

The Role of Culture in Parental Perceptions of Medical Mental Health Treatment for Adolescents

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ABSTRACT

This paper aims to address the increase in adolescents aged 10-17 suffering from mental health disorders and/or symptoms (e.g., depression, anxiety) in the United States after the COVID-19 pandemic, along with many of them going untreated. Upon examination of the existing body of research, many cultures have expressed different views on the use of mental health medication, and that these views are not always understood by psychologists and psychiatrists. Given that the U.S. has a growing culturally diverse population, it is imperative to examine if these sentiments continue to hold true. Using a self-report online survey method, quantitative and qualitative data was gathered from 44 parents from a variety of diverse cultures with adolescents between the ages of 10 and 17. Upon analysis of parents who strongly identified and did not strongly identify with their culture, no statistically significant differences were found in their perceptions of medical mental health treatment and psychologists and psychiatrists' understandings of various cultural backgrounds. This research demonstrates that how culture is viewed and taken into consideration varies from person to person and should be treated as such. It is suggested that future research with a larger sample size should be studied in order to further examine culture's influence and other possible factors, and to ensure a more reflective assessment of the U.S. population.

Introduction

According to studies conducted after the COVID-19 pandemic in the United States, an elevated number of adolescents between the ages of 10 and 17 are experiencing symptoms characteristic of depression and anxiety (Racine et al., 2021; Rogers et al., 2021), with a majority of them going untreated (Mental Health America, 2022). Although youth mental health has been an ongoing issue, the increased prevalence of psychological disorders in a post-COVID world suggests that the pandemic may have caused adolescents to experience exacerbated symptoms of a pre-existing mental health disorder, or to have begun showing signs of a mental health disorder. Nonetheless, in these cases, it is important for adolescents to receive the treatment they need to help alleviate their symptoms. However, adolescents, being under the age of majority in the United States, cannot make decisions about treatment for themselves—it is up to their parents to decide what is best for them (McNary, 2014). Thus, it is important to look into factors that could be preventing parents from seeking treatment for their children. Recent studies on the release of COVID-19 vaccines revealed that many parents perceived giving vaccines to their children negatively due to distrust linked with culture (Reuben et al., 2020; Szilagyi et al., 2021). If distrust stemming from differences in culture is found in vaccinal treatment, it may also be found within other forms of modern medicine. Given that mental health disorder symptoms are on the rise, it is important to examine if potential sentiments are present within medical treatment used to treat mental health disorder symptoms, or mental health disorders overall (e.g., psychotropic medication, psychotherapy). Exploring this inquiry will be crucial to mental health professionals (e.g., psychologists and psychiatrists), who can consider parents' cultural backgrounds in order to minimize the potential for disconnection and distrust.

According to Merriam-Webster (n.d.), culture is defined as “the customary beliefs, social forms, and material traits of a racial, religious, or social group.” In the United States, there are an abundance of diverse cultures. Furthermore, as reported by the U.S. Census Bureau (2022), between 2020 and 2021, the prevalence of all racial and ethnic groups has increased. Due to the evident cultural diversity within the United States, culture could play a strong role in parental perceptions of medical mental health treatment. It has already been outlined in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5): “...it is important for clinicians to be aware of relevant contextual information stemming from a patient’s culture, race, ethnicity, religion or geographical origin” (American Psychiatric Association, 2019, para. 1). However, little pre-existing studies have explored the role of culture in the U.S., mostly examining only one specific cultural population, and little have explored medical treatment specifically. Since the United States has a diverse population, this makes it more imperative to analyze culture, and its potential influence on perceptions of medical treatment for mental health disorders.

This leads to the question: in a post-COVID America, how strong of a role does culture play in parents’ perceptions of medical mental health treatment for adolescents? This research aims to determine if culture is a significant factor in parent’s perceptions of medical mental health treatment for adolescents, in hopes to address the majority of adolescents who are going untreated. If culture is found to play a strong role in preventing parents from seeking medical treatment for their children, it will be imperative for psychologists and psychiatrists to consider cultural backgrounds, needs, and understandings into consideration when addressing patients and their parents.

