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Factors Influencing Parent Help-Seeking

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ABSTRACT

There exists a large disparity between children in need of mental health services and those that actually receive assistance. Previous research has identified many sociodemographic variables thought to contribute to this disparity (e.g., family income, marital status, child difficulty, parenting stress, parenting efficacy). More recent research suggests that cognitive factors may not only predict parent willingness to seek help, but may also predict which types of treatment interventions that parents prefer. Help-seeking research often focuses on perceived barriers/interest in receiving therapy services, and largely ignores assessment. The present study examined the extent to which parent attributions predict parent willingness to seek help for their children, as well as the type of services parents preferred, after accounting for child/family sociodemographic factors known to serve as barriers to help-seeking. It also examined obstacles experienced while seeking assessment and therapy services. The Parent Cognition Scale, Obstacles to Therapy Services Questionnaire, Obstacles to Assessment Questionnaire, and a measure of help-seeking behavior was administered to 52 parents of children ages 5-13. Multiple regression analyses revealed that parent attributions was the only significant predictor of help-seeking. Contrary to hypotheses, sociodemographic barriers known to be influential in predicting parent help-seeking behaviors (i.e., family income, parenting stress) and the number or intensity of treatment obstacles were not significant predictors of parent help-seeking. Parents endorsing greater child-responsible attributions for problematic child behaviors endorsed greater interest in help-seeking overall. They endorsed similar interest

in both child- and parent-focused services, but less interest in family services. As predicted, the number and intensity of assessment obstacles experienced by parents were very similar to obstacles anticipated for therapy services. Results highlight the importance of cognitive and attributional factors on parent help-seeking behaviors in a clinical sample, and also suggest future directions for attribution research.

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CHAPTER 1

INTRODUCTION

The National Institute of Mental Health (NIMH) estimates that as many as 26% of adults and approximately 20% of children and adolescents meet diagnostic criteria for one or more psychiatric disorders each year in the United States, and these percentages nearly double if one takes lifetime prevalence numbers into account (Kessler, Chiu, Demler, & Walters, 2005; Merikangas et al., 2010). Unfortunately, significant disparity exists between the number of individuals in need of mental health services and those that actually receive them. In fact, it has been estimated that as many as 70% of individuals in need of services never receive any type of mental health treatment. Moreover, of the one-third of individuals who do receive mental health services, it is estimated that as many as one-third will drop-out of treatment prematurely (Kessler et al., 2005).

Among adults, variables that can influence the decision to seek mental health services include family income, lack of insurance, access to facilities or practitioners, concern about stigma, ethnic and cultural barriers, as well as everyday life obstacles (e.g., lack of transportation, lack of childcare; Kazdin, 1996; Kazdin & Holland, 1997; Kazdin, Holland, & Crowley, 1997; Snell-Johns, Mendez, & Smith, 2004). In the case of child clients, research examining treatment barriers must also consider parent or caregiver involvement, given that children seldom refer themselves for treatment.

Although a significant percentage of parents endorse mental health and/or behavioral concerns regarding their children (Douma, Dekker, De Ruiter, Verhulst, & Koot, 2006), research suggests that only a small percentage of these parents actually obtain treatment for them. This finding is likely due to a number of factors, some of which include: failure to recognize symptoms or perceive the need for care, parent stress, poor parent perception regarding parenting ability, failure to perceive burden related to the problem, lack of available treatment settings, distrust in the service provider, and prior negative treatment experiences. In the case of minority clients, the unavailability of informal services and/or culturally competent service providers, previous experience with racism, lack of transportation, and level of acculturation have also been identified as barriers to treatment (Cauce et al., 2002; Snell-Johns et al., 2004).

More recent treatment barrier research has also focused on the influence of cognitive variables on parent help-seeking behaviors. Research suggests that cognitive factors may not only predict initial parent/caregiver willingness to seek treatment services for problematic child behaviors, but may also predict which types of treatment interventions parents are more likely to prefer. One such cognitive factor includes parent attributions regarding problematic child behavior. For example, research has found that parents who perceive their child's problematic behavior as stable and unmanageable are more likely to identify a greater number of treatment barriers as compared to parents who view their child's problematic behavior as transient and manageable (Janicke & Finney, 2003; Peters, Calam, & Harrington, 2005). As a result, these parents are less likely to seek treatment services, and are more likely to terminate prematurely, especially when services fail to fit their preconceived treatment expectations (Hoza et al., 2000; Johnston & Ohan, 2005; Miller et al., 2003; Peters et al., 2005).

Such research highlights the importance of better understanding parent/caregiver

cognitions as a means of improving parent help-seeking and adherence to treatment services. This topic is especially important when one considers that many childhood disorders, if left untreated, may lead to increased problems in adolescence and adulthood. One such disorder is Attention-Deficit/Hyperactivity Disorder (ADHD), which is a behavioral disorder characterized by the core symptoms of inattention, impulsivity, and hyperactivity (American Psychological Association [APA], 2000). Of the approximately 20% of children in the U.S. who will meet criteria for a diagnosable disorder, nearly 8.6% are diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD), making it the most commonly diagnosed childhood behavior disorder (Kessler et al., 2005; Merikangas et al., 2010). According to outcome research, ADHD is a chronic disorder, meaning that every adult with ADHD also had it as a child, whether or not they were ever formally diagnosed. While some children and adolescents may "outgrow" (i.e., learn to effectively manage their symptoms via medications or behavioural/lifestyle adjustments), approximately two-thirds of individuals will continue to experience clinically significant symptoms well into adolescence and adulthood (Turgay et al., 2012). In addition to ADHD symptoms, outcome research indicates that ADHD is also associated with poorer overall functional outcomes. For example, research suggests that as many as 75% of individuals diagnosed with ADHD experience persistent interpersonal problems (Weiss & Hechtman, 1993), 23-45% of individuals will have juvenile convictions and go on to display symptoms of antisocial personality disorder (Barkley, Fischer, Smallish, & Fletcher, 2004; Fischer, Barkley, Smallish, & Fletcher, 2007), and nearly 20-27% of individuals with ADHD develop substance use disorders (Fischer, Barkley, Smallish, & Fletcher, 2002). Given these startling statistics, it becomes evident how important it is to gain a better understanding of the factors that influence parent help-seeking as a means of improving assessment, treatment adherence, and long-term

individual outcomes.

The present study explored parent attributions of perceived parent control over difficult child behavior and the types of mental health services that parents prefer in a clinical sample of children referred for ADHD assessment. Given that extant barrier research has focused on barriers to therapy and/or has failed to parcel out barriers experienced specifically during the assessment process alone, the present study also examined similarities and differences between perceived barriers to assessment versus anticipated barriers to recommended therapy services.

CHAPTER 2

LITERATURE REVIEW

Models of Help-Seeking

Research has consistently shown that many people in need of mental health services never receive the help they need. This finding likely stems from numerous factors, which include but are not limited to motivational issues, individual differences in willingness and interest to seek help, cognitive factors, and treatment barriers. Preliminary research that examined the impact these variables had on help-seeking originally arose within a medical context (i.e., treatment adherence). Medical help-seeking models often incorporated concepts such as the stages of change (DiClemente & Prochaska, 1982), motivation, and resistance (Miller & Rollnick, 1991). Numerous help-seeking models have been proposed since these early medical models, which now seek to address factors that influence adult, adolescent, and child medical and mental health service utilization (Andersen, 1995; Cauce et al., 2002; Eiraldi, Mazzuca, Clarke, & Power, 2006; Kulka, Veroff, & Douvan, 1979; Power, Eiraldi, Clarke, Mazzuca, & Krain, 2005).

Early Help-Seeking Models

The Behavioral Model of Health Service Use was one of the earliest help-seeking models created, and it remains the model upon which most successive research is derived (Eiraldi et al., 2006). The Behavioral Model of Health Service Use was originally constructed in order to study

access to medical care and general help-seeking behaviors. It is a 3-stage model describing how health service use is a function of the interplay between individuals' need for care and their predisposition to use services (Andersen, 1995). Kulka et al. (1979) is credited with developing one of the first widely used behavioral models of adult mental health help-seeking. They described the mental health help-seeking process to involve three stages: problem recognition, decision to seek help, and selection/utilization of treatment services. According to Kulka and colleagues (1979), help-seeking cannot begin until an individual first recognizes a problem or need as a "mental health" issue, and perceives it to be relevant for professional help. Following recognition of the problem, individuals must then make the conscious decision to seek services for the problem. After an individual has made the decision to seek services, he or she must then make a decision as to where to obtain services, and with which service provider.

Current Help-Seeking Models

Many of the current help-seeking models represent an expansion of the Behavioral Model of Health Service and Kulka's model. One such influential model was proposed by Andersen (1995), who placed greater emphasis on the cognitive decision-making process that individuals go through as they journey through the help-seeking process. Andersen (1995) highlighted the importance and necessity of examining predisposing psychological characteristics of individuals, positing that in addition to perceived barriers, a person's predisposition, attitude towards service, and their perceived need for care can all affect service utilization rates. In 2002, Cauce and colleagues expanded Kulka's original model by adding a cultural component to the help-seeking process. In their model, they highlight the lifestyle and help-seeking characteristics of minority youths at risk for emotional and behavioral disorders. As such, their help-seeking model stressed that help-seeking behaviors arise out of dynamic interactions between individual, family, and

cultural values and beliefs regarding mental health/help-seeking, as well as contextual and systemic factors (e.g., availability of services, availability of referrals). They posit that the interaction between these factors predicts how minority youth respond to mental health problems within the context of their larger social environment, and also affects which types of services they consider.

A model developed by Power, Eiraldi, Clarke, Mazzuca, and Krain (2005) describes the critical nature that familial factors can play in health service utilization for children and adolescents. By incorporating these factors, they developed a model of help-seeking specific to parents seeking help for their children. Power et al. (2005) point out that numerous sociopolitical and cultural/familial factors contribute to low service utilization rates among individuals and families in need of service. Specifically, they suggest that sociopolitical variables (e.g., access to health insurance) can influence how readily parents can locate and gain access to services for their children. They also describe several other factors that can significantly impact parent treatment utilization rates, such as familial demographic factors (e.g., race, ethnicity, socioeconomics, and marital status), cultural beliefs regarding mental health conditions and treatment, and knowledge of available treatments and service providers.

Potential Barriers to the Help-Seeking Process

Many factors have been found to negatively impact help-seeking, and these factors can arise at each stage of the help-seeking process. It is important to identify and examine treatment barriers that parents/caregivers are likely to experience when seeking help for their child, as they have been found to predict not only underutilization of treatment services for children, but to also act as a strong indicator of premature treatment termination (Kazdin & Holland, 1997; Kazdin, et al., 1997: Kazdin & Mazurick, 1994). For example, research suggests that as much as seventy

percent of youth who are in need of mental health services never receive them, often due to treatment barriers their parents experience while seeking services (Kazdin, 1996; Snell-Johns et al., 2004). Following is a brief review of factors found to negatively affect parent utilization of mental health services for their children. These factors are organized by stage of the parent help-seeking process (e.g., problem recognition, decision to seek help, service selection, and service utilization).

Problem Recognition

When faced with a general and/or mental health concern, individuals must first accept the idea that there is a problem. As such, the first stage of most help-seeking models involves the initial recognition of a problem. In terms of child clients, problem recognition refers to awareness on the part of the parent or caregiver that the child's behavior or level of functioning is unusual and/or problematic (Power et al., 2005). Parent perceptions and attributions regarding symptom severity, functional impairment, and perceived burden can all affect a parent's recognition of a problem.

Effectively recognizing a problem is one of the most important factors in determining the likelihood that a family will pursue treatment (Power et al., 2005). Although acknowledgement of a problem does not guarantee actual help seeking, problem recognition greatly increases the likelihood that a parent will attempt to obtain necessary health services.

Symptom recognition and severity. The perceived severity of a child's symptoms also influences problem recognition, and in turn, the decision to seek help (Douma et al., 2006; Morrissey-Kane & Prinz, 1999). Many children lack insight regarding the impact of problematic behaviors they display. Because of this, symptoms are often first recognized by other individuals in the child's life, such as parents or caregivers, teachers, other adults, and/or peers. Decisions

about help-seeking and service selection are largely determined by a child's caregiver, particularly the mother, in consultation with others (Burns et al., 1995; Combs-Orme, Chernoff, & Kager, 1991). Research suggests that perceptions of the parent, rather than clinicians or teachers, have the most impact on seeking help, as parents spend the greatest amount of time with the child (Morrissey-Kane & Prinz, 1999; Power et al., 2005; Raviv, Sharvit, Raviv, & Rosenblat-Stein, 2009).

Difficulties can arise that negatively influence parent perceptions of problem behavior. For example, some research suggests that mothers and fathers differ in the likelihood in which they rate their child's behaviors as problematic. For example, Singh (2003) found that only 18% of fathers as compared to mothers agreed that their son's ADHD behavioral issues warranted medical attention. While fathers recognized and were willing to concede that their sons did in fact evidence behavioral issues such as difficulty following instructions, experiencing academic difficulties or causing trouble at school, or social awkwardness, fathers tended to "explain away" these issues as not warranting treatment attention due to several factors (e.g., indulgent mothers, lack of motivation on their son's part, and a "boys will be boys" mentality). In addition to parent gender, the type of symptoms displayed (i.e., internalizing versus externalizing) is also important. For example, parents are more likely to be aware of more externalizing behavioral problems than more internalizing emotional problems. Research suggests that parents are also more likely to recognize problems when the child's peer and/or adult relationships are negatively impacted (Power et al., 2005). The presence of comorbid conditions and a concomitant increase in behavioral symptoms may also increase awareness of a problem.

