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Parental Attitudes Toward Help-Seeking Behaviors for Mental Health in the Hispanic Community

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Abstract

Hispanic families may experience numerous barriers to physical and mental health care and tend to underutilize mental health services (Haack et al., 2018; Umpierre et al., 2015). English proficiency and cultural factors related to perceptions of mental health may impact the likelihood of Hispanic families seeking professional help for child mental health concerns (Alvarado & Modesto-Lowe, 2017; Eiraldi et al., 2006). The present study examined parental attitudes towards seeking professional help for child mental health concerns as well as possible differences in help-seeking for child mental (i.e., ADHD and depression) and physical health (i.e., stomach flu) concerns. Fifty-one Hispanic immigrant parents (40 mothers, 11 fathers; *M*age = 35.62 years, *SD*= 8.19) completed measures to assess parental attitudes toward psychological help-seeking, likelihood to seek help for child physical and mental health concerns from formal and informal sources, and their level of familism, religiosity, and acculturation. Participants indicated a higher likelihood to seek help from informal sources than from formal sources for both child mental and physical health conditions. Additionally, participants were more likely to seek help for a child's physical health condition than for mental health concerns. These results speak of the need to examine the process of help-seeking for Hispanic parents regarding mental health concerns in their children as well as the influence of other factors in their help-seeking process, including acculturation, familism, and religiosity. Understanding these relationships can guide clinicians in identifying and problem-solving treatment barriers.

Keywords: help-seeking attitudes, service selection, familism, religiosity, acculturation

Parental attitudes toward help-seeking behaviors for mental health in the Hispanic community

The Hispanic Population

The United States (U.S.) Census estimates that over 60 million Hispanic individuals live in the U.S., making up 19% of the population and the largest minority group in the U.S. (U.S. Census Bureau, 2019). In 2016, Hispanic children represented about 25% of all children enrolled in elementary and high schools across the United States (U.S. Census Bureau, 2019). The U.S. Office of Management and Budget (OMB) defines “Hispanic” or “Latino” as “a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race” (U.S. Office of Management and Budget, 1997, p. 58789). Most Hispanic individuals use their own, or their family’s country of origin to describe their identity (Taylor et al., 2012). This preference may be so given the fact that every Latin-American country has unique ways in which they embody Latin culture. Nearly seven out of ten Hispanics living in the United States report having many different cultures, which adds to the complexity behind Hispanic cultural identity (Taylor et al., 2012). Indeed, most Hispanic individuals living in the United States deny a shared common culture with other Hispanic individuals in the same country (Taylor et al., 2012).

Hispanics also report that each one of them has a unique immigration experience, especially since their journey may be influenced by their country of origin (Taylor et al., 2012). For example, Cubans are able to claim political asylum and seek refuge under the American government (U.S. Citizen Services, 2019). However, this is not the case for individuals who come from Central or South America, even though they may be fleeing from the violence and poverty in their country as well. Additionally, immigration regulations vary by state, which may

explain why the Hispanic population in the United States has dispersed. For instance, there are over 357,000 Hispanics in Ohio alone, with 50% of them coming from Mexico, 27% of them coming from Puerto Rico, and 23% from Spain, Guatemala, or other Spanish-speaking countries (The Greater Cincinnati Latino Coalition, 2016). There are around 60,000 Hispanics in Cincinnati, with almost half of them under 18 years of age (The Greater Cincinnati Latino Coalition, 2016).

Hispanics experience racial and ethnic disparities in Child mental health (Alegria et al., 2010). The stigma of mental illness among the Hispanic population is significant (Rastogi et al., 2012; Young & Rabiner, 2015). Mental illness in the Hispanic population is often accompanied by shame, guilt, and secrecy, preventing individuals from accessing mental health resources (Yeh et al., 2003). Parents often feel stigmatized when their child has a mental illness given that they are often blamed for their child's behavior (Lawton et al., 2014).

Attention Deficit/Hyperactivity Disorder (ADHD)

ADHD is a common neurodevelopmental disorder among children and adolescents, with hallmark symptoms including inattention, hyperactivity, and impulsivity (American Psychiatric Association, 2013). The current Diagnostic and Statistical Manual of Mental Disorders (DSM-5) describes three presentations of ADHD: inattentive, hyperactive/impulsive, or combined (American Psychiatric Association, 2013). Children diagnosed with the inattentive presentation of ADHD may have significant problems focusing, staying on task, and being easily distracted. Other common challenges include making careless mistakes on classwork and/or homework assignments, staying organized, completing tasks, and disliking activities that require sustained mental effort (American Psychiatric Association, 2017). In contrast, children diagnosed with the hyperactive/impulsive presentation of ADHD may have difficulties with staying in their seats,

running or climbing in inappropriate circumstances or when staying seated is expected, and waiting their turn (American Psychiatric Association, 2017). They may act as if they are driven by a motor, unable to play quietly, and blurt out answers before a question has been finished. Children with the combined presentation experience a combination of the problems mentioned above.

An estimated six million children in the United States have a diagnosis of ADHD (National Survey of Children's Health, NSCH, 2016). The reported prevalence rate for ADHD is 9.4% for the overall U.S. population, and 6% among Hispanic children (NSCH, 2016). While data from the NSCH suggests a lower prevalence rate among Hispanic children in the United States, the actual prevalence of ADHD among Hispanic children and youth may be higher, given the disproportionally low rates of service utilization among Hispanic parents and youth (Haack et al., 2018). Such a discrepancy in service utilization further illustrates the extent to which racial and ethnic disparities in child mental health may affect the Hispanic population (Alegria et al., 2010; Gerdes et al., 2013). In essence, Hispanic children and adolescents with ADHD, and their parents, may not be aware of the treatment they need, and as a result are less likely to seek and receive appropriate treatment.

Multiple ADHD treatment modalities have been developed, including psychotropic medications as well as psychotherapy. The gold standard in ADHD treatment entails a combination of behavioral management and stimulant medication (Daly et al., 2007). Despite effective treatments, less than 50% of children diagnosed with ADHD receive treatment or professional assistance of any kind (Gerdes et al., 2013). This percentage is even lower for minority youth, especially for the Hispanic community (Gerdes et al., 2013; Yeh et al., 2003). Researchers have proposed a number of possible reasons why Hispanic children receive services

for ADHD at a rate that is lower than non-Hispanic white youth, such as, poverty, stigma, language limitations, and cultural factors (Alvarado & Modesto-Lowe, 2017; Eiraldi et al., 2006). Another significant barrier to obtaining treatment for ADHD includes parental level of acculturation.

Acculturation and Barriers to Care

According to Berry et al. (1989) acculturation is a process of cultural learning that occurs when two different groups, usually an immigrant group and a cultural majority, come into contact with each other, resulting in changes in both groups. The process of acculturation as described above can be understood as a bidimensional model, which theorizes that an individual's adherence to the dominant culture is independent of maintaining their original culture (Berry, 2003, as cited in Lara et al., 2005). According to Berry et al. (1989) there are four styles of acculturation: assimilation, integration, separation, and marginalization. *Assimilation* occurs when an individual relinquishes their cultural identity and embraces that of the cultural majority. *Integration*, on the other hand, refers to the process in which an individual maintains their cultural identity while also integrating aspects of the new culture. *Separation* occurs when the individual maintains their cultural identity while rejecting that of the new culture. In this case, the individual may lead a traditional, independent existence, detached from the dominant's culture's lifestyle. Lastly, *marginalization* occurs when an individual loses their cultural identity and is unable to identify with the majority culture as well (Berry et al., 1989). As research on acculturation continued, the definition mentioned above was adapted according to the acculturation patterns and experiences of cultural groups around the world.

The early period of investigation regarding acculturation described it as an inevitable process in which the likely result was assimilation (Teske & Nelson, 1974). Modern views of

acculturation describe it as a fluid and adaptive process that allows for personal choice, which is important since many immigrants identify with two or more cultures (LaFromboise et al., 1993). Hence, the more recent definitions do not necessarily abide to the four stages of acculturation that Berry et al. (1989) described. For instance, Antshel (2002) created an acculturation model that described acculturation as an adaptation process immigrant groups experience after interacting with the dominant culture. The theories and measures of acculturation adapted from Berry et al.'s acculturation model have been adapted to investigate the relationship between acculturation and other variables, such as health outcomes and barriers to care. For example, Eiraldi (2006) found parental acculturation to be associated with level of mental health service utilization for children in ethnic minority families.

Parental acculturation should be considered when examining barriers to care for mental health in the Hispanic population, since a lack of acculturation has been identified as an intrapersonal cultural barrier for Hispanic parents in seeking mental health services (Leong et al., 1995). Highly acculturated individuals express more positive attitudes toward the use of mental health services than do less acculturated individuals (Sanchez & Atkinson, 1983; Sanchez & King, 1986). Sanchez and King (1986) also found that, in a sample of primarily Mexican participants, a strong cultural commitment to the Mexican culture produced less favorable attitudes toward using psychological services, including counseling. However, there appears to be some discrepancy between studies regarding the effect that acculturation can have on Hispanic individuals' attitudes on mental health help-seeking behaviors. For instance, some studies have found an inverse relationship between acculturation and attitudes related to use of mental health services among Hispanic individuals, in that those who are less acculturated to the American culture tend to have positive attitudes toward mental health help-seeking behaviors

(e.g., Ramos-Sanchez et al., 1999; Ramos-Sanchez & Atkinson, 2009; Ruelas et al., 1998). Thus, research has demonstrated that Hispanic individuals' level of acculturation may influence their help-seeking behaviors, including those related to mental health. However, the discrepancy in the literature regarding the relationship between acculturation and help-seeking behaviors in the Hispanic population suggests a need to further investigate this relationship.

Models for Understanding Help-Seeking

Several models have been developed to understand when, how, and where individuals determine to seek assistance for mental health concerns (Andersen, 1995; Goldsmith et al., 1988; Pescosolido, 1991, 1992; Power et al., 2005). Generally, these models involve the following four stages of help-seeking: problem recognition, decision to seek help, service selection, and service utilization. In the problem recognition stage, individuals first recognize they have a problem they may need additional assistance solving. Following problem recognition, individuals tend to weigh the pros and cons of seeking help and the extent to which additional assistance may be helpful (i.e., decision to seek help). This pattern of thinking leads individuals to decide which types of services will be most beneficial under their circumstances (i.e., service selection), with a final commitment to utilizing specific services to resolve their problems (i.e., service utilization). Although the aforementioned models reference these four stages, each provides relevant factors to consider when aiming to understand help-seeking behaviors. For example, Pescosolido (1991, 1992) emphasized the influence that size and cohesion of an individual's social network can have on a person's decision to seek help. Hence, some of these models have been adapted and expanded to account for the needs of specific populations, including their social network. Eiraldi et al. (2006) is an excellent example of this, for the authors recognized the need for a model that

would incorporate the unique needs of ethnic minority children and adolescents coping with specific conditions, particularly ADHD.

ADHD Help-Seeking Behavior Model

Eiraldi et al's. (2006) ADHD Help-Seeking Behavior Model (HSB) was adapted from Cauce et al's (2002), Srebnik et al's (1996), and Goldsmith et al's (1988) models, all of which incorporate the influence of cultural and contextual factors across the help-seeking process. Eiraldi et al's ADHD HSB model describes the four stages of help-seeking within the context of factors that are hypothesized to influence each stage. Since the model focuses on the help-seeking process for ADHD, the model considers several variables that pertain to ADHD and are likely to differentiate across ethnic minority groups, such as sociocultural norms and values (e.g., acculturation, stigma), economic factors (e.g., transportation, Medicaid eligibility), and community resources (e.g., bilingual staff, English language proficiency). Additionally, some variables may be more applicable in some stages of the help-seeking process than in others.

