

**MOTHERS SEEKING MENTAL HEALTH CARE FOR THEIR CHILDREN:
A QUALITATIVE ANALYSIS OF PATHWAYS TO CARE**

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University of Pittsburgh, 2009

Approximately 20% of youth meet criteria for a psychiatric disorder. Despite the availability of effective community-based psychosocial treatments, nearly 80% of youth with a psychiatric disorder do not receive treatment. In the United States, parents (typically mothers) are primarily responsible for accessing mental health services for their child. Consequently, researchers have suggested that one of the most promising ways to close the gap between unmet need and service use for youth is to improve our understanding parental help-seeking. However, our understanding of parental help-seeking has been limited by the dominance of atheoretical studies that focus on the characteristics of help-seekers, problem-types, and service locations, that are useful in establishing public health policy but have limited application to front line service delivery. Consequently, almost no research has examined the process that mothers go through - the how and why - to seek mental health services for their children.

This dissertation sought to describe and characterize the perceptions and experiences of mothers who accessed mental health services for their child. This study is a qualitative secondary analysis of a random selection of 60 of 127 interviews gathered from mothers 3 months after accessing mental health services. Grounded theory analysis was used to code the interviews and identify themes and patterns. The analysis suggested that mothers went through four stages of help-seeking: 1) recognizing a problem: mothers became concerned about their child's behaviors and then tried to identify the cause of the behaviors; 2) responding to the problem: mothers

identified six coping strategies they used to try and resolve their child's problem(s); 3) using mental health services (MHS): mothers identified the type and modality of treatment they received, their mode of entry into services, and their reasons for seeking services; 4) evaluating services: mothers determined if the pathway had terminated, deviated, or changed.

This study suggests that most mothers use mental health services only after other coping strategies have been exhausted. Social workers can improve services by clarifying the mother's reasons for seeking services, identifying prior coping strategies, and recognizing that most mothers see MHS as a stop along an on-going pathway, rather than an endpoint or solution to their child's problems.

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PREFACE

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1.0 INTRODUCTION

The prevention and treatment of youth mental illness is a primary focus of public health policy in the United States (Evans & Seligman, 2005; US Public Health Service, 2000). Epidemiological studies have suggested that approximately 20% of youth meet criteria for a psychiatric disorder (Costello et al., 1988; Costello, Mustillo, Erkanli, Keeler, & Angold, 2003; Shaffer et al., 1996), and between five and seventeen percent of youth ages nine to seventeen meet criteria for severe emotional disturbance (Costello, Messer, Bird, Cohen, & Reinherz, 1998).

Youth mental health problems, defined as emotional, behavioral or cognitive problems, as well as associated impairments (Sayal, 2006), affect every facet of youth development and functioning, including relationships with peers and family, school behavior, and transition to adulthood (US Department of Health and Human Services, 2001; US Public Health Service, 2000; Wang et al., 2005). For example, youth with mental health problems are at greater risk than those without for school dropout (Stoep, Weiss, Kuo, Cheney, & Cohen, 2003), homelessness (Gewirtz, Hart-Shegos, & Medhanie, 2008), victimization through sexual or physical assault (Unger, Kipke, Simon, Montgomery, & Johnson, 1997), parent-child conflict (Verhulst & van der Ende, 1997), use of alcohol or illicit drugs (White, Xie, Thompson, Loeber, & Stouthamer-Loeber, 2001), involvement in the juvenile justice system (Cocozza & Skowrya, 2000, April; Huber & Wolfson, 2000, December), violent behavior (Taylor, Deane, & Podd, 2007) and death by suicide (Beautrais, 2000; US Public Health Service, 1999). Families of

children with mental health problems report increased burden (Costello, Messer et al., 1998), loss of work, and increased parent-child conflict (Brannan & Heflinger, 2006; Brannan, Heflinger, & Foster, 2003). The cost to society of youth mental health problems can be calculated in increased rates of academic failure, juvenile incarceration, suicide attempts, and psychiatric hospitalizations (Srebnik, Cauce, & Baydar, 1996; US Public Health Service, 2000). A recent study suggested that the economic burden of youth mental health problems is close to \$12 billion dollars annually (Hoagwood & Olin, 2002). Despite the copious research documenting unmet need, and the devastating sequelae of untreated mental illness in youth, nearly 80% of youth with a psychiatric disorder do not receive treatment (Leaf et al., 1996; US Public Health Service, 2000).

There is some research to suggest that youth who receive psychosocial treatments in community mental health fare better than youth who do not receive treatment (Dalton et al., 2000). Unpublished data from the Comprehensive Community Mental Health Services for Children and Their Families Program (SAMHSA, 2007) found that nearly 50% of youth in treatment reported improvements in functioning, compared to only 10% reporting deterioration between intake and 6 months, 12 months and 18 months. Furthermore, treatment of childhood mental disorders appears to have lasting effects. Longitudinal studies have shown that adults who received mental health services as adolescents reported significantly fewer problems as adults (Harington, Rutter, & Fombonne, 1996; McGee, Feehan, & Williams, 1996). The benefit of treatment might also extend beyond symptom reduction and improvement in functioning. Developmental psychologists suggest that, independent of intervention, the act of help-seeking itself strengthens the parent-child bond. Specifically, when parents seek help for their children, children perceive their parent as having responded to their distress (Lamb, 2005).

Despite improved prevention and treatment efforts, there continues to be a gap between service need and service utilization (US Public Health Service, 2000). One approach to closing that gap is to better understand help-seeking behavior (Alegria et al., 2004; Alegria et al., 2002; Pescosolido, 1991; Pescosolido & Boyer, 1999; Rosenstock, 1966; Srebnik et al., 1996). Although some older adolescents seek their own mental health treatment, most youth receive mental health treatment because their parents (typically the mother) seek services (Broadhurst, 2003; Logan & King, 2001). Therefore, to improve access to mental health services for youth, we must understand the process mothers go through to seek help for their children.

Until recently there has been very little research on the process parents go through to seek help for their children. Most empirical studies of help-seeking distinguish *characteristics* of treatment seekers from non-treatment seekers (Alegria et al., 2004; Alegria et al., 2002; Fox, Blank, Rovnyak, & Barnett, 2001; Lin, Goering, Offord, Campbell, & Boyle, 1996; Mowbray, Lewandowski, Bybee, & Oyserman, 2004; Owens et al., 2002; Vingilis, Wade, & Seeley, 2007). These studies have suggested that parental characteristics, such as the presence of psychopathology, lower educational level, and smaller social network, reduce the likelihood of service utilization. They have also found that a child's characteristics, such as being male, older, and having identified behavior problems, increase the likelihood of service utilization. However, understanding the *characteristics* of help-seekers is not the same as understanding the *process* that people go through to seek help (Rogler & Cortes, 1993). A better understanding of the help-seeking process might suggest where interventions or resources could most effectively tailor services to people's needs.

Only a handful of studies have looked at the process parents go through to seek mental health services for their children (Arcia, Fernandez, Jaquez, Castillo, & Ruiz, 2004; Wilcox,

Washburn, & Patel, 2007). The paucity of research in this area has prompted both researchers (Mowbray et al., 2004) and the United States government (US Public Health Service, 2000) to call for efforts that will improve our understanding of how and why parents access mental health services for their children. This study is a response to that call.

1.1 OVERVIEW OF THE STUDY

The purpose of the study was to characterize and describe the perceptions and experiences of mothers who sought mental health services for their children. Although researchers have been developing models of help-seeking for 60 years (Ajzen, 1985; Andersen, 1995; Cauce et al., 2002; Goldsmith, Jackson, & Hough, 1988; Logan & King, 2001; Pescosolido, 1991, 1992; Srebnik et al., 1996), we still know very little about the process of maternal help-seeking. This study addresses that gap by using a unique data set of interviews gathered from mothers who sought community mental health services for their children.

1.1.1 Description of the Data

The data used in this study came from research conducted at the University of Pittsburgh and supported through the National Institute of Mental Health (C. Anderson, and C. Greeno, NIMH R24 MH 066872). The purpose of that study was to find out how many mothers had significant mental health problems, along with their rates of referral acceptance. Mothers who brought their children in for mental health services at one of four community mental health clinics were asked

by their children's clinicians if they would like to be involved in research study that would provide a free screening and referral for themselves. The interviews for the current study were gathered from a subset of 371 mothers who were screened for depressive or anxiety disorders at the time they accessed services for their child. Of these, 271 (73%) met criteria for significant anxiety or depressive symptomology and were referred for services by a member of the study team. Of these, 127 mothers were asked to be interviewed about their experiences seeking services for their children and of their own referral for mental health services (Anderson et al., 2006). The study discussed in this dissertation analyzed a random sample of 60 of the 127 interviews.

In order to answer the research question, I analyzed the 60 interviews using techniques drawn from grounded theory analysis (Charmaz, 2006). I immersed myself in the interviews, reading them multiple times and analyzing them incident-by-incident until initial codes were established. I then grouped the codes into categories, and finally organized the categories into a model that describes the process that mothers went through to seek mental health services for their children.

1.2 SIGNIFICANCE OF THE STUDY AND RELEVANCE TO SOCIAL WORK

The findings of this study have implications in the areas of service delivery, treatment development, mental health policy, and knowledge building. Because this study looks at the help-seeking process of mothers who accessed services for their children, the results are of direct relevance to clinicians and treatment development researchers (Goodman et al., 1997). This study provides a relatively unique opportunity to gain access to the conceptual world of these 60

mothers. By analyzing their stories, we can develop an understanding of how and why these mothers sought mental health services for their children. We have the opportunity to gain a deeper understanding of mothers' experiences seeking help, and in turn have richer and more valuable conversations with them (Geertz, 1973). The importance of this type of communication is highlighted every time a mother says, "my kid's therapist didn't understand me," or "the agency doesn't meet my needs," or "I didn't know why it was important to continue." If we as social workers are truly "service providers," then we need to know what we need to provide and how to best communicate with those seeking our services.

Social workers provide the majority of the mental health services in the United States (O'Neill, 1999, June). As a result, they are in the position to impact the health and well-being of a large number of consumers of mental health services. Because mental health services for youth in the United States is more like a patchwork quilt than a system of care, the pathway to the "right" care is often unclear. Social workers often perform a linkage function; they recognize treatment needs and refer clients to the appropriate services. A more concrete understanding of the process mothers go through to seek help for their children will help social workers be more sensitive to the needs of mothers and increase their effectiveness as facilitators in the help-seeking process.

Because social workers also administer the majority of the social service programs in the United States, they are responsible for policies that affect hundreds of thousands of consumers. These policies affect how and when services are delivered. Because this study looks at the process of help-seeking, the findings have the potential to inform which intervention points during the help-seeking process will increase the likelihood that children and families will receive appropriate mental health services, which in turn may inform policy changes.

Finally, the NASW policy statement on mental health (National Association of Social Workers, 2005), argues that social workers should pursue knowledge-building in the area of mental health access. As noted earlier, help-seeking bridges the gap between service need and access. Help-seeking has been addressed by researchers in public health (Nicholson, Larkin, Simon et al., 2001), epidemiology (Alegria, Canino, Lai et al., 2004; Alegria, Robles, Freeman, Vera, & et al., 1991; Costello, Angold, Burns, Erkanli, Stangl et al., 1996), sociology (Andersen, 1995; Andersen & Newman, 1973; Pescosolido & Boyer, 1999), anthropology (Estroff, Lachicotte, Illingworth, & Johnston, 1991; Estroff, Patrick, Zimmer, & Lachicotte, 1997), psychology (Shanley, Reid, & Evans, in press) but rarely in social work (Mowbray, Lewandowski, Bybee et al., 2004). Since the existing models of parental help-seeking assume that parents' experiences must be understood within their socio-environmental context (Cauce et al., 2002; Costello, Messer et al., 1998; Logan & King, 2001; Stiffman et al., 2006), social work's silence is notable; the social work profession is the primary advocate for the "person in environment" perspective (Karls, 2002). Using a sample from rural and urban community mental health clinics to better understand maternal help-seeking pathways is therefore consistent with both the social work perspective and the current understanding of the help-seeking process. This study has the potential to make a contribution in the general understanding of help-seeking as well as to demonstrate the importance of addressing this issue within the profession of social work.

1.3 SUMMARY

Untreated or undertreated mental health problems have a profound effect on the well-being of individuals, families and communities. Research over the past 25 years has consistently found that 1 in 5 youth have an emotional, cognitive or behavioral disorder, and yet only 20% of those in need receive services. Researchers have suggested that one approach to closing the gap between unmet need and service use is to better understand help-seeking behaviors. Although parents and guardians (usually mothers) are responsible for seeking mental health services for youth, there is very little research on how and why parents seek mental health services for their children. This exploration of mothers' experiences of help seeking will fill a gap in the literature and improve our understanding of service delivery. It is also congruent with the historical mission of social work to address the needs of vulnerable and oppressed populations.

2.0 LITERATURE REVIEW

This literature review presents what is known and not known about maternal help-seeking for youth with mental health problems. This information provides a context for the current study and underscores the need for qualitative research on maternal help-seeking.

As illustrated in Figure 1, there are three areas of scholarship that inform the current study: service need and use; models of help-seeking; and empirical research on help-seeking pathways.

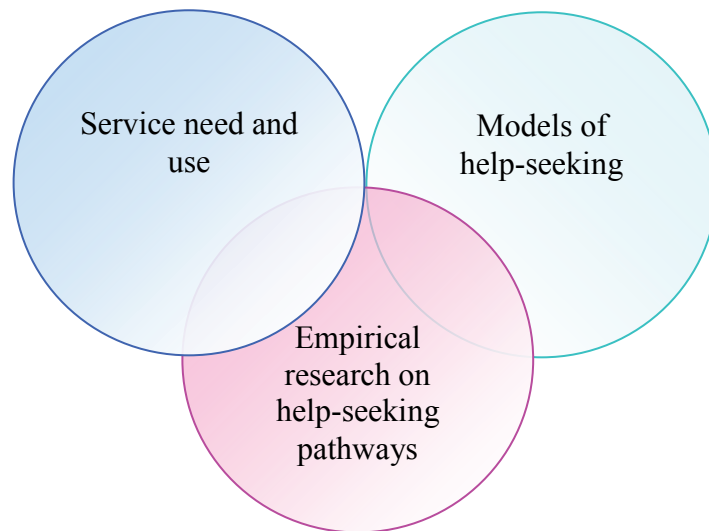


Figure 1. Three areas of scholarship that inform the current study

Research on service need and use identifies rates of mental health problems, types of services used, and correlates of service use. The majority of this research identifies the *characteristics* of help-seekers rather than the *process* they go through to seek help (Cauce, Domenech-Rodriguez, Paradise et al., 2002). Its purpose is to inform policy makers on ways to improve access to mental health services (Alegria et al., 2004).

In contrast, theoretical models of help-seeking focus on process. The majority of existing models are called “stage-process” models because they conceptualize help-seekers as moving through a series of specific steps on their way to services. Other models focus less on specific stages and more on the multiple entrances into and exits out of services. The purpose of these theoretical models is to provide explanations and/or predictions of help-seeking behavior.

Although these two areas of research rarely overlap, the third area, empirical research on help-seeking, draws from both. This body of literature includes studies using qualitative, quantitative and mixed-methods approaches to help-seeking. The quantitative studies evaluate how well service need and use factors correlate with the stages of help-seeking identified in the models. The qualitative studies, which comprise a much smaller set of empirical research, mostly explore the process of help-seeking for parents of children with disruptive disorders.

The sections that follow describe in more detail each of these three areas of scholarship, thereby providing the context for the research question in the current study.

2.1 RESEARCH ON SERVICE NEED AND USE

Two major longitudinal epidemiological studies of urban and rural youth ages 9-17 in the U.S. suggest that between 8.5% and 22% of youth meet criteria for a psychiatric disorder (Burns et

al., 1995; Costello, Messer et al., 1998; Farmer, Burns, Phillips, Angold, & Costello, 2003; Farmer, Stangl, Burns, Costello, & Angold, 1999) and between 5% and 17% meet criteria for severe emotional disturbance (SED; Flisher et al., 1997; Glied, Hover, Moore, Garrett, & Regier, 1997; Leaf et al., 1996). Youth are considered to have SED when they meet criteria for both a psychiatric disorder and have significant functional impairment (Farmer et al., 2003). Youth who meet criteria for psychiatric disorder and associated functional impairment are considered to be in *need* of services, and those who meet criteria for need but who have not received mental health services in the past 6 months are considered to have *unmet need* (Flisher et al., 1997). Only 20% of youth with a psychiatric disorder receive mental health treatment (Leaf et al., 1996; US Public Health Service, 2000), suggesting a significant gap between service need and service use. A better understanding of help-seeking behaviors is one of the most promising approaches to bridging the gap (Broadhurst, 2003).

The Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA; Flisher et al., 1997; Glied et al., 1997; Leaf et al., 1996) and the Great Smoky Mountain Survey (GSMS; Burns et al., 1995; Farmer et al., 2003; Farmer et al., 1999) are the two longitudinal epidemiological surveys that establish prevalence rates of mental illness and service access in youth. Although neither is a nationally representative sample (Costello et al., 2003), together they cover urban (MECA) and rural (GSMS) youth ages 9-17. Both were designed to provide information about youth symptomology, impairment and help-seeking behaviors. Both studies identified characteristics of those who used services and those who did not.

The MECA was a large-scale study conducted from 1989-1992, examining the use of mental health services among adolescents in four geographic areas of the U.S. The study involved 1,285 parent/youth pairs interviewed in their homes by trained child and adolescent

interviewers using both paper-and-pencil and computer-based tools (Lahey et al., 1996). The MECA study reported that 17.1% of the total sample demonstrated an unmet need for mental health services (Flisher et al., 1997). Unmet need was significantly associated with economic disadvantage; perceived poor mental health; poor school grades; parent-reported access barriers, such as concern that the child would be hospitalized or taken away against the parents' wishes; and parental psychopathology (Flisher et al., 1997). A subsequent epidemiological study of the Pittsburgh region replicated many of the findings of the MECA study, and extended the findings by demonstrating that unmet need was also associated with history of anxiety disorder and current substance use disorders in *parents* (Cornelius, Pringle, Jernigan, Kirisci, & Clark, 2001). For both the MECA and Cornelius et al studies, youth-reported barriers did not correlate with unmet need, suggesting the importance of parental factors in the unmet treatment need of their children.

The GSMS is an ongoing longitudinal epidemiologic study begun in 1993, examining mental health problems and service use in a predominantly rural region of the southeastern U.S. (Burns et al., 1995). A total of 4,500 children ages 9, 11, and 13 were randomly selected from all public school districts in the 11 participating counties. Of that group, those who scored above a predetermined point on a behavioral screening questionnaire were included in the final sample of 1,015 children. Children and their parents were interviewed using the Child and Adolescent Psychiatric Assessment (CAPA), the Child and Adolescent Services Assessment (CASA), and measures of family burden, maternal depression, the child's physical health and development, and the family's psychiatric history (Burns, et al, 1995). Results from the first wave of data indicated that 20.3% of the children met criteria for a DSM-III disorder, and youth were also more likely to use specialty mental health services if parents perceived that their child's

symptoms negatively impacted the parent's life, which the authors called "parental burden" (Angold et al., 1998).

These studies also suggest that parents play an important role in the gap between service need and service use. Both studies found that parents were responsible for getting youth into mental health services. Factors that significantly influenced parents' decisions to seek mental health services for their child included *parental burden* and, *perception of need*. Parents are significantly more likely to access mental health care for their children if they experience *parental burden* (Angold et al., 1998), also known as *caregiver strain* (Brannan & Heflinger, 2006; Brannan et al., 2003) and *parental distress* (Alegria et al., 2004). In this experience, parents perceive that their child's symptoms negatively impact the parents' lives. For example, when a child's problems limit parents' ability to work, this increases parental distress and results in higher rates of service use (Sayal, Taylor, & Beecham, 2003). In a study of Health Maintenance Organization (HMO) patients, caregiver strain not only predicted service use, but also the combination of services used, the sequence of services used, and the gaps in care (Brannan et al., 2003). Parental burden has been reported to increase specialty mental health utilization rates by a factor of three for youth with clinical levels of impairment and symptomology, and by a factor of 19 for youth with impairment only (Angold et al., 1998). The difference in utilization rates suggests that problems in day-to-day living trigger parental help-seeking more so than clinically determined symptomology. Goodman, Lahey, Fielding et al (1997) reported similar findings from the MECA study, noting that what distinguished mental health service use from non-use in youth were high rates of distress and functional impairment, rather than the presence of symptomology. Although it is possible that parents developed their concepts of impairment as a result of, rather than in advance of treatment (Goodman et al.,

1997), child problems have been found to be the most consistent predictor of parental burden (Brannan & Heflinger, 2006). Prior research with the mothers in the current study found that the most common stressor was “having to manage an emotionally or behaviorally disturbed child” (Anderson et al., 2006, p. 932). Anderson et al, noted that an underlying reason for the perceived distress was that mothers felt responsible for their child’s problems and therefore sought help. The mothers in current study met criteria for a depressive or anxiety symptomology, and thus suggest that there might be an influence of maternal mental health problems on perceived parental burden.

Parental psychopathology has been associated with both decreased and increased service utilization. In studies that evaluate service use in non-specialty mental health settings (e.g. school, juvenile justice, child welfare, and primary care) parental psychopathology has been associated with decreased service use (Flisher et al., 1997). Similar results were reported in nationally representative studies of help-seeking in British and Dutch samples (Sayal et al., 2003; Verhulst & van der Ende, 1997). In contrast, studies that evaluate service use in specialty mental health settings only, parental psychopathology has been associated with increased service use (Cunningham & Freiman, 1996; Goodman et al., 1997; Mowbray et al., 2004; Zimmerman, 2005). It is unclear why these differences exist. Researchers have speculated that mothers with mental illness are more likely to seek specialty mental health care because they: are more likely to blame themselves and take responsibility for their child’s problems; are more sensitized to the burden of mental illness; or might be more familiar with, have more access to, and have more trust in, mental health services and consequently are more willing to seek help (Cornah, Sonuga-Barke, Stevenson, & Thompson, 2003; Mowbray et al., 2004; Zimmerman, 2005). Or it could be simpler than that; evidence suggests that when parents seek service for themselves, their children

are more likely to receive services (Cunningham & Freiman, 1996). Since the current study sample is mothers who met criteria for significant depressive or anxiety symptoms, it will not be possible to evaluate the role of maternal psychopathology on use versus non-use. However, the sample might provide insight into the role that maternal depression and anxiety played in mothers' development of concern, perception of need, or decision to seek mental health services.

Parents are also more likely to seek services for their children when parents experience a *perception of need*, meaning that parents perceive that the child's symptoms negatively impact the child's life (Alegria, Canino, Lai, Ramirez, Chavez, Rusch, et al., 2004; Sayal, Taylor & Beecham, 2003). Parental perception of need is important because youth rarely seek their own mental health services (Srebnik, Cauce, & Baydar, 1996), youth often look to adults to legitimize their problems (Murray, 2005), and parents often act as gatekeepers to mental health and other services, based on their understanding of their child's needs, and they are unlikely to seek mental health services if they perceive their child's need as something other than mental health related (Arcia & Fernandez, 2003a; Stiffman, Pescosolido, & Cabassa, 2004). Research has consistently suggested that severity of child problems does not predict service use (Zwaanswijk, Verhaak, Bensing, van der Ende, & Verhulst, 2003). Therefore parental perception of need, along with parental burden and parental psychopathology, appears to mediate the relationship between the severity and persistence of emotional, behavioral and social problems of children, as well as the presence of coexisting disorders, and service use (Alegria et al., 2004; Barker & Adelman, 1994; Farmer et al., 2003; Harris, 1996; Horwitz, Leaf, & Leventhal, 1998; Sourander et al., 2005). However, not all problems are perceived the same. Children with externalizing disorders (i.e. behaviors that are directed outwards, such as aggression and hyperactivity) are more likely to enter mental health treatment (Brannan & Heflinger, 2006; Mowbray et al., 2004; Wu et al.,

1999; Wu et al., 2001) and receive more services (Hodges & Wong, 1997) than children with internalizing problems (i.e. behaviors that are directed inwards, such as fear, anxiety, and depression) (Logan & King, 2002), even controlling for age, race, and sex (Mowbray et al, 2004).

Child age and gender appear to influence service usage (Zwaanswijk et al., 2003). During childhood and early adolescence, boys receive more services and are, in general, more likely to be diagnosed with externalizing disorders than girls. In late adolescence, girls receive more services. Girls are also more likely to be diagnosed with internalizing disorders. However, when controlling for age, race and gender, service utilization is more significantly correlated with the diagnosis (Mowbray et al, 2004). Girls are 1/5 less likely to receive treatment for behavior problems, controlling for symptom severity, than boys (Zimmerman, 2005).

In the United States, pathways to care vary based on where services are sought. For example, if mental health services are in schools, or if youth are in foster care the pathway is more direct and shorter (Burns et al., 1995; Zima, Bussing, Yang, & Belin, 2000). Data from the GSMS suggested that schools were the primary source of mental health services for youth (Burns et al., 1995). Both quantitative and qualitative studies have found that in the United States, schools are the most significant referral source for parents seeking mental health services for their children (Arcia et al., 2004; Costello et al., 1996). Difficulty performing school work was found to be one of three factors that distinguished service users vs. no service use in a sample of Puerto Rican youth (Alegria et al., 2004). Specialty mental health services are not the first choice and therefore the pathways tend to be less direct and longer (Farmer et al., 2003).

2.2 SUMMARY OF FINDINGS AND GAPS IN THE LITERATURE

Research on service need and use has shown a significant unmet need for mental health services among youth, with 20% of youth meeting criteria for a psychiatric disorder and of those, only 20% receiving specialty mental health services (Costello et al., 1988; Costello, Messer et al., 1998). Furthermore, this research has indicated that parental factors such as parental burden, parental psychopathology, and perceived need significantly influence whether youth get needed mental health care.

However, even though the MECA and GSMS established rates of service use versus non-use and suggested there was significant unmet need among youth, there are important limitations to the research. Both studies are atheoretical and therefore do not provide explanations about the relationships between the variables. Additionally, the definitions of perceived need and perceived burden were established by the researchers, not the parents. Therefore it is possible that our understanding of what parents perceive to be significant or what they find burdensome is not entirely accurate. The current study has the potential to address both of these issues. Finally, while these studies did establish who met criteria for psychiatric disorders and what factors distinguished help-seeking parents from non-help-seeking parents, they provided no insight into the process that parents went through to seek mental health services for their child. To develop a more accurate understanding of maternal help-seeking and the role that certain factors play in that process, the current study will explore mothers' experiences and perceptions of the help-seeking process.

Researchers have recently noted the need to complement our understanding of the characteristics of help-seekers with a better understanding of the process of help-seeking (Cauce et al., 2002; Logan & King, 2002; Mowbray et al., 2004). A review of existing help-seeking models

will provide a context for the current study, and identify how others have attempted to make sense of the complex help-seeking process.

2.3 THEORETICAL MODELS OF HELP-SEEKING AND MENTAL HEALTH SERVICE USE

Several models have been developed to explain how people seek help. The first help-seeking models were developed to address *physical health* help-seeking by adults (e.g. the Health Belief Model, Theory of Reasoned Action/Theory of Planned Behavior, and the Socio-Behavioral Models). More recent models have been developed to explain or understand *mental health* help-seeking by adults (e.g. the Help-seeking Decision Making model and the Network Episode Model). The most recent development in help-seeking research is the attempt to create models that explain how *parents* seek mental health services *for their children*, (e.g. the Family Network Episode Model).

The purpose of this study is to understand how and why mothers brought their children for mental health services. Since one of the functions of grounded theory is to evaluate the emergent model against existing models (Morse & Field, 1995), it is useful to provide an overview of existing help-seeking models. As I will demonstrate, scholars are increasingly recognizing the need for qualitative research on maternal help-seeking to provide insight into the findings of the mostly atheoretical help-seeking literature. In order to better understand the continued need to engage in model development, I will provide a brief history of help-seeking

models, followed by a detailed critique of existing models. I will end with a summary of what current models tell us and what gaps exist.

2.3.1 A brief history of help-seeking models

The first models of help-seeking were developed in the 1950s to predict, explain, and understand physical health help-seeking behaviors. Figure 2 illustrates the genealogy of help-seeking models. Reading the figure from the top down, you can see the influence of early models of adult help-seeking on current models of youth help-seeking. The models on the left use the individual as the unit of analysis. The models on the right use the community as the unit of analysis.

The first major help-seeking model, The Health Belief Model (HBM; Rosenstock, 1966, 1988), was developed to improve participation rates in public disease detection and prevention programs (e.g. TB x-rays). In response to perceived limitations of the HBM to explain *how* people *decided* to seek help, Fishbein and Ajzen (1975) developed the Theory of Reasoned Action (TRA). The TRA was later expanded to include Bandura's (1991) concept of self-efficacy and renamed the Theory of Planned Behavior (Ajzen, 1985, 1991). Both the HBM and the TRA/TPB were developed by social psychologists to explain the cognitive processes involved in individual decision making about health behaviors. Another socio-cognitive model was developed in the late 1950's by Gurin and colleagues (Gurin, Veroff, & Feld, 1960). Unlike the HBM and the TRA/TPB, the Gurin et al model was intended to describe the *process* that adults went through to *address* mental health problems.

