Mental Health Literacy and Treatment-seeking Behaviors in Youth

by

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Bachelor of Science in Nursing, University of Pittsburgh, 2023

Submitted to the Undergraduate Faculty of the
University Honors College in partial fulfillment
of the requirements for the degree of
Bachelor of Science in Nursing

University of Pittsburgh

2023
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Adolescence is a critical period in a person’s life because youth are undergoing physical, social, and emotional change, and mental health issues emerge. This study examined mental health literacy and the extent to which recognition of mental illness impacts the underutilization of mental health services in youth. The social determinants of health underpin this study. The study design was an exploratory cross-sectional design. Twenty-eight participants, ranging in grades from 8th to 12, were recruited from two urban schools and completed an online survey comprised of the Knowledge and Attitudes to Mental Health Scale and Barriers to Adolescents Seeking Help shortened scale. Using an open-ended textbox, participants also had the option to list mental health treatment facilitators and barriers. Understanding of mental health and help-seeking behaviors were found to have a significant positive correlation \((p=0.683; \ p<.001)\), indicating the higher one’s understanding of mental health, the more likely they are to seek treatment. The most frequently reported facilitators to seeking treatment included supportive parents, receiving a reward, and perceived need. The most reported barriers were embarrassment and a lack of trust in the provider. Healthcare professionals need to work to remove barriers to treatment so that care is not delayed. Larger-scale studies would be required to further assess Black youth’s mental health treatment-seeking behaviors.
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Preface

I would like to sincerely thank my research committee for all the help they have provided me throughout this process and the Reva Rubin Memorial Undergraduate Research Fund.
Introduction

1.1 Overview

Approximately one in every five adolescents has major depressive disorders, which are inversely related to not only academic achievement and school bonding but also their mental health in adulthood (Bitsko et al., 2022, Thapar et al., 2012). Mental Health Literacy (MHL) allows a person to have the awareness that something is wrong, and that treatment is necessary. MHL is defined as an individual’s ability to recognize that they have a problem that requires medical treatment and locate the appropriate services. Despite rising need, recent studies indicated that Black adolescents with depression use fewer mental health services (Lu, 2019, 2020). Racial/ethnic minority groups are less likely to perceive a need for mental health services than Non-Hispanic Whites while others report no differences between racial groups (Ault-Brutus & Alegria, 2018; Nadeem & Lange, Miranda, 2009; Tanielian et al., 2009). The purpose of this study was to assess MHL and determine the extent to which recognition of mental illness impacts the underutilization of mental health services in Black youth.

**Specific Aim 1**: Investigate MHL and treatment-seeking behaviors (TSB) of Black youth ages 14-18 in comparison to non-Black youth.

**Specific Aim 2**: Examine the extent to which an individual’s perception of mental illness impacts their likelihood of seeking treatment for themselves.

**Specific Aim 3**: Explore the facilitators and barriers of youth in utilizing mental health services.

The results of this study can then be used to determine ways to most effectively serve Black communities to decrease mental health disparities.
1.2 Theoretical Framework

This proposed research is grounded in the social determinants of health (SDOH), which describes how social factors influence our health outcomes. The nine “core” social determinants of mental health are racial discrimination and social exclusion, adverse early life experiences, poor education, job insecurity, poverty, income inequality, insufficient healthy food options, housing instability, and poor access to health care (Compton & Shim, 2015). Figure 1 illustrates the social determinants for mental health specific to adolescents (Office of the U.S. Surgeon General, 2021). Ethnic minority populations are more likely to experience these social determinants of mental health (SDOMH) (Compton & Shim, 2015). Since Black youth's environment predisposes them to have lower levels of MHL, they may not fully understand issues around mental health and, therefore, undervalue the significance of utilizing mental health services.

