

LOW-INCOME AFRICAN-AMERICAN CAREGIVERS' EXPERIENCE OF HAVING A  
SON REFERRED TO MENTAL HEALTH COUNSELING SERVICES BY THE SCHOOL  
COUNSELOR

By

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Dedicated to the memory of  
Todd Owen Carter

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Abstract of Dissertation Presented to the Graduate School  
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By

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The intersecting factors of social class and race are essential markers of place and shapers of behavior and perception in the United States. In this phenomenological study, six low-income African-American caregivers were interviewed about their experience of having a son referred for mental health care by the school counselor. Issues of how the participants viewed the school, mental health care, and the process of being referred were explored.

Key findings of the study included; the caregivers' experiences of alienation and powerlessness in the face of a rigid, hierarchical system for parent involvement in educational decision making, caregivers' perceived lack of power in relationship to school staff members, and caregivers' lack of understanding of school administrative processes. Other findings, as well as implications for practice and research, were examined.

## CHAPTER 1 INTRODUCTION

School counselors are key figures in the referral of children to mental health care facilities (Baker, 1996; Ritchie & Partin, 1994). School counselors' job descriptions have long included referral of students to outside service providers for a large array of health and social service needs (Baker, 1996; Brown & Trusty, 2005; Erford, 2003). However, limited literature is available for assisting school counselors in understanding the dynamics of referring low-income African-American families for outside help. Poor African-American families make up a disproportionately large number of referrals to mental health agencies, yet there is mounting evidence that African-Americans view help seeking differently than Whites. More research is needed to uncover the reasons behind these trends (Boyd-Franklin, 1989; Liu, et al, 2004; Logan, 2001; McMiller & Weisz, 1996).

Yet, in a search of the tables of contents of the *Journal of Counseling and Development* from 1995-2005, only 9 article titles included terms that directly indicate an emphasis on class and/ or poverty issues. Words such as at-risk, marginalized, elitism, disadvantaged, social justice, and lack of money were included in this category. Many of these terms are poorly defined and change from one article to the next. For example, the term 'at-risk' may or may not include children who live under the poverty line, children whose parents are incarcerated, or children whose siblings have left school without graduating. By contrast, 90 articles had titles that included terms related to race, culture, national origin, ethnicity, or multiculturalism.

Three special issues in the past 10 years have been devoted to issues of multiculturalism, diversity, and race, but none have dealt directly with issues of poverty and class based oppression. Not even the "Dimensions of Personal Identity Model," which takes into account multiple internal and external factors in the shaping of a person's identity, explicitly include

social class, although it does include level of education, work experience, and historical context (Arredondo, Rosen, Rice, Perez, & Tovar-Gamero, 2005). Arredondo, and her associates (2005) go on to say at the conclusion of their content analysis of the *Journal of Counseling and Development* from 1995-2005, “No longer can multiculturalism be relegated to one course, mentioned as a passing comment in a publication or presentation, or avoided by educators and administrators... ” (p.160). This already powerful statement would be strengthened by the inclusion of class. In a review of tables of contents for the *Professional School Counseling* from 1997 to the present, similar ratios were found. However, the journal’s recent special issue entitled “Professional School Counseling in Urban Settings” (February, 2005) did include articles on poverty related issues.

Liu and colleagues (2004) reviewed three journals, *The Journal of Counseling Psychology*, *The Journal of Counseling and Development*, and *The Journal of Multicultural Counseling and Development* from 1981-2000, and discovered that social class was a key variable in only 1.4% of all empirical research articles, even though social class data was collected on participants in 17.5% of the studies. Social class was referred to more often in theoretical/conceptual articles, and was at least mentioned as a variable in 33.5% of the studies. In total, between 20 and 30% of all 3915 articles reviewed mentioned social class in some form. However, only a very small percentage made social class a focus of the research. These findings highlight the need for more research in the area of social class in the counseling literature. In particular, the subjective experience of social class has been excluded from previous work, in spite of the evidence that subjective accounts of social class are more reliable and robust than available objective measures (Liu, et al, 2004). The two most frequently used objective indices of social class, the Hollingshead Index of Social Position (1958), and the Duncan Socioeconomic Index (1961) are

both over 45 years old and reflect census data and occupational categories from the 1950's. In a separate content analysis of the *Journal of Counseling Psychology* from 1973-1999 (1999), Buboltz, Miller, & Williams found that most (56%) social class research in the past thirty years has been carried out using college students as research participants, greatly lowering the diversity of the samples. Therefore, even our 'objective' understanding of social class as a variable in counseling research is highly questionable.

Many variables of family poverty and health care have been examined by various agencies and researchers. However, the voices of African-American families in poverty are still silent in the professional counseling and psychology literature (Moreira, 2003; Sue & Lam, 2002; Smith, 2005; Van Galen, 2004). The actual lived experience of being referred to mental health care for a African-American child in a low-income family in the United States has not yet been adequately explored (Smith, 2005). To better inform future policy making and counseling practice, this study addressed this gap in knowledge.

Much is known about the negative effects of poverty on children and families, but little is known about the lived experiences of African-American families in poverty who are referred by school personnel to mental health care services for their children. The voices of the people most impacted by poverty and mental health care policy are missing from the current literature.

Also absent from the school counseling literature are guidelines for school counselors about making effective referrals for low income families to outside agencies. Very little has been published in recent years about the referral practices of school counselors, although making referrals is an important aspect of the school counselor's job (Baker, 1996; Brown & Trusty, 2005; Davis, 2005). School counselors make an average of thirty referrals per year, primarily for help with emotional and family concerns (Ritchie & Partin, 1994). Although the counselors

Ritchie & Partin surveyed twelve years ago reported mostly positive experiences with making referrals to outside agencies, a significant number (48%) also reported occasional frustration with parents not following through on their recommendations (Ritchie & Partin, 1994).

Most current school counseling textbooks offer some variation on the following advice to new professionals about making out-of-school referrals:

- Be aware of laws and policies regarding sharing confidential information.
- Develop collaborative working relationships with the care providers in your area.
- Keep some record of the dates and places families were referred to service providers (Baker, 1996; Brown & Trusty, 2005; Erford, 2003; Ritchie & Partin, 1996).

Some texts also offer models for problem-solving with families in crisis (Baker, 1996; Erford, 2003) which could be employed when making referrals. However, only Erford's text offers a chapter on helping what is termed "at-risk" students; none of the texts seemed to include any guidance on working with families in poverty per se (Brown & Trusty, 2005; Davis, 2005 both include chapters on multicultural counseling, but focus only on race and heritage issues, not class). Additionally, most texts do not differentiate between sub-groups within races, such as Mexican- American versus South or Central American or Caribbean Hispanics, or between Haitian and African-Americans.

Conversely, a large percentage of children seen in mental health facilities have a history of school problems and are initially referred by school counselors or teachers. The research that does exist on the process poor families experience between initial referral for and entry into mental health services suggests that there is often a long delay between the two (Chow, Jaffee & Snowden, 2003; French, Reardon, & Smith, 2003; Potter, et al, 2002; McKay, Lynn, & Bannon, 2005; Huang, Stroul, Freidman, Mrazek, Freisen, Pires, & Mayberg, 2005; Bussing, Zima, Gary,

& Garvan, 2003). During this delay, children's problems often worsen, and parents feel overwhelmed and frustrated by the time they reach the clinic. Understanding the essence of the experience of African-American families who are referred to mental health services by school counselors would add enhance our current understanding of the dynamics of how, where, and when poor African-American caregivers access mental health care services for their children.

### **Social Class and Access to Mental Health Care in the United States**

Although vast changes have occurred in both standards and methods of care for the mentally ill over the past two centuries (Grob, 1994), social class disparities are still reflected in access to mental health care (Busch & Horowitz, 2004; Howell, 2004; Leventhal, 2003). Differences in access to care occur among rural and urban populations, between wealthy and poor people, and between various racial groups. Perhaps the group most affected by lack of access to care is children living in poverty, regardless of race and location (Chow, Jaffee, & Snowden, 2003; Samaan, 2000; Takeuchi, Bui, & Kim, 1993).

As defined by financial parameters, 16% of American children lived in poverty in 2002 with one in four families in the United States with young children earning less than \$25,000 a year (Child Welfare League of America, October 23, 2005). The federal poverty level (FPL) for 2004 was \$19,157 per year for a family of four. Low income was calculated as 100-200% of the FPL for a family of four (US Census Bureau, 2005). In terms of raw numbers, over 13 million children in the United States lived at or below the poverty line in 2004, an increase of 12.8% over the number reported in 2000 (Children's Defense Fund, 2005). Financial need is but one of many defining characteristics of poverty. In this study, poverty was defined more globally as; "A condition that extends beyond the lack of income and goes hand in hand with a lack of power, humiliation and a sense of exclusion," (Raphael, 2005).

Children living in poverty were less likely to have access to health care services, including mental health care than their peers from higher socio-economic levels (Howell, 2004). Approximately one in ten children in the United States have a ‘serious’ mental health need at any given time. As of 2002, children living in poverty were twice as likely as are middle and upper class children to demonstrate serious mental health needs (Pottick, Warner, Isaacs, Henderson, Milazzo-Sayre, & Manderscheid, 2002). While children living in poverty were more likely than are their non-poor age mates to find themselves in need of mental health care services, they were much less likely to receive adequate help (French, Reardon, & Smith, 2003; Potter, et al, 2002; McKay, Lynn, & Bannon, 2005; Huang, Stroul, Freidman, Mrazek, Freisen, Pires, & Mayberg, 2005; Bussing, Zima, Gary, & Garvan, 2003). As explained by Simpson, Scott, Henderson, & Manderscheid (2002), “ children with the highest level of perceived unmet medical needs or who were unable to afford counseling were those who were uninsured, living in families with income below 100% of the poverty level, or who lived with a single parent”(p. 117).