Individual-level -----> -----> -----> -----> -----> -----> Community-level

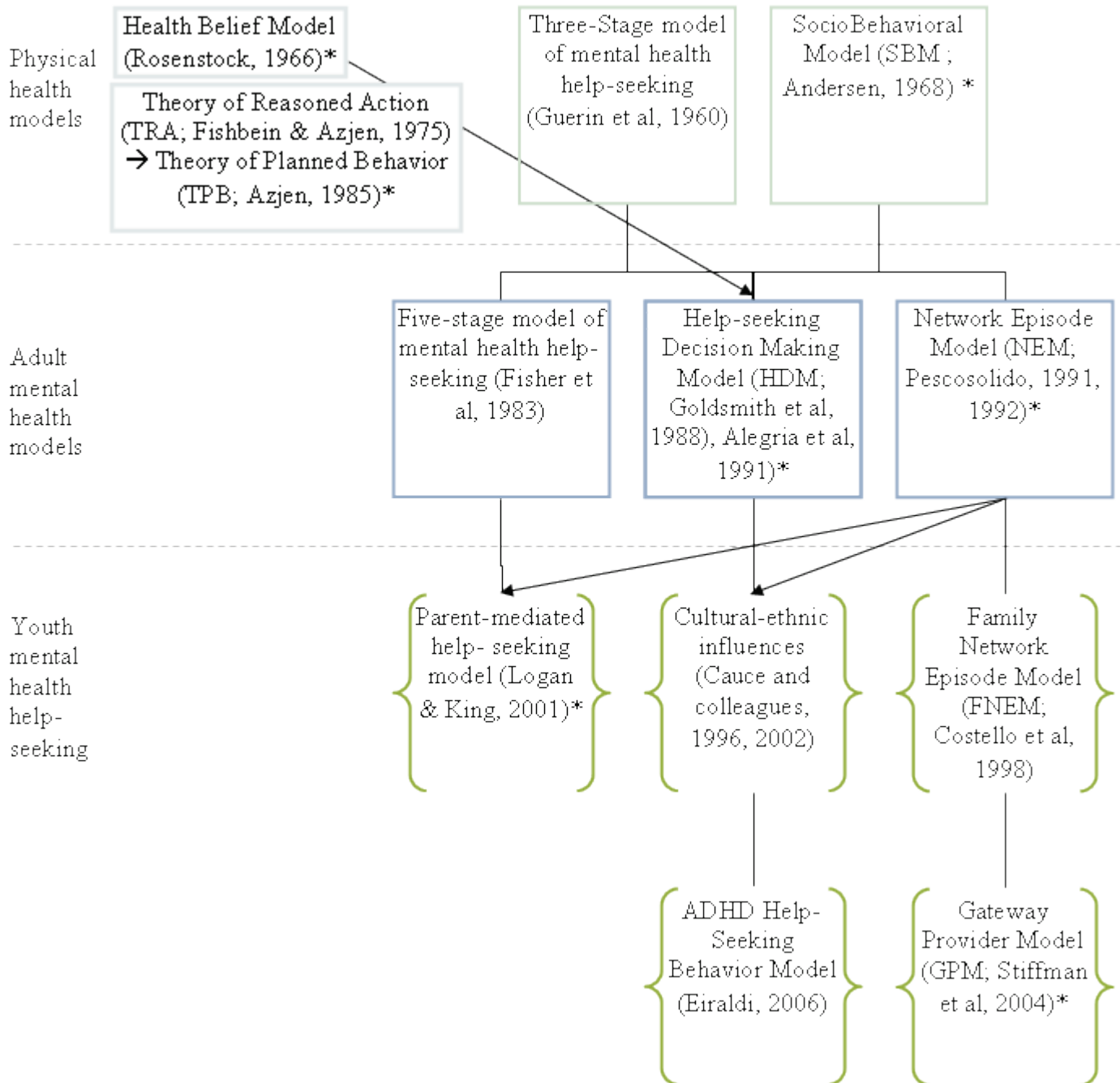


Figure 2. Genealogy of help-seeking models

Key: * = models with empirical support

The Gurin et al model identified three stages of help-seeking: defining a situation as a mental health problem; deciding to seek help; and selecting services. These stages have become the basis of most empirical research on mental health help-seeking (Logan & King, 2001). These first three models are categorized as socio-cognitive models because they privilege the role of thoughts and beliefs in help-seeking (Pescosolido, 1991). In contrast, Andersen and colleagues developed a socio-behavioral model (SBM) that privileges the role of structural factors, such as access to care and insurance, in the help-seeking process (SBM; Andersen and Anderson, 1968). This model identifies three stages: identifying a problem, deciding to seek services and selecting service.

The socio-cognitive and socio-behavioral models have evolved over time to be more similar than different, with the HBM now including structural factors and the SBM now including health outcomes (Andersen, 1995; Pescosolido, 1999). Although these models have been useful in explaining some of the variances in help-seeking for physical health problems, they have been less useful in explaining help-seeking for *mental* health problems, which tend to be more stigmatizing, more difficult to identify, and more chronic. Because these models were not designed to explain mental health treatment seeking, researchers developed models specifically to address issues of mental health help-seeking.

In the mid-1980's, changes in health care, such as the rise of managed care and an increase in public acceptance of mental health treatment, resulted in a re-evaluation of the value of existing socio-cognitive and socio-behavioral models (Phelan, Link, Stueve, & Pescosolido, 2000). Traditional help-seeking models were criticized for relying too heavily on "the rational decision-making ability of the individual" (Pescosolido, 1991, p. 166) and for failing to

adequately account for specific conditions associated with mental health treatment seeking (e.g. social stigma). In response, two models were developed to explain mental health help-seeking; the Help-seeking Decision Making Model (HDM; Goldsmith, Jackson, & Hough, 1988) and the Network Episode Model (NEM; Pescosolido, 1991; NEM; Pescosolido & Boyer, 1999). Both models expanded Andersen's SBM to account for the social process of involving other people in help-seeking. The HDM assumed that social context was important, but that ultimately individuals made decisions about help-seeking while moving through a series of stages that were influenced by specific population characteristics (Alegria, Robles, Freeman, Vera, & et al., 1991). In contrast, the NEM assumed that decisions about help-seeking were made at the community level and that people could be in several stages simultaneously. These newer models provided theoretical frameworks for adult mental health help-seeking.

In the 1990's, the first nationally representative epidemiological studies of *youth* mental health were published, and they reported high rates of mental illness and low rates of service utilization (Burns et al., 1995; Costello et al., 1996; Lahey et al., 1996). In response, scholars adapted the HDM and the NEM to help explain the process of help-seeking for youth with mental health problems. Since then, several models of youth mental health help-seeking have been based on these two models. Those based on the HDM were developed to account for cultural and ethnic factors that might influence help-seeking (Cauce, Domenech-Rodriguez, Paradise et al., 2002; Srebnik, Cauce, & Baydar, 1996) Puerto Rican youth (Alegria et al., 2004) and ethnic minority children with ADHD (Eiraldi, Mazzuca, Clarke, & Power, 2006). Those based on the NEM were developed to explain help-seeking by families (FNEM; Costello, Pescosolido, Angold et al., 1998) and the role of adults in providing to adolescents both information about and access to mental health services (The Gateway Provider Model; Stiffman

et al., 2004). Logan and King (2001) developed a parent-mediated model to mental health services for depressed adolescents based on Costello's FNEM (Costello, Pescosolido, Angold, & Burns, 1998) Fischer's five-stage model of help-seeking (Fischer, Weiner, & Abramowitz, 1983) and Prochaska and DiClemente's (1983) stages of change model. Although Logan and King's model includes features of the NEM, it was developed and tested as a model of individual help-seeking (Logan & King, 2002; Zwaanswijk, Van Der Ende, Verhaak, Bensing, & Verhulst, 2007).

In summary, models of help-seeking were first used to explain physical health help-seeking for adults, and have most recently been modified to explain mental health help-seeking for youth. Help-seeking models have been developed for ethnic minority adolescents (Cauce et al., 2002; Srebnik et al., 1996), youth with depression (Logan & King, 2002) and disruptive disorders (Eiraldi et al., 2006), and adults who act as gatekeepers to mental health services (Stiffman et al., 2004). A more detailed review of existing models of help-seeking will provide greater context for the current study.

2.3.2 Socio-cognitive and socio-behavioral help-seeking models

The earliest models share the following assumptions (Pescosolido, 1991): (1) Individuals make rational choices about health care; (2) decisions are made about acute or single episode problems, rather than chronic problems and these models were developed to describe such illnesses and; (3) decisions are made at an individual rather than an interpersonal or "social process" level.

2.3.2.1 Health Belief Model

The health belief model (HBM; Rosenstock, 1966; Rosenstock, Strecher, & Becker, 1988) was developed and used primarily for investigating a single episode of treatment-seeking for physical health issues (e.g. HIV testing, vaccinations, etc). The model was later applied to patients' responses to symptoms and diagnoses. Rooted in cognitive *value-expectancy* theory, the HBM assumes that help-seeking behavior is a function of an individual's beliefs about treatment; a person perceives a *value* in treatment and *expects* that their behavior will achieve the desired outcome.

As illustrated in Figure 3, there are seven components to the HBM. True to its social psychology roots, the first four seek to explain the individual's thought process: (1) *perceived susceptibility* to contracting an illness; (2) *perceived severity*, both medically and socially, of that illness; (3) *perceived benefit* from taking a feasible action; and (4) *perceived barriers, or the possible negative results of taking an action*, determined through unconscious cost/benefit analyses. The HBM assumes that people weigh the risk of illness against the benefits and barriers of seeking help. The fifth component of the model refers to factors that could somehow modify an individual's perceptions (e.g. demographic characteristics such as age and sex, and psychosocial factors such as developmental status).

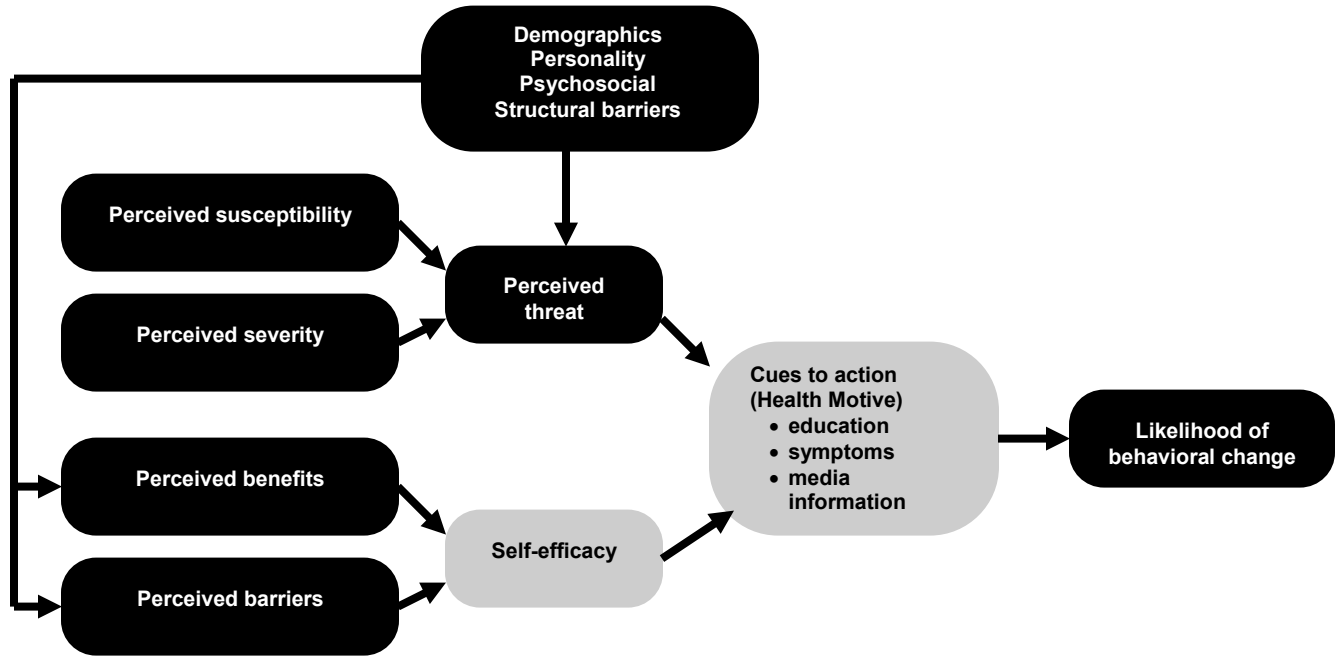


Figure 3. Contemporary Health Belief Model

(adapted from Becker, Drachman, & Kirscht, 1974 and Nutbeam & Harris, 1998).

Note: the grey indicates components that were later incorporated into the original model

In the original model, it was believed that the first four components, when accounting for modifying factors, would predict behavior. This hypothesis was supported by Hochbaum’s 1952 research on readiness for TB x-rays (Rosenstock, Strecher, & Becker, 1988), which found that 80% of adults who believed they had a susceptibility to tuberculosis and who perceived a benefit from the screening took advantage of the screening. However, when researchers attempted to apply the original HBM to chronic illness, including mental health problems, the model was much less effective for predicting behavior (Rosenstock, Strecher, & Becker, 1988).

In response to the original HBM’s inability to predict the health behaviors of people with chronic illness, the sixth and seventh components were added to the model; 6) *cues to action*, which are unconscious triggers for behavior, and 7) Bandura’s concept of *self-efficacy*, which

refers to beliefs about the likelihood of successfully completing an action. Cues to action was added because, although a person might report a perceived threat and perceived benefit, they might need a cue, such as seeing an advertisement on TV (media cue) or feeling a lump in their breast (symptom cue), to act (Rosenstock, Strecher, & Becker, 1988). Self-efficacy was added because, when a behavior was more complicated or long-term than the receipt of a service (such as a TB shot), peoples' beliefs about their likelihood of engaging in that behavior might come into play. In summary, the HBM is a socio-cognitive model that was developed to explain *why* someone would or would not decide to seek treatment.

2.3.2.2 Theory of Reasoned Action/Theory of Planned Behavior

The Theory of Reasoned Action (TRA; Fishbein & Ajzen, 1975), and the related Theory of Planned Behavior (TPB; Ajzen, 1985, 1991), were developed partly in response to perceived limitations of the HBM to explain *how* people decided to seek help (Fishbein and Ajzen, 1975). Like the HBM, researchers modified the TRA to include Bandura's concept of perceived self-efficacy, and then named the updated model the TPB. There is a significant amount of empirical support for the TRA/TPB models (Armitage & Conner, 2001; Madden, Ellen, & Ajzen, 1992). As illustrated in Figure 4, the TPB is essentially the TRA plus a measure of perceived behavioral control.

The TRA was developed to explain human behavior (Ajzen, 1985). As is implied by its name, the TRA assumes that behavioral choices are the result of a rational process that can be quantified and evaluated (Ajzen, 1985). Specifically, a reasonable person gathers information and then evaluates the relative merits of one behavior over another. As a result of this deliberate and detailed process, a person decides whether to act. As illustrated in Figure 4, the theory

proposes three general constructs related to a specific behavior: (1) attitude toward behavior; (2) subjective norms; and (3) behavioral intentions (Ajzen, 1985).

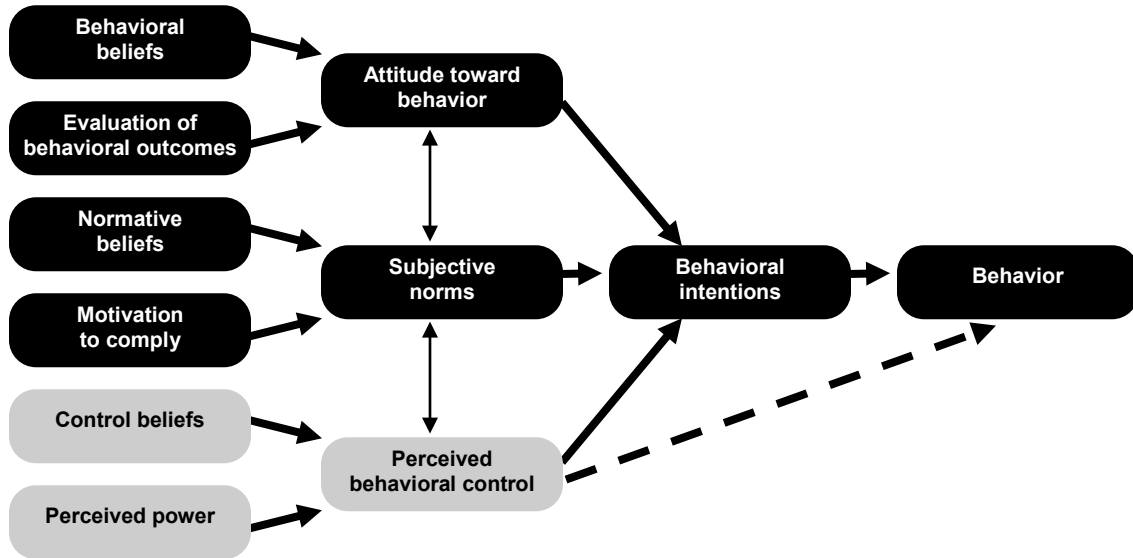


Figure 4. Theory of Reasoned Action/Theory of Planned Behavior

(Adapted from Rimer & Glanz, 2005, p. 18. and Ajzen, 1991, p. 182.).

Note: Black shows the Theory of Reasoned Action. Grey shows the incorporation of social cognitive theory. Entire figure shows the Theory of Planned Behavior.

The first construct, *attitude toward behavior*, refers specifically to the person’s positive or negative evaluation of performing a specific behavior. The second construct, *subjective norms*, refers to the amount of social pressure an individual believes is being placed on him or her to engage in that behavior. The influence of attitude and subjective norms on actual behavior is mediated by the third construct – *behavioral intentions*. TRA assumes that people tend to act in accordance with their intentions; that is, we are rational beings and we act in reasonable ways. The stronger our intention, the more likely we are to perform the behavior (Ajzen, 1991).

The original TRA did a poor job of accounting for behaviors “over which people have incomplete volitional control” (Ajzen, 1991, p. 181). In order to account for volitional control of behavior, Ajzen borrowed Bandura’s (1991) concept of perceived self-efficacy, renamed it *perceived behavioral control* (PBC), and placed it within the broader framework of the relationship between beliefs, attitudes, intentions and behaviors. In recognition of this added factor, Ajzen renamed the TRA the Theory of Planned Behavior TPB (Ajzen, 1991). The inclusion of PBC improved the TPB’s effectiveness in predicting behavior by providing for situations where weak intentions still resulted in behavior (Rimer & Glanz, 2005). In summary, the Theory of Planned Behavior is a socio-cognitive model that attempts to predict *how* a causal chain of beliefs, attitudes, intentions and self-efficacy drives behavior (Rimer & Glanz, 2005).

2.3.2.3 Socio-Behavioral Model

The socio-behavioral model was developed in the late 1960s by Andersen and Anderson (1968) “to assist in the analysis of national survey data” (Andersen, 1995, p. 1). The original model focused on the family as the unit of analysis and stressed the role of social structures in enabling or impeding people’s use of formal health care services. As illustrated in Figure 5, the model assumed that predisposing characteristics, enabling resources, and need for care influenced access to health services. According to Andersen (1995), the model was originally intended to both predict and explain behavior. As a prediction model, Andersen argued that individual components make independent contributions towards explaining service use. As an explanatory model, the SBM was intended to account for demographic and social structure variables that explain service use. As both a predictive and explanatory model, the original SBM was fundamentally concerned with structural factors (e.g. insurance) that influenced access to services (Pescosolido & Boyer, 1999).

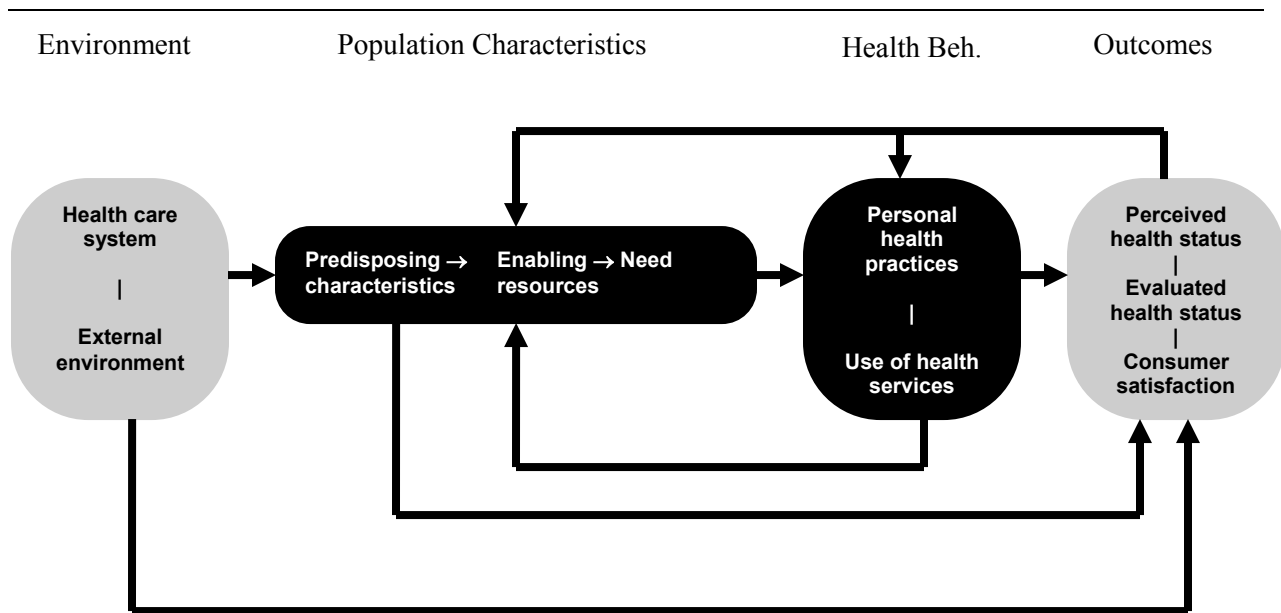


Figure 5. The final version of the Socio-Behavioral Model

(Adapted from Andersen, 1995).

Note: The original 1968 model is in black and components to the most recent version are in grey

By the mid-1990's, the SBM was in its fourth iteration and had evolved to include both environmental influences and health outcomes. A parallel evolution had occurred with the HBM until the two models were more similar than dissimilar (Pescosolido & Boyer, 1999). As shown in Figure 5, the entire original model is preceded by environmental influences (health care system, etc.) and followed by health outcomes, such as perceived and evaluated health status and consumer satisfaction. Perhaps the most radical departure from the original model was the reconceptualization of components that had originally been causally linked that were now understood to be recursive. For example, in the original model, health behavior did not influence population characteristics. In the final model, Andersen (1995) suggested that population

characteristics not only influenced health behavior but were influenced by health behavior and the outcomes of help-seeking behavior.

Although the SBM went through four versions, most researchers use the population characteristics outlined in the original model and exclude the additions from subsequent models (Andersen, 1995). Andersen's conceptualization of population characteristics (predisposing characteristics, enabling resources, and need) as predictors of health behavior is considered an integral component of contemporary mental health help-seeking models. The characteristics are routinely correlated with Gurin et al's (1960) stages of mental health help-seeking as a proxy measure for the process of help-seeking in empirical studies (Alegria et al., 2004; Alegria et al., 2002; Alegria et al., 1991; Logan & King, 2002; Zwaanswijk et al., 2007) The centrality of Anderson's population characteristics in contemporary help-seeking literature is somewhat ironic considering that the original SBM was never intended to explain pathways to care or health outcomes (Andersen, 1995).

2.3.3 Summary and critique socio-cognitive and structural help-seeking models

The original help-seeking models attempted to explain either the cognitive decision making process people went through to seek help (HBM, TPB), or the role of structural factors that affected their access to care (SBM). These models were developed to explain help-seeking for physical health issues such as getting vaccines. The models assumed that people make rational choices about their health care, and that people seek help for short-term rather than chronic problems. Furthermore, the HBM, the TRA/TPB and the SBM provided highly specified models with clearly operationalized variables that could be tested.

Researchers have noted several limitations of these models in explaining or predicting mental health help-seeking behaviors. These models 1) assume that people make rational decisions about help-seeking, 2) characterize health care utilization as a single-episode event rather than a series of interconnected events that are more reflective of the acute or chronic nature of mental health problems, 3) assume that services are voluntary, 4) do not consider developmental issues, and 5) offer no way to measure the effect of time in the process of help-seeking (Morgan, Mallett, Hutchinson, & Leff, 2004; Norman & Rosvall, 1994; Ogden, 2003; Pescosolido, 1991, 1992; Pescosolido, Gardner, & Lubell, 1998; Stiffman et al., 2004).

2.3.4 Mental health help-seeking models

In response to the noted limitations of the cognitive and behavioral models to explain mental health help-seeking, two models were developed in the late 1980s and early 1990s: the Help-seeking Decision Making Model (HDM; Goldsmith et al., 1988) and the Network Episode Model (NEM; Pescosolido, 1991, 1992). The HDM and the NEM modified existing models to account for some of the issues specific to mental health help-seeking. The HDM assumes that decisions to seek help happen at the individual level. In contrast, the NEM assumes that decisions are made primarily at the community level.

2.3.4.1 Help-seeking Decision Making Model (HDM)

As illustrated in Figure 6, the HDM (Goldsmith, Jackson, & Hough, 1988) combines the stages of mental health help-seeking developed by Gurin et al (in white; 1960) with the population characteristics of Andersen's (1995) socio-behavioral model (in black). The HDM assumed that, prior to accessing services, a person had to: (1) recognize a problem; (2) decide to

seek services; (3) select services. Alegria (1991) added a fourth stage (in grey) to account for what happened after an individual selected services, including the decision to continue, change or cease care. The HDM assumes that the stages of help-seeking are influenced by the population characteristics identified by Andersen’s SBM: need for services (re-named *illness profile* in the HDM), predisposing factors and enabling factors. The *illness profile*, which involves a perceived and evaluated need, and the risk for or severity of problems, influences only the first stage of help-seeking: recognize a problem. *Predisposing factors*, which include the perceived benefit of help-seeking, perceived self-efficacy, and psychological resources and coping strategies; and *enabling factors*, which include availability of services, insurance status, social support, social or cultural barriers, or social pressures, influence all three stages of help-seeking. As illustrated in Figure 6, the lack of arrows from the population characteristics to the fourth stage of the model represents Alegria et al.’s (1991) assumption that population characteristics did not influence the decision to continue, change, or cease using services. The model assumes that help-seekers move through the stages sequentially, although the authors acknowledge that influencing factors can result in moving back and forth between stages.

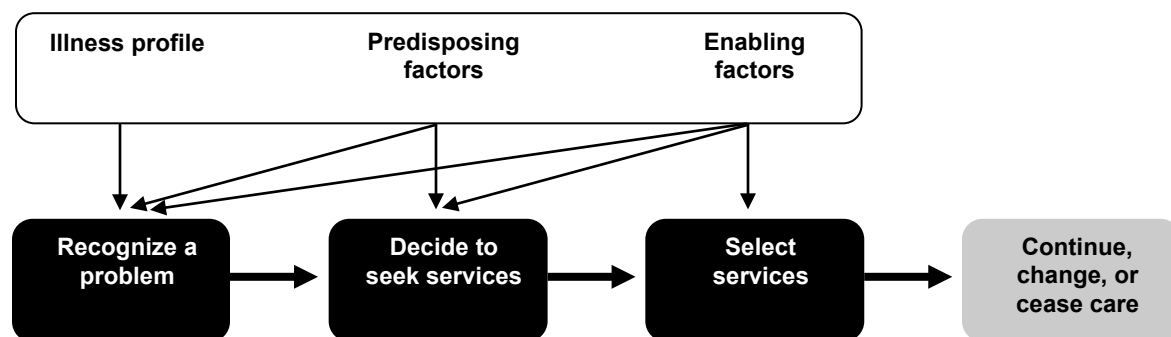


Figure 6. Help-seeking Decision Making Model

(adapted from Alegria, Robles, Freeman, Vera, et al., 1991).

Note: The grey indicates a component that was added to the revised version

The HDM has been modified by scholars to better explain parental help-seeking. Youth models derived from the HDM include those developed by Cauce and colleagues (Cauce et al., 2002; Srebnik et al., 1996), and most recently by Eiraldi et al (2006). These models have a stage-process basis, but have acknowledged the work of Pescosolido and integrated socio-cultural influences and social networks into their models. Similarly, Logan and King (2001, 2002) based their parent-mediated help-seeking model on a five-stage variant of Gurin's original model, with the contextual factors identified by Pescosolido, and within the Stages of change model. Thus, many of the youth models incorporate concepts from cognitive / stage-process *and* social network models.

2.3.4.2 Network Episode Model (NEM)

In contrast to the HDM, the NEM (Pescosolido, 1991, 1992) assumes that help-seekers move in and out of services and that there are multiple influences that dynamically affect how people obtain mental health service. A review of the literature identified five empirical studies that used, or whose findings endorsed, community-level models of help-seeking (Arcia & Fernandez, 2003a, 2003b; Arcia, Fernandez, Jaquez et al., 2004; Pescosolido, Gardner, & Lubell, 1998; Shanley, Reid, & Evans, 2008; Stiffman, Freedenthal, Dore, Ostmann, Osborne et al., 2006; Stiffman, Pescosolido, & Cabassa, 2004).

These community-level models were developed in response to criticism in the mid 1980's that traditional models of help-seeking were out of step with current needs due to changes in health care (e.g. the rise of managed care) and the perception of mental illness (Phelan, Link, Stueve et al., 2000), and for relying too heavily on "the rational decision-making ability of the individual" (Pescosolido, 1991, p. 166). Considering the perceived limitations of existing

models, Pescosolido (1991, 1992) reconceptualized the SBM model to explicitly incorporate social networks, removed the “rational-actor” bias, explained pathways to care by incorporating the sociologically-based and qualitatively derived illness career model, and changed the focus from physical health to mental health (Pescosolido et al., 1998)

According to Pescosolido et al. (1998), the NEM (shown in its second iteration; Figure 7) “... makes no single assumption about how clients come into the treatment system. Rather, it focuses on the dynamic processes underlying the use of services, making problematic the mode of entry into the service sector. The NEM targets the importance of social influence (exerted through ‘community’ social networks) on when, how and if individuals receive care” (p. 276).

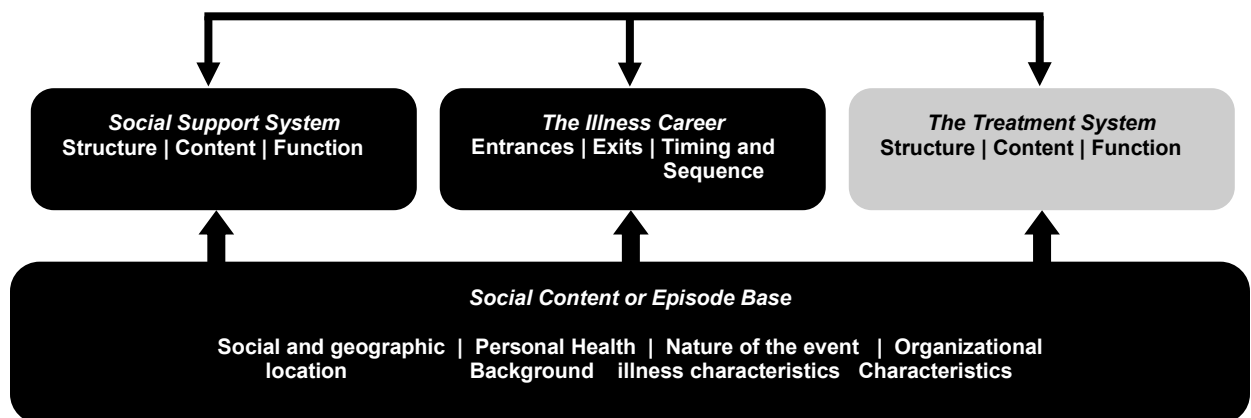


Figure 7. Network Episode Model - II

(adapted from Pescosolido & Boyer, 1999).

Note: The grey indicates a component that was added to the revised version

The NEM incorporates models of service access derived from qualitative research, called “career models,” and quantitative models, called “contingency models.” Although career models lack the explanatory power of contingency models, which means they cannot account for the amount of variance in the behavior in each stage, career models do an excellent job at describing

how, at each stage of an illness, there are decisions to accept or reject socially constructed labels and choices.

Pescosolido identified four assumptions of the NEM (Pescosolido, 1991). First, society provides a vast number of people that someone can turn to for information and consultation when ill. Second, people make decisions through a process of "bounded" rather than "economic" rationality, meaning people consider only the most relevant factors, rather than doing an exhaustive cost-benefit analysis. Third, decision-making is a process that occurs over time and is influenced by the consequences of prior decisions. Fourth, people make decisions about their health care based on interactions with their social networks. Pescosolido (1991) defined a network tie as, "any source contacted during an illness episode. It is through mutual exchange (or lack thereof) that individuals come to attach meaning to their situation and determine appropriate behavior (e.g. seeing a problem as amenable to psychiatric treatment)" (p. 172).