Figure 1
1.3 Significance

Ample research exists on the sustained underutilization of mental health services by Black adolescents and adults alike but explanations of why this phenomenon occurs remains understudied. Although several factors have been proposed to explain why Black people do not use mental health resources at the same rate as other racial groups, research obtained directly from the perspectives of Black community members is lacking. Therefore, the data from this study will provide critical insight into MHL and perceived need of services within Black communities. Since rates of mental health illness are increasing among Black youth, specifically targeting this age group is beneficial in understanding why this phenomenon is occurring. Likewise, since this population is actively in the process of adopting values from their guardians and environment, this study provides the insight into fundamental ideas perpetuated within Black communities necessary to develop strategies that can more effectively address mental health illnesses earlier.
Literature Review

2.1 Historical Background

Adolescence is a critical period in a person’s life because youth are undergoing physical, social, and emotional change while mental health issues emerge (Chandra & Minkovitz, 2006). Mental health illness in youth is inversely related to academic achievement and school bonding (Villatoro et al., 2017). Approximately one in every five adolescents ages 13 to 18 has major depressive disorders (Bitsko et al., 2022). According to the National Alliance on Mental Illness [NAMI] (n.d.), 37% of students with a mental health condition at age 14 or above drop out of school. This figure reflects the highest dropout rate of any disability group among youth. Likewise, 70% of youth in state and local juvenile detention centers suffer from a mental illness. This phenomenon demonstrates the impact that untreated mental illness may have on the lives of youth. Furthermore, 50% of all lifetimes cases of mental illness begin by age 14. This number rises to 75% by age 24. That 10-year gap in identifying the illness can make a great difference in the life of the adolescent.

Black youth have disproportionately lower rates of academic achievement, with higher rates of grade retention, suspensions, and expulsions, which are all considered markers of poor school bonding (Marrast, Himmelstein, Woolhandler, 2016). Studies indicate that adequate school bonding has been related to lower rates of suicidality, depressive episodes, anxiety, and overall improved mental health (Malhotra et al., 2015; Marrast, Himmelstein, Woolhandler, 2016; Villatoro et al., 2017). The difficulty treating and retaining racial minority youth and their families in mental health treatment has been documented by several research studies (Narendorf & Palmer,
2016; Tambling, D’Aniello, & Russell, 2021; Villatoro et al., 2017). Reasons for this have been attributed to inadequate access to mental health services, however psychosocial factors such as decreased perceived need for care have been considered as well (Ault-Brutus & Alegria, 2018). Since mental health has a crucial developmental impact on the educational and psychosocial outcomes of adolescents, the impact of untreated mental health illness in Black youth has lasting effects on the individual and the Black population in its entirety.

2.2 Youth and Mental Illness

The most common types of mental illnesses seen in youth are anxiety, depression, attention, and conduct disorders (Bailey, Mokonogho, & Kumar, 2019). Although Black children have always been diagnosed with attention deficit hyperactive disorders (ADHD) at higher rates than other racial groups, historically, rates of major depressive episodes and suicidal thoughts, plans, and attempts were among the lowest in Black and African American (Black) youth (Bailey, Mokonogho, & Kumar, 2019). One study found that Black children ages 5-12 were almost twice as likely to die by suicide than non-Black children of the same age (Bridge et al, 2018). Likewise, in recent years, Black youth have experienced a significant upward trend in suicidal thoughts, plans, and attempts, especially within the 15 to 17 age group (Tambling, D’Aniello, & Russell, 2021). In 2020, twelve of every 100,000 Black 10 to 24-year-olds died by suicide in comparison to eight of every 100,000 for White adolescents (California Department of Public Health [CDPH], 2020). In 2014 the Black suicide rate was about 25% lower than that of white students and 15% lower than the rate among Asian students (Tambling, D’Aniello, & Russell, 2021). Although more research needs to be conducted to fully understand why this increase is occurring, an analysis
conducted by the U.S. Department of Health & Human Services found that Black youth were more likely to experience a crisis in the two weeks prior to their death by suicide, unstable family relationships, and higher rates of past suicide attempts despite lower rates of a diagnosed mental health illness. This study indicates that Black youth’s previously low rates of mental illness and suicide are more likely attributed to limited access to and/or utilization of mental health services than the absence of mental illness (U.S. Department of Health & Human Services, 2020).

