Why Bother With Beliefs? Examining Relationships Between Race/Ethnicity, Parental Beliefs About Causes of Child Problems, and Mental Health Service Use

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In this study, the authors examined the role of parental beliefs about the causes of child problems in predicting later mental health service use in a large, diverse population of at-risk youths. Study hypotheses were that parental beliefs consistent with biopsychosocial causes would be associated with later mental health service use; sociological, spiritual, or nature disharmony etiologies would be negatively associated with service use; and beliefs would partially mediate the relationship between race/ethnicity and service use. Of the 5 biopsychosocial beliefs, 2 were positively related to later mental health service use. Unexpectedly, of the 6 parental beliefs related to sociological, spiritual, or nature disharmony etiologies, only 1 was negatively associated with later service use patterns. Parental endorsement of etiologies relating to physical causes, relational issues, trauma, and prejudice was found to partially mediate the relationship between race/ethnicity and service use for Asian/Pacific Islander American and Latino youths.

Previous research has revealed troubling racial/ethnic disparities in mental health service use for children and adolescents. Recent national survey data show higher levels of unmet need for Latino children as compared with Whites (Kataoka, Zhang, & Wells, 2002). In addition, higher levels of unmet need have been reported for African American, Asian/Pacific Islander American (APIA), and Latino children as compared with non-Hispanic Whites (NHWs) in a public service sector sample of youths with identified mental health needs (Yeh, McCabe, Hough, Dupuis, & Hazen, 2003).

Many have speculated that variability in culturally influenced beliefs about the etiology of mental health/behavioral problems may be one explanation for the troubling racial/ethnic disparities found in mental health services (Cheung & Snowden, 1990; Leong, Wagner, & Tata, 1995; Ruiz, 1995; Sue, 1994; U.S. Department of Health and Human Services, 2001). For example, if parents believe that their child’s emotional/behavioral problems are the result of a biological issue, then they may be more likely to seek medical/psychiatric services that may provide medication, whereas parents who believe that their children’s problems are due to spiritual issues may then seek a religious leader for guidance. Furthermore, client and provider discrepancies in beliefs may lead...
to differential expectations regarding treatment goals and approaches that may affect treatment compliance and outcomes (Kleinman, Eisenberg, & Good, 1978). For instance, if a parent believes that his or her child’s problems are a result of negative peer influences, whereas the provider considers the child’s problems to be a result of poor parenting skills, then the parent may object to parent-training sessions that may be recommended by the provider. Although meaningful hypotheses about the relationship between etiological explanations and service use have been put forth, there has been minimal empirical investigation of these proposed relationships, and even less as it relates to mental health services for children.

Although a dearth of empirical studies examining the relationship between causal beliefs and service use exists, the extant adult literature suggests that some racial/ethnic differences in the endorsement of etiological explanations are apparent. In the adult literature, research has yielded significant differences in etiological beliefs between African American women, Latinas, and European American women (Alvidrez, 1999; Schnittker, Freese, & Powell, 2000); White teachers and Black teachers (Hall & Tucker, 1985); White American college students and Japanese American students (Narikiyo & Kameoka, 1992); and British Asians, Pakistanis, and Western Europeans (Sheikh & Furnham, 2000).

Little is known about parental causal models for child mental health problems, but recent research has begun to shed light on this issue. In an Australian community sample, a high proportion of Vietnamese parents reported biological/chemical imbalance, trauma, and metaphysical/spiritual imbalance as etiological explanations of child mental illness (McKelvey, Baldassar, Sang, & Roberts, 1999). Although among parents of children with attention-deficit/hyperactivity disorder, Whites were more likely to use medical labels than were African Americans, no significant differences were found between the two groups in causal etiologies (Bussing, Schoenberg, Rogers, Zima, & Angus, 1998). Among the findings from a sample of youths with identified mental health problems, parents of APIAs and Latinos were less likely than were parents of NHWs to endorse etiologies related to physical causes, personality, and familial issues (Yeh, Hough, McCabe, Lau, & Garland, 2004). The next logical step is to investigate whether such racial/ethnic differences in causal etiologies help to explain racial/ethnic disparities in mental health service use.

