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Urban Latinx parents' attitudes towards mental health: Mental health literacy and service use

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Abstract

Latinx youth report elevated internalizing symptomatology as compared to their non-Latinx White counterparts and are less likely to access mental health care for these problems. This qualitative study examined the knowledge, beliefs and perceptions that Latinx parents (86% foreign-born; 66.7% monolingual Spanish speakers) living in urban communities have about mental health and service use for anxiety and depression in children. We used thematic analysis to analyze interview data from 15 Latinx parents who expressed concerns about their child's (age 6–13) worry or sadness. Analyses revealed that Latinx parents often have difficulty identifying mental health problems, report stigma about mental health problems and help-seeking and want more information about how they can help their children. Although Latinx parents report significant mental health and treatment-seeking stigma, the majority were open to seeking mental health services for their children or were already receiving services. Findings suggest that stigma although prevalent, may not deter service utilization for some Latinx families. Implications for community health and future research are discussed.

Keywords

attitudes; mental health literacy; stigma; Latinx mental health; service utilization

In the United States, Latinx youth present higher rates of internalizing disorders, such as depression and anxiety, compared to other racial/ethnic groups (Anderson & Mayes, 2010; Ginsburg & Silverman, 1996; Pina & Silverman, 2004; Varela et al., 2004). However, mental health service utilization among Latinx youth is significantly lower than non-Latinx Whites (Gudiño et al., 2009; Kataoka, Zhang & Wells 2002). Furthermore, Latinx parents of youth affected by internalizing disorders are even less likely to seek mental health services compared to parents of youth with externalizing disorders (Alegría et al., 2004; Gudiño et al., 2009). Individual and family-level factors, such as mental health literacy and attitudes towards help-seeking, are often-cited barriers to receiving mental health services (Wright, Jorm, Harris, & McGorry, 2007). Among immigrants, knowledge and recognition of mental illness (including symptoms, signs, modes of expression), beliefs about risk factors and

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causes of mental illness, knowledge about and attitudes towards help-seeking options, and self-help strategies and social support are all facets of mental health literacy that contribute to help-seeking and are often influenced by cultural beliefs and norms (Na, Ryder, & Kirmayer, 2016). Understanding mental health literacy and attitudes towards help-seeking may be particularly relevant in the context of immigrant Latinx families, in which parents are often faced with navigating new systems of care in order to obtain services for their children.

One barrier to service use for Latinx families is knowledge about mental health problems in youth. Individuals with limited English proficiency, in particular, often have low mental health literacy (Sentell & Braun, 2012), may be less likely to identify a need for treatment, and reportedly less likely to use available mental health services (Bauer, Chen, & Alegría, 2010). Additionally, Latinx parents and their children are less likely to agree about severity of mental health problems, with some findings suggesting that Latinx parents may only observe distress associated with more severe symptoms (Roberts, Alegría, Roberts, & Chen, 2005). Some studies suggest that the decision to seek services for youth in ethno-racial minority families is associated with parental conceptualizations of their child’s problems. As an example, Yeh et al. (2005) found that physical and trauma related explanations of mental illness increased the likelihood of service use while more sociological explanations (e.g., friends, prejudice, etc.) were associated with less service use. Thus, it may be that Latinx explanatory models of mental health problems are an important aspect of mental health literacy that has consequences for service use in this group.

Perhaps one of the most often cited barriers to mental health service use among racial/ethnic minorities is attitudes about mental health services. Mental health stigma may be of particular importance for Latinx youth with psychopathology, given numerous studies showing that Latinx parents identify stigma as a barrier to obtaining services for their children significantly more often than non-Latinx White parents (Chavira et al., 2017; Turner et al., 2015; Umpierre et al., 2014; Zuckerman et al., 2014). Additionally, several studies have documented that family members of those seeking mental health care in the Latinx community experience stigma by association (Gonzalez et al., 2007; Magaña et al., 2007). Furthermore, Latinx parents perceive specific interventions, such as pharmacotherapy, as highly stigmatizing (Interian et al., 2007; Vega et al., 2010). It is possible that within Latinx communities, perceived stigma towards pharmacological treatments for childhood anxiety and depression partially accounts for existing service use disparities despite overall increases of outpatient service use for children’s mental health concerns (Olfson, Druss, & Marcus, 2015). Other attitudes that deter Latinx families from seeking mental health care include anticipated discrimination and mistrust of providers (Clement, Schauman, & Graham, 2015; López-Cevallos, Harvey, & Warren, 2014).

