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A Mixed-Methods Exploration of Parent-Young Adult Child Mental Health Conversations Across Cultural Groups

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Doctor of Philosophy in Communication

by

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Abstract

A Mixed-Methods Exploration of Parent-Young Adult Child Mental Health Conversations Across Cultural Groups

by

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Rates of mental health challenges have risen over the past decade in the United States, with young adults (aged 18 to 25) experiencing greater rates of mental health challenges than any other age group. Young adults facing mental health challenges may seek support from their family, as social support is especially beneficial from a close family member (Shor et al., 2013). However, if young adults anticipate a negative reaction upon speaking about mental health with their parent, they may conceal their mental health challenges (Rasmussen et al., 2022). Research has yet to explore the process of family mental health communication from the perspective of both parents and children. Moreover, communication literature often centers the experiences of white Americans despite evidence that communication is "raced" (i.e., one's culture impacts how they understand and navigate the world; Davis & Cardwell, 2022). The present study recruited 116 racially diverse parent-adult child dyads to take a pre and post survey and have a conversation with their family member on Zoom about their thoughts on mental health in the United States, in their culture, and in their family. I used multiple analyses to explore the process, form, and function of parent-adult child mental health communication across cultural groups. The first analysis used structural equation modeling to test Actor Partner Interdependence Models that considered family members' extant perceptions of their family's ability to effectively communicate, their perceptions of

support and conflict from their family member during the mental health conversation, their mental health during the conversation, and their satisfaction in the parent-child relationship. Results underscored the importance of one's extant familial beliefs in this process, with one's perception of their family's level of functioning predicting their perceptions of conflict and support during the conversation, their mental health during the conversation, and their satisfaction in the parent-child relationship afterward. Moreover, the results provided evidence that a parent's perceptions of family functioning and their perceptions of conflict and support from their child may have the ability predict their child's mental health and satisfaction. The second analysis used an iterative thematic analysis to consider the cultural nuance within parent-child mental health conversations. This analysis illuminated a number of cultural scripts that impacted how families communicated about and understood mental health. Specifically, families often advocated for one of three mindsets: 1. Survival supersedes mental health, 2. The pressure of the collective, and 3. Religion as a solution. The appearance of (dis)confirmation served to reinforce and challenge these belief systems, and a family's conversation orientation to talking about mental health was one indicator of the amount of confirmation present during a conversation. Taken together, these two analyses illuminate the process of family communication, highlight the role of the individual and the unit, and considered the form and function of family mental health conversations.

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Chapter 1. Rationale

Rates of mental health challenges have consistently increased over the last decade in the United States (U.S.), with young adults between 18 and 25 years old consistently reporting the highest levels of mental health challenges compared to any other age group (Substance Abuse and Mental Health Services Administration; SAMHSA, 2020; 2022). In 2021, one fifth of American adults reported experiencing some form of mental illness that was sufficient enough to meet DSM-5 criteria (SAMHSA, 2022). When broken down by age group, one third of adults aged 18 to 25 in 2019 reported experiencing mental illness, as did 28% of those age 26 to 49, and 15% of those 50 or older (SAMHSA, 2022). Other than those above the age of 50, each of these percentages represents a statistically significant increase in reported mental illness over the previous decade (SAMHSA, 2020; 2022). Those 18 to 25 years old showed the starkest increase, jumping from 18.5% in 2008 to 33.7% in 2021. Young adults are the group most impacted by mental health challenges, with 50% of college students reporting experiencing at least moderate psychological distress over the previous year in 2022 (SAMHSA, 2022; ACHA, 2023). With a greater number of individuals recognizing and reporting their mental health challenges than in the past, the frequency of mental health conversations has likely increased as well.

Mental health stigma (i.e., the social disapproval linked to mental health challenges) makes it more difficult for individuals to seek both formal and informal forms of help (Sickel et al., 2019). Despite the growing number individuals facing mental health challenges, less than half of U.S. adults who have been diagnosed with a mental health problem seek professional treatment (SAMHSA, 2022). Anticipated mental health stigma (i.e., the expectation that one will be categorized as a member of a socially devalued group; Rosenthal

et al., 2019) is cited as one of the largest barriers to seeking out mental health care (Ebert et al., 2019; Essau, 2005; Rickwood et al., 2005). Mental health stigma manifests in a number of contexts including in family relationships (Martinez & Hinshaw, 2016). Many individuals internalize stigma about themselves, which can be especially detrimental for seeking help—be that from professionals or their family (Kam et al., 2019; Keum et al., 2018; Martinez & Hinshaw, 2016).

Young adults facing mental health challenges may choose to turn to their parents for support, as family communication is crucial to well-being throughout all stages of life (Dailey, 2006). However, many young adults are apprehensive about approaching the topic of mental health because they could receive a visceral, negative reaction from their parents (Rasmussen et al., 2022), highlighting the possibility for conflict to arise during a parent-child mental health conversation. Rasmussen et al. (2022) note that parents' and children's existing beliefs regarding their family likely affect their perceptions of support or conflict in an interaction (Rasmussen et al., 2022). Consequently, one's perception of their family member's communication during a conversation should predict their personal and relational outcomes after a mental health conversation. Moreover, as families are interdependent systems (Afifi et al., 2018), one family member's behaviors and perceptions can have effects on the entire family, making it important to consider how parents' and children's perceptions and behaviors are interrelated.

An exploration of parent-child mental health conversations would be remiss without considering how culture can impact a family's mental health communication. Racial and ethnic identity impacts many facets of one's communication, both in form and function (Chang, 2014; Davis & Cardwell, 2022). Davis and Cardwell (2022) argue that family

communication is raced; the systems of oppression present in the U.S. influence how people of color interact with and communicate within the world. Therefore, the communicative tactics families use to build resilience are likely influenced by their cultural background (Davis & Cardwell, 2022). Therefore, how families understand and communicate about mental health is affected by cultural identity, with social norms and beliefs driving not only what they say, but how they say it.

The use of formal mental health resources are especially stigmatized in communities of color, which means that many individuals never seek treatment for their mental health challenges (Sickel, 2019). Therefore, informal parent-child conversations about mental health should be studied across cultural groups. The family environment provides a primary foundation from which young adult children learn schemata about mental health, determine how and whether they should communicate about mental health, develop essential coping skills, and generate a sense of resilience (Flood-Grady & Koenig Kellas, 2019). Because racial and ethnic minority families tend to be more collectivistic, the safety and success of the family is often perceived as more important than the needs of one individual (Chang, 2014). Given that these cultures center and prioritize the good of the family, some young adults may have trouble asking their parents for support with mental health challenges, in part because they do not want to inconvenience, disappoint, or disrupt their family (Chang, 2014). The cultural norms and constraints embedded in the enactment of family communication can influence how individuals navigate their relationships and their mental health challenges. Therefore, it is pertinent to include a cultural lens in the study of family mental health communication.

Family mental health communication has yet to be deeply explored, and much of the research relies on retrospective self-report data. Participants may suffer from desirability bias when answering questionnaires or may inaccurately recall events or conversations, which may result in less accurate conclusions. Moreover, these measures often elicit more holistic evaluations of communication, which can be affected by an individual's overall perception of their close others and may fail to accurately capture communicative behaviors as they occurred. While this research is invaluable, deeper insight can be gained by having parents and young adult children communicate about mental health with one another and then deconstructing the actual talk itself. Considering the form and function of parent-child mental health conversations allows scholars to apply theoretical concepts to actual family interactions. Moreover, this analysis is not limited to the perspective of one individual, whose accuracy could be inhibited by time, space (emotional and/or physical), or any other number of factors. Instead, this form of inquiry considers the process of communication, and how two individuals co-create and make sense of their communicative environment together. The meanings generated between parents and children may stay with them, and could ultimately predict their own mental and relational health, as well as their family member's. Although the conclusions generated through parent-child mental health conversations must be situated within the worldviews and experiences of those interpreting them, exploring conversations as they unfold provides a form of reflection and candor that may not be ascertained from other methods.

The Present Study

For the purposes of this dissertation, *mental health* refers to one's state of psychological and emotional well-being (or a lack thereof; CDC, 2023). *Mental health*

challenges refer to any threat to one's mental well-being; this could include diagnosed mental disorders, as well as symptoms that do not meet the criteria of the DSM-5 but have an effect on wellness. This dissertation may use the terms *mental illness, mental health condition,* and *mental health disorder* interchangeably to refer to symptoms that meet the criteria of diagnosis in the DSM-5 (American Psychiatric Association, 2022). *Mental health stigma* or *mental illness stigma* refers to the social devaluation of individuals with mental health challenges (Sickel et al., 2019). These individuals are often stereotyped as dangerous, untrustworthy, or incapable of making their own decisions (Flood-Grady & Koenig Kellas, 2019; Pescosolido et al., 2010).

This dissertation will first take a "macro" or broad approach to the subject of family mental health communication to understand what communicative processes correspond with better relational and mental health outcomes for both parents and young adult children when speaking about mental health. Then, it will take a more "micro" approach to consider the content of parent-child conversations about mental health and describe the nuance present in these conversations according to racial, ethnic, generational, or gender-related cultural norms.

This dissertation includes two phases of analysis. The first "macro" phase uses a quantitative approach by considering how parents' and children's perceptions of family functioning correspond with their perceptions of support and conflict when talking about mental health with each other, which likely affects their mental health and relational satisfaction following the conversation. This phase of analysis uses an Actor Partner Interdependence Model (APIM; Cook & Kenny, 2005; Kashy & Kenny, 1999; Kenny, 1996) to consider both actor effects (i.e., the effects from one's own variables) and partner effects

(i.e., the effects of one person's variables on another), in an effort to better understand the interdependent nature of mental health communication between parents and young adult children. This analysis will provide insight into the process of family mental health communication, generally. The second phase of the analysis adopts a "micro" approach by dissecting parent-child mental health conversations themselves. I used an iterative thematic analysis (Tracy, 2018) to explore the nuance of parent-adult child communication about mental health across various cultural groups. I consider how confirming and disconfirming communication reveal themselves during family mental health conversations and their role in reinforcing or challenging extant beliefs. Taken together, these two analyses provide valuable insight into the process of family mental health communication, the form and function of the communication employed by parents and children, and the role of culture in shaping parent-child mental health conversations.

Chapter 2. Analysis Phase One: Modeling Parent-Child Relationships

Preview

This chapter proposes a quantitative model of family mental health communication, in which the beliefs and behaviors of parents and young adult children are interdependent. This chapter provides an overview of the family mental health communication literature and proposes a processual model of family mental health communication. Specifically, I contend that parents and children with greater family functioning will have greater perceptions of social support and lower perceptions of conflict from their family member during a conversation about mental health. Parents and children who perceive more support and less conflict should have better assessments of their mental health during the conversation and should be more satisfied in their relationship afterward. Additionally, I hypothesize that family functioning should impact these outcomes through their perceptions of social support and conflict in the conversation. Parents and children who believe their family is highly functional should have better perceptions of social support during a mental health conversation which should, in turn, correspond with better feelings about their mental health during the conversation and greater relational satisfaction after the conversation. This model considers what families bring into an interaction (i.e., their history of family functioning) as well as the communicative tools they employ during a mental health conversation (in this case, social support, broadly), and how these processes correspond with relational and mental outcomes for both parents and their adult children.

In addition, the proposed model considers how parents and children are interdependent, or how one person's perceptions or behaviors affect the other. Figures 1 through 4 show the hypothesized models, which will be explored in greater depth below.

Overall, this model contends that healthier family environments predict higher levels of social support when parents and their adult children talk about mental health with each other, which, in turn, should predict better mental health and relationship satisfaction. Notably, this model does not include culture in its logic. This is because this process should hold true across all racial and ethnic groups and robust research should include diverse samples. In the current study, I attempt to include as diverse of a sample of parents and young adult children as possible. This chapter will provide an overview on the family mental health literature and relevant communicative frames. Then, I will present the hypothesized models. Finally, this chapter describes data collection for the present study and details the first phase of data analysis.

Introduction

Adults in the U.S. have reported greater rates of mental health challenges over the last decade, with young adults (age 18 to 25) consistently reporting the greatest instances of mental health symptoms than other age groups (SAMHSA, 2020; 2022). Mental health challenges have the potential to negatively impact one's quality of life if suppressed or left untreated (CDC, 2023; NAMI, 2020). When young adults experience mental health challenges, they may choose to seek support from their parents, as healthy family communication can facilitate well-being across all life stages (Dailey, 2006). Parent-child mental health conversations may present an opportunity for both young adults and their parents to regulate their well-being. In particular, the social support provided during parent-child mental health conversations likely dictates how well an adult child is able to cope with their mental health challenges (Alsubaie et al., 2019). Similarly, parents are also likely to benefit psychologically and relationally from their adult child's support. Social support tends

to be associated with positive physical and mental health outcomes (Alsubaie et al., 2019; Chu et al., 2010; Cobb, 1976). This support is especially beneficial when the provider is a close family member, compared to other network members (Shor et al., 2013). Therefore, supportive communication about mental health likely has beneficial effects for parents and their young adult children. Alternatively, conflict within the parent-child relationship has been connected to higher rates of adolescent problematic behavior (Khlar et al., 2011) as well as an association with higher levels of psychological distress for children (Qu et al., 2021). Consequently, many young adults worry that broaching the subject of mental health could result in disapproval or rejection from their parents (Rasmussen et al., 2022), making mental health an especially difficult topic to navigate.

What parents and children bring into an interaction likely affects the receiver's perception of support or stigma (Rasmussen et al., 2022). The present study considers family functioning, or a family's ability to operate as a unit and communicate well prior to a mental health conversation, as a predictor of the levels of social support and conflict one perceives during the conversation and one's mental and relational satisfaction afterward. The hypothesized models argue that family functioning corresponds with more positive outcomes by improving one's assessment of their partner's communication during a family mental health conversation.

The communicative process of parent-adult child mental health conversations has yet to be studied. Some communication research has explored the barriers to disclosing a mental illness to a parent (e.g., Rasmussen et al., 2022), the outcomes related to mental health disclosure (e.g., Taniguchi-Dorios et al., 2022), the stories family members share about mental illness (e.g., Flood-Grady & Koenig Kellas, 2019), and the factors that contribute to

network members providing support to those with mental illnesses (Thompson et al., 2020). While these studies provide insight into mental illness communication, they focus on those who have been diagnosed with mental illness (i.e., they or their family member have mental health challenges that rise to the level of the DSM-5), leaving a large number of families unstudied. Underreporting is common (Sickel et al., 2019), and limiting a sample to those who have been diagnosed can limit the insight gleaned. It is important to study families with a large range of experience with mental health to understand the family mental health communication process generally. Moreover, much of the extant mental health communication research, though invaluable in exploring mental health communication, has primarily been self-report in nature, relying on retrospective accounts of past mental health conversations with family members or close others (e.g., Rasmussen et al., 2022; Thompson et al., 2022). This will serve as one of the first dyadic studies to examine the communicative tools used by parents and adult children when talking about mental health. This study will be able to move beyond one individual's overall perception of communication with their family member to instead consider both parents' and children's immediate responses to a mental health conversation, gaining accuracy and insight into the process of family mental health communication.

Mental Health and Families in the United States

Twenty percent of American adults reported experiencing some form of mental illness that met the criteria of the DSM-5 over the past year (SAMHSA, 2020). In 2021, 33% of adults between 18 and 25 reported experiencing mental health challenges, as did 28% of those between 26 and 49, and 15% of those over 50 (SAMHSA, 2022). These figures represent a statistically significant increase in the number of people who report experiencing

mental illness compard to the previous decade (SAMHSA, 2020; 2022). Adults between 18 and 25 years old had the greatest increase, with 18.5% of young adults experiencing mental illness in 2008 compared to 33% in 2021. In line with young adults' high levels of mental health challenges, over half of surveyed college students reported feeling over the past year (SAMHSA, 2022; ACHA, 2023).

Underreporting is common when it comes to mental health problems, especially for those who experience challenges that do not rise to the level of DSM-5 criteria (Sickel et al., 2019). The emergence of the COVID-19 pandemic in 2020 exacerbated the stress and hopelessness experienced by many individuals, with financial hardship reported as one of the largest stressors in the beginning of the pandemic (Mazur et al., 2023). The pandemic corresponded with higher rates of anxiety, depression, and suicidal thoughts in the general population (Davenport et al., 2020). In addition, young adults experienced the largest increase in mental health problems during the first year of the pandemic (Barzilay et al., 2020; Davenport et al., 2020). Therefore, mental health has been especially relevant in the wake of the COVID-19 pandemic.

Despite the greater number of people who report experiencing mental health challenges, mental health stigma is still a formidable barrier to open and supportive communication about mental health (Ebert et al., 2019). The social disapproval tied to mental illness (i.e., stigma) is reported as a major barrier to seeking both formal and informal forms of mental health support (Sickel et al., 2019). The majority of individuals who experience mental health challenges do not seek formal treatment (NIMH, 2021). Many individuals anticipate that they may be categorized as a part of a socially devalued group (i.e., they may face stigma; Rosenthal et al., 2019) upon seeking mental health care (Ebert et al., 2019;

Essau, 2005; Rickwood et al., 2005). Mental health stigma impacts many facets of an individual's life, including their family relationships (Martinez & Hinshaw, 2016). As a result, many individuals internalize their own mental health stigma, which can be especially detrimental for seeking help from professionals or one's family members (Kam et al., 2019; Keum et al., 2018; Martinez & Hinshaw, 2016). Chaudoir and Fisher (2010) note that having mental health challenges is a concealable stigmatized identity, because while it is socially devalued, it is often not readily apparent to others. Many young adults may anticipate a visceral negative reaction from their parents if they were to broach the subject of mental health (Rasmussen et al., 2022), which makes mental health challenges especially threatening to discuss and may hinder one's ability to turn to their close others for support (Rasmussen et al., 2022). Families are a foundational source of knowledge, support, and norms, and the communication within these interdependent systems serves to create, reinforce, and challenge existing beliefs (Flood-Grady & Koenig Kellas, 2019). This is especially the case as young adults transition to college and experience the stressors associated with university life (e.g., risky behaviors and peer pressure, getting good grades, deciding on a career, fitting in) and living away from their parents (Lowe & Dotterer, 2018). Therefore, it is important to consider how families understand and communicate about mental health challenges.

The research on family mental health communication is still in its infancy. Much of the mental health communication research centers on romantic relationships, and often focuses on specific disorders (e.g., depression; Flood-Grady et al., 2023; Knobloch-Fedders et al., 2016). Sharabi et al. (2016) asked couples with at least one partner diagnosed with depression to articulate how depression impacted their relationships. Their participants spoke of the emotional toll that depression put on their relationship (Sharabi et al., 2016). These

couples reported difficulty communicating, a dearth of intimacy, and feelings of uncertainty as some obstacles that depression exacerbated (Sharabi et al., 2016). Knobloch and Knobloch-Fedders (2010) found that relational uncertainty mediated the relationship between depression and quality of the relationship—depression may serve to increase uncertainty in the relationship, which negatively impacts relationship satisfaction. Knobloch et al. (2016) considered how uncertainty functioned to enable topic avoidance in depressed couples. Research has established a connection between depressive symptoms and avoidance; individuals with depression have been documented to avoid difficult topics and situations to regulate their emotions (Aldao et al., 2010; Grant et al., 2013; Knobloch et al., 2016). Knobloch et al. (2016) found that relational uncertainty was, in fact, a major driving factor in depressed individuals' avoidance.

Some observational research has compared conflict interactions between couples where at least one member has depression with couples who do not. This research highlights the relatively high occurrence of negative communicative behaviors during conflict (e.g., high levels of hostility, poorer problem-solving skills, and less warmth) in couples with a depressed member compared to those who are not depressed (Knobloch-Fedders et al., 2013). Knobloch-Fedders et al. (2013) compared how depressed and non-depressed couples spoke about their favorite parts of a relationship. Their results corresponded with the conflict research and showed that even in a positive conversation, the non-depressed partner is more likely to show hostility toward the depressed partner (e.g., ignoring, attacking, or blaming) in depressed compared to non-depressed couples (Knobloch-Fedders et al., 2013).

Interpersonal mental health communication inquiry has spanned multiple theoretical lenses, including inconsistent nurturing as control theory (Duggan, 2007; Duggan & LePoire,

2006), uncertainty and topic avoidance (e.g., Knobloch et al., 2011; Knobloch et al., 2016; Knobloch & Delaney, 2012), and the disclosure decision-making model (Venetis et al., 2018). Duggan and LePoire (2006) used inconsistent nurturing as control theory to elucidate some of the behaviors partners of depressed individuals use to navigate their relationship (Duggan, 2007; Duggan & LePoire, 2006). Duggan and LePoire (2006) interviewed non-depressed partners about their communicative attempts to prevent depression and found that partners' attempts to curtail depression varied over time, with many individuals employing more negative strategies as time went on and their partner's condition continued. In a follow-up analysis, Duggan (2007) found gendered differences. Non-depressed female partners altered their behavior toward their partner over time and actively attempted to help their partner both before and after their partner's depressive behavior was labeled problematic (Duggan, 2007). Male partners, however, began by helping their partners get better but their attempts decreased over time, and ultimately contributed to their partner's depressive symptoms (Duggan, 2007). Although the previous studies focused on romantic relationships, their insights can still be used to better understand family mental health communication.

Much of the family mental health communication literature focuses on the family communication patterns that correspond with mental health challenges (Segrin, 2022). Segrin (2022) states that this body of research posits that one's interpersonal relationships have the potential to help or hinder one's mental health. Of the patterns that correspond with poor well-being in both parents and children, some of the most detrimental share a lack of care, affection, and support from a parental figure (e.g., parental affectionless control-parent strictly controls the child while showing little affection or care; expressed emotion-characterized by frequent criticisms and emotionality from parents; Segrin, 2022). This body

of research shows that parents who are overly restrictive and unsupportive create an environment with a higher risk for mental health challenges. This literature shows that the ways families (especially parents) communicate has a strong impact on the entire family's relational outcomes (Theiss, 2018). This research emphasizes the interconnected nature of families—the behavior of each family member can impact others. However, this research does not consider communication about mental health, solely the communicative patterns that correspond with mental health outcomes. Moreover, this literature tends to study specific disorders (e.g., depression, schizophrenia) and note the patterns that correspond with families whose members exhibit symptoms (Segrin, 2022). Although this research connects a family's communication patterns to their mental health, it does not illuminate how families communicate about the subject and how that communication, in turn, affects their well-being.

Ioffe et al. (2020) documented the gendered effects of parental communication on adolescents' mental health outcomes. Their participants reported greater levels of communicative openness, co-rumination, and co-problem-solving with their mothers compared to their fathers. This evidence is found in conjunction with research that suggests that children are less open with their fathers than their mothers (Ackard et al., 2006; Ioffe et al., 2020). However, modeling showed that fathers' communication had more significant effects on adolescents' anxiety and depression than mothers' communication (Ioffe et al., 2020). This study suggests that fathers' communication may be especially impactful in part because this communication is less frequent (and therefore may be more meaningful; Ioffe et al., 2020). While this study shows how parental communication can affect the mental health outcomes of children, it does not consider stigmatized subjects (like mental health challenges) that may elicit different reactions from parents.

Other research has begun to examine the features of family mental health communication. Flood-Grady and Koenig Kellas (2019) considered the narratives families employ when discussing mental illness. They argued that storytelling is a primary way group members are socialized and learn stigmatic beliefs (Flood-Grady & Koenig Kellas, 2019). The stories participants reported hearing from their parents about mental illness were able to provide insight into the norms and beliefs of the entire family, and how those families communicated about mental illness. Flood-Grady and Koenig Kellas (2019) uncovered two primary forms of mental illness narratives: caution and struggle. Caution narratives were those that warned children about the shameful and harmful actions that correspond with mental illness. Caution narratives were found to reinforce stigmatized beliefs. Struggle narratives were more empathetic, and focused on the hardships that contributed to a parent's own experiences with mental health challenges. Young adults emphasized learning the importance of mental illness through these stories (Flood-Grady & Koenig Kellas, 2019).

Flood-Grady et al. (2023) considered young adult children's memorable messages about depression from parents. Using a survey, they asked young adult participants to share memorable messages from their parents. This retrospective technique provided insight into some of the primary forms that parental mental health communication assumed. Some themes were relatively supportive (e.g., *we will be there (for you), Depression is serious)* while others were more stigmatizing, and negated the importance of conversations about depression (e.g*., Depression isn't real, I don't want to deal with it*; Flood-Grady et al., 2023*)*. The message type repeated most frequently was *Depression is no big deal; get over it (and try to be happy)* with one quarter of their participants reporting this message type. Flood-Grady et al. (2023) note that this messaging acknowledged the child's depression but

minimized their difficulties. In addition, these parental messages suggested that the child was able to control their mental health and should be able to “snap out of it” (Flood-Grady et al., 2023). This study also highlighted that mothers (and not fathers) were the most frequent source of memorable messages about depression.

Some research has begun to document the memorable mental health messages that young adults have received from their parents and considered these messages’ effects on young adults’ outcomes. Greenwell (2019) asked 193 young adults to describe a memorable message they had received from a family member in an open ended-survey question. Greenwell (2019) highlighted three memorable message types: strategizing, normalizing, and minimizing. Nearly half of their sample reported receiving strategic messages, in which they were encouraged to be proactive regarding the management of their mental health (Greenwell, 2019). Normalizing messages validated the existence of mental health challenges and positioned them as stigma-free. Minimizing messages dismissed and diminished the realities of mental health challenges (Greenwell, 2019). Notably, participants who received minimizing messages had the least positive attitudes about mental health, were less close to the message provider, and were less satisfied with those messages than participants who reported strategizing or normalizing messages (Greenwell, 2019). Three-quarters of their respondents said these messages came from one or both parents, highlighting the importance of parent-child mental health communication.

Some family mental health communication research has considered how adolescents choose to disclose their mental health challenges to their parents. Rasmussen et al. (2022) note that mental health is an especially difficult topic to communicate about due to how private and personal mental health challenges can be. Adolescents in focus groups reported

that there were multiple factors they would consider before disclosing mental illness to their parents. One factor was the perception of a parent's ability to empathize with their challenges. If they felt their parents could not understand or would challenge the legitimacy of their concerns, they were less likely to disclose than those whose parents demonstrated empathy (Rasmussen et al., 2022). Adolescents also reported a fear of potential adverse emotional responses from their parents upon sharing mental health challenges (Rasmussen et al., 2022). In addition, their participants said the quality of their relationship with their parents would impact their decision to disclose, with those who felt their parents were more open and supportive overall being more likely to share mental health challenges with them (Rasmussen et al., 2022). While this study looks at disclosure, its results illustrate the importance of considering family members' past communication environment when examining mental health conversations. Family members' relationships with each other and the family's ability to communicate effectively has an impact on how they communicate about mental health.

Family Functioning

One indicator of a family's extant relationship is family functioning, or the extent to which family members are able to effectively communicate, organize, and coexist (Koerner & Fitzpatrick, 2002). The circumplex model argues that cohesion, flexibility, and communication are three pillars to strong family functioning (Olson et al., 2019). Cohesion and flexibility are curvilinear; too much or too little of either hinders family functioning (Olson et al., 2019). Communication is thought to be a linear dimension, in which more communication allows families to regulate their levels of cohesion and/or flexibility (Crowe & Lyness, 2014; Olson et al., 2019). Olson et al. (2019) argue that communication is a

"facilitating dimension" through which families can influence their flexibility and cohesion. That is, a family's communication has the potential to shape their family functioning. In turn, one's family functioning likely predicts how they will communicate about a challenging issue like mental health. Crowe and Lyness (2014) found in their study of families with a member with significant mental illness that there is a strong association between a family's level of functioning and its ability to cope with stressors.

Family functioning has been linked to family communication patterns, which describes a family's positionality on an index of conformity orientation (i.e., the extent to which children are expected to go along with their parents' beliefs) and conversation orientation (i.e., a family's openness to discussion; Koerner & Fitzpatrick, 2002). Scholars have found that families with a strong conversation orientation have more positive outcomes relating to adolescent socialization and confidence than those without (Koerner & Fitzpatrick, 2002). Koerner and Fitzpatrick (2002) note that families with higher conversation orientations have higher family functioning. However, Koerner and Fitzpatrick (2002) argue that it is how a family navigates a high conformity orientation that predicts their family functioning.

For this reason, I argue that family functioning is a crucial predictor of perceptions of support and conflict when talking about mental health with a family member. Families with higher levels of functioning are generally more harmonious, resulting in better mental and relational health outcomes (Koerner & Fitzpatrick, 2002). Therefore, family functioning likely plays a strong role in the ways that families communicate about mental health, which, in turn, should predict one's mental health and satisfaction in their familial relationships. I contend that families with low levels of functioning likely provide less support when

discussing difficult topics like mental health than highly functioning families. In other words, a family's level of functioning directly corresponds with the ways they communicate about mental health, which ultimately affects their mental health and satisfaction in the relationship. There are numerous communication patterns that are potentially important in parent child mental health conversations, but two crucial elements are social support and conflict.

Social Support and Conflict

Individuals who experience mental health challenges may be able to maintain or revitalize their well-being by seeking support from close others (Lietz, 2011; Van Loon et al., 2015). Social support has been linked to many positive physical (Chu et al., 2010; Cobb, 1976) and mental (Harandi et al., 2017) health outcomes. Effective social support has the ability to minimize the negative effects that mental illness has on one's well-being (Henderson, 1992).

Scholars have identified five types of social support. Emotional support encompasses supportive gestures that serve to show empathy, love, and caring from a conversational partner (Xu & Burleson, 2001). Tangible support refers to practical forms of support, like providing a good or service (Xu & Burleson, 2001). Informational support consists of advice or suggestions (Xu & Burleson, 2001). Esteem support is support that reminds a conversational partner about their positive characteristics that make them able to manage a stressor (Xu & Burleson, 2001). Finally, network support generates feelings of belonging and social connection (Xu & Burleson, 2001). Some scholars have found that emotional support plays the largest role in individual outcomes. Burleson et al. (2003) argue that "Emotional support… addresses matters residing at the core of our being: our sense of self, the things we

aspire to, our hopes, our fears, and our deepest feelings" (p. 2). Therefore, the reason that social support, in general, may have such positive effects is due to the validation and respect inherent within it.

