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Racial/ethnic Differences in Parent-reported Barriers to Accessing Children's Health Services

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Abstract

The goals of this study were to identify whether barriers that parents perceived to using health care differed by service type (medical vs. mental health care) and whether there were racial/ethnic differences in barriers. Participants were a community sample 275 parents (34.2% African American, 36.7% Caucasian, and 29.1% Hispanic) of children ages 9 – 13 years old who rated the extent to which potential barriers in three broad domains (stigma-related, logistical, and socioeconomic) would prevent or delay them from obtaining services. They also rated internalizing and externalizing problems exhibited by their child. Overall, parents reported greater socioeconomic and stigma-related barriers to obtaining mental health services than medical services. Hispanic parents reported socioeconomic and stigma-related barriers as more inhibiting than did African American parents. Findings highlight the importance of strengthening relationships between mental health care providers and the community to reduce stigma associated with seeking mental health treatment for children and better educating parents about the potential benefits of treatment. Policy focused on educating parents about their insurance options and improving insurance coverage may help to reduce socioeconomic barriers.

Keywords

children; racial/ethnic differences; health disparities; mental health services

Previous research has established that racial/ethnic minorities in the United States use outpatient mental health and general medical health services less frequently than their Caucasian counterparts (e.g., Flores & The Committee on Pediatric Research, 2010; Garland, Landsverk, & Lau, 2003; Gary, 2005; Howell & McFeeters, 2008; Lau, Lin, & Flores, 2012), suggesting that there may be many members of racial/ethnic minority groups who could benefit from health services are not receiving them. Unlike most adults, children in need of mental health care are dependent on the adults in their lives to seek and obtain care and are less skilled than adults at communicating their needs. Thus, parents attitudes towards seeking mental health care may be important determinants of whether children obtain the mental health care they may require (e.g., Corrigan, 2004). As a result, racial/

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ethnic differences in parents' attitudes towards mental health care may contribute to disparities in children's utilization of mental health services. Studying parents' attitudes towards mental health care, whether they vary by racial/ethnic status, and how they differ from attitudes about general medical care could thus be important in understanding the racial/ethnic disparities in utilization of child mental health services that have been documented (Busch & Horwitz, 2004; Howell & McFeeters, 2008; Kodjo & Auinger, 2004; Zahner & Daskalakis, 1997; Zimmerman, 2008). Further examination of parental attitudes and perceived barriers to accessing mental health services can inform targeted interventions and policy to improve access to care.

Previous Research

Research examining disparities in health and health services utilization more generally have been conducted for several decades (Anderson, 2008). This research has generally found less service use and poorer health outcomes among lower SES and ethnic minority persons (e.g., Alegria, Pescosolido, Williams, & Canino, 2011; Benz, Espinosa, Welsh, & Fontes, 2011; Centers for Disease Control and Prevention, 2013; Dressler, Oths, & Gravlee, 2005; Flores & The Committee on Pediatric Research, 2010; Trivedi, Zaslavsky, Schneider, & Ayania, 2005). While research on disparities in access to medical care may help guide research focused on mental health care, factors related to disparities in access to mental health care specifically are likely to differ in several important ways. Stigma may be a less influential on access to medical care for children than for mental health care (Martin, Pescosolido, Olafsdottir, & McLeod, 2007). Parents may be less likely to feel that parenting strategies contributed to a child's physical problem than an emotional or behavioral problem and, therefore, be more willing to seek care for a physical illness (Mukolo, Heflinger, & Wallston, 2010). Health insurance coverage may be different for general visits to a physician than for mental health services. Because different factors may contribute to disparities within each domain of care, it is important to study whether racial/ethnic disparities in access to children's care differ for medical problems versus mental illness; differences in barriers across domains could highlight a need for differing targets for health policy.

Barriers to Accessing Mental Health Services

Sociodemographic factors—The few studies that have focused on identifying barriers to accessing child mental health services have found that sociodemographic factors including minority race/ethnicity, lower socioeconomic status (SES), and no insurance or private insurance are associated with decreased likelihood of initiating or continuing treatment (e.g., Alexandre, Martins, & Richard, 2009; Fernandez & Eyberg, 2009; Kazdin, Holland, & Crowley, 1997; Pelkonen, Marttunen, Laippala, & Lonnqvist, 2000). African Americans report more barriers (including, cost, not having enough choices in types of services offered, and having to travel too far) to obtaining mental health services for themselves and their children than do Caucasian parents (Thurston & Phares, 2008). And, the more barriers parents reported, the less likely they were to report that they would to use child mental health services in the future (Thurston & Phares, 2008). Logistical problems, such as the geographic availability of mental health services, are also important predictors of access to services for children. For instance, the distance between a family's home and the nearest mental health care facility may be a significant barrier to obtaining proper care, especially for racial minorities (Ronzio, Guagliardo, & Persaud, 2006).