2.3 Mental Health Literacy

Utilization of mental health services such as therapy remains low among Black youth despite rising need (Cummings & Druss, 2011; Manuel, 2017). Current evidence on factors contributing to the underutilization of mental health services by Black youth include limited availability and inaccessibility of mental health services, inefficient problem recognition, and stigma towards mental health services (Malhotra, et al., 2015). Of these factors, a stigma within Black communities is the most cited reason. Research on MHL and perceived need for care in Black communities is markedly low (Tanielian et al., 2009). Health literacy allows a person to have the awareness that something is wrong, and treatment is necessary. This process often begins with the recognition that the distress the person is experiencing is inappropriate relative to other peers or family members. Healthy people 2030 defines health literacy as “the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others” (Office of Disease Prevention and Health Promotion, n.d.). The capacity of an individual to recognize they have a problem that requires medical treatment and locate the appropriate services needed is thus determined by health literacy. For these reasons, health literacy and the utilization of health services are most prevalent in groups of higher social and economic status since they often have more education and access to higher
levels of healthcare (Tanielian et al., 2009). Ethnic minority populations, however, are more likely to experience life stressors such as violence and poverty on a continuous basis so when they experience symptoms of depression, like apathy, anorexia, or suicidality, they are more likely to attribute these symptoms as consequences of their impoverished environment rather than an underlying mental disorder (Creamer, 2020; Lindsey et al., 2012). Likewise, since this environment predisposes Black youths to have lower levels of MHL, Black youths might not be able to appropriately appreciate the significance of utilizing mental health services.
Method

3.1 Study Design and Participants

The study utilized a cross-sectional observational design to explore mental health literacy in a sample of adolescents between the ages of 14-18 years old, or 8th to 12th grade from two urban preparatory schools in the western Pennsylvania region. A convenience sample of 50 students were recruited. The inclusion criteria for the study are subjects who are: a) in grades 8th-12th; b) able to provide parental consent if under the age of 18. Individuals were excluded if their guardians completed the opt-out form. A university Institutional Review Board (IRB) approved this research protocol.

3.2 Procedure

Designated representatives from each of the schools recommended qualifying youth to participate in the study. Once identified, students were provided with an information sheet regarding the study and a parental opt-out letter. A parental opt-out form was used to make it easier for guardians to passively express their permission. Prospective participants were to review the information and show the parental opt-out letter to their parents or guardians. Parents and guardians were also emailed a copy of this letter with instructions to complete the form and return it to the school in by within two weeks if they did not consent to their child’s participation. After obtaining consent from parents and assent from youth, participants were provided a link to
complete a standardized survey online via Qualtrics using their personal devices. The survey was de-identified to protect participants’ privacy and confidentiality. Participants had one month to complete the study with one reminder sent to participants at the two-week mark. Participants could withdraw from the study at any point by stopping the survey. No follow-up was conducted after the survey was completed, but at the end of the survey participants had the option to be redirected to a different Qualtrics where they could provide their email for a random chance to receive a 20-dollar gift card. 25 participants were randomly selected and emailed an electronic gift card to their provided email address.

3.3 Measures

3.3.1. Demographic Information

Three demographic identifiers: grade, gender, and race were collected from all participants for data analysis purposes. Their grade and race are particularly important for comparing the data collected relative to the statistical data found in previous research studies (Bailey, 2019, Bridge, 2018). Participants had the following options for choosing their gender: female, male, transgender, non-binary, or prefer not to respond. Gender was relevant to analyzing how responses vary depending on the gender identity of the individual. Race was collected by allowing participants to pick from the options White, Black, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander, and prefer not to answer. Race used to compare how results differed between Black and non-Black participants.
3.3.2 Mental Health Literacy

