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The Effect of Racial Socialization on Urban African American Use of Child Mental Health Services

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SUMMARY

Objective—To examine how parental endorsement of racial socialization parenting practices relates to child mental health service use among an urban sample of African American families.

Methods—A cross-sectional sample of urban African American parents (n = 96) provided ratings of their beliefs concerning various dimensions of racial socialization constructs, i.e., spiritual or religious coping (SRC), extended family caring (EFC), cultural pride reinforcement (CPR), and assessed regarding their use of child mental health services.

Results—At the multivariate level, the use of child mental health services was significantly positively associated with moderate levels of endorsement of SRC and EFC. Inversely, scores in the moderate range of CPR were associated with a reduced likelihood of child mental health service use.

Conclusion—Parental endorsement of racial socialization parenting practices appear to play a salient role in child mental health service use among an urban African American families. Further research with larger and more representative samples should be pursued.

Keywords

Service use; child mental health; racial socialization; urban

The need to understand the reasons for racially disparate rates of mental health service use has been identified as a national priority (DHHS, 1999; NIMH, 2001; U.S. Public Health Service,

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2000, 2001). Major epidemiological studies have identified that as many as two-thirds to three-quarters of children in need of mental health care never have contact with a service provider, with significantly lower rates of contact among African American children (NIMH, 2001), especially those residing in low income, urban communities (Padgett, et al., 1994a, 1994b; DHHS, 1999).

Considering inner-city African American children represent an especially vulnerable group due to their increased likelihood of having unmet mental health need(s), both national reports and prior findings have emphasized a need to expand research efforts to identify help-seeking variables which may account for lower rates of service use in comparison to other racial groups (Snowden, 1999, 2001; Sue, Zane, & Young, 1994; U.S. Public Health Service, 2001). Accordingly, the purpose of the current study is to examine whether specific cultural variables, in particular racial socialization beliefs and parenting practices, enable the help-seeking process, and have an effect upon child mental health outcomes.

Racial socialization has been defined as "what Black parents communicate to Black children about what it means to be a Black American, what they may expect from Black and White persons, how to cope with it, and whether or not the disparaging messages of the broader culture are true" (Greene, 1990, p. 13). Summarized below are three types of racial socialization messages identified in the emerging body of literature examining the topic:

Spiritual or Religious Coping

Through *spiritual and religious coping* (Stevenson, 1994), African American parents teach children that a belief in God, dependence on religion, and family practice of religion through organized religious institutions are resources vital to their well-being and a source of support available throughout their lives. Messages reflect that "depending on religion and God can make a person better able to make good life decisions" and "a belief in God can help a person cope through life struggles" (Stevenson, 1994, p. 455). Through religious or spiritual coping, African American children are taught from an early age that a belief that God can protect them from the racial hatred of this world and are provided with a larger network of support (e.g., other church members) to draw upon as a resource.

Extended Family Caring

A second institution that children are made aware of as part of racial socialization parenting practices is an extended network of blood related and non-blood related kin, which has traditionally been utilized by African Americans as a means of providing various material and social support (Stevenson, 1994; Jarret, 1996). This practice, referred to as *extended family caring* (Stevenson, 1994) in the literature, encourages children to utilize this extended family as a means of making important decisions, learning valuable knowledge, gaining support, and developing a racial identity. Through extended family caring, children are not only offered support from their nuclear family, but may be provided with an entire community as a resource.

Cultural Pride Reinforcement

Through *cultural pride reinforcement*, African American parents draw children's attention to many of the cultural strengths that have historically supported African Americans in American society (Hughes, Rodriguez, Smith, Johnson, Stevenson, & Spicer, 2006; Stevenson, 1994). Through this process, the following themes are emphasized to African American children: (1) African American heritage and culture are helpful to their growth and survival in American society; (2) the importance of education in attaining societal and professional advancement for African Americans; (3) preparedness for subtle and blatant experiences and messages of racism that occur in educational and social environments; and (4) the need to advocate for themselves as a means of being successful in American society (Stevenson, 1994).

