IMPACT OF PARENT TRAUMA ON PARENTS' BELIEFS REGARDING THE BENEFIT OF CHILD MENTAL HEALTH CARE SERVICES

by

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This is dedicated to my parents, Michael and Paula Martin, who always hoped and had faith I would find my calling and finish my education. I did it, but I certainly did not do it alone.

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TABLE OF CONTENTS

LIST OF TABLES

ABSTRACT

The purpose of this quantitative study was to examine the interaction between parents' own trauma and their assessment of their child's functioning and its relationship to the parent's belief that their child would benefit from mental health care services. The parents' trauma experience was measured using the Adverse Childhood Experiences (ACEs) questionnaire and Trauma History Questionnaire (THQ), and the child's functioning was measured using the Columbia Impairment Scale (CIS). It was hypothesized that the higher number of traumas a parent experienced was associated with a weaker relationship between a parent's assessment of their child's functional impairment and the likelihood a parent recognizes the benefit of mental health care services for their child. One hundred and eighty-four people participated in this study. Data were analyzed using multiple binary logistic regression, and no significant relationship was found between a parent's assessment of their child's functional impairment and that parent's belief that their child would benefit from mental healthcare services. The parent's childhood THQ score and age were found to have significant positive relationships with the parent's belief that their child would benefit from mental healthcare services. The variable found to have the most significant positive relationship with the parent's belief that their child would benefit from mental healthcare services was an educational or healthcare professional telling the parent that the child would benefit from mental health care services. Clinical implications, limitations, and future directions for research were addressed.

CHAPTER 1: INTRODUCTION

Statement of the Problem

According to the National Alliance on Mental Illness (NAMI, 2019), one in five children ages 13-18 has or will have any mental illness while 13% of children aged 8-15 will experience a serious mental illness. The National Institute of Mental Health (NIMH) defines any mental illness as "a mental, behavioral, or emotional disorder that can vary in impact, ranging from no impairment to mild, moderate and even severe impact," and serious mental illness as "a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities" (NIMH, 2019, p. 3). Having a mental illness makes these children 37% more likely to drop out of school, more likely to encounter the juvenile justice system, and is a risk factor for numerous other concerns, such as dying by suicide and substance abuse (NAMI, 2019). For adults who experience a severe mental illness, half of those severe mental illnesses will have started before the age of 18 (NAMI, 2019). While mental illness occurs in one in five children, only 50.6% of children aged 8-15 with a mental health condition received mental health care services within the past year, and only 20% of children diagnosed with a mental health disorder receive care from provider who is specialized in mental health care (CDC, 2019; NAMI, 2019). The other 80% of children who do not see a provider who is specialized in mental health care typically see a pediatrician (CDC, 2019; NAMI, 2019). Only one out of every three pediatricians report that they have sufficient training to diagnose or treat children with mental health disorders (CDC, 2019). This low rate of use of and impaired access to quality mental health services is even more pronounced for communities of color, immigrant communities, the LGBTQ+ community, areas of low socioeconomic status, and rural communities (CDC, 2019).

While there are elevated risks for social, behavioral, emotional, and health problems for children and adolescents who are experiencing mental illness, this risk increases significantly for children and adolescents who are experiencing mental illness and do not receive any or adequate mental health care services to treat that mental illness (CDC, 2019; NAMI 2019; NIMH 2019). According to NIMH, children and adolescents with a mental illness who receive inadequate or do not receive any mental health care services are at risk for worsening mental illness, episodes of violence, issues with physical health, decreased quality of interpersonal relationships, increased issues with education and/or work, decreased ability to engage in daily responsibilities, increased risk of victimization, increased risk of incarceration, increased risk of homelessness, increased risk of more severe clinical outcomes, and increased risk of death by suicide or substance abuse above and beyond the risk posed with a mental illness diagnosis (NIMH, 2001; NIMH, 2019). Furthermore, the length of time a child or adolescent waits to receive treatment is positively correlated with a longer treatment time to adequately treat the disease, and positively correlated with more severe disease symptoms and a higher degree of risk for the social, behavioral, emotional, and health problems listed above (CDC, 2019; NAMI 2019; NIMH, 2001; NIMH 2019).

It is important to note that there are a multitude of barriers that can keep both children and adults from receiving mental health care services they believe they need, or could benefit from. These barriers, which are particularly impactful for children, include: lack of insurance or limited services, an under-sized mental health care work force, long waiting lists, poor communication or connection between medical and behavioral health systems, insufficient number of available treatment types (inpatient, intensive outpatient, individual therapy, family therapy, psychiatry), insufficient funds to cover the costs of care, lack of transportation, and

others (CDC, 2019; Jones, Pastor, Simon, & Reuben, 2014; Mental Health America, 2019). While these external barriers are numerous, significant, and deserve careful consideration and attention to navigate and correct, this research focuses on the internal family barriers that are faced in relation to securing mental health care services for children and adolescents, rather than those external barriers. The author acknowledges that due to the aforementioned external barriers that impede access to mental health care services, not all parents who would like their children to receive mental health care services are able to actually locate, access, afford, or partake in those mental health care services. Therefore, this study examined only a parent's belief that there could be a benefit to their child receiving mental health care services, not actual utilization of those services.

Currently, there is a body of research on how internal family factors, specifically parental factors such as the parent's own experiences with mental health care services, religious beliefs, and parent trust in health care and mental health care professionals impact children's utilization of mental health care services (Albright Bode et al., 2016; DeRigne, Porterfield, & Metz, 2009; Haine-Schlagel & Walsh, 2015; Hoza, Johnston, Pillow, & Ascough, 2006; Morrissey-Kane & Prinz, 1999; Nolte & Wren, 2016; Shanley & Reid, 2014; Smokowski, Bacallao, Cotter, & Evans, 2015). Additionally, there is a body of research on the accuracy of parent evaluation of children's potential benefit from mental health care services compared to evaluations of that same child by mental health professionals (Baker-Ericzen et al., 2010; DeRigne et al., 2009; Morrissey-Kane & Prinz, 1999). However, there is a gap regarding research specifically focused on how a parent's experiences of trauma in their own life may impact the likelihood of that parent recognizing that their child may benefit from mental health care services. This research

aimed to address that gap in research and provide insight regarding the potential impact of a parent's experience of trauma on their child's access to mental health care service.

CHAPTER 2: SIGNIFICANCE OF THE PROBLEM

Trauma

The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM – V) defines trauma as:

> exposure to actual or threatened death, serious injury or sexual violence in one or more of four ways: (a) directly experiencing the event; (b) witnessing, in person, the event occurring to others; (c) learning that such an event happened to a close family member or friend; and (d) experiencing repeated or extreme exposure to aversive details of such events, such as with first responders (APA, 2013, p. 271).

According to APA (2013), actual or threatened death must have occurred in a violent or accidental manner; and experiencing cannot include exposure through electronic media, television, movies or pictures, unless it is work-related (APA, 2013). The Substance Abuse and Mental Health Services Administration (SAMHSA) defines individual trauma as

> an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (SAMHSA, 2019, para. 2),

and the US Department of Veteran's Affairs describes trauma as a potential trigger for mental health issues (2018). According to SAMHSA, 61% of men and 51% of women report experiencing at least one traumatic event in their lifetime, and 90% of people utilizing public behavioral health settings have experienced at least one incident of trauma (2019).

While some people who experience a traumatic event are able to process the occurrence and return to their lives with few lasting effects, other people who experience the same traumatic

event may find themselves suffering from lasting effects on the their physical, emotional, and mental health (Anda et al., 2006; Felitti & Anda, 2010; CDC 2019; SAMHSA 2019; US Department of Veteran Affairs, 2018). Unaddressed trauma may significantly increase the risk for mental illness and substance use disorders, suicide attempts, death by suicide, chronic physical illness, incarceration, and premature death (CDC 2019; SAMHSA 2019; US Department of Veteran Affairs, 2018). Trauma is often something that is thought of as occurring mainly to individuals, but it is important to note that trauma can occur in family and community settings as well. Just as trauma can have community and family occurrences, it also carries not only a personal cost but a societal cost as well. Presently, there is a lack of data that focuses on the social cost of trauma alone, but there are data available on the cost of problems associated with traumatic experiences, especially those traumatic experiences that occur during childhood. The US Centers for Disease Control and Prevention (CDC) estimates that 75% of the national health expenditure is spent addressing chronic illness (2019), which studies have shown is linked to trauma (Anda et al., 2006; Felitti et al., 1998; Felitti & Anda, 2010).

Impact on Physical, Emotional, and Mental Health. Trauma has a direct negative impact on brain development, as well as brain functioning (Felitti et al., 1998; van der Kolk, 2014). Trauma also alters the body's mechanisms dedicated to processing and responding to stress (Felitti et al., 1998; van der Kolk, 2014). When people experience normal amounts of stress, they experience a temporary increase in stress hormones in response to a threat, and then those stress hormones return to a normal level within that person (van der Kolk, 2014). However, when people experience prolonged or extreme stress, as in the case of trauma, their stress hormones begin to operate differently. In these cases, the individual's stress hormones may spike more easily or at unpredictable times, take longer to return to baseline, develop a new baseline,

or respond disproportionately to the stimuli at hand (van der Kolk, 2014). The effects of these distortions in stress response affect both physical and mental health. According to van der Kolk (2014), the body and brain can experience the world and relationships very differently after experiencing trauma. The body can become hyperaware and hyper-vigilant, exist in a near-constant state of arousal, and even become numbed or deadened to new threats due to this constant state of arousal. Essentially, the body may respond to innocuous stimuli as a threat or fail to recognize a new threat, putting the individual who experienced the trauma at risk for further detriment in either case (van der Kolk, 2014).

Trauma can result in functional impairments in the limbic system in the brain. The limbic system is mostly formed through experiences and interactions and is the part of the human brain that is largely in charge of group living, relationships, and emotions (van der Kolk, 2014). Therefore, these functional impairments in the limbic system that are caused by trauma can have a significant impact on the relationships of a person who has experienced trauma. Long-standing research indicates that while traumatic events are very much related to impaired brain function, emerging research also indicates that traumatic events are related to disturbances in immune system response and function as well (SAMHSA, 2019; van der Kolk, 2014).

Adverse Childhood Experiences (ACEs)

The ACEs study is a landmark study that was the first of its kind and showed that traumatic experiences that occur in childhood are particularly linked with both behavioral and chronic physical health concerns that can be harmful to careers and jobs, relationships with others, and other important facets of life (Anda et al., 2006; CDC 2019; Felitti et al., 1998; Felitti & Anda, 2010; SAMHSA, 2019). The term ACEs refers to three kinds of childhood adversity that children may encounter in their home environment: 1) physical abuse and neglect; 2)

emotional abuse and neglect; and 3) household dysfunction, which includes lack of support or closeness within the family of origin, sexual abuse by anyone, loss of a parent, witnessing domestic violence, substance abuse, mental illness or incarceration of a family member (Felitti et al., 1998). The ACEs study included more than 17,000 participants between the ages of 19 and 94, and the majority of the study participants were white, well-educated, and had access to quality health care (Felitti et al., 1998). The researchers who conducted the ACEs study sought to examine the relationship between ACEs and significant public health issues such as alcoholism, alcohol abuse, chronic obstructive pulmonary disease (COPD), depression, fetal death, ischemic heart disease, liver disease, job performance issues, financial difficulty, risk for intimate partner violence, multiple sexual partners, sexually transmitted infections (STIs), smoking, suicide attempts, unintended pregnancies, early initiation of smoking and sexual activities, risk for sexual violence, and poor academic achievement (Felitti et al., 1998; Anda et al., 2006; Felitti & Anda, 2010). The results of the ACEs study showed a relationship between experiencing ACEs, adult health risk behaviors, and the principal causes of death in the United States such as heart disease, respiratory illness, cancer, ischemic heart disease, chronic obstructive pulmonary disease, lung cancer, and liver disease as well as other health concerns such as greater likelihood of being a current smoker, risky sexual behaviors, teen pregnancy, obesity, substance abuse, depression, suicide attempts, hallucinations, and multiple types of cancer (Anda et al., 2006; Felitti et al., 1998; Felitti & Anda, 2010; Larkin, Felitti, & Anda, 2014).

Child Utilization of Mental Health Care Services

Parent Impact on Children's Mental Health

It is widely acknowledged in current and historical research that parents have a significant impact on their children's mental health. Children learn more from their parents than they do from any other presence in their lives (such as school, church, peers) in regard to recognizing and coping with feelings, interacting with other people, interacting with organizations and institutions in children's lives, and adjusting to circumstances that occur in children's lives (Albright Bode et al., 2016; Baker-Ericzen et al., 2010; De Rigne et al., 2009). The way that parents relate to, nurture, and interact with their child(ren) has a significant impact on not only their child(ren)'s lives, but their child(ren)'s personhood and mental health (Haine-Schlagel & Walsh, 2015; Nolte & Wren, 2016; Smokowski et al., 2015).

