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When the gatekeeper is also unwell: Parental mental health problems and mental health service use among children with psychiatric diagnoses

Hoon Jang

hoonjang@korea.ac.kr

Korea University

Research Article

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Abstract

When a parent has mental health problems, does the child's use of mental health services rise or fall? Two accounts make opposite predictions: a double-burden account, in which parental symptoms deplete the capacity to seek care for the child, and a gateway account, in which the parent's own experience of distress makes the child's need easier to recognize and act on. We adjudicated between them using the 2022 Korean National Mental Health Survey of Children and Adolescents, a nationally representative survey of 6,275 parent-child dyads in which caregivers completed standard depression and anxiety screens and each child's diagnostic status was established by structured interview, independently of parental report. Among 426 children with a current psychiatric diagnosis, lifetime service use was higher, not lower, when the parent was also affected: 30.6% versus 16.1% (adjusted odds ratio 2.21, 95% confidence interval [1.15,4.22]), a difference that held despite greater socioeconomic disadvantage in the both-affected group. Part of the association was carried by the parent's perceived need for the child's care (+ 7.6 percentage points, 95% CI [3.3, 14.0]); the direct component was not statistically significant. Yet 69.4% of children in the both-affected group had never used services, and their parents were distinguished not by greater stigma but by the expectation that the problem would resolve without help (71.2% versus 48.3%). Adult mental health services are an underused entry point to children who need care; reaching these families requires addressing minimization, not only awareness.

Introduction

Most children and adolescents who meet criteria for a psychiatric disorder receive no treatment for it. A meta-analysis of adolescent samples put the pooled prevalence of unmet need at 54% (Ghafari et al., 2022); roughly a third of US adolescents meeting criteria received treatment (Merikangas et al., 2011), and the shortfall persists in the most recent national estimates (Burnett et al., 2026). Korean evidence is sparser and points the same way: in a community sample of children aged 9 to 12, parents perceived a need for mental health services for 11.4% of the children, while 2.7% had used them (Cho et al., 2007). Most of the burden of child psychiatric disorder therefore falls on families who never reach a service, so any account of why children do or do not receive care has to begin outside the clinic, with the people who decide on behalf.

Those people are parents. Children rarely refer themselves; they are brought, or they are not, by an adult who must first notice that something is wrong, then judge that it warrants help, and then act (Sayal, 2006). The empirical literature locates the decisive steps at the first two, in the parent's recognition of a problem and the parent's judgement that services are needed (Flisher et al., 1997; Zwaanswijk et al., 2007). The parent is, in the ordinary sense of the word, a gatekeeper, the role that models of youth service access formalize as the gateway provider (Stiffman et al., 2004). At the same time, parents are adults with mental health of their own. Depressive and anxiety disorders are common among Korean adults (Rim et al., 2023), and children of affected parents face elevated psychiatric risk (Goodman et al., 2011). The two facts together define the situation this study examines: a gatekeeper who is not well, deciding on behalf of a child who may not be well either.

Literature review and the present study

Two competing accounts

What happens at that gate is contested, and the literature makes two predictions that point in opposite directions. The first, which we call the double-burden account, holds that parental mental health problems consume the resources a parent would otherwise devote to a child's care. Caregiving burden is measurable (Brannan et al., 1997), and parental psychological distress is associated with poorer executive functioning (Nordenswan et al., 2021). On this account a symptomatic parent should be less likely to recognize a child's difficulty, to act on it, and to sustain contact with a service; parental cognitions and parental mental health have both been linked to weaker engagement in community child services (Haine-Schlagel et al., 2019; Morrissey-Kane & Prinz, 1999).

The second, which we call the gateway account, draws on the literature on mental health literacy and experiential knowledge. A parent who has felt symptoms, named them, and perhaps sought help has a working vocabulary for distress; such a parent may recognize similar difficulty in a child sooner and regard professional help as ordinary rather than alarming (Jorm, 2000; Maddox et al., 2025). On this account the same parent should be more likely, not less, to bring a child to care. Both accounts have supporting literature, and a recent review finds the evidence mixed (Engelhard et al., 2022). They share a premise: the parent's condition matters for whether the child reaches care. They part company only on the sign, which makes the disagreement tractable. It is an empirical question about direction, answerable in principle by a single well-designed comparison, and it has not been answered.

Evidence from the prior studies

The studies that come closest have each been built to answer a different question. Williams et al. (2011) followed 108 parent-adolescent pairs already attending community outpatient care; when parent and adolescent agreed that help was needed, more appointments were kept. The study measured both perceived need and actual attendance, but its sample had already crossed into care, and it did not measure the parents' own mental health. Schnyder et al. (2020) mapped, in 2,310 Australian adolescents and parents, how the two disagree about need and barriers to care, but did not model service use as an outcome or measure parental symptoms. Caregivers' ADHD treatment preferences for children at the point of diagnosis or already in care were elicited by dosReis et al. (2017). Pfefferle and Spitznagel (2009) came closest: in nationally representative US data they measured mothers' own mental health alongside their children's service use, and traced a path running through parenting aggravation to *more* service use rather than less. The mediator was a burden construct, the very mechanism double-burden invokes. That was an early signal against the barrier prediction, but the design could not separate the signal from how it was generated: child behavior, service use, and maternal mental health were all reported by the mother, so a mother whose distress sharpens her appraisal of her child registers on all three at once. Establishing the child's diagnosis independently, by structured interview, is what lets the

two accounts be told apart. But across these studies, the three quantities needed to set the two accounts against each other were never measured together in one sample: the parent's own mental health, the child's diagnostic status established by structured interview, and whether the child had in fact used services.

This leaves the questions the field has circled without answering. When the gatekeeper is also affected, does parental mental health open the gate to children's services, or close it? If the gate opens, is the pathway the parent's recognition of need, as the gateway account implies, or something else? And once it has opened, what still stands in the way, given that opening a gate is not the same as walking through it?