The number of uninsured children, who are most at risk for not receiving adequate care, is increasing in the United States. According to the US Census Bureau, as of August 2004 ([www.census.gov/Press-Release](http://www.census.gov/Press-Release)), 8.4 million, 11.4% of all of the children in the United States, were uninsured. Foreign born Hispanic children had the highest proportion of uninsured members with 32.7%, followed by African-American children with 19.5% uninsured, and white children with 11.1% uninsured. These numbers have increased over the past several years in spite of expansions of government programs and the recent development of the State Children’s Health Insurance Program (SCHIP) which “make nearly half of all children potentially eligible” to receive public health insurance benefits (Howell, 2004, p.1). However, since not all of the

potentially eligible youth are enrolled, their access to all forms of health care, including mental health care, remains problematic.

Children without health insurance coverage were three times less likely to receive mental health services than were children who had Medicaid or other insurance (Howell, 2004), reinforcing the idea that the children most in need of mental health services were the least likely to get them. Possible causal explanations for the delay or failure to receive services have been many and complex. Causes ranged from parents' lack of confidence in professionals and a preference for seeking help from family and neighbors, to parental worries about stigma (Arcia, Fernandez, Marisela, Castillo, Ruiz & Partin, 2004; French, Reardon, & Smith, 2003; McMiller & Weisz, 1996; Smith, 2005) to lack of income and transportation (Arcia, Fernandez, Marisela, Castillo, Ruiz & Partin, 2004; Bussing, Zima, Gary & Garvan, 2003), to fear of reprisal from social service agencies (USGAO, 2003). Confusing Medicaid and insurance regulations (Boothroyd & Armstrong, 2005; Howell, 2004) were also identified as a cause of parents failing to seek treatment for their children.

Researchers report that parents' perceptions of mental health care have been an important factor influencing children's attendance versus non-attendance at health care facilities. Parenting a child with mental health needs can be very stressful and frustrating (Foldemo, Gullberg, & Ek, 2005; Harden, 2005; Renk, 2005; Scharer, 2002). Parents may avoid treatment because they felt blamed by health care professionals for their children's problems (Harden, 2005), perceived a lack of support from professional staff (Scharer, 2002), and/or lacked a clear understanding of treatment protocols and prognosis (Scharer, 2002). Low-income families in particular experienced specific barriers to seeking help for their children. Smith (2005) identified four barriers frequently presented by low-income clients that seemed to be ignored by clinicians.

- The mismatch between client's immediate needs and therapists' goals.
- The idea that clients are often so overwhelmed by multiple problems that interventions suggested by clinicians may seem insignificant.
- A lack of understanding by middle class therapists of the inherent privileges and insulation they possess, which Smith calls "classist distancing".
- The cultural stigmatization of mental health services.

These issues, combined with possible financial and transportation problems emphasize the need for careful listening on the part of mental health and school counselors when working with low income families.

Arcia and her colleagues (2004) found that low income Hispanic mothers often delayed seeking treatment for their children's behavioral problems until the problems escalated to a point where the stress was untenable. These mothers reported they lacked knowledge about services available in their area, pointing out the need for school counselors to be more concrete and thorough in sharing information about health care options, at least for Hispanic parents. Arcia and colleagues (2004) described the help seeking of the group of parents they studied as being similar to pinballs in a game, where they appeared to bounce around from agency to agency seeking help for their children, without seeming to have a plan or method for obtaining help. All of these issues may be compounded for low-income African-American families, who often have negative perceptions of formal helping networks in general (Logan, 2001).

### **African-American Families**

According to the United States Census Bureau (2004), 12.7% of the total population of the country lived in poverty. However, 24.7% of African-Americans versus only 8.6% of whites lived in poverty. The highest percentage of poor people (14.1%) lived in the southern part of the country as compared to 11.6% in the north and Midwest. The number of African-American

families living in extreme poverty, which is defined as a family of three with an annual income below \$7,610, has increased precipitously since 2000 (Children's Defense Fund, 2005).

The impact of poverty on the emotional well-being of African-American children is staggering. According to Chow, Jaffee, & Snowden (2003), African-American children in high poverty neighborhoods were significantly more likely than their middle-class peers, or than white, Hispanic, or Asian children in poverty, to be referred for early mental health intervention services. Moreover, low income African-American children were found to be over represented in the special education diagnostic category of children with severe emotional disturbance (Colpe, 2000).

Poor African-Americans of all ages were more likely to be hospitalized for mental health problems and to be diagnosed as schizophrenic. African-Americans in general were less likely than whites to receive mental health counseling and more likely to receive pharmacotherapy at mental health clinics (Richardson, Anderson, Flaherty, & Bell, 2003). One study estimated that African-American adults received approximately 50% less outpatient mental health services of any type than their white counterparts (Lasser, Himmelstein, Woolhandler, McCormick, & Bor, 2002). This result held true even when income variables were controlled (Alegria, Canino, Rios, Vera, Calderon, Rusch, & Ortega, 2002). African-American adults seeking treatment for substance abuse or mental health problems were found to have greater unmet needs than whites (Wells, Klap, Koike, & Sherbourne, 2001).

African-American children were also more likely than were white or Hispanic children to be referred coercively to services, meaning there were negative consequences resulting from non-attendance such as; removal from the home and placement in group homes, Juvenile Justice or other punitive settings (Stevens, Harman, & Kelleher, 2005; Takeuchi, Bui, & Kim, 1993).

Even forty years after the American Civil Rights Movement, African-American children were still more likely than children of all other racial groups to be removed from their homes due to abuse or neglect, and were more likely not to be returned to their families by social service agencies (Ghose, 2006). African-American children made up only 15% of the entire child population of the United States in 2004, yet constituted 27% of children living in foster care (Ghose, 2006). Even though African-American children had far more contact with social service agencies than white children, they were far less likely to receive adequate mental health care (Angold, Erkanli, Farmer, Fairbank, Burns, & Costello, 2002; Takeuchi, Bui, & Kim, 1993).

### **African-American Males**

African-American males were over represented in almost every negative category of outcomes in America at the dawn of the 21<sup>st</sup> century. Fifty two percent of African-American males who left school without graduating have prison records before the age of thirty (Day-Vines & Day-Hairston, 2005). African-American men were over-represented in the prison population in the United States with 3218 out of every 100,000 African-American men in prison in 2005, as compared to 1220 of every 100,000 Hispanics and 463 of every 100,000 White men (U.S. Department of Justice, 2006). African-American boys were more likely to be adjudicated and face serious more consequences in juvenile court than white boys (Breda, 2003). African-American men lead the nation in unemployment, new HIV infections, suicides, and homicide deaths (Noguera, 2003).

These disturbing negative trends extend into academic performance as well. African-American boys were dramatically over-represented in special education classrooms. While comprising only 15% of the population of the United States in 2001, African-American children were over-represented in specific learning disabilities (18%), mental retardation (34%), and emotional disturbance (28%) categories (OSEP, 2005). African-American males made up a

majority of students identified as emotionally disturbed in the United States (Colpe, 2000). African-American male students were far more likely than their white or female peers to be suspended, expelled, or subjected to corporal punishment (National Center for Education Statistics, 2001). Conversely, African-American males were disproportionately absent from advanced courses and college campuses (Noguera, 2003).

There have been many possible causes for these discrepancies put forward by researchers. African-American boys who attended schools in high poverty areas were more likely to be taught by poorly prepared and inexperienced teachers (Day-Vines & Day-Hairston, 2005). For those African-American males who lived in poverty, health concerns may have fueled excessive absences which interfered with learning (Rothstein, 2004). Children in poverty in general also tended to receive less help and support from their parents for academic issues. However, not all underperforming African-American males were from poor families, thus seeming to underscore the influences of race and gender as potentially more powerful variables than social class and wealth.

There are many theories as to why African-American males suffer negative life outcomes in such large numbers. Three of these theories, including social and cultural capital differences, social class world view theory, and oppositional culture theory are discussed in the next section.

### **Cultural and Social Capital Theory**

In examining issues of poverty, social class, and race a discussion of cultural capital theory is helpful in understanding how these factors pervade everyday life, including health care and education. In the 1970's sociologist Pierre Bourdieu coined the term "cultural capital" to refer to an individual's access to "signals" such as styles, attitudes, ideas, jargon, and preferences that either help or hinder people from entering high-status social groups (Bourdieu, 1977). The

purpose of the “signals” was purported to be maintenance of the status quo among those occupying the higher strata of society.

Around the time Bourdieu was writing about social capital, anthropologist John Ogbu was writing about social caste in the United States and its role in African-American life. Ogbu’s theory was that African-American achievement suffered due to the history of repression and enslavement of Africans in the United States. According to Ogbu (1978) the enduring legacy of racial discrimination resulted in lower expectations of African-Americans for success in traditionally white middle class American institutions, such as schools and corporate workplaces. Ogbu pointed to the differences in expectations of the possibility of success in the United States held by recent immigrants of African extraction versus those of African-Americans who descended from slaves. Recent African-American immigrants tended to be more hopeful about their ability to achieve success in America, while those descended from slaves tended to be more mistrustful of white middle class culture and institutions and less hopeful about their chances of achieving middle class success. Furthermore, among African-Americans who were not recent immigrants, being successful in mainstream white America could be perceived by peers as “acting white” and betraying one’s culture (Ogbu, 2001). The idea that African-American youth lower their expectations and desire for achievement became known as “oppositional culture theory” (Carter, 2003).

Recently, researchers have contested the idea that African-American youth do not share the same aspirations as American youth of other races (Carter, 2003). Carter and others (Hall, 1992; Lareau, 2000) argued that instead of opposing achievement in traditional terms (going to college, getting a good job), African-American youth “resist the cultural default... of white middle class standards of dress, musical taste, and interactional styles” (Carter, 2003, p. 137).

Instead, African-Americans (and perhaps other minorities) developed both dominant and non-dominant cultural capital (Carter, 2003). That is to say, African-American people develop and maintain their ability to employ differential standards of dress, speech, and behavior in order to function differently in various cultural contexts.

