STIGMA AS A BARRIER TO MENTAL HEALTH TREATMENT AMONG RACIALLY AND ETHNICALLY DIVERSE FAMILIES

by

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Abstract

The current study investigated the association between barriers to mental health treatment and treatment attendance and whether there is a significant relationship between stigma and financial related barriers and the number of treatment sessions attended by participants. It further examined whether the diagnosis of an internalizing or externalizing disorder is a possible factor in the decline of treatment attendance. This study also explores race as a moderator for the barriers to treatment and the treatment session attendance. The participants were 205 adolescents and their primary caregivers who resided in New York City. These families were identified as experiencing significant internalizing or externalizing symptoms and were linked with treatment providers operating out of community-based behavioral health clinics around New York City.

Family treatment attendance was tracked for one year and both adolescents and their primary caregivers participated in quarterly, home-based interviews with research staff. Financial and stigma related barriers were assessed via the Caregiver using Barriers to Participation Treatment scale. The results indicated that none of the predictors in the model were significantly associated with the treatment session attendance. These results suggest that stigma and financial barriers to mental health treatment may not be as significant a factor in treatment attendance declining as other variables. In addition to stigma and financial barriers there are other factors that relate to clients not attending mental health treatment.

Stigma as a Barrier to Mental Health Treatment among Racially and Ethnically Diverse Families

Roughly one-fifth of adults in mental health treatment each year drop out before completing the recommended course of treatment (Olfson, Mojtabai, Sampson, Hwang, & Kessler, 2009). The communities who need access to mental health facilities find themselves with a lack of access due to various social barriers that have impeded their attendance and deterred them from receiving help for their mental health disorders (Ayalon & Alvidrez, 2007). Among many ethnic and cultural minority communities, there exists deep-rooted stigma around seeking and receiving mental health treatment. This is particularly true among individuals who identify as Native American, Black and African American, and Hispanic/Latinx in the United States (Knifton et al., 2010). Within these communities, mental health problems are viewed as a negative thing to have. They are viewed as negative because they incur a sense of danger about the individual with the disorder and emphasize a lack of social contribution within their communities. Individuals with mental health problems are seen as outcasts and are considered unsuitable as partners due to their inability to fit into the societal norm (Knifton & Quinn, 2008).

Prior Research on Barriers to Treatment

Barriers to treatment are obstacles that prevent individuals with mental health problems from accessing counseling and therapeutic services. These are socially constructed and structurally based obstacles that impede the individual by hindering their social status, and deterring them from access because of their socioeconomic status, race, and mental health stigma (Mojtabai et al., 2011). The Barriers to Treatment Model proposes families experience multiple barriers that impede participation in treatment. For example, many families deal with relatives in their

community who lack knowledge about mental health or who do not trust mental health professionals and their distrust and lack of knowledge is demonstrated when they outcast or separate the individuals in their family who have mental health problems (Knifton et al. 2010). Families who experience low socioeconomic status have trouble accessing transportation to treatment due to high costs of public transportation and others may have trouble getting time off work to take family members to clinics where treatment is provided (Walton, Berasi, Takeuchi, Uehara, 2009). Race is a significant factor; many Black families in the U.S face a dilemma when deciding whether they want their adolescents to attend mental health treatment or to get help from within their own communities (Vázquez & Villodas, 2018). The distrust and stigma about mental health within racially and ethnically diverse communities is a defining factor on whether individuals with mental health problems in these communities' access treatment facilities.

Multiple studies focused on barriers to mental health treatment expressed similar ideas that perceived barriers, whether internal like stigma or external like financial issues, have deterred access to treatment facilities. These studies expressed that time-efficient, cost-effective and destigmatized services were an efficient method to remove barriers and an increase of educating communities about these services and mental illness could benefit treatment attendance.

