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Perceived Cultural Stigma and Professional Help-Seeking Intentions Among Families of Children with Mental Health Difficulties: A Multigroup Mediation Model Across Urban and Rural Communities

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A B S T R A C T

Objective: This study aimed to examine the direct and indirect association between perceived cultural stigma and professional help-seeking intention through family social support and determine whether this mediation model differed between urban and rural Canadian communities.

Methods and Materials: This cross-sectional study included 648 parents and primary caregivers of children aged 6–17 years with clinically significant mental health difficulties, comprising 356 urban and 292 rural participants from six Canadian provinces. Participants completed measures of perceived cultural stigma, family social support, professional help-seeking intention, child psychological difficulties, and demographic characteristics. Confirmatory factor analysis and measurement invariance testing preceded multigroup structural equation modeling. Indirect effects were evaluated using 5,000 bias-corrected bootstrap samples, with caregiver, child, clinical, and regional variables controlled.

Findings: Perceived cultural stigma significantly predicted lower family social support ($\beta = -.41$, $p < .001$) and weaker professional help-seeking intention directly ($\beta = -.27$, $p < .001$). Family social support significantly predicted stronger help-seeking intention ($\beta = .39$, $p < .001$). The indirect effect of stigma through family support was significant ($\beta = -.16$, 95% CI [−.33, −.19]), indicating partial mediation. The stigma-to-support pathway was significantly stronger among rural than urban caregivers ($\beta = -.52$ vs. $-.33$, $p = .009$). The indirect effect was also stronger in rural communities ($\beta = -.18$ vs. $-.15$, $p = .036$), whereas the support-to-help-seeking and direct stigma-to-help-seeking pathways did not differ significantly between groups.

Conclusion: Perceived cultural stigma may discourage caregivers from seeking professional care for their children partly by weakening family support, particularly in rural communities, highlighting the need for culturally responsive and family-centered interventions.

Keywords: *cultural stigma; family social support; professional help-seeking intention; child mental health; caregivers; mediation; rural communities; urban communities; Canada*

1 Introduction

Mental health difficulties during childhood and adolescence constitute a major concern not only for affected children but also for the families responsible for recognizing symptoms, interpreting their meaning, and deciding whether professional intervention is necessary. Although effective psychological, psychiatric, medical, and school-based services are increasingly available, many children experiencing emotional, behavioral, or developmental difficulties do not receive timely professional support. The pathway from symptom recognition to service use is rarely determined by clinical need alone. It is shaped by caregivers' knowledge, cultural beliefs, previous experiences, perceived accessibility of services, anticipated social consequences, and confidence that seeking help will be supported by significant others. Research on adult help-seeking similarly indicates that recognizing a possible mental disorder does not automatically result in formal service use, because willingness to seek care remains influenced by stigma, perceived necessity, social norms, and beliefs about professional treatment (Lewandowska et al., 2025). For children, this process is even more dependent on the family because parents and primary caregivers generally act as gatekeepers who identify concerns, select sources of support, arrange appointments, provide consent, and determine whether treatment is sustained. Consequently, understanding family-level barriers is essential for explaining why children with comparable psychological needs may follow very different pathways into care.

Professional help-seeking intention refers to a caregiver's stated likelihood or willingness to consult qualified mental health or medical professionals when a child's psychological difficulties persist, intensify, or interfere with daily functioning. Although intention does not guarantee service utilization, it represents a critical motivational stage preceding active help-seeking and is particularly relevant when structural opportunities for care are available but remain underused. Studies involving adolescents have shown that attitudes toward professional psychological assistance are influenced by symptom interpretation, perceived usefulness of services, social acceptance, and expectations regarding how others will respond to treatment seeking (Chen et al., 2026). Qualitative accounts of children's distress also indicate that young people may face uncertainty about whom to approach, fear that adults will not understand them, and concern about the consequences of disclosure (Chia et al., 2024). However, even when children express a desire for assistance, access often depends on whether caregivers perceive the problem as legitimate and believe that professional care is socially and culturally acceptable. Parental decision-making is therefore central to the transition from recognized distress to formal intervention. This gatekeeping role is especially important because delays in help-seeking can allow symptoms to become more severe, impair family relationships and school participation, and increase the complexity of later treatment.

Perceived cultural stigma is one of the most persistent barriers within this decision-making process. It encompasses caregivers' expectations that a child's mental health difficulty will be interpreted as weakness, defective parenting, lack of discipline, family failure, moral deficiency, or a threat to collective reputation. Cultural stigma may also include pressure to conceal the child's condition, manage problems within the family, or avoid contact with mental health services because treatment could publicly confirm a socially discrediting identity. Research involving mothers and fathers has demonstrated that stigmatizing attitudes toward child and adolescent mental health problems remain evident within parental populations and may differ according to the type of difficulty being considered (Ramiro et al., 2024). Adults' stigmatizing beliefs can also shape whether children's symptoms are viewed as requiring treatment or deserving condemnation, thereby influencing support for service use (Lange et al., 2022). Caregivers of children and adolescents with mental illness may themselves experience associated stigma because of their relationship with the child, including shame, blame, social distancing, and concern about unfavorable judgments from others (Minichil et al., 2021). Such experiences transform stigma from an abstract public attitude into a family-level social pressure with direct implications for disclosure and treatment decisions.

Cultural stigma does not operate uniformly across ethnocultural groups. Within some sociocultural settings, emotional distress may be interpreted through moral, spiritual, familial, or somatic frameworks that differ from professional mental health explanations. Parents may fear that acknowledging a psychological problem will expose the family to gossip, imply inadequate caregiving, or reduce the child's future educational, marital, and social opportunities. Research within the Chinese sociocultural context has shown that parental attitudes toward young people's mental health may be shaped by concerns about resilience, generational fragility, family responsibility, and the legitimacy of psychological distress (Frost, 2025). Among

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second-generation Chinese individuals in Germany, stigma and acculturation processes have been found to influence how mental health difficulties are understood and whether professional assistance is considered acceptable (Shu et al., 2022). Asian American underutilization of mental health services has likewise been associated with cultural stigma, limited culturally responsive care, family expectations, and preferences for managing distress privately (Kim & Gonzales, 2024). Parenting norms emphasizing achievement, obedience, emotional restraint, and preservation of family harmony may further affect adolescents' disclosure and help-seeking behavior (Feng, 2023). These findings suggest that the cultural meaning attached to mental health problems may shape both caregivers' appraisal of symptoms and their willingness to authorize professional intervention.

Similar mechanisms have been identified across other cultural and national settings. Rural Mexican adults have described mental health and help-seeking through sociocultural narratives involving self-reliance, family responsibility, gender expectations, and the belief that individuals should resolve problems without outside intervention (Davila, 2025). Among young Barbadians living with mental health conditions, lived experiences of stigma have been linked to concealment, social judgment, and hesitation to seek help (Gallimore et al., 2026). Research in Oman has shown that help-seeking intentions may be influenced by stereotypes regarding mental health providers and beliefs about the appropriateness of professional care (Roach et al., 2025). In Kuwait, practitioners have emphasized the importance of integrating cultural sensitivity with ethical child and adolescent mental health practice, particularly when family values and community expectations influence treatment engagement (Chebli & Calia, 2025). Studies in India have similarly demonstrated that adolescent psychotherapy utilization reflects an interaction among family beliefs, awareness, referral pathways, service availability, and sociocultural acceptance (Sharma, 2025). Collectively, these findings indicate that cultural stigma is not a single universal belief but a contextually organized system of meanings that can determine whether families interpret professional help-seeking as responsible care or as a socially risky act.

The influence of stigma is particularly consequential because parents may respond to children's difficulties differently depending on the child's characteristics and the anticipated social meaning of the problem. Evidence indicates that stigma affects how parents interpret and respond to their children's mental health needs, while the child's gender may further complicate expectations regarding acceptable emotion, behavior, and vulnerability (Villatoro et al., 2025). Parental stigma and mental health literacy have also been shown to influence attitudes and intentions concerning help-seeking for a child at risk of suicide, confirming that caregivers' beliefs can become decisive during periods of severe psychological vulnerability (Burke et al., 2023). Caregivers of children with attention-deficit/hyperactivity disorder frequently report barriers involving stigma, limited recognition, fear of medication, distrust of services, financial constraints, and uncertainty about where to seek care (Kappi & Martel, 2021). In contexts of poverty and social marginalization, caregivers may additionally possess limited knowledge of mental health first aid while holding stigmatizing beliefs that discourage referral to professional services (Ghadirian & Sayarifard, 2022). These barriers may be intensified when the child's symptoms are perceived as disruptive or when caregivers anticipate blame for failing to control the child's behavior.