Since parents have such a significant impact on their child(ren)'s development, it follows that parents would have a significant impact on their children's mental health (Nolte & Wren, 2016; Smokowski et al., 2015). Research indicates that a parent's own mental health concerns may have a negative impact on their child(ren)'s mental health, particularly if a parent does not seek services or manage their mental health concerns (Haine-Schlagel & Walsh, 2015). A negative impact on children can occur even if the parent is seeking services and working to manage their mental health concerns (Albright Bode et al., 2016; Baker-Ericzen et al., 2010). Instances in which this negative impact can still occur could be if the parent's mental health concerns diminish the parent's ability to work and provide steady income, have affected relationships with extended family and other social supports, or have affected other aspects of the parent's life that the child also has contact with (Albright Bode et al., 2016; Baker-Ericzen et al., 2010). Children of parents with mental health concerns are at a higher risk for developing

social, emotional, and/or behavioral issues, such as substance abuse, adverse mental health outcomes, low self-esteem, issues at school, abuse, and neglect (Melchior & van der Waerden, 2016; Nolte & Wren, 2016; Smokowski et al., 2015).

Perpetuating or dismantling the stigma around mental health issues is another way that parents can have an impact on their child(ren)'s mental health. A parent working to dismantle the stigma around mental health issues can include behaviors such as normalizing the child's mental health issues, supporting the child without judgement or shame, helping the child to understand that mental health issues are common, and advocating for others to treat their child the same way (Nolte & Wren, 2016). Parents can perpetuate the stigma around mental health issues by showing shame regarding their child's mental health issues, encouraging or demanding that the child hide their mental health issues, making judgmental or derogatory statements regarding people with mental health issues, insisting that the child can manage their mental health issues by praying, "trying harder," or telling the child that their life is too good to have issues (Albright Bode et al., 2016; Smokowski et al., 2015). Children who are experiencing mental health issues are shown to have better long- and short-term outcomes when their parents engage in behaviors that dismantle the stigma around mental health issues and normalize these concerns, rather than stigmatizing mental health care issues (Albright Bode et al., 2016; Smokowski et al., 2015).

Intergenerational Impact of Trauma and Parenting. The intergenerational endurance of trauma, particularly trauma related to child maltreatment, has been well established and documented (Felitti & Anda, 2010; Kuh, Ben-Shlomo, Lynch, Hallqvist, & Power 2003; Larkin, Felitti, & Anda, 2014; Le-Scherban, Wang, Boyle-Steed, & Pachter, 2018; Narayan et al., 2017; van der Kolk, 2014;). Studies show that trauma, particularly that which is experienced in childhood, may lead to a "chain of risk" throughout a person's life, which is likely to result in

stressful or detrimental living circumstances. These circumstances can affect not only the individual themselves, but those they interact with, particularly family members and especially their children (Anda et al., 2006; Felitti & Anda, 2010; Kuh et al., 2003; Larkin, Felitti, & Anda, 2014; Le-Scherban et al., 2018; Narayan et al., 2017).

Lange, Callinan, and Smith (2016) state the following regarding the relationship between trauma, particularly ACEs, and the impact of these experiences on parenting:

> Given the relationship found between ACEs and parenting stress, it is important to develop both psychosocial and policy interventions to address these issues…one potential mechanism for the increased parenting stress found in this study might be the dysregulation of the stress-response system caused by traumatic experiences as a child (p. 9).

Lange et al. go on to state that this dysregulation could have a negative impact on parenting practices, including a parent's ability to be sensitive to their child and to their child's needs. The risk for a negative impact on parenting practices and decreased ability to be sensitive to their child is higher in the case of parents who have experienced repeated exposure to trauma, as this repeated exposure can have a more significant impact on the body's ability to process and manage stress (2016). Furthermore, studies show that outcomes associated with trauma throughout the lifespan, such as an increased likelihood of mental and physical illness, substance abuse, and an impaired stress response, are associated with negative parenting behaviors (Downey & Coyne, 1990; Lange et al., 2016; Lovejoy, Graczyk, O'Hare, & Newman, 2000;). These negative parenting behaviors include diminished parent-child attachment, decreased parent sensitivity and impairment in or a lack of coping skills regarding issues with the child (Downey & Coyne, 1990; Lange et al., 2016; Lovejoy et al., 2000). Additional research echoes these

findings and states that a parent's experience of trauma, particularly a parent's experience of trauma in childhood, significantly impacts parenting and the parent-child relationship and states that "the potential intergenerational effects of ACEs are supported by research revealing increased risk of adverse health outcomes among children of parents who experienced trauma" (Bowers & Yehuda, 2016, p. 232). Le-Scherban et al. (2018) also showed that experiencing trauma in childhood alters neural functioning and increases the likelihood of experiencing mental illness as an adult. Le-Scherban et al. (2018) linked this altered neural functioning and increased likelihood of experiencing mental illness as an adult with negative parenting attitudes and behaviors. This research demonstrates that the "full scope of health effects of ACEs is not limited to the exposed individual," referring to the parent, but that these effects extend intergenerationally (Le-Scherban et al., 2018, p. 7).

Lange et al. state that while this research is indicative of a significant relationship between ACEs and parenting stress, more research is needed to understand the scope and depth of this relationship, as well as to address the gaps in current research and inform treatment and public interventions to address such issues (2016). Lange et al. (2016) suggest that there is also a need for larger and more diverse sample sizes, to examine the relationships through other measures analyzing trauma and parenting or trauma and parent-child relationships, to examine the influence of potential mediators, such as genetics and social support, and to discover if the children of parents who experience trauma are experiencing negative emotional, behavioral, or school-related outcomes. While there is a significant body of research regarding the impact of parent mental health and parent substance use disorders on children's mental health care, the field is currently lacking research that specifically focuses on the impact of a parent's experience of trauma on their child(ren)'s mental health care. This study attempted to contribute to this

aspect of the research by investigating the impact of a parent's experience of trauma on the likelihood that that parent will recognize that their child could benefit from mental health care services.

Parent Impact on Children's Mental Health Care Access

As previously mentioned, parents' behavior that either stigmatizes or normalizes their child(ren)'s mental health care issues can have a significant impact on how their child(ren) may view themselves or others who have mental health issues. However, parents' attitudes about mental health issues being normal or stigmatized can also impact their child(ren)'s access to mental health care services. Parents who perpetuate the stigma around mental health issues are less likely to believe their child needs or could benefit from mental health care services, less likely to seek out services, and less likely to make sure their children attend sessions or attend their child(ren)'s sessions (Albright Bode et al., 2016; Baker-Ericzen et al., 2010; Haine-Schlagel & Walsh, 2015; Smokowski et al., 2015). Even if they are not intentionally perpetuating stigma around mental health issues, parents who internalize stigma they encounter regarding their own mental health issues are also less likely to believe their child needs or could benefit from mental health care services, less likely to seek out services, and less likely to make sure their children attend sessions or attend their child(ren)'s sessions (Albright Bode et al., 2016; Baker-Ericzen et al., 2010; Haine-Schlagel & Walsh, 2015; Smokowski et al., 2015). Furthermore, parents who perpetuate the stigma around mental health issues or internalize the stigma they have encountered around their own mental health issues are less likely to aid their children in work to be done outside of therapy, be medication compliant, and seek support within the family or at the child(ren)'s schools (Albright Bode et al., 2016; Baker-Ericzen et al., 2010; Haine-Schlagel & Walsh, 2015; Smokowski et al., 2015).

Conversely, if parents work against the stigma around mental health issues and normalize these concerns, they are more likely to help their child(ren) realize therapy services are needed or will be beneficial, and also help their childr(en) find suitable services and attend those services regularly (Albright Bode et al., 2016; Baker-Ericzen et al., 2010; Haine-Schlagel & Walsh, 2015; Smokowski et al., 2015). Additionally, these parents are more likely to help their child(ren) with the work that needs to be done outside of therapy, be medication compliant, and seek support in the family or services at the child's schools (Albright Bode et al., 2016; Haine-Schlagel & Walsh, 2015; Smokowski et al., 2015). Parents who participate in one, some, or all of these behaviors improve outcomes for their children who are seeking mental health care services (Albright Bode et al., 2016; Baker-Ericzen et al., 2010; Haine-Schlagel & Walsh, 2015; Smokowski et al., 2015).

Parents' own experiences with mental health care services can have a significant impact on their child(ren)'s access to mental health care services as well. Parents who have had blaming, shaming, pathologizing, dehumanizing, difficult, confusing, or otherwise especially difficult encounters with mental health care services are less likely to seek out further services for themselves or services for their child(ren) (Baker-Ericzen et al., 2010; Melchior & van der Waerden, 2016; Nolte & Wren, 2016). It is important to note that parents who occupy a low socioeconomic status, are persons of color, are immigrants, identify as LGBTQ, or belong to other vulnerable populations are more likely to have these adverse experiences in mental health care settings (Baker-Ericzen et al., 2010; Melchior & van der Waerden, 2016; Nolte & Wren, 2016).

Accuracy of Parent's Rating of Child's Mental Health. Parental beliefs or perceptions are generally acknowledged in research as being influential in their children's diagnosis,

treatment, and usage of mental health care services (Hoza et al., 2006; Morrissey-Kane & Prinz, 1999; Shanley & Reid, 2014). Studies have found that the decision to seek mental health care services for children experiencing behavioral or emotionally distress typically involves at least one parent (Williams & Chapman, 2012). However, studies have drawn a slightly ambiguous conclusion regarding whether parents are likely to assess their own child(ren)'s mental health accurately (Hoza et al., 2006; Morrissey-Kane & Prinz, 1999; Renk, 2005; Shanley & Reid, 2014). Furthermore, the current body of research included ambiguity and even some disagreement about the meaning of "accurate assessment" in this matter (Hoza et al., 2006; Shanley & Reid, 2014). Research has investigated whether a parent's assessments of their child(ren)'s mental health matches the assessment of relevant professionals in their child(ren's) life such as teachers or school counselors and whether a parent's assessment of their child(ren)'s mental health matches that of trained mental health professionals assessing the child(ren) (Hoza et al., 2006; Renk, 2005; Shanley & Reid, 2014). According to Renk (2005), mental health professionals appear to be most accurate in assessing a child's mental health (as corroborated by assessments and comparing multiple mental health professionals' assessments of the same child), followed by teachers and school counselors as the next most accurate evaluators, followed by mothers, then fathers, and then other adults in the children's lives.

Research suggests that the best way to accurately assess a child's need for mental health services is to assess the child(ren)'s mental health by observing emotional and behavioral functioning, as well as administering assessments at multiple points of contact, such as from parents, teachers, school counselors, and therapists and synthesizing this information to form an assessment (Renk, 2005). Renk's (2005) research demonstrates that parents are essential to accurately evaluating children's mental health. However, if issues or concerns regarding a

parent's ability to assess their child can be identified, the support of the surrounding structures in a child's life can work in conjunction with the parent to evaluate children's mental health (Renk, 2005). Ideally, this occurs while the parents are getting support and treatment of their own (Morrissey-Kane & Prinz, 1999; Renk, 2005; Shanley & Reid, 2014).

Kelley et al. (2017) found that parents who are suffering from mental illness or substance abuse themselves are less likely to accurately report their children's symptoms and level of severity of those symptoms. This is particularly relevant to this study because if a parent experiences one or more traumas, they are more likely to experience mental illness or substance abuse disorders (Anda et al., 2006; Felitti et al., 1998; Felitti & Anda, 2010; Larkin, Felitti, & Anda, 2014). Anda et al. (2006), Felitti et al. (1998), Felitti and Anda (2010), and Larkin et al. (2014) establish the link between trauma and mental illness/substance abuse disorders, and Kelley et al. (2017) established a link between substance abuse/mental illness and parents having a decreased capacity to accurately evaluate their children's mental health. This study worked to bridge those two concepts by attempting to show a direct link between trauma and parents' likelihood to identify that their child may benefit from mental health care services.

Theoretical Basis

Transgenerational Family Therapies

Transgenerational family therapies conceptualize families as an "emotional unit" and try to understand the interactions of families through generations in order to address current issues and anticipate future challenges (Ballard, Fazio-Griffith, & Marino, 2016; Kerr & Bowen, 1988). A central tenet of transgenerational family therapies is that the origin of the greatest human problems and the greatest attainments of human adaptation are not rooted in the individual, but rather through generations of one's family (Kerr & Bowen, 1988). The main goal of

transgenerational family therapies is to interrupt the intergenerational cycle of dysfunction by becoming aware of unhealthy ways of relating and operating that have been transmitted between generations (Boszormenyi-Nagy & Krasner, 1986; Kerr & Bowen, 1988). According to Bowen Family Systems theory, a form of transgenerational family therapy, both relational and genetic information are transmitted through generations (Kerr & Bowen, 1988). This transmission of relational information occurs in many contexts, from intentional teaching and learning of information and ways of interacting with the family and the world around the family to a more automatic and unconscious programming of emotional reactions and behaviors that the parent or caregiver might not even recognize in themselves, let alone as something they are passing onto their child(ren) (Kerr & Bowen, 1988). It is important to note that even though some parts of this transgenerational transmission process are conscious and intentional, other elements of this transmission process are unconscious and automatic (Kerr & Bowen, 1988). Whether the transmission process is conscious and intentional or unconscious and automatic, all of the transgenerational transmission processes take an active and central role in shaping the "self" of the child(ren) the processes are being transmitted to (Kerr & Bowen, 1988). According to Kerr and Bowen (1988), the intergenerational transmission process not only impacts the level of "self" an individual develops, but it also determines how individuals interact with others – with their family of origin, with friends and acquaintances, with strangers, with future partners, and with their own or future children.