To our knowledge, studies have not tested whether explanatory etiologies do in fact mediate the relationship between race/ethnicity and mental health service use for adults or for children. By mental health services, we mean services offered by the mainstream Western professional mental health community, including individual counseling/therapy, medication, social skills training, family therapy, or parent training. It is possible that these types of services may be more readily used by families who hold etiological explanations related to biopsychosocial causes, whereas such services may be perceived as less relevant by those who believe that their child’s problems arise from sociological, spiritual, or nature disharmony origins.

In the current study, we investigated the relationship between a broad range of parental explanatory etiologies for child problems and specialty mental health services use in a large, diverse population of at-risk youths. Longitudinal data allowed us to determine whether parental beliefs about the causes of their child’s problems were prospectively associated with mental health service use at 2-year follow-up. We were also interested in understanding whether parental explanatory etiologies mediated the relationship between race/ethnicity and mental health service use, as suggested by the theoretical literature. We tested the following hypotheses:

Hypothesis 1. Etiological beliefs involving biopsychosocial beliefs (physical causes, personality, relational issues, familial issues, and trauma) would be associated with an increased likelihood for mental health service use at 2-year follow-up.

Hypothesis 2. Etiological beliefs involving sociological (friends, American culture, prejudice, economics), spiritual, or nature disharmony foundations would be associated with a decreased likelihood for mental health service use at 2-year follow-up.

Hypothesis 3. Parental beliefs about the causes of child problems would partially mediate the relationship between race/ethnicity and mental health service use at 2-year follow-up.

**Method**

**Participants**

This study involved a subsample of participants drawn from a large survey called the “Patterns of Youth Mental Health Care in Public Service Systems” (Patterns of Care [POC]). The POC study drew from a stratified random sample of 1,715 youths (6–17 years of age) who were active in one or more of the following public service sectors during the latter half of the 1996–1997 fiscal year in a large, metropolitan area: alcohol/drug, child welfare (court-ordered dependents), juvenile justice (adjudicated delinquents), mental health, and public school services for youths with serious emotional disturbance (SED; now called ED). The stratification procedure involved service sector affiliation, race/ethnicity, and level of treatment setting restrictiveness (i.e., home vs. aggregate care setting). Comparisons of participants with nonparticipants yielded no significant differences on age, gender, sector affiliation, or race/ethnic distribution, with the exception of a slightly lower participation rate by APIAs (see Garland et al., 2001, for more information).

All youths in the POC survey who were African American (n = 271; 20.3% of the resulting sample), APIA (n = 91; 6.8%), Latino (n = 385; 28.8%), or NHW (n = 590; 44.1%) and who had complete data for all study variables were included in this study, resulting in a sample size of 1,337 youths. The mean age of youths in this sample was 14.07 years (SD = 3.17), and 66.9% were male youths. Median household income fell between $19,000 and $19,999 per year, and 68.3% of primary caregivers obtained a high school diploma or lower level of education. During the fiscal year 1996–1997, public service sector involvement by the sample was as follows: 9.3% alcohol/drug treatment, 25.1% child welfare, 28.4% juvenile justice, 52.7% mental health, and 25.1% ED services. Of primary caregiver respondents, 1,017 were biological parents (76.1%), whereas 69 were adoptive/stepparents (5.2%), 132 were blood relatives (9.9%), 98 were nonrelative foster parents (7.3%), 20 were other nonrelative caregivers (1.5%), and 1 was of unknown relationship (0.07%).

**Procedures and Measures**

Primary caregiver (hereafter referred to as parents) and youth surveys included data collection on demographic characteristics, emotional/behavioral problems, explanatory etiologies for the child’s problems, and service use. Institutional review board approval and informed consent were ob-
tained prior to data collection. In-person surveys took place at baseline and at 2-year follow-up. Recruitment procedures were as follows: The current caregiver/parent was first contacted by mail, followed by a telephone call 1 week later to explain the study according to scripted guidelines and to schedule interviews for those interested in participation. If a family could not be reached by telephone, then an in-person contact was attempted. Study purpose and procedures were again explained by the interviewer during the consent/assent process at baseline and follow-up interviews. All measures used for the specific study described here were taken at the time of baseline interview, with the exception of mental health service use, which was taken at the time of 2-year follow-up. Parents received $40, and youths received between $10 and $40 depending on age for their participation at each time point.