Latinx parents may also be more likely to rely on informal sources of support – rather than formal mental health services – for help with their child’s mental health problems. Seeking help from friends and family members may be more acceptable than seeking treatment from mental health agencies in the Latinx community. In a study of Latinx and non-Latinx college students who were survivors of intimate partner violence, both groups were equally likely to seek help from informal supports (e.g., talking to family members and friends about IPV); however, Latinx were less likely to access formal services (e.g., psychotherapy) than non-Latinx (Ingram, 2007). In another study, Villatoro and colleagues (2014) found that in sample of Latinx adults with any mood, anxiety or substance use disorder, high *familismo* (defined in this study as the level of perceived family support) was related to increased use of informal and religious services and less use of specialty or medical services. Interestingly, in this case, a culture value such as *familismo* may deter appropriate service seeking, for a variety of reasons including preservation of family harmony. Prior research also has shown that the size of social support networks is related to help-seeking for mental health problems (Maulik, Eaton, & Bradshaw, 2009; Ten Have, Vollegergh, Bijl, & Ormel, 2017) with smaller social support networks being associated with higher rates of formal service use. Larger social support networks may act as a buffer in stressful times and may decrease the need for services; alternatively, they may also exert an influence through their impact on cultural values, attitudes, and beliefs. (Albizu-Garcia, Alegría, Freeman, & Vera, 2001; Cabassa, Zayas, & Hansen, 2006; Pescosolido, Wright, Alegría, & Vera, 1998).

Present Study

Given the increased risk for internalizing disorders in Latinx youth, it is essential to better understand the barriers and facilitators of help-seeking. Specifically, it is important to understand how parents' culturally-informed beliefs and attitudes about child mental health problems affect treatment-seeking, as parents are often the “gatekeepers” of mental health services for youth. Furthermore, beliefs and attitudes as described in models of mental health literacy are amenable to change, and as such may be one means by which barriers to treatment seeking are addressed. Additionally, the extant literature largely examines factors associated with treatment-seeking for individual care, with few studies examining treatment-seeking for children and even fewer studies examining the challenges that immigrant parents may face. The present study sought to examine the question: What does mental health literacy look like in immigrant Latinx families and how does it influence treatment seeking? This study qualitatively assessed knowledge and recognition of mental illness, knowledge about and attitudes towards help-seeking options, and informal sources of support in a sample of primarily Spanish speaking, urban immigrant Latinx parents. We used thematic analysis to examine our data and used an existing framework of mental health literacy inclusive of many of the constructs previously described (Na et al., 2016) to theoretically base our study. In this study, we analyze narrative accounts from parents (mostly mothers) who reported concerns about feelings of worry or sadness in their children. Given that we recruited a community sample, we used the terms worry and sadness in this study to refer more broadly to mental health concerns in Latinx youth. The participants were not limited to treatment-seeking Latinx parents or to parents of children who had received a diagnosis of anxiety or depression. By studying culturally-influenced constructs of mental health literacy we add to the understanding of factors that both facilitate and hinder service use for Latinx youth, a population that experiences more internalizing symptoms and greater disparities in service use than various other racial/ethnic groups.

Method

Participants and Procedures

Fifteen participants were included in this study. Participants were all parents who identified that they had concerns about their child's worry and/or sadness and who self-identified as Latinx or Hispanic. Parents were recruited from low-income urban neighborhoods in a large city on the west coast. Flyers were posted in community spaces in neighborhoods with a large resident representation from Latinx families, such as in coffee shops, grocery stores, and libraries. Additionally, we partnered with charter schools in these neighborhoods to distribute our recruitment materials to parents at their schools. Twelve of the parents were Spanish-speaking only and three of the parents were English-speaking only.

Semi-structured qualitative interviews were conducted with parents. Study visits were conducted in participants' homes (all participants were also given the option to come to the research lab space at the university). Bilingual and bicultural members of the study staff conducted all study visits. Study staff obtained written informed consent from participants and conducted a qualitative interview, which lasted about 45 minutes. Participants were financially compensated for their participation in this study. The Institutional Review Board (IRB) at the University of California, Los Angeles approved all study materials and procedures.

