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Stigmatization of Mental Health Issues in Children and Adolescents among their Family in Eradah Complex and Mental Health-Dammam 2024

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ABSTRACT: Background: The stigma surrounding mental health issues in children and adolescents is a critical concern, especially in settings like hospitals, mental health complexes, or institutions providing specialized care. In 2024, focusing on the stigmatization of mental health issues among families in institutions like Eradah Complex and Mental Health-Dammam offers valuable insights into how families, a key social support system, respond to mental health challenges faced by their children and adolescents.

The study aims: To describe and relate attitudes toward mental health in children and adolescents along with myths associated with suicide in this population, familiarity with mental health, and potential professional help-seeking.

Method: A cross-sectional study was used in a sample (N = 268). Socio-demographic variables, stigma associated with mental health problems in childhood and adolescence, myths about suicide, familiarity with mental health, and seeking professional help were assessed. Descriptive analyses mean difference and regression models were carried out.

Results: The results reveal medium levels of stigma, the presence of myths about suicide and average familiarity with mental health. Mothers were a higher level of education, showed lower levels of stigma and fewer myths about suicide. A regression model explains the 44% of the variance with myths about suicide, stigma and familiarity with mental health as predictors of seeking professional help attitudes.

Conclusions: Stigma, myths close suicide, and parental unfamiliarity with mental health may act as obstacles to appropriate diagnosis and treatment. Practical implications and recommendations are discussed.

INTRODUCTION:

Stigma has been recognized as a likely crucial factor in mental health services access and utilization, mainly under-utilization of existing services by some segments of society, most notably minority racial/ethnic children [1-3]. In child mental health services research, the role of stigma has not been well-conceptualized though it is supposed to be important. Literature on caregiver strain and burden of care has discovered processes and implications of coping with children's emotional and behavioral disorders [4].

However considering perceptions (including concerns about public attitudes) and acknowledging the social implications of childhood mental disorders, caregiver strain and burden of care literature has not adequately considered the implications of public stigma. Few stigma researchers address child mental illness [5, 6]. Therefore, the field lacks suitable and empirically tested theoretic frameworks and conceptualizations. Predominantly, lacking are conceptual frameworks addressing help-seeking that adequately account for the role of stigma among barriers to care [7] or caregiver strain variables [4].

Our premise is that the field needs conceptual frameworks that link stigma to how parents/family caregivers cope with children's emotional and behavioral problems such as seeking professional help. One way parents/family caregivers cope with children's mental health problems is to seek mental health services [8]. Hence, stigma likely compounds the burden of care and affects caregiver's help-seeking behavior. For example, caregiver strain literature indicates an association between caregiver depression and child symptomatology [9]. Depression has been shown to be related to the under-use of mental health service [10].

The stigma towards mental health problems (MHP) refers to the prejudices, stereotypes, and discrimination that exist in society towards people with those problems [11]. In recent years, research on social stigma has increased notably, revealing that beliefs of dangerousness, unpredictability, and guilt are common, as well as a general lack of knowledge about MHP [12, 13]. In addition, stigma may also be a barrier to secondary prevention in obtaining specialized psychological or psychiatric care, preventing access at institutional, community, and individual levels [14], which results in delays in seeking PH interrupted treatment and generally poorer quality of care [15].

In children and adolescents, the prevalence of MHP ranges between 17% and 26% (Amerian Psychiatric Association, 2013) [16], being necessary to highlight the enormous psychological impact that the Covid-19 pandemic has had on the young population [17], as well as recording alarming increases in suicide rates [18]. In this population, stigma also has negative effects, finding that children and adolescents often feel rejected, have feelings of shame or guilt and try to keep their problems hidden by not seeking PH [19].

In this context children and adolescents appear to be a particularly vulnerable group. Therefore, progenitors are of vital importance, since as primary caregivers and socializing agents they can have a strong influence on the approach and management of their children's MHP [20]. Parental negative attitudes have been found to affect the stigma that children may experience [19], determining negative beliefs towards taking medication or affecting self-labeling as "crazy" or "psychopathic" by family role models, linking positive family beliefs to lower stigma in children [21, 22].

However, despite the importance of attitudes towards mental health in fathers and mothers, few studies have focused on stigma among them. The research on the subject has found that, in general, when adults are asked about stigma in childhood, attitudes are negative. Pescosolido et al., (2007) [23] found that 45% of their sample of more than 1,300 people from the general population, thought that a child with MHP would be ostracized at school, or would suffer in the future if someone else found out that they had MHP, with 36% of people saying that a parent would feel like a failure if their child had to receive psychological treatment.