According to Pescosolido, there are five stages that are used to describe the career of an illness. In the first stage, there is *recognition* that a problem exists. An individual then chooses to take on the "sick role." Unless a person identifies with the sick role, there is no assumption about help-seeking. In the illness career there is simply the acknowledgment that the person has rejected the notion of being sick. In the second stage, *utilization*, individuals have acknowledged they are sick and decide to seek out help. Help can be accessed through formal or informal supports. This stage does not assume a single data point; people can simultaneously or sequentially consult with formal and informal supports. The third stage, *initial compliance*, is when people decide to enter formal services. After deciding to enter formal services, the model allows for those who decide to terminate care. Again, the model does not explain why the decision is made at that point; it simply describes the pathway. Stage four is called *outcome*. This

stage describes the results of the medical intervention. Pescosolido suggests four possibilities: The first two result in the termination of the illness career either through (1) recovery (e.g. cessation of the need for services) or (2) death. The last two result in the illness career continuing indefinitely because of (3) permanent disability or (4) chronic illness. The last two lead to stage five, *secondary compliance*. This is the stage where people go back for more help. In stages four and five, people can leave the pathway, regardless of the state of their illness, allowing for decisions to seek informal rather than formal care.

In the NEM, Pescosolido reconceptualizes the illness career in terms of entrances, exits, timing and sequences. This assumes that there are *multiple pathways to care*. As a result, modes of entry into services vary, based on the degree of choice, coercion or muddling through (Pescosolido, Gardner, & Lubell, 1998). This assumption leaves the NEM vulnerable to Ogden's (2003) critique of socio-cognitive models in that it is not empirically testable (although for different reasons). Unlike the SCMs, which tend to over-specify their models, the NEM is underspecified and difficult to operationalize (Stiffman, Pescosolido, & Cabassa, 2004). The NEM also assumes that decisions about service use are made primarily at the community, rather than individual, level, which privileges the meso and macro levels of analysis. With this, the NEM has moved far enough away from the individualistic models that it does a poor job of considering the individual. For example, looking at the model, it is unclear where the individual is and how the individual moves through services.

However, assumptions and limitations aside, two models of youth help-seeking have been derived from the NEM: the Family Network Episode Model (FNEM; Costello, Pescosolido et al., 1998) and the Gateway Provider Model (GPM; Stiffman et al., 2004).

The FNEM shares the conceptual layout of health care utilization with the NEM: (1) There is a social context (or Episode base) that influences the (2) social support system, the (3) illness career, and the (4) treatment system. The major modification to the NEM was to incorporate not only features of the child as the recipient of services but also the family as the entity that access services. The FNEM also acknowledges the role of the school as a major venue for mental health services (Burns et al., 1995). In contrast to adults who use specialized mental health services more frequently, youth receive most mental health services through their primary care physicians and their schools. The “network” metaphor is apt because it recognizes the variety of sources from which youth can access mental health services (primary care, school, specialty mental health clinics, emergency rooms, residential treatment facilities, juvenile justice, child welfare, etc.)

Many of the features used to characterize the patient in the NEM are modified to describe family characteristics in the FNEM. For example, in the NEM, social context includes demographic factors such as age, gender, education, etc. In the FNEM, the demographic factors ask for child age and gender and family race/ethnicity. Parents are acknowledged to have their own educational status that is different from their children. Interestingly, one characteristic that is missing from the FNEM under “treatment symptoms” is the child diagnosis as a proxy for family problems or as the focus of parental psychopathology. One limitation of the FNEM is that there are no empirical studies from which to assess the usefulness of the model.

The second NEM-derived model, the GPM, is not specifically related to maternal or parental help-seeking, but it does suggest why adults are important in the help-seeking process. The GPM takes one piece of Pescosolido’s model and combines it with Glissen’s Organization theory and Decision theory (Stiffman et al., 2004). In the GPM, the role of the adult is essential

in youth help-seeking. The GPM predicts that youth service utilization is directly tied to the knowledge, social agreement and norms that exist within a given community. Specifically, whether a child is referred to mental health services is thought to depend on an adult's ability to identify problems and refer youth to the appropriate mental health services. In other words, youth service access is moderated by adult characteristics (e.g. training, provider type, knowledge of resources and assessment). Adults who can accurately identify the nature of the child's problem and who are knowledgeable about the services available are more likely to connect youth to appropriate services.

The GPM is the only NEM-derived model with any empirical support. In a recent study, Stiffman and colleagues (2006) interviewed 188 gateway providers of American-Indian adolescents ages 12-19 who had received outpatient mental health services the prior year. Seventy providers were informal helpers (e.g. parents or foster parents), one hundred and eleven were professionals, and seven were traditional healers. The authors used a structural equation model to determine how well the GPM fit the data. Results suggested that the model fit the data and accounted for 30% of the variance of service receipt. The implications of the study are that adult knowledge of community resources is essential in reducing the gap between service need and use.

2.3.5 Summary and critique of models on adult and youth mental health help-seeking

The HDM and NEM provided the foundation for current youth help-seeking models. The HDM advanced help-seeking by combining the influencing factors of the SBD with the cognitive components of Gurin et al's stages of help-seeking. The HDM improved on earlier cognitive models by conceptualizing the help-seeking process as occurring over time, accounting for the

chronic nature of many mental health problems. The HDM assumes that people go through specific stages sequentially and identifies specific factors that influence the help-seeking process at each stage. Consequently the model is easier to operationalize than the NEM. As a result the HDM has been used as the basis for most empirical studies of youth mental health help-seeking (Alegria, Canino, Lai et al., 2004; Bussing, Zima, Gary, Mason, Leon et al., 2003; Verhulst & van der Ende, 1997; Zima, Bussing, Yang, & Belin, 2000), although the model itself has not been subject to empirical testing.

There are a number of limitations of stage-process models. As illustrated in Table 1, a review of the literature identified eight stages of help-seeking.

Table 1. Stages of Help-Seeking

Stage	Authors
1. Awareness of problem	2
2. Recognition that problem is MH	1, 2, 3, 4, 5, 6, 7, 8
3. Weighing options	1, 2, 6, 7, 8
4. Cue to Action	1, 6
5. Decision to seek help	1, 2, 3, 4, 5, 6, 7, 8
6. Service selection	1, 2, 4, 5, 8
7. Service utilization	2, 3, 5, 6, 7, 8
8. Continue, change or cease care	3, 6, 8

1. Fischer, Weiner, & Abramowitz, 1983
2. Logan & King, 2001
3. Pescosolido, 1991, 1992; Costello, Pescosolido, Angold et al., 1998
4. Gurin et al (1960); Goldsmith et al (HDM; 1988)
5. Alegria et al (1991); Cauce et al (2002); Eiraldi et al (2006)
6. Rosenstock (HBM; 1966) ^a
7. Azjen (TPB; 1985) ^a
8. Andersen (SBM; 1995) ^a

a. These theories were not developed to explain mental health help-seeking, but have a complementary physical health stage.

Although different models conceptualize the stages differently, there is little research to support the conceptual differences between the stages. For example, it is unclear how stage one

(awareness of a problem), and stage two (recognition that the problem is a mental health problem) are conceptually, temporally, or functionally distinct. Although Gurin and colleagues developed the original three-stage model out of a survey, it is unclear whether the stages reflect the perspective of the people seeking help. For example, although most studies assume that problem identification is the first stage, Arcia et al (Arcia & Fernandez, 2003a) noted that some mothers in her study disagreed that they were seeking help for a problem. The authors also found that for most mothers, the help-seeking process did not follow a series of stages. This critique of stage-process models in part informs Pescosolido's (1991) NEM.

The NEM advanced help-seeking by combining the influencing factors of the SBD with the illness career model. One of the biggest strengths of the NEM is that it allows people to be in different places of help-seeking simultaneously. For example, it is congruent with the NEM for someone to be identifying a problem while accessing services, even though these are considered distinct stages in the HDM. However, the NEM is difficult to operationalize and evaluate (Costello, Pescosolido et al., 1998), although parts of it have been successfully adapted into a testable model (Stiffman et al., 2006; Stiffman et al., 2004).

It is possible that current help-seeking models have limited utility in understanding help-seeking behaviors because most were developed from quantitative studies that imposed conceptual frameworks of the researchers on to the participants. For example, Andersen's SBM focused on structural issues because it was developed "to assist in the analysis of national survey data" that was primarily looking at factors like insurance and transportation (Andersen, 1995, p. 1). Similarly the Gurin et al model developed out of a survey, and the HBM developed out of research on people getting the TB vaccine. It is possible that the current study, which will

identify a model of help-seeking based on mothers' reports, will better reflect the mothers' lived experiences and therefore provide a better understanding of help-seeking.

2.4 EMPIRICAL RESEARCH ON PARENTAL HELP-SEEKING PATHWAYS

In 1993, Rogler and Cortes referred to the help-seeking pathways literature “voluminous and ever-increasing” (p. 554). Much of the research has focused on how adults seek care both in the U.S. (Cabassa & Zayas, 2007) and abroad (Angermeyer, Matschinger, & Riedel-Heller, 1999; Cabassa & Zayas, 2007; Gasquet, Chavance, Ledoux, & Choquet, 1997). A smaller and more recent set of research has looked at the ways in which adolescents seek care (Boldero & Fallon, 1995; Buston, 2002; Gasquet et al., 1997; Israelashvili, 1999; Kuhl, Jarkon-Horlick, & Morrissey, 1997; Lindsey et al., 2006; Murray, 2005; Rickwood, Deane, Wilson, & Ciarrochi, 2005). A still smaller set of research has looked at how parents seek care for children (Arcia, Fernandez, Jaquez, Castillo, & Ruiz, 2004; Bussing, Zima, Gary, & Garvan, 2003). A brief review of empirical studies on parental help-seeking will provide further context for the current study.

Researchers have used quantitative and qualitative methods to investigate parental help-seeking for children with mental health problems. Quantitative studies have either sought to clarify how certain variables influences parents' decisions at certain stages of help-seeking (Logan & King, 2001), or have tested entire models of help-seeking (Verhulst & van der Ende, 1997; Zwaanswijk, van der Ende, Verhaak, Bensing, & Verhulst, 2005). Qualitative studies have investigated issues such as problem recognition and modes of entry (Arcia & Fernandez, 2003a; Arcia et al., 2004), barriers and facilitators (Boydell et al., 2006), maternal explanatory models

(Wilcox et al., 2007), and the effects of the help-seeking process on problem conceptualization (Czuchta & McCay, 2001).

The first phase of help-seeking has long been assumed to be the recognition of a problem. Recent qualitative research has explored the issue of problem identification and recognition in the parental help-seeking process. Problem identification appears to be important because, when parents are unsure of the meaning of a child's symptoms, it takes them longer to identify the behaviors as problematic and therefore they delay treatment (Arcia & Fernandez, 2003a; Czuchta & McCay, 2001). However, schools appear to be important in speeding up the process of identifying a behavior as a problem. Quantitative and qualitative studies have found that parents are more likely to identify a problem when they receive school reports of problematic behavior (Arcia & Fernandez, 2003b; Sayal et al., 2003; Wilcox et al., 2007). One study suggested that, for some mothers, schools facilitated problem recognition and service use, but for others, interactions with school staff were discouraging and were described as barriers to treatment (Arcia et al., 2004).

However, parental help-seeking research has suggested that the concept of problem identification does not fit all consumers (Arcia & Fernandez, 2003a). Arcia and colleagues noted that eleven (18%) of the 62 mothers never labeled their child's behaviors as a problem. For those mothers, it appeared that the label indicated a more serious problem than the behaviors warranted in their eyes. "Thus, mothers who pursued assistance without problem labeling were doing so in order to prevent their children's behavior from becoming a problem" (Arcia & Fernandez, 2003a, p. 170). The authors noted that caregiver burden, social networks, and school input were all significant factors in the development of concern. The authors suggested that the concept of 'saturation point' rather than 'problem identification' better described the experience of these

mothers. This calls into question the assumption made by most research on help-seeking that problem identification is a required first step in the help-seeking process. This study also identified the process mothers went through to cross the threshold from awareness to concern.

Studies have also found that, even when parents identify behaviors as problematic, their definition of “problem” is different than clinical definitions (Arcia & Fernandez, 2003b). For example, in a recent study of children with disruptive disorder, Arcia and Fernandez found that, despite having a child with the same diagnosis as another, the mothers differed substantially on the symptoms they found burdensome. These studies point to the challenge for families and clinicians to agree on what problem to address during treatment. It also suggests that pathways to care may be convoluted in part because parents might experience burdensome symptoms that are not part of the same diagnosis. While these mothers would see the problems as the same, clinicians would recognize two different diagnoses and might identify two different treatments.

Research on help-seeking has challenged the idea that people enter services the same way. Traditional help-seeking models assume that people chose to enter services, and they do not account for, nor do they consider the effects of treatment on, multiple ways of entering services. For example, a client who enters services by choice will have a very different set of expectations of treatment than a client who enters through coercion (Pescosolido et al., 1998). Research by Arcia and colleagues (Arcia, Fernandez, Jaquez et al., 2004) found that mothers of young children with disruptive behaviors entered into services in one of four ways: coercion, accepting a referral, choice, and taking a convoluted path (similar to Pescosolido’s “muddling through” category). The authors concluded that the cognitive bias in traditional stage-process models obfuscated the affective component of help-seeking. Although the Arcia and colleagues study

did not result in model development, their study provided a critique of existing linear help-seeking models and called into question the “required” first stage: problem recognition.

Parents’ causal attributions and explanatory models appear to influence their help-seeking behaviors. A recent study by Wilcox et al (2007) found that parental causal attributions correlated with help-seeking. For example, when parents attributed the cause to academic problems, they consulted school personnel. Parents who contacted professionals were provided with more medically-based explanatory models, whereas parents who contacted friends reported explanatory models such as, “it's just boys.” As a result of help-seeking, parents saw their child's behavior as less volitional, blamed themselves less, adopted new strategies to deal with their child's behavior, and changed their perceptions of the future. Therefore, a greater understanding of the parental help-seeking process will benefit not only the child but the parents as well.

2.5 SUMMARY OF FINDINGS FROM THE EMPIRICAL LITERATURE

There continue to be questions about how well existing models explain or describe the help-seeking pathways of parents who seek mental health services for their children. While quantitative studies have provided empirical evidence to support the correlation between factors and stages of help-seeking, qualitative studies have provided insight into the complex process of help-seeking, at times challenging the fit and relevance of linear help-seeking models.

Research on help-seeking has produced conflicting findings about the role of problem identification in help-seeking. While some research has supported the idea that parents need to identify a problem prior to accessing services, other studies have suggested that problem recognition is not the first stage, nor is it even a requirement for accessing mental health services.

Thus, it appears that the current study could contribute to the literature by identifying what behaviors concerned mothers and if they identified a problem prior to accessing services.

Help-seeking research has suggested that there might be racial differences in coping with a child's problem prior to accessing mental health services. Because the current study is 55% white mothers and 45% African American mothers and therefore might provide insight into whether or not there are differences by race in the help-seeking process. By looking at mothers' descriptions of their coping strategies, we might gain valuable information about the types of resources parents have outside of formal mental health services to address the child's behaviors.

Another area of contention in the help-seeking literature is around the idea that there can be multiple ways of entering services. Help-seeking models such as the HDM, and empirical studies such as the one by Verhulst and van der Ende (1997) suggest that people enter services by choice. Yet research by Pescosolido and colleagues (1998) and Arcia and colleagues (2004) have suggested that there are multiple ways to enter services. It is unclear if the mode of entry influence service use or expectations of services. How does a mother's reason for seeking services influence her help-seeking pathway? Answers to these questions would improve our understanding of help-seeking and consequently improve the services we provide to children and their families.

Despite the growing body of information on factors that influence caregiver's decisions to use mental health services for their children (Alegria et al., 2004), there continues to be limited understanding about the *experience of mothers* who access mental health services for their children. Researchers have called for more qualitative research to "unpack" the relationships between influences on help-seeking and the process of help-seeking (Alegria et al., 2004; Mowbray et al., 2004), only one study has explored maternal help-seeking in the United

States (Arcia & Fernandez, 2003a, 2003b; Arcia et al., 2004). That study looked at Latina moms with children with disruptive disorders. Another limitation of existing research is that service utilization is the *de facto* end of the help-seeking pathway, even though models of help-seeking have long assumed that people have moved in and out of formal services (Alegria et al., 1991; Farmer et al., 2003; Pescosolido, 1991; Rogler & Cortes, 1993). Therefore, we have very little information on how the using services influences the help-seeking process.

A final limitation of existing research is that it has overwhelmingly evaluated help-seeking on a stage-process model that hypothesizes three basic stages that people go through prior to using services. In contrast, research by Pescosolido, Gardner, and Lubell (1998), and Arcia, Fernandez, Jaquez et al (2004) suggested that less than half of help-seekers followed recognizable stages to care. Because questions remain about how children get to mental health services, scholars have called for continued research in this area. “Additional qualitative research is needed to assess the process whereby these high-risk children come to educational or mental health services. We need to find out from mothers themselves, through semi-structured and probative interviews, what is it that causes their children to be in services....” (Mowbray, Lewandowski, Bybee et al., 2004, p. 181). Mowbray and colleagues suggested that hypotheses generated from qualitative research should be the basis for future studies of children’s mental health service use. The current study will answer that call by exploring the experience of mothers with mental health problems who sought mental health services for their children.

2.6 RESEARCH QUESTION

Cauce and colleagues (2002), commenting on the paucity of research on the process of help-seeking noted, “The sparseness of work in this area is so great that no single direction for future research is necessarily more compelling than another direction” (p. 51). In light of existing limitations of models of maternal help-seeking for distressed youth, the purpose of the current study was to characterize and describe the perceptions and experiences of mothers who sought mental health services for their children. The research question was: What factors influenced the mothers’ help-seeking?

3.0 METHODS

This chapter focuses on the research design and methods used in this study. Because the study involved a secondary analysis of qualitative data using grounded theory analysis, I first present the theoretical framework (grounded theory method), and then define qualitative secondary analysis (QSA) and discuss its fit with traditional grounded theory method. I then explain the study methods, including the sample selection criteria and sample description. Then I describe the data analysis method, including the use of Atlas.ti, a qualitative data analysis software program, and finally conclude the chapter with the methodological challenges and limitations of the study.

3.1 GROUNDED THEORY METHOD

The choice of research methodologies is typically based on the purpose of the investigation and the nature of the research question (Morse & Field, 1995). Within the qualitative paradigm, the choice of research methodology may also be influenced by the participants in the study, the sites of the data collection, the expertise and preferences of the investigator, and the investigator's experience with the subject matter.

My goal was to describe and characterize the help-seeking experiences and perspectives of mothers who accessed mental health services for their children. Consequently I used

qualitative inquiry, which is well suited for answering questions about people's lived experiences (Morse & Field, 1995). Specifically, I chose elements of grounded theory method because it is designed to both build new and critique existing models (Corbin & Strauss, 2008), and the existing models of help-seeking have been criticized as being insufficient to explain the process that parents go through to seek help for their children (Costello, Pescosolido, Angold et al., 1998; Stiffman, Pescosolido, & Cabassa, 2004).

Grounded theory method is used to develop theory from data (Strauss & Corbin, 1998). It is an inductive technique that allows for exploration and description. Grounded theory method does not test *a priori* hypotheses, but rather poses general questions of the data which are refined and developed into a coherent model that can explain relevant variations in an experience (Sandelowski & Barroso, 2003b). This method typically involves the simultaneous collection and analysis of data (Strauss & Corbin, 1998). There has been much discussion and controversy around the defining nature of grounded theory analysis (Charmaz, 2006; Corbin & Strauss, 2008; Glasser & Strauss, 1967; Strauss & Corbin, 1998), but all authors do agree that the approach requires constructing explanations and theoretical formulations based on data, not preconceived notions. Grounded theory method, like ethnomethodology, transforms data into a “fully integrated explanation of some phenomenon, case or event” (Sandelowski & Barroso, 2003a, p. 914). This study is rooted in that approach. Grounded theory method was used to describe the experience of this particular group of mothers. Consistent with grounded theory analysis, this study (1) constructed analytic codes based on what emerged from iterative engagement with the data, not preconceived notions; and (2) used the constant comparative method to organize those codes into themes (Charmaz, 2006; Guba & Lincoln, 1994; Strauss & Corbin, 1998).

As mentioned previously, grounded theory method typically involves the simultaneous collection and analysis of data. However, because this study was designed as a secondary analysis, the simultaneity was precluded. Yet, these data could be analyzed using Charmaz's (2006) guidelines for grounded theory analysis to construct a model that fits with, and is relevant to, the help-seeking experiences of mothers.

Because qualitative secondary analysis (QSA) is emerging as a legitimate approach to qualitative research (Gladstone, Volpe, & Boydell, 2007), the next section defines QSA and provides a rationale for its use for the current study. In order to maintain methodological clarity (Drisko, 2005), the section also discusses what makes this data set appropriate for QSA, why QSA is compatible with grounded theory method, and how performing QSA on this data set has the potential to strengthen the trustworthiness of the grounded theory analysis.

3.2 QUALITATIVE SECONDARY ANALYSIS

Qualitative secondary analysis (QSA) is similar to the secondary analysis of quantitative data in that new questions are asked of existing data and different analytic strategies are developed (Heaton, 2004). According to Heaton (2004), in the past decade, the governments in Britain and Australia have encouraged the secondary analysis of existing large-scale qualitative studies. Heaton noted that QSA is rarely discussed in American research and she speculates that it is because there is no government initiative to encourage QSA. In QSA, the study that involved the initial data collection is referred to as the "original study" and the QSA is referred to as the "current" study (Gladstone et al., 2007).

The small and recent literature on QSA argues that there are two criteria for an effective QSA: (1) the original context is known and understood, and (2) the current research question arose from and fits with the original data (Gladstone, Volpe, & Boydell, 2007). The first criterion is fulfilled in the current study by understanding where the data were collected, by whom and for what purpose; how the participants were recruited; and how the participants understood the purpose of the original study. Understanding the context of the original study reduces the chance of developing a theory that might be elegant, but would not expand or deepen our understanding of the participants. Furthermore, the data are appropriate for QSA because I have access to information about the original study, both from publications and through interactions with members of the original study research team. The second criterion is fulfilled in the current study because my study question arose from the original data and also fits the intent of the original researchers. Although the goal of the original study was to develop a richer understanding of mothers' views of mental health services for themselves (Anderson, Robins, Greeno, Cahalane, Copeland et al., 2006), the original analysis suggested that addressing their children's problems was their primary concern. Therefore, the current study's exploration of mothers' experiences of help-seeking for their children is consistent with the goals of the original study.

Although there are challenges associated with QSA, there are a number of benefits worth mentioning. First, the original study provided a unique opportunity to explore the experiences of mothers who sought help for their children, while the secondary analysis of the same dataset examined both the experiences *and perceptions* of mothers who sought help for their children. The original study gathered the data, but the secondary analysis enabled me to systematically place those stories into a context that could result in further knowledge building and improve

services for these mothers. The secondary analysis provided a new perspective on the experiences of those mothers.

Additionally, using QSA in conjunction with grounded theory method addresses some of the criticisms of grounded theory analysis. One such criticism is that the intent to “let the data speak” often falls short of expectations (Charmaz, 2006). Charmaz (2006) suggested that research findings are often predictable and tend to reflect the perspective of the researcher due to researcher bias in data collection and analysis. The current study addresses these concerns because the data set is large, the sample is very relevant and appropriate, and there was no particular incentive on the part of either the researchers or the participants to hold a particular point of view for the main study questions, or for the current study question. As a result, the mothers’ responses reflect aspects of help-seeking that they deemed important to discuss.

The next section summarizes the original collection method of the data used in the current study, as well as the method I used to select the data subset for the current study. The complete description of the original study methods and the results from the original qualitative analysis can be found in Anderson et al (2006).

3.3 SAMPLE SELECTION CRITERIA

The sample comprises mothers who brought their children in for mental health services at one of four community mental health clinics: two in urban areas and two in semirural communities. Mothers were eligible for baseline assessment if they: 1) agreed to participate in the evaluation plus three follow-ups and a review of their clinical records, 2) had a 6-17 year old child referred for evaluation, 3) were older than 17, and 4) lived with the child referred for evaluation. Mothers

were excluded if: 1) their child had a diagnosis of a psychotic disorder, because the child would need to complete self-report forms, 2) they did not have custody of or live with their child, 3) they were seeking solely mental retardation services for their child, 4) their child required inpatient hospitalization and would therefore not receive outpatient services, 5) the mother was suicidal, homicidal, or required hospitalization – i.e. if their immediate treatment needs would make it unethical and impractical to gather the required data for the study, or 6) if the mother was at serious risk for child abuse or neglect and required intervention.

Five hundred and twenty six mothers were asked by their child's clinician if they would be interested in being approached by a research staff member to participate in a study that would involve the assessment and follow-up of their own mental health. Three-hundred and seventy-one mothers agreed to participate in the baseline assessment. These mothers were screened using the Patient Health Questionnaire (PHQ, the mood/anxiety disorders screen from the Prime the MD; Spitzer, Kroenke, & Williams, 1999), and the Beck Depression and Anxiety Inventories (BDI and BAI, respectively; Beck, 1978; Beck, Epstein, Brown, & Steer, 1988). Because the original study was interested in identifying distress rather than severity or specific diagnosis, the threshold for triggering a referral was relatively low (a score of 10 and above on the BDI and BAI, or a positive score on any of the depression or anxiety scales of the PHQ). The University of Pittsburgh Institutional Review Board approved the study. Of the 371 mothers who were screened, 271 (73%) met criteria for anxiety or depressive disorders and were referred for services by a member of the study team (Anderson, Robins, Greeno et al., 2006). The 271 mothers who met criteria for an anxiety or depressive disorder were eligible to be interviewed. Of those, 127 mothers were asked to be interviewed in their homes three months later. The original study investigators interviewed mothers until they believed they had enough data to

answer the research question. In an effort to ensure that African American women's voices were heard, the original study purposely oversampled African American mothers by continuing to recruit them after general recruitment was closed. Using this strategy, 50 (40%) of the original study sample of 127 interviewees self-identified as African American.

Three months after the screening, members of the original study team contacted the referred mothers for follow-up procedures that included in-depth interviews. After receiving permission from the participants, one semi-structured at-home interview was conducted by members of the original research team. Interviews were audio taped and transcribed for team review and analysis. Participants were reimbursed \$75 for their time after the interview was completed. The interviewers used a protocol ([See Appendix A](#)) that first asked the mothers about what led them to the clinic to seek treatment for their child three months prior. There were four probes that gathered more information about the child and five probes that gathered more information about the mother. After the initial question, mothers were asked about their experience of being told that they might be depressed or anxious, their social networks, and the experience of mothers who are trying to work through difficulties with their children. The interview ended with an invitation for the mothers to discuss anything that the interviewers did not ask, but which the mothers thought would be important to share.

The current study is an analysis of a random sample of 60 of the 127 interviews in the original study. The following process was used to randomly select 60 interviews: First, I assigned consecutive numbers (1 through 127) to each of the 127 interviews. Next, I used an online random number generator (<http://www.random.org>) to generate a set of randomized non-repeating numbers ranging from 1 to 127. To ensure that the interviews would contain the necessary data for analysis, I reviewed the 127 transcripts for missing data (e.g. excessive

instances of responses coded as “inaudible,” or partial interviews resulting from tape recorder error or poor recording quality). I then selected the first sixty randomized numbers and paired them with the corresponding interview. After the interviews were selected, I analyzed the demographics and relevant information from the original study database for the sample description.

3.4 SAMPLE DESCRIPTION

As presented in Table 2, the mothers interviewed for this study were ethnically diverse (45% African American, 55% White) and had an average age of 37.8. Forty-seven percent were married or living with a partner; 50% were working full- or part-time, averaging 40.4 hours per week. Fifty-seven percent were living on a household income under \$15,000 while supporting a mean of 2.5 children under the age of 18. Eighty-eight percent had a high school education or greater. Fifty-nine of the mothers were biological and one was an adoptive mother. The average age of the child receiving services was 11.7. An equal number of boys and girls are represented in this sample.

Table 2. Sample Characteristics

Category	n	(%)
Race		
Black	27	(45)
White	33	(55)
Average Age	37.7	
Married or living with partner	28	(46.7)
Working full- or part-time	30	(50)
Average hours worked / week	40.4	
Household income		
Less than \$5,000	5	(8.3)
\$5,001 to \$10,000	19	(31.7)

\$10,001 to \$15,000	10	(16.7)
\$15,001 to \$20,000	5	(8.3)
\$20,001 to \$30,000	11	(18.3)
\$30,001 to \$40,000	3	(5.0)
\$40,001 to \$50,000	2	(3.3)
\$50,001 to \$75,000	3	(5.0)
More than \$75,000	2	(3.3)
Education		
Did not complete high school	7	(11.7)
High school or GED	17	(28.3)
Some college, no degree	10	(16.7)
Associate's degree	10	(16.7)
Completed occupational or voc program	13	(21.7)
College graduate	2	(3.3)
Post-graduate	1	(1.7)
Average number of children	2.5	
Child receiving services		
Average age	11.7	
Female	30	(50)
Male	30	(50)

3.5 DATA ANALYSIS

In the current study, I analyzed sixty interviews in their entirety to better understand how and why these mothers brought their children to mental health services. My analysis adhered to the analytical approach outlined by Charmaz (2006).

According to Charmaz, grounded theory analysis requires the researcher to be immersed in the data to develop a complete familiarity with the patterns and themes. Immersion starts with the first interview and continues through theory development. In order to immerse myself in the data, I read and re-read the interviews to identify and index themes and categories (Pope, Ziebland, & Mays, 2000). Charmaz identified two components of grounded theory analysis. The first component is *coding*. The goal of coding is to “remain open to all possible theoretical

directions indicated by [the] readings of the data” (Charmaz, 2006, p. 46). The second component is *memo-writing*. Memo writing is a tool that allows the researcher to reflect on the analytical categories found in the data so that codes can be organized into themes and ultimately a coherent model (Charmaz, 2006).

Throughout my analysis, I used a software program called Atlas.ti to help me organize my codes and memos. I chose Atlas.ti over other similar programs because it was used to code the data in the original study and continues to be used for on-going analysis.

Unlike statistical software (e.g. SPSS, SAS, and STATA) that performs mathematical calculations and statistical analyses, Atlas.ti does not perform data analysis; it is strictly an organizational tool. This is because, while computers are well-suited for performing complex calculations that are subject to well-defined rules, humans are better-suited for understanding complex patterns of social situations for which the rules are often ill-defined (at least until the analysis is completed). For example, if the rapid closing of an eyelid was always a twitch, then Atlas.ti could be used to “analyze” twitches. However, as Geertz (1973) noted, the rapid closing of an eyelid is sometimes a twitch and sometimes a wink, and these two behaviors have different social significance; differences that software programs cannot discern. Hence, I used Atlas.ti to help me organize the elements of my analysis, rather than expecting Atlas.ti to perform the analysis for me (Corbin & Strauss, 2008).

The following sections describe in detail my implementation of Charmaz’s analytical approach and my use of Atlas.ti in the process.