Mental health literacy can reduce some of these obstacles by improving recognition of symptoms, knowledge of effective interventions, and understanding of when and where professional assistance should be obtained. Research has shown that empowerment and mental health literacy may help families overcome stigma as a barrier to children's mental health care (Kosyluk et al., 2022). Cross-cultural comparisons of parental knowledge regarding attention-deficit/hyperactivity disorder have nevertheless identified continuing gaps in symptom recognition, causal beliefs, and awareness of treatment options (Mah & Li, 2025). Among children and adolescents in low- and middle-income countries, mental health literacy is shaped by developmental level, educational opportunity, cultural beliefs, and access to reliable information (Renwick et al., 2022). The development of measures such as the Youth Mental Health Literacy Scale reflects growing recognition that knowledge, beliefs, and help-seeking competencies must be assessed in age-appropriate ways (Riebschleger et al., 2022). Similarly, the Knowledge and Attitudes to Mental Health Scales were developed to evaluate both knowledge and attitudinal dimensions of mental health literacy among children and adolescents (Simkiss et al., 2021). School-based educational interventions have demonstrated that structured mental health literacy programs can improve students' knowledge and attitudes toward psychological difficulties (Zare et al., 2021), while emotion literacy programs seek to strengthen

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children's ability to identify, communicate, and respond to emotional experiences before difficulties become entrenched (Calear et al., 2024). Nevertheless, knowledge alone may be insufficient when families anticipate social rejection or lack support for acting on that knowledge.

Family social support may therefore constitute a central mechanism linking cultural stigma to professional help-seeking intentions. Family support includes emotional reassurance, practical assistance, validation of caregivers' concerns, help with navigating services, and approval of decisions to obtain professional care. When caregivers believe that relatives will understand the child's difficulties and assist with treatment-related responsibilities, the perceived costs of help-seeking may be reduced. Conversely, when family members endorse stigmatizing beliefs, minimize symptoms, blame the child or caregiver, or insist that difficulties remain private, caregivers may experience social isolation and become less willing to pursue professional intervention. Family support is particularly relevant in collectivist or closely interconnected communities, where decisions regarding children may be negotiated with spouses, grandparents, extended relatives, and influential community members. Parental perspectives on mental health screening and support for families of children with autism demonstrate that caregivers' willingness to engage with services is closely related to whether support is accessible, acceptable, and responsive to family circumstances (Tan et al., 2025). The importance of family support is also evident in contexts where caregivers fear institutional judgment. Queer parents experiencing postpartum mental health difficulties have reported delayed help-seeking because disclosure was perceived as risky and potentially associated with child welfare scrutiny (Goldberg & Frost, 2024). Although this context differs from child-focused help-seeking, it illustrates how fear of family-related consequences can suppress engagement with professional services even when substantial distress is present.

The association between stigma, family support, and help-seeking may also vary according to community context. Urban communities generally offer a larger and more diverse service infrastructure, greater anonymity, and more opportunities to access specialized providers, although families may still encounter long waiting periods, financial constraints, cultural mismatch, and fragmented referral systems. Rural communities may present additional barriers related to geographic distance, transportation, professional shortages, limited choice of providers, and reduced confidentiality within closely connected social networks. In smaller communities, caregivers may fear that seeking mental health care will become visible to neighbors, schools, employers, or extended family members. Cultural stigma may consequently carry greater interpersonal weight when social relationships are dense and privacy is difficult to maintain. Underutilization of school-based mental health services among Korean immigrant adolescents demonstrates how cultural beliefs, limited trust, stigma, and concerns about confidentiality can persist even when services are physically available within educational settings (Choe, 2024). A systematic review of mental health stigma and service use among Black American youth similarly found that structural inequities, mistrust, discrimination, cultural beliefs, and anticipated stigma interact in shaping engagement with care (Fields-Oriogun et al., 2024). These findings caution against treating residence or culture as isolated predictors; instead, help-seeking should be understood as emerging from the interaction between social meanings, family relationships, service systems, and local conditions.

Community-based and culturally responsive interventions may help modify this interaction. A lay health worker model designed for Black and African American families demonstrated the potential of trusted community members to reduce child mental health stigma and promote parents' professional help-seeking (Chakawa, 2023). Such approaches may be effective because they address stigma within the social networks where beliefs are formed and reinforced rather than relying exclusively on conventional clinical messaging. Providers also recognize that improving youth mental health care requires attention to implementation barriers, including limited coordination, insufficient resources, inadequate cultural responsiveness, and difficulties engaging families (Goodcase et al., 2021). Effective interventions must therefore extend beyond increasing the number of services and consider whether caregivers perceive those services as trustworthy, confidential, culturally legitimate, and compatible with family needs. Programs that strengthen family communication, normalize professional care, increase practical support, and involve respected community figures may be particularly valuable in rural or culturally cohesive settings.

Despite growing evidence that stigma restricts mental health service use, several limitations remain in the existing literature. Many studies examine stigma, mental health literacy, or service barriers separately, without clarifying the family processes through which cultural stigma becomes

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translated into weaker intentions to obtain care. Other investigations focus on adults seeking help for themselves, adolescents' personal attitudes, or actual service utilization after contact has already occurred. Research on dementia-related help-seeking, for example, demonstrates that stigma beliefs can influence intentions to respond to hypothetical signs of illness (Noguchi et al., 2025), but the decision-making dynamics involved in seeking care for a dependent child require separate investigation. Parents must balance concern for the child with anticipated reactions from relatives, schools, service providers, and community members. Moreover, relatively few studies test whether family social support mediates the relationship between perceived cultural stigma and professional help-seeking intention. Fewer still determine whether the strength of this mediation process differs between urban and rural families. Without such comparisons, it remains unclear whether family support functions similarly across residential contexts or becomes more consequential where service access is limited and social visibility is greater.

A multigroup mediation framework can address these limitations by simultaneously examining the direct effect of perceived cultural stigma on professional help-seeking intention, the association between stigma and family social support, the effect of family support on help-seeking intention, and the extent to which the indirect pathway differs across urban and rural communities. This approach recognizes that cultural stigma may discourage help-seeking directly through fear, shame, concealment, and negative expectations about treatment, while also operating indirectly by reducing the emotional and practical support available to caregivers. It further permits assessment of whether rural community conditions amplify the effect of stigma on family relationships or whether family support exerts a stronger protective influence when professional resources are less accessible. Clarifying these mechanisms has practical relevance for the design of family-centered, culturally responsive, and geographically appropriate interventions intended to reduce delays in children's mental health care.

Accordingly, the aim of this study was to examine the direct and indirect association between perceived cultural stigma and professional help-seeking intention through family social support and to determine whether this mediation model differed between families living in urban and rural Canadian communities.

2 Methods and Materials

2.1 Study Design and Participants

This study employed a cross-sectional, analytical, and comparative design to investigate the direct and indirect relationships between perceived cultural stigma and professional help-seeking intentions among families of children experiencing mental health difficulties. Family social support was examined as the mediating variable, while urban and rural place of residence was treated as the grouping variable in a multigroup mediation model. The target population consisted of parents and primary caregivers of children and adolescents with diagnosed or clinically significant mental health difficulties residing in Canada. Participants were recruited from urban and rural communities in Ontario, British Columbia, Alberta, Manitoba, Saskatchewan, and Nova Scotia to enhance geographical, cultural, and socioeconomic diversity. Recruitment was conducted through child and adolescent mental health clinics, family health teams, pediatric practices, school-based mental health services, community counseling centers, parent support organizations, and online caregiver networks. A combination of purposive, quota-based, and community-based sampling procedures was used to obtain sufficient representation from both urban and rural communities. Urban or rural status was determined according to the residential postal code reported by the participant and its classification under the Statistics Canada population-centre and rural-area framework applicable during the data-collection period.

