

# Mental Health Literacy and Attitudes Towards Seeking Psychological Support Among Parents of Children With Special Needs and Mental Illness Diagnosis

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## Research Article

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# Abstract

## Background

The present study aimed to examine the relationship between the mental health literacy of parents of children with special needs and mental illness and their attitudes towards seeking psychological support.

## Materials and Methods

The study was conducted in a cross-sectional and correlational design. The sample consisted of 196 parents, 98 of whom had children with special needs and 98 of whom had a mental health diagnosis. The data were collected using a descriptive questionnaire for parents and children, the Mental Health Literacy Scale (MHLS), and Attitude Scale Towards Receiving Professional Psychological Support-Short Form (ATSPPH-SF) in face-to-face interviews. In the evaluation of the data, the SPSS 22.0 statistical program was employed.

## Results

General mental health literacy levels were moderate in both groups, with a higher difference in the resource-oriented approach among parents of children with special needs, but no significant relationship was found with the ATSPPH-SF or its sub-dimensions.

## Conclusion

Mental Health Literacy levels did not differ significantly between parent groups, but attitudes affecting psychological support-seeking behaviors depend on more complex psychosocial factors. It can be speculated that individuals' knowledge and beliefs about mental health influence their propensity to seek psychological support, but knowledge of access to resources is not a determining factor in this process. From a clinical perspective, this highlights the importance of not only providing information but also stigma-reducing and motivation-enhancing interventions aimed at changing attitudes. Knowledge of the MHLS alone may be insufficient to motivate help-seeking behaviors. Providing awareness training aimed at increasing the MHLS levels to help parents in both groups protect both their mental health and the mental health of their child will not only be effective in coping with stressful situations but will also support their attitudes toward seeking psychological first aid.

## INTRODUCTION

Mental Health Literacy (MHLS) refers to individuals' ability to recognize and understand mental disorders, learn about appropriate treatment methods, and guide their help-seeking behaviors [1]. Parents' knowledge levels in this field directly impact not only their children's access to services but also their psychological well-being. Parental mental health literacy can become more complex for parents of children with special needs and children diagnosed with mental illness who visit child and adolescent clinics, both in terms of accessing information and emotional coping.

Among the first group, the level of Mental Health Literacy (MHL) in parents of children with special needs can be a determining factor in recognizing their children's behavioral problems and directing them to appropriate health services. This is because caring for a child with special needs is associated with high stress, burnout, and social isolation [2, 3]. A previous study reported that parents of children with special needs are many times more likely to

experience psychological problems than other parents [4]. Having a child with special needs can isolate family members from society, causing them to withdraw into their inner worlds. Providing psychological support to the family during this process is only possible through educational support that will enable them to effectively participate in their child's education [5]. A previous study conducted on this topic revealed that parents of children with intellectual disabilities and comorbid psychiatric disorders have sufficient knowledge to recognize symptoms associated with depression and autism, but this literacy decreases in complex situations. Also, it was found that the factors that hinder parents' help-seeking attitudes are mostly associated with dissatisfaction and lack of knowledge about service systems [6]. It was also found that the positive coping style of parents of children with special needs plays a mediating role between social support and mental health literacy [7].

Another important group is parents presenting to child and adolescent psychiatry clinics as outpatients, a significant portion of whom exhibit symptoms of severe psychological stress, anxiety, and depression [8]. Adolescence is one of the most critical periods of life during which individuals struggle to establish their identity, and mental disorders that burden individuals more than expected, leading to disability, are common [9]. The literature indicates that individuals and their families in the 12–25 age group, where mental illnesses are most common, cannot adequately access mental health services because of reasons such as stigma, especially in developed and wealthy countries, and that adolescents and their families need such services [10]. Also, it is reported that three-quarters of mental disorders begin by the age of 24. This situation creates a significant burden on parents responsible for adolescent mental health and care. Significant mental symptoms were detected in 37% of parents who presented to child psychiatry services, and it has been reported that these symptoms intensify with the child's age and the duration of the psychiatric disorder [11]. This shows the importance of parental support, especially in early diagnosis and intervention processes. An Australian study also indicated that nearly half (46.5%) of adolescents with mental health problems and their families need help [12]. On the other hand, to reduce the internalized stigma felt by adolescents diagnosed with mental illness and their families, psychosocial interventions should be planned and implemented to facilitate access to treatment for this group [8]. In this respect, mental health literacy is crucial and can be achieved through the development of mental health help-seeking behavior. For both groups of parents, perceived stigmatizing attitudes from the social environment have been shown to negatively impact rates of seeking services for children with mental disorders [8, 13]. Parents' concerns that their children with mental disorders will be stigmatized by society may lead to delays in seeking help. In this context, increased MHL levels may facilitate seeking psychological support by increasing not only individual awareness but also resilience to stigmatization.