Stigma—Research examining stigma (feelings of alienation or shame) related to child mental health is receiving increasing attention (Pescosolido, 2007). Most research on stigma and mental health focuses on adults and has generally shown that stigma is inversely related to mental health service utilization (e.g., Vogel, Wade, & Hackler, 2007); few studies link stigma to child mental health services use (Helfinger & Hinshaw, 2010). Many ethnic minority parents whose children were recently diagnosed with a mental illness may experience stigma related to the diagnosis and mental health service use and many report initial hesitance to identify children's behavior as problematic which contributes to delayed treatment seeking (dosReis, Barksdale, Sherman, Maloney, & Charach, 2010; dosReis, Mychailyszyn, Myers, & Riley, 2007). Minority adolescents also report more barriers to obtaining care (e.g., not wanting their parents to know, being afraid of what the doctor would say) than do white adolescents (Kodjo & Auinger, 2004).

In a study on public response to mental illness, Pescosolido et al. (2010) sought to determine whether stigma had improved in a decade after policy (US Department of Health and Human Services, 2003) and commercial attempts to reduce it. Researchers found that the public was not less likely to endorse stigma in 2006 compared to 1996 (Pescosolido, Martin, Long, Medina, Phelan, & Link, 2010), suggesting that public stigma continues to be a problem and potential barrier to using mental health services. Pescosolido and colleagues (2007a & 2007b) examined adults' perceptions of stigma surrounding mental health care for children. Most participants agreed that receiving mental health treatment would make a child an outsider at school, cause a child to suffer as an adult, and that people in the community would know that the child was being treated despite confidentiality. Racial/ethnic differences in concerns about stigma were nonsignificant in these studies (Pescosolido et al., 2007a and 2007b). However, participants in these studies were not necessarily parents and were not specifically asked about stigma associated with obtaining mental health services for their own child.

Research specifically assessing parents' attitudes about child mental health services shows that many parents endorse negative perceptions of mental health services held by family and friends as a barrier to obtaining mental health care for their children (Novilitis, Scime, & Lee, 2002; Owens et al., 2002). Turner (2010) found that African American parents tended to report less positive attitudes about mental health services and more stigma compared to Hispanic and Caucasian parents; stigma was negatively associated with help-seeking for Hispanic parents.

The Present Study

Several barriers have been linked to service use for children and adolescents (e.g., Kazdin et al., 1997). As noted above, SES (insurance-related or other financial issues) and logistical/institutional barriers have been shown to be important predictors of whether children receive needed care. Past research suggests that stigma may also be a barrier to obtaining mental health care for children and that it may predict mental health services utilization; however, more research is needed to clarify how parents' perception of stigma as a barrier relates to service utilization. Whether stigma varies by race/ethnicity and other demographic variables is also unclear. Additonally, few studies have examined whether these barriers differ by service type. Research aimed at improving understanding of these differences would not only help to inform health policy related to reducing barriers specific to each treatment type and could provide support to ongoing initiatives to improve access to health and mental health care (one of the goals of the Patient Protection and Affordable Care Act of 2010 [ACA]). Attitudes about general health care, as a more commonly used accessible service, will also serve as a helpful comparitor to parents' attitudes about mental health services.

The current study sought to provide a better understanding of the barriers that affect access to mental health care services for children, how they differ from those of general health care services, and how these barriers might vary by race/ethnicity. We predicted that parents would report fewer barriers (particularly stigma-related barriers) to accessing medical care than mental health services for their children, consistent with previous research. We also expected that racial/ethnic minority parents would report more barriers overall to accessing medical and mental health care.

Methods

Participants

Data for this study were collected as part of a longitudinal study examining how different parenting styles affect child adjustment. To recruit participants in the first year of this larger study, 3rd and 4th graders attending 15 public schools and two private schools in central North Carolina were given a letter for their parents describing the study (in English and Spanish) and asking parents to return the letter with their contact information if they were interested in learning more about it. Because teachers were directly responsible for distributing the letters it is impossible to know the exact number of families who received them. However, approximately 2,290 families should have received letters in the first year. In the third year (the year during which the current data were collected), the 311 families who had previously participated were contacted by research staff to inquire about participation in the current wave of data collection.