Barriers to Treatment (with a Focus on Stigma-Related and Financial Barriers)

Stigma is defined as an attribute that is deeply discrediting (Goffman, 1964). The stigma that racial and ethnic minority communities describe in relation to mental health are those that relate to social identity and individual perception. Barriers to treatment are the obstacles and stressors minorities encounter when accessing mental health treatment. Individuals who identify as Black/African Americans and Hispanic/Latinx have a more complex situation when facing

barriers to treatment and often report seeking treatment less often than their White/European counterparts due to anticipated barriers (Shefer et al., 2013).

Many racially diverse communities have noted that those with mental health conditions are discriminated against and ostracized by their own peers. Multiple studies have expressed similar ideas involving discrimination and stigma in Black and Latinx communities. The generalization that those with mental health issues are dangerous (Knifton et al.2010) ties into the stereotype threat that infers black people are violent and have tendencies to act out which is indicative of behavioral issues. This fear of being equated to individuals who are distanced from society and who are "dealt with" by being placed into prisons and not given the required mental help leads those within stigmatized communities to avoid accessing help due to self-stigmatization and the possibility of diminishing social status (Huffstead, 2016). More commonly to avoid outside judgement, there is a significant case of individuals' using community-based programs to aid adolescents. They utilize community-based programs rather than private counseling or other services because they would rather have individuals within the community that they relate to aid them. In some cases, these issues are diminished by downplaying the possible severity of their symptoms either due to their lack of awareness of the disorder or their disdain towards the idea that someone within their community having this mental illness could negatively affect how others within the community view them (Salloum, Johnco, Lewin, McBride, & Storch, 2016).

These views are compounded with the belief that these conditions are incurable and are an immense source of shame. This creates a cycle in which mental health awareness is limited and knowledge about treatment options is not shared. The combination of fear of being stigmatized and lack of knowledge about mental health treatment means that relatively few

individuals seek treatment for themselves or other family members when it could be helpful (Miranda, Soffer, Polanco-Roman, Wheeler, & Moore, 2015).

Finally, financial concerns are one of the most cited barriers for racially and ethnically diverse students. Some of the adversities Black and Latinx families face when accessing treatment are difficulty accessing transportation to get to regular appointments, long waiting lists at community-based treatment providers, and lack of insurance that covers behavioral health treatment more generally (Arday, 2018).

Mental Health Stigma among Racially and Ethnically Diverse Youth

Barriers to treatment have led to a notable decline in attendance to Mental Health Treatment sessions. Race is a key component to barriers to treatment for ethnically diverse individuals, African American/Black Individuals face more socioeconomic barriers when accessing Mental Health Treatment than their White counterparts. Individuals who identified as White tend to seek personal counseling at higher rates than their racially ethnic counterparts (Hatzenbuehler et al., 2008; Seidler, Rice, River, Oliffe, & Dhillon, 2017).

Parent, Hammer, Bradstreet, Schwartz, and Jobe (2018) examined the intersection of gender, race, ethnicity, and poverty with help-seeking behavior. The income-to-poverty ratio was positively related to help-seeking for White males and negatively associated for African American males. White males who had more income, were more likely to seek counseling, whereas African American males were less likely to seek counseling due to lower income and less access to culturally compatible and competent providers (Parent et al., 2018).

Socioeconomic status is one of the various Barriers to Treatment for racially/ethnically diverse communities. Financial concerns are a barrier that is prevalent among Black and African American, Native American and Hispanic/Latinx communities in the United States. The

financial concerns that were most noticeable included lack of access to insurance, the need to work multiple jobs to afford necessities, fear of out-of-pocket expenses for medication, and lack of access to transportation. (Walton, Berasi, Takeuchi, Uehara, 2009). This is important because it shows how one's financial status can impede them from accessing help and the community, they grew up in could also affect their access if they're from an impoverished area.

Racial discrimination has always been related to Stigma in various ways. When discussing Barriers to Treatment, race and cultural stigma are important factors in why access to mental health treatment is declining for racially/ethnically diverse individuals. Black/African American Individuals and Hispanic/Latinx individuals have a negative connotation about Mental Health and Psychotherapy. Vazquez and Villodas (2018) focuses on Black African Americans and their stigma about counseling. There is a stigma that Black caregivers have towards psychotherapy and counseling in contrast to youth mentorship groups. Youth mentorship groups are typically community-led or run by individuals within their own communities.