Research suggests that parent perceptions regarding symptom severity may also predict help-seeking behavior as well as treatment engagement and attrition (Angold et al., 1998; Hoza

et al., 2000; Miller et al., 2003, Morrissey-Kane & Prinz, 1999). That is, several researchers have found that the more severe a child's problems, the more likely families are to drop out of treatment prematurely (Kazdin & Mazurick, 1994; McKay, Gonzales, Quintana, Kim, & Abdul-Adil, 1999). Although their research did not specifically measure the reasons behind observed early termination rates, the authors noted that parents of children with more severe problems often report greater levels of stress and more disruptive life events, which may help to explain this finding.

Cultural factors may also affect parents' perceptions regarding whether a set of behaviors is sufficient enough to warrant concern. What is considered "typical" behavior can vary within families, neighborhoods, and/or different cultures. For example, in a neighborhood in which aggression is common, a parent may view aggressive behavior as instrumental to self-protection. The extent to which the behavior impacts the child's academic performance, peer relationships, and/or adult relationships has also been found to contribute to a parent's willingness to accept that there is a problem (Cauce et al., 2002). Both social norms and the degree of perceived impairment have been shown to vary as a function of cultural background (Power et al., 2005). For example, some cultures have been found to be simply more accepting of certain psychiatric symptoms, and there is evidence of intercultural differences in "distress thresholds" exhibited by parents (Weisz & Weiss, 1991). Moreover, cultural beliefs might include alternative explanations for mental health issues. Among families with strong ethnic affiliations in the African American and Native American culture, for example, supernatural, spiritual, and religious theories of emotion and behavior may be particularly prominent (Cheung & Snowden, 1990).

Perceived parent/caregiver burden. Parent psychological distress is one of the most important predictors of parent help-seeking behavior (Angold et al., 1998). Morrissey-Kane and

Prinz (1999) found perceived parent burden to be the strongest predictor of treatment initiation for difficult child behavior. In fact, parent/caregiver perceived burden has been suggested to account for as much as 50% of the variance observed in symptom recognition (Douma at al., 2006). Examples of parent burden can include parent-child conflict, tension between siblings, stigma, threat to parent well-being, restriction of personal activities, school reports of academic or behavior problems, and/or family-school conflict (Douma et al., 2006; Janicke & Finney, 2003). Adult-related stressors such as family health problems, parent psychopathology, and/or financial difficulties may also contribute to perceived caregiver burden (Angold et al., 1998).

Research indicates that the stressors mentioned above can impact problem recognition in several ways. For example, if parents or caregivers experience increased stress related to their child's symptoms, they are more likely to be sensitive to their child's problem (Bussing, Gary, Mills, & Garvan, 2003; Douma et al., 2006) and consult others for help (Mechanic, 1978). Interestingly, opposing research has also suggested that parents shouldering much greater than average burdens may actually be less apt to recognize psychological problems in adolescent children (Brannan, Heflinger, & Bickman, 1997), perhaps as a result of being overloaded with other stressors. Parents under significant stress, for example, have been found to be more likely to attribute problematic child behaviors to their own interactions with the child, as opposed to identifying or labeling their child as having mental health issues (Cauce et al., 2002).

Decision to Seek Help

After a parent has recognized that a problem exists, the second step involves deciding whether or not to seek help for the issue. This decision often involves an analysis in which the parent must decide whether the anticipated benefits of seeking help will outweigh the effort and/or cost of obtaining services (DiClemente & Prochaska, 1982). Thus, the decision to seek

help most often occurs when mental health issues are both recognized and perceived as undesirable, and when the perceived benefits of treatment outweigh perceived barriers.

A parent's decision to seek help can be influenced by a multitude of factors, some of which include: possessing adequate knowledge about the problem and/or available treatment options, parent attitudes toward seeking help in general, previous experiences with the mental health field, parent characteristics (e.g., age, gender, level of parenting self-efficacy), and parent beliefs about the cause of the illness. Additionally, research suggests that parent defensiveness might also play a role. For example, while assessing parent self-referral behaviors, Raviv, Raviv, Edelstein-Dolev, and Silberstein (2003) found that parents were more willing to refer another parent's child to therapy before their own, and that they were also more likely to refer another parent for therapy services, even if both their child and the other parent's child displayed similar problematic behaviors.

Perception of the need for care. Perceptions that treatment is irrelevant to a problem, or that treatment is too demanding have also been found to reduce the likelihood an individual seeking help. Several factors are likely to influence parent perceptions regarding seeking mental health services, such as past experiences of treatment success and/or failure and knowledge or familiarity with available services (Eiraldi et al., 2006; Johnston, Seipp, Hommersen, Hoza, & Fine, 2005; Nock & Kazdin, 2001; Snell-Johns et al., 2004). Douma et al. (2006), for example, found that the most cited reason for parents of children with borderline intellectual abilities to not seek help was lack of information about resources, as well as previous negative treatment experiences. Kerkorian, McKay, and Bannon, Jr. (2006) found that previous treatment experience, particularly a feeling of respect from a provider, as well as parent recognition of the utility of previous treatment were strong predictors of repeat help-seeking behavior. Morrissey-

Kane and Prinz (1999) suggest that parents with expectations that do not match the treatment process are more likely to drop out of treatment prematurely, and are also less likely to seek out treatment a second time.

Parent perceptions regarding the need for care can also be influenced by the fact that children are in a continual state of development (Holmbeck et al., 2000). For example, parents can be influenced by the fact that children are likely to exhibit an arguably "normal" amount of affective instability and disequilibrium during their formative years (Moffit, Caspi, Dickson, Silva, & Stanton, 1996). If problems exist, therefore, parents may be more apt to question whether the problem is likely to remit on its own. This may result in some parents deciding to ignore a certain amount of emotional instability and/or disruptive behaviors with the expectation that the child's behaviors will dissipate and/or remit altogether as he or she matures. Indeed, one of the most commonly cited reasons for parents to miss their first scheduled treatment appointment was a shift in their perception that their child's problem had improved to the point of no longer being problematic (Cauce et al., 2002).

Sociodemographic treatment barriers. Parent decisions to seek help for problematic child behaviors can also be significantly affected by sociodemographic treatment barriers (i.e., variables such as family income, parent pathology, location, and cultural factors that negatively affect the treatment process). Treatment barrier research often classifies treatment barriers to exist on four levels: individual, family, community, and cultural levels (Cauce et al., 2002; Mojtabai et al., 2011; Snell-Johns et al., 2004).

Individual and family variables. Individual and family barriers are often grouped together and can include: low socioeconomic status (SES), low level of education, unemployment, young age, single marital status, and parent psychopathology. Daily hassles such

as time constraints, scheduling conflicts, and lack of transportation can also impede parent help-seeking (Kazdin, 1996; Kazdin et al., 1997; Morrissey-Kane & Prinz, 1999; Snell-Johns, et al., 2004).

Low SES can act as a treatment barrier for several reasons. Parents with limited financial resources may not be able to afford the cost of assessments and/or recommended treatment interventions. They also may not be able to afford the transportation or child care costs associated with attending treatment. Snell-Johns et al. (2004) further noted that families living in poverty are more likely to have limited access to telephones for scheduling appointments, and may also have poor or limited verbal and social skills that may also negatively impact help-seeking. Younger parent age has also been identified as a treatment barrier, given that younger parents are often under increased levels of financial stress and they typically possess more negative attitudes towards seeking help for mental health issues as compared to older parents.

Successful treatment outcomes also depend on the overall level of family functioning. Parent psychopathology, marital conflict, and maternal social isolation are associated with decreased treatment benefits (Dumas, 1984; Snell-Johns et al., 2004). Maternal depression has been found to predict fewer treatment gains and higher rates of attrition, which Furey and Basili (1988) propose are likely due to negative perceptions of treatment progress on the part of mothers. Increased levels of parent and marital distress can also negatively affect treatment. Marital distress, for example, has been found to predict fewer treatment gains as well as premature termination (Kazdin & Mazurick, 1994). Parents facing multiple problems in addition to parenting issues are also more likely to drop out of treatment prematurely (Prinz & Miller, 1994). This is a very important concept to consider given that Kazdin and Wassell (1999) found

that parent perceptions of treatment interventions being too demanding was one of the most influential barriers to treatment, and was most negatively related to therapeutic change.

Community barriers. Community barriers refer to variables related to one's physical locale or area of residence that interfere with client service utilization. Rural areas, for example, can offer somewhat limited treatment options as a result of well-trained professionals being less attracted to living and working in remote areas. Families living in rural areas are also more socially isolated, and are thus required to travel greater distances to seek out and receive services. In populations of children diagnosed with disruptive behavior disorders, social isolation was found to predict more negative treatment outcomes including failure to initiate services and/or premature drop out of treatment (Connell, Sanders, & Markie-Dadds, 1997). Similarly, families living in inner cities are also less likely to receive services and/or are more likely to drop out of therapy prematurely (Bischoff & Sprenkle, 1993; Kazdin, 1996; McKay et al., 1999). This is thought to occur for a number of reasons, the most likely of which is insufficient access to mental health professionals due to a lack of available services. Prevalence rates of childhood disruptive behavior disorders in inner city communities, for example, can range from as high as 24-40%, which unfortunately often results in discrepancies between the amount of services available and individuals in need of those services (Snell-Johns et al., 2004).

Cultural barriers. Cultural barriers are also an important factor to consider when addressing parent decisions to seek help for their children, especially when those parents are minority or immigrant individuals (Cheung & Snowden, 1990; Snell-Johns et al., 2004; Sue & Sue, 2012). Research suggests that Latino, Asian American, and Native American youth are less likely to receive treatment than their Caucasian counterparts (Bui & Takeuchi, 1992; Ku & Matani, 2001). Also, minority families are less likely to experience positive treatment outcomes

(McKay et al., 1999; Webster-Stratton, 1994) and are more likely to terminate treatment early (Kazdin & Mazurick, 1994).

Several factors are thought to contribute to this phenomenon, the most salient of which are likely stress and socioeconomic disadvantage (Kazdin et al., 1997). Sareen and colleagues (2007) point out that cultural and ethnic minorities often experience barriers such as lack of transportation, communication difficulties due to language barriers, an inability to secure an appointment due to inflexible provider hours, and far distances between home and treatment settings. Several studies also point to the current lack of culturally-competent treatments and service providers available to culturally or ethnically diverse populations (Lee et al., 2009; Takeuchi, Bui, & Kim, 1993). Cultural norms and stigma related to seeking help for mental health issues can also negatively impact minority parent help-seeking (Snell-Johns et al., 2004). As a result of stigma, minority parents often show a preference for more informal sources of support (e.g., close friends, significant others, religious figures such as priests or clergy). Previous experiences with racism or discrimination (Gee, 2002) as well as lack of knowledge regarding available resources and/or the importance of care have also been found to negatively impact minority parent help-seeking (Lee et al., 2009). In general, research suggests that families that are more acculturated are more likely to seek help for children than families that are less acculturated (Power et al., 2005).

Service Selection and Utilization

The final step of the help-seeking process involves selecting and utilizing services. After parents make the decision to seek help for their child, they must then decide on the treatment setting (e.g., school versus private setting), who they would like to provide the intervention

(formal versus informal services), and the types of intervention they would prefer (e.g., medication versus child-, parent-, and/or family-focused interventions).

Treatment setting. There are many different types of treatment settings that parents can choose from when seeking help for children. Some examples include, but are not limited to: hospitals, clinics, counseling centers, independent private practices, schools, public health institutions, and primary care centers. Parents and families can differ in their preferences regarding different treatment settings for different reasons. For example, parents who are embarrassed that they need help with their child's problematic behavior may seek services in inconspicuous settings that offer a greater sense of anonymity (e.g., small outpatient clinics in remote areas). This idea is supported by Raviv et al. (2003), who found that parents referred to public mental health settings (i.e., school counselors and psychologists) endorsed more anxiety and worry related to seeking help for their children as compared to parents referred to more private settings (e.g., private practices). A child's culture can also affect the type of setting parents select for their children. As mentioned previously, cultural and ethnic minorities are more likely to seek out and engage in informal types of treatment services (e.g., speaking to friends and family, speaking to clergy, community-based programs) as compared to more formal mental health services such as individual therapy in private practice settings (Cauce et al., 2002; Eiraldi et al., 2006; Harrison, McKay, & Bannon, 2004; Kerkorian et al., 2006).

Trust in the service provider. Parent trust in the service provider or institutional agency that they will behave in a competent, compassionate, and ethical manner that is consistent with child and family expectations can also be an important factor for parents when selecting services for children (Raviv et al., 2003). Research has shown that issues of trust can be related to the initial likelihood of seeking services, satisfaction with the service provider, as well as willingness

to comply with practitioner recommendations (Hall, Camacho, Dugan, & Balkrishnan, 2002). Several researchers have found that parent perceptions regarding a provider's inability to be trusted can be significantly detrimental to parent help-seeking behaviors (Harrison et al., 2004; Keller & McDade, 2000; Kerkorian et al., 2006; Power et al., 2005). Trust in the service provider can become especially important when considering the help-seeking behaviors of ethnic and cultural minorities. Takeuchi et al. (1993), for example, found that African American families in particular, as compared to families of other ethnicity, have less faith and trust in the usefulness of psychotherapeutic interventions, and also report greater concern that contact with mental health providers may result in the institutionalization of their child.