A total of 275 families agreed to participate in the current wave; demographic information is presented in Table 1. Thirty-four percent of parents self-identified as African-American, 36.7% Caucasian, and 29.1% Hispanic. Of the Hispanic parents, 58.75% reported their country of origin as Mexico, 12.5% Honduras, 10% El Salvador, and the remaining 18.75% as various other countries. Hispanic parents reported having lived in the United States an average of 12.29 years (SD= 6.06; *mode*= 12). Caucasian parents were on average older and had more years of education than African American and Hispanic parents ($p < .05$). There were also relatively small but significant differences in child grade, with Caucasian children on average being in a higher grade than Hispanic children. Household income differed by race/ethnicity with Caucasian families reporting higher incomes ($p < .001$; see Figure 1). In this community sample, mean levels of internalizing and externalizing problems were fairly low (raw score M= 7.13 and 8.06, SD= 6.28 and 8.06, respectively). Externalizing problems (as measured by the Child Behavior Checklist [CBCL], described below) did not significantly differ across racial/ethnic groups, though African American parents reported fewer child internalizing problems ($M = 4.92$) than did Hispanic ($M = 8.37$) or Caucasian ($M = 8.23$) parents, $p = .001$.

One parent from each family completed a survey about barriers to accessing children's health and mental health services, the CBCL, and a demographics form. As compensation for participating, each parent received $30. The larger study encompassing the current study was funded by the Eunice Kennedy Shriver National Institute of Child Health and Human Development grant R01-HD054805. The study procedure and materials were approved by the local Institutional Review Board (IRB).

Procedure

Families who participated in the longitudinal study in the first and/or second year were contacted to arrange a time and place of their choosing to complete questionnaires. Questionnaires were administered by a group of trained research assistants who were supervised regularly by study principal investigators and project managers to insure consistency in administration. Training involved reviewing study measures with project managers and practicing administration of the questionnaires; all research assistants were college-educated. Depending on parents' preferences, research assistants either read the questionnaires aloud or were available for questions while parents completed forms in writing. Bilingual staff administered the questionnaires Hispanic families, who were given the option of completing the forms in Spanish or English (91% of Hispanic parents reported Spanish as their primary language; language was not related to study outcomes).

Materials

As part of the larger study, each parent completed several measures; however, only those relevant to the current study are discussed here. Parents first provided demographic information including, race/ethnicity and country of origin, age of parents and child, household income, and parents' years of education.

Access to Health Care[1]—The measure used in this study was partly based on the National Center for Health Statistics 2005 version of the National Health Interview Survey (NHIS). It primarily focused on parents' attitudes about and perceived barriers to obtaining health services for their children – both non-psychiatric medical services and mental health services. In introducing the measure, parents were informed that there are many reasons people may delay getting care they need and then asked how likely they would be to delay obtaining care medical and mental health care for their child for each of several reasons.

The measure asks about barriers in three broad domains: logistical/institutional, socioeconomic, and stigma-related barriers. Parents were asked to rate the likelihood of each presented item being a barrier to obtaining care for their children on a 5 point Likert scale where 1 is 'Not at All', 3 is 'Somewhat', and 5 is 'Very Much'. Five items assessed the

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[1] This measure is partly based on the National Center for Health Statistics 2005 version of the National Health Interview Survey (NHIS), though has been greatly modified to answer the questions of the current research study. To review the original NHIS questionnaire, please go to: http://ftp.cdc.gov/pub/Health_Statistics/NCHS/Survey_Questionnaires/NHIS/2005/English/QCHILD.pdf

logistical/institutional barriers (e.g., ‘*not being able to get through on the telephone*’, ‘*not being able to get an appointment soon enough*’). Five items inquired about socioeconomic factors (e.g., ‘*not having transportation*’, ‘*not being able to afford the services*’). There were also five items in the stigma domain (e.g., ‘*worrying about friends and family finding out*’, ‘*worrying about the child’s teacher or school finding out*’). One item asked parents how likely they would be to delay care because their child refused to go to the doctor’s office/ clinic.