The present study

To adjudicate the first question and make progress on the others, a single dataset must satisfy five conditions at once: a standard measure of the parent's own mental health; the child's diagnostic status established by structured interview rather than symptom checklist or parent report; the child's service use; the parent's perceived need for care; and, for non-users, the reasons given. To our knowledge, the 2022 Korean National Mental Health Survey of Children and Adolescents is the only nationally representative parent-child dyadic survey in Korea that meets all five. Each child was paired with a caregiver who completed depression and anxiety screening instruments in the same interview in which the child's diagnostic assessment was conducted. That pairing allows the two accounts to be tested on a common footing: among children who meet diagnostic criteria, we can compare service use between those whose parent is symptomatic and those whose parent is not.

We pursued five research questions. First, among children with a current psychiatric diagnosis, is lifetime service use higher or lower when the parent also reports mental health problems? This is the adjudication. Second, is any such difference carried by the parent's perceived need for the child's care? This is the mechanism question. Third, does the child's probability of diagnosis rise with the parent's symptom score in a graded fashion? This is the clinical background for reading the first two answers. Fourth, among both-affected families whose child has not used services, which barriers do parents report, and do they differ from those reported in child-only families? Finally, does the pattern in the first question hold under a clinical parental threshold, and when stratified by responding caregiver and child age band?

Methods

Data source

This study is a secondary analysis of de-identified microdata from the 2022 Korean National Mental Health Survey of Children and Adolescents, a nationally representative, government-approved survey of the child and adolescent population of the Republic of Korea (Kim et al., 2025). The survey employed a

stratified cluster sample, with households drawn within strata defined by region and residential type, and paired each child with the caregiver who knew the child best so that the two could be linked at the dyad level. In the same interview, the caregiver reported on their own recent mood and anxiety symptoms while the child's diagnostic assessment was completed. The microdata are not publicly redistributable; we obtained them from the data-providing agency through its standard application procedure, and analysis code is available from the corresponding author on request.

The analytic sample comprised 6,275 parent-child dyads aged 6 to 17 years. Of the survey's two weight variables we applied the standardized weight throughout, which preserves the achieved sample size and keeps model-based standard errors interpretable; the population weight is appropriate only for population totals, which we do not report.

Two features of the survey shaped what we could estimate. Caregiver symptom measures were administered to every respondent, so no dyad was lost on the exposure. The service-use items, however, were presented only to caregivers who reported that the child had ever experienced a mental health problem; we describe our treatment of that skip pattern in the Measure section.

Study design: a four-group framework

Our design turns the two competing predictions into a comparison between groups that share the child's diagnostic status and differ in the parent's. Crossing parental mental health problem status with the child's current diagnostic status defines four groups: neither affected (Group A, n = 5,485), child only (Group B, n = 341), parent only (Group C, n = 364), and both affected (Group D, n = 85).

The adjudication rests on Group B versus Group D. Both contain children who meet criteria for a current disorder; they differ in whether the parent is also affected. Double-burden anticipates lower service use in Group D; gateway anticipates higher. Groups A and C contribute to the background analysis described in the Statistical analysis section and reported in the Results section, but not to this comparison.

Measures

Parental mental health

Caregivers completed the nine-item Patient Health Questionnaire (PHQ-9) and the seven-item Generalized Anxiety Disorder scale (GAD-7), each item scored 0 to 3 over the preceding two weeks (Kroenke et al., 2001; Spitzer et al., 2006). Korean versions of both instruments show adequate internal consistency and convergent validity (Kim et al., 2023; S.-H. Lee et al., 2022). In Korean validation samples assessed against structured diagnostic interviews, a threshold of 5 was the optimal cut-off for the PHQ-9 against major depression (Kim et al., 2023) and for the GAD-7 against any anxiety disorder (Ahn et al., 2019). We defined a parental mental health problem as a PHQ-9 or GAD-7 total of 5 or above, a symptom-severity threshold conventionally read as mild or greater rather than a diagnostic

classification; this yielded 449 caregivers (7.2%). For sensitivity analysis we applied the clinical threshold of 10 or above on either scale (63 caregivers, 1.0%). Item-level data were complete for both scales.

Child psychiatric diagnosis

Child diagnostic status came from the computerized Korean version of the Kiddie Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS-COMP), a structured diagnostic interview (J. Lee et al., 2023; Townsend et al., 2020). We used the aggregate any-current-disorder indicator supplied by the survey agency, the validated composite released with the data, rather than constructing our own from the individual disorder flags; the two do not coincide, as summing individual diagnoses returns a larger count. On this definition, 426 children (6.8%) met criteria for a current disorder.

Mental health service use

Our outcome was lifetime use of any mental health service; a child was classified as a user if either the caregiver-reported or the adolescent-reported items indicated any lifetime contact with a mental health professional. Because these items were conditional on a reported history of mental health problems, non-response was set to no use. The assumption is conservative: it can only understate use, does so in both comparison groups alike, and therefore does not inflate the contrast between them; we return to it in the Limitations.

We report lifetime rather than past-year use because the gateway question concerns whether a family ever crossed the threshold into care. Past-year use in the diagnosed group was 6.6%, too sparse for the subgroup analyses reported below.

Parental perceived need

Perceived need was measured by a single caregiver item asking whether the caregiver considered that the child needed professional help for a mental or behavioral problem; unlike the service-use items, this question was presented to every respondent regardless of reported problem history, and it had no missing data.

Reported barriers to care

The survey presented fourteen reasons for not using services to every caregiver, with no skip pattern; caregivers indicated which applied, and our analysis uses the responses of non-users. We grouped the reasons into four domains defined a priori: structural constraints such as cost, distance, and time; stigma and disclosure concerns; doubts about service quality or effectiveness; and minimization of the problem. A domain was scored positive if any constituent item was endorsed. Three items are reported separately because they carry distinct meaning: the expectation that the problem would resolve without help, the judgement that it was not severe enough, and concern about a medical record.

Covariates

Adjusted models included child age, child sex, family structure (intact, defined as parents in a first marriage, versus other), household income tertile, highest parental education, and age band; the same set entered every adjusted specification reported below, so that estimates across research questions remain comparable. Child sex was recorded as sex assigned at birth. Non-response on the family-structure item (n = 65) was classified as non-intact.

Statistical analysis

For the primary comparison we contrasted service use in Groups B and D using Fisher's exact test, then fitted a survey-weighted logistic regression adjusting for the covariates listed above. The odds ratio from Fisher's exact test is a conditional maximum likelihood estimate rather than the sample odds ratio, and we report it as such.

