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PARENTING STYLE AND HELP-SEEKING FOR CHILD ANXIETY AND DEPRESSION: A VIGNETTE STUDY

BY

HAYLEY E. POMERANTZ

A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE

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ABSTRACT

Anxiety and depression are known to have a significant impact on the daily functioning of children and their families; yet only a fraction of diagnosed children receive treatment from professional mental health services. To better understand the discrepancy between high rates of child psychopathology and low rates of mental health service use, the current study examined parenting style and the time at which a parent decides to seek mental health treatment for their child. The current study hypothesized that parents would seek help when their child's symptoms and interference were moderate. It also hypothesized that parents with an authoritative or permissive parenting style would seek help earlier than parents with an authoritarian style. Additionally, it was hypothesized that parents would seek help for child depression earlier and more often than for child anxiety. Results indicated that parents sought help for their children when symptoms and interference were mild in severity. Parents sought help for their child significantly earlier for depression than for anxiety. No significant difference in help-seeking points was found between authoritative, authoritarian, or permissive parenting styles. Limitations of the current study and future directions are discussed.

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CHAPTER 1

INTRODUCTION

Research has established that a significant number of children suffer from mental health difficulties each year (Ghandour et al., 2019). Among the most prevalent psychological disorders seen in children are anxiety and depression (Bitsko, 2022). Although both anxiety and depression are known to have a significant impact on the daily functioning of children and their families, only a fraction of diagnosed children receive treatment from professional mental health services (Mulraney et al., 2020). To better understand the discrepancy between high rates of child psychopathology and low rates of mental health service use, researchers must begin to explore the factors that influence when and why parents seek help for their child. The purpose of the current study is to examine whether parenting style influences the time at which a parent decides to seek mental health treatment for their child. In addition, the current study aims to investigate whether this decision to seek help is influenced by whether the child is experiencing symptoms of anxiety or depression.

CHAPTER 2

REVIEW OF LITERATURE

Previous literature has begun to explore both child and parent characteristics that may influence parental help-seeking including age, gender, and environmental factors (e.g., Zwaanswijk et al., 2003), however; no study to date has investigated whether parenting style in particular plays a role in the help-seeking decision making process.

Parental help-seeking

The classic models of help-seeking proclaim that an individual must: (1) recognize a problem, (2) decide to seek help for it, and (3) choose a specific source for help (Fischer, Weiner, & Abramowitz, 1983; Gurin, Veroff, & Feld, 1960). There are many factors that may impact any or all of these help-seeking components. Whether children actually receive mental health services has been found to be influenced by different individual and family factors, as well as by the type of symptoms exhibited (e.g., Wu et al., 2001). The current review will address the literature on help-seeking for child anxiety and depression specifically, as well as the factors and barriers that have been found to influence this process.

Help-seeking for child anxiety and depression

Depression and anxiety are among the most common disorders experienced by children in the United States (Bitsko, 2022), and it has been found that children who experience frequent depressive and/or anxiety symptoms are twice as likely to suffer from depression later on in life (Bittner et al., 2007). In addition, they are also more likely to experience other mental health problems including increased substance use and suicidal behaviors (Arteaga et al., 2010; Batterham et al., 2013). Nonetheless, research

has continually found a large discrepancy between numbers of individuals diagnosed with these disorders and those who seek out and/or receive treatment. It is important to note that much of the help-seeking literature has focused on participation in treatment, the mechanisms by which parents seek help, and the outcomes of receiving mental health services (e.g., Costello et al., 2014; Reid et al., 2011; Shanley et al., 2008). Significantly less is known about the factors that influence the *timing* of a parent's decision to initially seek help for their child, which has significance in understanding the help-seeking process.

With regard to child anxiety, Reardon and colleagues (2020) found that within a sample of parents with children diagnosed with anxiety, less than 3% had received evidence-based treatment (Reardon et al., 2020). In addition, a study examining 12-month rates of service use for mental, emotional, and behavioral disorders among adolescents found that those diagnosed with an anxiety disorder were least likely to receive services (Costello et al., 2014). Interestingly, service use rates for childhood depressive disorders tend to be higher. One study examining treatment in children aged 3-17 years found that nearly 80% of the children with depression received treatment in the previous year, compared to only 59.3% of those with anxiety problems (Ghandour et al., 2019). Given these differences in service use, understanding the factors that influence initial help-seeking for these specific disorders are especially important to consider.

Factors influencing parental help-seeking

There are many factors that play into whether a parent seeks mental health services for their child. A recent study investigating help-seeking for anxiety disorders specifically found that parent-reported factors leading to decreased help-seeking included

difficulties differentiating between developmentally appropriate and clinically significant symptoms in their children, a lack of help-seeking knowledge, perceived negative consequences of help-seeking, and limited service provision (Reardon et al., 2020). A recent meta-analysis on parent's perception of help-seeking barriers and facilitators found that the cost of treatment and other logistical type factors such as inconvenient appointment times were commonly reported as barriers (Reardon et al., 2017). In addition, parental attitude toward treatment, as well as parental recognition of the existence, severity, and impact of a child's mental health problem were commonly reported (Reardon et al., 2017). Interestingly, there is limited research on other individual parental factors, such as parenting style, and whether it may influence the help-seeking process.

