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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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1. Round 1

1.1. Reviewer 1

Reviewer:

In the first paragraph of the Introduction, the manuscript argues that “many children experiencing emotional, behavioral, or developmental difficulties do not receive timely professional support.” This central problem statement requires a more clearly defined Canadian context. The authors should distinguish between unmet need, delayed help-seeking, intention to seek help, referral completion, and actual service utilization because these represent different stages of the care pathway. The Introduction would be strengthened by explaining specifically why professional help-seeking intention is an important outcome among Canadian caregivers and how it differs conceptually from previous service use, treatment initiation, and continuity of care.

The Introduction repeatedly uses the term “perceived cultural stigma,” particularly in the paragraph beginning, “Perceived cultural stigma is one of the most persistent barriers within this decision-making process.” However, the manuscript does not sufficiently differentiate this construct from public stigma, affiliate stigma, anticipated stigma, self-stigma, family stigma, and treatment stigma. The authors should provide a precise conceptual definition and explain why the proposed construct is culturally specific rather than a general measure of anticipated social judgment. This clarification is especially important

because the scale was developed for the present study and appears to combine several theoretically distinguishable dimensions, including community judgment, family reputation, shame, and concealment.

The manuscript introduces the "Perceived Cultural Stigma Scale for Child Mental Health, an 18-item caregiver-report measure developed for the present study." Because this newly developed instrument is central to the model, its validation procedures are currently insufficiently reported. The authors should provide the item-generation process, theoretical source domains, expert-selection criteria, content validity indices, cognitive-interview procedures, pilot-sample characteristics, item-reduction criteria, exploratory factor analysis results, and rationale for retaining three domains. The full scale or a supplementary item list should be provided to permit replication and critical evaluation of whether the instrument measures cultural stigma rather than general concern about social judgment.

Response: Revised and uploaded the new document.

1.2. Reviewer 2

Reviewer:

In the Introduction paragraph stating that "family social support may therefore constitute a central mechanism linking cultural stigma to professional help-seeking intentions," the mediation rationale remains plausible but underdeveloped. The authors should identify a formal theoretical framework that explains why cultural stigma would reduce perceived family support and why family support would subsequently affect help-seeking intention. For example, the manuscript could draw on social support theory, stigma process models, the Theory of Planned Behavior, or the Behavioral Model of Health Services Use. A clearly articulated framework would help establish whether family social support is expected to function as emotional validation, subjective norm, practical facilitation, stigma buffering, or a combination of these mechanisms.

In the "Study Design and Participants" section, the manuscript reports that "a combination of purposive, quota-based, and community-based sampling procedures was used." The exact implementation of these methods should be described in greater detail. The authors should specify the quotas applied, the number of recruitment sites in each province, the proportion of participants recruited through clinics, schools, community organizations, and online networks, and whether recruitment differed between urban and rural communities. Without this information, the representativeness of the sample and the possibility of differential selection bias across residential groups cannot be adequately assessed.

The paragraph reporting that "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" should include a formal sample-size justification. The current statement that the sample was "considered sufficient" is not adequate for a multigroup latent-variable mediation model. The authors should report an a priori power analysis or Monte Carlo simulation specifying the expected path coefficients, alpha level, target power, number of latent indicators, anticipated missingness, and minimum group size required to detect the indirect-effect difference. This is particularly important because the most consequential result is the relatively small urban–rural difference in the standardized indirect effect.

In the participant eligibility paragraph, the manuscript includes children with either "a formal diagnosis" or "clinically meaningful symptoms that had raised concern among the family, school personnel, or a health professional." These categories may differ substantially in symptom certainty, service exposure, perceived need, and caregiver knowledge. The authors should explain how clinically meaningful symptoms were verified when no diagnosis was present and whether the Strengths and Difficulties Questionnaire was used as an eligibility threshold. Sensitivity analyses should also compare the structural model between families of formally diagnosed children and families whose children had significant but undiagnosed difficulties.

The classification of residential status requires further clarification. The methods state that "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." The authors should identify the exact Statistics Canada classification, reference year, coding procedure, and population threshold used. They should also indicate whether small population centres were categorized as urban or rural and whether participants living in remote communities

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were distinguished from those living near metropolitan areas. A binary classification may obscure meaningful heterogeneity in remoteness, service density, travel burden, and community connectivity.

Response: Revised and uploaded the new document.

2. Revised

Editor's decision: Accepted.
Editor in Chief's decision: Accepted.

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