We then asked whether parental perceived need accounts for the group difference, estimating a mediation model with parental mental health problem as the exposure, perceived need as the mediator, and lifetime service use as the outcome, with the same covariates. Effects were decomposed into average causal mediation, average direct, and total components using nonparametric bootstrap with 1,000 resamples (Imai et al., 2010; Tingley et al., 2014), expressed on the probability scale in percentage points. One asymmetry deserves statement: the primary comparison is survey-weighted and the mediation model is not, because the estimation routine does not accept complex survey design objects. We treat the mediation results as describing the analytic sample rather than the population and revisit this in the Limitations.

For the background analysis we tabulated child diagnosis rates across bands of parental symptom severity and fitted survey-weighted logistic regressions estimating the odds of a current child diagnosis per one-point increase on each scale. Groups B and D were compared on sample characteristics using Welch's t test for age and Fisher's exact test for proportions. Barriers among non-users were compared with chi-square or Fisher's exact tests as cell sizes required; these seven comparisons were exploratory, and we report unadjusted p values while noting which differences survive Holm adjustment. We repeated the primary comparison under the clinical symptom threshold and stratified it by responding caregiver and age band; these analyses involve small cells and establish direction rather than magnitude.

Effect estimates are presented with 95% confidence intervals, p-values to three decimal places with a leading zero ($p < 0.001$ below that). Analyses were conducted in R 4.5.2 with a fixed random seed.

Results

Sample characteristics

Table 1 describes the sample. Of 6,275 children, 426 met criteria for a current psychiatric disorder, and 449 caregivers reported symptoms at or above the screening threshold (63 at the clinical threshold).

Crossing the two indicators gives 5,485 in Group A, 341 in Group B, 364 in Group C, and 85 in Group D. Among children with a diagnosis, 19.0% had ever used mental health services.

Table 1
Sample characteristics

Characteristic	Full sample (*n* = 6,275)	Diagnosed children (*n* = 426)	Group B: child only (*n* = 341)	Group D: both affected (*n* = 85)	*p*-value (B vs D)
Child age, years, mean (SD)	11.8 (3.6)	13.0 (3.5)	12.9 (3.5)	13.2 (3.5)	0.571
Female, %	51.5	40.8	40.2	43.5	0.622
Adolescent (12–17 years), %	53.9	70.0	68.6	75.3	0.290
Urban residence, %	80.2	79.1	78.0	83.5	-
Intact two-parent household, %	87.6	85.2	87.7	75.3	0.006
Household income					
Lowest tertile, %	33.3	35.0	30.2	54.1	< 0.001
Middle tertile, %	33.3	31.9	33.1	27.1	-
Highest tertile, %	33.3	33.1	36.7	18.8	-
Parental education ≥ tertiary, %	75.7	66.4	67.7	61.2	0.251
Mother respondent, %	86.9	86.9	86.2	89.4	-
Parental PHQ-9, mean (SD)	1.39 (2.05)	2.66 (2.91)	1.52 (1.23)	7.22 (3.20)	-
Parental GAD-7, mean (SD)	0.97 (1.57)	2.00 (2.46)	1.12 (1.11)	5.55 (3.10)	-

Note. Parental mental health problem: PHQ-9 ≥ 5 or GAD-7 ≥ 5. B vs D: Welch's t test (age), Fisher's exact test (proportions).

Children with a diagnosis were older, more often adolescents, and more often boys than the sample as a whole, and their caregivers reported higher symptom levels (Table 1). Within the diagnosed sample, Groups B and D did not differ in child age, sex, adolescent proportion, or parental education; caregiver symptom scores separated sharply, as the group definitions imply (Table 1).

Two socioeconomic contrasts did distinguish the groups, and both ran against Group D: its families fell more often in the lowest household income tertile (54.1% against 30.2%, p < 0.001) and were less often intact two-parent households (75.3% against 87.7%, p = 0.006). Socioeconomic disadvantage is ordinarily associated with lower rather than higher service use, so the comparison that follows runs against the direction these differences would predict. The adjusted model in the next section controls for both.

Service use among diagnosed children, by parental mental health status

Among diagnosed children, lifetime service use was 16.1% in Group B, where only the child was affected (55 of 341), against 30.6% in Group D, where the parent was also affected (26 of 85). Figure 1 displays both proportions with confidence intervals.

The difference ran opposite to the double-burden prediction. Parental mental health problems were associated with roughly twice the odds of the child having used services (OR = 2.29, 95% CI [1.27, 4.06], $p = 0.005$), and adjustment left the estimate essentially unchanged (adjusted OR = 2.21, 95% CI [1.15, 4.22], $p = 0.017$; Table 2). The confidence intervals are wide, as the size of Group D implies, but both exclude the null and neither approaches the region below one that double-burden would require.

Table 2
Parental mental health problems and children's lifetime service use ($n = 426$)

Model	Odds ratio	95% CI	p-value
Unadjusted (Fisher's exact test)	2.29	[1.27, 4.06]	0.005
Adjusted (survey-weighted logistic regression)	2.21	[1.15, 4.22]	0.017
Note. Reference: Group B (child only)			

A second contrast pointed toward the pathway examined in Section 4.3: 41.2% of parents in Group D reported that their child needed professional help, against 14.1% in Group B. The gap in perceived need was proportionally larger than the gap in service use itself.

Perceived need as a pathway

We decomposed the association between parental mental health problems and children's service use into a component transmitted through parental perceived need and a remainder, with effects expressed on the probability scale in percentage points.

The total effect was an increase of 16.3 percentage points in the probability of lifetime service use (95% CI [4.7, 29.0], $p < 0.002$). The mediated component was 7.6 percentage points (95% CI [3.3, 14.0], $p < 0.002$); the direct component was 8.7 percentage points (95% CI [− 2.2, 20.8], $p = 0.114$). The estimated proportion mediated was 47% (95% CI [19%, 145%]). Figure 2 presents the path structure and Table 3 the decomposition. Both constituent paths were strong: parental mental health problems were associated

with markedly higher odds of the parent perceiving a need for care (OR = 4.44, 95% CI [2.55, 7.77], $p < 0.001$), and perceived need in turn with higher odds of the child having used services (OR = 4.73, 95% CI [2.67, 8.43], $p < 0.001$). On the odds scale, the direct association adjusted for perceived need was 1.75 (95% CI [0.92, 3.26], $p = 0.083$).