Stage 1, problem recognition, entails a comprehensive multi-informant, multi-method diagnostic assessment (American Psychiatric Association, 2013; Barkley, 2015). This assessment procedure usually includes clinical interviews with the parents and the child, parent and teacher rating scales, behavioral observations, and testing (Barkley, 2015). Notably, the Hispanic population has been deemed particularly vulnerable to certain barriers regarding problem recognition for ADHD. These barriers include socioeconomic influences (i.e., poverty and being underinsured), lack of knowledge about ADHD, and the influence of cultural values regarding parental beliefs about the cause of ADHD-related behaviors (e.g., Haack et al., 2018; McLeod et al., 2007; U.S. Census Bureau, 2019; Zambrana & Carter-Pokras, 2004). Stage 2, or the decision to seek help, can be influenced by multiple variables, including parental fears due to stigma,

parental mistrust in the health care system, acculturation, parental knowledge of ADHD, and acceptability of treatment for ADHD (Arcia & Fernandez, 1998; Eiraldi et al., 2006; Fernandez & Arcia, 2004; Gerdes et al., 2013). These variables are culturally based, and culture is hypothesized to influence all help-seeking stages.

Stage 3, service selection, may be impacted by different variables as well, including community and social networks, service characteristics, societal factors, and economic factors. Similar to Caucasian parents, parents of ethnic minorities tend to rely on their friends and family members first before they seek professional assistance (Eiraldi et al., 2006). Hence, the composition of their social network may affect which type of professional assistance, if any, they will seek. Bussing et al. (2003) found that individuals whose social network included health care professionals were more likely to seek professional or medical treatment than those whose social network was more restricted. Service characteristics can also determine what types of services parents select, especially given other related factors, such as the stigma of mental health in the Hispanic community (Rastogi et al., 2012). Thus, Hispanic families may be reluctant to seek psychological assistance if their child is exhibiting ADHD symptoms. Economic factors need to be considered as well, given that many ethnic minorities do not have access to health insurance due to financial instability and for some, undocumented immigrant status in the United States. Hence, they may not have access to the same resources as others living in the United States.

Lastly, stage 4, or service utilization, is influenced by parents' perceived quality of care, service integrity, and treatment adherence (Eiraldi et al., 2006). Notably, service utilization patterns are likely to differ markedly as a function of a family's ethnic and cultural membership. Consequently, factors such as acculturation and cultural values may influence service selection

and service utilization patterns. This is particularly significant for chronic mental health conditions, such as ADHD.

ADHD is a condition that requires long-term monitoring and treatment, with optimal care defined as using behavioral parent training, psychostimulant medication, and accommodations at school (American Psychiatric Association, 2013). Importantly, the ADHD HSB model attempts to incorporate factors that may promote or diminish service utilization and adherence over time. Eiraldi et al. (2006) divided these factors into three categories: quality of care, service integrity, and treatment adherence. Regarding quality of care, studies have found that individuals in ethnic minorities believe they receive mental health services of substandard quality compared to the services non-minority populations receive (Alegría et al., 2002; Bridges et al., 2012). This negative perception regarding the quality of care they receive may preclude parents in ethnic minorities to seek mental health services. Furthermore, quality of care and service integrity go hand in hand. Thus, Eiraldi et al. hypothesized that ethnic minorities may believe health care institutions lack service integrity. Treatment adherence may also be impacted, especially since ADHD requires long-term care. Literature has found that low socioeconomic status (SES) and minority status correlate to early drop out and poor adherence to parent training in behavior management (Kazdin & Mazurick, 1994). Notably, the four stages of the ADHD HSB model are interrelated and families typically navigate the pathway in a unidirectional way. Although the model incorporates hypothesized variables specific to each stage of the process, these variables have the potential to impact all four stages. The ADHD HSB model is also unique in that it accounts for hypothesized variables affecting the help-seeking process in ethnic minorities, including the Hispanic population. One of the variables that warrants further exploration is acculturation.

Multiple studies have focused on developing and researching help-seeking behavior models for Hispanic/Latinx parents with children diagnosed with ADHD as well as the influential factors leading parents to seek psychological assistance (e.g., Eiraldi et al., 2006; Hack & Gerdes, 2011; Lawton et al., 2014). However, the extent to which parental acculturation and the behaviors parents consider abnormal affect help-seeking behavior in this population is still largely unexplored (Araujo et al., 2017; Haack et al., 2011; Koneru et al., 2007; Nguyen et al., 2007). The evaluation of these factors coupled with the identification of predictors of parental help-seeking behaviors for Hispanic parents could lead the psychological community to further assist Hispanic youth with ADHD. The influence of cultural values on help-seeking behavior is also relevant, as these values may be applied to further decrease the stigma in the Hispanic community regarding help-seeking behaviors for mental health (Abdullah & Brown, 2011). As a result, the influence of cultural values and acculturation on help-seeking behaviors for mental health is worth exploring.

Cultural Values of the Hispanic Population

There is a large body of research identifying cultural values of familism and religiosity as being strong predictors of help-seeking behaviors in the Hispanic population (Keeler et al., 2014; Ramos-Sanchez & Atkinson, 2009; Sabina et al., 2012). *Familism* is defined as a strong attachment to and reliance on the nuclear and extended family; it is characterized by loyalty, honor, and unity (Lawton et al., 2014; Schwartz, 2007). Individuals are expected to respect authority figures and be interdependent and sacrificial for the good of the family. *Religiosity* may take the form of religious faith, or other means of spiritual expression depending on a person's belief system. Religiosity can be understood as a heightened awareness, consciousness, and connectedness with all beings, including an all-powerful universal being, should the person

believe this being exists (Baez & Hernandez, 2001). Parents may view disruptive behavior as an indication that the child is out of balance in their religiosity, leading them to seek services from spiritual leaders rather than health care providers (Yeh et al., 2005). Another important predictor of help-seeking behaviors in the Hispanic population includes individual attitudes regarding help-seeking for mental health concerns.

Parental Attitudes toward Help-Seeking for Child Mental and Physical Health

Hispanics are considered the fastest growing minority in the United States and are at an increased risk for physical and mental health concerns (Valdez et al., 2011). As a group, they have low rates of seeking services for physical health concerns and even lower rates for seeking mental health services (Alvidrez, 1999). Hispanics and other minority groups are thought to have a lack of trust in the health care system (Mayo et al., 2007), and such distrust may influence parental attitudes toward seeking help for child physical and mental health conditions, including ADHD. Research has found that Hispanics in general and Hispanic children in particular tend to underutilize mental health services or significantly delay entry to care (Umpierre et al., 2015). An underlying variable in Eiraldi et al's (2006) ADHD HSB model is parental attitudes toward help-seeking behaviors regarding mental health conditions. These parental attitudes, especially regarding mental health concerns for ethnic minority youth, may preclude or promote help-seeking behaviors (Turner & Liew, 2010).

McKay et al. (2001) conducted two studies to examine child, family, and environmental influences on initial attendance and ongoing mental health service at an urban treatment center. Study 1 examined the relationship between child characteristics and service use in a large sample of clinic-referred youth. The authors identified several child factors (i.e., age, gender, race/ethnicity, and mental health need) and their relationship to ongoing service usage. The

sample consisted of 405 children (*M*age = 9.5, *SD* = 3.6 years) whose parents requested an appointment at an urban child mental health center. The children included in the study were primarily African American (73%), with Caucasian (15%), Hispanic (11%), and other ethnicities (< 1%) making up a smaller portion of the sample.

Results demonstrated that only 64% of the children were ever brought to an appointment, even though parental reports signaled clinically significant mental health needs for their children during the telephone intake assessment. Children who did attend appointments had a higher impulsive-hyperactive score than those who did not attend services. Given these results, McKay et al. (2001) completed a second study exploring the influences of family factors and environmental barriers on initial attendance and ongoing service. A new sample of 100 children (*M*age = 10.1, *SD* = 3.7 years) whose caregivers had requested an appointment at the same facility were included. Similar to Study 1, level of child mental health need, gender, and age of the child did not significantly predict initial attendance at intake appointment. However, findings indicated that parental efficacy and positive attitudes toward mental health services significantly correlated with child attendance at the initial intake appointment. Specifically, there was a 49% decrease in the odds of a child coming to the intake if caregivers expressed skepticism regarding the efficacy of mental health care. Additionally, there was a 26% decrease in the odds of attending the initial appointment as parental report of discipline problems increased. Results further demonstrated that higher levels of family stress predicted lower attendance at scheduled appointments. Thus, McKay et al. found that for a sample of urban largely minority parents, low parental efficacy, negative attitudes toward mental health services, and family stress significantly correlated with decreased attendance at an initial intake appointment.

Turner et al. (2015) also examined the role of parental attitudes toward help-seeking behaviors for their child's mental health concerns. The authors aimed to understand parental attitudes across ethnic groups and explored the extent to which ethnicity and stigma moderated the relationship between parental attitudes and intentions to seek mental health service. A total of 238 caregivers (*M*age = 43.4 years, *SD* = 6.1 years; 48% European American, 35% African American, and 17% Hispanic American) were recruited from urban Head Start programs and community public schools in Texas, Louisiana, and Mississippi. Participants completed a demographic questionnaire during which they indicated past experience with mental health services. They also completed the Parental Attitudes Toward Psychology Services Inventory (PATPSI; Turner, 2012), a 21-item questionnaire assessing attitudes, intentions, and stigmatization regarding mental health services. Results demonstrated that positive attitudes regarding mental health services was associated with an increased likelihood of seeking services for European-American parents. However, this was not the case for African American or Hispanic American parents. Moderation by ethnicity was also found for the relationship between stigma and help-seeking intentions, such that Hispanic Americans who reported more stigma were less likely to seek treatment. Thus, results from Turner et al. demonstrated that stigma within Hispanic American caregivers perpetuate negative attitudes toward mental health services, reducing the likelihood they would seek psychological services when necessary.

McKay et al. (2001) and Turner et al. (2015) demonstrate that negative attitudes regarding mental health can impact help-seeking behaviors. Their findings are consistent with the broader literature regarding mental health help-seeking among Hispanic parents. Negative attitudes towards help-seeking are partly due to the stigma surrounding mental illness in the Hispanic community (DeFreitas et al., 2018; Mendoza et al., 2015). Specifically, studies

examining depression and mental health treatment in the Hispanic population demonstrated that certain attitudes (e.g., being ashamed of discussing emotional problems with clinicians, not wanting to discuss emotional problems outside the family, believing that antidepressants are addictive, and endorsing self-reliant attitudes) may deter individuals from seeking mental health care (Alvidrez, 1999; Cooper et al., 2003; Givens et al., 2007; Ortega & Alegría, 2002).

Additionally, these negative attitudes seem to affect individuals who seek help when experiencing mental health symptoms. Cabassa (2007) found that Hispanic men who reported the aforementioned attitudes toward mental health services found faith in God and seeking help from family members as important help-seeking strategies. Nevertheless, other factors such as financial and structural barriers may influence the help-seeking process. For instance, cultural values and acculturation level may influence help-seeking behaviors; however, the extent to which they do so is unclear. Research has demonstrated the relationships between acculturation, cultural values, and help-seeking behaviors, and yet the type of relationship these factors have is unclear. Specifically, it is unclear whether these elements moderate the relationship between attitudes toward mental health services for a child and help-seeking in general (i.e., service selection).