Family income was determined by an incremental scale allowing participants to select a value (range = 1–32) corresponding with distinct income levels (range < $1,000–$200,000; Use, Needs, Outcomes, and Costs in Child and Adolescent Populations Work Group).

Emotional/behavioral problems were assessed by the Child Behavior Checklist (CBCL; Achenbach, 1991). The CBCL is a parent-report measure of child emotional/behavioral symptoms, with well-established reliability and validity (Achenbach, 1991). It provides age-normed comparisons of behavioral/emotional symptomatology for children 2–18 years of age and produces summary indices for total behavior, internalizing behavior, and externalizing behavior problems.

Explanatory etiologies for child problems were measured by a semi-structured questionnaire developed following literature review, consultation with cultural experts, and previous research (Beliefs About the Causes of Child Problems—Parent Version; Yeh & Hough, 1997). Respondents were asked to answer yes/no to a stem question of whether they believed that “any emotional, behavioral, or alcohol/drug problems that your child has” were “due, at least in part,” to issues in each of 11 belief scales: Physical Causes (eight items; e.g., “A physical health problem or disabling condition your child was born with?”), Personality (five items; e.g., “Your child’s character or personality?”), Relational Issues (four items; e.g., “Your child’s problems with relationships? [e.g., in the family or with friends]”), Familial Issues (four items; e.g., “Conflict within the family? [e.g., arguing in the family, violence in the family]”), American Culture (three items; e.g., “The influence of popular American culture [e.g., through TV or movies?]”), Prejudice (one item: “racial discrimination or prejudice?”), Economic Problems (three items; e.g., “Not having enough money for things like food, clothing, housing, etc.”), Spiritual Causes (10 items; e.g., “Spirit possession or the influence of spirits or ghosts?”), and Nature Disharmony (four items; e.g., “Disruption of your child’s energy or vitality flow?”). No specific timeframe for the etiologies was indicated. Endorsement of the global question prompted specific questions within that category, with the exception of the Prejudice area, for which the stem question served as the sole item. Dichotomous variables for each global category reflected the endorsement of one or more specific items within that category.

Sample respondents endorsed an unweighted average of 3.64 (SD = 2.14) categories. The individual belief categories were endorsed by the sample as follows: Physical Causes = 32%, Personality = 68%, Relational Issues = 44%, Familial Issues = 66%, Trauma = 47%, Friends = 44%, American Culture = 23%, Prejudice = 8%, Economic Problems = 24%, Spiritual Causes = 6%, and Nature Disharmony = 3%. Pilot 1-week, test-retest reliability (average time between telephone administrations = 8.23 days) with the parents of 23 youths from a separate sample showed that 7 of the 11 scales had kappas demonstrating “excellent reproducibility” or greater than 85% agreement between administrations; two scales had “good reproducibility”; and only two scales had “marginal reproducibility” (Personality and Friends; using guidelines from Rosner, 1995), even with this small sample size. Construct validity is supported by racial/ethnic differences on the biopsychosocial scales in generally hypothesized ways (Yeh et al., 2004). In addition, confirmatory factor analysis was used to examine whether the 11 etiologic categories could be grouped into the broader biopsychosocial, sociological, and spiritual/nature disharmony domains that were hypothesized to be differentially related to mental health service use. Confirmatory factor analysis was conducted with a restrictive model that did not allow for cross-loading of items, and it found adequate fit for both an a priori two-factor model (biopsychosocial vs. sociological/spiritual/nature disharmony) and an a priori three-factor model (biopsychosocial vs. sociological vs. spiritual/nature disharmony), with a somewhat stronger fit for the two-factor model (comparative fit index = .91; root-mean-square error of approximation = .06).