A total of 711 caregivers initially accessed the study survey. Of these respondents, 29 did not meet the eligibility criteria, 21 discontinued the survey before completing the principal study measures, and 13 submitted responses with substantial missing data or failed the embedded response-quality checks. The final analytical sample therefore consisted of exactly 648 parents and primary caregivers, including 356 participants from urban communities and 292 participants from rural communities. This sample size was considered sufficient for estimating the proposed mediation model separately across the two residential groups, testing measurement invariance, controlling for relevant demographic and clinical covariates, and identifying small-to-moderate indirect effects through bias-corrected bootstrap procedures. The primary caregiver was defined as the adult family member who had the greatest responsibility for the child's daily care, health-related decisions, and contact with educational, medical, or mental health services. In families

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in which more than one caregiver was interested in participating, only the caregiver who identified as having the primary caregiving role was enrolled to preserve the independence of observations.

Participants were eligible when they were at least 18 years of age, currently resided in Canada, were the parent or primary caregiver of a child between 6 and 17 years of age, and had lived with or regularly cared for that child for at least the preceding 12 months. The child was required to have either a formal diagnosis of a mental health or neurodevelopmental condition associated with significant emotional or behavioral difficulties or clinically meaningful symptoms that had raised concern among the family, school personnel, or a health professional during the previous year. Eligible difficulties included anxiety disorders, depressive disorders, trauma-related symptoms, attention-deficit/hyperactivity disorder, disruptive behavior problems, obsessive-compulsive symptoms, eating-related difficulties, emotional dysregulation, self-harming behavior, and other persistent psychological or behavioral concerns requiring professional assessment or support. Caregivers were excluded when they were unable to complete the questionnaire in English or French, did not have sufficient knowledge of the child's current psychological condition and service-use history, or were caring for a child whose acute medical or developmental condition prevented the caregiver from meaningfully evaluating mental health help-seeking decisions. Temporary visitors to Canada and caregivers whose residential status could not be classified as urban or rural were also excluded.

Data were collected through a secure web-based survey, with paper-and-pencil questionnaires made available at selected community and clinical sites for participants who had limited internet access or preferred a printed format. Recruitment materials described the study as an investigation of family experiences, social attitudes, available support, and decisions about obtaining professional assistance for children's emotional and behavioral difficulties. Interested caregivers received an information statement explaining the study objectives, voluntary nature of participation, confidentiality protections, potential emotional discomfort, and right to discontinue participation without penalty. Informed consent was obtained before access to the questionnaires was provided. Participants completed the survey individually and were instructed to answer all child-related questions with reference to the child whose mental health difficulties had created the greatest need for professional support during the preceding 12 months. Completion required approximately 25 to 35 minutes. No identifying information was included in the analytical dataset, and postal codes were converted into residential classifications before being removed from the working data file. Participants were provided with contact information for provincial crisis services, community mental health resources, and family support organizations at the end of the survey.

2.2 Measures

A caregiver and family information questionnaire was used to collect demographic, socioeconomic, residential, and service-related characteristics. The questionnaire assessed caregiver age, gender, relationship to the child, marital status, educational attainment, employment status, household income, ethnocultural background, immigration status, language spoken most frequently at home, and length of residence in the current community. Child-related variables included age, gender, primary mental health difficulty, diagnostic status, duration of symptoms, current treatment status, previous use of professional mental health services, and the caregiver's perception of symptom severity. Participants were also asked whether the family had experienced practical barriers to care, including transportation difficulties, financial pressure, waiting lists, lack of locally available specialists, concerns about confidentiality, and uncertainty regarding where to seek assistance. These variables were collected to characterize the sample and to identify potential covariates that could influence professional help-seeking intentions independently of perceived stigma and family support.

Perceived cultural stigma was assessed using the Perceived Cultural Stigma Scale for Child Mental Health, an 18-item caregiver-report measure developed for the present study to evaluate culturally embedded beliefs and anticipated social consequences associated with having a child with mental health difficulties. Item development was informed by the conceptual domains of public stigma, anticipated stigma, family-associated stigma, cultural shame, concealment, and concern for family reputation. The scale included statements addressing anticipated criticism from relatives or community members, fear that the child or family would be viewed as weak or defective, concern that disclosure could damage the family's social standing, expectations that emotional problems should be managed privately, and discomfort with others knowing that professional mental health services were being considered.

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Responses were recorded on a five-point Likert scale ranging from 1, indicating strongly disagree, to 5, indicating strongly agree. Item scores were averaged to produce a total perceived cultural stigma score, with higher scores representing stronger perceptions of culturally based judgment, shame, concealment pressure, and social disapproval related to the child's mental health condition and the family's use of professional services.

The preliminary content validity of the perceived cultural stigma measure was evaluated by a panel of seven Canadian experts with professional experience in child and adolescent mental health, transcultural psychiatry, family psychology, rural mental health, and community-based service delivery. Panel members examined the clarity, relevance, cultural sensitivity, and conceptual representativeness of each item. The measure was subsequently pilot-tested with 52 caregivers who were not included in the main study. Cognitive interviews conducted during the pilot phase were used to identify ambiguous wording and to ensure that items were understandable across different educational, cultural, and residential backgrounds. The final instrument represented three closely related domains: anticipated community judgment, family reputation and cultural shame, and pressure to conceal or privately manage the child's difficulties. English items were translated into French by a bilingual mental health researcher and independently back-translated by a second bilingual specialist. Discrepancies were resolved through consensus to maintain semantic and conceptual equivalence across the two language versions.

Family social support, the proposed mediator, was measured using the family subscale of the Multidimensional Scale of Perceived Social Support. The subscale consists of four items evaluating the extent to which respondents perceive their family as emotionally available, willing to assist with problems, supportive of important decisions, and prepared to provide help during periods of difficulty. Participants rated each statement on a seven-point scale ranging from 1, indicating very strongly disagree, to 7, indicating very strongly agree. The mean of the four items was calculated, with higher scores indicating stronger perceived family support. In the context of the present study, family social support represented the caregiver's perception that immediate or extended family members would provide emotional reassurance, practical assistance, understanding, and encouragement when the caregiver experienced concerns about the child's psychological condition or considered seeking professional care. The measure was administered in English or French according to participant preference. Because support could operate differently in urban and rural communities, the measurement properties of the family-support construct were evaluated separately in both residential groups before structural pathway comparisons were conducted.

Professional help-seeking intention, the principal outcome variable, was assessed through an adapted child mental health version of the General Help-Seeking Questionnaire. Participants were presented with a brief scenario asking them to consider that the child's current emotional or behavioral difficulties continued, became more disruptive, or did not improve without additional assistance. They then rated the likelihood that they would seek help from four categories of qualified professionals: a psychologist or psychotherapist, a psychiatrist, a mental health counselor or clinical social worker, and a family physician or pediatrician. Responses were provided on a seven-point scale ranging from 1, indicating extremely unlikely, to 7, indicating extremely likely. The four ratings were averaged to create an overall professional help-seeking intention score. Higher scores reflected a stronger stated likelihood of initiating contact with formal health or mental health services for the child. The instructions distinguished professional services from informal sources of assistance, such as friends, relatives, religious leaders, online groups, or self-help materials. Additional items assessed whether the caregiver had previously sought professional help for the child, whether previous experiences with services had been positive or negative, and whether the caregiver believed that appropriate services were realistically accessible in the local community. Previous service use was treated as a background variable rather than as part of the primary outcome score.

The parent-report version of the Strengths and Difficulties Questionnaire was included to estimate the severity of the child's current emotional and behavioral difficulties. The questionnaire assessed emotional symptoms, conduct problems, hyperactivity and inattention, peer relationship problems, and prosocial behavior. The total difficulties score was calculated by summing the emotional symptoms, conduct problems, hyperactivity and inattention, and peer problems subscales. Higher total scores indicated greater psychological and behavioral difficulty. The symptom-severity score was used to describe the clinical characteristics of the children represented in the study and was entered as a covariate in the mediation analysis because caregivers of children with more severe symptoms might report stronger help-seeking intentions regardless of their

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perceived cultural stigma or available family support. The survey also included two instructed-response items distributed across the questionnaire to identify inattentive responding. Cases failing both attention checks or demonstrating invariant response patterns across the major measures were reviewed before inclusion in the analytical sample.