In studies conducted directly with parents, we found that progenitors of children with developmental disorders or MHP report higher levels of shame and stigmatization, and perceive the stigma associated with these problems as a source of chronic stress [24]. Another study shows the mediating role of parental self-stigma between insight and parental stress [25]. On the other hand, Villatoro et al. (2018) [26] showed how stigma can bias recognition of mental illness, finding that greater stigmatizing beliefs mean a lower likelihood of believing that a child may have a mental health problem.

Considering the above, our main hypothesis is that the stigma related to child and adolescent MHP exists among both fathers and mothers, and that it may act as a barrier to seeking specialized professional care. In response to this

hypothesis, an exploratory cross-sectional study is conducted in a sample of parents to describe and relate attitudes toward mental health in children and adolescents along with myths associated with suicide in this population, familiarity with mental health, and potential professional help-seeking.

METHOD

After approval by the university ethics committee and prior to data collection, all participants were informed in writing about the characteristics of the study and the voluntary nature of their participation by completing the informed consent form. Subsequently, the assessments were carried out individually using the Google Forms tool. The average time to complete the evaluation was 10 minutes. The final sample, obtained by the snowball method, consisted of 268 participants from the general population in Dammam, KSA.

Participants were recruited through various social media networks (WhatsApp, email, Facebook, Twitter). Since the interest was to recruit fathers and mothers of children and adolescents, the legal age of the children was the main inclusion and exclusion criterion. The legal age is 18 years, which is also considered the approximate limit between adolescence and young adulthood. Inclusion criteria were: a) being of legal age themselves (over 18 years) and b) having at least one minor child (under 18 years) at the time of the assessment. Exclusion criteria: a) having children of legal age (over 18).

Ad hoc questions were developed to collect data on age, sex (male, female), educational level (basic, university, postgraduate), profession (general health, mental health, social services, education, economic sector, state or security forces, others), marital status (single or partner, married, separated or divorced, widowers), place of residence (city vs. rural places), and religion (believer in any religion vs. non-believer).

Psychosocial Variables

Stigma towards Mental Health in Childhood and Adolescence: It was measured through the Attribution Questionnaire-9 (AQ-9; Corrigan et al., (2014) [27] in its Arabic version of 9 items [28]. This instrument assesses stigmatizing attributions about mental illness through questions that follow a vignette with a mental health problem case example. The vignette in this case included the description of a mental health problem in a minor (age limit between childhood and adolescence) attending a regular school with MHP who has visited a hospital care unit in the past. The scale consists of 9 Likert-formatted items with 9 response alternatives ranging from not at all to very much. The questionnaire consists of the following factors: blame, anger, pity, help, dangerousness, fear, avoidance, segregation, and coercion. The higher score, the more stigmatizing the attributions. Cronbach's $\alpha = .76$.

Myths about Suicide

Noting the lack of tools describing myths about suicide, 12 questions were developed that included the most frequent myths according to the literature: "most suicides happen suddenly without prior warning" [29]; "whoever commits suicide is brave" [30]; "people who talk about suicide will not attempt suicide or will not commit suicide" [31]; "everyone who attempts suicide has depression" [31]; "genetic predisposition alone does not determine whether a suicide attempt is made" [31]; "people who attempt suicide do not want to die, they only brag about it or try to draw attention to themselves"; "suicide cannot be prevented"; "anyone who commits suicide is a coward" [31]; "anyone who has ever attempted suicide will never stop trying" [29], "a person who attempts suicide is determined to die" [29]; "talking about suicide openly and honestly can give the person the possibility to consider other options or the time to think about their decision" [31]; and "one does not necessarily have to have a mental disorder to make a suicide attempt" [31]. The items were Likert-type with 4 response alternatives ranging from strongly disagree to strongly agree. The higher the score, the more myths towards suicide are detected. Cronbach's $\alpha = .79$.

Attitudes towards Seeking Professional Help

Assessed through the Attitudes toward Seeking Professional Psychological Help Scale-Short Form (ATSPPH-S; Elhai et al., (2008) [32]. It explores the importance and usefulness that the person (in this case a father or a mother) finds in the use of psychological services. It consists of 10 items; with a Likert-type scale response with 4 response alternatives ranging from strongly disagree to strongly agree (1-4). Several items were adapted to make reference to seeking PH for a child. The higher score, the more help-seeking. Cronbach's $\alpha = .81$.

