# Why Lower Income Mothers Do Not Engage With the Formal Mental Health Care System: Perceived Barriers to Care

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*Lower income mothers who bring their children for mental health services also have high rates of depression and anxiety, yet few seek help. Maternal and child mental health are intimately intertwined; thus, the distress of both is likely to continue if the mother's needs are unaddressed. Because mothers overcome numerous instrumental challenges to help their children, the authors identify potential perceptual barriers to mothers' help seeking. An ethnographic analysis of in-depth qualitative interviews with 127 distressed mothers suggests several critical perceptual factors. For example, mothers attributed their distress to external causes (e.g., poverty, negative life stressors), which they believed individually focused mental health services could not affect. Interviewees also anticipated negative ramifications for seeking care, including being labeled unfit mothers, and thus potentially losing custody of their children. The authors discuss the implications of these and other key themes for engaging lower income mothers and their children.*

**Keywords:** *mental health services; perceptual barriers to care; treatment engagement*

Recent studies have indicated high rates of emotional distress (Bruce & Hoff, 1994; Park, Turnbull, & Turnbull, 2002) but low rates of mental health service use among lower income populations (Angold et al., 2002; Edlund et al., 2002; Olfson, Marcus, Druss, Pincus, & Weissman, 2003; Sturm & Sherbourne, 2000). These service use patterns can be only partially explained by a relative lack of services and resources in lower income communities and the instrumental challenges (e.g., finances, transportation, affordable child care) that add to the

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difficulties in accessing them (Armstrong, Ishiki, Heiman, Mundt, & Womack, 1984; Diamond & Factor, 1994; Greeno, Anderson, Shear, & Mike, 1999; Kendall & Sugarman, 1997; Maynard, Ehreth, Cox, Peterson, & McGann, 1997). Finding ways to improve treatment access for lower income populations requires a more thorough understanding of their perceptions and experiences.

Our study focuses on one such underserved population, specifically, lower income mothers with mental health needs who bring their children for behavioral health care. Our ongoing work and that of others has demonstrated a high prevalence of distress in this population, with as many as 60% of the mothers meeting *DSM-IV* criteria (American Psychiatric Association, 2000) for depression or anxiety disorder (Dover, Leahy, & Foreman, 1994; Ferro, Verdeli, Pierre, & Weissman, 2000; Swartz et al. 2005); despite the high rates of depression and anxiety, this population evinces markedly low rates of treatment participation. Like other lower income populations, these mothers face so many daily difficulties that seeking treatment might seem like just one more burden (Kazdin, 2000; Owens et al., 2002; Verhulst & van der Ende, 1997). Yet, mothers' failure to follow through on recommendations of treatment for themselves is not due solely to insurmountable practical challenges, because they do manage to overcome practical barriers to care and serious service inconveniences to initiate help for their children.

Thus, as part of a larger National Institutes of Mental Health (NIMH)–funded study of distressed mothers of emotionally or behaviorally disordered children, we conducted an ethnographic qualitative investigation of attitudes and perceptions that might constitute barriers to care. Following a diagnostic assessment, those who met criteria were referred to services and followed to determine their response to the referral. Our specific goal was to use qualitative interviews and focus groups to gain a better understanding of mothers' perceptions of their own distress and their children's problems, their treatment experiences, and their views of the formal mental health service delivery system.[1] This understanding of maternal perceptions of mental health treatment, including perceptions of its basic relevance to their needs, could help to target barriers that must be overcome if we hope to improve the quality of life for lower income mothers and their children and facilitate the design of more effective community services.

## METHOD

### Participants

In this article, we report on qualitative interviews conducted with 127 women who initiated treatment for their children at community mental health centers in four disadvantaged communities, two in urban areas and two in two semirural communities. The facilities deliver a wide array of services to lower income populations that are characterized by high rates of unemployment, poverty, mental illness, substance abuse, and frequent family crises.

Our interviewees consisted of a subset of a larger four-community study documenting mothers' mental health needs and various aspects of their life circumstances[2] at the time they brought their children for mental health care. Three hundred seventy-one mothers were screened, of whom 271 met the criteria for

significant mood and anxiety disorder. Our 127 ethnographic interviewees were recruited from this distressed subsample. As noted earlier, study participants were recruited from four mental health service sites in the Greater Pittsburgh area. We recruited consecutively from women who met our diagnostic criteria for significant mood disorder symptomatology at each site until we were confident that themes generated would be thoroughly represented. In an effort to ensure that African American women's voices were heard, we purposely oversampled African American mothers by continuing to recruit them after general recruitment was closed. Using this strategy, 50 (40%) of the sample of 127 interviewees self-identified as African American.