Child Behavior Checklist (CBCL)—Parents also completed the CBCL, a psychometrically sound measure (Achenbach & Rescorla, 2001) that assesses internalizing and externalizing symptoms. This measure lists various symptoms of child psychopathology and asks parents to rate the extent to which their child displays these symptoms on a 3-point Likert scale. Raw scores were summed to create scales for internalizing problems and externalizing problems, to be used to control for the effects of symptom severity.

Data Analytic Plan

Hypotheses that parents would report more barriers to accessing mental health services than medical services and to explore whether barriers varies by race/ethnicity were tested with a mixed model multiple analysis of covariance (MANCOVA). Race/ethnicity and treatment type were independent variables; covariates included parent education, household income, and child internalizing and externalizing problems; the dependent variables were parents’ ratings of the 16 barriers. Analyses included planned paired comparisons of racial/ethnic groups and of treatment types. While only significant results are described in the text, all paired comparisons are presented in Table 2. Analyses were completed using SPSS version 20.

Results

The results of the mixed model MANCOVA examining differences in perceived barriers to obtaining health services yielded a significant multivariate effect of race/ethnicity, Wilk’s lambda = .79, F (32, 418) = 1.62, $p = .019$, partial $\eta^2 = .11$, and service type, Wilk’s lambda = .89, F (16, 209) = 1.74, $p = .031$, partial $\eta^2 = .12$; the nature of these effects will be described in the following section. The multivariate race/ethnicity X service type interaction, as well as the effects of household income, parent education, and child internalizing and externalizing problems were nonsignificant ($ps > .05$).

Univariate analysis indicated significant effects of race/ethnicity and treatment type in predicting several barriers. The details of these effects as well as results of planned comparisons can be found in Table 2. There were significant ($p < .05$) race/ethnicity effects for barriers in the logistical/socioeconomic domain including: *child had to wait too long to see the doctor, couldn’t afford it, child’s health insurance limits access to mental health and counseling services, and the clinic/doctor’s office was too far away*. Hispanic parents consistently rated these barriers as more inhibiting than did African American parents ($p < .05$). Hispanic parents rated the child having to wait too long as more inhibiting than Caucasian parents as well ($p < .05$). Caucasian parents rated the children refusing to go as a greater barrier than did African American parents ($p < .05$).

There were also significant race/ethnicity effects for stigma-related barriers including: *worried about child's teacher and/or school finding out, concerned that it would reflect poorly on parent, worried that child would be teased or made fun of by peers, and worried that the parent would feel too embarrassed*. Hispanic parents rated each of these barriers as more likely to prevent or delay them from obtaining services (mental health or medical) for their child than did African American, and rated worries that the child would be teased as well as worries that the parent would feel too embarrassed as more inhibiting than Caucasian parents ($p < .05$).

Parents rated several stigma-related worries as greater barriers to obtaining mental health care than medical care. These included: *concern that it would reflect poorly on parent, worries that child would be teased or made fun of by peers, worries that the parent would feel too embarrassed to discuss any concerns,* and *worries about friends and family finding out* ($ps < .05$). The results also indicated that parents rated affordability, lack of transportation, and the distance to the clinic/doctor's office as more inhibiting for mental health care than medical care.

Discussion

Previous research has demonstrated that minority parents report more barriers to accessing mental health care for their children than do Caucasian parents (e.g., Thurston & Phares, 2008). However, few barriers were identified in past research and little was known about how barriers to obtaining mental health care might be different or similar to those to medical care. This study was intended to clarify and expand upon previous research on barriers to obtaining child mental health services, with the ultimate goal of identifying areas to target with intervention and policy. As past research in health disparities has primarily focused on medical health, it seemed important to assess whether parents' report of barriers differed for medical care and mental health care. We predicted that parents would report fewer barriers to accessing medical care than mental health services for their children as medical care may be more readily available and more commonly used. Whether this difference varies by race had not been previously explored, though we expected that minority parents would endorse more barriers overall across service type. The results provide good support for our hypotheses.