Mental health service use was assessed with the National Institute of Mental Health’s Service Assessment for Children and Adolescents (Horwitz et al., 2001), which has adequate reliability and validity (Hoagwood et al., 2000; Horwitz et al., 2001; Stiffman et al., 2000). Mental health service use for this study was defined as any past year use of specialty mental health services (i.e., services involving a psychologist/psychiatrist/other mental health professional, community mental health center, day treatment facility, psychological hospitalization, or psychiatric unit in a general hospital). In this sample, 38.4% reported specialty mental health service use in the year prior to the baseline interview.

Results

A logistic regression equation was used to investigate our first hypothesis that parental beliefs consistent with biopsychosocial conceptions of mental health would be associated with a greater likelihood of mental health service use at 2-year follow-up. Specialty mental health service use at 2-year follow-up was our dependent variable (use = 1). Our analyses controlled for demographic variables (age, gender, household income, parent education) and youth symptomatology (CBCL Total Problems T score). We wanted to investigate the relationship between each of the five biopsychosocial beliefs (Physical Causes, Personality, Relational Issues, Familial Issues, and Trauma) and service use. Therefore, we created five dichotomous variables representing endorsement of each of the five biopsychosocial beliefs (endorsement = 1) and entered these into our model simultaneously. Odds ratios (ORs) were computed for each of the variables in our logistic regression equations. The use of ORs provided a convenient means of interpreting the magnitude as well as the direction of the effects. For example, an OR of 2.00 for gender (female youths as the reference group) would mean that male youths were twice as likely as female youths to have a particular outcome while controlling for the other variables in the model, whereas a significant OR of less than one would indicate that male youths were less likely than female youths to have the same result. As displayed in Table 1, we found that the hypothesis of a greater likelihood for service use held true for Physical Causes (OR = 1.56, p < .01) and Trauma (OR = 1.35, p < .05) but not for Personality (OR = 1.06, ns), Relational Issues (OR = 1.30, ns), or Familial Issues (OR = 1.22, ns). Lower child age (OR = 0.82, p < .001), higher income (OR = 1.04, p < .001), and higher CBCL Total Problems T score (OR = 1.05, p < .001) were also significantly related to later service use.

Next, a logistic regression equation tested our second hypothesis that parental beliefs related to sociological, spiritual, or nature disharmony etiologies would be associated with a lesser probability of mental health service use at 2-year follow-up. Again, spe-
cially mental health service use at 2-year follow-up was our dependent variable (use = 1). Our model involved the simultaneous entry of our control variables (age, gender, household income, parent education, youth symptomatology) and six dichotomous variables representing endorsement of each of the sociological, spiritual, and nature disharmony orientations (endorsement = 1): Friends, American Culture, Prejudice, Economics, Spiritual Issues, and Nature Disharmony. A significant relationship was found for Friends in the expected direction of lower likelihood of service use (OR = 0.74, p < .05), but no statistically significant findings for the other beliefs tested in this model were found. Lower age (OR = 0.83, p < .001), higher income (OR = 1.04, p < .001), higher parental education (OR = 1.41, p < .05), and higher CBCL Total Problems T score (OR = 1.06, p < .001) were also significantly related to later service use (see Table 2).

Finally, logistic regression analyses were also used to examine the four conditions of a mediational relationship (Baron & Kenny, 1986; Holmbeck, 1997): (a) Race/ethnicity is significantly associated with parental explanatory beliefs; (b) Race/ethnicity is significantly associated with mental health service use at 2-year follow-up; (c) Parental explanatory beliefs show a significant association to mental health service use at 2-year follow-up; and (d) The relationship between race/ethnicity and mental health service use at 2-year follow-up is decreased when controlling for parental explanatory beliefs at baseline. Because of previous research showing greater unmet need for African Americans, APIAs, and Latinos in comparison with NHWs (Kataoka et al., 2002; Yeh et al., 2003), NHWs were selected as the reference group to examine racial/ethnic differences in service use. A reduction in effect was shown in the follow-up as the dependent variable while controlling for demographics (age, gender, income) and child symptomatology (CBCL Total Problems T score; and child symptomatology (CBCL Total Problems T score). Significant relationships emerged in 8 of the 11 belief categories: Physical Causes, Personality, Relational Issues, Familial Issues, Trauma, American Culture, Prejudice, and Spiritual Issues (see Table 3).