Parent Acculturation, Cultural Values, and Help-Seeking for Child ADHD

Ramos-Sánchez and Atkinson (2009) examined the relationship between acculturation, cultural values, gender, and help-seeking intentions among 262 Mexican American community college students (80 male, *M*age = 27.00, *SD* = 9.02). Ramos-Sánchez and Atkinson hypothesized that greater endorsement of Hispanic cultural values (e.g., familism, machismo, folk illness beliefs, religiosity, and fatalism) would be associated with less favorable attitudes toward seeking mental health services. This assumption is based on the notion that values

inherent in the Hispanic culture conflict with values inherent in psychotherapy. Contrary to their hypothesis, results demonstrated that as the participants' level of acculturation increased, their attitudes toward help-seeking in regard to mental health services became less favorable. Nevertheless, the literature regarding level of acculturation, cultural values, and help-seeking behavior has produced mixed findings, allowing this to be an area of interest when evaluating help-seeking behaviors in the Hispanic community.

In an effort to investigate the relationship between cultural values, level of acculturation, and etiological beliefs about ADHD in the Hispanic community, Lawton et al. (2014) recruited 74 Hispanic parents (*M*age = 37.30, *SD* = 5.30) who had at least one child between the ages of 5 and 12 years. Lawton et al. (2014) found that the cultural values of familism and traditional gender roles were positively correlated with sociological and spiritual beliefs regarding the etiology of ADHD. Additionally, both familism and traditional gender roles were associated with several belief subcategories within the sociological and spiritual domain, such as beliefs about friends (e.g., friends causing ADHD), religiosity, and nature disharmony. Thus, Lawton et al. identified cultural factors (i.e., acculturation level and cultural values) that correlated to parents' etiological beliefs regarding ADHD, indicating that cultural factors may influence parental help-seeking behaviors, including service selection. This is why service selection warrants further exploration.

The present study examined parental attitudes towards mental health help-seeking as well as possible differences in help-seeking for mental and physical health concerns (i.e., depression, ADHD combined type, and stomach flu). The study further explored whether acculturation and cultural values of familism and religiosity moderated the relationship between these attitudes and help-seeking behaviors, such as service selection for Hispanic parents.

Method

Participants

Parents who identified as Hispanic and had a child who was younger that 18 years of age were recruited from a non-profit service agency in a Midwest state. Inclusion criteria included participants residing in the greater Cincinnati area who had the ability to communicate either verbally or written in English or Spanish. A total of 51 Hispanic parents provided consent to participate in the study. The mean age of participants was 35.62 years (*SD* = 8.19), with the majority of the sample being mothers (40 mothers, 11 fathers). The majority of participants were born in Guatemala (52.9%), followed by Mexico (23.5%). About 14.7% of participants identified their country of origin as Other, which included Cuba, Dominican Republic, El Salvador, Nicaragua, and Venezuela. Approximately 10% of participants identified as being born in Honduras. Regarding participants' length of time residing in the United States, 66.7% indicated living in the United States for more than 5 years, 25.5% indicated between 1 to 5 years, and the rest of the participants had lived in the United States between 6 months to 1 year. Participants' scores on the Brief Acculturation Scale for Hispanics (BASH; Norris et al., 1996) ranged from 1 to 3, indicating that all participants were considered to be low in acculturation. Per self-report, 72% of parents spoke only Spanish at home, 72.5% read only in Spanish, 78.4% of parents speak only Spanish with friends, and 74.5% of participants thought only in Spanish. Demographic variables are summarized in Table 1.

Measures

Demographic Information. Participants completed a demographics questionnaire (Appendix A) containing items pertaining to participant's age, gender identification, country of

birth, length of residency in the United States, and the age of the youngest and oldest child living with them in the United States.

Acculturation. The Brief Acculturation Scale for Hispanics (BASH; Norris et al., 1996) was used to measure participants' level of acculturation. The BASH is a four-multiple choice-item, language-based measure of acculturation and is available in both English and Spanish (Appendix B and C). Participants selected the best answer choice for them, with item responses scored as 1 = *only Spanish*, 2 = *Spanish more than English*, 3 = *Spanish and English equally*, 4 = *English more than Spanish*, and 5 = *only English*. In order to obtain an acculturation score, items are summed and divided by the number of items completed. Scores range from 4 to 20, with higher scores indicating greater levels of acculturation. The BASH uses a score cut-off point of 4.0 to create a dichotomous acculturation grouping variable, with scores less than or equal to 4.0 indicating "low acculturation" and scores greater than 4.0 indicating "high acculturation." The BASH has been used in other studies as a continuous measure with the Hispanic population as well (Heerman et al., 2017; Heerman et al., 2019; Nuyen et al., 2016).

The BASH items were derived from the Language Use subscale of the Short Acculturation Scale for Hispanics (Marín et al., 1987). Relevant literature has demonstrated that language accounts for the greatest proportion of variance in acculturation and is suggested to be the most reliable indicator of the construct (Marín et al., 1987; Norris et al., 1996). Norris et al., (1996) found that it can be used with all Hispanic groups, as opposed to other acculturation measures developed for particular Hispanic subgroups. The BASH demonstrates strong internal consistency, with Cronbach's alpha values ranging from 0.74 to 0.94 (Hsin et al., 2010; Norris et al., 1996, Unger & Molina, 1998, 2000). Mills et al. (2014) found strong internal consistency for both English and Spanish versions as well, with Cronbach's alpha values of 0.89 and 0.90,

respectively. Cronbach alpha for present sample was 0.85. The BASH also demonstrates strong convergent validity (Hsin et al., 2010; Mills et al., 2014; Norris et al., 1996; Unger & Molina, 2000). An additional advantage of the BASH is its brevity, demonstrating that the BASH significantly contributes to the literature in a more useful, efficient, or accurate manner than existing measures (Mills et al., 2014).

Service Selection. Preference of formal versus informal sources of service selection was measured through the use of three vignettes (Appendices D, E, F, G, H, and I) based on the General Help-Seeking Questionnaire-Vignette (GHSQ-V; Wilson et al., 2011). Three vignettes depicting a child experiencing physical (i.e., stomach flu) and behavioral health (i.e., depression and ADHD) were developed for this study. The Child depression vignette was adapted from Olivari and Guzmán-González's (2017) Spanish version of the GHSQ-V and the other two vignettes were developed to be similar with regard to length as well as duration and severity of the condition. These vignettes were translated, back translated, and pilot tested to ensure the integrity of the items. Following each vignette, participants read the following prompt before responding, "If your child was having these problems, how likely is it that you would seek help from the following sources?" The original GHSQ-V contains seven vignettes (e.g., depression, anxiety) with 12 follow-up questions where participants rate likelihood of seeking help from a variety of sources (e.g., intimate partner, friend, parent, family member who is not a parent, mental health professional, or family doctor) using a seven-point scale. Sources of support for the current study were adapted to reflect common formal and informal sources for the population of interest, which is consistent with developer recommendations (see Deane & Wilson, 2007). Formal sources for this study were mental health professional, teacher or school counselor, and medical provider, and informal sources of support were family members or intimate partner,

friend or neighbor, and religious leader. In the original GHSQ-V, higher scores indicate greater likelihood of seeking help, however, due to a translation error in the current study, the anchor points were reversed with 1 = *"Extremely Likely"* and 7 = *"Extremely Unlikely"*. As such, in the present study, lower average scores indicate higher likelihood of help-seeking.

Although there is limited information regarding the range of scores for the GHSQ-V, the original measure from which it was adapted from, the GHSQ, provides information regarding typical scoring patterns and divides the different sources of support into two categories: formal (e.g., doctor/general practitioner, phone helpline) and informal (e.g., friend, relative; Wilson et al., 2005). Cronbach alpha for the scales in this study were as follows: ADHD formal sources = 0.68, ADHD informal sources = 0.40, stomach flu formal sources = 0.71, stomach flu informal sources = 0.43 , depression formal sources = 0.82 , and depression informal sources = 0.53 .

Cultural Values. Participants' cultural values of familism and religiosity were measured with the Spanish translation of the Mexican American Cultural Values Scale for Adolescents and Adults which is available in English and Spanish (MACVS; Knight et al., 2010; Appendices J, K, L and M). The MACVS is a 50-item measure containing nine subscales that assess traditional Hispanic and mainstream American values, including familism, respect, religion, and traditional gender roles as well as independence/self-reliance and competition/personal achievement. Despite the name of the measure, the items are not specific to a particular Hispanic nationality (e.g., Mexican). Thus, the measure is acceptable to use with a wide Hispanic population. The item responses are measured on a five-point Likert scale, ranging from 1 (*not at all*) to 5 (*completely*). Higher scores represent higher presence, or endorsement of cultural values. Sample items from the familism and religion subscales include "*children should always be polite when speaking to an adult*" or "*one's belief in God gives inner strength and meaning to life*." The

present study only included items from the "familism" and "religion" scales since these are the two cultural values explored in the study.

The familism scale contains three subscales, familism-support, familism-obligations, and familism-referent, totaling 16 items, whereas the religion scale contains a total of seven items. To reduce burden on participants, only the five items pertaining to the familism-referent subscale were included in this study. The familism-referent subscale measures three main components of familism, which includes relying on family for support and the use family values as behavioral and attitudinal referents (Marín & Marín, 1991). The scores for the familism-referent subscale range from 5 to 25, whereas for the religion scale, scores can range from 7 to 35. Notably, other studies have also utilized a few scales of the MACVS instead of the entire measure and have found the scales to be valid and reliable indicators of participants' values (Gonzales et al., 2008; Morgan-Consoli et al., 2016). The scale has been used individually and in conjunction with other MACVS scales with the Hispanic population and in similar types of studies (Gonzales et al., 2008; Umaña-Taylor et al., 2011). The MACVS also demonstrated adequate construct validity, as it related to similar constructs, including ethnic pride, social support, and parental acceptance (Knight et al., 2010). Cronbach alpha in this sample was 0.72 for the MACVS Familism scale and 0.75 for the MACVS Religiosity scale.

Parental Attitudes Toward Help-seeking. Parental attitudes toward help-seeking were measured with the Parental Attitudes toward Psychological Services Inventory (PATPSI; Turner, 2012). The PATPSI (Appendix N and O) is a 21-item measure assessing parents' help-seeking attitudes, intentions, and mental health stigma. The measure is available in both English and Spanish. Individuals rate each item on a 6-point Likert-type scale ranging from 0 (*Strongly Disagree)* to 5 (*Strongly Agree*). The item scores are totaled into domain scores for help-seeking

attitudes, intentions, and mental health stigma. Domain scores range from 0 to 25 for the help-seeking intention items while ranging from 0 to 40 for the help-seeking attitude and stigmatization items. Higher scores on each domain represent more positive attitudes, higher likelihood of seeking services, and more stigma toward services. Notably, the help-seeking attitude items are reverse coded. In this study, only the help seeking attitudes scale was used.

The PATPSI has demonstrated adequate internal consistency for the PATPSI total scale and subscales (i.e., help-seeking intentions, help-seeking attitudes, and stigmatization). The test-retest reliability of the measure is adequate to strong, and Cronbach’s alphas range from 0.66 to .84 (Turner, 2012). Cronbach alpha for the help seeking attitudes scale in this sample was .78. The PATPSI been demonstrated to have sound psychometric properties when used with the Hispanic population as well (Selles et al., 2015; Turner, 2012; Turner et al., 2015).

Procedure

Permission for the study was obtained from Xavier University Institutional Review Board (IRB; Appendix P) and Su Casa Hispanic Center’s Continuous Quality Improvement (CQI) Committee (Appendix Q). Upon IRB and CQI approval, participants were recruited using flyers (Appendix R and S) at health fairs and sponsored events at a non-profit organization offering services to the Hispanic population in Cincinnati, Ohio. Participants who met inclusion criteria and provided informed consent (Appendix T) were then administered a demographics questionnaire, followed by the BASH, the three vignettes and pertinent questions adapted from the GHSQ-V, MACVS Familism-referent and Religion scales, and the PATPSI. The questionnaires were administered in that specific order through the use of a data collection script (Appendix U and V) to ensure standardization of data collection procedures. All participants completed the questionnaires in either their vehicles or in conference rooms at Su Casa Hispanic

Center to ensure privacy and confidentiality. To protect participants and researchers from possible COVID-19 exposure, participants wore masks while researchers wore masks and gloves during active data collection. Upon questionnaire completion, participants were given a $10 gift card to Walmart. Recruitment took place from March 18 through June 9, 2021.