Table 3
Decomposition of the association through parental perceived need ($n = 426$)

Effect	Estimate (pp)	95% CI (pp)	*p*-values
Total effect	+ 16.3	[4.7, 29.0]	< 0.002
Indirect effect, via perceived need	+ 7.6	[3.3, 14.0]	< 0.002
Direct effect	+ 8.7	[-2.2, 20.8]	0.114
Proportion mediated	47%	[19%, 145%]	
Note. pp = percentage points. Nonparametric bootstrap decomposition, 1,000 resamples.			

This is a pattern of partial mediation. The mediated pathway was statistically distinguishable from zero and the direct pathway was not, but the direct point estimate was not small; it was, if anything, slightly larger than the mediated one. The interval around the proportion mediated is correspondingly wide, and we do not treat that percentage as an estimate of how much of the association runs through perceived need. What the decomposition shows is narrower and more secure: a pathway through parental perceived need was present, and the remainder of the association was not resolved by these data.

Parental symptom severity and child diagnosis

Child diagnosis rates rose monotonically across bands of parental depressive symptoms: 3.2% where the parent scored zero on the PHQ-9 (n = 2,862), 7.8% at 1 to 2 points ($n = 2,238$), 11.0% at 3 to 4 points ($n = 790$), 17.4% at 5 to 9 points ($n = 328$), and 28.1% at 10 points or above ($n = 57$). Figure 3 shows the gradient.

Anxiety symptoms showed the same shape, from 3.8% at zero ($n = 3,437$) to 30.4% at 10 points or above ($n = 23$), though the uppermost band contains few families; Supplementary Table S1 reports the full GAD-7 gradient.

In survey-weighted models adjusting for the covariates listed in the Measures section, each additional PHQ-9 point was associated with higher odds of the child meeting diagnostic criteria (adjusted OR = 1.11, 95% CI [1.05, 1.18], $p < 0.001$); the GAD-7 estimate was 1.17 (95% CI [1.08, 1.27], $p < 0.001$). The probability of meeting diagnostic criteria was, on average, greater where the parent was also affected, the background against which the service-use comparison should be read.

Barriers reported by families who had not used services

Opening the gate did not carry most families through it: of the 85 children in Group D, 59 had never used services (69.4%). We compared the reasons these families gave (n = 59) with those given by non-users in Group B (n = 286). Figure 4 presents the comparison by domain; item-level responses for all fourteen reasons are reported in Supplementary Table S2.

Three differences reached conventional significance, all in the same direction. Non-users in Group D were more likely to expect the problem to resolve without help (71.2% versus 48.3%, p = 0.002), to endorse at least one item in the minimization domain (91.5% versus 76.2%, p = 0.015), and to voice doubts about service quality (67.8% versus 50.0%, p = 0.019). The remaining comparisons did not separate the groups: structural constraints (72.9% versus 59.1%, p = 0.067), severity judgement (72.9% versus 60.8%, p = 0.111), stigma (78.0% versus 71.3%, p = 0.379), and medical-record concern (62.7% versus 54.5%, p = 0.314). Under Holm adjustment for the seven comparisons, only the expectation that the problem would resolve on its own remained significant (adjusted p = 0.015); the minimization domain and quality concerns did not (adjusted p = 0.087 and 0.094).

Sensitivity and stratified analyses

Restricting the exposure to the clinical threshold reproduced the direction of the primary comparison (17.9% versus 44.4% service use; n = 18 in the affected cell; Supplementary Table S3). Stratifying by responding caregiver gave the same picture among mothers (17.0% versus 32.9%; affected cell n = 76); the paternal affected cell (n = 8) was uninformative (Supplementary Table S4). Stratification by age band was consistent in both bands (10.3% versus 28.6% at ages 6 to 11; 18.8% versus 31.2% at ages 12 to 17), though adolescents made up 75.3% of Group D and so carried most of the weight in the pooled estimate (Supplementary Table S5).

Discussion

Principal findings

Three answers emerged, and they belong together. Among children with a current psychiatric diagnosis, those whose parent also reported mental health problems were about twice as likely to have ever used mental health services: 30.6% against 16.1%, with an adjusted odds ratio of 2.21. The gate, in the terms of the Introduction, opened rather than closed. Part of that opening ran through the parent's perception that the child needed care. And an opened gate was not a crossed one: seven in ten children in the both-affected group had never used services, and the reasons their parents gave were not the reasons the field usually targets. We take these findings in turn, then their implications, then their limits.

Adjudicating between the gateway and double-burden accounts

The direction of the primary comparison is consistent with the gateway account and inconsistent with the double-burden prediction, which anticipates that a symptomatic parent, with less capacity to notice, judge, and act, will bring a diagnosed child to care less often. The association ran the other way, and did so under the clinical symptom threshold, in the maternal stratum, and in both age bands. We state the conclusion in terms of consistency rather than confirmation because the design permits no more, but the pattern is not ambiguous. A similar direction has been reported in nationally representative US data (Pfefferle & Spitznagel, 2009); US children of depressed parents used services 2.8 times as often after adjustment (Olfson et al., 2003); and parental illness has elsewhere been linked to greater specialist use (Heradstveit et al., 2023) and to delayed treatment (Stalujanis et al., 2019). A pattern appearing in two national samples with different instruments is unlikely to be an artifact of either. To our knowledge this is the first adjudication between the two accounts in nationally representative parent-child dyadic data in which the parent's own mental health, the child's structured diagnosis, and the child's actual service use were all measured in the same families.