This results in, adolescents with externalizing disorders in Black communities becoming less likely to access counselling as their primary aid and instead more likely to be placed in a youth group. Counseling unlike youth mentorship programs tends to be run by individuals who do not live within their communities and therefore do not have any perspective on possible environmental factors affecting the adolescents. Black caregivers were significantly less likely to report that their adolescent needed psychological counseling and were more likely than White caregivers to report that their adolescents needed a youth mentoring program if they had clinically elevated externalizing problems (Vázquez & Villodas, 2018).

Mental Health Problems and Mental health Treatment among Adolescents

There are vast differences between adolescents and patients with externalizing disorders versus internalizing disorders and the number of barriers they must face to access treatment and complete it. These barriers are significant in how individuals address their disorders, the perceived need for treatment and how they confront various forms of treatment especially with the social stigma from their communities.

Individuals with externalizing disorders, such as Conduct Disorder, ODD, Substance Abuse Disorder must deal with various issues in relation to barriers to mental health treatment. One of these issues they must consider is the type of therapeutic service they choose to go to, such as whether counseling is the preferred method or youth mentorship for those with externalizing disorders. Counseling is viewed with a negative lens as the community bases it around the stigma of mental disorders and lack of understanding of the community's perspective. Youth mentorship involves community-based programming with individuals within their own communities leading the children in intervention programs and group work to lessen their behavioral issues. How individuals and their communities face the stigma around psychological treatment via counseling in contrast to a youth mentoring program needs to be explored (Vázquez & Villodas, 2018).

Individuals with internalizing disorders (i.e., depression, anxiety) deal with mental health stigma and the issue of whether their symptoms are considered “severe” enough to receive treatment. The internalized stigma the individual would feel establishes this idea that if there mental illness is not showcased through external symptoms or acting out than their caregiver would be less likely to perceive their adolescent’s mental illness as being “enough of an issue” to access mental health facilities (Salloum, Johnco, Lewin, McBride, & Storch, 2016).

A study by Alegria et al. (2008) focused on Racial/Ethnic minorities with Depression and addressed the patients' lack of attending any treatment within a year and the disparities between the quality of treatment and access between the minorities in contrast to their White counterparts. Partnered with financial issues, many minorities with Depression must encounter barriers that stem from their own social issues (i.e., poverty and status and individualized concerns and stigma from their counterparts), as well as the stigma around depression in society. Symptom severity plays a role in barriers to treatment, the severity of the symptoms can determine how likely the patient is willing to address the concerns and get help. The fear of judgement or lack of knowledge about treatment resources will lead them to avoid attending treatment. (Goetter et al., 2018)

The Present Study

The present study explored barriers to treatment among a diverse sample of families in New York City who sought out treatment for adolescent behavioral disorders and considered the extent to which community stigmatization of mental health treatment is significantly associated with mental health treatment attendance. The study utilized archival data collected from a sample of approximately 200 adolescents and their primary caregivers residing in New York City (Fisher, Lichvar, Hogue & Dauber 2018). The following research questions were addressed:

1. What is the association between stigma-related barriers to treatment and number of mental health treatment sessions attended?
2. What is the association between financial barriers to treatment and number of mental health treatment sessions attended?

3. Does presence of an internalizing or externalizing disorder moderate the association between stigma-related barriers to treatment and number of mental health treatment sessions attended?
4. Does race moderate the association between stigma-related barriers to treatment and number of mental health treatment sessions attended?

It was hypothesized that both stigma- and financial-related barriers to treatment would be negatively associated with number of mental health treatment sessions attended, meaning that the families who report more barriers would attend less treatment sessions. It was also hypothesized that those the association between stigma-related barriers to treatment and treatment attendance would not be as strong for adolescents who meet diagnostic criteria for either an internalizing or externalizing disorder, and that this association would be stronger for non-White adolescents compared to White adolescents.