Familiarity with Mental Health

It was assessed with the Level of Familiarity Questionnaire (Corrigan et al., 2001) [33]. This questionnaire, through 11 dichotomous (yes/no) response situations, assesses the degree of familiarity that a person has with others who have a mental disorder. The higher score, the higher the level of contact with people with mental illness. Cronbach's $\alpha = .61$.

Analysis

For the description of the sample, different descriptive statistics, means, standard deviations, frequencies, and percentages were estimated. Means comparisons were performed with Student's t-tests, and ANOVA of independent samples in the different groups were carried out. The Bonferroni test was used as a post hoc comparison. To test the relationship between the quantitative variables in the study, Pearson correlations were conducted. To identify predictors of the help-seeking variable, a stepwise multiple regression analysis was performed with the total help-seeking score as the criterion variable and variables that were hypothesized to predict help-seeking and that showed significant correlations with the Help-Seeking Questionnaire (ATSPPH-SF) as predictors. All statistical analyses adopted a significance level of .05 and were conducted using SPSS statistical processing software version 28.0.

RESULTS

Table (1) shows that Socio-demographic Characteristics of the Sample. The sample consisted of a majority of mothers (81%) with a mean age of 42 years (SD = 7.45). Most people lived in a city as opposed to rural areas (78%), married or in a couple (91%) and with university or postgraduate studies (84%). The majority of the sample showed religious beliefs (54%), with a variety of professional areas.

Table (1): Descriptive Data of Study Variables

Variables		n (%)
Sex	Women	217 (81%)
Place of residence	City	209 (78%)
Educational level	Basic studies	43 (16%)
	University studies	131 (48.9%)
	Postgrads studies	94 (35.1%)
Marital status	Single or partner	38 (14.2%)
	Married	206 (76.9%)
	Separated or divorced	19 (7.1%)
	Widowers	5 (1.9%)
Profession	General health	17 (6.3%)
	Mental health	78 (29.1%)
	Social services	23 (8.6%)
	Education	47 (17.5%)
	Economic sector	61 (22.8%)
	State security forces	6 (2.2%)
	Others	36 (13.4%)
Religion	Believers	145 (54.1%)

Variables	n (%)
M (SD)	
Stigma towards mental health	37.77 (10.09)
(AQ-9)	
Blame	1.63 (1.36)
Anger	1.60 (1.34)
Pity	6.40 (2.18)
Help	7.50 (1.54)
Dangerousness	3.99 (2.04)
Fear	4.42 (2.31)
Avoidance	3.30 (2.01)
Segregation	2.49 (2.01)
Coercion	6.45 (2.14)
Familiarity with mental health	5.72 (1.95)
Myths towards suicide	21.59 (5.81)
Seeking professional help attitudes	33.22 (5.08)

Note. AQ-9 = Attribution Questionnaire.

Stigmatizing Attributions to MHP

Regarding stigma, the results **table (2)** shows average levels of stigma in the sample towards MHP in childhood and adolescence (M = 37.77, SD = 10.09). When analyzing each subscale of the questionnaire, we found that the most stigmatizing attributions have to do with "help" (M = 7.50, SD = 1.54), followed by "coercion" (M = 6.45, SD = 2.14) and in third place "pity" (M = 6.40, SD = 2.18). The least stigmatizing attributions refer to "anger" (M = 1.60, SD = 1.34), then "blame" (M = 1.63, SD = 1.36), and the third least stigmatization is "segregation" (M= 2.49, SD = 2.01).

Furthermore, we found significant differences in relation to gender identity, with the highest presence of stigma in the group of men, t (266) = - 5.56, $p < .001$, $v_p^2 = .10$. Likewise, in relation to religion, where believers have greater stigma towards mental health, t (266) = 2.26, $p > .001$, $n_p^2 = .01$. There were also differences according to educational level, F (2, 265) = 8.11, $p < .001$, $n_p^2 = .06$, with post hoc analyses revealing significant differences between the group with the lowest educational level and those with postgraduate studies ($p < .001$). On the other hand, significant differences were observed according to profession, F (6, 261) = 8.39, $p < .001$, $n_p^2 = .16$. Post hoc analyses show significant differences when comparing mental health and social service professionals with those in education ($p < .001$) and business ($p < .001$). (**Table 2**)