In a recent qualitative study of forty four African-American adolescents, Carter (2003) learned that all of the study participants used both non-dominant (“African-American”) cultural capital and dominant (“white”) cultural capital in their daily lives. In most cases, the students used dominant social capital for instrumental purposes (to please teachers or to make good grades) and non-dominant social capital to express themselves and gain acceptance from other African-American youth as “authentic” members of the African-American community. Balancing both sets of cultural capital successfully, although difficult, seemed to allow participants to be successful both in the “white world” and in their racially-identified communities. Continually reading social signals filtered through two very different lenses and deciding which set of social skills to apply was reported to be a source of stress by the adolescents in Carter’s study.

African-American males in academic settings often experienced the cultural disconnect between themselves and their teachers as a lack of respect (Ladson-Billings, West-Olatunji, Baker & Brooks, 2007). Some researchers asserted that African-American males greatly value being respected, and when they feel they are not respected at school, this feeling can lead to disruptive behavior, disengagement, and academic failure (Noguera, 2003). It seems possible that in attempting to view the world through multiple and conflicting lenses, African-American males may experience great distress and dissonance.

In applying Liu's (2001) construct of social class world view to the concept of dominant and non-dominant forms of cultural capital, it is possible to see that African-Americans could feel a nearly constant sense of cognitive dissonance by rejecting the dominant worldview for the non-dominant, and vice-versa. Not having a single set of lenses through which to judge appropriate versus inappropriate actions for any given setting could lead to frustration and confusion. This may be especially problematic when the dominant and non-dominant cultures demand nearly opposite reactions to similar situations. Furthermore, it would seem that younger African-Americans and/or those who have greater difficulty switching between cultural lenses may experience more conflict and distress about having two sets of intrapsychic frameworks by which to judge cultural and social situations. To what extent this duality of cultural and class framing affects African-Americans who are making decisions about seeking help for their children's mental health problems remains unknown.

### **Conceptual Framework**

When conducting research with people in poverty, it is helpful to distinguish socio-economic status (SES) from social class in order to clearly define what is being studied. Both SES and social class are important factors in examining the lives of people. Social class, although less well defined in counseling and psychological literature, was of greater interest in this study. According to Liu, Ali, Soleck, Hopps, Dunston & Pickett (2004) a person in an, "SES framework is assumed to occupy a temporary position because he or she is socially mobile around the hierarchy" (p. 15), whereas social class impacts a person's life long world view. For example, an aristocrat may lose all of his money, yet retain the bearing, opinions, and attitudes of the upper class, while a child from a very poor family may grow up to be wealthy, yet retain his or her original outlook on life, values, and attitudes.

In Liu's (2001) social class worldview model, social class was divided into three components. First, people tend to live up to expectations placed on them by their local environment in order to maintain homeostasis both cognitively and emotionally. Failure to meet the expectations of the other members of a person's social class causes a form of cognitive dissonance, which Liu refers to as "internalized classism." Liu further divides the economic culture's demands into three types of cultural capital: social (networks of contacts), cultural (tastes and preferences), and human capital (abilities and skills).

The second component of Liu's social class worldview model is the "intrapyschic framework." A person uses his or her intrapsychic framework as a lens through which he or she examines and makes sense of the economic and social cues and demands of class. The lens is used to filter information about the social and economic environment, and respond appropriately within it. Manners, economic choices, relationships to property, and choice of peers are all filtered through the lens of the intrapsychic framework.

The third component of Liu's social class worldview model is classism. In this sense, classism is a social psychological construct whose purpose is to encourage people to engage in behaviors congruent with his or her perceived social class. Classism can be upward (e.g. feelings against those one considers to be 'snobs') downward (e.g. feelings against those one sees as 'trashy' or 'common') or lateral (e.g. keeping up with the neighbors). Classism can be experienced as external pressure, (e.g. peer pressure to engage in class-appropriate behaviors), or as internal pressure (e.g. pressure within the individual to behave consistently with group norms).

How internal models of class and feelings of classism affect people seeking mental health care has not yet been explored in the professional literature. However, the social class worldview model was chosen as the conceptual framework for this study, since current research

demonstrates dramatic differences in use patterns of health care between social classes and racial groups, with low income African-Americans being least likely to access services (Bussing, Zima, Gary, & Garvan, 2003; Chow, Jaffee, & Snowden, 2003; French, Reardon, & Smith, 2003; Harden, 2005; McKay, Lynn, & Bannon, 2005; Huang, Stroul, Freidman, Mrazek, Freisen, Pires, & Mayberg, 2005; Potter, et al. 2002 ).

### **Phenomenological Theoretical Framework**

Since little is known about the subjective, internal process of making decisions about mental health care among poor African-American parents (Van Galen 2004), a qualitative methodology was chosen for this study. Qualitative research allows the researcher to learn about the lived experience of the population of interest. Instead of collecting large amounts of data at a superficial level from a large sample of families, qualitative inquiry yields rich, deep, and often unexpected information from the first person perspective in a smaller number of families (Strauss & Corbin, 1990).

To learn about the actual lived experience of families in poverty who are referred for mental health care for their children by school personnel, phenomenological research methods were used in this study. The goal of all phenomenological research is to return to the “things themselves” (Husserl, 1970). In other words, the purpose of conducting research is to, “understand phenomena in their own terms, to provide a description of human experience as it is experienced by the person herself” (Bentz & Shapiro, 1998, p. 96). The phenomenological researcher’s task is to understand the subject at hand from the point of view of the participant, in the most direct way possible.

In phenomenological research, the investigator enters the life world of the participants by leaving behind his or her preconceived ideas of how things should be (Wertz, 2005). The researcher then gathers data, usually via interviews, and/or archival means, and reflects on the

meanings and subjective realities of the phenomena under consideration (Wertz, 2005). “The phenomenon is perceived and described in its totality, in a fresh and open way” (Moustakas, 1994, p. 34). Through a series of reflections on the meanings within the data, the researcher constructs a portrait of the experience of the participants.

### **Need for the Study**

“Although the intervening years have seen the advent of important multicultural scholarship regarding therapeutic biases around other aspects of difference, classist bias has gone largely unexamined, and psychologists know little more today about the therapeutic experiences of poor people today than they did decades ago” (Smith, 2005, p. 687). Much of the current research examining poor children’s experiences in mental health care is actuarial in nature; it focuses on large numbers of children from various racial, ethnic, or income groups accessing care (Busch & Horowitz, 2004; Bussing, Zima, Gary, & Garvan, 2003; Chow, Jaffee, & Snowden, 2003; Howell, 2004; Samaan, 2000; Simpson, Scott, & Henderson, 2002; Pottick, et al., 2002; Stevens, Harman & Kelleher, 2005).

Although the interplay between key variables such as race, ethnicity, income, and mental health is by no means clear-cut; the results of the research has established that children in low-income neighborhoods, particularly those of color, seem to be referred to services more often and more coercively, and seem to either drop out prematurely or never attend counseling at all. This circumstance may be due at least in part to convoluted nature of insurance and Medicaid rules, which change often and can be difficult to negotiate (Boothroyd & Armstrong, 2005; Howell, 2004; Johnson, Knitzer, & Kaufman, 2002; Pumareiga, Nace, England, Diamond, Fallon, & Hanson, 1997; Willging, Waitzkin & Wagner, 2005). However, the factors underlying the inability or unwillingness of low-income parents to bring their children for mental health service

are not well understood (Arcia, Fernandez, Marisela, Castillo, & Ruiz, 2004; Bussing, Zima, Gary & Garvan, 2003; Earls, 2001; French, Reardon, & Smith, 2003; Renk, 2005).

Smith's (2005) argument that "classist distancing" (p. 693) hampers the effectiveness of mental health services is echoed by Van Galen (2004) in her call for more voice to be given in the professional literature to poor clients. She posits that middle-class researchers too often speak for poor people, and although the intentions of the researchers may be noble, the poor are still left voiceless.

More information about when, how, and why low-income parents seek help for their children's mental health problems is needed. A greater understanding of the process of help-seeking from the parents' point of view is also needed. Gaining a clearer picture of the reasons low income parents decide to access mental health services, and their difficulties in doing so, would help counselors more effectively engage low-income clients, and perhaps contribute to helping clients remain in counseling until their goals are reached. Understanding more fully what low income parents experience in seeking out mental health services would also be helpful to referring agents, such as school counselors, family medical professionals, and social workers. By making more relevant and effective referrals, the referring agents might reduce the "pinball effect" of delaying help seeking until the problem becomes untenable (Arcia, Fernandez, Marisela, Castillo, & Ruiz, 2004).

### **Purpose of the Study**

The purpose of this study was to describe the phenomenon of low-income African-American boys being referred to mental health services by school counselors from the point of view of their caregivers. Understanding the essence of the experience of African-American families who are referred to mental health services by school counselors would enhance our current understanding of the dynamics of how, where, and when poor African-American

caregivers access mental health care services for their children. Caregivers' feelings, thoughts, and perceptions of the referral were explored.

### **Research Questions**

- 1) What is the lived experience of low-income African-American caregivers referred for mental health services for their sons?
  - A) What are the initial reactions (thoughts, feelings, and actions) of the caregivers to the school counselor's referral of their child to mental health services?
  - B) How do the caregivers perceive the school staff making the referral during and after the referral meetings?

### **Definition of Terms**

**Poverty:** "A condition that extends beyond the lack of income and goes hand in hand with a lack of power, humiliation and a sense of exclusion. Defining it solely from the income level or as an inability to acquire basic food and shelter limits our ability to understand its' true nature and make effective interventions" (Raphael, 2005).

**Phenomenology:** "to describe things in themselves, to permit what is before one to enter consciousness and be understood in its meanings and essences in the light of intuition and self-reflection. The process, "involves a blending of what is really present from the vantage point of possible meanings; thus a unity of real and unreal" (Moustakas, 1994, p. 27).

**Low-income:** Participants in this study will have family income sufficient to qualify their children for free or reduced school lunch, as determined by federal guidelines.