Data Analysis

All study measures were assessed for skewness and kurtosis. The average scores on the BASH were not normally distributed (median = 1.00) with skewness of 1.71 (*SE* = 0.33) and kurtosis of 2.51 (*SE* = 0.33), reflecting participants' low levels of acculturation. Indeed, all participants were considered to be in the "low acculturation" group based on measure developer criteria (i.e., score of 4.0 and below). All other variables had acceptable levels of skew and kurtosis (i.e., within -1 and +1) with the exception of the average likelihood scores of seeking assistance from formal sources for child depressive symptoms (GHSQ-V; Median = 5.67), which had a skewness of -1.54 (*SE* = 0.33) and kurtosis of 2.56 (*SE* = 0.66) as well as religiosity scores (MACVS Religiosity; Median = 34.00), with a skewness of -1.70 (*SE* = 0.34) and kurtosis of 3.00 (*SE* = 0.66). Although skew and kurtosis were higher than expected, they did not deviate substantially from normality and analyses proceeded as planned (West et al., 1996). Means and standard deviations are used to summarize normally distributed data, and median values are presented for skewed variables. For the purpose of the current study, bivariate correlations were run to examine relationships between parental help-seeking attitudes for child mental and physical health concerns and likelihood of seeking formal and informal sources of assistance, parental level of familism, parental level of religiosity, and acculturation. Given the small sample size and exploratory nature of this study, no corrections for multiple bivariate comparisons were made. A two-way within-subjects ANOVA was run to examine differences in scores for formal

and informal sources for help-seeking across the three vignettes. Lastly, a hierarchical multiple regression analyses were run to determine whether parental levels of acculturation, familism, and religiosity moderate the relationship between parental help-seeking attitudes for child mental health concerns and formal service selection for child ADHD.

Results

The aim of this study was to examine parental attitudes towards help-seeking for child mental health concern as well as possible differences in sources of help-seeking for child mental and physical health concerns (i.e., depression, ADHD combined type, and stomach flu) in a sample of Hispanic parents. In addition, the study sought to explore whether familism and religiosity moderate the relationship between these help-seeking attitudes and likelihood of seeking formal and informal sources of support for a child displaying symptoms of ADHD. The results section begins with a summary of participant scores across all measures, followed by a list of each hypothesis identified in the dissertation proposal and the result of each analysis.

Summary of Participant Scores on Study Variables

Participants scores on all study variables are summarized in Table 2. Regarding participants' cultural values, participants' familism scores ranged from 11 to 25 (*M* = 19.88, *SD* = 3.87) while their scores on religiosity ranged from 24 to 35 (*M* = 33.04, *SD* = 2.63). Participants' ratings regarding their attitudes toward help-seeking behaviors (i.e., Attitude score on the PATSI) ranged from 8 to 40 (*M* = 26.50, *SD* = 7.84). This mean is comparable, i.e., within one standard deviation of scores reported in similar samples by Turner et al. (2015; i.e., *M* = 23.43, *SD* = 10.28).

Participants' scores regarding their likelihood of seeking help from informal sources for the child ADHD vignette ranged from 2 to 7 (*M* = 4.72, *SD* = 1.22) and for formal sources for

ADHD also ranged from 2 to 7 (*M* = 5.48, *SD* = 1.16). Participants' scores regarding their likelihood to seek help from formal sources for the child vignette depicting symptoms of depression ranged from 1 to 7 (*M* = 5.51, *SD* = 1.46), and scores for informal sources ranged from 1 to 7 (*M* = 4.48, *SD* = 1.53). Participants' scores regarding their likelihood to seek help from informal sources for the child stomach flu vignette ranged from 1 to 7 (*M* = 4.24, *SD* = 1.48), and for formal sources ranged from 1 to 7 (*M* = 4.87, *SD* = 1.70).

Individual Hypotheses and Results

H1: *There will be a positive correlation between parental attitudes toward psychological services for child mental health concerns (i.e., score on the Help-Seeking Attitudes scale of the Parental Attitudes Toward Psychological Services Inventory) and parental likelihood of seeking formal or informal sources of assistance for a child's ADHD and depression (i.e., score on formal and informal sources on General Help-Seeking Questionnaire-Vignette version).*

Pearson product-moment correlation coefficients were calculated to test the first hypothesis. The results, found in Table 3, show that there are no significant correlations between participants' attitudes toward seeking help for mental health services and their likelihood of seeking formal or informal sources of assistance for a child displaying symptoms of depression or ADHD.

H2: *There will be a negative correlation between parental attitudes toward psychological services (i.e., score on the Help-Seeking Attitudes scale of the Parental Attitudes Toward Psychological Services Inventory) and parental levels of familism (i.e., score on the Familism scale on Mexican American Cultural Values Scale for Adolescents and Adults).*

A Pearson product-moment correlation coefficient was calculated to test the second hypothesis. The results, found in Table 3, show that there was a significant negative correlation

between parental attitudes toward seeking help for mental health services and participants' level of familism, $r = -.32$, $p = .03$. Specifically, participants who endorsed high levels of familism tended to have more negative attitudes toward seeking help for child mental health concerns.

H3: *There will be a negative correlation between parental attitudes toward psychological services (i.e., score on the on the Help-Seeking Attitudes scale of the Parental Attitudes toward Psychological Services Inventory) and parental levels of religiosity (i.e., score on the Religion scale on Mexican American Cultural Values Scale for Adolescents and Adults).*

A Pearson product-moment correlation coefficient was calculated to test the third hypothesis. The results, found in Table 3, show that there was not a significant correlation between participants' help-seeking attitudes for child mental health concern and their level of religiosity.

H4: *There will be a positive correlation between parental attitudes toward psychological services for child mental health concerns (i.e., score on the Help-Seeking Attitudes scale of the Parental Attitudes toward Psychological Services Inventory) and parental levels of acculturation (i.e., score on the BASH).*

A Pearson product-moment correlation coefficient was calculated to test the fourth hypothesis. The results, found in Table 3, show that there was not a significant correlation between participants' help-seeking attitudes for child mental health concern and parental level of acculturation. Of note, there was limited variability with scores on the BASH and all participants were classified as being in the low acculturation category based on developer cut-offs.

H5: *There will be significant differences in scores for formal and informal sources for help-seeking across the three vignettes.*

A 3 (vignette type) x 2 (source of support) within-subjects ANOVA was conducted to examine the effect of vignette type (i.e., child displaying symptoms of ADHD, depression, or stomach flu) and source of support (i.e., formal or informal sources) on parental likelihood to seek assistance for child mental and physical health concerns. The means, standard deviations and ANOVA results are presented in Table 5. The results indicate that there was no interaction between vignette type and source of support, $F(2, 98) = 2.23$, $p = .113$.

Further, results indicated that there was a main effect of vignette type, $F(2, 98) = 7.30$, $p = 0.001$, on parental likelihood to seek support. Post hoc tests using the Bonferroni correction revealed that parents demonstrated significantly higher likelihood of seeking help for child stomach flu than for child ADHD combined presentation ($p = 0.009$) and depression ($p = 0.01$). In addition, results indicated that there was a main effect of source of support, $F(1, 49) = 25.56$, $p < 0.001$, on parental likelihood to seek support. Post hoc tests using the Bonferroni correction revealed that parents demonstrated significantly higher likelihood of seeking help from informal versus formal sources of assistance ($p < 0.001$).

H6: *The relationship between parental attitudes toward psychological services for child mental health concerns and formal service selection for child ADHD will be moderated by familism, such that parental attitudes will be more predictive of formal service selection for child ADHD among participants who endorse lower levels of familism.*

A hierarchical multiple regression analysis was conducted to examine whether level of familism (i.e., MACVS familism score) moderated the relationship between parental attitudes toward psychological services for child mental health concerns (i.e., PATSI attitudes score) and formal service selection for child ADHD (i.e., GHSQ ADHD vignette formal score). In the regression, PATSI and MACVS scores were entered in Step 1 and the product term for the

interaction between the variables in Step 1 was entered in Step 2. The results of this analysis (Table 6) indicated that participants' level of familism, β = -0.14, *t* = -0.93, *p* = 0.36, and attitudes toward psychological services for child mental health concerns, β = -0.01, *t* = - 0.07, *p* = 0.95, were not predictive of parental likelihood of formal service selection for child ADHD. Moreover, familism did not moderate the relationship between parental attitudes toward psychological services for child mental health concerns and formal service selection for Child ADHD, $\beta = 0.13$, *t* = 0.88, R^2 = 0.04, R^2 change = 0.02, *F*(1,44) = 0.78, *p* = 0.38.

H7: *The relationship between parental attitudes toward psychological services and formal service selection for child ADHD will be moderated by religiosity. Parental attitudes will be more predictive of formal service selection for child ADHD among participants who endorse lower levels of religiosity.*

A hierarchical multiple regression analysis was conducted to examine whether level of religiosity (i.e., MACVS religiosity score) moderated the relationship between parental attitudes toward psychological services for child mental health concerns (i.e., PATSI attitudes score) and formal service selection for child ADHD (i.e., GHSQ ADHD vignette formal score). In the regression, PATSI and MACVS scores were entered in Step 1 and the product term for the interaction between the variables in Step 1 was entered in Step 2. The results of this analysis (Table 7) indicated that participants' level of religiosity, β = -0.07, *t* = -0.46, *p* = 0.62, and attitudes toward psychological services for child mental health concerns, β = 0.03, *t* = 0.18, *p* = 0.86, were not predictive of parental likelihood of formal service selection for Child ADHD. Moreover, religiosity did not moderate the relationship between parental attitudes toward psychological services for child mental health concerns and formal service selection for Child ADHD, β = 0.14, *t* = 0.92, R^2 = 0.03, R^2 change = 0.02, *F*(1,44) = 0.85, *p* = 0.36.

H8: *The relationship between parental attitudes toward psychological services and formal service selection for child ADHD will be moderated by acculturation. Parental attitudes will be more predictive of formal service selection for child ADHD among participants who endorse higher levels of acculturation.*

A hierarchical multiple regression analysis was conducted to examine whether level of acculturation (i.e., BASH score) moderated the relationship between parental attitudes toward psychological services for child mental health concerns (i.e., PATSI attitudes score) and formal service selection for child ADHD (i.e., GHSQ ADHD vignette formal score). In the regression, PATSI and BASH scores were entered in Step 1 and the product term for the interaction between the variables in Step 1 was entered in Step 2. The results of this analysis (Table 8) indicated that participants' level of acculturation, β = -0.26, t = -1.83, p = 0.07, and attitudes toward psychological services for child mental health concerns, β = 0.03, t = 0.22, p = 0.83, were not predictive of parental likelihood of formal service selection for child ADHD. Moreover, acculturation did not moderate the relationship between parental attitudes toward psychological services for child mental health concerns and formal service selection for child ADHD, β = -.14, t = -.98, R^2 = 0.88, R^2 change = 0.02, $F(1,45)$ = 0.97, p = 0.33.

Discussion

The aim of this study was to examine parental attitudes towards mental health help-seeking as well as possible differences in help-seeking for child mental and physical health concerns (i.e., depression, ADHD combined type, and stomach flu). Moreover, this study aimed to explore whether cultural values of familism and religiosity moderate the relationship between these attitudes and likelihood of seeking help for a child displaying symptoms of ADHD.

