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Parental Perceived Need for Counseling for Adolescents' Anxiety and Depression Symptoms: A Cross-Sectional Study

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ABSTRACT

Objective: This study examined the association between parental perceived need for counseling or mental health care services and adolescents' subgroups of anxiety and depression symptoms (Anxiety-only, Depression-only, Anxiety-Depression, and None).

Method: Adolescent sample ($N = 20,486$, $M = 14.69$ years old, $SD = 1.69$) was drawn from the National Survey of Children's Health 2017–2018 (NSCH 2017–2018). A chi-square test was used to analyze the association between two categorical variables.

Results: The Chi-square test was statistically significant, $X^2(6) = 7,914.33$, $p < .01$, $V = .44$. Adolescents from the Anxiety-Depression group received counseling or mental health care the most (80.94%), while 69.03% of those in the depression-only group and 44.86% in the Anxiety-only group received mental health services.

Conclusions: Caregivers of adolescents with Anxiety-only tended to perceive the least need for counseling or mental health care, compared with those with depression or both, suggesting the need to enhance mental health awareness.

KEYWORDS

Parental perceptions; counseling; adolescents; anxiety; depression

Anxiety and depression are the most common types of mental health concerns among adolescents in terms of relevant symptoms and diagnosis.

Researchers indicated that approximately 20% of youth experience anxiety or depression symptoms by the age of 18 (Essau et al., 2012; Merry et al., 2012). Specifically, a recent study that used nationally representative data also showed, out of adolescent sample ages 12–17 years old, 6.1% had symptoms of depression, and 10.5% had those of anxiety (Ghandour et al., 2019). Anxiety, depression, and their comorbid conditions were associated with adverse consequences among adolescents, including dysfunctions in cognition, social relationships, and other psychological and physical health (Cummings et al., 2014). These consequential difficulties of anxiety and depression indicated a need for appropriate counseling services by mental health professionals.

Researchers have suggested that perceived need for counseling or other mental health care services may differ by service recipients' clinical status and comorbid conditions of anxiety and depression (Mojtabai et al., 2002; Prins et al., 2008; Ricky et al., 2017). Mojtabai et al. (2002), from a sample of 1,792 participants aged 15–54, investigated the discrepancies in perceived need among those who suffered from different mental health concerns, including mood and anxiety disorders. Researchers found the greater percentages of people having perceived needs for professional help when participants had both mood and anxiety disorders (56%), in comparison with mood disorder only (49%) and anxiety disorder only (21%). Ricky et al. (2017) also examined factors related to delayed diagnosis of mood and anxiety disorders among Canadian adults ($N = 3,212$). Their findings suggested that individuals with an anxiety disorder were more delayed to seek and receive a diagnosis than those with mood disorders, such as depression and bipolar disorder. In addition, Lin and Parikh (1999) used a large-scale Canadian sample ($n = 8,116$) aged 15–64 years old and found that a comorbid condition of anxiety and affective disorders increased the chance of experiencing a need for treatment. Consistent to the prior studies, Prins et al. (2008) in their systematic review article concluded that those with both anxiety and depression were found having the highest likelihood of perceiving a need for mental health care, while people with an anxiety disorder only had the lowest chance of experiencing the need for care. Overall, researchers examining the topic outlined two major findings:

first, people with more mental disorders were likely to have greater levels of perceived need for professional help; second, anxiety was less recognized as a critical mental disorder that requires diagnosis or care, compared to depression or comorbidity of both.

The perceived need to seek help for adolescents' mental health problems also involves various determinants at individual, parental, social, and cultural levels (Olfson et al., 2015; Sayal, 2006). Particularly, parental perception toward mental health care plays a critical role in taking youth into mental health care services because parents serve as a key gatekeeper to treatment access (Reardon et al., 2017; Sayal, 2006; Sayal et al., 2010). A qualitative study that implemented focus group discussions with 34 parents described barriers of parental help-seeking for their children. The barriers included feelings of embarrassment, the stigma of mental health problems, concerns about labeling on their child, previous experience of ineffective help, and fear of being judged as a poor parent (Sayal et al., 2010). Further, Sayal (2006) conducted a systematic literature review and concluded that parental perception of their child's problems and symptoms were key initial steps in the help-seeking process. More recently, Reardon et al. (2017) in their systematic review from forty-four qualitative and quantitative studies synthesized the findings; that is, parental perception toward psychological treatment for mental health problems played a critical role as either barriers or facilitators to accessing mental health care.