Parenting style and help-seeking

It is clear that parents play an integral role in help-seeking for mental health issues in children. However, there is a need to better understand the individual parenting factors that contribute to help-seeking. Parenting style is a construct that may prove useful in this process; yet, there is very limited research on this factor. One recent study analyzing parental authoritativeness and help-seeking in adolescents discovered that authoritativeness and positive parenting were associated with greater help-seeking intentions from professional sources (Maiuolo et al., 2019). This study, however, explored the adolescents' intention to seek help rather than their parents'. In addition, it solely examined authoritativeness in terms of parenting styles. Given that parenting style has been linked to child mental health problems (e.g., Pinquart, 2017; Čablová et al.,

2014; Alizadeh et al., 2011), it is important to consider the way it may affect how and when children are receiving help.

Parenting Styles.

Baumrind (1979) outlined various parenting styles and later found that three main trajectories of parenting may significantly impact child socialization and functional outcomes (Baumrind, 1991). These parenting styles are authoritative, authoritarian and permissive parenting. The following sections will outline each of Baumrind's parenting styles and the ways in which they may influence a parent's decision to seek help for their child.

Authoritative Parenting

Authoritative parenting involves defining clear rules and limits, setting high expectations, creating a warm and responsive environment, and valuing independence for children. When compared to the other parenting styles, authoritative parenting has been associated with positive outcomes for children such as increases in independence, psychological well-being, and academic performance (Steinberg, Elmen, & Mounts, 1989; Baumrind, 1991; Alizadeh et al., 2011). Given the fact that recent studies have found that authoritative parenting impacts whether a child or adolescent seeks mental health help for themselves (Maiuolo et al., 2019; Lu, 2019), authoritativeness may also have an influence on whether the parent seeks help for their child. Authoritative parenting involves providing warmth and responsiveness to children, and therefore, it is possible that more authoritative parents might be more aware of their child's symptoms and exhibit a greater likelihood of seeking help for their child than less authoritative parents. In addition, an authoritative parent may also create an environment where a child feels

more comfortable sharing their feelings with their parent, which may increase the parent's likelihood of seeking help.

Permissive parenting

Permissive parenting styles are characterized by high responsiveness and low demand. Parents who have a permissive style are described as noncontrolling, nondemanding, and relatively warm. Permissive parenting has often been found to be detrimentally related to child mental health. For instance, studies have found that permissive parenting is associated with decreases psychological wellbeing (Khodabakhsh et al., 2014). Permissive parenting has also been associated with a child's likelihood of readmission to inpatient psychiatric units (Fite et al., 2009). Given these associations, it is probable that this type of parenting may also be associated with whether these parents seek help for their child's mental health problems and when they choose to do so. Although no research to date has investigated help-seeking behaviors among permissive parents, it is possible that the high responsiveness of permissive parenting may lead these parents to seek help more often and sooner than other types of parents, particularly if the child is explicitly asking their parent for help.

Authoritarian parenting.

Authoritarian parenting consists of high levels of demandingness with low responsiveness. Authoritarian parents are often described as detached, controlling, and less warm than other parents. Authoritarian parenting has long been associated with problems such as disruptive behavior, overall mental health, and academic difficulty (Stevens et al., 2019; Uji et al., 2014), as well as an increase in conduct problems (Thompson et al., 2003). Regarding help-seeking for these negative outcomes, one study

investigating adolescent's perception of their parents' parenting style found that those with perceived authoritarian parents were less likely to seek help for themselves (Fallon & Bowles, 2001) for problems including depression and suicidality. However, no literature currently exists on parent's help-seeking decisions in relation to authoritarianism. It is possible that the low responsiveness and detached nature of authoritarian parents may make them less likely to seek help for their child as they often have high expectations and children may not feel comfortable disclosing internal symptoms of anxiety or depression that they are experiencing.

Parenting styles have been found to influence the development of emotional problems in children (e.g., Querido et al., 2002) and, therefore, may also influence if and when they are seeking help. Additionally, help-seeking attitudes differ depending on symptomatology, with more negative attitudes emerging toward help-seeking for depressive symptomatology versus anxiety. Therefore, the primary aims of the current study were to: (1) assess the point at which a parent decides to seek mental health treatment for their child, (2) explore whether parenting style plays a role in deciding to seek help for their child, and (3) investigate whether this decision is impacted by whether the child is experiencing anxiety or depression. The current study hypothesized that (1) parents would, on average, seek help for their child once symptoms and interference reach a moderate level, (2) parents with an authoritative or permissive parenting style would seek help earlier than parents with an authoritarian style, and (3) that parents would seek help for child depression earlier than for child anxiety.

CHAPTER 3

METHODOLOGY

Participants

Participants (*n* = 218) were parents and caregivers from the general population recruited through social media advertisements and letters to local schools in Rhode Island. Participants were entered into a raffle to win one of four ($25) gift cards for their participation. Of the participants, 87.6% identified as female, 11.9% identified as male, and one participant identified as non-binary. Approximately one percent of parents were between the ages of 18 and 24, 23.9% were 25-34 years old, 55% percent were 35-44 years old, 18.3% were 45-54 years old, and 1.8% were above the age of 55. Approximately two-thirds of the participants reported engaging in mental health treatment for themselves in the past while only 31.5% reported being diagnosed with a mental illness. Approximately half of the sample reported that they have a child who has participated in mental health treatment in the past, and 30.9% reported they have a child who has been diagnosed with a mental illness. This demographic information is displayed in Table 1. Crosstabulations for categorical variables are presented in Tables 2-9.

Measures

Demographics and outcome measures. Participants were asked a series of demographic questions regarding both parent and child age and gender identity. Based on previous literature associating help-seeking with both parent gender and parent age (e.g., Wendt & Shafer, 2016; Mackenzie, et al., 2008), these were the primary demographic variables assessed in the current study. Additionally, information about parental

accommodation of child anxiety, child and parent therapy status and history, and the degree to which the child shares their inner feelings and thoughts was collected.