The process of seeking psychological support is often complex, exhausting, and multi-stage for parents. Inadequate MHL can cause delays in recognizing psychological problems for parents of children with special needs and those diagnosed with mental illness. Also, personal and environmental factors that make it difficult to seek help shape the process and the impact of service experiences. Parents often consult with multiple professionals, lose time because of a lack of information during referral processes, and struggle to cope with the complexity of service systems [14]. Another factor that affects mental health service-seeking attitudes is cultural characteristics. Attitudes toward seeking psychological support can vary depending on social structure, race, religion, and language, leading to consequences such as stigmatization [15]. A previous study that was conducted with Latino parents found that parents felt more stigmatized and, for this reason, did not seek psychological support [16]. Indeed, parents' mental health literacy affects their decisions to seek child and adolescent mental health services [17]. Doğan et al. (2021) found that, as well as the factors affecting parents' attitudes toward seeking psychological support, increasing their level of mental resilience can positively influence help-seeking behavior [1]. Also, the development of more positive attitudes toward help-seeking may be associated with support and motivation from the social environment [18]. Such studies can provide important information to support parents' mental health and encourage their psychological support-seeking behavior. Consequently, examining mental health literacy and help-seeking attitudes among parents

of children with special needs and those who present to general child and adolescent psychiatry outpatient clinics is crucial for increasing the effectiveness and accessibility of mental health services, as well as implementing parental education programs, strengthening social support mechanisms, and policies to combat stigma. To this end, the following hypotheses were formulated in the present study.

H1: There is no difference between the mental health literacy of parents of children with special needs and parents with a mental diagnosis.

H2: There is no difference between the attitudes of parents of children with special needs towards seeking psychological support and parents with a mental diagnosis.

## Methods

**Type of Research:** The study employed a cross-sectional, correlational design. The data were collected from parents who presented with their children for follow-ups at the Pediatrics and Child and Adolescent Mental Health outpatient clinics of a Training and Research Hospital in eastern Türkiye between May 10, 2025, and July 10, 2025. This hospital has nine pediatric outpatient clinics and two Child and Adolescent Psychiatry outpatient clinics. The working hours were 9:00 am to 5:00 pm, and collaboration with the outpatient physicians was conducted throughout the data collection process. The sample consisted of parents/guardians/caregivers of children admitted to the clinic for routine follow-up between the specified dates. Inclusion criteria for participants were being over 18 years of age, literate, having primary care and healthcare responsibility for at least one year, having provided care for at least six months, and having no mental or psychological illness. The sample size was determined for the analysis planned to test whether there were significant differences between two independent groups. The power analysis was conducted using the One-Tailed Independent Samples T-Test. The analysis was based on a medium effect size (Cohen's  $d = 0.5$ ), a 5% margin of error ( $\alpha = 0.05$ ), and 95% test power ( $1 - \beta = 0.95$ ). Calculations assuming equal distribution between groups (1:1 ratio) found that 98 participants were needed for each group, for a total of 196 participants. The results of the analysis were reported as the noncentrality parameter  $\delta = 3.32$  and the critical  $t$  value = 1.65. With this sample size, the actual power reached was 0.951, indicating that the study was designed with a statistically robust structure. For this reason, the probability of detecting the predicted effect is considered quite high. Reliability analyses were conducted for the Mental Health Literacy Scale (MHLS) and the Attitude Towards Seeking Psychological support Scale-R (ATSPPH-SF-R) used in the study, and internal consistency coefficients (Cronbach's alpha) for both scales were calculated. Based on the analysis results, Cronbach's alpha coefficient was found to be 0.91 for the entire MHLS scale. When evaluated at the sub-dimensions, internal consistency coefficients were obtained as 0.88 for the knowledge-oriented sub-dimension, 0.84 for the belief-oriented sub-dimension, and 0.82 for the resource-oriented sub-dimension. In the analysis regarding the ATSPPH-SF-R scale, the overall reliability coefficient of the scale was calculated as 0.91. When the sub-dimensions were examined separately, Cronbach's alpha was found to be 0.89 for *the positive attitude sub-dimension* and 0.85 for *the negative attitude sub-dimension*.

### Data Collection Tools

A three-part questionnaire was used in the study.

**Descriptive characteristics questionnaire.** The questionnaire containing information on children and parents was created by the researchers with the help of the literature (.....). This form consisted of 15 questions on age, gender, education level, caregiving period, and disease diagnosis.