The Knowledge and Attitudes to Mental Health Scale (KAMHS) was used to assess participants' ability to recognize symptoms of mental illness and their beliefs about mental illness in middle and high school-aged individuals. The KAMHS showed good internal consistency and moderate test-retest reliability (Simkiss et al., 2021). Attitudes and knowledge of mental health are evaluated across 5 domains: self-stigma (6 questions), help-seeking behaviors (6 questions), understanding of mental health (6 questions), presence of public stigma toward others (7 questions), and avoidant coping behaviors (5 questions) for a total of 30 questions. Some questions had to be removed from the original scale to comply with the guidelines of the partnership schools. For example, questions asking students to admit illegal activities were removed. To complete the scale, participants were asked to rate their agreement with statements on a five-point Likert scale (Strongly Agree, Agree, Don’t Know, Disagree, Strongly Disagree). “Correct” responses, defined by the authors as responses that are factually correct or showing the least stigma would equal five points. Questions where negative responses were “correct” were reverse scored (Simkiss et al., 2021). For example, if a participant responded strongly disagree to the statement “regular exercise has no effect on your mental health”, they would receive five points towards their total score. Total scores were computed by adding the total sum of each individual item with higher scores ideal for all domains. Scores for each subfactor were evaluated by comparing the participant’s average response to how close they were to the predetermined “correct” response of five.

3.3.3 Treatment-seeking Behaviors

Treatment-seeking behaviors were measured with the Barriers to Adolescents Seeking Help shortened scale (BASH-B). This 11-item scale assesses participants' openness to seeking professional help and their perceived value of seeking such help (Vogel, Wade, & Haake, 2006).
Each item is rated on a 5-point scale (1 = “strongly disagree” to 5 = “strongly agree”). Participants total scores were summed so that greater scores indicated higher barriers to seeking professional psychological help.

3.3.4 Facilitators and Deterrents in Utilizing Mental Health Services

Facilitators and deterrents of utilizing mental health services were assessed through participants responses to the scenario statements provided in the BASH-B scale. Participants also had the option to further explain their opinions using two open-ended text boxes. One textbox asked participants to describe some factors that would increase their chances of seeking counseling, and the second asked participants to describe the reasons they would be less likely to utilize mental health services like therapy. Open-ended responses were evaluated using thematic analysis. Similar responses were grouped into categories. Responses that could not be grouped within a category were placed in an “other” group.

3.4. Data Analysis

The data was de-identified and stored on the university’s secure server. IBM SPSS Statistics for Windows, Version 25 (IBM Corp., Armonk, N.Y., USA), was used to analyze the data. The data was checked for outliers before any statistical analysis was done. Descriptive statistics were used for exploratory data analyses. Wilcoxon-Mann Whitney and Spearman's correlation tests were used to examine the extent to which an individual’s perception of mental illness correlates to their likelihood of seeking treatment for themselves. Cohen’s d was used to
measure the effect sizes of the findings. Data from the open-ended question was analyzed with a thematic-content analysis.
Results

4.1 Demographics

A total of 30 responses were received. Two participants did not complete the entire survey, leaving 28 respondents for the final data analysis. There were 26 respondents in the 8th grade, while two were in the 12th grade. 51 percent (n=16) of participants were male, 45 percent (n=14) were female, and 3 percent (n=1) did not report their gender. 29% (n=9) of participants were Black, 42% (n=13) were White, 19% (n=6) were Asian, and 10% (n=3) did not report their race, for a total of 29% Black and 71% non-Black.

4.2 Mental health literacy

Table 1 summarizes descriptive statistics for KAMHS-measured mental health literacy. As shown, Black participants on average demonstrated lacked higher levels of self-stigma with a mean response score of 2.524 (SD=0.868) and avoidant coping behaviors with a mean score of 2.619 (SD=0.756) in comparison to non-Black participants who on average responded with a mean score of 2.167 (SD=0.208) for self-stigma and 2.205 (SD=0.286) for avoid coping behaviors. Furthermore, Black participants demonstrated lower levels of understanding of mental health with a mean score of 2.429 (SD=0.615) and help-seeking behaviors with a mean score of 2.000 (SD=1.080) in comparison to non-Black participants who on average scored 2.846 (SD=0.161) for their understanding of mental health and 2.646 (SD=0.191) for help-seeking behaviors. There was no significant differences in KAMHS subscales and total scores between Black participants and
non-Black participants \((p > 0.05)\) using a non-parametric Mann-Whitney U Test. In spite of statistical insignificances, Cohen’s d of 0.463 for self-stigma and 0.441 for avoidant coping indicates there may be moderate to large mean differences between the groups. Figure 3 shows the box plot for this category. The boxplots (see Figure 2 & 3) provide a visual representation of some of the differences between the two groups.