The second step of our mediational analysis involved demonstrating a significant relationship between race/ethnicity and mental health service use at 2-year follow-up. Race/ethnicity variables (with NHWs as the reference group) were entered into a logistic regression equation with past year mental health service use at 2-year follow-up as the dependent variable while controlling for demographics (age, gender, income) and child symptomatology (CBCL Total Problems T score). APIAs and Latinos were both significantly less likely than NHWs to use mental health services at 2-year follow-up (OR = 0.35, p < .01; OR = 0.72, p < .05), thus meeting this condition (see Table 4, Model 1).

Step 3 of our mediational analyses involved simultaneously entering our control variables (age, gender, income, child symptomatology), race/ethnicity, and parental beliefs (those for which racial/ethnic differences were found in Step 1) into a logistic regression equation with mental health service use at 2-year follow-up as the dependent variable. Partial mediation was determined by a significant relationship between parental beliefs and mental health service use as well as a reduction in the relationship between race/ethnicity and mental health service use found in Step 2. We found that four of the eight parental beliefs entered were significantly associated with mental health service use at 2-year follow-up: Physical Causes (OR = 1.52, p < .01), Relational Issues (OR = 1.36, p < .05), Trauma (OR = 1.37, p < .05), and Prejudice (OR = 0.58, p < .05). Furthermore, the relationship between race/ethnicity and mental health service use at 2-year follow-up was significantly reduced for both APIAs and Latinos; the OR for APIA became 0.44 (from 0.35), reflecting a 25.7% reduction in the effect and a change in significance level (from $p < .05$ to $p > .05$).
Table 3
Racial/Ethnic Differences in Parental Beliefs About the Causes of Child Problems: Odds Ratios for Logistic Regression Equations Controlling for Age, Gender, Income, Parent Education, and Child Symptomatology

<table>
<thead>
<tr>
<th>Variable</th>
<th>Physical causes</th>
<th>Personality</th>
<th>Relational issues</th>
<th>Familial issues</th>
<th>Trauma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>0.94***</td>
<td>1.11***</td>
<td>1.07–1.16</td>
<td>1.06–1.15</td>
<td>1.01</td>
</tr>
<tr>
<td>Male youths</td>
<td>1.02</td>
<td>1.31*</td>
<td>1.01–1.71</td>
<td>0.82–1.36</td>
<td>0.81</td>
</tr>
<tr>
<td>Income</td>
<td>1.03**</td>
<td>1.01–1.05</td>
<td>1.01</td>
<td>1.00–1.03</td>
<td>1.00</td>
</tr>
<tr>
<td>Parent education</td>
<td>1.40*</td>
<td>1.08–1.83</td>
<td>1.31</td>
<td>1.09–1.75</td>
<td>1.14</td>
</tr>
<tr>
<td>CBCL</td>
<td>1.04***</td>
<td>1.03–1.05</td>
<td>1.05–1.07</td>
<td>1.05–1.07</td>
<td>1.03***</td>
</tr>
<tr>
<td>AA*</td>
<td>1.08</td>
<td>0.79–1.48</td>
<td>0.74</td>
<td>0.53–1.05</td>
<td>0.47–0.88</td>
</tr>
<tr>
<td>APIA*</td>
<td>0.34**</td>
<td>0.18–0.65</td>
<td>0.37***</td>
<td>0.22–0.61</td>
<td>0.39***</td>
</tr>
<tr>
<td>Latino*</td>
<td>0.61**</td>
<td>0.44–0.84</td>
<td>0.53***</td>
<td>0.39–0.73</td>
<td>0.59***</td>
</tr>
</tbody>
</table>

Note. OR = odds ratio; CI = confidence interval; CBCL = Child Behavior Checklist Total Problems T score; AA = African American; APIA = Asian/Pacific Islander American.