**Mental Health Literacy Scale (MHLS).** The original form of the MHLS was developed by Jung et al. (2016)[18]. The Turkish validity-reliability study of the scale was performed by Göktaş et al. (2019)[19]. The MHLS consists of 22 items and three sub-dimensions. There are 10 items in the Knowledge-Oriented MHL (MHL-KO) sub-dimension, eight items in the Belief-Oriented MHL (MHL-BO) sub-dimension, and four items in the Source-Oriented MHL (MHL-SO) sub-dimension. The 18 items in the first two sub-dimensions of the scale are six-point Likert-type. The four items in the MHL-KO sub-dimension are answered as “yes” and “no”. In the scale evaluation, one point is not taken from the “I strongly agree”, “I agree”, and “yes” answers given to the items, and no points are taken from the other answers. Items 11, 12, 13, 14, 15, 16, 17, and 18 of the scale are reverse-coded. The total score that can be obtained from the scale varies between 0–22.

### **Attitude Scale Towards Receiving Professional Psychological Support-Short Form (ATSPPH-SF)**

This form was used to evaluate the attitudes of the participants towards receiving psychological support. The original form of the ATSPPH-SF, the “Attitudes Scale Towards Seeking Help from the Expert”, was developed by Fischer and Turner (1970). It is a revised version of the Attitude Scale Towards Receiving Psychological support, which consists of 30 items and four sub-dimensions, adapted by Türküm (1997) [20], which aims to measure attitudes towards receiving psychological support among students. The scale, which was reduced to 18 items after the revision, provides a five-point Likert-type measurement. The psychometric characteristics of the first form show that the scale is a valid and reliable measurement tool. ATSPPH-SF consists of 18 items with a 5-point Likert-type scale. The respondent is asked to read the statements in each item and mark 1 if they do not agree at all, 2 if they agree somewhat, 3 if they are undecided, 4 if they agree a lot, and 5 if they agree completely. The answers are scored in the same order from 1 to 5. Thus, the lowest score a respondent can get from the scale is 18, and the highest score is 90. A high score from the scale indicates a high positive attitude towards psychological support. The results of the factor analysis showed that the scale was collected in two factors. The first factor includes positive views about seeking psychological support, while the second factor includes negative opinions. The increase in the score obtained from the scale indicates that a positive attitude towards receiving professional psychological support is adopted. In the reliability study, the Cronbach’s alpha coefficient for the entire scale was 0.90. The internal consistency coefficients of the scale were found to be  $r = .87$  for positive views on seeking psychological support,  $r = .70$  for negative views on seeking psychological support, and  $r = .81$  for the entire scale. Cronbach’s alpha value was found to be 0.87 for this study.

### **Ethical Aspects of the Research**

Before starting the study, the researchers received approval from the Ethics Committee of the University where they worked (IRB# 2025/2–19), and written consent was obtained from the Provincial Health Directorate (E-68051626-770-269433476, 25.02.2025). Participants in the sample were informed of the purpose of the study, how the results would be used, and how they would benefit. Participants were asked to use pseudonyms rather than names on the data collection forms, and verbal and written consent was obtained, adhering to the principle of voluntary participation in the study. Every stage of the research was conducted following the principles of the Declaration of Helsinki.

**Statistical Analysis of Data:** The data obtained in the research were evaluated using the SPSS 22.0 statistical program. Frequency and percentage analyses were used to determine the descriptive characteristics of the parents, and mean and standard deviation values were used in the analysis of the scales. Kurtosis and Skewness values were examined to determine whether the research variables showed normal distribution (Table 1). In the relevant literature, it is accepted as a normal distribution when results regarding kurtosis-skewness values of variables are between + 1.5 and - 1.5 [21] and + 2.0 and - 2.0 [22]. It was determined that the variables showed normal distribution.

Parametric methods were used in the analysis of the data. The relationships between the dimensions determining the scale levels of the parents were examined through Pearson correlation analyses between + 1.5 and - 1.5 [21] and + 2.0 and - 2.0 [22]. It was determined that the variables showed normal distribution. Parametric methods were used in the analysis of the data. The relationships between the dimensions determining the scale levels of the parents were examined through Pearson correlation analyses. Correlation coefficients (r) were as follows: 0.00–0.25 very weak, 0.26–0.49 weak, 0.50–0.69 moderate, 0.70–0.89 high, and 0.90–1.00 very high [23]. The independent samples t-test was used to examine the differences in the scale levels of the parents according to the groups. Differences between the ratios of categorical variables in independent groups were analyzed using the Chi-Square and Fisher’s Exact Tests. The results were evaluated at a 95% confidence interval and  $p < 0.05$  significance level.