Interview Guide Development

In line with the study aims, members of the research staff developed the interview guide, keeping in mind common facets of mental health literacy (e.g., Jorm, 2012; Na et al., 2016). The interview guide queried: 1) how parents describe worry and sadness in their children; 2) how parents describe their child's problems to their family, friends, and community; 3) perceived stigma of child's mental health problems and help-seeking; 4) cultural views about mental health; 5) knowledge of treatments for anxiety and depression; and 6) where and how people access information about their child's mental health problems. The principal investigator and graduate student researchers reviewed and finalized the interview guide. To ensure credibility, we used triangulation both in interview guide development to assess constructs of interest in addition to repeatedly asking participants throughout the interviews similar questions to assess constructs of interest (i.e., iterative questioning; Shenton, 2004).

Data Collection, Transcription, and Coding

Participants participated in a 45-minute qualitative interview in their preferred language (i.e., English or Spanish). We sought to increase the dependability of the data by interviewing participants until saturation was reached and keeping investigator field notes of all participant interviews. All interviews were audio-recorded and transcribed by members of the study team. Transcripts were imported into NVIVO 10 software (http://www.qsrinternational.com/nvivo/nvivo-products) to facilitate data management. This study utilized thematic analysis (Braun & Clarke, 2006; Vaismoradi, Turunen, & Bondas, 2013) in order to uncover common themes across qualitative data sources.

Guided by thematic analysis (Braun & Clarke, 2006), two graduate-level members of the study staff independently coded eight participant interviews to generate initial themes for the codebook. Coders were bilingual and thus, transcripts were coded in their original language (i.e., interviews originally conducted in Spanish were not translated, but rather coded in Spanish). Then, two other graduate-level members further refined the codebook to determine the emergent themes and establish codebook reliability by double-coding a sub-set of interviews (*n* = 6). Coders met weekly to review new codes and to determine if other codes should be merged or changed. Meetings were supervised by a master coder, who, if the two coders could not agree on how a section should be coded, resolved the discrepancy. The codebook was refined and finalized when both coders independently double-coded the transcripts and >80% agreement was achieved. Thereafter, all transcripts were re-coded with the final codebook. By checking our interview guide against existing mental health literacy frameworks, we increased the confirmability of our data. Additionally, as described above, every effort was made to reduce conscious and unconscious bias in coding, thus increasing confirmability (Shenton, 2004).

Measures

Participants completed a demographics questionnaire, which asked them about their racial/ethnic identity, income, length of time living in the United States, educational attainment, preferred language, and ages of their children (Table 1). Participants also completed a measure of treatment-seeking, the SACA.

Services Assessment for Children and Adolescents (SACA).—The SACA (Horwitz et al., 2001) is a short checklist of mental health services including inpatient and outpatient services, specialty mental health, schools, child welfare, primary care, juvenile justice, and informal community referrals. Psychometric analyses for the full SACA reveal good test retest reliability for the more intensive services (e.g., inpatient, out of home, juvenile justice) and adequate consistency for outpatient, crisis and other professional services (Hoagwood et al., 2000; Horwitz et al., 2001; Stiffman et al., 2000b). Face valid questions regarding medication use were also included.

Results

Most participants identified as foreign-born (*n* = 13) and female (*n* =14). The sample was comprised primarily of low-income parents with all but three parents reporting a household income of less than $20,000 per year. None of the parents were from the same family; four parents were single parents, seven parents were married or living with a partner, and four were separated or widowed. A full summary of demographic information can be found in Table 1. In terms of service use for their children as measured by the SACA, the most frequently-used services included psychologists/social worker/MFT (*n* = 6; 40%), in-home therapists/counselor (*n* = 5; 33.3%), and in-school counseling (*n* = 4; 26.7%). Sixty-seven percent of parents (*n* = 10) reported using services in the last year (8 parents reported using between one and three services; 2 parents reported more than three services). Five parents reported not using any services in the past year. Only one parent stated that their children had ever used psychotropic medication for behavioral or emotional problems.