Intervention type. There are a number of different interventions available to parents for the treatment of problematic child behaviors (e.g., child-focused versus parent or family-focused treatment, pharmacotherapy). When selecting services, parents may initially be limited to certain types of providers (e.g., generalist versus specialist) and/or treatment interventions as a result of insurance reimbursement practices (Janicke, Finney, & Riley, 2001). Parents may also have certain perceptions regarding different available treatment interventions, and these views can affect parent service selection and utilization of mental health services (Morrissey-Kane & Prinz, 1999). For example, parents may differ in how reasonable they feel intervention goals are, or whether the suggested intervention is acceptable or likely to result in worthwhile outcomes (Power et al., 2005). Given an option, research suggests that both parents and teachers typically prefer behavioral interventions to pharmacological treatment (Connell et al., 1997; Janicke & Finney, 2003; Liu, Robin, Brenner, & Eastman, 1991; Power et al., 2005). However, both behavioral and pharmacotherapy interventions were preferred over other types of treatment that require more parent/family involvement (e.g., parent training techniques, family therapy;

Johnston & Ohan, 2005), or that are perceived as challenging to implement (i.e., response-cost procedures as opposed to positive reinforcement procedures; Power et al., 2005).

Parent Attributions and Help-Seeking

Attributions derive from attribution theory, which states that individuals assign causes to others' behaviors in an attempt to explain and make sense of them (Heider, 1958). Parent attributions refer to the attitudes and explanations that parents make regarding their child's behavior. There are several types of attributions parents can make regarding problematic child behaviors, which involve locus of control [i.e., perceptions regarding the internal (child-dispositional) versus external (parenting practices) causes of problematic behaviors], the stability of behaviors, and whether or not they can be controlled (Johnston et al., 2005). Parent perceptions regarding problematic child behaviors are important to address because they can affect parenting style, disciplinary practices, and general parent-child interactions (Morrissey-Kane & Prinz, 1999). Parent attributions of problematic child behaviors are also thought to moderate parent help-seeking behaviors throughout the entire help-seeking process, as well as influence and predict parent engagement and associated treatment outcomes (Jenson, Green, Singh, Best, & Ellis, 1998; Johnston & Ohan, 2005; Morrissey-Kane & Prinz, 1999). For example, research suggests that parent attributions can predict premature dropout (Angold et al., 1998; Kazdin et al., 1997; Morrissey-Kane & Prinz, 1999) and that they can also affect parent preferences for individual treatment interventions (Hoza et al., 2000; Mah & Johnston, 2008).

Parenting Self-Efficacy

Parenting self-efficacy refers to how much a parent feels they have control over problematic child behaviors. Parent perceptions of control over a situation and belief about their parenting abilities are important factors in determining parent-child interactions (Bornstein &

Bradley, 2003). Parents high in parenting self-efficacy view problematic child behavior as resulting, at least in part, from their own parenting practices (Campis, Lyman, & Prentice-Dunn, 1986; Morrissey-Kane & Prinz, 1999). Such parents feel responsible for their child's behavior, and feel more confident in their ability to manage problematic behaviors if and when they arise. Research has found greater parenting self-efficacy to be associated with lower overall levels of parent/child conflict (Ohan, Leung, & Johnston, 2000), as well as more consistent, confident, and effective parenting responses to difficult child behavior (Morrissey-Kane & Prinz, 1999). According to Bornstein and Bradley (2003), greater feelings of parenting self-efficacy also predict higher levels of time, energy, and effort expended during parenting. Research suggests that greater parenting self-efficacy also predicts service utilization and treatment outcomes (e.g., adherence; Janicke & Finney, 2003; Power et al., 2005). Several researchers have found that parents low in self-efficacy are more likely to have negative pre-treatment expectations of behavioral intervention treatment outcomes, which often translates to premature termination (Hoza et al., 2000; Johnston & Ohan, 2005).

Research has generally found that parents of children with hyperactive, oppositional, and conduct-disordered disruptive behaviors often endorse lower ratings of parent self-efficacy and parent competence, as well as greater feelings of inadequacy (Bornstein & Bradley, 2003; Johnston & Mash, 1989; Johnston & Patenaude, 1994). Parents with a low sense of parenting efficacy tend to view their child's problems as stable, unchangeable, and outside parental influence. When faced with a difficult child, such parents might feel powerless and take a defeatist and apathetic approach to intervening. Parents with low self-efficacy have been found to be less effective in coping with difficult child behavior, they are more likely to adopt a more authoritarian parenting style, and/or may tend to respond to problematic child behaviors in more

negative and harmful ways (Bugental, Blue, & Cruzcosa, 1989; Bugental & Shennum, 1984; Johnston & Mash, 1989). Parents with low self-efficacy have also been found to perceive behavioral parent management strategies to be less relevant and acceptable, are generally more dissatisfied with treatment, and have poorer treatment outcomes overall (Morrissey-Kane & Prinz, 1999).

Parental self-efficacy scores have been found to be sensitive to intervention effects (Johnston & Mash, 1989; Lovejoy, Verda, & Hays, 1997). Research suggests, for example, that parents who receive psychoeducation endorse improved levels of parent self-efficacy and associated treatment outcomes (Roberts, Joe, & Rowe-Hallbert, 1992).

Parenting Attributions of Control

Parenting attributions of control refer to a parent's perceptions regarding their child's abilities to control his or her own behavior. Parenting attributions involving a child's perceived ability to control their behavior typically involve factors such as the child's disposition, judgment, and ability (Johnston & Ohan, 2005; Morrissey-Kane & Prinz, 1999). Parent perceptions of misbehavior are important to consider because they have been found to influence parenting style and help-seeking behaviors. For example, research suggests that parents who perceive their child's misbehavior as intentional and within their child's control are likely to be more aware of misbehavior and to react in more negative and hostile ways (Bugental et al., 1989). In contrast to parents who view their child's problematic behavior as unintentional and out of their child's control, these parents are also more likely to adopt a preference for sterner, more authoritarian disciplinary styles (Morrissey-Kane & Prinz, 1999). In addition, research indicates that the more negative the perceived problematic child behavior, the more likely a parent is to view that problematic behavior as solely a function of child factors. This relationship

is thought to reflect an almost protective tendency on the part of parents to minimize their own responsibility for child misconduct, and thus preserve their own self-esteem. This tendency can be problematic, however, given that mental health treatment utilization can be hampered by an individual's inability and/or unwillingness to accept a measure of personal responsibility for a treatment issue (Bundek, Marks, & Richardson, 1993). Thus, parents who attribute child disruptive behavior solely to child factors and not at all to their own parent control are less likely to participate in the treatment process (Morrissey-Kane, & Prinz, 1999), and may be less likely to prefer certain types of treatment interventions involving a parent focus. Reimers, Wacker, Derby, and Cooper (1995), for example, found such parents to rate parent management behavioral intervention strategies as less acceptable. As a result, one hypothesis of the current study is that child-responsible parent attributions will be associated with a preference for more child-focused versus family- or parenting-focused interventions.

Parent Attitudes and Attributions as a Predictor of Preferred Treatment Intervention

Research also suggests that parent expectations regarding treatment can play a role in determining not only the types of treatments that parents seek for their children, but may also influence their willingness to participate in recommended interventions (Morrissey-Kane & Prinz, 1999). For example, Morrissey-Kane and Prinz (1999) posited that parents who view their child's problematic behavior as stable, unchanging, and internal to the child demonstrate less treatment success in therapy, and are more likely to prefer treatments involving medication or individual therapy solely with the child. Reimers and colleagues (1995) also found that parents seeking mental health services for their child's problematic behavior who attributed misbehavior to occur solely as a result of child factors rated parent-focused intervention strategies less favorably than other treatment options. In general, parents reporting low parent self-efficacy

were less likely to be interested and/or fully engaged in parent training interventions, which the authors attributed to feelings of hopelessness on the part of the parent in controlling their child's problematic behaviors. Morrissey-Kane and Prinz (1999) echoed this idea, reporting that parents with low parenting self-efficacy are more likely to perceive behavioral parent management strategies as less relevant and acceptable, and thus found them to be associated with poorer treatment outcomes.

Parent Attitudes and Attributions as a Predictor of Treatment Adherence and Overall Outcomes

Parent attributions have been found to play an important role in service utilization, engagement, adherence, and successful completion (Jenson et al., 1998; Johnston & Ohan, 2005; Johnston & Patenaude, 1994; Johnston et al., 2005; Morrissey-Kane & Prinz, 1999). Kazdin and Wassell (1999), for example, found that families who perceive greater numbers of treatment barriers are less likely to be involved in and/or committed to treatment and are also less likely to carry out proposed treatment recommendations. Not surprisingly, premature termination from therapy was also found to be associated with parent perception of increased amounts of treatment barriers (Kazdin & Wassell, 1999), as well as low perceived treatment quality (Mojtabai et al., 2011). Individuals with treatment expectations that differed from actual services provided (i.e., parents with child-causal attributions expecting child-focused treatment interventions that were asked to participate in parent-focused interventions) were more likely to drop out of treatment services prematurely (Hoza et al., 2000; Plunkett, 1984). In such instances, research suggests that these parents are more willing to attribute treatment difficulties to ineffective medications and/or perceive a lack of effort on the part of their child rather than attribute negative treatment outcomes to their own efforts (Henson & Chang, 1998).

Present Study

Previous research examining predictors of parent help-seeking has identified many sociodemographic variables thought to contribute to the disparity observed between children in need of services and those that actually receive them. More recent research has also focused on the influence of cognitive variables on parent help-seeking behaviors, and suggests that cognitive factors may not only predict parent willingness to seek treatment, but may also predict which types of interventions parents are most likely to seek out and adhere to.

Such research is still in its infancy, however, and additional studies examining the influence of parent cognitions on the help-seeking process are necessary. Moreover, help-seeking research often focuses on perceived barriers and/or attributions in relation to therapy services, while largely ignoring help-seeking as it relates to initial assessment. In many cases, child assessment results are the foundation on which recommendations are made for therapy. Therefore, the current study explored the extent to which cognitive factors (i.e., perceived obstacles to assessment and therapy, attributions of child behavior, treatment outcome expectancies) predict parent interest in help-seeking in a clinical sample of children aged 5-13 referred to an ADHD Evaluation Clinic. Based on the results of previous studies, the following hypotheses were considered:

1. Known child/family sociodemographic factors (i.e., family income, level of child difficulty, parenting stress) would significantly predict parent help-seeking.
2. After accounting for the well-established sociodemographic factors described above, the intensity of service obstacles would also significantly predict parent help-seeking.

3. After accounting for the sociodemographic and barrier factors described above, parent attributions regarding problematic child behavior would also significantly predict parent interest in help-seeking.

4. Parents scoring higher in child-responsible attributions as compared to parent-causal attributions would endorse greater interest in child-focused treatment and less interest in family and parenting-focused treatment.

5. There would be a significant positive correlation between parent report of obstacles associated with assessment services and obstacles associated with therapy services.

CHAPTER 3

METHOD

Design

The current study used a hierarchical regression model with five predictor variables and one criterion variable. Predictor variables included annual household family income, level of child behavioral difficulty, level of parent stress, the total number of perceived obstacles to treatment, and the CRA-PCA difference score, which was derived from subtracting the Parent-Causal attribution score from the Child-Responsible attribution score, with higher scores reflecting greater child-responsible attributions. The criterion variable was parent/caregiver rating of willingness to seek help for their child. Correlational analyses were also utilized to examine the relationships between sociodemographic variables, perceived obstacles to treatment, and parent attributions regarding problematic child behavior on parent interest in help-seeking. Paired-samples *t* tests were also conducted between assessment and therapy obstacle items in order to examine the similarity and differences between obstacles experienced for each type of service.

Participants

Participants included parents or guardians of children between the ages of 5-13 referred to a university-based ADHD clinic for assessment of suspected ADHD. A total of 53 parents and caregivers agreed to participate by completing the study questionnaires. One participant was

excluded due to missing data from two questionnaires. Another participant failed to complete one of the Obstacles questionnaires and thus was not included in one of the regression analyses. However, data from this participant was used in all other analyses. Children not diagnosed with ADHD as well as those diagnosed with comorbid disorders in addition to ADHD were included in the study.

Results are based on responses from 52 parent/caregiver participants. Information on participant demographic information is presented in Table 1. There were significantly more female participants (90.4%) than male participants (9.6%). Most participants were the child's biological parent (82.7%), and were either married or re-married (55.8%). When questionnaires were completed by someone other than the biological parent (i.e., grandparents, foster or adoptive parents), the respondent identified themselves as the primary caregiver and/or guardian of the child of focus. Participants ranged in age from 23-64 years old (M = 32.05, SD = 7.29). The majority of respondents had at least a high school education. Family income ranged from less than $10,000 to over $100,000, with the largest percentage of participants reporting income between $10,000 to $20,000 (36.5%). A majority of participants (69.2%) endorsed household family incomes below the median for the county ($40,547), as well as the state ($48,374). Information on caregiver ethnicity was not available for this study.