Differentiation. Differentiation is a central element of Bowen Family Systems Theory that "is a product of a way of thinking that translates into a way of being" (Kerr & Bowen, 1988, p. 108). Differentiation has a personal aspect, which refers to one's ability to separate thoughts from feelings and make decisions based on behavior and observations, rather than from

emotional reactions (Kerr & Bowen, 1988). Differentiation also has a relational aspe ct, which refers to one's ability to distinguish one's own self (and one's own thoughts and feelings) from other people while in connection with a strong system dynamic (Kerr & Bowen, 1988). An important thing to note when discussing differentiation is that differentiation exits on a continuum, in degrees of higher and lower differentiation. A person or system is not "poorly" or "well" differentiated, and there is no "good" or "bad" differentiation. Bowen (1992) recognizes that a family with low differentiation can function reasonably well and that a family with a higher degree of differentiation can experience a significant amount of difficulty in an especially high stress situation. Kerr and Bowen (1988) also acknowledge that less and more differentiated families can look very similar during calm times. In this way differentiation is relatively non-pathologizing.

This research focused on the relationship between a parent's experience of trauma in their own lives and the likelihood that a parent will recognize that their child could benefit from mental health care services. Transgenerational family therapy is important to this research because it forms a basis for all the elements previously discussed to interact with one another. It has already been established that a parent's experience of trauma may have a negative impact on their parenting skills and relationship with their child and reduce parent functioning (Kelley et al., 2017; Kuh et al., 2003; Lange et al, 2016; Le-Scherban et al., 2018; Narayan et al., 2017). This type of family system is likely in a state of frequent stress and the child is also being exposed to stressful behaviors on the part of the parent. Because of this dynamic, when the child begins to exhibit signs of mental health issues (which can be a stressful situation, individually and as a family) the response from the parent is more likely to be emotionally reactive, rigid, or

avoidant (Kerr & Bowen, 1988; Zerach, 2015), and such a response would likely impact the parent's recognition that their child would benefit from mental health care services.

When it comes to children's access to mental health care, parental beliefs or perceptions are generally acknowledged in research as being influential in their children's diagnosis, treatment, and usage of mental health care services (Hoza et al., 2006; Morrissey-Kane & Prinz, 1999; Shanley & Reid, 2014), but research also acknowledges that parents often struggle being accurate in their ratings of their children's mental health (Hoza et al., 2006; Morrissey-Kane & Prinz, 1999; Renk, 2005; Shanley & Reid, 2014). A parent's experience of trauma may not only impact that parent's physical, mental, and emotional health (Felitti et al., 1998; Anda et al., 2006; Felitti & Anda, 2010), but it can also have a negative impact on their parenting skills and relationship with their child and reduce parent functioning (Kuh et al., 2003; Lange et al, 2016; Kelley, 2017; Narayan et al., 2017; Le-Scherban et al., 2018). This type of family system is likely in a state of frequent stress, this is likely to lead to a lower degree of personal and relational differentiation (Zerach, 2014). Because there is likely to be a lower degree of personal and relational differentiation in these family systems, if the child begins to exhibit signs of mental health issues (which can be a stressful situation, individually and as a family) the response from the parent is more likely to be emotionally reactive, rigid, or avoidant (Kerr & Bowen, 1988; Zerach, 2014), and such a response would likely impact the parent's recognition that their child would benefit from MHCS.

CHAPTER 3: METHODOLOGY

Research Question and Hypothesis

Question 1: Is the relationship between a parent's assessment of their child's functional impairment and the likelihood that parent will recognize the benefit of mental health care services for their child impacted by the number of traumatic events the parent experienced in childhood?

Hypothesis 1: The higher the number of traumas a parent experienced in childhood, the less strong the relationship between a parent's assessment of their child's functional impairment and the likelihood that parent will recognize the benefit of mental health care services for their child will be.

Question 2: Is the relationship between a parent's assessment of their child's functional impairment and the likelihood that parent will recognize the benefit of mental health care services for their child impacted by the number of traumatic events the parent experienced in adulthood?

Hypothesis 2: The higher the number the of traumas a parent experienced in adulthood, the less strong the relationship between a parent's assessment of their child's functional impairment and the likelihood that parent will recognize the benefit of mental health care services for their child will be.

Design

The purpose of this qualitative study was to examine the interaction between parents' own trauma and their assessment of their child's functioning and its relationship to the parent's belief that their child would benefit from mental health care services.

Variables

The independent variables in the design were the parent's assessment of the functional impairment in the child of the parent participant, the parent experience of trauma during childhood, and the parent's experience of trauma in adulthood. The dependent variable was whether the parent participant recognizes that their child might benefit from mental health care services. Demographic questions asked included race/ethnicity of parent and child, household income, child insurance status, educational level of parent, educational setting of the child, gender of parent and child, age of parent and child, number of children in the household, relationship status of the parent, importance of religion in the life of the parent, and whether the child is currently on or has been prescribed medication for behavioral or emotional issues. Some of the demographic data were used as control variables in study, but the primary use was to examine and understand the sample that participated. The demographic questions that were used as control variables were race/ethnicity of parent and child, household income, child insurance status, educational level of parent, educational setting of the child, gender of parent and child, age of parent and child. Two additional control variables were whether the parent or child has previously or is currently receiving mental health care services and whether the parent has been told by an education or health services professional that their child would benefit from mental health care services.

Participants

The population studied in this research was parents who are over the age of 18 who have at least one minor child and who has at least joint custody of and the authority to make healthcare decisions for their child. The parent and child also resided in the United States. If the parent had more than one child who met the criteria for the study, the parent was asked to respond to the survey regarding the child they perceived as having the highest degree of emotional, behavioral, or educational issues. To obtain the necessary statistical power for the variables of parental experience of trauma, the child's functional impairment, and the parent's ability to recognize their child's need for mental health care services, it was recommended to have a sample size of 107 for three independent variables and nine control variable and a medium effect size with a Cronbach's alpha of .05 (Cohen, 1992). In order to have 107 participants complete the survey, it was estimated that it would require approximately 150 people begin the survey.

Measurements

Demographic Information

The survey contained questions regarding the demographic characteristics of each participant, such as age of parent and age of that parent's child(ren), race/ethnicity, gender, relationship status, education level, work status, income, importance of religion in participant's life, health insurance status, number of children in the household, and educational environment of the child of that parent. Additional questions were asked regarding parent attitudes and previous experience with mental health care services as well as whether the child's school or health care professional had ever contacted the parent to recommend the child participate in mental health care services.

Columbia Impairment Scale

The Columbia Impairment Scale (CIS) was used to indicate the parent's assessment of their child's functional impairment. The CIS was developed to measure functional impairment in children and was designed to be a brief assessment that could be completed by non-clinical interviewers or as a self-report assessment rather as an alternative to most of the measures that existed at the time which required clinical training or expertise to administer and complete (Attel, Capelli, Manteuffel, & Li, 2018; Bird, Shaffer, Fisher, & Gould, 1993). The CIS includes 13 items and the available responses to each item range from 0 (no problem at all) to 4 (a very bad problem). The CIS measures functional impairment across four domains: interpersonal relations, broad psychological domains, functioning in school or at work, and use of leisure time. The CIS has both a parent and a child version. The parent version of the CIS has a consistently higher reliability and validity than the child version, with the alpha level of the parent version ranging from .85 to .90 (Attel et al., 2018; Bird et al., 1993) which has led to more frequent and widespread use of the parent CIS in research and clinical practice (Singer, Eack, & Greeno, 2011). The CIS has been shown to be well correlated with other accepted measures such as the Children's Global Assessment, Pediatric Symptom Checklist, Behavioral and Emotional Rating Scale for Youth, and the Child Behavior Checklist (Attel et al., 2018). The CIS has been acknowledged as one of the most commonly implemented scales in the National Institute of Mental Health's research related to children and adolescents (Barch et al., 2016).

ACE Questionnaire

The ACE questionnaire is a 10-item self-report scale developed, as a result of the ACE study, to identify three kinds of childhood adversity that children may encounter in their home environment – physical abuse and neglect, emotional abuse and neglect, and household

dysfunction (Felitti et al., 1998). The ACEs study questionnaire generates a score from 1-10, indicating how many of the adverse childhood experiences the study participant experienced before age 18. The adverse childhood experiences being assessed by the study include emotional abuse; physical abuse; neglect; lack of support or closeness within the family of origin; sexual abuse by anyone; loss of a parent; witnessing domestic violence; witnessing substance abuse; mental illness in the home; or incarceration of a family member (Felitti et al., 1998; Felitti & Anda, 2010). The ACE questionnaire includes 10 questions that can be responded to with "yes" or "no" and each "yes" answer is assigned one point; the points are added for a highest possible score of 10. Questions from the ACE questionnaire include the first question "Did a parent or other adult in the household often swear at you, insult you, put you down, or humiliate you or act in a way that made you afraid that you might be physically hurt?" and the sixth question "Were your parents ever separated or divorced?" (Felitti et al., 1998). The ACE questionnaire is designed to be utilized as a self-report measure. The kappa coefficient, is one of the most frequently used statistic to test interrater reliability for scales which measure counts rather than using Likert scales (Cohen, 1960; Fleiss, 1981; McHugh, 2012). According to Dube, Williamson, Thompson, Felitti, and Anda (2004), the nature of the ACE questionnaire and the tendency of those reporting childhood abuse to underreport occurrences make kappa statistic, and other reliability calculations for this measure "imperfect" and highly variable. The ACE questionnaire was used to assess parent experiences of trauma that occurred before the age 18.

Trauma History Questionnaire

The Trauma History Questionnaire (THQ) is a 24-item self-report scale with a yes/no response format that assesses experiences with "potentially traumatic events such as crime, general disaster, and sexual and physical assault" that the respondent has experienced at any

point in their life" (Hooper, Stockton, Krupnick, & Green, 2011, p. 260). In addition to each "yes" answer, respondents are asked to disclose how many times the traumatic event occurred and what age the respondent was at each occurrence. An example of a question is, "have you ever had a serious accident at work, in a car, or somewhere else?" ask the respondent to "specify" the nature of the traumatic incident. The THQ also includes an open-ended question in item 24 that asks the respondent "Have you ever experienced any other extraordinarily stressful situation or event that is not covered above? If yes, please specify" (Green, 1996, p. 368). An additional example of questions without the opportunity to specify include "Has anyone ever tried to take something directly from you by using force or the threat of force, such as a stick up or mugging?" (Green, 1996, p. 368). The THQ is designed for use in both clinical settings and for research purposes (US Department of Veteran Affairs, 2018). Because the THQ is a trauma history data collection instrument, there is no standard scoring method. Therefore, it has been adapted and modified to meet the needs of the projects in which it has been utilized, with the most common adaptations or modifications being to count the number of the types of events endorsed and/or the subscale scores by even type or to categorize participants into low- or high-trauma life experiences (Hooper et al., 2011). The strengths of this measure include the range of occurrences the questionnaire recognizes as well as the "careful wording" of each question (Norris & Hamblen, 2004). Mueser et al. (2001) examined the interrater reliability of the THQ in relation to the Clinician-Administered Post Traumatic Stress Disorder Scale (CAPS) and the PTSD Checklist (PCL). Mueser et al. found that the kappa statistic varied greatly and was difficult to calculate (much like the ACE questionnaire), and state that, generally, the THQ "showed good levels of test-retest reliability" (2001, p. 114). The THQ assessed trauma the parent has experienced cumulatively throughout their entire life as well as the trauma

experienced in childhood and the trauma experienced in adulthood separately. The THQ also assessed the number of occurrences of those traumas.

Procedures

After obtaining approval from the IRB, the survey was placed on Mturk and a link was provided to the survey. Mturk, which is a crowdsourcing program, has a large, diverse workforce of over 100,000 people residing in over 100 countries while the majority of participants reside in India and the United States (Buhrmester, Kwang, & Gosling, 2011). In regard to quality of data that can be obtained using Mturk, a study found that the amount offered for compensation had no significant effect on the quality of data, the data obtained by Mturk is at least as reliable as data obtained with more traditional methods, and that Mturk participants are slightly more demographically diverse than standard internet samples and much more diverse than standard American college samples (Buhrmester et al., 2011). Potential participants who were interested in taking the survey clicked on a link within Mturk, which sent them to the survey on Qualtrics, a program that presents the online survey and stores the recorded answers.

The first page of the survey was the informed consent and if participants agreed to the informed consent, participants were allowed to complete the survey. Participants were paid a small incentive ($0.40) for participation. The Statistical Program for Social Sciences (SPSS, 26th ed.) was used to analyze the data. Basic frequencies were run on the data to find descriptive statistics about the sample's demographics.