The coding of transcripts ($n = 15$) resulted in 491 coded segments, with approximately 39.8 coded segments in each transcript ($SD = 10.63$; min = 20, max = 58). Transcripts were coded in the language in which the interview was conducted by bilingual members of the study staff. After coding the data, nine themes and 19 sub-themes emerged (see Table 2). Although most of the interviews were conducted in Spanish ($n = 12$), for the purposes of this manuscript, the quotations have been translated into English by a bilingual/bicultural member of the study team (for original quotations, see Appendix A).

Qualitative Themes

Parents description/recognition of depression and anxiety in their children— Generally, parents viewed their child's worry or sadness as intertwined with other problems that they were having at home or at school, such as family discord or difficulties keeping up with coursework in school. Findings revealed that parents often could not distinguish between symptoms of anxiety, depression, and behavior problems. The most commonly described child problems were nervousness/worry (*inquieto*, *ansioso*), sadness (*tristeza*), withdrawal (*retirarse*), and irritability (*irritabilidad*). One parent described their child's depression and anxiety as follows:

> The anxiety is when he goes to school and he doesn't know what he is going to say to the teacher, but that is also sadness. Those are worries because he thinks that they [the problems] are going to become bigger. I mean, that everything is going to become bigger. [translated from Spanish (1)]

Knowledge about and attitudes towards problems like anxiety and depression—Most parents stated that other family members, their friends, or members of their community lack knowledge and have prejudicial beliefs about people with mental illness. One parent reported:

> When people are not informed… That affects [their perception of children with depression/anxiety]. Because family members say: "In my town, that is called laziness [having symptoms of depression/anxiety]. Oh, the kid has depression? What depression? She is just acting crazy to not help at home." But yes, that affects because that is the way our parents educated us, we are carrying that culture. [translated from Spanish (2)]

Many participants stated that they believed their community would benefit from educational materials about what anxiety and depression is. Furthermore, parents identified the belief that anxiety and depression are not "real" problems, as common in their communities and expressed that they wanted others to know that mental health concerns are legitimate problems. One parent said:

> A lot of people make fun of them [children with anxiety/depression symptoms]. They think that they are "crazy" o that "this is punishment from God because you were a bad person and now look what's going with your child." That is a lie […] Sometimes people make fun of what is going on in other families [translated from Spanish (3)].

Attitudes towards seeking treatment for anxiety/depression—Parents reported significant stigma from family members, friends, and community members for seeking treatment for their child's mental health problems. One parent described cultural attitudes about help seeking. She said that others in her community believe that people with mental health problems should, "Suck it up…You just go with the flow and grow, grow out of it or snap out of it." Another parent described the reaction from her family when she sought treatment for her child:

> They [Latinos] never or almost never seek treatment because they think they are going to be judged, or they feel they know how to raise their children, or they think they are going to be discriminated or being put down. And the Latino person is like pau pau [physical punishment]. [translated from Spanish (4)]

Additionally, parents reported several fears about seeking treatment, such as fear of judgment from medical or mental health professionals or fear of losing control of their child/their parental rights. Parents also stated that other people in their community were often suspicious or fearful of mental health professionals. Some parents associated seeking treatment with receiving medication and stated that they would not consider medicating their child for any reason.

Most participants stated that many members of their community or family have negative views about people with mental health problems or people who are seeking treatment for anxiety or depression. A subset of these participants specifically identified these beliefs as being tied to Latinx or Hispanic culture. One parent stated:

> Well, I think that that the Latino race, we think that saying psychiatrist or psychologist, we consider them like crazy, they are crazy. Because you say 'I'm going to take the boy to the psychiatrist. Ah, he is crazy.' We consider it, the Latino race, well not all of them, but out of a hundred, fifty think so, fifty believes it. [translated from Spanish (5)]
>
> Another parent described:
>
> I think it does influence you, eh, and even more, even more is the "what will they say?" Because they are scared of, of what people will say if they tell. And also, Latinos hide if you have a child with any given condition; you always try to hide it. [translated from Spanish (6)]

Self-Help Strategies and Social Support

Informal support for anxiety/depression in children—Parents identified many ways that they receive support and resources to help deal with their child's worry or sadness, the most common of which were community resources, such as parent workshops or events at their local churches. Parents also identified ways that their child accesses support, the most common of which was talking to other family members or friends. Some parents also described activities or strategies that they use with their child to help manage feelings of worry or sadness. To manage her daughter's somatic symptoms of anxiety and depression, one parent described: "Sometimes when I see her like that, I tell her 'Okay, let's go!' I take her with me on a walk… we don't take the bus, we walk so she relaxes. And I tell her, 'let's go!' And she, but when I start to see that she calms down." [translated from Spanish (7)]