In the study packet, parents were asked to focus their responses on the behaviors of the child referred to the ADHD Clinic. A little over half of participants focused on a male child when filling out study questionnaires (59.6%), as seen Table 2. Children of focus ranged from 67 to 160 months in age (i.e., 5 to 13 years old) (M = 98.29, SD = 23.08). The most common ethnicity for the child of focus was Caucasian (86.5%), followed by African American (5.8%). Approximately half of the children of focus were in kindergarten or 1st grade. Children were

most commonly diagnosed with ADHD-Combined Type (48.1%) and 9.6% of children were diagnosed with ADHD, Predominantly Inattentive Type. A total of 67.8% of children received a secondary diagnosis (in addition to ADHD), with the most common second diagnosis being ODD (26.5%), followed by anxiety or depression (9.6%). A large majority of participants endorsed an immediate family history significant for psychiatric issues ranging from ADHD and learning disorders, to depression and anxiety, and Bipolar Disorder and Schizophrenia (69.2%).

Measures

Measures Included in the ADHD Assessment Battery

The assessment battery includes a DSM-IV-based clinical interview with a parent or caregiver, a developmental history questionnaire, parent and teacher behavior and executive functioning rating scales, a computerized test of attention, and measures of parenting stress, intelligence, and academic achievement. For the present study, information was collected from the Conners-March Developmental Questionnaire, the Parenting Stress Index, and the BASC-2 in order to obtain descriptive statistics of the sample, the level of parenting stress, and the level of child behavioral difficulty, respectively.

Conners-March Developmental Questionnaire (CMDQ). The CMDQ (Conners & March, 1996) is a self-report questionnaire used to solicit information about developmental history. The CMDQ is appropriate for children and adolescents ages 3-17 years, and takes approximately 20 minutes to complete. The CMDQ provides a wide range of information regarding sociodemographic information (i.e., age, ethnicity, education level); child educational history and academic performance; birth/developmental history; health functioning; current medication use; and child/family psychiatric history (i.e., previous psychological diagnoses and

mental health service utilization). Information on child age, parent age and education, ethnicity, and family income was obtained through the CMDQ for the current study.

Parenting Stress Index-Short Form-4th edition (PSI-4-SF). The PSI-4-SF is a parent/caregiver self-report questionnaire that assesses parent endorsement of parent stress. The PSI-4-SF is a modified and abbreviated version of the original Parenting Stress Index (PSI) (Abidin, 1983) that typically requires approximately 5-10 minutes to complete. The PSI-4-SF consists of 36 Likert-type items in which parents or caregivers rate on a 5-point scale (strongly disagree, disagree, not sure, agree, strongly agree) how much they agree that each item describes their child, themself, or their current situation. It is divided into three clinical subscale domains: Parental Distress (PD; e.g., feelings of depression, negative interactions between parents, lack of social support, perceptions of restriction due to being the child's parent, and feelings of parental incompetence); Parent-Child Dysfunctional Interaction (P-CDI; e.g., parent views regarding their relationship with their child, with high scores suggesting a lack of adequately-established child-parent bond, or one that is close to rupturing); and Difficult Child (DC) (e.g., assessing child behavioral traits that affect how easy (or hard) it is to manage their child's behavior). These three domains combine to form a Total Stress scale score, which provides a measure of the overall level of parenting stress. Parent stress level scores greater than the 70th percentile are considered clinically significant (Abidin, 1983).

The PSI-4, from which the PSI-4-SF is based, is based on normative data from a sample of 534 mothers and 522 fathers stratified to match the demographic composition of the 2007 U.S. Census. Alpha reliability coefficients based on the responses of the sample ranged from 0.78 to 0.88 for the Child Domain subscales and from 0.75 to 0.87 for Parent Domain subscales. A high degree of internal consistency was found for these measures, with reliability coefficients for the

two domains and for the Total Stress scale to be at 0.96. Test-retest reliability coefficients ranged from 0.55 to 0.82 for the Child Domain, from 0.69 to 0.91 for the Parent Domain, and from 0.65 to 0.96 for the Total Stress score.

Shortened versions of the PSI have become a widely used instrument in the assessment of parenting stress, and have demonstrated good reliability (test-retest reliability coefficient = 0.84, internal consistency coefficient alpha = 0.91) and valid psychometric properties in clinical populations with low socioeconomic status (e.g., Whiteside-Mansell et al., 2007), diverse ethnicity (e.g., Reitman, Currier, & Stickle, 2002), and those with externalizing, internalizing, and autism spectrum disorders (Zaidman-Zait et al., 2010). Coefficient alphas for each of the PSI-4-SF scales were found to be above 0.90.

Behavior Assessment System for Children- 2nd Edition (BASC-2). The BASC-2 is a broad behavior rating scale that addresses child behaviors in both the home and school settings (Reynolds & Kamphaus, 2004). The BASC-2 is a well-established, widely used instrument in child assessment, with established norms for several different age groups. The BASC-2 has demonstrated high content, criterion, and construct validity, and has been found to have high reliability, with average internal consistency scale coefficients of approximately 0.80. According to Reynolds and Kamphaus (2004), the BASC-2 parent rating scale demonstrates strong concurrent validity with other child behavior rating scales. In the 2004 revision of the BASC and concomitant creation of the BASC-2, four normative samples were used: general norm sample, clinical norms, learning disability norms, and ADHD norms. For the purposes of this study, general norms were used as children in the sample were referred for an ADHD evaluation but not yet diagnosed with ADHD or any other disorder. Reynolds and Kamphaus (2004) report internal consistency coefficients ranging between 0.87 and 0.97 for the BASC-2 subscales, as well as one

week test-retest reliability coefficients ranging between 0.84 and 0.90 (e.g., Dowdy, Chin, Twyford, & Dever, 2011; McClendon et al., 2011).The BASC-2 provides self, parent, and teacher rating forms for the assessment of the child behaviors. Specifically, instructions ask respondents to rate individual child behaviors on a four point scale depending on the frequency of the behavior (i.e., never, sometimes, almost always, or always occurs). For the current study, the parent rating form of the BASC-2 was used to assess parent perception of problematic child behaviors. The parent rating form of the BASC-2 consists of 160 Likert-type questions using a four-point scale ranging from 1 (never) to 4 (always), and typically takes approximately 20 minutes to complete. The BASC-2 parent rating form yields standard scores for five broad domains, as well as several subscales within each domain (noted in parentheses). The broad domains include: Externalizing Problems (e.g., hyperactivity, oppositionality, conduct disorder); Internalizing Problems (e.g., withdrawal, anxiety, depression); Adaptive Skills (e.g., age-appropriate self-care and social skills), School Problems, and Behavioral Symptoms Index. Reynolds and Kamphaus (2004) reported the broad domain and individual subscale results as *T*-scores in their manual (M=50, SD=10). When interpreting clinical significance, they suggest a clinical significance cut off of $T \geq 70$. Parent behavior ratings from 60 to 69 are considered to be in the "at risk" range for developing clinically significant problems. For this study, the Internalizing and Externalizing Indices t-score values were added together to create a total child behavioral difficulty level variable.

Research Measures

In addition to measures completed as part of the ADHD assessment battery, participants were asked to complete the following questionnaires.

Parent Cognition Scale. Parent attributions regarding problematic child behavior were measured using the Parent Cognition Scale (PCS; Snarr, Smith Slep, & Grande, 2009). The PCS is a 30-item questionnaire that asks parents or guardians to contemplate their child's misbehavior over the past 2 months, and to rank possible causes for their child's misbehavior on a 6-point Likert scale format, 1 (always true) to 6 (never true) (see Appendix A). The PCS was developed as a brief self-report measure of both child-responsible and parent-causal attributions. Its two subscales measure the degree to which a parent indicates child-responsible versus parent-causal attributions for their child's misbehavior. During the scoring process, each item on the scale is reverse scored, with higher scores indicating greater levels of child-responsible or parent-causal attributions. Snarr et al. (2009) found good psychometric support for the PCS in a study evaluating its reliability and validity. They found good discriminant validity and good internal consistency for its Child-Responsible and Parent-Causal subscales (e.g., alpha levels of 0.90 for the Child-Responsible Scale and 0.88 for the Parent-Causal scale). The PCS demonstrated good internal consistency in an unpublished dissertation study, with alpha levels of 0.89 and 0.83 for the Child-Responsible and Parent-Causal Scales, respectively. The PCS also demonstrated good internal consistency in the current study, with alpha levels of 0.94 and 0.87 for the Child-Responsible and Parent-Causal Scales, respectively (Appendix A).

Parent Help-Seeking Questionnaire. The parent help-seeking questionnaire was developed for an unpublished dissertation study (Hutchens, 2013). It was adapted from scripts used by Raviv et al. (2003) that sought to assess parent attitudes towards help-seeking (see Appendix B). The Parent Help-Seeking Questionnaire asks respondents to rate their willingness to seek help for their child through a variety of treatment modalities (e.g., child-focused therapy services, parent-focused therapy services, family-focused therapy services), sources of support

(e.g., family and/or friends, community support such as teacher or clergy member), as well as preference to deal with the problem on their own (i.e. through the use of self-help books or researching information on the internet). On this 6-item questionnaire, participants were asked to rate their willingness to make use of each type of support on a 7-point Likert-type scale, 1 (absolutely not) to 7 (definitely). A total help-seeking score was calculated from participant responses by adding the Likert ratings across each of the 6 items. In addition, the Parent Help-Seeking Questionnaire also contains two subscales which provide information on parent level of interest in formal services (sum of first 3 items) versus informal services (sum of items 4-6). The Parent Help-Seeking Questionnaire demonstrated good internal consistency for participants in an unpublished dissertation study (Hutchens, 2013), with alpha levels of 0.94 for the formal help-seeking items and 0.86 for the informal help-seeking items. In the current sample, the Parent Help-Seeking Questionnaire demonstrated good internal consistency for formal help-seeking items, with an alpha level of 0.91. Internal consistency for the informal help-seeing items (α = 0.65) was much lower and thus results for this subscale should be interpreted with caution.

Obstacles to Therapy Services Questionnaire. The Obstacles to Therapy Services Questionnaire was also developed for an unpublished dissertation study on help-seeking in a community sample (Hutchens, 2013). It was revised slightly for use with this study by adding two extra items: “Concerned about type of treatment that might be suggested (i.e. medication)” and “Sought help before and disappointed with services.” The directions at the beginning of the questionnaire were also revised to be consistent with ADHD clinic procedures regarding feedback on evaluation and clinical recommendations (e.g., “it is possible that therapy services might be recommended for your child”). The Obstacles to Therapy Services Questionnaire consists of 16 items, and was originally developed based on treatment obstacle research by

Hornblow, Bushnell, Wells, Joyce, and Oakley-Browne (1990), who demonstrated that attitudinal barriers (e.g., "no one could help," "it was too embarrassing to discuss") were more prevalent than practical barriers to help-seeking (i.e., lack of transportation, lack of time). Parents were asked to rate the extent to which items on this measure might pose a barrier to seeking help for their child using a 7-point Likert Scale, 1 (not a reason) to 7 (primary reason) (see Appendix C). A total intensity score of anticipated obstacles to therapy services was calculated by adding parent Likert ratings of all 16 items. An additional variable was also created to identify the total number of obstacles endorsed by parents (i.e., by summing obstacles rated 2 or greater on the Likert scale). In an unpublished dissertation study utilizing 98 participants, the Obstacles to Therapy Services Questionnaire demonstrated good internal consistency, with an alpha level of 0.86. The Obstacles to Therapy Service Questionnaire demonstrated good internal consistency in the current study as well, with an alpha level of 0.75.

Obstacles to Assessment Questionnaire. The Obstacles to Assessment Questionnaire is a modified version of the Obstacles to Therapy Services Questionnaire described above. It was developed for this study in order to assess parent perceptions regarding obstacles experienced during the process of seeking assessment services for their child at the ADHD Clinic. Parents were again asked to rate potential obstacles using a 7-point Likert scale, 1 (not a reason) to 7 (primary reason). Similar to the Obstacles to Therapy Services Questionnaire, a total intensity score of obstacles experienced during the assessment process was calculated by adding parent Likert ratings of all 16 assessment obstacle items. Number of obstacles endorsed was calculated by summing obstacles rated 2 or greater on the Likert scale. The Obstacles to Assessment Questionnaire demonstrated good internal consistency in the current study, with an alpha level of 0.73 (see Appendix D).

Procedure

Caregivers were asked to participate in a survey on parent help-seeking. Individuals agreeing to participate were given a study packet consisting of informational materials and four study questionnaires (see Appendices A through I). Questionnaires were organized in the packet according to the progression of the help-seeking process (i.e., parents were presented with the Parent Cognition Scale, the Barriers to Assessment Questionnaire, the Parent Help-Seeking Questionnaire, and the Barriers to Therapy Services Questionnaire, respectively). Most caregivers completed study questionnaires in the clinic waiting room during their child's initial assessment appointment. Participants unable to complete all study questionnaires before leaving their initial assessment session were allowed to complete any remaining measures during their follow-up feedback appointment. These participants were asked to complete all study questionnaires prior to receiving feedback results, as their responses to help-seeking/obstacles measures could potentially differ after receiving diagnosis and treatment recommendations. Participants that completed the study packet were entered into a drawing for a $50 Walmart gift card.

Power Analysis

Given that Johnston et al. (2005) found a medium effect size for the influence of parent attributions on help-seeking for children with ADHD, a medium effect size was anticipated for the current study. Consistent with suggestions for determining sample size with five predictor variables, a sample of at least 90 participants were needed in order to obtain a medium effect size with a confidence level of alpha at 0.05 (Cohen, 1992; Green, 1991). Due to a higher than average number of cancellations and no-shows during the data collection period, the current sample size was significantly less (52 participants) than the anticipated number.