Table 1. Descriptive statistics of mental health literacy measured with KAMHS

<table>
<thead>
<tr>
<th>Domains</th>
<th>Mean (SD)</th>
<th>U statistics (p value)</th>
<th>Cohen’s d</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total (n=28)</td>
<td>Black (n=9)</td>
<td>Non-Black (n=19)</td>
</tr>
<tr>
<td>Self-Stigma</td>
<td>2.244 (0.808)</td>
<td>2.524 (0.868)</td>
<td>2.167 (0.208)</td>
</tr>
<tr>
<td>Help-seeking Behaviors</td>
<td>2.364 (0.789)</td>
<td>2.000 (1.080)</td>
<td>2.646 (0.191)</td>
</tr>
<tr>
<td>Understanding of Mental Health</td>
<td>2.744 (0.580)</td>
<td>2.429 (0.615)</td>
<td>2.846 (0.161)</td>
</tr>
<tr>
<td>Avoidant Coping</td>
<td>2.345 (0.829)</td>
<td>2.619 (0.756)</td>
<td>2.205 (0.286)</td>
</tr>
<tr>
<td>Public Stigma</td>
<td>2.960 (0.544)</td>
<td>2.816 (0.191)</td>
<td>2.912 (0.171)</td>
</tr>
<tr>
<td>KAMHS total score</td>
<td>12.657 (2.394)</td>
<td>12.388 (1.062)</td>
<td>12.77 (0.777)</td>
</tr>
</tbody>
</table>

Figure 2 & 3. Visual representation of KAMHS subscales
The bivariate relationships between these subscales were also analyzed. These results were summarized in Table 2. Using Spearman’s rho correlation, understanding of mental health and help-seeking behaviors were found to have a significant positive correlation ($\rho=0.683; p<.001$) indicating the higher one's understanding of mental health, the more likely they are to seek treatment. Help-seeking behaviors and lack of avoidant coping behaviors were found to have a significant positive relationship ($\rho =0.491; p=0.008$) indicating that the more they do not avoid addressing their own mental health issues, the more likely they are to seek treatment.

Table 2. Spearman’s rho Correlations among KAMHS subscales and total score (p values)

<table>
<thead>
<tr>
<th></th>
<th>Self-stigma</th>
<th>Help-seeking behaviors</th>
<th>Understanding of mental health</th>
<th>Avoidance coping</th>
<th>Public stigma</th>
<th>KAMHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-stigma</td>
<td>1</td>
<td>0.341 (0.076)</td>
<td>0.097 (0.623)</td>
<td>0.308 (0.111)</td>
<td>0.189 (0.336)</td>
<td>0.688 (&lt;0.001)</td>
</tr>
<tr>
<td>Help-seeking behaviors</td>
<td>1</td>
<td>0.683 (&lt;.001)</td>
<td>0.491 (0.008)</td>
<td>0.288 (0.137)</td>
<td>0.808 (0.001)</td>
<td></td>
</tr>
<tr>
<td>Understanding of Mental Health</td>
<td>1</td>
<td>0.237 (0.224)</td>
<td>0.288 (0.137)</td>
<td>0.582 (0.001)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidance coping</td>
<td>1</td>
<td>0.100 (0.611)</td>
<td></td>
<td>0.705 (&lt;0.001)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public stigma</td>
<td>1</td>
<td></td>
<td>0.401 (0.305)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KAMHS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>
4.3 Treatment-seeking Behaviors