2.3 Data Analysis

Data analysis was conducted using IBM SPSS Statistics and Mplus. Initial analyses included data screening, descriptive statistics, reliability evaluation, confirmatory factor analysis, measurement invariance testing, and multigroup structural equation modeling. The dataset was first examined for duplicate submissions, invalid response patterns, impossible values, excessive missingness, and univariate or multivariate outliers. Cases with more than 20% missing responses across the principal measures were excluded before the final sample was established. For retained cases, missing values were handled using full-information maximum likelihood estimation under the assumption that data were missing at random. The distributions of continuous variables were examined through skewness, kurtosis, histograms, and standardized residuals. Because stigma and help-seeking responses can depart from multivariate normality, structural models were estimated using robust maximum likelihood estimation, which provides standard errors and test statistics adjusted for non-normality.

Descriptive statistics were calculated for all demographic, clinical, and study variables. Means, standard deviations, observed ranges, skewness, and kurtosis were reported for continuous variables, while frequencies and percentages were calculated for categorical variables. Urban and rural participants were compared regarding caregiver characteristics, child characteristics, prior mental health service use, symptom severity, perceived cultural stigma, family social support, and professional help-seeking intention. Independent-samples tests were used for continuous variables, and chi-square tests were used for categorical variables. Effect sizes were examined alongside significance levels to prevent small group differences from being interpreted solely according to sample size. Pearson correlation coefficients were calculated separately for urban and rural participants to provide preliminary estimates of the relationships among perceived cultural stigma, family social support, professional help-seeking intention, and continuous covariates. Internal consistency was assessed using Cronbach's alpha and McDonald's omega, with coefficients of .70 or higher considered acceptable for the principal constructs.

Before testing the mediation hypotheses, confirmatory factor analyses were conducted to evaluate the measurement structure of perceived cultural stigma, family social support, and professional help-seeking intention. The stigma measure was specified using its three conceptual domains, while family social support and professional help-seeking intention were represented by their respective observed indicators. The adequacy of the measurement model was evaluated using the chi-square statistic, comparative fit index, Tucker–Lewis index, root mean square error of approximation with its confidence interval, and standardized root mean square residual. Values of at least .90 for the comparative fit index and Tucker–Lewis index and values of .08 or lower for the root mean square error of approximation and standardized root mean square residual were interpreted as indicating acceptable model fit. Standardized factor loadings, residual variances, composite reliability, and correlations among latent constructs were examined to assess indicator performance, convergent validity, and construct distinctiveness.

Measurement invariance across urban and rural participants was evaluated sequentially before structural pathway coefficients were compared. The configural invariance model tested whether the same factor structure was supported in both groups. The metric invariance model constrained corresponding factor loadings to equality, and the scalar invariance model additionally constrained corresponding item intercepts. When full scalar invariance was not supported, partial invariance was examined by releasing a limited number of parameters with the largest modification indices, provided that the changes were theoretically defensible. Changes in comparative fit index, root mean square error of approximation, and standardized root mean square residual were considered together with chi-square difference testing when evaluating whether additional equality constraints resulted in a meaningful deterioration in model fit. Establishing at least partial metric invariance was required before comparing structural associations across urban and rural groups.

The hypothesized mediation model specified perceived cultural stigma as the independent variable, family social support as the mediator, and professional help-seeking intention as the dependent variable. The model estimated the pathway from perceived cultural stigma to family social

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support, the pathway from family social support to professional help-seeking intention, the direct pathway from perceived cultural stigma to professional help-seeking intention after accounting for family social support, and the indirect effect of perceived cultural stigma on professional help-seeking intention through family social support. The anticipated direction of the model was that stronger perceived cultural stigma would be associated with lower perceived family support or a reduced willingness to mobilize family support, which would subsequently be associated with weaker intentions to obtain professional assistance for the child. A statistically significant indirect effect was interpreted as evidence that family social support mediated part of the relationship between perceived cultural stigma and professional help-seeking intention.

The mediation model was first estimated for the full sample and was subsequently estimated simultaneously for urban and rural participants. In the unconstrained multigroup model, all structural paths were freely estimated within each residential group. A series of constrained models was then tested by setting the stigma-to-support pathway, the support-to-help-seeking pathway, and the direct stigma-to-help-seeking pathway equal across groups. Wald tests and changes in overall model fit were used to determine whether individual structural pathways differed significantly between urban and rural participants. The residential difference in the indirect effect was examined by calculating the indirect effect separately for each group and directly testing the contrast between the two group-specific indirect effects. A significant contrast was interpreted as evidence that the mediating role of family social support differed according to urban or rural residence.

Indirect effects were evaluated using 5,000 bias-corrected bootstrap samples. An indirect effect was considered statistically significant when its 95% bootstrap confidence interval did not contain zero. The total effect of perceived cultural stigma on professional help-seeking intention was calculated as the sum of the direct and indirect effects. Mediation was interpreted as partial when both the direct and indirect effects remained significant and as indirect-only mediation when the indirect effect was significant but the direct effect was no longer statistically distinguishable from zero after family social support was included. Standardized path coefficients, unstandardized estimates, standard errors, confidence intervals, and exact probability values were used to interpret the magnitude and statistical precision of the associations.

Caregiver age, caregiver gender, educational attainment, household income, ethnocultural minority status, child age, child symptom severity, prior use of professional mental health services, and language of questionnaire completion were initially considered as covariates. Covariates were retained in the final structural model when they were theoretically important or demonstrated a statistically meaningful association with the mediator or outcome. Province of residence was represented through indicator variables to account for broad differences in service organization and regional access. Before the final model was estimated, multicollinearity was examined using correlations, tolerance values, variance inflation factors, and latent construct correlations. Statistical tests were two-tailed, and the level of significance was set at .05. The results were interpreted with primary emphasis on effect sizes, confidence intervals, model fit, and consistency of the estimated pathways across urban and rural communities rather than on probability values alone.

3 Findings and Results

The final analytical sample consisted of 648 parents and primary caregivers of children with mental health difficulties, including 356 participants from urban communities and 292 participants from rural communities. Participants were recruited from Ontario, British Columbia, Alberta, Manitoba, Saskatchewan, and Nova Scotia. The caregivers ranged in age from 23 to 68 years, with a mean age of 41.73 years and a standard deviation of 6.84 years. Of the participants, 479 caregivers were women (73.9%), 163 were men (25.2%), and 6 identified as nonbinary, gender-diverse, or another gender identity (0.9%). Most participants were biological or adoptive parents of the child (n = 601, 92.7%), while 27 were grandparents serving as primary caregivers (4.2%) and 20 were other legal guardians or family caregivers (3.1%). A total of 445 participants were married or living with a partner (68.7%), whereas 203 were single, separated, divorced, or widowed (31.3%). Regarding educational attainment, 367 participants had completed a bachelor's degree or a higher academic qualification (56.6%), 184 had completed a college diploma or technical qualification (28.4%), and 97 had a high school education or lower qualification (15.0%). At the time of data collection, 489 caregivers were employed either full-time or part-time (75.5%), 72 were unemployed and seeking work (11.1%), and 87 were students, retired individuals, homemakers, or individuals unable to work (13.4%).

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The children represented in the study ranged from 6 to 17 years of age, with a mean age of 12.14 years and a standard deviation of 3.12 years. The sample included 348 boys (53.7%), 294 girls (45.4%), and 6 gender-diverse children or adolescents (0.9%). A formal mental health or neurodevelopmental diagnosis had been received by 523 children (80.7%), while 125 children had clinically significant emotional or behavioral symptoms but had not yet received a formal diagnosis (19.3%). The primary reported difficulties included attention-deficit/hyperactivity disorder for 172 children (26.5%), anxiety-related disorders or symptoms for 149 children (23.0%), depressive disorders or symptoms for 104 children (16.0%), disruptive behavior or conduct-related difficulties for 83 children (12.8%), and trauma-related symptoms, obsessive-compulsive symptoms, eating-related difficulties, emotional dysregulation, self-harming behavior, or other mental health concerns for 140 children (21.6%). The average reported duration of the child's difficulties was 3.42 years, with a standard deviation of 2.17 years. A total of 403 caregivers reported that the child had previously received help from a mental health or medical professional (62.2%), and 271 children were receiving an active form of professional treatment or support at the time of the study (41.8%).