Contrary to what was hypothesized, a significant correlation was not found between parental attitudes toward psychological services and parental likelihood of seeking formal or informal sources of assistance for a child's ADHD and depression among this sample of Hispanic immigrant parents. This finding is inconsistent with prior research that found there were associations between parental attitudes toward mental health services and intention of help-seeking for Hispanic parents (McKay et al., 2010; Turner et al., 2015). There are two important factors regarding this finding that need to be considered. First, the GHSQ-V that was used in this study may not have been the most robust measure of sources of help-seeking. Specifically, internal consistency of the formal and informal scales were relatively low. This could reflect that different sources of support may be relevant to different parents. It is also possible that the sources of support identified for this sample were not representative enough of the typical sources of support utilized. Future studies expanding in the present study may want to consider using mixed-methods to further develop the GHSQ-V to make it more suitable for this population. For example, researchers could use open-ended interviews to identify common sources of support and follow that with quantitative methods to determine formal and informal sources of support to include in the measure. The second factor to consider related to these findings was the unique nature of the sample, which was homogenous in their acculturation level as well as their embodiment of familism and religiosity. Hence, results suggest that help-seeking attitudes may not be a useful predictor of help-seeking behaviors in similar samples of less acculturated Hispanic parents in the United States. Other predictors, such as health care literacy and community factors (e.g., access to health care services and number of Spanish-speaking providers) should be considered in future research.

For instance, limited health care literacy has been shown to exacerbate difficulties for Hispanic parents as they contemplate entering health care systems (Alegria et al., 2012; Cabassa et al., 2011). Interestingly, health and mental health literacy interventions developed for Hispanic parents have shown efficacy in increasing knowledge and improving attitudes towards the health care (Barrio & Yamada, 2010). Future researchers may want to develop health and mental health literacy interventions for Hispanic parents with low levels of acculturation. Researchers may find that an improvement in Hispanic parents' understanding of the health care system may result in increased likelihood to seek services for child physical and mental health concerns.

As hypothesized, there was a significant negative correlation between parental attitudes toward seeking help for mental health services and participants' level of familism. Specifically, participants who endorsed high levels of familism tended to have more negative attitudes toward seeking help for child mental health concerns. There is very limited literature regarding the influence of familism on help-seeking behaviors. However, a concept that is particularly relevant for the findings of the current study is Cultural Barrier Theory. According to Cultural Barrier Theory, adherence to cultural values may preclude Hispanic individuals from using counseling services (Ramos-Sanchez and Atkinson, 2009). Interestingly, Ramos-Sanchez and Atkinson (2009) conducted a similar study, but found that participants who endorsed high levels of familism indicated stronger help-seeking intentions than did generations with presumably lower levels of familism. This discrepancy in results, in addition to the lack of literature in this area, speak to the need to further study the role of familism on help-seeking behaviors for Hispanic parents.

Moreover, results demonstrate that there was not a significant relationship between parental attitudes toward psychological services and religiosity. Research has shown that

religious individuals within the Hispanic community prefer religious counseling services that were consistent with their religious beliefs and complimented their extant ways of coping with adversity (Moreno & Cardemil, 2013). The questionnaires used for this particular study did not allow for individuals to indicate their attitudes toward religious counseling services, which may have been a reason behind the non-significant correlation between parental attitudes toward psychological services and religiosity within this particular sample. Indeed, as detailed above, further developing and refining the GHSQ-V for use with similar samples would be important and this work would likely result in more relevant sources of help support for parents to select, which would improve validity and reliability of the measure when adapted for different groups of participants.

Regarding participants' level of acculturation, results demonstrated a non-significant relationship between parental attitudes toward psychological services for child mental health concerns and parental levels of acculturation. Acculturation is an important factor to consider when examining experiences and outcomes of Hispanic immigrant families. Overall, there are discrepancies in relevant literature regarding the relationship between acculturation and Hispanic individuals' attitudes on mental health help-seeking behaviors. For example, studies have found that highly acculturated individuals express more positive attitudes toward the use of mental health services than do less acculturated individuals (Sanchez & Atkinson, 1983; Sanchez & King, 1986). However, other studies have found an inverse relationship between acculturation and attitudes related to use of mental health services among Hispanic individuals, in that those who are less acculturated to the American culture tend to have positive attitudes toward mental health help-seeking behaviors (e.g., Ramos-Sanchez et al., 1999; Ramos-Sanchez & Atkinson, 2009; Ruelas et al., 1998). All participants in the current study were considered to be in the "low

acculturation" category based on cutoffs on the BASH. The homogenous nature of the sample concerning acculturation level may be contributing to a non-significant relationship between acculturation and parental attitudes toward psychological services for child mental health concerns.

Analysis of variance revealed important information regarding participants' likelihood to seek formal versus informal sources of assistance across the three vignettes. The presenting problem (vignette) had a statistically significant effect on parental likelihood to seek help for child mental and physical health concerns. Specifically, participants reported a higher likelihood to seek help for child stomach flu than for child symptoms of ADHD, combined presentation and depression. Moreover, the types of sources (formal vs. informal) of assistance had a statistically significant effect on parental likelihood to seek help for child mental and physical health concerns. Overall, participants reported a higher likelihood of seeking help from informal than formal sources of assistance for child mental and physical health concerns. This is consistent with previous research documenting that Hispanic individuals who seek help for mental health concerns tend to turn first to family, friends, or religious leaders (Derr, 2016; Vásquez et al., 2021). Findings from the current study further revealed that the interaction between presenting concerns (vignette) and sources of assistance (formal vs. informal) was not significant, clarifying that the effect of presenting concern on parental likelihood to seek help was not dependent on the types of sources of assistance for this sample. Thus, such results indicate that, regardless of the types of sources presented with, Hispanic parents with lower levels of acculturation are likely to seek help for physical rather than mental health concerns. These results may speak to different variables possibly influencing Hispanic parents' help-seeking behaviors (e.g., stigma, health literacy, health insurance status).

Lastly, hierarchical multiple regression analyses revealed that participants' attitudes toward psychological services for child mental health concerns, familism, religiosity, and acculturation were not predictive of parental likelihood of formal service selection for child ADHD. Additionally, these hierarchical multiple regression analyses revealed that familism, religiosity, and acculturation did not moderate the relationship between participants' attitudes toward psychological services for child mental health concerns and parental likelihood of formal service selection for child ADHD. To date, the literature relating to the predictive qualities of attitudes toward psychological services for child mental health concerns, familism, religiosity, and acculturation is scant. Interestingly, Keeler et al. (2014) found that a reduction in familistic values could be partially responsible for reduced help seeking among Mexican–Americans with depression. Although this is information related to familism as a potential predictor of help-seeking, Keeler et al. (2014) evaluated the mediating role of familism, whereas the current study evaluated the moderating role of familism on parental help-seeking behaviors. Additionally, the sample for the current study was very unique given their homogeneity regarding familism, religiosity, and acculturation levels. Future replication studies with a similar sample might be useful in identifying the predictive of qualities of participants' level of familism on help-seeking behaviors regarding child mental health concerns.

The current study did not find predictive and moderating qualities for parental level of religiosity and acculturation. Similarly, to that of familism, this is an area that warrants further research in terms of the relationship between acculturation, religiosity, and parental help-seeking behaviors regarding child mental health concerns. The current study is one of few studies evaluating the moderating effect of these variables. Thus, it is difficult to analyze the extent to which it is exactly related to the current literature, which is limited as it is. Future studies should

further the literature by examining the extent to which Hispanic parents with low levels of acculturation and high levels of religiosity differ in terms of help-seeking behaviors regarding child mental and physical health concerns.

Limitations and Future Directions

Results of the present study need to be considered in the context of several limitations. First, the final sample size was smaller than planned, largely due to challenges recruiting families during the COVID-19 pandemic. A second limitation was participant's understanding of some of the survey items. Specifically, while measures used in this study had been used successfully with Hispanic populations, a number of participants in the present study experienced difficulty understanding terms such as "mental health" and "psychological problems/difficulties," leading researchers to provide further explanation regarding these terms, affecting the standardization of data collection procedures. This may be due to unique qualities of this sample, such as the fact that the sample comprised of Hispanic parents with low levels of acculturation and limited understanding of concepts related to mental health. This is noteworthy as measures selected had been used with a range of Hispanic populations and the issues with wording of some items underscores the diversity of Hispanic families in the United States and different understanding of mental health terminology, and mental health more broadly.

Another consideration related to language was that for some parents, Spanish was their second language, with a native tongue being their first (e.g., Quiché, Q'eqchi). Although the instruments used for the purposes of the current study were validated for Spanish-speaking populations, the measures may not have been validated for Hispanic individuals who speak Spanish, but whose primary language is a native tongue.

Relatedly, a large number of participants had difficulties understanding the concept of "probability" when asked to select how likely they were to seek help from formal or informal sources. Future researchers should identify and include different ways in which to explain the concept of "probability" or "likelihood" when using the GHSQ-V with similar populations to improve standardization. In addition, a number of participants found it challenging to use a rating scale when responding to items, even participants who were fluent and literate in Spanish. Overall, these issues with language and survey administration underscore the need for pilot studies with unique Hispanic populations to ensure that measures selected are suitable for the population studies.

Another limitation to consider is that of self-reporting, as participants used self-report measures, which often lead participants to select socially acceptable answers rather than genuine responses. Relatedly, a large portion of participants needed the researchers' assistance to complete one or more measures. The researcher's presence during questionnaire completion may have influenced participants' responses. Additionally, the current study made use of hypothetical vignettes, which required participants to imagine a scenario, rather than to think about their own experience. This mental task may have been harder for participants who did not relate to the content presented in the vignettes.

Lastly, the current study is correlational in nature and only examined the relationship between two cultural values (i.e., familism and religiosity) and help-seeking behaviors for child physical and behavior heal condition. Future research should broaden the scope and examine the relationship between other cultural values and help-seeking behaviors. Moreover, the limitations and suggestions addressed above should allow researchers to access this population when

designing studies that aim to improve the quality of services and help-seeking behaviors among the Hispanic population, including Hispanic parents with low levels of acculturation.

Implications

The current study emphasizes the importance and need of future research regarding factors that influence or even predict parental help-seeking behaviors for Hispanic families. Results of the current study demonstrated that Hispanic parents were more likely to seek assistance for child physical rather than mental health concerns. As previously stated, the sample for the current study was unique in demographic composition. Future research should examine the process of help-seeking for Hispanic parents regarding mental health concerns in their children as well as the influence of other factors in their help-seeking process, including acculturation, language, and composition of social network. Understanding these relationships can guide clinicians in identifying and problem-solving treatment barriers. In addition, further research is needed to compare help-seeking attitudes among different groups of parents to understand if these differences are also seen in parents from different racial and cultural backgrounds.

Conclusions

Overall, this study's findings indicate there was a significant effect of presenting concern (i.e., ADHD, depression, and stomach flu) and sources of assistance (formal vs. informal) on parental likelihood to seek help for child mental and physical health concerns. Specifically, participants reported a higher likelihood to seek help for child stomach flu than for child symptoms of ADHD, combined presentation and depression. Moreover, participants reported a higher likelihood of seeking help from informal than formal sources of assistance for child mental and physical health concerns. Additionally, the current study found a significant negative

correlation between parental attitudes toward seeking help for mental health services and participants' level of familism. Specifically, participants who endorsed high levels of familism tended to have more negative attitudes toward seeking help for mental health concerns. Contrary to what was hypothesized, there was not a significant relationship between parental attitudes toward psychological services and parental levels of religiosity or acculturation. Further, parental attitudes toward psychological services was not found to correlate with parental likelihood of seeking formal and informal sources of assistance for child mental and physical health concerns.