Familiarity with Mental Health

The general results **table (2**) show average values with respect to the familiarity of the sample (M = 5.72, SD = 1.95). Significant differences were found in relation to gender identity with greater familiarity with mental health in the female group, t (266) = 4.22, $p < .001$, $n_p^2 = .06$. In relation to religion, non-believers have higher familiarity, t (266) = -2.07, $p > .001$, $n_p^2 = .01$. There were also differences in educational level, F (2, 265) = 15.42, $p < .001$, $n_p^2 = .10$, with post hoc analyses showing significant differences between the group with the lowest educational level and university and postgraduate students ($p < .001$), as well as between undergraduate and postgraduate students ($p < .001$).

Significant differences were also found according to the profession of the participants, F (6, 261) = 15.23, $p < .001$, $n_p^2 = .26$. Post hoc analyses apply significant differences between mental health professionals with respect to those in

teaching (p < .001), those in business (p < .001) and those in other professions (p < .001), as well as those in general health versus business (p < .001). We also found significant differences between the group of social service professionals with the group from the company (p < .001) and from other professions (p < .001). **(Table 2**)

Table (2): Stigma towards Mental Health and Familiarity in Relation to Socio-demographic Variables

Stigma towards Mental Health						**Familiarity with Mental Health**				
Variable	**Category**	**M**	**SD**	**Statistical test**	**P**	**Category**	**M**	**SD**	**Statistical test**	**p**
Gender identity	Men	44.49	12.60	$t_{(266)} = -5.56$	.000	Men	4.71	2.07	$t_{(266)} = 4.22$	.000
	Women	36.20	8.72			Women	5.95	1.85		
Religion	Believers	39.06	9.17	$t_{(266)} = 2.26$	.026	Believers	5.49	1.93	$t_{(266)} = -2.07$	.039
	The non-believers	36.27	8.72			Non-believers	5.98	1.95		
Educational level	Basic studies	42.58	14.67	$F_{(2,265)} = 8.11$	.000	Basic studies	4.51	2.26	$F_{(2,265)} = 15.42$	.000
	University studies	37.97	9.04			University studies	5.63	1.83		
	Postgraduate studies	35.31	8.01			Postgraduate studies	6.39	1.68		
Profession	General health	34.76	7.83	$F_{(6,261)} = 8.39$	.000	General health	6.18	1.94	$F_{(6,261)} = 15.23$	.000
	Mental health	33.54	7.23			Mental health	6.90	1.56		
	Social services	31.61	5.98			Social services	6.57	1.64		
	Education	49.96	9.62			Education	5.62	1.55		
	Business	42.20	13.12			Business	4.39	1.83		
	State security forces	42.83	5.03			State security forces	5.33	1.50		
	Others	39.83	8.10			Others	4.83	1.87		

Note. M = mean; SD = standard deviation.

Myths towards Suicide

The results are shown in detail in **Table (3)**. Regarding the myths towards suicide, we found average scores (M = 21.59, SD = 5.81) that reveal the presence of myths towards suicide among the fathers and mothers of the sample. Significant differences are observed in relation to gender identity, with men having a higher level of myths about suicide, t (266) = -3.30, p < .001, n_p^2 = .06, as well as in relation to religion, where believers have a higher number of myths about suicide, t(266) = 2.44, p < .001, n_p^2 = .01. There were also differences according to educational level, F(2, 261) = 42.41, p < .001, n_p^2 = .24, with post hoc analyses revealing significant differences between the group with the lowest level of education with university studies (p < .001) and with postgraduate studies (p < .001).

Significant differences were also found according to profession, F (6, 265) = 10.40, p < .001, n_p^2 = .19. Post hoc analyses show significant differences when comparing mental health professionals with the rest of the professions (p < .001). We also found significant differences between the group of social service professionals and the group from the company (p < .001). (**Table 3**)

Table (3): Myths towards Suicide and Seeking Professional Help Attitudes in Relation to Socio-demographic Variables