Research has noted that it is an individual's perceptions of received support that predicts their well-being (Haber et al., 2007). Research on physical health has noted that those who perceive themselves as having more support available have been shown to have better outcomes than those who perceive themselves as having inadequate support (Gidron & Ronson, 2008; Haber et al., 2007). Social support has been connected to lower levels of pain and disability for chronically ill populations (Gidron & Ronson, 2008; Kim et al., 2010), lower levels of mortality among healthy adults (Zhou, 2014), and lower mortality after heart attacks or HIV diagnoses (Zhou, 2014). On the other hand, those who perceive little to no support in their network are likely to have poorer physical quality of life (Zhou, 2014).

Likewise, research with healthy adults demonstrates that those who perceived themselves as having more support reporter higher levels of emotional well being than those with less support (Harandi et al., 2017; Zhou 2014). In addition, research shows that social support is associated with lower levels of depressive symptoms for individuals who have received an HIV or cancer diagnosis, or who recently experienced a heart attack (Zhou, 2014). It follows that social support would be extremely beneficial for personal and relational outcomes in the case of conversations about mental health with a loved one.

Research suggests that social support is most beneficial when it is received from a close family member, rather than friends or acquaintances (Shor et al., 2013). Marsh and Johnson (1997) argue that in families, mental health challenges impact the entire family system and not just the diagnosed individual. Families are systems of stress and resilience—

the feelings, behaviors, and actions of one family member have effects on everyone else in the system (Afifi et al., 2018). Consequently, the provision of social support from a family member is likely to have positive impacts on relational and mental well-being, while conflict during a difficult conversation could negatively influence one's well-being.

Individuals who are facing mental health challenges could find relief in receiving support from their family members. In fact, Taniguchi-Dorios et al. (2022) used a longitudinal diary study with college students to consider the within-person effects of disclosure to parents about mental illness, support, and well-being. They found that increases in participants' parental disclosure was associated with better well-being through perceptions of support quality. When participants disclosed more than usual, they perceived better support which, in turn, corresponded with greater well-being (Taniguchi-Dorios et al., 2022).

On the other hand, young adults may face stigma from their parents upon discussing the topic of mental health. This stigma could result in conflict during a parent-child mental health conversation. The appearance of negative conflict in a parent-child mental health conversation could be detrimental to one's mental wellness and could lead them to be less satisfied in their relationship with their family member afterward. Notably, research suggests that how a family handles conflict predicts their well-being, as conflict is inevitable (Curran & Scharp, 2019). Positive conflict interactions in families have been shown to improve some relational qualities, while negative conflict behaviors have been shown to predict a number of outcomes such as depression, anxiety, cognitive impairment, and premature mortality (Curran & Arroyo, 2018; Curran & Scharp, 2019). Extant research has documented the effects of negative parent conflict behaviors and a child's mental health, and research has begun to emerge that considers parental well-being in addition to child well-being (Curran &

Scharp, 2019). Curran and Scharp (2019) conceptualized constructive conflict as communication which fostered collaboration, brainstorming, and negotiation in order to find an outcome that was satisfying for all parties (Rinaldi & Howe, 2003). Unproductive, or destructive conflict can be considered any behaviors that serve to invalidate another person's feelings, show aggression, or undermine the other person (Curran & Scharp, 2019). Verbal aggression is one of the hallmarks of destructive conflict in families and has been linked to many mental health symptoms for adolescents (Curran & Arroyo, 2018). Therefore, the occurrence of negative conflict behaviors in these conversations may correspond with poorer mental health and lower levels of satisfaction for adult children, especially.

Younger generations are documented to have less stigmatizing attitudes toward mental illness than older generations (Schomerus et al., 2015), which may present an opportunity for conflict within intergenerational mental health conversations. Some research suggests that the differences in mental health beliefs between older and younger individuals may be due to a wide range of sociocultural factors, although there is also evidence that attitudes toward mental health may become more negative with age (Schomerus et al., 2015). This increases the potential for conflict to arise between young adult children and their parents when they talk about mental health. This conflict may stem from generational differences in levels of mental health stigma and the differing beliefs regarding mental health challenges and seeking treatment. Regardless of its cause, the presence of conflict during a parent-adult child a mental health conversation may be especially detrimental to parents' and children's mental health and satisfaction following the conversation. In addition, parents and children could have differing perceptions of support and conflict during a mental health conversation, making it necessary to measure parent and child perceptions of conflict and

support during a mental health conversation. Moreover, one family member's perceptions of conflict or support during a conversation could correspond with their family member's well-being and satisfaction, due to the interrelated nature of families (Afifi et al., 2020).

Importance of a Diverse Sample

Much of the foundational communication literature is based on a Eurocentric norm. The majority of theoretical frames and extant research center whiteness but claim generalizability (Afifi & Cornejo, 2020; Chakravartty et al., 2018). Afifi and Cornejo (2020) note that sample representativeness, though a foundational scientific principle, "…is summarily ignored by the vast majority of published social scientists" (p. 245). Moving forward, it is crucial for communication scholars to a) explicitly describe and consider the implications of the composition of their sample (*especially* when it is a majority-white sample) and b) make every effort to recruit racially diverse samples. By failing to report racial/ethnic demographics, scholars center whiteness and reinforce the exclusionary structures of academe (often unwittingly). Therefore, scholars should strive for sample diversity in order to produce more robust research.

With that perspective in mind, the present study assesses a model of parent-child mental health communication using a diverse sample. The hypothesized relationships should hold true regardless of cultural identity. However, it is still essential to include racially diverse participants so that the results reflect the population's experiences as much as possible.

Hypothesized Models

Four models will be tested for the current analysis (see Figures 1 through 4 for the hypothesized models). The outcomes of mental health and resilience will be tested in

separate models due to the number of parameters to be estimated and the small sample size, which limits power and the ability to properly fit the models. Additionally, separate models were run for support and conflict, also as a response to power constraints.

As shown in Figures 1 through 4, parents' and adult children's perceptions of their family functioning should be positively associated with their perceptions of the other's social support and negatively associated with their perceptions of conflict during a conversation about mental health. In turn, these more positive perceptions of their family member's communication should be positively associated with their own and the other's mental health and relationship satisfaction. In this sense, perceptions of social support and conflict may mediate the association between family functioning and participants' mental health during the conversation and their satisfaction after. In other words, family functioning enhances mental health and relational satisfaction by increasing one's perceptions of social support from their family member and lowering one's perception of conflict during a mental health conversation.

Because of the interdependent nature of family relationships, Actor-Partner Interdependence Models (APIM; Cook & Kenny, 2005; Kashy & Kenny, 1999; Kenny, 1996) will be used to test actor and partner effects, whereby children and parents' perceptions of family functioning should predict their own and the other person's perceptions of support when talking about mental health. Their perceptions of support, in turn, should also predict both family members' perceptions of mental health and their relationship satisfaction following the conversation. For example, a parent's perceptions of how functional their family is could positively predict their child's perceptions of support from their parent during the conversation.

Methods

Participants

One hundred sixteen parent-adult child dyads (232 participants total) participated in this study. The average age for parents in the sample was 51 years old (range: 35- 63, *SD* = 5.62) and children were, on average, 20 years old (range: 18-34, *SD*= 1.97). The average age distance between parents and children was 31 years (range = 15 to 44 years, *SD* = 5.74). Most parents identified as women (n = 91 or 78.4%; men n = 21 or 18%; nonbinary n = 1; Trans man =1; no response = 2). The majority of parents were heterosexual (n = 102 or 88%; bisexual n = 2; no response = 12) and most were married (n = 82 or 71%; 10% in a relationship; 10% divorced; 6% single). Half of parents reported a household income above $100,000 (n = 66 or 50%), 11% of participants had an annual income below $60,000 (n = 13), and 23% of parents chose not to respond (n = 27). Seventy nine percent of parents had earned a two-year degree or higher (n = 92). Twenty seven percent of parents reported receiving a mental health diagnosis (n = 31).

Sixty nine percent of adult children identified as women (n =80; men n = 33 or 28%; nonbinary n = 2; Trans man =1). Children self-identified their racial/ethnic identity as Asian (*n* = 24 or 21%), Black/African American (n =16 or 14%), Latinx (n = 9 or 8%), white (n= 48 or 41%), mixed-heritage including one or more of those races (n =17 or 15%) or another race (n = 2). Most children were heterosexual (n = 97 or 84%; homosexual n = 2; pansexual n= 4; queer/questioning n = 3). Sixty nine percent of children were single (n = 80; in a relationship n = 36). The majority of young adult children were currently attaining an undergraduate degree (n = 74 or 64%). One third of adult children had received a mental health diagnosis (n = 34).

Procedure

This study includes 116 parent-adult child dyads (232 participants) consisting of one young adult (18+ years old) and a parent/guardian of their choosing. The first author and a diverse group of trained research assistants collected data from April to December 2020 and collected additional Black and Latinx dyads (N = 12 dyads, 24 participants) in August of 2022. Initially, participants were recruited from a pool of undergraduate communication students at a large Western university in the U.S., with an emphasis on collecting additional minority dyads for a robust qualitative analysis. The second round of recruitment used Instagram ads and snowball sampling to recruit additional Black and Latinx participants. Participants in the first round of recruitment received class credit, while those recruited from outside of the university were compensated with $25 gift cards or Venmo payments (for a total of $50 per dyad).

Researchers asked interested individuals to invite their family member (either their parent/guardian or their adult child) to complete the study with them. In order to participate, both the parent and young adult child had to have access to a camera connected to the internet and feel comfortable reading and speaking in English. Members of the data collection team informed all potential participants about the study procedures, the subject matter they would discuss, and that their conversation would be recorded. All video conversations were conducted and recorded via Zoom, allowing parent-child dyads who were not in the same geographic location to participate simultaneously.

On the morning of their conversation, young adults and their parent/guardian both completed a pre-conversation survey on Qualtrics, which included measures of family functioning, mental health, demographic information, and other variables not included in this

study. Next, participants had a 15-minute conversation about mental health with their family member on Zoom. Each discussion was started by a member of the data collection team, who was primarily on the call to make sure their upper body was included in the camera and in the event that either participant expressed discomfort and needed them to redirect the conversation. The researcher did not interject during the conversation and turned their camera and microphone off to create a sense of privacy between the parent and adult child. Participants were instructed to discuss the following prompt:

> Please engage in a conversation together about your thoughts and experiences with mental health. Please address the following points in order: What are your thoughts about conversations surrounding mental health in the United States? What are your thoughts about mental health in your culture? What are your thoughts about mental health in your own family? Interact as you normally would if the two of you were to engage in a conversation about this topic and speak for 15 minutes.

The conversation was audio- and video-recorded by the researcher. Immediately following the interaction, participants completed a post-conversation survey measuring their perceptions of support during the conversation, mental health, and resilience. Videos were transcribed by research assistants, with all identifying information removed from the transcripts.

Measures

Family Functioning

Family functioning was measured in the pre-survey using an adapted version of the McMaster Family Assessment Device (Epstein et al., 1983). This 52-item device assesses family functioning along seven subscales (i.e., problem solving, communication, roles,

affective responsiveness, affective involvement, behavior control, and general functioning). To maintain relevance to this study's purpose, the questionnaire only included the general functioning subscale, totaling 12 items. Example items include, "We cannot talk to each other about the sadness we feel", "Individuals are accepted for what they are", and "In times of crisis we can turn to each other for support." Participants rated each statement on a four-point scale (*1 = strongly disagree, 4 = strongly agree*; Cuhadar et al., 2015). Higher scores indicate greater levels of family functioning. Cronbach's alpha was used to assess the reliability of all scales (Parent M =3.25 , SD = .47, α = .90; Child M = 3.08, SD = .46, α = .85).

Support Received During the Conversation

After the mental health conversation, participants responded to 10 items from Xu and Burleson's (2001) social support scale that measured emotional, esteem, and instrumental support. Example items include, "My family member expressed confidence in my ability to deal with the issues we discussed", "My family member made me feel like they can be counted on to be there for me when needed", "My family member provided useful advice about what to do", and "My family member made me feel cared for". Items were measured on a 7-point Likert-type scale (*1 = strongly disagree, 7 = strongly agree*). Higher scores indicated greater support received from their family member. Both parents and children had moderately high perceptions of support received during the conversation.(Parent M =5.81 , SD = 1.05, α = .83; Child M = 5.50, SD = 1.38, α = .95).

Mental Health During the Conversation

Participants' mental health during the conversation was measured using a modified version of the five-item Mental Health Inventory (MHI-5; Viet & Ware, 1983; Ware et al.,

1993) following the conversation. Participants responded to questions like, “During the conversation that just occurred, how often… Did you feel calm and peaceful? Did you feel downhearted and blue? Were you a very nervous person?” Items were rated on a five-point Likert-type scale *(1 = none of the time, 5 = all of the time).* Higher ratings indicated better mental health during the conversation (Parent *M* =4.38, *SD* = .63, α = .79; Child *M* = 4.15, *SD* = .71, α = .78).

Relational Satisfaction

Participants’ satisfaction in their relationship with their family member was measured immediately following the conversation using a shortened version of Huston, McHale, & Crouter’s (1986) relationship satisfaction scale. Participants responded to three sematic differential items asking how they felt about their relationship (“Miserable-Enjoyable,” “Doesn’t give me much-brings out the best in me,” “Hard-Easy”) on a scale from 1 to 7. The 2019; a = 0.89 and 0.95). Higher scores indicate greater relational satisfaction. (Parent *M* =4.55 , *SD* = .67, α = .91; Child *M* = 4.39, *SD* = .69, α = .89).

Data Analysis

Structural equation modeling with Maximum Likelihood Estimation in AMOS was used to test the hypothesized models. First, I ran confirmatory factor analyses for each model in which all latent variables were correlated with one another. Each latent construct had three parcels loading onto it, except for relationship satisfaction and mental health during the conversation, which had two parcels each. To test the hypothesized models, four Actor Partner Interdependence Models (Cook & Kenny, 2005; Kashy & Kenny, 1999; Kenny, 1996) were run using Structural Equation Modeling with maximum likelihood estimation in AMOS. Figures 1 through 4 show the hypothesized models. Parents’ and children’s variables

were allowed to correlate with one another (e.g., parent satisfaction and child satisfaction) though they are not in the hypothesized models for clarity.

Mediation Tests Using Bootstrapping

I assessed mediational paths using bootstrapping, which builds upon the work of Baron and Kenny (1986) to produce more reliable estimates. In accordance with Baron and Kenny (1986), bootstrapping calculates the effect of the independent variable on the mediating and dependent variables, the meditating variable's effect on the dependent variable when controlling for the independent variable, and the mediational path from the independent variable to the mediator to the dependent variable (or the indirect effect; Preacher & Hayes, 2004). Bootstrapping relies on theoretical sampling distribution and is "accomplished by asking a large number of samples of size *n* (where *n* is the original sample size) from the data, sampling with replacement, and computing the indirect effect, *ab*, in each sample" (Preacher & Hayes, 2004, p. 722). It is especially useful with small samples and non-normality (Hayes, 2012; Preacher & Hayes, 2004). Using AMOS, indirect effects were tested with 2,000 bootstrap replications and a 95% accelerated bias corrected and accelerated bootstrap confidence interval. Significant indirect effects indicate that mediation has occurred (Mallinckrodt et al., 2006). To assess specific mediational paths, I created a user-specified estimand in AMOS according to the steps outlined in Fawad (2021). Using the total indirect effects output, I named only paths that approached significance and asked AMOS to calculate the indirect estimate and its significance for each mediational path. Mediational paths that at least approached significance are presented below.

Chapter 3. Actor-Partner Interdependence Model Results and Discussion

Preview

This chapter provides the results and discussion for the hypothesized actor partner interdependence models introduced in the previous chapter. The analysis explored both direct and mediational paths.

Results

Preliminary Results

Descriptive statistics and correlations of all variables are provided in Table 1. Parents and children had moderately high perceptions of family functioning. Parents and children both reported moderately high levels of support received from each other during the conversation about mental health. Parents and children also had high perceptions of mental health during the conversation and relationship satisfaction after the conversation. Both parents and children perceived low levels of conflict during the conversation, on average.

The correlations in Table 1 support the hypothesized directions for the variables, with all variables correlating positively with each other, except conflict, which was negatively correlated with all other variables. All of the parents' variables were significantly correlated with one another. Parents' mental health was correlated with their perceptions of support received from their child during the conversation. Parents' perceptions of family functioning, satisfaction, and support were all positively correlated. Parent mental health during the conversation was correlated with parent perceptions of family functioning and strongly correlated to parents' satisfaction in the parent-child relationship.

Some of the children's correlations were nonsignificant, suggesting a weak relationship between some of the children's variables. Children's perceptions of support

received from their parent during the conversation did not significantly correlate with any other variables, suggesting that the support from a parent in the conversation may not be enough to impact a child's perceptions of the family and relationship, nor their mental health. Children's perceptions of family functioning were positively correlated with their mental health during the conversation and their satisfaction in the relationship with their parent. Parents' perceptions of their family functioning were also inversely associated with their perception of conflict during the conversation. Children who felt their families were highly functional tended to perceive less conflict, were highly satisfied in their relationships, and had better perceptions of their mental health during the conversation. Children's mental health during the conversation was positively correlated with their satisfaction with the relationship following the conversation and negatively correlated with their perceptions of conflict during the conversation.

Parents' perceptions of family functioning, mental health during the conversation, and satisfaction in the relationship were positively correlated with children's perceptions of family functioning, relationship satisfaction, and mental health during the conversation (range = .23 to .48, $p < .05$). Parents' perception of conflict during the conversation was highly correlated with children's perceptions of conflict. Parents' and children's perceptions of conflict were strongly and negatively correlated with their partner's family functioning, mental health during the conversation, and relationship satisfaction after the conversation. Parents' perception of support during the conversation was positively correlated with children's satisfaction and their mental health during the conversation and negatively correlated with children's perception of conflict during the conversation. Children's perceptions of support did not significantly correlate with any of the parents' variables, and

parent perceptions of support during the conversation did not correlate with children's perceptions of family functioning.

Measurement Models

Family Functioning, Conflict, and Satisfaction Model. All parceled elements loaded acceptably onto their respective constructs (range .74 to .96, $p < .001$). The standardized estimates and significance levels for the correlations in the family functioning, conflict, and satisfaction measurement model are provided in Table 2 and the factor loadings are provided in Table 3. The measurement model was an excellent fit to the data, χ^2 (89, N = 116) = 116.98, $p = .03$, CFI = .98, NFI = .93, IFI = .98, RMSEA = .05. All fit indices were strong (CFI, NFI, and IFI above .90; Bentler, 1990; RMSEA less than .08; Browne & Curdeck, 1993).

Family Functioning, Conflict, and Mental Health Model. All parceled elements loaded acceptably onto their respective constructs (range = .66 to .93). The standardized estimates and significance levels for the correlations in the family functioning, conflict, and mental health measurement model are provided in Table 4 and the factor loadings are provided in Table 5. The measurement model was an excellent fit to the data, χ^2 (89, N = 116) = 110.84, $p = .06$, CFI = .98, NFI = .92, IFI = .98, RMSEA = .05.

Family Functioning, Support, and Satisfaction Model. All parceled elements loaded acceptably onto their respective constructs (range .74 to .99, $p < .001$) The standardized estimates and significance levels for the correlations in the family functioning, support, and satisfaction measurement model are provided in Table 6 and the factor loadings are provided in Table 7. The measurement model was an excellent fit to the data, χ^2 (89, N = 116) = 86.48, $p = .56$, CFI = 1, NFI = .95, IFI = 1, RMSEA = .00.

Family Functioning, Support, and Mental Health Model. All parceled elements loaded acceptably onto their respective constructs (range = .60 to .99). The standardized estimates and significance levels for the correlations in the family functioning, support, and mental health measurement model are provided in Table 8 and the factor loadings are provided in Table 9. The measurement model was an excellent fit to the data, χ^2 (89, N = 116) = 110.31, $p = .06$, CFI = .98, NFI = .92, IFI = .98, RMSEA = .05.

Structural Equation Models

Family Functioning, Conflict, and Satisfaction Model. The hypothesized family functioning, conflict and satisfaction model was an excellent fit to the data, χ^2 (89, N = 116) = 116.98, $p = .03$, CFI = .98, NFI = .93, IFI = .98, RMSEA =.05. All parcels loaded highly onto their corresponding latent constructs (range = .74 to .96; see Figure 5 for the estimated parameters and significance levels). Parents' and children's perceptions of family functioning were significantly correlated ($r = .48$, $p < .001$). Parents' and children's satisfaction were correlated with one another ($r = .26$, $p < .05$), as were their perceptions of conflict ($r = .50$, $p < .001$). Both parents and children with perceptions of higher levels of family functioning perceived less conflict during the conversation and were more satisfied in their relationship. In addition, for both parents and children, their perceptions of conflict during the conversation were associated with less relationship satisfaction following the conversation. Parents' perceptions of family functioning were also inversely associated with children's perceptions of conflict during the conversation. That is, the better the parents believed their family to function, the less their adult child thought they experienced conflict with their parent in the conversation about mental health.

Family Functioning, Conflict, and Mental Health Model. The hypothesized model was an excellent fit to the data, χ^2 (89, N = 116) = 110.84, p = .06, CFI = .98, NFI = .92, IFI = .98, RMSEA =.05. All parcels loaded highly onto their corresponding latent constructs (range = .73 to .93; see Figure 6 for the estimated parameters and their significance levels). Parents' and children's perceptions of family functioning were positively correlated (r = .48, $p < .001$). In addition, parents' and children's reported conflict were positively correlated (r = .26, $p < .05$), and their mental health approached significance in terms of being positively correlated (r = .31, $p < .10$). Both parents' and children's perceptions of how well their family was able to communicatively function was inversely associated with conflict during the conversation. Greater perceptions of conflict during the conversation were associated with poorer mental health during the conversation for both parents and children. Moreover, children's perceptions of family functioning was positively associated with their perceptions of their own mental health during the conversation. Parents' perceptions of family functioning negatively predicted children's perceptions of conflict. In addition, parents' perceptions of conflict during the conversation were associated with poorer child mental health during the conversation.

Family Functioning, Support, and Satisfaction Model. The hypothesized family functioning, support, and satisfaction model showed excellent fit overall, χ^2 (89, N = 116) = 86.48, p = .56, CFI = 1, NFI = .95, IFI = 1, RMSEA =.00. All of the composite variables loaded highly onto their corresponding latent constructs (range = .74 to .99; see Figure 7 for the estimated parameters and their significance levels). Children's perceptions of support did not seem to play a large role in the process. Parents' and children's perceptions of family functioning were positively correlated (r = .47, p < .001). Parents' and children's satisfaction

were also positively correlated (r = .30, p = .01), although their support was not ($p > .10$). Children with higher perceptions of family functioning were more satisfied in their relationship with their parent. The association between children's perceptions of family functioning and their perceptions of support approached significance. Parents who felt their families were highly functional perceived greater amounts of support from their child during the conversation and were more satisfied with their relationship with their child after the conversation. Parents' perceptions of support during the conversation were positively associated with their own relationship satisfaction as well as the satisfaction of their child. In other words, when parents felt more supported during the conversation, both they and their child were likely to be more satisfied in the relationship after the conversation.

Family Functioning, Support, and Mental Health Model. The hypothesized family functioning, support, and mental health model showed excellent fit overall, χ^2 (89, N = 116) = 110.31, $p = .06$, CFI = 98, NFI = 92, IFI = .98, RMSEA =.05. All of the composite variables loaded highly onto their corresponding latent constructs (range = .89 to .98; see Figure 8 for the estimated parameters and their significance levels). Parents' and children's perceptions of family functioning were positively correlated, ($r = .48$, $p < .001$) as were their perceptions of their mental health after the conversation ($r = .47$, $p < .05$). Children with higher perceptions of family functioning reported higher levels of mental health following the conversation. Parents who felt their family was highly functional had greater perceptions of support from their child during the conversation. Parents' perceptions of support positively predicted their child's mental health during the conversation. The path from child family functioning to parent mental health approached significance, as did the association from

children's perceptions of support from their parent during the conversation to their parent's mental health during the conversation.

Mediation Results

Family Functioning, Conflict, and Satisfaction. Table 10 reports the significant mediational paths in the family functioning, conflict, and satisfaction model. The association between parent family functioning and parent satisfaction was mediated by parents' perceptions of conflict (standardized indirect estimate = .16, p = .01). Parents' perceptions of family functioning was also associated with lower children's perceptions of conflict, which, in turn, was associated with greater children's satisfaction (standardized indirect estimate = .08, p =.02), which represented a full mediation. Parents' perceptions of how functional their family was predicted better satisfaction for both themselves and their adult child by softening their assessment of conflict. In other words, parents' family functioning negatively predicted both their perceptions and their children's perceptions of conflict which, in turn, predicted better relationship satisfaction for both of them.

Family Functioning, Conflict, and Mental Health. Table 11 reports the mediation results for the family functioning, conflict, and mental health model. Parents' perceptions of family functioning predicted better appraisals of conflict from the parent which, in turn, predicted better mental health for both parents (standardized indirect estimate =-.18, p =.01) and children (standardized indirect estimate = .15, p =.02) during a mental health conversation. Additionally, parents' perceptions of family functioning predicted lower assessments of conflict from their children which, in turn, predicted better mental health from their children (standardized indirect estimate = .09, p =.04). All of the aforementioned moderations were full mediations. Children's perception of conflict was a marginally

significant mediator of children's perceptions of family functioning and their mental health (standardized indirect estimate = .07, p = .06). All other indirect effects were nonsignificant.

Family Functioning, Support, and Satisfaction. Table 12 reports the mediation results from the family functioning, support, and satisfaction model. Parents' perceptions of family functioning corresponded with better perceptions of support received from their child which, in turn, was associated with higher parent satisfaction, (standardized indirect estimate = .07, p =.01). In addition, parents' family functioning corresponded with higher perceptions of support received from their child, which, in turn, was associated with their child being more satisfied (indirect estimate = .10, p =.00), which was a full mediation.

Family Functioning, Support, and Mental Health. Table 13 reports the mediation results for the family functioning, support, and mental health model. Only the mediational path from parent family functioning to parent's perceptions of support to children's mental health was significant (standardized indirect estimate = .13, p =.02) and it was a full mediation. Notably, the relationship between parent family functioning and child mental health was nonsignificant when accounting for parent support, suggesting full mediation. These results suggest that parent perceptions of family functioning predict better mental health for children by increasing parents' perceptions of support from their child.

Discussion

Rates of mental health challenges have increased over the last 10 years in the U.S., with young adults reporting the greatest rates of mental health challenges compared to other age groups (SAMHSA, 2020). Experiencing mental health challenges can impact one's quality of life if not properly managed (NAMI, 2020), and turning to close others for support about these challenges may be one way individuals and families can regulate their well-being

(Chu et al., 2010; Cobb, 1976; Dailey, 2006). However, if mental health conversations fail to be supportive, and conflict arises, both conversational partners may leave an interaction dissatisfied and feeling unwell (Qu et al., 2021). Young adults who experience negativity and conflict in their families about mental health often report lower levels of closeness and satisfaction and describe feeling disconnected from their parents (Rasmussen et al., 2022). Therefore, it is important to understand what communicative practices predict better personal and relational outcomes in a parent-adult child conversation about mental health.

Family mental health communication research is limited, and few studies have simultaneously considered both parents' and children's perspectives during a mental health conversation or explored the interconnected nature of families. The present study considered a processual model of family communication about mental health. The model assessed the relationship between each family member's perception of their history of family functioning, their perceptions of the communication employed by their family member during a mental health conversation (specifically, support and conflict), and their mental health and relationship satisfaction afterward. Family functioning served a strong role in the process, predicting family members' evaluation of support and conflict from a family member during a mental health conversation. In turn, their perceptions of support and conflict during the conversation predicted their mental health and satisfaction following the conversation. Parents' family functioning had both direct and indirect effects on their children's variables, with parent family functioning operating through family members' perceptions of support and conflict to predict their child's mental health during the conversation and their satisfaction in the relationship afterward. These results provide evidence that a parent's

perceptions of conflict and support during a conversation may influence children's mental heath and relational satisfaction.

The literature suggests that families can be an excellent source of social support around challenging issues (Shor et al., 2013), but a lack of support and/or the appearance of conflict during these challenging conversations could have negative effects on one's mental state and satisfaction with familial relationships (Rasmussen et al., 2022). The results showed support for the hypothesized models, with family functioning serving as a significant driver of how individuals assessed conflict and support from their family member, how they felt during the conversation, and their satisfaction in the relationship afterward. Partner effects were found, with parents' perceptions of their family's ability to communicatively function in the past and their appraisals of conflict and support from their child during the conversation predicting their children's satisfaction and mental health. Moreover, mediational analyses showed that parents' family functioning predicted better appraisals of conflict and support for both parents and children which, in turn, corresponded with better child mental health during a conversation and with greater child satisfaction following the conversation. The results suggest a full mediation. In other words, a parent's perceptions of family functioning may influence how young adult children assess their parent's communication which, in turn, may correspond with better mental health and greater relational satisfaction.