This study adds to the growing body of literature on Hispanic parents' help-seeking process and preferences regarding formal and informal sources as it is the first study comparing Hispanic parents' preference for formal and informal sources of assistance for child mental and physical health concerns. Replication studies should be conducted to assess the generalizability of these results across different types of Hispanic nationalities.

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Table 1

Frequencies of Demographic Variables among Participants (N= 51)

Demographics	*N*	%
Gender		
Male	11	21.6
Female	40	78.4
Country of Birth		
Mexico	12	23.5
Guatemala	27	52.9
Honduras	5	9.8
Other	7	13.7
Length of Time in the U.S.		
Less than 6 months	3	5.9
6 months to 1 year	1	2.0
1 year to 5 years	13	25.5
More than 5 years	34	66.7
Demographics	*Mean*	*SD*
Parent Age (years)	35.62	8.13
Age of Children in the Home (years)		
Youngest	6.04	4.92
Oldest	13.21	5.58

Table 2

Means, Medians, Standard Deviations, and Ranges of Participants' Results of Study Measures

Measure	Mean (SD)	Median
BASH	1.31 (.49)	1.00
GHS_ADHD_Inf	4.72 (1.22)	5.00
GHS_ADHD_Fr	5.48 (1.16)	5.33
GHS_DEP_Inf	4.49 (1.53)	5.00
GHS_DEP_Fr	5.51 (1.46)	5.67
GHS_SF_Inf	4.24 (1.48)	4.33
GHS_SF_Fr	4.87 (1.70)	5.00
MACVS_F	19.88 (3.89)	21.00
MACVS_R	33.04 (2.63)	34.00
PATPSI_HSA	26.50 (7.84)	27.50

Note. BASH = Brief Acculturation Scale for Hispanics; GHS = General Help Seeking Questionnaire, Inf = Informal, Fr = formal, SF = Stomach Flu; MACVS_F = Mexican American Cultural Values Scale for Adolescents and Adults, Familism scale, MACVS_R = Religion Scale; PATPSI_HSA = Parental Attitudes toward Psychological Services Inventory, Help-Seeking Attitudes Scale

Table 3

Summary of Correlations between Primary Variables

	PATPSI_HSA	MACVS_F	MACVS_R	BASH	GHS_ADHD_Inf	GHS_ADHD_Fr	GHS_DEP_Inf	GHS_STOMACHFLU_Inf	GHS_STOMACHFLU_Fr
PATPSI_HSA									
MACVS_F	-.32*								
MACVS_R	.06	.42**							
BASH	.96		-.030						
GHS_ADHD_Inf	-.10	.20	.065	-.085					
GHS_ADHD_Fr	.03	-.15	-.078	-.25	.36**		.		
GHS_DEP_Inf	-.09	.070	.051	-.028	.71**	.39**			
GHS_DEP_Fr	.20	-.13	.064	-.37**	.24	.64**	.51**		
GHS_STOMACHFLU_Inf	-.24	.099	-.032	-.14	.53**	.29*	.78**	1	
GHS_STOMACHFLU_Fr	-.16	.077	.039	-.39**	.39**	.51**	.57**	.71**	1

Note. * = $p < .05$, ** = $p < .01$. PATPSI_HSA = Parental Attitudes toward Psychological Services Inventory, Help-Seeking Attitudes Scale; GHS = General Help Seeking Questionnaire, DEP = depression, Inf = Informal, Fr = formal. MACVS_F = Mexican American Cultural Values Scale for Adolescents and Adults, Familism scale, MACVS_R = Religion Scale

Table 4

Means and Standard Deviations for Vignettes and Sources of Assistance

Variable		Formal Sources		Informal Sources	
		M	*SD*	*M*	*SD*
Vignette	ADHD-C	5.48	1.16	4.72	1.22
	Depression	5.51	1.46	4.48	1.53
	Stomach Flu	4.87	1.70	4.24	1.48

Note. $N = 50$. ANOVA = analysis of variance; ADHD-C = attention-deficit/hyperactivity disorder, combined presentation

Table 5

Two-Way ANOVA Statistics for Vignettes and Sources of Assistance

Variable	*df*	*F*	*p*	η^2
Vignette (A)	2, 98	7.30	0.001**	0.13
Sources of Assistance (B)	1, 49	25.56	< 0.001**	0.34
A × B	2, 98	2.23	0.113	0.044

Note. $N = 50$. ANOVA = analysis of variance. * = $p < .05$, ** = $p < .01$

Table 6

Multiple Regression Analysis for the Non-Significant Interaction between Parental Attitudes toward Psychological Services (PATPSI) and Parental Level of Familism (MACVS_FamTot) on Formal Service Selection for Child ADHD

Regression Step		β	*t*	*p*	Δ R^2
Step 1					
					.02
	PATPSI	-.01	-.07	.95	
	MACVS_FamTot	-.14	-.93	.36	
Step 2					
					.02
	PATPSI X MACVS	.13	.88	.38	

Note. * = $p < .05$, ** = p < .001.

Table 7

Multiple Regression Analysis for the Non-Significant Interaction between Parental Attitudes toward Psychological Services (PATPSI) and Parental Level of Religiosity (MACVS_RelTot) on Formal Service Selection for Child ADHD

Regression Step		β	*t*	*p*	Δ R^2
Step 1					
					.006
	PATPSI	.03	.18	.86	
	MACVS_RelTot	-.07	-.50	.62	
Step 2					
					.02
	PATPSI X MACVS	.14	.92	.36	

Note. * = $p < .05$, ** = p < .001.

Table 8

Multiple Regression Analysis for the Non-Significant Interaction between Parental Attitudes toward Psychological Services (PATPSI) and Parental Level of Acculturation (BASH_Avg) on Formal Service Selection for Child ADHD

Regression Step		β	*t*	*p*	Δ R^2
Step 1					
					.07
	PATPSI	.031	.22	.83	
	BASH_Avg	-.26	-1.83	.073	
Step 2					
					.02
	PATPSI X BASH	-.14	-.98	.33	

Note. * = $p < .05$, ** = p < .001.

Appendix A

Demographic Questionnaire

1. Your age:

2. Gender:
    a. Male
    b. Female
    c. Other

3. Country of birth:
    a. Mexico
    b. Guatemala
    c. Honduras
    d. Puerto Rico
    e. Other:

4. Total time in the United States:
    a. Less than 6 months
    b. 6 months to 1 year
    c. 1 year to 5 years
    d. More than 5 years

5. Age of youngest and oldest child living with you in the United States:

Spanish Translation:

1. Edad:

2. Identidad de genero:
    a. Hombre
    b. Mujer
    c. Otro:

3. País natal:
    a. México
    b. Guatemala
    c. Honduras
    d. Puerto Rico
    e. Otro:

4. Tiempo viviendo en los Estados Unidos:
    a. Menos de 6 meses
    b. 6 meses a 1 año
    c. 1 año a 5 años
    d. Mas de 5 años

5. Edad del niño mayor y menor viviendo con usted en los Estados Unidos

Appendix B

Brief Acculturation Scale for Hispanics (BASH)

1. What language do you speak at home?
   - ☐ Only Spanish
   - ☐ Spanish more than English
   - ☐ Spanish and English equally
   - ☐ English more than Spanish
   - ☐ Only English
   - ☐ Language other than English or Spanish

2. What language do you speak with your friends?
   - ☐ Only Spanish
   - ☐ Spanish more than English
   - ☐ Spanish and English equally
   - ☐ English more than Spanish
   - ☐ Only English
   - ☐ Language other than English or Spanish

3. What language do you read in?
   - ☐ Only Spanish
   - ☐ Spanish more than English
   - ☐ Spanish and English equally
   - ☐ English more than Spanish
   - ☐ Only English
   - ☐ Language other than Spanish or English

4. What language do you think in?
   - ☐ Only Spanish
   - ☐ Spanish more than English
   - ☐ Spanish and English equally
   - ☐ English more than Spanish
   - ☐ Only English
   - ☐ Language other than Spanish or English

Appendix C

Brief Acculturation Scale for Hispanics (BASH) – Spanish Translation

1. En general, ¿qué lenguaje Ud. lee y habla?
    - ☐ Sólo español
    - ☐ Español Más Que ingles
    - ☐ Los Dos Por Igual
    - ☐ Ingles Más Que español
    - ☐ Sólo inglés

2. ¿Qué idioma habla usualmente en su hogar?
    - ☐ Sólo español
    - ☐ Español más que ingles
    - ☐ Los Dos Por Igual
    - ☐ English Más Que español
    - ☐ Sólo inglés

3. ¿En qué idioma piensa usualmente?
    - ☐ Sólo español
    - ☐ Español Más Que ingles
    - ☐ Los Dos Por Igual
    - ☐ Ingles Más Que español
    - ☐ Sólo inglés

4. ¿En qué idioma habla usualmente con sus amigos?
    - ☐ Sólo español
    - ☐ Español más que ingles
    - ☐ Los Dos Por Igual
    - ☐ Ingles Más Que español
    - ☐ Sólo inglés

Appendix D

Child Symptom Vignette – ADHD, combined type

"Imagine you have a 7-year-old child who is in first grade. The teacher tells you that they are distracted at school and you notice the same behavior at home. You also notice that your child has been losing things, is refusing to do homework, and is constantly on the go, like a little motor."

If your child was having these problems, how likely is it that you would seek help from the following sources?

1 = Extremely unlikely 3 = Unlikely 5 = Likely 7 = Extremely Likely

a. Family member/Intimate partner (e.g., spouse, parent)

1 2 3 4 5 6 7

b. Friend/Neighbor

1 2 3 4 5 6 7

c. Mental Health professional (psychologist, social worker, counselor)

1 2 3 4 5 6 7

d. Teacher/School counselor

1 2 3 4 5 6 7

e. Medical provider (primary care physician, doctor)

1 2 3 4 5 6 7

f. Religious leader

1 2 3 4 5 6 7

g. Other (please list):

1 2 3 4 5 6 7

Appendix E

Child Symptom Vignette – ADHD, combined type (Spanish Translation)

"Imagine que tiene un niño de 7 años en el primer grado. Su profesora le informa que el niño esta distraído en la escuela, lo cual tu has notado en casa también. A la misma vez, has notado que el niño ha perdido cosas, se niega a terminar su tarea, y siempre esta en movimiento, como un motor."

Escoja la probabilidad de que buscaría ayuda de estas fuentes de ayuda si su hijo/a tuviera estos problemas:

1 = extremadamente probable 3 = probable 5 = improbable 7 = extremadamente improbable

a. Miembro familiar/Compañero íntimo (pareja, padre/madre, amigo/a etc.)

1 2 3 4 5 6 7

b. Amigo(a)/Vecino(a)

1 2 3 4 5 6 7

c. Profesional de salud mental (psicólogo/a, psiquiatra, trabajadora social)

1 2 3 4 5 6 7

d. Maestro(a)/Consejera escolar

1 2 3 4 5 6 7

e. Médico general (doctor)

1 2 3 4 5 6 7

f. Líder religioso (ministro, sacerdote, cura)

1 2 3 4 5 6 7

g. Otro (por favor liste)

1 2 3 4 5 6 7

Appendix F

Child Symptom Vignette – Depression

"Imagine you have a 7-year-old child who is in first grade. In the past two weeks, your child has been cranky and unusually sad. Your child doesn't feel like eating and has lost some weight. They are also having a hard time concentrating. When upset, your child says things like "I'm stupid," or "I'm worthless."

If your child was having these problems, how likely is it that you would seek help from the following sources?

1 = Extremely unlikely 3 = Unlikely 5 = Likely 7 = Extremely Likely

a. Family member/Intimate partner (e.g., spouse, parent, etc.)