Perceived Parenting Style. The Parenting Styles and Dimensions Questionnaire – Short Version (PSDQ-Short Version; Robinson, Mandleco, Olsen & Hart, 2001) is a 32-item measure that explores an individual's perceived parenting style. The questionnaire assesses parents' utilization of strategies from three parenting approaches—authoritative, permissive, or authoritarian parenting that have been outlined by Baumrind (1971). The PSDQ – Short Version produces three scores, one for each parenting style, and the items for each subscale are rated on a five-point scale (1 = never, 5 = always). Scores on the items for each parenting style are averaged to get an overall score for each style. The authoritative and authoritarian scales were shown to have high internal consistency, while the permissive parenting scale was found to have adequate internal consistency. All scales were shown to be valid (Robinson, Mandleco, Olsen, & Hart, 2001).

Parental Accommodation. The Family Accommodation Scale – Anxiety (FASA; Lebowitz et al., 2013) is a 13-item measure that assesses parental accommodation for child anxiety. The first 9 items assess the frequency of accommodations and are summed for the total accommodation score. Four additional items assess parental distress associated with accommodation (1 item) and children's short-term responses to not being accommodated (3 items). Items are rated on a 5-point scale of 0 to 4 ("*Never"* to "*Daily"*). Total 9-item family accommodation scores range from 0 to 36, with higher scores indicating more accommodation. The 9-item total accommodation scale has been found to have high internal consistency (α = .87; Lebowitz et al., 2020). Table 2 provides

information about the range, mean, and standard deviation for both the parenting style and accommodation scales.

Vignettes. A vignette can be defined as “a short, carefully constructed description of a person, object, or situation, representing a systematic combination of characteristics” (Atzmüller and Steiner, 2010). The current study assessed parental help-seeking decision making using two vignettes designed for the current study: one illustrating a child with symptoms of anxiety and one illustrating a child with symptoms of depression. Both vignettes were broken into a series of four chronological stages of disorder progression (see Appendix). As each stage progressed, the severity of symptoms and level of interference of the disorder increased. Table 10 provides a description of each of the four stages presented in the anxiety vignette (labeled S1–S4). Table 11 provides a description of each of the four stages presented in the depression vignette (labeled S1–S4). For both vignettes, participants were instructed to imagine themselves as the parent of the child in the scenario. Each stage of the scenario was presented consecutively to the participants on a computer screen, one at a time, in the same order. After reading each stage, participants clicked a “Next” button, which prompted them to answer a question that was used as an outcome measure: Would you seek professional help for your child at this point? (Yes/No; subsequently labeled as the help-seeking point). Participants were scored on a scale from 1 to 4 depending on which stage they decided to seek help (i.e., a parent who sought help at stage 2 would be given a score of 2). If parents did not choose to seek help, they were asked an open-ended question about why they did not choose to do so.

CHAPTER 4

FINDINGS

Preliminary Analyses

Chi-Square Tests of Independence were performed on all categorical variables, and these results are displayed in Tables 2-9. There was a significant relationship between parent gender and parent therapy status [$X^2(2, N=218) = 11.23, p = .004$] such that men were less likely to have reported participating in therapy compared to women (See Table 4). There was a significant relationship between parent age and child therapy status [$X^2(4, N=218) = 23.67, p < .001$] such that younger parents were less likely to report having a child in therapy compared to older parents (See Table 7). There was also a significant relationship between parent age and parent therapy status [$X^2(4, N=218) = 9.61, p = .047$] such that younger parents were less likely to report engaging in therapy themselves compared to older parents (See Table 9). No significant relationships were found between parent gender and child therapy status, parent gender and child diagnosis history, parent gender and parent diagnosis history, parent age and child diagnosis history, or parent age and parent diagnosis history.

Ranges, means, and standard deviations for the primary variables of interest are presented in Table 12, and correlations among the primary variables of interest are presented in Table 13. Authoritarianism (AN) (M = 1.95, SD = 0.55) was found to be significantly and negatively associated with authoritativeness (AV) (M = 3.99, SD = 0.45; r = -.38, $p < .01$). AN was significantly and negatively related to permissiveness (PM) (M = 2.59, SD = 0.64; r = -.62, $p < .01$) as well, such that individuals who reported

higher degrees of AN were also more likely to report lower levels of PM. AN was significantly and negatively related to parental perception of child's comfort in sharing their feelings (M = 3.01, SD = 0.86) such that those who endorsed having more AN were less likely to consider their child as feeling comfortable in sharing their thoughts and feelings ($r = -.29$, $p < .01$). Additionally, AN was significantly and negatively related to parental accommodation (M = 19.79, SD = 6.38) with individuals reporting higher degrees of AN reporting lower levels of parental accommodation ($r = -.42$, $p < .01$). AN was positively associated with both the anxiety (M = 2.22, SD = 0.73) and depression (M = 2.35, SD = 0.97) help seeking points indicating that those with more AN parenting practices sought help later than those with AV and PM parenting practices for both the anxiety ($r = .22$, $p < .01$) and depression ($r = .23$, $p < .01$) vignettes. In addition, parent mental illness was positively associated with AN such that those parents who reported being diagnosed with a mental illness were also more likely to report AN ($r = .14$, $p < .01$). AN was also positively related to parent therapy such that those parents who reported engaging in therapy for mental health were also more likely to endorse AN ($r = .24$, $p < .001$).