Method

Participants

205 adolescents and their primary caregivers participated in this study. The caregivers who completed the interviews included 171 biological mothers, seven biological fathers, four adoptive parents, one stepparent, two foster parents, 12 biological grandmothers, and eight other relatives. The adolescents were between the ages 12 to 18, (M = 15.7, SD = 1.5). Adolescents were both male (70.3%) and female (27.7%) (Table 1). The study was conducted in New York City. Self-reported ethnicities were Hispanic (59%), African American (21%), multiracial (15%), and other (6%). There were predominantly more Non-White participants (56.8%) in this study in contrast to White participants (41.2%). The number of treatment sessions attended by the participants were 135 treatment sessions. Only three participants attended 0 sessions (Table 2).

Design

The data established in this study comes from evaluating whether the intervention between caregiver reported externalizing symptoms and adolescent reported internalizing symptoms is connected to the stigma and financial related barriers that were evaluated within the study. These data were compared to the number of treatment sessions attended by participants. Each family participated in quarterly interviews with research staff throughout one year of participation in the original study. In this archival study, only three of the study measures were used: the Child Behavior Checklist (CBCL), Youth Self-Report (YSR) and the Barriers to Treatment Participation Scale (BTPS).

Measures

The Child Behavior Checklist (CBCL; Achenbach, 1991) measured adolescent externalizing behavior through the caregiver's perspective. Some items caregivers were asked to respond to in this study on the CBCL are, "Drinks alcohol without caregivers' approval" and "Gets in many fights," and all behaviors were reported on a scale from 0 (Never) to a 2 (Often or Very Often). This measure asked about 100 different externalizing behaviors. The CBCL has been used in various studies as a reliable method to determine a child's externalizing behavior. One study that addresses the validity of the CBCL compares the predictive validity of different diagnostic classifications for disruptive behavioral disorder (DBD) in youth ages 9 to 15. They utilize the DSM-V, the symptoms of DBD and the CBCL to determine the accuracy of the diagnosis. The incremental validity, after including clinical structured interviews with parents and children into models that contained CBCL scores was reported. The results were that the CBCL scores obtained the best predictive results and assessment based on clinical interviews.(Granero et al., 2009).

The Youth Self Report (YSR; Achenbach, 1991) is a measure used in this study to examine adolescents' self-reports of their own internalizing problems. The YSR is a measure that has 119 items, such as, "I feel that I have to be perfect" and "I feel worthless or inferior." Adolescents answer these questions on a scale of 0 (Never) to 2 (Often or very often). One study that addresses the validity of the YSR uses data from hospitalized psychiatric adolescents, to test the unidimensionality of each narrowband syndrome and to conduct confirmatory factor analysis on broadband syndromes. The results support Achenbach's findings in that four of the seven narrowband syndromes were found to be valid. The internalizing and externalizing symptoms were valid broadband syndromes (Song, Singh, & Singer, 1994). The results demonstrated that the measures of the YSR are valid for measuring internalizing symptoms of adolescents.

The Barriers to Treatment Participation Scale (BTPS) (Kazdin, Holland, Crowley, & Breton, 1997) assesses various barriers that caregivers and their children face when deciding whether to attend mental health treatment. Although the full scale includes 58 items, the proposed study used seven items that focuses on the stigma related barriers and financial related barriers, including "It was embarrassing for me to share with friends or family members that my teen was in treatment" as a stigma-related barrier and "My medical insurance did not cover this treatment" as a financial barrier. Caregivers responded to these questions on a 5-point Likert-type scale (1 = never a problem, 5 = very often a problem). One study that showcases the BTPS reliability and validity is, Davis, R. G. et al. (2008) study that focused on the treatment barriers for low income Urban African American's with undiagnosed Post Traumatic Stress Disorder. The results demonstrated that individual and institutional barriers were extremely prevalent for these individuals. They faced immense financial constraints that included limited finances and transportation (most participants lived below poverty level). They also faced community

stigmatization of mental health and disapproval which is a very common barrier in ethnically diverse populations such as African American/Black communities and Latinx communities.