Prior research suggests that racial socialization parenting practices act as coping strategies which help African American parents operate effectively within larger social structures with varying levels of racial hostility (for review see Hughes et al., 2006). Thus, racial socialization beliefs may impact and potentially facilitate help-seeking for African Americans within mainstream systems of care, including the mental health system, because these beliefs help them surmount fear and/or experiences of racism during the child mental health help-seeking process.

In addition to examining the influence of racial socialization beliefs, the current study considers the relative importance of multiple additional factors that have been linked in prior studies with use of child mental health services. The choice of variables to be included in the current study is informed conceptually by Critical Race Theory. This theoretical framework offers guidelines for considering how racial socialization beliefs may affect urban African American use of child mental health services (Brown, 2003) and may provide critical information needed to address racial disparities in child mental health care.

Critical Race Theory is based upon the premise that race lies at the nexus of American life. The model identifies the importance of considering the relationship that exists between race, social systems, and society (Bell, 1993). Brown (2003) lists three considerations that critical race theory would make when attempting to obtain a culturally competent understanding of the role race plays in influencing mental health service use. The first distinction is the need to consider the role that social conditions play in the mental health outcome of interest. These social conditions must negatively affect persons of color more severely than Whites due to racism and increase the likelihood of a negative outcome for persons of color (Brown, 2003). Therefore, the current study includes societal conditions, specifically increased stress, which disproportionately impacts African Americans in comparison to Whites (O'Hare et al., 1991; Thernstrom & Thernstrom, 1997). The second consideration when examining mental health outcomes is conducting a culturally competent critique of the standard indicators of the subject under study. The current study makes a small but significant critique of indicators used to measure mental health service use. Briefly, several studies of service use only consider specialty mental health care or primary care service use as an indicator of having sought mental health care. However, data indicate that African Americans may be more likely to use informal sources of care, such as clergy, to treat mental health difficulties (Neighbors, 1988; Neighbors & Jackson, 1984; U.S. Public Health Service, 2001). Thus, a comprehensive inquiry into sources of care is warranted when examining mental health help-seeking for African Americans. As such, the current study goes beyond querying parents on their use of specialty mental health care or primary care as treatment, and asks parents if they sought "counseling," be it from a formal (e.g., psychiatrist, social worker, etc.) or informal source (e.g., family or friends).

Lastly, the third consideration critical race theory directs research to make is the examination of unique manifestations that are (1) related to racism and (2) affect the outcome of interest, namely, service use. Racial socialization variables qualify in both respects. First, as explained above, racial socialization is a manifestation among African Americans that has developed at least in part, to help this population face and surmount racism in the United States (Hughes et al., 2006). Second, as hypothesized in the current study, there is reason to believe that racial socialization may play a significant role in the use of mental health services for African Americans. Thus, when examining racial disparities in the use of mental health services, these considerations guided by critical race theory may facilitate a clearer view of the factors that drive service use for African Americans.

Guided by this theory, the current study examines the factors that drive service use for African American youth, along with examining treatment utilization by three types of racial

socialization beliefs: (1) spiritual or religious coping; (2) extended family caring; and (3) cultural pride reinforcement. The following hypothesis will be tested: Higher levels of parental racial socialization beliefs will be associated with a greater likelihood of child mental health service use.

METHODS

Research Design

The current study employs secondary data analysis of existing data collected through an NIMH funded research project, entitled Knowledge about the African American Research Experience (KAARE; McKay, Paikoff, Bell, & Parenoff, 1997). The primary aim of KAARE was to understand the participation of vulnerable populations in research by identifying factors that influence informed consent, initial engagement, and ongoing involvement in developmental research among urban, low-income African American adult caregivers and their children.

The sample for the KAARE study was randomly drawn from participants in a larger family based HIV and mental health prevention study program entitled Collaborative HIV Prevention and Adolescent Mental Health Project (CHAMP). The targeted sample (n = 324) for the CHAMP Family Program was a randomly selected group of African American parents and their school-age inner-city children (ages 9–11), identified through class rosters at four elementary schools at the end of the 1995/1996 school year. Each elementary school was composed of over 99% African American children. Over 90% of children within each school participated in a free lunch program, which indicates that their household family income was below the poverty line.