Literature Review

Increase in Adolescent Mental Health Disorders and Symptoms

Many studies suggest that the number of adolescents with mental health disorders or symptoms has grown post-COVID-19, breaking pre-pandemic numbers. A study on 46.6 million adolescents in the United States, which analyzed findings from a 2016 survey, found that the national prevalence of at least one mental health disorder (e.g., depression, anxiety, attention deficit hyperactivity disorder (ADHD)), was 16.5%, or 7.7 million children between the ages of zero and 17 (Whitney & Peterson, 2019). These findings serve as a basis, indicating that many children and adolescents were experiencing a mental health disorder before the pandemic, may have gone into the pandemic with the disorder, and thus may have come out of it with exacerbated symptoms due to the isolation the pandemic caused. This theory can be supported by a recent study on the global prevalence of elevated mental health disorder symptoms among 80,879 adolescents. According to its findings, one in four youth globally are experiencing clinically elevated depressive symptoms, and one in five youth are experiencing clinically elevated anxiety symptoms (Racine et al., 2021). The study also suggests that these estimates increased over time and are double the estimates made before the pandemic (Racine et al., 2021). These findings are consistent with another study on 407 U.S. adolescents, which found that, in regard to depressive symptoms specifically, adolescents’ reports of symptoms were significantly higher than before the pandemic (Rogers et al., 2021). These studies suggest that adolescents who were diagnosed with a mental health disorder before the pandemic could be experiencing elevated symptoms post-pandemic, thus potentially leaving them in a worsened mental state today.

Untreated Adolescent Mental Health Disorders and Symptoms

Furthermore, many adolescents who developed mental health disorders or symptoms before or during the pandemic did not receive treatment. According to a study conducted before the pandemic, 49.4% of adolescents

did not receive treatment or counseling from a mental health professional (Whitney & Peterson, 2019). Since 2019, the statistics have increased; according to Mental Health America (2022), nearly two-thirds of children with mental health disorders get little to no help. These sources demonstrate that the prevalence of adolescents with untreated mental health disorders has significantly increased. This can leave detrimental effects on adolescents, such as "...increased risk of school failure, contact with the criminal justice system, dependence on social services, and even suicide" (Mental Health America, 2022, para. 2). This research emphasizes the need for adolescents to receive a form of medical treatment, as subsequent negative effects on their academics, behavior, and mental wellbeing could potentially occur.

Cultural Perceptions of Mental Health Treatment

Research on mental health perceptions shows that culture may be a noteworthy factor. This idea is consistent with findings from a study in Ethiopia, which found that 93.2% of parents attributed mental health disorders to magic; 81.8% attributed them to curses; and 73.9% attributed them to sin (Abera et al., 2015). Furthermore, 92.7% of parents agreed that, if their child developed a mental health disorder, they would seek help from religious and spiritual leaders (Abera et al., 2015). A similar study within the United States revealed that individuals with moderate or conservative religions believed children who received mental health treatment will be stigmatized (Pescosolido et al., 2007). These studies emphasize the need to explore the strength of culture's role today, given that these studies were conducted before the pandemic. One recent video, however, could potentially show that the culture of religion may still hold a significant influence, as a father speaking about his daughter's mental health struggles states: "As a father, it's pretty gut-wrenching to know that if Noelle had the structure and were part of a good *church* family, Noelle would be just fine" (Lpgnxtreme, 2022, emphasis added).

Cultural Boundaries

Due to diverse cultural backgrounds, some individuals may also experience difficulty in understanding mental health care in the United States. A study with 19 Asian-immigrant parents found that their hesitation and reluctance to school-based mental health services for their children was due to knowledge, attitudinal, structural/practical, and relational barriers, all of which were linked to cultural influences (Wang et al., 2019). Additionally, 21.1% of parents expressed that providers of school-based services lacked cultural competence and sensitivity. Some of the parents recalled experiences where providers did not account for cultural differences that led to exacerbated problems or adverse outcomes (Wang et al., 2019). This study provides insight into factors that may be contributing to a strong cultural influence, which could be causing a barrier between mental health professionals and parents.