AV was inversely related to PM such that those reporting higher levels of AV were less likely to endorse PM ($r = -.20$, $p < .01$). AV was positively associated with child's comfort level such that those who endorsed having more authoritative parenting practices were also more likely to consider their child as feeling more comfortable with sharing their inner thoughts and feelings ($r = .38$, $p < .01$). No relationship was found between AV and parental accommodation. In terms of the help seeking points, AV was negatively associated with both the anxiety and depression help seeking points, indicating

that those with more authoritative parenting practices were more likely to seek help earlier than authoritarian or permissive parents for both the anxiety ($r = -.14$, $p < .05$) and depression ($r = -.14$, $p < .05$) vignettes. Parent therapy was inversely related to AV such that parents who reported engaging in therapy for mental health were less likely to endorse AV ($r = -.17$, $p < .01$). No relationship was found between parent mental illness and AV.

PM was positively associated with parental perception of child's comfort in sharing their feelings ($r = .24$, $p < .01$) and with parental accommodation ($r = .40$, $p < .01$). Therefore, those who endorsed more PM parenting practices perceived their child as more comfortable in sharing their feelings. They also were more likely to report engaging in accommodating behaviors. For PM, there was a significant positive correlation with the depression help seeking point ($r = .15$, $p < .05$) such that those who endorsed more PM were more likely to delay help-seeking in the depression vignette. No relationship was found between PM and the anxiety help seeking point. Furthermore, no relationship was found between PM and parent or child therapy status or mental illness.

Perception of child's comfort in sharing thoughts and feelings was significantly associated with parental accommodation ($r = .26$, $p < .01$) such that those who perceived their children as being more comfortable in sharing their feelings were more likely to report accommodating behaviors. Perception of child's comfort in sharing thoughts and feelings was also significantly related to child therapy status such that those who reported their child participated in therapy were more likely to report an increase in their child sharing their thoughts and feelings ($r = .13$, $p < .01$).

Parental accommodation was inversely associated with both the anxiety ($r = -.30$, $p < .01$) and depression ($r = -.42$, $p < .01$) help seeking points, indicating that those who reported engaging in more accommodating behaviors were more likely to seek help earlier than those who did not. Parental accommodation was significantly related to child mental illness such that parents who reported engaging in more accommodating behaviors were also more likely to have a child diagnosed with a mental illness ($r = .35$, $p < .001$). Parental accommodation was also significantly related to child therapy status such that parents who endorsed more accommodating behaviors were more likely to have a child who has participated in therapy ($r = .29$, $p < .001$). No relationship was found between parental accommodation and parent therapy status or parent mental illness.

The help seeking points for anxiety and depression were significantly and positively associated with one another ($r = .61$, $p < .01$), meaning those who sought help for anxiety were also more likely to seek help for depression and vice versa. Child therapy status was associated with the depression help-seeking point such that those who reported their child had engaged in therapy sought help for depression later than those whose children were not in therapy ($r = .14$, $p < .01$). Parent therapy status was significantly associated with the anxiety help seeking point such that parents who reported participating in therapy sought help earlier for the anxiety vignette than those who did not participate in therapy ($r = -.17$, $p < .01$).

Parent mental illness was positively correlated with child mental illness as parents who reported being diagnosed with a mental health condition were also more likely to have a child diagnosed with a mental health condition ($r = .16$, $p < .01$). Parent therapy status was positively and significantly related to child therapy status such that parents

who reported engaging in therapy were more likely to have a child engaged in therapy as well ($r = .32$, $p < .001$). Parent mental illness was positively related to both parent therapy status and child therapy status such that parents who reported being diagnosed with a mental illness were more likely to be engaged in therapy themselves ($r = .43$, $p < .001$) and have a child who has participated in therapy as well ($r = .14$, $p < .01$). Lastly, child mental illness was significantly and positively related to both parent therapy and child therapy such that those who reported having a child diagnosed with a mental illness were more likely to have a child participating in therapy ($r = .59$, $p < .001$) and also participate in therapy themselves ($r = .17$, $p < .01$).

Results from independent sample t-tests indicated that there was a significant difference between parent gender for the anxiety help-seeking point ($t(215) = 4.21$, $p < .05$), such that women sought help earlier in the anxiety vignette compared to men. No significant difference in gender was found for the depression help-seeking point, parental accommodation, or any of the parenting styles.

Help-seeking scores in the overall sample ranged from 1 to 4. The average help-seeking score across both vignettes and all participants was 2.29, thus, falling within the mild symptoms and interference ranges. Results revealed that the average help-seeking score was 2.35 for the anxiety vignette and 2.22 for the depression vignette, both falling within the mild symptoms and interference ranges as well. The help-seeking points for the depression vignette were .13 points lower on average, meaning participants sought help earlier, than for the anxiety vignette. This difference between anxiety and depression help-seeking points was statistically significant ($t=-2.51$, $p<.05$). Figure 1 provides a visual graph of the vignette help-seeking points.