Data Analysis

A logistic multiple regression, which analyzes the relationship between one or more nominal, ordinal, interval or ratio-level independent variables and one binary dependent variable, was used to test Questions 1 and 2 (Babbie, 2016). The control variables for Question 1

were race/ethnicity of parent and child, household income, household access to insurance, educational level of parent, educational setting of the child, gender of parent and child, age of parent and child, number of children in the household, relationship status of the parent, religious affiliation of parent and child, whether or not the parent has previously or is currently receiving mental health care services, and whether or not the parent has been told by an education or health professional that their child might benefit from mental health care services. The independent variables for Question 1 were the parent's assessment of their child's functional impairment, the parent's trauma experiences as a child and as an adult, and the interaction between the parent's assessment of the child's functional impairment and their own trauma, and the interaction between the parent's trauma experiences and the parent's assessment of their child's functional impairment. The dependent variable for Question 1 was whether or not the parents believe that their child might benefit from mental health care services.

The control variables for Question 2 were race/ethnicity of parent and child, household income, household access to insurance, educational level of parent, educational setting of the child, gender of parent and child, age of parent and child, number of children in the household, relationship status of the parent, religious affiliation of parent and child, whether or not the parent has previously or is currently receiving mental health care services, and whether or not the parent has been told by an education or health professional that their child might benefit from mental health care services. The independent variables for Question 2 were the parent's assessment of their child's functional impairment, the parent's trauma experiences as a child, and the interaction between the parent's assessment of the child's functional impairment and their own trauma, the and the interactions between the parent's trauma experiences as a child and the parent's assessment of their child's functional impairment. The dependent variable for Question

2 was whether or not the parents believe that their child might benefit from mental health care services.

CHAPTER 4: RESULTS

Data Screening

A total of 244 participants accessed the survey via Mturk. All of the participants consented to participate in the survey, and 220 participants completed the survey and met the requirements of being over the age of 18, being a US resident, having a child under the age of 18, and having at least one child who resides with the participant at least 50% of the time. Thirty-six participants were excluded for one or more of the following reasons: 1) multiple missing answers or missing answers to questions essential to analyses, such as gender or child insurance status; 2) very short amount of time taking the survey, which the researcher defined as being less than four minutes; or 3) inconsistent patterns to answering questions. In the final analysis, 184 participants were included, which was 75% of the participants who originally accessed the survey. The participants who identified as "American Indian or Alaska Native" and "Native Hawaiian or Pacific Islander" were combined with the participants who identified as "Multiracial" for the purpose of analysis, due to low numbers of participants identifying as such. The participants who identified as "Transgender," "Other," or both "Man/boy" and "Woman/girl" were combined to create "Non-Cisgender" for the purpose of analysis due to low numbers of participants identifying as such. All data analysis and screening used the Statistical Package for the Social Sciences (SPSS 26). Before conducting the analyses, all data were screened for statistical assumptions, outliers, and normality. There was no out-of-bounds data, and no missing data. An analysis of the pairwise plots indicated linearity and homoscedasticity of the continuous variables. Significant skewness was found in several variables. Parent age had a skewness of 6.07 (SE = 0.18), child age had a skewness of 3.73 (SE = 0.18), total ACE score had a skewness of 8.05 (SE = 0.18), total childhood THQ score had a skewness of 13.35 (SE =

0.18), total adulthood THQ score had a skewness of 7.91 (SE = 0.18), and number of children residing in the home had a skewness of 9.56 (SE = 0.18). Significant kurtosis was also found in total childhood THQ score, which showed kurtosis of 23.539 (SE = 0.36). According to Tabachnick and Fidell (2007), if one's data is reasonably distributed and reasonably homogenous, which this data was, data transformation is not necessary and there is likely to be nothing gained through data transformation. Additionally, Dube et al. (2004) and Mueser et al. (2001) do not recommend transforming the ACEs Questionnaire or THQ scores in data analysis.

Demographics

The survey participants' ages ranged from 20 years old to 66 years old, and most of the participants (56.3%) were between the ages of 25 and 36. The survey participant children's ages ranged from less than one year to 17 years old with most of the children (76.7%) being between the ages of two and 10. Ninety-four participants identified as man/boy (51.1%), 80 identified as woman/girl (43.5%), and 10 participants identified as Non-Cisgender (5.4%). Regarding the children about whom the participants answered the survey, 120 identified as man/boy (65.2%), 57 identified as woman/girl (31%), six identified as Non-Cisgender (3.3%), and one participant stated they "prefer not to answer" (.5%).

While the participants varied in racial and ethnic identity, participants identifying as White made up the majority of participants. 137 participants identified as White (74.5%), 23 participants identified as Black or African American (12.5%), two participants identified as American Indian of Alaska Native (1.1%), eight participants identified as Asian (4.3%), one participant identified as Native Hawaiian or Pacific Islander (.5%), nine participants identified as Latino/a/x (4.9%), three participants identified as Multiracial (1.6%), and one participant identified as other and indicated "Hispanic" in the open text box (.5%). Participants who

identified as “Multiracial” had the opportunity to write their racial and ethnic identities into an open text box and wrote: Asian and White; Eurasian; Mixed. Regarding the children the participants answered the survey about, the racial and ethnic identity demographics were quite similar. One hundred twenty eight of the children identified as White (69.6%), 22 identified as Black of African American (12%), two identified as Native American or Alaska Native (1.1%), eight identified as Asian (4.3%), one identified as Native Hawaiian or Pacific Islander (.5%), 10 identified as Latino/a/x (5.4%), one identified as other (.5%) and 12 identified as Multiracial (6.5). The participants who identified as Multiracial were able to write in their ethnic and racial identities, and the following answers were submitted: American Indian; White and Asian; Asian, Hispanic, and White; Caucasian and African American; EurAsian; Hispanic White; Mexican and White; mixed; White/Tribal peoples; White and Latino; White/Black.

Participants were also asked about the highest level of education they have completed, with the majority of participants completing a two-year or four-year degree (58.2%). In regards to participant relationship status, 71.2% were married and 9.2% were cohabitating. The majority of participants were employed full time (80.4%), and 63.6% of participant said religion is somewhat or very important to them. The majority of children about whom participants answered the survey completed the majority of their school in public school (64.1%). Participants were asked about their yearly household income, and the majority of participants indicated a household income between $30,000 and $79,999 (56%).

Participants were also asked about their own and their children’s mental health care services. The majority of participants stated that their child does have health insurance that would cover mental health care services (65.2%). Participants were asked if they have or were currently using health care services and 128 (69.6%) stated they were not, while 56 (30.4%)

stated that they were currently using mental health care services. Participants were also asked if the child they answered the survey about has or is currently using mental health care services. One hundred forty-five (78.8%) stated "no," while 39 (21.2%) stated "yes." Additionally, participants indicated that 50 (27.2%) of the children about whom the survey was answered were prescribed medication for behavioral or emotional issues while 134 (72.8%) were not.

Table 1. Demographics (*n* = 184)

Parent Age (N = 184)	**Frequency**	**Percentage**
20 – 25	28	15.22%
26 – 30	55	28.89%
31 – 35	28	15.22%
36 – 40	31	16.85%
41 – 45	16	8.7%
46 – 50	11	5.98%
51 – 55	4	2.17%
56 – 60	6	3.71%
61 - 66	5	3.26%
Parent Gender (N = 184)	**Frequency**	**Percentage**
Man/Boy	94	51.1%
Woman/Girl	80	43.5%
Non-Cisgender	10	5.4%
Parent Racial/Ethnic Identity (N = 184)	**Frequency**	**Percentage**
White	137	74.5%
Black or African American	23	12.5%
American Indian or Alaska Native	2	1.1%
Asian	8	4.3%
Native Hawaiian or Pacific Islander	1	0.5%
Latino/a/x	9	4.9%
Multiracial	3	1.6%
Other	1	0.5%

Table 1. Continued

Current Relationship Status (N = 184)	**Frequency**	**Percentage**
Cohabitating	17	9.2%
Dating	11	6.0%
Divorced	10	5.4%
Married	131	71.2%
Never Married	3	1.6%
Separated	3	1.6%
Single	9	4.9%
Highest Level of Education Completed (N = 184)	**Frequency**	**Percentage**
Less than high school	1	0.5%
High school graduate	12	6.5%
Some college	43	23.4%
2 year degree	23	12.5%
4 year degree	84	45.7%
Professional degree	20	10.9%
Doctorate	1	0.5%
Current Employment Status (N = 184)	**Frequency**	**Percentage**
Employed full time	148	80.4%
Employed part time	21	11.4%
Not employed, looking for work	4	2.2%
Not employed, not looking for work	7	3.8%
Student	2	1.1%
Other	2	1.1%
Approximate Household Income (N = 184)	**Frequency**	**Percentage**
Less than $10,000	6	3.3%
$10,000 - $19,999	12	6.5%
$20,000 - $29,999	15	8.2%
$30,000 - $39,999	22	12.0%
$40,000 - $49,999	23	12.5%
$50,000 - $59,999	23	12.5%
$60,000 - $69,999	18	9.8%
$70,000 - $79,999	17	9.2%
$80,000 - $89,999	12	6.5%
$90,000 - $99,999	9	4.9%
$100,000 - $149,999	17	9.2%
More than $150,000	10	5.4%

Table 1. Continued

Importance of Religion (N = 184)	**Frequency**	**Percentage**
Not at all Important	49	26.6%
Not too Important	18	9.8%
Somewhat Important	53	28.8%
Very Important	64	34.8%
Child's Age (N = 184)	**Frequency**	**Percentage**
Less than 1 year	1	0.5%
1	6	3.3%
2	13	7.1%
3	13	7.1%
4	17	9.2%
5	32	17.4%
6	18	9.8%
7	11	6.0%
8	10	5.4%
9	9	4.9%
10	18	9.8%
11	4	2.2%
12	6	3.3%
13	7	3.8%
14	7	3.8%
15	3	1.6%
16	2	1.1%
17	7	3.8%
Child's Gender (N = 184)	**Frequency**	**Percentage**
Man/boy	120	65.2%
Woman/girl	57	31.0%
Non-Cisgender	6	3.3%
Prefer not to answer	1	0.5%
Child's Racial/Ethnic Identity (N = 184)	**Frequency**	**Percentage**
White	128	69.6%
Black or African American	22	12.1%
American Indian or Alaska Native	2	1.1%
Asian	8	4.3%
Native Hawaiian or Pacific Islander	1	0.5%
Latino/a/x	10	5.4%
Multiracial	12	6.5%
Other	1	0.5%

Table 1. Continued

Setting in Which Child has Completed Majority of Schooling (N = 184)	**Frequency**	**Percentage**
Public	118	64.1%
Private Secular	26	14.1%
Religious School	9	4.9%
Homeschool	22	12.0%
Other	5	2.7%
How Many Children Reside in the Home at Least 50% of the Time (N = 184)	**Frequency**	**Percentage**
1	84	45.7%
2	55	29.9%
3	29	15.8%
4	8	4.3%
5	6	3.3%
6	1	0.5%
8	1	0.5%

Instrumentation

The instruments used in this study were the Columbia Impairment Scale, the Trauma History Questionnaire, and the Adverse Childhood Experiences Questionnaire. The mean and standard deviation of each scale are listed in Table 2 below (see Table 2). The Cronbach's alpha was calculated for the CIS, but no kappa statistics were calculated for the THQ or ACE Questionnaire, which follows the procedures set by Dube et al. (2004) and Mueser et al. (2001) in previous uses of these scales for research.

Table 2. Instruments and Descriptive Statistics

Scales	# of items	Possible Range	Observed Range	N	Mean	Standard Deviation	Cronbach's Alpha	Cronbach's Alpha from This Study
Columbia Impairment Scale (CIS)	13	0 – 52	0 - 38	184	12.76	9.66	0.85 - 0.90	.823
Trauma History Questionnaire (THQ)	24	0 – 24	0 - 16	184	3.83	3.281	N/A	N/A
THQ Adult	24	0 – 24	0 – 16	184	2.49	2.601	N/A	N/A
THQ Child	24	0 – 24	0 – 16	184	1.91	2.399	N/A	N/A
ACE Questionnaire	10	0 - 10	0 - 10	184	1.95	2.459	N/A	N/A

Correlations

Pearson correlation analyses were run on continuous variables to assess for possible relationships (N = 184). Parent age and child age were significantly correlated ($r = .529$, $p < 0.01$). Parent age and THQ score for adulthood were significantly correlated ($r = .268$, $p < 0.01$). Child age was significantly correlated with THQ score for adulthood ($r = .156$, $p < 0.05$) and number of children residing in the home at least 50% of the time ($r = .207$, $p < 0.01$). The ACE score was significantly correlated with the THQ score for childhood ($r = .485$, $p < 0.01$) and the THQ score for adulthood ($r = .422$, $p < 0.01$), which was expected, due to the fact that both the ACE Questionnaire and the THQ are trauma measures. The total ACE score was significantly correlated with number of children residing in the home at least 50% of the time ($r = .176$, $p < 0.05$). The THQ score for adulthood is significantly correlated with the THQ score for childhood ($r = .416$, $p < 0.01$). Finally, the total CIS score was significantly correlated with the number of children residing in the home at least 50% of the time ($r = .336$, $p < 0.01$).