The Current Study

Overall, due to the significant increase in mental health disorders and symptoms among adolescents, it is recommended that mental health professionals ensure the availability of mental health interventions tailored to aid children and adolescents cope with public health crises such as the COVID-19 pandemic. (Tang et al., 2021). Indeed, past pre-existing research has emphasized that mental health professionals and care providers should explore cultural differences specifically (Bornstein, 2013). If beliefs are strong enough, it can lead to adolescents not receiving the necessary treatment to alleviate their mental health disorder and/or symptoms, causing subsequent detrimental effects on their academics and wellbeing (Mental Health America, 2022). This study

aims to explore how culture influences parents' perceptions of medical mental health treatment for adolescents in a post-COVID America. The goal is to emphasize the need for cultural sensitivity in the medical field; specifically, when discussing with parents about treatment options for their children. This is especially relevant to research after the COVID-19 pandemic, which left many adolescents with symptoms of anxiety and depression (Racine et al., 2021; Rogers et al., 2021). The hypothesis of this study is that there would be a significant difference in responses to medical mental health treatment for adolescents by participants who strongly identify with their culture, versus participants that do not strongly identify with their culture. Participants who strongly identify with their culture are theorized to use their culture to drive and influence their beliefs, as found by Abera et al. (2015), Pescosolido et al. (2007), and Reuben et al. (2020). Conversely, participants who do not strongly identify with their culture are theorized to base beliefs solely on their personal preferences, rather than cultural influences.

Method

Participants

The participants gathered for the study were parents with adolescents between the ages of 10 and 17. This specific demographic was chosen because, upon examination of past research, this age group was found to be the most psychologically affected by the COVID-19 pandemic. Additionally, since this age group is under the aforementioned age of majority—thus making parents responsible for giving consent to treatment—the demographic of parental participants was most relevant for this study (McNary, 2014, p. 43). In total, 44 responses were collected. Participants were categorized based on their responses to one question, which asked: “To what degree does your culture play a role in your values and beliefs?” Participants used a 1-5 Likert scale (1 = Culture plays no role, 5 = Culture plays a significant role); if a four or five was chosen, the participant was determined to strongly identify with their culture and were put into the Strongly Identified (SI) group. If a one, two, or three was chosen, the participant was determined to not strongly identify with their culture, and were put into the Not Strongly Identified (NSI) group (See Appendix E for full scales). Of the 44 participants, 28 (63.64%) chose a four or five, and 16 (36.36%) chose either a one, two, or three for this question.

Furthermore, participants were also asked about their culture; specifically, the culture they most strongly identify themselves with. The cultures that participants listed include: Italian (22.73%), American (13.64%), Asian (11.37%), Catholic (9.09%), Roman Catholic (4.55%), Jewish (4.55%), Irish (4.55%), Black (2.27%), Latino (2.27%), European (2.27%), Peruvian (2.27%), Spanish (2.27%), Greek (2.27%), Christian (2.27%), White (2.27%), Indian (2.27%), Mexican (2.27%), Agnostic (2.27%), Multicultural (2.27%), and Not Specified (2.27%). This prevalence of a variety of cultures fills a gap in pre-existing research, where a multitude of diverse cultures has not previously been examined.

Lastly, to ensure that participants met the target demographic for this study, they were asked about the age ranges of their children. 20% of participants indicated having a child between the ages of 10-11, 15.6% indicated having a child between 12-13, 40% indicated having a child between 14-15, and 80% indicated having a child between the ages of 16-17. Some participants selected multiple age ranges, showing that they have more than one child between the ages of 10-17.

Research Instruments

This study used a self-report online survey to gather data. The survey was created through Google Forms, an online software that allows for the organization of both numerical and non-numerical data. Seventeen questions were included in the survey. Five of these questions were researcher-created, while the other 12 were adapted

from the Mental Illness Stigma Scale (MISS) created by Day et al. (2007). The researcher-created questions allowed for the addition of questions specifically catered to the parameters of this study, while the MISS was used as it measures factors that produce certain perceptions of mental health.

The survey was divided into four sections: Consent Form, Information Questionnaire, Scale Questionnaire, and Debrief. Before beginning the survey, participants were required to select “Yes” to ascertain their consent to being part of the study. Upon clicking “Yes,” participants were to begin the survey (See Appendix A for full survey).

Quantitative data was collected through the 12 statements inspired by the MISS, which used a Likert scale from 1-7 (1 = Strongly Disagree, 7 = Strongly Agree). The 12 statements each centered around adolescents with a mental health disorder. Qualitative data was gathered through free-response questions created by the researcher, which supplemented two of the MISS statements.

