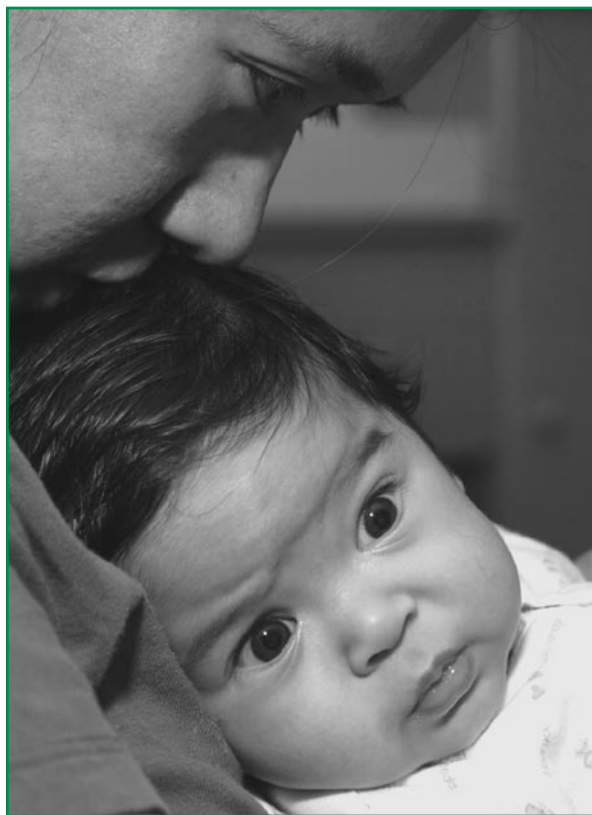


"You'd Be Depressed Too": Treatment Acceptability among Mothers who are Economically Disadvantaged

Although mothers who are economically disadvantaged have high rates of emotional distress, the rate of their use of mental health services is relatively low. What accounts for this underutilization of care? Although there is evidence that insurance coverage and access to care account for some of this disparity, barriers to mental health services reach beyond basic access issues. When considering why some choose to seek mental health care while others do not, it is important to consider treatment acceptability among low-income mothers.

Treatment acceptability is the extent to which recipients of care perceive that care as "reasonable, justified, fair, and palatable" (p. 158).⁵ In other words, it is not enough to make care accessible; it also has to be acceptable, or relevant to the consumer. And the more consumers view treatment as relevant or important, the more likely they are to work to overcome other barriers to seek mental health care. After all, mothers are more likely to overcome obstacles in order to get the care needed for their children than they are to get care for themselves.³ Therefore, other factors



must play a role in order to explain why low-income mothers do not get care for their own mental health.

One of the best studies addressing mental health treatment acceptability in low-income mothers was conducted by Carol Anderson and her colleagues.¹ Researchers interviewed 127 women who initiated treatment for their children at one of four community mental health centers based in disadvantaged communities. Of these women, 40% were African-American. The women had an average of 2.6 children, and more than half had a household income of less than \$15,000. Based on a routine screening,

all interviewees met the criteria for significant mood and anxiety disorder and were referred for mental health services—yet only 29 had seen a mental health professional in the past two months.

The interviews explored the mother's view of her life, problems and distress; her response to being diagnosed and referred for mental health services; and the reasons why she did or did not seek treatment following her referral. Overall, the study identified four themes that were connected to mothers' reluctance or refusal to accept mental health treatment: (1) agreement with diagnosis; (2) perceptions of the causes of the distress; (3) reactions to being referred for mental health treatment, and; (4) perceptions of their children's and other mental health services.

Agreement with Diagnosis

Virtually all the women interviewed agreed with the assessment results that suggested they were depressed or anxious. Simply disbelieving their diagnosis was not a barrier to seeking care. So, lack of care was due to either access or acceptability issues,

or a combination of the two. Because access issues seemed to be less likely in this sample, given that (1) these mothers were getting care for their children, and (2) they had a referral and place to go to get mental health care, it appears that other acceptability factors were a barrier to receiving mental health treatment.

Perceptions of the Causes of Distress

Depression and anxiety are internalizing disorders; that is, they are generally understood as mental health conditions that originate from within oneself. However, the women interviewed by Anderson and her colleagues did not see the origins of their distress in this way. These mothers most often believed that their mental health status was a normal response to extreme external stresses. Taking care of a behaviorally or emotionally disturbed child was by far the most common and overwhelming stressor cited by the mothers. In addition, poverty and past and/or current abuse were cited as reasons for their distress. As one mother put it, "Walk in my shoes for one week. You'll be depressed too" (p. 930).¹

In addition, many mothers were single and the heads of their households. Interviewees stated that this responsibility left them with little time to do anything but keep the home functioning. Some women expressed resentment of clinical labels of their mental health status, which they thought erroneously suggested that their distress was internally caused and not the inevitable result of their environment. Others believed it would be inappropriate or illogical for them to address their own needs before their child was well.