Table 3. Correlations

	Adjusted Parent Age	Adjusted Child Age	Total ACE Score	Total Child THQ Score	Total Adult THQ Score	Total CIS Score	Number Children in Home
Adjusted Parent Age		.529**	-0.059	0.037	.268**	-0.075	0.056
Adjusted Child Age	.529**		0.061	0.131	.156*	0.018	.207**
Total ACE Score	-0.059	0.061		.485**	.422**	0.075	.176*
Total Child THQ Score	0.037	0.131	.485**		.416**	0.080	0.132
Total Adult THQ Score	.268**	.156*	.422**	.416**		0.085	0.035
Total CIS Score	-0.075	0.018	0.075	0.080	0.085		.336**
Number Children in Home	0.056	.207**	.176*	0.132	0.035	.336**	

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

*. Correlation is significant at the 0.05 level (2-tailed).

Hypothesis One

A binary logistic regression analysis was conducted to study the first hypothesis regarding the impact of the parent's experience of trauma in childhood on the relationship between the parent's assessment of their child's overall functioning and the parent's belief that their child would benefit from mental health care services. The parent belief that their child would benefit from mental health care services was the dependent variable and the independent variables were as follows: parent ACE score, parent childhood THQ score, parent CIS score, interaction between parent ACE and parent CIS score, interaction between parent childhood THQ score and parent CIS score. Control variables were as follows: parent race, child race, parent gender, child gender, child insurance status, child mental health care utilization, parent mental health care utilization, health or educational professional belief that the child could benefit from mental health care services, parent relationship status. The regression sample consisted of 184 participants and missing information excluded one participant from the analysis.

The logistic regression model was statistically significant, $\chi^2(4) = 90.226$, $p < .0005$ with a Nagelkerke $R^2 = .539$. According to Babbie, this measure is an acceptable substitute in binomial logistic regression for the R^2 used in logistic (2016). The model explained 53.9% of the variance in the parent belief about whether their child would benefit from mental health care services, and correctly classified 83.6% of cases. Variables found to be significant were parent age, child mental health care services utilization, professional belief that child may benefit from mental health care services, parent relationship status, and total childhood THQ score (as shown in Table 4). Parent age and current or previous/current child mental health care utilization were positively associated with the likelihood that parents would believe their child would benefit from mental health care services. For each unit increase in the THQ childhood score, the parent

was 1.51 times more likely to believe that their child would benefit from mental health care services. Parents who reported that a health or educational professional had stated their child would benefit from mental health care services were 11.5 times more likely to believe that their child would benefit from mental health care services than parents who had not had a health or educational professional state their child would benefit from mental health care services.

This hypothesis was originally concerned with the interaction between the parents' own trauma in childhood and the parents' assessment of their child's functioning via the CIS and its relationship to the parent's belief that their child would benefit from mental health care services. However, data analysis of the sample showed no significant relationship between the parents' assessment of their child's functioning via the CIS and the parent's belief that their child would benefit from mental health care services. It was also of interest that while there was a relationship between the parent's childhood THQ score and the parent's belief that their child would benefit from mental health care services, there was no significant relationship between the parent's ACE score and the parent's belief that their child would benefit from mental health care services.

Table 4. Hypothesis One

	B	SE	Wald	*df*	*P*	Odds Ratio	95% CI for Odds Ratio	
							Lower	Upper
Parent Age	.074	.027	7.289	1	.007*	1.007	1.020	1.136
Child Age	-.102	.069	2.192	1	.139	.903	.789	1.034
Parent Education Level	-.088	.213	.171	1	.679	.916	.604	1.389
Household Income	.043	.092	.220	1	.639	1.044	.871	1.251
Parent MHCS Utilization	.531	.572	.863	1	.353	1.701	.555	5.216
Child Insurance Status	.503	.566	.792	1	.374	6.294	1.216	32.575
Child MHCS Utilization	-1.840	.839	4.810	1	.028*	.159	.031	.822
Professional Belief/Child Benefit	-2.442	.767	10.137	1	.001*	.087	.019	.391
Total Childhood THQ Score	.414	.192	4.641	1	.031*	1.512	1.038	2.204
Total ACE Score	-.127	.191	.441	1	.506	.881	.606	1.280
Total CIS Score	.061	.034	3.217	1	.073	1.063	.944	1.137
Total ACE X Total CIS	-.005	.010	.262	1	.609	.995	.976	1.014
Total Childhood THQ X Total CIS	-.012	.009	1.745	1	.186	.988	.970	1.006

* p < .05, ** p <.01

Hypothesis Two

A binary logistic regression analysis was conducted to study the second hypothesis regarding the impact of the parent's experience of trauma in adulthood on the relationship between the parent's assessment of their child's overall functioning and the parent's belief that their child would benefit from mental health care services. The parent belief that their child would benefit from mental health care services was the dependent variable and the independent variables were as follows: parent adulthood THQ score, parent CIS score, interaction between parent adulthood THQ score and parent CIS score. The following were control variables: parent race, child race, parent gender, child gender, child insurance status, child mental health care utilization, parent mental health care utilization, health or educational professional belief that the child could benefit from mental health care services, parent relationship status. The analysis used the following scales: Trauma History Questionnaire (THQ) adulthood score only, and Columbia Impairment Scale (CIS) to assess parent experience experiences of trauma and parent assessment of their child's functioning. The regression sample consisted of 184 participants and missing information excluded one participant from the analysis.

The logistic regression model was statistically significant, $X^2(4) = 84.950$, $p < .0005$ with a Nagelkerke $R^2 = .514$. The model explained 51.4% of the variance in the parent belief about whether their child would benefit from mental health care services and correctly classified 83.1% of cases. Variables found to be significant were parent age and professional belief that child may benefit from mental health care services (as shown in Table 5) For each year increase in parent age, parents were 1.06 times more likely to believe that their child would benefit from mental health care services. Parents who reported that a health or educational professional had stated their child would benefit from mental health care services were 7.59 times more likely to believe

that their child would benefit from mental health care services than parents who had not had a health or educational professional state their child would benefit from mental health care services.

This hypothesis was originally concerned with the interaction between the parents' own trauma in adulthood and the parents' assessment of their child's functioning via the CIS and its relationship to the parent's belief that their child would benefit from mental health care services. However, data analysis of the sample showed no significant relationship between the parents' assessment of their child's functioning via the CIS and the parent's belief that their child would benefit from mental health care services. It was also of interest that there was no significant relationship between the parent's adulthood THQ score and the parent's belief that their child would benefit from mental health care services.

Table 5. Hypothesis Two

	B	SE	Wald	*df*	*P*	Odds Ratio	95% CI for Odds Ratio	
							Lower	Upper
Parent Age	.060	.028	4.582	1	.032*	1.062	1.005	1.112
Child Age	-.088	.066	1.786	1	.181	.915	.804	1.042
Parent Education Level	.021	.207	.010	1	.919	1.021	.681	1.531
Household Income	.052	.087	.350	1	.554	1.053	.888	1.249
Parent MHCS Utilization	.500	.573	.762	1	.383	1.649	.537	5.064
Child Insurance Status	.437	.528	.687	1	.407	1.549	.550	4.357
Child MHCS Utilization	1.217	.699	3.030	1	.082	3.378	.858	13.303
Professional Belief/Child Benefit	2.026	.716	8.015	1	.005*	7.587	1.866	30.856
Total Adulthood THQ Score	.154	.183	.708	1	.400	1.166	.815	1.670
Total CIS Score	.023	.038	.369	1	.543	1.024	.950	1.103
Total Adulthood THQ X Total CIS	.000	.011	.000	1	.982	1	.978	1.022

* p < .05, ** p <.01

In summary, no significant relationship was found between parents' assessment of overall child functioning (via CIS) and parent belief about whether their child would benefit from mental health care services or between the interaction of the parent assessment of overall child functioning with the parent trauma and the parent belief about whether their child would benefit from mental health care services. However, significant positive relationships were found between the parent belief that their child would benefit from mental health care services and parent age, current or prior mental health care service utilization by the child, parent experience of trauma in childhood (as measured by the THQ) and a healthcare or education professional stating to the parent that they believe the child would benefit from mental health care services.

CHAPTER 5: DISCUSSION

The purpose of this study was to examine the interaction between the parents' own trauma and the parents' assessment of their child's functioning via the CIS and its relationship to the parent's belief that their child would benefit from mental health care services. While the researcher acknowledges that there are numerous significant external, systemic barriers to child and adolescent mental health care, this study aimed to achieve a greater understanding of some of the internal family barriers that impact children and adolescents' access to mental health care service, specifically parent assessment of whether their child would benefit from mental health care services.

Hypotheses

Hypothesis one and two both assumed that there would be a relationship between a parent's assessment of their child's overall functioning and the parent's belief about whether their child would benefit from mental health care services. However, data analysis showed no such relationship. In the data analysis, there was no significant relationship between the parent assessment of overall child functioning and the parent belief about whether their child would benefit from mental health care services, nor was there a significant relationship between the interaction of the parent assessment of overall child functioning with the parent trauma and the parent belief about whether their child would benefit from mental health care services. This lack of significant relationship between the parent's assessment of overall functioning and the parent's belief about whether their child would benefit from mental health care services is not entirely without precedent, as past research has indicated varying degrees of parental accuracy in rating their child's functioning and has also indicated that further research was necessary to

solidify the field's understanding of this relationship (Hoza et al., 2006; Morrissey-Kane & Prinz, 1999; Renk, 2005; Shanley & Reid, 2014).

Research offers a few possible internal family explanations of why a parent's belief about whether their child would benefit from mental health care services might not be significantly related with their assessment of their child's overall functioning. Williams and Chapman (2012) state that parents are not only required to recognize that there is a problem with their child's functioning, but that they must believe that that problem rises to level of warranting intervention in order to seek services for their child. Williams and Chapman (2012) also state that qualities of the parent-child relationship, such as degree of communication and degree of emotional support, may also affect parents' willingness to seek mental health care services for their children. Baker-Ericzen et al. (2010, p. 398) state that parents are the "key agent" in children seeking and utilizing mental health care services, but that "high levels of child dysfunction" alone are not enough to ensure that parents will seek mental health care services for their children, but rather that a high degree of child dysfunction *combined* with high levels of parent and family stress is the circumstance that is most likely to result in parents believing that their child would benefit from mental health care services.

While both Hypothesis One and Hypothesis Two were not supported due to the lack of significant relationship between the parent's assessment of overall child functioning and the parent belief about whether their child would benefit from mental health care services, the study did indicate some significant relationships between other variables.

Significant Variables

Parent Age

Parent age was shown to have a significant, positive relationship with parent belief that their child would benefit from mental health care services in both logistic regression analyses; that which examined the impact of parent childhood trauma and that which examined the impact of parent adulthood trauma. This significant relationship may exist for many reasons. Parents who are older may have had a higher degree of exposure to mental health education and/or mental health care services because they have had more time to be exposed to these things. Parents who are older may be more likely to have experienced mental health care concerns with previous children, whether it be with their own children or witnessing issues with family and friends' children because they have had more time to also be exposed to such mental health care concerns.

Previous or Current Child MCHS Utilization

Previous or current child mental health care service utilization was shown to have a significant, positive relationship with parent belief that their child would benefit from mental health care services in the analysis examining the impact of parent childhood trauma. It follows that a parent whose child has previously utilized mental health care services or is currently utilizing mental health care services would believe that that same child would benefit from mental health care services.

Parent Trauma

The parent's childhood THQ was shown to have a positive, significant relationship with the parent's belief that their child would benefit from mental health care services. For each unit increase in the THQ childhood score, the parent was 1.51 times more likely to believe that their

child would benefit from mental health care services. However, the ACEs score and the adulthood THQ score were not shown to have any significant relationship with the parent belief that their child would benefit from mental health care services. One possible explanation for the fact that the THQ childhood score was significant while the ACEs score was not, is that while they appear to be measuring the same variable (childhood trauma), the THQ questionnaire has 24 items while the ACEs questionnaire has 10 items, and so the THQ accounts for more traumatic experiences. For instance, the THQ asks about severe or chronic illness, natural disasters, seeing dead bodies, and other traumatic experiences that the ACEs questionnaire does not acknowledge. It is also worth noting that the ACEs questionnaire is concerned, almost exclusively, with traumas that occur in the home environment (Felitti et al., 1998), while the THQ is concerned with trauma that occurs in the home environment but also in a range of environments outside the home and family. Traumas that are associated with negative or shameful feelings, or considered to private family topics in society, such as sexual assault, criminal activity, and child abuse, are more likely to be underreported (Anda et al., 2006). It follows that there would be a significant relationship between the childhood THQ score and the parent belief that their child would benefit from mental health care services but not between the ACEs score and the parent belief that their child would benefit from mental health care services (Anda et al., 2006; Felitti et al., 1988). Because the childhood THQ score takes a greater range of experiences into account and this range also includes topics that are more likely to be reported on, it essentially provides a greater variety of experiences for the parent belief to have (Anda et al., 2006; Felitti et al., 1988).