CHAPTER 4

RESULTS

Descriptive Analyses

Means and standard deviations for the primary research variables are presented in Table 3. Parents expressed greater interest in formal services as compared to informal services. Parents endorsed an average of five obstacles with regards to both assessment and therapy services during the help-seeking process. Very few parents reported experiencing no obstacles when seeking help for assessment or therapy services (i.e., 5 and 6 parents, respectively). The reported intensity of the obstacles experienced by parents when seeking assessment (M=30) versus therapy services (M=29) was similar. Regarding parent ratings of child behavioral difficulty, parents endorsed an average externalizing behavior score of 63.38, which is in the slightly above average range. Parent ratings of internalizing behaviors were in the average range (M = 54.10). The median rating of parent stress level was at the 64th percentile, suggesting that the majority of participants endorsed parent stress levels approaching clinical significance.

Correlations between the primary research variables are presented in Table 4. As one might expect, the highest correlation between the primary research variables was between the number and intensity of obstacles endorsed by parents (r = .90, p = .000). The next highest correlation occurred between parent interest in formal services and total overall help-seeking (r = .89, p = .000). In the current study, the Child-Responsible and Parent-Causal Attribution scales

were moderately correlated (r = .48, p = .000), suggesting that parents tended to attribute child behavior difficulties to both their children as well as themselves. Level of parent stress was moderately correlated with level of child behavior difficulty (r = .51, p = .000). Specifically, a moderate positive relationship was found between the level of parent stress and endorsement of both the intensity (r = .43, p = .002) and number of obstacles experienced during the help-seeking process (r = .44, p = .002). A moderate negative relationship (r = -.32, p = .023) was observed between parent stress levels and parent attributions regarding difficult child behavior (i.e., as parent stress levels increased, parents viewed themselves as more responsible for difficult child behaviors). Total parent help-seeking interest was not significantly correlated with the level of parent stress, nor was it significantly correlated with the child behavioral difficulty level. Level of child behavior difficulty was not significantly correlated with the intensity of obstacles experienced by caregivers during the help-seeking process, and it also was not significantly correlated with the total number of obstacles experienced.

Primary Analyses

Effects of Parent Attributions on Help-Seeking

Based on correlational analyses, it was not anticipated that the overall model would be significant. However, in keeping with the goal to partially replicate and compare results to Hutchens' (2013) study, a hierarchical regression analysis was conducted in order to examine the extent to which parental attributions explained variance in help-seeking behavior. As can be seen in Table 4, the highest correlation between predictors in the regression analysis was found between the CRA-PCA difference score and the level of child behavioral difficulty (r = .51). This is an acceptable level of multicollinarity, as it does not exceed the value of .80 suggested by Grimm and Yarnold (1995).

Variables were entered into the regression in three steps in order to determine the relative contribution of each type of predictor. In the first step of the regression, family income, level of child behavioral difficulty (as measured by the BASC-2 Internalizing/Externalizing Indices Sum), and level of parent stress (as measured by the PSI-4-*SF* total stress percentage) were entered as predictors of interest in help-seeking. As seen in Table 5, the first step of the model was not significant, accounting for less than 5% of the variance, $F(3, 46) = .60$, $p = .62$. For the second step of the regression, the intensity of obstacles experienced by parents during the help-seeking process was added. The second step of the model was also not significant, $F(4, 45) = .46$, $p = .76$, accounting for only 4% of the variance. For the third and final step, the CRA-PCA difference score was entered into the regression in order to determine whether or not parent attributions of perceived control over their child's problematic behavior predicts help-seeking after accounting for sociodemographic and treatment barriers. As previously mentioned, the PCA-CRA difference score was calculated by subtracting the Parent-Causal Attribution total score from the Child-Responsible Attribution total score, with greater positive difference scores reflecting greater child-responsible attributions for problematic child behaviors. The third step of the model was also not significant, $F(5, 44) = 1.95$, $p = .11$. However, it should be noted that adding the PCA-CRA difference score to the model resulted in an increase of 14% of the variance explained. Parent attributions was the only significant individual predictor in the model ($p = .01$). In hypothesis 4, it was predicted that parents scoring higher on child-responsible attributions as compared to parent-casual attributions would endorse greater interest in child-focused services. Similarly, it was hypothesized that parents scoring higher in child-responsible attributions would report less interest in parent- and family-focused services. Correlational analyses revealed that the CRA-

PCA difference score was significantly correlated with interest in both child- and parent-focused services, as well as total parent help-seeking. Specifically, the CRA-PCA difference score was significantly correlated with interest in child-focused services (r = .30, p = .03), as well as with interest in parent-focused services and total help-seeking (r = .29, p = .04; r = .28, p = .05). The CRA-PCA difference score was not significantly correlated with family-focused services (r = .17, p = .23; see Table 6). Thus, there appears to be minimal support for Hypothesis 4, as parents endorsing greater child-responsible attributions reported similar interest in both parent-focused and child-focused services.

Obstacles to Therapy versus Assessment

A series of correlations were conducted to test the hypothesis that parent reports of obstacles associated with assessment would be similar to those anticipated for therapy services. Specifically, it was hypothesized that there would be a significant positive correlation between parent reports of obstacles associated with assessment services and those associated with therapy services (Hypothesis 5). Correlation analysis revealed that the intensity of assessment obstacles experienced did in fact show a very strong significant positive correlation with number of obstacles anticipated for therapy services (r = .84, p = .000). As seen in Table 7, correlations between endorsement of a specific assessment obstacle and the same type of obstacle in regard to therapy services ranged from .48 to .95. Participants that reported concern about what others may think as an obstacle for seeking assessment were very likely to endorse this same obstacle in regard to seeking therapy services (r = .95). The weakest correlation, although still of moderate strength (.48), was “don’t have time.”

Fifteen paired-samples t-tests were also conducted to consider the extent of significant differences between parent ratings of barriers to assessment versus barriers to therapy. As seen in

Table 7, significant differences were found for six of the obstacles. For three of the obstacles ("deal with it on my own," concerned about type of treatment," "problem will get better by itself"), parent ratings were higher on average in relation to assessment versus therapy. For the other three obstacles that differed between groups ("cost of service," "don't have time," and "inconvenient hours"), parent ratings were higher on average in relation to therapy versus assessment.

Additional Exploratory Analyses

Stepwise Regression Predicting Help-Seeking

Research has consistently found that help-seeking can be negatively influenced by a number of factors, one of the strongest of which includes barriers to treatment. The current study, however, did not find the intensity of service obstacles experienced by caregivers to be a significant individual predictor of help-seeking. This finding is somewhat more surprising given that a previous study examining parent attributions and help-seeking in a community sample (Hutchens, 2013) found treatment obstacles to be the greatest and most consistent individual predictor of help-seeking. In addition, results of the primary analyses also revealed that known predictors of help-seeking, such as family SES and level of child difficulty, also did not significantly predict help-seeking. As a result, an additional analysis was run considering the number of reported treatment obstacles, child and parent-predictors, and parent attributions using a stepwise model rather than a sequential stepwise model. The multiple regression was conducted entering family SES, level of child difficulty, level of parent stress, total number of obstacles, and parent attributions in a stepwise regression predicting help-seeking behavior. The model was significant F (1, 47) = 4.22, $p < .05$. Parent attributions was the only predictor that entered into the model, accounting for 8% of the variance in help-

seeking. Examining the Beta value for the CRA-PCA difference score (.26), it appears that greater endorsement of child-responsible attributions was associated with greater interest in parent help-seeking (see Table 8).

Correlational Analyses

Additional correlational analyses were conducted in order to further examine the relationship between assessment and therapy obstacles with overall parent help-seeking interest, as well as between assessment and therapy obstacles. As previously mentioned, there were no significant correlations found between assessment or therapy obstacles with parent total help-seeking interest. There were also no significant correlations found between obstacles to seeking assessment or therapy services and parent interest in formal versus informal services (all *p*-values > .383; see Table 9). Neither the total intensity nor the total number of individual obstacles reported by parents was significantly correlated with individual items on the help-seeking questionnaire (see Table 10). However, total parent help-seeking was found to be significantly positively correlated with the 'Availability of Service' obstacle item on the Obstacles to Assessment Questionnaire (r = .35, p = .011; see Table 11). Total parent help-seeking was not significantly correlated with any individual items on the Obstacles to Therapy Services Questionnaire (all *p*-values > .05; see Table 12). 'Availability of service' was the only individual obstacle significantly correlated with interest in formal services (see Table 13). This significance occurred both in terms of assessment (r = .35, p = .01) and therapy services (r = .29, p = .04). No other individual obstacle items on the Obstacles to Assessment or Obstacles to Therapy Services questionnaires were significantly correlated with parent interest in formal or informal help-seeking services.

CHAPTER 5

DISCUSSION

The primary goal of the present study was to examine the extent to which parent attributions regarding difficult child behavior predict parent help-seeking in a clinical sample of children referred for assessment of Attention-Deficit/Hyperactivity Disorder (ADHD). Specifically, this study explored whether parent attributions regarding difficult child behavior predicted parent willingness to seek help for their children, and also whether they predicted the type of services that parents preferred. This study also explored the similarity and differences of obstacles experienced by parents while pursuing assessment versus therapy services for their children.

Parent Attributions as a Predictor of Help-Seeking

A series of multiple regression analyses revealed that parent attributions regarding difficult child behavior was the only significant individual predictor of parent help-seeking. In addition, results suggest that greater endorsement of child-focused attributions, as opposed to parent-responsible attributions, was associated with greater endorsement of help-seeking behavior. Contrary to expectations, factors found to predict help-seeking behavior in previous research (e.g., parenting stress, SES, number of perceived obstacles) were not found to predict help-seeking in the current study. However, it should be noted that the current sample was fairly

small, and it is likely that limited power may have contributed to the lack of significance for predictors other than parent attributions.

Comparing Attributions towards Different Intervention Types

It was hypothesized that parent attributions regarding problematic child behaviors would predict parent preference in different types of interventions (child- versus parent- or family-focused treatment services). Specifically, it was hypothesized that parents scoring higher in child-responsible as compared to parent-causal attributions would endorse greater interest in child-focused interventions. There was some support for this hypothesis, as parents reporting greater child-responsible attributions did in fact endorse greater interest in child-focused services as compared to family-focused interventions. However, parents who endorsed greater child-responsible attributions also expressed similar interest in both child- and parent-focused interventions. This means that, contrary to hypotheses, child-focused interventions were not preferred exclusively over parent-focused interventions.

This hypothesis was based upon the assumption that parents would tend to endorse one attributional style more strongly over the other. In the current sample, however, there was a moderate correlation (r = .48) observed between child-responsible and parent-causal attributions, which suggests that parents tended to respond high (or low) on both types of attributions. If a portion of parents failed to more strongly identify as individuals possessing predominant parent-causal or child-responsible attributions, this could certainly affect analyses attempting to discriminate the two groups regarding their help-seeking preferences. Snarr et al. (2009) found correlations between the Parent-Causal and Child-Responsible subscales of the Parent Cognition Scale to be stronger than expected, which they hypothesized could have been due to characteristics of their normative sample. The current study assessed interest in help-seeking in a

sample of parents and caregivers seeking ADHD evaluation services. Although the majority of children were rated in the above average range in terms of hyperactive behavior, the overall mean for Externalizing behavior, which includes aggression and conduct problems, was in the "at risk" range. It is possible, therefore, that the current study's method of assessing child difficulty level (i.e., total Internalizing and Externalizing behavior) was overly broad, and that considering parent report of Inattention or Hyperactivity specifically might have resulted in different findings.

Parents in the current study were surprisingly willing to attribute child behavior difficulties to themselves as well as their children. It is possible that parents in the current study were less dichotomous in their attributional responses due to an inherent willingness to recognize or identify themselves more as causal agents in contributing towards their child's problematic behaviors. This could translate to a greater willingness to seek out treatment that would target potential issues in this area (i.e., parent-focused services), and help to explain why child-focused behaviors were not preferred exclusively. Parent interest in both child-focused and parent-focused interventions could also potentially reflect the needs of the current study sample. That is, in the present study, over half (i.e., 54%) of the children had at least one additional co-morbid diagnosis, 27% of which included Oppositional Defiant Disorder. Co-morbid disorders are likely to increase the number of symptoms of different types of problems exhibited by children, and could thus predict parent interest in a wider range of potential services. This could help to explain why, contrary to hypotheses, parents endorsed interest in both parent- and child-focused interventions. Lastly, virtuous responding could also help to explain why parents endorsed interest in both child- and parent-focused interventions. That is, parent report of interest in both child- and parent-focused interventions could have occurred out of an attempt to appear open to a

wide-range of services, but may not have actually reflected the inherent motivation or investment that parents would be likely to display in parent-focused and child-focused interventions within the treatment setting.

Obstacles as a Predictor of Help-Seeking

On average, parents in the present study experienced an average of 5 out of 15 possible obstacles during the assessment process. They also reported anticipating an average of 5 out of 15 potential obstacles to initiating therapy services, should they be recommended. Very few parents reported experiencing zero obstacles when seeking help for assessment or therapy services. Contrary to hypotheses, the current study found that neither well-established sociodemographic factors, nor the number of treatment obstacles significantly predicted parent help-seeking. Correlational analyses also did not reveal any significant association between intensity of obstacles and help-seeking (r = .01). Research has consistently found certain sociodemographic factors and treatment obstacles to be some of the strongest individual predictors of help-seeking. Kazdin et al. (1997), for example, found that parents endorsing a higher total number of barriers had a higher dropout rate for child-focused therapy as compared to parents who endorsed a smaller amount of barriers. Moreover, Hutchens (2013) examined the impact of parent attributions and barriers on help-seeking in a community sample, and found the intensity of treatment obstacles to be the only significant individual predictor of parent help-seeking. Finding that neither sociodemographic factors (i.e., family income, parent stress, level of child difficulty) nor treatment obstacles were significant predictors of help-seeking was, therefore, very unexpected.