Discussion

In this investigation, we used longitudinal data to examine three hypotheses about the relationship between parental explanatory etiologies for child problems and mental health service use. APIA and Latino youths in our sample were less likely than were NHWs to use specialty mental health services, even when controlling for demographic variables and severity of symptomatology. Analyses confirmed our first hypothesis that biospsychosocially oriented beliefs would be associated with a greater likelihood of mental health service use for two of the five belief categories examined. For our second hypothesis that sociological, spiritual, and nature disharmony beliefs would be related to a lower likelihood of mental health service use, support was found only for beliefs regarding Friends. Finally, parental beliefs about causes of child problems were found to be a partial mediator in the relationship between race/ethnicity and mental health service use at 2-year follow-up.

Parental beliefs that their child’s problems were due to Physical Causes and Trauma were associated with a greater likelihood of mental health service use at follow-up, even when controlling for socioeconomic status, child symptomatology, and other biospsychosocially oriented beliefs. In fact, those who endorsed Physical Causes were 1.56 times more likely to use specialty mental health services compared with those who did not report such etiologies. These beliefs may lend themselves to biospsychosocially based specialty mental health treatment options such as psychotropic medications and trauma counseling. The effects of Physical Causes and Trauma were apparent even when controlling for other biospsychosocially related beliefs. However, Relational Issues, Personality, and Familial Issues were not related to later mental health service use. It may be possible that Physical Causes and Trauma may be perceived as less socially stigmatizing than are the child’s personal characteristics, social skills, or concerns related to the family. Future research may explore this issue in greater depth.

On the other hand, no parental beliefs related to sociological, spiritual, or nature disharmony etiologies demonstrated a significant relationship to mental health service use at follow-up, beyond that for Friends, which was associated with an approximately 25% lesser likelihood for use when controlling for socioeconomic status, child symptomatology, and other sociological, spiritual, or nature disharmony etiologies. This was surprising, as we had anticipated that all such beliefs would be negatively related to later service use. In addition, the scales (albeit with just one significant effect) varied in the direction of relationship to later service use.

\[ OR = \frac{\text{OR}_{\text{AA}}}{\text{OR}_{\text{Latino}}} \]

whereas the Latino OR reduced from 0.72 to 0.82, reflecting a 13.9% reduction and a change in significance level (from \( p < .05 \) to nonsignificance; see Table 4, Model 2). Following our criteria regarding significant change in ORs, we concluded that the cluster of parental beliefs reflecting Physical Causes, Relational Issues, Trauma, and Prejudice was a partial mediator in the relationship between race/ethnicity and mental health service use.

\[ \text{OR} = 1.04^{***} \]

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which was also unexpected. However, the finding of a relationship between Friend beliefs and a lesser likelihood of service use suggests that parents may not consider mental health services to be helpful in such cases in which peer relationships are perceived to be the cause of the child’s problems.

Finally, the combined parental endorsement of beliefs relating to Physical Causes, Relational Issues, Trauma, and Prejudice partially mediated the relationship between race/ethnicity and mental health service use, even when controlling for age, gender, socioeconomic status, and child symptomatology, as well as other belief categories. As might be expected, biopsychosocial beliefs that predicted mental health service use at 2-year follow-up (Physical Causes, Trauma) also helped explain racial/ethnic disparities in service use at 2-year follow-up. In addition, Relational Issues and Prejudice beliefs were also part of the combination of explanatory etiologies that partially mediated the relationship between race/ethnicity and mental health service use. Notably, the endorsement of Prejudice as an etiology was associated with a 42% lesser likelihood of mental health service use, even when controlling for race/ethnicity. It appears that although parental beliefs related to Relational Issues and Prejudice may not be related to mental health service use in general, they do help explain differences for APIA and Latino youths in combination with Physical Causes and Trauma attributions.