Procedures

To ensure that parents would be keeping their own children in mind while answering the statements, “child” was used instead of “adolescent.” The researcher deemed that these words could be used interchangeably given the specific target demographic outlined. Upon obtaining approval from an Institutional Review Board (IRB), announcements were made via Gmail and various social media platforms to gather parent volunteers. The announcements emphasized that the survey was both anonymous and voluntary.

Data Analysis

Quantitative data was analyzed through a series of t-tests, which measured the statistical significance between the mean responses of the SI and NSI group ($p < 0.05$). For the purposes of this study, only five out of the 12 statements included in the survey were chosen for quantitative analysis; the statements chosen were statements one, four, seven, eleven, and twelve (hereinafter referred to as S1, S4, S7, etc., respectively). Appendix B contains these specific statements. Additionally, one researcher-created Likert-scale question was chosen, as this question determined each participants’ strength of identification to culture (Referred to as the TWD, or “To What Degree” question). While each question examined various aspects of the research variables, the questions picked were most relevant to the study. The other questions, upon further examination, did not directly address cultural perceptions of medical mental health treatment. However, omitting the questions deemed as unnecessary from the beginning may have prompted more participant engagement and participation overall.

To provide qualitative data, two supplemental free-response questions to Statements 11 (Known as Free Response Question One) and 12 (Known as Free Response Question Two) created by the researcher were chosen for analysis. These statements provided more detailed information on parental perceptions that may not have been revealed solely from the quantitative data (see Appendix B for questions). This data was further analyzed using thematic analysis, which reports patterns or themes within data (Braun & Clarke, 2006). These themes were coded, using a strategy and design process by Leedy et al. (2019). Correlational analysis was also used to examine if there were correlations between the participants’ responses and the strength of culture’s role in their values and beliefs.

Results

Quantitative Data

Tables 1 and 2 below indicate the means of the SI and NSI groups for each question. Data was rounded to the nearest hundredth unless it already fell into the hundredths place; the non-rounded numbers are listed in parentheses. According to these tables, there were no extreme mean differences between the groups. However, both groups, on average, selected either a five or a six for each statement, indicating that they somewhat agreed or agreed with the statements, but did not strongly agree. Additionally, both groups on average selected a two, three, or four for statements 11 and 12, indicating somewhat disagreement, disagreement, or neutrality, but not strong disagreement.

Table 1. Means of Strongly Identified Group (n = 28)

	TWD	S1	S4	S7	S11	S12
Strongly Identified (SI)	4.43 (4.429)	5.25	5.71 (5.714)	5.86 (5.857)	2.64 (2.643)	3.79 (3.786)

*Note: n = sample size

Table 2. Means of Not Strongly Identified Group (n = 16)*

	TWD	S1	S4	S7	S11	S12
Not Strongly Identified (NSI)	2.25	5.56 (5.563)	5.88 (5.875)	5.13 (5.125)	2.38 (2.375)	3.4

*Note: For S12, one person did not respond to the question, resulting in only 15 total responses. Thus, the mean may have been affected.

Table 3 indicates the statistical significance between the means of each group. Due to the lack of extreme differences between the means, the p values were all greater than the alpha value of 0.05, indicating that there was no statistically significant difference between the responses of those who strongly identified with their culture and those who did not strongly identify with their culture. Thus, this data does not support the hypothesis that there would be a significant difference in responses to medical mental health treatment for adolescents by participants who strongly identify with their culture compared to participants that do not strongly identify with their culture.

Table 3. Statistical Significance of Data Between Groups

	S1	S4	S7	S11	S12
Statistical Significance?	No (p = 0.242)	No (p = 0.329)	No (p = 0.961)	No (p = 0.692)	No (p = 0.783)

Qualitative Data

Qualitative data was gathered from participant responses to FR1 and FR2. The responses are quoted verbatim, and therefore may be subject to grammatical errors. If any were present that may have impeded understanding, corrections were made.