Of the participating caregivers, 234 identified as belonging to a racialized or ethnocultural minority group (36.1%), 178 had immigrated to Canada (27.5%), and 87 completed the French-language version of the questionnaire (13.4%). The proportions of caregivers with a university degree and previous experience using child mental health services were significantly higher in urban communities than in rural communities. Specifically, 61.8% of urban caregivers had completed a bachelor's degree or higher qualification, compared with 50.3% of rural caregivers, $\chi^2(1) = 8.67$, $p = .003$. Previous professional service use was reported by 67.4% of urban caregivers and 56.2% of rural caregivers, $\chi^2(1) = 8.54$, $p = .003$. Rural caregivers were substantially more likely to report transportation difficulties, long travel distances, or an absence of locally available child mental health specialists. These barriers were reported by 46.9% of rural caregivers and 19.7% of urban caregivers, $\chi^2(1) = 54.62$, $p < .001$. Urban participants were more likely to identify as members of racialized or ethnocultural minority communities, whereas rural participants were more likely to report annual household incomes below CAD 60,000. There were no statistically significant differences between the urban and rural groups in caregiver age, child age, caregiver gender, child gender, marital status, or the proportion of children with a formal diagnosis.

Table 1

Descriptive Statistics, Urban–Rural Comparisons, and Zero-Order Correlations Among the Principal Study Variables

Variable	Possible range	Total sample M (SD)	Urban M (SD)	Rural M (SD)	t	Cohen's d	1	2	3	4
1. Perceived cultural stigma	1–5	3.08 (0.74)	2.92 (0.70)	3.27 (0.73)	−6.22***	−0.49	—			
2. Family social support	1–7	4.71 (1.21)	4.79 (1.18)	4.61 (1.24)	1.89	0.15	−.41***	—		
3. Professional help-seeking intention	1–7	4.82 (1.17)	5.04 (1.08)	4.55 (1.22)	5.43***	0.43	−.47***	.52***	—	
4. Child total difficulties score	0–40	18.73 (5.48)	18.21 (5.36)	19.37 (5.56)	−2.69**	−0.21	.18***	−.09*	.24***	—

As shown in Table 1, the mean perceived cultural stigma score for the total sample was 3.08, indicating a moderate level of perceived culturally based judgment, shame, concealment pressure, and concern regarding family reputation. Rural caregivers reported significantly greater perceived cultural stigma than urban caregivers, $t(646) = -6.22$, $p < .001$. The standardized mean difference of 0.49 represented a moderate residential difference and indicated that concerns about community criticism, social disclosure, family reputation, and the expectation that mental health problems should remain private were more prominent in rural communities. Family social support was relatively high across the sample, with an overall mean of 4.71 on the seven-point scale. Although urban caregivers reported slightly higher family support than rural caregivers, the difference did not reach statistical significance, $t(646) = 1.89$, $p = .059$. Professional help-seeking intention was significantly higher among urban caregivers, who reported a mean of 5.04, compared with a mean of 4.55 among rural caregivers, $t(646) = 5.43$, $p < .001$. This difference was moderate in magnitude and indicated that urban caregivers were more likely to report an intention to contact psychologists,

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psychiatrists, counselors, social workers, family physicians, or pediatricians when their child's mental health difficulties persisted or intensified. Rural caregivers also reported significantly higher child total difficulties scores, although the magnitude of this difference was comparatively small.

The zero-order correlations were consistent with the hypothesized mediation model. Perceived cultural stigma was moderately and negatively associated with family social support, $r = -.41$, $p < .001$, indicating that caregivers who anticipated greater cultural judgment and social disapproval tended to perceive less emotional and practical support from their families. Perceived cultural stigma was also negatively associated with professional help-seeking intention, $r = -.47$, $p < .001$. Thus, stronger stigma-related concerns were associated with a lower likelihood of intending to obtain formal services for the child. Family social support demonstrated a positive and comparatively strong association with professional help-seeking intention, $r = .52$, $p < .001$, suggesting that caregivers who felt supported by their families were more willing to initiate professional care. Greater child symptom severity was positively associated with professional help-seeking intention, $r = .24$, $p < .001$, indicating that caregivers of children with more severe emotional and behavioral difficulties reported a stronger perceived need for professional intervention. Child symptom severity was also positively associated with cultural stigma and weakly negatively associated with family support.

Table 2

Reliability, Construct Validity, Confirmatory Factor Analysis, and Measurement Invariance Results

Model or construct	χ^2	df	CFI	TLI	RMSEA [90% CI]	SRMR	Standardized loadings	Cronbach's α	McDonald's ω	Composite reliability	AVE
Perceived cultural stigma	—	—	—	—	—	—	.64–.86	.92	.92	.92	.55
Family social support	—	—	—	—	—	—	.77–.90	.88	.89	.89	.67
Professional help-seeking intention	—	—	—	—	—	—	.74–.88	.89	.90	.90	.69
Full-sample three-factor CFA	311.84***	149	.957	.949	.041 [.035, .047]	.038	—	—	—	—	—
Urban-group CFA	228.16***	149	.956	.948	.039 [.029, .048]	.041	—	—	—	—	—
Rural-group CFA	244.73***	149	.943	.934	.047 [.036, .057]	.046	—	—	—	—	—
Configural invariance	471.52***	298	.951	.943	.042 [.035, .049]	.044	—	—	—	—	—
Metric invariance	489.76***	313	.950	.944	.041 [.035, .048]	.049	—	—	—	—	—
Scalar invariance	522.34***	328	.946	.942	.042 [.036, .049]	.052	—	—	—	—	—
Strict invariance	551.89***	346	.942	.940	.043 [.037, .049]	.057	—	—			

The measurement results presented in Table 2 supported the reliability and validity of the three principal constructs. The standardized factor loadings for the 18 perceived cultural stigma items ranged from .64 to .86, and all loadings were statistically significant at $p < .001$. Cronbach's alpha and McDonald's omega were both .92, demonstrating excellent internal consistency. The composite reliability coefficient was .92, and the average variance extracted was .55, indicating that the construct accounted for more than half of the variance in its indicators. The four family social support items had standardized loadings ranging from .77 to .90, with alpha, omega, and composite reliability values between .88 and .89. The average variance extracted for family support was .67. The professional help-seeking intention indicators also demonstrated strong psychometric properties, with loadings ranging from .74 to .88, an alpha coefficient of .89, an omega coefficient of .90, composite reliability of .90, and average variance extracted of .69. These findings indicated that the indicators adequately represented their respective latent constructs and that the amount of construct-related variance exceeded the amount attributable to measurement error.

The full-sample three-factor confirmatory factor analysis demonstrated a satisfactory fit to the observed data, $\chi^2(149)$

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= 311.84, p < .001, CFI = .957, TLI = .949, RMSEA = .041, 90% CI [.035, .047], and SRMR = .038. The hypothesized three-factor solution provided a better representation of the data than alternative models in which perceived stigma, family support, and professional help-seeking intention were combined. The separate urban and rural confirmatory factor analyses also produced acceptable fit indices, indicating that the measurement structure was suitable within each residential group. The configural invariance model showed that the same general factor structure applied to both urban and rural caregivers. Constraining the factor loadings to equality resulted in a change in CFI of only −.001, supporting metric invariance. The additional equality constraints imposed on item intercepts resulted in a CFI change of −.004, supporting scalar invariance. Strict invariance was also considered acceptable because the change in CFI remained below .010 and the remaining fit indices did not show a substantial deterioration. Therefore, differences in structural pathways and latent associations across urban and rural participants could be interpreted as substantive residential differences rather than consequences of the constructs functioning differently across the two groups.