**Mental health services referral:** Children of the participants in this study will have experienced some sort of behavioral or emotional problem at school which has prompted school counselors to request that the parents of the child arrange for mental health treatment outside of

the school in order to ameliorate the problem. Problems may vary in severity and duration. However, this must be the first attempt by the current school counselor to refer the family for treatment. Parents may or may not choose to access mental health services.

**Mental Health Counseling:** “Mental Health Counseling is the provision of professional counseling services, involving the application of principles of psychotherapy, human development, learning theory, group dynamics, and the etiology of mental illness and dysfunctional behavior to individuals, couples, families, and groups, for the purposes of treating psychopathology and promoting optimal mental health.

The practice of Mental Health Counseling includes, but is not limited to, diagnosis and treatment of mental and emotional disorders, psycho educational techniques aimed at the prevention of such disorders, consultation to individuals, couples, families, groups, organizations, and communities, and clinical research into more effective psychotherapeutic treatment modalities.” (American Mental Health Counselors Association, 2007).

## CHAPTER 2 REVIEW OF THE LITERATURE

### **Introduction**

This chapter summarizes the current level of knowledge in the counseling field about the pathways to mental health services for African-American children in poverty. Mental health service issues, as well as ways families are referred to services are discussed. Since many children are referred to mental health care services by school counselors, their referral practices are reviewed, as are more general educational issues concerning low-income African-American students.

Research on the programmatic aspects of mental health care delivery to poor children in the United States, and in Florida in particular, is reviewed. Professional literature examining client issues affecting mental health care is discussed. Client focused issues include: cultural contextual and historical issues specific to African-Americans, caregivers' and children's perceptions of mental health care, barriers to finding and entering mental health care services for children, and how parents report making decisions about accessing mental health care for their children.

### **School Counselor Referral Practices**

One of the primary roles of school counselors is to help students' families find and access a variety of community services (Baker, 1996; Erford, 2003 Ritchie & Partin, 1994). School counselors often play a critical role in students' families accessing mental health services, however, there is limited professional literature available to help school counselors understand the complex issues involved in making these referrals. In particular, there is a dearth of literature for school counselors regarding making referrals for low-income families of color, even though these families comprise the majority of patients at mental health clinics (Bussing, Zima, Gary, &

Garvan, 2003; Pottick, Warner, Isaacs, Henderson, Milazzo-Sayre & Manderschied, 2003).

Many current school counseling texts offer some information for beginning counselors regarding making referrals to outside agencies. Ritchie and Partin (1994) recommended that school counselors give parents as much concrete information as possible when making referrals to outside services, such as contact names, telephone numbers, cost of services, and types of treatment available.

Another model for school counselors to consider when making referrals to community agencies is outlined in Apter (1992). The direction model was originally developed to assist families with disabled children to navigate the complex system of medical and social helping agencies. In this model, counselors develop a trusting relationship with parents, then talk with parents to ascertain what types of help they want, give parents choices about which services to access, give specific information about what each agency does and how to make contact, and then provides follow along and follow up assistance (Apter, 1992, p. 495). When this model was developed and implemented in New York State, over 70% of families reported being able to find and access needed services for their disabled children (Musumeci & Cohen, 1982).

Also absent from the school counseling literature are guidelines for school counselors about making effective referrals for low income families to outside agencies. Very little has been published in recent years about the referral practices of school counselors, even though making referrals is an important aspect of the school counselor's job (Baker, 1996; Brown & Trusty, 2005; Davis, 2005). School counselors make an average of thirty referrals per year, primarily for help with emotional and family concerns (Ritchie & Partin, 1994). Although the counselors Ritchie & Partin surveyed twelve years ago reported mostly positive experiences with making

referrals to outside agencies, a significant number (48%) also reported occasional frustration with parents not following through on their recommendations (Ritchie & Partin, 1994).

Most current school counseling textbooks offer some variation on the following advice to new professionals about making out-of-school referrals:

- Know what resources are available in your community.
- Be aware of laws and policies regarding sharing confidential information.
- Develop collaborative working relationships with the care providers in your area.
- Keep some record of the dates and places families were referred to service providers (Baker, 1996; Brown & Trusty, 2005; Erford, 2003; Ritchie & Partin, 1996).

Some texts also offer models for problem-solving with families in crisis (Baker, 1996; Erford, 2003) which could be employed when making referrals. However, only Erford's text offers a chapter on helping what is termed "at-risk" students, which is a broadly used and ill defined term; none of the texts seemed to include any guidance on working with families in poverty per se ( Brown & Trusty, 2005; Davis, 2005 both include chapters on multicultural counseling, but focus only on race and heritage issues, not class). Additionally, most texts do not differentiate between sub-groups within races, such as Mexican- American versus South or Central American or Caribbean Hispanics, or between Haitian and African African-Americans.

Conversely, a large percentage of children seen in mental health facilities have a history of school problems and are initially referred by school counselors or teachers. The research that does exist on the process poor families experience between initial referral for and entry into mental health services suggests that there is often a long delay between the two (Chow, Jaffee & Snowden, 2003; French, Reardon, & Smith, 2003; Potter, et al, 2002; McKay, Lynn, & Bannon, 2005; Huang, Stroul, Freidman, Mrazek, Freisen, Pires, & Mayberg, 2005; Bussing, Zima, Gary,

& Garvan, 2003). During this delay, children's problems often worsen, and parents feel overwhelmed and frustrated by the time they reach the clinic.

### **Race and Class Issues in Academic Settings**

In academic settings, African-American children continue to struggle, regardless of family income. African-American students account for 33.4% of all suspensions from school and 14.7% of dropouts (Day-Vines & Day-Hairston, 2005). African-American children in American public schools are lagging behind their white and Asian peers on many academic success indicators, although Hispanics continue to have a higher drop out rate than African-Americans. According to the Educational Trust, African-American students made significant gains in both reading and math during the 1970's and 1980's, only to lose ground again in the 1990s. The achievement gap between African-American and White children in 2005 was 10% greater than in 1990. In a recent study conducted by the Educational Trust, African-American students in the 12<sup>th</sup> grade had math and reading skills commensurate with the math and reading skills of white eighth graders ([www.edtrust.org](http://www.edtrust.org) ; retrieved 7/26/06).

As in the family counseling literature, there is a body of work that attempts to explain some of the academic achievement gaps between African-American and White children. Many theorists invoke Bourdieu's cultural capital idea, which claims that children learn the invisible rules of various social classes from parents and other adults. They can then use these "signals" such as styles, attitudes, ideas, jargon, and preferences to help them enter high-status social groups (Bourdieu, 1977). The purpose of the "signals" was purported to be maintenance of the status quo among those occupying the higher strata of society.

Around the time Bourdieu was writing about social capital, anthropologist John Ogbu was writing about social caste in the United States and its role in African-American life. Ogbu's theory was that African-American achievement suffered due to the history of repression and

enslavement of Africans in the United States. According to Ogbu (1978) the enduring legacy of racial discrimination results in the low expectations of African-Americans for success in traditionally white middle class American institutions, such as schools and corporate workplaces. The idea that African-American youth lower their expectations and desire for achievement became known as “oppositional culture theory” (Carter, 2003).

Together, the theories of cultural capital and oppositional culture theory have been co-opted to create a deficit model of minority students. Some writers, such as Ruby Payne, have distilled the complex theories of Bourdieu and Ogbu down to a model of weakness and remediation (Payne, 1996). According to the deficit view of cultural capital, minority and poor students would be able to achieve more academically if the schools explicitly teach them the hidden “signals” of middle class culture (Payne, 1996).

Recently, researchers have contested the idea that African-American youth do not share the same aspirations as American youth of other races (Carter, 2003). Carter and others (Hall, 1992; Lareau, 2000; Majors, 2001) argue that instead of opposing achievement in traditional terms (going to college, getting a good job), African-American youth “resist the cultural default... of white middle class standards of dress, musical taste, and interactional styles” (Carter, 2003, p. 137). Instead, African-Americans (and perhaps other minorities) develop both dominant and non-dominant cultural capital (Carter, 2003). That is to say, African-American people develop and maintain the ability to employ the standards of dress, speech, and behavior in order to function differently in various cultural contexts.

In her recent qualitative study of 44 African-American adolescents, Carter (2003) learned that all of the study participants used both non-dominant (“African-American”) cultural capital and dominant (“white”) cultural capital in their daily lives. In most cases, the students used

dominant social capital for instrumental purposes (to please teachers, make good grades) and non-dominant social capital to express themselves and gain acceptance from other African-American youth as “authentic” members of the African-American community. Balancing both sets of cultural capital successfully, although difficult, seemed to allow participants to be successful both in the “white world” and in their racially-identified communities. Continually reading social signals filtered through two very different sets of lenses and deciding which set of social skills to apply was reported to be a source of stress for the adolescents in Carter’s study.

In applying Liu’s (2001) construct of social class world view to the concept of dominant and non-dominant forms of cultural capital, it is possible to see that African-Americans may experience a nearly constant sense of cognitive dissonance by rejecting the dominant world-view for the non-dominant, and vice-versa. Not having a single set of lenses through which to judge appropriate versus inappropriate actions for any given setting, but a double set from which to choose would likely lead to frustration and confusion- particularly when the dominant and non-dominant cultures demand nearly opposite reactions to similar situations. Further, it would seem that younger and/or those African-Americans for whom switching between cultural lenses is more difficult may experience more conflict and distress about having two sets of intrapsychic frameworks by which to judge cultural and social situations. Whether or not, or to what extent, this duality of cultural and class framing affects African-Americans when making decisions about whether and how to seek help for mental health problems remains unknown.

### **Intersecting Issues of Race and Class in Mental Health Referrals**

In spite of hints in the literature that both race and class impact both how people perceive and access mental health care in the United States, it is not clear how each factor influences people’s ideas and actions regarding mental health care. As discussed in Chapter One of this document, African-Americans are vastly over represented among the poor (US Census Bureau,

2004). The impact of poverty on the emotional well-being and educational outcomes of African-American children is staggering. According to Chow, Jaffee, & Snowden (2003), African-American children living in high poverty neighborhoods were significantly more likely than their middle-class peers, or than white, Hispanic, or Asian children in poverty, to be referred for early mental health intervention services. Low income African-American children were found to be over represented in special educational categories for children with severe emotional disturbance (Colpe, 2000).