The Process of Family Mental Health Communication

The hypothesized models were primarily supported, with perceptions of family functioning playing a central role in the communication used by family members and a family's outcomes. Perceptions of family functioning were a strong predictor of how satisfied both parents and children were in their relationship across all four models, with

greater perceptions of family functioning being associated with greater relationship satisfaction between the parents and adult children. In addition, children's family functioning predicted their mental health during the conversation, suggesting that children's existing assessment of their family was associated with their mental state while talking about mental health with their parent. Additionally, parents' perception of how well their family was able to function predicted less conflict which, in turn, corresponded with better mental health and more satisfaction. Previous research has emphasized the importance of family functioning to facilitate healthy, productive communication (Koerner & Fitzpatrick, 2002; Olson et al., 2019). When parents and children in the present study believed that their family was able to communicatively function and coexist, they were likely to perceive their conversations more positively and to fare better overall. If parents and children felt their family was communicatively dysfunctional, they may be more susceptible to negative personal and relational outcomes and were more prone to destructive communication patterns than families that were highly functional.

Notably, parents' and children's perceptions of family functioning, conflict, satisfaction, and mental health were all strongly positively correlated. However, parents' and children's perceptions of support received from each other were *not* correlated, suggesting that their assessments of the support they received during a conversation were independent of one another. Part of this may have to do with individuals' preferences for how they would like to receive support, which have been documented to impact one's perceptions of another's communication (McLaren & High, 2019).

Overall, a parent's perception of family functioning was a significant predictor of the assessments they and their child made about the other's communication along with their

personal and relational outcomes. How functional a parent believed their family to be was a predictor of the social support and conflict that was employed by both members of the conversation. Often, a parent's family functioning worked to help their and their child's outcomes through their perceptions of conflict and support. On the other hand, when parents felt that their family was more dysfunctional, they and their child reported more negative perceptions of their partner's communication and, consequently, were less content in their relationship than dyads whose parents felt they were highly functional.

Social Support

The results for the social support models revealed evidence of support's role in the process of parent-child mental health communication. Parents who reported higher levels of family functioning reported greater perceptions of social support received from their child during the conversation than parents who felt their families were less functional. Additionally, parents who felt their children were more supportive during the conversation were more satisfied in their relationship with their child than parents who felt their children were less supportive.

Notably, the amount of support parents received was a strong predictor of their child's mental health during the conversation as well as their child's satisfaction in the relationship following the conversation. In other words, when parents felt more supported during a mental health conversation, their children tended to have better mental health and were more satisfied in their relationship with their parent. These results provide evidence for the interconnected nature of family relationships and the communication inherent in them. When parents felt that their children were open and supportive in the conversation, their children felt better during the conversation and were more satisfied in their relationship

afterward.. In other words, how parents perceived their child's communication during a mental health conversation predicted their child's well-being. The results suggest that when parents are feeling supported and appreciated in a mental health conversation, their children are likely to fare better. Gender likely plays a role in this finding. Most of the parents in this sample were mothers, and mothers have been found to be the relationship maintenance "experts" of their families (Afifi et al., 2016). Moreover, research has suggested that the satisfaction and well-being of a child is often tied to their communication with their mother (e.g., Levin & Currie, 2010). In alignment with those findings, when mothers in the current study felt more supported by their children during a mental health conversation, their children had better mental health during the conversation and were more satisfied in their relationship with their parent. Notably, children's variables were not strong predictors for their parents' perceptions of communication and well-being, Suggesting that parents' thoughts and feelings are more influential on their children than the other way around. This speaks to the power dynamic in the parent-child relationship as well.

The relationships between children's family functioning, their perceptions of the support they received from their parent, and their parent's mental health approached significance. With a larger sample, it may have become apparent that children's perceived family functioning predicts how much support they report receiving from their parent. In addition, a larger sample may have shown that children's perceived family functioning, as well as their perceptions of support from their parent, predicted their parent's mental health during the conversation. A larger sample may also have shown that when children believed their parents were highly supportive during the conversation, their parents felt better during the conversation than the parents of children who perceived little support from their parent.

Unfortunately, the sample was not large enough to definitively detect the impacts of these variables.

Along with the direct relationships displayed in the model, multiple significant indirect effects appeared, showing the process of parent-child mental health communication. Parents' family functioning operated through parents' perceptions of support from their child to predict greater satisfaction for both them and their child. In other words, parents' assessments of family functioning corresponded with greater levels of support received from their child which, in turn, predicted their satisfaction and the satisfaction of their child. Moreover, parents' assessment of family functioning corresponded with greater perceptions of support which predicted better mental health for the adult child during a mental health conversation. Notably, children's perceptions of support received from their parent served a limited role in this process, which suggests that their well-being may not be impacted as much by their perceptions of support during a single conversation, though their outcomes are tied to their parent's perceptions of support received from them.

Conflict

The results for the conflict models suggest that both parents' and children's perceptions of conflict during a mental health conversation played a central role in the communicative process, supporting the hypothesized conflict models. Both parents' and children's perceptions of family functioning negatively predicted their perceptions of conflict during the conversation. Parents and children who believed their family was highly functional reported less conflict during the conversation. Additionally, both parents' and children's perceptions of conflict negatively predicted their own mental health during the conversation as well as their satisfaction in the relationship following the conversation. In

other words, when parents and children experienced more conflict during the conversation, they felt worse during the conversation and were less satisfied in their relationship afterward than those who perceived lower conflict which corresponds with accident literature that suggests that higher levels of family conflict predicts greater levels of depression and anxiety for parents and children (Curran & Arroyo, 2018; Curran & Scharp, 2019).

Furthermore, parents' perceptions of family functioning negatively predicted children's perceptions of conflict. When parents felt that their family was highly functional, their children were likely to perceive less conflict during the conversation compared to those who were not functional. Additionally, parents' perceptions of conflict during the conversation negatively predicted children's mental health. When parents felt there was more conflict in the mental health conversation, their children reported feeling worse during the conversation than those who did not have conflict. Again, this highlights the importance of parents' perceptions of their family's ability to function as well as their assessment of the communication they receive from their child. A parent's perceptions of how supportive their child was in the conversation or their appraisal of conflict may influence children's mental health during the conversation andtheir satisfaction in the relationship afterward. These results suggest that a parent's emotional or mental state can be impactful to their child and the tone of the conversation, which corresponds with previous research that highlights the importance of parent communication on children's perceptions and outcomes (e.g., Levin & Currie, 2010).

Social support was not as impactful as conflict in these mental health conversations, though family functioning did work through perceptions of support and conflict to improve well-being for both parents and children. Moreover, parents' variables appeared to have more

partner effects than children's, suggesting that a parent's appraisals of the family and their communication can influence how adult children evaluate an interaction and their relationship with their parent more generally. These results point to the value in considering both parent and child perceptions of communication, as appearance perceptions may greatly influence how their child understands and communicates about mental health. The appearance of conflict during these challenging conversations negatively influenced one's mental state and the quality of the parent-child relationship. This suggests that though the positive effects of support can be found in mental health conversations, conflict has the ability to put parents and children in jeopardy.

Limitations and Future Directions

One limitation to the current analysis has to do with the limited size of the sample. Larger samples might lend themselves to a single, large model instead of four separate models. However, the method I employed allowed me to test these hypotheses within the bounds of my data. Notably, the measures used in the present study do not take into account cultural norms, so future studies could validate the use of these measures across cultural groups and/or inductively derive measures that reflect specific cultural norms in the conceptualization and operationalization of constructs like social support, conflict, and family functioning.

It is a significant benefit that this study includes a diverse sample with individuals from multiple racial and ethnic groups. However, future studies should collect their samples with the intent to run a multiple-group actor-partner interdependence model that is able to account for racial or ethnic identity. This research should collect samples that are weighted for each racial group. Doing so could illuminate differences in the process of communication

across cultural groups, providing greater insight into the process of parent-child mental health communication across a number of groups.

Finally, as family functioning was found to be a strong driver in the models, future research should dissect the elements that shape family functioning to explore what elements of functioning are most impactful for parent child mental health conversations.

Overall, this project contributes to the mental health communication literature by explicating the process of family mental health communication. This analysis is part of a strong foundation for the family mental health communication literature. This study recruited a diverse sample of parents and adult children, which provided crucial insight that would not have been apparent with a solely-undergraduate sample. By including the perspectives of both parents and children, I was able to glean insight into the interconnected nature of family mental health communication.

Chapter 4. Analysis Phase Two: A Cross-Cultural Thematic Analysis of Parent-Adult Child Conversations

Preview

The previous analysis highlighted the process of parent-child mental health communication quantitatively. While it is important to test theoretically-derived models on diverse samples, there is important nuance missed through the sole use of quantitative analyses, which are limited by the questions asked and the scales used. Furthermore, the previous analysis could not elucidate the content of these parent-child conversations about mental health and the important role that culture played in the form and function of that communication. Considering culture in my analysis is essential to gaining a robust understanding of the process of family mental health communication. Racial and ethnic identity impact the form, function, and interpretation of one's communication (Chang, 2014; Davis & Cardwell, 2022). According to Davis and Cardwell (2022), family communication is raced. In other words, the ways people of color interact with and communicate within the world is tied to the systemic inequalities that are ingrained in the U.S. Therefore, the communicative tools families employ to build resilience during mental health conversations should be considered alongside the cultural background of those communicating (Davis & Cardwell, 2022). Families' beliefs and communication about mental health are likely affected by cultural identity, with social norms and cultural beliefs dictating the content and communicative tools family members use to discuss mental health.

This chapter dives into the cultural nuance that exists in the experiences of families of color in the U.S. In the pages that follow, I detail a number of cultural factors that likely influence the form and function of family mental health communication for the three largest

racial and ethnic minority (REM) groups in the U.S. I also consider confirmation theory as a foundation to gain greater insight into the form of family mental health conversations and the role of culture within them. Finally, this chapter describes the second phase of analysis, which uses Tracy's (2018) Phronetic Iterative approach to qualitative data analysis to uncover cultural themes that emerged from the parent-adult child conversations of mental health that were described in the second chapter.

Introduction

Culture is extremely important to consider in the examination of family mental health communication. The U.S. includes a number of REM groups, with so-called "minority" individuals constituting nearly half of its population, and the majority of the global population (U.S. Census, 2021; WHO, 2020). The three largest REM groups are Latinx (19%), Black (13%), and Asian (6%) Americans (U.S. Census, 2021). Research suggests that minoritized Americans are significantly less likely to utilize mental health treatments than white Americans, despite reporting similar rates of mental health challenges (SAMHSA, 2021). Additionally, REM Americans are documented to have more stigmatizing beliefs regarding mental health than white Americans (SAMHSA, 2021). Family communication, and the cultural norms and constraints embedded in its enactment, is essential to how individuals navigate the world, their social experiences, and their mental health challenges. Therefore, it is pertinent to include a cultural lens in the study of family mental health communication. Because communities of color are less likely to use formal mental health resources (SAMHSA, 2021), research should examine everyday conversations about mental health with family members. Overall, mental health stigma plays a central role in the

dialogue surrounding mental health and the barriers individuals experience in seeking mental health treatment and support.

Because the use of formal mental health resources is often stigmatized (Sickel et al., 2019), particularly in communities of color, many individuals never seek treatment for their mental health challenges. Therefore, it is important to study informal conversations about mental health across cultural groups. The family communication that individuals are exposed to in their youth is a primary source for young adult children to learn schemata about mental health. These schemata can teach children whether they should talk about mental health, help them develop the ability to cope, and reinforce resilience (Flood-Grady & Koenig Kellas, 2019). REM families are generally collectivistic, valuing the safety and success of the family over an individual's goals (Chang, 2014). This focus on the good of the family can make it difficult for young adults to seek support from their parents as many are concerned about disrupting their relationship and the group's harmony (Chang, 2014). The cultural norms that are entrenched in family mental health communication likely impact how family members understand their relationships and their mental health challenges. As a result, it is pertinent to include a cultural lens in the study of family mental health communication.

Despite the well-documented effects of cultural mental health stigma on treatment-seeking and disclosure, researchers know less about the way this stigma manifests and is proliferated in everyday conversation. Confirmation theory (Dailey, 2010; Ellis, 2002) may provide a useful frame to study family mental health communication. Confirmation theory argues that more confirming (i.e., accepting and challenging) communication corresponds with better outcomes (Dailey, 2010; Ellis, 2002). However, challenge (communication meant to encourage the other person to do better) could be disconfirming when communicating

about a subject as sensitive as mental health. The present study explores how (dis)confirmation serves to create, reinforce, and challenge the beliefs families have about mental health in their everyday conversations.

I use an iterative thematic analysis (Tracy, 2018) to discern how families communicate about mental health across cultural groups in the U.S.. I explore how (dis)confirming communication reveals itself in parent-child mental health conversations, and how that communication serves to reinforce or challenge extant norms. The present analysis goes beyond survey or retrospective data to explore the communicative processes—namely (dis)confirming messages —that create, reinforce, and challenge meaning around mental health. This study opens the door for research regarding mental health communication in the family and embraces complexity through the focus on racial and ethnic group identity.

This chapter will consider confirmation theory as a communicative tool families use to reinforce and challenge mental health beliefs. Then, it will provide an overview of historical background, social norms, and stigmatizing beliefs for three REM groups (Black, Latinx, and Asian Americans) and consider how and why their mental health communication may differ.

Confirmation Theory

Communication serves a prominent role in creating and reinforcing meaning around mental health in families. Confirmation theory can elucidate the form of these conversations and their cultural connections. Confirmation theory argues that confirming messages (i.e., any messages that supports or corroborates one's experiences) validate one's self-concept, which corresponds with feelings of acceptance and confidence (Dailey, 2006; 2010). In contrast, disconfirmation consists of messages that reject one's perspective or make them feel

inferior (Dailey, 2010). Individuals who report more disconfirmation in their family environment tend to have lower self esteem and less confidence than those in confirming family environments (Dailey, 2010). Parents that validate their children's experiences are likely to have more open and productive conversations than those who negate their children's experiences. Confirmation in one's family environment in general, then, may correspond with a greater willingness to talk about mental health and more open, encouraging conversations.

(Dis)Confirmation is especially relevant during difficult conversations, including subjects that foster disagreement (Dailey, 2010). The overall confirmation and disconfirmation in these challenging interpersonal moments can predict relational and personal health outcomes (Dailey, 2010). In these situations, confirmation can take the form of validating and engaging with a conversational partner, even if they disagree with what the other person is saying (Dailey, 2010). Central to confirmation theory, then, is the idea that relational partners are able to both challenge and validate each other during interactions in order to reach a better understanding of themselves (Dailey, 2010). Buber (1965) understood confirmation to be the process of demonstrating acceptance toward others while seeing or highlighting their future potential (Dailey, 2010). In this way, confirmation entails challenging the other person to reach their full potential. The dimensions of acceptance and challenge comprise the construct of confirmation.

Acceptance is characterized by perceptions of attentiveness, affection, and warmth from a conversational partner (Dailey, 2010). The primary function of acceptance is to affirm the validity of the other person's thoughts and experiences (Dailey, 2010). The second element of confirmation, challenge, consists of those communicative practices that push

one's conversational partner to improve. Challenge could be demonstrated through asking questions, having someone defend their opinions or decisions, or helping someone work through their emotions (Dailey, 2010). Young adults have a stronger sense of self when they perceive higher levels of acceptance from their parents, though unconditional acceptance corresponds with underachievement (Baumeister et al., 2003; Dailey, 2010).

Young adults who grow up a family environment where they are solely challenged are likely to have poorer self-concept than those in an atmosphere that is both challenging and accepting (Dailey, 2010). Some young adults whose families withhold acceptance are predisposed to strive for excellent performance, though it is not out of self-interest or the desire to excel (Dailey, 2010; Rathunde 1996). Instead, the theory suggests these young adult children are left feeling unfulfilled, even when they are achieving highly (Dailey, 2010). Therefore, an environment that is solely challenging may encourage behavior that could be construed positively but may negatively impact a young adult's self concept (Dailey, 2010).

Young adults with parents who behave in a disconfirming manner regarding mental health might face difficulties with their own mental health. They may pretend that they are not experiencing mental health challenges, but the suppression of these issues could have negative effects on their well-being (Dailey, 2010). Although children in a primarily challenging environment may try to negate their problems, ignoring mental health challenges can decrease one's quality of life (Dailey, 2010).

Research using confirmation theory in health contexts has primarily considered conversations about dieting and weight loss, which is a topic (like mental health) that can be stigmatizing and has the possibility to evoke negative responses from conversational partners (Arroyo et al., 2017; Neumark-Sztainer et al., 2010). This research has highlighted that

normative responses to “fat talk” (self-critical comments about one’s body) generally consist of denial (e.g., “you are not fat”), positivity, and complementarity (Arroyo et al., 2017; O’Dougherty et al., 2011). Despite the supportive nature of these responses, those on the receiving end fail to find them persuasive (Arroyo et al., 2017; O’Dougherty et al., 2011). According to Arroyo et al. (2017), part of the reason denial responses may be ineffective in changing fat talk has to do with these statements negating or dismissing an individual’s self image and feelings. Arroyo et al. (2017) found that the perception of acceptance from a conversational partner during “fat talk” was related to less health-damaging behaviors, while the appearance of challenge had no effect on participants’ health behaviors or outcomes.

There are crucial distinctions between “fat talk” and mental health conversations. While obesity is a known and widely acknowledged health barrier in the U.S., many individuals question the legitimacy of mental health challenges. In addition, health information regarding weight is widely available, while many individuals struggle to find resources regarding mental health challenges (Misra et al., 2021). However, this research lays a foundation to consider which communication patterns serve to create and reinforce social norms in conversations about stigmatized health problems.

Young adults’ relationship with their parents can serve to guide them and affirm their life goals as they enter adulthood (Dailey, 2006). As such, parent-child conversations about children’s experiences with mental health is a domain in which confirmation theory could provide important insights. Generally, the theory argues that challenge and acceptance should both be present for the best outcomes. However, in conversations regarding stigmatizing topics like mental health, there is the possibility that challenge, in itself, could be perceived as disconfirming.

Culture and Mental Health Communication

REM groups perceive mental health struggles as more stigmatizing, and often more shameful, than white Americans (Misra et al., 2021). There is evidence as to how mental health stigma uniquely manifests for each group, although there is a dearth of culturally-rooted inquiries into the proliferation of mental health stigma (Link et al., 2004; Misra et al., 2021). Even less research considers the way family communication serves to reinforce or challenge stigmatic norms and views. This communication, and the meaning embedded within it, likely differs across racial and ethnic groups.

Previous research has found a host of differences relating to mental health stigma across cultures. In the U.S., communities of color generally have more stigmatizing attitudes toward mental illness, which likely correlates with poorer communication, or no communication, about mental health issues. Papadopoulos et al. (2013) found that the variation in stigma across cultures can be partially explained by individualism and collectivism. Their findings revealed that collectivism was strongly related to stigmatizing attitudes while individualism was highly correlated with positive attitudes toward mental health. This corresponds with previous research that has found that Black, Latinx, and Asian Americans are generally more collectivistic than white Americans.

Individualism-Collectivism and Mental Health

Cultural dimensions theory outlines a range of behaviors and norms that impact the ways people communicate and how they interpret the communication of those around them (Hofstede, 1986; Papadopoulos et al., 2013). One dimension, in particular, individualism—collectivism, is compelling for the study of family mental health communication. This dimension influences how individuals define themselves, their goals, and their relationships

with others (Hofstede, 1986; Papadopoulos et al., 2013). People in more individualistic cultures tend to prioritize their own goals and well-being over that of the group, while those from more collectivistic cultures prioritize the needs of the group over their own (Papadopoulos et al., 2013). More collectivistic cultures place emphasis on taking care of those within the group, putting the good of others over the good of the self, and honoring one's family, among other traits (Benito-Gomez et al., 2020). Individualistic cultures generally emphasize the power of the individual to shape their own life, the desire to strive for individual goals, and putting one's own needs before the needs of others (Benito-Gomez et al., 2020).

Although mental health challenges are universally relevant, whether families have more individualistic or collectivistic values can have a major impact on family conversations about mental health (and the mythos surrounding it). These values also relate to one's likelihood to seek help from family, friends, or mental health professionals (Papadopoulos et al., 2012). Notably, the U.S. is culturally diverse, and many REM groups evidence a more collectivistic belief system (Benito-Gomez et al., 2020).

Black Americans tend to be collectivistic in their understanding of the family and their roles (Benito-Gomez et al., 2020). Kennedy and Winkle-Wagner (2014) suggest that Black American families value more interdependence within the family system because Black Americans are the descendants of African slaves who originally came from collectivistic cultures (Benito-Gomez et al., 2020). Researchers studying Black American families have found that the family system consists of a hierarchical structure that values obedience to elders and following expressed rules (Benito-Gomez et al., 2020; Collins et al 2000; Smetana, 2000). Scholars have suggested that this emphasis on collectivistic values

developed in response to the continued mistreatment and devaluation of Black Americans (Davis & Cardwell, 2022). Black families' use of obedience can be considered a protective strategy, given that Black Americans (especially Black men) are presently and historically particularly vulnerable to experiencing discrimination (Benito-Gomez et al., 2020).

Latinx American families are also more collectivistic than European Americans (Benito-Gomez et al., 2020). Latinx families tend to conform to family values and hold respect for elders (Benito-Gomez et al., 2020; Keller et al 2004). Latinx Americans embrace the value of familism, which involves prioritizing the family over the self, respect and obedience, and good manners (Benito-Gomez et al., 2020; Keller et al 2004), which all reflect collectivistic values. Like Black Americans, Latinx Americans likely turn to each other for social support and protection in a country that mistreats them and carries heavy anti-immigrant sentiment (Benito-Gomez et al., 2020).

Asian Americans are also documented to have a more collectivistic worldview (Benito-Gomez et al., 2020). Asian American families generally socialize their children to value family obligation, obedience, and interdependence (Benito-Gomez et al., 2020; Chen et al., 2013). Research has suggested that even as they get older, Asian American adolescents tend to place emphasis on the importance of deferring to their parents when making decisions and remaining dependent upon them (Chen et al, 2013). In contrast to Latinx families, emotional expression is not often encouraged in Asian cultures (Ruby et al., 2012).

Notably, younger generations in the U.S. are likely to be more individualistic than their parents, including young people of color. Studies on acculturation have found that many first-generation Asian American young adults have more individualistic values than their parents, though they are still more collectivistic than young white Americans, generally

(Benito-Gomez et al., 2020). Research on Latinx families has found that there is some variation in those who identified as more individualistic or collectivistic, depending on whether they were first or second-generation Americans (i.e., if they were born in the U.S.; Bácama-Colbert et al., 2012). Children with mothers from a Latin country were more collectivistic and their parents had more collectivistic expectations of them than those whose mothers were born in the U.S. (Bácama-Colbert et al., 2012). However, children of first generation Latinx Americans are likely to value independence somewhat more than their parents (Bácama-Colbert et al., 2012; Benito-Gomez et al., 2020; Roche et al., 2014).

Additionally, research has shown that some families who are more acculturated to American culture emphasize some individualistic attributes, while still remaining primarily collectivistic (Benito-Gomez et al., 2020). For example, many Asian American parents emphasize the importance of success and achievement to their children (Benito-Gomez et al., 2020). A focus on individual achievement is typically indicative of an individualistic orientation. However, these expectations to succeed have to do with family pride and the desire to meet their parents' expectations (Benito-Gomez et al., 2020).

While the motivations or reasoning underlying the ascription to communalistic values differs across American racial and ethnic groups, minoritized cultures generally show communicative and behavioral trends more related to collectivism than individualism, while European Americans embody the individualistic American that so many studies have identified (Benito-Gomez et al., 2020). However, there is much variation in the ways families of color communicate about and understand mental health. The histories and stigma of each group play into the form these conversations may take.

Cultural Nuance and Mental Health

Despite the fact that many REM groups in the U.S. are collectivistic, collectivism has been noted to manifest differently across REM groups (Ruby et al., 2012). Additionally, mental health stigma likely manifests differently across collectivistic cultural groups. Culture and stigma may work together to uniquely influence family mental health communication. The following sections provide a brief, holistic understanding of each REM group's historic background, their prejudices toward mental illness, and how these factors may impact parent-adult child mental health discussions. Black, Latinx, and Asian Americans all have lower rates of professional mental health treatment than white Americans, which is likely tied to mental health stigma in each group (SAMHSA, 2019). This chapter lacks the ability to sufficiently examine all relevant sociohistorical factors that may shape and influence family mental health communication across groups. However, a qualitative analysis of parent-young adult child conversations about mental health within and across the four largest cultural groups in the U.S. can serve as a starting point for more in-depth explorations of the nuance in family mental health communication.

There are a number of sociohistorical factors that may contribute to observable differences in family communication about mental health in the U.S. These same factors help explain the lower rates of the use of professional mental health resources for REM Americans compared to white Americans (SAMHSA, 2021). Understanding these factors provides a foundation upon which researchers can utilize communication theory to explain family mental health communication.

Though this paper uses the terms "Latinx Americans" and "Asian Americans," it should be understood that Asia and Latin America are incredibly diverse in terms of culture. The Asian continent has 50 countries, and Latin America includes 20. Each of these countries

has their own unique history, and individuals from any of these cultures cannot be assumed or stereotyped to act one way. Additionally, Latinx identity is often comprised of Spaniard, Indigenous, and African origins; Latinx individuals run the racial gamut from white to Black and any variation in between (Araújo & Borrell, 2006). However, the research has highlighted a number of trends relating to the cultural beliefs and behaviors that are similar across Asian and Latinx sub-groups. Therefore, these general approaches can provide insight into the behaviors family members might employ when talking about mental health.

Mental Health Research for Black Americans

Numerous studies have found that Black Americans have lower rates of mental health service use compared to white Americans, despite them having comparable levels of self-reported mental illness (Burkett, 2017; Holden & Xanthos, 2009; Stagman & Cooper, 2010). There are a bevy of factors that deter Black Americans from seeking mental health treatment, including low levels of access to treatment, mistrust in mental health professionals and/or the healthcare system, and stigmatized beliefs about mental health (Burkett, 2017). SAMHSA (2021) notes that less than one third of Black American individuals who have been diagnosed with a mental health problem actually seek treatment. Because Black Americans have low rates of treatment seeking, it is important to understand how Black families communicate about mental health. The sociohistorical reality of this group can provide insight into the communication Black families use.

The first African slaves arrived in what is now the U.S. in 1619, and Black Americans were enslaved, bred, and beaten for the next 250 years. Slaves were emancipated in 1865 and Black Americans faced a new form of discrimination in Jim Crow laws that enforced segregation and forbade miscegenation, labeling it unnatural or inappropriate to associate

with Black individuals. In addition, lynch mobs murdered Black individuals and families, driven by hate (Crowe, 1969; Messer, 2021). When Black communities began to thrive, white terrorists murdered hundreds of Black citizens and razed their communities to the ground (e.g., Crowe, 1969; Stockley, 2004; Messer, 2021). It is impossible to deduce how many communities were destroyed this way, or to find an accurate death toll for even the largest mass killings. However, what remains consistent is a lack of accountability for perpetrators by the government at all levels. Though a number of civil rights were won by Black American activists in the 1960s, Black Americans face institutionalized racism to this day. Black Americans have consistently been documented to face the highest levels of discrimination compared to other groups (Mekawi & Watson-Singleton, 2021). Scholarship notes that racism has negative effects on multiple aspects of one's well-being, with a number of studies connecting perceived discrimination to poorer physical, mental, and relational health (e.g., Mekawi & Watson-Singleton, 2021; Molina & James, 2016; Paradies et al., 2015).

Due to hundreds of years of mistreatment by white Americans, Black Americans have cultivated a culture that values strength (Davis & Afifi, 2019). Black Americans have needed to be self-sufficient and strong to survive systemic racism and overcome oppression in the U.S. The perspective of "Africanity" centers Black/African Americans' connection to an African worldview (Jones et al., 2018). This perspective would emphasize the "survival of the tribe (family)" as a value that is important to Black Americans' understanding of family and the behaviors they enact in their lives (Nobles, 1974, p. 14).

An intersectional approach to understanding this culture of strength, its enactment, and its effects must include gender. Many Black American families encourage children

(especially young girls) to persevere and overcome, rather than experience and confront negative emotions (Jones et al., 2018). The research examining Black American men is limited in comparison to that of Black women (Jones et al., 2018). Nevertheless, the research shows that Black men are taught to suppress their feelings and perform strength. Many Black men report that responsibility to one's family, self-determination, and pride in oneself and their racial community are foundational to their definition of masculinity (Jones et al., 2018). Black American men have been shown to report the highest levels of anticipated stigma regarding sharing mental health problems compared to other cultural groups and Black women (Misra et al., 2021; Sirey et al., 2014).

The research concerning Black women suggests that they are expected to take care of everyone without faltering (Jones et al., 2018). Over time, this ideal became the Strong Black Woman stereotype (SBW; Jones et al., 2018). The SBW is able to withstand and overcome any number of problems (including caretaking, working, and navigating systems of oppression) without showing a hint of weakness (Jones et al., 2018). Often considered a "positive" stereotype, many Black women may embrace this ideal as a monument to Black resilience (Donovan & West, 2015). However, multiple studies have found that high levels of adherence to the SBW stereotype correspond with poorer physical and mental health, as well as lower levels of self-esteem (Donovan & West, 2015; Jones et al., 2018). Black women who feel that they must live up to the SBW stereotype tend to have higher levels of stress, anxiety, and depressive symptoms than those who do not endorse the stereotype as much (Donovan & West, 2015). On the other hand, if not internalized excessively, there have been studies showing that Black women use their strength as an adaptive (i.e., protective) resource to manage the barriers they face (Davis & Afifi, 2019). Scholars have thus considered this

strength image as not "good or bad; rather it is functional" (Watson & Hunter, 2015, p. 448). It may be that when Black women neglect their own needs in order to adhere to this stereotype, they face poorer mental and physical health outcomes.

Inquiries into the SBW often consider the experience of managing racialized stressors (i.e., microaggressions, discrimination, etc.). Considering the SBW stereotype in a broader manner might shed light on the ways Black women a) understand mental health problems and b) communicate with their close others regarding mental health. Currently, little research examines the ways that Black women, and Black individuals more generally, communicate about their mental health within families. However, communication research has begun to integrate the influence of the SBW stereotype into its understanding of the processes that serve to support and uplift Black individuals in their social networks.