3.5.1 Coding

Charmaz (2006) identified three levels of coding in grounded theory: open, focused and theoretical. Although conceptually distinct, the three levels of coding can occur simultaneously. Corbin and Strauss (2008) commented that “though we break data apart, and identify concepts to stand for the data, we also have to put it back together again by relating those concepts. As analysts work with data, their minds automatically make connections because, after all, the connections come from the data” (p. 198). In order to clearly explain how I analyzed the data, I will describe the three levels separately.

3.5.1.1 Open Coding

Open coding includes identifying, naming, categorizing and describing what is found in the text. The purpose of open coding is to identify and define what is found in the data. Charmaz (2006) recommended Glaser’s approach to coding “with words that reflect action” (p. 48). Specifically, she recommended coding with gerunds; nouns ending in “ing” suggest process, action and sequence. During open coding I followed Charmaz’s recommendation to use simple and precise action words to describe what I saw in the interview. For example, I used the code “prior coping” to capture mothers’ descriptions of her attempts to address her child’s problems. Charmaz also recommended using *in vivo coding*, in which participants' words are used as the categories. The benefit of using the participants words (also referred to as “emic”) is that coding is anchored in the participants’ world and subsequent analyses will be grounded in the data. One example of an emic code was the use of the word “mouthy” to describe a child’s behavior. “Mouthy” is not a term that appears in the literature, but I used it as a code because the term was used by a number of mothers and clearly represented their experience. Since the code arose from

the mothers' descriptions, it transparently captured mothers' experiences. Charmaz noted, however, that "etic" codes, such as those that reflect concepts found in the literature, are consistent with grounded theory analysis, as long as the concepts arose from the data rather than being imposed on the data. One example of an etic code is "relieving burden." Research on help-seeking suggests that a parent's decision to access mental health services is influenced by the amount of burden they feel. Even though mothers did not use the term "relieving burden" in their interviews, the term reflects the mothers' experiences.

During open coding, the unit of analysis can be words, lines or longer segments of text. Data can be analyzed word-by-word, line-by-line, or incident-by-incident (also called segment-by-segment; Charmaz, 2006). Incidents (or segments) are series of lines that are on the same topic, e.g. a paragraph in which a mother answers a specific question. Although there are benefits to each type of coding, Charmaz noted that incident-by-incident coding is appropriate when the researcher did not interact with the participant and therefore has only a basic context for the interview. Because I neither interacted with nor interviewed the participants, I used incident-by-incident coding. I developed categories by comparing one incident to another. This process is known as the *constant comparison method* (Glasser & Strauss, 1967). Constant comparison is an analytical tool that is used to sort, compare and contrast codes until saturation is reached. According to Glasser and Strauss, saturation occurs when

... no additional data are being found whereby the (researcher) can develop properties of the category. As he sees similar instances over and over again, the researcher becomes empirically confident that a category is saturated ... when one category is saturated, nothing remains but to go on to new groups for data on other categories, and attempt to saturate these categories also. (1967, p. 65.)

The constant comparison method is a way of making sure that the nuances of the data are reflected in the codes (Charmaz, 2006).

Consistent with Charmaz's (2006) recommendations for grounded analysis, I read the interviews multiple times and developed initial codes using incident-by-incident coding. In the early stages of developing codes, I enlisted the help of two researchers, one who was part of the original interview team, and another who was doing qualitative analysis on a related project, to read interviews and identified themes. We discussed the themes and talked about how to code them. We used the constant comparative method to look for themes and pattern.

3.5.1.2 Focused Coding

After assigning codes to the unit of analysis (e.g. incident-by-incident), I grouped the codes into categories, which Charmaz (2006) calls *focused coding*. During this process, I evaluated the analytic value of the codes and identified which codes most accurately and completely described a process or experience. I then grouped those codes into categories that explained larger segments of data. Strauss and Corbin (1998) suggested that categories can be developed by either (1) looking at each code and determining what phenomena it seems to be associated with, or (2) thinking about all of the codes and deciding what they seem to be about. For example, a number of codes might suggest the etic category "coping strategies." Categories have *dimensions* and *properties* that derive from the data (Corbin & Strauss, 2008). The category "coping strategies" can describe as dimensional, ranging from fewer to more, and can have properties such as formal, informal, helpful, solution-making, problem-making, etc.

I coded the sixty interviews in Atlas.ti. Once the interviews were coded in Atlas.ti, I ran reports on the codes, the associated excerpts, and any memos (explained in Section 3.5.2) associated with the excerpts or codes. I imported the reports into Excel and created a spreadsheet

for each code. The spreadsheet made it possible to review the large number of excerpts and employ the constant comparative method. For example, there were 136 quotations under the code “concerning behaviors.” In order to compare the excerpts and clarify themes and identify patterns, I created a spreadsheet with 136 rows and multiple columns. The first column was the interview number. The second column was the excerpt. I read the excerpts and assigned a code for each sub-theme. For example, a number of mothers reported that their child was always upset and crying. I assigned these excerpts the code “mood: crying,” which I had identified during the first round of coding. I then used the sort function in the spreadsheet to sort by the sub-code. I used the constant comparative method to look at the excerpts in each sub-code to see if they seemed to reflect the same thing. I then compared the sub-themes to see if any could be merged into a larger theme. For example I noted that a number of excerpts included the phrase “abnormal.” The pattern of “abnormal” was not apparent until all of the excerpts were lined up together and I was able to compare the content. I concluded that mothers were concerned about these behaviors because they saw them as “abnormal.”

Once the codes and focused codes were finalized, I created a codebook, which I sent to two independent reviewers – research colleagues with experience in qualitative analysis. I asked them to randomly select five uncoded interviews and code them using the codebook. I reviewed their coded interviews and compared them with the interviews I coded. There was little variation in the coding of the text. For example, the independent reviewers and I were in agreement about which text was reflected the code “concerning behaviors.” These reviews suggested that the codes were reflective of the data in the interviews.

3.5.1.3 Theoretical Coding

The third level of coding is called *theoretical coding*. The purpose of theoretical coding is to synthesize focused codes into a coherent whole (Charmaz, 2006). Without this step, the study becomes a set of categories without internal relations (Gustavsson, 2007), similar to much of the atheoretical research currently available on help-seeking (Logan & King, 2002). After the data were broken down into open codes and then categorized in focused coding, I engaged in theoretical coding. The current study identified a four stage model of help-seeking that appeared to fit mothers' experiences. According to Charmaz (2006) the resultant conceptual model is evaluated according to *fit* and *relevance*. Fit refers to the extent to which the codes and categories reflect participants' experiences. Relevance refers to the extent to which the grounded theory (1) provides insight into the relationship between actions and processes, (2) makes the invisible visible, and (3) develops understanding of the participants' processes. The resultant model, or models, needs to fit the experiences of the mothers, as well as provide some insight into their experiences.

3.5.2 Memo-writing

According to Charmaz (2006), memo-writing is the process by which researchers analyze ideas about codes. Memos are informal notes meant for personal use and are written quickly without editing. Charmaz noted that spontaneous memo-writing helps the researcher to develop and preserve his or her natural voice.

I used memo-writing regularly during my analysis. Consistent with Charmaz's descriptions, memo-writing allowed me to stop and think about the data; to identify how codes might relate to each other under the same category; to discover gaps in the analysis; to maintain a

stance of exploration about the data; and to avoid forcing the data into extant concepts and theories. The memo in Table 3 is an example of how I used memos during the coding process. In this unedited memo from September 8, 2008, I'm thinking through how to code a specific excerpt:

Table 3. Example Memo

This paragraph is very confusing: in the first half, mom reports not believing what the school is saying about her daughter's problems. Finally, when she's about to get dragged to court she makes an appointment. This seems to be "pressure from others" (school, courts). But in the next sentence she says that she made an appointment because SHE felt like something was wrong with the kid, and goes on to list a whole bunch of concerning behaviors. This seems to be "mom's choice." Later in the paragraph, mom talks about how the school was exacerbating the problem and wouldn't listen to mom's input about why CL. was behaving poorly. Finally, mom says "They want her to come home and she's suspended. So I said I can't deal with no more. I needed to get some help." It seems like what she wants help with is dealing with school, but the way she's going about dealing with the school is addressing her daughter's behaviors. She goes on to say that her daughter's behaviors improved when she was switched to a different classroom, and started again when she was switched back. So, perhaps mom feels like she cannot "fix" the school, so she'll try to "fix" her daughter.

The answer, although far from clear, seems to be that MH services was more mom's choice than pressure because she identified that her daughter was having problems, but also because she was trying to get her daughter's school off her back. This story is different from the other "pressure" stories because mom reported wanting service for her child.

Writing this memo helped me to both clarify the properties of the code, and the meaning of the mothers' story.

3.5.3 Establishing Trustworthiness

Trustworthiness refers to the extent to which findings from qualitative research are believable (Glasser & Strauss, 1967). Qualitative secondary analyses have to address the issue of trustworthiness with regards to the original data collection and the analysis of the current study.

To increase the trustworthiness of responses in the original study, attempts were made to racially match interviewers with the participants. This is because research has shown that African American participants are likely to vary their responses based on the race (White or Black) of the interviewer (Boland-Perez, Cobb, & Lebaron, 2008). The interviewers were nine African American and White women whose educational attainment ranged from bachelors to Ph.D., who had prior experience interacting with the mental health system, and who demonstrated strong interpersonal skills (e.g. active listening and empathy). The interviewers also attended two-day training on ethnographic interviewing.

Trustworthiness of the secondary analysis was established using four techniques: (1) independent coding; (2) employing an auditor; (3) theoretical triangulation; (4) thick description. *Independent coders* are part of a systematic process by which the analytic codes are vetted (Barbour, 2001). More important than having multiple coders agree on a code, however, is the process of discussing possible alternate interpretations of the text. For example, during the discussions with the independent coders mentioned earlier, we discussed alternate interpretation of texts. This process alerted me to potentially competing explanations that I might otherwise have missed.

Auditors ensure trustworthiness by verifying that the process I used to analyze the data was systematic. Dr. Catherine Greeno, a principal investigator on the original study, and Dr. Sue Estroff, an outside expert in qualitative research, served as the auditors.

Theoretical triangulation is the process of evaluating the resultant model against existing models. A number of models have been developed to explain help-seeking behaviors. As noted in chapter 2, these models make certain assumptions about the process of help-seeking. I

compared the results of the current study with existing models as a way of adding credibility to the analysis.

Thick description is analysis that leads to the understanding of meaning (Geertz, 1973). Geertz suggested that one way to get at thick description is to ask "what is important about this?" In the context of the current study, when a mother says that she accessed mental health services because the school recommended it, thin description would be the statement "mother made an appointment." In contrast, thick description provides a construction of the mother's perception of why it is important to make an appointment. Thick description requires understanding the context of the mother's actions and what they mean to her, her child, the school, her social environment, the agency, etc. It represents the diversity of experiences and perspectives of the participant (Charmaz, 2006). Writing about the meaning of maternal help-seeking provides evidence of understanding the context in which the mothers made their statements. Accurately describing the context makes the analysis more trustworthy.

The use of these four techniques helped ensure that the analysis met the criteria for fit and relevance as discussed above. According to Mays and Pope (1995), auditing and independent coding are two techniques that improve the reliability of the analysis, and theoretical triangulation and thick description improve the validity of the analysis.

3.5.4 Theoretical sensitivity

Theoretical sensitivity is defined as "The ability to recognize what is important and to give it meaning" (Strauss & Corbin, 1990, p. 46). Quantitative researchers are concerned with the sensitivity of their instruments. In qualitative research, the researcher is the instrument (Mays & Pope, 1995). Therefore, theoretical sensitivity refers to the competence, procedures and

perspectives of the researcher. Theoretical sensitivity can be developed through familiarity with existing research, personal and professional experiences, and through the data.

Writing the literature review helped me to become familiar with existing research. Although I have never had experience seeking mental health services for a child, my professional experience prior to graduate school was that of a provider of mental health services for children and their families. For 10 years I worked with children whose parents sought community mental health services for them. I am familiar with this population and have a professional interest in developing a deeper understanding of their experience. As a clinical social worker I analyzed and interpreted the words of mothers and their children in therapy sessions and as part of regular chart review. During the analysis of the interviews in the current study, I found that my clinical experience provided some insight that helped me better understand mothers' experiences. For example, some of the mothers described frustrations with therapists who played with their child, as opposed to talking with him/her about the problems. As a clinical social worker, I know that a standard approach to working with children is play therapy; the assumption is that children communicate primarily through play, and therefore the social work maxim of "starting where the client is" can be achieved by playing rather than talking. This perspective allowed me to think critically about the mothers' concerns and identify some implications for treatment that might help clinicians assess mothers' expectations for treatments, and better explain the therapeutic approach to mothers. At the same time, I had to be aware of my tendencies to think of experiences in professional terms. For example, I found that I was using the short-hand "ADHD," which is the acronym for the DSM-IV diagnosis, Attention-Deficit/Hyperactivity Disorder, whenever mothers were describing a child who was having difficulty sitting still, daydreaming, or doing something that was a symptom of ADHD. I realized that my clinical

training was interfering with my ability to represent the mothers' experiences from their viewpoint. I was able to review my codes and re-analyze the excerpts to make sure I was taking an emic rather than etic perspective during the coding process. Thus, my clinical experience was both an advantage and a disadvantage in this analysis.

3.6 METHODOLOGICAL CHALLENGES AND LIMITATIONS OF THE STUDY

Although the purpose of grounded theory analysis is to develop models that can help explain experiences, specifically the processes that people go through (Field and Morse, 1995), an inherent limitation is that grounded theories are not generalizable beyond the sample until further testing with a more representative sample can be completed.

Because the theory will be developed without interacting with the original participants, there is no way to get feedback from them about the fit and relevance of the analysis (called "member checking"). Although this is an important form of establishing trustworthiness in traditional grounded theory method, I have discussed four other techniques that I used to ensure the believability of the analysis. Additionally, I had my analysis evaluated by a member of the original research team.

3.7 SUMMARY

This chapter reviewed the methodology of the study. The major points included: 1) A description of and rationale for using grounded theory analysis; 2) A description of qualitative

secondary analysis; 3) a discussion of the fit between grounded theory and secondary analysis; 4) A description of the original study methods and my data analysis approach; 5) A brief description of methodological challenges and limitations of the study.

4.0 RESULTS

This chapter presents the results of a grounded theory analysis of sixty mothers' descriptions of seeking help for their child. The goal of the analysis was to describe and characterize the experiences and perspectives of mothers who accessed mental health services for their child. The purpose of the analysis is to better understand how and why mothers seek help for their children.

As illustrated in Figure 8, the sixty narratives reflected a basic common pathway to mental health services: recognizing a problem, responding to the problem, accessing mental health services, and evaluating the current mental health services (MHS). The narratives suggested that within each of the basic stages some factors were more salient for some mothers than others in their pathway to mental health services.

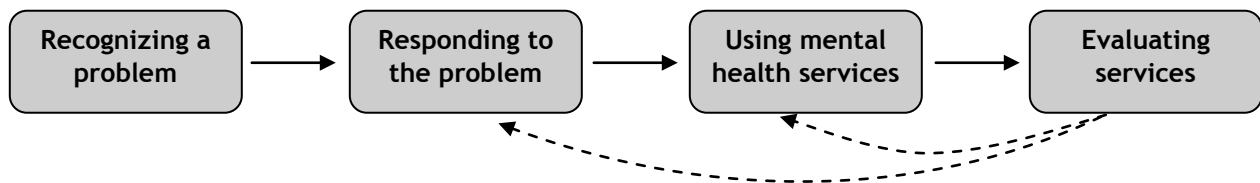


Figure 8. The four stages of the help-seeking pathway

4.1 RECOGNIZING A PROBLEM

Narratives in this study suggested that in the first stage, mothers became concerned about behaviors, and tried to understand the cause(s) of the behavior(s). Mothers described: 1) the

characteristics of the specific behavior, including the severity, frequency and duration of the behavior; 2) whether the behaviors occurred at home or at school; and 3) subjective norms. These three factors influenced mothers' degree of concern, which ranged from no concern about their child's behavior, to concern but uncertainty about the problem, to belief that their child had a mental health problem.

4.1.1 Becoming concerned

Interviews started with mothers answering the question “what led you to come to the clinic three months prior, including what difficulties you were having with your child.” Mothers described their child's behaviors and identified what factors influenced their concern about these behaviors. As reported in Table 4, mothers identified 136 behaviors that clustered around four broad categories (emotion, actions, academic problems, and abnormal behaviors) and 19 subcategories.

Table 4. Concerning Behaviors

Categories	sub-categories	Examples of behaviors (interview numbers in parentheses)
Emotion	crying	She still cries. You can't even (inaudible) what you're saying to her. She'll get very upset. She'll cry (1000). So it was bothering my son, and he'd tell me these things, but he still wouldn't believe daddy would do such a thing. Got to a point that my son, every week-end started crying (1019). She was crying at a drop of a dime. And she just, she wasn't getting along with her other two sisters. She wasn't the happy little girl that we knew (1091). I mean she'd come home from school crying (1106). Every time she got in trouble, she would cry or she thought she got in trouble, she cried.
	depression	He was very depressed (1077). depression (3002)
	mood swings	You know, she's still having the mood swings (3002). C. was basically having a real hard time, problems in school. His mood swings were really up and down, basically all over the place. One minute he'd be real happy. One minute he was just like down in the dumps (3114). She has mood swings (8010).
	other	She gets in those moods. She doesn't think -- she's constantly putting herself down (1036). She was just, you know, crawling out of her skin worrying about him (1223).
	worry	she has a lot of anxiety in her (1055); She was just, you know, crawling out of her skin worrying about him (1223)

	difficulty sleeping	Because she talks in her sleep. So she's not all the way in a (inaudible) sleep. Then when she gets up in the morning, she's exhausted (3002).
	self-esteem	She doesn't think very much of herself. She thinks everyone's better than her. Just that kind of stuff (1067); But, you know, her self esteem issues is coming more and more of a problem (3002)
	suicidal statements	She had told me that she was even considering suicide (1036). Just wishing she was dead (1067). He had written a note to a friend of his in school stating how terrible his life was and how he wanted to die and he wrote a poem about killing himself (1077). And then one day she was like really depressed and she said she just wanted to kill herself (1106). And he would make references like, "I don't want to live anymore. I could see he was being depressed and he would ask questions about suicide and everything like that and I was really concerned (1222). I could see he was being depressed and he would ask questions about suicide and everything like that and I was really concerned (1222). he was always saying I wish I was dead. Just kill me (3084). she threatened to kill herself (3110).
Actions	cutting	at one point she took scissors and cut chunks out of her hand at school. I mean, literally cut chunks (1000).
	being mouthy	She's out of control. I can't -- I can't -- she defies me at every step of the way. And she -- I mean all teenagers do to a point, but she is really out of hand (1003). (3027 - definition of mouthy); A smart mouth (3521)
	defiant	In school, he's very disrespectful to the teachers (3114); Just didn't listen. Teacher told her to do something and she got smart with him (3134).
	won't listen	now she won't listen to anybody (1020).
	antisocial	Sneaking out of the house. Having friends over. Lying to me (1083).
	stealing	He stole my sister's MAC card and took almost \$700 out of her account and spent it (1077); He was doing a lot of stealing. It was just so much like -- it was to the point where even if you just set something down, T. would pick it up. And then before you know it -- you ask him if he take it and he tell you no. Then you go upstairs and you find it in his drawer, you find it on his person, you'll find it anywhere that he would place it. So that was the start of it was the stealing (1368).
	violence	Daniel, my 14 year old, was in trouble. He got in trouble for, with no provocation, took a BB gun and shot at a Verizon worker outside of my home (1092).
	fighting	He started doing things that he wouldn't normally do like wanting to beat up on kids all the time, go after kids with objects (1360). Fighting was just like it became an everyday thing. He would be fighting with his brothers and sisters first at home (1368); She is jealous of my granddaughter, she like tears her sisters clothes up. She fights her brother (3155).
	hyperactive	And we knew Tyler was hyper. He's always been hyper, but we thought as he grew older, he would grow out of it, but T. didn't (1043).
	inattentive	He's having trouble focusing. They didn't say they had problems with his behavior (1116); Her attention was short. She wasn't getting into any trouble like behavior problems (3021)
Academic problems	problems with grades	She is doing very poorly in school (1003). And his grades, when he started school, his grades were horrible. He's a straight F student (1083); running up and down the halls, hiding up under her desk. Won't listen to like, the teacher or the principal. Um...lets see, like tearing up her work. Whatever they had to do in class, refusing to do it. Um...going through the teacher's desk, knocking stuff on the teacher's desk down (8064).
Abnormal		smearing feces; walking around like a dog; spitting on his hands; stopped talking for three months; shaves eyebrows

4.1.1.1 Characteristics of the behavior

Many maternal narratives suggested that they became concerned about their child's behavior because of the *severity, frequency* or *duration* of the behavior, rather than the type of behavior. The most severe behaviors were those that threatened harm to self or others. Threatening behaviors typically occurred once or over a short period of time and were likely to lead to a direct path to MHS. For example, one mother reported no time lag between her son's homicidal threat and her decision to seek MHS: "*He threatened to kill me so I took him to see if something was wrong*" (3027). In contrast, mothers described being concerned about the frequency and duration of behaviors like crying, repeatedly washing hands, or being defiant:

"She will never confide in me" (1001)

"He withdrew from everything" (1019)

"Got to a point that my son, every weekend started crying" (1019)

"She doesn't take no for an answer.... she does the same thing with everybody" (1020)

"So he's constantly washing his hand" (1027).

"She would come visit and she was always crying" (1036)

"She thinks everyone's better than her" (1077)

Some mothers were concerned about their child's behaviors because of the frequency or duration of the behavior, but it was the addition of a threatening behavior that was the tipping point for seeking services. The following excerpt is an excellent illustration of this type of pairing. In this interview, the mother described being concerned about her daughter's anger and attitude, but it was the daughters' reports of suicidal thoughts that prompted her mother to seek mental health services:

She's had a chip on her shoulder. Just angry at everything. She just didn't really care. She lost interest in herself. Didn't want to go nowhere. Didn't want to do anything. Was angry. Would snap out. We were constantly having disagreements. And then one day she was like really depressed and she said she just wanted to kill herself. And I said, 'well, you know, either you want to go for counseling or I'll commit you.' So I contacted the counseling center and they got her help. (1106).

For this mother, persistent problems were not enough to warrant seeking help. The tipping point was when her daughter threatened to kill herself.

4.1.1.2 Context of the behaviors

The second factor that influenced mothers' concern was where the behaviors occurred. Mothers were more likely to become concerned if they experienced their child's behavior in the home than if they received reports from others. In fifty out of sixty interviews, mothers first became concerned about their child's behavior. In the other 10 interviews, school staff became concerned and alerted the mother. School reports were important when children only exhibited problematic behaviors at school. *"See, the thing is the behaviors don't happen at home with ADHD. They're only at school"* (1043). When behaviors occurred only at school, information from school alerted mothers to the problem and made a case for why they should be concerned about the behavior. In other narratives, school reports legitimized mothers' concerns: *"When the school told me I needed to get my daughter into counseling, I said I agreed with them"* (1001). One mother reported that her although she had been concerned about her son's anger at home, it was only after the school called to report that he made suicidal statements that the mother recognized it as a mental health problem:

Well, it came to a head when the school called me. He had written a note to a friend of his in school stating how terrible his life was and how he wanted to die and he wrote a poem about killing himself. And thank God this girl took the note to the guidance counselor, you know... So the school immediately called me (1077).

Schools alerted mothers to behaviors that were not present at home, legitimized existing maternal concerns, and provided information that helped mothers recognize problems as mental health problems rather than academic problems.

4.1.1.3 Subjective norms

The third factor that influenced mothers' concern was the comparison of the child's behaviors to subjective norms. Mothers established subjective norms using their personal and parenting experiences; feedback from their social network and; and information from formal resources such as juvenile court, and other mental health service providers.

4.1.1.4 Mother as norm

Some mothers used themselves as the norm with which to compare their child's behavior. These mothers became concerned when their child's behavior reminded them of their own problems. They also became concerned when their child's behavior was significantly different from their own "normal" behavior. One mother recognized that she and her daughter shared not only the same low mood and self-esteem, but also had similar experiences in high school:

I don't feel like there's anything positive in my life. I have a terrible problem with self-esteem also. And H. is the same way. She gets in those moods. She doesn't think -- she's constantly putting herself down. And boys at this age are terrible. You have to look like Britney Spears, and H. doesn't, you know. But I keep trying to tell her, but I remember

myself how it was when I was in high school. And even then, they were terrible. You had to look like all the cheerleaders and everything. It really gets to her (1036).

4.1.1.5 Child as norm

Mothers became concerned when their child's behavior deviated what was typical behavior for their child. This was particularly concerning because mothers believed that they were losing or had lost their child. The following is an example of a mother who was more concerned by her daughter's change in behaviors than severity of the new behavior:

She was, she was acting out. She was a really happy happy kid. She was crying at a drop of a dime. And she just, she wasn't getting along with her other two sisters. She wasn't the happy little girl that we knew. Like she's not that bad now even. If my fiancée or I would tell her to do something like pick up her toy, she would scream at us. And that's just not M. She's always been respectful -- and she -- she would pick up her toys when she's done playing with them. And she just, she wasn't doing anything. And every time she was told to do anything, she would scream at us. (1091)

While some mothers recognized a change in their child following new behaviors, some mothers reported that their child's personality changed over time, and the cumulative change resulted in problematic behaviors:

And then I guess he -- you know, he started losing interest in things he used to really enjoy. You know, he was playing on the football team and then he, you know, decided he was quitting. He didn't want to do than anymore. He was working a part time job. He wanted to quit that. Just things -- and his personality started changed. And I -- these were just sort of trigger signs to me. And then it kind of came to a head then in July because then he and his friends were picked up under age drinking (3025).

4.1.1.6 Siblings or peers as norm

Some mothers recognized a problem because their child's behavior differed significantly from their siblings or peers, "*She was in second grade, but her average was first grade. She wasn't catching, and my 8 year old knew more than she new and she's 9*" (8041). In the following excerpt, the mother describes how her son's behavior is significantly different from his sister's. This mother uses the difference as support for the idea that her son has a problem:

His sister is total opposite. She has a good personality. She has a lot of friends. She has a good social life. She has things going for her. And she's being successful and he's being backwards down the dumps. She gets a babysitting job and he's angry because he don't get money. And he won't go out and play with his friends or anything. He'd rather just sit home. I don't know. I'm lost for words there. I don't know (1222).

Mothers also described not recognizing their child's behavior as a problem because it was no different from their peers, or not as bad as their sibling's behaviors: "*He would get like mad and angry and that, but I just assumed at the time that it was like his age group because other kids was doing the same thing. So I just assumed it was his age*" (1220). Another mother reported that she did not recognize a problem because her son's behavior was not as bad as his sibling's:

With my older son, it was a little wild because he always walked in his sleep. He was so hyper that I couldn't even get him to go to sleep all the way. He would get up and walk out the door. But with Nathan, Nathan would actually go to sleep at night, and that's why I didn't think there was really a problem because he would go to sleep and he would stay asleep all night. And I was like maybe it isn't ADHD/ODD. You know what I mean? Maybe it's just he's a typical bad boy (1008).

4.1.1.7 Society and developmental standards as norms

Mothers received information about societal and developmental norms from their *social networks*. However, the narratives identified only a few situations when this occurred. One mother reported that she knew that she had always had concerns about her daughter, but it wasn't until her father, who did not believe in mental health problems, said something that her concerns were legitimized:

And Christina always active, even in the womb. I mean she was constantly active. And one time, I think she was two, my dad, he's Archie Bunker, God love his heart, but he doesn't believe in any of this medical help and mental help. You know, "just go get a beer and you're fine." That's his philosophy. And he didn't believe that anything was wrong with Christina. And one time we were at camp, and there was this tree, and she was on this tire swing, and she was just going like this with her face hitting the tree, and her face is bloody, and it did not -- like she had no pain. And my dad looked at my mom and said, "she needs to get help." (1000).

One mother described recognizing that her son's school behavior deviated from developmental norms:

Ever since we had him enrolled in school, in kindergarten, he just always had a lot of difficulty sitting still, following direction, and he was more or less considered a behavior problem. We figured he would grow out of it. He was five... But every year it was the same thing (3025).

Maternal narratives identified a few instances where interaction with the legal system or mental health services influenced their perception of their child's behavior(s). One mother responded to her daughter's suicidal statement by bringing her to the emergency room. In this

excerpt, she talks about how she was not convinced her daughter had a problem until the psychiatric staff considered her daughter's behavior as dangerous.

I really did not believe her that day; I was just pulling her bluff. Cause C is a hypochondriac. Q. So is there anything that made you decide to believe her this time? A. Not until these people [hospital staff] said that if I did not commit her or if she didn't voluntarily do it, that they would do it themselves. I was like; maybe there is a problem here (3110).

4.1.1.8 Summary of Becoming Concerned

Mothers became concerned about their child's behaviors based on the types of behaviors, the characteristics, the context, and the relationship to subjective norms. Mothers became concerned primarily about how the child's behaviors or emotions were interfering with his or her ability to engage with, or be successful in, family or school activities. This suggests that mothers saw their child's problems primarily in terms of functional impairment, rather than symptomology. In other words, it wasn't the behaviors or emotions themselves, it was what they prevented their child from doing. For example, a number of mothers described being concerned that their child was "mouthy." What was important about being "mouthy" was that it interfered with the parent-child relationship and made it more difficult for the mother to parent effectively.

The greater the perceived functional impairment, the more likely mothers were to see the behavior as appropriate for mental health services. For example, mothers who reported that their child got into regular fights with siblings, but those fights did not interfere with family functioning, school work, etc, did not describe that child as needing mental health services. Two mothers reported not being concerned about their child's behavior, even though school reports indicated problems. These mothers did not see a problem at home, and commented that their

child was a “good kid” around the house. Other mothers were concerned about their child’s behaviors, but were not sure if they were appropriate for mental health services. These mothers recognized problems, but saw other venues (such as school, or law enforcement) as the first-choice intervention. When mothers were concerned about a behavior but did not see it as a mental health problem it was typically because the child was acting out in school and the parents attributed the problem to the school environment. Finally, mothers who perceived significant functional impairment were more likely to seek MHS.

4.1.2 Maternal Causal Attributions.

Mothers were asked, “What did you think might have caused some of these behaviors that you were seeing?” In response, mothers in the sample identified a total of 73 causes for their child’s behaviors. As listed in Table 5, maternal causal attributions clustered around six themes: inherent, heredity, developmental, psychological, family, school, and other. Multiple causal attributions were common. A few mothers simply said that there were multiple causes, “*It was everything that just kind of played a part in it*” (3525). Two mothers said they did not know what caused the problem.