Poor African-Americans were more likely to be hospitalized for mental health problems and to be diagnosed as schizophrenic. African-Americans in general are less likely than whites to receive mental health counseling and more likely to receive pharmacotherapy at mental health clinics (Richardson, Anderson, Flaherty, & Bell, 2003). African-Americans are also more likely to be referred coercively to services, meaning there are negative consequences resulting from non-attendance than are white or Hispanic children, such as; removal from home, entry into group homes, Juvenile Justice or other punitive settings (Stevens, Harman, & Kelleher, 2005; Takeuchi, Bui, & Kim, 1993).

African-Americans in counseling are sometimes perceived by White therapists as guarded, reluctant, or hostile due to differences in language and social norms (Logan, 2001). Negative perceptions may go a long way in explaining both why African-Americans frequently leave counseling early and are less likely to attend in the first place. As a result of generations of powerlessness and rebuke, many African-Americans feel more comfortable seeking help from informal networks than from formal institutions, in spite of recent changes towards a more enlightened and multicultural society (Logan, 2001). Additionally, some African-American families, particularly those living in poverty, often have negative perceptions of mental health

agencies based partly on confusion about the role of mental health facilities versus social services agencies. These families sometimes believe that going to counseling can lead to the loss of custody of children or other negative consequences (Boyd-Franklin, 1989). This view is complicated by the fact that African-American families are sometimes referred to treatment by the courts or social services and are in fact in danger of losing custody of children or facing other negative consequences for non-compliance in counseling (Chow, Jaffee, & Snowden, 2003; Ghose, 2006).

At the intersection of race and family, therapists often find families with multiple problems and need to be aware that basic needs such as food and shelter may need to be attended to prior to intervening in family systems or other issues (Boyd-Franklin, 1989; Madsen, 1999). Failure to recognize or address these issues can lead to a mismatch between therapist and family goals and dissatisfaction with counseling (Smith, 2004). Therapists are often not trained to attend to basic needs in multi-stressed families, nor are they often trained to be aware of different ways African-Americans in America may perceive themselves within the context of race and class, thus further hampering the therapists' ability to join effectively with the family (Boyd-Franklin, 1989; Madsen, 1999).

### **Mental Health Needs of Low-Income Children**

As defined by financial parameters, 16% of American children lived in poverty in 2002, and one in four families in the United States with young children earned less than \$25,000 a year (Child Welfare League of America, October 23, 2005). The current federal poverty level (FPL) is \$19,157 per year for a family of four. Low income is calculated as 100-200% of the FPL for a family of four (US Census Bureau, 2005). In terms of raw numbers, over 13 million children in the United States were reported to be living at or under the poverty line, an increase of 12.8%

over the number reported in 2000 (Children's Defense Fund, 2005). Of course, financial need is one of many defining characteristics of poverty.

Poverty is detrimental to the mental health of children. Research reveals that children who live at or below the federal poverty line are significantly more likely to report increased levels of anxiety, depression, and antisocial behaviors (Samaan, RA, 2000; Caughy, O'Campo, & Muntaner, 2003; African-American & Krishnakumar, 1998; Myers & Gil, 2004).

Additionally, children in low-income families tend to exhibit a greater incidence of behavioral difficulties and a lower level of positive engagement in school (National Survey of America's Families, 1999). The negative effects of poverty seem to hold even when racial and ethnic variables are controlled; poverty appears to be a more critical factor in the development of negative outcomes in children than is race and ethnicity (Samaan, RA, 2000; Chow, Jaffee, & Snowden, 2003; Takeuchi, Bui, & Kim, 1993).

Children living in poverty are also less likely to have access to health care services, including mental health care, than are their peers from higher socio-economic levels (Boothroyd & Armstrong, 2005; Busch & Horowitz, 2004; Colpe, 2000; Howell, 2004 Stevens, Harmon, & Kelleher, 2005). Moreover, poverty limits children's accumulation of social capital, that broad group of intangibles such as family support, educational opportunities, and enrichment activities, which is reported to impact school achievement (Caughy, O'Campo, & Muntaner, 2003; Christenson & Sheridan, 1997).

### **Parity Issues in Children's Mental Health Service**

Health care in the United States is in a state of turmoil as state and federal agencies struggle with providing care to the swelling rolls of indigent patients. According to the US Census Bureau, as of August 2004 ([www.census.gov/Press-Release](http://www.census.gov/Press-Release)), 11.4%, or 8.4 million, of all children in the US were uninsured. Foreign born Hispanic children had the highest proportion

of uninsured members, with 32.7%, followed by African-American children, 19.5% uninsured, and white children, 11.1% uninsured.

These numbers have been increasing over several years in spite of the expansion of government programs and the recent development of State Children's Health Insurance Program (SCHIP) which "make nearly half of all children potentially eligible" to receive public health insurance benefits (Howell, 2004, p.1). About one in ten children in the United States used some form of mental health service in 2002, according to the National Survey of America's Families. However, children with no health insurance coverage were three times less likely to avail themselves of mental health services than were children who had Medicaid or other forms of insurance (Howell, 2004). Twenty percent of children in the US are estimated to have treatable mental health problem, while one in ten children is estimated to have a 'serious' mental health need (Pottick, Warner, Isaacs, Henderson, Milazzo-Sayre, & Manderscheid, 2002). However, children living in poverty are twice as likely to demonstrate serious needs as are middle and upper class children, and about 66% of all children with mental health needs do not receive treatment (Pottick, Warner, Isaacs, Milazzo-Sayre, & Manderscheid, 2002). The review of the 1997 Client/Patient Sample Survey (CPSS) data conducted by Pottick, Warner, Isaacs, Henderson, Milazzo-Sayre, & Manderscheid (2002) for the Annie E. Casey Foundation further revealed that although the numbers of children accessing mental health care facilities increased by 87.1% between 1986 and 1997, increases do not appear to be equitable for children from poor families, poor neighborhoods, or minority groups. For example, African-American children, children in foster care, and children on public assistance are overrepresented in admission to inpatient and residential services as compared to their White, middle class peers.

Race, class, and gender disparities in mental health care were reported again in a review of the National Health Interview Survey on Disability (NHIS-D) conducted in the mid-1990s (Colpe, 2000). This national study surveyed caregivers of over 41,100 school-aged children in the US about children's health and use of medical and mental health services. The NHIS-D data revealed that boys are far more likely than girls to be identified as having mental health problems. Boys received a reported 67.3% of services, compared to 32.7% for girls. This data does not make it clear whether girls need fewer services, or simply have less access. Again, African-American and poor children were found to be over represented in categories of children with severe emotional disturbance (Colpe, 2000).

Simpson, Scott, & Henderson (2002) found in a sample of over 26,500 children that the children with the greatest unmet perceived need for mental health services were those who lived in single parent families, were uninsured, and had family incomes of less than 100% of the poverty level. This study also revealed that 8.8% of those children who had been diagnosed with depression and 5% of those children who were diagnosed with ADD lived in families that could not afford counseling or other needed services.

Location may also be a factor in children's access to mental health care. Chow, Jaffee, & Snowden (2003) found that minority children living in high poverty neighborhoods were significantly more likely than their middle-class peers, or than white, Hispanic, or Asian children living in poverty: a) to be referred for early mental health intervention services, b) were more likely to be hospitalized for mental health problems, and c) more likely to be diagnosed as schizophrenic. African-Americans were also significantly more likely than whites to be involuntarily brought in for care. This study also reported that white children living in high poverty areas were more likely to use mental health services than white children living in low

poverty areas, possibly confirming the hypothesis that living in high poverty areas induces high stress, which then triggers mental distress.

In another large scale quantitative study, Angold, Erkanli, Farmer, Fairbank, Burns, Keeler, & Costello (2002) surveyed 920 parents of public school students in North Carolina about their children's behavior. Similar numbers of white (21.9%) and African-American (20.5%) respondents met criteria for DSM IV diagnosis. However, white students were almost twice as likely to be engaged in mental health services as African-American students (6.1% vs. 3.2%). These results are reinforced by the work of Alegria, Canino, Rios, Vera, Calderon, Rusch, & Ortega (2002) using a national sample of 8,098 people. They found that even when insurance and income status were controlled, African-Americans were almost half as likely as whites to receive mental health care.

### **Barriers to Mental Health Treatment for American Children in Poverty**

Research reveals that although children living in poverty are more likely to need mental health care services, they are less likely to receive adequate help than their non-poor age mates (French, Reardon, & Smith, 2003; Pottick, Warner, Isaacs, Milazzo-Sayre, & Manderscheid, 2002; McKay, Lynn, & Bannon, 2005; Huang, Stroul, Freidman, Mrazek, Freisen, Pires, & Mayberg, 2005; Bussing, Zima, Gary, & Garvan, 2003). These findings are supported by both in-depth qualitative studies (Arcia, Fernandez, Marisela, Castillo, & Ruiz, 2004; French, Reardon, & Smith, 2003; Wilton, 2003) and by larger-scale quantitative studies (Busch & Horowitz, 2004; Bussing, Zima, Gary, & Garvan, 2003; Chow, Jaffee, & Snowden, 2003; McKay, Lynn, & Bannon, 2005; Pottick, Warner, Isaacs, Milazzo-Sayre, & Manderscheid, 2002; Takechi, Bui, & Kim, 1993). Several policy analyses confirm these findings as well (Howell, 2004; Huang, et al, 2005, Leventhal, 2003; Smith, 2005).

The reasons for this are complex and not completely understood (O'Neal, 1998; Bussing, Zima, Gary, & Garvan, 2003; African-American & Krishnakumar, 1998). Several factors have been identified as barriers to mental health service for poor children in the United States. According to the US Surgeon General's Report on Children's Mental Health (1999), the major types of barriers to mental health services for poor children are; service delivery issues including state and federal policies, and family difficulties. Each of these will be examined in some detail here.