Many parents stated that in response to their child's mental health problems, they wish to be helpful and do what they can to help their children: "We talk to him, we tell him that we may take him to talk to the psychologist so he can talk to the psychologist and feel more comfortable [talking about his problems]." [translated from Spanish (8)]

Another parent described using community organizations, such as athletic teams, to help manage isolation and loneliness:

> For example, eh, he told that we have to put them, eh, distract them like put them in a sport or something like that because his [son] is almost the same age as mine and he had his in a sport. I asked [my son] if he wanted to play a sport and he said yes, he wanted to play soccer. I looked for information and signed him up in a team, in a league. [translated from Spanish (9)]

Barriers and facilitators to mental health services—The most common barrier to service use was dissatisfaction with quality or availability of care. One parent described:

> I did take her to a therapist and I, we kind of jumped around cause I just didn't really feel like she was getting what she needed out of it. Like I'm like tools, I want tools, like I don't want my daughter to go sit down and just talk about her feelings or. Like I understand that maybe, that's the progress of it, but like… like after 6 sessions, I'm like "Honey, like, so like how did she teach you? What did she-?" Because I'm still seeing you doing this. Like she was still doing the same like anxiety um, like methods, so I'm like I was getting frustrated.

On the other hand, parents described several facilitators to accessing care, such as family or community engagement in seeking care (e.g., "I heard about therapy through parents at my child's school"), use of case managers to connect families to services, and integrative healthcare systems. Parents stated that by going to their pediatrician, they were often identified as needing services and connected to mental health treatment, thus improving pathways to care.

Parents stated that they would seek mental health care for their child if they thought that they needed it and/or if they believed their child could benefit from it. Most parents identified their pediatrician, a community center, or a mental health professional as the person that they would go to if they wanted to access mental health care for their children. Among parents who had accessed care for their children, the majority had done so through their child's school or a community mental health agency.

The need for knowledge, resources and support—Most parents endorsed wanting more knowledge about what to do as a parent to help their child better manage their worry or sadness. Further, parents wanted to know about the available treatment options and wanted more information on anxiety and depression (i.e., psychoeducation).

Parents also expressed a need for more community resources related to mental health. For example, some parents stated support groups for both themselves and their children would be helpful in order to talk with other people who are dealing with similar problems. They also stated that they wanted workshops or classes to help them learn more about parenting strategies in general as well as specific to managing their child's anxiety and depression. For instance, one parent described: "That there would be classes for parents. Classes where they can teach them about the stages of life in children, how sometimes children can be sad, mad, and all the things that change with them." [translated from Spanish (10)] Another parent stated:

> Yeah, workshops in the community. Uh, events where they provide these workshops at no costs obviously if it's a low-income place, yeah. Um, I'm pretty sure a lot of parents would attend. [Interviewer: What kind of content would you like included in those workshops?] Um, presentations, data, research.

Latinx Families Who Used Services vs. Those Who Did Not

Although we did not have enough participants to adequately compare themes among service users (i.e., parents who accessed care for their children in the past year) vs. non-service users, we did a preliminary exploratory examination of frequency and content of themes. Many of the themes were similar across the groups however a few differences emerged. One interesting difference was that parents who used services in the past year were more likely to describe their child's problems in terms of observable behavior (e.g., fidgeting) or somatic symptoms (e.g., stomachaches), whereas those who had not used services were more likely to describe their child's problems in terms of internal mood states (e.g., "nervous" and "sad"). Furthermore, parents who had sought treatment were also more likely to discuss more positive attitudes towards help-seeking and were more likely to utilize informal sources of support (e.g., church groups, community support groups) compared to those who had not sought treatment.