Of families targeted, 85% (n = 274) could be located and invited to participate. The remaining 15% of youth moved to other communities or their correct address could not be determined. Of the 274 families invited to participate in the CHAMP family program, 73% (n = 201) of youth and families participated in the CHAMP Family Program and the research associated with CHAMP. Next, a randomly selected subsample (n = 170) of the 274 families were invited to participate in an additional research interview for the KAARE project. The KAARE project purposely oversampled youth and families who declined participation in the CHAMP Family Program. This was done in order to include a group of youth and families that were particularly at risk of negative outcomes and whose responses are seldom included in research studies (Kazdin, 1993).

Analyses for the current study are based upon data gathered in both the CHAMP and KAARE projects. Specifically, mental health service use data and parent social support data were gathered through CHAMP, while all other data were gathered through the KAARE study. Only data gathered from overlapping participants between the two studies was used. Thus, data provided by 99 of the 170 respondents that participated in the KAARE were used in analyses. Of these 99 parents that participated in both CHAMP and KAARE, 3 failed to provide complete data and were excluded from current analyses. In total, data provided by 96 African American parents were used in the current study. IRB approval was obtained.

Sample

The current sample includes 96 low-income, inner-city African American children (ages 9–14; 60% female) in the 4th and 5th grades, living in a community characterized by significant psychosocial stressors, including poverty, high levels of community level violence, substance use and HIV infection. Adult caregivers provided all data employed in the current research. Ninety-three percent of adult caregivers were mothers and 7% were fathers. The mean age of adult caregivers was 33.8 years (SD = 7.4). More than half (62%) of adult caregivers became

parents in adolescence (age 18 or younger). The average adult caregiver had three to five (*SD* = .98) children living with them. Most adult caregivers were not married (77%) at the time of interview: 70% were single, never married; and 7% were separated, divorced, or widowed.

The majority of adult caregivers a high school level education (79%); 20% had some trade school or college education; and 1% had an education level below high school. More than half of adult caregivers (58%) were not working outside their home at the time of data collection. The average annual income reported by adult caregivers was between $5,000–$9,999. Sixty-six percent of the sample reported that their total income for the prior year was less than $9,999; 20% between $10,000 and $19,999; and 12% above $20,000. Seventy-four percent of all adult caregivers reported that they were receiving public assistance at the time of their interviews. Approximately 95% of families live in subsidized housing.

Procedures

Data were collected by KAARE research staff who were exclusively adults of color residing in the target community of the original study (Madison, McKay, Paikoff, & Bell, 2000; McCormick et al., 2000). Interviewers assisted adult caregivers in completing a series of standardized administered using read aloud procedures. Data collection occurred at community sites, such as schools, community centers, and public libraries. The measures were pilot-tested with community parents and their 4th and 5th grade children prior to data collection to ensure readability and cultural sensitivity.

Measures

Independent Variables

CHAMP Demographic Questionnaire: Child and family demographic characteristics are measured via the *CHAMP Demographic Questionnaire* (McKay et al., 2000), which was created for the CHAMP study. Adult caregivers were asked to provide child and family demographic information (e.g., annual family income, parent education level, parent employment status, parent marital status, child gender).

Child Behavior Checklist- CBC-L/6–18: Child mental health need is measured via the Child Behavior Checklist (CBC-L/6–18; Achenbach, 1991), which is a widely used parent and youth report form that measures problem behavior in children. Parents rate the extent to which children have displayed symptoms (e.g., destroys own property) over the past month along a 3-point Likert scale (0 = *not true*, 2 = *extremely true*). The CBCL/6–18 uses a hierarchical factor structure in which eight first-order factors load on two higher order factors (i.e., Internalizing Behavior and Externalizing Behavior). The 14-item higher order factor for Child Externalizing behavior (possible range = 0–52; alpha = .90) is used in the current study. This higher order factor contains cutoff values representing levels of clinical significance (yes/no) for child externalizing behavior, which are used in the current analyses.