Primary Analyses

In order to capture the individual differences in parental help-seeking, multilevel modeling was utilized. In the current study, multilevel modeling procedures will address interdependence of scores nested within participants and allow for the simultaneous examination of both vignette- and respondent-level characteristics explaining variability in the measured outcomes (Aguinis, Gottfredson, & Culpepper, 2013). Therefore, in the current study, multilevel modeling will be able to provide critical information regarding the individual differences in decision-making across the vignette events for both child anxiety and depression, as well predictors and outcomes thereof. To test the hypotheses that: (1) parents would seek help when symptoms and interference became moderate, (2) that parents with a perceived authoritative or permissive parenting style would seek help earlier than parents with an authoritarian style, and (3) that parents would seek help for child depression earlier and more often than for child anxiety, the following multilevel model was tested:

Level 1: Yij (Help Seeking Point) = β0j + rij

Level 2: β0j = γ00 + μ0jβ0j = γ00 + μ0j

where Y_{ij} represents respondent's help-seeking point (i.e., timepoint in vignette where respondent decides to seek help for their child) for vignette i by respondent j:

β_{0j} represents the intercept of respondent j (i.e., the average help-seeking point across vignettes); and r_{ij} represents random error for individual j. Effects were modeled as random; that is, a random error parameter (μ) was estimated for each parameter, and Level 1 parameters included a constant and a unique error term (at Level 2). Respondent variables (i.e., perceived parenting styles, parental accommodation) were added to Level

2, and vignette variables (i.e., the disorder characterized in the vignette) were added to Level 1 to test each of the study hypotheses.

Table 14 shows the results for the multilevel model predicting help-seeking, parenting styles, accommodation behaviors, and vignette ratings. Model 1, the unconditional random intercept model, shows that 58% of the total variability in help seeking scores were attributable to differences among participants, and the average correlation for any pair of responses from the same individual was moderate (ICC = .58).

To explain this variation, Model 2 added vignette disorder to level 1 and Model 3 added parental accommodation and the perceived parenting styles to level 2 as predictor variables. Results indicated that participants who exhibited higher levels of parental accommodation had a help-seeking score that was .05 points lower, on average, than participants who exhibited lower levels of accommodation. Therefore, parents who reported engaging in more accommodating behaviors sought help earlier than those who did not. The difference between help-seeking points for high versus low parental accommodation was found to be statistically significant ($t=-5.77$, $p<.001$). The multilevel model revealed no significant evidence that help-seeking points differed, on average, between authoritative, authoritarian, or permissive parenting styles.

CHAPTER 5

CONCLUSION

The current study is the first of the reviewed literature to assess whether perceived parenting style plays a role in parental decision making regarding the point at which a parent decides to seek mental health treatment for their child. Based upon previous research, it was anticipated that parents would seek help when symptoms and interference became moderate. It was hypothesized that parents with a perceived authoritative or permissive parenting style would be more likely to seek help earlier than parents with an authoritarian style. Given that previous research has identified service use rates for childhood depressive disorders tend to be higher (e.g., Ghandour et al., 2019), it was also hypothesized that parents would seek help for child depression earlier and more often than for child anxiety.

Results indicated that on average, parents sought help for their children when symptoms and interference were mild. This finding may have emerged because of an obvious escalation in symptoms and interference within the vignettes but might also speak to a lessening of stigma around help-seeking for mental health. Although research has indicated that mental health stigma negatively effects help-seeking (e.g., Clement et al., 2015; Gaddis et al., 2018), the current finding may indicate a possible reduction in parents’ stigma around seeking help for child anxiety and depression specifically. Additionally, data was collected during the COVID-19 pandemic in the summer of 2020. A national survey concluded that 71% of parents said the pandemic had taken a toll on their child’s mental health, and 69% said the pandemic was the worst thing to happen to their child (Canady, 2021). Additionally, recent literature suggests COVID-19 related

stressors were associated with increased caregiving burden (Tambling et al., 2021). Therefore, during the time of data collection, heightened parental concern regarding child mental health and wellbeing, as well as their own caregiving burden, might have resulted in parents seeking help earlier than hypothesized.

Results of the current study indicated that perceived authoritative parenting was associated with earlier help seeking than perceived authoritarian parenting; however, these results were correlational in nature. The multilevel model found no significant evidence that help-seeking points differed significantly between authoritative, authoritarian, or permissive parenting styles, which may have resulted from the study's small sample size and the uneven number of participants across parenting styles. Therefore, further studies are required to confirm or reject the hypothesis that authoritative parents seek help earlier than authoritarian or permissive parents.

Results indicated that parents who reported engaging in more accommodating behaviors sought help for their child earlier than those who did not. Parents who engage in accommodating behaviors seek to reduce their child's distress by making changes to their own behavior. Therefore, accommodating parents might attempt to reduce their child's distress by seeking help for them early on when symptoms first arise. Parental accommodation has long been associated with the maintenance of anxiety symptoms and reduced treatment outcomes, however; research has also indicated that parents who accommodate their anxious children often experience their own distress resulting from said accommodation (Lebowitz et al., 2012). Therefore, it is also possible that this parental distress might contribute to earlier help-seeking on their child's behalf.

Consistent with study hypotheses, results indicated that parents sought help for their child significantly earlier for depression than for anxiety. This finding supports previous research findings indicating that children receive services for depression more often than anxiety (e.g., Ghandour et al., 2019) and that individuals with mood disorders have a shorter time to help-seeking as compared to those with anxiety disorders (Raven et al., 2017). Studies have long determined lower quality of life associated with depressive disorders versus anxiety disorders (Hanson, 2002). Therefore, parents might view their child's symptoms of depression as more severe or life interfering than symptoms of anxiety, which may have led them to seek help for their child at an earlier point. This finding highlights the concerning nature of depressive disorders in children and might explain why parents tend to seek earlier intervention for such problems.

Of note, the current findings may generalize beyond only those who have already been diagnosed with a mental illness. Although the demographic measures asked participants to report whether they or their child have been diagnosed with a mental illness, it is likely that the sample included individuals who meet criteria for a mental health condition but were not yet diagnosed.