Table 1  
Normal Distribution

<b>Variables</b>	<b>Kurtosis</b>	<b>Skewness</b>
MHLS Total	0.48	-0.35
MHLS – Knowledge-Oriented	0.87	-0.45
MHLS – Faith-oriented	-0.21	0.33
MHLS – Resource Oriented	1.25	-0.89
ATSPPH-SF Total	-0.92	0.41
Positive Attitude	1.12	-0.77
Negative Attitude	-0.68	0.58

## RESULTS

Table 2. Distribution of Descriptive Characteristics of Parents and Children

		Child/Parent with Special Needs		Child/Parent with a Mental Illness Diagnosis		Total		p
		n	%	n	%	n	%	
Parental Gender	Female	91	92.9%	57	58.2%	148	75.5%	X2 =31.894 P =0.000
	Male	7	7.1%	41	41.8%	48	24.5%	
Parent Age	18-25	5	5.1%	8	8.2%	13	6.6%	X2 =9.372 P =0.025
	26-34	29	29.6%	24	24.5%	53	27.0%	
	35-42	54	55.1%	41	41.8%	95	48.5%	
	Above 42	10	10.2%	25	25.5%	35	17.9%	
Parental Education Status	Illiterate	1	1.0%	4	4.1%	5	2.6%	X2 =35.981 P =0.000
	Literate	21	21.4%	3	3.1%	24	12.2%	
	Primary school	27	27.6%	17	17.3%	44	22.4%	
	Moderate school	7	7.1%	30	30.6%	37	18.9%	
	High school	26	26.5%	22	22.4%	48	24.5%	
	University	14	14.3%	22	22.4%	36	18.4%	
	Master's/PhD	2	2.0%	0	0.0%	2	1.0%	
Marital status	Married	82	83.7%	75	76.5%	157	80.1%	X2 =5.786 P =0.055
	Single	5	5.1%	15	15.3%	20	10.2%	
	Widowed/divorced/separated	11	11.2%	8	8.2%	19	9.7%	
Economic Situation	Good	9	9.2%	21	21.4%	30	15.3%	X2 =6.039 P =0.049
	Moderate	77	78.6%	64	65.3%	141	71.9%	
	Poor	12	12.2%	13	13.3%	25	12.8%	
Special Child Age	1-5	30	30.6%	1	1.0%	31	15.8%	X <sup>2</sup> = 80.334 P = 0.000
	6-10	27	27.6%	31	31.6%	58	29.6%	
	11-15	12	12.2%	47	48.0%	59	30.1%	
	16-20	5	5.1%	19	19.4%	24	12.2%	
	21-25	24	24.5%	0	0.0%	24	12.2%	
Child's Gender	Female	36	36.7%	50	51.0%	86	43.9%	X2 =4.061 P =0.031
	Male	62	63.3%	48	49.0%	110	56.1%	
Children's Hospitalization	Yes	21	21.4%	14	14.3%	35	17.9%	X2 =1.704 P =0.131
	No	77	78.6%	84	85.7%	161	82.1%	

Individual Receiving Care in the Family	Yes	11	11.2%	12	12.2%	23	11.7%	X <sup>2</sup> =0.049 P =0.500
	No	87	88.8%	86	87.8%	173	88.3%	
Caregiver's Care Duration (in years)	1-3 Years	19	19.4%	21	21.4%	40	20.4%	X <sup>2</sup> =1.129 P =0.569
	4-10 Years	36	36.7%	29	29.6%	65	33.2%	
	10 Years and Above	43	43.9%	48	49.0%	91	46.4%	
Status of receiving support in care	Yes	58	59.2%	73	74.5%	131	66.8%	X <sup>2</sup> =5.179 P = <b>0.017</b>
	No	40	40.8%	25	25.5%	65	33.2%	
Status of Receiving Training in Care	Yes	39	39.8%	20	20.4%	59	30.1%	X <sup>2</sup> =8.754 P = <b>0.002</b>
	No	59	60.2%	78	79.6%	137	69.9%	
Presence of a Physical Illness Diagnosis	Yes	37	37.8%	22	22.4%	59	30.1%	X <sup>2</sup> =5.456 P = <b>0.014</b>
	No	61	62.2%	76	77.6%	137	69.9%	
Interest in Psychological Matters	Yes	58	59.2%	64	65.3%	122	62.2%	X <sup>2</sup> =0.782 P =0.231
	No	40	40.8%	34	34.7%	74	37.8%	