Whereas previous literature does not provide operational definitions regarding the concept, researchers used different terms to indicate parents' perceived need for their children to receive mental health care including (a) parent's perceived need for adolescent mental health services or parental perception of a child's mental health service need (Wu et al., 2001), (b) perceived need for help or parental attitudinal factor (Zahner & Daskalakis, 1997), and (c) parental concerns (Dulcan et al., 1990). In our study, we defined parental perceived need for counseling or mental health care as whether parents or guardians believed the need for mental health care for the adolescent and had him or her receive the care.

Despite the critical role of the parental attitudes toward adolescents' mental health concerns in receiving counseling or mental health care, only few researchers examined potential differences in their perceived need for mental health care for adolescent anxiety, depression, and both. While a handful of researchers investigated the perceived need for mental health care of anxiety and mood disorders (Lin & Parikh, 1999; Mojtabai et al., 2002; Prins et al., 2008), most of them focused on the adult population or patients' perspectives, not adolescent populations perceived by their parents. Also, previous studies that investigated parental perceived need for their child's mental health concerns had not paid enough attention to specific mental disorders, such as anxiety, depression, and comorbidity. These literature gaps leave room for further investigation on potential discrepancies in parental perceived need for their child's counseling or mental health care. Considering the results of the aforementioned studies, perceived needs from parents for adolescents' anxiety and depression may differ depending on their condition, which would result in disparities in determining service use for the adolescents.

Present Study

Taken together, the purpose of the current research study is to investigate the relationship between parental perception of receiving counseling or mental health care and prevalence of their child's anxiety and depression. Our examination was guided by the question: Do caregivers of adolescents have different perceived needs for receiving counseling or mental health care for their child, depending on the adolescent's anxiety and depression symptoms?

Method

Data Source and Sampling

The study sample was drawn from the 2017–2018 National Survey of Children's Health (NSCH), which is a cross-sectional, nationally representative survey conducted by the Data Resource Center for Child and Adolescent Health to

assess children’s health and wellbeing. The survey was implemented with an address-based sampling, covering the fifty states and the District of Columbia. The respondents of the NSCH 2017–2018 consisted of parents or caregivers of children who are 0 and 17 years old. More information on the NSCH’s sampling method can be found on the Data Resource Center website (Data Resource Center for Child and Adolescent Health, 2020). A total of 52,129 surveys were completed for 2017 and 2018. Our sample was limited to 12-17 aged adolescents, resulting in 21,496 surveys. Further, we restricted our sample to the current conditions of anxiety and depression symptoms, excluding those who have a history of anxiety or depression symptoms but do not currently have the condition, leading to the final analytic sample as 20,486 respondents.

Table 1. Descriptive Statistics of Study Sample (N = 20, 486).

Category		M	SD
Age		14.69	1.69
	N	Unweighted n	Weighted%
Sex	20,486		
Male			52.24
Female			47.76
Race/ethnicity	20,486		
White, non-Hispanic			69.90
Black, non-Hispanic			6.87
Hispanic			11.10
Asian, non-Hispanic			5.23
Other/Multi-racial, non-Hispanic			6.91
Receiving mental health care	20,391		
Yes, received mental health care			14.60
Non, but needed mental health care			2.25
No, did not need mental health care			82.69
Subgroups	20,486		
Anxiety-only			7.18
Depression-only			1.52
Anxiety-Depression			6.29
None		17,416	85.01

Note. N of 'receiving mental health care' differs due to cases with missing values.