Table 5. Causal Attributions for Child Behaviors

Causal Category	Sub-category	#	Examples of causes (interview number in parentheses)
Inherent	child is inherently bad born that way	4	She is selfish, she is evil (3155)
		2	I knew from the time Christina -- I held her in my arms for the first time, something was different (1000).
Heredity	heredity	3	I adopted [him] when he was two and I think some of the problems that his parents was going through is showing up in him now. ; if Tracy is suffering from depression, I also blame myself for that because it's -- I know it's hereditary, and if I suffer from depression and she does then it's my fault. Or, at least, that's how I see it in my mind.
Developmental	puberty / teenage	3	She is at that age of puberty. Maybe it's just kicking in for her with the hormones and these feelings; I guess he's just going through the teenage stage and thinks he can do whatever he wants.
	other	1	I don't understand why she's like that. Well, she was a late talker too; Chrissie and I never seemed to bond (3110)
Psychological	depression	2	Maybe she's just depressed, and she's acting out this way... (1003); Well, he was depressed. He's been taking medication (3084)
	grief	1	my son had been in accident, which was we almost lost him. And they had lost a best friend, and her best friend lost her mother to cancer. Nan was sick with cancer. We just lost her a couple of weeks ago. (1001)
	crazy	1	I thought she was crazy personally. I knew something was wrong. I was like why is my baby snapping like this? Something was wrong... She was like unbalanced. (3099)
Family	father	21	Not being able to see her father. Her father not coming around.; he hasn't seen his father since he was two years old so you know by now, 13, he's starting to be, he's angry at the world because his dad's not around.
	mother	6	things really started to go downhill, I think, after I took my overdose. That's why I pinpoint it back to that period of time; I think a lot of it is my fault. I haven't been as consistent as I should have and I should have disciplined more.
	parenting	2	We sort of spoiled her. You know, it's our first child, you know.
	abusive environment	3	the last couple times when Joe choked me, Ryan was beside me screaming, yelling, "Daddy, stop it." So my main thing was knowing that my son was already damaged (3119); She was abused in foster care. That is why they gave her back to me early. I don't know what's going on. She don't want to talk (3155).
	changes in home / family environment	10	So she was in that atmosphere, which really was getting to her. (1036); the only time that we had a problem with her behavior was like she would come home [from her father's house] (1091); Um, my exboyfriend, he's been here like the last three years, turned from a social drinker to a raging alcoholic morning, noon, and night. So the entire house was like insane; it was just the point of leaving him, and that's basically -- her grades started going down hill; then I took on Matthew and I think she had a chip about that because she was the baby all the time
	other	5	Something to do with her dad. Something to do with me. Something to do with her dad's ex-girlfriend. Kids in school. Just a lot of things. You know what I mean? She's dealing with a lot of things (1106); Because Chris has no male anything; I think Dan wanted to try to bring Rick and I together.
School	staff	5	there's nothing wrong with my daughter. She was a high honor roll student up until she came to this school. It's something with this school... But this teacher was constantly yelling at her... So I felt there was a problem with the teacher.
	school bullying	2	they used to tell her she was fat. They used to tell her she smelled. And she said that didn't help her self esteem. And that brought it on.
	peer pressure	3	Peer pressure (1363). As soon as she got to like the middle school... She's definitely hanging out with the wrong kids (1039).
Other		2	I don't think she's getting enough sleep (3002); She was trying to get out of taking a test (3132); When Tyler was a preemie, he had four operations in four years

4.1.2.1 Inherent

Six mothers attributed the cause of their child's problems to something inherent within the child. Although mothers in this category acknowledged a variety of influences on their child's behaviors, these mothers distinguished themselves from the other mothers by suggesting that something within their child was responsible for their problems. Four mothers suggested that their child's "bad" or "evil" nature caused the problems. In one interview, the mother described significant problems with the child's father. When the interviewer asked if the mother attributed her child's problems to the father the mother responded: *"I used to always tell the counselor that I don't think it's from her father. I think she's just bad and she just wants her way"* (3160). Two mothers reported that they knew that their child was different from the time she was born: *"I knew from the time I held her in my arms for the first time, something was different"* (1000). *"She was always distant. As a baby, she was distant. And she always kept to herself"* (1001). One mother described her process for identifying the cause of the problem. At first she blamed herself. Then she decided that the problem must be the girl, because her two sons did not have any problems: *"I think there was problems from the beginning there. Then I just blamed stuff on myself because I was so involved in other things. Then I would sit there and think well, I got this boy here who's fine and I got this boy here who's fine. It has to be her"* (3110).

4.1.2.2 Heredity

Three mothers attributed the cause of their child's problems to heredity: transmission of the problem from a biological parent. These mothers reported a long history of problems, and attributed the cause of the problem to the child's parents. One adoptive mother attributed the problems to the birth mother, *"I adopted T. when he was two and I think some of the problems that his parents was going through is showing up in him now. They were on drugs."* (1363). One

mother attributed her daughter's depression to her own depression, suggesting that she sees depression as hereditary: *"If Tracy is suffering from depression, I also blame myself for that because it's -- I know it's hereditary, and if I suffer from depression and she does then it's my fault. Or, at least, that's how I see it in my mind"* (1003). The third mother attributed her child's bipolar disorder to her family's history of mental illness (1089).

4.1.2.3 Developmental

Four mothers attributed the cause of their child's problem to developmental phases. Three mothers attributed their child's problems to puberty. The following excerpts illustrate how these mothers compared their child's pre-puberty "good" behavior to their post-puberty "bad" behavior: *"I mean basically teenage stuff, preteen stuff, you know, the mouthiness because until he hit about probably 11, 12, right when the hormones start kicking in, you know, when he starts, he was, he was fine, you know. He was this really good kid, you know"* (1092). Another mother: *"He's 12. I guess he's just going through the teenage stage and thinks he can do whatever he wants. Besides that, I think he's just a normal teenager"* (3027). These mothers made a connection between the onset of puberty and their child's behaviors; this temporal marker helped them make sense of the changes. One mother attributed her daughter's selective mutism to having delayed speech as a child, *"Well, she was a late talker too. She didn't start talking in sentences until she was three"* (1055).

4.1.2.4 Psychological

Even though 12 mothers reported that their child had an existing psychiatric diagnosis, only three mothers attributed their child's problems to something psychological, and of those only one attributed her child's problems to the diagnosis: *"Well, he was depressed. He's been*

taking medication” (3864). One mother reported that that her daughter’s behaviors were the result of acute grief due to the recent loss of friends and family. One mother reported that her daughter was “crazy”, “I thought she was crazy personally. I knew something was wrong. I was like why is my baby snapping like this? Something was wrong... She was like unbalanced” (3099).

4.1.2.5 Family

Mothers most often identified the family as the cause of the child's problems. Within the category of family, mothers identified the father as the most significant contributing factor to the child's problems. There were 21 instances in the study where mothers placed attributed the cause of the problem to the father, and six instances when moms saw themselves as the cause.

According to the maternal narratives, fathers caused the child’s problems either by being absent (11), or by being abusive (4). Children with absent or abusive fathers were often described as angry, pubescent, and male. *“He hasn't seen his father since he was two years old so you know by now, 13, he's starting to be, he's angry at the world because his dad's not around” (3003). “His father is incarcerated... And it's been a problem with him. So I always put that in to why he has problems because that does affect him. You know, he worries about him” (1106). The following excerpts are typical in the sample of children with abusive fathers: “My husband, her dad, was very ugly toward all of us. He had no -- I know that made it worse” (1000). “And things were just really getting bad between his father and him. It was getting to the point of physical violence” (1077). One mother reported that she knew she wasn’t the cause of the child’s problems because of the influence of the child’s fathers and peers: “I see that it wasn't me. It was the influence of their dad and the influence of the peer pressure that put them*

where they are now. Cause I did everything right, I know I did. I know I did everything right” (1363).

Six mothers described their shortcomings as causing their child’s problems. One mother attributed the cause of her child’s problems to her suicide attempt: *“Things really started to go downhill, I think, after I took my overdose. That's why I pinpoint it back to that period of time... I've really ruined my kids lives over all this” (1003).* Three mothers said they had not provided enough discipline, *“I think I overcompensated for him not having a dad. And even though we have struggled with paying the bills and stuff, he's always had what he wanted. So I think a lot of it is my fault. I haven't been as consistent as I should have and I should have disciplined more” (3114).*

Other family factors included mom's challenges bonding when the child was a baby, *“Chrissie and I never seemed to bond. I made excuses for it. I guess the first three weeks I couldn't even hold her.” (3110);* divorce, *“I think somewhere deep inside of him, he still thinks that everything would be perfect if Rick and I were together” (1092).* ; lack of a male role model *“Because Chris has no male anything. He's never had a male in his life. His dad is pretty much a loser. He comes around, but he's a loser. His grandfather doesn't really bother with him. My brother was in a wheelchair and he died a few months ago. So he never really had -- he never had anybody”(3114);* poor parenting *“We sort of spoiled her. You know, it's our first child, you know” (1055);* separation from the parent *“I guess the separation from us. I think that is what actually triggered it... It started while she was in foster care. It wasn't like that before she left.”(3155);* and mother's boyfriend *“Then the boyfriend that I had that’s been dead now for seven years because he was murdered, that took a lot on everybody”(3000);* and living in a distressing family environment, *“So H. decided to move with her dad. So she was up there for a*

year, and that atmosphere is terrible. My ex-husband's sister is bipolar, and she's paranoid schizophrenic. She has three kids. And her ex-husband abused her terribly. So she was in that atmosphere, which really was getting to her” (1036).

Three mothers attributed their child’s behavior problems to being in an abusive environment. For example, one mother reported that her daughter was abused while in foster care, *“She was abused in foster care. That is why they gave her back to me early. I don't know what's going on. She don't want to talk” (3155).*

The number of maternal attributions to family suggests that mothers saw the family environment as having a significant influence on child behavior.

4.1.2.6 School

Mothers in this category attributed the child’s problems to his or her school or social environment. Five mothers attributed their child’s problems to the school environment: bullying, school staff, and peer pressure. For example, one mother described how bullying led to her daughter’s suicide attempt:

For four years at school -- she used to have long beautiful hair and some of the kids were so ignorant and so rude, they used to throw spit balls in her hair. They used to tell her she was fat. They used to tell her she smelled. And she said that didn't help her self esteem. And that brought it on (1106).

One mother described how her daughter was told not to speak by a teacher and ended up not speaking to any adult for three months:

And then one day she came home from school, she wasn't talking to me or her dad. And so I called the school and I asked the teacher. The teacher had told me that there was this little girl, Gabby, that's in her school, she has a lot of problems too, I guess she told them

-- they get along, but then they argue back and forth. So they -- the teacher told them just to quit talking to each other. Okay. So I think that's how it came about. So Madison came home from school that day and she just quit talking to me and her dad. (1055)

Mothers who attributed their child's problems to peer pressure noted changes in behavior subsequent to their child hanging out with a new group of kids. Similar to mothers who attributed their child's problems to puberty; these mothers were able to identify a specific point in time that marked the change in their child's behaviors. Unlike mothers who attributed their child's problems to puberty, mothers in this category blamed their child's peer environment. For example, one mother was concerned that her 12-year-old daughter was using drugs and having sex with multiple partners. Although her daughter's behaviors might have been attributed to puberty, this mother identified her peer group as the cause of the problems because the change was instantaneous, *"Until this past year, she was always a really good kid. She was never any problem. Very good kid. As soon as she got to like the middle school - big change. She's definitely hanging out with the wrong kids"* (1039).

4.1.2.7 I Don't Know

Three mothers reported not knowing the cause of their child's behaviors. Two mothers suggested that they did not have a context for their child's behaviors *"I have never seen anything like this. So I didn't know what the cause was"* (8010). *"I had no idea. And I don't know. I think - I really don't know what triggered it, but it just like came suddenly and then before we knew it, it has just got like really bad to the point where he was uncontrollable... And I guess he chose to listen to the bad side"* (1368). One mother reported that although she didn't know the cause of her son's problems, his counselor attributed the cause to anger:

I'm not sure. I'm not sure. I didn't know that it was anger until the counselor said it. The third time we went to him, he said there's a lot of anger inside of him and we need to figure out why it is there and start dealing with it. Maybe because -- I don't know (3114).

It appeared, though, that this mom did not “buy” the counselor’s attribution. This excerpt suggests the possibility that other maternal causal attributions had been influenced by the help-seeking pathway. However this was the only narrative that explicitly established a time-frame.

4.1.2.8 Summary of Maternal Causal Attributions

Maternal causal attributions provided mothers with an explanation for their child’s behaviors. Some of the causes seem to be at the root of the problem, such as having an absent father, or being inherently bad. Although mothers adopted coping strategies based on these causal attributions, such as getting a child a Big Brother to address abandonment issues, they did not seem to consider those causes malleable. Rather, it seemed that they hoped the coping strategies would minimize their child’s pain and suffering. Other causal attributions (e.g. school bullying and peer pressure) seemed to be more immediately linked to the child’s problems. Interestingly, mothers attributed their child’s problems most frequently to family and least frequently to psychological causes. This sheds some light on the finding that most mothers used formal mental health services only after trying to cope with their child’s problems within the family or within their social network. Mothers who identified the father as the cause of the problem tended to use interpersonal coping as one of their strategies to deal with their child’s problems. For example, one mother reported the cause of her child’s problems was his father’s absence. Her coping strategy was to reassure him that even though his father was absent, he still had a father: *“Oh, yeah. I mean I used to try to tell him, “Tyler, you know, you and I are a family.” I would get little videos. Everybody has a dad. Yours just doesn’t live in the household”*

(1043). In contrast, mothers who attributed the cause of the problem to something inherent or essential within the child, most commonly used formal services, including mental health, residential treatment, and juvenile court, to cope with their child's problems. Mothers who attributed the cause to development tended to chose services and use a variety of coping strategies.

It was not uncommon for mothers to first state that they did not know what caused the child's problems, and then to provide some explanation. For example, one mother who sought treatment because she was concerned that her child had stopped talking, initially said she didn't know, but eventually attributed her child's problems to developmental issues, "*I don't understand why she's like that. Well, she was a late talker too. She didn't start talking in sentences until she was three*" (1055). Another mother reported seeking services because her son was doing poorly in school initially said she didn't know, but suggested a family history of mental health problems, "*I wouldn't know. I really couldn't tell you. There's been mental health, there's been a history of mental health in my family*" (1089). Most mothers, often after prompting by the interviewer, provided responses that clustered around the six categories identified above. There are a few explanations for the plethora of answers that combined "I don't know" with "I think this is the cause." It is possible that answering "I don't know" was a way to buy time while thinking of the answer. Alternately, "I don't know" might have been the most accurate answer and the subsequent causal attribution was an off-the-cuff speculations. It is possible that there was a social desirability bias wherein mothers provided answers that they thought the interviewers wanted to hear. It is also possible that mothers' causal attributions were influenced by the help-seeking process rather than driven by it.

Whatever the reasons, the narratives suggested that many mothers were actively engaged in trying to make sense of their child's behavior. One mother reported that she was not sure why her daughter was having difficulty in school and defiant at home, but was seeking mental health services to find out:

Like I said, I'm not sure if she's acting out against what I had done or if she is -- I'm not sure. She may be suffering from depression herself. But, I wanted to get her help. I see a counselor once a week. I see a psychiatrist once a month for my medication check-ups, and it's been helping me so I thought it would help her as well. So I've taken her to Family Services (1003).

4.1.3 Summary of Recognizing a Problem

In sum, the first stage in the help-seeking process was recognizing a problem. The first part of recognizing a problem was identifying and becoming concerned about specific behaviors. The narratives provided insight into how mothers recognized behaviors, what factors were influential in becoming concerned, and to what mothers attributed their child's problems. Once mothers identified a problem, they moved to the next stage – responding to the problem.

4.2 RESPONDING TO THE PROBLEM

After becoming concerned about a behavior, mothers reported trying multiple ways of trying to respond to the behavior. Responses included informal and formal coping strategies.

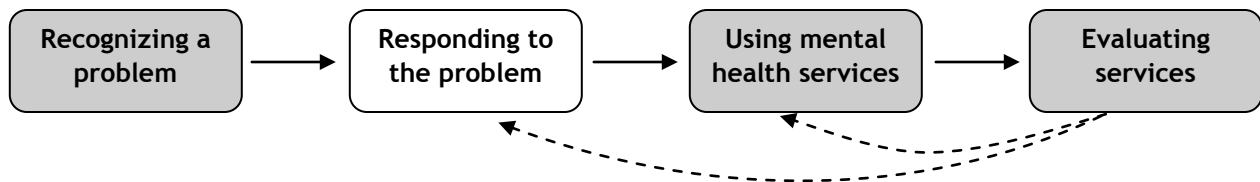


Figure 9. Responding to the problem

4.2.1 Coping strategies

Maternal narratives identified a variety of strategies to cope with their child's problems prior to seeking current mental health services. As listed in Table 6, maternal coping fell into 6 broad category use: 1) of behavioral interventions; 2) formal services; 3) interpersonal coping; 4) activating the social network; 5) changing environments; 6) and no prior coping. Mothers often used multiple methods to cope with their child's problems, which accounts for the total number of coping strategies exceeding 60. Across the six categories, three themes emerged to suggest why prior coping was important in shaping mothers' help-seeking pathway: (1) When mothers' attempts to deal with their child's behavior "didn't work," they turned to mental health services as a next resort; (2) The lack of response to mothers' interventions reinforced the severity of the problem for the mother; (3) Mother contacted people who acted as gatekeepers to mental health services.

Table 6. Maternal Coping Strategies

Coping category	subcategory	#	Examples of coping strategies (interview number in parentheses)
Behavioral intervention	punishment	11	"Time out, grounding, corner. She got a lickin'. It's everything" (1020); "You can't watch TV. You can't play with your computer. Video games would be gone" (1092).
	rewards	5	"I was giving her money to let her go places to try being with friends" (1106); "And she likes trolls. We would reward her with trolls. It did make a difference" (3021).
	both	2	"We'd take things away, but when he had good days, we would reward his good behavior" (3525)
Formal services	legal	4	pre-probation (1083); residential treatment (3143); calling police (3000); filing criminal charges against child (3114)
	medical	5	"I took him to my family doctor first" (1008); pediatrician (1043, 3084); medication services (3084, 3093)
	mental health	4	psychological assessment (3000); counseling (1000, 3143, 8032)
	school	5	change schools (1000); seek support from administrators and teachers (1083; 1106; 3000; 3143)
Interpersonal	talking	12	"I always have tried to tell him when he does good things, as well as bad (1077)" I mean I used to try to tell him, "T., you know, you and I are a family." Everybody has a dad. Yours just doesn't live in the household (1043); use of compliments, problem-solving, being honest (1027, 3155, 1067, 3092, 1092, 1106, 3000, 3107, 8040)
	building family	4	"me and the kids always had family night" (1155); "I tried to get her closer to her father's side of the family and to her brother... even know it's not (her dad) that would still help because there's still the love of all the other family members. That did help a little bit" (1223).
Social Network	church	2	"A lot of prayer. My uncle's a minister, and I counseled with him. I just, you know, prayed, books, and that's pretty much it" (1000)
	big brother	1	"If I have a problem with T I can call his big brother and talk to him about it. Maybe he'll come stop by and pick T up and they will go talk about it or something." (1363)
	activities friends and family	4 3	getting involved with youth organizations; having friends and family take the child; mother's employer; talking with others
Changing environments	moving	2	Because what would happen is we would move, we'd literally have to move her out because she would hurt herself (1000).
No prior coping	emergent situation	3	"There was no warning with that" (1001); sought help that day (1093)
	did not know what to do	3	"There was nothing I really could do because I didn't know what I would be doing. I didn't know" (8010), (8058).
	no problems	2	"I didn't think there was nothing wrong with her" (8014; 8012)
	no action	2	"I didn't do anything" (1220)
	maternal mental illness	1	"I didn't do anything because I was going through my own thing so I wasn't able to be there for him" (1360).

4.2.1.1 Behavioral interventions

Sixteen mothers reported using behavioral interventions, including punishment (11), rewards (5), or both (2), to respond to their child's behaviors. Four mothers (1083, 1092, 1106, & 3027) reported using behavioral interventions and at least one other method of coping with their child's behavior. Examples of punishment included: time out, grounding, removal of privileges, spanking, etc. Most mothers reported that their attempts at punishing their child did not address their concerns: "*Time out, grounding, corner. She got a lickin. It's everything. Nothing works. It still don't*" (1020). One mother described how punishment made the situation worse: "*Restrictions.... We took TV, video games. He wasn't allowed to go anywhere, do anything. That didn't help. All that did was make it worse*" (1089). One mother described how she was unable to discipline her child in the way she would like to because of changing societal standards. However she was undeterred and committed to removing privileges as a way of punishing her son for misbehaving in school:

But see, I feel nowadays that they're not letting you really discipline your child like you should... My kids, they know they can call [child welfare] -- the schools teach them that. Well, you know, if your mom hits you in the wrong way, call [child welfare]. If your child gets smart, we used to get popped. It didn't matter. My dad still tries to pop me in my mouth and I'm 31. But see, things like that, he knows all that. So I just try to take whatever I can away that I know he likes. And I'm sticking to it. He's changing all the time. I'm sticking to it. Two weeks. The teacher called me yesterday said he was getting in trouble so he got the two weeks. I'm not letting him off (3027).

Mothers who described using rewards reported similarly disappointing results. Three of the mothers gave their children money in the hopes of changing their behaviors:

I try to get him things that he wants, you know. I try to give him money. He goes bowling once a week. You know, that's a good social activity. I let him go to the movies. I buy him stuff, food that he wants to eat or whatever... But he just won't listen... he's not bad, he just won't listen (1222).

One mother reported that her daughter “likes trolls. We would reward her with trolls. It did make a difference” (3021).

Two mothers reported using both punishments and rewards, “We’d take things away, but when he had good days, we would reward his good behavior” (3525). Ten mothers reported that their behavioral interventions “did not work,” meaning that they continued to have concerns about their child’s behavior.

4.2.1.2 Formal services

Twelve mothers reported using formal services prior to the current episode of mental health services. They worked with four different formal systems of care: school (5), legal (4), medical (5), and mental health (4). Five mothers sought help from multiple formal systems. Mothers used these formal systems in a variety of ways. Some mothers relied on formal services to identify the problem. One mother sought information from both the police and a psychologist:

I went to the police station to see if they had any advice for me.... I took him to a psychologist so that I could finally find out where the problem is. You know, so I could get him the help that he needed (3000).

This mom sought formal services based on her concern for her son’s behavior, but without knowing what the problem was. Medical and mental health systems were accessed for consultation purposes, as described above, or for ongoing treatment of an existing problem. An unintended consequence of accessing formal systems of care was that some most mothers were

in contact with people who had some knowledge of mental health services, and could act as referrals to mental health services. Most mothers reported that these formal systems provided them with misleading information, or failed to address their child's problems. In this excerpt, the mother's daughter has stopped talking to adults and rarely talks with children:

Well, I did mention to her pediatrician, I said, "I'm a little worried. She doesn't talk a whole lot. She doesn't talk to people." And, you know, they said she'd grow out of it. Well, okay. She'll just grow out of the shyness, you know. She never did (1055).

In this excerpt the mother describes using a variety of mental health services to address her son's acting out behaviors:

I had him in all types of counseling. We went to a mental health clinic... BF[residential treatment]... We went to the counseling, but, unfortunately, it really did not help. It didn't help (3143).

Mothers tried to cope with their child's problems by accessing services at schools and moving their child to another school. Mothers often disagreed with the way the schools tried to deal with the child's behaviors:

"They wanted to send him to magistrate court. And I felt as though that was not the right move because I understood why. So we withdrew him from school and put him in a GED program" (3143).

It is possible that had some of these mothers been successful in getting the academic setting they were looking for, their help-seeking pathway would have ended there. However, schools routinely put up obstacles that prevented the child from getting the services the mother wanted.

And it was like I tried to get him into a different school. I thought it would be better for him to be in a limited classroom with people who deal with special ed. children that can give him the proper education that he needs. Now these, the school down here just didn't want to do that because see, that means they have to pay for it and they didn't want to do that (3000).

One mother described how changing schools addressed 75% of her daughter's problems:

The last two years, she's been at a private school, it's been I'd say not 100% better, but at least maybe 75% better. It's made a world of difference for her being in that school. And it's expensive, but you know what, my husband and I -- even if I would have to take a second job, she would stay in that private school.

This mother is clearly dedicated to do whatever it takes to help her daughter. Although these mothers described getting misinformation, poor customer services, and no resolution to their child's problems, these mothers continued to seek help for their child in formal mental health services.

4.2.1.3 Interpersonal coping

Fourteen mothers reported using two types of interpersonal coping – building a family (4), and talking (10) – to address their child's problems. These mothers described using their role as mother as a way of addressing the concerning behaviors.

Four mothers described building family – doing things that they hoped would strengthen the child's sense of his or her place in the family. This coping strategy was used by two mothers who attributed their child's behavior problems to the father not being involved in the child's life. *“Oh, yeah. I mean I used to try to tell him, “Tyler, you know, you and I are a family.” I would get little videos. Everybody has a dad. Yours just doesn't live in the household” (1034).* And,

“And I tried to explain to him that we can still be a family, but a separate family. Two different directions, but no -- nothing was going to change love wise, you know” (1019).

One mother commented that even though family time was not going to cure her child, it was still important to do because it makes their child feel better:

I -- me and the kids always had family night. Just me and the kids. We'll go to like Pizza Hut. I'll rent a car and we'll go to the movies. Or we'll take the bus and we'll go to the movies. We'll take the bus and we'll go to a friend's house. Take a bus and go to the park or something. So I try to do things like that to make them feel better, but that, in essence, doesn't always cure them. A child is going to go through stages just like adults go through stages. And you just have to be with that child during those stages to help them through them things. You know, I did the best I possibly do (1115).

Mothers saw themselves as being a listening ear, a place for advice, a comfort zone, or a reality check for their child. Mothers saw themselves as responsible for their child's happiness. Even when they identified that there was something inherently wrong with their child, mothers in this study still saw themselves as their child's primary support. One of the most common ways they tried to support their child was to use their role as mother to talk with their child about whatever might be bothering him or her. One mother noted that talking is a way of letting the child know you love them:

Well, I always tried to do whatever I could to improve his self-esteem. I always have tried to tell him when he does good things, as well as bad. I think that's important because my mother never did that (1077)

Mothers recognized that sometimes it might take talking with someone other than mom for the child's problems to be addressed:

So I would say do you want to go talk to a doctor, do you want to go talk to your aunt, this friend, that friend, do you want to talk to me, your grandmother, whoever? I would suggest a million people (3107).

Mothers acknowledged that although talking might be important, it was not sufficient for addressing mental health issues, and did not always work:

Trying to treat her like more of her age instead of like a little baby. Like hollering at her all the time, like talk to her, try to do things with her. Always complimenting her. Telling her I love her. Nothing seems to work (3155).

4.2.1.4 Activating the social network

Nine mothers described activating their social network to cope with the child's behavior problems. Mothers described getting their child involved in extracurricular activities such as youth organizations, the Big Brother program, and sports. They also called upon their families, employers and churches to help out: *I signed him up with another group. It was like a youth organization that helped troubled teens (3143).* and *A lot of prayer. My uncle's a minister, and I counseled with him. I just, you know, prayed, books, and that's pretty much it (1000).*

Mothers who activated their social networks tended to be coping with divorce, custody battles, adoption, or dealing with an absent father. They saw the absence of social support, or problems with the social network, as part of the reason why their child was having problems. For example, one mother (1363) described how her adopted son was “acting out” at home and school and saying, “*I want my dad*” (1636). This mother attributed some of the cause of the problem to her son wanting his father and not being able to get in touch with him. Her response was to activate her social network in an attempt to find a positive male figure that her son could look think of, perhaps not as a father, but as a “*male figure in his life*”:

Well I got him a big brother. That seemed to help a little bit. I mean it seemed to help a lot but he just you know, he has a big brother and a big sister because they are couple. They take him and do things that I couldn't take him too... Although he has male figures in his life in church, he only sees them like maybe once a week, maybe twice a week. If I have a problem with T. I can call his big brother and talk to him about it. Maybe he'll come stop by and pick T. up and they will go talk about it or something. (1363)

Activating the social network provided relief for the child, and in this case, for the mother as well because she was not alone in coping with his problems. However, it did not solve the problem, and it is unclear from the interview if this mother thought it would resolve the concerning behavior. As noted above, there appears to be a relationship between root causes of problems, such as an absent father, and coping approach, such as activating the social network. On one level the connection is obvious; if your child is missing a key member of the social network, it would make sense to get a substitute. However, the mother and the child know that the “rent-a-dad” is a temporary fix, and cannot be considered a solution. Mothers who did not attribute the cause of the problem to social factors reported less success with activating their social network. For example one mother (3114) reported that she did not know the cause of her son’s anger and aggression. She attempted to cope with the problem by using behavioral interventions (punishment), accessing formal services (school), and finally activating her social network (having her boss hire her son), *My boss tried taking him out to his house and giving him some male companionship. That didn't work (3114).*

4.2.1.5 Changing environments

Two mothers reported changing their environments in order to cope with their child’s problems. In both instances, the moves were in response to concerns for safety. One mother

reported that her daughter had become suicidal at her father's house, and the other reported that she left an abusive situation. In both cases, the mother saw the environment as a contributing factor to her child's problems.

4.2.1.6 No Prior Coping

Eleven mothers reported not engaging in efforts to address their child's problems prior to accessing mental health services. Three mothers reported that they sought services because of an emergency (suicidal ideation, suicide attempt, and shooting a utility worker) and had no time to engage in other coping activities. Two mothers reported that they did not know their child was having problems until they got the referral to mental health services. *"There was nothing I really could do because I didn't know what I would be doing. I didn't know"* (8010). Two mothers were not concerned about their child's behaviors. Two mothers reported that they knew of a problem but did not believe they could do anything in the situation so they did not respond, *"We just pretty much let her do anything because we were afraid of what they'll [the courts] say and do. So she just, she was the princess. She did whatever"* (1091). One mother reported knowing that her child had problems, but that her own mental health problems prevented her from doing anything about them, *"I didn't do anything because I was going through my own thing so I wasn't able to be there for him"* (1360). For these mothers, MHS was the first attempt to cope with their child's problems. Although two mothers voluntarily sought treatment, most responded to referrals or reported being pressured into services.

4.2.2 Summary of Responding to the Problem

The 60 mothers in this study described approaches to coping with their child's problems that organized around six broad themes: *use of behavioral interventions, formal services, interpersonal coping, activating the social network, changing environments, and no prior coping*. Although coping strategies varied, there were some common factors that suggested how this process contributed to mothers' help-seeking. Maternal narratives suggested that most mothers recognized a problem and then attempted to deal with it using the resources available to them, either through their social network, the mother-child relationship, parenting skills, or by changing their child's environment. Some narratives suggested that mothers made choices about prior coping based on what they saw as the cause of the problem. In many cases, mothers did not think their attempts to deal with the problems were successful. In some cases, mothers reported that their coping attempts were unsuccessful because they needed others, such as school staff, to do provide different services or interact with the child differently. Once parents access services, social workers can become advocates for the parents to get the expected changes, or act as intermediaries to help the mothers to understand why the school staff are unable to provide requested services.