#### Chi-Square Analysis

The results regarding the descriptive characteristics of children and parents are presented in Table 2. A significant difference was found between the groups in terms of gender and age of the children ( $p < 0.001$ ). When the descriptive characteristics of the participating parents were examined by groups, a significant difference was observed in the gender variable ( $X^2=31.894$ ;  $p=0.000$ ). While 92.9% of the parents of children with special needs were female, the proportion of women in the group of parents of children with mental illness was 58.2%. A significant difference was found between the groups in terms of **age** distribution ( $X^2=9.372$ ;  $p=0.025$ ). The majority of the parents of children with special needs were in the 35–42 age group, while the proportion of those with mental illness was 58.2%. In the group of parents with children, the age distribution is more balanced. A statistically significant difference was also found between the two groups in terms of educational status ( $X^2=35.981$ ;  $p=0.000$ ). The proportion of illiterate and low-educated parents among parents of children with special needs is higher. The difference between the groups in the marital status variable is borderline significant ( $X^2=5.786$ ;  $p=0.055$ ). When evaluated in terms of economic status, a significant difference was observed ( $X^2=6.039$ ;  $p=0.049$ ); the proportion of parents who

come to the child and adolescent outpatient clinic who perceive the economic status as “good” is higher. A quite significant difference was found between the groups in the variable of the age of the special child ( $X^2=80.334$ ;  $p=0.000$ ). The proportion of caregivers of children between the ages of 1-5 and 21-25 is relatively higher among parents of children with special needs. There was a significant difference between the two groups in terms of the child's gender ( $X^2=4.061$ ;  $p=0.031$ ), and the proportion of boys was higher in the group with special needs. No significant differences were found between the groups in variables such as the child's hospitalization status, the presence of another family member receiving care, and the duration of care ( $p>0.05$ ). However, significant differences were observed in variables such as receiving support in child care ( $X^2=5.179$ ;  $p=0.017$ ) and receiving care training ( $X^2=8.754$ ;  $p=0.002$ ). While the rate of receiving support in care for mentally-diagnosed patients was higher in the group of parents with children, the rate of receiving training in care was higher among parents of children with special needs. Also, a statistically significant difference was found between the groups in terms of whether the individual had a physical illness diagnosis ( $X^2=5.456$ ;  $p=0.014$ ) and the presence of someone with a mental health diagnosis in their

immediate circle ( $X^2=6.039$ ;  $p=0.010$ ). The results indicate that the two parent groups have different characteristics regarding demographics and caregiving experiences.

Table 3. Correlation Analysis Between Parents' Mental Health Literacy and Attitude Scale Scores Towards Seeking Psychological support

		Parents of Children with Special Needs				Parents with a child diagnosed with a mental illness			
		MHLS Total	MHLS Information-Oriented	MHLS Faith-Based	MHLS Resource Oriented	MHLS Total	MHLS Information-Oriented	MHLS Faith-Based	MHLS Resource Oriented
<b>ATSPPH-SF Total</b>	r	0.379**	0.311**	0.236*	0.137	0.328**	0.095	0.407**	0.013
	p	0.000	0.002	0.019	0.178	0.001	0.354	0.000	0.896
<b>Positive Attitude</b>	r	0.382**	0.297**	0.240*	0.164	0.322**	0.188	0.281**	0.042
	p	0.000	0.003	0.017	0.107	0.001	0.064	0.005	0.680
<b>Negative Attitude</b>	r	0.280**	0.277**	0.167	0.026	0.228*	-0.051	0.427**	-0.026
	p	0.005	0.006	0.100	0.798	0.024	0.621	0.000	0.798

\* $<0.05$ ; \*\* $<0.01$ ; Pearson Correlation Analysis

Table 3 shows the relationships between the scores of the Mental Health Literacy Scale (MHLS) and the Attitude Towards Seeking Psychological support Scale, their distributions at the sub-dimensions, and by parent groups. In parents of children with special needs, positive and significant relationships were detected between the MHLS total score and the ATSPPH-SF total score ( $r=0.379$ ;  $p<0.01$ ), and the positive attitude sub-dimension ( $r=0.382$ ;  $p<0.01$ ). The knowledge-oriented sub-dimension was also significantly correlated with both the total attitude ( $r=0.311$ ;  $p<0.01$ ) and the positive attitude ( $r=0.297$ ;  $p<0.01$ ). The belief-oriented sub-dimension showed low-level significant relationships with the ATSPPH-SF total score ( $r=0.236$ ;  $p<0.05$ ) and the positive attitude ( $r=0.240$ ;  $p<0.05$ ). However, the resource-oriented MHLS sub-dimension did not have a significant relationship with any ATSPPH-SF component ( $p>0.05$ ).