Service delivery issues in mental health care are broad ranging and complex. According to Dr. Michael Hogan, of the President's New Freedom Commission on Mental Health (2002), "a fragmented services system is one of several systemic barriers impeding the delivery of effective mental health care." (Cited in Children's Defense Fund Report on Children's Mental Health Care, [www.cdf.org](http://www.cdf.org), accessed 10/01/2005). The report cites: a) a lack of coordination between agencies, particularly between Medicaid and private providers, b) a lack of resources, including lack of public funds for care, c) a lack of qualified providers willing to accept low Medicaid reimbursement rates for services, and d) a lack of communication between state and federal agencies, and conflicting policies, as major barriers to services. State's abilities to design their own Children's Health Insurance Programs give flexibility to state level lawmakers, but also mean that there is no national standard for care or coverage (Howell, 2004). Medicaid requires that children who are exhibiting symptoms of possible mental health problems receive comprehensive developmental screenings, but states have the flexibility to cover or not cover this service in their SCHIP plans (CDF, 2005). Additionally, although federal law requires children who receive screenings for mental health issues to be granted access to needed follow up care,

individual states may limit access to such services under the state-administered health care program (CDF, 2005).

Alongside the tangle of state and federal regulations and difficulties in policy alignment, families who live in poverty face more quotidian barriers to accessing care. Cultural-contextual issues, such as a stigma against help-seeking, negative expectations, financial barriers, and a lack of perceived need for services hamper some groups of families from receiving care, as found in Bussing, Zima, Gary, & Garvan's (2003) study of help-seeking behavior for families with children diagnosed with ADHD. Lack of information about how to access services, what services are available, and denial of the severity of a child's need for help are also common among low-income mothers (Arcia, Fernandez, Marisela, Castillo, & Ruiz, 2004). Families in rural areas may have difficulty finding transportation to appointments (Meyers & Gill, 2004). Homeless families often face the additional difficulty of not having an address or telephone number to receive communications from health care providers (French, Reardon, & Smith, 2003).

Additionally, many families are referred for mental health services by school personnel who may not be aware of the difficulties facing low income families in following through on their recommendations (Apter, 1992). As an additional hurdle to understanding low income families experiences, social class is not a well defined construct in social science research (Liu, Ali, Soleck, Hopps, Dunston & Pickett, 2004).

Perhaps the most insidious trend in families' reluctance to seek out mental health services for their children is highlighted in a report from the U.S. General Accounting Office (2003). The GAO report outlines the phenomenon of parents having to give up custody of their children to the state in order to access mental health care for more serious, chronic problems. The GAO estimated in that in 2001, more than 12,700 children were placed in the custody of state agencies

solely to make them eligible for expensive mental health treatments, primarily in residential care facilities. Obviously, families with fewer existing financial resources are more likely to have to make drastic custody decisions to receive treatment for their children. However, with residential treatment for mental health problems costing in excess of \$250,000 per year in some cases, this is an issue that extends to middle class families as well.

### **Barriers to Children’s Mental Health Services in Florida**

According to the Children’s Defense Fund (2005), there are 704,817 children in the state of Florida living at or below the Federal Poverty line. Most of these children (63.8%) under age 6 live in families where all adults are in the labor force. In Florida, 677,000 children under 18 do not have health insurance, which constitutes 16.6% of the entire population of children ages 0-18 in the state.

During the fiscal year 1997-98, the most recent year for which statistics are available, The Division of Children’s Mental Health in Florida served 45,595 children (Department of Children and Families, 2000). Half (22,104) of these children were classified as children and adolescents with a “severe emotional disturbance”, (SED), the others were classified as having “emotional disturbance”, (ED) (13,101) or ‘being at risk of developing an emotional disturbance’ (10,390) (DCF, 2000). By far, the majority of the state funding spent on Children’s Mental Health Services (CMH) in 1997-98 was focused on the SED population, disproportionate to the number of children in this category who received services.

The three categories above were established in 1998 as part of the Comprehensive Child and Adolescent Mental Health Services Act (Chapter 98-5, Laws of Florida). The 1998 law set up the three categories of care, called for that care, whether residential or outpatient, to be family and community centered, and required providers to track client progress. The bill also cleared the way for the highly controversial privatization of CMH services (DCF, 2005).

Under the Comprehensive Child and Adolescent Mental Health Services Act and Part III of Chapter 394 of the Florida Statutes, the State of Florida provides five types of CMH services:

- 1) Baker Act, or short-term involuntary commitment services,
- 2) non-residential mental health services including outpatient counseling, case management, and assessment,
- 3) residential services including state hospitals and group homes,
- 4) the Behavioral Network, a group of providers working with the Department of Children and Families (DCF) to meet the needs of children with SED, and
- 5) Juveniles Incompetent to Proceed Services, which helps young people with severe disabilities receive counseling, pharmacotherapy, and life skills training, along with assistance in residential placement in concert with the Department of Juvenile Justice (Department of Children and Families, 2005). Services in the first four areas are provided by private agencies under contract with DCF. Services for incompetent juveniles are provided under a separate contracting system. Much of the funding for CMH in Florida comes from federal Medicaid dollars. Other sources of funding may include block grants, general revenue, and state trust funds. All totaled, the State of Florida spent \$101 million on CMH in fiscal year 2005-6, not including expenditures for children receiving mental health services while in the custody of the Department of Juvenile Justice, or through school funded programs. ([www.oppaga.state.fl.us/profiles/5014](http://www.oppaga.state.fl.us/profiles/5014)).

### **Low-Income Families in Counseling**

A review of the contents of the *Journal of Counseling and Development* from 1995-2005, revealed that only 9 articles included terms that directly indicate an emphasis on class and/ or poverty issues. Words such as: at-risk, marginalized, elitism, disadvantaged, social justice, and lack of money were used as search terms. By contrast, 90 articles had titles that included terms related to race, culture, national origin, ethnicity, or multiculturalism. Three special issues of the

journals in the past 10 years have been devoted to issues of multiculturalism, diversity, and race. However, there have been no special issues devoted to oppression and poverty issues as they relate to counseling.

Even the “Dimensions of Personal Identity Model”, which describes multiple internal and external factors shaping a person’s identity, does not explicitly include social class, although it does include level of education, work experience, and historical context (Arredondo, Rosen, Rice, Perez, & Tovar-Gamero, 2005). Arredondo, Rosen, Rice, Perez, & Tovar-Gamero, (2005) state in the conclusion of their analysis of the *Journal of Counseling and Development* from 1995-2005 that: “No longer can multiculturalism be relegated to one course, mentioned as a passing comment in a publication or presentation, or avoided by educators and administrators...” (p.160). This powerful statement would be strengthened by the explicit inclusion of socioeconomic class. A review of the contents of the *Professional School Counseling* from 1997 to present revealed similar ratios. However, the journal’s recent special issue entitled, “Professional School Counseling in Urban Settings” (2005) does include articles on poverty-related issues.

In Liu and colleagues (2004) review of three journals, *The Journal of Counseling Psychology*, *The Journal of Counseling and Development*, and *The Journal of Multicultural Counseling and Development* from 1981-2000, discovered that social class was only made a key variable in 1.4% of all empirical research articles, even though social class data was collected on participants in 17.5% of studies. Social class was referred to more often in theoretical/conceptual articles, and was at least mentioned as a variable in 33.5% of them. In total, between 20 and 30% of all 3915 articles reviewed mentioned social class in some form. However, only a very small percentage made social class a focus of the research. These findings highlight the need for far

more research in the general area of social class in counseling literature. Liu and colleagues (2004) also found no agreed upon definition of class among the articles reviewed.

In a separate content analysis of the *Journal of Counseling Psychology* from 1973-1999, (1999), Buboltz, Miller, & Williams found that most (56%) social class research in the past thirty years has been carried out using college students as research participants, greatly lowering the diversity of the samples. Counselors' understanding of the impact of dual forms of cultural capital, and multiple lenses of social class worldviews among African-Americans has not been explored thus far.

The majority of research conducted to date on poor families in counseling falls into two general categories: 1) Programmatic research focus issues such as: numbers of people served by race, age, gender, and other demographic variables, and what types of services agencies and states offer poor families in need of service (included here would be policy initiatives and insurance programs). 2) Client focused issues, such as: reasons families seek services, perceptions about services and service-providers, and satisfaction with the outcome and process of getting services.

### **Programmatic Research Focus**

The vast majority of research on mental health services for poor families falls into this first category. Within the broad area of structural-collective issues, four major sub-categories emerge.

- Race/ethnicity specific research on service use.
- **Research focused on agency issues**, such as specific programmatic choices.
- Research focused on rural and/or urban settings and their impact on mental health.
- **Research on funding of services**, such as SCHIP and Medicaid.

Most of the research on programmatic research issues uses large-scale and quantitative methodologies, often drawing on census or national survey data. There are some qualitative and smaller scale studies, but they are clearly the minority of the research.

Chow, Jaffee, and Snowden (2003), in their research on the effect of race, ethnicity, and poverty on mental health service use, drew data from New York State Health records and the US Census. They conducted a bivariate and logistical regression analysis and found that African-Americans, Hispanics, and Asians used more services at younger ages than Whites, particularly in high poverty areas. African-Americans in particular were more likely to be diagnosed with schizophrenia than other racial groups, and most likely to be referred to mental health services by juvenile justice or child protection agencies. Only in low poverty areas, Asian and Hispanic people were more likely than Whites to use inpatient services. By contrast, in high poverty areas, Asians and Hispanics were less likely to use inpatient services than Whites.