An institutional ethics committee reviewed and approved the study. Mothers were eligible to participate if they were between the ages of 18 and 55; were the biological, step-, or adoptive mother living with the child being presented for care; and had no mental or physical condition that precluded their understanding the study procedures. Diagnostic eligibility for the study was determined by 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, 1990). Because our primary interest was identifying distress rather than severity or specific diagnosis, we allowed relatively low thresholds on the screening instruments to trigger a referral (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). Seventy-three percent of the mothers met criteria for significant depression or anxiety disorder symptomatology and were referred for services by a member of the study team.

Three months later, we contacted the initial sample for follow-up procedures that included the ethnographic interviews for the subsection of the mothers described in this report.[3] The mothers completing these interviews were recruited from those meeting the criteria described above. These mothers were ethnically diverse (56% White, 40% African American, 4% other) and had an average age of 37.8. They were also relatively well educated, 83.5% having a high school education or greater. Thirty-eight percent were married or living with a partner; 43.3% were working full- or part-time an average of 36.2 hours per week. They were strikingly low in income, with over half living on a household income under $15,000 while supporting a mean of 2.6 children under the age of 18.[4]

The ethnographic interview explored the mother's view of her life, problems, and distress; her response to being diagnosed and referred for services; her network of social supports or stressors; and the reasons why she did or did not seek treatment following referral. General probes were followed by questions related to emerging themes that we thought could constitute barriers to service usage, particularly perceptual factors that could be targeted for change (such as causal assumptions, attitudes, or knowledge). Interviews were conducted in the interviewees' homes, offering team members experiential insight into the daily challenges of these mothers' lives and generating immense respect for our respondents' abilities to cope with the apparently never-ending multiplicity of problems that could be observed even during a single session. With each respondent's permission, interviews were tape-recorded and transcribed for team review.

## Training and Supervision of Interviewers

Nine female interviewers were hired based on their educational experience (bachelor's degree at a minimum), their previous experience interacting with the mental health system, and the strength of their interpersonal skills (e.g., empathy, active listening). All were required to participate in an initial 2-day training session that focused on both the epistemology of ethnography (i.e., multiple worldviews) and on how to use standard ethnographic techniques (i.e., using semistructured protocols and the process of asking probes). Special attention was given to skills in maintaining a neutral stance when soliciting a mother's views. Prior to conducting interviews independently, all trainees conducted a pilot interview that was observed, tape-recorded, transcribed, and reviewed by senior members of the project staff. Interviewers participated in regular follow-up sessions with our ethnographic consultant to review their work in the field, answer emerging questions, clarify methodological or epistemological points, and review assumptions or behaviors that could bias respondents.

## Analysis of Transcripts

To identify and reconcile key themes that emerged across the set of respondents, senior members of the study team, the ethnographic consultant, and the group of field interviewers reviewed transcripts. Our team's initial task, the results of which are represented in this article, was to begin to identify the various interpretations mothers attached to their own and their child's distress and how they believed their distress could best be alleviated. The study team identified key themes related to attitudes and experiences likely to be operating as barriers to service use, particularly perceptual factors and apparent misinformation. The themes identified were then verified through a series of focus groups conducted with a random sample of the women who had participated in the interviews. ATLAS software was used to code themes to support the qualitative analysis.

The findings reported here include those beliefs or perceptions that were commonly cited by these mothers, as well as some perspectives, perhaps not as frequently expressed, that challenged our team members' assumptions about our respondents' beliefs, values, and motivations. We present here the maternal perspectives and views that appeared to be the most significant contributions to mothers' general reluctance or unwillingness to engage with the mental health care delivery system.

# FINDINGS

Of the 127 distressed mothers we interviewed, 29 had seen a mental health professional within the previous 2 months, of whom 15 were taking psychotropic medications prescribed by a psychiatrist; an additional 29 women were taking psychotropic medications prescribed by their primary care physician or gynecologist. Despite some participants' receipt of care for their distress, all 127 women met diagnostic criteria at baseline. An analysis of all the interviews identified four areas relevant to understanding a mother's reluctance or refusal to accept mental health treatment:

- acceptance of a diagnosis,
- perceptions of the causes of her distress,
- reactions to being referred for mental health treatment, and
- perceptions of their child's and other mental health services.

Each of these areas is discussed in turn below.

## Acceptance of a Diagnosis of Depression and/or Anxiety

One of our original assumptions was that mothers might not accept a treatment referral because they did not see their distress experiences as depression or anxiety. One of the basic tenets—and therefore contributions—of medical anthropology is that "target populations" quite often assign meanings to their distress experiences that differ significantly from the classifications used by the medical system (Brown & Moran, 1997; Hammen & Brennan, 2003; Sargent & Johnson, 1996). Thus, one of the questions in our ethnographic interview was, "What did you think when [research team member] told you that you were depressed/ anxious?" Contrary to expectations, mothers rarely expressed a disconnect with the diagnostic feedback provided by the interviewer. This is illustrated by the following reactions:

> "Duh." Well, I knew that . . . because they put these different stupid commercials on TV. Do you do this? Do you do that? Yeah, yeah, yeah, yeah, yeah, oh gee, I must be depressed. . . . I knew.