Myths towards Suicide Attitudes						Seeking Professional Help				
Variable	**Category**	**M**	**SD**	**Statistical test**	**p**	**Category**	**M**	**SD**	**Statistical test**	**p**
Gender identity	Men	23.96	8.66	t = -3.30	.000	Men	30.24	7.93	t = 4.86	.000
	Women	21.03	4.77	(266)		Women	33.93	3.84	(266)	
Religion	Believers	22.38	5.06	t = 2.44	.000	Believers	33.08	4.30	t = -.517	.615
	Non-believers	20.66	6.54	(266)		Non-believers	33.40	5.88	(266)	
	Basic studies	27.60	8.92			Basic studies	28.47	8.06		
Educational level	University studies	21.47	4.28	$F_{(2,261)}$ = 42.41	.000	University studies	33.65	3.56	$F_{(2,265)}$ = 28.84	.000
	Postgraduate studies	19.00	3.43			Postgraduate studies	34.81	3.71		
	General health	21.94	4.02			General health	34.18	2.65		
	Mental health	18.55	3.16			Mental health	35.26	2.96		
	Social services	19.00	4.10			Social services	34.83	3.97		
Profession	Education	22.11	4.72	$F_{(6,265)}$ = 10.40	.000	Education	32.68	4.02	$F_{(6,261)}$ = 6.11	.000
	Business	25.20	8.39			Business	31.28	7.81		
	State security forces	21.67	3.93			State security forces	27.83	5.56		
	Others	22.86	3.96			Others	32.25	3.12		

Note. M = mean; SD = standard deviation.

Attitudes towards Seeking Professional Help

Regarding help seeking, the general results show somewhat higher levels in the sample of fathers and mothers and there seems to be a greater commitment in terms of seeking PH attitudes (M = 33.22, SD = 5.08). Furthermore, we found significant differences in relation to gender identity, with women being more likely to seek professional help, t (266) = 4.86, $p < .001$, $n_p^2 = .08$. The same occurs in relation to religion, where non-believers are more likely to seek help, t (266) = -.517, $p > .001$, $n_p^2 = .001$. There were also differences according to educational level, F(2, 265) = 28.84, $p < .001$, $n_p^2 = .18$), with post hoc analyses revealing significant differences between the group and the lowest educational level and the rest ($p < .001$), as well as according to profession, F(6, 261) = 6.11, $p < .001$, $n_p^2 = .12$), where the post hoc analyses show significant differences between mental health professionals and those in the company ($p < .001$). The results are shown in detail in **Table 4**.

Table (4): Correlations between Stigma, Familiarity, Attitudes towards Professional Help-seeking and Myths about Suicide

Variables	**1**	**2**	**3**
Myths			
Stigma	.537***		
Seeking PH	-.639***	-.489***	

Variables	1	2	3
Familiarity	-.415***	-.337***	.384***

Note. PH = professional help. ***p < .001.

Correlations

A direct, significant and positive correlation was found between myths about suicide and stigma (r = .537, p < .001), and between seeking PH attitudes and familiarity with mental health (r = .384, p < .001). The correlation between familiarity and mental health and myths about suicide was negative and significant (r = -.415, p < .001), as was the correlation between seeking PH attitudes and myths about suicide (r = -.639, p < .001). Significant negative correlations were also found between stigma towards the child/youth population and help-seeking (r = -.489, p < .001), and between stigma and familiarity (r = -.337, p < .001).

Regression Model

A significant model was obtained that explained 44% of the variance, F (3, 264) = 71.70, p < .001, R2 = .449, R2 corrected = .443. Suicide myths were the variable that contributed the most to the prediction model, explaining 40.8% of the variance in seeking PH, followed by mental health stigma and finally mental health familiarity. In **Table (5)** the model developed can be observed in detail.

Table (5): Results of the Multiple Regression Analysis on the Variable Attitudes towards Seeking Professional Help

						95% IC B	
Final model	**B**	**SE(B)**	**α**	**t**	**Sig.**	**Inf.**	**Sup.**
Constant	44.240			27.832	.000	41.112	47.372
Myths towards suicide	-0.428	0.050	-.490	-8.645	.000	-0.526	-0.331
Stigma towards MH	-0.093	0.028	-.186	-3.386	.001	-0.148	-0.039
Familiarity with MH	0.307	0.132	.118	2.332	.020	0.048	0.567

Note. B = unstandardized coefficient; SE(B) = standard error of B; α = standardized coefficient; t = contrast statistic; Sig. = statistical significance; 95% CI B = 95% interval for B; Inf.

= lower, Sup. = upper; MH = mental health.