In smaller scale studies, African-American youth were referred more often for mental health services than were Whites and often more coercively, meaning that they were more likely to be threatened with negative outcomes for noncompliance, such as foster care placement or juvenile justice intervention than Whites (Stevens, Harman, & Kelleher, 2005; Takeuchi, Bui, & Kim, 1993). The interplay of race and poverty is still being untangled, with some findings showing that race is the primary factor in mental health referrals (Costello, Keeler, & Angold, 2001; Stevens, Harman, & Kelleher, 2005; Takeuchi, Bui, & Kim, 1993), while others claim that poverty is the key variable (Chow, Jaffee, & Snowden, 2003; Samaan, 2000). Obviously, further research is needed to examine the effects of both race and poverty on children's mental health. Which variable contributes more heavily to coercive referrals and varied treatment outcomes is

not yet clear, but what is apparent is that poor children, particularly those of color, are more frequently referred for services.

A closely related set of variables which have been studied in some detail are rural and urban dwellers' patterns of mental health problem incidence and service use. Both rural and inner-city populations are more likely than suburban populations to live in high poverty areas (African-American & Krishnakumar, 1998) making both rural and inner-city children more likely to experience mental distress than children in suburban areas. One innovative longitudinal study followed 550 families who moved from inner city public housing to private housing in more affluent neighborhoods. At the three-year follow up, adults reported much lower levels of stress, and children (boys in particular) reported much lower levels of anxiety and depression than did families who remained in public housing (Leventhal, 2003). Other studies found that the increased stress levels associated with living in high poverty rural areas (Costello, Keeler, & Angold, 2001) and in high poverty urban areas (African-American & Krishnakumar, 1998; Leventhal, 2003; McKay, Nudelman, McCadam, & Gonzales, 1996) appear to contribute to negative mental health outcomes for children and adults.

The final two areas of programmatic types of research are closely related. Policy decisions frequently drive changes in how agencies operate based on changes in funding, and policy is sometimes shaped by research regarding use patterns and epidemiological data. Of particular interest in the recent past has been the issue of uninsured and underinsured people, and how the lack of adequate insurance coverage impacts their use of health care services. Researchers from a variety of professions (Boothroyd & Armstrong, 2005; Busch & Horowitz, 2004; Howell, 2004; Raphael, 2005; Willging, Waitzkin, & Wagner, 2005) have studied under- and uninsured children and have found that lack of coverage negatively impacts service access. Howell's

(2004) review of data from the National Survey of America's Families data found that mental health service use by children with Medicaid and State children's health insurance programs (SCHIP) coverage was significantly higher than service use among the uninsured (13.1% versus 4.5%). Howell (2004) also found that although children with Medicaid or other health insurance used services at nearly three times the rate of uninsured children, they did not have higher reported rates of behavioral or emotional problems, indicating that health insurance coverage is a key variable in helping families of all income levels access appropriate services.

There is also a growing body of research addressing the outcomes of varying delivery systems to provide treatment. In particular, the various forms of managed care and systems of care policies have been under scrutiny (Huang, Stroul, et al 2005; Pumariega, et al., 1997; O'Neal, 1998; Simpson, Scott, Henderson, & Manderscheid, 2002; Tolan & Dodge, 2005). Most of these researchers argue for a systemic approach to integrated services for families across a broad spectrum of need levels. This idea is echoed in the recommendations from the Presidents New Freedom Commission on Mental Health (2003). Highlighted in that report are ten interrelated 'values' aimed at improving access and service delivery to children in the United States, based on research from various state and national programs. The ten values and their corresponding standards of care are as follows:

- 1) Comprehensive home and community based services and supports: Endeavors to keep children out of institutional settings, and provide care in "natural" settings, such as homes and schools, rather than in hospitals or group homes.
- 2) Family partnerships and supports: Engaging families and/or caregivers in treatment planning and decision making is seen as a crucial element in mental health care reform. Seeing families as valuable partners, rather than as marginal players is another key concept of this value.
- 3) Culturally competent care: Services that are responsive to diverse cultures and beliefs are seen as important to reform.

- 4) Individualized care: A strengths-based program of services should be individually designed for each family, not packaged in a “one-size fits all” manner.
- 5) Evidence-based practices: Families should be informed about the scientific evidence supporting treatment choices.
- 6) Coordination of services, responsibility, and funding: Services should be linked together and in communication with each other. Adult and child services should be coordinated to best serve families.
- 7) Prevention, early identification, and early intervention: Prevention should be emphasized to minimize later problems, and enhance healthy development.
- 8) Early childhood intervention: Early intervention is needed to reduce negative outcomes associated with risk factors documented by the literature.
- 9) Mental health services in schools: Schools should “be supported” to create and maintain healthy social and academic environments.
- 10) Accountability: Agencies should be required to report evidence of service delivery and effectiveness to a central collection agent to reduce ineffective, inadequate service delivery, and foster continual improvement.

State programs that more closely follow the ideals of these recommendations appear to have more positive outcomes than those whose programs are not as well integrated and systemic (Howell, 2004; Willgin, Waitzkin, & Wagner, 2005). These recommendations have only been published in the last two years, and research is ongoing to determine the most appropriate methods of design and delivery of services.

### **Client Focused Issues**

Research on internal client based issues falls into three broad categories: client perceptions of care, parental perceptions of care, and referral process issues. The least studied of these internal-process issues is that of the child clients’ perceptions of the care they receive. Adult experiences of mental health care are only slightly better understood (Wilton, 2003). Whether this is due to lack of access by researchers to mental health care consumers, lack of interest in client experiences, or some other factor is unknown, however, it is clear that very little is known

currently about the clients' perceptions and experiences of care (Claveirole,2004; Dogra, 2005; Wilton, 2003).

What is known about children's and adolescents' perceptions of mental health care is that youth, parents, and therapists often have differing goals and expectations of counseling (Garland, Lewczyk-Boxmeyer, Gabayan, & Hawley, 2004). Additionally, several researchers found that young people need to feel they can trust the therapist (French, Reardon, & Smith, 2003; Shelton, 2004; Smith, 2004), and want more information about the services (French, Reardon, & Smith, 2003; Street, 2004). Young people also expressed a desire to be involved in decision-making about services (Dogra, 2005; Shelton, 2004; Street, 2004). This may be a particularly salient point in light of Garland's (2004) finding that of 170 adolescents interviewed; only about one-third were in agreement with their caregivers about the goals of treatment. This finding supported Yeh and Weisz's 2001 research. They asked 381 child and parent dyads in an outpatient mental health clinic to list the child's target problems. Sixty three percent did not agree on a single item. Disagreement among key stakeholders about the desired outcomes of counseling is likely to limit the young persons' engagement in counseling and hinder positive outcomes.

Slightly more research has been conducted on parents' perceptions of health care for their children. This work has primarily examined perceptions of care among parents of children with serious psychiatric problems (Foldemo, Gullberg, & Ek, 2005; Harden, 2005; Scharer, 2002). Harden (2005) conducted interviews with 25 parents of children and adolescents with diagnosed mental illnesses in Scotland. She reported that these parents were frustrated trying to balance their role as family experts with that of learning about their child's illness. In particular, the parents voiced concern over the lack of sensitivity of doctors to their plight and their desire for

knowledge, the lack of emotional support from psychiatrists, and the lack of clear answers about their child's condition. Many of these parents also mentioned feeling blamed by health care professionals for their child's mental problems. In a similar study conducted in the United States, Scharer (2002) reported that parents of children in mental hospital settings wanted more information about their child's condition and treatment, greater emotional support from health care staff, and more information on managing the child after he or she returned home. Interestingly, a qualitative study conducted with parents of obese children found similar concerns about their interactions with health care staff (Edmunds, 2005). These research findings may indicate that the problems of communication between parents and medical staff extend beyond the arena of mental health problems. Mental health problems in children are, however, particularly stressful to families. A Swedish study involving over 700 parents of non-schizophrenic and schizophrenic children revealed a lower quality of life rating, a higher perceived level of stress reported by families with schizophrenic children (Foldemo, Gullberg, & Ek, 2005).

Another aspect of children's mental health treatment which needs further study concerns how parents decide to seek services for their children. Renk (2005) found that mothers who brought their children to a mental health clinic had significantly higher reported parenting stress and reported higher levels of acting out behaviors in their children than did mothers in a control group of Latino children without behavioral problems. Arcia, Fernandez, Marisela, & Ruiz (2004) found that out of 62 Latina mothers interviewed, about half (32) reached the mental health clinic's door "almost by happenstance...the mother's search looked like a pinball in a game" (p.1225). About half of the mothers in the study (31) were directly referred either by a school, or a medical professional, or a social worker, or family member and once referred, made

arrangements for services. Six of the Latina mothers were self-referred; out of concern over their child's behavior (these mothers had significantly more education at 16.1 years on average, than did the rest of the sample, at 11.9 years). In contrast, those mothers who delayed treatment often reported that increasing actions by the school (such as suspension of the child), increased concern by relatives, or an escalation in the child's difficult behaviors finally caused the mothers to make an appointment for services. Whether these findings would be consistent in other ethnic groups is unknown, however, the important implication from Arcia, Fernandez, Marisela, Castillo, & Ruiz (2004) is that direct referrals may help facilitate mother's accessing mental health services, and may reduce the time and worry of the "pinball" effect.

### **Summary**

In examining the current professional literature on school counselors' referral practices, mental health parity issues, and the specialized needs of low-income African-American families, it becomes clear that there is very little research that directly addresses the intersection of these related issues. While literature does exist that examines each strand of this puzzle individually, there is a lack of literature to guide school counselors' referral practices with diverse families.

This is problematic when viewed in context. African-American males make up a disproportionate percentage of students with serious behavioral problems which impede their academic and social development (Colpe, 2000). However, African-Americans are also less likely to receive mental health counseling than are Whites (Richardson, Flaherty, & Bell, 2003). How much of this disparity is due to barriers to service that might be ameliorated by improved referral practices is unknown. It does seem possible that at least some of the African-Americans who are in need of, but who are not receiving, mental health care, could be linked with needed services by school counselors who have training in reaching out to low-income families of color and are using culturally responsive referral practices. This is indicated in past research (Arcia,

Fernandez, Marisela, & Ruiz, 2004; Ghose, 2006; Logan, 2001; Madsen, 1999) and will be examined further in the remainder of this study.