> I mean, everybody's like, "What do you got to be depressed about?" It's like, hello! Walk in my shoes for one week. You'll be depressed, too.

Much to our surprise, virtually all the women readily agreed they were depressed or anxious, strongly suggesting that classificatory differences do not explain why mothers do not accept referrals for care. Further analysis of the narratives suggests, however, that how mothers account for the cause of the distress might be significant.

## Perceptions of Causes of Distress

In each interview, we asked mothers what they believed to be the source of their depression and/or anxiety. Although mothers endorsed a variety of explanatory models of the etiology of their distress, they most often viewed it as a normal response to extreme external stresses. The following quotes typify this attribution:

> Just years of bad life, you know? I've had a lot of people say it to me . . . "God only gives you as much as he feels you can handle." Sometimes I sit and I look and I say, "Hey do you think I've had enough?"

> I'm stressed because I worry . . . about everything. You know, your job, your home, your finances. You know, it's not just that. It's everything. You feel very stressed and you feel tired all the time . . . so you're stressing over it and you *know* it's stress. You feel that it's just a part of everybody's life. So everybody has that.

Three specific external stresses were most frequently perceived by mothers as causing their depression/anxiety: the daily hassles of poverty, past and/or current abuse, and the stress inherent in managing a behaviorally or emotionally disturbed child.

*Poverty*. Living in poverty creates a set of daily challenges that often go unrecognized by the nonpoor (Katz, 1995). These mothers eloquently confirmed research findings that indicate that living in poverty and dealing with the demands placed on already-strained resources creates stress and negatively influences mental health (Park et al., 2002; Reading & Reynolds, 2001; Schultz et al., 2000). They also validated the reports in the public health literature (Earle & Heymann, 2002; Mann, Hudman, Salganicoff, & Folsom, 2002), noting that working-class women not only make a lower wage than their middle-class counterparts but also receive fewer benefits, such as paid leave time, despite the fact that their children are significantly more likely to have a chronic, disabling health condition (Heymann & Earle, 1999). The mothers in our study frequently discussed the challenges of maintaining a job and a steady income in the face of frequent calls to go to their child's school over a behavior problem, or even to get their child to therapy. Absences from work put a financial strain on the family and often caused a loss of employment altogether:

> I have a job where I don't get sick days. I don't get personal days. I mean, the money's great. Yeah, I work nine and a half hours, but if my child's sick, I have to send him to daycare and hope that I have a backup where someone can watch him.

Beyond the often-cited concrete problems of limited or nonexistent health insurance, inadequate transportation, need for affordable child care, and insufficient funds for basic necessities, their narratives emphasized the emotional strain of what it meant to live at the proverbial edge, with a constant and painful awareness that any one of a number of external events could tip the balance from "survival" into "crisis":

> I lived off my credit cards; I was grocery shopping on them. And it's like the snowball's rolling down the hill now, you know? I miss a day of work, I have no sick days. And my last pay wasn't quite $100.00. You know, it's like that—nothing can go wrong. It's the pressure that nothing can go wrong, but everything seems to.

The financial difficulties described by all of these women were suffocatingly real. In addition, many mothers were single, leaving them with sole responsibility for meeting the financial, instrumental, and emotional needs of an entire household. These priorities left little time for managing the behaviors of a troubled child, much less for taking care of their own needs. Those who were only recently on their own were struggling to deal with a new reality that included both a serious decrease in household income and, often, a simultaneous loss of portions of their network. Subsisting on public assistance left women who once had reasonable and stable lower class lifestyles in serious trouble. One mother accounted for her distress in fairly straightforward terms: "You'd be depressed, too, if you lived my life." Another mother said,

> So I guess I just feel desperate at times. God, is it ever going to end? Am I going to make it through this? Having to deal with going up and signing up for welfare for the first time in my life. . . . I took myself to a point where I had no money, was getting change together to buy milk for my kids.

*Abuse*. Many mothers also attributed their depression to past or current experiences of abuse. Espousing a view that is consistent with psychologists' models on how trauma affects emotional well-being, women viewed early physical or sexual abuse as having been sufficiently traumatic to have had long-standing effects on their mental health:

> My mother. She'd beat me all the time. I swear to God, it was all because of her, because . . . just as a teenager, she just said I don't *want* you. She said, "I have two sons. I wish I would have had a third son. I never wanted a girl."