Four subgroups of anxiety and depression symptoms were presented as follows: Anxiety-only (adolescents with anxiety but not depression, $n = 1,470$; 7.18%), Depression-only (adolescents with depression but not anxiety, $n = 311$; 1.52%), Anxiety- Depression (adolescents with both conditions, $n = 1,289$; 6.29%),

and None (adolescents with neither anxiety nor depression, $n = 17,416$; 85.01%). Male adolescents were 10,702 cases consisting of 52.24% of the total sample, and White, non-Hispanic (69.90%), was the most major racial group comprising approximately seventy percent of the sample, followed by Hispanic (11.10%), Others/Multi-racial (6.91%), Black (6.87%), and Asian (5.23%). Table 1 summarizes descriptive statistics about the study sample.

Measures

Subgroups of Anxiety and Depression Symptoms

Respondents (i.e., parent or guardian of adolescents) were initially asked to report if their children had anxiety or depression ever, with binary items (i.e., 1 = Yes, 2 = No). If the caregivers answered yes to those items, they were subsequently asked to answer if their children currently have the mental health conditions, with binary items again (i.e., 1 = Yes, 2 = No). In this study, the secondary questions (i.e., current conditions of anxiety and depression symptoms) were used to create the four subgroups of an anxiety- depression dyad: Anxiety-only, Depression-only, Anxiety-Depression, and None. The responses regarding anxiety and depression were based on parent recollection and were not medically verified.

Use of Counseling or Mental Health Care

Parental perceived need for adolescent's use of counseling or other mental health care services was measured by a single question: *During the past 12 months, has this child received any treatment or counseling from a mental health professional?* Respondents had three response options including: (a) *Yes, received mental health care*; (b) *No, but needed to see a mental health professional*; and (c) *No, did not need to see a mental health professional*.

Analytic Plan

Preliminary Analyses and Data Diagnostics

The analyses proceeded in multiple steps. To begin with, we created four

mutually exclusive groups of anxiety and depression symptoms. Then, we analyzed descriptive statistics to present sample characteristics, including age, sex, race/ethnicity, use of counseling or mental health care, and the composition of the subgroups representing the anxiety-depression dyad. Assumptions of the Chi-square analysis were tested, guided by the suggestions of McHugh (2013). We found the current investigation fulfilling the six assumptions for a Chi-square test: (a) the data in the cells should be counts of cases; (b) the categories of the variables are mutually exclusive; (c) each subject may contribute data to one and only one cell in the X^2 ; (d) the study groups must be independent; (e) there are two categorical variables tested; and (f) the value of the cell expected should be 5 or more in at least 80% of the cells.

Sample Size, Power, and Precision

The total sample of the current study was 20,486, which justified the required sample size for the Chi-square analysis. There are three different measures of effect size for the Chi-square test, which include Cramer's V (V), Phi (ϕ), and odds ratio (OR). Among the measures, ϕ and OR are not suitable for variables with more than two categories but can be used only in 2 x 2 contingency tables (Kim, 2017). Thus, we adopted Cramer's V as effect size because the variables in the analysis, such as the Anxiety- Depression subgroups and parental perceived need for counseling, had four and three categories, which resulted in the 4 x 3 contingency table. We referenced Cohen's guideline (1988) and Watson et al.'s four-step method (2016) for interpretation of the effect size. Because it is recommended to compare proportions rather than solely focusing on the V value (Sun et al., 2010), we also visualized the proportion of the cell frequencies in Figure 1. After obtaining the effect size, we implemented post hoc power analysis (alpha was set to .05, df = 6) using G*Power version 3.1.9.2.

Primary Analysis

A Chi-square analysis was conducted to examine the differences in parental perception of receiving counseling or mental health care services across

the adolescent subgroups of anxiety and depression symptoms. The data was analyzed using IBM SPSS statistics (v. 26) and statistical significance was determined at $p < .05$.

Results

As a result of the chi-square analysis, the relationship between parental perceived need for receiving counseling or mental health care and the subgroups of anxiety and depression symptoms was statistically significant, $X^2(6) = 7,914.33$, $p < .01$, $V = .44$, indicating a large effect (Cohen, 1988) in which the null hypothesis is rejected. The post hoc power analysis demonstrated that the statistical power was 1.00, which implies no probability for Type II error but a vulnerability to Type I error. However, because p value ($< .01$) was much smaller than alpha ($.05$), we considered potential for Type I error acceptable. Overall, caregivers of adolescents with anxiety symptom perceived less need for counseling or mental health care than those whose child having depression symptom or both anxiety and depression symptoms.