Hassles & Uplifts Scale: Parent hassles and uplifts are measured via the *Hassles and Uplifts Scale* (Delongis, 1982). This instrument is a 69-item self-report measure designed to tap perceptions about daily situations that may act as stressors (a sample item is: not having enough money) or uplifts (a sample item is: feeling healthy). The instrument contains two subscales. The first subscale contains 30 items that measure the presence of hassles. Parents rate each hassle items along a four-point (0 thru 3) Likert-type scale from “not a hassle” to “extremely severe,” with higher scores indicating a greater presence of hassles. The second sub-scale contains 39 items that measure the presence of uplifts. Parents rate uplifts items along a four-point (0 thru 3) Likert scale from “not pleasant” to “extremely pleasant,” with higher scores indicating a greater presence of uplifts. For the purposes of the current study, a higher number

of stressors are seen as inducing parental stress, while a greater number of uplifts buffer parents from stress.

Social Support Network Inventory: Parent Social Support is measured via the *Social Support Network Inventory* (Flaherty, Gaviria, & Plathanak, 1983). This instrument is a 6-item scale measuring sources of practical and emotional support or parenting. Adult caregivers are asked to identify one supportive person and score their willingness to listen, provide advice, and assist in parenting tasks (e.g., This person is available when I need him or her). Items are measure along a five point Likert scale (1 = never, 5 = always) with higher scores indicating a greater amount of support. The scale has a reliable amount of internal consistency (alpha = .83).

Scale of Racial Socialization for African American Adolescents: Racial Socialization is measured via the *Scale of Racial Socialization for African American Adolescents* (SORS-A; Stevenson, 1994), which is a 45-item instrument completed by caregivers that assesses race-related beliefs and messages of child rearing in multiple dimensions of racial socialization in the African American culture. The scale contains four subscales: cultural pride reinforcement (range = 7–28, alpha = .71), racism awareness teaching (range = 6–24, alpha = .59), extended family caring (range = 9–36, alpha = .70), and spirituality and religious coping (range = 7–28, alpha = .71). Each item is scored along a 4-point Likert scale (1 = Strongly agree, 4 = Strongly disagree).

Dependent Variable

Child Mental Health Service Use: The CHAMP Service Use Questionnaire (McKay et al., 2000) was created to capture help seeking within the CHAMP Family Program study, a NIMH-funded, family-based HIV prevention and mental health promotion study involving hundreds of inner-city youth and their families. Parents were asked a number of questions concerning: (1) their past use of mental health services (i.e., Did you ever take your child for counseling—Yes/No); and (2) If yes, where did you take your child for counseling?

Data Analysis

There are three steps involved in the data analysis plan, which were conducted using the statistical software SPSS version 13.0 (2004). First, an initial series of chi-square and *t*-test analyses was conducted to determine if parent use of adult and/or child mental health services differ by demographic characteristics. Second, a second series of bivariate statistical tests was conducted to determine which independent variables are significantly related to the outcome variables. Third, binary logistic regression models were used for hypothesis testing. Checks for multicolinearity revealed this would not be a problem (Manard, 1995).

Each racial socialization variable (*Spirituality or religious coping, Extended family caring, Cultural pride reinforcement*, and *Racism awareness teaching*) was trichotomized into the lower, middle, and upper thirds of scores in order to create three equal sized groups based on parent responses. This method was used by Frabutt, Walker, and MacKinnon-Lewis (2002) toward examining how maternal-child interactions differ by various levels of parental racial socialization belief. Frabutt et al. (2002) found the middle range of parent racial socialization scores were most influential in contributing to outcomes. While the majority of research on parental racial socialization beliefs examines linear relationships between this construct and outcomes, Frabutt et al. (2002) identified more moderate levels of racial socialization belief may have the most influence on outcomes. Therefore, current analyses will examine how parent use of mental health services differs by lower, middle, and upper levels of racial socialization belief.