Two features of the sample make the direction harder, not easier, to explain away. The first is the background gradient: the probability that a child met diagnostic criteria rose monotonically with the parent's symptom score, so children in the both-affected group came from families in which a child diagnosis was markedly more probable. One might argue that their higher use simply tracks that elevated risk, but double-burden is precisely the claim that heavier need in the child arrives together with reduced capacity in the parent, and that the second overwhelms the first. Had that been so, greater need would have coincided with lower use; it did not. The second feature is socioeconomic. Families in the both-affected group were poorer (54.1% against 30.2% in the lowest income tertile, $p < 0.001$) and less often intact two-parent households (75.3% against 87.7%, $p = 0.006$), while the remaining covariates (age, sex, age band, education) were similar. Socioeconomic disadvantage is, in most of the literature, associated with lower service use (Islam et al., 2023; but see Bøe et al., 2021), so the confounding one would ordinarily worry about runs against the observed association; and the adjusted estimate, which controls for income and family structure, is essentially the same as the crude one. A result that survives adjustment for a confounder pointing the other way is not one the confounder can be producing.

What the design cannot settle is the direction in which the gate opened. The data are cross-sectional, and a parent's symptoms may follow a child's difficulties as readily as precede them, as when a disorder visible enough to prompt service use raises the parent's distress in the process. This does not undermine the adjudication. The double-burden account predicts a negative association whatever its temporal origin, because it is a claim about capacity; the gateway account is compatible with either ordering. What the reverse pathway does undermine is any claim that child service use is a consequence of parental symptoms, and we make no such claim. The finding is that the two co-occur in the direction one account predicts and the other forbids.

Perceived need as a partial pathway

The mediation analysis identifies one route and is careful about how much that route carries. Parental mental health problems were associated with a fourfold increase in the odds that the parent perceived

the child to need care, and perceived need in turn with a fourfold increase in the odds of service use, consistent with its place in standard models of health service access (Andersen, 1995) and with evidence that parental perceived need raises specialist use independently of diagnosis and impairment (Brattfjell et al., 2021). The indirect component's interval excluded zero; the direct component's did not, but its point estimate was at least as large, and its failure to reach significance is as consistent with limited power in a group of 85 as with a true null. The proportion mediated (47%, 95% CI [19%, 145%]) is too imprecise to interpret. We rest the conclusion on structure alone: a pathway through perceived need was present, and the association was not exhausted by it.

The mediator identified here differs from that in the closest prior study, and the two results are complementary rather than competing. Pfefferle and Spitznagel (2009) traced the association through parenting aggravation, a burden construct, and did not measure whether parents recognized a need for care; the present analysis traces it through recognition and could not measure burden, because the survey carries no parenting-strain instrument. Neither study can say which pathway carries more, or whether the two run in sequence: a symptomatic parent may be both more burdened and more alert to what the burden is about. Williams et al. (2011) showed, in a clinical sample, that when parents and adolescents agreed about the need for care, more appointments were kept. The present study reaches further back along the same chain and asks what shapes the parent's perception in the first place; the answer, in part, is the parent's own condition. What remains unexplained is the direct path, and we can only speculate about what runs along it: familiarity with how services work, an existing relationship with a clinician, a lower threshold for regarding a referral as ordinary (Mojtabai et al., 2016; Spence et al., 2016).

One theoretical consequence deserves statement. Perceived need was strongly associated with use and was the only pathway the data could identify, but it was not sufficient: 41.2% of parents in the both-affected group perceived a need for care, yet 69.4% of the group's children had never used services, and the two figures come from the same families. Recognition, on this evidence, is where the process starts, not where it ends.

The residual gap

Most of the families for whom the gate had opened did not walk through it, and the reasons they gave reorder the usual list of barriers (Graaf et al., 2023). Parents of non-users in the both-affected group were more likely than those in the child-only group to expect the problem to resolve on its own, to endorse minimization, and to doubt that services would help; stigma and medical-record concern showed no difference, and structural differences fell short of significance. The clearest signal was the expectation that the problem would pass; neither the minimization domain nor doubt about quality survived adjustment for multiple comparisons. What distinguished these families was how they appraised the problem and the service, not what it would cost them to be seen seeking help. The ordering is consistent with national survey evidence in adults, where low perceived need is the most common reason for not seeking treatment and attitudinal barriers outweigh structural ones among those who do perceive a need (Mojtabai et al., 2011).

These appraisals form a minimization paradox. Psychiatric risk was most concentrated in the families with both a symptomatic parent and a diagnosed child; these same families were the most likely (71.2%) to expect the child's difficulty to pass without help. Risk and optimism were co-located. One untested explanation is normalization: a parent who has carried symptoms without treatment, and has functioned, may read a child's symptoms through that experience and conclude that they too will pass (Martin et al., 2025; Reardon et al., 2017). If so, the mechanism is specific and reachable, because the belief is held by parents who are, by definition, in contact with their own distress; we offer it as a hypothesis for direct study, not a finding.

The absence of a stigma difference is itself informative. Interventions to increase child service use frequently begin from the premise that families are held back by shame (Song et al., 2023). Here the families most in need reported no more shame than other non-using families, only a stronger expectation that the problem would pass and, less robustly, doubt about services; a message designed to reduce stigma would be aimed at the wrong target.

Implications for policy and services

Taken together, the three answers point to three implications. First, adult mental health services are a point of entry to children who need care and have not yet reached it (RQ1, RQ3). A parent presenting with depressive or anxiety symptoms has a child whose probability of disorder rises with the parent's score, and is already more likely than a well parent to have recognized the child's need; asking about the children of adult patients is a low-cost inquiry with elevated expected yield. In Korea the two systems are reached by different routes: adults are screened for depressive symptoms within the national health examination program (Shin et al., 2022), while children and adolescents reach services largely through schools and community centers (Kim & Lee, 2023), and no routine referral pathway links the two. The finding argues for a two-generation linkage in which contact with the adult service prompts a brief structured question about dependent children, with a defined referral route when the answer warrants one. Work on family-focused practice in adult services describes how such linkage has been attempted elsewhere (Bauer et al., 2021; Stolper et al., 2024), and the premise has partial support: children of depressed mothers improved after maternal remission but worsened among non-remitters' children (Wickramaratne et al., 2011), and integrated two-generation treatments are now in trial (Roubinov et al., 2023), though neither bears directly on linkage at the point of contact. We describe this as an entry point rather than a screening program, because the data bear on the first and have not evaluated the second.

Second, raising awareness is necessary and is not enough (RQ2, RQ4). The mediation result is consistent with the premise of awareness campaigns: perceived need was associated with higher use. But among the families in which need was most often perceived, seven in ten children remained outside services. Whatever closes the residual gap will have to act on something other than recognition.