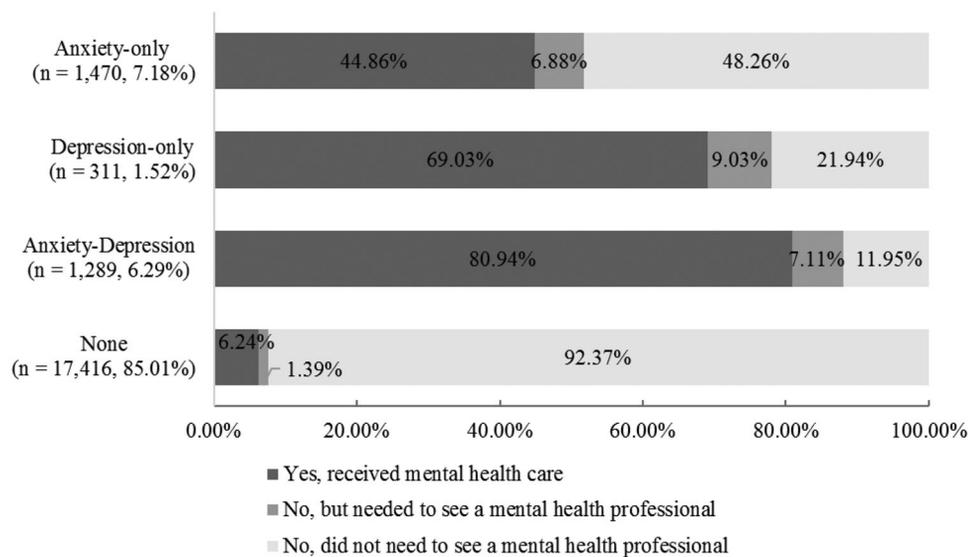


Figure 1. Parental perceived need for counseling or mental health care by the anxiety-depression subgroups.

Adolescents from the Anxiety-Depression group (80.94%) were the most likely to receive counseling or mental health care, followed by those of Depression-only (69.03%), and Anxiety-only (44.86%). While approximately 1 in 5 of caregivers (21.94%) in the Depression-only group perceived no need for mental health care for their child, around half of the respondents (48.26%) in the

Anxiety-only group reported no need to seek professional help for the child. With regards to the response rates of 'perceived need, but did not receive mental health care,' the response rates ranged from 6.88% (Anxiety-only) to 9.03% (Depression-only). It was also noted that more than one-tenth (11.95%) of caregivers whose child experiencing both anxiety and depression symptoms did not perceive any need for receiving counseling or mental health care services. Figure 1 describes the disparities in perceived parental need for counseling or mental health care depending on adolescents' anxiety and depression symptoms.

Discussion

The present study investigated the different parental perceived need for counseling or mental health care depending on adolescents' anxiety and depression symptoms. Findings indicated a disparity in the use of counseling or mental health care by the subgroups of anxiety and depression symptoms. Results showed that caregivers of adolescents with the Anxiety-only condition had the lowest levels of perceived need for mental health care service and use of services, in comparison with those of the Depression-only and Anxiety-Depression conditions, which corresponds to the works completed by Lin and Parikh (1999), Mojtabai et al. (2002), and Prins et al. (2008). The large effect size ($df = 6, V = .44$) and the disproportion depicted in Figure 1 support that this treatment gap is critical.

Overall, findings indicate that some caregivers of adolescents may not fully recognize the importance of receiving counseling or mental health care to mitigate their child's anxiety and depression symptoms. This result further seems to suggest that those caregivers may underestimate the critical need for mental health care for their child's anxiety, depression, or both, possibly leaving the mental health concerns untreated. Particularly, the current study's finding implies that adolescents with anxiety symptom may be at greater risk of staying untreated. Given that parents are the primary gatekeepers to receiving mental health care for their child (Reardon et al., 2017; Sayal et al., 2010), caregivers' insufficient awareness of anxiety problems may result in adolescents' continued or

exacerbated experience of anxiety symptoms without appropriate interventions. It is imperative that professional counselors improve our efforts for early recognition of mental health needs among adolescents and foster greater awareness among parents, particularly when an adolescent presents anxiety symptom.