Discussion

The aim of this study was to describe Latinx parents' beliefs and perceptions of depression and anxiety in their children, as well as to understand how culture, knowledge, and attitudes affect service utilization for these problems. Parents, who were primarily immigrant Latinx mothers from a large urban city, mostly discussed their own and others' knowledge about anxiety and depression, knowledge of available services and attitudes about help-seeking, and self-help strategies that they use to help manage their child's problems. To a lesser extent, parents also discussed beliefs about where mental health problems come from and how they are maintained. Barriers to service use and facilitators of mental health literacy in the Latinx community were also discussed.

An important component of mental health literacy is knowledge and recognition of mental illness, defined as knowing symptoms, signs, modes of expression, and thresholds of tolerance of mental health problems. Thematic analysis revealed that many parents in our study (i.e., urban Latinx parents of anxious/depressed children) did not perceive that they had adequate knowledge about mental health problems and treatment in their community.

Findings also revealed that parents described their children’s problems in terms of observed symptoms –most often behaviors (e.g. won’t talk, fidgeting, stays in room)–rather than psychological constructs (i.e., “depressed”). These findings are significant given that Latinx parents, such as those in our sample, may tend to focus on outwardly visible behaviors while more internal mood states are overlooked. This is also important to consider as poor symptom recognition can lead to lower rates of treatment-seeking (Coffman & Norton, 2010; Wright et al., 2007).

In addition to limited knowledge of mental health symptoms, parents in our sample reported significant stigma associated with treatment-seeking. Many parents identified these beliefs as being tied to their Latinx culture. These findings are consistent with previous studies that have found that Latinx parents are more likely than non Latinx White to identify stigma as a barrier to service utilization (Chavira et al., 2017; Turner et al., 2015; Umpierre et al., 2014; Zuckerman et al., 2014). Notably, in this study many of the statements about low knowledge and recognition of mental health problems in children were intertwined with statements about stigma, highlighting the connection between poor recognition of problems and attitudes about mental health.

Despite endorsing stigma about mental health problems and treatment-seeking, most parents stated that they wanted to help their children improve their worry or sadness, both formally and informally. Parents asked for ways to access care in their communities, highlighting the potential importance of community-based implementation of evidence-based treatments for mental health problems (Sheehan, Walrath, & Holden, 2007). Interestingly, our sample described facilitators to accessing care such as school programs and community health clinics (Costello, He, Sampson, Kessler, & Merikangas, 2014). Such resources may address typical barriers to care such as access and stigma, and may be a useful pathway to care for Latinx children (Costello et al., 2014). For example, school-based programs have shown to be an effective and feasible means to provide care for immigrant children, some of whom may be uninsured (Costello et al., 2014; Kataoka et al., 2003), and not feel comfortable or mistrust more formal mental health agency settings.

Importantly, parents discussed past experiences with mental health services that have affected their preferences for help-seeking. Parents expressed a desire for treatments that better address their children’s problems by providing them with “tools” to use when children are in need. Additionally, parents reported seeking support from their community, especially extended family and other social networks. Some parents cited social networks as being important in managing their child’s worry or sadness, where others discussed how stigma made it difficult to talk about their child’s problems in an effort to seek care.

Parents also discussed how family members or those in the Latinx community viewed mental health problems as being caused by a weakness in the child or family, because the child was crazy, and/or because the child needed attention. As suggested in previous studies, concerns about parental blame, stigma, and etiological explanations of mental illness (e.g., problems stem from poor discipline) are all factors that deter appropriate service use and treatment adherence in Latinx communities (Alegría, et al., 2004; Yeh, et al., 2005). Engagement interventions that address these barriers, and strengths-based approaches may be particularly relevant to Latinx families (Gopalan, et al., 2010; Haine-Schlagel & Walsh, 2015; Ramos & Chavira, in press). Furthermore, interventions themselves may be modified to address these attitudes and beliefs, such as in the case of Parent Child Interaction Therapy (PCIT), which has been modified based on parental attitudes towards different parenting practices (Matos, Torres, Santiago, Jurado, & Rodríguez, 2006; McCabe, et al., 2005; Ramos, Blizzard, Barroso, & Bagner, 2018).