Procedure

The study utilized archival data collected from a treatment-seeking sample of approximately 200 adolescents and their primary caregivers residing in New York City (Fisher, Lichvar, Hogue & Dauber 2018). The adolescents were identified as experiencing significant internalizing or externalizing symptoms by their caregivers and were therefore linked with treatment providers operating out of community-based behavioral health clinics around New York City. Family treatment attendance was then tracked for one year and both adolescents and their primary caregivers participated in quarterly, home-based interviews with research staff. Financial- and stigma-related barriers to treatment was assessed via the caregiver-reported Barriers to Treatment Scale (BTS; Kazdin, Holland, Crowley, & Breton, 1997). Treatment session attendance was operationalized as the number of sessions attended by at least one family member over the course of one year. This archival study used SPSS to analyze the data.

Results

Table 1: Descriptives

Racial Group

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	White non Hispanic	61	41.2	42.1	42.1
	Other (predominantly Black/Hispanic)	84	56.8	57.9	100.0
	Total	145	98.0	100.0	

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	male	104	70.3	71.7	71.7
	female	41	27.7	28.3	100.0
	Total	145	98.0	100.0	

Table 2: Session Attendance

Statistics

Total number of treatment sessions attended

N	Valid	135
	Missing	13
Mean		20.5259
Median		15.0000
Std. Deviation		17.45392
Range		93.00
Minimum		.00
Maximum		93.00

Table 3: Stigma and Financial Related Barriers and Treatment Session Attendance

Correlations

		StigmaSum	FinancialSum	Externalizing	InternalizingSum	Total number of treatment sessions attended
StigmaSum	Pearson Correlation	1	.546**	.131	-.048	-.089
	Sig. (2-tailed)		.000	.273	.695	.452
	N	77	74	72	69	73
FinancialSum	Pearson Correlation	.546**	1	.057	.064	-.220
	Sig. (2-tailed)	.000		.637	.602	.066
	N	74	75	71	68	71

Externalizing	Pearson Correlation	.131	.057	1	-.076	.163
	Sig. (2-tailed)	.273	.637		.404	.078
	N	72	71	129	122	118
InternalizingSum	Pearson Correlation	-.048	.064	-.076	1	-.059
	Sig. (2-tailed)	.695	.602	.404		.536
	N	69	68	122	127	114
Total number of treatment sessions attended	Pearson Correlation	-.089	-.220	.163	-.059	1
	Sig. (2-tailed)	.452	.066	.078	.536	
	N	73	71	118	114	135

**. Correlation is significant at the 0.01 level (2-tailed).

To address the first research question, a correlation analysis was conducted to see whether the relationship between stigma related barriers to treatment and the number of treatment sessions attended were significant. The results of this analysis indicated that there was not a significant correlation between the two variables, $r(71) = -0.89$, $n = 73$,$p < .452$.

To address the second research question, another correlation analysis was conducted to examine the relationship between financial-related barriers to treatment and the number of treatment sessions attended. The results of this analysis indicated that there was not a significant correlation between the two variables, $r(69) = -.220$, $n = 71$, $p < .066$. To address the third research question, a regression analysis with moderation was run to see whether those with diagnoses of either an internalizing or externalizing disorder would moderate the association between stigma-related barriers to treatment and number of treatment sessions attended. Although all adolescents enrolled in the study exhibited *some* level of either internalizing or externalizing problems, only half of them met diagnostic criteria, indicating a more severe level of problem. Therefore, this regression analysis allowed for a comparison between those who met

diagnostic criteria (coded as 1) and those who did not meet diagnostic criteria (coded as 0). The independent variable in this analysis was stigma-related barriers to treatment, the dependent variable was number of treatment sessions attended, and the moderator was whether the adolescent met diagnostic criteria for either an internalizing disorder or externalizing disorder. The results of the regression analysis suggested that although the overall model was significant, there was not a significant moderation effect for the presence of a mental health disorder (r^2 = 0.23, F(1,61) =.489, p < .01). Therefore, the relationship between stigma-related barriers and the number of treatment sessions was not affected by whether there was a diagnosis of an internalizing/externalizing disorder or not.