Limitations

When considering the results of this study, there are several limitations that should be noted. First, in attempt to identify groups of parents with similar perceived parenting styles, latent profile analysis, a person-centered statistical method for identifying related cases from multivariate continuous data, was conducted. However, the parenting style variable was unable to be clustered into unique classes due to a low number of participants in the smallest class (i.e., authoritarian parenting). Therefore,

perceived parenting style was examined as a predictor variable, and it is possible that the sample contains overlapping participants across parenting styles, which might explain the finding that help-seeking points did not differ significantly among perceived parenting styles.

Another limitation pertains to the study's assessment of parenting practices. Perceived parenting style and parental accommodation were assessed using self-reported measures that require participants to reflect on their own parenting style. Although these measures have been validated and have demonstrated a high degree of internal consistency, it is possible that participants' reports of their own practices are biased or simply inaccurate due to social desirability. Direct observations of parenting might have been a more accurate representation of these variables.

In addition, sampling parents from the general population may have limited the findings of this study. It is likely that not all participants experience parenting a child with anxiety or depression. The vignettes provided hypothetical situations for parents to consider, and therefore, some participants' responses might differ from how they would respond in actual practice. It may have been beneficial to use a more specific sample of parents who have children formally diagnosed with anxiety and depression.

The current sample was also uneven in terms of both gender and age. The majority of parents (55%) were between the ages of 35 and 44, and 87% were female. Results may have differed given a more even distribution of mothers and fathers, as well as older and younger parents.

Results indicated a high proportion of parents who sought therapy for both themselves and for their children. Sixty-seven percent of parents reported seeking therapy

for themselves and 50% reported seeking therapy for their children. In 2019, research revealed only 19.2% of adults had received any mental health treatment in the past year (Terlizzi and Zablotsky, 2019). This large difference in treatment seeking might illustrate that the current sample was not representative of the larger population; however, it may also be attributable, in part, to the COVID-19 pandemic considering the drastic increases in stress, workload, and uncertainty among the general population during this time. Nonetheless, this high proportion of therapy participation may have influenced the results of the study as parents who pursue treatment for themselves might be more apt to seek help for their child more often and at an earlier point than parents who do not participate in their own therapy.

Based on the findings of previous literature and the narrow focus of the topic, the current study focused solely on age and gender identity as demographic variables. Therefore, the current study did not investigate race, ethnicity, or other socioeconomic factors in relation to parenting style or help seeking behaviors. Research has found that individuals from diverse ethnic and racial groups are less likely to utilize mental health services (Turner et al., 2021) and therefore, examination into these factors may have provided additional insight into the help-seeking differences found among participants in this study.

Future Directions

Although the current study has provided a meaningful starting point for examining the relationship between perceived parenting style and help seeking behaviors, there are numerous ways that future researchers can improve and expand upon the current findings. Prior research has demonstrated that only a small number of children with

anxiety and depressive disorders receive treatment for their disorder (Mulraney et al., 2020). Therefore, additional research in parental help-seeking can aid in narrowing the gap between those who are diagnosed and those who seek treatment. Additionally, more research in this area can help to educate parents on how to recognize a mental health problem in their child and advise them on when to seek treatment for it. Further examination of the relationship between parenting style and help seeking might also enhance parent training programs by educating parents about important differences in parenting styles and the influence of those practices on children's mental health.

Future studies in this area of research should utilize a larger and more representative sample to increase reliability in results. Future research should also consider race, ethnicity, and other socioeconomic factors that might influence help-seeking decisions. Researchers who are interested in furthering this line of research might benefit by incorporating data that does not rely solely on self-report measures. Observing individuals' actual parenting practices may be a useful way to gain more information about their parenting style. In addition, collecting information from outside informants such as spouses or relatives would likely result in more reliable data as well.

Future research should explore other potential factors that might influence parental help-seeking. For example, stigma related to mental health treatment in children may be influential in a parent's decision to seek help for their child.

Conclusion

In sum, findings indicated that parents sought help for their children when symptoms and interference were mild in severity, and parents were found to seek help for their child significantly earlier for depression than for anxiety. No significant

difference in the timing of help-seeking was found among perceived parenting styles. Future research should explore other possible factors by which parental help-seeking might be influenced to gain a better understanding of parental help-seeking behaviors for their children. In addition, replication of the current findings with larger, more representative samples will help to further define the relationship between parenting style and help-seeking for children with anxiety and depression.

APPENDIX

Table 1. *Demographic Characteristics of Participants*

Characteristic	*n*	%
Parent Gender		
Female	191	87.6
Male	26	11.9
Non-binary	1	0.5
Parent Age		
18-24	2	0.9
25-34	52	23.9
35-44	120	55.0
45-54	40	18.3
55+	4	1.8
Parent Mental Illness [a]	68	31.5
Child Mental Illness [a]	67	30.9
Parent Therapy History [a]	146	67.0
Child Therapy History [a]	110	50.5

Note. N = 221. [a] Reflects the number and percentage of participants answering "yes" to this question.