Importantly, our sample demonstrated higher rates of service utilization than other studies (e.g., Kataoka et al., 2002). In fact, two-thirds of our sample has received services in the past year for their children, a rate double that of other studies (see Reardon, Harvey, & Creswell, 2019). It is possible that there was a self-selection bias in our study, in which parents with greater mental health literacy (and knowledge of resources) were more willing to participate in a study about children's mental health, and as such also had less stigma about mental health service use. Additionally, our sample was recruited from large and diverse urban city, where there are more mental health services, including bilingual services, compared to other geographical areas, enhancing access in this sample. As previously mentioned, families also discussed various facilitators to care such as school programs and integrative healthcare which may have partially addressed barriers such as stigma and access and enhanced treatment seeking. Although families in urban areas may have more facilitators to treatment-seeking such as availability of services, our participants originate from communities that also experience barriers to care common in other communities, such as quality of services (e.g., access to evidence-based treatments), structural barriers (e.g., wait times), and individual level factors (e.g., family support).

In an attempt to further understand the higher rates of service use in our sample, we evaluated themes across those parents who utilized services and those who did not. While any conclusions are limited by the small sample sizes of the groups, a few differences emerged. For example, those who had used services in the past year more often described mental health problems in terms of physical symptoms (e.g., stomachaches) or observable behavior (e.g., isolation, fidgeting with hands), whereas those who had not used services were more likely to describe nervousness/worry or sadness as their child's problems. Some research has suggested that physical symptoms increase Latinx individuals' perceived need for mental health services (Bauer, Chen, & Alegría, 2012). In fact, physical symptoms have been cited both as a pathway to mental health care and a way to offset stigma related concerns (Talebi, Matheson, & Anisman, 2016). While both service-users and non-service users described stigma with regard to seeking treatment for mental health problems, those who had sought treatment for their child in the last year were more likely to report more positive attitudes about help-seeking, whereas those who had not sought treatment were less likely to discuss such attitudes. However, service utilizers also had more to say about the quality of mental health services and expressed that they wanted treatment to be more skills-based (i.e., more "tools"). Lastly, parents who had sought mental services for their children in the past year were more likely to describe utilizing informal sources of support to assist with their parenting (e.g., church groups, community support) compared to those who had not sought mental health services. While the exact nature of the support is not known for parents in this study, previous research suggests that the family or social network of Latinx can help the individual identify a need for mental health care and can influence use of mental health services (Villatoro, Morales, & Mays, 2014; Alegria, et al., 2008).

Limitations

This was a small sample of Latinx parents (mostly mothers) living in an urban neighborhood on the West Coast, and there were several characteristics of the sample that limit the generalizability of our findings. First, our sample was not randomly-selected from the entire population of interest. We likely encountered respondent bias, given that our participants were mostly female parents who were willing to discuss issues of child mental health. Additional interviews with Latinx fathers would help to highlight themes that are consistent across mothers and fathers in our sample and may also elucidate differences in mental health knowledge and attitudes based on gender and parenting roles. Most of the parents who participated had male children, which may affect how parents conceptualize mental health problems such as anxiety and depression, perhaps taking greater note of such behaviors in boys compared to girls. Lastly, although we see the inclusion of a majority foreign-born sample as a strength of this study, our data do not capture the experiences of US-born Latinx parents, who may have different knowledge and attitudes toward mental health and treatment seeking.

Additionally, there are several limitations of our research methodology. Our qualitative methodology prevents us from drawing causal conclusions from the data. Using thematic analysis is a technique meant to limit researcher bias by letting the data “speak for itself”; however, it is possible that through the construction of an interview guide or through other means, the qualitative analysis was biased by the authors, especially since the authors’ program of research focuses on mental health disparities and interventions to reduce these disparities. However, to minimize bias, the interview guide allowed for open-ended responses and coding methods allowed for new themes to emerge based on participant responses. Lastly, children were not interviewed, which limits our understanding of children’s experience of mental health and opinions about disclosing mental health problems to trusted adults. Future research should examine the degree to which children’s own experiences of mental health problems and perceptions of mental health and treatment-seeking stigma affect disclosure of symptoms in Latinx families.

Conclusions

Findings from this study suggest that there is a need and a desire for improved mental health literacy in this sample of Latinx parents who expressed concerns about their child’s worry or sadness. Our results highlight the complexity of barriers to service-seeking that require more attention in research, such as under what conditions attitudes towards mental health may actually deter service utilization in Latinx parents of youth with mental illness. Efforts are underway to improve recognition of symptoms and knowledge of mental health resources among Latinx adults (López et al., 2009; Unger, Cabassa, Molina, Contreras, & Baron, 2013). However, little has been done to improve the mental health literacy of parents of underserved youth. Given the prevalence of youth anxiety and depression among Latinx youth (Potochnick & Perreira, 2011), efforts to develop and test the effectiveness of parent directed mental health literacy interventions that are culturally-appropriate and ecologically valid are of critical importance.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1.