In parents of children with a mental health diagnosis, a similar tendency was observed. Significant correlations were detected between the MHLS total score and the ATSPPH-SF total ( $r=0.328$ ;  $p<0.01$ ) and positive attitude ( $r=0.322$ ;  $p<0.01$ ) scores. It is noteworthy that the belief-oriented sub-dimension in this group showed significant and positive correlations with both total attitude ( $r=0.407$ ;  $p<0.01$ ) and positive attitude ( $r=0.281$ ;  $p<0.01$ ). In contrast, the knowledge-oriented sub-dimension was only marginally significant with positive attitude ( $r=0.188$ ;  $p=0.064$ ), and the resource-oriented sub-dimension did not show a significant correlation with any of the attitude components in this group ( $p>0.05$ ). A positive and significant correlation was found between the negative attitude sub-dimension and the MHLS total ( $r=0.280$ ;  $p<0.01$ ) and the knowledge-oriented sub-dimension ( $r=0.277$ ;  $p<0.01$ ) in parents of children with special needs. In the group of parents of children with a mental health diagnosis, the highest correlation was observed with the belief-oriented sub-dimension ( $r=0.427$ ;  $p<0.01$ ). However, notably, the resource-oriented sub-dimension did not correlate with negative attitudes in either group.

Table 4. Differentiation of MHLS and ATSPPH-SF Scores by Groups

Groups	Parents of Children with Special Needs (n=98)		Parents with a child diagnosed with a mental health condition (n=98)		t	SD	p	d
	Mean	SD	Mean	SS				
MHLS Total	12.969	3.873	12.561	2.640	0.862	194	0.390	0.123
MHLS Information-Oriented	7.439	2.454	7.276	1.757	0.535	194	0.593	0.077
MHLS Faith-Based	2.684	2.204	2.990	1.684	-1.093	194	0.276	0.156
MHLS Resource Oriented	2.847	1.342	2.296	1.096	3.149	194	<b>0.002</b>	0.450
ATSPPH-SF Total	56.776	14.980	61.551	5.644	-2.953	194	<b>0.004</b>	0.422
Positive Attitude	41.520	11.898	43.265	3.643	-1.388	194	0.168	0.198
Negative Attitude	15.255	4.052	18.286	2.985	-5.962	194	<b>0.000</b>	0.852

Independent Groups T-Test; t, p: Significance. DF: Degrees of Freedom; Cohen(d): Effect Size

Table 4 shows the differences in MHLS and ATSPPH-SF scores by groups. No significant differences were detected between parents of children with special needs ( $12.97 \pm 3.87$ ) and parents of children with a mental health diagnosis ( $12.56 \pm 2.64$ ) in terms of the total MHLS score ( $t=0.862$ ;  $p=0.390$ ;  $d=0.123$ ). Similarly, no significant difference was detected between the groups in the knowledge-oriented ( $t=0.535$ ;  $p=0.593$ ;  $d=0.077$ ) and belief-oriented ( $t=-1.093$ ;  $p=0.276$ ;  $d=0.156$ ) sub-dimension scores. However, the resource-oriented MHLS score was found to be significantly higher in parents of children with special needs ( $2.85 \pm 2.30$ ;  $t=3.149$ ;  $p=0.002$ ). The effect size of this difference was moderate ( $d=0.450$ ), suggesting that parents of children with special needs may have a higher awareness of accessing psychological support resources. The ATSPPH-S F total score was found to be significantly higher in parents who came to the child-adolescent outpatient clinic ( $61.55 \pm 56.78$ ;  $t=-2.953$ ;  $p=0.004$ ;  $d=0.422$ ). This result indicates that their attitudes towards seeking psychological support were generally more positive. While there was no significant difference between the groups in terms of the positive attitude sub-dimension ( $t=-1.388$ ;  $p=0.168$ ;  $d=0.198$ ), the negative attitude score was found to be significantly higher in parents who came to the child-adolescent outpatient clinic ( $18.29 \pm 15.26$ ;  $t=-5.962$ ;  $p=0.000$ ). The effect size of this difference was quite high ( $d=0.852$ ), indicating that the statistical difference is also significant in practice.

## DISCUSSION

Mental health is an integral component of health and well-being, as the foundation of our individual and collective abilities to make decisions, form relationships, and shape the world we live in. It is also one of the most fundamental human rights, vital for personal, social, and socioeconomic development [24]. Lack of knowledge about mental illnesses and low mental health literacy can lead to failure to seek help for mental health problems, underutilization of health services, lack of treatment, and social exclusion [25]. The development of more positive attitudes toward seeking help for mental health problems is associated with support and motivation from the environment, as opposed to social exclusion [18]. In light of this, caring for children with special needs and those diagnosed with mental illness is a process that requires patience, understanding, and dedication. Supporting these children, providing care appropriate to their needs, and contributing to their healthy development requires parents to use the MHLS along