There were significant effects of both race/ethnicity and treatment type on the barriers parents reported to obtaining care for their child. In relation to race/ethnicity, Hispanic parents consistently rated barriers as more inhibiting than other parents. Specifically, Hispanic parents rated the distance to the doctor's office or clinic and their health insurance limitations as more likely to prevent or delay them from obtaining services for their children compared to African American parents. Hispanic parents were also more likely to endorse having to wait too long and several stigma-related concerns as more inhibiting than African American parents and Caucasian parents across treatment type. This is inconsistent with previous research (Turner, 2010), which indicated that African American parents reported less positive attitudes than both Hispanic and Caucasian parents. This may be due to differences in study methodology. For instance, Turner (2010) asked parents about stigma while the current study asked about barriers several domains. Hispanic parents in the current study reported barriers in several areas as more likely to prevent them from obtaining services (across treatment type) if they felt their children needed them. With the mean age of Hispanic parents in this sample being about 35 years, and nearly 80% of those parents reporting having lived in the United States for 15 years or less, most of the Hispanic parents in the study would have been first generation immigrants. It seems likely that immigrants, who may have less experience with and information about how to navigate the health system in the United States, would be more likely to experience barriers to accessing services across treatment types. Additionally, due to potential language differences (91% of Hispanic families in this study reported that Spanish was their primary language), some barriers (e.g., difficulty communicating with the child's school and health care providers) may be more inhibiting for non-English speaking families. Hence, more efforts should be made to provide accessible health care information to recent immigrant families so that they can establish supports as needed. Furthermore, health and healthcare information should be made available in multiple languages.

Irrespective of race/ethnicity, parents rated affordability, lack of transportation, distance, and stigma-related barriers as more likely to prevent or delay them from seeking treatment for mental health care than medical care. This is consistent with our hypotheses. It is likely that parents feel less stigma regarding medical care because it is more common and routine. A visit to a medical doctor may not necessarily mean there is a problem with a child's health, whereas parents may be more likely to seek mental health care only when there is a problem or concern.

Limitations

This study did not examine language barriers, which likely influence child mental health utilization among non-English speaking populations in the United States. Although our sample size did not allow us to further divide the racial/ethnic categories, it is also important to note that participants identified as "Hispanic" come from a variety of cultural backgrounds. There may be important country of origin differences within this group that this study did not examine. Additionally, to increase the comfort of participants, sample size, and participant retention, parents were not asked about their citizenship/immigration status other than their country of origin and the number of years they have lived in the United States. It will be important for future studies with access to a larger immigrant population to assess differences in barriers by immigration status as it is likely influences comfort and ability to access treatment.

While recruitment methods did allow us to reach many families, relying on teachers to distribute information about the study to families may have limited our ability to reach some potential participants. Although perceptions of barriers to health care may be highly related to actual barriers, as this study relied on parent report, the extent to which study results reflect true barriers is unclear. Due to the large number of variables included in the analyses, our study may have lacked power to detect some effects, such as that of income and education. Finally, the sample is a community (not a clinical) sample which allows for assessment of community perception of health services but may or may not be reflective of barriers experienced by children with the greatest need. Nonetheless, this study provides valuable information about barriers, as public opinion can contribute to service use disparities (Pescosolido et al., 2010).

Implications and Future Directions

The results of this study have implications for policy and for mental health service providers. Practitioners should work to be culturally and linguistically sensitive and aware of potential barriers their patients may face that might have delayed help-seeking and could potentially interfere with families' ability to participate in treatment regularly. Providers should also carefully assess for parents attitudes and concerns about child mental health services and address these concerns in a culturally sensitive way. As suggested by McMiller and Weisz (1996), forming a stronger alliance between minority parents and mental health care providers and increased efforts to develop community outreach programs may reduce stigma and improve access to mental health services. Addressing families' concerns and barriers could reduce those barriers, improve families' comfort in interacting with mental health professionals, and could ultimately lead to decreased utilization disparities and improved treatment retention.

As shown by Pescosolido (2010), past health policy has not been effective in reducing public stigma associated with mental illness. Providing incentives for multi-lingual mental health care providers or training multi-lingual community leaders to provide psychoeducation to non-English speaking parents might help decrease stigma associated with mental health and mental health services and increase parents' understanding of how to obtain services. Parents reported that affordability is a greater barrier for mental health care. Increasing the availability of mental health facilities accepting public insurance or offering sliding fees may make mental health care more affordable for many families. As insurance often provides less coverage for mental health care, improving this coverage would make mental health care more affordable. The ACA may be a helpful mechanism for uninsured families to obtain health care coverage as well as improve coverage for mental health care; continued efforts should be made to educate families about eligibility for public insurance and other insurance options. Future research should address how this new policy affects barriers and disparities in access to care. Improving knowledge and awareness about mental health services may also increase child mental health services utilization among for children who could benefit from them.