Some communication research includes the SBW ideal in its understanding of communicative processes in close relationships. The Strong Black Woman Collective theory (SBWC; Davis, 2019) argues that Black women reappropriate the SBW ideal in order to regulate strength in each other and promote unity (Davis & Afifi, 2019). The SBWC suggests that Black women may seek reassurance and support in their friend groups and, in turn, are likely encouraged to move beyond difficult experiences, to become angry rather than upset, and to avoid being vulnerable (Davis, 2016). This theory combines feminist theory and post-positivism in its understanding of Black women's communicative norms, values, and communicative practices (Davis & Afifi, 2020). The idea of supportive strength regulation has been observed in Black adult female friendships when they discuss one group member's experiences with racial stress (in this context, a microaggression from a white woman; Davis & Afifi, 2020). Davis and Afifi (2020) argue that strength regulation serves two functions in

the SBWC: to stand up to aggressive outsiders and to provide a safe space for Black women to collectively communicate about their problems. Davis and Afifi (2020) write that, "Black women affiliate with each other through a Black female communication discourse that is laden with idiosyncratic sociocultural and historical properties" (p. 7). In other words, the communicative patterns, functions, and processes that are observed in Black female communication are historically and culturally unique (Davis & Afifi, 2020).

While microaggressions and mental health are different phenomena, both relate to identity-based stigma. In the research conducted by Davis (2016; 2019), Black women sought support in their friend groups due to the prejudices of white individuals. With mental health, however, if Black individuals choose to turn to their close others to disclose mental health problems, their network may engage in strength regulation. In this instance, what may be considered "unsupportive" communication in the previous literature could be seen as supportive, due to the norms of the SBWC and its focus on overcoming challenges. For example, a family member might encourage one of its other family members seeking help to take care of their mental health problems inside rather than outside of the family. This family member might believe they are helping their loved one and their advice could be received as such, but these communication patterns contradict extant literature regarding what constitutes effective social support. The communicative process of strength regulation documented in Black female friend groups in the SBWC may be relevant to Black families as well. It would stand to reason, then, that when a family member communicates about mental health challenges they have been experiencing, they might be encouraged to simply 'push through' the problem rather than seek treatment. This study potentially expands the scope of the

SBWC's idea of supportive strength regulation in family contexts regarding a topic (i.e., mental health) that may be stigmatized within their support system.

Mental Health Research for Latinx Americans

Latinx Americans are the largest REM group in the U.S. (U.S. Census Bureau, 2021). Latinx Americans have similar levels of self-reported mental health as white Americans but use formal forms of mental health help half as often as non-Hispanic whites (SAMHSA, 2021). Among the reasons Latinx Americans may choose not to utilize mental health services are barriers to accessing care, a lack of knowledge about mental health resources, the absence of culturally appropriate mental health care, and mental health stigma from the healthcare system or their own networks (Chang, 2014). Sociohistorical exploration can provide insight into the factors that may impact how Latinx American families communicate about mental health. Indigenous peoples were the original inhabitants of North and South America, including the land the U.S. now occupies. Despite the Indigenous people's inhabitance of the land, European colonizers "claimed" the land as their own, and forcibly removed Indigenous Americans from their homelands. These same colonizers then devised borders which have been enforced over time, barring international travel without explicit permission.

While the British colonized the east, the Spanish colonized the southwest, starting with New Mexico and Texas (Novas, 2008). In the 1840s the U.S. annexed Texas, beginning the first of many land acquisitions. The violence and land-seizure tied to the Mexican Revolution in the 1910s led over one million Mexicans to immigrate to the U.S. (Ruiz, 2006). In the 1920s, the U.S. limited the number of immigrants in the country and formed the border patrol (Novas, 2008).

During the Great Depression, the government deported hundreds of thousands of Mexican individuals living in the U.S.—many of whom were U.S. citizens (Balderrama & Rodriguez, 2006; Novas, 2008; Ruiz, 2006). Their coercive and often illegal tactics forced many legitimate citizens out of the country (Balderrama & Rodriguez, 2006). Then, facing a shortage of workers during World War II, the U.S. government brought in millions of Mexican individuals as cheap, temporary labor (Novas, 2008; Ruiz, 2006). Many citizens who had been wrongly deported returned and attempted to assimilate following this injustice (Balderrama & Rodriguez, 2006). Some historians assert that these events intensified Mexican Americans' mistrust of white Americans and the government (Novas, 2008; Ruiz, 2006).

Concurrently, hundreds of thousands of Latinx Americans chose to enlist during WWII (Novas, 2008). Despite serving in the military, many Latinx veterans faced discrimination upon returning to the U.S. and would don their uniforms in white-only establishments in protest (Ruiz, 2006). Latinx civil rights groups advocated for equality through the 1960s for Latinx individuals across the country in a number of social and occupational contexts (Novas, 2008). One of the most well-known advancements came when Latinx farm workers rights groups made strides in the '60s for those who had long been abused, neglected, and underpaid, guaranteeing them a minimum salary and better work conditions (Novas, 2008).

As with Black Americans, the battle for civil rights in the 1960s did not signal the end of discrimination against Latinx Americans. In the 1980s, hundreds of thousands of Cubans migrated to the U.S. The media painted them as dangerous, mentally ill criminals, though the

majority were law-abiding citizens—a stereotype that was popularized in media (Novas, 2008).

A number of present-day social and political factors have led many Latin American families to risk their lives to cross the border into the U.S. (Novas, 2008). The Pew Research Center (2020) estimates that there are 10.5 million undocumented immigrants in the U.S. (i.e., they reside in the country without authorization from the government). Forty-five percent of all immigrants are Latinx Americans, and Mexican Americans comprise the largest percent of both documented and undocumented immigrants in the U.S. (Pew, 2019). Undocumented Latinx immigrants are often exploited for cheap labor and treated poorly, given that they are especially vulnerable (Novas, 2008). Undocumented immigrants cannot work legally and face the threat of deportation, which can separate families and detour lives (Novas, 2008).

Nativism and anti-immigration sentiment in regard to Latin American individuals, specifically, have been powerful political forces over the last three decades (Ayón et al., 2010; Novas, 2008). Some southwestern states like Arizona and California passed propositions that severely hindered undocumented immigrants' rights and authorized police to profile Latinx individuals (Ayón et al., 2010). These practices do not solely impact undocumented immigrants—Latinx Americans whose families have lived in the U.S. for generations may still face ignorance and discrimination. Ayón et al. (2010) argue that anti-immigrant policies, poverty, and the discrimination inherent in both can negatively impact the mental health of Latinx individuals. Latinx Americans may be faced with ignorance or xenophobia in the U.S., and over time cultural discrimination can hurt one's mental health (Ayón et al., 2010). Considering the cultural values Latinx Americans are documented to

display may provide insight into how their history and identity connect with their modern-day relationships and understandings of mental health.

One common value across Latinx subgroups is familism (i.e., *familismo*), which is the culturally-bound belief that families should be sources of closeness, emotional support, and respect (Cahill et al., 2021; Chang, 2014). While Latinxs are a diverse group with a number of differing experiences, Latinx individuals and families are documented to share the prioritization of these family-focused values (Cahill et al., 2021). Familism can be conceptualized as attitudinal (i.e., one has the belief that family should be a source of loyalty and obligation) and behavioral (i.e., one takes actions that reflect the prioritization of the family; Cahill et al., 2021). Familism consists of four subdimensions that reflect its nuanced nature. These dimensions include the values of support (and keeping close family relationships), obligation (to take care of your family members), family subjugation (i.e., prioritizing the needs of the family over individual members' needs), and the behaviors of each family member reflecting on the family (and that one should bring honor with their actions; Cahill et al., 2021). In accordance with these values, many Latinx American families place importance on openness and emotional expressivity, with many Latinx parents encouraging their children to lean on them for support (Cahill et al., 2021; Chang, 2014). However, this openness is couched within the cultural value of *simpatía,* which encourages minimizing negative emotions, acting with charm, and openly expressing positive emotions to preserve group harmony (Ruby et al., 2012). This emphasis on *simpatía* can discourage the expression of negative emotions, making it more difficult to seek support from one's family because discussing one's problems might violate that norm (Ruby et al., 2012). Therefore,

despite parents' encouragement to be open, many Latinx American young adults may refrain from sharing their mental health challenges with their family.

Some Latinx young adults choose not to talk about their challenges with their parents in order to prevent their family members from worrying unnecessarily (Chang, 2014). These individuals may believe that managing a problem on one's own is better than burdening their loved ones (Chang, 2014). Consequently, despite the general culture of support that has been documented in Latinx families, mental health challenges (or the true scope of one's mental health challenges) may be hidden from the family to keep the peace and avoid concerning one's close others (Chang, 2014). These behaviors are, in part, a manifestation of their collectivistic values which prioritize the needs of the group over those of the individual.

A lesser-studied phenomenon relating to the decision to discuss mental health problems in Latinx American culture concerns the Spanish phrase *el que dirán* (what others will think; Chang, 2014). This phrase may be used in reference to family members, friends, and community members (Chang, 2014). Many Latinx young adults suggest that they are not as worried about what others will think as much as how their parents will be affected by those judgements (Chang, 2014). As a result, in order to maintain group harmony and stifle the detrimental social effects of gossip, many Latinx young adults may choose to avoid talking about stigmatized issues like mental health with their older family members, especially (Chang, 2014).

Mental Health Research for Asian Americans

Asian American adults have consistently been reported to use mental health services less than any other REM group, with only six percent of Asian Americans reporting using any mental health service between 2015-2019 (SAMHSA, 2021). Asian Americans' lower

use of formal mental health help does not suggest that they are not in need of mental health support. In fact, some research suggests that Asian Americans report signs of mental health challenges at similar rates to white Americans (Chu & Sue, 2011). Asian Americans' beliefs and behaviors around mental health are impacted by the historical and present realities of Asian Americans.

The Asian continent is made up of 50 countries, all with their own unique historical experiences. Though the present study refers to "Asian Americans," there is a great deal of diversity in the continent as well as within specific countries. However, Asian ethnic subcultures are documented to value family interdependence (Chang, 2014). Therefore, there may be commonalities across Asian Americans' conversations about mental health.

Many Asian American individuals face similar cross-cultural stressors as other REMs in terms of family ties, peer relationships, and academic achievement (Lohman, 2018), along with more specific sociohistorical factors concerning stereotyping, familism, acculturation, and discrimination (Lee et al., 2009). All of these stressors have the potential to negatively impact Asian Americans' well-being. A brief consideration of the sociohistorical background of Asian Americans can provide insight into their cultural values and communication.

The history of Asians in America is wrought with prejudice, xenophobia, and institutionalized racism targeted at Asians, specifically. The first groups of Asian immigrants came to the U.S. in the mid-1800s, many searching for economic opportunity following the Gold Rush (Wong, 1995). Chinese immigrants, facing language impediments and hostility from locals, were exploited for life-threatening labor at lower rates of payment than white workers (Karuka, 2019) and were vital to the completion of the transcontinental railroad by 1869. Despite their contributions to American infrastructure, Asian Americans have

historically been targeted by legislation that has social and political repercussions beyond their immediate legal effects (Kiang et al., 2016). The Page act in 1875 and the Chinese Exclusion act in 1882 aimed to limit the number of Asian Americans in the country (see Ling & Austin, 2015). Kiang et al. (2016) argue that these biased laws not only restricted Asian immigration, but gave way to societal stigma and the devaluation of Asian individuals. National legislation gave way to local ordinances enacted solely to impede Asian immigrants' thriving (Kiang et al., 2016). In turn, these conditions influenced the nature of interactions within the family and community, leading to unique communication patterns for Asian Americans (Kiang et al., 2016).

In 1941, the government forcibly displaced 120,000 Japanese Americans into internment camps following the bombing of Pearl Harbor (National Archives, 2022). Of those removed from their homes, 60% were American citizens—none of whom were charged with a crime (National Archives, 2022). Japanese Americans were held in crowded barracks for as long as three years, with most losing their homes, possessions, livelihood, and sense of security (National Archives, 2022).

As this brief historic overview demonstrates, there are diverse experiences both across and within Asian American cultural groups. In other words, Asian American identity is multilayered, and one's communication could depend on a number of factors other than country of origin like acculturation, generational status, and gender (Kiang et al., 2016). Kiang et al. (2016) note that historical context interacts with individual agency and cultural identity to shape one's communication.

Asian Americans, despite the unique stressors they encounter in their lives, underutilize formal forms of help-seeking, such as seeing a mental health professional

(Chang , 2015; Chiang et al., 2021). This is likely due to the high levels of mental health stigma Asian Americans are documented to have in comparison to white Americans, which discourages the use of formal forms of mental health help (Chiang et al., 2021; Misra et al., 2021). Additionally, many Asian American individuals do not seek help or support informally (such as speaking with spiritual leaders, attending peer groups, or confiding in their close networks), as they may expect that the response from their network will be unsupportive (Chiang et al., 2021). Chang (2014) found that their Asian American young adult participants chose not to seek support from their parents as they anticipated a response that emphasized forbearance (i.e., using restraint and enduring challenges). Their participants also stated that their parents' reactions would be unhelpful and unsupportive (Chang, 2014). Overall, these Asian American young adults shared that they used family support less because of their duty to uphold the family's honor (Chang, 2014).

Due to the under utilization of both formal and informal forms of assistance, many Asian Americans might feel as though they have few options for support when faced with mental health challenges. Therefore, it is important to understand what informal mental health conversations look like in Asian American families. Observing Asian American family conversations about mental health will serve to illuminate the form and function of communication in this context and may provide insight into culturally-based communicative norms with regard to the discussion of mental health.

There are high levels of stigma regarding mental health in many Asian American communities and families (Ai et al., 2022; Chang, 2015; Chiang et al., 2021; Misra et al., 2021). Asian American families are generally collectivistic, and culturally emphasize the need to work hard, achieve highly, and prioritize the family (Ai et al., 2022). Guo et al.

(2015) note that Asian cultures value emotional restraint, harmony, and respect. In part because of these values, seeking treatment for a mental health problem is shameful (Guo et al., 2015; Leong et al., 2011). Shame has been documented as a prominent theme surrounding mental health in Asian American families across numerous studies (Chiang et al., 2021;Leong et al., 20ll; Misra et al., 2021). This shame, in part, stems from the belief that mental health problems are indicative of a lack of self-control (Chiang et al., 2021; Lee et al., 2009). If one member of a family has a mental health problem, the entire family is held responsible or shamed: their family member's illness often being ascribed to a dearth of will-power in the family (Chiang et al., 2021). Therefore, communication about any mental health challenges could be harmful to the entire family (Chiang et al., 2021). Due to the importance of family reputation, many Asian Americans hide signs of mental health challenges in order to save face (Chiang et al., 2021; Misra et al., 2021). Asian Americans often report a lack of openness with their families (Chiang et al., 2021), which could impede young adults' ability to seek help from their parents regarding their mental health. Some research has noted that Asian American adolescents are less open emotionally than white adolescents and aim to be self-sufficient in how they handle their distress (Chang, 2014; Chiang et al., 2021; Wei, 2013). This inclination to manage problems on one's own may make it even more difficult for Asian American young adults to cope with mental health challenges than white Americans and could result in the use of unhealthy coping mechanisms.

Some research has suggested that a large portion of the stigma relating to mental health in Asian families stems from a lack of knowledge about issues relating to mental health (e.g., Lee et al., 2009; Ling et al., 2014). Many Asian American individuals may be unaware that they are struggling with mental health problems, and may attribute it to cultural

understandings of behavior such as mental illness just being “stress” (Na et al, 2016, p. 214), or suggesting distress is due to “imbalances” or “biological changes” (Chiang et al., 2021; Wang et al., 2020), or may believe that mental health challenges have to be to a certain degree to seek treatment (Chiang et al., 2021; Lee et al., 2009).

Some scholars have begun to inspect the relationship between the model minority stereotype and Asian Americans’ well-being. This stereotype suggests that Asians are more academically and financially prosperous than other REM groups (Chiang et al., 2021; Yoo et al., 2010) and, as individuals, are posited to be hard-working and successful with no psychological challenges (Chiang et al., 2021; Inman & Yeh, 2007). Because of this stereotype, Asian Americans may feel additional pressure to hide their mental health problems and could be less likely to recognize when they need help (Chiang et al., 2021).

As the above sections illustrate, REM groups have differing reasons for avoiding help-seeking for mental health challenges in the family. It would significantly contribute to the extant literature to better understand how these cultural differences manifest and affect family mental health communication. These differing norms regarding mental health are likely to affect the ways that parents and young adult children talk about mental health with each other.

With this information in mind, the following research questions guided this phase of analysis:

RQ1: How do parents and adult children communicate about mental health?

RQ2: How does culture affect the form and function of that communication?

Method

The second phase of analysis for this project explores transcripts of the recorded parent-child conversations described in phase one. Research assistants created verbatim transcriptions of the conversations and removed names and identifying information. Transcripts were checked by another coder for accuracy.

Iterative Phronetic Approach

I, along with a trained team of four racially diverse research assistants (RAs), used an iterative approach to the coding, reading every transcript multiple times to gain a better understanding of the themes, behaviors, and appearance of family mental health communication for each cultural group. Tracy's (2018) Iterative Phronetic Approach to qualitative data was used as a foundation for these analyses. The research team met once a week for two academic quarters (20 weeks) to discuss emergent themes, refine those themes, and focus the analysis.

The stages outlined in Tracy (2018) were followed. First, the coders and I read the transcripts by racial/ethnic group to familiarize ourselves with and immerse ourselves in the data over a three-week period. Following data immersion, we began the primary coding cycle. In this stage, we open coded 30 transcripts. Twenty-five transcripts were chosen by a random number generator, then I weighted the remaining transcripts for REM families. In accordance with Tracy (2018), codes at this phase were primarily descriptive. The team met to discuss what descriptive codes emerged, and how the first-level codes grouped together to help with our research goals. Then, I assigned the coders readings on confirmation, social support, culture, and mental health stigma, so they could approach the next phase of coding with a theoretically informed perspective.

Next, we went through secondary cycle coding on the same subset of the data. In this phase, we focused on interpretating and synthesizing the data and creating themes. We used a constant comparative method by going back and forth between extant theory, emergent themes, our own lived experiences, and the research questions. This phase involved hierarchical coding, in which we grouped codes into larger themes. During this phase, we developed a codebook with themes that encompassed what we had observed. Themes and subthemes were discussed, challenged, and combined until the codebook was strong. The coders also began watching some of the videos to develop a deeper appreciation and understanding of the specific family communication patterns in this stage.

In the next stage, the coders used the codebook as a frame to deductively analyze a new selection of 30 transcripts. The research team discussed how the codebook fit the additional data and refined it as required. Finally, the coders used the codebook as a frame to deductively analyze the remainder of the transcripts. We explored how well the frame fit the data as a whole and reached agreement regarding the bounds of each theme. Throughout the entire process, the coders contributed their insights and opinions. After the coding was complete, the themes were represented in visual form in Figures 9 through 12.

Chapter 5. Thematic Results and Discussion

This chapter will provide the results from the iterative thematic analysis. Then, it will discuss these findings in the context of extant research and explore its implications for future family mental health communication work.

Results

Overall, the results suggest that culture (racial/ethnic, generational, and religious, with gender-related norms couched within) affected the way these American parents and adult children understood and communicated about mental health with each other (see Figure 9). Despite families of color in the U.S. having more collectivistic mindsets, the way they understood mental health varied within and across REM groups. Latinx and Asian families in this study spoke about a number of factors that contributed to the **Pressure of the Collective**, and how these high expectations encouraged them to suppress their mental health challenges for the good of the collective. Many Black families in this study put forth the idea that **Survival Supersedes Mental Health,** and that they do not have the *time, space,* and/or *resources* to face their mental health challenges. Systemic issues, day-to-day challenges, and the sociohistorical context of this group were mentioned as being a higher priority than mental health. Beyond racial/ethnic culture, many families considered **Religion as a Solution** for mental health challenges. Many parents and young adult children spoke about messages they had encountered that encouraged a spiritual connection but were often inadvertently disconfirming. Often participants confronted the idea that devoutness to God or one's religion could serve to "fix" one's mental health.

Two themes emerged that describe the form that this communication assumed. The first concerns a family's **Conversation Orientation.** Families who talked about mental

health in the past tended to have the most open, accepting conversations, suggesting that a family's conversation orientation was a major factor in how they communicated about mental health. However, this relationship was impacted by the culture of those communicating, with families of color seeming less likely to have open conversations about mental health than white families.

Confirming, Disconfirming, and Challenging Communication created and upheld intergroup dynamics. Many participants (parents, especially) spoke positively about seeking help for mental health challenges within the family but were disconfirming when it came to formal sources of help. Some adult children said they might talk to their mothers when they had mental health challenges, but not their fathers, suggesting that fathers had been unable to provide adequate support in the past. In addition, many children preferred support from outside of the family, even though their parents encouraged open communication.

These results will explore these three themes regarding culture and mental health communication and will consider how a family's conversation orientation about mental health, as well as how confirming and disconfirming communication created and upheld intergroup dynamics. It examines how these communicative phenomena serve to (re)create and reinforce these beliefs and behaviors in relation to mental health.

Conversation Orientation about Mental Health

A family's openness to communicating about mental health challenges seemed to correspond with more positive communication about mental health. Many families described how the communication around mental health has become more frequent and less stigmatized in the U.S. One Asian and white mother said, "…within maybe the last 5-10 years… the conversations about mental health have been much more prominent, … accepted, and

normalized…it used to be … a Scarlet Letter… now it's become much more- not necessarily acceptable, but just more commonly known" (Family 03, Asian and White, Mother). Some families emphasized that although stigma has decreased over time, there is still work that needs to be done:

> C: ...in my lifetime I've seen a lot of that stigma improve…I see a lot of people becoming more, much more open [father agrees]...
>
> P: …it feels, I don't know, it feels to me like people still aren't talking.
>
> C: That's a good point. On the surface it feels like there's progress that's been made but when it comes to how it actually impacts people systemically, there's still a lot of work to be done. (Family 140, Black and White, Father and Daughter)

As U.S. culture has become more open to talking about mental health, families have opened up about these mental health challenges to varying degrees.

Openness to communicating about mental health emerged as a major factor in how families spoke about and understood mental health. Conversation orientation, or the extent to which a family is open to speaking about mental health, was not initially considered. However, this openness was crucial in determining the form of the conversation. Many families suggested that they had shared mental health stories previously, which demonstrates receptivity to communicating about mental health and mental illness. Additionally, many families explicitly stated that they were open to communicating about mental health, and how this open communication was beneficial for their well-being. One white and Asian mother said, "...this family is 'pitch-in'. I think it's good that we talk about things that bug us, you know, we don't let too much get bottled up, which is probably good for our mental health"

(Family 9, Asian and white, Mother). Some young adults emphasized the openness they felt in her family around mental health challenges, with one Black daughter saying:

> It's just really nice that [in] our family, like we've grown up knowing that we're all there for each other and like it's like nothing but love there. So, like if we need help with something like this …we don't even need to like worry about it …or like think we're going to get judged… (Family 82, Black, Mother and Daughter)

Conversations that evidenced previous communication about mental health were generally confirming and supportive. Some families described how their openness had changed over time, with one Black daughter saying, "I think mental health in our family wasn't really something that was ever talked about. I feel like we're like kind of a family to like not talk about issues. But I think we're getting a lot better at that" (Family 52, Black, Daughter).

Within these mental health conversations, many parents explicitly reinforced their preference for openness around mental health problems, especially when this openness contradicted cultural norms. One Asian father told his daughter:

> …it is definitely a cultural thing between Asian households and western households, but you know I've always felt I'm open for discussion. Maybe my approach, they were–my daughters were not able to communicate as freely as they wanted to, but now at least in my mind I always made myself available [and] open minded to hear that. (Family 48, Asian, Father and Daughter)

One Asian mother emphasized not only openness to speaking about mental health within the family, but openness to seeking external support as necessary:

> …mental health should be talked about, emotions should be talked about within a family, but …sometimes the family can't really fix anything [so] they need to go to

> outside help. But sometimes it's easier to hear things back from someone that's not related to you. So, I think it's important for everyone in a family to be aware of each other emotionally but then sometimes you need outside help… sometimes it's easier to hear from somebody else. (Family 24, Asian, Mother)

Many open families emphasized the normalcy of facing mental health challenges. One Latinx mother told her daughter, "I think that the idea of a perfect family is a joke…I've always said it's just each family represents a different level of… screwed up, crazy, you know?" (Family 21, Latinx, Mother). Some families spoke about others' inclination to hide mental health challenges despite their commonality. One white and Asian mother and daughter (Family 90) said:

> P: …pretty much everybody has mental illness, but everybody wants to act like everybody is okay.
>
> C: Yeah, I mean you think everyone has mental illness? I kind of agree with that.
>
> P: Yeah… Living in a society such as ours, something or other is going to affect you and cause you to feel, you know, inadequate or sad or just angry, so I don't think anybody can live in this society and not have their mental health affected. (Family 90, Asian and white, Mother and Daughter)

Other families emphasized that everyone can be susceptible to mental health challenges, with one Latinx family saying:

> P: …[mental health challenges] can happen to anybody… There's no
>
> C: any restrictions
>
> P: yeah, there is no
>
> C: limits

P: There is no shield that's gonna keep you from not getting it… Nobody's immune to it, in other words. (Family 17, Latinx, Father and Daughter)

Despite the trend that previous communication about mental health generally corresponded with more positive conversations, some families had relatively closed-off conversations despite having communicated about these challenges in the past. This would often consist of a parent minimalizing their child's past mental health experiences. Family 114, a father and son, acknowledged that the son and his sister had previously been diagnosed with depression. Although both children had sought professional mental health help in the past, the father said, "...I get scolded when I really announce my opinion about depression, 'cause I don't understand it. So, I think it's something that you can snap yourself out of. But I know other people say there's no freaking way, so." (Family 114, white, Father and Son). His son asked his father how he perceived his sister's experience with depression:

C: yeah, but do you think it's all in [sister]'s head?

P: oh, having a broken heart? No, that's real as shit

C: no… before that

P: no, I don't think it's all in her head, it's just how she manages it.

This parent suggested that physical exercise should solve mental health challenges that arise, saying "...when she's eating right, and she would work out…her head was on straight… we all get [a] little depressed here and there. Like I was getting all low the other day, I'm like okay, jumped on the bike, you know, snap myself out of it" (Family 114, white, Father and Son). Although the son attempted to help his father understand their experience, his father reaffirmed his lack of understanding:

C: …I can't control when I feel… depressed or whatever. Like I'll be like in a situation like where you should be having fun but like you just like– I don't know, I guess it's really just like trying to live in the moment, I guess would be the solution. But… it's hard to snap yourself out of it when you just feel sad …and you can't explain why. 'Cause you're doing everything that should make you happy, but it doesn't.

P: Yeah, I guess that's just hard for me to understand. Again, something like a broken heart I totally get that's a whole different thing… I've always been okay with loneliness, 'cause I keep myself busy. So, I just expect other people can do the same…(Family 114, white, Father and Son)

This son seemed hesitant to assert his views too firmly, because he often cut himself off, or took a moment to ramp up to his opinion. As his father's perspective did not shift much, it is understandable that his communication with his father would be less open.

Some children (often male) were closed-minded about mental health although their parent encouraged openness. Family 1, a white mother and son, spoke about their understanding of and relationship to mental health:

P: I think there's not enough conversation about mental health.

C: I'm kind of on the other side, I'm not really a big advocate for mental health.

Throughout this conversation, the son emphasized privacy over his thoughts, while the mother tried to encourage openness. When speaking about their family's culture around mental health, they said:

P: …I think we talk about it more often than some other families…

C: I feel like we don't really talk about it that much like ever

P: Well, **I** talk about it but you know... I think I'm sort of just talking out loud.

C: You somewhat open up the conversation for it.

P: I try... whether the-the conversation gets extended beyond what I'm saying is... questionable. (Family 1, white, Mother and Son)

The pattern of the son choosing not to share his thoughts during the conversation seemingly reflects their overall relationship, suggesting that a family's individual interactions can provide insight into the relationship more generally. The mother (Family 1) stated that she tried to talk with her family about mental health, but that they were not as receptive as she would like:

C: …me and my brother and my dad are not as open as my mom when it comes in regard to that but, I don't know, if the setting's right I guess we'd discuss it.

P: I think we've gotten better… because I've been able to start speaking about my own sort of mental health… more honestly and I can identify my own triggers … so as I share those experiences with the family, I think that it does sort [of] crack the door for the subject a little bit and people are, at least I hope, more willing … [and] able to sit back and identify their own issues. (Family 1, white, Mother and Son)

Notably, this mother took ownership of past closed-mindedness and how it impacted her family's ability to talk about mental health in the present. Another family spoke about the mother's past attempts to talk about mental health, and how her other family members would invalidate the legitimacy of her experiences. They said:

C: … I feel like for a long time we like swept it under the rug…

> P: I totally always told you guys about it and you guys would be like “you don't have an issue with this.” Like you would say with whatever, you know allergies or some types of things that I have too, like “that's not true”…
>
> C: Well, you were talking about your– well that’s different 'cause you’re also kinda dramatic.
>
> P: That’s true. I mean I think it's normal for a topic like this to talk about it as you get older.
>
> C: yeah, I agree yeah I think you just got a better understanding of it
>
> P: [than] as a child
>
> C: which is why I think like we're talking about it more now as a family. (Family 52, Black, Mother and Daughter)

This family stated that as time went by, the rest of the family became as open to the idea of mental health as the mother had been. Additionally, the mother suggested that mental health is a topic individuals may take seriously with additional life experience. Some families spoke about how their openness around mental health has changed over time. One young adult said:

> … in high school, …I was dealing with mental health stuff…we didn't talk, like it wasn't as normalized…I usually went to like [name] to talk about stuff...I would not talk to you or dad as much, because I feel like she would get it more. But now, I feel like I can talk to you guys, now that I'm older, and that…in general [it is] more normalized, and I think we can relate on a lot of stuff, … like dealing with our mental health through our spirituality and stuff. So, like that's why I like talking to you about that kind of stuff. (Family 96, Asian daughter)

Some families had not communicated much about mental health with each other in the past, and many explicitly stated that they had not spoken about these issues before. An Asian mother said, “No, we never talk about this…” (Family 33, Asian, Mother and Daughter). Some parents expressed surprise, having believed their family was open before participating. One Black family said:

> P: I don’t think you can just look at someone and tell they have a mental health issue.
>
> C: [shakes head] uh uh
>
> P: So, I don’t know, maybe that means we don’t talk about it. I just thought we didn’t have those issues” (Family 41, Black, Mother and Daughter)

This family’s interaction was open-minded, with the parent expressing agreement with their child. So, even though this family had not communicated about this issue in the past, they were able to have an open conversation. Some young adults articulated that although they felt that their parent was open to talking about mental health, they had not spoken about it before:

> …we don’t really talk about it, but if I …had something to tell you, I would… I feel like I can totally come to you with [mental health challenges], even though we don't necessarily talk about it much, but like that's because there's not much to talk about with it. (Family 6, white, Mother and Daughter)

Some families described varying levels of openness within the family, and how it related to gender:

> C: It's not like we can’t talk about it, but it just maybe doesn't come up as much. I'd say you and I probably talk more honestly about that. Like we wouldn't necessarily at family dinner bring up like mental health.