Third, what it will have to act on is minimization and doubt about services (RQ3, RQ4). To a parent who already believes the child has a problem, the useful information is not that a problem exists but what happens if it is left, and what a service concretely does, so that doubt about its value can be met with

description rather than reassurance. These beliefs were most prevalent in the highest-risk families, and the national health examination already elicits parental depressive symptoms at a routine, treatment-independent contact point (Shin et al., 2022), giving the message an identifiable audience and delivery point. Whether it changes behavior is a question for evaluation, which this design cannot provide.

Limitations

The design has strengths, nationally representative parent-child dyads and a child diagnosis established independently of parental report, but its conclusions should be read against the following limitations. First, the data are cross-sectional. The reverse pathway does not overturn the adjudication, but it prevents any claim about which came first; the language of association throughout is deliberate. Second, the comparison rests on small and selected cells. The both-affected group contained 85 children, so the confidence interval around the adjusted odds ratio is wide, and analyses on smaller subsets (eighteen children under the clinical threshold, eight reported on by fathers) establish direction only. Because 86.9% of responding caregivers were mothers, the gateway pattern reported here is, in practice, a finding about mothers; whether it holds for fathers, whose help-seeking differs in documented ways (Dadds et al., 2018; Reay et al., 2024), these data cannot answer.

Third, the exposure is measured with error that runs toward the null. The prevalence of parental mental health problems was low (7.2% at the screening threshold, 1.0% at the clinical one), under-reporting cannot be excluded, and the instruments cover the past two weeks, so a parent whose symptoms had remitted would be classified as well. Each of these dilutes the both-affected group, making the estimate more likely conservative than inflated.

Fourth, service-use items were asked only of caregivers who reported a problem history, and non-response was coded as no use. The assumption cannot inflate the contrast, but the absolute use figures are lower bounds; and because adolescent self-report supplemented caregiver report only from age 12, contact was more fully captured in the older band, though the stratified estimates reported above ran the same way in both.

Fifth, the mediation analysis carries three caveats of its own: it is unweighted and describes the analytic sample rather than the population; the proportion mediated is too imprecise to interpret, so the conclusion rests on the significance pattern of the indirect and direct components; and the mediator was measured at interview while the outcome is lifetime use, with exposure, mediator, and outcome all resting on caregiver report, so the independence the structured diagnosis lends to the primary comparison does not extend to the pathway analysis.

Conclusion

When the parent who decides on a child’s behalf, most often the mother in our sample, is also affected, the gate to children’s mental health services opens rather than closes. In nationally representative

parent-child dyads, diagnosed children whose parent reported depressive or anxiety symptoms were about twice as likely to have used services, and the difference held against a socioeconomic gradient that should have pushed it the other way. Part of the opening ran through the parent's recognition that the child needed care; part did not, and remains to be explained. But recognition was not enough. Seven in ten children in the highest-risk families had never reached a service, and their parents reported no more stigma than other non-using families. What set them apart was the belief that the problem would pass, the minimization paradox at the center of the residual gap. For those who design services, the implication is a point of leverage rather than a new campaign: the parents most likely to be standing at an unopened gate can be reached through a routine contact point that already elicits their own depressive symptoms and does not yet ask about their children.

Declarations

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Author Contribution

HJ is the sole author and was responsible for the conception and design of the study, data analysis and interpretation, and drafting and revising the manuscript. The author read and approved the final manuscript.