The fourth research question examined whether the associations between the study variables differed for White and non-White participants. To address this, another regression analysis with moderation was conducted. The results indicated that race did not moderate the association between stigma and number of treatment sessions attended (R^2 = 0.88, F(3,69) = 2.22, p < .093). Therefore, none of the predictors in the model was significantly associated with the treatment session attendance.

Discussion

The research questions addressed in the study were, what is the association between stigma related barriers to treatment and the number of treatment sessions attended? What is the association between financial related barriers and the numbers of treatment sessions attended? Whether the presence of an internalizing or externalizing disorder moderates the association between stigma related barriers to treatment and the number of mental health treatment sessions attended. And

whether race moderates the association between stigma related barriers and the number of mental health treatment sessions attended.

The current results suggest that there was no significant relationship between stigma-related or financial barriers to treatment and mental health treatment attendance. Further, there were not significant moderation effects for internalizing or externalizing disorder or race. These results are not consistent with previous studies, which found that barriers to mental health treatment, including those that are stigma-related and financial, impede treatment participation (e.g., Kazdin, 1997). In fact, prior research reported that stigma-related and financial barriers are two of the most identified barriers to treatment among ethnically diverse groups (Miranda, Soffer, Polanco-Roman, Wheeler, & Moore, 2015).

The implications of the study suggest that community-based treatment providers need to do more research focusing around stigma and financial barriers to treatment. Educating racially and ethnically diverse communities on mental illness and how to access mental health services will establish the idea that mental health is a topic that should be conversed about without shame or guilt. More resources will be available for those who face self-stigmatization and they could utilize these resources to educate their own communities about the necessity of treatment.

Research on stereotype threat and its affect in Black and Latinx communities could be a huge component for addressing stigma related barriers to treatment. The interaction between White and Non- White communities is another significant factor in addressing stigma and how Non-White individuals who are accessing treatment may feel when interacting with treatment providers and therapists who are not their race or ethnicity. Financial related barriers could be resolved with a focus on giving accessible and affordable transportation to and from treatment facilities. This would mean working with the Metropolitan Transportation Authority in NYC and

giving out reduced fare metro cards or to utilize mental health facilities within neighborhoods that are in walking distance to avoid the issues that stem from the bus or subway. The results from this study is different from previous studies because of its focus on the stigma and financial related barriers that Non-White participants face when accessing treatment. Previous studies briefly spoke of stigma as a barrier for racially and ethnically diverse individuals who attend treatment, but none were specifically focused on an urban population of adolescents and none of them were from such a small population sample. Other studies utilized bigger samples and focused more on adults and pre-teens.

The limitations of the study were that the data was from a small population of Urban NYC residents (i.e., 205 adolescents and their primary caregivers). The small sample size did not account for the trends that were noticed when addressing the relationship between financial related barriers and the number of treatment sessions and the moderation of race in relation to stigma related barriers and the number of treatment sessions attended. Having a population that is only focused in the city does not account for the how these barriers function in other environments such as rural and suburban locations. Another component that also limited the study was its setting in community-based health clinics. This leaves room for further research in private clinics or government offered therapy programs. Utilizing community-based health clinics does not account for those who have access to private clinicians and those who only have access to government or state programs.

Future research should utilize a bigger population, different setting (i.e., rural and suburban areas) and focus on other barriers to treatment (i.e., severity of mental illness, lack of access to mental health professionals/quality of care, mental health system barriers,etc.)