Free Response Question One (FR1)

Participants were encouraged to answer FR1 if they answered with a five, six, or seven for S11, indicating a level of agreement to using at-home remedies to treat their children if they had a mental health disorder. In total, seven responses were analyzed. Four of these responses were from participants in the SI group, and three of the responses were from participants in the NSI group. Out of the seven responses, only four fit the criteria (responding with a five, six, or seven) for the question. Although the other three responses did not fit the criteria to answer the question, their results were included for further analysis. After coding the data (Appendix C), two overarching themes were identified: (1) the use of at-home remedies, and (2) the use of other remedies.

Use of At-Home Remedies

The five participants who expressed the potential use of at-home remedies to treat their child's mental health disorder were further placed into categories depending upon the number of remedies they stated. Two participants expressed one singular remedy (IA, #s 1 and 2, Appendix C), while three participants expressed multiple remedies (IB, #1-3, Appendix C). Out of the five participants, four of them expressed nutrition as a remedy (IA, #2; IB, #s 1-3; Appendix C). However, these remedies could not be positively correlated with culture playing a stronger role, as not all participants answered TWD with a four or five. (Appendix C).

Other Remedies

Two participants expressed remedies other than those considered "at-home." These included: having "Knowledge of early intervention therapies" (IIA, Appendix C), and "Attention to the root causes" (IIB, Appendix C). These results could also not be associated with culture playing a stronger role, as one participant answered TWD with a five, and the other answered TWD with a three.

Free Response Question Two (FR2)

Participants were encouraged to answer FR2 if they answered with a one, two, three, or five for S12, indicating that they, in some form, either disagreed with the idea that psychologists and psychiatrists account for parental cultural beliefs when it comes to treating mental health disorders within children, or somewhat agreed, thus expressing some uncertainty. In total, 14 responses were collected. Nine of these responses were from participants in the SI group, and five of these responses were from participants in the NSI group. Eleven fit the criteria to answer FR2, while two did not. Their results, however, were also kept for further analysis to add more dimension to the inquiry. After coding the data (Appendix D), four themes emerged: (1) Positive perceptions of culture, (2) Negative perceptions of culture, (3) Neutral responses to culture, and (4) Other responses to culture.

Positive Perceptions

A positive perception of culture, in this case, means that participants believe that culture is well-understood in the medical field. They expressed culture being a factor or suggested that it would be beneficial to be considered when assessing medical treatment for children. Two participants were placed into this category. One participant expressed that "...both psychologists and psychiatrists are trained to take into account all aspects of a patient's background", (IA,#1, Appendix D) while another participant expressed that "...it will be easier if they [the

patient] are able to follow through with the treatment if it aligns with their cultural beliefs” (IA, #2, Appendix D). These responses both demonstrate that culture is and/or should be taken into account by psychologists and psychiatrists in order to effectively help adolescents.

Negative Perceptions

A negative perception of culture either means that culture is not well-understood, or that it should not be a factor at all. Three participants were placed into this category. One participant noted that they had a “personal experience” with psychologists and psychiatrists in regards to their beliefs, stating that, “Psychologists and psychiatrists don’t take parents beliefs into account and rely on medical training even if it is to the detriment of the patient” (IB, #1, Appendix D). Although this person stated a personal experience that demonstrates potential consequences to a lack of consideration and accommodation by psychologists and psychiatrists, two participants stated that this lack of consideration of culture may be necessary, as “...cultural beliefs are too strong and should not be a factor in treating the child. The child’s health, mental and physical is what should be first” (IB, #2, Appendix D), and “...the Dr. wants to make the best recommendation to help the child, even if it works against the family beliefs” (IB, #3, Appendix D). As the fourth participant in this category states, “They would want what’s best for the patient” (IB, #4, Appendix D). The variations in responses illustrate that a lack of consideration can affect parents differently, which depends on the parent themselves, and not on how strongly they identify with their culture (See Notes under IB #s 1, 2, 3, and 4 Appendix D).

Neutral Responses

A neutral response indicates that culture is not a factor, and that this is neither positive nor negative. Three participants were placed into this category. Two participants expressed that culture does not play a role, with one participant stating, “I don’t think they [psychologists and psychiatrists] are really concerned with it” (IC, #2, Appendix D).