Although mothers were not systematically asked about the success of their coping strategies, the information available suggested that between the different coping styles, mothers who described using behavioral interventions were the most likely to describe the intervention as not working. It is unclear why this was. It is possible that mothers who used behavioral interventions had the most immediate feedback as to the success or failure of their coping strategy. For example, a mother who sent her son to "time out" and spent the next 20 minutes fighting to keep the child in time out would have a more immediate sense of failure than a

mother who talked to her child, but was not sure of the impact of the conversation. Ten mothers reported that they had “tried everything” or that “nothing worked.” In contrast, three mothers who used formal services, four mothers who tried interpersonal coping and one mother who activated her social network reported that their efforts did not work. Most mothers used a combination of coping strategies. One mother, who is engaged in an on-going custody battle, described using multiple coping strategies, none of which helped resolve her daughter’s problems:

I’ve tried removing us from the home. I’ve tried getting her into extracurricular activities to keep her mind occupied. I’ve tried talking with the school to, you know, see if we could get some type of help for her. It’s just no matter how much I’m trying to find solutions for her, it’s like banging my head against a brick wall because nobody wants to help (1102).

It seems likely that when nothing worked, these mothers turned to the MHS as a next step.

Mothers’ engagement in prior coping contributed to help-seeking in two other ways. First, it reinforced the idea that mom could not resolve the problem by herself, or by using informal means, *“I mean that’s the only thing I tried to do. I tried to deal with it myself, but with me, it just wasn’t working” (3160)*. Second, as a result of their efforts to address the problem, some mothers received information and referrals to mental health services. For example, one mother (1027) described how she was talking about her son’s obsessive hand-washing with a friend who recommended that she seek professional help. The mom then called her insurance company and received a referral for the current mental health services. This mother was unclear what to do and was reaching out to her social network for support, which resulted in getting mental health services.

4.3 USING MENTAL HEALTH SERVICES

The third phase of help-seeking was using formal mental health services. In this phase, mothers described how (mode of entry) and why (reasons for seeking services) they entered services. Mothers reported using office based individual and family therapy; home-based individual and family therapy; school-based individual therapy; wrap-around services; and medication services.

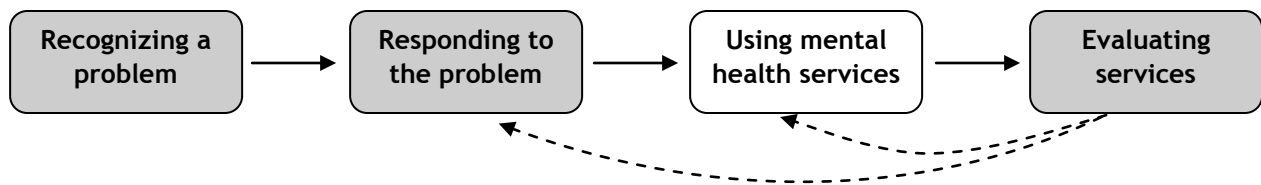


Figure 10. Using mental health services

4.3.1 Mode of Entry

Every mom in this study reported that she was the one who contacted services and made the intake appointment. However, as listed in Table 7, there were six distinct modes of entry into MHS: (1) mother's decision; (2) accepting a referral; (3) continuation of prior mental health services; (4) pressure; (5) consultation; and (6) request from the child. One narrative did not provide information on how the mother entered services.

Table 7. Mode of Entry

Category	#	Excerpts (interview number in parentheses)
mother's decision	20	And I just became so worried, I decided I had to get her some help (1036)
accepting a referral	16	I called his insurance, and that's where they sent me (1027)
continuing prior mental health services	10	She was in and out of therapy since she was seven (3093)
responding to pressure	5	We had a meeting with the school and they were just like, "if there's not a change, he's not coming back next year." (3525)
in consultation with others	4	So my lawyer and I talked and we decided that it would be best if she had some counseling and I took her to FS (1091)
responding to their child's request	4	But he finally said to me, "mom, I need somebody to talk to." So that's when we started at FS. (1019)

4.3.1.1 Mother's decision

Twenty mothers described entering MHS as their choice; that is, they did not accept a referral, consult with others, experience pressure, continue prior services, or respond to a child's request. These mothers stated that they were the ones who made the decision to seek MHS: "*And I just became so worried, I decided I had to get her some help*" (1036). "*She don't listen... So I started taking her to counseling*" (8040). Factors that were most influential in mothers decision to seek services were the type, setting and severity of the concerning behavior, and prior experience with mental health services. Surprisingly, there were no consistent patterns among reasons for seeking services and maternal causal attributions among mothers who made the decision to seek MHS. These mothers gave reasons for seeking services in each category (wits end, identifying a problem, belief in mental health services, etc), and identified causal attributions in all of the categories.

Mothers who decided to access MHS reported being concerned with more than one type of behavior, and that these behaviors tended to present in both home and school, as illustrated in the following excerpt:

And my youngest daughter, Tracy, whom I sought counseling for, is very troubled at school. She's more than a handful here at home. She's out of control. I can't -- I can't -- she defies me at every step of the way. And she -- I mean all teenagers do to a point, but she is really out of hand. She is doing very poorly in school. And I thought it was time to get counseling for her. Like I said, I'm not sure if she's acting out against what I had done or if she is -- I'm not sure. She may be suffering from depression herself. But, I wanted to get her help. (1003).

The most commonly reported behaviors were depressed mood with suicidal ideation, defiance and aggression (including threats to others), and hyperactivity and inattention. Behaviors that threatened harm to self or others were triggers for immediate service access. The following excerpts illustrate the influence of suicidal and homicidal threats on a mother's decision to seek services:

And then one day she was like really depressed and she said she just wanted to kill herself. And I said, "well, you know, either you want to go for counseling or I'll commit you." So I contacted the counseling center in NK and they got her help. (1106).

My 13 year old was out of control. He threatened to kill me so I took him to see if something was wrong. (3027).

Mothers whose children who expressed depressed mood without suicidal ideation were likely to wait longer before accessing MHS:

And like I said, Heather is very sensitive, and she picks up on everything. And I just became so worried, I decided I had to get her some help. She wasn't sleeping. She wasn't eating. She didn't want to do anything. She was constantly crying. So that's why I take her to counseling. (1036).

Similarly, mothers who reported defiant or aggressive behaviors were more likely to have a longer period of time between becoming concerned and accessing services, *You know, it's just like she's defies me every step of the way" (1003)*. Although defiant or aggressive behaviors were significant in mothers' decision to seek services, most mothers described seeking services only if there were additional behaviors, such as depressed mood, suicidal ideation, or social anxiety. There are a couple of possible explanations for this counter-intuitive finding. Mothers in this category were both active and directive. It is possible that those traits enabled them to feel more confident in their abilities to cope with defiance and aggression at home. At the same time, since these mothers meet criteria for significant depressive and anxiety symptoms (by virtue of being in the sample) there might be some interactions between their mental health problems and their child's mental health problems that influenced which problems they sought help for. For example, depression and anxiety are interpersonal problems, meaning that depressive symptomology causes problems in interpersonal relationships, and problems in interpersonal relationships can exacerbate depressive symptomology. This might make them feel less capable of coping with their child's depressed mood or social anxiety. Research has suggested that mothers with depression and anxiety engage in more permissive parenting (Oyserman, Bybee, & Mowbray, 2002) and more self-blaming (Cornah et al., 2003). It is possible that these mothers were less likely to set limits with their aggressive and defiant children and less likely that they would see their child as responsible for his or her defiance or aggression. Consequently the

mothers in this sample might have sought help for their child's aggressive and defiant behavior only when their severity, frequency and duration became too much. Another explanation is that because a number of mothers sought MHS for their own anxiety and depression, they were more likely to consider it for their children. For the same reason they might not think about MHS as an appropriate place to address aggression and defiance.

The other factor that appeared to be an important influence on mothers' decision to seek MHS was prior experience with mental health services. Ten mothers reported having a prior history with mental health services. Seven mothers reported current or prior service use for themselves or another child. Three mothers reported that their child had received MHS in the past. These mothers reported positive experiences with mental health services: *Knowing how therapy helps me so there was like no question. I knew it would help her (1067).*

I took him to counseling when he was 5 or 6. He kind of straightened up so I took him out of counseling. But then when he started in 5th grade or sixth grade he started acting up again. I started to take him back to counseling because I think it's getting out of hand a little bit now. (1363).

Prior experience gave these mothers both the knowledge that services existed, an understanding of what to expect, and a positive experience that left the door open for them to return.

For mothers with no prior service use, the narratives did not provide information on how they chose mental health services. This is due to a limitation of the interviews. For example, one mother reported this child was the first one she'd had in MHS. Rather than asking, "how did you know about MHS" or "How did you decide to use MHS," the interviewer asked about changes the mothers had seen in the past three months:

Q. Was he, was I. the first child you'd ever taken to a clinic? He's your oldest?

A. Uh-huh.

Q. So he was your first experience with that?

A. Yeah.

Q. What changes, if any, have you seen in the last three months? (3003).

In sum, mothers who decided to access MHS were most significantly influenced by the severity and/or multiplicity of behaviors exhibited by their child, and their prior experiences with mental health services.

4.3.1.2 Accepting referral

Sixteen mothers described following up on the recommendation of someone else to seek access mental health services for the child. Most mothers described sole-source referrals, meaning that mothers contacted someone and were referred by that person for mental health services. In a few situations moms described a multi-source referral situation wherein she contacted a non-mental health professional, only to be referred to mental health services. Only one mother described accepting a referral from an informal source - her family. The others accepted referrals from her insurance company (1); juvenile court (1); a mental health professional (3); a physician (3); and school (6). One interview was unclear as to the source of the referral. Mothers who entered services through “consultation” and “accepting a referral” reported both interactions with formal and informal sources prior to accessing services. The distinguishing factors between the two modes of entry is that mothers who accepted a referral identified people who recognized the child’s problem as a mental health problem and directed

the mother to mental health services. Although most of these mothers initially sought out advice, their pathway to MH services is best described as accepting a referral.

Single-source referrals

One mother reported accepting a referral from her family:

But I listened to my mom and my sister because she's a manic depressive, "oh, you should take her to counseling and everything."... But I just thought -- well, my family thought because her father died so violently that she should talk to a counselor. (3521)

One mother described talking with her insurance company because she knew something was wrong, but was not sure what the problem was nor what was the best course of action.

I called his insurance, and that's, that's where they sent me. Here's a list, and here's close to your area. That's how we ended up. I didn't have specifics in mind or anything like that. (1027)

The majority of mothers accepted referrals from school personnel. In four cases, moms described a very straightforward referral. The following excerpt is a good illustration of this type of description.

When I called my -- when the school told me I needed to get my daughter into counseling, and I said I agreed with them. (1001)

Multiple referrals:

Two mothers described multiple referrals that started with the school.

So I started talking to them and everything, and we decided that -- they brought in the school psychiatrist, and they diagnosed him ADHD, and told me that I needed to take him to mental health or set up an appoint. So I said, all right, fine. So I did that

because I was already used to mental health anyway so I went ahead and did that. (1008).

Well, I had to...after constantly going up to the school and having little meetings. They told me about getting her into like a program. There was somebody at the school that worked with her I guess because of her behavior... And so she talked to me and everything told me what procedures to go through and what numbers to call. And that's how I got to the clinic. (8064)

One mother described the sequence of referrals that led her to MHS:

Well, it started when she was around 12 last summer. She was hanging out with older kids like 18. And probably what started everything is when I walked in my house, and she was with two teenage boys, one was 17 and one was 18, and the boys were smoking pot in the house. My daughter said she wasn't, and I ended up giving her a drug test, and it showed up negative so she had been telling the truth. But I ended up taking her to -- well, I contacted a police officer. He's the one that referred me to take her to juvenile court... [Juvenile court] referred me to definitely seek a therapist to get a psychiatric evaluation, which I did. (1039)

One mother described having a school evaluation, then sharing the findings with her doctor who in turn refers her to MH services.

The school evaluated her. That's when I told her doctor and stuff. And her doctor sent her to Allegheny East. (8014)

4.3.1.3 Continuation of prior mental health services

Ten mothers indicated that the current episode of service use was only the latest in a long history of mental health services use. For these mothers, mental health services were an oft-used

resource. Although there were descriptions of consultation, referrals and individual decisions, the common element was that MH services were part of the family's existing repertoire of solutions.

We've been to MHS for a long time. He was seeing a counselor down there before, which the main reason I took him down there is because he was getting in a lot of trouble at school... So we took him down there to see if we could straighten out some of the strange behaviors, plus get him to socialize a little better in school. (1221)

Since these parents have long-term relationships with MHS, the question is not what influenced their decision to seek services, but rather, why did services stop before? Maternal narratives suggested three reasons why mothers stopped their prior service use. First, mental health services were effective in addressing the concerning behavior:

She was in and out of therapy since she was, I want to say seven. Maybe like in first grade or so. She had a lot of difficulties. And that's when she was first diagnoses being ADHD. She's always been on medication and stuff. She does so well and then she backslides. Then she does well again and then she backslides (3093).

Second, staff turnover at MHS interrupted treatment. "We weren't sure he was really making any progress and then that counselor left" (1221). Third, other events such as a mother's surgery, change in insurance coverage, and the death of a father, resulted in termination of services:

She had started going before. And well, she had to stop because her dad passed away. So she always had ADHD we knew that. And she was going to her counselor to talk about how she put together her problem with her feelings. And she stopped after he father passed away like I said. And then I got her back into it and she started going. (8027)

4.3.1.4 Pressure

Five mothers (12%) described situations in which they felt pressure from either school or family to seek services. In each situation, the mother's statements suggested that without the pressure from others mothers would not have made the phone call to set up services. What sets this category apart from all the others is the clear picture that the mothers and the school staff see the world completely differently. Consistent with the criteria for recognizing a problem discussed in section 4.1, these mothers identified a variety of behaviors but did not see them as severe, frequent or having a long duration. Mothers determined that their child's behaviors did not violate subjective norms, *"He would get like mad and angry and that, but I just assumed at the time that it was like his age group because other kids was doing the same thing"* (1220). None of the mothers, including the one whose child had a pre-existing diagnosis of ADHD, identified their child as having a mental health problem. In each case, mothers reported that their child's behavior might be problematic, but did not require outside intervention. In other words, these mothers did not identify their child's problems as psychiatric or mental health related, and not surprisingly, did not see mental health services as necessary. As one mother put it, *"I don't have a problem with her"* (3121).

In contrast, when schools informed mothers of problem behavior, mothers informed the school that the behavior was either not present in the home, or not seen as problematic. When school staff determined a behavior to be inappropriate for school, mothers suggested that schools were an appropriate place to address the behavior: *"We're parents. We want to say he just has some problems. He's going to be okay. Just deal with him"* (3525). One mother suggested that the behaviors that the school identified as problematic were simply misdirected friendliness, not psychiatric problems in need of medication:

And see, D's really sensitive and she's friendly at the same time and then when she doesn't, when she can't direct her energy in that friendliness and that sensitiveness in the right areas, she gets, she gets a little rambunctious, kind of like hyper a little bit. But not hyper enough to be on pills or anything. (1368).

Even if mothers did agree that there was a problem, it is questionable whether or not they would take their child to MHS. Mothers in this category did not believe in mental health services, especially when it came to medication: *"The strong black woman that I am, you're not going to tell my kid is crazy or anything else. I'm not going to hear it, you know" (1368). "I told them she's definitely not going to get on any kind of medication. It's not necessary" (1155).*

If mothers were not concerned about their child's behavior, and adamant that they were not going to go to MHS, how were they pressured into services? One mother reported that her child's father convinced her:

Finally, I couldn't be strong no more. And [his father] convinced me and said, "You have to take him to be seen because obviously what he's doing is for a reason." (1368).

Four mothers described overt and covert tactics used by schools to get them to make an appointment. One mother described the school's covert suggestion that unless mom sought services, she was not doing her job as a parent.

And then they call me in for a meeting and, not inadvertently, well not outright, but inadvertently make it seem like, you know, well, maybe you're not doing something you're supposed to be doing and maybe you need to take her into counseling so someone else can -- you know what I mean? And I'm like -- I'm letting them know okay, I'll take her into counseling. (1155)

More common, however, than covert pressure, was overt pressure. Three mothers described overt pressure from school for service access. In one situation, the mother reported that she was “made” to take her child in for services.

And this lady that was in, she's like a social worker or something in school, she made me take him down to St. Francis for an evaluation. And that's what got me started into taking him to therapy. (1220)

Two mothers reported that the school refused to allow the child to return to school without a psychiatric assessment:

If she was in school and she had to take a test, she would cry and she told them that she was stressed out. I guess when you're school aged, when you say stressed out, they all make you go see a psychiatrist. So I had to take her to see one before I had permission to bring her back to school. (3132)

This mode of entry was characterized by divergent viewpoints, conflicting definitions of appropriate behavior, and attacks on the mothers’ character as a way of pressuring her to access services. Of note, this is the only category in which a mother explicitly mentioned race as a factor in the help-seeking process. The mother who said, “*The strong black woman that I am,*” seemed to suggest that she had to be pressured into services because as a Black woman she did not agree with the characterization of her child as crazy, and therefore would not chose to take her child to mental health services. I will discuss this finding more in the discussion section.

4.3.1.5 Consultation with others

Four mothers described making the decision to access services after meeting with someone specifically to address the issue of the child’s concerning behaviors. Three mothers describe meeting with formal supports (lawyer, therapist, teacher), and one described a

conversation with her husband. In each case, the mother describes an interaction where she sought and received information that informed her decision. *“So my lawyer and I talked and we decided that it would be best if she had some counseling and took her to Family Services.”* (1091). *“I was worried. So I just went to the Allegheny East and I talked to my therapist and she introduced me... she got me hooked up with [his] therapist”* (8019). *“I talked to his teachers and everything and I decided to put him in counseling (1222).* In one interview, the mother clearly identifies consulting with her husband as to what should be done, *“My husband and I sat down and talked and we thought it was the best thing. Told S. what we were going to do and we did it”* (1089). In this mode of entry, the mother actively sought out feedback from others about what to do. The decision to enter services appeared to be a joint effort. This mode of entry differed from “accepting a referral” in that these mothers recognized a problem and were wondering where to turn for appropriate care.

4.3.1.6 Request from child

In four interviews, mothers reported that their decision to access services was prompted by requests from their child. In all of these situations, the child’s request was to begin services. *“But he finally said to me, “mom, I need somebody to talk to.” So that’s when we started at the clinic”* (1019). *“What led me to the clinic was B., he came to me one morning and he said, ‘Mom, I think I have ADD.’ So I made the appointment and we went to the clinic”* (3143).

One mother described her daughter requesting services, but didn’t take her seriously until she agreed to go to a hospital:

So it was a Monday, I woke her up and she came down stairs and said "I need help."

"What do you mean you need help?" Well, she contemplated taking a bottle of pills.

So it was like, I was actually pulling her bluff that day. "If you need help that bad, we

will go down to [the psychiatric] hospital." And when she agreed to it, I thought maybe the girl does need some help here (3110).

4.3.2 Reasons for Seeking Services

Mothers in this study described a number of reasons why they sought formal mental health services. Descriptions of reasons for seeking services typically included the phrase, “the reason why I took him was...”, or “I took her because...” As displayed in Table 8, mothers’ reasons for seeking services clustered around 9 themes. Some mothers identified more than one reasons for seeking services, and seven mothers did not explicitly identify a reason for seeking services.

Table 8. Maternal Reasons For Seeking Services

Category	#	Excerpt (interview number in parentheses)
Improve functioning	18	She is very sensitive, and she picks up on everything. And I just became so worried, I decided I had to get her some help. She wasn't sleeping. She wasn't eating. She didn't want to do anything. She was constantly crying. So that's why I take her to counseling; That's when we decided Kayla needed help because she was acting out in school, getting suspended, fighting. Just doing stuff (3160).
Wits end	10	And that's how I knew it was really bad. You know, for me to even want to think of losing control and hit my daughter, you know. I was at my wits end. I didn't know what to do (1000). My son was acting up. My girls were acting up. And I think really what it was was the income and everything. It's just I couldn't take it no more. Really, when I took him to get help, I took -- we both went (3003).
Concern for the future	10	I would hate her to feel like I felt when I was feeling my worst. I don't want her going through that. I would do whatever I could to prevent that (1003); Make sure they're not going to slip into some kind of disorder later on down the line. You know, be on a killing spree like in all them schools out there. I don't want my kids doing that. I don't want to sit back and be like, "oh my God. My kid shot up a school." (1008)
Identifying the problem	9	A lot of things at home I knew weren't normal and I was trying to figure out why he was doing them (1221); I took him to a psychologist so that I could finally find out where the problem is. You know, so I could get him the help that he needed (3000).

Improving communication	8	I just thought that she needed somebody else to talk to other than me to help her to feel a little more normal, a little more accepted (1223); She don't listen... So I started taking her to counseling... Because if she don't want to listen to me, maybe she'll listen to somebody else. So hopefully that will work (8040).
Relieving burden	7	Burden on family, mother, and burden from school.
Doing whatever it takes	3	"And I'll do whatever I can to help Christopher get better." (3144). "I took him because I love him" (1363).
Belief in MH services	3	Knowing how therapy helps me so there was like no question. I knew it would help her (1067)
Other	5	protecting self, responding to a referral, no reason ("I didn't have specific in mind or anything like that" (1027).)
Unclear	7	In seven interviews there was no indication of why mothers sought services.

4.3.2.1 Improve functioning

Eighteen mothers described seeking help in order to improve their child's functioning. Although all but two participants reported being concerned about their child's behaviors, mothers in this category recognized that the child's behavior was making it difficult for him/her to function in family or school situations. Mothers in this category reported being concerned about a variety of behaviors in both home and school. Behaviors included threats of harm to self or others, psychosis, academic problems, and aggression and defiance.

Four mothers described the concerning behaviors as crises - suicidal ideation or attempts, or psychosis. The crisis event was significant because it prompted mom to seek services when other concerning behaviors had not. For example, one mother (1368) reported that her son started stealing first from his parents and then from people at school. The parents tried to deal with the stealing by talking with the school about the behaviors and using a behavioral intervention at home. Their responses did not work and his behavior became worse; he started fighting with his siblings, and became violent at school. However, it wasn't until he started reporting auditory hallucinations, that his mother sought MHS. *"Then it turned into him saying this, and that, and*

the other. "I'm hearing voices. I'm doing this. I'm doing that. Finally, I couldn't be strong no more" (1368). Mothers also brought their child for services because of suicidal ideation:

And he would make references like, "I don't want to live anymore. I'll just kill myself like she did." And so it started -- we started to get -- my mother was like -- he said it at my mom's and she just like freaked out. "You have to get him in therapy." And so that really accompanied with everything else was like okay, this is a wake up call. (3525).

One mother reported a long history of concerning behaviors with her daughter. Her prior coping included use of the family physician to prescribe medications for headaches, and counseling to address some of the behavior issues. She was motivated to seek mental health services this time because of the severity of her daughter's symptoms, "*The reason why I took Chrissie to the hospital that day was because she threatened to kill herself*" (3110).

Mothers in this category also sought services for non-crisis behaviors: "*I started to take him back to counseling because I think it's getting out of hand a little bit now*" (1363). "*Another reason I took him down there three months ago was because there were a lot of problems in the school*" (1221). "*That's when we decided Kayla needed help - because she was acting out in school, getting suspended, fighting. Just doing stuff*" (3160).

Mothers in this category were recognized that their child's behaviors were problematic and not going to resolve themselves. One mother was concerned enough about the duration of her daughter's behaviors that she decided she "had to get her some help":

And like I said, Heather is very sensitive, and she picks up on everything. And I just became so worried; I decided I had to get her some help. She wasn't sleeping. She wasn't eating. She didn't want to do anything. She was constantly crying. So that's why I take her to counseling (1036).

4.3.2.2 Wits End

Ten mothers sought services because they were at their "wits end." These mothers described being at a tipping point where they no longer knew what to do. The threshold for this tipping point differed. Mothers who were at their "wits end" exhausted all possibilities of which they were aware for coping with their child's problems. One mother knew she was at her wits end when she almost lost control and hurt her daughter: *"And that's how I knew it was really bad. You know, for me to even want to think of losing control and hit my daughter, you know. I was at my wits end. I didn't know what to do"* (1000). A number of mothers reported that they could no longer handle their child's problems:

I need to help. He seems to have so much anger inside of him and it's all directed at me.

I've been raising him by myself for 12 years. He has no male influence whatsoever in his life. I just need help. I'm stressed to the max. I can't take him anymore (3114).

I just don't know what to do with K. I just can't handle K. (3160).

So I said I can't deal with no more. I needed to get some help. So that's what made me go down to [Mental Health Services] (3092).

Although most mothers who were at their wits end wanted someone else to deal with their child's problems, one mother indicated that she wanted to be clear on what the problem was so that she could deal with it: *"And I pretty much had enough of it so I didn't know what to do so I figured I could go sit there and see why she'd be acting this way. Maybe then I could curb her behavior"* (1020). Mothers who gave this reason for seeking services were more likely to have chosen services on their own, without accepting a referral or consulting with others. For these moms, MHS seemed like a last resort.

4.3.2.3 Concern for the future

Ten mothers sought services because of concerns for their child's future. These mothers were both concerned about their child's current behavior and worried about what that behavior meant for their child's future; using mental health services was intended to address current behaviors and prevent future problems. Mothers described wanting to prevent their child from growing up and doing bad things.

Make sure they're not going to slip into some kind of disorder later on down the line. You know, be on a killing spree like in all them schools out there. I don't want my kids doing that. I don't want to sit back and be like, "oh my God. My kid shot up a school." (1008).

Sometimes I think, gee, is he going to turn out to be like -- you know, he holds everything in. Is he going to turn out when he gets older to hurt somebody? I don't know what goes through people's minds. There's a lot of crazy people out there. I don't him to turn into one of those (1222).

Mothers were also concerned that without intervention, their child's actions would be misunderstood by the police or people on the street:

But now I really have to be strict on him because he's a 12 year old boy. If he goes out on the streets and he says some of the things that he says to somebody in the streets, somebody's going to hurt my son. And I don't want to see my son in those streets for real (3027).

I don't feel really that he is ready to go out because of the ADHD. You know, I'm afraid that he's going to get out on his own, you know, something is going to result. He might not take his medication. One thing is going to lead to another and, you know, he could

end up in trouble with the cops. And they're not going to understand that he has a, you know, a problem (3143).

So I took him for counseling because I didn't know what else to do with him. I mean I was very disappointed. I was upset. You know, I don't want my son to be a criminal. So I decided to take him for counseling (1077).

One mother was concerned about her daughter's future in general:

I just worry constantly the road she's on. Is she just going to possibly end up in jail? That's my biggest concern. I just worry about her constantly because I see, you know, kids heading on the path's she on. And there's not going to be any future for her at the rate she's going, and that scares me (1039).

One mother was concerned about his near future – high school, “I wanted to do something because he just got to go to the high school” (1089). Not all mothers feared for the future. One mother reported seeking services so that her son could be a better person: “*C. has his whole life ahead of him. And I figure if I could get him help now, get it straightened out, that might make him for a better adult*” (1220).

Mothers in this category seem to be motivated primarily by the perceived threat of future problems. This future orientation is unique among this sample. While other mothers thought about the future, many were focused on the past. For example, mothers who attributed their child's problems to growing up in an abusive household, or whose father was absent, focused on present solutions to address past concerns. These mothers used present solutions to prevent future problems. The future they imagined for their child was bleak. In order to change a likely future for their child, these mothers enlisted the help of a social service agency. It is unclear if they anticipated being in a long-term relationship with the agency, or if they expect that the

future will be altered in a matter of a few sessions. If it is the former, mothers might find themselves frustrated by high staff turnover, short-term present focused treatment models. If it is the latter, mothers might return time and again in order to change the future piece by piece.

4.3.2.4 Identifying the problem

Nine mothers described seeking mental health services because they wanted to understand what the problem was; their child's behaviors did not make sense to them and they were looking for an explanation. One mother said, *"I'm like puzzled by the whole thing. I don't understand why she's like that"* (1055). In contrast with mothers who sought MHS to resolve the concerning behaviors, these mothers were unclear about how to address the problem, either because they had tried things and they hadn't worked, or because they didn't know the cause of the problem and therefore were unclear what might solve the problem. Trying to figure out the problem was an important motivator for many mothers, *"A lot of things at home I knew weren't normal and I was trying to figure out why he was doing them"* (1221). Mothers saw mental health services as being able to provide a thorough assessment of the problem. In this excerpt, the mother was responding to a question about what she thought might have caused her son's problems: *"Well, that's why we were talking to the counselor and trying to get to the point"* (3147). Mothers looked to MHS to identify the problem when they were unable to. It is possible that their attempts at coping further reinforced their opinion that they did not understand what was going on with their child. These mothers seem to have more faith in a traditional medical model where there are experts who assess, diagnose, and treat. It seems likely that these mothers are comfortable with someone else taking an expert role and accepting the professional explanation is provided by MHS.

One mother sought mental health services because she assumed her role as mother would keep her from being able to figure out what was going on with her son. This mother saw the therapist as an expert, and “not-mom,” and therefore someone who would be able to identify the problem:

And with the therapy, I hope that they can help him deal with the issues that he has because there's something there and I just don't know. They might be buried within. He won't talk to me. I'm mom. Most kids his age, he won't talk to me. He'll talk to somebody else. He won't talk to me. Q. Like his therapist? A. Uh-huh (1083).

Some mothers sought services for assessment and treatment:

And with the therapy, I hope that they can help him deal with the issues that he has because there's something there and I just don't know. They might be buried within. He won't talk to me. I'm mom. Most kids his age, he won't talk to me. He'll talk to somebody else. He won't talk to me. Q. Like his therapist? A. Uh-huh (1083)

This mother is hoping that MHS can assess and treat. For other mothers, the hope was that mental health services could let mom know what the problem was so that they could deal with it: “*I don't know what's wrong with him... I don't know what to do with him*” (3114). Another mother saw her role as helping her son, even if she wasn't the one who solved the problem, “*I took him to a psychologist so that I could finally find out where the problem is. You know, so I could get him the help that he needed*” (3000). These mothers sought mental health services to get answers to the questions, “what is going on and why?” For some mothers the assumption was that mental health service providers would be able to address the problem. Other mothers wanted the information so they could address the issues themselves. Mothers in this category looked to MHS to identify the problem when they were not able to.

4.3.2.5 Improving communication

Eight mothers reported seeking services to improve communication. These mothers saw problems in communication to be one of the biggest impediments in identifying or resolving the problem. For these mothers it was important that their child be able to express themselves, either to the mother or to someone else. Some mothers recognized that their child might need to talk, but not to their mother.

So I figured it might be easier for her to talk to someone else... I just thought that she needed somebody else to talk to other than me to help her to feel a little more normal, a little more accepted. (1223).

And I wanted to know -- I thought if maybe he went to the clinic and talked to somebody other than me because he's not a very open child -- if he could possibly talk to somebody about what was bothering him or what provoked him to even think about doing this (1092).

She don't listen... So I started taking her to counseling... Because if she don't want to listen to me, maybe she'll listen to somebody else. So hopefully that will work (8040).

One mother identified her suicide attempt as the moment that her children stopped talking with her. For this mother, MHS was an opportunity to communicate to her children that they are not to blame for her suicide attempt:

I wish that I could let them know that I love them and that they're not the reason that -- they played no part in my decision to take my life. It was -- it wasn't them at all. And I wonder if they blame themselves a little bit or what their thoughts are on it. I just wish I knew. And if they don't talk to me, I want them to talk to a counselor (1003).