Other mothers attributed their depression to experiences of current abuse, which left them feeling especially vulnerable to the possible impact of using mental health services. Like other mothers, they not only believed that mental health services would not work but, in addition, worried more that seeking services might make things worse by providing ammunition that their abusive partners could use against them. Although these women did not disagree that they were depressed or anxious, they expressed resentment, even indignation, at clinical labels suggesting that the distress was somehow internal to them. In their view, as we note below, their abusive partners were the source of the problem.

> And I *know* it's not me. I know it's [abusive husband]. And I know it's never going to change unless I get away. To go in front of somebody and say, "Okay, well, I think you're depressed." . . . You know, *you* don't know. I don't want them to think that it's me and there's something wrong with me, because I do know it's *not* me . . . it's the lifestyle I'm in. It's the way he's doing things to me is making me like that.

*Managing a troubled child*. By far the most common and overwhelming depression- and anxiety-producing stress mothers endorsed was having to manage an emotionally or behaviorally disturbed child. Whether the child displayed the internalizing symptoms of severe depression or the externalizing symptoms of attention deficit–hyperactivity disorder (ADHD) or conduct disorder, all of our mothers described the challenges of trying to find ways to manage their child's behaviors as contributing strongly to their distress. Most troubling of all were those respondents whose children displayed behaviors that would have challenged the best-trained clinicians, as is reflected in the frustrations described by the mother of an extremely violent 4-year-old who was abusing both her younger and her older siblings:

> It was just awful. Not knowing what was going to come next. I couldn't leave the room unless my husband was in there. I couldn't go do laundry. I couldn't do anything. I had to be in the room watching [my daughter] 24/7. . . . And it makes me feel like I had to have failed her in some way that she turned out because this is not a normal child. Nothing she does or says is normal. And it upsets me I just don't know what it is, and I can't help her if I don't know what the problem is.

Another offered a description of her child's issues:

> What he started out doing was spitting in his hands. So I didn't really notice at first, but then as we started noticing, he started hiding it. Just to constantly have his hands wet. And from that, he went to washing. So he's constantly washing his hands no matter what. His hand washing was a problem, and [the therapist] didn't think it was a problem. She said if it wasn't interrupting his daily schedule, then it wasn't really a problem. A 9-year-old little boy in there washing his hands like every 5 minutes. Then he quit. He wouldn't turn off the spigots with his hands; he would do it with his arms. He would flush the toilet. He started not touching the light switch. . . . It was progressively getting worse, and the therapist said, "Well, that's not an issue." To me, it *was* an issue.

In addition to the problems produced by having to manage their child's behaviors, mothers experienced serious additional distress stimulated by feelings that they were responsible for their children's problems. Their wholehearted acceptance of society's motherhood mandate, that is, that a mother's mission in life is to ensure her child's well-being (Arendell, 2000; Bradley, Whiteside-Mansell, Brisby, & Caldwell, 1997; Braverman, 1989), resulted in a clear and pervasive sense of guilt over the fact that something had "gone wrong." Often, as the interview progressed, even those mothers who did not initially mention any sense of responsibility for their child's problems admitted they frequently struggled to understand what they had done wrong and what they could have done differently:

> I try to stay strong for my two other kids, but it's really rough, you know, because it makes you start thinking, well, what did I do wrong, why is he doing this, what did I do that was different? You ask all them questions, you know . . . what if I did it this way? What if I did it that way? . . . I felt like I was worthless, that I couldn't help my son when he needed help. . . . As a mother, you want to fix everything . . . sometimes it doesn't work that way.

Many mothers felt so deeply responsible for their child's problems that their guilt inspired a philosophy of "mother's last," that is, they believed it would be clearly inappropriate to address their own needs before their child was well.

> You know, I can suffer. I'll be okay . . . but you don't want to see this little person. . . . I just want him to be successful and I want him to be okay . . . then I'll make time for myself. So it's more or less, you know, you're sacrificing yourself for their well-being.

> She's a child and without me, [she] wouldn't, you know, make it. So I just feel that the children always have to come first . . . they come first no matter what . . . and, as far as me, I feel I'm older; I've been through a lot. I've been through everything thus far and nothing bad has come of it to where I can't function anymore.

The perceived indissoluble tie between maternal distress and the child's disorder provides one explanation for why mothers are reluctant to seek care for themselves (Rishel, Greeno, Marcus, & Anderson, in press), but other mothers expressed an even more complex explanation. They viewed the intimate bond between them and their child[5] as the direct cause of their emotional pain. One mother said, "It's like I'm suffering for both of us." When a mother views her

distress so totally as the result of her child's problems, then getting the child into treatment might be as much about alleviating her distress as it is about helping the child:

> At this point, I just want to feel better. I want my daughter to be better. I mean, I want to know if she has an emotional problem or if it's a behavior problem. I just want to know what's wrong with her. And that will make me feel better.