1 2 3 4 5 6 7

b. Friend/Neighbor

1 2 3 4 5 6 7

c. Mental Health professional (psychologist, social worker, counselor)

1 2 3 4 5 6 7

d. Teacher/School counselor

1 2 3 4 5 6 7

e. Medical provider (primary care physician, doctor)

1 2 3 4 5 6 7

f. Religious leader

1 2 3 4 5 6 7

g. Other (please list):

1 2 3 4 5 6 7

Appendix G

Child Symptom Vignette – Depression (Spanish Translation)

"Imagine que tiene un niño de 7 años en el primer grado. Durante las ultimas dos semanas, su hijo ha estado irritable y deprimido. Ha perdido el apetito y un poco de peso, y tiene dificultades concentrándose. Cuando se siente triste, su hijo dice "soy tonto" o "no valgo nada."

Escoja la probabilidad de que buscaría ayuda de estas fuentes de ayuda si su hijo/a tuviera estos problemas:

1 = extremadamente probable 3 = probable 5 = improbable 7 = extremadamente improbable

a. Miembro familiar/Compañero íntimo (pareja, padre/madre, amigo/a etc.)

1 2 3 4 5 6 7

b. Amigo(a)/Vecino(a)

1 2 3 4 5 6 7

c. Profesional de salud mental (psicólogo/a, psiquiatra, trabajadora social)

1 2 3 4 5 6 7

d. Maestro(a)/Consejera escolar

1 2 3 4 5 6 7

e. Médico general (doctor)

1 2 3 4 5 6 7

f. Líder religioso (ministro, sacerdote, cura)

1 2 3 4 5 6 7

g. Otro (por favor liste):

1 2 3 4 5 6 7

Appendix H

Child Symptom Vignettes – Stomach Flu

"Imagine you have a 7-year-old child who is in first grade. In the past two weeks, your child has seemed unwell and complains of a stomachache. Your child doesn't feel like eating and has lost some weight. They also complain of abdominal pain, has a fever, and mentions that they feel like vomiting."

If your child was having these problems, how likely is it that you would seek help from the following sources?

1 = Extremely unlikely 3 = Unlikely 5 = Likely 7 = Extremely Likely

a. Family member/Intimate partner (e.g., spouse, parent, etc.)

1 2 3 4 5 6 7

b. Friend/Neighbor

1 2 3 4 5 6 7

c. Mental Health professional (psychologist, social worker, counselor)

1 2 3 4 5 6 7

d. Teacher/School counselor

1 2 3 4 5 6 7

e. Medical provider (primary care physician, doctor)

1 2 3 4 5 6 7

f. Religious leader

1 2 3 4 5 6 7

g. Other (please list):

1 2 3 4 5 6 7

Appendix I

Child Symptom Vignette – Stomach Flu (Spanish Translation)

"Imagine que tiene un niño de 7 años en el primer grado. Durante las ultimas dos semanas, su hijo ha estado enfermo y se queja de dolores de estomago. Ha perdido el apetito y un poco de peso. También se queja de dolor en su abdomen, tiene fiebre, y ganas de vomitar."

Escoja la probabilidad de que buscaría ayuda de estas fuentes de ayuda si su hijo/a tuviera estos problemas:

1 = extremadamente probable 3 = probable 5 = improbable 7 = extremadamente improbable

a. Miembro familiar/Compañero íntimo (pareja, padre/madre, amigo/a etc.)

1 2 3 4 5 6 7

b. Amigo(a)/Vecino(a)

1 2 3 4 5 6 7

c. Profesional de salud mental (psicólogo/a, psiquiatra, trabajadora social)

1 2 3 4 5 6 7

d. Maestro(a)/Consejera escolar

1 2 3 4 5 6 7

e. Médico general (doctor)

1 2 3 4 5 6 7

f. Líder religioso (ministro, sacerdote, cura)

1 2 3 4 5 6 7

g. Otro (por favor liste)

1 2 3 4 5 6 7

Appendix J

Familism Scale – Adapted from the Mexican American Cultural Values Scales for Adolescents and Adults (Knight et al., 2010)

The next statements are about what people may think or believe. Remember, there are no right or wrong answers. Tell me how much you believe that…

1. Children should always do things to make their parents happy.
   1 = Not at all
   2 = A little
   3 = Somewhat
   4 = Very much
   5 = Completely

2. When it comes to important decisions, the family should ask advice from close relatives.
   1 = Not at all
   2 = A little
   3 = Somewhat
   4 = Very much
   5 = Completely

3. A person should always think about their family when making important decisions.
   1 = Not at all
   2 = A little
   3 = Somewhat
   4 = Very much
   5 = Completely

4. Children should be taught to always be good because they represent the family.
   1 = Not at all
   2 = A little
   3 = Somewhat
   4 = Very much
   5 = Completely

5. It is important to work and do one's best because this work reflects on the family.
   1 = Not at all
   2 = A little
   3 = Somewhat
   4 = Very much
   5 = Completely

Appendix K

Familism Scale – Mexican American Cultural Values Scales for Adolescents and Adults (Knight et al., 2010) – Spanish Translation

Las siguientes frases son acerca de lo que la gente pueda pensar or creer. Recuerda, no hay respuestas correctas e incorrectas. Dime que tanto crees que…

1. Los niños siempre deberían hacer las cosas que hagan a sus padres felices.
   1 = Nada
   2 = Poquito
   3 = Algo
   4 = Bastante
   5 = Completamente

2. La familia debería pedir consejos a sus parientes más cercanos cuando se trata de decisiones importantes.
   1 = Nada
   2 = Poquito
   3 = Algo
   4 = Bastante
   5 = Completamente

3. Se le debería enseñar a los niños a que siempre sean buenos porque ellos representan a la familia.
   1 = Nada
   2 = Poquito
   3 = Algo
   4 = Bastante
   5 = Completamente

4. Es importante trabajar duro y hacer lo mejor que uno pueda porque el trabajo de uno se refleja en la familia.
   1 = Nada
   2 = Poquito
   3 = Algo
   4 = Bastante
   5 = Completamente

5. Uno siempre debería considerar a su familia cuando toma decisiones importantes.
   1 = Nada
   2 = Poquito
   3 = Algo
   4 = Bastante
   5 = Completamente

Appendix L

Religion Scale – Mexican American Cultural Values Scales for Adolescents and Adults (Knight et al., 2010)

The next statements are about what people may think or believe. Remember, there are no right or wrong answers. Tell me how much you believe that…

1. One's belief in God gives inner strength and meaning to life.
   1 = Not at all
   2 = A little
   3 = Somewhat
   4 = Very much
   5 = Completely

2. God is first, family is second.
   1 = Not at all
   2 = A little
   3 = Somewhat
   4 = Very much
   5 = Completely

3. Parents should teach their children to pray.
   1 = Not at all
   2 = A little
   3 = Somewhat
   4 = Very much
   5 = Completely

4. If everything is taken away, one still has their faith in God.
   1 = Not at all
   2 = A little
   3 = Somewhat
   4 = Very much
   5 = Completely

5. It is important to thank God every day for all one has.
   1 = Not at all
   2 = A little
   3 = Somewhat
   4 = Very much
   5 = Completely

6. Religion should be an important part of someone's life.
   1 = Not at all
   2 = A little
   3 = Somewhat
   4 = Very much
   5 = Completely

7. It is important to follow the word of God.
   1 = Not at all
   2 = A little
   3 = Somewhat
   4 = Very much
   5 = Completely

Appendix M

Religion Scale – Mexican American Cultural Values Scales for Adolescents and Adults (Knight et al., 2010) – Spanish Translation

Las siguientes frases son acerca de lo que la gente pueda pensar or creer. Recuerda, no hay respuestas correctas e incorrectas. Dime que tanto crees que…

1. La creencia en Dios da fuerza interna y significado a la vida.
   1 = Nada
   2 = Poquito
   3 = Algo
   4 = Bastante
   5 = Completamente

2. Dios esta primero, la familia esta segundo.
   1 = Nada
   2 = Poquito
   3 = Algo
   4 = Bastante
   5 = Completamente

3. Los padres deberían enseñarles a sus hijos a rezar.
   1 = Nada
   2 = Poquito
   3 = Algo
   4 = Bastante
   5 = Completamente

4. Si a uno le quitan todo, todavía le queda la fe en Dios.
   1 = Nada
   2 = Poquito
   3 = Algo
   4 = Bastante
   5 = Completamente

5. Es importante darle gracias a Dios todos los días por todo lo que tenemos.
   1 = Nada
   2 = Poquito
   3 = Algo
   4 = Bastante
   5 = Completamente

6. La religión debería ser una parte importante de la vida.
   1 = Nada
   2 = Poquito
   3 = Algo
   4 = Bastante
   5 = Completamente

7. Es importante seguir la palabra de Dios.
   1 = Nada
   2 = Poquito
   3 = Algo
   4 = Bastante
   5 = Completamente

Appendix N

Parental Attitudes Toward Psychological Services Inventory (PATPSI; Turner, 2011)

Measure not in Public Domain

Appendix O

Parental Attitudes Toward Psychological Services Inventory (PATPSI; Turner, 2011) – Spanish Translation

Measure not in Public Domain

Appendix P

Xavier University Institutional Review Board Approval Letter

February 12, 2021

Beatriz Rodriquez

Dear Ms. Rodriquez:

The IRB has completed the review of your protocol #20- 057, *Parental attitudes toward help-seeking behaviors for mental health in the Hispanic community* using expedited review procedures. We appreciate your thorough treatment of the issues raised and your timely response. Your study is approved in the Expedited category under Federal Regulation 45CFR46.

Approval expires February 11, 2022. A progress report, available on our website, is due by that date. If the IRB has not received a progress report from you before MIDNIGHT on the study's expiration date, we will AUTOMATICALLY set your study's status to "Closed". **No further data collection is allowed at that point, and if you wish to re-commence data collection, you will be required to submit a new application, along with all relevant materials, to our office.**

Although we will endeavor to send you a reminder, it is **your responsibility** as the researcher to ensure that your progress report and any request for an extension of data collection is submitted to our office before your approval expires.

If you wish to modify your study, including any changes to the approved Informed Consent form, it will be necessary to obtain IRB approval prior to implementing the modification. If any adverse events occur, please notify the IRB immediately.

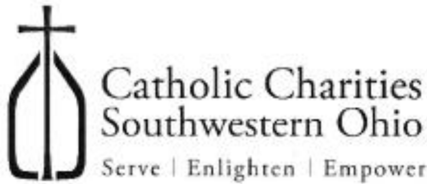
If you have any questions, please contact the IRB office at 745-2870. We wish you success with your research!

Sincerely,

Tammy L. Sonnentag, PhD.
Chair, Institutional Review Board
Xavier University

Appendix Q

CQI Committee Letter of Approval



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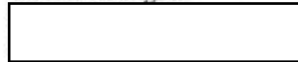
Beatriz Rodriguez

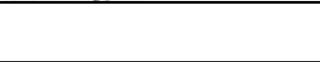


Dear Ms. Rodriguez,

I have reviewed your research proposal and grant permission for you to recruit clients of Su Casa Hispanic Center for the purpose of your research, *Parental attitudes toward help-seeking behaviors for mental health in the Hispanic community*

Should you receive any input from Xavier's IRB that affects the study in any of its components, please let us know.

Sincerely,



José Nine
Director, Quality and Innovation

Appendix R

Recruitment Flyer

If you are Latino/a, live in Cincinnati, are 18 years old or older, and have a child who is underage, please consider participating in our study!

We only need 15 minutes of your time.
Participants will receive a $10 gift card.

Questions?
Contact Beatriz Rodriguez at rodriguezb4@xavier.edu

More Info Here
Made with PosterMyWall.com

Appendix S

Recruitment Flyer – Spanish Translation

Si es Latino/a, vive en Cincinnati, tiene o es mayor de 18 años, y tiene un hijo/hija menor de edad, por favor considere participar en nuestro estudio!

