over the course of one year (U.S. Surgeon General, 1999), but a majority of these individuals do not seek mental health treatment (Kessler et al., 1996; Whitaker et al., 1990). Negative attitudes toward mental illness and mental health services are cited as some of the most formidable barriers to receiving mental health treatment (Jackson et al., 2007; U.S. Surgeon General, 1999), and negative attitudes are thought to be particularly important barriers to mental health treatment in rural areas (Fox, Blank, Rovnyak, & Barnett, 2001). However, there is a lack of studies that investigate rural-urban differences in youth attitudes and how these attitudes might impact how and if these individuals receive mental health treatment. Therefore, the purpose of the present study was to expand on previous research and investigate attitudes toward help-seeking and mental illness between adolescents residing in rural and urban areas in the Southeastern United States.

Method. The present study compared two samples of adolescent high school students from rural and urban areas in the Southeastern United States. A total of 182 students participated. The rural sample consisted of 89 students, while the urban sample was comprised of 93 students. Students ranged in age from 14 to 19-years-old (M age = 16.83). Of the 182 participants, 73 (40.1%) were male, 109 (59.9%) were female, and 166 (91.2%) were Caucasian.

Rural and urban high schools were selected based on the U.S. Department of Agriculture Economic Research Service’s Rural-Urban Continuum Code and U.S. Census Bureau’s classification systems (Hart, Larson, & Lishner, 2005; United States Department of Agriculture Economic Research Service [ERS], 2004). Rural high schools were in a nonmetropolitan (nonmetro) county (Rural-Urban Continuum Code of 8) and were not located in an urbanized area or an urban cluster. In contrast, urban high schools were in a metropolitan (metro) county (Rural-Urban Continuum Code of 2) and were located in an urbanized area.

On a single occasion, participants completed a series of questionnaires that assessed their attitudes toward mental illness and seeking help for psychological problems.

Findings. To determine if there was a significant difference between the rural and urban samples in regards to an indicator of socioeconomic status (SES), a preliminary chi-square analysis was conducted. Since a significant difference was detected, two ANCOVAs were used to assess the dependent variables, while controlling for an indicator of SES.

A one-way ANCOVA revealed that the rural sample had significantly more negative attitudes toward seeking help for a psychological problem compared to the urban sample, $F(1, 179) = 6.05, p = .015$, partial eta squared = .03.

In contrast, another one-way ANCOVA indicated no significant difference between the rural and urban adolescents' attitudes toward mental illness, $F(1, 179) = .48, p = .488$, partial eta squared = .00. While no significant difference was detected between samples, both rural and urban adolescents endorsed somewhat negative attitudes toward mental illness, particularly
regarding the perception that individuals diagnosed with a mental illness are violent and out of control.

Frequency statistics were computed for the additional research questions. Rural and urban adolescents reported they would most likely seek help for a drug/alcohol problem, suicidal ideation, and experiencing hallucinations, while they were least likely to seek help for described manic symptoms, general behavior problems, and relationship problems.

Rural and urban youth reported they would be most likely to first seek help from family members and friends, while they were least likely to first seek help from crisis hotlines, police, teachers, and social workers. Several adolescents reported being open to seeking help from other professionals such as family doctors, psychologists, and clergy.

Participants reported several barriers that might prevent them from seeking help for a psychological problem. The most commonly reported barriers were: cost, thinking that one can take care of the problem alone, believing one should be strong enough to handle the problem alone, and believing the problem will get better by itself. There was only one statistically significant difference found between rural and urban adolescents’ perception of treatment barriers. The rural sample reported a lack of mental health services where they lived as a significant treatment barrier.

Implications. This study demonstrated that there are unique concerns regarding seeking psychological help among a sample of rural youth. Results of this study also indicated youth in both rural and urban samples endorsed somewhat stigmatizing attitudes toward mental illness. Since negative attitudes toward mental illness and mental health services are thought to be some of the most formidable barriers to receiving mental health treatment (Jackson et al., 2007; U.S. Surgeon General, 1999), these findings suggest the mental health needs of teenagers, especially in rural areas, may often go unaddressed. In an attempt to better meet the mental health needs of rural and urban youth, this research underlines the importance of considering youth attitudes toward help-seeking and mental illness and how these attitudes may play a role in facilitating or deterring adolescents from actually seeking help for psychological problems.

Moreover, there should be more concerted efforts, especially in rural areas, to educate youth about mental health issues and increase awareness of the sources of help available (Rickwood, Deane, & Wilson, 2007). The benefits of seeking help should be emphasized (Kazdin, 2000; Weisz, Donenberg, Han, & Weiss, 1995). Mental health treatment agencies/providers should be cognizant of the hesitancy of some youth, especially in rural areas, to seek treatment. Since parents are typically involved in the help-seeking process (Srebnik, Cauce, & Baydar, 1996), public mental health outreach programs should be actively involved with both youth and parents of youth.

Finally, educational efforts via anti-stigma programs (e.g., Schulze, Richter-Werling, Matschinger, & Angermeyer, 2003) may help dispel myths and reduce mental illness stigma. Specifically, these programs should address the perception that mentally ill people are violent and out of control.