Table 3 summarizes the descriptive statistics of participant responses to treatment-seeking behaviors measured with the BASH-B. As presented, average participant responses were within the range of 2 to 4, indicating the provided factors were moderate barriers to participants seeking treatment. On average, Black participants were less embarrassed to talk to counselors (mean 2.7 vs. 3.2), more distrustful of adults (mean 3.0 vs. 2.6), more afraid of their family finding out they were in therapy (mean 4.0 vs. 3.5), and more concerned about not having time for therapy (mean 3.6 vs 3.1). On each item, there was no statistically significant difference between the two groups using a non-parametric Mann-Whitney U Test ($p$s>.05). Cohen’s d values indicate the extent of the differences between two group means. The difference in means for "I couldn't afford counseling" is considered large, with a Cohen’s d of $d =-0.853$. Time availability for treatment ($d = 0.478$), and concerns about their family finding out they were in therapy ($d=0.464$) show moderate differences between Black and non-Black youths.

Table 3. Treatment-seeking behaviors measured with the BASH-B

<table>
<thead>
<tr>
<th>Description</th>
<th>Total (N=28)</th>
<th>Black (n= 9)</th>
<th>Non-Black (n=19)</th>
<th>U statistics (p value)</th>
<th>Cohen’s d</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would solve my problems myself.</td>
<td>2.52 (1.156)</td>
<td>2.570 (0.481)</td>
<td>2.540 (0.386)</td>
<td>66 (0.808)</td>
<td>0.061</td>
</tr>
<tr>
<td>I think I should work out my own problems.</td>
<td>2.30 (0.953)</td>
<td>2.430 (0.429)</td>
<td>2.310 (0.286)</td>
<td>60 (0.607)</td>
<td>0.164</td>
</tr>
<tr>
<td>I’d be too embarrassed to talk to a counsellor.</td>
<td>2.85 (1.099)</td>
<td>2.710 (0.421)</td>
<td>3.150 (0.355)</td>
<td>76 (0.766)</td>
<td>-0.166</td>
</tr>
<tr>
<td>Adults can’t understand adolescent problems.</td>
<td>2.85 (0.989)</td>
<td>3.000 (0.436)</td>
<td>2.620 (0.290)</td>
<td>60 (0.607)</td>
<td>0.199</td>
</tr>
<tr>
<td>Even if I wanted to, I wouldn’t have time to see a counsellor.</td>
<td>3.150 (1.199)</td>
<td>3.570 (0.481)</td>
<td>3.080 (0.288)</td>
<td>52 (0.314)</td>
<td>0.478</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>----------------</td>
<td>----------------</td>
<td>----------------</td>
<td>------------</td>
<td>-------</td>
</tr>
<tr>
<td>A counsellor might make me do what I don’t want to.</td>
<td>2.560 (1.013)</td>
<td>2.290 (0.360)</td>
<td>2.850 (0.317)</td>
<td>82 (0.533)</td>
<td>-0.357</td>
</tr>
<tr>
<td>I wouldn’t want my family to know I was seeking a counsellor.</td>
<td>3.630 (1.079)</td>
<td>4.000 (0.309)</td>
<td>3.460 (0.351)</td>
<td>54 (0.370)</td>
<td>0.464</td>
</tr>
<tr>
<td>I couldn’t afford counseling.</td>
<td>3.670 (1.109)</td>
<td>3.000 (0.535)</td>
<td>3.540 (0.243)</td>
<td>97 (0.145)</td>
<td>-0.853</td>
</tr>
<tr>
<td>Nothing will change the problems I have.</td>
<td>3.330 (1.177)</td>
<td>3.430 (0.571)</td>
<td>3.380 (0.290)</td>
<td>63 (0.685)</td>
<td>0.107</td>
</tr>
<tr>
<td>If I go to counselling, I might find out I’m crazy.</td>
<td>3.700 (1.171)</td>
<td>3.860 (0.459)</td>
<td>3.620 (0.331)</td>
<td>63 (0.725)</td>
<td>0.174</td>
</tr>
<tr>
<td>If I went for help, the counsellor would not keep my secret.</td>
<td>3.330 (1.271)</td>
<td>3.000 (0.488)</td>
<td>3.380 (0.368)</td>
<td>85 (0.431)</td>
<td>-0.352</td>
</tr>
</tbody>
</table>