RESULTS

Description of Independent and Dependent Variables

Of the 96 urban African American parents in the current study, 14% ($n = 13$) of parents reported using child mental health services. Additionally, a large proportion of children (39%, $n = 37$) met criteria for a clinically significant degree of externalizing behavior. The average parent described experiencing a relatively low number of hassles (possible range = 0–90; Mean = 22.7, SD = 13.6) and a fair amount of uplifts (possible range = 0–117; Mean = 74.3, SD = 22.7). Additionally, parents described low mean ratings on the scale measuring social support (possible range = 6–30; Mean = 9.4, SD = 4.0). Lastly, mean parent values parents reported strong endorsement of racial socialization parenting practices for spiritual and religious coping (possible range = 7–28; Mean = 21.1, SD = 4.8), extended family caring (possible range =11–44; Mean = 36.0, SD = 4.5), and cultural pride reinforcement (possible range = 11–44; Mean = 29.3, SD = 5.1).

Bivariate Analysis

Bivariate analysis revealed that child mental health service use was not significantly related to the presence of parent uplifts. However, analysis revealed that the presence of a greater amount of parent hassles was significantly related to a greater likelihood of child mental health services use, $t\ (94) = 2.22$, $p < .05$. Likewise, use of child mental health services was associated with a child having a clinically significant score on the CBCL externalizing behavior scale, but at a probability level that approached clinical significance, $\chi^2\ (1, n = 96) = 3.36$, $p < .067$.

Furthermore, analysis revealed that African American child mental health service use was related to parental endorsement of racial socialization parenting practices at a statistically significant level. More specifically, child mental health service use was significantly related to parental endorsement of spiritual and religious coping, $\chi^2\ (2, n = 96) = 5.99$, $p < .05$. Mean scores in the moderate range of values on the spiritual and religious coping subscale were most likely to have used child mental health services. In terms of actual numbers, 24% ($n = 9$) of parents in the middle range of values on the spiritual or religious coping subscale used adult mental health services, in comparison to 7% ($n = 2$) in the low value and 7% ($n = 2$) in the high value range. However, bivariate analyses revealed that levels of parental belief in extended family caring and cultural pride reinforcement were not related to use of child mental health services at a statistically significant level.

Multivariate Analysis

In spite of the fact that at the bivariate level several racial socialization variables were not significantly statistically related to child mental health service, once placed in the full model multivariate analyses revealed all three racial socialization variables explained a significant amount of variance concerning parent use of child mental health services.

Specifically, the full model examining child mental health service use by levels of parental endorsement of spiritual and religious coping racial socialization parenting practices was statistically significant (Model = $X^2 = 16.64$, $df = 8$, $p < .05$). Within the full model, of the variables identified as predictors of mental health service in prior research, only the presence of a greater amount of parent hassles was significantly related to parent use of child mental health services [ß = .06; $X^2(8, N = 96) = 5.37$, $p < .05$]. Multivariate analysis also revealed that child mental health service use was related to levels of parental endorsement of spiritual and religious coping racial socialization parenting practices. More specifically, in comparison to the third of parents that scored lowest on the spiritual or religious coping subscale, the third of parents that scored in the moderate group were almost eight times (OR = 7.79; CI = 1.16–

52.24) more likely to have taken their child to mental health services [ß = 2.05; $X^2(1, N = 96) = 4.47, p < .05$].

Further, the full model examining child mental health service use by levels of parental endorsement of extended family caring racial socialization parenting practices was statistically significant (Model = $X^2 = 15.88$, $df = 8$, $p < .05$). Within the full model, of the variables identified as predictors of mental health service in prior research, only the presence of a greater amount of parent hassles was significantly related to the use of child mental health services [ß = .06; $X^2(8, N = 96) = 4.93, p < .05$]. Multivariate analysis also revealed that use of mental health services for their children was related to levels of parental endorsement of extended family caring. More specifically, in comparison to the third of parents that scored lowest on the extended family caring subscale, the third of parents that scored in the moderate group were over ten times (OR = 10.41; CI = 1.17–92.33) more likely to have taken their child to mental health services [ß = 2.34; $X^2(1, N = 96) = 4.43, p < .05$].