An interesting finding is also that there appeared to be quite consistent percentages of caregivers across the subgroups (i.e., approximately 7 to 9%) who reported perceived need for professional help but did not or could not take the adolescent into counseling or mental health care. This service gap might have been explained by psychological barriers, as previously mentioned, such as fears of stigmatization and being judged as a poor parent (Sayal et al., 2010). Moreover, those caregivers may experience practical barriers, including financial reasons (e.g., service costs, health insurance coverage, loss wages, travel costs), difficulties in accessibility (e.g., transportation, distance, location), and demands (e.g., wait-time, space, availability) (See this systematic review, Reardon et al., 2017). These obstacles also might have affected underutilization of mental health care services, without getting appropriate treatment for adolescents with anxiety and depression symptoms.

Implications for Professional Counselors and Future Researchers

Previous studies support that parents are likely to seek mental health services when they acknowledge the existence of a problem and that the problem may affect their child in a negative way (Sayal et al., 2006; Teagle, 2002). In order to enhance their mental health literacy and actual utilization of counseling and other mental health care services, professional counselors should take preemptive measures, such as raising awareness of the related symptoms and resources that families can easily have access to. Specifically, counselors in school and community are encouraged to step in and offer parental education to raise their awareness, such as educating the unique, critical impacts of anxiety disorders, enhancing their help-seeking attitudes, and informing community resources they can use for their children.

Given that untreated anxiety and depression symptoms become risk factors for comorbid disorders and chronic illness, and extant literature demonstrated the benefits of treating the symptoms early on (Cummings et al., 2014; Ginsburg et al., 2014; Wolk et al., 2015), counseling professionals should promote early detection and treatment for those mental health concerns. For instance, mental health professionals are recommended to implement programs that may facilitate early detection for adolescents in mental health needs and intervene in a timely manner, including referring students for outside resources. Overall, counselors working with adolescents and their families should put intentional efforts to minimize barriers to adolescents receiving counseling or other mental health services in order to improve their mental health ultimately.

Future researchers are recommended to examine underlying mechanisms behind this different parental perception depending on mental disorders and explore possible interventions to address the disparities in accessing mental health care for their child. In addition, investigating how sociodemographic characteristics may affect their view on mental health service needs can provide better understanding of the phenomenon given the existing evidence on their impacts on this disparity (Chavira et al., 2004; Kataoka et al., 2002). Specifically, further examinations can be done by investigating other individual and social determinants of receiving mental health care such as symptom severity, race/ethnicity, cultural backgrounds, and socioeconomic status. Lastly, it is imperative to develop a new measurement assessing parental perceived need of using counseling service for their child because parental recognition and perception of the adolescent's mental health needs are strongly associated with mental health service use.

Limitations

Despite unique contributions to the literature of the current study, several limitations warrant further explorations. First, the use of self-report measures from caregivers may involve response biases. Researchers may consider collecting data from multiple sources to ensure the validity of the item responses. Second, the

current study ruled out cases that experienced either anxiety or depression before but currently do not. The exclusion may influence the result of the analysis, warranting caution in interpreting the findings and further investigation. Third, although the sample of this study well represented the U.S. children population, our research question did not cover the effects of diversity, such as race, gender, and religion. Researchers are suggested to consider how intersections of diversity are associated with the current study findings.

Conclusion

The present study showed existing disparities in perceived parental need for counseling regarding their child's mental health difficulties depending on types of disorders. Although further investigation is warranted, the findings highlighted the need to enhance more understanding of specific mental health concerns including anxiety as compared to depression and comorbidity of both. Overall, increasing parents' understanding of different mental health concerns would help adolescents in receiving appropriate mental health care as needed.

Notes on Contributors

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