It is worth noting that the childhood THQ score had a significant relationship with the parent belief that their child would benefit from mental health care services but the adult THQ score did not have a significant relationship with the parent belief that their child would benefit

from mental health care services. Essentially, the data analysis showed that while there was a significant, positive relationship between a parent's childhood trauma and the parent belief that their child would benefit from mental health care services, there was no relationship between trauma that a parent experiences in adulthood and that parent's belief that their child would benefit from mental health care services. One possible explanation for the presence of significant relationship for childhood trauma and lack of significant relationship for adulthood trauma is that trauma experienced in childhood affects the brain and body differently than trauma experienced in adulthood (CDC 2019; Felitti et al., 1998; Felitti & Anda, 2010; SAMHSA, 2019). The difference in the effect of the trauma in childhood versus adulthood could impact the parent's perception of their child and whether or not their child would benefit from mental health care. Another possible reason that the effect of the trauma experienced in adulthood was different than the trauma experienced in childhood could be that the trauma that participants stated they had experienced in adulthood could be ongoing or very recent at the time the participant took the survey. If the participant was currently experiencing or had very recently experienced that trauma, they could be extremely preoccupied by coping with the emotional effects or logistical issues concerning the ongoing trauma. Additionally, the parent might be more likely to be experiencing diminished parent-child attachment, decreased parent sensitivity and impairment in or a lack of coping skills regarding issues with the child (Downey & Coyne, 1990; Lange et al., 2016; Lovejoy et al., 2000) with a recent trauma that has not been processed or resolved.

It is also worth noting that parents who experienced trauma in their own childhood may be more likely to associate childhood with trauma and/or emotional hardships and therefore may be more likely to believe that their child is encountering similar difficulties or suffering from similar emotional distress. This could be attributed to family projection process, a concept in

transgenerational family therapies that refers to a way that parents can transmit their own emotional issues to their children (Kerr & Bowen, 1988). Family projection process involves three components: the parent focuses on a child out of fear that something is wrong with the child; the parent interprets the child's behavior as confirming the fear; and the parent treats the child as if something is really wrong with child (Kerr & Bowen, 1988).

Health or Educational Professional Belief

The variable that had, by far, the strongest significant relationship with parent belief that their child would benefit from mental health care services was a health or education professional stating that they believed the child would benefit from mental health care services. In the analysis that focused on childhood trauma, parents who reported that a health or educational professional had stated their child would benefit from mental health care services were 11.5 times more likely to believe that their child would benefit from mental health care services than parents who had not had a health or educational professional state their child would benefit from mental health care services. In the analysis that focused on adulthood trauma, parents who reported that a health or educational professional had stated their child would benefit from mental health care services were 7.59 times more likely to believe that their child would benefit from mental health care services than parents who had not had a health or educational professional state their child would benefit from mental health care services.

The presence of this relationship is supported by previous research. Parents are widely acknowledged as being a key part of their children's diagnosis, treatment, and usage of mental health care services but are sometimes not the most accurate rater of their children's need for services and require additional raters to make appropriate decisions about the need for mental health care services (Baker-Ericzen et al. 2010; Hoza et al., 2006; Morrissey-Kane & Prinz,

1999; Renk, 2005; Shanley & Reid, 2014). In terms of additional raters to collaborate with parents, Renk (2005) found that mental health professionals appear to be most accurate in assessing a child's mental health (as corroborated by assessments and comparing multiple mental health professionals' assessments of the same child), followed by teachers and school counselors as the next most accurate evaluators, followed by mothers, then fathers, and then other adults in the children's lives. Furthermore, Williams and Chapman (2012) state that in order to believe their child would benefit from mental health care services, parents do not only need to recognize that there is a problem with their child's functioning, but they also must believe that that problem rises to level of warranting intervention in order to seek services for their child.

When reviewing this body of supporting research, it makes a great deal of sense that parents' belief that their child would benefit from mental health care services is significantly increased by a health or education professional stating that they believe the child would benefit from mental health care services. Parents may normalize their child's mental health issues and be unaware they may be rating their child inaccurately. In such instances, parents' belief may be influenced by the recommendation of an educational or mental health professional, by an increase in family stress due to the child's issues or by the recommendation to seek services, or if the severity of the child's issues increases significantly. Taking into account the existing body of research and results of the data analysis of this study, it follows that parents would be significantly more likely to believe their child would benefit from mental health care services if a health or education professional were to state they believe the child would benefit from mental health care services.

Clinical Implications

The two variables that were found to be most significantly related to parents' belief that their child would benefit from mental health care services were the parent's experience of trauma in childhood (as measured by the childhood THQ score) and a healthcare or education professional telling the parent they believe the child would benefit from mental health care services. While marriage and family theories, especially the transgenerational family therapies theory discussed in the literature review, acknowledge the impact of parent's experience on their child, the findings of this study reinforce the importance of having the parent of the child actively involved in the child's therapy as a central figure, not as a peripheral figure. The data analyses make it quite clear that a parent's experience of trauma in childhood has a significant impact on their child in that it has an impact on the child's access to mental health care services. Previous research indicates that a parent's experience of trauma in childhood has a significant impact on their child's mental health (Anda et al., 2006; Felitti & Anda, 2010; Larkin, Felitti, & Anda, 2014; Kuh, Ben-Shlomo, Lynch, & Hallqvist, 2003; Le-Scherban et al., 2018; Narayan et al., 2017; van der Kolk, 2014). Because the parent's experience of trauma in childhood not only affects their child's mental health, but also that child's access to services, it is imperative that therapists help parents to feel central to therapy in order to encourage parents to actively participate and recognize their central role. Actively involving the parent in the child's therapy may also familiarize the parent with therapy and help the parent become more comfortable with the process. If the parent feels more comfortable with and involved in the child's therapy, the therapist may be able to gain some degree of understanding of the parent's background and functioning and could recognize if the parent themselves may be in need of therapy to address any existing childhood trauma. If the parent is already familiar with therapy and the therapist,

they may be more receptive to the therapist's possible recommendation to therapy which would not only benefit the parent but the child as well.

A healthcare or education professional telling the parent that their child would benefit from mental health care services was, by far, the variable that was most significantly related to the parent's belief that their child would benefit from mental health care services. Essentially, a healthcare or education professional expressing that a child would benefit from mental health care services was more important the parent's experience of trauma and the parent's assessment of their child's overall functioning. This result indicates that increasing healthcare and education professionals' awareness of two things would have the greatest positive effect on a child's access to mental health care services: 1) the signs and symptoms of behavioral and emotional distress in children and 2) how and when to communicate a belief that a child would benefit from mental health care services to the parent(s). Therefore, it is essential that marriage and family therapists, as well as other mental health care professionals, advocate to be employed and placed more in schools, school systems, school administration, health care offices, and in health care education. According to NAMI (2019), during the 2015-2016 school year, approximately 71% of US public schools reported that they have access to diagnostic assessments for mental health disorders for students and approximately 64% of US public schools actually have some type of mental health treatment available. These numbers frequently change between school years due to shifts in funding, and NAMI (2019) states that it is necessary for these numbers to increase and remain stable in order to best serve the children in the schools. If marriage and family therapists can not only increase their presence in these systems, but also their role in training employees in these systems, there is a significant possibility that child access to mental health care services could be

improved, children could be referred earlier, and successful treatment could occur more frequently.

Limitations

One limitation of this study is that the sample of individuals who responded to the study was rather homogenous. In terms of demographics, 74.5% of respondents identified as white, 56.3% were between the ages of 25 and 36, 71.2% were married, 80.4% were employed full time, and 94.6% of respondents identified as cisgender. This homogeneity can be accounted for by the fact that "people with lower incomes, less education, living in rural areas or age 65 or older are underrepresented among internet users and those with high-speed internet access" (Pew Research Center, 2019, para. 2). The Pew research center states that the two out of ten adults who would be excluded from an internet only sample are very different from one another in "almost all major demographic, economic and political characteristics" while the adults who would not be excluded from an internet only sample tend to much more similar to one another (2015, para. 12). Because the survey was distributed solely online, it follows that individuals with lower incomes and lower education levels are underrepresented in the sample, and that the people who did respond to this internet only survey often answered questions similarly. People with lower incomes may not have the discretionary income to purchase a computer or an internet connection, and may not have the spare time to utilize a computer in a library due to working multiple jobs to survive.

The racial and ethnic breakdown of the sample population closely mimics the results reflected by the most recent US Census, with the percentage of all racial and ethnic groups being within 2% of one another between the sample population and the census population, except for the Latino/a/x population, which was 18.3% in the Census data and 4.9% in the sample data

(United States Census Bureau, 2018). While the sample population somewhat mimics the general population in this sense, the homogeneity of the sample means that the study may not have captured the experience or ideas of members of the population who occupy different identities than those who made up the majority of the sample, and make the study results less generalizable. Another issue that was related to the homogeneity of the sample was that the researcher needed to combine some identity groups for the purposes of still being able to analyze the responses of all respondents. For example, "transgender," "non-cisgender," and "other" responses were combined into a single "non-cisgender" category in the parent and child gender questions and "American Indian or Alaska Native," "Native Hawaiian or Pacific Islander," "Multiracial," and "Other" responses were combined into a single "Multiracial" category in parent and child race/ethnicity questions for analysis. The author acknowledges that merging that combining these different identities into one single category is not necessarily in line with the identities that the respondents reported. The author decided to merge the responses into one response in order to still be able to utilize the responses of these individuals and keep their experiences and perspectives present in the study rather than fully eliminate participants whose identity was not often claimed in the demographic questions.

There were also some limitations that associated with the study of trauma in this research. Firstly, survey respondents generally tend to under-report experiences and feelings that are generally considered negative, shameful, or private in society (Anda et al., 2006). Therefore, there is a risk that the respondents under-reported the traumas they have experienced in their lives, which could then have an impact on the significance of the relationship between variables or the relationships themselves. Additionally, the researcher asked the respondent if they had

experienced trauma while they were over the age of 18, but did not ask if the trauma was ongoing, recent, or had occurred in the distant past. It may have been beneficial for the researcher to know if the participant was currently experiencing or had very recently experienced that trauma because that participant could be extremely preoccupied by coping with the emotional effects or logistical issues concerning the ongoing trauma. Additionally, the participant might be more likely to be experiencing diminished parent-child attachment, decreased parent sensitivity and impairment in or a lack of coping skills regarding issues with the child (Downey & Coyne, 1990; Lange et al., 2016; Lovejoy et al., 2000) with a recent trauma that has not been processed or resolved. Both of these circumstances that might result from a very recent or ongoing trauma could have significantly affected the participant's responses to survey questions, and being able to control for whether the trauma was had occurred recently or in the distant past could have provided the researcher with valuable insight.

Finally, it is worth noting that the researcher only asked parents to provide information about themselves and their children and did not collect any directly from the children themselves. Because the researcher only collected information from one party in this dyad, it must be acknowledged that there is only one side of the relationship being represented in the responses, not both sides of the relationship.

Future Directions

This study aimed to achieve a greater understanding of some of the internal family barriers that impact children and adolescents' access to mental health care services by examining the impact of parents' experience of trauma on the interaction between a parent's assessment of their child's overall functioning and the parent's belief that their child would benefit from mental health care services. A possible direction for future research could be to examine this internal

family barrier in the context of external family barriers that can also have a significant impact on mental health care service access, such as availability of services, cost of services, available education on mental health care services and how to access them.

Another future direction for research could be to conduct similar research to the research conducted in this study but with a greater diversity in the sample in areas such as race, gender, geographic location, education level, and socioeconomic status. This research may lead to more generalizable results and important information about how these aspects of respondents' identities and lives impact a possible relationship between a parent's assessment of their child's overall functioning and that parent's belief about whether their child could benefit from mental health care services. Additionally, the body of research regarding the accuracy of parent ratings of their children's mental health, which included this study, offers an ambiguous conclusion about the overall accuracy of this rating. Future research should also focus on the accuracy of parent's rating of their children's mental health, what factors influence this rating, and even the meaning of an "accurate" rating itself.

Conclusion

The importance of parents to their children's access to, and successful participation in mental health care services cannot be overstated. However, there appears to be a disruption between a parent's assessment of their child's overall functioning and their belief that their child would benefit from mental health care services. While a parent's own experience of trauma as a child makes a parent more likely to believe their child would benefit from mental health care services, a high degree of functional impairment in the child's behavior does not appear to make parents more likely to believe their child would benefit from mental health care services. However, an education or healthcare professional telling the parent that the child would benefit

from mental health care services is a stronger predictor of a parent believing their child would benefit from mental health care services than any other variable examined in this study, parental experience of childhood trauma included. Armed with this knowledge of the importance of health care and education professionals in helping parents to recognize the possible benefit of mental health care services for their children, researchers, clinicians, and all those interested in children's access to mental health care can focus on training educators and health care professionals on how to recognize the signs that a child may need mental health care services and also how to communicate this belief to the parents of the child and assist those parents in locating services. This collaborative approach to improving children's access to mental health care services could prove to be beneficial for all collaborators in this system, but especially the children.