Table 3

Direct, Indirect, and Total Effects in the Full-Sample Mediation Model

Structural effect	Unstandardized B	SE	Standardized β	z	p	95% confidence interval
Perceived cultural stigma → Family social support	−0.67	0.07	−.41	−9.57	<.001	[−0.81, −0.53]
Family social support → Professional help-seeking intention	0.38	0.04	.39	9.50	<.001	[0.31, 0.46]
Perceived cultural stigma → Professional help-seeking intention, direct effect	−0.43	0.06	−.27	−7.17	<.001	[−0.55, −0.31]
Perceived cultural stigma → Family social support → Professional help-seeking intention, indirect effect	−0.26	0.04	−.16	—	<.001	[−0.33, −0.19]
Perceived cultural stigma → Professional help-seeking intention, total effect	−0.69	0.06	−.43	−10.70	<.001	[−0.81, −0.56]

The full-sample mediation model demonstrated an acceptable fit to the data, $\chi^2(391) = 620.48$, p < .001, CFI = .947, TLI = .941, RMSEA = .030, 90% CI [.026, .034], and SRMR = .046. Perceived cultural stigma was a significant negative predictor of family social support, B = −0.67, SE = 0.07, β = −.41, p < .001. This coefficient indicated that a one-unit increase in perceived cultural stigma was associated with an estimated 0.67-unit decrease in perceived family support after the demographic, clinical, and regional covariates had been controlled. Caregivers who anticipated greater community judgment, cultural shame, damage to family reputation, or criticism for disclosing the child's difficulties were therefore less likely to perceive their families as emotionally available, practically helpful, or supportive of professional treatment decisions.

Family social support was a significant positive predictor of professional help-seeking intention, B = 0.38, SE = 0.04, β = .39, p < .001. A one-unit increase in perceived family support was associated with a 0.38-unit increase in the professional help-seeking intention score. This finding indicated that emotional reassurance, practical assistance, understanding, and approval from family members were associated with a greater willingness to contact formal mental health or medical services. Perceived cultural stigma also retained a significant direct association with professional help-seeking intention after family social support had been entered into the model, B = −0.43, SE = 0.06, β = −.27, p < .001. Thus, cultural stigma reduced professional help-seeking intention through mechanisms that extended beyond the availability of family support, including anticipated social judgment, fear of disclosure, concerns regarding family reputation, and beliefs that children's psychological difficulties should be managed privately.

The bootstrapped indirect effect of perceived cultural stigma on professional help-seeking intention through family social support was statistically significant, B = −0.26, SE = 0.04, β = −.16, 95% CI [−0.33, −0.19]. Because the confidence interval did not include zero, the mediation hypothesis was supported. Approximately 37.7% of the total association between perceived cultural stigma and professional help-seeking intention was transmitted through family social support. The remaining association was represented by the statistically significant direct effect, indicating partial rather than complete mediation. The total effect of perceived cultural stigma on professional help-

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seeking intention was substantial and negative, B = −0.69, β = −.43, p < .001. The model explained 24% of the variance in family social support and 43% of the variance in professional help-seeking intention. Child symptom severity and previous professional service use were additional positive predictors of help-seeking intention, whereas lower household income and perceived service inaccessibility were associated with weaker intentions to seek professional assistance.

Table 4

Multigroup Mediation Effects for Urban and Rural Caregivers

Structural effect	Urban B (SE)	Urban β	Rural B (SE)	Rural β	Rural–urban difference	z	p	95% CI for difference
Perceived cultural stigma → Family social support	−0.52 (0.09)	−.33	−0.86 (0.10)	−.52	−0.34	−2.62	.009	[−0.59, −0.09]
Family social support → Professional help-seeking intention	0.42 (0.05)	.46	0.34 (0.06)	.35	−0.08	−1.00	.317	[−0.24, 0.08]
Perceived cultural stigma → Professional help-seeking intention, direct effect	−0.35 (0.08)	−.23	−0.53 (0.09)	−.32	−0.18	−1.50	.134	[−0.42, 0.06]
Indirect effect through family social support	−0.22 (0.04)	−.15	−0.29 (0.05)	−.18	−0.07	−2.10	.036	[−0.14, −0.01]
Total effect of perceived cultural stigma	−0.57 (0.09)	−.38	−0.82 (0.11)	−.50	−0.25	−1.79	.073	[−0.52, 0.02]

The unconstrained multigroup model provided an acceptable fit to the data, $\chi^2(782) = 1008.46$, $p < .001$, CFI = .948, TLI = .943, RMSEA = .030, 90% CI [.025, .035], and SRMR = .051. A model constraining all three principal structural pathways to equality across urban and rural groups produced a statistically significant deterioration in fit, $\Delta\chi^2(3) = 9.84$, $p = .020$, indicating that at least one structural association differed by residential context. The pathway from perceived cultural stigma to family social support was significant in both groups but was substantially stronger among rural caregivers. In the urban group, perceived cultural stigma predicted lower family social support with a standardized coefficient of β = −.33, whereas the corresponding coefficient was β = −.52 in the rural group. The unstandardized difference between the two pathways was statistically significant, B_difference = −0.34, z = −2.62, p = .009. These findings indicated that stigma-related beliefs were more strongly associated with diminished perceived family support among caregivers living in rural communities.

Family social support positively predicted professional help-seeking intention in both residential groups. The association was somewhat stronger among urban caregivers, β = .46, than among rural caregivers, β = .35; however, the group difference was not statistically significant, p = .317. Family support therefore appeared to facilitate professional help-seeking across both community types. The direct negative association between perceived cultural stigma and help-seeking intention also remained significant in each group. The standardized direct effect was β = −.23 among urban caregivers and β = −.32 among rural caregivers. Although the rural coefficient was larger in absolute magnitude, the difference between the two direct effects did not reach statistical significance, p = .134.

The indirect effect of perceived cultural stigma through family social support was statistically significant for both urban and rural caregivers. Among urban participants, the indirect effect was B = −0.22, β = −.15, with a 95% bootstrap confidence interval from −0.31 to −0.14. Among rural participants, the indirect effect was B = −0.29, β = −.18, with a 95% bootstrap confidence interval from −0.41 to −0.19. The contrast between the two indirect effects was statistically significant, B_difference = −0.07, p = .036, showing that the mediating influence of family social support was stronger in rural communities. The total association between cultural stigma and professional help-seeking intention was also larger among rural caregivers, although the group difference in the total effect fell slightly above the conventional significance threshold. The model explained 20% of the variance in family social support and 45% of the variance in help-seeking intention among urban caregivers. Among rural caregivers, it explained 34% of the variance in family social support and 41% of the variance in professional help-seeking intention. The higher explained variance for rural family support was consistent with the stronger association between perceived stigma and the availability or mobilization of support within rural family networks.

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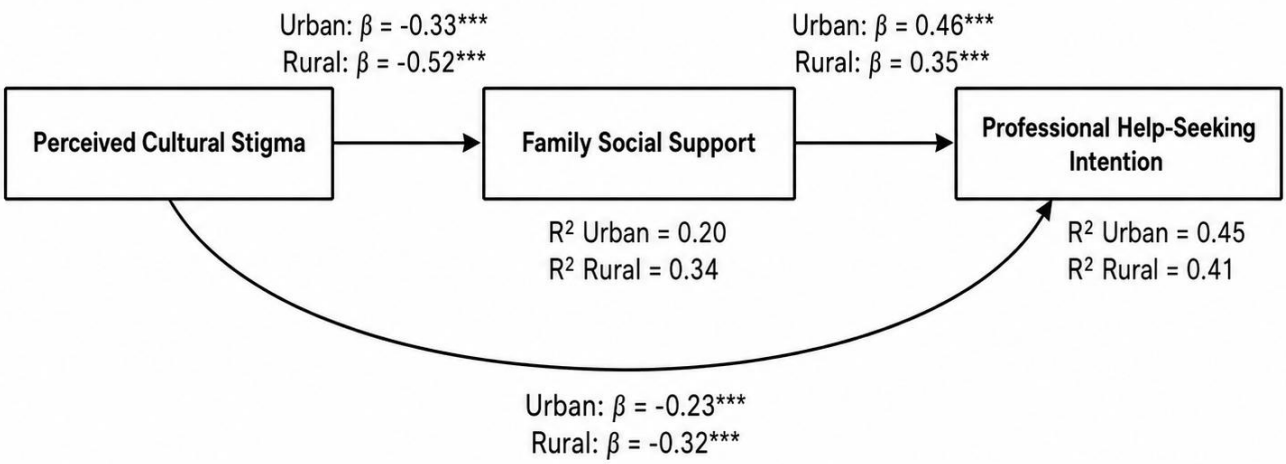
Figure 1