P: …it's not a taboo conversation in our house. I think if it came up, it would be like not uncomfortable, it would just be like something that we talked about. …for sure the females in our family talk openly much more than the males in our family

C: I mean yeah, I think that that's just the case in general so … that doesn't say much, the fact that we're more comfortable talking about that together.

P: yeah, and even if it was at family dinner, it would probably still be you and me talking and then the others are listening (Family 59, white, Mother and Daughter)

On the other end of the spectrum, some families had less flexibility or openness in their conversations, which had the potential to hinder their closeness. One Latinx young adult daughter emphasized how a lack of communication about mental health had the potential to harm the parent-child relationship, "I think that youth culture… has become a lot more understanding. I think… a lot of us feel like we don't have relationships with our parents… or like our parents wouldn't be as understanding [about mental health challenges]" (Family 43, Latinx, Daughter). Some families spoke in ways that conveyed a lower conversation orientation. This often consisted of parents asserting their viewpoints, talking over their child, and letting their child say little (e.g., Family 99, Black; Family 17, Latinx). Overall, a family's openness to communicating about mental health was strongly tied to how they spoke about it.

Personal Connection to Mental Illness

Family members' own experiences with mental health challenges impacted the degree of openness that was displayed in the conversation. Many of the more open families shared mental health stories about their immediate family as well as grandparents, extended family, and close friends. Some families argued that personal experience was crucial to

understanding and empathized with those facing mental health challenges. One multiethnic daughter said, “I just feel like it’s something that …if you’ve never experienced it yourself or with … someone close in your family, you just don’t understand… for those people it’s …a challenge to recognize it… when you haven’t experienced it yourself” (Family 62, Latinx, White, and Indigenous, Daughter). Notably, this understanding was linked to the way these families communicated. One Latinx daughter said that her mother’s experiences with mental health in the past have made the entire family more open to communicate about mental health. She indicated:

> …when you were younger you were like depressive … so it’s like you experiencing it … yourself …made it easier for all of us… so you don’t invalidate… if we feel sad… and like my dad is also pretty supportive about it … (Family 02, Latinx, Mother and Daughter)

Another family argued that sharing personal experiences with mental health challenges is one way to normalize and destigmatize them.

> P: …there’s still a lot of obstacles for people feeling comfortable with [talking about mental health challenges].
>
> C: Yeah, no that’s true…when you have to turn the conversation to your personal experiences people aren’t ready… And that’s… what’s going to bring down that stigma…it’s people talking about their own personal experiences.
>
> P: Absolutely
>
> C: It's the only way it's going to be done.

P: Right and it's the whole vulnerability thing… I'm not suggesting, you know, its "Hi, I'm [name] and just want you to know I do have depression and anxiety." It would be- it would look like

C: What a surprise

P: Right, but I mean that would be such a weird way to

C:It's not…yeah, it's not polite conversation yet

P: Exactly. (Family 140, Black and white, Father and Daughter)

Having a personal connection to mental health made it more likely that these families would have supportive, open conversations. One son told his mother that talking about their experiences with mental health has been beneficial. He said, "in some ways, it's made me and your relationship stronger… so I think there are benefits to mental health conditions, as weird as that sounds. And because you gain another person's perspective that's close to you." (Family 69, white, Mother and Son).

Generational and Cultural Gaps in Knowledge and Communication

Younger generations spoke more about their generation's acceptance of mental health, while many parents said their generation was more hesitant to talk about the subject. Moreover, many parents described how they have seen the communication around mental health increase over time. One family said:

P: Well, I know that in my lifetime that it's something that's more openly spoken about than it used to be. Before you didn't hear about mental health at all.

C: Yeah… I feel like everybody in my generation talks about it, it's just the thing…

P: Mhm, yeah, not in my generation. We don't talk about mental health. (Family 41, Black, Mother and Daughter)

Although this mother had noticed an increase in communication about mental health, she was not personally communicating about it with her peers. This mother noted, “I didn’t realize that I don’t know a lot about mental health until I started reading the survey” (Family 41, Mother, Black). This lack of knowledge was likely due to a dearth of openness and education around mental health when she was maturing. Another Black mother described how her generation was opening up about mental health as a result of younger generations’ openness:

> C: Does your generation talk about it? Like with you and your cousins, are you all talking about it now?
>
> P: we talk about it more. We talk about it more because it’s more open because now people realize because the younger generation is bringing it, is opening up more about it. They’re putting it on the table.
>
> C: destigmatizing
>
> P: Yes. They’re putting it on the table to say … hey, this is nothing to be ashamed of, this is something that so many people have issues with, and …if you need the services, you know, then you should be able to…get some help and talk about it.
>
> (Family 135, Black Mother and Daughter)

Some families directly addressed the gaps in knowledge and understanding among older adults and emphasized that it was not an issue of character, but one of education. One white mother said, “ …I think that [older generations are] just as capable of compassion and understanding… we all came from them… that's how we got our values… But their generation didn't [talk about mental health] so they're… learning along with you” (Family 57, white, Mother). Some families spoke of the interactions that occur because of this generational gap. One Black daughter said:

... I have like a few friends who want to get help and then they try to like go to their parents for that and their parents are the ones who are telling them like ‘What have I done wrong? Why are you feeling this way?’ They take it more personally than just like the issue of mental health itself. I feel like there’s like a disconnect there sometimes” (Family 82, Black, Daughter)

This daughter articulated the misunderstandings that can arise as a result of generational gaps in understanding mental health.

Cultural differences in the acceptability of mental health were broached by some families. Many first-generation immigrants compared the U.S. to their country of origin and noted that the U.S. was much more open. One Asian mother (Family 35) said, “...among Koreans, it’s kind of a shame [if] they have mental problems, so it is less open comparing with Americans… Korea has more pressure in their society [and is] more competitive comparing to America” (Family 35, Asian, Mother).

Educating About or Redefining Mental Health

Some families noted that they had only recently begun learning about mental health through their children. One Asian family, after speaking about how mental health is taboo in their culture said:

C: And in our family we never talked about this too

P: No

C: But only now… we talk a little more.

P: Yeah. Because you guys go [to] school and you guys know something and you guys [told] me… If you guys don't [tell] me, I don't know how to. Everything I need a

help, I don't know how to find them. I think that language problem or something. (Family 33, Asian, Mother and Daughter)

Here we see this mother talk about learning about mental health as an adult, as it had not been spoken about in her youth. In addition, she described how her children were able to educate her about mental health, and how she learned about resources from them. This mother than went on to say, "That's why you…young people have to learn this kind [of] thing and try to help the old people…Why you guys go to school…to help us and do all this kind of thing" (Family 33, Asian, Mother and Daughter). By going off to college, some young adults were able to expand their parents' worldview. When their parents were open to learning about these challenges, they seemed to get more out of these conversations. One Asian family (93) described how the daughter's experience with depression impacted the entire family's understanding of mental health, and the emotion embedded in this change:

> P: So, in our family. We, yes, we care about the knowledge, about depression. We are open to depression and, yeah, we don't avoid this topic in our family. And still, we are shocked when we find our daughter in this kind of trouble, because still we think it is far from us. We don't think… that it will it happened to our family, to our dear daughter. And- [silently cries]
>
> C: It is okay.
>
> P: I do not **know.** We do not know, you need help. And we want to help her, we love her, and we are **sorry** we didn't know that.
>
> C: It's okay, it's okay. I, I don't think we got any problems, so far, so everything's fine.
>
> P: Yeah, we think we can get through it… because we love each other… we want to support each other in this family, and …we are eager to get know more about the

> depression, and want to cope with it scientifically…we want to do the right things …to help you…Still, we have some difficulties, because this is a new situation… So, I think **mental health** is a problem, but it's only a problem. I mean, the family supporting is much more important…I think everything will find solution, whatever it is, and love is the best way of it. (Family 93, Asian, Mother and Daughter)

Ultimately, the daughter described how this openness to talk and learn about depression made their bond stronger:

> …before my parents know that I got depressed, we are not really understand to each other, like basically, maybe, they just think like, this is something I can relieve myself, and I'm just like worrying for things that are not existing. After I got some medication, we have realized … we have to talk to each other, and we know that this is a mental health problem and we have to treat it…And what is interesting is that after we have talked about this, we do get closer to each other. (Family 93, Asian, Mother and Daughter)

By being able to openly share her challenges, and to have them validated by her parents, their relationship became healthier and closer. This family ended their conversation with two words, "love and knowledge" as the answer to mental health challenges.

(Dis)Confirming and Challenging Communication

(Dis)confirming and challenging communication (often employed by the parent) served to steer these conversations. The communicative tools used by parents and children created, reinforced, and challenged their beliefs around mental health. Some parents applied confirming behaviors in the conversation, which served to bolster the young adult's self-esteem. Acceptance was a large part of the appearance of confirming communication about

mental health, as expected. Some parents (and children) reinforced the idea that they would accept their family member regardless of mental health challenges they faced. One Asian mother stated,"...in the end, [they] know that we love and support them, and I want to be there for them" (Family 98, Asian, Mother).

Challenge from a parent often served to help the young adult expand their understanding of mental health. One father and daughter (Family 67) said:

> P: Well so your perspective, though, back to your definition and I like your definition better because it's more expansive…what do you do to enhance your mental health?
>
> C: You just gotta do things you like to do, can't make yourself do things you don't want to do.
>
> P: Mhm, okay, it's not always possible. But you have to make yourself get up in the morning, and you have to make yourself do some other things…in order to have a positive mental health, I think there [are] different components right? There's physical components, because you can get really depressed if you're injured, and that affects your mental health (Family 67, white, Father and Daughter).

In this excerpt, the father both validates her thoughts and opinions and asks her to dive deeper. Further on in the conversation, they display acceptance and a healthy family relationship:

> P: Well, here's a good question though. Do we as a family, do we support each other and **promote** mental health? Or do we go the other direction and cause a ton of stress and make mental health an issue?
>
> C: I don't think it's an issue. I don't think we really talked about it much growing up, but like I just don't think it's an issue.

P: And that’s a good thing! Yeah, I mean even with big changes as this last year, we’ve I think come through pretty well huh?

C: Mhm!

P: We’ve adjusted. (Family 67, white, Father and Daughter)

Another parent challenged their child’s beliefs around the norms their generation has around mental health:

C: A lot of like people kind of like use humor to cope with [mental health challenges]. And people are really open with sharing their mental health experiences especially on social media. Just like the way they talk about it, it’s really an everyday thing.

P: But do you feel like that is sometimes making light of it in terms of trying to make it humorous?

C: I feel like it's just a way that people cope with it and are just able to kind of normalize it, make it less like you know an overwhelming thing for them… people know that like it's not like …they’re making fun of it … that’s the way that people kind of cope with things, like and it's kind of a shared way to do that.

P: I would agree with that. I guess the reason that I asked that is because I think it does depend generally, generationally” (Family 82, Black, Mother and Daughter)

These examples of challenge helped young adults think critically and allowed the parent to glean insight into their children’s understanding of mental health.

However, some parents may have inadvertently negated their child when employing challenging behaviors in these conversations. In these cases, the challenging was likely

disconfirming, despite that not necessarily being the parent's intention. This emphasizes the importance of understanding how someone is receiving these messages.

(Dis)confirmation and the Group

Families employed (dis)confirmation throughout their conversations to reinforce and uphold familial and cultural beliefs. Families who were more open to communicating about mental health generally had more confirming communication about these challenges. An Asian and Hawaiian daughter told her mother, "...you always make sure like, you tell us our feelings are valid and how we feel is okay…you won't tell us like it's wrong to feel a certain way, like everything is valid" (Family 92, Asian and Hawaiian, Daughter).

Some families communicated in a confirming fashion about seeking help within the family but communicated in disconfirming manners about external support. One Latinx mother indicated, "… Hispanic culture isn't so much going to get outside help, as more inside help…you talk through your problems... And you still deal with blame because families give you a hard time" (Family 16, Latinx, Mother and Daughter). Although these families encourage open sharing in the family, the messages around external help were disconfirming:

> …they always say if there's a problem, we're gonna deal with it at home. Don't tell nobody… You're not crazy…And we're supposed to resolve it at home, you're not supposed to tell nobody… [they say] 'it doesn't exist'... 'That's not true, you're just making it up'. Yeah, you have to deal with it at home and you're not supposed [to] talk about it nowhere else (Family 45, Latinx, Mother)

Notably, when one seeks support in the family, they receive messages that negate their experience. Therefore, individuals in these families may feel they have nowhere to turn. One

Black and white young adult daughter told her mother about her experience with her Latinx boyfriend:

> C: ...Hispanic culture… [is] similar to…African American culture. like I've noticed that with my significant other…he doesn't believe in depression, he doesn't believe in anxiety and [he might say] 'why do you need to go to therapy like you can just talk to your friends'…And I feel like our relationship has, like, made him develop a sort of like openness and awareness… (Family 12, Black and white, Daughter)

This daughter brings up how her boyfriend's beliefs changed with exposure to her acceptance of mental health challenges.

Familial Support Gaps

(Dis)confirmation ultimately reinforced familial norms. In families where parents were confirming about mental health challenges, children understood that their perspectives were valid, and that their parents were excellent sources of support and understanding. Alternatively, when young adults believed that their parents were likely to be disconfirming about mental health challenges, they were less likely to speak with their parents about these issues. Many young adults preferred to seek support about mental health challenges from their friends rather than their parents. This was often because their parents provided inadequate support, and they were left unsatisfied. One Asian daughter stated:

> I depend on my friends for like my community and my support and not my family because like I feel like I can't really talk to my family about things and like my family doesn't really understand…a lot of it… has to do with parenting. (Family 60, Asian, Daughter)

Another Asian daughter (Family 48) told her father:

> …you're not a very open person, you're more private and you don't talk about things that happened to you. And I talk about a lot of things that happened to me with my friends, but I don't like talking about it with you …there's different experiences that will make you relate in a different way, and I want …someone from my own age to give their opinion. (Family 48, Asian, Daughter)

Some young adults felt that their parents were the root of their mental health challenges, making it counterproductive to seek support from them. One Asian son said:

> I definitely don't like talking about it with our family because most of my mental health problems stem from our family so it's kind of like going into the fire to talk about the fire sort of thing. So, I do talk about it with people that I deem are like close friends… (Family 74, Asian, Son)

Upon seeking support from their parents, some young adults received messages that implied the parents had done something wrong if their child was experiencing mental health challenges.

> C: …I have like a few friends who want to get help and then they try to like go to their parents for that, and their parents are the ones who are telling them like 'what have I done wrong? Why are you feeling this way?' They take it more personally than just like the issue of mental health itself. I feel like there's like a disconnect there sometimes. (Family 82, Black, Daughter)

Acculturation likely played a role in families' communication when talking about mental health. One second-generation multiethnic young adult speculated that:

> I think where you see the most like negative impacts from culture on mental health is when… not only is the kid adjusting to culture but like the parents are too, so they

don't even know… how to act… in a way that will support the kid. (Family 03, Asian, white, and Pacific Islander, Daughter)

Further in the conversation, her mother spoke about her experiences with her own parents who had immigrated to the U.S., and how that impacted their mental health communication.

…it's a little taboo…in a lot of Asian cultures to have mental health illness. and so sometimes …those kids their parents are maybe you know maybe they've immigrated but maybe they're first generation and they still carry… those taboos with them…those kids get really under-recognized … and … sometimes those families'... first instinct… is to act as if it's a choice. (Family 03, Asian, mother)

Here she articulated the gaps in support many young adults may face who have parents who have immigrated to the U.S.

The Pressure of the Collective

The pressure of the collective influenced how many families, especially Asian and Latinx families, communicated about mental health (see Figure 10). These families spoke about the cultural factors that both reinforce and are reinforced by the pressure of the collective, including collective and individual reputation concerns, culturally-bound stigma, and misconceptions about mental health. Ultimately, members of the collective were implicitly discouraged from sharing their mental health challenges, so as not to hurt their family or community. The stigma linked to an individual's mental health challenges negatively affected the entire family system. This theme encapsulates the immense weight individuals within the collective felt to be perceived as successful, and how this was tied to their (lack of) communication about mental health within their family.

Self Sufficiency

Many families emphasized the importance of self-sufficiency, or the ability to take care of oneself and regulate one's mental state without help from others. This hailed ability to be self-sufficient was deeply tied to pride. Self-sufficiency showed an expectation of individual responsibility within the collective, especially in relation to mental health. One Asian and Hawaiian daughter (Family 92) said, "I think it's like a pride thing… I guess being seen as weak in a way and not asking for help. I feel like, yeah, there's a lot of pride behind it and people don't want to talk about it." Because individuals wanted to protect their pride, they desired to be self-sufficient.

Some families said that it was important to handle one's emotions alone so that they did not burden or hurt their family. One white son said, "Men are taught to like keep their emotions to themselves or– 'cause maybe they might view like their emotions as causing like a burden on others if they talk about it." (Family 84, white, Father and Son). This family spoke about a gendered experience with self-sufficiency, where men especially feel pressure to face their challenges on their own. One Latinx mother also described this gendered relationship:

> Hispanic men would be the ones to … refuse any kind of mental health care… and if it comes to that point then they're like ashamed. They don't want to talk about it, they don't want to face it, they don't want to deal with it. They're in denial, they won't get help (Family 23, Latinx, Mother).

Some families suggested that relying on others for help with mental health challenges made them appear weak. Many described needing to "prove" themselves to avoid seeming weak:

> C: I feel like maybe a part of the reason that it in Hispanic culture it's so like mental health isn't talked about is because like yeah you don't want to look weak because… you feel like you can't ask for help… a lot of times like Mexican people feel like they need to do everything on their own [or] like need to prove something. So, like when you ask for help on something like that, you… appear weak so like you don't want to talk about that
>
> (Family 23, Latinx, Daughter)

Because broaching the subject of mental health could be perceived by family members as weakness, many individuals felt a pressure to perform. One Asian daughter (Family 60) said:

> I feel like displaying feeling, like I've been taught that it's like a sign of weakness. And so now I just like I feel like all that pent up like feelings and stuff. Like I recently started therapy and like that was the only time where I felt like I finally like let everything out but I feel like most of the time in like Asian culture it's typically like more respectable for you to like just move on with your life as if nothing happened
>
> (Family 60, Asian, Daughter).

This daughter explained how she was culturally encouraged to manage her mental health challenges alone, and how seeking external support was ultimately beneficial to her well-being.

Mental Toughness

The ideal of mental toughness was frequently evoked when families of color spoke about their relationship to mental health. Some participants suggested that mental toughness allowed them and their family to avoid mental health challenges by fostering a strong will of

mind. Many families spoke about mental strength, or mental toughness, as the explanation for why they did not witness any mental health challenges in their family. Couched within this ideology is the idea that mental health challenges are undesirable, and if you do not have visible mental health symptoms, it is because your family members are mentally tough.

Many of these families confidently stated that their family does not have mental health challenges. One Filipino mother said, “We don't talk about [mental health] 'cause we don't really have nothing in the family” (Family 83, Filipino, Mother). These families say that their family is “mentally tough.” The suggestion of a lack of mental health challenges reverberated throughout the family.

> C: …we're all very mentally tough. And like we show it like every single like year, month, day. like we all get together and …eventually like we're together, we're happy, and that's what matters… everyone's gonna have their bad days and like everyone can be down every once in a while, but I think that we're all very mentally tough, and we were all raised to be mentally tough, and we've been put through situations that have made us mentally tough. I just think that's a great trait to have as a family. (Family 86, Latinx, Son)

Another facet of this quote is the idea that because their family was able to come together and be “happy,” that they were all mentally tough. This suggested that mental health, and the visibility of mental health challenges, are tied to mental strength.

In these quotes, the collectivist aspect of mental toughness emerges. These individuals suggested that their entire family unit was strong-minded and capable. One Asian mother and daughter said:

P: we've been through a lot which is health issues and financial issues and I think we're all survivors I would definitely categorize us all as survivors we don't fall apart

C: yeah, I feel like we overcome like things like pretty easily so minor things really don't really bug us…I guess we're strong mentally in that kind of aspect

P: and emotionally none of us really fell apart or break down. (Family 37, Asian, Mother and Daughter)

This language reinforced the interwoven nature of family members' understanding of mental health. Plus, it spoke to the group identity of these family members. This idea of mental toughness in the family emphasizes that the entire family is well, leaving little room for individual variance. While this perspective seems inclusive and confirming on the surface, it could be alienating for an individual who is facing mental health challenges. This group-forward way of thinking likely encourages individuals to hide their challenges rather than seek support from their family.

One Filipino and Black son (Family 83) began following the collectivistic toughness way of thinking when speaking to his mother, "I know me and you don't have no problems like that really, but we don't ever talk about mental health, it's not really a subject, you know?" However, he followed that sentiment with a statement that seemed to contradict his assertion that they do not have mental health challenges, "It's like something that you just kind of deal with internally" (Family 83, Filipino and Black, Son). By suggesting that one should handle their problems without external support, he brings light to the fact that he has experienced challenges with his mental health, and that he does not share them with others. If one family member was hiding their mental health challenges, other family members would

be less likely to have an accurate understanding of their family members' mental health, given that they may keep their challenges hidden.

Upon violating the norm to remain mentally tough (i.e., show no signs of mental health challenges), some participants faced judgement and stigma upon discussing mental health challenges. One Latinx family stated that:

> C: there's a stigmatized approach I guess to having depression because it's more like a 'suck it up' or 'have a different approach to it and then and then you'll feel differently' and it's not really that right
>
> P: even you don't talk about depression or with your friends because you look bad [or] you look [like a] crazy person.
>
> C: or weak, yeah. (Family 58, Latinx, Mother and Daughter)

This response connects to the idea of self-sufficiency; if an individual was doing everything in their power, they would be cured of mental health challenges. This response also reinforces the idea that one should deal with mental health challenges alone, so that they do not to tarnish their reputation or damage their relationships.

Some families spoke about how their family's mindset regarding mental health and mental toughness were shifting,

> C: Now they're seeing that it's not a matter of being strong-minded or having a different mindset, it's more about it's more about actually it is an actual mental illness…it's an illness just like any other right? 'Cause your brain essentially is not producing the certain chemicals that… you need … but …I do believe that our family does not take it the way that they should, and they ridicule, and they use it against, I feel like both of us? Maybe?

P: Yes, more when we have some kind of discussion. (Family 58 Latinx, Mother and Daughter)

Despite this family's concession that their extended family was starting to acknowledge the reality of mental illness, this mother and daughter still experienced difficulty when attempting to speak about mental health challenges with them. Overall, the ideal of mental toughness played a significant role in families' understanding of mental health.

Gender and Toughness. Within the theme of mental toughness, some families spoke about gendered experiences. When talking about the idea of mental health traditionally in Mexican culture, one mother and daughter said:

C: people thought that essentially if you feel this way, you're weak minded right? And it even came down to sexualizing it like 'oh you feel this way because you're a woman' right? you've heard that before from your family.

P: yes

C: very Mexican thing to say right

P: yes, or you're on your period

C: or you're on your period

P: I always say to you

C: you always say that too. Right, I hate it. I hate that so much, because it's like …I could feel this anxiety and I can feel these feelings and …it's all these surrounding things, not just my hormones, which hormones do take a big part.

P: yes, hormones change your mood

C: Huge, but you have to understand that like, I know you're big on that one but you, [as] somebody who suffers from depression, should know that you can defer from

> you know your womanhood to your actual … *humanity* and how your brain is working. (Family 58, Latinx, Mother and Daughter)

This interaction reveals information about their previous communication patterns: the daughter notes that her own mother, who had depression, would weaponize her gender and claim it was a determining factor in how she behaved or how she felt. The notion of challenging communication also surfaces in this conversation. The daughter challenges the rhetoric that her mother had used with her in the past, which her mother had inherited that from her parents. The daughter highlighted that mental health challenges were not necessarily about gender, but about one experiencing their feelings as they come. In some ways, this narrative allowed women to be more emotional. Simultaneously, it invalidated their feelings and concerns, and suggested that women are hormonal and irrational.

Men faced their own stereotypes that impeded their ability to express themselves. Some families spoke about machismo, with one Latinx son saying:

> Especially like being Mexican, you're taught like 'oh you gotta be a man, you gotta like just man up and like deal with it' and like there's a lot of machismo out there. I think for some parts it's okay … [but] if you're really suffering from…something very big… I think you should really talk about it and like seek help. Cause… people think 'I should not talk about [it], I should just man up and keep moving forward.' And…it just ends up becoming a really big problem… (Family 45, Latinx, Son)

This son described a culture where vulnerability is perceived as a sign of weakness, and men are taught to avoid it as much as possible. Even when facing a major loss, men are not traditionally allowed to show emotion.

Some Hispanic families spoke about how men and women are both expected to adhere to this idea of mental toughness with regard to mental health:

> C: …I feel like a lot of like Mexican and Hispanic people think it's not real, like they'll just kind of put it off as … if you have like depression… like, 'oh, you're just sad'
>
> P: 'It's in your head'
>
> C: Yeah, 'you just need to like go outside' or something like that.
>
> P: Yeah
>
> C: Like you don't actually need to go to like the doctor
>
> P: [nods in agreement] mhmm they don't believe in it
>
> C: Yeah, and I don't know why…
>
> P: Yeah. I don't know either, but [it] tends to be a thing like pride.
>
> C: [nods in agreement] Mhmm yeah, I think that definitely has something to do with it because a lot of
>
> P: If you need help with mental health or you're not strong
>
> C: Mhmm
>
> P: You know you're weak and for men to be considered weak it's huge, you know? I mean even women. (Family 23, Latinx, Mother and Daughter)

This standard of mental toughness ultimately made it difficult for men and women to communicate about mental health even within their families, as pride was tied to a lack of mental health challenges.

Necessity of Appearing to Thrive

Many families articulated that the pressure and expectations placed on them by the group made it difficult to be vulnerable, even with their family members. Many families spoke about the general expectation parents had for young adults to thrive, with parents often hoping their children would achieve success in their careers and personal lives. One young adult spoke about the pressure she faced, stating that her parents told her to:

> …just make money [and] get good grades… Whenever I'm with them, it's literally, every single time, are you, are you getting A or are you a straight A student, are you the first in the class? I'm like, I'm trying but not everyone is going to be good at math, and not everyone is going to be a nurse… I know the route, that's not me. I don't like math…I'm not interested in nursing like others are, but I still want to like make them proud and be happy that I'm going to school and that I want to graduate… (Family 98, Asian, Daughter)

Some spoke about how high scholarly expectations in Asian families could reinforce this necessity to appear to thrive:

> I know in Asian households people talk about the tiger moms and tiger moms are so down on their kids for having an A minus and imperfection and they need to go to ivy leagues and all that stuff and that can take a huge toll on their kid's mental health but to a tiger mom the most important thing is that their kid goes to the best school possible and has the best grades. (Family 22, Asian, Daughter)

Some participants did not want to tarnish the image their family had of them or worried that sharing mental health challenges might disappoint them. Therefore, many young adults felt that they must keep up the appearance of success in order to make the family proud. One Asian son said:

> We have to be like the best always and like if we complained we'd get shut down and growing up with that in mind like throughout say elementary school or like even younger than that… I think that really hit a nerve in development, like psychologically, where it's like we were almost manufactured to like trudge through hardship and … keep like… trying to be better than other people. (Family 74, Asian, Son).

These expectations for excellence made it difficult to open up when they were struggling, and even discouraged open communication about mental health challenges. Another Asian daughter stated that being part of a family that appears to be perfect can make it even more difficult for her to face her challenges:

> …dealing with [mental health challenges], it's hard being in our family, especially because nobody talks about those things, especially your side of the family…so coming from …like one side of [the] family being like a picture [of] perfect health, and then me struggling … It's like difficult to talk about because it feels like I'm not really going through the same thing that you or anybody else went through. And so, since we're still an Asian household, it's hard to talk about anything relating to mental health, 'cause it's kind of like 'oh sleep it off' or 'you'll get over it'...kind of mentality. (Family 48, Asian, Daughter)

As she felt like the "odd one out," this daughter was unable to seek support about her mental health challenges with her family. Part of the reason this pressure of appearances impacted young adults so deeply is because their actions reflect the family. One white daughter said, "I think in our family and… our culture… you want to make yourself appear perfect and like the perfect family. Because it's that idea of… the perfect family that has like kids who are

super successful…" (Family 10, White, Daughter). Therefore, family members may feel the pressure to perform for the sake of their family's reputation.