with the ATSPPH-SF. For this reason, this study makes significant contributions to understanding the relationship between Mental Health Literacy (MHLS) and Attitudes Toward Seeking Psychological support (ATSPPH-SF). Overall mental health literacy levels were moderate in both groups based on the scale score range, while the difference was high in the resource-oriented approach among parents of children with special needs. The result that the knowledge- and belief-oriented MHLS sub-dimensions were positively correlated with help-seeking tendencies in both parent groups is consistent with the existing literature. In a previous study, Yap et al. (2011) reported that the knowledge- and belief-oriented dimensions predicted help-seeking behaviors, particularly in young parents. In this study, the significant correlation between the knowledge-oriented MHLS scores and the positive attitude sub-dimension of the ATSPPH-SF in parents of children with special needs suggests that these parents internalize psychological support more [26]. This result suggests that knowledge-based decision-making processes may be more prevalent in families with children with special needs. A previous study conducted by Whitaker et al. (2008) reported that the psychological support-seeking behaviors of parents of children with disabilities were strongly influenced by their knowledge level [27]. Additionally, studies have reported that as parents' education and knowledge levels increase, they develop a more positive attitude toward mental illness and that help-seeking behavior is positively affected [28]. However, the fact that the source-oriented knowledge level of the same group did not show a significant relationship with any ATSPPH-SF sub-dimension suggests that access to information may have a limited impact on the attitude development process. This suggests that not only access to information but also its reliability, relevance, and relevance to individual belief systems are important [29].

It is noteworthy that among parents presenting to the child and adolescent psychiatry outpatient clinic, the belief-based MHLS scores showed a strong correlation with both total and positive attitude scores. This suggests that individuals' personal acceptance and normative values regarding mental health are among the determining factors shaping help-seeking behavior. Rickwood et al. (2005) supported such results by suggesting that an individual's beliefs about psychological problems play a motivational role in the decision to seek help [30]. Especially in contexts where stigma towards mental problems is widespread in society, the facilitating effect of faith-based literacy on this process becomes even more important, as help-seeking behavior may conflict with an individual's belief system. The results regarding the negative attitude sub-dimensions paint a more complex picture. Although the positive correlation found between the MHLS and negative attitudes in both groups may seem contradictory on the surface, this can be interpreted as suggesting that individuals with high MHLS are more aware of mental health, leading them to express their negative feelings more openly. Yardley et al. (2015) also discussed this similarly, noting that individuals with high mental health awareness may develop critical attitudes based on systemic inadequacies or previous negative experiences [31]. Overall, the results suggest that mental health literacy is a multidimensional construct encompassing not only knowledge but also beliefs and emotional acceptance, and that these constructs exert selective effects on psychological support-seeking behavior. From a clinical perspective, it is crucial to develop psychoeducation programs that not only inform individuals but also foster positive attitudes toward the process of seeking psychological support. Also, the ineffectiveness of the resource-oriented sub-dimension suggests that simply having access to service systems is not sufficient; how individuals perceive, evaluate, and experience these systems must also be considered. At the societal level, cultural interventions aimed at reducing stigmatization, as well as providing information, are necessary to transform attitudes toward help-seeking.

The results in Table 4 include a comparison of two parent groups in terms of mental health literacy (MHLS) and attitudes toward seeking psychological support (ATSPPH-SF). The lack of significant difference in MHLS scores between the two groups supports the "disconnect between access to information and attitudes," frequently emphasized in the literature. A previous study conducted by Kaur, Verma, and Ghildiyal (2021) also reported that a significant portion of parents were knowledgeable about their children's mental health problems but still hesitated to seek help [32]. Similarly, a previous study conducted by Ebrahimi et al. (2019) found that although parents had

positive attitudes toward children's mental health, only 56.25% preferred formal help sources [28]. This suggests that knowledge alone may not be sufficient to motivate help-seeking behavior. It is reported that negative beliefs and attitudes about mental illnesses lead to stigmatization and discrimination of individuals with mental illness [33]. Doğan et al. (2021) reported a significant positive correlation between parents' MHL levels and their positive attitudes toward seeking psychological support [1]. The same study also found that perceived stigma from the environment was a mediating factor negatively affecting this relationship.

However, it is noteworthy that the resource-oriented sub-dimension scores were significantly higher among parents of children with special needs, which suggests that this group of parents has a greater awareness of mental support systems and resources because of their long-term caregiving experiences. As well as awareness of long-term caregiving processes, Hurley et al.'s (2019) systematic review reported that having a family member with a mental health diagnosis was associated with greater mental health information seeking and increased mental health literacy [34]. Parmar (2014) reported that the ongoing provision of multidisciplinary counseling services for parents of children with special needs increases resource awareness in this group [35]. In this context, it is natural that parents of children with special needs have more advanced knowledge and experience in this area because of their greater contact with social services, special education institutions, and the healthcare system.