DISCUSSION

The current study examines the stigma surrounding MHP in childhood and adolescence in a sample of mothers and fathers by examining the primary stigmatizing beliefs, suicide myths, and mental health knowledge, as well as the primary predictors of seeking help for these kinds of issues. The findings indicate that the mean levels of stigma towards MHP in children and adolescents are marginally greater than those found in earlier studies using the same evaluation tool that focused on adult mental health [27], and consistent with other studies on stigma in childhood and adolescence [23, 24]. More specifically, we found that the dimensions of stigma with the highest scores were help, coercion and grief, showing attributes of overprotection, which may hinder independence and autonomy processes, necessary for adequate development at this stage. Parental stigma towards children with MHP seems to be a major problem to be faced, which even exceeds the data found in the adult population, which is already alarming.

Regarding myths about suicide, the results also show mean scores (myths = 21.59) that reveal the presence of myths about suicide in childhood and adolescence in the sample studied. These results are consistent with other studies on suicide myths in the adult population [34], but cannot be compared with myths about suicide in the children and adolescent population, due to the lack of previous research. Therefore, further research in this line is essential to allow comparisons and more in-depth analysis of this phenomenon, the frequency of which has increased in recent years [18]. On the other hand, in relation to familiarity with mental health, we observed that the scores were also average, although

these values revealed less familiarity than in the original study on the scale [33]. Concerning help-seeking scores, the results were lower than those found in previous studies conducted in adults [32]. Thus, the parents evaluated showed a lower valuation of the usefulness, importance and use of psychological services in childhood and adolescence.

In relation to the differences in the socio-demographic variables studied, it is observed that in general stigmatizing attitudes and myths about MHP are significantly higher in fathers than in mothers ($p < .001$), with religious beliefs, with a lower level of education ($p < .001$), and who did not have professions related to mental health or social services ($p < .001$). Similarly, these individuals also showed significantly lower scores for familiarity with MHP in childhood and adolescence ($p < .001$) and help-seeking in the face of MHP ($p < .001$). The data obtained on stigma and myths about suicide are consistent with previous studies that analyzed some of these socio-demographic variables in adult population [34, 35], as well as in studies focused on the stigma associated with MHP in childhood and adolescence, where the results coincide on a greater stigma in men [23, 24].

These data reveal the importance that certain social and cultural variables may have in relation to mental health. Perhaps the traditional caregiving role of culture with greater empathy, which is usually more represented by mothers, is related to less stigma and myths and to greater familiarity with MHP and search for help for their children. However, there is still a need for parenting models in which fathers can develop, in the same proportion as mothers, less stigmatizing and more care-seeking attitudes towards MHP for their children. Secondly, it seems that the educational level is also key, since lower educational levels have more stigma and myths, and at the same time they are less familiar with mental health and seek less help.

Access to information has been shown to be a protective factor against stigma and gives people a better problem-solving repertoire. On the other hand, the type of profession also marks differences, supporting the hypotheses on contact as a strategy to reduce stigma [36], as people with professions related to mental health show better attitudes and a greater predisposition to seek help. Another interesting factor is religiosity. It seems that those with religious beliefs present more myths toward suicide and more stigmatizing beliefs toward MHP in childhood than those who do not consider themselves religious. This is also found in studies conducted in adult population [37]. It is known that certain MHP have been considered as divine punishments [38]. Suicide was also silenced among believing populations. Moral objections to suicide, especially the conviction of going to hell after committing suicide, have a restraining effect on suicide and suicidal tendencies [39].

The regression model developed confirms our main hypothesis, revealing stigmatizing parental attitudes as a barrier to seeking specialized professional help when necessary. The model shows how negative attributions along with the presence of myths about suicide and low familiarity with MHP are key variables that may prevent parents from seeking PH, explaining 44% of the variance of this variable. The suicide myths alone predicted the highest percentage of the total variance of the negative help-seeking attitudes, followed by stigma and finally by the familiarity. Previous studies have already warned of the detrimental impact of parental stigma on children [19, 21 and 22]. Considering the results obtained in the present study, the impact could be doubly negative: parents with stigmatizing attitudes towards mental health will not only transmit them to their children, but these children will also be less likely to be attended by a professional, and therefore receive early diagnosis and the necessary care.

CONCLUSION

Parents seeking professional assistance are crucial to ensuring a proper approach to children's and teenagers' mental health in a setting where these issues have become much more prevalent in recent years. Myths about suicide, stigma, and familiarity with MHP have hindered this help-seeking, hence anti-stigma awareness initiatives aimed at the parent community are required. Additionally, some groups are recommended that have higher levels of stigma and myths, such men, religious people, those with low educational attainment, and those in occupations that are not closely related to mental health.

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