Other Responses

Six participants were placed into this category. These participants explained reasons why cultures may not currently be considered when prescribing treatment, as expressed in the one response: “...psychiatrists are more concerned about prescribing medication than taking cultural beliefs into consideration” (ID, #1, Appendix D). Although this participant expressed that psychiatrists are “more concerned” about prescribing medication, they do not explicitly state whether it has a positive or negative effect on the parent or the patient (the child). Furthermore, two responses expressed uncertainty, stating that psychologists and psychiatrists may be unable to understand all cultures (ID, #2, Appendix D), or that whether or not culture is considered depends on the psychologist or psychiatrist themselves (ID, #4 and 6, Appendix D). Additionally, one participant expressed a willingness to relinquish their culture (specifically, religion) in order for their child to receive “...the care they deserve” (ID, #3, Appendix D), and one participant expressed that psychologists should do “...whatever is necessary for the child’s mental health to improve”. However, they did not explicitly state whether this means considering the parent’s culture (ID, #5, Appendix D).

Discussion

Upon analyzing both the quantitative and qualitative data, no significant differences were found between the perceptions of those put into the SI group and those put into the NSI group, rejecting the original hypothesis. Similar perceptions were especially prevalent when coding the free response questions (Appendix C and D), where participants varied in response regardless of how strongly they identified with their culture. However, the qualitative data provided more insight. For instance, out of eight participants who indicated the use of alternative remedies, three participants also indicated that their culture plays a significant role in their values and

beliefs, while four participants indicated their culture does not play a significant role in their values and beliefs (Appendix C). This theme was also present in FR2. Although two participants who indicated that they strongly identified with their culture agreed that psychologists and psychiatrists do and should take cultural beliefs into account (IA, #s 1 and 2, Appendix D), one other participant who also strongly identified with their culture stated that cultural beliefs are “too strong” (IB, #2, Appendix D) and two others stated that psychologists and psychiatrists should do what is best for the patient, regardless of culture (IB, #s 3 and 4, Appendix D). Nonetheless, whether it was viewed as for better or for worse, all participants, on average, disagreed with the notion that culture is taken into account, regardless of how strong of a role culture played in their values and beliefs.

This research introduces a new understanding: that culture is a complex concept viewed differently by each individual. As indicated by the qualitative data, a strong identification to culture is not always indicative of influencing perceptions of medical treatment options for mental health disorders. Culture can play a different role for each individual and could also be contingent on the issue itself (Abera et al., 2015; Reuben et al., 2020; Szilagyi et al., 2021; Wang et al., 2019). This idea is also consistent with the responses given when participants were asked to list the culture they most strongly identified with; some chose their religion, others chose their ethnicity, and others chose their nationality, supporting the idea that culture is ambiguous and is defined differently by each person. This emphasizes the need for personalized and individualized care. While culture should still be examined (Bornstein, 2013), psychologists and psychiatrists can use this information to better understand individual parent needs in order to help adolescents get the treatment they need to restore their psychological wellbeing.

Furthermore, there were some limitations to this study. Due to the small sample size, these results are unable to apply to the entire U.S. population. In addition, although this study solely examined if culture plays a strong role in parents’ perceptions of adolescent medical mental health treatment, it was not tested among other variables in order to determine if it was the sole contributor. Other factors, such as location and past experience, were not explored, which also have been found to have an influence in parental perceptions (Pescosolido et al., 2007). Although cultural sensitivity is mentioned as an influence in the DSM-5 (American Psychiatric Association, 2019), if other aspects are found to affect parents’ perceptions, it would be imperative to also highlight them in the DSM-5. For future research, a larger pool of participants should be surveyed to determine more meaningful results. Furthermore, as mentioned above, other factors should be looked into that may also influence perceptions. Overall, emphasizing the need for sensitivity, whether cultural, personal, or individual, could help address today’s issue of untreated adolescent mental health disorders and symptoms in America.

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References

- Abera, M., Robbins, J. M., & Tesfaye, M. (2015). Parents’ perception of child and adolescent mental health problems and their choice of treatment option in southwest Ethiopia. *Child and Adolescent Psychiatry and Mental Health*, 9(1). <https://doi.org/10.1186/s13034-015-0072-5>
- Bornstein, M. H. (2013). Parenting and child mental health: A cross-cultural perspective. *World Psychiatry*, 12(3). <https://doi.org/10.1002/wps.20071>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology.