As if to emphasize the desire for a systemic treatment perspective, one mother expressed the sentiments of many when she discussed this inextricable mother-child bond and underlined her request for treatment "by proxy" by stating simply, but emphatically, "Fix my kids and I will be fine."

## Reaction to a Mental Health Referral

These views of the etiology of their emotional distress appeared to be a core part of women's negative response to a referral for mental health services. First, they perceived that the clinical system would focus on creating internal changes, a focus that made little sense to them when they perceived their distress to be caused by external pressures. Relief would come with a change in life circumstances, not medication or "talk therapy." The message was a clear and understandable version of Maslow's (1954, 1987) hierarchy of needs: first, better food and shelter, quality affordable child care, a steady source of income, a better living environment, and a moving van to help them leave an abusive spouse. Meeting these concrete needs was seen by many of our mothers as more important and relevant than dealing directly with their mental distress. Indeed, many felt that a change in circumstances might alleviate the distress altogether. When one respondent was asked what the clinic could offer her that would improve her depression, she replied, "A job, one that pays me more than I'm making now."

The second factor contributing to a negative reaction to a mental health referral was how mothers evaluated the seriousness of their emotional problems. Although they used the same terms for the constellation of symptoms that mental health professionals use to describe an affective disorder, their responses indicated that they actually saw two types of depression: one that they viewed as a normal, in fact inevitable, response to a difficult life, and one that involved seriously impaired functioning. They believed their depression was the first type, one that could be handled without medical intervention. Indeed, many mothers were very emphatic about their tenacious ability to manage in spite of their distress, as the following 3 mothers make the point clearly:

> You know, I get through life managing. . . . I'm depressed but I manage, I'm not one of those women who falls apart.

> I don't know, I've always been one to deal with it and move on. . . . At times I be down, but never letting anyone know that I broke down, you know, because as a parent you're put there to be strong. You're there for your children. So when you can take your moment, you take your moment, but when you have a child like I have, you have to learn to be a lot stronger.

> [Depressed?] Well, yes. What else is new? That in itself is okay. That's part and parcel for what I'm dealing with, the ups and downs. And I prefer to look at it as overwhelmed, quite honestly . . . but what upset [me] was the response, was that . . . it was recommended that [I] go get counseling. . . . And that, like in itself, it's . . . throw[ing] sprinkles on the problem . . . that . . . you know, in no way, shape, or form addresses the situation. I joked with my friend, I said, you know, that really irritated me. If they really want to make a difference here, throw $10,000 at me.

They were very clear that a serious "mental illness" type depression, the only kind that would merit medical intervention, was not what they had as long as they could function. One mother described the difference between a "real" depression and her own this way:

> [Somebody who is depressed is] constantly sad, is tuned out of the world and wants to kill themselves. They want to hurt their children, something like that. Supposedly when parents hurt their children, its because they had depression, right? . . . If you can't change it, there is no reason to dwell on it, that's how I think. I don't need a therapist. I don't think so because I function fine. I go to work; I do what I have to do, so it's fine. I take care of the kids, it's fine.

Yet it was perhaps a concern that "the system" would fail to make this distinction between "manageable" and "dysfunctional" depression that stimulated a worried response from our respondents about accepting a referral for care, even when they indicated to us that they were in a lot of distress.

The third, and perhaps even more compelling, reason mothers gave for their negative reactions to the possibility of using mental health care was associated with their fear of being judged inadequate by professionals, who, they believed, had the power to take their children away. Although mental health professionals might not see themselves as having the same mandate and authority as workers from agencies of social control, mothers approach mental health services with the same wariness and skepticism they feel toward all agencies with such authority. Mothers frequently expressed the view that they were powerless, on the basis of their limited income as well as their gender. Seeing the clinic as an integral part of the larger system of public services with power over their lives appears to constitute one of the most serious barriers to women accepting services. Although they had tremendous pride in their autonomy and ability to cope under duress, this did not diminish their fears that admitting a need for mental health assistance would give those in power the idea that they were not coping adequately, that they were by definition unfit mothers. This exacerbated their sense of vulnerability and their view of therapists as judges, as the following comments from 3 mothers illustrates:

> A therapist may look at your mental capabilities and . . . that's where the threat comes in. Are you mentally able to take care of your day-to-day responsibilities? If you mentally are not able to take care of yourself, how are you taking care of your children? That's always a threat.

> [Women] be afraid. Because, see, at first like before I started going to the clinic, I always thought that if I would go to one of them services or something, I thought that the first thing they was going to do was take my kids off of me. . . . I was afraid, I didn't know.

> I'm nervous about somebody constantly questioning my motherhood. You know, to make me feel like I'm not a good enough mother. I feel violated.