Clearly this mother wishes she could be the one to “right the wrong.” But she is willing to have someone else play the role of healer as long as her children heal. Other mothers see MHS not as a substitute pair of ears, but a place that will reinforce the importance of communication between mother and child:

“I want her to be able to know that she can tell me anything, and as much as I tell her that, she’s just very quiet and keeps to herself with it. She’s basically turning out to be me. And I don’t want that” (1001).

One mother sought MHS because she was having difficulty communicating with her daughter’s school, *“Communicating with the school and communicating -- you know, I wasn’t getting anywhere. I needed a little more help” (1221).* For these mothers, problems with communication were a significant factor in seeking services.

4.3.2.6 Relieving burden

Eight mothers sought services because they were trying to relieve the stress on themselves or their family caused by their child's problems, or by the school. These mothers reported that they were being negatively impacted by their child’s problems. Although some of these mothers might have felt like they were at their wits end, they emphasized how tired or frustrated they felt, rather than how they had reached a tipping point. Mothers saw MHS as a way of reducing overall burden by taking care of the child's problems. Mothers in this category often described themselves as being “tired”: *I got tired of her with her frustration (3099). We would always argue, "where's your homework? Did you do your homework? Why you sitting there?" I was tired of being the master and chief (1089).*

Mothers in this category reported burden due to their child's behaviors, as well as other things going on in their lives. In this excerpt, the mother describes what she was going through when her daughter told her she was suicidal:

I didn't know how to deal with hardly anything. I was just going through trying to deal with her, and deal with the bills, and working, and having trouble at work, and I couldn't work. And I've been off work since January 3 because I've had two back surgery. And now I have scar tissues that's causing trouble on my back. So I was on like short term disability, okay, but my short term disability ran out because they said I didn't cooperate with them, but I sent them all the doctor reports and everything they wanted. So they shut my income off in April. Then I got a letter from my place of employment, which I haven't been medically released yet, they terminated my employment. And I've just been going through like a lot. I mean I didn't know which way to turn (1106).

Mothers sought services to reduce burden experienced by family and schools. One mother reported that her daughter's behavior was not a problem for her, but it was a problem for the school. Another mother reported that her child's problems were causing significant problems for her family:

But when I saw that she was still struggling we needed some type of help and support because, you know, I was feeling guilty. She was very frustrated. She just wasn't doing well. It was really tearing the family apart (3021).

One mother described help-seeking as an attempt to reduce the burden she felt from the school, "So when I decided to take him, his school was driving me totally batty" (1008). One mother's reason for seeking services could be considered "burden prevention." This mother described losing trust in her social supports after her daughter's suicide attempt was hidden from

her: “So when I found out that I couldn’t rely on her to be honest with me as well as anybody else, that’s when I went and took a step to find some help elsewhere” (1001). She turned to formal supports as a way of preventing the burden that she might have felt trying to deal with the problem in isolation.

4.3.2.7 Doing whatever it takes

Three mothers reported that they would do whatever it took to get their child help. Two mothers in this category chose MHS, and one accepted a referral for services. Mothers in this category described seeking services because they loved their child:

And I’ll do whatever I can to help Christopher get better. If it means that I’m the one that’s been poisoning him and screwing him up, I’m willing to face that and do whatever I need to do to change that. That doesn’t mean that I’m a bad mom. It just means that I loved him too much and I made a mistake, but I want to fix it (3114).

Because I want anything to help her (1055).

I took him because I love him (1363).

4.3.2.8 Belief in MH services

Three mothers sought MHS for their child because they were currently in mental health treatment and believed in the benefit of mental health services.

I see a counselor once a week. I see a psychiatrist once a month for my medication check-ups, and it’s been helping me so I thought it would help her as well. So I’ve taken her to Family Services (1003).

Knowing how therapy helps me so there was like no question. I knew it would help her (1067).

Do you think you being in therapy first kind of ... P: Yeah, that's what kind of lead me to do what I needed to help M. (8019).

4.3.2.9 Other

Five mothers identified other reasons for seeking services: Three mothers had no particular reason and were responding to a referral. Two mothers reported feeling pressure to seek services and were complying to protect themselves:

As long as I'm not being pulled into court, I'm okay with it, which was getting real close for my youngest one so that's why I had to take him to mental health. I mean he beat up the principal three times. Got kicked out of school (1008).

But I'm still going to keep him in counseling because if you don't keep him in counseling and he goes to school and gets in trouble, they'll look back at you like you're a bad parent and stuff like that. So I'd rather be safe than sorry... I just think that he needs to go down there just in case something goes wrong in school because they will try to take him to a magistrate and all that (3027).

4.3.3 Summary of Using Mental Health Services

Mothers described three components of their help-seeking process during this phase: how they entered service or their *mode of entry*, why they entered services (their *reasons for seeking services*) and the types of services they used. Mothers described entering mental health services in one of six ways: mother's decision; accepting a referral; continuation of prior mental health services; pressure; consultation; and request from the child. Maternal narratives suggested that different factors influenced which mode of entry mothers would use. For example, mothers who

decided to seek MHS all believed that their child had a problem, whereas with the mothers who felt pressured into services did not believe their child had a problem. With the exception of mothers who were pressured into services, all mothers actively sought help for their child. Mothers who recognized their child's behavior as a mental health problem could be characterized as "directive," and those who were concerned but not sure what services were most appropriate could be characterized as "receptive" to feedback from others. Mothers provided a variety of reasons for seeking services. Most mothers were seeking services to address their child's issues, but some were accessing services as much to get relief as to deal with their child's problems. The different *reasons for seeking services* have a number of implications for practice that will be discussed in the next chapter.

4.4 EVALUATING MENTAL HEALTH SERVICES

After mothers recognized a problem, responded to the problem with informal and/or formal resources, and entered mental health services, the next stage in the help-seeking process was deciding if current mental health services were addressing the concerning behaviors, or if other services were needed. Maternal narratives suggested that although most mothers found the help they sought, there were some whose help-seeking pathway continued, even after accessing mental health services. Three factors influenced mothers to continue, diverge from, or terminate the help-seeking pathway: (1) there was no change, or insufficient change in their child's behavior; (2) there was a poor fit between the client/mother and the therapist or service; (3) barriers such as transportation or staff turnover prevented continuing current services. The responses in this section are mutually exclusive.

Figure 11 illustrates how mothers' process of service evaluation influenced the help-seeking pathway. Mothers for whom services did not meet expectations terminated current mental health services and sought other responses to the problem, or sought other formal services.

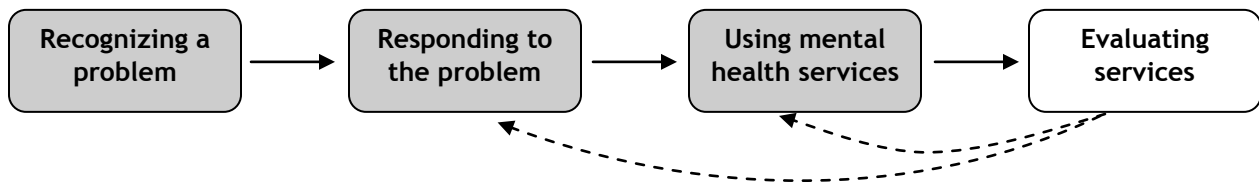


Figure 11. Evaluating mental health services

4.4.1.1 Changes in behavior

In nearly all of the interviews, mothers were asked if they had seen a change in their child's behavior since the intake appointment, three months prior to the interview. The majority of mothers (46) reported positive changes in the child's behavior (either some improvement or symptom remediation). Ten (10) mothers reported that they had seen no change in behaviors; three (3) mothers reported that the child's behavior was significantly worse than at the start of services; and one (1) mother did not answer due to the fact that her child had not returned to services since intake. Mothers who reported that MHS had addressed their child's concerning behavior did not describe plans to seek additional or alternative services, suggesting that their help-seeking pathway had ended. Table 9 provides examples of concerning behaviors and the corresponding maternal reports of positive changes in behavior:

Table 9. Examples of Concerning Behaviors and Changes in Behaviors

Concerning behaviors	Changes in Behaviors
Christina was having outbursts. She would be totally out of control, and my husband would call me at work, and she would just be throwing things, breaking mirrors, kicking,	And so we told her that, if we started taking an uncontrollable rage, and I pick up the phone, and she's stopped like that... Since she knows now that there's someone who will come [from

clawing at the wall, and then she, at one point - it happened a few months before that, she took scissors and cut chunks out of her hand at school. I mean, literally cut chunks (1000)

the crisis service unit], she doesn't do it anymore (1000).

She's had a chip on her shoulder. Just angry at everything. She just didn't really care. She lost interest in herself. Didn't want to go nowhere. Didn't want to do anything. Was angry. Would snap out. We were constantly having disagreements (1106).

She's more patient. Because she's more calm. She's learning how to deal with it and how to talk about it. And she's trying to talk more and tell me if there is a problem (1106).

Her attention was short. She wasn't getting into any trouble like behavior problems. Her grades were sliding down. I was very concerned. She was struggling with just about every subject in school (3021).

I've seen great turnaround. She's excited about school now. Her grades are up. She seems happier... She does her homework. She gets it done within an hour's time. She's not so frustrated. We don't have to fight like we did. (3021).

Mothers reported improved behavior when the child's school functioning progressed:

So that's why I took him to the clinic, but they got him straightened out. Now, he's in his new school, and he's doing really good (1008).

A lot quieter. He don't scream as much. Like I said, he almost got all A's and B's on his report card. Also, I was running back and forth to school all the time because he would forget his homework. He would forget his book. That stopped (1089).

Mothers who reported seeing some changes in behavior, but no overall improvement, usually reported that their child's behavior had improved in one context (e.g. home), but not another (e.g. school), or had improved for a time but was back to being a concern:

She's opening up a little bit more since we've been in the, you know, down at the therapy sessions. But just a couple days ago, we had another incident to where now she is suspended again and we're back to she doesn't want to talk, she's withdrawn. She made

honor roll, which surprised me because from what they were saying, she wasn't turning in homework and doing work in school (3092).

Two mothers attributed a negative change in behavior to extra-therapeutic factors (e.g. birth of a child; and return to an abusive family situation): *“It's gotten worse since the baby came” (1020)*

It's gotten worse. Because three months ago, I picked up and moved out of the house... but unfortunately we got into a position where we had to go back. He came back a few days after we did. It was really good at first, but it's just gotten violent again... she [the child] doesn't even want to associate with friends anymore. She doesn't want to help out anymore. She's just always daydreaming out the window... She's now dropped to a D student. So it's definitely showing (1102).

4.4.1.2 Changing or altering the pathway

Mothers described changing MHS through the addition of concurrent services such as medication or changing to a different treatment modality (e.g. in-school MHS, or home-based services). For example, one mother (8058) reported although there had been some improvement in her daughter's behaviors due to MHS, she continued to have problems in school. Consequently the mother sought help through the school, in addition to MHS: *“The school is trying to work with me... they're trying to do some psychological testing”* Another mother said that she thought MHS were effective, but she wanted to get her daughter into more intensive services: *“She makes an effort to do her work in school. But she still has problems. I am still trying to get her in wrap around” (8064).*

Among the narratives that described the influence of mental health services on the help-seeking pathway, one of the most common reasons mothers gave for terminating services was

staff turnover. Specifically, mothers commonly reported that their child had a good relationship with their first counselor. The counselor would leave and either the child/mother decided not to go back, or the replacement counselor was not meeting the child's needs:

I wish he would have had more than just one counselor session because he was seeing Jim there. Jim was really reaching him. They were going to another session and "boom" he couldn't see Jim anymore and they said he had to see this lady. It was enough for me to pull to get him there and you know when you see somebody and you focus and you are reaching out to him and you finally are reaching to him and all of a sudden "boom" you are pulled away from him and then they say you have to see somebody else. And then they call and talk to me about we have to go somewhere else instead of Turtle Creek, they want us to go somewhere else. Then I snapped, I was like well wait a minute, you were finally reaching him, you got somebody to reach him and then all of a sudden you guys are going to go change us up, let him see somebody else and he just didn't click with that person. (3147).

The mother reported that her son was not interested in seeing the new therapist, so the mother stopped bringing him in:

When he would go there he would just sit there and give her a nasty look. Well I felt as though that's just going to put more pressure and that's going to make it worse than helping us... So we haven't been back (3147).

One mother reported that her child's behavior was worse after the child had a bad experience in therapy and decided not to return (3155).

[MHS] are not helping because like I told them, transportation is a problem for me... Her therapist never called me back. I only took her in there for the intake. She has not been

back since. I keep calling and leaving messages, but [the therapist] is not calling me back. (3155)

However, not all mothers terminated services if her child had a bad experience with therapy. Mothers who thought that services were and might be useful were willing to continue services, despite the child's protestations:

Q. So you're not really seeing too many changes with her?

A. Not really.

Q. Do you think you're going to stick with the counseling?

A. Yeah.

Q. How come?

A. She needs it. I think she needs it. (8040)

One mother described a poor fit between her reasons for seeking services – to identify the problem – and the therapist's treatment approach. This mother discontinued services:

A. I just figured maybe that if something was bothering her that maybe she, you know, they'd be able to figure it out or recognize something that I'm not trained to see or, you know what I mean, if there was something bothering her or maybe she'd actually want to talk to somebody else, you know, other than me, or like my mom and dad, or something. So, but they never really talk to her about anything so I didn't see the point... She's old enough that she can carry a conversation on. She's perfectly fine with that. She'll talk to you. And all they did was let her sit there and play with toys while they discussed how her behavior was with me and what I should do to curb it.

Q. So they'd talk to you in other words?

- A. *Yeah. Instead of trying to find out why she was acting the way she was.*
- Q. *How does that make you feel that they were talking to you rather than her?*
- A. *Just pointless. It was kind of like a lost cause because, you know, you're not going to figure out what's going on in her head if you don't talk to her. So that was like my biggest thing. (1020).*

Another mother had a similar complaint about staff turnover:

Well, I haven't had him back to the therapist in about a month. I didn't really like her, and I tried to get to another one, and the name they gave me, when I called them number, they said, "we've never had anybody by that name here." And then I just never got him back, but she wasn't addressing -- I wasn't happy with her. She was not addressing the issues that I thought were the problems at all (1027).

Another mother said that her child's therapist did not know what she was doing, so she discontinued services:

I took him to counseling at AK, and that was a disaster. That was a disaster with this woman. She didn't want to talk to Tyler. Tyler, he loves to talk. He'll tell you what's wrong. He'll tell you. She didn't want to talk. She wanted me to -- I can't tell you what's wrong with Tyler. I know, but you need to talk to Tyler and see what he's doing without me being in the room. I'm not afraid of what my child is going to tell you. And that was not the issue. And we went, "so how was Tyler's day today?" Ask Tyler. I'm not with him from 7:00 until 5:15. You need to talk to him. And she just didn't do that. The list of goals she made for a six year old were just outrageous, you know. And her and I -- and it was just a disaster... It's not a racial thing, but it's hard for someone to understand what it is to be a black woman first of all in this society and to deal with a black child that is a

male by yourself. It's a tough job. And this woman just had no conceivable conceptions on anything I was talking to her about. And I just discontinued going to her. (1043).

This mother, however, believed in the benefits of MHS, so she sought out a new therapist at the same agency. She had positive evaluations of the services with the new therapist:

The woman we go to now, she's great. She just sits down. She gets down on the floor with Tyler. They role play with little puppets. "Tyler, what are you feeling?" And he's getting so much more out of it. (1043).

4.4.2 Summary of Evaluation of Services

In sum, maternal narratives described how using MHS contributed to either continuing, diverge, or terminate the help-seeking pathway. Narratives suggested that most mothers were satisfied with services and appeared to have ended their help-seeking pathway. Mothers for whom the help-seeking pathway continued described either changing or terminating services. When the help-seeking pathway diverged, mothers described adding related services, or switching the primary service. Mothers who sought to terminate services provided a number of reasons, including dissatisfaction with services and staff turnover.

5.0 DISCUSSION

The current study sought to describe and characterize the perceptions and experiences of mothers who accessed mental health services for their children. Secondary data were gathered from a study of mothers who initiated treatment for their children ages six to eighteen at one of four community mental health centers (CMHC) in Western Pennsylvania. As part of that study, 127 mothers were interviewed three-months after initiating services for their children. The goal was to better understand the context of the mothers' lives at the time they brought their children in for services; how they perceived their lives, problems and distress; their responses to being told they had significant depressive or anxiety symptoms; their network of social supports or stressors; and the reasons why they did or did not seek treatment following referral (Anderson et al., 2006). The current study analyzed a random selection of 60 of the 127 interviews to improve our understanding of how and why mothers accessed mental health services for their child. This chapter provides a summary of the results of the current study; how the results inform our understanding of maternal help-seeking for children with emotional, behavioral, and/or cognitive problems a discussion of study limitations; and the implications of the results for future social work practice and research.

5.1 SUMMARY OF FINDINGS

The sixty interviews that I analyzed suggested that the mothers went through a four-stage process to address their children's social, emotional and/or behavioral problem(s): (1) recognizing a problem; (2) responding to the problem; (3) using mental health services; (4) evaluating mental health services. However, the heterogeneity of their experiences suggested that, even though they all went through the same process, each stage was influenced by several factors that varied in importance to the mother.

5.1.1 Stage 1: Recognizing a problem

In the first stage of help-seeking, mothers described becoming concerned about their children's behavior and trying to understand the cause(s) of that behavior. Mothers' perspectives spanned a continuum from no concern about their child's behavior, to concern but uncertainty about the problem, to belief that their child had a mental health problem. Mothers who were not concerned about their children's behavior reported no problem behavior at home but said that school staff perceived a problem. These mothers either did not know what the cause of the problem was or they attributed the problem to the school or school staff. Mothers who were concerned about or convinced of a problem suggested that the severity, frequency, and duration of the child's problem behavior were significant factors in problem recognition. For example, mothers reported becoming concerned when their child threatened suicide, cried every day, or washed hands for hours. Mothers described being concerned about their child's *emotion or affect*, e.g. feeling bad, crying all the time, and worrying; *actions*, e.g. being disrespectful, stealing, difficulties sitting

still or paying attention; *academic performance*, e.g. failing classes; and *abnormal behaviors*, e.g. smearing feces, acting like a dog, and not talking for three months.

Mothers reported these triggers with varying degrees of concern. Typically the most concerning behaviors were those that threatened harm to self or others, or indicated emotional problems, such as crying, having low self-esteem, or excessive worrying. Mothers recognized a problem by comparing their child's behaviors to a norm or by accepting someone else's opinion that their child had a problem. Mothers gauged what was normal against developmental norms, their personal experiences, and what they witnessed in their family, including the child's prior behavior and the behavior of his/her siblings. Although mothers relied primarily on their own observations, they received information from informal and formal sources. Some mothers reported that their child had no problems at home, but were told by someone (usually school staff) that their child's behavior was concerning. In some cases, mothers were not affected by the external concern, even though they accepted that someone else perceived a problem with their child's behavior. In other cases, mothers did develop concern about their child in response to the external concern. These mothers valued concrete evidence, regardless of source, that indicated that their child's behavior interfered with or limited the child's involvement with family or school activities. For example, one mother (3114) became concerned because her son's mood swings were interfering with his ability to do well in school.

During the first stage, mothers tried to make sense of their child's behaviors. Mothers attributed their child's problems to seven basic causes: 1) inherent, e.g. bad child; 2) heredity, e.g. got it from mom; 3) development, e.g. going through puberty; 4) psychological, e.g. depressed or crazy; 5) family, e.g. absent or abusive father, chaotic household; 6) school environment, e.g. teachers, peer pressure; 7) other, e.g. don't know. The majority of mothers

attributed the cause of their child's problems to school environment or family environment, specifically an absent or abusive father. Only four mothers attributed their child's problems to something psychological. This suggests that mothers saw their children's problems as contextual and systemic, rather than individual or intrapsychic. After mothers recognized a problem and tried to identify its cause(s), they entered the second stage of the help-seeking process.

5.1.1.1 Relationship between stage 1 and existing research

In the first stage, mothers reported becoming concerned about behaviors that clustered around four themes. Mothers reported being concerned with and more likely to seek services due to emotion-based problems than action-based problems. This finding stands in contrast with much of the existing research on service use. Most research has reported that parents have an easier time recognizing action-based or externalizing problems such as ADHD, than emotion-based or internalizing problems such as depression (Logan & King, 2002). Furthermore, epidemiologic studies have suggested that youth with externalizing problems are more likely to use mental health services (Flisher et al., 1997; Glied et al., 1997; Leaf et al., 1996). However, the mothers' concerns with emotion-based problems are consistent with the first nationally representative study of public responses to child mental health problems (Pescosolido et al., 2008). Pescosolido and colleagues reported that the 1,393 parents surveyed were less likely to see action-based problems (such as those present in ADHD) as serious, as a mental illness, or needing treatment compared with emotional problems (such as those present in a diagnosis of depression). It is possible that the mothers in the current study believed, as those in the Pescosolido study, that action-based problems were more likely to resolve on their own than emotion-based problems. It is also possible that they did not see actions as mental health

problems, and therefore not appropriate for mental health services. Pescosolido et al recommend increasing education about the role of mental health services in treating externalizing disorders.

Empirical research has found support for different “first” stages of help-seeking. Most studies lend support to the idea that the first stage in the help-seeking process is recognizing a mental health problem (Alegria et al., 1991; Andersen, 1995; Logan & King, 2001; Zwaanswijk et al., 2005). However, recent research has challenged that idea, suggesting instead that parents first become aware of behaviors, and then identify them as mental health problems (Logan & King, 2001). Arcia and Fernandez (2003a) reported similar findings, but went further, suggesting that families can enter mental health services without ever identifying a mental health problem. The current study lends support to the idea that recognizing a mental health problem was not a required first stage, nor a pre-requisite for accessing services. Mothers who entered services to identify the problem or who were pressured into services clearly never identified a mental health problem. Most mothers recognized a problem, but only a few clearly identified it as a mental health problem.

Prior research (Logan & King, 2002; Verhulst & van der Ende, 1997) has found that one of the most significant influences on the early stages of the help-seeking process is parental psychopathology. Although one study reported that depressed parents were less effective at identifying depression in their adolescent child (Logan & King, 2002), most studies have found that parental psychopathology increases problem identification (Verhulst & van der Ende, 1997; Zwaanswijk et al., 2007). Researchers have suggested that parents with mental health problems are less tolerant of children with emotional and behavioral problems and therefore more likely to label their child’s behaviors as problematic (Verhulst & van der Ende, 1997). The current study suggested that while that might be true for some mothers, there are other reasons why maternal

depression and anxiety might influence problem recognition. Mothers in the current study described becoming concerned about their child's behavior when they recognized similarities between their child's behavior and their own depressive or anxious behavior. For these mothers maternal psychopathology moderated their understanding of the meaning of their child's behaviors. Mothers also described how their lives had been limited by their mental health problems, and they were motivated to seek mental health services to prevent their child from having the same experience. This finding stands in contrast to existing research that has found that maternal psychopathology correlates with problem recognition, but not help-seeking (Verhulst & van der Ende, 1997). As noted below in the limitations section, one limitation of this study is that all mothers in this sample reported mental health problems, and consequently it is not possible to correlate problem recognition or service access with maternal psychopathology. Nevertheless, these findings suggest that the role of maternal psychopathology in problem recognition and accessing mental health services for children is more nuanced than previously reported.

5.1.2 Stage 2: Responding to the problem

In the second stage, mothers described attempting to address their child's behaviors in a seven ways: 1) using behavior interventions, e.g. rewards and/or punishment; 2) formal services, e.g. school, legal, medical, or mental health; 3) interpersonal coping, e.g. building family and talking; 4) activating the social network, e.g. involving the child in extracurricular activities, or contacting friends or extended family; 5) changing environments; e.g. leaving an abusive home; 6) no prior coping. Mothers chose how to respond based on their child's concerning behavior and its perceived cause(s). For example, mothers used behavioral interventions most often in

response to behavioral problems. Mothers who attributed their children's problems to an absent or abusive father responded by engaging the child's social network. Other mothers responded to being in an abusive environment by changing environments. There were two situations in which mothers did not attempt to address the problem(s) prior to entering mental health services: 1) when the child was threatening harm to self or others and consequently needed immediate professional attention; or 2) when the mother believed the child did not have a problem and consequently saw no reason to engage in prior coping. With the exception of mothers who did not use prior coping, all mothers reported that their attempts to address their child's problems did not work.

5.1.2.1 Relationship between stage 2 and existing research

Surprisingly, there is very little research on what strategies parents employ outside of specialty mental health services to address their child's problems. Most research has discussed parents' use of social networks in coping with children's problems. McMiller and Weisz (1996) explored how racial and ethnic characteristics influenced the types of contacts made by African American, Latino and Caucasian families prior to accessing care at mental health clinics. The authors suggested that when parents perceive a problem, they test their perception against the views of people in their socio-cultural environment. This process of seeking feedback was viewed as an early step in the help-seeking process. They reported that Caucasian parents were three times more likely to contact professionals prior to accessing care than were African American and Latino parents. The authors provided a number of different explanations for lower rates of professional contact by African American and Latino parents, including cultural mistrust, availability of stronger informal networks, and financial limitations (although the later was not supported by their data). The authors concluded that social networks played an important role in

the help-seeking process. Although the mothers in this study described accessing their social network, and nearly half of the sample was African American mothers, few mothers described using their social networks as part of their coping strategy. This issue is further discussed in section 5.4.1.3.

5.1.3 Stage 3: Using mental health services

In the third stage, mothers described their *mode of entry* (how they accessed mental health services, or MHS) and their *reasons for seeking services* (why they accessed MHS) for their child. Mothers reported using office-based individual and family therapy, home-based individual and family therapy, school-based individual therapy, crisis services and medication services.

Mothers identified six *modes of entry*: 1) mother's decision; 2) accepting a referral; 3) continuing prior mental health services; 4) responding to pressure; 5) in consultation with others; 6) responding to the child's request. In three interviews, mothers did not provide information on how they entered MHS. With the exception of mothers who were pressured into services, the modes of entry were "active and directive" (mother's decision, and continuing prior services) or "active and responsive" (accepting a referral, consulted with others, responded to child's request).

Mothers identified nine *reasons for seeking services*: 1) improving the child's functioning; 2) at their wits' end; 3) concerned for the future; 4) identifying the problem; 5) improving communication; 6) relieving burden; 7) doing whatever it takes; 8) believing in mental health services; 9) other. In seven interviews, it was unclear why mothers accessed MHS. Mothers who had identified one or more problems sought services in hopes of finding a solution [characterized by reasons 1) improving the child's functioning, 3) concerned for the future, 5)

improving communication, and 7) doing whatever it takes]. Other mothers sought services because they had been unable to identify the problem themselves and wanted the mental health worker's assistance to do so [characterized by reason 4) identifying the problem]. The final set of mothers, characterized by reasons 2) at their wits' end and 6) relieving burden, sought services as much for themselves as for the child.

5.1.3.1 Relationship between stage 3 and existing research

Traditional help-seeking models assumed that people entered services by choice. More recent theory development and research has challenged this notion (Arcia et al., 2004; Pescosolido, 1991, 1992), and suggested that people enter services in multiple ways. Empirical studies of adults seeking mental health services, and parents seeking services for children have identified "choice," "coercion," and "muddling through" as three modes of entry (Arcia et al., 2004; Pescosolido et al., 1998). Arcia et al, identified a fourth mode, "accepting a referral." The current study lends support to the concept of "modes of entry." Mothers identified six modes of entry, three of which are consistent with the modes of choice, coercion, and accepting referral. More significant, however, was the absence of a mode of entry that could be considered "muddling through." In Pescosolido's study, one-third of participants "muddled through," and in the Arcia et al study, approximately half of the sample "muddled through." However, none of the mothers in the current study described entering through a convoluted pathway. It is possible that mothers' prior experience with mental health services, and their desire to address their child's problems precluded a "convoluted" entrance to services. Implications for research are discussed below.

Although race has been identified as a salient factor in parental help-seeking for children (McMiller & Weisz, 1996), only one mother in the current study explicitly mentioned race as a

factor in the help-seeking process. This mother was describing the context within which she felt pressure to access services. This mother seemed to suggest that she had to be pressured into services because as a Black woman she did not agree with the characterization of her child as crazy, and therefore would not chose to take her child to mental health services. This mother's concerns is consistent with the majority of research that has looked at race and mental health help-seeking. With the exception of a recent study by Pescosolido and colleagues (Pescosolido et al., 2008) that found no differences in perceptions of stigma between African American and White parents regarding mental health services, research has consistently found that African Americans were more distrustful of formal services (Whaley, 2001), and more likely than white parents to utilize friends and family to cope with problems (McMiller & Weisz, 1996). Research on adults who use mental health services has reported that compared with white patients, African American patients are significantly more likely to report being coerced or pressured into services (Pescosolido et al., 1998). In the current study, four of the five mothers who described being pressured into services were African American, and one was white. Although it is tempting to see this as a finding, since this is not a representative sample, and because only one mother mentioned race as an issue, it is not possible to say that race was a significant factor in help-seeking. In fact, since only one out sixty mothers provided any information about the role of race as a factor in help-seeking, it is possible that the important finding is race was *not* an important factor. Perhaps since these mothers all accessed mental health services for their children, any barrier that could be attributed race was overcome, or not perceived as a barrier. It is also possible that there is something about the African American mothers in this study that makes them different from African American mothers who perceive race as a barrier to service access. That is a question for another study.

Mothers in the current study identified nine reasons for seeking services. Three of them, improve functioning, and wits end / relieve burden are consistent with much of the literature that suggests that the two of the most important factors in parental help-seeking is perceived need, and parental burden (Alegria et al., 2004).

5.1.4 Stage 4: Evaluating mental health services

In the fourth stage, mothers described evaluating whether mental health services (MHS) provided the help they sought to address their child's problem(s). Mothers described deciding to continue, deviate from, or terminate services. Most of the mothers who evaluated MHS as useful cited reasons like noticing positive changes in their child's overall behavior and specifically in the behavior that had initially caused them concern, feeling there was a good fit between the child and the therapist, and feeling like the services they received met their needs. For example, mothers who had sought to improve communication said they were most satisfied when the child enjoyed talking with the therapist or reported being able to open up to the therapist. Mothers who had sought to identify the problem said they were most satisfied when the services they received resulted in a diagnosis or an explanation of the behavior.

Mothers who found MHS useful seemed to conclude their help-seeking process after using MHS, However, mothers who evaluated MHS as unsatisfactory described either continuing to seek help or stopped bringing in their child.

5.1.4.1 Relationship between stage 4 and existing research

For the mothers in the current study, service use influenced their decision to continue, deviate from, or terminate mental health services. Only two models of help-seeking, The HDM

and the NEM (Alegria et al., 1991; Pescosolido, 1991) assume that people's experiences of services are an important factor in the help-seeking process. Few empirical studies have looked at role of mental health services in the help-seeking process (Kazdin, Holland, & Crowley, 1997; Kazdin & Wassell, 2000). However, two recent studies investigated the factors that present barriers to participating in urban (Kerkorian, McKay, & Bannon, 2006) and rural (Stevens, Kelleher, Ward-Estes, & Hayes, 2006) community mental health treatment. In both studies, the most significant barriers to treatment participation were attitudinal: relationship problems between the clinician and family, and the perception that treatment was irrelevant to the child's problems minority status. Interestingly, structural factors such as low SES, insurance status and amount of coverage, were not significant barriers to treatment participation. Consistent with these findings, the mothers in the current study made decisions to continue, deviate from or terminate services primarily due to attitudinal rather than structural factors.