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APPENDIX A: INFORMED CONSENT

Research Participant Consent Form
Impact of Parent Trauma on Child Mental Health Care Services
Dr. Anne B. Edwards and Rachael Martin Department of Behavior Sciences Purdue University

What is the purpose of this study?
You are being asked to participate in a study designed by Dr. Anne B. Edwards and Rachael Martin. We want to understand the trauma experiences you have had and your child's general level of functioning.

What will I do if I choose to be in this study?
If you choose to participate, you acknowledge that you are at least 18 years old, a U.S. citizen, a parent, and you have at least one child between the ages of 4 and 18 that is currently living in your home at least 50% of the time and who you also have at least joint legal custody over. If you have more than one child residing in your home who meets these criteria, please respond to the survey regarding the child you believe to have the most difficulty at home and/or at school. You will be asked to complete a survey asking about your personal experiences with trauma and your child's overall functioning. There will also be questions regarding your own and your child's experiences with mental health care services. You may choose not to answer any particular question if it makes you feel uncomfortable, or you may withdraw your participation at any time without penalty.

How long will I be in the study?
The survey should take approximately 15 to 20 minutes to complete.

What are the possible risks or discomforts?
Breach of confidentiality is a risk. To minimize this risk, only the researchers listed above will access the data from this study, and no personally identifying information will be collected during the study. The questions may make you feel uncomfortable and could result in minimal emotional distress. You can go to therapistlocator.net or therapists.psychologytoday.com to locate a therapist or trained mental health professional to discuss any distress you feel while taking this survey. You can find resources regarding trauma and trauma-informed care at www.samhsa.gov/trauma-violence or www.ptsd.va.gov. You can find resources and information regarding Adverse Childhood Experiences at www.cdc.gov/violenceprevention/childabuseandneglect/ACEstudy/index.html. Thank you for participating in this survey.

Are there potential benefits?
You will not directly benefit from this study. You will have a chance to take part in research, and your participation may, thus, contribute to the scientific understanding about the impact of trauma experienced by parents on their children's access to mental health care services.

Will I receive payment or other incentive?
You will receive payment of 40 cents for participating in this research project, so long as you meet the study inclusion criteria and you complete the appropriate verification question to ensure your active participation.

Will information about me and my participation be kept confidential?
There is no personally identifying information on this survey; all responses will remain anonymous and will be used only in combination with the responses of other participants in this and related studies. In addition, you may choose not to answer particular questions or to withdraw your participation at any time, without penalty. All data gathered in this study will be accessed by the researchers. The data file will be used for preparation of research reports related to this study and kept for a period of three years after publication of any articles related to this study. The project's research records may be reviewed by departments at Purdue University responsible for regulatory and research oversight.

What are my rights if I take part in this study?
Your participation in this study is voluntary. You may choose not to participate, and if you agree to participate, you can withdraw your participation at any time without penalty or loss of benefits to which you are otherwise entitled.

Who can I contact if I have questions about the study?
If you have questions, comments, or concerns about this research project, you can talk to one of the researchers. Please contact Rachael Martin at mart1309@pnw.edu. If you have questions about your rights while taking part in the study or have concerns about the treatment of research participants, please call the Human Research Protection Program at (765) 494-5942, email (irb@purdue.edu), or write to: Human Research Protection Program - Purdue University Ernest C. Young Hall, Room 1032 155 S. Grant St., West Lafayette, IN 47907-2114.

Documentation of Informed Consent
I have had the opportunity to read this consent form and have the research study explained. I have had the opportunity to ask questions about the research study, and my questions have been answered. I am prepared to participate in the research study described above. By answering "Yes" I certify that I am least 18 years old, a U.S. citizen, a parent, and that I have at least one child between the ages of 4 and 18 that is currently living in my home at least 50% of the time and who I also have at least joint legal custody over. If I have more than one child residing in my home who meets these criteria, I certify that I am responding to the survey regarding the child I believe to have the most difficulty at home and/or at school, and that I agree to participate in this study.

o Yes
o No

APPENDIX B: SURVEY QUESTIONS

If you have more than one child who meets the requirements for the study, please answer all questions about the child who you believe to have the most behavioral and emotional difficulties.

What is your age? _____

What is your child's age? _____

How many children reside in your home at least 50% of the time? _____

Check one or more options that reflect your gender
- o Man/boy
- o Non-binary
- o Transgender
- o Woman/girl
- o Other _____
- o Prefer not to answer

Check one or more options that reflect your racial/ethnic identity
- o American Indian or Alaska Native
- o Asian
- o Black or African American
- o Latino/a/x
- o Multiracial _____
- o Native Hawaiian or Pacific Islander
- o White
- o Other _____

What is the highest level of education you have completed?
- o Less than high school
- o High school graduate
- o Some college
- o 2-year degree
- o 4-year degree
- o Professional degree
- o Doctorate

What is your current relationship status? (Choose all that apply)
- o Cohabiting
- o Dating
- o Divorced
- o Married
- o Never married
- o Separated
- o Single
- o Widowed

What is your relationship status with the parent of your child?
- o Dating
- o Cohabiting
- o Married
- o Widowed
- o Divorced
- o Separated

What is your current employment status?
- o Disabled
- o Employed full time
- o Employed part time
- o Retired
- o Student
- o Unemployed looking for work
- o Unemployed not looking for work
- o Other _____

What is your religious affiliation?
- o Agnostic
- o Atheist
- o Buddhist
- o Christian - Catholic
- o Christian - Mormon
- o Christian - Orthodox
- o Christian - Protestant
- o Christian - Other _____
- o Hindu
- o Jewish
- o Muslim
- o Spiritualist _____
- o Other World Religion _____

Check one or more options that reflect your child's gender
- o Man/boy
- o Non-binary
- o Transgender
- o Woman/girl
- o Other _____
- o Prefer not to answer

Check one or more options that reflect your child's racial/ethnic identity
- o American Indian or Alaska Native
- o Asian
- o Black or African American
- o Latino/a/x
- o Multiracial _____
- o Native Hawaiian or Pacific Islander
- o White
- o Other _____

What is the highest level of education your child has completed?
- o Less than high school
- o High school graduate
- o Some college

In what school setting has your child has completed the majority of their education? (Choose all that apply)
- o In a public school setting
- o In a private school setting
- o In a religious school setting
- o In a home school setting

What is your approximate household income?
- o Less than $10,000
- o $10,000 - $19,999
- o $20,000 - $29,999
- o $30,000 - $39,999
- o $40,000 - $49,999
- o $50,000 - $59,999
- o $60,000 - $69,999
- o $70,000 - $79,999
- o $80,000 - $89,999
- o $90,000 - $99,999
- o $100,000 - $149,999
- o More than $150,000

The following is a series of questions about serious or traumatic life events. These types of events actually occur with some regularity, although we would like to believe they are rare, and they affect how people feel about, react to, and/or think about things subsequently. Knowing about the occurrence of such events, and reactions to them, will help us to develop programs for prevention, education, and other services. The questionnaire is divided into questions covering crime experiences, general disaster and trauma questions, and questions about physical and sexual experiences. For each event, please indicate whether it happened by answering "yes" if it did and "no" if it did not. If you answer "yes" please indicate the number of times and your approximate age when it happened (give your best guess if you are not sure). Also note the nature of your relationship to the person involved and the specific nature of the event, if appropriate.

Has anyone ever tried to take something directly from you by using force or the threat of force, such as a stick-up or mugging?

- o No
- o Yes

Display This Question:
If Has anyone ever tried to take something directly from you by using force or the threat of force,... = Yes

Please indicate the number of times this occurred

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Display This Question:
If Has anyone ever tried to take something directly from you by using force or the threat of force,... = Yes

At what age did this/these event(s) occur?

- o 18 or younger
- o 19 or older
- o Both

Has anyone ever attempted to rob you or actually robbed you (i.e., stolen your personal belongings)?

o No
o Yes

Display This Question:
If Has anyone ever attempted to rob you or actually robbed you (i.e., stolen your personal belonging... = Yes

Please indicate the number of times this occurred
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Display This Question:
If Has anyone ever attempted to rob you or actually robbed you (i.e., stolen your personal belonging... = Yes

At what age did this/these event(s) occur?
o 18 or younger
o 19 or older
o Both

Has anyone ever attempted to or succeeded in breaking into your home when you were not there?
o No
o Yes

Display This Question:
If Has anyone ever attempted to or succeeded in breaking into your home when you were not there? = Yes

Please indicate the number of times this occurred
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Display This Question:
If Has anyone ever attempted to or succeeded in breaking into your home when you were not there? = Yes

At what age did this/these event(s) occur?
o 18 or younger
o 19 or older
o Both

Has anyone ever attempted to or succeeded in breaking into your home when you were there?
o No
o Yes

Display This Question:
If Has anyone ever attempted to or succeeded in breaking into your home when you were there? If Yes,... = Yes

Please indicate the number of times this occurred
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20 or over

Display This Question:
If Has anyone ever attempted to or succeeded in breaking into your home when you were there? If Yes,... = Yes

At what age did this/these event(s) occur?
o 18 or younger
o 19 or older
o Both

Have you ever had a serious accident at work, in a car, or somewhere else?
o No
o Yes

Display This Question:
If Have you ever had a serious accident at work, in a car, or somewhere else? = Yes

Please specify below
_____

Display This Question:
If Have you ever had a serious accident at work, in a car, or somewhere else? = Yes

Please indicate the number of times this occurred
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Display This Question:
If Have you ever had a serious accident at work, in a car, or somewhere else? = Yes

At what age did this/these event(s) occur?
o 18 or younger
o 19 or older
o Both

Have you ever experienced a natural disaster such as a tornado, hurricane, flood or major earthquake, etc., where you felt you or your loved ones were in danger of death or injury?
o No
o Yes

Display This Question:
If Have you ever experienced a natural disaster such as a tornado, hurricane, flood or major earthqu... = Yes

Please specify below
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Display This Question:
If Have you ever experienced a natural disaster such as a tornado, hurricane, flood or major earthqu... = Yes

Please indicate the number of times this occurred
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Display This Question:
If Have you ever experienced a natural disaster such as a tornado, hurricane, flood or major earthqu... = Yes

At what age did this/these event(s) occur?
o 18 or younger
o 19 or older
o Both

Have you ever experienced a "man-made" disaster such as a train crash, building collapse, bank robbery, fire, etc., where you felt you or your loved ones were in danger of death or injury?
o No
o Yes

Display This Question:
If Have you ever experienced a "man-made" disaster such as a train crash, building collapse, bank ro... = Yes

Please specify below
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Display This Question:
If Have you ever experienced a "man-made" disaster such as a train crash, building collapse, bank ro... = Yes

Please indicate the number of times this occurred
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Display This Question:
If Have you ever experienced a "man-made" disaster such as a train crash, building collapse, bank ro... = Yes

At what age did this/these event(s) occur?
o 18 or younger
o 19 or older
o Both

Have you ever been exposed to dangerous chemicals or radioactivity that might threaten your health?

o No
o Yes

Display This Question:
If Have you ever been exposed to dangerous chemicals or radioactivity that might threaten your health? = Yes

Please indicate the number of times this occurred

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Display This Question:
If Have you ever been exposed to dangerous chemicals or radioactivity that might threaten your health? = Yes

At what age did this/these event(s) occur?

o 18 or younger
o 19 or older
o Both

Have you ever been in any other situation in which you were seriously injured?
o No
o Yes

Display This Question:
If Have you ever been in any other situation in which you were seriously injured? = Yes

Please specify below
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Display This Question:
If Have you ever been in any other situation in which you were seriously injured? = Yes

Please indicate the number of times this occurred
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Display This Question:
If Have you ever been in any other situation in which you were seriously injured? = Yes

At what age did this/these event(s) occur?
o 18 or younger
o 19 or older
o Both

Have you ever been in any other situation in which you feared you might be killed or seriously injured?
o No
o Yes

Display This Question:
If Have you ever been in any other situation in which you feared you might be killed or seriously in... = Yes

Please specify below
_____

Display This Question:
If Have you ever been in any other situation in which you feared you might be killed or seriously in... = Yes

Please indicate the number of times this occurred
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Display This Question:
If Have you ever been in any other situation in which you feared you might be killed or seriously in... = Yes

At what age did this/these event(s) occur?
o 18 or younger
o 19 or older
o Both

Have you ever seen someone seriously injured or killed?
o No
o Yes

Display This Question:
If Have you ever seen someone seriously injured or killed? = Yes

Please specify who below
_____

Display This Question:
If Have you ever seen someone seriously injured or killed? = Yes

Please indicate the number of times this occurred
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Display This Question:
If Have you ever seen someone seriously injured or killed? = Yes

At what age did this/these event(s) occur?
o 18 or younger
o 19 or older
o Both

Have you ever seen dead bodies (other than at a funeral) or had to handle dead bodies for any reason?
o No
o Yes

Display This Question:
If Have you ever seen dead bodies (other than at a funeral) or had to handle dead bodies for any rea... = Yes

Please specify below
_____

Display This Question:
If Have you ever seen dead bodies (other than at a funeral) or had to handle dead bodies for any rea... = Yes