Table 2. *Crosstabulation of Parent Gender and Child Therapy Status.*

Gender	*% Yes*	*% No*
Female	51.3	48.7
Male	46.2	53.8
Non-binary	0.0	100
Total	50.5	49.5

χ^2 (2) = 1.26, p = .531

Table 3. *Crosstabulation of Parent Gender and Child Diagnosis.*

Gender	*% Yes*	*% No*
Female	32.1	67.9
Male	23.1	76.9
Non-binary	0.0	100
Total	30.9	69.1

χ^2 (2) = 1.32, p = .516

Table 4. *Crosstabulation of Parent Gender and Parent Therapy Status.*

Gender	*% Yes*	*% No*
Female	70.7	29.3
Male	38.5	61.5
Non-binary	100	0.0
Total	67.0	33.0

χ^2 (2) = 11.23, p = .004

Table 5. *Crosstabulation of Parent Gender and Parent Diagnosis.*

Gender	*% Yes*	*% No*

Female	33.0	67.0
Male	16.7	83.3
Non-binary	100	0.0
Total	31.5	68.5

χ^2 (2) = 4.82, $p = .090$

Table 6. *Crosstabulation of Parent Age and Child Diagnosis.*

Age (years)	*% Yes*	*% No*
18-24	0.0	100
25-34	21.6	78.4
35-44	31.7	68.3
45-54	42.5	57.5
55+	25.0	75.0
Total	30.9	69.1

χ^2 (4) = 5.59, $p = .231$

Table 7. *Crosstabulation of Parent Age and Child Therapy Status.*

Age (years)	*% Yes*	*% No*
18-24	0.0	100
25-34	30.8	69.2
35-44	50.0	50.0
45-54	75.0	25.0
55+	100	0.0
Total	50.5	49.5

χ^2 (4) = 23.67, $p < .001$

Table 8. *Crosstabulation of Parent Age and Parent Diagnosis.*

Age (years)	*% Yes*	*% No*
18-24	0.0	100
25-34	33.3	66.7
35-44	27.7	72.3
45-54	37.5	62.5
55+	75.0	25.0
Total	31.5	68.5

χ^2 (4) = 5.96, $p = .202$

Table 9. *Crosstabulation of Parent Age and Parent Therapy Status.*

Age (years)	*% Yes*	*% No*
18-24	50.0	50.0
25-34	55.8	44.2
35-44	65.8	34.2
45-54	82.5	17.5
55+	100	0.0
Total	67.0	33.0

χ^2 (4) = 9.61, $p = .047$

Table 10. *Summary of Events in the Generalized Anxiety Disorder Vignette.*

	T1	T2	T3	T4
S1- Child A is a shy and reserved 10-year-old from a close and supportive family. Over the past few months, Child A sometimes worries about things, like doing well in school, their friends, and their performance in sports and other activities. Child A sometimes asks their parents questions for reassurance and to help them problem-solve and manage their emotions. Child A is attending school regularly, spending time with friends, and not experiencing any difficulties in school, either academically or socially.	Subclinical Symptoms; No Interference			
S2- Over time, Child A's worries seem to become more frequent. Child A begins to have occasional trouble falling asleep at night and has complained that their mind is occupied by thoughts on topics such as school and friends. Child A tends to worry before school and complains of mild stomach aches that go away over the course of the day. Child A is still attending school regularly and not experiencing any difficulties academically. Child A has turned down a few invitations to visit friends and didn't want to go to a recent sleepover.		Mild Symptoms; Mild Interference		
S3- As time progresses, Child A's worries become more numerous and take up more time each day. Child A is losing more sleep at night due to worried thoughts while lying in bed. Child A's stomach aches are taking longer to go away and are resulting in going to school a few minutes late or missing the day completely. Child A attends sports and other activities although they experience stomach aches and feel a good deal of anxious distress while in those situations. At home, Child A avoids the news due to worries about things going on in the world, and parents turn off the tv when Child A is around. Their grades and social relationships are being negatively impacted by the worries and avoidant behaviors. When the news is off, sports practice is over, or they are home from school, they are happy-go-lucky, productive, and relaxed.			Moderate Symptoms; Moderate Interference	
S4- As more time progresses, Child A has missed many days of school due to worsening stomach aches, loss of sleep, and anxiety. Their worries have become uncontrollable. Child A avoids going to school and sports practices. Child A also worries about maintaining friendships. Child A's parents have had to miss some time at work to stay home with Child A during the day or pick Child A up from school. They have altered their daily routines to make their child more comfortable (for example, they watch the news only after Child A is in bed). Child A's anxiety has caused their grades to fall as a result of missing so much school, and their friendships have suffered.				Severe Symptoms; Severe Interference

Note. S1–S4 denotes the 4 stages; T1–T4, themes 1–4.

Table 11. *Summary of Events in the Major Depressive Disorder Vignette.*

	T1	T2	T3	T4
S1- Child B is a happy-go-lucky 10-year-old who recently moved to a new town. Since moving one week ago, Child B has been irritable and has reported feeling a little bit sad and tired. Occasionally, Child B will wonder whether they will be able to make new friends. Child B attends their new school and joins the soccer team.	Subclinical Symptoms; No Interference			
S2-. Over time, Child B's feelings of sadness and irritability become more frequent. Child B occasionally makes statements such as "I feel like I will never make friends here". Child B is increasingly irritable and has been arguing with their siblings more than usual. Child B is not having any difficulties in school, academically or socially. However, Child B feels as if it is becoming more difficult to concentrate. Child B continues to play on the soccer team but sometimes feels as if it is becoming a chore.		Mild Symptoms; Mild Interference		
S3- As time goes on, Child B begins to have low energy and experiences some trouble some with daily tasks. Sometimes they find it difficult to wake up and get ready for the day. Child B is beginning to complain about going to soccer practice and has skipped a few practices. When asked about why, Child B will make statements such as "I am not very good" or "why should I bother?" Child B does not see any friends outside of soccer practice and their time spent with other people has diminished. Child B has shown increased irritability and has been short tempered with other members of the family.			Moderate Symptoms; Moderate Interference	
S4- As time progresses, Child B's sadness and irritability become more prevalent. Child B exhibits a depressed mood for most of the day, more days than not. After school, Child B stays in their room alone and does not want to be around other family members. Child B has been eating less and when offered food will say "I'm not hungry". Child B is finding it increasingly difficult to concentrate at school and has missed several homework assignments. Child B tells their parent they no longer wish to play soccer. When asked about why, Child B makes statements such as "I am no good" and "what is the point?".				Severe Symptoms; Severe Interference

Note. S1–S4 denotes the 4 stages; T1–T4, themes 1–4.