Reactions to Being Referred for Mental Health Treatment

Believing in the effectiveness of mental health treatment is essential to engaging and remaining in care.^{2,5} However, many of the women in Anderson's study did not believe that

counseling would help them. This was because these women more often than not perceived the reasons for their distress to be external causes. And, as mental health services usually address *internal* issues, this type of treatment was deemed to be irrelevant and therefore unacceptable.

These mothers believed that their distress would be relieved by improvements in their life circumstances, not through counseling or medication: "It was recommended that [I] go get counseling. ... And that, like in itself, ... in no way, shape, or form addresses the situation. I joked with my friend,

Mothers believed that their distress would be relieved by improvements in their life circumstances, not through counseling or medication.

I said, you know, that really irritated me. If they really want to make a difference here, throw \$10,000 at me" (p. 935).¹ These women viewed their depression and anxiety as natural responses to a difficult life. These findings offer insight as to why previous research has shown that both socioeconomic disadvantage and higher levels of stress are associated with lower levels of perceived treatment acceptability.⁵

Perceptions of Mental Health Services

Finally, negative experiences with mental health services while caring for their children also biased mothers against seeking care themselves. Their interactions with their children's therapists led them to believe that the therapists had little credibility and lacked life experience. They also expressed frustration when clinicians did not appear to want their input as to what they believed was best for the child: "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?" (p. 936).¹ A strong, positive relationship between a parent and his or her child's therapist is associated with higher levels of treatment acceptability.⁵

Being a mother has many positive associations for women with mental health conditions. When asked what changes motherhood had brought to their lives, three fourths of a sample of women with various mental health diagnoses named factors that were positive in nature—that being a mother gave them a sense of pride and accomplishment, and caused them to change their habits and behavior for the better. In contrast, just over one third mentioned negative changes associated with being a mother, such as feeling angry and losing free time.⁶ The importance and positive associa-

tions these women place on motherhood demonstrate that their relationships with their children are essential components to their well-being. Any perceived threat to this bond would be seen as a barrier to receiving mental health support. The distressed women from Anderson's sample expressed fear of being judged by professionals as inadequate caregivers. The professionals, they believed, had the authority to take their children away, if they were assessed as inadequate caregivers. Thus, many mothers became skeptical of mental health professionals: "I don't tell them [everything] because I don't know what they might try to do. I ain't that stupid" (p.937).¹ A lack of trust between a person and her therapist makes it difficult for them to work together to improve the situation.

Increasing Treatment Acceptability

Treatment acceptability is an important issue to consider when examining why low-income mothers with mental health concerns are not seeking treatment. There is evidence that these mothers are reluctant to seek care because of a mismatch between their beliefs and those of mental health professionals regarding



the causes of their distress, and their negative perceptions of the usefulness and intentions of mental health service providers. The stories of these mothers suggest that a model of mental health that implies their symptoms of distress are evidence of an illness (and thus internal) may not fit with their perceptions and experiences that their distress is caused by a tough living environment. Additionally, this population needs more reassurance that mental health professionals understand their situations and are committed to helping them get the support and resources they need and not threaten their relationships with their children. Even though Anderson and her colleagues emphasized in their research that many mothers named their child's condition as a source of their own mental health difficulties, other research indicates that motherhood is a positive experience for women with mental health conditions and therefore may be a good strength to focus on during treatment.

Engaging mothers to address their own mental health needs requires a sympathetic understanding of their perceptions of the problems that underlie their distress. Grote and her colleagues developed a program specifically designed to engage and retain depressed women who are economically disadvantaged.⁴ Using a combination of ethnographic and motivational interviewing, their

program aims to elicit and resolve a woman's reluctance towards coming into treatment. This involves taking into account the client's understanding of and explanation for her depression, which entails gathering information on social problems and chronic stress. Additionally, counselors in this program are instructed to consider clients' personal and cultural resources that have helped them cope thus far. Preliminary results have demonstrated higher levels of client engagement and retention when compared to standard treatments.

Working with both mother and child together may send the message that the counselor cares about all family members equally and wants to help preserve the family—not destroy it, as some clients may fear. When working with low-income mothers, focusing on finding sources of support to alleviate external stressors can be an important first step in the therapeutic relationship. This approach also conveys the understanding that many of the sources of their stress are externally based. This would ultimately enhance the therapeutic alliance between mental health service providers and low-income mothers. By working together to lessen the burdens these women face every day, it is possible that the family situation would become less stressful, and both the mother and child would remain in a treatment setting that felt relevant,

fair, and acceptable to the family.

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