Future studies that more closely assess for linguistic barriers and immigration status and examine barriers in a clinical population would further contribute to our understanding of racial/ethnic differences in barriers to mental health services. Additionally, as our results do not explore the underlying causes of racial/ethnic differences in barriers to treatment, it will be important for future research to investigate the origins of these differing attitudes and identify additional targets for intervention and policy.

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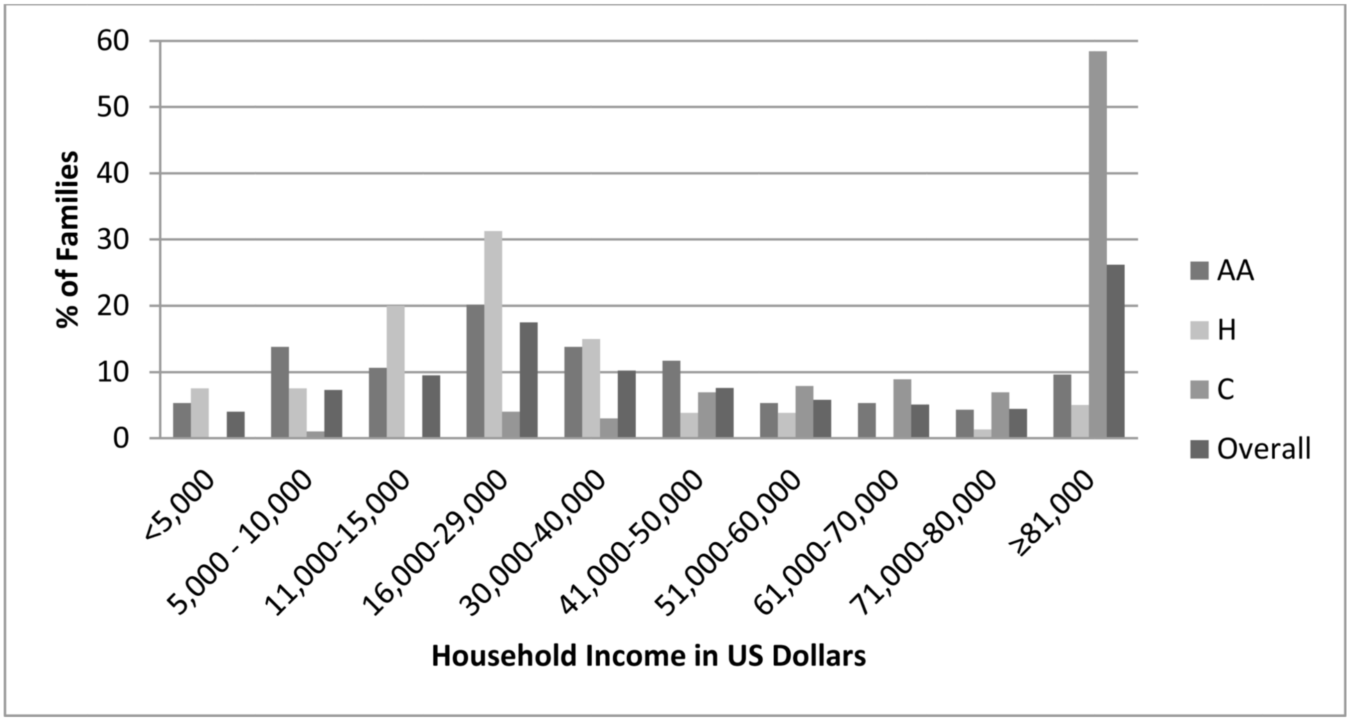

Figure 1.
Families' reported household income.

Table 1

Participant Gender and Education by Race/ethnicity

Characteristic	M±SD or n (%)[1]				F or χ^2	p
	Overall	**African American**	**Hispanic**	**Caucasian**		
Parent age (years)	39.47 ± 7.77	38.73 ± 8.67^a	35.98 ± 6.13^b	43.10 ± 6.51^c	22.61	< .001
Parent education (years)	13.77 ± 4.15	13.64 ± 2.29^a	10.15 ± 4.17^b	16.76 ± 2.98^c	96.58	< .001
Parent gender: Female	266 (97.10)	94 (100.00)	75 (93.80)	97 (97.00)	5.96	.051
Child gender: Female	136 (50.00)	51 (54.30)	44 (56.40)	41 (41.00)	5.20	.074
Child age (years)	10.64 ± .70	10.62 ± .66	10.51 ± .70	10.76 ± .67	2.85	.060
Child grade	5.33 ± .74	5.30 ± .72^{ab}	5.15 ± .81^a	5.47 ± .61^b	4.53	.012

Note: Included with female parents are 1 aunt and 1 grandmother who are caregivers. χ^2 tests (rather than F tests) were used to assess racial/ethnic group differences for dichotomous characteristics (i.e., gender).