Solamente necesitamos 15 minutos de su tiempo. Los participantes recibiran una tarjeta de regalo por $5.

Preguntas?
Contacte a Beatriz Rodriguez a rodriguezb4@xavier.edu

More Info Here
Made with PosterMyWall.com

Appendix T

Informed Consent Form

Concise Summary

My name is Beatriz Rodriguez and you are invited to take part in a study conducted through Xavier University and Su Casa Hispanic Center. The purpose of this study is to examine Hispanic parents' help-seeking attitudes regarding mental and physical health concerns. Participants in this study will be asked to read three vignettes and answer a series of questionnaires related to the vignettes as well as cultural values and attitudes toward mental health services. Your participation should take no more than 15 minutes. There are no known or anticipated benefits or risks associated with your participation and you are free to discontinue participation at any time. Choosing not to participate will have no effect on any services which you receive or be entitled to receive at Su Casa or Xavier University.

Full Study Description

Nature and Purpose of the Project
This study will examine parental attitudes towards help-seeking for their child as well as factors that may impact attitudes and help seeking behaviors.

Why You Were Invited to Take Part
You are being invited to participate in this study as we are interested in learning about help-seeking attitudes among Hispanic parents, like yourself.

Study Requirements
In order to take part, you must identity as Hispanic, be at least 18 years old, and be the parent of a child/ren under 18 years of age. If you choose to participate, you will be asked to respond to questions about your acculturation, cultural values, and help seeking attitudes. We would anticipate that most participants should take no more than 15 minutes to complete the study.

Anticipated discomforts/risks
There are no anticipated risks based on taking part in the study.

Benefits
There are no direct benefits to you based on taking part in the study; however your answers will help expand the understanding of help seeking among Hispanic parents like yourself.

Confidentiality/Anonymity
Please note that your answers will be anonymous. This means that you will not include your name or identifying information in any of these forms and no one will be able to know what your responses were. Completed survey packets will be stored in a locked file cabinet in a locked room that only the study team can access. The questionnaires will be retained for five years after and subsequently destroyed. After survey packets have been collected, the research team will enter the data into a password protected computer file. Only aggregate, de-identified data will be

shared with others outside the study. Additionally, some of the anonymous data (e.g., demographic information, survey responses) may be shared with other researchers to promote best practices in psychological science.

Compensation

In appreciation of your time, you will receive a $10 gift card after completing the survey. We will need your name and an email address for compensation purposes only. Your name and email will not be shared with anyone outside Xavier University. The paper with your name and email address will not be stacked with the survey responses and once we have collected a few surveys, there is no way to connect your name with your survey responses.

Refusal to participate in this study will have NO EFFECT ON ANY FUTURE SERVICES you may be entitled to from Su Casa Hispanic Center or Xavier University. You are FREE TO WITHDRAW FROM THE STUDY AT ANY TIME WITHOUT PENALTY. Because compensation can only be awarded to individuals who complete the study, if you elect to withdraw, you will not be compensated for this study.

If you have any questions, you may contact me, Beatriz Rodriguez (rodriguezb4@xavier.edu) or my advisor, Dr. Stacey Raj (rajs@xavier.edu). Questions about your rights as a research subject should be directed to Xavier University's Institutional Review Board at (513) 745-2870.

Reading this document and completing the questionnaires indicates you have freely given your consent to participate in this study. By completing the following surveys, you are confirming that you have been given information about this research study and its risk and benefits and have had the opportunity to ask questions and have questions answered. Please do not sign this form or write your name anywhere on here or the questionnaire packet. This form is yours to keep.

THE DATE APPROVAL STAMP ON THIS CONSENT FORM INDICATES THAT THIS PROJECT HAS BEEN REVIEWED AND APPROVED BY XAVIER UNIVERSITY'S INSTITUTIONAL REVIEW BOARD

APPROVED
Xavier University
Institutional Review Board
Date: 2/12/21

Appendix U

Data Collection Script

Good morning/afternoon. Thank you for your interest. My name is ____________ and I am a graduate student in the School of Psychology at Xavier University.

We are interested in help seeking behaviors of Hispanic parents like yourself. To participate, you must be a parent residing in the Greater Cincinnati area with at least one child below 18 years of age and have the ability to communicate either verbally or written in English or Spanish. You are not eligible to participate if you are underage, do not identify as Hispanic/Latinx, and are not a parent. If you choose to participate you will answer questions about yourself and help seeking for your child. There are no right or wrong answers. If you feel uncomfortable answering any of the questions, you may choose to not respond to that particular statement or you may stop participating all together. All of the answers you give today will be anonymous, as your name will not appear anywhere in the forms. Parents who complete the questionnaires will receive a $10 gift card. Please know that while the questionnaires remain anonymous, I will need your name and email address to provide the gift card and your contact details will not be attached or linked to your answers. Do you have any questions?

Here is the informed consent form providing more information. I can read this to you if you would like. Would you prefer the form in English or Spanish? [PROVIDE PHYSICAL COPY OF INFORMED CONSENT FORM]. If you would like, I can read these documents to you or you can read them on your own. Would you like me to read these documents to you?" [Wait for participant response]. Please feel free to ask any questions as you are reading the form [or, if researcher reading form – "Please stop me to ask any questions"].

After informed consent is read, say – "If you agree to participate, please proceed to complete the questionnaire packet, which should take between 15 to 20 minutes to complete." [Participants who have opted to read the form themselves will be asked once again – "If you would like, I can read these documents to you or you can read them on your own. Would you like me to read these documents to you?"; participants who opted to have the form read to them will continue to have the questionnaire read to them]

Appendix V

Data Collection Script – Spanish Translation

Buenos días/tardes. Gracias por su interés en el estudio. Mi nombre es ___________ y soy una estudiante en el programa de psicología en la Universidad de Xavier.

Estamos interesados en el comportamiento de búsqueda de ayuda de padres hispanos como usted. Para participar debe ser un padre/madre que vive en Cincinnati y tiene un(a) hijo/a menor de edad. También debe tener la habilidad de comunicarse verbalmente o por escrito en inglés o español. Si tiene menos de 18 años, no se identifica como hispano/latino, y no tiene hijos, no es elegible para participar. Si decide participar, responderá unas preguntas sobre usted y su búsqueda de ayuda para su hijo(a). No hay respuestas correctas o incorrectas. Si se siente incómodo respondiendo una pregunta, puede dejarla en blanco o puede dejar de participar completamente. Todas sus respuestas serán anónimas, ya que su nombre no aparecerá en ninguno de los cuestionarios. ¿Tiene alguna pregunta?

Aquí está el formulario de consentimiento informado, que contiene más información. Si usted prefiere, se lo puedo leer. ¿Prefiere el formulario en español o en inglés? [ENTREGAR UNA COPIA IMPRENTA DEL FORMULARIO DE CONSENTIMIENTO INFORMADO AL PARTICIPANTE]. Por favor no dude en hacerme preguntas mientras lee el formulario [o, si el investigador está leyendo el formulario – "por favor, no dude en pararme si tiene preguntas"].

Después que el formulario de consentimiento informado sea leído – "si decide participar, por favor proceda a completar el resto de los cuestionarios, los cuales deben tomar 15 a 20 minutos en completar. Si a usted le gustaría, yo le puede leer estos documentos o los puede leer usted mismo. ¿Le gustaría que le leyera estos documentos?"

Summary

Title: Parental Attitudes Toward Help-Seeking Behaviors for Mental Health in the Hispanic Community

Problem: There is a gap between the need for mental health services and service utilization in the Hispanic population in the United States. The current study aims to Examine parental attitudes towards help-seeking for child mental health concerns as well as possible differences in sources of help-seeking for child mental and physical health concerns (i.e., ADHD combined type, depression, and stomach flu) in a sample of Hispanic parents. The findings from the following study can guide clinicians in identifying treatment barriers for Hispanic patients and problem-solve through those barriers, further educate clinicians and assist them in correcting misinformation. Additionally, the current study can assist clinicians in using culturally competent strategies and identify clients' needs regarding mental health concerns.

Method: The sample included fifty-one Hispanic immigrant parents (40 mothers, 11 fathers; *M*age = 35.62 years, *SD*= 8.19). The majority of participants were born in Guatemala (52.9%), followed by Mexico (23.5%). About 14.7% of participants identified their country of origin as Other, which included Cuba, Dominican Republic, El Salvador, Nicaragua, and Venezuela. Approximately 10% of participants identified as being born in Honduras. Regarding participants' length of time residing in the United States, 66.7% indicated living in the United States for more than 5 years, 25.5% indicated between 1 to 5 years, and the rest of the participants had lived in the United States between 6 months to 1 year. Participants' scores on the Brief Acculturation Scale for Hispanics (BASH; Norris et al., 1996) ranged from 1 to 3, indicating that all participants were considered to be low in acculturation. Participants completed a demographics

questionnaire, followed by the BASH, the three vignettes and pertinent questions adapted from the GHSQ-V, MACVS Familism-referent and Religion scales, and the PATPSI.

Findings: There were no significant correlations between parental attitudes toward psychological services for child mental health concerns and parental likelihood of seeking formal or informal sources of assistance for a child displaying symptoms of depression or ADHD, parental level of religiosity, and parental level of acculturation. However, there was a significant negative correlation between parental attitudes toward psychological services for child mental health concerns and parental level of familism, $r = -.32$, $p = .03$. Regarding the effect of vignette type and sources of assistance on parental likelihood to seek services for child health concerns, there was a main effect of vignette type, $F(2, 98) = 7.30$, $p = 0.001$, on parental likelihood to seek services. Moreover, there was a main effect of source of support, $F(1, 49) = 25.56$, $p < 0.001$, on parental likelihood to seek services. Nevertheless, there was no interaction effect between vignette type and source of support, $F(2, 98) = 2.23$, $p = .113$. The current study further examined whether the relationship between parental attitudes toward psychological services for child mental health concerns and formal service selection for child ADHD was moderated by participants' level of familism, religiosity, or acculturation. However, results indicated that participants' attitudes toward psychological services for child mental health concerns, familism ($\beta = -0.14$, $t = -0.93$, $p = 0.36$), religiosity ($\beta = -0.07$, $t = -0.46$, $p = 0.62$), and acculturation ($\beta = -0.26$, $t = -1.83$, $p = 0.07$) were not predictive of parental likelihood of formal service selection for child ADHD. Importantly, the relationship between parental attitudes toward psychological services for child mental health concerns and formal service selection for child ADHD was not moderated by familism, $R^2 = 0.04$, R^2 change = 0.02, $F(1,44) = 0.78$, $p = 0.38$. Similarly, the relationship between parental attitudes toward psychological services for child mental health

concerns and formal service selection for child ADHD was not moderated by religiosity, R^2 = 0.03, R^2 change = 0.02, $F(1,44) = 0.85$, $p = 0.36$. Lastly, the relationship between parental attitudes toward psychological services for child mental health concerns and formal service selection for child ADHD was not moderated by acculturation, R^2 = 0.88, R^2 change = 0.02, $F(1,45) = 0.97$, $p = 0.33$.

Implications: The current study emphasizes the importance and need of future research regarding factors that influence or predict parental help-seeking behaviors for Hispanic families. The current study is unique in looking at the moderating effects of familism, religiosity, and acculturation on help-seeking behaviors for the Hispanic community. Additionally, the current study adds to the growing body of literature on Hispanic parents' help-seeking process and preferences regarding formal and informal sources. Of note, the current study is one of few studies evaluating the moderating effect of familism, religiosity, and acculturation. To date, the literature relating to the predictive qualities of attitudes toward psychological services for child mental health concerns, familism, religiosity, and acculturation is scant. Replication studies should be conducted to assess the generalizability of these results across Hispanic nationalities.