Finally, the full model examining child mental health service use by levels of parental endorsement of cultural pride reinforcement racial socialization parenting practices was statistically significant (Model = $X^2 = 19.60$, $df = 8$, $p < .01$). Within the full model, of the variables identified as predictors of mental health service in prior research, only the presence of a greater amount of parent hassles was significantly related to parent use of child mental health services [ß = .06; $X^2(8, N = 96) = 4.93, p < .05$]. Multivariate analysis also revealed that the use of child mental health services was also related to levels of parental endorsement of cultural pride reinforcement. More specifically, in comparison to the third of parents that scored lowest on the cultural pride reinforcement, the third of parents that scored in the moderate group were almost seventeen times (OR = .06; conversion = 1/.06 = OR = 16.67; CI = .01–.87) less likely to have used child to mental health services [ß = -2.75; $X^2(1, N = 96) = 4.26, p < .05$].

DISCUSSION

The findings that emerged from the two of the three measures of racial socialization demonstrated a fairly consistent effect on child mental heath service use. That is, children of parents in the moderate spiritual or religious coping and extended family caring racial socialization groups were most likely to have used child mental health services. Inversely, children of parents in the moderate cultural pride reinforcement racial socialization group were least likely to have used child mental health services. Thus, the study hypotheses (i.e., a greater likelihood of child mental health service use among parents with the highest level of endorsement of racial socialization parenting practices) were not supported by these data.

These findings suggest that the relationship between parental belief in racial socialization messages and child mental health service use is not linear. The presence of a low or high belief in racial socialization messages did not evidence a strong influence on child mental health service use. These findings are similar to those of Frabutt et al. (2002) who found that parents who expressed more moderate levels of racial socialization messages were most likely to evidence the highest levels of parent-child communication, child monitoring, child involvement, and lowest levels of negativity. Although this is the sole pre-existing study that examines the effect of parent racial socialization messages at low, moderate, and high levels, it is interesting that the findings indicate the same type of curvilinear relationship between parental endorsement of racial socialization parenting practices and outcomes.

The specific findings of Frabutt et al. (2002) also have implications in the current study, particularly in reference to the parents in the moderate spiritual or religious coping and extended family caring racial socialization groups who were most likely to have used child mental health

services. More specifically, the authors linked moderate levels of parental belief in racial socialization to stronger family processes. In turn, parents in the current sample that evidenced moderate belief in spiritual or religious coping and extended family caring racial socialization may have had stronger family processes that may have contributed to their success in identifying and using mental health services for their children. It is possible that parents with better parent-child communication, child monitoring, and child involvement, may have felt more confident about the needs of their child and were therefore more steadfast about bringing them to services. Simultaneously, research has indicated that parents often have difficulty using child mental health services because their child is resistant to attending sessions (Coatsworth, Santisteban, McBride, & Szapocznik, 2001; Santisteban et al., 1996). It is possible that an enhanced parent-child relationship, associated with more moderate parent racial socialization, contributed to the parents' ability to motivate or convince a potentially resistant child to attend services.

It is important to note that the enhanced family processes Frabutt et al. (2002) examined have been identified as factors that are protective of child mental health (Barnes & Farrel, 1992; Hanlon, Bateman, Simon, O'Grady, & Carswell, 2004). Therefore, it seems counterintuitive that children of parents with moderate levels of spiritual or religious coping and extended family caring racial socialization continue to have a need for mental health services and may make it unclear why these children were more likely to be brought to care. However, as previously noted, the children in this sample live in a community characterized by significant psychosocial stressors (e.g., poverty, high levels of community violence, inadequate child serving resources, under supported schools, substance abuse and multiple health epidemics), which have been linked to considerable child mental health difficulty among inner-city youth (Cohen, 2002; Tolan & Henry, 1996; Tolan, Guerra, & Kendall, 1995). Thus, in spite of potential protective factors such as racial socialization, children in this and similar communities are likely to need mental health care because of significant and chronic community-level stressors.