One potential explanation for this finding could be that treatment barriers are recognized and/or experienced as more significant (i.e., limiting) according to the different stages of the

help-seeking process. According to the 3-stage mental health model of help-seeking proposed by Kulka et al. (1979), help-seeking cannot begin until an individual first recognizes a problem as a "mental health" issue, and furthermore perceives it to be relevant and significant enough to seek out services. It is, therefore, during the later stages of the help-seeking process where most treatment barriers are typically experienced. Moreover, barrier research is founded on the assumption that participants have in fact recognized and believe difficult child behaviors to be significantly problematic. If parents fail to perceive difficult child behavior as significantly problematic to justify the need for services, then predictors of help-seeking that have been found in the research literature to be important in later stages of the help-seeking process (e.g., SES, transportation) are not likely to be significant. This may help to explain why SES and level of child difficulty failed to significantly predict help-seeking in the model.

Stages of change (DiClemente, 1982) and motivation (Miller & Rollnick, 1991) models of help-seeking might also help to explain why barriers were not found to be a significant predictor of help-seeking. Models describing motivation and readiness for change highlight the important differences in cognitions and subjective perception of potential barriers experienced in pre-contemplative versus contemplative individuals during the help-seeking process. Parents in the current study had already engaged in help-seeking behavior by either self-referring or following through with a recommendation to initiate ADHD assessment services for their child. It is possible, therefore, that parents in the current study may have perceived potential treatment obstacles as less problematic or hindering as compared to parents who had less or no previous experience with help-seeking and who were in a pre-contemplative phase of help-seeking. Indeed, this suggestion is supported by current results. Although parents in both the current sample as well as a community sample (Hutchens, 2013) experienced an average of 5 out of 15

total obstacles during the help-seeking process, parents in the current clinical sample rated the perceived intensity of these treatment obstacles to be nearly two times less than parents in the community sample.

In the present study, a strong negative correlation was observed between level of child difficulty and child-responsible attributions; however, there was no significant correlation between report of child difficulty and parent-causal attributions. This finding is consistent with previous research which has found that as problematic behaviors increase, parents tend to engage in greater child-focused attributions.

Comparison of Obstacles to Assessment versus Obstacles to Therapy

Although there is a large amount of research on obstacles to help-seeking, most studies focus primarily on obstacles to therapy and/or combine assessment and therapy obstacles together during research. To our knowledge there are no existing studies that compare obstacles experienced during assessment with that of therapy services. Therefore, a secondary goal of this study was to explore obstacles experienced while seeking out assessment services specifically, and to then compare and contrast assessment and therapy obstacles directly.

As predicted, parents reported that obstacles they experienced during the assessment process were generally very similar to obstacles that they anticipated for therapy services. This strong similarity was found both in terms of the number as well as the intensity of assessment and therapy obstacles experienced by parents. Overall, parents reported that they tended to experience an average of 5 out of 15 possible obstacles while seeking both assessment and therapy services. Very few parents reported experiencing zero obstacles during the help-seeking process.

In the current study some obstacles appeared similarly important to both assessment and therapy services, whereas others appeared more important to assessment versus therapy, and vice versa. For example, parents tended to identify obstacles such as "cost of services," "don't have time," and "inconvenient hours" as more important when seeking out therapy versus assessment services. This finding is understandable given that parents likely anticipate therapy to involve a greater cost in terms of money, time, and transportation due to the recurrent and potentially lengthy nature of this type of service.

It is interesting to note that obstacles endorsed during the assessment process in general appeared more cognitive and attitudinal than the obstacles reported for therapy services (e.g., parents reported obstacles such as "problem will get better by itself" and "deal with it on my own"). This finding would make sense given that parents considering assessment would have still been in the pre- or contemplative phases of help-seeking. As previously mentioned, more concrete obstacles such as lack of money, time, or transportation have been found to be important factors only after an individual first recognizes a problem and perceives it to be significant enough to warrant seeking out assistance. It makes sense, therefore, that parents would experience greater attitudinal barriers involving whether services were in fact necessary if they had yet to move past the problem recognition phase of the help-seeking process. "Concerned about type of treatment" was also identified as a barrier very significantly important to assessment versus therapy. This finding may be due to the specific population of children/parents involved in the current study, as they were seeking ADHD assessment services and so may have been concerned about the possibility of receiving a specific recommendation for psychopharmacological interventions.

Obstacles rated similarly important in regard to both assessment and therapy services involved worry over confidentiality and potential criticism from others. This finding is consistent with previous research which has found that concerns about confidentiality and trust in the service provider consistently predict lower service utilization (Kerkorian et al. 2006; Power et al, 2005). It would stand to reason, therefore, that these types of concerns would act as important barriers to the utilization of all types of treatment (i.e., both assessment and therapy services alike).

Lastly, contrary to hypotheses, there were no significant correlations found between the number or intensity of obstacles and parent interest in formal versus informal services. A potential explanation could be due to methodological concerns involving the help-seeking measure included in the current study. Although the Help-Seeking Questionnaire demonstrated good internal consistency for the formal help-seeking items (e.g., "child-focused services," "parent-focused services," "family-focused services," "talking with a doctor about medication"), it demonstrated questionable internal consistency ($\alpha = 0.65$) for the informal items of help-seeking ("talking with family and friends," "other support," "seek out information on my own"). If items included on the informal subscale on the Help-Seeking Questionnaire were not truly representative of "informal" services, this could help to explain why parents did not endorse a difference in interest in formal versus informal services. As previously mentioned, it is also possible that parents in the current study may have been more willing to seek out a wider range of services, which could also help to explain why parents in the present study were less likely to endorse preference for formal versus informal services.

Limitations

A primary limitation of the current study was the small sample size. As previously mentioned, the current study sample was much smaller than anticipated due to an unprecedented number of no-shows and cancellations in the ADHD Clinic within the data collection period. Results of a power analysis indicated that a sample size of 90 subjects would be necessary in order to detect a medium effect size within the model. However, the current study sample only included a total of 52 participants, limiting the ability to detect significant effects. Despite the limited power, parent attributions was found to be a significant individual predictor of help seeking, suggesting that further research on the role of parent attributions with a lager sample size is needed.

Another limitation of the current study involved the representativeness of the sample. The majority of parents were middle-aged Caucasian women who were married and had attended at least some college. Previous research has found that ethnicity (Sareen et al., 2007), parent age, and marital status (Snell-Johns et al., 2004) are strong predictors of problem recognition and mental health service utilization. The attitudes of married mothers living in the Midwest may differ significantly from the general U.S. population. As a result, findings from the current study may fail to generalize to a larger and more diverse sample of individuals in terms of ethnic, gender, and sociodemographic diversity. Generalizability issues may also apply to characteristics found of the children referred for services. Children tend to be referred to the ADHD clinic for externalizing behaviors such as hyperactivity and impulsivity, as well as internalizing symptoms such as inattention. As mentioned earlier, the mean for internalizing behavior was in the average range, suggesting less concern for internalizing behaviors among parents in the present study. The parent mean endorsement for externalizing behaviors in children in the clinical sample was

in the “at risk” range, suggesting that children in the clinical sample exhibited a slightly above average level of externalizing behaviors. The types of symptoms displayed by children (i.e., internalizing versus externalizing) is important consider in relation to help-seeking, as parents are more likely to become aware of and seek help faster for externalizing behaviors given their more overt and often problematic nature (Power et al., 2005). Results of the present study, therefore, may not generalize well to samples in which parent report of problem behavior was significantly higher. Lastly, nearly 70% of parents in the current study endorsed a familial history significant for psychiatric issues, suggesting that at least some of the parents may have previous experience with assessment or treatment for either themselves or other family members. Past experience with mental health services has been found to be very influential on parent views regarding help-seeking. Douma et al. (2006), for example, found the most cited reason for parents of children with intellectual and behavioral difficulties to not seek help was previous negative experiences within the mental health system. If parents in the current sample had indeed encountered previous negative treatment experiences, then this would have likely had an impact on their ratings of obstacles and preferred type of services, and could have potentially skewed the generalizability of their responses. Future research should, therefore, consider and measure previous experience with parent help-seeking in terms of both parenting/child behavioral difficulties and personal mental health issues as well.

The current study relied on self-report measures of perceived obstacles and interest in help-seeking. Due to the nature of self-report, it is possible that results were skewed by participant effects such as virtuous responding or memory difficulties. Raviv et al. (2003a), for example, found that it was only when mothers contemplated referring someone else’s child for treatment services that parent-causal attributions were found to be significantly associated with

help-seeking, which suggests that mothers tended to respond defensively when contemplating difficulties in their own children. If parents in the current study rated their level of parent stress or problematic child behaviors as less significant or subjectively distressing than was accurate out of defensiveness, this could have resulted in artificial decreases in these variables, and potentially reduced their strength as predictors within the model. Unfortunately, the current study did not include a measure of defensiveness, so it is unclear whether, or to what extent, parents responded in a defensive manner on study questionnaires. In examining the data, however, there is some indication that defensiveness may have occurred. Parents rated problematic internalizing behaviors of children in the current study to be in the normal range and their externalizing behaviors to be in the "at risk" range. While above average, this "at risk" level of externalizing child behavioral difficulty remains below the technical cut-off for clinical significance, and less than what one might expect of children referred for potential ADHD. Moreover, 27% of the children in the current study were also diagnosed with co-morbid Oppositional Defiant Disorder, which would also argue for children in the current study to have displayed disruptive externalizing behaviors at a level greater than the "at risk" range. Distinguishing the degree to which parents may have responded defensively when reporting about level of child difficulty is important, as it points to the possibility that parents may have also responded defensively on other study variable measures such as attributions, assessment and therapy barriers, and/or interest in help-seeking.

Lastly, parents who participated in the current study completed the obstacle and help-seeking measures after completing other numerous questionnaires for their child's ADHD evaluation, generally within the same 2-3 hour period of time. Given the large volume of questions/measures that parents were required to complete in a relatively short amount of time, it

is possible that participant fatigue or careless responding may have influenced the accuracy or validity of parent responses. Careless responding would have been of particular importance in relation to obstacles questionnaires. One of the major areas of focus of the current study was to measure the similarities and differences between obstacles experienced during assessment versus therapy process. If parents were careless or fatigued when responding to these very similar questionnaires, they could have been tempted to rate obstacle items more similarly than was accurate.

Clinical Implications

The current study adds to the growing body of research on the influence of cognitions (i.e., attributions) on the help-seeking process. To our knowledge, this is the first study to explore the influence of barriers and parent attributions on parent willingness to seek assessment services for their children. It is also the first study to directly compare parent attributions and experience of obstacles with regard to assessment versus therapy services within a clinical sample.

The current study found parent attributions to be the only significant individual predictor of help-seeking. Furthermore, results indicate that greater report of child-responsible attributions, as opposed to parent-causal attributions, was associated with greater interest in help-seeking overall. Contrary to previous research (Kazdin et al., 1997; Morrissey-Kane & Prinz, 1999; Snell-Johns, et al., 2004), well-established sociodemographic factors and treatment barriers were not found to significantly predict parent help-seeking. Thus, current results suggest that attributions may be more important than other factors in predicting parent help-seeking behavior.

Current results serve to highlight the importance of better understanding the attitudes and attributions that parents may experience during the different stages of the help-seeking process, as well as their respective impact on parent decision-making and help-seeking behaviors. For

example, it is interesting to note that although parents in both the current study and a community sample (Hutchens, 2013) endorsed an average of 5 out of 15 total obstacles during the help-seeking process, parents in the current clinical sample rated the perceived intensity of these obstacles to be nearly two times less than parents in a community sample. In looking specifically at the obstacles data, parents in the current study tended to identify obstacles involving cost (e.g., in terms of money, time, transportation) as more important when seeking out therapy services, whereas they tended to identify attitudinal barriers (e.g., problem will get better by itself, deal with it on my own) as more important to the assessment process.

The finding that parent attributions regarding difficult child behavior does in fact predict parent help-seeking is very important from a clinical standpoint. If research can continue to gain a greater understanding of the types of cognitions and attributions that govern such perception differences and interest in different types of services, then we can actively target them and hopefully pre-emptively intervene at the most optimal times in order to improve overall treatment engagement and adherence outcomes. Proper identification of specific attitudinal/attributional factors will help to improve treatment outcomes and adherence to interventions, prevent premature termination, and identify more effective ways of providing services to populations who may otherwise not engage in treatment. Most importantly, it will hopefully begin to decrease the large disparity between children in need of treatment services and those that actually receive them.

Barrier and attribution research is also of particular importance in regards to the assessment and treatment of chronic disorders such as ADHD, which require proper assessment before effective treatment can begin. Given that assessment is the first line of treatment contact between providers and clients, it is especially important to gain a greater understanding of the

sociodemographic and attitudinal factors that negatively impact parents or caregivers from seeking this first line of treatment for their children. If treatment providers can gain a better understanding of factors that negatively affect the assessment process, they can work to actively address them and to hopefully reduce the gap between children assessed and determined to be in need of psychological services and those that actually receive treatment. With ADHD in particular, decreasing the period of time between the emergence of difficulties and successful treatment is important given the negative effects possessing such an untreated disorder can have on successful life outcomes. Given that parent perceptions regarding the intensity of obstacles experienced appear to differ according to which stage in the help-seeking process they are, it would make sense to strive to better understand and intervene with obstacles that negatively affect assessment services as a means of getting a "foot in the door" with regard to actual treatment.