Stigma of Mental Illness being Revealed

Stigma and its social repercussions played a major role in how families spoke about and understood mental health. Many participants articulated a vested interest in keeping mental health challenges private, and not searching for support outside of the family. Families frequently mentioned stigma in their culture as a hindering factor to seeking mental health treatment. One Asian father and daughter said:

> C: … in like Asian culture nobody talks about mental health, and it's never focused [on]. Even now, like they don't think mental health is an issue or even exists.
>
> P: Yeah, I think Asian culture is a much more family-enclosed culture where discussing things outside of the family with strangers, 'specially mental issues within the family, it's … not acceptable… So people will have more difficulty… going for treatment in the Asian household. (Family 48, Asian, Father and Daughter)

Many suggested that the revelation of mental health challenges to those outside of the family was a major threat, not necessarily the potential for mental health challenges to worsen. One white daughter described the stigma that came with divulging mental health challenges, even those that were relatively normalized:

> C: I think people are more hesitant to like form close relationships with people who have mental health issues … I know like many people … are like 'oh, like she has depression' and they kind of get put in like this cage almost by our culture, where they have this label on 'em… whereas them and probably 50 other people … all have

> the same stuff but someone who comes out as having these issues is… looked at as, like put in a cage like an animal, you know? (Family 46, white, Daughter)

This daughter articulated that even when community members may, themselves, be facing similar mental health challenges, revealing those challenges was taboo and opened the family to criticism. Families described the backlash they would receive upon sharing their mental health challenges, including social isolation, judgment, and gossip within their community. Individuals who were known to have mental health challenges were ostracized, "...if somebody went to a therapist or a psychologist, that kid was one that you didn't want to play with, you know they had problems" (Family 19, White, Mother). Ultimately, this stigma prevents individuals from seeking support, as articulated by one white mother, "There's probably tons of people out there who don't want to admit they have a problem, so they just never seek help because they don't want to be labeled" (Family 61, white, Mother).

Notably, stigma manifested uniquely for Asian and Latinx families. Asian American families often spoke of shame and encouraged individuals to handle their mental health challenges on their own. One Asian daughter said,

> There's a lot of shame when it comes to being open about your mental health issues [in Asian cultures] and if you are to express … your mental issues then it's kind of embarrassing… They think that mental illness is your own fault and … [that] it's something that you can help. So, saying like 'if you do have mental issues then it's your fault because you could have done something to stop it' or 'you're just not mentally strong enough or you're not smart enough to keep yourself away from situations that would put you in a place to harm your mental health.' (Family 35, Asian, Mother and Daughter)

This shame blames the person who is experiencing mental health challenges. Within this quote, there are also signs of disconfirming narratives one might expect upon sharing their challenges. Some Asian young adults did not turn to their parents or family for support because they expected disconfirming responses.

Latinx families often encouraged sharing, though they also emphasized toughness. Some families argued that Latinx cultures are more open to talking about their challenges, in contrast to U.S. culture. One Latinx daughter said, "Mexicans are very like loving and not that Americans aren't, but… it's more like you're open to talk about what is going on… And I feel like a lot of Mexican cultures, you, you hide it with humor" (Family 16, Latinx, Daughter). In these families, support was encouraged within the family, and family members were discouraged to seek external support. However, some individuals reported some disconfirming mental health messages from family, often encouraging hardiness. Therefore, although Latinx families encouraged open communication, young adults may choose to keep their challenges to themselves.

Mental Illness as a Plague on the Entire Family. Many families spoke about how the stigma of mental illness transfers onto the entire family. One Latinx son said, "I think our culture [emphasizes]…the idea of a group. So, when someone is mentally ill, he or she may be too afraid to talk about it. … It feels like some mental problems [are] contagious" (Family 34, Asian, Son).

Because the stigma can be contagious, family members may refrain from discussing their challenges to protect the family. One Latinx family spoke about the family-wide shame of mental health challenges:

P: …I think it's been kind of something that people don't want others to know about they don't want to talk about it they don't want to admit to it

C: Mhmm

P: Or talk about that they have family that has it.

C: Yeah because … even if you just talk about like someone in your family [who] has a problem, then it like kind of reflects onto you and says something about you.

P: People might assume that it's genetic, you know like everything else. (Family 23, Latinx, Mother and Daughter)

This stigma around mental health served to make it more difficult for families to prosper. One mother spoke about how mental health was treated in Japan while she was growing up, "if you know members of your family are mentally ill you just don't talk about it just … ignore and pretend like … that's not happening" (Family 44, Asian, Mother). She went on to speak about the repercussions of others knowing about one mentally ill family member, "People think that it's around in your family. So, if … your daughters … [or] your sons try to get married and the people think … that's …the family we should avoid. So, they don't wanna really talk about it" (Family 44, Asian, Mother). The last line of this quote summarizes the impact of this stigma that affects the entire family. Because it hurts the whole family and can hurt their family's future prospects for happiness and success (which are highly prioritized), people choose to avoid talking about these challenges because talking about them could lead to a host of other problems.

Suppression for the Collective

The cultural focus on self-sufficiency (within the context of the group), mental toughness, the stigma of revelation, and the necessity to appear to thrive, comprise the

pressure of the collective. Many families described how this pressure persuaded them to suppress their mental health challenges, even in times of severe strain. One Asian mother (Family 35) said, “It’s kind of a shame to cry in front of family members… my dad passed away… and I was afraid, and I thought it is a shame to cry in front of family members, so I had… a hard time…” (Family 35, Asian, Mother). Even when grieving for a close family member, this mother felt she needed to put on a good face in front of her family. One Black daughter stated that, “...you have to act a certain way, you’re not supposed to show much emotion supposed to be like strong for your family…” (Family 52, Black, Daughter). These families articulated how the good of the group superseded self-expression or treating mental health challenges. One Asian father and son said that:

> C: the reason why…we're not talking enough about it [is because]... there's something in our culture that's like you know “you shouldn't be different than other people” it's … paying more attention to collective interest… instead of individual interests… like you shouldn't cause inconvenience to other people.
>
> P: right, right
>
> C: But then you know if you have mental health problems and then you need accommodation from other people, … you often are afraid of asking for that because… you don't want to cause inconvenience to other people. (Family 124, Asian, Father and Son)

When simply asking for help can be taken as an inconvenience, hiding one’s emotions was incentivized. Later in the conversation, the son mentioned:

> …in the larger East Asian culture… there's certainly a trend of … us trying to hide our I guess failures or hide our negative emotion from- from each other, from like

> within the family, because … you don't wanna disrupt the harmony you know within the family. And the second thing is that you don't you don't want to really share your… negative emotion. (Family 124, Asian, Father and Son)

The negative repercussions of sharing one's mental health challenges could range from mildly inconveniencing others to tarnishing the entire family's reputation. These consequences encourage family members to handle mental health challenges alone, demonstrating the power of self-sufficiency within a collective. One Asian daughter said:

> I can't really say like, " hey I'm sad, can someone do something about it?" Because I feel like that's something I should figure out for myself. It's not something I should put on my parents, or my family in general, because I feel like I could try to figure things out, even though it's healthy to talk to someone else about how I'm feeling… if I have an issue with my mental health, I just wouldn't wanna just put that out on the table for them to hear or listen to, because I'm sure there are so many other different things in the world that should be emphasized, not my [problems]. (Family 98, Asian, Daughter)

Some young adults felt their mental health challenges were not worthy of discussion, and that discussion would only cause additional difficulties. One Black and white family (Family 140) spoke about the daughter's ability to talk about mental health challenges with some of her Black family members:

> C: ... I didn't feel like I couldn't talk, we just didn't. And that was the culture of our family… And it felt more like a burden thing than like a shame thing. Like "Oh I don't want to talk about it", you know what I'm saying? I just got the sense that

people wanted to keep it to themselves because they didn't wanna like put it, put that "burden" [finger quotes] on somebody else, if that makes sense?

P: Yeah… I think that there's a little bit of both. I mean I think that burden and shame kind of go together. If you think that you're a burden, you know that means that there's something wrong.

C: Yeah, you're right (Family 140 Black and white, Father and Daughter)

This father challenged his daughter's statement that this suppression was not tied to shame, ultimately expanding her understanding of her family dynamics. A similar sentiment was shared in one white family:

C: I feel like we're all really good at like not showing like when we're like sad or stuff

P: like we don't I think what you're saying is we don't in our family we try not to burden the other person

C: yeah

P: with less stress (Family 116, white, Mother and Daughter).

One family described the process that results in the suppression of mental health challenges:

C: …if I was ever feeling like my mental health was bad or if I was in a bad place, I would say something to you …But then also …there's times where I feel sad or…

P: And you think **deep**

C: Well, I mean yeah, I think a lot, but I'm saying … sometimes … [I] just deal with it myself…

P: Now I'm gonna tell you …if you feel something …that's making … you down … you have to tell us right away. Don't wait till, you know…

C: …I know what you're saying, but …even when I'm feeling sad, I always have like that positive mindset. like …I'm'a get through it… if I'm really sad about something, or if like if I'm feeling like really depressed or whatever… you could tell. But there's times where I do feel that way but like I could just deal with it…

P: The same thing with me…you see me quiet. I cope with it okay. Afterwards I just let it go and it goes away.

C: True, but I don't know. See, now hearing you say that makes [me] sad, I'm like 'I want you to tell me something'.

P: Aw…Sometimes … it's just for adult-adult

C: adult-adult? [laughing]

P: Sometimes I don't even tell dad, you know? But there's times that I'm stressed I'm just— if you see I'm quiet, I just [have] like a lot of stuff in my mind you know?

C: But you never feel like "oh maybe I should talk about it" or no? …

P: no, no

C: ...that doesn't change your outlook on on your life right like you do does it ever get you like so sad like you're like oh this and that?

P: no, no

C: right, 'cause that's when it's something you should talk about you know?" (Family 83, Filipino and Black, Mother and Son).

This interaction is also unique, in the show of empathy from the son to his mother. After she shared that she also suppresses her emotions, as he had just described, her son expressed sadness. This again shows the interconnected nature of these parent-child interactions about

mental health. This mindset was passed down through generations, and only now may they begin to challenge it.

Family 33 compared their experiences communicating with their network about mental health challenges in the U.S. compared to China:

C: Who do you go to to talk to? …Your husband, your children or your friends or nobody?...

P: I think my children, the friend, we talk [about]this and they don't want to talk. I think, you know, the Asian people they don't like to talk [about] this kind thing.

C: Yeah, why?

P: I don't know…It's not that open, they don't want to tell the person nothing, or this kind of thing to outside.

C: So, you act happy all the time?

P: Yeah, even… [if they are not] happy they just make it they happy, they don't want to tell…

C: That's so lonely

P: [speaks foreign language]

C: Not open

P: Not open

C: yeah

P: Even… friend, they don't want to say this kind of thing, they just keep keep. That's why a lot of people-

C: get sad

P: … only the family they talk… they don't talk to outside people.

They went on to describe in greater depth,

P: Being American, they very open, they, they have something, they just tell you. But the Chinese… they just afraid to tell you…

C: How do you feel about that?

P: …I don't like it, they [are] so tricky… America is so straight … I like it.

C: Genuine

P: That's why I stay here. I like the people, like open.

C: Like if somebody is mad at you or upset about something. Do you like when they talk to you about [it]?...

P: yeah, they tell me, [and] I know what's wrong [so] I can fix.

C: so, you can be a good friend right

P: But when they don't tell me, they [are] just afraid.

C: Then you never know

P: Yeah (Family 33, Asian Mother and Daughter)

This family also articulated how these cultural limitations can impede someone's ability to be a good friend by providing support.

Ultimately, many families thought about mental health in relation to the pressure of the collective. This cultural foundation made it more difficult for these families to express themselves and seek help both within and outside the family.

Survival Supersedes Mental Health

Some families understood mental health in relation to survival and endurance (see Figure 11). These families articulated a number of barriers that impeded their ability to confront their mental health challenges. Many spoke about systemic issues and ambient

racial anxiety as factors that impacted their ability and/or desire to confront their mental health challenges. These issues laid the groundwork for the cultural ideal that survival supersedes, or is more important than, mental health. This ideal was reinforced through strength regulation, in which case elders often communicated a lack of choice, arguing that one must ignore mental health challenges to survive. Endurance served as a bottom line for families that believed survival supersedes mental health. Many elements of these family conversations emphasized the importance of making it through a system that was not built for them. Black families often spoke in terms of "have to" and "need to", with little room for deviance. This language could suggest that paying attention to one's mental health is futile or that someone who focuses on mental health is not prioritizing the right things. Some families brought up the limits to the ideal of strength. One Black daughter said, "[Black Americans] are stereotyped to be like very strong …very tough. We can take a lot of things, especially like mentally. And like Black women specifically… we're stereotyped to put those things aside…and just focus on specific tasks…" (Family 100, Black, Daughter). These expectations can discourage and stigmatize talking about mental health. Generally, parents described or advocated for a more traditional (i.e., survival-based) approach to mental health.

This theme was especially common in Black families, with many of them describing how systemic issues impeded their ability to confront their mental health challenges. Many families spoke about survival taking prominence over their mental health in one form or another. Many of these families had trouble defining mental health (and mental illness), and often spoke about survival over all else.

Systemic Issues Affecting the Present

Some families suggested that part of the reason it was difficult for them to confront their mental health challenges was that systemic, often historically-rooted, issues are affecting how some families understand and communicate about mental health. One Black family described the political and structural forces that set the stage for minorities' present-day behaviors and beliefs around mental health:

> P: ... Reagan is the one who shut down a lot of the mental facilities… it…wasn't a priority to the government. And if you didn't have any money then–
>
> C: you are getting no help
>
> P: –that was too bad. Because the rich were able to, of course, take their loved ones to a therapist… the government really didn't provide those kind of services for the Black and Brown community with mental illness. Food and clothing and that kind of stuff, but mental illness? **No**. So, it wasn't like as if they could seek help through–
>
> C: assistance, like financial assistance
>
> P: financial assistance, through public aid, or something like that. Because there weren't social workers or therapists who were available … because the government wasn't paying them enough money… or paying them at all. I mean it was just such just such a weak thing that the government just did not care about. It wasn't something that they really-
>
> C: It wasn't a public benefit…
>
> P: Well, as a police officer working on the street working with the mentally ill… I could see that if people … had gotten proper intervention, medications, [or] to see a therapist… they could have led a better life, a more productive life. But the government failed us in that area. (Family 135, Black, Mother and Daughter)

While this family talked about the larger system's propensity to let down Black and Brown families and individuals, many spoke about how those limitations were reinforced in their own families. One Black mother described slavery's connection to Black Americans' present-day mindset. She stated that the proclivity to ignore mental health challenges was passed, "… from generation to generation. I mean you go back to slavery day, it's like, 'depressed? [laughing] who got time to think about depressed? I need to get this and this done, 'else I may be beaten black and blue'" (Family 99, Black, Mother). She went on to explain how this mindset continued on as the discrimination against Black Americans evolved, saying, "…even with your grandparents, I mean, they came from a culture where, you know, [scoffs] depressed? Look, you got this 'n this. You still gotta … be able to get that stuff done that I told you need to." (Family 99, Black, Mother). One Latinx daughter (Family 21) described how these limitations were maintained over time within the family, "...grandpa… didn't have resources or [know how] to talk about it… [or how] to help himself. And then that just carries on to your kids, [and] carries on to their kids." (Family 21, Latinx, Daughter). A Black mother explained that although communication about mental health has begun to be accepted more recently, these conversations are hindered by systemic issues that were beyond the control of Black individuals:

> P: I believe that [mental illness] was out there but it wasn't talked about. I feel that it's talked about more now, and I feel that people are more open and honest about how they're feeling now than when it was back in the day… back in the …50s and 60s where your granny and them grew up …they started working at a very young age. They had to be seen as strong, they couldn't show that they were breaking down or

depressed. It was like, ‘okay get over it we got things we got to do.’ (Family 100, Black Mother)

Because their elders had to work to survive from an early age, they did not have the time or space to consider any mental health challenges they may have faced. Consequently, they passed down these beliefs to subsequent generations. Another Black family described how a lack of resources and cultural norms kept mental health a stigmatized subject:

> P: Prior to the 2000s, it was always a secret when people had mental ill issues. It was ignored, misunderstood, [and] overlooked because the community, the Black community, the Black and Brown community, really didn’t know how to handle it and didn’t have financial resources… they weren’t educated on the topics. It was something that you really had to figure out on your own…and something that was brushed under the rug.
>
> C: Because ‘what goes on in this house stays in this house’.
>
> P: Exactly.
>
> C: But a lot of those issues spilled outside of the house, outside of the family. And into people’s personal lives, which led to like a lot of outside bad behavior (Family 135, Black, Mother and Daughter).

The systemic issues that these families’ elders faced created a culture in which mental health was not able to be adequately managed. These beliefs were passed down and reinforced in the culture and in families, ultimately stigmatizing mental health communication.

Ambient Racial Anxiety

When speaking about mental health, many families articulated an ambient anxiety tied to their racial identity. This thought was shared most frequently among Black families,

who often referenced incidences of racism and police brutality as impacting their wellbeing. One Black mother said that her mental health, "... was affected by… George Floyd, the woman in New York and what she did [in] Central Park [Christian Cooper and Amy Cooper], the other woman who was killed in her bed [Breonna Taylor]...my mood was greatly affected by that" (Family 52, Black, Mother). Family 41, a Black mother and daughter, discussed the anxiety they felt Black Americans experienced on a daily basis in relation to discrimination and its potentially fatal impacts:

> C: I feel like maybe [Black Americans are] more open now, especially with the George Floyd thing, because they know everybody's feeling anxious, and it feels like there's really nothing they can do…
>
> P: Is that a mental health issue?
>
> C: Well anxiety is, and maybe you're feeling depressed because you feel like helpless.
>
> P: Mmm [nodding] okay
>
> C: I don't know if that's like a permanent thing-- Well, I'm sure it is for some people. I don't know.
>
> P: I don't know, Black people feel anxious--
>
> C: --all the time?
>
> P: You know, walking down the street, you just never know…with all this craziness… it just takes a cop to pull you over and then it escalates… that's a concern I have daily when you leave the house. Every time you go to work, I say to you, be safe…" (Family 41, Black, Mother and Daughter).

This constant burden can weigh on Black Americans. Ultimately, this mother said, "…I don't think that's a mental health issue, I think that's just a daily living with Black skin issue". When one's racial identity can be a source of discrimination or even violence, they may begin to accept this distress as a part of life. This ambient anxiety makes it so that Black Americans must always be on guard, severely limiting their ability to be vulnerable. Family 135 spoke about how this danger impacts the way Black individuals interact with the world:

> P: ... we're taught to keep that smile on our face and stay happy because you don't want to seem aggressive you know.
>
> C: oh yeah, that's a big thing.
>
> P: yeah, you just don't want to seem aggressive to other people when … actually mentally things are not right. And it's hard to explain it to other people and to deal with it…because we are taught to be strong, because we are told from a younger age…'don't do this because it can be looked at as aggressive'. We don't talk about a lot of our feelings. And because we don't talk about our feelings, we never get the help. So, it just festers, and it just builds up and builds up and builds up. So, I think it's very sad and so because we don't talk about it's hard to get help for it. (Family 100, Black, Mother and Daughter)

Displays of emotion that are seen as aggressive could lead to a number of negative outcomes, including death. Therefore, Black families may teach their children to suppress emotion so they do not appear aggressive and can survive.

Rank Ordering Stressors

As a result of the challenges these families described, many rank-ordered their stressors, and mental health ranked last. Families suggested that when there were more

pressing, life-threatening issues at hand, mental health was not a priority. One Black daughter stated that, “I feel like Black people don’t really talk about [mental health], like they have other things to worry about; people have bigger problems” (Family 41, Black, Daughter). This quote succinctly captures a common belief held by many of the Black families in this study--that mental health is not worthy of discussion and that other challenges are more important. However, this family (41) articulated how the stressors that are traditionally ranked above mental health are likely hurting family members’ mental health:

> P: People are thinking about other things like you said people have bigger problems, I guess.
>
> C: Well, I’m sure those bigger problems contribute to it, like the Floyd thing is making people feel depressed and … anxious” (Family 41, Mother and Daughter, Black)

Some immigrant families also spoke about rank ordering their stressors in service of survival. One Asian mother told her daughter that back in China, “We don't have time to talk [about it] because we need to find the food to eat…You need to find out how to find a job, how to make money, to make you a stomach full” (Family 33, Asian, Mother). Another Asian mother argued that in her home country:

> ...the priorities and our culture were different. it's more about survival. It's not about feelings. It's about putting food on the table, working hard to survive…I hate to say that we make excuses that they didn't put mental health as a priority, but I think that's what they knew, and that's how they were raised, and that was a different priority for them. (Family 98, Asian, Mother)

These families spoke of the hardships they had faced, and the necessity to get through each day. Many were taught that wellness was irrelevant to the ultimate goal of surviving. Therefore, mental health fell to the bottom of the list of priorities for those needing to survive.

Within the sample, many families, especially white families, provided a foil to this way of thinking. These families had the privilege to have the time, space, and resources necessary to confront their mental health challenges. Notably, white families referred to resources more often than families of color. One white daughter, when explaining how mental health has become more acknowledged in recent years, said:

> …a lot of America, not all of America, but a good chunk of America is blessed to at least have food on the table and [a] roof over their heads…once you have that, your higher needs become more important like mental health. And so, I think that's also part of the reason that mental health is more discussed, it's the higher quality of living… (Family 08, White, Daughter)

This daughter notes that for many Americans, their essential needs are met, and they are able to face their mental health. While this daughter was correct about the hierarchy of needs, she did not consider culturally-bound factors that impact if and how people face their mental health challenges. Some families spoke of the ease of finding mental health care, sometimes taking this ease for granted. Notably, some families who had access to mental health resources articulated their privilege and the fact that many other people did not have those options.

Strength Regulation

With a culture that values endurance and strength above all else, Black families were especially likely to describe or enact strength regulation. Generally, Black elders reinforced and upheld strength-based beliefs through behaviors that could be perceived as disconfirming. Black families often described (or demonstrated) a pattern of communication that negated the legitimacy of mental health problems and discouraged discussion. One Black mother discussed how this mentality is reinforced across generations:

> …[Black Americans] are raised up **strong**… [there were] so many other things we had to fight against so when it comes to our mentals it's like 'what do you mean that you're depressed? What do you mean you're sad? What do you mean you're having all these different types of emotions and these things going on in your head?' … a lot of times that's just not acceptable. (Family 100, Black, Mother)

By making it clear that talking about mental health challenges was a nuisance and foolish, elders embedded the impracticality of talking about mental health challenges. Some families spoke of the messages they had received regarding mental health challenges from those in their community–many of which centered personal strength and will power over help-seeking both formally and informally. One family said:

> C: …it's kind of the norm to keep it to yourself… it's kind of like deep-seated … [in] Black… culture that… most people think it's not like as serious of an issue as it is. They feel like 'oh you're just sad you'll get past it eventually'. Like 'you can work towards being happier'...
>
> P: Or that everybody goes through that, everybody goes through ups and downs.

> C: Yeah, and they'll just push the mentality that you have to like work hard to get out of that, like you're not doing something right if you're feeling that way. I feel like that's what the norm is in our culture… (Family 82, Black, Mother and Daughter)

These messages served to maintain strength within the family as a protective mechanism. This suppression was meant to hide weakness so that these Black individuals and their families had the best chance of survival in a system built to discriminate against them. This strength regulation impacted multiple facets of individuals' lives, with those who sought external mental health support facing criticism from their network. One Black daughter described an incident where her family engaged in strength regulation:

> …when we went to the doctor's office, they gave us like an evaluation … to see if you have depression or any other form of mental illnesses. And I had put down some things that … reflected how I was feeling but then when I was giving it to the doctor, granny had taken it from me and was like looking over it… And then she was like "we don't do this." And I was like 'how you gon' tell me how I feel? This is what I feel… if I feel this way, I feel this way'. And like [family member] you know, he read it. I don't even know how he read it, but he was just like "you don't feel that way. Like that's really mean that's messed up that you think that" and I was just like this is my mental health and like if I don't feel okay 100% of the time, I'm allowed to feel that way… it asked me to be honest and I didn't want to lie, I have no reason to lie, it doesn't make sense. But just like that example really told me …how …granny and all that stuff feels about like depression and mental illnesses … it kind of sucked because … this is probably what you did to other members in the family, and/or this is

probably what your ideologies on mental illnesses are like (Family 100, Black, Daughter)

Family 99, a Black mother and daughter, had an especially challenging conversation during the study. The mother communicated strength and excused ignorance of mental health challenges, while the daughter attempted to help her mother see her side. Their conversation began with the mother saying, "I have no problem talking about mental health." From there, their conversation was characterized by the mother taking control, and the daughter attempting to speak her piece. When they began talking about mental health in their culture, challenge became especially apparent in the conversation.

C: … remember that …TikTok, with the Black boy told his mom he was depressed, and she was like… "Go be depressed and wash the dishes" or something like that? …it's kind of like funny but not, because like on the serious note, like sometimes like Black parents maybe don't… take it as serious if that makes sense?

P: It's not that they don't take it serious, it's because of everything. First of all, it's in the culture. I mean, for years, you know, we have basically been put in a position where you have to get up and get over it and get what needs to be taken care of. It's not that, you know, that it's not serious, or we're not taking what it says serious, but it's just that, you know what, there is so much involved in life itself. You being depressed... I mean I really don't have time to **be** depressed, because there's just so much to do. So, it's more like that…

C: Yeah

P: okay

This mother firmly argued that Black Americans were rank ordering their stressors as a necessity, and that mental health was frivolous. Upon her daughter attempting to widen her perspective, the mother interrupted and asserted:

> C: But also, maybe they don't know like how to handle it too, is what I was going to say. you know? Or maybe it goes back to–
>
> P: It's not— Well, it's not about what to handle. It's just that, you know, with so many other concerns that you had to focus on…[scoffs] depression… I mean that wasn't even something worthy of talking about. Because there's so many other… situations going on…**you** say I'm depressed… you know, it's just… [shaking her head] you know.
>
> C: Well, it doesn't even have to be depression because it could just be
>
> P: Well, depends
>
> C: because you know people who have like…
>
> P: on what you said, you brought that up as an example. I'm just saying, you know, for our culture, they don't focus… or didn't **consider** that, because there are just so many other… **major** …things to think about, or situations or… [gestures] you know what I'm saying.
>
> C: yeah, yeah
>
> P: You had too many concerns… [so you should] concentrate on something that it appears that you have more control over.

Notably, this mother suggests that mental health is out of her control–which suggests a perceived lack of self-efficacy in handling mental health challenges. This belief system may inadvertently tell individuals that they should not attempt to work on their mental health, as it

is out of their control, much like systemic issues and racial stress. Although this mother spoke as if she were detailing mindsets from the past, she reinforced this belief system at the end of the conversation. Her daughter attempted to engage her mother in thinking about her experiences:

> C: But…what about me and [sister]? What do you think like, how would you deal with depression? because you remember, I went to counseling and stuff.
>
> P: Yes…
>
> C: In regards to depression and sometimes
>
> P: was it depression? that's not what she said
>
> C: Okay, fine, I guess that's self-diagnosed. Sorry. But I mean I would get like really sad and have suicidal thoughts and stuff. I mean I can't say that the doctor said that that was depression, but you know.
>
> P: [making a face] She didn't say that was depression
>
> C: I said— I said she didn't say that.
>
> P: No, she didn't.
>
> C: Anyways, but that's mental health either way.
>
> [long pause]
>
> P: Okay, I'm not sure what you're asking me.
>
> C: I'm just asking what do you think about that? Like, how do you feel about that?
>
> P: Feel about what?
>
> C: Like my mental health state.
>
> P: Well, it wasn't… it was more of there were things that you need to focus on more, and I think that's what that counseling session was more on. Basic ways of you, you

know, way of you basically working through some of the issues you have, as well as finding other ways to address it…That was a way of you basically … looking outside the box, where you were at at that point. so, you know, 'okay well, yes, I need to get my life and focus, and this is easier for me to conceive that'. I mean with you… it's always been you were easily distracted.

C: [quietly] I guess

P: Okay. Like [the] kindergarten teacher said, well you know, '[daughter] be in a class [and] if a girl passed by with the butterfly barrette in her head, she's looking that way'. So, it's like… that and problem solving, I think. That has been the issues, those two things.

C: [quietly] I guess so.

P: Okay, so I don't think that was mental health issues. I think that was something totally different…. (Family 99, Black, Mother and Daughter)

This is an example of strength regulation—when the daughter brought up her own mental health challenges, her mother tested their legitimacy and suggested that the daughter needed to focus and try harder. Notably, the mother did not acknowledge the daughter's comments about suicidality and would not accept her use of the word depression. This mother was regulating strength, with an underlying message that asserts the daughter's strength, ability to overcome, and re-direction toward the things that are more important. This method of strength regulation did not allow for much vulnerability.

This excerpt is also an example of how disconfirming this ideology can be for those who share their mental health challenges. While the parent may have been attempting to reframe the daughter's experience, it ultimately stifled her ability to share her thoughts and

feelings, becoming disconfirming. This disconfirmation served to reinforce the reigning ideologies around strength that they spoke of. This excerpt also serves to demonstrate an example of an adult child attempting to redefine mental health or expand her mother's understanding of mental health.

Religion as a Solution

Some families understood mental health through the lens of religion and spirituality (see Figure 12). These families often spoke about how their spiritual foundation contributed to their mental health. One white family said:

> C: …in terms of like mental health, we like try and work on that every day… we're …constantly trying to say 'hey, let's do positive affirmations' or just little things that can like better our mental health…just to get us out of the pit that we were in or whatever
>
> P: Yeah, and when we were talking about our family … I would say at least three of the five are very spiritual and…think it was not just really as a body, but more there's a mind and a spirit and such, much bigger than that. (Family 28, White, Mother and Daughter):

Whether this use of religion was more positive or potentially harmful depended on whether those communicating conceptualized religion as one resource to encourage mental well-being or as the only solution for mental health challenges.