The higher total ATSPPH-SF scores in the group of parents with a mental health diagnosis suggest that this group has a more positive overall attitude toward seeking psychological support. However, the significantly higher negative attitude scores in the same group (with a high effect size of  $d = 0.852$ ) suggest that there might be significant ambivalence underlying these positive attitudes. Kaur et al. (2021) reported that approximately 46% of parents did not want their children to receive a psychiatric diagnosis, and 35% found seeing a psychiatrist stigmatizing, which suggests that positive attitudes toward seeking external help may be weakened by fear of stigma, cultural beliefs, or past experiences [32]. Another particularly striking result was the lack of a significant difference in positive attitude scores between the two groups, which shows that the variables affecting help-seeking behavior cannot be explained solely by knowledge or access, and that personal, cultural, and experiential factors may be more decisive in this process. Cottrell et al.'s (1988) study conducted on parents who did not attend child psychiatry clinic appointments revealed that the parents' attitude towards psychiatric referral constituted a significant obstacle to children's access to services [36]. As in many other areas, education plays an important role in improving mental health literacy levels.

## Conclusion

Based on the results of this study, no significant differences were detected between the two parent groups in terms of mental health literacy levels; however, a significant difference was found in parents of children with special needs in terms of resource-oriented knowledge regarding access to resources. The results of the present study showed the importance of awareness-raising efforts to prevent negative attitudes toward seeking psychological help and to encourage its use. By emphasizing that psychological help is a healthcare service and that everyone faces difficult times in their lives, negative perceptions about seeking help must be challenged and support must be encouraged. For this reason, it is important to provide counseling and support to parents of children with a mental diagnosis to develop both the resource-seeking dimension of the MHLS and the positive attitude toward seeking psychological support. The results suggest that individuals' knowledge and beliefs about mental health influence their propensity to seek psychological support, but knowledge about access to resources is not a determining factor in this process. They suggest that not only knowledge but also attitudes and awareness of resources should be targeted in the process of seeking psychological support for parents of children with special needs, particularly those with a mental diagnosis. For this reason, this study should be conducted on many issues for both groups of parents, and training and new strategies should be developed to improve the level of mental health literacy.

## Implications for practice

Nurses must consider the sensitivities of both parent groups when developing care plans for children and adopt a holistic approach to support their physical and psychosocial well-being. Establishing a therapeutic relationship with parents from both groups and assessing stress factors and coping resources is an important part of nursing care. Nurses must also identify parents in need of psychological support by fulfilling their roles of counseling, education, care, and guidance, and should work to protect and improve their mental health. Increasing parents' mental health literacy will contribute to the positive development of their attitudes toward seeking psychological support. This demonstrates that individual and structural barriers can be overcome through public awareness efforts. The present study is the only comparative research conducted with a selected sample in our country in the literature and is of significant value for its contribution to practice. Providing the information and resources needed by both parent groups is crucial.

## Strengths and limitations

The study had several limitations that must be noted. Firstly, most of the participants were female. While mothers are often the primary caregivers of children in most traditional cultures, the limited number of fathers and other caregivers might affect the reliability of the statistical analysis. Secondly, the results have limited generalizability because the data were collected from only one hospital. Thirdly, the use of a self-assessment questionnaire with a large number of questions affected the accuracy with which participants answered all questions correctly. Another limitation was the use of nonprobability sampling, which made it impossible to randomly select study participants. However, this sampling method facilitated data collection and allowed us to include a larger number of participants. No distinction was made between the parents included in the study, whether they had a mental health diagnosis or a child with special needs. The strength of the study was that it is the first time that two different groups with different sensitive characteristics have been studied in a comparative and simultaneous manner, demonstrating the power, scientific value, and originality of this study.

## Declarations

### *Declaration of Conflicting Interests*

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

**Ethical Aspects of the Study:** Before starting the study, the researchers received approval from the Ethics Committee of the University where they worked (IRB# 2025/2-19), and written consent was obtained from the Provincial Health Directorate (E-68051626-770-269433476, 25.02.2025). Participants in the sample were informed of the purpose of the study, how the results would be used, and how they would benefit. Participants were asked to use pseudonyms rather than names on the data collection forms, and verbal and written consent was obtained, adhering to the principle of voluntary participation in the study. Every stage of the research was conducted following the principles of the Declaration of Helsinki.

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Author Contributions Percentage of work each researcher has contributed to the study.

## Data availability statement

The data that support the results of this study are available on request from the corresponding author. The data are not publicly available because of privacy or ethical restrictions.

## Consent for publication

Not applicable.

## Competing interests

The authors declare no competing interests.

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