4.4 Facilitators and Deterrents for Seeking Treatment

Appendix A provides the open-ended responses of participants who elected to share additional information regarding factors that would increase or decrease their likelihood of seeking mental health treatment. 25 out of 28 respondents chose to answer the open-ended responses. Seven of these respondents were Black. The most reported facilitators to seeking treatment included supportive parents, receiving a reward, accessibility of treatment, and perceived need. The most frequently reported barriers were embarrassment, lack of time, and distrust in providers’ capacity to understand them or keep their information confidential.
Discussion

The study aimed to investigate mental health literacy and treatment-seeking behaviors of Black youth relative to non-Black youth and explore the facilitators and barriers of youth in utilizing mental health services. Recruiting participants for the study through schools proved to be very difficult. Several private schools as well as the local public school systems’ IRB denied my request for partnership on the grounds that they did not see the value in this research for students or did not like that students would not be paid. As a result, only students selected from private schools were eligible to participate. Previous studies that found lower levels of mental health literacy in Black youth recruited participants through public schools or community wide advertisements (Malhotra, et al., 2015, Tanielian et al., 2009). Since the study’s participants came from private school backgrounds, it was hypothesized that the difference in education would cause youth to demonstrate moderate to high levels of literacy and lower levels of stigma. That said, considering the literature, it was still theorized that Black participants would report lower levels of literacy and a higher stigma relative to their non-Black peers. Although no statistically significant differences were noted between Black and non-Black responses, differences in the mean response values between the two groups did exist, as supported by medium- to large Cohen’s $d$ effect sizes. Previous literature also found underutilization of mental health services by Black youth could primarily be attributed to limited availability and inaccessibility of mental health services, inefficient problem recognition, and stigma towards mental health services (Narendorf & Palmer, 2016; Tambling, D’Aniello, & Russell, 2021; Villatoro et al., 2017). Although this study found that Black respondents practiced lower levels of help-seeking behaviors on average, the
findings that Black youth practiced lower levels of avoidant coping behaviors and lower levels of help-seeking behaviors would be contradictory to previous research. It is possible that these findings are the result of underpowered data from the small sample size. That said, prior studies have found health literacy and the utilization of health services to be most prevalent in groups of higher social and economic status since they often have more education and access to healthcare (Compton & Shim, 2015; Malhotra et al., 2015; Tambling, D’Aniello, & Russell, 2021). Since a large effect size was noted between groups for the statement “I couldn’t afford counseling”, it is also possible that Black youth are willing to go to treatment but lack the financial means to afford it. Considering the current literature, it was also hypothesized that the primary barriers to youth receiving care are related to embarrassment or lack of access, and that facilitators would be supportive social networks and perceived need. The results found were consistent with those posited, although there was a consistently low level of perceived need amongst all races. A possible explanation for this phenomenon is that most participants reported not having any mental health concerns in the open-ended responses and thus were not in need of any mental health services. It is worth noting however that the highest mean response for Black participants was for the statement “I wouldn’t want my family to know I was seeking a counselor.” This finding, in conjunction with the open-ended responses stating that an individual’s family and friends knowing they were receiving care was a barrier to them seeking treatment, demonstrates that confidentiality is a major consideration for youth.