Table 12. *Ranges, Means, and Standard Deviations of Primary Variables*

.

Variable	*Possible Range*	*Sample Range*	*Mean*	*SD*	*Scored >3*
Authoritative Parenting	1 – 5	2.60 – 5.00	3.99	0.45	97.5%
Authoritarian Parenting	1 – 5	1.00 – 4.36	1.95	0.55	5.1%
Permissive Parenting	1 – 5	1.20 – 4.80	2.59	0.64	33.6%
Parental Accommodation	0 – 36	9.00 – 36.00	19.79	6.38	–
Comfort Sharing	1–5	1–5	3.01	0.86	–
HSP Depression	1–4	1–4	2.35	0.97	–
HSP Anxiety	1–4	1–4	2.22	0.73	–

Note. Participants who scored >3 on the parenting style scales reported utilizing those parenting practices "often" or "always".

Table 13. *Descriptive Statistics and Correlations for Study Variables*

Variable	1	2	3	4	5	6	7	8	9	10	11	12
1. Authoritarian	—											
2. Authoritative	−.38**	—										
3. Permissive	−.62**	−.20**	—									
4. Comfort Sharing	−.29**	.38**	.24**	—								
5. Accommodation	−.42**	−.046	.40**	.26**	—							
6. HSP Depression	.23**	−.14*	.15*	.10	-.42**	—						
7. HSP Anxiety	.22**	−.14*	.08	.06	-.30**	.61**	—					
8. Parent Therapy	.24**	−.17*	.11	−.03	.06	−.08	−.17*	—				
9. Parent Illness	.14*	−.11	.02	−.02	−.01	−.11	−.08	.43**	—			
10. Child Therapy	.02	−.11	.01	.13*	.29**	.14*	.01	.32**	.14*	—		
11. Child Illness	.02	−.09	−.03	.09	.35**	.13	.02	.17*	.16*	.59**	—	
12. Parent Age	.29**	−.13*	−.08	−.04	−.11	.19**	.31**	−.21**	−.08	−.33**	−.14*	—

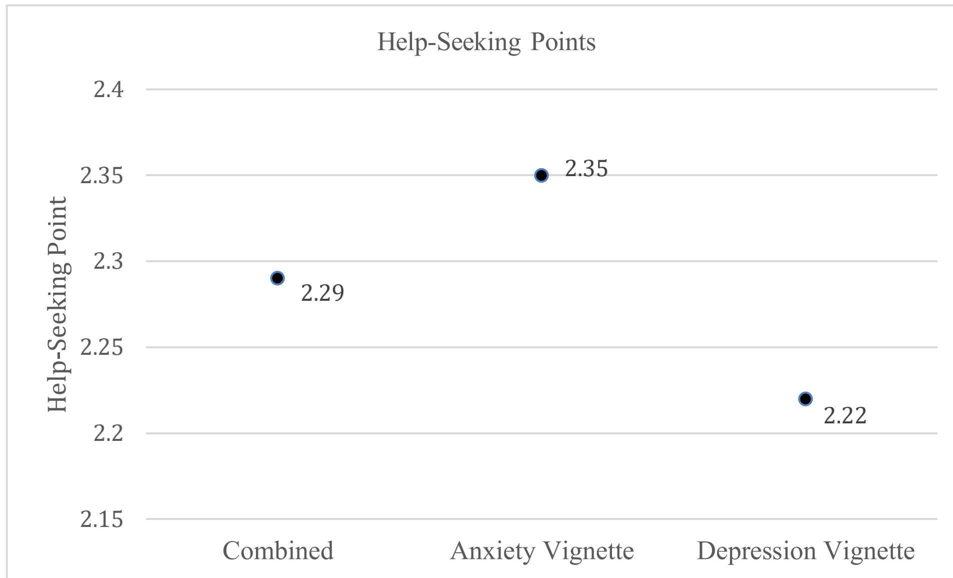
`*Note*. $^{*}p < .05$. $^{**}p < .01$. HSP=Help Seeking Point

Table 14. *Model Summary Statistics.*

	Model 1			Model 2			Model 3		
Predictors	*Estimates*	*CI*	*p*	*Estimates*	*CI*	*p*	*Estimates*	*CI*	*p*
(Intercept)	2.29	2.18 – 2.39	<0.001	2.44	2.32 – 2.55	<0.001	2.87	1.77 – 3.98	<0.001
Vignette (Dep)				-0.13	-0.24 – -0.03	0.012	-0.15	-0.26 – -0.04	0.006
Accommodation							-0.05	-0.06 – -0.03	<0.001
Authoritarian							-0.09	-0.32 – 0.15	0.471

Authoritative	0.08	-0.14 – 0.31	0.470
Permissive	0.11	-0.07 – 0.30	0.237

Figure 1. Graph of Help-Seeking Points.



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