Besides noting the reasons that youth with moderate endorsement of spiritual or religious coping and extended family caring racial socialization parenting practices were more likely to attend mental health services, it is essential to note why children whose parents were in the low and high categories were less likely to use services, as it is probable that these two groups were less likely to use services for different reasons. First, it is possible that the original hypothesized relationship for the current study holds some merit. It is plausible a somewhat higher or moderate level of parental endorsement of racial socialization parenting practices may facilitate successful mental health service use. Therefore, parents with the lowest level of belief in racial socialization (i.e., spiritual and religious coping and extended family caring) may be less likely to bring their children to services in comparison to parents who report moderate levels of belief in these variables. However, more extreme views about using these same (i.e., religion or extended family) institutions may be detrimental to mental health service use. For example, a strong focus on spiritual or religious coping and extended family caring may influence one to utilize these institutions to treat child mental health difficulties, in place of professional services. Subsequently, it is possible that parents with moderate belief in spiritual or religious coping and extended family caring may have achieved a balance of reliance on these institutions for support and a willingness to use other sources of care (i.e., professional mental health care) when appropriate.

The finding that moderate belief in cultural pride reinforcement was associated with a reduced likelihood of child mental health service use is curious. It is possible that a somewhat higher or moderate amount of cultural pride reinforcement may be associated with a reluctance to use formal mental health care. This may explain why parents with moderate belief in cultural pride reinforcement are less likely to initiate care for their children, in comparison to those with low

belief. The reluctance of parents with moderate levels of belief in cultural pride reinforcement to become involved in mainstream services may reflect a perception on behalf of parents that services are not culturally sensitive and/or are provided by a racially hostile service system and should therefore be avoided. However, it is possible that parents with high belief in cultural pride reinforcement may be more aggressive than parents with lower and moderate levels in seeking mental health care for their children, in spite of concerns that services may be not culturally sensitive or that they may encounter racial hostility. Thus, parents with high cultural pride reinforcement may foster the same concerns about child mental health care as parents with moderate levels, but also may have a stronger conviction that African Americans must be more aggressive in seeking care in order to prosper in American society.

When examining why moderate levels of cultural pride reinforcement were associated with not bringing children to services, it is crucial to bear in mind the limitations of the current study. More specifically, the only indicator of child mental health measured in the current study was child externalizing behavior, via a parent checklist. Thus, there are several other dimensions of child mental health and clinical diagnoses that were not measured. Since cultural pride type variables have been linked to better child mental health in past research (Bowman & Howard, 1985; Caldwell, Zimmerman, Bernat, Sellers, & Notaro, 2002; Caughy, O'Campo, Randolph, & Nickerson, 2002; McAdoo, 1985; Sanders-Thompson, 1994), it is possible that parents with moderate levels of belief in cultural pride reinforcement did not bring children to services because these children had better mental health in dimensions that were not measured in the current study. This possibility is consistent with Frabutt et al.'s (2002) findings linking moderate levels of parent belief in racial socialization to preferred family outcomes. In other words, too little or too extreme a belief in cultural pride reinforcement may have been deleterious, whereas moderate levels may have optimally benefited child mental health and decreased the need for services.

Lastly, analyses of the broader array of factors identified in prior studies as salient influences on child mental health service use produced findings counter to the effects noted in literature review. It is likely that each of these findings were related to low levels of statistical power due to a relatively small sample size. However, several other factors were likely to have contributed to these findings. For example, child mental health need was not significantly related the mental health service use. This finding may not reflect a lack of parental concern over child mental health, but a concern that services may not be culturally sensitive and/or will not benefit the African American child or adolescent with mental health need, as these concerns are common within this community (Isaacs & Hernandez, 1998).

Although the literature had identified that the presence of chronic hassles in everyday life may act as a barrier to service, current analyses identified these factors were actually positively associated with mental health service use. A possible explanation for this finding is that from another perspective, the presence of hassles may not represent time consuming concerns that may service use less likely, but greater mental health need that may promote service use. For example, Carney & Wade (2002) found among a sample of single and married mothers, single mothers were more likely to use mental health services, perhaps due to the presence of a greater number of stressors that may represent mental health need. These findings remained constant even after controlling for diagnoses such as maternal depression need and socio demographic factors. Thus, it seemed that a higher rate of chronic stressors which single mothers are often prone to experience, contributed to a greater rate of mental health service utilization.