Qualitative Research in Psychology, 3(2), 77-101.
<https://doi.org/10.1191/1478088706qp063oa>

- Cultural Concepts in DSM-5*. (2013). American Psychiatric Association.
https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM_Cultural-Concepts-in-DSM-5.pdf
- Day, E. N., Edgren, K., & Eshleman, A. (2007). Measuring stigma toward mental illness: Development and application of the Mental Illness Stigma scale. *Journal of Applied Social Psychology*, 37(10), 2191-2219. <https://doi.org/10.1111/j.1559-1816.2007.00255.x>
- Leedy, P. D., Ormrod, J. E., & Johnson, L. R. (2019). *Practical Research: Planning and Design* (12). Pearson.
- Lpgnxtreme. (2022, May 12). *Beautiful Disaster? (April 21, 2022) | Dr. Phil 2022 (Full Episode)* [Video]. YouTube. https://www.youtube.com/watch?v=_ocnTjEEN9M
- McNary, A. (2014). Consent to treatment of minors. *Innovations in Clinical Neuroscience*, 11(3-4), 43-45. <https://innovationscns.com/consent-to-treatment-of-minors/>
- Merriam-Webster. (n.d.). Culture. In *Merriam-Webster.com dictionary*. Retrieved April 4, 2023, from <https://www.merriam-webster.com/dictionary/culture>.
- Pescosolido, B. A., Perry, B. L., Martin, J. K., McLeod, J. D., & Jensen, P. S. (2007). Stigmatizing attitudes and beliefs about treatment and psychiatric medications for children with mental illness. *Psychiatric Services*, 58(5), 613-618.
<https://doi.org/10.1176/ps.2007.58.5.613>
- Racine, N., McArthur, B. A., & Cooke, J. E. (2021). Global prevalence of depressive and anxiety symptoms in children and adolescents during COVID-19: A meta-analysis. *JAMA Pediatrics*, 175(11), 1142-1150. <https://doi.org/10.1001/jamapediatrics.2021.2482>
- Recognizing Mental Health Problems In Children*. (2022). Mental Health America.
<https://www.mhanational.org/recognizing-mental-health-problems-children#:~:text=Untreated%20mental%20health%20problems%20can,social%20services%2C%20and%20even%20suicide>
- Reuben, R., Aitken, D., Freedman, J. L., & Einstein, G. (2020). Mistrust of the medical profession and higher disgust sensitivity predict parental vaccine hesitancy. *PLOS One*, 15(9), 1-12. <https://doi.org/10.1371/journal.pone.0237755>
- Rogers, A. A., Ha, T., & Ockey, S. (2021). Adolescents' perceived socio-emotional impact of COVID-19 and implications for mental health: Results from a U.S.-based mixed-method Study. *Journal of Adolescent Health*, 68(1), 43-52.
<https://doi.org/10.1016/j.jadohealth.2020.09.039>
- Szilagyi, P. G., Shah, M. D., Delgado, J. R., Thomas, K., Vizueta, N., Cui, Y., Vangala, S.,

- Shetgiri, R., & Kapteyn, A. (2021). Parents' Intentions and Perceptions About COVID-19 Vaccination for Their Children: Results From a National Survey. *Pediatrics*, 148(4), 1-11. <https://doi.org/10.1542/peds.2021-052335>
- Tang, S., Xiang, M., Cheung, T., & Xiang, Y. (2021). Mental health and its correlates among children and adolescents during COVID-19 school closure: The importance of parent-child discussion. *Journal of Affective Disorders*, 279, 353-360. <https://doi.org/10.1016/j.jad.2020.10.016>
- United States Census Bureau. (2022). <https://www.census.gov/quickfacts/fact/table/US/PST045222#PST045222>
- Wang, C., Do, K. A., Frese, K., & Zheng, L. (2019). Asian immigrant parents' perception of barriers preventing adolescents from seeking school-based mental health services. *School Mental Health*, 11, 364-377. <https://doi.org/10.1007/s12310-018-9285-0>
- Whitney, D. G., and Peterson, M. D. (2019). US national and state-level prevalence of mental health disorders and disparities of mental health care use in children. *JAMA Pediatrics*, 179(4), 389-391. <https://doi.org/10.1001/jamapediatrics.2018.5399>