Religion as a Resource

Some families spoke about religion and spirituality as one tool of many to help with mental health challenges. One daughter said, "… in my like experience…I feel like going to church and like praying and like talking to God or whatever has like helped me cope with

things …" (Family 12, Black and white, Mother and Daughter). When used along with other forms of support, many parents and adult children described finding solace. One family spoke about religion, and religious resources, as one facet of many for maintaining one's well-being:

> P: … I think that they try to offer that type of service through their… local churches too, you know, they may not be licensed … doctors or psychiatrists or psychologists, but I know that they offer like therapy.
>
> C: like support groups…
>
> P: … pastoral counseling and following the religious beliefs, but sometimes, I think, people need a little bit more than that…I think anything can help. I mean sometimes, you know, ourselves, we don't need necessarily always need to talk to a therapist. We can go to each other… Or go to our friends and family and just kinda throw up all over 'em and then you know process through things and move on. (Family 12, Black and white, Mother and Daughter)

This mother spoke about religious help in tandem with other forms of support, even suggesting that their family was able to unload onto one another. Another young adult son said:

> C: ...since you're Catholic you deal with like anything that comes your way through faith, and that's like how you kind of keep your sanity a little bit. And just knowing that you can kind of like [turn] toward the higher power. As far as dad goes, he just kinda puts on the persona 'I'm capable of handling anything that comes your way'... and then growing up in like that kind of duality I've been able to … pick and choose what works best for me and like kind of realizing…I'm only able to do everything

within my power. If it doesn't work out, those are just factors outside of my control. (Family 55, Pacific Islander and White, Son)

This family demonstrates a balance between faith and self-fulfillment, with an openness to multiple perspectives.

Some families spoke more about spirituality (an individual element) than religion (an organized set of beliefs), and the practices one could integrate to improve their mental health:

> C: …my mental health has been way better, because of like the holistic approaches that you've been teaching me and just like, I don't know, stuff that like isn't medicine.
> P: And [medication] can be helpful, but …I do feel like other approaches with counseling, or energy healing, or acupuncture, or you know, just a lot of things that they could even do on their **own.** Practices like yoga and meditation can really– I see more progress. It's kind of the reason why I left the mental health field… I experienced that it worked better to approach healing in that way, so less of a treatment model and then more of a healing model. (Family 96, Asian, Mother and Daughter)

By entering into a spiritual practice over traditional medicine, this mother was able to rethink her understanding of mental health and well-being. This family went on to say:

> P: I'm just seeing more people…more receptive like they've done all of the other stuff, and then they come, and they realize it's like, 'oh this has shifted or this has changed or I feel so much better.' So, to look at more holistic, especially more, I want to say spirit-based and energy-based practices.
> C: ...my friends …have like mental health issues, … they … have like their therapists, but then they always like come to me, like 'can you teach me how to manifest'...

whenever I teach them how to manifest…and like think about …how to deal with it like spiritually, they always say that they feel a lot better.

P: yeah… even traditional psychologists and psychiatrists, are also more open to doing like more image work. I have therapists that refer me quite a bit to do a lot of the shamanic work that I do along with their regular therapy. (Family 96, Asian, Mother and Daughter)

They went on to articulate how this spirituality connects with cultural factors. The mother said:

…especially with the Filipinos, I think they would also be very suspicious of going to a doctor. They would probably want to handle it within the family, and then they are very spiritual, so they would pray. Like, if somebody is sick, yeah, they would pray, yeah, they would go to the doctor, but they would pray. You know, so, the prayer is great, I do believe that prayer is a wonderful way from helping with a lot of illnesses, so I do feel that there is a strong component of seeking out, you know, seeking God (Family 96, Asian, mother and daughter)

When religion and spirituality were used as one tool of many, the conversations were more confirming and supportive.

Religion Should Replace Formal Help

When religion was hailed as the ultimate solution for mental health challenges, the messages employed by family members were often disconfirming. These messages centered devoutness as the solution to all mental health challenges and were ultimately discouraging. Some families described the messages they had received regarding mental health challenges and religion in the past:

P: ...with people being religious they would take you to their religion rather than

C: oh yeah. Pray about it.

P: pray about it rather than taking it to

C: a mental health professional [or] getting clinical help for it. (Family 135, Black, Mother and Daughter)

Another family described how their neighborhood reinforced the religious belief system:

P: … we live in a neighborhood that's …very faith-oriented, very religious …strong Christian beliefs. And sometimes they … believe that if you just pray about it it'll – it'll go away …sometimes I think they're a little bit misunderstood… (Family 5, White, Mother and Daughter)

Their neighbors reinforced the attitude that prayer was the solution to mental health challenges. Another family spoke about how religious and cultural stigma can interact to prevent individuals from getting the professional help they need. One white mother said:

P: if you're very religious that might be against your religion …or you know some cultures feel like it's a really bad thing, it's really stigmatized to have mental health disorders. (Family 57, White, Mother)

Some conversations took a disconfirming turn in regard to non-religious forms of mental health support—especially medication. One Latinx daughter spoke about her opinions on medication and her relationship with religion:

C: I know people that … for mental illnesses … they'll take medication… as Christians I feel like we have different beliefs or like a different perspective with mental illness? a lot of like our validations come from our religion … my hope comes from like God…like that's how I like personally get through it …whenever I get sad

> or depressed …I feel like that's why like we're so close…that's how we're able to get through hard times as a family … for other people that just don't rely on that, you know don't have …something they can depend on, like they're not religious, I think sometimes that's all they have, like prescription medicine. They try to … fill a void for something that will help them… (Family 02, Latinx, Daughter)

This participant implied that many of the individuals she knew who took medication were missing something in their lives and that that was part of the reason they needed to take those medications. This argument suggests that religion and prayer are the most legitimate cures for mental health challenges. This quote corresponded with sentiments other families expressed experiencing. One Black and white daughter joked that religious entities say people should, "Just pray about it, and it'll all go away [laughing]" (Family 12, white and Black, Daughter). Overall, those who asserted that religion was the only legitimate way to handle mental health challenges invalidated the reality of those challenges.

Discussion

This study explored parent-adult child conversations about mental health and considered racial and ethnic identity's relationship to the form and function of family mental health communication (Chang, 2014; Davis & Cardwell, 2022). The qualitative results support the argument that cultural beliefs and norms shape the communicative tools family members employ, as well as the intention behind that communication (Chang, 2014; Davis & Cardwell, 2022). The results support the idea of raced communication (see Davis & Cardwell, 2022), with families of color interacting with and understanding the topic of mental health in unique ways. Many families of color reinforced and upheld cultural beliefs, with communication serving to facilitate these beliefs. Beyond its contributions to the

confirmation literature, the present study found three themes that described how families understood and communicated about mental health.

Survival Supersedes Mental Health

Many families (especially Black families) articulated and/or reinforced the belief system that says that survival supersedes mental health. Often this belief served to invalidate the legitimacy of mental health challenges and instead prioritized endurance, which aligns with research that highlights how Black American culture often prioritizes perseverance (Jones et al., 2018). Black mothers typically advocated for this mindset more so than children, who sometimes challenged their parent's perspective. Some parents endorsed the idea that survival in a hostile society was more important than, or even in conflict with, the desire to seek treatment for one's mental health challenges. These parents frequently demonstrated challenging, and sometimes disconfirming, communication about using formal mental health resources to bolster this set of beliefs. Strength regulation, as articulated by Davis (2016), was a large part of the parent-child mental health communication process in these families, both reinforcing and being reinforced by the overarching prioritization of survival over all else. This communication corresponds with research that illuminates a culture of strength in Black American communities (Davis & Afifi, 2019). It also aligns with research that highlights the importance of the survival of the "tribe" or family above all else (Jones et al., 2018; Nobles, 1974). It also aligns with research that highlights how strength can serve as a double-edged sword for Black women; while it is essential to survive in an inequitable society, it may also limit your ability to be vulnerable.

Many of these families spoke of the impact of systemic issues on the beliefs (and therefore communication) of their elders and explained how these belief systems were

reinforced over time, in part due to strength regulation. Families in the current study spoke about how the prioritization of survival was passed through generations, enabling vulnerable communities to survive. Moreover, some families spoke about present-day systemic barriers that could reinforce the belief that survival supersedes mental health and that caused ambient racial anxiety for many parents and children. Ultimately, several families underscored endurance as a bottom line and encouraged family members to push through their challenges. These findings may provide insight into the beliefs of Black Americans regarding mental health. When Black Americans have historically and presently been taught to negate their mental health challenges, it is especially difficult for scholars to reshape those beliefs and encourage open communication about mental health and the reframe vulnerability as strength. Future research should design interventions with these norms and limitations in mind. This project can help provide a foundation for culturally-informed mental health interventions designed to help parents navigate the subject of mental health with their children in a healthy, productive way.

Notably, this analysis considered strength regulation in Black families, especially. This is because the strength regulation work by Davis (2016) studied Black women, specifically, in the creation of the strong Black woman collective theory. In line with the theory, strength regulation was present in some conversations with Black mothers and daughters. Often, mothers reinforced their children's ability to face their problems, as well as emphasized the importance of pushing through one's challenges. Sometimes, this regulation stressed the importance of staying safe from outsiders, which could include mental health professionals. Often, strength regulation corresponded with challenging and/or disconfirming communication, which minimized the role of mental health challenges in everyday life.

While mothers were attempting to build strength in their children, the method they used to do so could potentially result in a child feeling invalidated or unheard. Future research should explore generational differences in strength regulation as well as how age corresponds with the assessment of that communication. As younger generations become more open about mental health, the appearance of strength regulation may evolve.

Part of the reason Black families in this study may have been especially vocal about societal and institutional structures that prevent them from facing their mental health challenges could be because the majority of these data were collected in the first year of the COVID-19 pandemic, which was especially devastating for Black Americans (CDC, 2020). Additionally, Black Lives Matter protests across the country gained traction in the summer of 2020, which likely brought the issues of police brutality and racial inequity to the forefront of many Black individuals' minds. This corresponds with the work done by Hawkins (2022), in which Black Americans reported their mental health being negatively impacted by news of police brutality. Their participants described having a constant fear of wrongful death and violence and spoke of an ambient anxiety tied to state-sanctioned violence (Hawkins, 2022). This suggests that Black Americans have an additional, life-threatening burden that is likely to harm their mental health. Yet, this cultural script prioritizing survival requires one to suppress and endure mental health challenges, which may set some up for failure.

While the theme of survival and ambient anxiety was especially present in Black parent-adult child mental health conversations, there is research that suggests other racial groups may have similar experiences, even though parents and children in this study did not articulate them. Scholars have noted the frequent anxiety that many undocumented Latinx individuals report experiencing as a result of their undocumented status (e.g., Kam et al.,

2022; Suarez-Orozco & López Hernandez, 2020). Future research could explore the intricacies of the belief that survival supersedes mental health. With a protocol created to explore the roles of survival and endurance in family mental health conversations, future research may be able to delve into more deeply-ingrained, culturally-specific beliefs that reinforce this idea of survival over all else. Moreover, this research could explore strength regulation in Black families in comparison to other racial/ethnic groups.

The Pressure of the Collective

Some families spoke about the pressure of the collective and how it ultimately encouraged individuals to hide their mental health challenges to protect the interests of the group. Many family members emphasized the importance of self-sufficiency when it came to mental health; individuals were expected to handle their problems on their own. Many families spoke of the ideal of mental toughness, which suggested that individuals (and families) who were mentally tough were not affected by mental health challenges. Conversely, the appearance of mental health challenges suggested weakness and often corresponded with feelings of shame. As a result, some family members spoke about the necessity of appearing to thrive to protect their family. Many families spoke about the stigma that corresponded with the revelation of mental health challenges. This mental illness stigma transferred onto the entire family, "infecting" them, and threatening their future prospects. Ultimately, many family members suppressed their challenges for the good of the collective, and to protect group harmony.

This theme was found most commonly in Asian and Latinx families, which corresponds with the research about each group. Latinx families in this study often expounded upon the guiding properties of familism (Benito-Gomez et al., 2020; Cahill et al.,

2021), with many parents and children articulating the importance of family and a strong support system in preventing mental health challenges. These results align with previous research that has shown that Latinx families often prioritize close relationships and the family (Cahill et al., 2021). Some Latinx parents in the present study emphasized their own openness around mental health conversations, while other Latinx parents described the culture of emotional openness in their countries of origin. These findings build upon previous research that highlighted the importance of emotional expressivity in Latinx cultures (e.g., Cahill et al., 2021; Chang, 2014) to show how this mindset corresponds with a family's understandings of and communication about mental health. Ruby et al. (2012) argued that Latinx families often prefer more expressivity and positive affect, while Asian cultural norms generally encourage subdued emotional expression. The present study's results speak to these communicative norms. Both Asian and Latinx parents and children in this study spoke about how the pressure of the collective ultimately encouraged them to hide their mental health challenges. Although Latinx families encouraged openness, many Latinx participants, especially young adults, spoke about not wanting to share mental health challenges so they would not be an emotional burden on their family. This corresponds with the Latin American value of *simpatía* (Ruby et al., 2012; Triandis et al., 1984) as does the way Latinx American parents and children in this study spoke about mental toughness. These families often spoke positively and with pride, saying that their family members were all mentally strong, which is why they are able to come together and be positive. Often, this positivity was interpreted as a lack of mental health challenges.

In contrast, Asian participants often spoke of mental health challenges as shameful and spoke to one's duty to hide emotion for their family's reputation. This corresponds with

previous research that has emphasized the value of self-restraint in Asian cultural groups (Chang, 2014; Chiang, 2021). Additionally, when Asian participants spoke about the pressure to appear to thrive, it was often tied to excellence and success, with many young adults stating that their parents prioritize achievement over emotional expression. Latinx young adults spoke about the emotional burden and stigma they did not wish to bring upon their family when facing mental health challenges. Therefore, although parents and children in Asian and Latinx families both spoke of the pressure they felt from the collective to suppress their mental health challenges, this experience and the driving forces behind it differed according to culture.

Future research could tease apart cultural differences in the pressure of the collective to better understand the bounds of the belief system. Studies might benefit from homing in on families of color to further compare and contrast their perspectives, cultural scripts, and behaviors when communicating about mental health. Additionally, future research may benefit from exploring the nuance within each group. “Latinx American” and “Asian American” are wide-sweeping terms that cover a multitude of cultural groups. Considering even regional differences could provide insight into the nuance embedded within the pressure of the collective. Finally, future research should consider how having immigrated to the U.S. influences the form and function of family mental health communication. Moreover, this research should consider how acculturation interacts with the pressure of the collective, as these pressures vary according to a number of factors, many of which may be culturally-bound.

Religion as a Solution

The final theme highlighted families' experiences with religion as a solution to mental health challenges. This communication varied from beneficial to potentially harmful. Some families advocated for religion as one tool at their disposal to confront mental health challenges alongside social support and professional resources. This view of religion and spirituality generally corresponded with more open conversations and greater confirmation. In contrast, some families advocated for religion over professional mental health resources, often suggesting that prayer should heal any ailments, with some even suggesting that others were missing something in their life (religion) and that that was why they needed medication. This mindset aligned with relatively disconfirming communication about those who sought treatment for mental health challenges, often questioning their judgement and actions.

These findings correspond with the literature on religious beliefs about mental health. Prejudice against mental illness is widespread among Christian faiths, with many believing that mental health challenges are the result of sin, generational curses, or spiritual deficiencies (Lloyd, 2021; Lloyd & Hutchinson, 2022). In light of the parent-child conversations in the present study, Lloyd and Hutchinson (2022) highlighted the dissonance many Christians experienced when facing mental health challenges, with many internalizing shame and feeling as though they lacked the spiritual efficacy to overcome their mental health challenges. They found that these beliefs often originated from and were reinforced by their spiritual community (Lloyd & Hutchinson, 2022). The families in the present study spoke about similar messages they had received when disclosing mental health challenges, which often touted prayer and spiritual connection as the answer to all mental health problems.

Lloyd and Hutchinson (2022) also emphasized the danger of reductive spiritualization—a practice which treats all mental health problems as spiritually-based. Similarly, the findings from the current study found that conversations that negated the legitimacy of mental health challenges and instead spoke of religion as the only solution were generally negative, closed off, and often disconfirming toward mental health challenges. Alternatively, parents and children who advocated for spirituality in tandem with social support and professional resources were generally open to nuance in their discussions and understandings of mental health challenges. Notably, the literature referenced here centers Christian beliefs. While Christians are the religious majority in the U.S. (Gallup, 2021), future research may benefit from considering non-Christian narratives regarding mental health. Some families in this study referred to spirituality as a guide more so than organized religion when they faced mental health challenges. Distinguishing among parents' and children's understandings of their spiritual belief systems may help to further tease out the spiritual and religious factors that operate in conjunction with (dis)confirming communication when talking about mental health. Furthermore, religious identification has been documented to be tied to culture, with research about Black, Latinx, and Asian Americans speaking to the cultural factors that may influence the form of religious family mental health conversations.

These findings are also invaluable as family communication literature does not often focus on the role of religion in the process of family communication. The present study illuminated how religion could serve as a double-edged sword; on one end, belief in a higher power is likely able to help one manage their mental health challenges. On the other, this mindset can be stifling or oppressive (Lloyd, 2021; Lloyd & Hutchinson, 2022). The current

study provided evidence that the way families approach talking about religion in relation to mental health is one indicator of if the communication will be more confirming or disconfirming regarding mental health challenges. When they believe that religion is the only correct way to mitigate mental health challenges, the communication is likely to be much more disconfirming. Therefore, additional research may consider how communication about religion can serve as a positive coping mechanism for mental health challenges, compared to how it is used to stifle the discussion of mental health challenges.

Confirming, Disconfirming, and Challenging Communication

These results also expand upon confirmation theory, as families used (dis)confirming and challenging communication to regulate strength and reinforce group norms. Notably, challenge in these conversations was sometimes used positively (e.g., expanding a family member's understanding of mental health), though challenging messages more often came off as disconfirming. These results challenge the bounds of the confirmation literature, which argues that challenge is a necessary facet of confirmation (e.g., Dailey, 2010). Mental health is a sensitive topic, and the appearance of challenge could be seen as disconfirming. Future research should consider which challenging messages are more confirming or disconfirming in the context of parent-child mental health conversations. This research should consider at which point challenge in mental health conversations becomes disconfirming. Moreover, future studies should consider the role of culture along with individual factors (such as personal experiences with mental health challenges and preferences for support) in the use and interpretation of challenge during parent-child mental health conversations. These factors may provide insight into the impacts of challenge during a mental health conversation and an opportunity to refine the concept of challenge within the framework of confirmation theory.

Limitations, Implications, and Future Directions

This project provided an abundance of information on the form and function of family mental health communication. In addition, by emphasizing cultural norms and beliefs, the present study took a multidimensional approach to understanding how parents and children communicate about mental health. These results illustrate how the form and function of family mental health communication is intersectional. The structure and tone of these conversations varied according to a number of factors including racial/ethnic identity, gender, and generational differences. Cultural identity shaped the beliefs of parents and children along with their behaviors, patterns of communication, and the motivations underlying that communication. This project is an excellent addition to the limited family mental health communication literature and can serve as a foundation for future research.

This study, though invaluable in introducing a number of themes regarding mental health, is somewhat limited. There were uneven sample sizes for my racial/ethnic groups, with white and Asian participants comprising a majority of the sample. In addition, some parents in this study were first-generation immigrants, but I did not have the foresight to ask this question in the demographics. However, their experiences in their country of origin absolutely shape the way they understand and communicate about mental health. Future research could consider how immigration influences family mental health communication. This research could also consider how acculturation and one's time in the U.S. influences their beliefs and behaviors regarding mental health. Lastly, I did not interview participants to find out how they felt about their conversation with their family member. Future research could interview both family members afterward and/or could have participants complete a video recall task to understand their own perceptions of the conversation.

Overall, this study showed how parents and children communicate about mental health. Furthermore, it explored culture's impact on family mental health communication. Using a diverse sample that considered parent-child interactions, themselves, I was able to gain insight into the form and function of family mental health communication.

Chapter 6. Conclusions on the Present Study: Considering the Analyses in Tandem

On their own, each analysis yielded invaluable insight into the process, form, and function of parent-child mental health communication. The more “macro” quantitative analysis employed an Actor-Partner Interdependence Model to study the process of parent-child mental health communication. This analysis showed that one’s perception of how well their family was able to communicatively function in the past predicted their evaluation of the social support and conflict employed by their family member during the conversation and their personal and relational outcomes. Individuals who saw their family as more functional tended to appraise their family member’s communication during the conversation more positively which, in turn, predicted better mental health during the conversation and greater relationship satisfaction afterward. Parents’ perceptions of family functioning were especially strong drivers in all four models, having both direct and indirect effects on children’s mental health and satisfaction. Parents’ assessments of family functioning positively influenced both parents’ and children’s appraisals of conflict and support during a parent-child mental health conversation which, in turn, predicted better mental health and greater satisfaction for their child.

These findings elucidated the influence of a parent’s perceptions of family functioning, support, and conflict on their child’s mental health and satisfaction. In turn, they highlighted the interconnected nature of the family, and provided evidence that what an individual brings into an interaction may influence their perceptions of a family member’s mental health communication as well as their well-being and satisfaction. However, this analysis was lacking a great depth of nuance. While it illustrated that a parent's perceptions were important to the well-being of themselves and their child, it said nothing about factors

like racial and ethnic culture that likely influence the communicative process. Moreover, the first analysis was not able to distinguish between cultural understandings of family functioning, social support, or conflict, which may vary according to cultural norms. Lastly, the quantitative analysis was not able to show how parents and children employed communicative tools to navigate a parent-child mental health conversation.

The second analysis addressed these shortcomings by qualitatively exploring the form and function of family mental health communication during a parent-child conversation. The analysis highlighted the perspectives of minoritized groups, and named a number of overarching beliefs that guided these parent-child mental health conversations. This analysis provided evidence that communication served to (re)create and uphold these belief systems. Notably, a family's conversation orientation toward mental health was incredibly important to the form of their communication. Families who were more open to discussing mental health generally had more positive, uplifting, and confirming conversations about these issues than families who were not open. Previous communication about and experience with mental health challenges corresponded with more openness toward mental health challenges. Additionally, families used confirming and disconfirming communication to reinforce, recreate, and uphold these guiding belief systems. However, there was nuance in the way that families employed these tools, which was tied to cultural identity.

The second analysis identified three overarching themes that described how families, especially families of color, communicate about and understand mental health. The first theme centered on the pressure of the collective to suppress one's mental health challenges. Found most often in Asian and Latinx families, parents and children spoke about their culturally-bound duty to conceal mental health challenges, appear to thrive, and protect their

family's reputation. Within this collectivistic culture, there was an individual responsibility to refrain from introducing the topic of mental health challenges within the family and from seeking professional treatment. The second theme considered the belief that survival supersedes mental health. This belief system limited one's ability to handle their mental health challenges by invalidating the reality of those challenges. This belief system was often tied to historic and present-day inequities, and some families spoke about experiencing an ambient racial anxiety. Ultimately, this belief system advocated for individuals to rank order their stressors and put aside foolish things (like discussing one's mental health) in order to survive. The final theme considered religion as a solution for mental health challenges. A key factor in the parent-child communication was whether they understood religion as one tool of many to help with mental health challenges, or if they argued that devoutness was the only solution to mental health challenges. Those who implied that religion was the only way to face mental health challenges generally used more disconfirming communication and spoke more negatively about professional mental health resources. Some parents and children discussed messages they had received from their social network in the past that had invalidated the reality of mental health challenges. Ultimately, a mindset that centered devoutness as the solution to mental health challenges encouraged suppression and shame for those facing mental health challenges. Overall, the qualitative analysis provided insight into the form of family mental health communication along with the beliefs underlying that communication.

Taken together, these analyses show that the elements that individuals and family members bring into their conversations have a significant impact on the communication they employ and their perception of the communication of their family member. As was evident in

the quantitative analysis, parents' understandings of and previous experiences with mental health challenges were a good indicator of how open and confirming a conversation was. When a parent thought more negatively about mental health challenges or was more closed-off to talking about these issues, the conversation was limited. Each study built upon the strengths of the other to answer a multitude of questions. The first analysis considered the process of family mental health communication and provided evidence of the interconnected nature of families. The second analysis qualitatively explored parent-child mental health conversations to unearth cultural beliefs that influenced how these families understood and managed mental health challenges. This qualitative analysis encouraged nuance by considering families' racial and ethnic identities and was able to discover novel cultural patterns within these themes.

Moreover, these findings reiterate the importance of considering the role families play in communication and beliefs about mental health. Extant beliefs, norms, and perceptions were large drivers of the type of communication that was employed, the intention behind that communication, and its effects on the parent and adult child. Both studies considered the interconnected nature of family mental health conversations. The first measured each family member's effects on the other. The qualitative study showed how these belief systems are upheld communicatively in a parent child dyad. Additionally, the qualitative findings provided insight into the parent-child dynamic during a mental health conversation and illuminated the communicative characteristics that contributed to creating and reinforcing these belief systems. Moreover, this study was able to explore generational differences in communication about and understandings of mental health.

Both analyses contribute a great deal of insight to the process of family mental health communication. One established the process of family mental health communication, illuminating family functioning's influence on one's perceptions of support and conflict during a mental health conversation. As a result of this influence, family members with more positive appraisals of the communication used by their family member had better mental health during the conversation and were more satisfied in their relationship afterward. Parents' perceptions of family functioning were especially influential, predicting a child's mental health and satisfaction both directly and indirectly. The second analysis considered the nuance within family mental health conversations and explored cultural differences. Culture impacted how families understood and communicated about mental health. Moreover, the results revealed cultural scripts that influenced the form and function of family mental health communication across multiple groups. This analysis also provided insight into how families use confirmation, disconfirmation and challenge to reinforce and recreate these cultural scripts about mental health. Future research should recruit diverse samples, especially when attempting to generalize to a large population like college students or young adults. Additionally, the combination of these two analyses shows the depth that can be missed by simply testing models based on extant research. While previous research provided a foundation for the quantitative processual model, examining these conversations qualitatively provided insights that would have been missed using only quantitative measures.

This dissertation connected a number of theoretical concepts to describe, explain, and predict the process of family mental health communication. This study established family functioning's role in this process, and showed how perceptions of family functioning may

influence one's mental health and satisfaction by softening their perceptions of the other's communication (specifically, conflict and support). Future research can take this study as a starting point for additional parent-child mental health communication research. Eventually, this research can provide a foundation for interventions meant to foster healthy parent-child mental health communication. These interventions should be culturally grounded; the messages that researchers create should be determined by each group's understandings of mental health, and should attempt to educate individuals, families, and communities about common cultural misconceptions about mental health challenges.

Theoretically, this study provided evidence that the way parents and children communicate about mental health challenges is culturally bound or "raced" (Davis & Cardwell, 2022). With this in mind, future research should explore how these cultural understandings may serve to influence the process of parent-child communication and its impacts on their relational and individual well-being. Future research should consider culture in quantitative research designs and assess the accuracy in interpretation of scales like support, conflict, and family functioning across cultural groups. Moreover, future research should consider the applications of challenge within confirmation theory to better understand when challenge can go from confirming to disconfirming during a family mental health conversation. In conclusion, this dissertation provided a plethora of information, which can be built upon by other scholars to explore the impact of family mental health communication.

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Tables

Table 1

Pearson Correlations for the Variables in the Structural Equation Models.

	P FF	P Support	P Conflict	P MH in Convo	P Satisfaction	C FF	C Support	C Conflict	C MH in Convo
P Support	0.30**								
P Conflict	-0.43**	-0.55**							
P MH in Convo	0.25**	0.18	-0.47**						
P Satisfaction	0.48**	0.35**	-0.56**	0.60**					
C FF	0.44**	0.12	-0.30**	0.26**	0.32**				
C Support	0.02	0.04	-0.09	-0.10	-0.05	0.11			
C Conflict	-0.40**	-0.37**	0.57**	-0.35**	-0.41	-0.36**	-0.16		
C MH in Convo	0.27**	0.32**	-0.47**	0.38**	0.48**	0.38**	0.12	-0.48**	
C Satisfaction	0.39**	0.32**	-0.42**	0.23*	0.42**	0.61**	0.08	-0.53**	0.43**

Note. P= Parent, C = Child, FF = Family functioning, MH in Convo = Mental health during the conversation.

Note. Correlations are standardized estimates. a = $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$.

Table 2

Conflict and Satisfaction Confirmatory Factor Analysis Results.

Path	Estimate	SE
C Fam. Fun.↔ P Fam. Fun.	0.48***	0.03
C Fam. Fun.↔ C Satisfaction	0.70***	0.04
C Fam. Fun. ↔ P Satisfaction	0.35**	0.03
P Fam. Fun. ↔ P Satisfaction	0.56***	0.04
P Satisfaction ↔ C Satisfaction	0.49***	0.05
P Fam. Fun. ↔ C Satisfaction	0.41***	0.04
C Fam. Fun. ↔ C Conflict	-0.39***	0.03
C Satisfaction ↔ C Conflict	-0.55***	0.04
P Conflict ↔ P Fam. Fun.	-0.47***	0.03
P Conflict ↔ P Satisfaction	-0.60***	0.04
P Conflict ↔ C Fam. Fun.	-0.33**	0.03
P Fam. Fun.↔ C Conflict	-0.41***	0.03
P Conflict ↔ C Conflict	0.61***	0.03
P Satisfaction ↔ C Conflict	-0.43***	0.04
P Conflict ↔ C Satisfaction	-0.44***	0.04

Note. P= Parent, C = Child, Fam Fun = Family functioning, MH in Convo = Mental health during the conversation.

Note. Correlations are standardized estimates. a = $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$.