This study provides an empirical, longitudinal examination of how parental beliefs about the causes of child problems relate to mental health service use in a large, diverse population of youths. The investigation specifically addresses the intriguing question of whether parental beliefs help explain the striking racial/ethnic disparities found in mental health service use. However, several limitations to the study must be noted.

First, although it was advantageous to have a sample of at-risk youths who were likely to need services, the study must be interpreted in the context of youths who have had contact with public service sectors. At the time of first interview, 83.6% of the sample reported previous contact with specialty mental health services at some point during their lifetimes. Although 5.1% of the sample reported that the child received counseling from a priest, rabbi, or minister during the year prior to baseline, and 1.3% reported the child received treatment from a healer or other alternative health provider during the past year, it is possible that our sample differs from the community in terms of access to alternative care. In addition, service receipt occurring directly following baseline may not have been reflected in our assessment of service use at 2-year follow-up. Therefore, the results of this study best reflect first-time and continuing service use of high-risk populations and cannot be assumed to be applicable to first-time service users from community populations. Nonetheless, the study’s findings suggest that the examination of explanatory beliefs in a community sample may be a fruitful next step of investigation. In other words, although the baseline explanatory etiologies preceded service use at 2-year follow-up, we do not know for certain whether service use prior to baseline affected those baseline beliefs. Future research with representative community samples would help to address this issue.

Second, race/ethnicity in this study was broadly defined, and specific ethnic groups and differing acculturation levels were not taken into account. It is hoped that future studies will examine
specific groups comprehensively and also investigate factors that may produce intragroup variability. In addition, because this study only included those youths who were African American, APIA, Latino, or NHW, it would be meaningful to examine similar questions for other racial/ethnic groups and those who have a multiracial background.

Third, in the absence of an established measure of parental beliefs about the causes of child problems at the time of study implementation, a new, unproven measure was implemented. The dichotomous nature of the measure’s items also did not allow us to investigate the strength of the respondent’s endorsement in a particular explanatory etiology; the use of a Likert-type scale would have provided additional meaningful information. In addition, the 11 belief scales were developed on the basis of theory rather than exploratory factor analysis. However, preliminary analyses provide some support for the psychometric properties of the questionnaire.

Fourth, the simultaneous entry of beliefs into the logistic regression equations meant that the effects of one belief were examined while controlling for other parental beliefs. Now that a partial mediating effect for parental explanatory etiologies has been found, future research may like to examine the contribution of each belief when entered individually.

Finally, many alternative factors not assessed by this study (e.g., geographic proximity to services, social support, etc.) may have accounted for mental health service use at follow-up, and these variables may or may not be related to the key construct examined in this study. Nevertheless, this study provides one of the first examinations of the relationships between race/ethnicity, beliefs about etiology, and mental health service use.

The findings suggest that it would behoove mental health service providers to take parental beliefs about the causes of child problems into account when addressing racial/ethnic disparities in the use of mental health services. For example, service agencies may need to engage in outreach activities to ethnic minority populations to provide information about emotional/behavioral problems that may indeed have an empirically supported physical or trauma-based cause. Given the importance of preventing treatment dropout, service providers may also need to elicit, discuss, and engage in “negotiation” (Kleinman et al., 1978) of the differences between patient and provider explanatory etiologies to ensure consistent treatment goals and the means for achieving them. Particular attention to explanatory etiologies related to prejudice may be warranted. The development of interventions to incorporate parental explanatory etiologies into outreach, referral, and treatment efforts may be an important next step in reducing racial/ethnic disparities in mental health service use for children. The development of such “negotiation” techniques may be highly compatible with engagement interventions described in the literature (Coatsworth, Santisteban, McBride, & Szapocznik, 2001; McKay, Stoewe, McCadam, & Gonzales, 1998; Szapocznik, Perez-Vidal, Brickman, & Foote, 1988). The development of etiological explanation interventions may entail reframing services to be consistent with parental beliefs. Or, perhaps incorporation of parental input may involve providing completely different services from what is currently generally available. Further research is necessary to understand when differential beliefs may lead families to seek help and also whether collaborative efforts between service providers and client families improve the effective delivery of services.

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