A different environment could lead to different results if set in a suburban or rural environment in contrast to the urban environment of NYC. Those in rural areas do not have access to multiple forms of transportation and the reliance on being driven by their relatives could be more of a barrier towards getting access to treatment. Similarly, those in suburban areas may face other issues being in small-knit communities, as there is a greater chance of everyone knowing each other and increasing stigmatization towards mental illness as everyone in the community could know about the issues the individual or family are facing. This contrasts with urban areas where there is more chance for isolation and neighbor's not communicating or sharing services.

Access to participants of a higher socioeconomic status and lower socioeconomic status who attend community-based behavioral health clinics is something that should be focused on in further research. The SES of the participants is a huge component of how financial barriers affect them as well as their access to treatment facilities. If they have a higher SES they could access better quality treatment and facilities that can focus on their needs more personally than those who are low SES and do not have access to mental health treatment facilities of the same quality, and might be affected by limited services or overcrowding due to need. Examining other barriers to treatment allows other studies to test what various barriers may have a more noticeable effect on treatment attendance. Many barriers to treatment are reflective of the situations of the communities that need treatment and resources. Whether that means focusing on the stigmatization and lack of quality treatment and disorganization due to the mental health system in correctional facilities, or the interaction between teachers, adolescents and their caregivers when addressing behavioral issues; barriers can hinder individuals from accessing the necessary treatment. Further research could also be benefitted by doing a regression with both barriers (i.e stigma and financial related barriers) rather than just stigma related barriers. This could help

future researchers get a better understanding of both barriers as there was a noticeable trend regarding the financial related barriers and the number of treatment sessions attended. Future research should acknowledge the varying barriers that adolescents and caregivers face due to lack of education, financial limitations, through stigmatization and racial/cultural boundaries.

References

Alegría, M., Chatterji, P., Wells, K., Cao, Z., Chen, C., Takeuchi, D., … Meng, X.-L. (2008). Disparity in depression treatment among racial and ethnic minority populations in the United States. *Psychiatric Services*, *59*(11), 1264–1272. http://dx.doi.org/10.1176/appi.ps.59.11.1264

Arday, J. (2018). Understanding Mental Health: What Are the Issues for Black and Ethnic Minority Students at University? *Social Sciences; Basel*, *7*(10). http://dx.doi.org/10.3390/socsci7100196

Davis, R. G., Ressler, K. J., Schwartz, A. C., Stephens, K. J., & Bradley, R. G. (2008). Treatment barriers for low-income, urban African Americans with undiagnosed posttraumatic stress disorder. *Journal of Traumatic Stress*, *21*(2), 218–222. https://doi.org/10.1002/jts.20313

Ebesutani, C., Bernstein, A., Martinez, J. I., Chorpita, B. F., & Weisz, J. R. (2011). The Youth Self Report: Applicability and Validity Across Younger and Older Youths. *Journal of Clinical Child & Adolescent Psychology*, *40*(2), 338–346. https://doi.org/10.1080/15374416.2011.546041

Fisher, J. H., Lichvar, E., Hogue, A., & Dauber, S. (2018). Perceived need for treatment and engagement in mental health services among community-referred racial/ethnic minority adolescents. *Administration and Policy in Mental Health and Mental Health Services Research*, *45*(5), 751-764.

Goetter, E. M., Frumkin, M. R., Palitz, S. A., Swee, M. B., (2018). Barriers to mental health treatment among individuals with social anxiety disorder and generalized anxiety disorder. *Psychological Services*. http://dx.doi.org/10.1037/ser0000254

Hatzenbuehler, M. L., Keyes, K. M., Narrow, W. E., Grant, B. F., &, Hasin, D. S. (2008). Racial/ethnic disparities in service utilization for individuals with co-occurring mental health and substance use disorders in the general population: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *The Journal of Clinical Psychiatry*, *69*, 1112–1121.

Huffstead, R. (2016). Mental Health Related Stereotype Threat, Self-Stigma, and African American College Students' Willingness to Seek Counseling. Retrieved from https://etd.auburn.edu/handle/10415/5464

Kazdin, A. E., Holland, L., Crowley, M., & Breton, S. (1997). Barriers to Treatment Participation Scale: evaluation and validation in the context of child outpatient treatment. *Journal Of Child Psychology And Psychiatry, And Allied Disciplines*, *38*(8), 1051–1062.