Table 3

Factor Loadings for the Conflict and Satisfaction Confirmatory Factor Analysis

Path	Estimate
C Fam. Fun. → CFamFun P1	0.87
C Fam. Fun. → CFamFun P2	0.74
C Fam. Fun. → CFamFun P3	0.82
P Fam. Fun.→ pFamFun P3	0.83
P Fam. Fun. → pFamFun P2	0.80
P Fam. Fun. → pFamFun P1	0.93
P Satisfaction → PSatisfaction P2	0.95
C Satisfaction → CSatisfaction P2	0.96
C Satisfaction → CSatisfaction P1	0.87
P Satisfaction → PSatisfaction P1	0.92
C Conflict → CConflict P1	0.90
C Conflict → CConflict P2	0.91
C Conflict → CConflict P3	0.93
P Conflict → PConflict P3	0.92

P Conflict → PConflict P2	0.94
P Conflict → PConflict P1	0.89

Note. P= Parent, C = Child, Fam Fun = Family functioning. P1, P2, and P3 = Parcels 1, 2, and 3.
Note. All parameters are significant at $p < .001$.

Table 4

Conflict and Mental Health Confirmatory Factor Analysis Results.

Path	Estimate	SE
C Fam. Fun. ↔ P Fam. Fun.	0.48***	0.03
C Fam. Fun. ↔ C Mental Health	0.48***	0.03
C Fam. Fun. ↔ P Mental Health	0.30*	0.03
P Fam. Fun. ↔ P Mental Health	0.31*	0.03
P Mental Health ↔ C Mental Health	0.57***	0.04
P Fam. Fun. ↔ C Mental Health	0.37**	0.03
C Fam. Fun. ↔ C Conflict	-0.39***	0.03
C Mental Health ↔ C Conflict	-0.61***	0.04
P Conflict ↔ P Fam. Fun.	-0.46***	0.03
P Conflict ↔ P Mental Health	-0.51***	0.04
P Conflict ↔ C Fam. Fun.	-0.33**	0.03
P Fam. Fun. ↔ C Conflict	-0.42***	0.03
P Conflict ↔ C Conflict	0.61***	0.03
P Mental Health ↔ C Conflict	-0.42**	0.03
P Conflict ↔ C Mental Health	-0.62***	0.04

Note. P= Parent, C = Child, Fam Fun = Family functioning, MH in Convo = Mental health during the conversation.

Note. Correlations are standardized estimates. $a = p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$.

Table 5

Factor Loadings for the Conflict and Mental Health Confirmatory Factor Analysis

Path	Estimate
C Fam. Fun. → CFamFun P1	0.87
C Fam. Fun. → CFamFun P2	0.75
C Fam. Fun. → CFamFun P3	0.82
P Fam. Fun.→ pFamFun P3	0.84
P Fam. Fun. → pFamFun P2	0.81
P Fam. Fun. → pFamFun P1	0.92
P Mental Health → P MH P2	0.73
C Mental Health → C MH P2	0.74
C Mental Health → C MH P1	0.66
P Mental Health → P MH P1	0.82
C Conflict → CConflict P1	0.90
C Conflict → CConflict P2	0.90
C Conflict → CConflict P3	0.93
P Conflict → PConflict P3	0.93
P Conflict → PConflict P2	0.93
P Conflict → PConflict P1	0.89

Note. P= Parent, C = Child, Fam Fun = Family functioning. P1, P2, and P3 = Parcels 1, 2, and 3.
Note. All parameters are significant at $p < .001$.

Table 6

Support and Satisfaction Confirmatory Factor Analysis Results.

Path	Estimate	SE
C Fam. Fun. ↔ C Support	0.15	0.06
C Fam. Fun.↔ P Satisfaction	0.35**	0.03
C Satisfaction. ↔ C Fam. Fun.	0.69***	0.04
P Fam. Fun. ↔ C Support	0.01	0.06
P Fam Fun. ↔ P Satisfaction	0.56***	0.04
C Satisfaction. ↔ P Fam. Fun.	0.40***	0.04
P Support ↔ C Support	0.07	0.13
C Satisfaction ↔ P Support	0.36***	0.07
C Support ↔ P Satisfaction	-0.70	0.09
C Satisfaction ↔ C Support	0.13	0.09
C Satisfaction ↔ P Satisfaction	0.48***	0.05
C Fam. Fun. ↔ P Support	0.15	0.05
P Fam. Fun. ↔ P Support	0.36***	0.05
C Fam. Fun. ↔ P Fam. Fun.	0.47***	0.03
P Support ↔ P Satisfaction	0.37***	0.07

Note. P= Parent, C = Child, Fam Fun = Family functioning, MH in Convo = Mental health during the conversation.

Note. Correlations are standardized estimates. a = $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$.

Table 7. *Factor Loadings for the Support and Satisfaction Confirmatory Factor Analysis*

Path	Estimate
C Fam. Fun. → CFamFun_P1	0.87
C Fam. Fun. → CFamFun_P2	0.74
C Fam. Fun. → CFamFun_P3	0.81
P Fam. Fun.→ pFamFun_P3	0.82
P Fam. Fun. → pFamFun_P2	0.79
P Fam. Fun. → pFamFun_P1	0.95
P Support → PSupport_P3	0.87
P Support → PSupport_P2	0.98
P Support → PSupport_P1	0.90
C Support → CSupport_P1	0.94
C Support → CSupport_P2	0.99
C Support → CSupport_P3	0.92
P Satisfaction → PSatisfaction_P2	0.98

C Satisfaction → CSatisfaction_P1	0.85
C Satisfaction → CSatisfaction_P2	0.98
P Satisfaction → PSatisfaction_P1	0.89

Note. P= Parent, C = Child, Fam Fun = Family functioning. P1, P2, and P3 = Parcels 1, 2, and 3.
Note. All parameters are significant at $p < .001$.

Table 8

Support and Mental Health Confirmatory Factor Analysis Results.

Path	Estimate	SE
C Fam. Fun. ↔ P Fam. Fun.	0.46***	0.03
C Fam. Fun.↔ C Support	0.15	0.06
C Mental Health ↔ C Fam. Fun.	0.44**	0.03
C Fam. Fun. ↔ P Mental Health	0.29*	0.02
P Fam Fun. ↔ C Support	0.01	0.06
P Fam. Fun. ↔ P Mental Health	0.31*	0.03
P Support ↔ C Support	0.07	0.13
C Mental Health ↔ P Support	0.42**	0.07
C Mental Health ↔ C Support	0.13	0.07
C Support ↔ P Mental Health	-0.14	0.06
C Mental Health↔ P Mental Health	0.54**	0.04
C Fam. Fun. ↔ P Support	0.15	0.05
C Mental Health ↔ P Fam. Fun.	0.37**	0.03
P Fam. Fun. ↔ P Support	0.36**	0.05
P Support ↔ P Mental Health	0.22a	0.05

Note. P= Parent, C = Child, Fam Fun = Family functioning, MH in Convo = Mental health during the conversation.

Note. Correlations are standardized estimates. a = $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$.

Table 9

Factor Loadings for the Support and Mental Health Confirmatory Factor Analysis

Path	Estimate
C Fam. Fun. → CFamFun_P1	0.87
C Fam. Fun. → CFamFun_P2	0.74
C Fam. Fun. → CFamFun_P3	0.82
P Fam. Fun.→ pFamFun_P3	0.83
P Fam. Fun. → pFamFun_P2	0.80
P Fam. Fun. → pFamFun_P1	0.93
P Support → PSupport_P3	0.87
P Support → PSupport_P2	0.98
P Support → PSupport_P1	0.90
C Support → CSupport_P1	0.94
C Support → CSupport_P2	0.99
C Support → CSupport_P3	0.92
P Mental Health → PMH_P2	0.67
C Mental Health → CMH_P2	0.81
C Mental Health → CMH_P1	0.60
P Mental Health → PMH_P1	0.89

Note. P= Parent, C = Child, Fam Fun = Family functioning. P1, P2, and P3 = Parcels 1, 2, and 3.

Note. All parameters are significant at $p < .001$.

Parameter	Estimate	Lower	Upper	P
P FF > P Con> C sat	.04	-.090	.194	.675
P FF > C con>C sat	**.08**	**.012**	**.402**	**.019**
P FF >P con >P sat	**.16**	**.028**	**.546**	**.013**
P FF >C con > P sat	.01	-.066	.275	.353

Table 10

Indirect and Direct Effects and Confidence Intervals for the Conflict and Satisfaction Mediation Model.

Note. . P= Parent, C = Child, FF= Family functioning, con = conflict, sup = support, MH = Mental health during the conversation, sat = satisfaction.

Note. Estimates are standardized. Significant mediational paths are bolded.

Table 11

Indirect and Direct Effects and Confidence Intervals for the Conflict and MH Mediation Model.

Parameter	Estimate	Lower	Upper	P
PFF > C Con > P MH	.03	-.037	.170	.22
PFF >C Con > C MH	**.09**	**.003**	**.357**	**.04**
PFF >P Con >P MH	**.18**	**.034**	**.409**	**.01**
PFF >P Con >C MH	**.15**	**.030**	**.434**	**.02**
CFF >C Con >C MH	.07	-.002	.350	.06

Note. . P= Parent, C = Child, FF= Family functioning, con = conflict, sup = support, MH = Mental health during the conversation, sat = satisfaction.

Note. Estimates are standardized. Significant mediational paths are bolded.

Table 12

Indirect and Direct Effects and Confidence Intervals for the Support and Satisfaction Mediation Model.

Parameter	**Estimate**	**Lower**	**Upper**	**P**
P FF > C Sup > P Sat	.010	-.017	.084	.286
P FF > C Sup > C Sat		-.046	.029	.772
P FF > P Sup > P Sat	**.07**	**.023**	**.324**	**.012**
P FF > P Sup > C Sat	**.10**	**.045**	**.447**	**.000**

Note. . P= Parent, C = Child, FF= Family functioning, con = conflict, sup = support, MH = Mental health during the conversation, sat = satisfaction.

Note. Estimates are standardized. Significant mediational paths are bolded.

Table 13

Indirect Effects and Confidence Intervals for the Support and MH Mediation Model.

Parameter	Estimate	Lower	Upper	P
P FF > C Sup > C MH	.00	-.108	.025	.565
P FF > P Sup > C MH	**.13**	**.028**	**.448**	**.024**

Note. . P= Parent, C = Child, FF= Family functioning, con = conflict, sup = support, MH = Mental health during the conversation, sat = satisfaction.

Note. Estimates are standardized. Significant mediational paths are bolded.

Figures

Figure 1

Hypothesized Conflict and Satisfaction Model

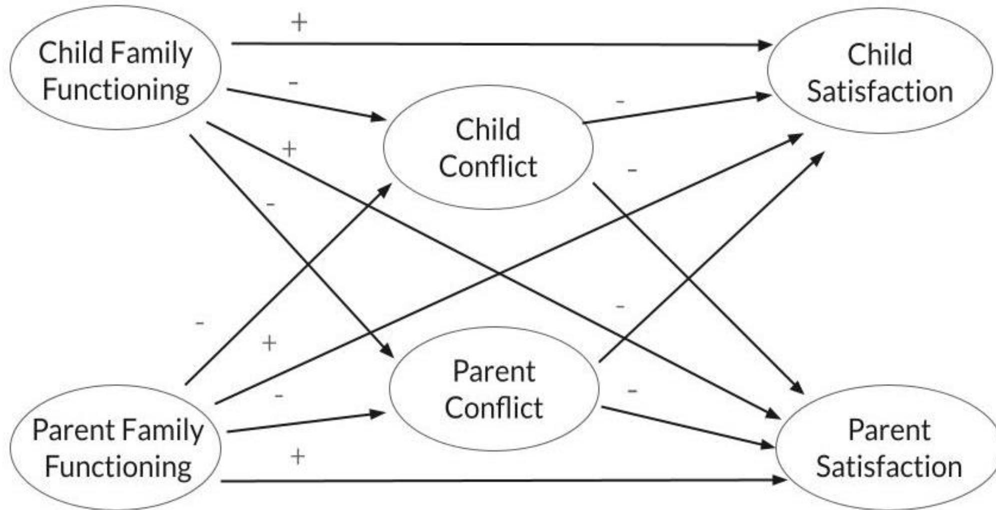


Figure 2

Hypothesized Conflict and MH Model

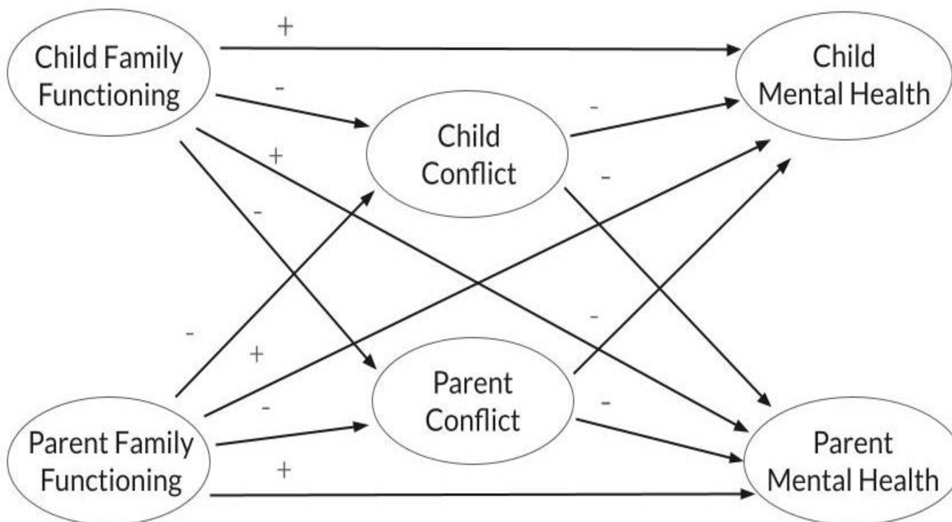


Figure 3

Hypothesized Support and Satisfaction Model

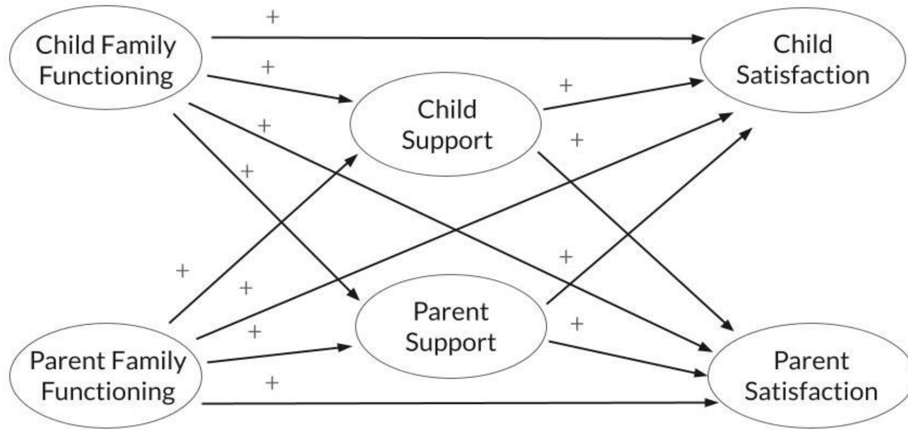


Figure 4

Hypothesized Support and Mental Health Model

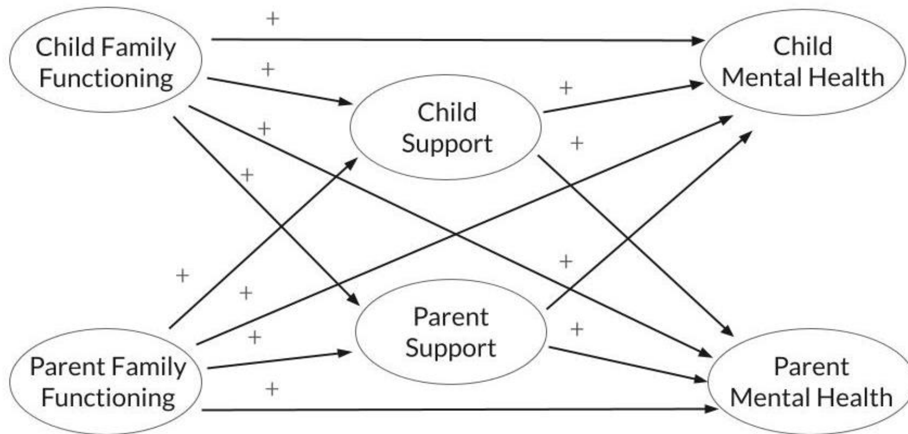
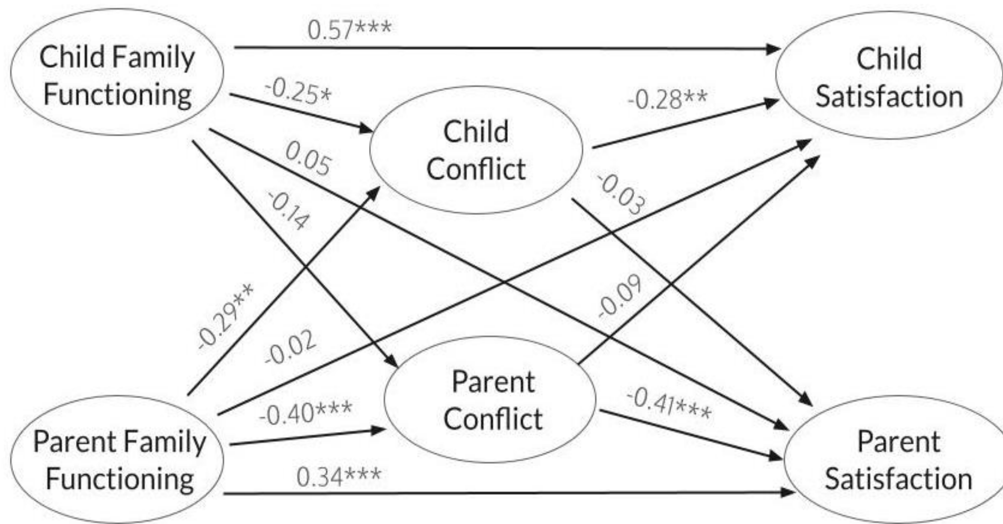


Figure 5

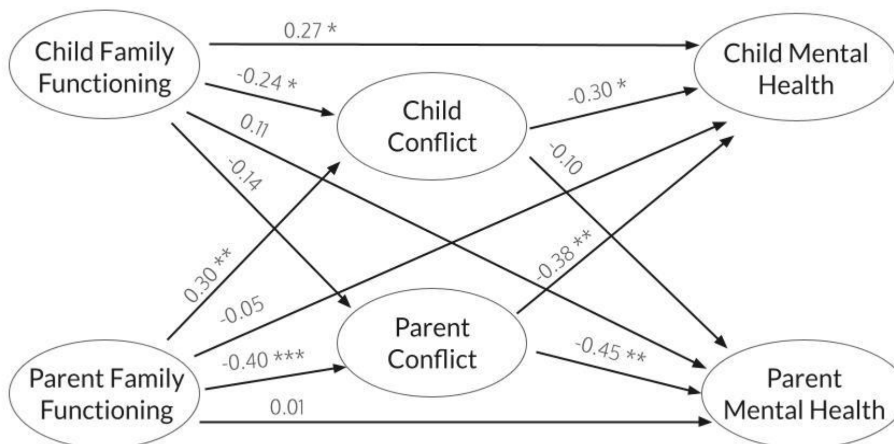
Results for the Conflict and Satisfaction Model



Note. Parameters are standardized estimates. a = p < .10; * p < .05; ** p < .01; *** p < .001.

Figure 6

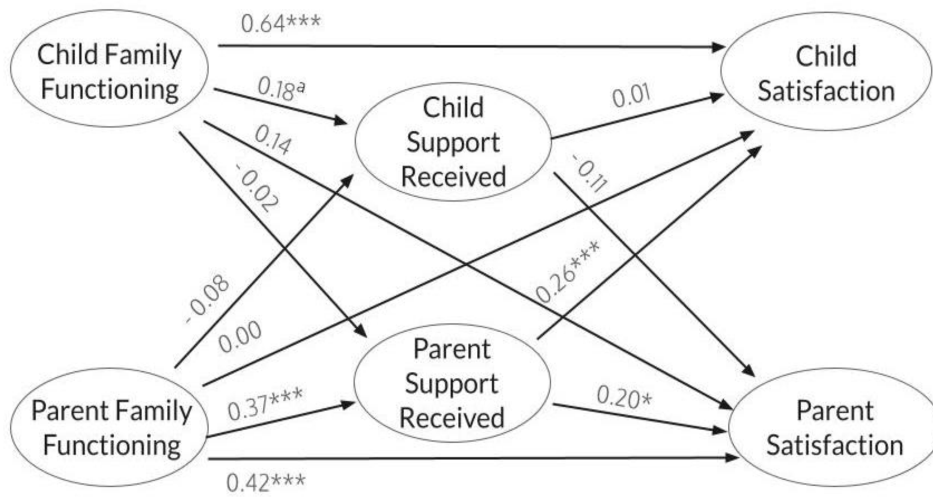
Results for the Conflict and Mental Health Model



Note. Parameters are standardized estimates. a = p < .10; * p < .05; ** p < .01; *** p < .001.

Figure 7

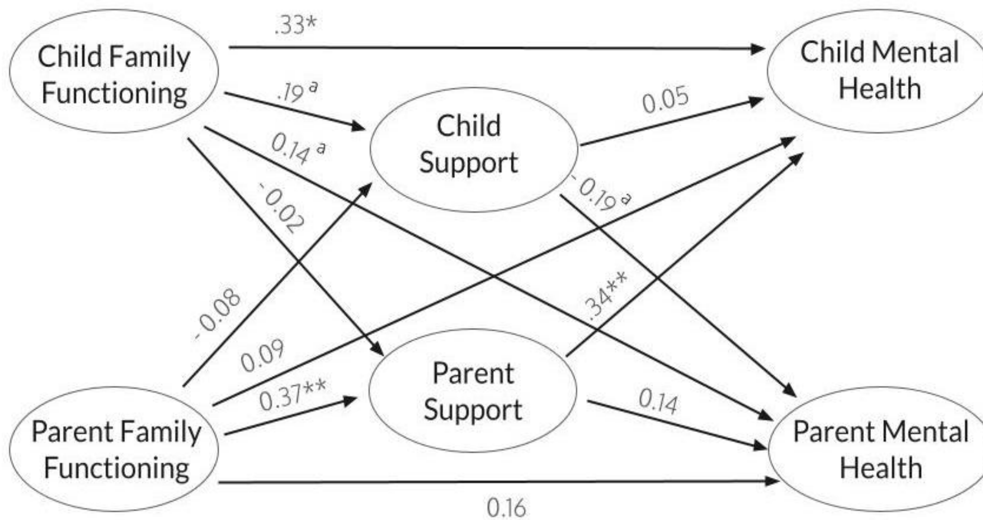
Results for the Support and Satisfaction Model



Note. Parameters are standardized estimates. a = p < .10; * p < .05; ** p < .01; *** p < .001.

Figure 8

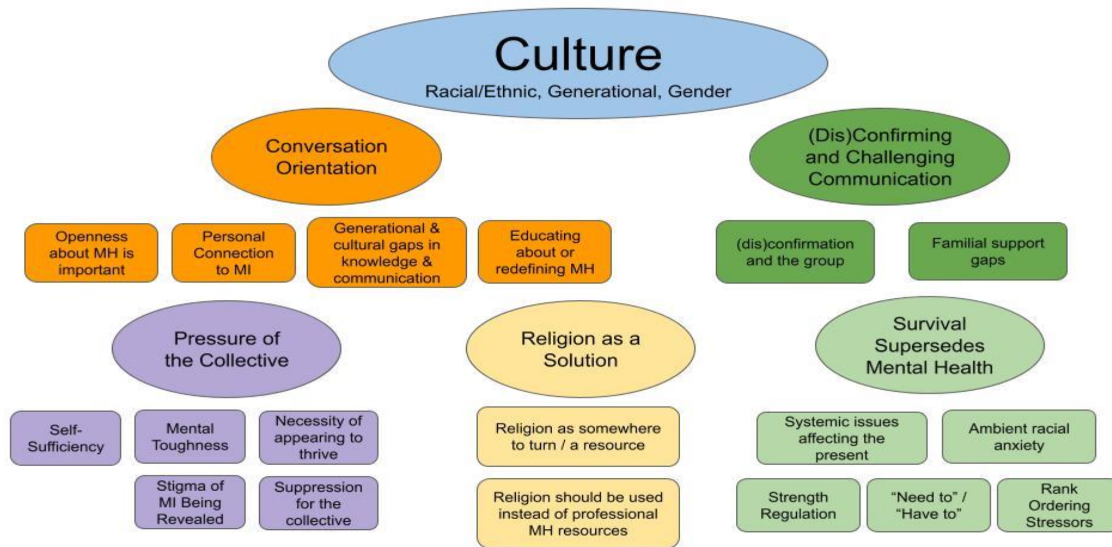
Results for the Support and Mental Health Model



Note. Parameters are standardized estimates. a = p < .10; * p < .05; ** p < .01; *** p < .001.

Figure 9

Qualitative Findings Framework



Note. MH = Mental health and MI = Mental illness.

Figure 10

The Pressure of the Collective

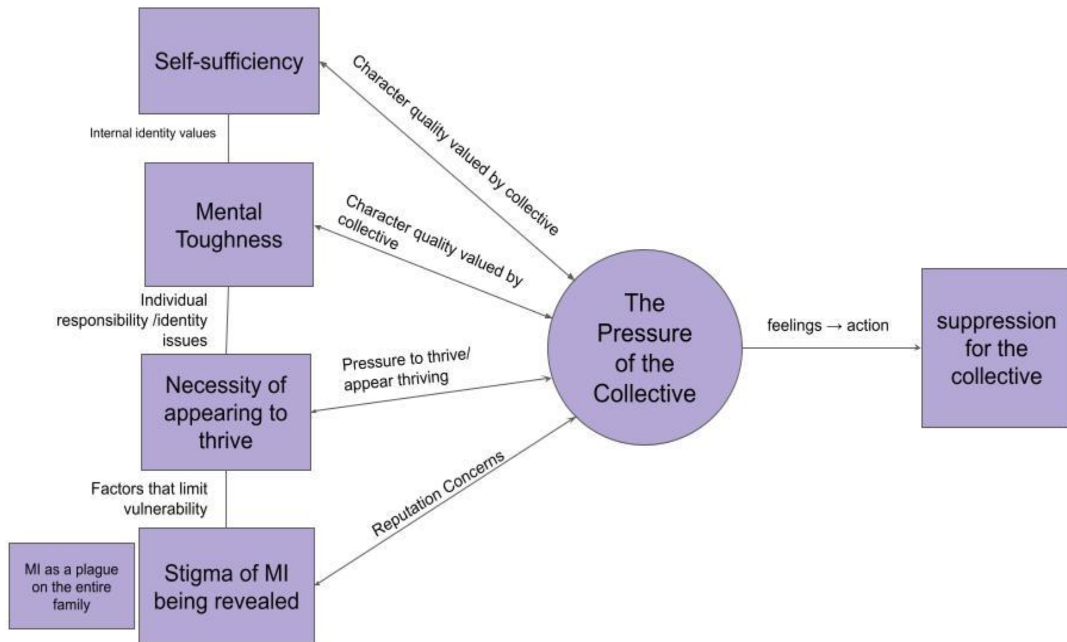


Figure 11

Survival Supersedes Mental Health

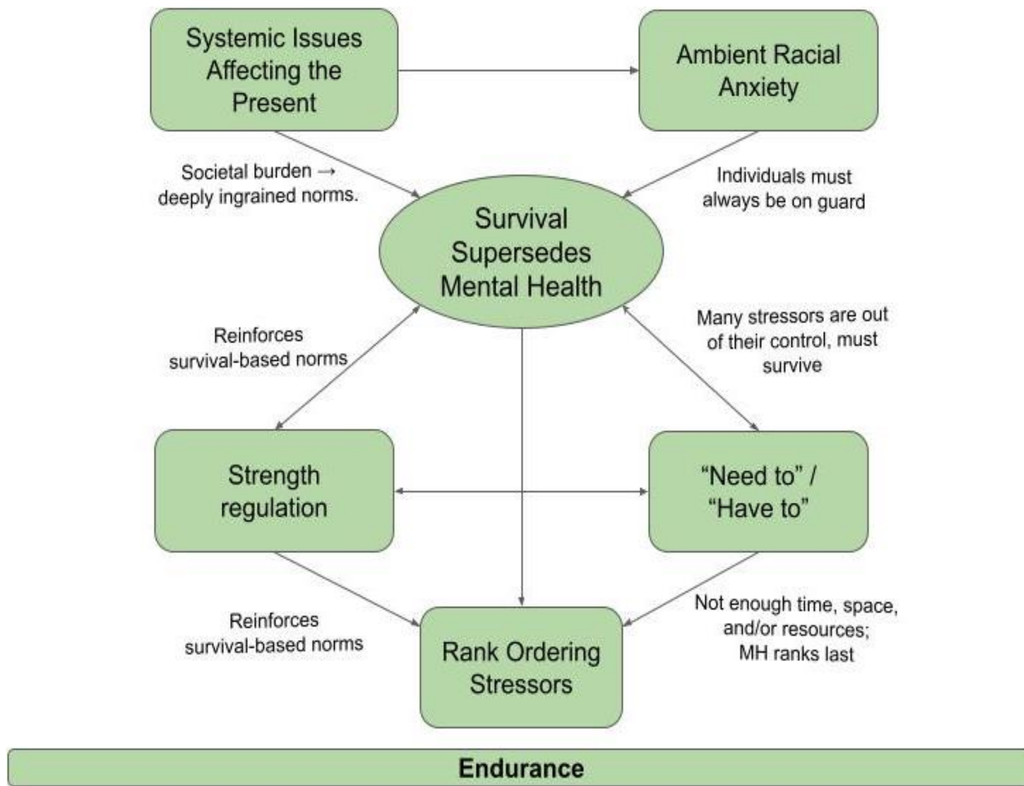


Figure 12

Religion as a Solution