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Figures

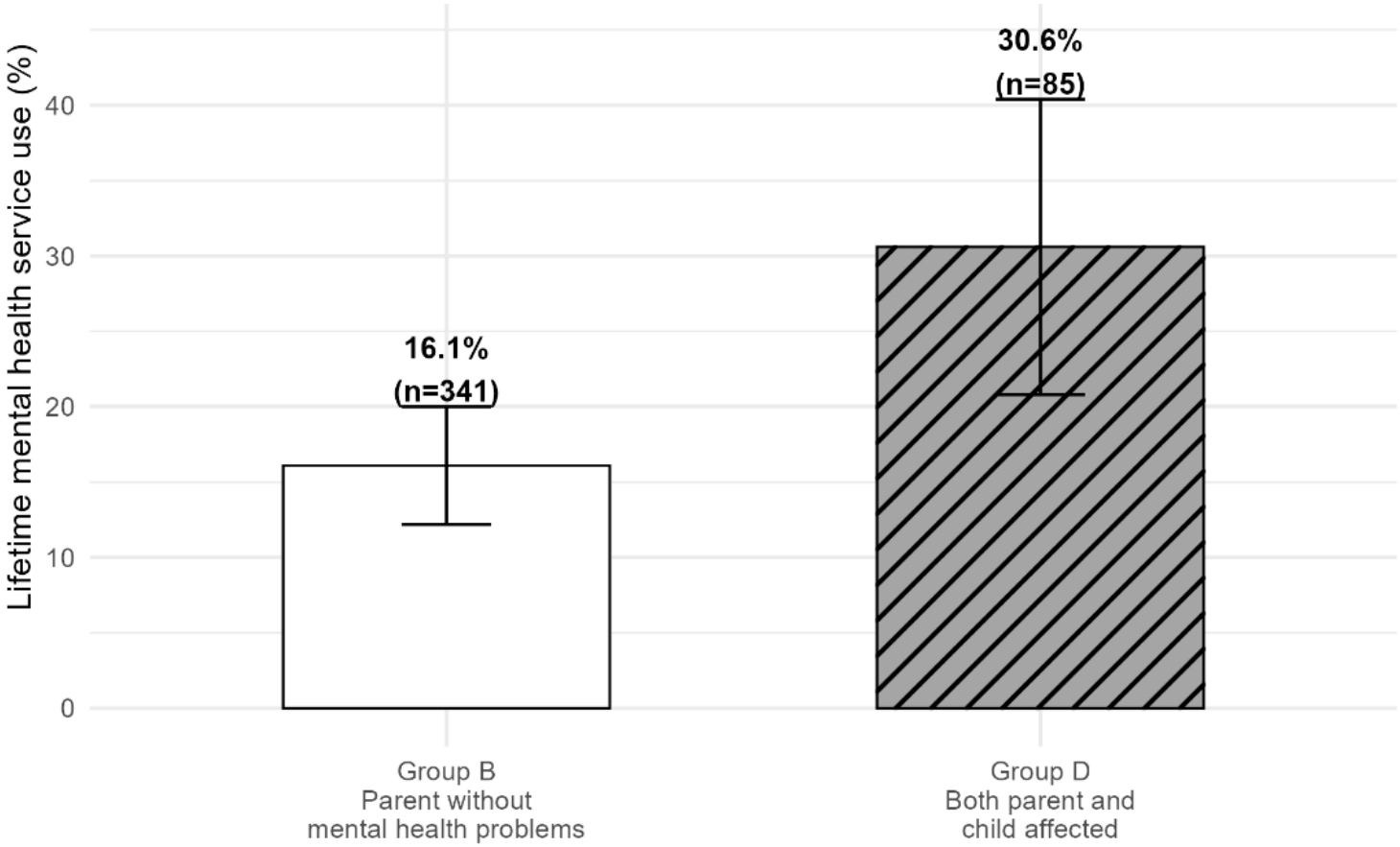


Figure 1

Lifetime service use among diagnosed children, by parental mental health status

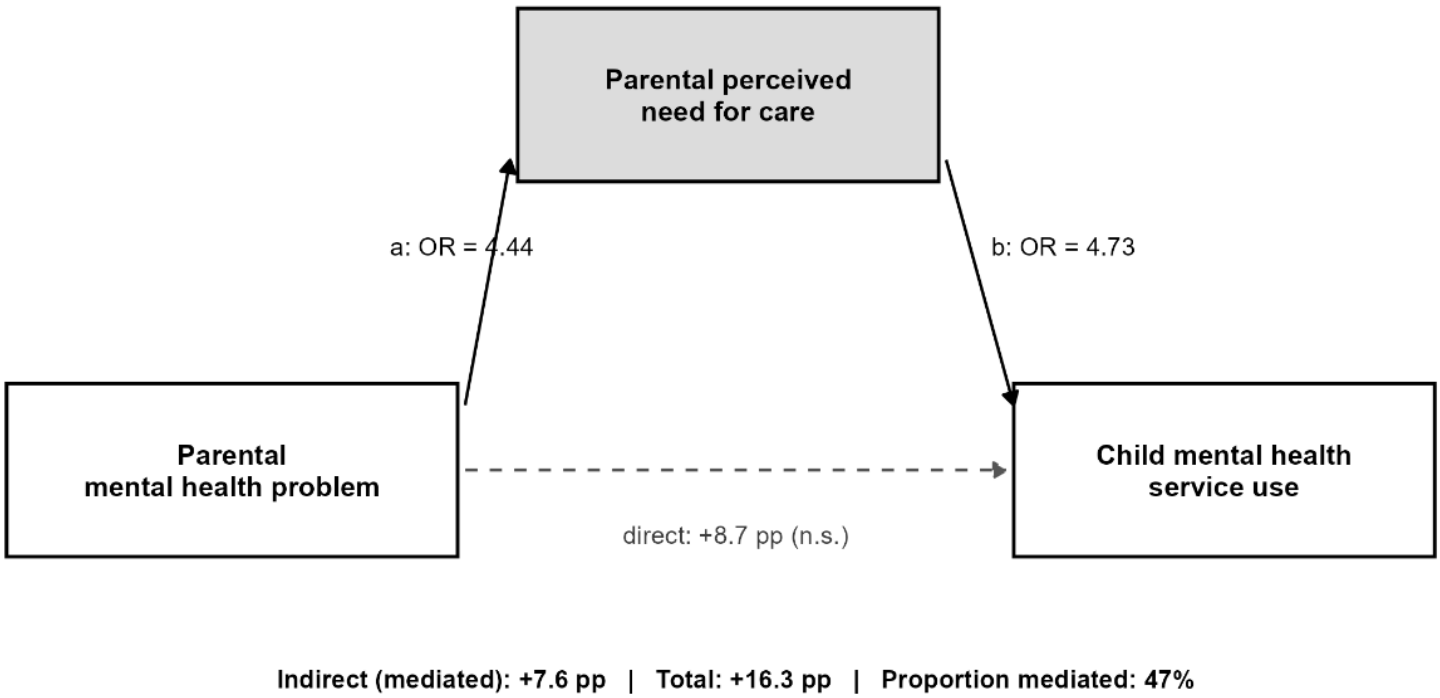


Figure 2

Mediation of the association between parental mental health problems and children's service use through parental perceived need (*n* = 426)