Originally, our team thought that minority mothers might be reluctant to go for care out of concern that the mental health system might be insensitive to issues of race. Only a few minority women, however, stressed the importance of race as a barrier, even when the interviewer specifically asked about the importance of this issue.

> Race doesn't make a difference, gender does. Because I'm finding whether you're White or Black, if you went through the same thing, it doesn't make a difference.

> I need someone who understands, who's walked in my shoes, not just as a Black woman, a single Black woman with a child, but a woman who's had a child by herself.

## Perceptions of Mental Health Experiences

Despite their fears and discomfort about services for themselves, most mothers were willing to be involved in their child's treatment, perhaps because many, as noted previously, believed that their and their child's distress were interrelated. Unfortunately, those mothers who approached services for their children with the hope that their own needs also would be addressed were most often disappointed. Virtually all our mothers indicated that few of the clinicians they had seen with their children had asked them how they themselves were doing, leaving mothers with the impression that their problems and burdens were not thought to be relevant:

> They don't ask about me. And technically they should be asking about me because I'm the one that has to deal with the situation. . . . And depending on how stressed I am, is going to be how well I deal with the situation. And there are days I don't deal with the situation real well, let me tell you.

> When I came in there, they wasn't really concerned about me. Because I wasn't the reason why the initial visit was for, but it always starts with the mother. You know, if there's a problem with a child, nine times out of ten there's problems with the mother . . . so I mean that's where they should start is with the mother because maybe they would be surprised if they could resolve it though the mother.

Even those mothers who were invited to participate in sessions were frequently disappointed by the way they were treated. Said one mother, "[Therapists] treat you like you have no clue." Another echoed, "Why is it that we're [mothers] relegated to stupid status, you know, when we're the ones who really know what's going on?" Often they perceived therapists as too naive or inexperienced to appreciate their life difficulties. Therapists with little life experience, in particular, had little credibility with mothers who saw themselves as having way too much life experience. Some noted they would have been more impressed if a therapist had her own child's drawings on her walls rather than her diploma. In fact, "book learning" in general was regarded with scorn:

> And I figured [therapy] is not going to work because all she is going to do is read from a textbook. You know, she's not going to really know my experiences or nothing else.

> And I, myself, wouldn't go there because I don't think their advice is good. . . . because a lot of these people you get have not even been through [a situation like mine] and don't even know. . . . And here you have people who don't have kids, never been molested in their life, and never had children that have been molested. . . . She's real young, and I believe that wisdom comes with age. And me sitting there talking to this girl would be like talking to my daughter.

They also criticized the skills of therapists who did not take time to know the child before asking questions that they saw as difficult, inappropriate, or intrusive. For example,

> The lady when we walked in there was asking her [my daughter] a group of questions. One of the questions was "Do your stuffed animals talk to you?" And my daughter looked at this lady like she's absolutely crazy, you know. . . . So after that, she said, "Mom, I don't want to go back to this woman." And I can't blame her. . . . I'm sure they were just trying to see if there was any kind of, you know, if she was actually out of herself . . . if she's hearing voices, if she's schizophrenic, or something like that . . . [but] . . . that's not getting to know the child. . . . I think that just totally distanced my daughter . . . to the point where she said, "Mom, I think this lady needs help."

Thus, mothers repeatedly expressed frustration when clinicians did not appear interested in their input about the child; that what they had learned in their struggles going through all the child's ups and downs was simply ignored in planning the child's treatment. The following quote illustrates this perspective:

> The problem I'm having right now is that the doctor doesn't listen. . . . It's like it doesn't matter to her that my son is misbehaving at home. . . . And I've already told the therapist, "Look, you know, it's to the point now it's so bad at home, you know, that removing him is actually going through my mind, because it's just so disruptive anymore." And then her thing to me, "Well, we're not trying to break up families."

Not surprisingly, negative treatment experiences caused many mothers to become more generally skeptical and guarded in their dealings with clinicians and service systems, not only causing a sense of distrust and alienation but also decreasing meaningful participation in the treatment process. As one mother succinctly put it, "I'll talk to them, but I don't tell them [everything] because I don't know what they might try to do. I ain't that stupid." Whether they encountered negative experiences with their child's therapist or whether they had negative experiences when they sought mental health care for themselves, the result was an increasing alienation from treatment systems and an unwillingness to return. One mother described her single therapeutic encounter with an inflexible clinician:

> [The therapist] just sat there and she wrote for a little bit at her desk. And I'm sitting there. And she said, "Why are you here?" I said, "I was referred here." "Yes, but why are you here?" I said, "I'm not sure. I don't know." And she would say, "Okay. When you're ready to talk, talk." And I was like, oh my God, what's that mean? What do

> I say? And I sat there uncomfortably for the next 50 minutes and did not say one word. I kept saying, "I'm sorry. I don't know what to say. I don't know what to say." And she was determined to force me to say something. And I just—I didn't like that approach, I didn't like that feeling at all. That was the end of my therapy.