[1] Differing superscripts within rows denote significantly different group means or proportions ($p < .05$).

Table 2

Summary of Univariate Analyses and Planned Contrasts of the Effects of Race/ethnicity and Treatment Type on Perceived Barriers

	Race/ethnicity^{1}				Treatment Type^{1}		
	F (2,224)	Between Group Means (SE)			*F* (2,164)	Within Group Means (SE)	
Barrier		**African American**	**Hispanic**	**Caucasian**		**Mental health**	**Medical**
Couldn't get through on the phone.	2.43	1.15 (.08)	1.41 (.10)	1.32 (.09)	.01	1.30 (.06)	1.28 (.05)
Couldn't get an appointment soon enough.	2.28	1.26 (.09)	1.57 (.12)	1.36 (.10)	3.24	1.37 (.06)	1.42 (.06)
Once there, had to wait too long to see the doctor.	7.40**	1.12 (.08)^{a}	1.58 (.10)^{b}	1.20 (.08)^{a}	.67	1.23 (.04)	1.37 (.05)
The clinic/doctor's office wasn't open when you could get there.	1.45	1.11 (.07)	1.11 (.09)	1.29 (.07)	6.41*	1.18 (.05)^{a}	1.16 (.04)^{b}
Didn't have transportation.	1.93	1.06 (.07)	1.26 (.09)	1.18 (.07)	3.92	1.15 (.05)^{a}	1.18 (.04)^{b}
Couldn't afford it.	2.20	1.14 (.07)	1.39 (.10)	1.25 (.08)	4.73*	1.32 (.06)^{a}	1.20 (.04)^{b}
Couldn't find care for your other children.	2.23	1.03 (.05)	1.13 (.06)	1.17 (.05)	.99	1.13 (.04)	1.08 (.03)
Child did not have health insurance.	1.99	1.12 (.08)	1.39 (.11)	1.22 (.09)	<.01	1.27 (.05)	1.22 (.05)
Child's health insurance limits access to mental health/counseling services.	2.98	1.10 (.07)^{a}	1.37 (.09)^{b}	1.20 (.08)^{ab}	1.27	1.35 (.06)	1.10 (.03)
Child refused to go.	3.65*	1.04 (.04)^{a}	1.10 (.05)^{ab}	1.20 (.04)^{b}	.37	1.21 (.04)	1.21 (.04)
Worried about friends or family finding out.	1.55	1.04 (.03)	1.14 (.04)	1.06 (.04)	4.21*	1.11 (.03)^{a}	1.05 (.02)^{b}
Worried about child's teacher/school finding out.	3.56*	1.02 (.03)^{a}	1.16 (.04)^{b}	1.07 (.04)^{ab}	2.19	1.09 (.02)	1.07 (.02)
Would reflect poorly on your abilities as a parent.	5.81**	1.03 (.05)^{a}	1.31 (.07)^{b}	1.11 (.06)^{ab}	9.40**	1.23 (.05)^{a}	1.07 (.02)^{b}
Worried that child would be teased by peers.	12.70***	1.02 (.06)^{a}	1.46 (.07)^{b}	1.15 (.06)^{a}	5.54*	1.30 (.05)^{a}	1.12 (.03)^{b}
Worried that you would feel too embarrassed.	9.17***	1.04 (.05)^{a}	1.36 (.06)^{b}	1.08 (.05)^{a}	6.52*	1.24 (.04)^{a}	1.09 (.02)^{b}
The clinic/doctor's office was too far away.	4.77**	1.00 (.04)^{a}	1.19 (.05)^{b}	1.10 (.04)^{ab}	5.88*	1.11 (.03)^{a}	1.08 (.02)^{b}

	Race/ethnicity[1]				**Treatment Type**[1]		
	***F* (2,224)**	**Between Group Means (SE)**			***F* (2,164)**	**Within Group Means (SE)**	
Barrier		**African American**	**Hispanic**	**Caucasian**		**Mental health**	**Medical**

* $p < .05$.

** $p < .01$.

*** $p < .001$.

[1] Differing superscripts within rows denote significantly different group means ($p < .05$).