These two studies provide support for the idea that the process of help-seeking continues after parents have accessed services. In particular, both studies indicated that relationship problems between the clinician and the client, and the perception that services were not useful, were identified as barriers to treatment participation. Although neither study indicated that parents stopped using services as a result of these treatment barriers, research has indicated that drop-out rates of families in mental health services are as high as 60% (Kazdin, Holland, & Crowley, 1997). If the ultimate goal of help-seeking research is to reduce the sequelae of mental illness, then researchers need to include treatment participation as a stage of help-seeking. These studies and the current research also suggest that if service providers want to keep clients in treatment post-intake, they should focus on their relationship with the client, engagement and the therapeutic alliance (Hubble, Duncan, & Miller, 1999; McKay et al., 2004; Wampold, 2001).

In sum, across the sixty interviews that I analyzed, mothers described a process of seeking help for their child that comprises four stages: 1) recognizing a problem; 2) responding to the problem; 3) using mental health services; and 4) evaluating mental health services.

5.2 RELATIONSHIP TO EXISTING MODELS

The current study provides support for some models of help-seeking and suggests ways that we can improve our understanding of the help-seeking process. This section discusses the relationship between the current study results and the existing help-seeking models, including the Health Belief Model (Rosenstock, 1966; Rosenstock et al., 1988); Theory of Reasoned Action / Theory of Planned Behavior (Ajzen, 1985, 1991, 2002); Help-seeking Decision Making Model (Alegria et al., 1991; Goldsmith et al., 1988); and the Parent mediated model (Logan & King, 2001).

5.2.1 Health Belief Model

The Health Belief Model (HBM; Rosenstock, 1966) was one of the first theories of health behavior (Rimer & Glanz, 2005). It provides a model of the cognitive process that people go through when deciding whether to engage in a health behavior. Although the model as a whole has been shown to do a poor job of explaining help-seeking for mental health problems (Ogden, 2003), some of its components fit the help-seeking experience of mothers in the current study. These mothers described influencing factors that were similar to the HBM components of *perceived threat*, *perceived benefit*, and *cues to action*.

In the current study, some mothers sought mental health services (MHS) because they believed their child's behaviors were a threat to his/her future survival or happiness: *perceived threat*. Some mothers explicitly reported that they sought MHS because they believed that doing so would address the concerning behavior: *perceived benefit*. These mothers typically described having positive experiences with MHS for themselves or their other children. However, of all of the mothers in the current study who accessed care, only a few reported being confident that services would be helpful. This handful of mothers reported having positive experiences with MHS for themselves. So while *perceived benefit* was an influencing factor for some, it did not apply to all mothers. On even rarer occasions, mothers reported that they sought MHS based on a single piece of information: *cues to action*. This only occurred when mothers were told that their child was threatening harm to self or others. Typically, mothers described receiving many cues from formal supports, such as school staff, other mental health professionals, the legal system, or the medical system. A few mothers described receiving cues from informal supports, such as a friend saying, "you should get him help." However, considering that most mothers became concerned about their child's behavior over time due to increasing frequency or severity, whereas the HBM was developed to explain how people make decisions about health care in response to a single behavior, and, it is reasonable that a single *cue to action* would rarely be enough to motivate a mother to act.

Although the HBM describes components of help-seeking that were consistent with the mothers' descriptions of help-seeking, the model makes certain assumptions that do not fit with this study. The model does not account for chronic conditions or problems that develop over time and therefore does not accurately reflect the experience of most mothers in this study. The model also posits that people seek help because they expect services to have a certain value in

addressing the problem, but this does not account for the nearly half of the mothers in the current study who reported entering services through referral or pressure. Thus, it is not accurate to assume that these mothers expected services to help. In fact, two mothers expected that services would not help their children, but they chose to seek help to avoid getting themselves into trouble with the law or the school system. Therefore, the HBM offers limited usefulness for understanding maternal help-seeking.

5.2.2 Theory of Reasoned Action / Theory of Planned Behavior

Maternal narratives suggested that some components of the Theory of Reasoned Action / Theory of Planned Behavior, or TRA/TPB, (Ajzen, 1991, 1998, 2002) were salient in their help-seeking process. Most prominent was the component of *behavioral intention*, defined as the person's intention to engage in a specific behavior. In the TRA/TPB, *behavioral intention* is assumed to be predictive of action. The salience of *behavioral intention* in maternal help-seeking appeared to vary by mode of entry. For example, mothers who chose to enter services were most likely to causally link their intention to seek services with their child's problematic behaviors. These mothers most resemble the traditional help-seeker. Other mothers in the current study described being unsure about the best action to take for their child. Yet these mothers also accessed services. Therefore, *behavioral intention* seems useful in understanding the help-seeking of mothers who were most like traditional or "rational" help-seekers, but does not fit the reports of mothers who entered through pressure, referral, or in response to a child's request. A component of the TRA/TPB that does not fit maternal narratives is *subjective norms*, defined as the amount of social pressure being placed on an individual to engage in a behavior. Other models, most notably Pescosolido's Network Episode Model (Pescosolido, 1991, 1992; Pescosolido et al.,

1998), also suggest that social pressure is a significant factor in help-seeking. However, in the current study, while some mothers did describe becoming concerned about a child's behavior by comparing those behaviors to a variety of subjective norms, including developmental and social norms, very few indicated that their intention to seek services was influenced by social pressure. Mothers who reported accessing services because they felt pressured to do so identified formal supports as the source of the pressure. It is possible that mothers felt social pressure to seek care for their child and chose not to discuss it during the interviews. But mothers did discuss interactions with members of their social networks (both formal and informal), which they typically described as informative or legitimizing, rather than pressuring.

5.2.3 Help-seeking Decision Making Model

The stages of help-seeking that emerged from the current study are similar to those identified in the Help-seeking Decision Making model, or HDM, (Goldsmith et al, 1988; Alegria et al, 1991). The HDM posits that families 1) recognize a problem, 2) decide to seek help, 3) select service providers, 4) enter services, and then 5) choose to cease, continue, or change services (Alegria et al, 1991). In the current study, mothers described 1) recognizing a problem, 2) responding to the problem, 3) using services, and then 4) evaluating mental health services. These stages are most similar to the first, fourth and fifth stage of the HDM. However, the third stage of the HDM, select service providers, is inconsistent with the model that emerged from the current study. Mothers in the current study did not discuss how they selected MHS for their child. Among the one-third of the mothers who chose to seek services, it was largely unclear how they knew about MHS. Some mothers reported knowing about MHS either through prior use or through people in

their social network, but it was common for mothers to report that they called for an appointment without clarifying how they knew who to call.

The HDM suggests that the client's illness profile, predisposing and enabling factors influence the first three stages of help-seeking. Consistent with the HDM, the current study found that components of the illness profile, perceived need and severity of problems, were significant factors in the first stage – recognizing a problem. The HDM suggests that coping strategies influences problem recognition. The current study does not support that assumption. Rather, coping strategies were found to occur in the second stage – responding to problem.

5.2.4 Parent Mediated Model

Logan & King's (2002) Parent mediated model (PMM) integrates the Socio-Behavioral Model (Andersen, 1995) with elements of Pescosolido's (Pescosolido, 1991, 1992) Network Episode Model, and Prochaska and DiClemente's (1983) Stages of Change model. The model focuses on two stages: contemplation and action. During the contemplation stage, parents become aware of a problem, decide that the problem is a mental health problem and evaluate possible treatment options. During the second stage, action, parents develop their intention to seek services, attempt to address the mental health problem through both formal and informal means and finally access mental health services.

The first two stages of the help-seeking model that emerged from the current study are very similar to the PMM stages of contemplation and action, respectively. For example, our stage "recognizing a problem," is similar to PMM's contemplation stage; mothers became concerned about their child's behavior and tried to make sense of it. However, the current study differed from the PMM in that most mothers did not identify their child's behavior as a mental

health problem. Mothers most commonly attributed their child's behavior to family and school environments, rather than psychological, developmental, heredity or inherent problems. Furthermore, a number of mothers reported seeking services because they wanted to identify the problem.

The stage “responding to the problem,” is similar to PMM’s action stage: mothers actively attempted to cope with their child's behavior. In the PMM, using mental health services is considered the same as any other "action." But in the current study, while nearly all mothers reported actively trying to cope with their child's problems, they did not all access services in the same way. This prompted our third stage, “using mental health services.” The current study suggests that some mothers entered MHS to identify the problem. The PPM assumes that parents have already identified their child’s problems as mental health related prior to accessing services. This assumption is not supported by the current study, even though the basic stages of contemplation and action fit well with maternal descriptions.

5.3 LIMITATIONS

The ethnographic interviews analyzed in this study were not gathered for the purpose of exploring how and why mothers sought mental health services for their children. Consequently, there were instances in every interview where interviewers did not gather key information about the mother’s help-seeking process. For example, although mothers were asked about how they coped with their child’s behaviors, there were no probes into how their coping strategies influenced their help-seeking pathway. My conclusions about the role of maternal coping strategies in the help-seeking process are limited by the absence of this information.

Additionally, mothers were not asked how they selected mental health services for their child. As noted above, a number of models of help-seeking identify “service selection” as the stage that directly precedes “service access.” Because the mothers were not asked about service selection, I am unable to comment on its importance or relevance for these mothers.

Another limitation is that the narratives are retrospective. Consequently, it is possible that some descriptions of the help-seeking pathway were conceptualized *after* services were accessed. Therefore, it is possible that the causal attributions identified in our first phase of help-seeking, “recognizing a problem,” were informed by the process of help-seeking and service use, rather than preceding them (Wilcox et al., 2007). For example, one mother in the current study reported that her causal attribution for the child’s behaviors was suggested by the therapist. Although this was one of the few examples of a mother clarifying the sequence of events, it is possible that experiences from later stages influenced the conceptualization or recollection of earlier stages of help-seeking.

A third limitation is that all of the mothers in this sample met criteria for significant depressive or anxiety symptomology (Anderson et al., 2006). Extant literature has found that maternal mental illness affects problem recognition (Verhulst & van der Ende, 1997), service use (Zwaanswijk et al., 2003), and parenting strategies (Vostanis et al., 2006). Given these findings, it is likely that the experiences of the mothers in the current study are different from those of the general population. Furthermore, the homogeneous sample precludes making assertions about the role of maternal mental illness in the help-seeking process.

A final limitation is the lack of economic diversity of the sample (the mothers were overwhelmingly low-income), and by the absence of the perspective of men or fathers. Nearly half of the mothers reported being married or in a significant relationship, yet they rarely

discussed the influence of their partner on the help-seeking process. Future research could follow-up on both maternal and paternal perceptions and experiences of help-seeking.

5.4 IMPLICATIONS

5.4.1 Implications for Social Work Practice

The results of this study have a number of implications for practice. The most important implications derive from the insight gained from mothers' experiences trying to cope with their child's problems, their reasons for seeking services, and their evaluation of mental health services.

5.4.1.1 Identifying prior coping strategies

Nearly all mothers reported using various coping strategies to address their child's problems before accessing services. For most of these mothers the coping strategies were unsuccessful. Therefore, clinicians should assess for prior coping strategies. First, they should identify what strategies did not work. For example, if the clinician learned that the mother had unsuccessfully tried a behavioral intervention, like removal of privileges, then the clinician would know not to assign the same behavioral intervention. This would avoid setting the client up to fail and potentially causing the mother to perceive a poor fit between the clinician and the family and to seek services elsewhere. Mothers reported that poor match between family needs and treatment provided was one of the factors that led them to continue looking for services after accessing MHS. Second, doing a thorough assessment of what mothers have already tried can

help the clinician identify how their expertise might be of greatest use. Going back to the example of the mother who was unsuccessful with her behavioral interventions, if a clinician knew the specific steps taken by the mother to remove privileges, he might be able to identify ways that the mother could be more successful. Alternately, the clinician might help the mother identify a coping strategy that would be a more appropriate fit for the child's problem.

5.4.1.2 Explore reasons for seeking services

Clinicians should clarify parents' expectations from services by asking them specifically what they expect out of services. Mothers who had specific expectations for services evaluated treatment satisfaction or dissatisfaction based on whether those expectations were met. For example, several mothers reported that they had sought services to identify the problem. For these mothers, it was important that their service provider shared their child's diagnosis or offered a non-diagnostic explanation of why the child was engaging in these behaviors. In contrast, mothers who sought services because they wanted their child to talk with someone were less interested in diagnoses than in the relationship between the therapist and the child/mother.

A clinician who worked with mothers like these would need to provide different services to meet their different needs, or explain why their recommendation for services is different from what the mother expected. This is a collaborative model that while not explicitly addressing the mother's treatment expectations, might address a mother's concerns about being heard and understood by treatment providers. For example, for the mother who sought services to identify the problem, the clinician would focus on assessment and diagnosis. This could be challenging in agencies where the assessment is conducted by one mental health worker and the treatment is provided by another. Mothers looking for assessment might rightly expect the treatment provider to follow-up on the assessment.

If clinicians identify the reasons behind seeking services, they would be better prepared to close the gap between need and service, thereby improving parental experiences with and perceptions of therapy. Satisfaction with services has been shown to correlate with expectations (Gerkenmeyer, Austin, & Miller, 2006). However recent research found that only 38% of clinicians clarify client and family expectations for services as a way of improving attendance (Watt & Dadds, 2007). Identifying why parents are seeking services for their child could only improve the fit between service expectations and provision.

In the current study, two mothers reported that they were dissatisfied with services because the service provider who performed the assessment was not their assigned therapist. In this situation, having the intake worker follow-up with the family would best meet the family's needs. However this is practically impossible in agencies where the assessment and treatment functions are divided. Even in agencies where one provider does both, it is rare that providers will spend more than one session on an intake due to limits set by insurers, agency policies, or brief-treatment models that assume between four and six sessions. In her study on parents of children in in-patient psychiatric settings, Scharer (2002) concluded that mental health service providers need to be proactive in providing information about a child's diagnosis, prognosis, treatment, role of the school, and specific management skills the parent needs to have. This type of psychoeducation is considered a best-practice approach in the treatment of a number of serious mental illness (SAMHSA, n.d.). These conclusions are applicable to the current study, suggesting that there might be some similarities between in-patient and out-patient clients in terms of their needs from service providers. Scharer (2002) also noted that parents in her study did not know enough about mental health services to know to ask questions about assessment and diagnosis. Although this study did not have data on what mothers knew or did not know

about mental health services, it would be reasonable to remind service providers to provide information to their families about assessment and diagnosis. It is possible that children received services that would have addressed mothers' needs regarding diagnosis and assessment, but the service provider forgot to inform the mother. Scharer (2002) also noted that that parents in her study needed emotional support for themselves as well as reassurance that their child's emotional needs were being met.

5.4.1.3 Exploring the family's social network

Mothers in the current study reported surprisingly little contact with friends and family prior to accessing services. This is surprising in light of theoretical predictions of a number of help-seeking models, including the TRA/TPB and the Network Episode Model (NEM). Both models suggest that the social network is an important factor help-seeking, albeit for different reasons. The TRA/TPB assumes that when people become aware of a problem, they look to their social network to establish the "subjective norms" for that behavior. When the behavior is considered not-normal, then the TRA/TPB assumes that individuals will take that information into consideration when making a decision about whether or not to seek services. The concept of subjective norms has been the least predictive component of the TRA/TPB (Armitage & Conner, 2001). In contrast, the NEM assumes that decisions about help-seeking typically happen at the community, rather than the individual level. The NEM assumes that most people seeking mental health services do not take a direct pathway. Instead they interact with their social network, which the NEM defines as friends, family, and professionals, to define the problem, establish need for services, and ultimately influence the decision to enter services. Pescosolido and colleagues (1998) found that a minority of adults "chose" mental health services. The rest reported being coerced or "muddling through," and identified specific network ties as significant

factors in their eventual entry into mental health services. Research has suggested that role of social networks in help-seeking varies by race. Research on mental health help-seeking for youth has found that African-American and Latino families are more likely to use their informal support network first, whereas white families are more likely to use formal supports (McMiller & Weisz, 1996). Thus, it is surprising that the mothers in this study, both African American and White, reported very few contacts with informal supports prior to accessing formal mental health services.

There are three reasons why mothers in this study might have reported relatively few contacts with informal supports prior to accessing mental health services. First, since mothers were not explicitly asked about the friends and family members they contacted, they might have omitted information about these interactions. Parents might be less likely to recall interactions with friends and families, since they are more common and more informal. In contrast, accessing formal supports might be more memorable because they suggest a higher level of intensity. For example, the mother who described calling the police in response to her daughter smoking pot might have called a friend or family member for advice prior to calling the police. However, when the interviewer asked the mother to talk about what factors were important in their help-seeking, she might have decided to talk about the phone call with the police, rather than the discussion with the friend that preceded calling the police. Future research could use prospective designs to identify informal contacts.

Another reason mothers might have reported limited contact with informal supports is that they felt socially isolated due to their child's problems and their own mental health problems. Quantitative and qualitative research has found that families of children with mental health problems report greater social isolation than families with children without mental health

problems (Albert, Becker, McCrone, & Thornicroft, 1998; Scharer, 2002). Furthermore, parents of youth with more severe mental health problems report significantly higher rates of loss in the social network over time (Bussing et al., 2003). Although the current study was not able to draw conclusions about the role of maternal mental health problems on the help-seeking process because the entire sample consisted of mothers with mental health problems, it is possible that mothers had limited contact with informal supports due to the presence of mental health problems in both the mother and the child.

A third reason is mothers might have avoided contact with friends and family due to the stigma associated with emotional and behavioral problems. Although Pescosolido and colleagues reported no difference between white and black families' perceptions of stigma and mental health services (Pescosolido et al., 2008)

These findings have implications for both theory and practice. If informal supports are less important than formal supports in the help-seeking pathway of mothers of children with mental health problems, then models that argue for the centrality of social networks in help-seeking (such as the NEM; Pescosolido, 1991) would need to be modified to account for greater influence of formal supports. Models such as the Gateway Provider Model (GPM; Stiffman et al, 2004; 2006) that emphasize the importance of disseminating information about services to adults responsible for connecting youth with mental health services would shift the focus to parents of at-risk students and service providers and away from educating the general public (i.e. those who would be in a family's informal network). Smaller social networks might also reduce the amount of information or the resources that parents could access to address their child's problem. In the current study a number of mothers had prior experience with mental health services. It is possible that mothers who access services have significantly more experience with mental health services

than mothers who do not access services. Prior service use could provide both an understanding of the purpose of mental health services, as well its availability as a solution to their child's problems. Bussing et al (2003) suggested that health care providers need to recognize that they might represent a source of significant social support for mothers, for whom informal supports have likely been few and have decreased as the child's problems increased. They also suggested that mental healthcare providers should spend time identifying the parent's and child's informal support network.

In addition to the assessment, diagnosis and treatment functions, helping families develop a strong and supportive social network could buffer against future problems. Maguire (2002) suggested that social workers can use the Social Network Diagram, a visual assessment tool, to identify the size, composition, and relative support provided by each network tie (as indicated by the proximity of the individual to the center of the circle). Use of this assessment tool is a practical way of identifying existing and potential social supports.

5.4.2 Implications for Research

This study found that mothers had different reasons for seeking services, and that for some mothers, there was a relationship between the reasons for seeking services, and service use and satisfaction. For example, mothers who accessed services to identify the problem were dissatisfied with service providers who did not provide thorough assessments. Conversely, mothers who accessed services to address a specific problem, were frustrated by service providers who did not address the presenting problem. Future research could evaluate people's reasons for seeking services and correlate that with service use and satisfaction. For example, part of the intake form could be a series of check boxes with options such as, "I would like more

information on why my child is acting this way,” or “I have a good idea of what the problem is and I would like services to address it.” These two options would then direct consumers to either a detailed biopsychosocial assessment, or directly to a therapist. The hypothesis is that matching reasons for seeking services with types of services will result in greater service satisfaction. A recent study by Gerkenmeyer, Austin, & Miller (2006) found that the strongest predictor of parent satisfaction with their child’s mental health services was met expectations.

One of the assumptions in the help-seeking literature is that parents do not seek services for their children in part because the system of care is too confusing and there are too many barriers to services (Burns et al., 1995; Costello, Pescosolido et al., 1998; Farmer et al., 2003; Farmer et al., 1999). Pescosolido (1991, 1992) has suggested that there are many ways to enter services and that one of the most important is “muddling through,” which accounts for the convoluted pathway that many people take to get to services. Although the concept of “muddling through” has found support in studies of adult help-seeking (Pescosolido et al., 1998) and parent help-seeking (Arcia et al., 2004), none of the mothers in the current study described a mode of entry that was consistent with “muddling through.” Future research could investigate the concept of mode of entry to see if the concept of “muddling through” is a useful description of parental help-seeking.

This study took a retrospective look at help-seeking. As a result it is possible that mothers did not experience the pathway in the same order that they described it. Future research could follow parents over a period of time to identify their help-seeking pathway. A prospective design would address some of the limitations identified in the current study, like the challenges of recalling informal contacts, or establishing a timeline of events. Clearly the challenge of a prospective design is identifying who will use services; accurately predicting who will use

services is sort of a Holy Grail for service research. However, following enough people over time might provide the data needed to improve how we target prevention and intervention activities.

The current study looked at narratives from mothers of children with a variety emotional and behavioral problems. Researchers have recently started investigate maternal help-seeking for youth with different disorders, including disruptive disorder (Arcia et al., 2004; Czuchta & McCay, 2001; Wilcox et al., 2007), schizophrenia (Czuchta & McCay, 2001), and depression (Logan & King, 2001). This approach to exploring help-seeking behaviors makes sense given that service use varies by diagnosis (Burns et al., 1995; Farmer et al., 2003), and the practical requirement to connect research with specific disorders. However, the mothers in the current study made decisions about what problems to seek treatment for based on more on functional impairment than diagnostic symptoms (Mark & Buck, 2006). Thus the question is, should research on maternal help-seeking focus on how impairment in certain areas of functioning, such as interpersonal and school/work influences help-seeking? For example, are there differences in help-seeking between parents of children with functional impairment in interpersonal, academic, peer, and other areas of functioning? The current study suggests that when mothers recognize significant functional impairment, in this case in the form of suicidal or homicidal behaviors, that the help-seeking pathway was quick and direct. Research has suggested that people receiving mental health treatment are more likely to describe their problems in terms of functional impairment than severity of symptoms, whereas clinicians focus more on symptoms than impairment (Alegria et al., 2004; Costello et al., 1996; Ezpeleta, Granero, Osa, Doménech, & Guillamón, 2003; Garland, Haine, & Boxmeyer, 2007). If our treatment models are designed around diagnostic symptomology, and the assumption is that people will seek services based on

diagnosis, then there is an enormous disconnect between the expectations of consumers and the expectations of service providers.

The current study found that youth who were suicidal tended to have a short and direct pathway to care. There has been very little research on help-seeking of youth who are suicidal. The current study is limited in its usefulness in understanding help-seeking of parents of suicidal youth because all of the mothers in this sample accessed care. Future research could use grounded theory method to explore parents' experiences with a child who is suicidal. Researchers have recently started looking at help-seeking attitudes for suicidal youth (Freedenthal, 2005; Molock et al., 2007) However, there have been no studies that have focused on maternal help-seeking for suicidal youth. In order to develop potentially life-saving interventions, future research could build on the current study and use grounded theory method to characterize the experience of mothers of youth who have been suicidal. Interviews would start with a question like, "Starting where you would like, tell me what your experience has been of having a child who has wanted to die." Starting with the first interview, transcripts would be analyzed for themes and participants would be re-interviewed to gather more data on relevant themes, and review the accuracy of the coded transcripts. Although the results of a true grounded theory analysis cannot be predicted, it would be my hope that the interviews would shed some light on mothers' help-seeking pathway, including coping strategies and experiences with formal services (if accessed). The results of the study might then be used to develop a preliminary intervention for parents of youth who are suicidal. This area of research is a good fit with the historic mission of social work.

5.4.3 Proposed study design

One study design that can address a number of the limitations noted above is a mixed-methods, longitudinal panel study to investigate how and why mothers seek mental health services for their children. A panel study follows the same participants over a period of time (Rubin & Babbie, 2005), allowing the study to draw conclusions about how certain factors influenced individual participants. In order to address some of the questions raised by the current study about the role of fathers in help-seeking, the effect of insurance on the help-seeking process, the influence of psychopathology on help-seeking, and the role of race on help-seeking, the sample would include both mothers and fathers, parents with and without psychopathology, with a range of income levels, and be racially diverse. Participants would be recruited from the community through use of fliers and word-of-mouth. Because the study is interested in seeing how parents seek help over time, an exclusion criteria will be parents with a child currently in mental health services.

I will collect quantitative data in the form of surveys and qualitative data in the form of individual and group interviews. I will collect quantitative data on parental burden; perceived need child's level of functioning; type, duration, frequency, and severity of behaviors; coping strategies; the family's social network; and knowledge of resources. For each area I will use a standardized measure, and a self-report measure. For example, I will look at parental burden using a measure such as the Home Situations Inventory (HSI; Breen & Altepeter, 1991) which is a ten item measure that asks parents to rate on a 7-point scale how difficult it is to accomplish daily activities with their children. During the individual interviews, I will identify ways in which parents conceptualize these areas. For example, a mother might report that she can see how things might get to be "too much." Since "too much" has something to do with the etic

concept of “burden” I would ask the mother to rate how much is going on right now on a scale of 1 – 10, with 10 being “too much” and 1 “not a problem.” I would follow up with parents on their individual self-report scales over the course of the study to see how their ratings had changed, while at the same time administering the standardized measures. The benefit of having parents complete self-report scales is that they measure change in concepts that are personal to the parents and are therefore more likely to accurately reflect their worldview. All of the quantitative measures will be used to measure how participant’s attitudes and perceptions change over time. For example, as child problems increase, is there any change in the parents’ report of their social network, perceived burden etc? In addition, quantitative data will be used to triangulate the qualitative data.

Qualitative data will include both individual/couple and group interviews. The individual/couple interviews will have open-ended questions about how parents feel about, and are dealing with, their child’s behavior. I will use the interviews as an opportunity to identify which stage the participant is in – if any – in the help-seeking process. As parents report dealing with specific issues, I will follow-up with questions about what they see as the cause of the problem and how that relates to their decisions for taking action. I will use the information learned in the current study to make connections between the different stages of the help-seeking process as a way of evaluating whether or not the parents’ experience fit the model. Group interviews focus more on the broader issues of parenting. Group settings are conducive to talking in more general terms about areas of commonality between participants. The qualitative data will provide depth to the parents experiences and “flesh out” some of the quantitative results.

The study will continue until the money runs out. Because help-seeking is an ongoing process in a parents’ life, the participants are expected to be in different stages of help-seeking

during the study. The longitudinal design will enable me to draw conclusions about how this process changes over time and how help-seeking evolves. The use of quantitative measures will help to correlate some of the most salient factors to the stages of help-seeking that were identified in the qualitative interviews.

APPENDIX A

INTERVIEW PROTOCOL

I. Study overview

We're talking to women like you who have experienced difficulties with a child and have brought the child in to the clinic for help. We're interested in learning why moms decide to bring their children in to the clinic. We're also interested in hearing about the kinds of issues that people like yourself think can be made better by the services offered through the clinic.

II. Opening question

I'd like to start off by having you tell me a story about what led you to come to the clinic 3 months ago. I'm interested in hearing about the difficulties you were having with your child, and what life was like for you – what you were going through – around that time. You can start your story wherever you like and talk as long as you like, but tell me whatever you think is important in order for me to understand your decision to bring your child to the clinic.

A. PROBES for Response to Opening Question

1. Child

- What did you think might have caused some of these behaviors that you were seeing?
(PROBE for what others' theories were – “boys will be boys”?)

- Before you decided to come into the clinic, what other things had you tried to do – or had you thought about doing – to help deal with your child? Tell me a little bit about how you thought [remedy] would help.
- [IF MOM ALREADY HAD A CHILD AT THE CLINIC] – How did your experience with [Child 2] compare with what you went through with [Child 1]? {Looking for “made it easier,” “knew what was happening this time,” etc.)}
- What changes – if any – have you seen in your child in the last 3 months?

2. Mother

- Tell me [more] about what your own life was like 3 months ago...How were you doing around this time?
- If you can, tell me about those things that happen day-to-day that seem to make [those feelings] worse.
- What kinds of things have you tried – or thought about doing - to make [those feelings] better?
- When you came into the clinic, did a clinician talk to you about how you were feeling?
- Were there other times in your life when you had felt like this? [if yes (and if necessary):
What do you think caused you to have [those feelings] then?

III. Key Question for Mom

Do you remember [Charlene or Judith] saying that she thought you might be “depressed” or “anxious”?

IF NO

- “Describe for me what you think about when you hear the word “depression” [“anxiety”] or that someone “is depressed” [“is anxious”].

- What kinds of things do you think people who are depressed/anxious might do in order to feel better?

IF YES

- What was your reaction when s/he said that to you?
- What did [Charlene or Judith] suggest that you do to feel less [XYZ]?
- What were your thoughts when s/he suggested that? (helpful/not?)

1. IF NOT HELPFUL

One of the things we're trying to learn more about is when people think that the services or treatment offered by the clinic will or will not be helpful.

- Tell me why you didn't think that the services would be helpful for you (probe for previous negative experiences with the service system).
- What kinds of things did you think would be more helpful?
- How much better do you think you'd feel if your financial situation was better? Why?
- Help me to understand the difference between your child's situation and your own, that is, how you see the services offered by the clinic as being helpful to him/her, but not for someone like yourself?

2. IF HELPFUL but DID NOT FOLLOW THROUGH

- One of the things we're trying to learn more about is why some moms might want the services that are suggested, but are not able to actually get the services for themselves.
- What kinds of things do you think are getting in the way of your being able to (do suggested intervention)?
- What kinds of things do you have to overcome in order to bring your child to the clinic?

- [IF ISSUES ARE THE SAME] – Tell me a little bit about why you think you’re able to make sure your child gets to the clinic for services, but you are still facing various barriers.

IV. Questions on networks

A. Positives Thinking about your life in general:

- Who are the people that you call on if you need someone to help you do something, like [transportation, money, childcare, or if you just wanted to talk?
- And if you wanted to feel less [XYZ], who would you call on? (This is assuming that this was not discussed earlier.)

B. Stressors Conversely:

- Who are the people in your life that make it more difficult for you to do the things you want/need to do, like [get to the store, get to the clinic, etc.]?
- And are there people in your life who seem to make you feel more [XYZ]?

C. Summary for Networks

- Who in your life do you think really understands you and your situation the best? [Tell me a bit about why you think that is.]

V. Comparison Question

I’d like you to think for a moment about the kinds of things that you and your child [children] have been going through lately. Because we’re trying to better understand the experiences of moms like yourself, describe how you see the relationship between moms and their children who are trying to work through these kinds of difficulties.

VI. Summary Question

Is there anything about your decision to bring your child into the clinic, or your own feelings, that I haven't asked about but that you think it's important for me to hear in order to understand your experiences better?

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