## DISCUSSION

Many researchers have explored the reasons lower income populations do not use mental health services, primarily focusing on the logistical barriers presented by such factors as transportation, child care, and the cost of services. Because the distressed mothers in our study were willing to override these challenges to ensure that their children received services, we concentrated on gaining a better understanding of the perceptions and attitudes that kept them from accessing mental health services for themselves as the crucial factor in finding a way better to meet their needs. The use of qualitative methods offered us the opportunity to explore in depth maternal perceptions and experiences that could be contributing to the intractable problems involved in engaging this population. These findings, and their implications for practice, speak to the importance of employing this research method. These extensive qualitative interviews revealed two significant and related perceptual gaps between lower income mothers and mental health professionals that operate as barriers to care: Perception of the causes of their distress, and perceptions of the intent and/or usefulness of services.

*Causes of distress*. Mental health systems operate using a diagnostic model that implies that symptoms of distress are evidence of an illness. Alternatively, the majority of our lower income mothers viewed their symptoms as the result of their difficult life circumstances, including the challenges of poverty, the effects of their experiences of abuse or neglect, and the struggles of raising a troubled child. Thus, it is not surprising that so many of them reject medical model "answers," which imply that psychotherapy or medication are needed to combat the disorders of depression and anxiety, especially when these answers are offered in an initial contact. The result of early interventions of this sort appears to be an alienation of women who feel their views of their "real world" problems have not been acknowledged, leaving them with the impression that the services they are being offered are not relevant. In many cases, they might be right.

This is not to say that some lower income mothers did not readily accept the idea that they had a clinical or biological disorder that could respond to psychotropic medication, or psychological issues that might respond to psychotherapy. Services as they are traditionally offered are certainly appropriate for such women. Ironically, the fact that this minority of clients responds well to traditional services probably provides clinicians with periodic reinforcement for limiting their assessments and interventions to the medical model.[6] Unfortunately, the result of this sometimes-successful approach is a failure to engage those women whose worldviews clash with the medical model and who are then dismissed by many clinicians as "unmotivated."

*Intent and usefulness of mental health services*. Our findings also suggest that connecting successfully with these lower income women is further complicated by a

disjuncture between the intent of mental health services and how those services are perceived by the women and children targeted to receive them. Clinicians believe they are well meaning in their offers to help, but lower income mothers believe clinicians are part of “the system,” one that potentially has dangerous power over their lives. Although perceptual discontinuities with service providers are not limited to lower income mothers (Lupton & Fenwick, 2001; Pottick & Davis, 2001; Young, Dixon-Woods, Findlay, & Heney, 2002), the implications for lower income women are likely to be more severe, as these women often do not have the financial resources, skills, or power to advocate for themselves in the hierarchical settings of services. Indeed, because they occupy a marginal social position, lower income women believe themselves to be—and, in fact, frequently are—vulnerable to having their shortcomings used against them by an unforgiving and perhaps uninformed system (Callahan & Lumb, 1995; Mohr, 2000). This, combined with the fears of losing custody of their child to that system, furthers the likelihood that mental health clinics will miss a crucial opportunity for treatment engagement that lower income mothers provide by overcoming both instrumental and perceptual barriers to seek care for their children.

Finally, although we are undertaking additional analyses, we have been surprised by initially finding so few differences between the stories of White and minority mothers. It appears that any possible differences might be obscured by the overwhelming nature of the poverty and/or class issues that dominate the reports of both groups. This is not to say that there are not more African American women who live in poverty as a result of historical and current discrimination, but once poor, women in both groups appear to concentrate on their economic deprivation as a primary contributing factor to their distress.

## IMPLICATIONS FOR INTERVENTION

Many experienced clinicians know the crucial lessons in this work; lower income mothers come to care with their own view of their problems, their own priorities of what should be done about them, and a set of experiences that has left them feeling that mental health services are not necessarily benign. In fact, those with experience might know that lower income mothers will need to be “courted” to use services. Unfortunately, many clinicians are inexperienced and/or unprepared to address the two disjunctures we have described. The result is that they have virtually no chance of engaging significant numbers of lower income mothers, and probably lower income clients in general.

Clearly, this work supports the need for a bridge between the worldviews of mothers bringing children for mental health care and the clinicians whose responsibility it is to engage them. Indeed, all efforts to develop and disseminate efficacious interventions are irrelevant without one. A good bridge must be based on a recognition that depressed and/or anxious lower income mothers have a variety of needs, perceptions, and levels of receptivity to services. Before offering a one-size-fits-all diagnostic assessment and standard treatment follow-up, initial clinical contacts must include at least some chance for mothers to tell the story of their needs and priorities. Treatment engagement and adherence would be enhanced if mothers had a chance to share their worldviews, priorities, and life experiences, and clinicians were prepared to employ a tailored combination of medical and

social models of change as needed. This might include offering a range of interventions, from intensive therapy, to pragmatic help in managing life's difficulties, to no therapy at all.