Knifton, L., Gervais, M., Newbigging, K., Mirza, N., Quinn, N., Hunkins-Hutchison, E. (2010). Community conversation: Addressing mental health stigma with ethnic minority communities. *Social Psychiatry and Psychiatric Epidemiology: The International Journal for Research in Social and Genetic Epidemiology and Mental Health Services*, *45*(4), 497–504. http://dx.doi.org/10.1007/s00127-009-0095-4

Miranda, R., Soffer, A., Polanco-Roman, L., Wheeler, A., & Moore, A. (2015). Mental health treatment barriers among racial/ethnic minority versus white young adults 6 months after intake at a college counseling center. *Journal of American College Health*, *63*(5), 291–298. https://doi.org/10.1080/07448481.2015.1015024

Mojtabai, R., Olfson, M., Sampson, N. A., Jin, R., Druss, B., Wang, P. S., … Kessler, R. C. (2011). Barriers to mental health treatment: Results from the National Comorbidity

Survey Replication. *Psychological Medicine*, *41*(8), 1751–1761. https://doi.org/10.1017/S0033291710002291

Olfson, M., Mojtabai, R., Sampson, N. A., Hwang, I., & Kessler, R. C. (2009). Dropout from Outpatient Mental Health Care in the United States. *Psychiatric Services (Washington, D.C.)*, *60*(7), 898–907. https://doi.org/10.1176/appi.ps.60.7.898

Parent, M. C., Hammer, J. H., Bradstreet, T. C., Schwartz, E. N., & Jobe, T. (2018). Men's mental health help-seeking behaviors: An intersectional analysis. *American Journal of Men's Health*, *12*, 64–73. doi:10.1177/1557988315625776

Salloum, A., Johnco, C., Lewin, A. B., McBride, N. M., & Storch, E. A. (2016). Barriers to access and participation in community mental health treatment for anxious children. *Journal of Affective Disorders, 196*, 54–61. https://doi.org/10.1016/j.jad.2016.02.026

Shefer, G., Rose, D., Nellums, L., Thornicroft, G., Henderson, C., & Evans-Lacko, S. (2013). 'Our community is the worst': The influence of cultural beliefs on stigma, relationships with family and help-seeking in three ethnic communities in London. *International Journal of Social Psychiatry*, *59*(6), 535–544. https://doi.org/10.1177/002076401244759

Song, L., Singh, J., & Singer, M. (1994). The Youth Self-Report inventory: A study of its measurements fidelity. *Psychological Assessment*, *6*(3), 236–245. http://dx.doi.org/10.1037/1040-3590.6.3.236

Subramaniam, M., Abdin, E., Picco, L., Pang, S., Shafie, S., Vaingankar, J. A., … Chong, S. A. (2017). Stigma towards people with mental disorders and its components - a perspective from multi-ethnic Singapore. *Epidemiology and psychiatric sciences*, *26*(4), 371–382. doi:10.1017/S2045796016000159

Timbo, D. M. (2016). *African American clients' perceptions of therapists' multicultural counseling competencies* (Doctoral dissertation, Carlow University).

Vázquez, A. L., & Villodas, M. T. (2018). Racial/ethnic differences in caregivers' perceptions of the need for and utilization of adolescent psychological counseling and support services. *Cultural Diversity and Ethnic Minority Psychology*. http://dx.doi.org/10.1037/cdp000255

Walton, E., Berasi, K., Takeuchi, D., & Uehara, E. (2009). Cultural Diversity and Mental Health Treatment. In T. Scheid & T. Brown (Eds.), *A Handbook for the Study of Mental Health: Social Contexts, Theories, and Systems* (pp. 439-460). Cambridge: Cambridge University Press. doi:10.1017/CBO9780511984945.027