Study Limitations

The current study has several limitations. First, the current sample represents a small, homogeneous portion of the population, i.e., low-income urban families of African American descent. Consequently, the generalizability of the current study is limited by the relatively

homogenous nature of the sample. Future research should consider the inclusion of rural and suburban African American families of varying levels of SES to obtain a clearer picture of how parental belief in racial socialization affects the use of mental health services among this population.

In addition, parents were only asked about attending counseling as a measure of mental health services. Accordingly, parents may have utilized another type of service as mental health treatment (e.g., medication services). Thus, the definition of mental health service use should be expanded in future studies. Also, besides initial use of mental health services, service use should also be measured as frequency and duration of time in services to provide a fuller description of mental health service use. And, the current study is limited by reliance on a single source of data, the adult caregivers. Future studies could be enhanced through the inclusion of a variety of sources, including teachers (for child data) and clinicians.

Lastly, the study of racial socialization itself is limited by a dearth of research and the absence of theory to explain the effects of this construct. The single publication in the literature that reviews the work done concerning racial socialization (Hughes et al., 2006), clearly identifies that “the literature on racial socialization is still under-developed, and is marked by gaps and uncertainties.” Furthermore, the article mentions that theoretical perspectives of how racial socialization operates in the lives of African Americans have also not been discussed. In short, the article concludes that racial socialization is of great importance in the lives of African Americans, yet, there is currently a very limited amount of research informing the filed of mental health services how this construct functions in daily life and relates to important outcomes. Thus, the current study was limited in its approach to examining racial socialization, as it was not informed by extensive research or theoretical perspectives that specifically address the role of racial socialization in the lives of African Americans.

Future Research

The findings of the current study, while bearing in mind the limitations presented by the small sample size, suggest that parental belief in racial socialization parenting practices plays an important role in child mental health service use for urban African American families. This is an important finding, especially in light of the fact that research has indicated that unidentified variables exist that impact child mental health service use for African Americans (U.S. Public Health Service, 2001). However, the major implication of this study is that future research needs to be conducted that examines how parental belief in racial socialization influences mental health service use for urban African American families using stronger study designs. More specifically, the findings in the current study should attempt to be replicated using a larger and more representative sample of African Americans, using more precise measurement of other study variables (e.g., child mental health), and more rigorous study methods.

Furthermore, the current study indicates that various racial socialization variables may have different effects on mental health service use. More specifically, middle levels of endorsement of spiritual or religious coping and extended family caring were associated with a greater likelihood of child mental health service use. Inversely, scores in the middle range of cultural pride reinforcement were associated with a reduced likelihood of child mental health service use. Thus, these results indicate that racial socialization is not a uni-dimensional construct that may bolster an African American parent’s ability to seek mental health services as the current study initially proposed. Instead, data indicate that parental endorsement of different aspects of the racial socialization process may have positive, negative, and no effects on African American parental mental health help-seeking for their child. Subsequently, as future research on racial socialization is conducted, careful attention should be paid to the unique effects of different elements of the racial socialization process on the use of mental health services.

Future research should also consider a qualitative component that would help reduce speculation on quantitative findings regarding endorsement of racial socialization beliefs and mental health service use. In terms of both adult and child mental health service use, study participants should be asked about factors that impact service use across populations, such as fear of mental service use stigma and belief in efficacy of services, in order to control for more general factors impacting service use. Subsequently, African American participants should be asked about how they feel their views on racial socialization impact mental health service use. Including how it may differentially impact their use of adult and child mental health services. Considering the differential impact of various aspects of racial socialization, it may be advantageous to apply these questions to each aspect of the racial socialization process individually (spiritual or religious coping, extended family caring, cultural pride reinforcement, racial awareness teaching). Questions should be geared also to examine impressions participants have regarding the mental health system (e.g., views of racism) and how specific aspects of racial socialization may be provide a sense of empowerment to face these elements. Lastly, open-ended questions should also address if participants feel the use of alternative (e.g., church services) forms of mental health care are more or less appropriate according to their racial socialization beliefs.

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