Although the current study considered attributions and barriers experienced by parents of children referred for potential ADHD, results could also potentially generalize to other types of child difficulties. Seeking proper assessment of autistic spectrum disorders in children would be one obvious example. It is also possible that findings could generalize to adult attitudes in regard to seeking mental health services for themselves or other adults. An area in which this type of research may have considerable effect would be in the early detection and treatment of neurodegenerative diseases. With Alzheimer's dementia, for example, early detection and treatment is critical. It would, therefore, be of paramount importance to gain a better understanding of attitudinal factors that may impede family members or caregivers from taking individuals in for neurocognitive assessment at an early enough stage where treatment could be most beneficial.

Future Research Directions

Future research should seek to include larger sample sizes as well as utilize study measures allowing for greater examination between child-focused and parent-focused attributions. Additionally, it could be helpful to further explore factors that could potentially moderate the relationship between parent attributions such as the type of behavioral issues displayed by children (i.e., internalizing versus externalizing), with parent preference for the different types of interventions. Lastly, considering the interaction of specific predictors such as SES with minority ethnicity may help to reveal the interactive influence of specific variables on help-seeking behavior.

Future research should also seek to explore additional variables that can potentially affect the help-seeking process such as previous experiences with mental health services. Additionally, the current study assessed attributions regarding help-seeking using a measure comprised of generic potential barriers and treatment resources which may or may not have been specifically representative of the geographic area. It would be helpful if future studies ensured that they have a good understanding of typical barriers experienced towards services actually available in their geographic locale in order to ensure that study findings are most representative of parent attitudes and experiences. For example, the availability of service or transportation may vary as an obstacle depending on the location of the family, and these types of factors need to be taken into account in future studies.

Studying disorders such as ADHD which require proper assessment prior to treatment offer a unique opportunity for comparing obstacles experienced towards assessment versus therapy. Future research could expand this topic to other disorders, such as neurodegenerative conditions. It would also be interesting to continue comparing attitudinal differences between

community samples and clinical samples regarding the help-seeking process. It would be especially interesting to follow a single cohort of participants throughout the help-seeking process in order to better examine attitudinal differences between group participants who elect not to pursue assessment services after referral with those who do. Such a study would help to eliminate the problematic "hypothetical" scenarios that potentially skew respondent answers in community samples and the difficulty related to representativeness of a participant group due to its already being in treatment (i.e., its clinical sample status). Further research within that cohort could also examine attitudinal factors affecting treatment adherence or preference for specific interventions.

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Table 1

Characteristics of Participants: Means, Standard Deviations, Frequencies, and Percentages

Variable	*n*	*%*	*M*	*SD*	*Range*
Age	43		32.05	7.29	23-64
Mother's Education Level	44		13.07	2.10	8-18
Father's Education Level	34		12.15	1.84	8-16
# of Children in Household	52		2.75	1.40	1-6
Gender					
Male	5	9.6			
Female	47	90.4			
Relationship to Child					
Biological Parent	43	82.7			
Grandparent	5	9.6			
Foster/Adoptive Parent	3	5.8			
Other	1	1.9			
Marital Status					
Married/Re-Married	38	55.8			
Divorced/Separated	7	13.5			
Single/Never Married	7	13.5			
Living with Romantic Partner	7	13.5			
Other	2	3.8			
Combined Household Income					
Up to $10,000	4	7.7			
$10,001-$20,000	19	36.5			
$20,001-$30,000	8	15.4			
$30,001-$40,000	5	9.6			
$40,001-$50,000	4	7.7			
$50,001-$60,000	8	15.4			
$60,001-$70,000	2	3.8			
$70,001-$80,000	0	0.0			
$80,001+	2	3.8			

Table 2

Characteristics of Child of Focus: Means, Standard Deviation, Frequencies, and Percentages

Variable	*n*	*%*	*M*	*SD*	*Range*
Age (in months)	52		98.29	23.08	67-160
Gender					
Male	31	59.6			
Female	21	40.4			
Ethnicity					
Caucasian	45	86.5			
African American	3	5.8			
Hispanic/Spanish	1	1.9			
Biracial/Multiracial	1	1.9			
Other	2	3.8			
Diagnoses					
Diagnosis 1: ADHD					
Inattention	5	9.6			
Hyperactivity	0	0.0			
Combined	25	48.1			
ADHD NOS	5	9.6			
No ADHD Diagnosis	10	19.2			
Diagnosis 2:					
No 2nd Diagnosis Given	23	44.2			
ODD	14	26.9			
Anxiety/Depression	5	9.6			
Learning Disorder (any type)	3	5.8			
Other	5	9.6			
PDD	1	1.9			
Adjustment Disorder	1	1.9			

Note. ADHD NOS = Attention-Deficit/Hyperactivity Disorder Not Otherwise Specified, ODD = Oppositional Defiant Disorder, PDD = Pervasive Developmental Disorder

Table 3

Means and Standard Deviations for Primary Research Variables

Variable	*N*	*M*	*SD*	Range	
				Potential	Actual
CRA-PCA Difference Score	52	-1.67	10.45	-33 - 47	-26 - 14
Child-Responsible Attributions		32.69	11.87	9 - 54	9 - 54
Parent-Causal Attributions		34.37	6.24	7 - 42	17 - 42
Total Help-Seeking	52	33.52	9.12	1 - 42	7 - 49
Interest in Formal Services		17.94	5.95	4 - 28	4 - 28
Interest in Informal Services		15.58	4.73	3 - 21	3 - 24
Obstacles					
Number of Obstacles Endorsed					
Assessment Services	52	4.77	3.42	0 - 16	0 - 14
Therapy Services	51	4.53	3.68	0 - 16	0 - 16
Intensity of Obstacles Endorsed					
Assessment Services	52	29.90	10.87	15 - 105	15 - 56
Therapy services	51	29.10	11.48	15 - 105	15 - 64
Level of Child Behavioral Difficulty	52	117.48	20.05	30-120	83-170
BASC-2 Externalizing Total Score		63.38	13.05	30-120	42 - 93
BASC-2 Internalizing Total Score		54.10	12.17	30-120	39 - 87
Level of Parent Stress	50	58	28.34	1 - 99	1 – 99

Note. CRA = Child Responsible Attributions, PCA = Parent Causal Attributions, BASC-2 = Behavior Assessment Scale for Children, 2nd Edition

Table 4

Correlations between Primary Research Variables

Measure	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*
1. Total Help-Seeking	-										
2. CRA	.20	-									
3. PCA	-.09	.48**	-								
4. CRA-PCA Diff Score	.28*	.85**	-.06	-							
5. Formal Services	.89**	.17	-.07	.24	-						
6. Informal Services	.81**	.17	-.08	.24	.45**	-					
7. Obstacles Intensity	-.01	-.30*	-.52**	-.03	.07	-.10	-				
8. No. of Obstacles	.11	-.30*	-.55**	.01	.13	.06	.90**	-			
9. PSI	.12	-.50**	-.40**	-.32*	.17	.01	.43**	.44**	-		
10. Child Behavior Difficulty	.05	-.48**	-.05	-.51**	.10	-.02	.15	.13	.51**	-	
11. Family Income	.11	.33*	.11	.31*	.17	.01	-.19	-.12	-.31*	-.30*	-

Note. CRA = Child Responsible Attributions, PCA = Parent Causal Attributions, CRA-PCA Diff Score = Child Responsible Attributions-Parent Causal Attributions Difference Score, PSI = Parent Stress Index

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

Table 5

Hierarchical Regression Analysis for Variables Predicting Parent Help-Seeking Using Intensity of Obstacles Endorsed

Variables Entered	R^2	ΔR^2	B	*F*	*df*
Step 1	.04			.60	3, 46
Family Income			.17		
Child Difficulty Level			.01		
Parent Stress Level			.16		
Step 2	.04	.00		.46	4, 45
Family Income			.17		
Child Difficulty Level			.01		
Parent Stress Level			.18		
Obstacles Intensity			-.04		
Step 3	.18	.14		1.95	5, 44
Family Income			.09		
Child Difficulty Level			.20		
Parent Stress Level			.23		
Obstacles Intensity			-.09		
CRA-PCA Diff Score			.45**		

Note. CRA-PCA Diff Score = Child Responsible Attributions-Parent Causal Attributions Difference Score

** $p < .01$.

Table 6

Correlations between CRA-PCA Difference Score and Help-Seeking

Formal Services	CRA-PCA Difference Score
Child-Focused	.30*
Parent-Focused	.29*
Family-Focused	.17
Total Help-Seeking Intensity Score	.28*

Note. CRA-PCA Diff Score = Child Relational-Parent Causal Difference Score

*$p < .05$.

Table 7

Comparisons between Ratings for Individual Assessment Obstacles and the Same Content Therapy Obstacle

Obstacles Items	*Obstacles to Assessment Mean*	*Obstacles to Therapy Mean*	*t*
Deal with it on my own	3.24	2.55	-2.65*
Do not think anyone can help	1.47	1.55	.60
Cost of Service	1.82	2.41	2.88**
Availability of Service	1.73	1.88	1.02
Transportation	1.14	1.37	1.63
Don't have time	1.47	1.92	2.19*
Sought help before and disappointed with services	2.08	1.96	-.53
Dislike sharing personal info	1.76	1.80	.53
Worried about confidentiality	1.71	1.69	-.33
Concerned what others may think	1.49	1.51	.33
Inconvenient hours	1.39	1.88	2.72**
Family may object	1.67	1.59	-1.07
Concerned about type of treatment	3.35	2.47	3.75***
Problem will get better by itself	2.88	2.29	-3.09**
Lack of info on who can help	2.06	1.88	-1.06

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

Table 8

Stepwise Regression Predicting Parent Help-Seeking

Predictors	R^2	*df*	*F*	*β*
Model 1	.10	1, 48	5.02*	
Variables Entered				
CRA-PCA Diff Score				.26*
Variables Not Entered				
Child Difficulty Level				.27
Parent Stress Level				.24
Obstacles Intensity				.03
Family Income				.01

Note. *$p < .05$.

Table 9

Correlations between Assessment and Therapy Obstacles with Help-Seeking

Obstacles	PHS Total	Formal PHS	Informal PHS
Obstacles to Assessment	.01	.11	-.12
Obstacles to Therapy Services	.01	.07	-.07

Note. PHS = Parent Help-Seeking

Table 10

Correlations between Individual Help-Seeking Items and Number and Intensity of Total Obstacles

Help-Seeking Items	Intensity of Total Obstacles	Number of Total Obstacles
Child-focused services	.10	.08
Parent-focused services	.11	.12
Family-focused services	-.02	.05
Talk with doctor about meds	.02	.17
Talk to family and friends	-.11	.01
Other support (i.e., doctor, teacher, clergy)	-.15	-.03
Seek Information on my own	-.04	.07

Table 11

Correlations between Individual Assessment Obstacles and Parent Help-Seeking

Assessment Obstacles	*Total Parent Help-Seeking*
Deal with it on my own	.07
Do not think anyone can help	-.23
Cost of Service	.04
Availability of Service	.35*
Transportation	-.12
Don't have time	-.06
Sought help before and disappointed with services	.14
Dislike sharing personal info	-.12
Worried about confidentiality	-.20
Concerned what others may think	-.12
Inconvenient hours	.12
Family may object	-.04
Concerned about type of treatment	.15
Problem will get better by itself	.12
Lack of info on who can help	.01

Note. $*p < .05$.

Table 12

Correlations between Individual Therapy Obstacles and Parent Help-Seeking

Therapy Obstacles	*Total Parent Help-Seeking*
Deal with it on my own	.07
Do not think anyone can help	-.25
Cost of Service	-.04
Availability of Service	.22
Transportation	-.02
Don’t have time	-.10
Sought help before and disappointed with services	.12
Dislike sharing personal info	-.10
Worried about confidentiality	-.19
Concerned what others may think	-.07
Inconvenient hours	.04
Family may object	.04
Concerned about type of treatment	.15
Problem will get better by itself	-.02
Lack of info on who can help	.09

Table 13

Correlations between Individual Items on Obstacles to Assessment and Therapy Services Scales and Parent Interest in Formal versus Informal Help-Seeking Services

Items on Obstacles Scales	Obstacles to Assessment		Obstacles to Therapy	
	Formal PHS (N = 52)	*Informal PHS* (N = 52)	*Formal PHS* (N = 51)	*Informal PHS* (N = 51)
Deal with it on my own	.02	.12	.04	.08
Do not think anyone can help	-.23	-.15	-.21	-.22
Cost of Service	.07	-.00	.11	-.21
Availability of Service	.35*	.23	.29*	.06
Transportation	-.17	-.02	-.11	.10
Don't have time	.07	-.19	-.03	-.15
Sought help before and disappointed with services	.17	.04	.08	.13
Dislike sharing personal info	-.02	-.21	-.02	-.17
Worried about confidentiality	-.09	-.28	-.09	-.24
Concerned what others may think	-.02	-.20	.00	-.14
Inconvenient hours	.23	-.07	.20	-.17
Family may object	-.06	-.00	.02	.06
Concerned about type of treatment	.18	.07	.07	.20
Problem will get better by itself	.20	-.03	.03	-.07
Lack of info on who can help	.10	-.11	.12	.03

Note. PHS = Parent Help-Seeking, *$p < .05$.