The main limitation of the study was the small sample size. A two-sided, independent t-test power analysis was conducted with an assumption of power of 0.9, standard deviation of 1, and significance of 0.05. Based off these assumptions, a minimum sample size of 46 was generated, with 23 participants in each group. Considering this study only had 28 participants, it
is believed the small sample size affected the lack of statistically significant differences. Likewise, since the population of this study was comprised primarily of 8th graders from private schools, the results may not be representative of all youth, especially those from low socioeconomic backgrounds who attend public schools. Likewise, since the study was only able to analyze responses from a limited number of Black youths, the data collected cannot be used to draw significant conclusions about the treatment-seeking behaviors of the Black population. Moreover, two participants who identified as Hispanic expressed displeasure with not having the option to provide their ethnicity instead of race. Future research should take into consideration the inclusiveness of demographic information. Overall, while this study does offer some trends regarding the attitudes of Black youth, further research on the relationship between race and mental health needs to be conducted on a larger scale for definitive conclusions to be made.
Conclusion

By examining the mental health literacy and treatment-seeking behaviors of youth, this study showed that youth do not have a strong stigma regarding obtaining treatment for mental health or interacting with those who are experiencing a mental health illness. Even though the study does not have enough power to test causal inferences, our data demonstrated some trends regarding differences in knowledge and behaviors between Black and non-Black youth. That said, these results can be used to help healthcare professionals engage in inclusive conversations with youth. Participants across all races demonstrated moderate levels of mental health literacy, with participants with higher levels of mental health literacy being more likely to seek treatment if needed. With embarrassment and a lack of trust in health care being the two most reported barriers to seeking treatment, it is crucial that medical professionals are proactive in educating youth that their treatment is confidential. Furthermore, traditional means of survey collection proved difficult for collecting Black youth responses in sufficient quantity. In order to fully understand the scope of mental health literacy in the Black community, future research must implement more personal and targeted forms of data collection.
Recommendations

- Future research needs to compare how views differ among youth who attend public schools versus private schools.
- Data needs to be obtained from more high school aged participants.
- Rather than open-ended text boxes, an alternative method of data collection, such as individual interviews, may be useful to collect more detailed information regarding facilitators and barriers.
- Responses from Black youth were harder to obtain than those from other racial backgrounds. Future research needs to consider settings outside of schools, such as community centers, to acquire more Black participants.
- Since ethnicity was not collected, future research could examine how responses differ between ethnicities. Likewise, race and ethnicity are not the only factors that may affect a person’s perception of mental illness. Other determinants, such as household income and environment, should also be examined.
- Increased awareness of youth confidentiality and privacy protection when utilizing mental health services needs to be done.
- Since time constraints and not wanting to leave the house were barriers to youth seeking treatment, telehealth should be offered as an option to youth.
Appendix A. Facilitators and Deterrents Open Ended Responses

If needed, what are some reasons you would not want to get counseling?

Embarrassment
   It might be embarrassing.
   Embarrassment**
   Not certain if it's needed and embarrassing
   People knowing, embarrassment, not having time, annoying

Time Related Barriers
   Time.
   People knowing, embarrassment, not having time, annoying
   Taking up free time
   Takes time**

Provider or Confidentiality Related Barriers
   The counselor may not actually change anything for me.
   Because they tell me to do things I do not want to do. No sir. But that's kind of a main point of therapy.**
   I doubt a therapist would help me
   They would tell my parents everything
   My peers knowing
   I might not want to share my issues with others.**

Other
   Being tired or just not wanting to leave the house.
   I wouldn’t want to
   I don’t need it**
   I do not need counseling.
   Overall, I'm enthusiastic
   No reward
   Not needed.
   No reasons**
   No reasons**
   No reasons
If needed, what would increase your chances of seeking therapy?

Parent Related Facilitators
   My parents**
   I am currently seeking therapy. My mom does not seem wholly supportive, though.
   Enforced therapy

Receiving a reward
   Bribery of some sort
   Reward

Perceived need for treatment.
   Nothing if i needed it**
   If I had terrible mental health and wasn’t myself I would get better by seeking therapy.
   Excessive stress I can’t deal with**

Accessibility and Quality of Care
   Having easy access to resources,**
   Easily accessible and reliable therapy.
   More therapist options to find the person right for me.**
   Having a therapist with my mental problems too

Other
   I’m all good : )
   I am in therapy already.
   Idk when I went it just didn't feel like it helped
   I do not need therapy,**
   Nothing would increase because i don't want to go to therapy.
   Nothing**
   Nothing

*Statements are direct quotes from participants
**Marked responses are from Black Participants
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