Demographics (N=15)

Variable		
	n	***%***
Parent Gender: Female	14	93.3
Parent Marital Status		
Single	4	26.7
Married or Living with Partner	7	46.7
Separated or Widowed	4	26.7
Parent Highest Education Level		
Eighth Grade or Less	6	40.0
Some High School	1	6.7
High School Diploma	5	33.3
Any Higher Education	3	20.0
Parent Ethnicity: Latinx or Hispanic	15	100.0
Parent Nativity		
Foreign-Born	13	86.7
US-Born	2	13.3
Parent Language Use		
English Only	2	13.3
Spanish Only	10	66.7
Both English and Spanish	3	20.0
Parent Job Status: Working for Pay	6	40.0
Parent Income Per Year		
Under $10,000	5	33.3
$10,000-$15,000	5	33.3
$15,000–20,000	2	13.3
>$20,000	3	20.0
Child’s Gender: Male	11	73.3
Child’s Past Diagnosis of Mental Health Problems		
Any Diagnosis	5	33.3
Learning Disability	1	6.7
Anxiety	4	26.7
Depression	2	13.3
	Mean	***SD***
Parent Age	40.47	10.06
Child’s Age	10.53	2.17

Table 2.

Themes, Sub-themes, and their Definitions

Theme	Definition
Description of Anxiety/Depression	The parent describes worry or sadness in their child.
Etiology of Anxiety/Depression	The parent describes what they to be the origin of their child's worry or sadness.
Phenomenology of Anxiety/ Depression	The parent describes what they observe in their child when they are worried or sad, or describes how they know that their child is worried or sad.
Impact	The parent describes the impact that the child's worry or sadness has on the parent themselves or other members of the family.
Response to Presence of Anxiety/ Depression	The parent describes reactions to their child's worry or sadness.
Parents	The parent describes how they react to their child's worry or sadness.
Other family members/friends/ community	The parent describes how other members of the family or community react to their child's worry or sadness.
Response to Seeking Treatment for Anxiety/Depression	The parent describes reactions to help-seeking for mental health issues.
Parents	The parent describes how they have or have not sought treatment for their child, or describes beliefs they have about seeking treatment or help.
Other family members/friends/ community	The parent describes how other family members or people in the community have responded to help seeking.
Previous Mental Health Care	The parent describes previous experiences with mental health care.
Barriers to Treatment	The parent describes barriers to seeking or accessing mental health services for their child.
Facilitators to Treatment	The parent describes factors that have made it easier to seek or access mental health services for their child.
Experiences with Treatment	The parent describes previous positive or negative experiences receiving treatment for their child's worry or sadness.
Future Mental Health Care	The parent describes how they would go about getting help in the future.
When I would access care	The parent describes how they would know to seek care for their child.
Who I would ask for care	The parent describes who they would ask to help them obtain mental health services in the future.
Accessing Informal Support/Resources for Anxiety/Depression	The parent describes ways in which the child is supported outside of a formal mental health care context.
Parent	The parent describes ways in which they access support or information for themselves.
Child	The parent describes ways in which their child implements strategies to help cope with their worry or sadness.
Coping Strategies	The parent describes systems that they have put in place to help manage symptoms of worry or sadness with their child or family.
What Parents of Anxious/Depressed Children Want	The parent describes the resources they want for their child.
Knowledge	The parent describes wanting more knowledge (i.e., psychoeducation) on child mental health problems.
Services	The parent describes wanting more services in their community for children's worry or sadness.
Perceived Knowledge Gaps in Latinx Community	The parent describes what they believe to be areas in which their community is lacking in knowledge.
Anxiety and Depression are real issues	The parent describes wanting others in their community to know that anxiety and depression are real problems.
Normalizing	The parent describes wanting others to be able to normalize symptoms of worry and sadness, or decrease stigma beliefs.
Psychoeducation	The parent describes wanting others to have more general knowledge of children's mental health problems