APPENDIX A: PARENT COGNITION SCALE

Instructions. At one time or another, all children misbehave or do things that could be harmful, wrong, or that the parents don't like. Examples include: *hitting someone, whining, not cleaning room, not doing homework, lying, refusing to go to bed, arguing back, taking things that aren't theirs, having a tantrum, cursing, coming home late, running into the street.*

Parents have many different ways of thinking about these types of problems, and may think differently about problems depending on their specific children.

Please rate how much you would agree, in general, that the following reasons for misbehavior are true for your child and his/her behavior for the **past two months**.

	Always True	Frequently True	Sometimes True	Occasionally True	Rarely True	Never True
1. I was not as firm as I usually am	1	2	3	4	5	6
2. My child won't listen	1	2	3	4	5	6
3. I'm not structured enough with my child.	1	2	3	4	5	6
4. My child cannot understand the rules.	1	2	3	4	5	6
5. My child thinks that he/she is the boss.	1	2	3	4	5	6
6. I don't know how to handle my child.	1	2	3	4	5	6
7. I don't give my child enough attention.	1	2	3	4	5	6
8. My child is headstrong (stubborn).	1	2	3	4	5	6
9. It's hard for me to set limits.	1	2	3	4	5	6
10. My child is in a stage.	1	2	3	4	5	6
11. My child wants what he/she wants when he/she wants it.	1	2	3	4	5	6
12. I was tired at the time.	1	2	3	4	5	6
13. I handle my child in a non-confident way.	1	2	3	4	5	6
14. My child purposely tries to get me angry.	1	2	3	4	5	6
15. My child feels like there is no time for him/her.	1	2	3	4	5	6
16. I'm not patient.	1	2	3	4	5	6
17. My child tries to get my goat or push my buttons.	1	2	3	4	5	6
18. My child wants things his/her way.	1	2	3	4	5	6
19. It's difficult for my child to do what I want.	1	2	3	4	5	6

20. I can't control my child.	1	2	3	4	5	6
21. I couldn't respond quickly enough at the time.	1	2	3	4	5	6
22. I'm not able to be clear.	1	2	3	4	5	6
23. My child is very demanding.	1	2	3	4	5	6
24. I handled things in an unusual way.	1	2	3	4	5	6
25. My child likes to see how far he/she can push me.	1	2	3	4	5	6
26. I was busy with something else at the time.	1	2	3	4	5	6
27. I don't do the right thing.	1	2	3	4	5	6
28. My child tires easily.	1	2	3	4	5	6
29. I have a hard time really listening to my child.	1	2	3	4	5	6
30. My child refuses to do what I think he/she should do.	1	2	3	4	5	6

APPENDIX B: PARENT HELP-SEEKING QUESTIONNAIRE

The following are possible types of services that may be recommended for you and your child following the ADHD Evaluation, as well as other types of support that you may find helpful in coping with difficult child behavior. Please indicate, based on your current experiences and concerns, which types of services or supports you would most likely be interested in.

	Absolutely Not			Maybe			Definitely
Child-focused counseling services (for example: individual child therapy, play therapy)	1	2	3	4	5	6	7
Parenting counseling services (for example: parenting education, behavioral parent training)	1	2	3	4	5	6	7
Family-focused counseling services (for example: family therapy)	1	2	3	4	5	6	7
Talking with a doctor about medication	1	2	3	4	5	6	7
Talking with family and friends	1	2	3	4	5	6	7
Other support (for example: teacher, clergy)	1	2	3	4	5	6	7
Seeking out information on your own (for example: parenting books, websites)	1	2	3	4	5	6	7
Other: _____ (please describe above)	1	2	3	4	5	6	7

APPENDIX C: OBSTACLES TO THERAPY SERVICES QUESTIONNAIRE

Whether or not your child is diagnosed with ADHD, it is possible that therapy services (child-focused, parenting-focused, or family-focused) might be recommended for your child. Please rate which of the reasons below might be obstacles to you seeking those therapy services.

	Not a Reason			Possible Reason			Primary Reason
1) Thought I could deal with it on my own	1	2	3	4	5	6	7
2) Did not think anyone can help	1	2	3	4	5	6	7
3) Cost of services (i.e., too expensive/not covered by insurance)	1	2	3	4	5	6	7
4) Availability of services (services not available in my community)	1	2	3	4	5	6	7
5) Transportation (can't get there)	1	2	3	4	5	6	7
6) Didn't have time	1	2	3	4	5	6	7
7) Sought help before and disappointed with services	1	2	3	4	5	6	7
8) Dislike sharing personal information	1	2	3	4	5	6	7
9) Worried about confidentiality (i.e., others will find out what I've shared)	1	2	3	4	5	6	7
10) Concerned what others may think	1	2	3	4	5	6	7
11) Inconvenient hours	1	2	3	4	5	6	7
12) Member of the family may object	1	2	3	4	5	6	7

13) Concerned that therapist might suggest medication	1	2	3	4	5	6	7
14) Anticipate that problem will get better by itself	1	2	3	4	5	6	7
15) Lack of information about who can help	1	2	3	4	5	6	7
16) Other: _____	1	2	3	4	5	6	7

APPENDIX D: OBSTACLES TO ASSESSMENT QUESTIONNAIRE

Some parents do not immediately seek help when their child begins to have problems with behavior. Please indicate ***if*** any of the reasons below caused you to delay your decision (e.g., waited several weeks) to have your child evaluated at the ADHD Evaluation Clinic.

	Not a Reason			Possible Reason			Primary Reason
1) Thought I could deal with it on my own	1	2	3	4	5	6	7
2) Did not think anyone can help	1	2	3	4	5	6	7
3) Cost of services (i.e. too expensive/not covered by insurance)	1	2	3	4	5	6	7
4) Availability of services (services not available in my community)	1	2	3	4	5	6	7
5) Transportation (can't get there)	1	2	3	4	5	6	7
6) Didn't have time	1	2	3	4	5	6	7
7) Sought help before and disappointed with services	1	2	3	4	5	6	7
8) Dislike sharing personal information	1	2	3	4	5	6	7
9) Worried about confidentiality (i.e,. others will find out what I've shared)	1	2	3	4	5	6	7
10) Concerned what others may think	1	2	3	4	5	6	7
11) Inconvenient hours	1	2	3	4	5	6	7
12) Member of the family may object	1	2	3	4	5	6	7

13) Concerned that therapist might suggest medication	1	2	3	4	5	6	7
14) Anticipate that problem will get better by itself	1	2	3	4	5	6	7
15) Lack of information about who can help	1	2	3	4	5	6	7
16) Other: _____	1	2	3	4	5	6	7

APPENDIX E: RECRUITMENT FLYER

STUDY PARTICIPANTS NEEDED

You are invited to participate in our study on help-seeking related to parenting

Participation in this study would require:

- You (the parent) filling out additional questionnaires today (which will take about 15 minutes)
- All your responses will be kept confidential

Parents that participate in the study may enter into a lottery for a $50 Wal-Mart Gift Card (by providing name and phone number on a lottery entry form)

Please let the examiner know if you are interested in participating in this study

If you have any questions or concerns regarding this study, please contact Liz O'Laughlin, PhD at 812-237-2455.

Your participation is greatly appreciated!

APPENDIX F: CONSENT TO PARTICIPATE

Liz O'Laughlin, Ph.D. and Stephanie Murphy, M.S. of the Psychology Department at Indiana State University are asking you to take part in a study to better understand a parent's decision to seek help for his/her child. Parents/caretakers of children between the ages of 5 and 12 years old that are seen at the ISU ADHD Clinic are invited to participate. Parents who agree to participate will be asked to:

- Fill out 4 short questionnaires which take about 15 minutes to complete.
- Allow us to look at information from your child's ADHD evaluation (e.g. questionnaire on parent stress, ratings of child behavior, information on parent education, family income, etc.)
- You may complete the questionnaires today (during your child's evaluation) or when you come back in a few weeks to get results from your child's evaluation.
- Completed questionnaires can be returned to any of the Psychology Clinic staff or the clinician that does the evaluation with your child.

Participation in this study is voluntary. If you decide to participate:

- You can skip any questions that you don't want to answer
- You can fill out a slip to be included in a drawing for a $50 Wal-Mart Gift card.

If you decide *not* to participate

- There will be no penalty
- There will be no change in the services provided by the ADHD Clinic
- If you later decide to withdraw, we will destroy the questionnaires you completed for this study and the information will not be used.

All study data will be kept for a period of 3 years. All information from this study will be kept confidential. Only numbers and not names will be used to identify the questionnaires that you complete. All researchers, including Dr. O'Laughlin, will review results identified by code number only. If information from this study is prepared for an article or presentation, only average results for groups of participants (and not individual participants) will be presented.

This study has been reviewed and approved by the ISU Institutional Review Board (IRB) as protecting the rights of participants. **Any concerns or questions regarding your rights and welfare as a research study participant may be addressed to the IRB chairperson at (812) 237-8217 or irb@indstate.edu.** Questions specifically about this study should be directed to

Dr. Liz O'Laughlin at (812) 237-2455 or Stephanie Murphy at (812) 237-3317. Generally, participating in this study is no more risky than everyday activities. Your participation in this study will help us to better understand what is important to parents that may need help related to their child. This is important because many children who need help do not get necessary services.

I, _____, the parent or legal guardian of _____,
(print name) (print child's name)

have received a copy of this consent form describing the procedures and the risks and benefits of participating in this study. I understand that by signing this form I am agreeing to participate in this study and to complete the questionnaires that are part of this study. I also understand that I may withdraw from participation at any time by telling the researcher, or by contacting Dr. O'Laughlin at any time at the phone number above.

_____ _____
(Participant Signature) (Date)

APPENDIX G: HIPAA AUTHORIZATION FORM

HIPAA [1] AUTHORIZATION TO USE AND DISCLOSE
INDIVIDUAL HEALTH INFORMATION FOR RESEARCH PURPOSES

1. Purpose. As a research participant, I authorize Liz O'Laughlin, PhD, Stephanie Murphy, MS, and the researchers' staff to use and disclose my and my child's individual health information for the purpose of conducting the research project entitled "Factors Influencing Parental Help-Seeking."

2. Individual Health Information to be Used or Disclosed. Individual health information from my child's evaluation that may be used or disclosed to conduct this research includes: information from the clinical interview and developmental history questionnaire, parent/guardian and teacher responses to the behavior ratings scales *(Behavior Assessment Scale for Children-2, Parenting Stress Index, Developmental Questionnaire).*

3. Parties Who May Disclose My Child's and My Individual Health Information. The researcher and the researcher's staff may obtain my child's and my individual health information from:

Indiana State University Psychology Clinic, 750 N 7th, Terre Haute, IN 47809

4. Parties Who May Receive or Use My Individual Health Information. The individual health information disclosed by parties listed in item 3 and information disclosed by me during the course of the research may be received and used by the director of the ADHD Clinic: Liz O'Laughlin, PhD, Stephanie Murphy, MS, as well as research assistants.

5. Right to Refuse to Sign this Authorization. I do not have to sign this Authorization. If I decide not to sign the Authorization, I may not be allowed to participate in this study or receive any research related treatment that is provided through the study. However, my decision not to sign this authorization will not affect any other treatment, payment, or enrollment in health plans or eligibility for benefits.

6. Right to Revoke. I can change my mind and withdraw this authorization at any time by sending a written notice to Liz O'Laughlin, PhD to inform the researcher of my decision. If I withdraw this authorization, the researcher may only use and disclose the protected health information already collected for this research study. No further health information about me or my child will be collected by or disclosed to the researcher for this study.

7. Potential for Re-disclosure. My individual health information and that of my child disclosed under this authorization may be subject to re-disclosure outside the research study and no longer protected. For example, researchers in other studies could use my and my child's individual health information collected for this study without contacting me if they get approval from an Institutional Review Board (IRB) and agree to keep the information confidential.

7A. Also, there are other laws that may require my or my child's individual health information to be disclosed for public purposes. Examples include potential disclosures if required for mandated reporting of abuse or neglect, judicial proceedings, health oversight activities and public health measures.

This authorization does not have an expiration date.

I am the research participant or personal representative authorized to act on behalf of the participant.

I have read this information, and I will receive a copy of this authorization form after it is signed.

_____	_____
signature of research participant or research participant's personal representative	date
_____	_____
printed name of research participant or research participant's personal representative	description of personal representative's authority to act behalf of the research participant

1 HIPAA is the Health Insurance Portability and Accountability Act of 1996, a federal law related to privacy of health information.

APPENDIX H: PARTICIPANT INFORMATION LETTER

Dear Parent/Guardian:

Thank you for agreeing to participate in our study on parent help-seeking. Please keep the following in mind as you complete the questionnaires.

If you have more than one child in your home (between the ages of 5-12), please remember to answer items on the questionnaires based on your child that has been referred for the current ADHD evaluation.

Please answer all questions on the questionnaires to the best of your ability. Remember that your responses will not be attached to any identifying information, so you are encouraged to answer each question openly and honestly.

Please return all study questionnaires to the researcher when you are done.

If you begin to feel concerned about your child's behavior problems or your ability to parent as you are completing the study questionnaires, please consider making an appointment at the ISU Psychology Clinic (812-237-3317), or at the Hamilton Center Child and Adolescent Services (812-231-8376) to speak to a professional about your concerns.

Your participation is greatly appreciated!

Sincerely,

Liz O'Laughlin, Ph.D.
Psychology Department
Indiana State University

Stephanie Murphy, M.S.
Psychology Department
Indiana State University