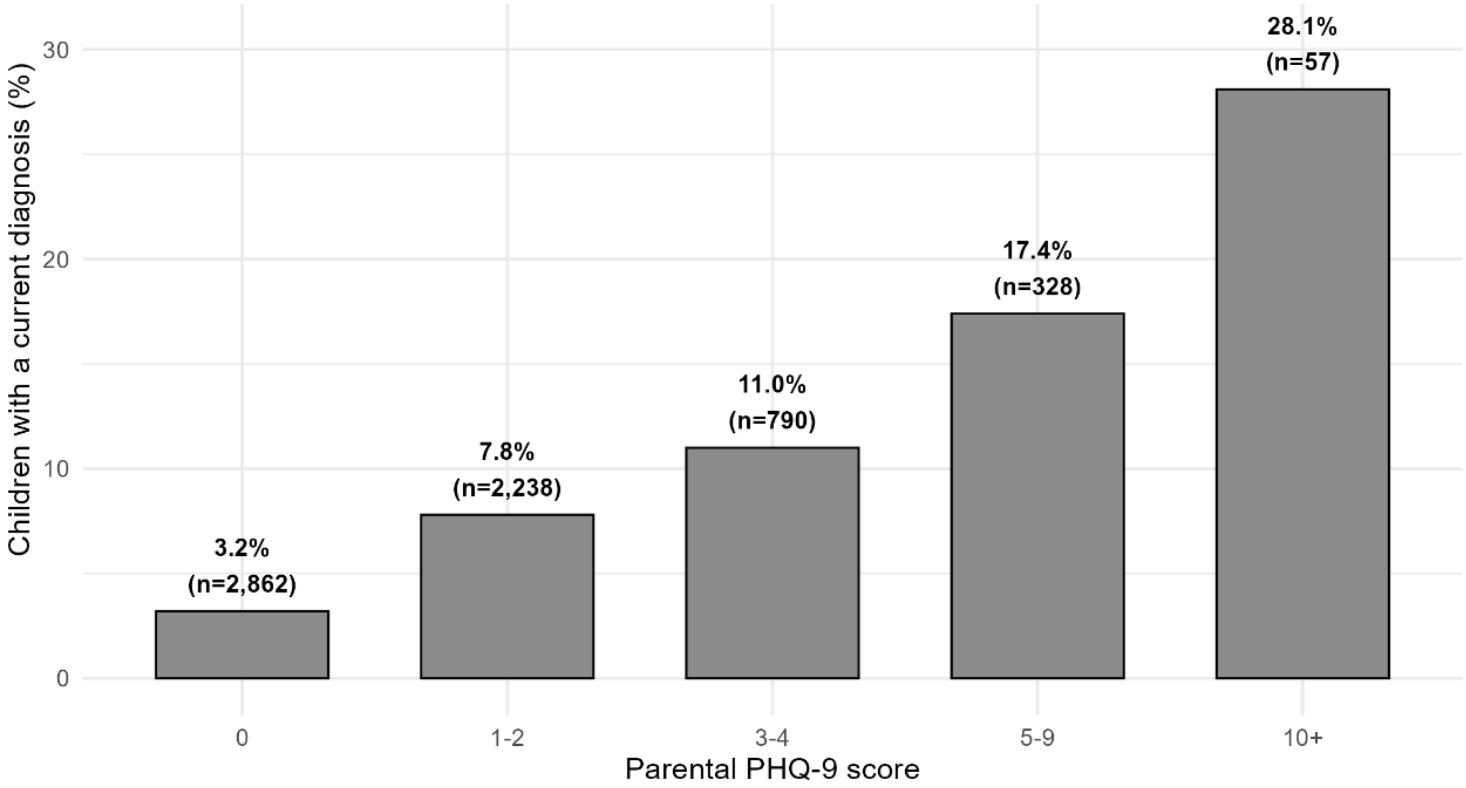


Figure 3

Percentage of children with a current diagnosis, by parental PHQ-9 score category

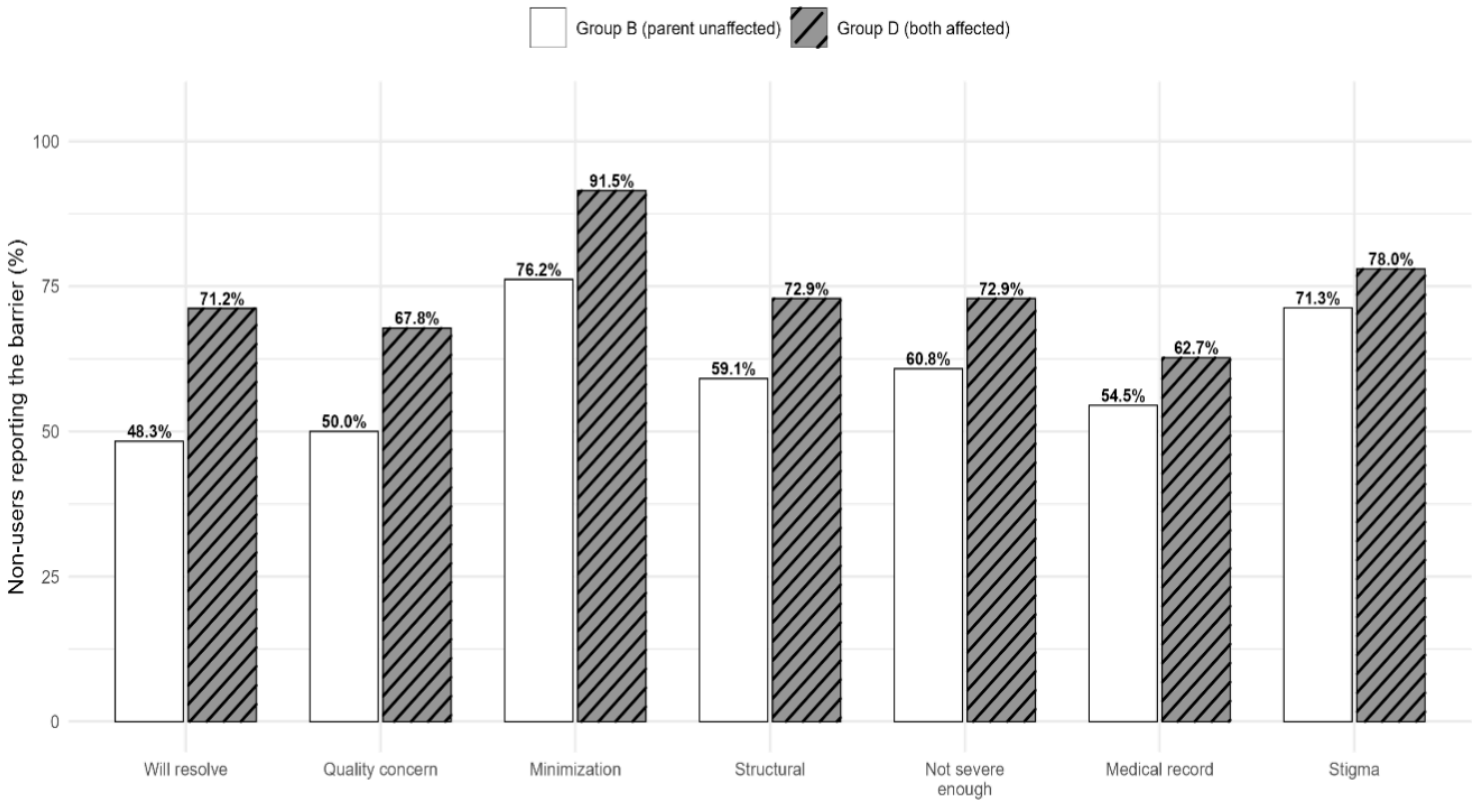


Figure 4

Barriers reported by non-users in Groups B (n = 286) and D (n = 59), ordered by between-group difference

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