Standardized Multigroup Mediation Model of the Association Between Perceived Cultural Stigma and Professional Help-Seeking Intention Through Family Social Support Among Urban and Rural Caregivers



The standardized multigroup model illustrated that perceived cultural stigma was negatively associated with family social support in both urban and rural communities, although this pathway was considerably stronger in the rural group. Family social support was positively associated with professional help-seeking intention in both groups, demonstrating that supportive family relationships increased caregivers' willingness to consult qualified mental health and medical professionals. Perceived cultural stigma also had a remaining direct negative association with help-seeking intention after the mediating role of family support had been taken into account. The combination of significant direct and indirect pathways confirmed partial mediation in both residential settings. However, the significantly stronger indirect effect in the rural group indicated that family social support played a more central role in transmitting the influence of cultural stigma to professional help-seeking decisions among rural caregivers. In practical terms, cultural stigma appeared to discourage professional help-seeking partly by weakening caregivers' perceptions that their families would understand, approve of, and assist with the decision to obtain mental health services for the child. This mechanism was evident in both communities but was especially pronounced in rural settings, where family and community relationships may be more interconnected and where concerns about visibility, confidentiality, and social reputation may carry greater weight.

4 Discussion

The present study examined whether family social support mediated the association between perceived cultural stigma and professional help-seeking intention among Canadian caregivers of children with mental health difficulties and whether this process differed between urban and rural communities. The findings supported the proposed conceptual model. Perceived cultural stigma was negatively associated with family social support and professional help-seeking intention, while family social support was positively associated with help-seeking intention. The indirect effect of stigma on help-seeking through family social support was statistically significant, although the direct effect of stigma also remained significant after the mediator was included. This pattern indicated partial mediation, meaning that cultural stigma appeared to reduce caregivers' willingness to seek professional assistance both directly and indirectly through diminished perceptions of family support. The multigroup analysis further showed that the negative pathway from stigma to family support and the overall indirect effect were stronger among rural caregivers. By contrast, the positive relationship between family support and help-seeking intention was evident in both residential groups and did not differ significantly between them.

The finding that stronger perceived cultural stigma was associated with weaker professional help-seeking intention is consistent with evidence showing that stigma affects

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whether caregivers regard mental health services as acceptable, necessary, and socially safe. Parents may avoid or postpone consultation when they expect that the child will be labeled, that the family will be blamed, or that professional involvement will expose private difficulties to the community. Previous research has demonstrated that mothers and fathers may hold stigmatizing beliefs about child and adolescent mental health problems and that these beliefs can shape their judgments regarding the legitimacy of treatment (Ramiro et al., 2024). Adults who interpret psychological difficulties through blame-oriented or condemnatory frameworks may be less likely to support service use for children, even when symptoms are clinically significant (Lange et al., 2022). The present findings extend this evidence by demonstrating that culturally embedded stigma was not merely associated with general attitudes toward mental illness but was directly related to caregivers' stated intentions to contact psychologists, psychiatrists, counselors, social workers, physicians, or pediatricians for their children.

The direct negative effect of perceived cultural stigma remained significant after family support was included in the model. This suggests that stigma may restrict help-seeking through several mechanisms beyond the availability of support from relatives. Caregivers may fear disclosure, anticipate criticism from community members, worry about reputational damage, or believe that seeking mental health care signifies parental inadequacy. Research across different sociocultural settings has shown that such beliefs may encourage families to manage difficulties privately and delay contact with professional services. Within Chinese sociocultural contexts, parents' responses to young people's mental health concerns may reflect beliefs about resilience, family responsibility, emotional control, and generational weakness (Frost, 2025). Among second-generation Chinese individuals, stigma and acculturation have also been associated with reluctance to disclose psychological difficulties and seek help (Shu et al., 2022). Similar patterns have been identified among Asian American populations, where family reputation, cultural expectations, mistrust, and limited cultural responsiveness contribute to the underutilization of mental health services (Kim & Gonzales, 2024). The present results therefore support the view that help-seeking decisions are embedded within wider systems of cultural meaning rather than being determined exclusively by symptom severity or service availability.

The significant association between perceived cultural stigma and lower family social support represents an important contribution of the study. Cultural stigma may affect not only the caregiver's personal attitudes but also the quality and accessibility of support within the family system. When relatives interpret a child's symptoms as evidence of poor discipline, weak parenting, moral failure, or family shame, caregivers may be less likely to disclose the child's difficulties or request assistance. They may also anticipate that relatives will minimize the problem, discourage treatment, or blame the caregiver for involving mental health professionals. Caregivers of children and adolescents with mental illness frequently experience affiliate or family-associated stigma, including social judgment, embarrassment, and responsibility for the child's condition (Minichil et al., 2021). Caregivers with limited knowledge of mental disorders may also hold beliefs that intensify stigma and reduce supportive responses to the child's needs (Ghadirian & Sayarifard, 2022). The present results suggest that perceived stigma can weaken the family network that might otherwise provide reassurance, practical assistance, and approval for treatment seeking.

Family social support was positively associated with professional help-seeking intention in both urban and rural communities. Caregivers who believed that family members would understand their concerns, support important decisions, and provide help during periods of difficulty reported a greater willingness to seek professional care. This result can be interpreted through both emotional and practical mechanisms. Emotional validation may reduce shame and uncertainty, while practical assistance may make it easier to attend appointments, manage transportation, arrange childcare, or sustain treatment. Parental perspectives on mental health screening and support indicate that caregivers are more likely to engage with services when support is perceived as accessible, acceptable, and responsive to family circumstances (Tan et al., 2025). Family approval may be especially important when caregivers remain uncertain about whether symptoms justify professional intervention. Research on parental suicide stigma and literacy similarly indicates that caregiver beliefs influence attitudes and intentions regarding obtaining help for a child (Burke et al., 2023). The present findings extend this literature by identifying family support as a mechanism through which stigma becomes associated with lower help-seeking intention.

The partial mediation effect showed that family social support accounted for a meaningful proportion of the overall relationship between stigma and help-seeking. Approximately 37.7% of the total association was

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transmitted through family support, indicating that cultural stigma may reduce professional help-seeking partly because it limits the caregiver's perception that relatives will support the decision. This finding is compatible with research emphasizing that empowerment, supportive relationships, and mental health literacy can help families overcome stigma-related barriers to children's mental health care (Kosyluk et al., 2022). However, the persistence of a significant direct effect also indicates that strengthening family support alone may not fully eliminate the influence of stigma. Caregivers may continue to fear community judgment or institutional consequences even when their immediate families are supportive. For example, some parents delay seeking mental health care because they fear that disclosure will result in scrutiny, discrimination, or involvement from child welfare institutions (Goldberg & Frost, 2024). Therefore, stigma-reduction efforts should address both family relationships and broader community or institutional beliefs.

The urban–rural comparisons provided additional evidence that residential context shapes the operation of cultural stigma. Rural caregivers reported higher perceived stigma and lower professional help-seeking intention than urban caregivers. They were also more likely to report transportation difficulties, long travel distances, and limited access to local child mental health specialists. These results indicate that attitudinal and structural barriers may accumulate in rural settings. When services are geographically distant or scarce, the decision to seek help may already require greater time, expense, and public visibility. Under such circumstances, anticipated stigma may carry additional weight. In small or socially interconnected communities, caregivers may worry that attending a mental health clinic, speaking with school personnel, or requesting a referral will become known to neighbors or extended family members. Although rurality was examined as a residential classification rather than a single cultural identity, the findings resemble evidence from rural populations showing that self-reliance, privacy, family responsibility, and social expectations can influence attitudes toward mental health care (Davila, 2025).