Given the emphasis many mothers place on the interrelated stress of their and their child's behavior, a family systems treatment orientation that provides some attention to maternal needs is likely to be the most acceptable way of involving mothers in their child's care. Such family interventions, however, should go beyond the usual parent training, with its emphasis on child management strategies, to include simultaneous attention to the mother's needs, particularly those that might interfere with her ability to carry out child care tasks and child management programs. Such interventions might even attend to the problems that are being contributed by what one mother called the "sometimes father," and how these could be turned into a resource.

Not all maternal needs, however, can be addressed using a family focus. Some seriously depressed and/or anxious mothers might require individual attention, that is, personal therapy or psychotropic medication. Clinicians who encounter mothers who need help, but are skeptical about accepting it, might need to take the time to make a case for the relevance of individual treatments, but this is likely to be effective only after hearing the mother's immediate needs as she defines them.

Still other mothers might be better served by offering advocacy and case management services as the primary intervention. Those women who are acutely aware that their real-life dilemmas cannot be fixed with a prescription, altered cognitions, or a sympathetic ear might respond to concrete services that facilitate survival and indirectly decrease the emotional stress they are experiencing. Once these issues are addressed, they might or might not need or want therapy or medication. In addition, many mothers who do not believe they need formal services might remain receptive to the offer of a self-help support group with other mothers who have had similar experiences. Such groups offer important advantages in and of themselves but also might contribute to diminishing the negative views of the treatment agency. Finally, the serious impact of poverty on the mental well-being of mothers and children suggests the need for advocacy for public health policies that ensure that lower income families receive adequate financial support.

In summary, engaging mothers in any of these interventions requires that their views of their problems and needs be addressed. Our experience with the qualitative interviews conducted in this study revealed that mothers love to tell their stories and regarded our interest in them as an affirmation and sign of our respect for their experiences. They liked having the chance to tell us that mothering is a tough job under any circumstances and even more so when coping with the pressing priorities of a difficult child, abuse, and poverty. If clinicians took the time to hear these maternal views and experiences, to clearly acknowledge their significance, the likelihood of overcoming negative attitudes about mental health services, of developing a therapeutic alliance would be enhanced.

## NOTES

1. Our focus on mothers is not meant to ignore the influence of fathers living in or outside the home, with or without contact with the mother or child. Rather, we simply aim to recognize that there is a high percentage of single mothers in lower income populations, and that mothers are most likely

to bring their children for care and, because of a variety of life stressors, are likely to experience high levels of distress.

2. Questionnaire results will be reported elsewhere (manuscript in preparation).

3. A copy of the interview protocol may be obtained by request from the first author: Carol M. Anderson, PhD, University of Pittsburgh Medical Center/WPIC, 3811 O'Hara, Pittsburgh, PA 15213, USA; e-mail: andersoncm@upmc.edu

4. As a point of comparison, the Federal Poverty Level (FPL) for a family of three, two of whom are children under the age of 18, is US$14,824; for a family of four, three of whom are under the age of 18, the FPL is $18,725 (U.S. Census Bureau, 2004)

5. The relationship between parental and child distress has been well documented (Diaz-Caneja & Johnson, 2004; Lyons-Ruth, Wolfe, Lyubchik, & Steingard, 2003). Some researchers have explored the negative impact of depressed mothers on their children (Beardslee, Bemporad, Keller, & Klerman, 1988; Coiro, 2001; Cummings & Davies, 1994; Dover et al., 1994; Downey & Coyne, 1990; Goodman & Gotlib, 1999; Hammen & Brennan, 2003; Kramer et al., 1998; Mowbray, Oyserman, Bybee, McFarlane, & Rueda-Riedle, 2001; Weissman, Feder, et al., 2004; Weissman, Warner, Wickramaratne, Moreau, & Olfson, 1997). Other studies have demonstrated the converse, namely, how the child's behavioral disorder influences family relationships and interactions, causing increased parental distress and caregiver burden (Kovacs, Devlin, Pollack, Richards, & Mukerji, 1997; Puig-Antich et al., 1989). Our findings do not focus on the direction of the impact but merely serve to underscore the strength of the mother-child relationship.

6. Clinicians are reinforced for using the medical model not only by the sometimes-helpfulness of their offerings but also by the reimbursement structure, which usually provides payment only for medical model interventions, and then only if the woman shows up for treatment.

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