Please indicate the number of times this occurred
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Display This Question:
If Have you ever seen dead bodies (other than at a funeral) or had to handle dead bodies for any rea... = Yes

At what age did this/these event(s) occur?
o 18 or younger
o 19 or older
o Both

Have you ever had a close friend or family member murdered, or killed by a drunk driver?
o No
o Yes

Display This Question:
If Have you ever had a close friend or family member murdered, or killed by a drunk driver? = Yes

Please specify relationship (e.g., mother, grandson, etc.,) below
_____

Display This Question:
If Have you ever had a close friend or family member murdered, or killed by a drunk driver? = Yes

Please indicate the number of times this occurred
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Display This Question:
If Have you ever had a close friend or family member murdered, or killed by a drunk driver? = Yes

At what age did this/these event(s) occur?
o 18 or younger
o 19 or older
o Both

Have you ever had a spouse, romantic partner, or child die?
o No
o Yes

Display This Question:
If Have you ever had a spouse, romantic partner, or child die? = Yes

Please specify relationship below
_____

Display This Question:
If Have you ever had a spouse, romantic partner, or child die? = Yes

Please indicate the number of times this occurred
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Display This Question:
If Have you ever had a spouse, romantic partner, or child die? = Yes

At what age did this/these event(s) occur?
o 18 or younger
o 19 or older
o Both

Have you ever had a serious or life-threatening illness?
o No
o Yes

Display This Question:
If Have you ever had a serious or life-threatening illness? = Yes

Please specify below
_____

Display This Question:
If Have you ever had a serious or life-threatening illness? = Yes

Please indicate the number of times this occurred
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Display This Question:
If Have you ever had a serious or life-threatening illness? = Yes

At what age did this/these event(s) occur?
o 18 or younger
o 19 or older
o Both

Have you ever received news of a serious injury, life-threatening illness, or unexpected death of someone close to you?
o No
o Yes

Display This Question:
If Have you ever received news of a serious injury, life-threatening illness, or unexpected death of... = Yes

Please specify below
_____

Display This Question:
If Have you ever received news of a serious injury, life-threatening illness, or unexpected death of... = Yes

Please indicate the number of times this occurred
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Display This Question:
If Have you ever received news of a serious injury, life-threatening illness, or unexpected death of... = Yes

At what age did this/these event(s) occur?

- o 18 or younger
- o 19 or older
- o Both

Have you ever had to engage in combat while in military service in an official or unofficial war zone?
o No
o Yes

Display This Question:
If Have you ever had to engage in combat while in military service in an official or unofficial war... = Yes

Please indicate where below
_____

Display This Question:
If Have you ever had to engage in combat while in military service in an official or unofficial war... = Yes

Please indicate the number of times this occurred
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Display This Question:
If Have you ever had to engage in combat while in military service in an official or unofficial war... = Yes

At what age did this/these event(s) occur?

- o 18 or younger
- o 19 or older
- o Both

Has anyone ever made you have intercourse or oral or anal sex against your will?
o No
o Yes

Display This Question:
If Has anyone ever made you have intercourse or oral or anal sex against your will? = Yes

Please indicate nature of relationship with person (e.g., stranger, friend, relative, parent, sibling) below
_____

Display This Question:
If Has anyone ever made you have intercourse or oral or anal sex against your will? = Yes

Please indicate frequency of occurrence
o Single occurrence
o Repeated occurrences

Display This Question:
If Has anyone ever made you have intercourse or oral or anal sex against your will? = Yes

Please indicate the number of times this occurred
1
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16
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18
19
20 or over

Display This Question:
If Has anyone ever made you have intercourse or oral or anal sex against your will? = Yes

At what age did this/these event(s) occur?

- o 18 or younger
- o 19 or older
- o Both

Has anyone ever touched private parts of your body, or made you touch theirs, under force or threat?
o No
o Yes

Display This Question:
If Has anyone ever touched private parts of your body, or made you touch theirs, under force or threat? = Yes

Please indicate nature of relationship with person (e.g., stranger, friend, relative, parent, sibling) below
_____

Display This Question:
If Has anyone ever touched private parts of your body, or made you touch theirs, under force or threat? = Yes

Please indicate frequency of occurrence
o Single occurrence
o Repeated occurrences

Display This Question:
If Has anyone ever touched private parts of your body, or made you touch theirs, under force or threat? = Yes

Please indicate the number of times this occurred
1
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18
19
20 or over

Display This Question:
If Has anyone ever touched private parts of your body, or made you touch theirs, under force or threat? = Yes

At what age did this/these event(s) occur?
- o 18 or younger
- o 19 or older
- o Both

Other than incidents mentioned in the two previous questions, have there been any other situations in which another person tried to force you to have an unwanted sexual contact?
o No
o Yes

Display This Question:
If Other than incidents mentioned in the two previous questions, have there been any other situation... = Yes

Please indicate frequency of occurrence
o Single occurrence
o Repeated occurrences

Display This Question:
If Other than incidents mentioned in the two previous questions, have there been any other situation... = Yes

Please indicate the number of times this occurred
1
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17
18
19
20 or over

Display This Question:
If Other than incidents mentioned in the two previous questions, have there been any other situation... = Yes

At what age did this/these event(s) occur?

- o 18 or younger
- o 19 or older
- o Both

Has anyone, including family members or friends, ever attacked you with a gun, knife, or some other weapon?
o No
o Yes

Display This Question:
If Has anyone, including family members or friends, ever attacked you with a gun, knife, or some oth... = Yes

Please indicate frequency of occurrence
o Single occurrence
o Repeated occurrences

Display This Question:
If Has anyone, including family members or friends, ever attacked you with a gun, knife, or some oth... = Yes

Please indicate the number of times this occurred
1
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18
19
20 or over

Display This Question:
If Has anyone, including family members or friends, ever attacked you with a gun, knife, or some oth... = Yes

At what age did this/these event(s) occur?

- o 18 or younger
- o 19 or older
- o Both

Has anyone, including family members or friends, ever attacked you without a weapon and seriously injured you?
o No
o Yes

Display This Question:
If Has anyone, including family members or friends, ever attacked you without a weapon and seriously... = Yes

Please indicate frequency of occurrence
o Single occurrence
o Repeated occurrences

Display This Question:
If Has anyone, including family members or friends, ever attacked you without a weapon and seriously... = Yes

Please indicate the number of times this occurred
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19
20 or over

Display This Question:
If Has anyone, including family members or friends, ever attacked you without a weapon and seriously... = Yes

At what age did this/these event(s) occur?

- o 18 or younger
- o 19 or older
- o Both

Has anyone in your family ever beaten, spanked, or pushed you hard enough to cause injury?
o No
o Yes

Display This Question:
If Has anyone in your family ever beaten, spanked, or pushed you hard enough to cause injury? = Yes

Please indicate frequency of occurrence
o Single occurrence
o Repeated occurrences

Display This Question:
If Has anyone in your family ever beaten, spanked, or pushed you hard enough to cause injury? = Yes

Please indicate the number of times this occurred
1
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18
19
20 or over

Display This Question:
If Has anyone in your family ever beaten, spanked, or pushed you hard enough to cause injury? = Yes

At what age did this/these event(s) occur?

- o 18 or younger
- o 19 or older
- o Both

Have you experienced any other extraordinarily stressful situation or event that is not covered in the previous questions?
o No
o Yes

Display This Question:
If Have you experienced any other extraordinarily stressful situation or event that is not covered i... = Yes

Please specify the situation(s) or event(s) below
_____

Display This Question:
If Have you experienced any other extraordinarily stressful situation or event that is not covered i... = Yes

Please indicate frequency of occurrence
o Single occurrence
o Repeated occurrences

Display This Question:
If Have you experienced any other extraordinarily stressful situation or event that is not covered i... = Yes

Please indicate the number of times this occurred
1
2
3
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18
19
20 or over

Display This Question:
If Have you experienced any other extraordinarily stressful situation or event that is not covered i... = Yes

At what age did this/these event(s) occur?
- o 18 or younger
- o 19 or older
- o Both

The following is a series of questions about serious or traumatic life events that. These types of events actually occur with some regularity, although we would like to believe they are rare, and they affect how people feel about, react to, and/or think about things subsequently. Knowing about the occurrence of such events, and reactions to them, will help us to develop programs for prevention, education, and other services. For each event, please indicate whether it happened by answering "yes" if the event did occur in your life when you were age 18 or younger. Answer "no" if the event never happened in your life or if the event happened when you were age 19 or older.

Did a parent or other adult in the household often swear at you, insult you, put you down, or humiliate you or act in a way that made you afraid that you might be physically hurt?
o No
o Yes

Did a parent or other adult in the household often push, grab slap, or throw something at you or ever hit you so hard that you had marks or were injured?
o No
o Yes

Did an adult or other person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way or try to actually have oral, anal or vaginal sex with you?
o No
o Yes

Did you often feel that no one in your family loved you or thought you were important or special or your family didn't look out for each other, feel close to each other, or support each other?
o No
o Yes

Did you often feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you or your parents were too drunk or high to take care of you or to take you to the doctor if you needed it?
o No
o Yes

Were your parents ever separated or divorced?
o No
o Yes

Was your mother or stepmother often pushed, grabbed, slapped, or had something thrown at her or sometimes or often kicked, bitten, hit with a fist, or hit with something hard or ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

o No
o Yes

Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

o No
o Yes

Was a household member depressed or mentally ill or did a household member attempt suicide?

o No
o Yes

Did a household member go to prison?

o No
o Yes

Following are thirteen areas of your child's behavior for you to rate from 0 (No problem) to 4 (Very bad problem). Using your best judgement, rate each item by circling the number that best describes at the present time your child's behavior. Since your child's behavior will change over time, only take into consideration recent behavior (within the past week or two). PLEASE RATE ALL THIRTEEN ITEMS. Choose the number 5 if you don't know or the question does not apply to your child. If you have more than one child who meets the requirements for the study, please answer all questions about the child who you believe to have the most behavioral and emotional difficulties.

In general, how much of a problem do you think your child has with:

	No problem (0)		Some problem (2)		Very bad problem (4)	Not applicable/ Don't know
…getting into trouble						
…getting along with (you/[her/his] mother/ mother figure)						
…getting along with (you/[her/his] father/father figure)						
…feeling unhappy or sad?						

How much of a problem would you say your child has:

	No problem (0)		Some problem (2)		Very bad problem (4)	Not applicable/ Don't know
…with [her/his] behavior at school? (or at [her/his] job)						
…with having fun?						
…getting along with adults other than (you and/or [her/his} mother/father)?						

How much of a problem would you say your child has:

	No problem (0)		Some problem (2)		Very bad problem (4)	Not applicable/ Don't know
…with feeling nervous or afraid?						
…getting along with [her/his] [sister(s)/brother(s)]?						
…getting along with other kids [her/his] age?						

How much of a problem would you say your child has:

	No problem (0)		Some problem (2)		Very bad problem (4)	Not applicable/ Don't know
…getting involved in activities like sports or hobbies?						
…with [her/his] schoolwork (doing [her/his] job?)						
…with [her/his] behavior at home?						

The following questions are regarding access to health insurance and mental health care services for your child. Please respond to each item with "yes" or "no".

Do you have access to health insurance through your work, the Healthcare Marketplace, Medicaid, Medicare, private insurance, or another source?

o No
o Yes - Please specify source _____

Do you currently have health insurance through your work, the Healthcare Marketplace, Medicaid, Medicare, private insurance, or another source?

o No
o Yes - Please specify source _____

Does your child have access to health insurance through your work, the Healthcare Marketplace, Medicaid, Medicare, private insurance, or another source?

o No
o Yes - Please specify source _____

Does your child currently have health insurance through your work, the Healthcare Marketplace, Medicaid, Medicare, private insurance, or another source?

o No
o Yes - Please specify Source _____

Have you ever utilized or are you currently utilizing mental health care services (therapy, counseling, intensive outpatient services, inpatient services, group therapy, psychiatry, psychology, etc.?)

o No
o Yes

Has your child ever utilized or is your child currently utilizing mental health care services (therapy, counseling, intensive outpatient services, inpatient services, group therapy, psychiatry, psychology, etc.?)

o No
o Yes

Do you believe that your child would benefit from mental health care services?

o No
o Yes

Has an education or health professional ever recommended your child to mental health care services or stated that your child would benefit from mental health care services?

o No
o Yes

Has your child ever stated that they believe are interested in or would benefit from mental healthcare services?

o No
o Yes

Is there anything you would like the researcher to know about your experience with this survey?

_____

If you experienced any discomfort while participating in this study, you may wish to contact a mental health provider. You can find mental health services from the American Association of Marriage and Family Therapy at www.therapistlocator.net or you can visit Psychology Today at www.psychologytoday.com and use the therapist locator on the home page. You can find additional resources regarding trauma and trauma-informed care at www.samhsa.gov/trauma-violence or www.ptsd.va.gov. You can find additional resources and information regarding Adverse Childhood Experiences at www.cdc.gov/violenceprevention/childabuseandneglect/ACEstudy/index.html Thank you for participating in this survey.