The stronger negative relationship between cultural stigma and family social support among rural caregivers was particularly notable. Perceived stigma appeared to have a more substantial effect on the family support available to rural participants than to urban participants. One possible explanation is that family and community networks may overlap more extensively in rural settings. When relatives, neighbors, schools, and service providers are embedded within the same social environment, concerns about confidentiality and reputation may influence whether caregivers disclose problems or mobilize assistance. The family may become both a potential source of support and a channel through which stigmatizing community norms are reinforced. In contrast, urban caregivers may have access to more socially diverse networks, specialized support groups, and anonymous services that reduce their dependence on immediate or extended family approval. Underutilization of school-based mental health services among immigrant adolescents has likewise been linked to stigma, mistrust, concerns about confidentiality, and cultural beliefs despite the physical availability of services (Choe, 2024). The present findings indicate that service proximity alone may be insufficient when families believe that using those services could produce adverse social consequences.

The indirect effect through family support was also significantly stronger among rural caregivers. This suggests that family support occupies a more central position in the pathway between stigma and help-seeking in rural communities. When family members are supportive, they may help caregivers overcome uncertainty, transportation difficulties, service shortages, and concerns about community judgment. When family members reinforce stigma, however, caregivers may have few alternative sources of encouragement. The positive effect of family support on help-seeking did not differ significantly between urban and rural groups, showing that support was beneficial in both settings. The residential difference in mediation was therefore primarily attributable to the stronger negative effect of stigma on family support in rural communities. This result supports a contextual interpretation in which the protective value of support is broadly consistent, but the extent to which stigma disrupts that support varies according to the social organization of the community.

The findings also have implications for mental health literacy interventions. Stigma and limited knowledge often interact because caregivers who do not recognize symptoms or understand treatment may be more likely to rely on culturally stigmatizing explanations. Cross-cultural research has documented gaps in parental knowledge regarding attention-deficit/hyperactivity disorder and other child mental health conditions (Mah & Li, 2025). Systematic evidence also shows that children's and adolescents' mental health literacy varies according to cultural context, educational opportunity, and access to reliable information (Renwick et al., 2022). School-based educational

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interventions can improve knowledge and attitudes toward mental health difficulties (Zare et al., 2021), while validated measures have been developed to assess mental health literacy among children and adolescents (Riebschleger et al., 2022; Simkiss et al., 2021). However, the current results suggest that programs focused exclusively on individual knowledge may be less effective than approaches that involve caregivers and family members. Improving recognition without changing stigma or increasing social support may leave families aware of a problem but unwilling to seek professional assistance.

The findings are also consistent with evidence supporting culturally responsive and community-based approaches. A lay health worker intervention developed for Black and African American families demonstrated the potential of trusted community figures to reduce child mental health stigma and encourage parental help-seeking (Chakawa, 2023). A systematic review of Black American youth similarly showed that stigma interacts with discrimination, mistrust, cultural beliefs, and structural barriers to influence service use (Fields-Oriogun et al., 2024). Provider perspectives indicate that family engagement and youth mental health service implementation are affected by coordination problems, resource shortages, cultural responsiveness, and the accessibility of care (Goodcase et al., 2021). These studies support the present finding that help-seeking intentions develop through the interaction of cultural beliefs, family relationships, and service environments. Interventions should therefore be designed to change the social conditions surrounding decisions about care rather than treating reluctance as an individual caregiver deficit.

The association between greater child symptom severity and stronger help-seeking intention was expected, as more visible or disruptive difficulties may increase caregivers' perceptions that professional intervention is necessary. Nevertheless, higher symptom severity was also associated with greater perceived stigma, suggesting that more severe problems may make the child's difficulties harder to conceal and may increase anticipated judgment. Parents' responses can also vary according to the child's characteristics, including gender, because cultural expectations may shape whether emotional or behavioral symptoms are interpreted as serious, acceptable, or shameful (Villatoro et al., 2025). Research on barriers to services for children with attention-deficit/hyperactivity disorder has similarly shown that symptom interpretation, stigma, treatment concerns, and service access jointly influence parental decisions (Kappi & Martel, 2021). Thus, increased clinical need may strengthen the motivation to seek help while simultaneously increasing exposure to stigmatizing reactions.

5 Conclusion

Overall, the study supports a relational and contextual model of professional help-seeking among families of children with mental health difficulties. Cultural stigma was associated with reduced help-seeking intention not only because caregivers personally anticipated shame or judgment but also because stigma was related to weaker perceived support from their families. This process was evident across urban and rural communities but was more pronounced in rural settings. The results suggest that reducing delays in children's mental health care requires interventions that address cultural beliefs, strengthen supportive family responses, improve confidentiality and trust, and reduce practical barriers to services. Evidence from international contexts consistently demonstrates that stereotypes regarding mental health professionals, culturally shaped explanations of distress, and lived experiences of stigma influence whether individuals seek formal care (Gallimore et al., 2026; Roach et al., 2025; Sharma, 2025). The present findings add to this literature by demonstrating that family support is one pathway through which perceived cultural stigma may influence caregivers' intentions to obtain professional help for a child.

Several limitations should be considered when interpreting the findings. The cross-sectional design prevented conclusions about temporal order or causality, and it remains possible that caregivers with lower help-seeking intentions perceived both their family environment and community attitudes more negatively. Professional help-seeking intention was assessed rather than verified service utilization, and stated willingness may not translate into actual behavior when families encounter waiting lists, financial costs, transportation difficulties, or changes in the child's condition. The data were based on caregiver self-report and may have been influenced by social desirability, recall error, or differences in interpretation across cultural groups. Although the sample included caregivers from several Canadian provinces, it was not designed to be nationally representative, and families in remote northern, Indigenous, or highly isolated communities may have been underrepresented. The urban–rural classification was based on residential location and could not fully capture variation in community size, service availability, cultural

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composition, or distance from specialized care. In addition, the study assessed perceived family support as a general construct and did not distinguish support from spouses, grandparents, siblings, extended relatives, or chosen family members.

Future studies should employ longitudinal designs to determine whether perceived cultural stigma predicts later changes in family support, help-seeking intention, and actual service use. Prospective research could follow families from initial recognition of a child's symptoms through referral, assessment, treatment initiation, and treatment continuation. It would also be valuable to test the model across specific ethnocultural, linguistic, immigrant, Indigenous, and religious communities rather than treating culture as a broad background characteristic. Future research should differentiate emotional, informational, practical, and treatment-specific forms of family support and examine whether particular family members facilitate or obstruct access to care. More detailed measures of rurality should include travel distance, provider density, community population, internet connectivity, perceived anonymity, and availability of culturally appropriate services. Qualitative interviews with caregivers, children, relatives, educators, and providers could clarify how stigma is communicated within families and how decisions about disclosure and treatment are negotiated. Experimental and intervention studies should also determine whether family-based stigma reduction, mental health literacy training, peer navigation, or telehealth support can modify the pathways identified in the present model.

Mental health services should address cultural stigma and family support as interconnected targets rather than treating help-seeking as an individual parental choice. Clinicians, schools, and community organizations should provide culturally sensitive information that distinguishes children's mental health difficulties from parental failure, weak character, or inadequate discipline. When appropriate and with the caregiver's consent, assessment and treatment planning should involve supportive family members who can assist with transportation, childcare, appointment attendance, crisis planning, and treatment adherence. Rural services should strengthen confidential referral procedures, tele-mental-health options, mobile outreach, and partnerships with schools, primary care providers, and trusted community organizations. Public education messages should emphasize that obtaining professional assistance is a responsible form of caregiving and should be adapted to local languages, beliefs, and community concerns. Training for professionals should also include strategies for discussing stigma without dismissing families' legitimate fears about judgment, discrimination, or loss of privacy. By combining family-centered engagement with practical improvements in service access, providers may increase the likelihood that caregivers seek timely professional help for children experiencing mental health difficulties.

Authors' Contributions

All authors have contributed significantly to the research process and the development of the manuscript.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

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Declaration of Interest

The authors report no conflict of interest.

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Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

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