## CHAPTER 3 RESEARCH METHODS

### **Chapter Overview**

Chapter Three describes the epistemology and general philosophical assumptions of transcendental phenomenology, the research method chosen for this study. The selection of participants and the methods of data collection are explained. Data analysis methods, including steps the process of analysis are fully explained.

### **Theoretical Framework**

Edmund Husserl, a philosopher who lived and worked in Europe in the early part of the twentieth century, is generally acknowledged as the founder of the phenomenological movement (Crotty, 1998; Giorgi & Giorgi, 2003; Wertz, 2005). Although Husserl was not a psychologist, he devoted much of his career to questions of human experience and perception.

Phenomenology's distinctive focus on the individual's first hand experience of life and the world deviated sharply from the focus of other psychological studies conducted during this period that focused on overt behavior and physical processes (Wertz, 2005). Later therapists who embraced the existential therapies, such as Victor Frankl, Irving Yalom, and Gordon Allport were heavily influenced by Husserl's work (Halling & Nill, 1995), as were existential philosophers Jean-Paul Sartre, Martin Heidegger, and Maurice Merleau-Ponty (Giorgi & Giorgi, 2003).

At its core, phenomenological inquiry is concerned with gaining insight into lived experience with as little interference from outside schemas as possible (Wertz & Shapiro, 1998). Phenomenological researchers are concerned with learning about how human consciousness interacts with the world in order to create meaning (Wertz & Shapiro, 1998). "Phenomenologists search for the essential or fundamental structures underlying experience", usually by listening to

the lived experiences of participants and seeking to describe the most basic essences of the experience (Wertz & Shapiro, 1998, p. 98).

Phenomenology assumes that although there is an objective reality, it is only made meaningful via interaction with human perception. Therefore, the epistemological basis for phenomenology is both subjectivism and objectivism. The purpose of phenomenological inquiry is not to form theories or test ideas, but to discover and describe the life worlds of individuals. According to Wertz (2005), phenomenology is, “ a low-hovering, in-dwelling, meditative philosophy that glories in the concreteness of person-world relations and accords lived experience with all its indeterminacy and ambiguity, primacy over the known” (p. 175). Reality does not need to be constructed for the phenomenologist, merely described.

Husserl’s famous phrase, “*Sachen selbst*” or “to the things themselves” (Husserl, 1931) is a keystone of phenomenological thought, and is the cornerstone of his first epoche. *Epoche* is a Greek word meaning to stay away or abstain from (Moustakas, 1994, p. 85). The first epoche, which Husserl called the “epoche of the natural sciences” (Husserl, 1939/1954, p. 135) brings the researcher to the every day lived experience, without reflection or analysis. If the researcher wishes to learn about the natural world via observation without considering the element of human consciousness and its interaction with the observed world, the first epoche is sufficient (Wertz, 2005). However, if the researcher wishes to learn about the interaction between the observable, objective world and human experience, he or she must employ the second epoche; the epoche of the natural attitude (Husserl, 1939/1954). Moustakas (1994) does not mention two distinct epoches in his work, but combines them.

Wertz describes the second epoche as, “a methodological abstention used to suspend or put out of play our naïve belief in the existence of what presents itself in our life world in order

to focus instead on its subjective manners of appearance and givenness- the lived through meanings and subjective performances that subtend human situations”, (Wertz, 2005, p. 168). The second epoche is essentially a shift in thinking for the researcher, away from the collection of raw observational data about the objective world, and towards a subjective or intrapersonal interaction with the collected data. The second epoche asks the researcher to, “empathetically enter and reflect on the lived world of other persons in order to apprehend the meanings of the world as they are given in a first-person view” (Wertz, 2005, p. 168). The researchers own biases and pre-conceived ideas about the object of the study are bracketed, or put aside, so that the researcher is able to enter the life-world of the research participant as fully as possible (Moustakas, 1994). Bracketing requires the researcher to be aware of his or her own biases and to develop an empathic, open relationship with the participants and the data (Wertz, 2005).

Once a researcher has entered the epoche, and has put aside his or her prejudices and unexamined biases about a thing, he or she then turns to Transcendental-Phenomenological Reduction to begin to describe it (Moustakas, 1994). In this context, the word transcendental is meant to denote that the researcher is moving away from the everyday, to bracket away previous ideas, and see the data anew (Moustakas, 1994). This process is described in detail in the data analysis section.

### **Subjectivity Statement**

In this work, I acknowledge my status as an outsider. I am not the child of a poor family, nor did I need mental health intervention as a child. My family is White and middle class. While I was growing up, we lived in a small Southern city in the United States, and always had health insurance. I attended public schools during the early years of desegregation, but was never bussed far, and was generally in the majority population demographic at school. I never experienced learning or behavioral problems, although some of my peers did. I attended school

from first through eighth grade with children who lived at the local children's home. These children had often been placed at the home due to abusive conditions at home, and many of them experienced difficulties at school. I heard from them about their awful experiences, and I believe that learning about the harshness of some of my friends' and classmates' lives so early in my own life helped me to develop empathy.

As a member of the White, middle class, native born, educated, American cultural group, my personal beliefs about seeking mental health care reflect those of other members of my demographic group. I generally trust professionals to be helpful and honest, and I believe that some one who is educated in a particular field is better at helping me with a problem in that area than some one who is not. For example, if I felt anxious or depressed, I would think of consulting a therapist before talking to my aunts or my neighbors about my feelings. Doing this work has helped me understand how much my cultural context influences these feelings and beliefs.

I worked as an elementary school counselor for nine years, eight of which were spent in a semi-rural high poverty school. The school had around seven to nine hundred students, about 80% of whom qualified for free or reduced lunch, 70% were African-American, and a significant number were new immigrants from Central America or Mexico. While at that school, I met many families whose plight is very similar to those interviewed in this study. As a school counselor, I was often puzzled and frustrated by families who did not follow through on referrals from me, other educators, and medical professionals. The child clearly had problems and we told the parents where to go for help. Why did they not follow through? I helped parents to arrange transportation and child care, to apply for the state health insurance, and even made the appointment for counseling with them. Why the lack of follow through? I did not think then, nor

do I now, that the parents who did not follow up on mental health referrals were being malicious. However, I was unsure as to why some families did make it to the clinic, and others did not.

### **Participants**

The study participants were six individuals representing five low income African-American families from elementary schools in a community in north central Florida. Four of the participants were single parents, and two were an unmarried partners who were co-parenting their children from previous relationships. Five participants were women. One was a grandmother, one was an adoptive mother, the male participant was a stepfather, and the other three were biological mothers. All participants had legal and physical custody of the children in question, with the exception of the ‘step father’ who was co-parenting with the child’s mother, and did not have any legal rights to the child, but was interviewed in the company of the mother. The sons who were the focus of the interviews attended four different elementary schools in the local public school system. One child changed schools between the first and second interviews with his mother. All of the children attended majority African-American schools; although recruitment was open to all elementary schools in the local public school district.

Families were recruited after they experienced their first referral for mental health services for their sons by their school counselors. School counselors asked families if they were interested in participating in the study after they referred the family to treatment, regardless of the families’ plans to attend or not attend mental health services. If the family agreed to participate, the school counselor secured appropriate informed consent documents and relayed contact information to the researcher.

To participate in the study, caregivers had to meet the following requirements:

- Child eligible for free or reduced lunch at school, meaning that the family was living at or below the federal poverty line.

- The caregiver must be the legal and physical guardian of the child.
- The caregiver had to have a male child who had been referred to mental health care by the school counselor due to behavioral problems at school.
- The caregiver had to be self-identified as African-American.
- The caregiver had to be fluent in English.
- The caregiver could not be under investigation for child abuse or neglect.
- The caregiver had to agree to participate in a minimum of two and a maximum of three interviews.

Interviews took place at any location of the caregivers' choosing. Most preferred to talk in their homes, but the researcher did meet with two caregivers at their children's schools. Participants received compensation for completing interviews in the form of gift cards to a local grocery store chain. Gift cards were given at the end of each interview. Funding for participant compensation was drawn from a Chi Sigma Iota research excellence grant.

African-American caregivers were chosen for interviews due to the higher rate of coercive referrals for mental health care for children, and boys in particular, in that group (Chow, Jaffee & Snowden, 2003; Colpe, 2000) and a need to eliminate as many possible variations in the sample as possible (Kuzel, 1999). Boys were chosen instead of girls due to the need to homogenize the participants and the volume of literature available on the disproportionate referral of African-American boys to mental health and special education services. Family composition varied. Due to legal issues around informed consent, only families in which one or both biological or adoptive parent (s) was the legal and physical guardian were included. Students might have been receiving specialized educational services at school, or might have been undergoing treatment for other medical conditions (e.g. asthma, bedwetting, allergies, etc.). The boys might have had some sort of mental health intervention or evaluation before, but not due to a school referral.

## **Sampling Criteria**

Participants were chosen by matching several criteria so that this sample represented the local African-American low-income population. In order to qualify for participation, people had to be: African-American caregivers with sons in elementary school that had been referred to mental health services by the school counselor. The children had to be eligible for free or reduced lunch to qualify as “low income” in the study. Caregivers had to be the legal and physical guardian of the child in order to give consent to participate. School counselors were give a list of these criteria and made initial contact with families based on these criteria. Once the family was contacted for the first interview, the criteria were reviewed to insure a homogeneous sample.

In phenomenological research, a homogenous sample is critical to the outcome of the analysis (Moustakas, 1994). Method- appropriate sampling methods are crucial to doing solid qualitative research (Gubrium & Holstein, 1997). According to Kuzel (1999), a homogenous sample is one that, “focuses, reduces, and simplifies” (p. 39). To insure that participants are homogenous enough to conduct a trustworthy phenomenological analysis from the data they provide, as many obvious differences in demographics (race, socio-economic class, geographic location, age of child being referred, involvement with agencies, custody status) as possible will be eliminated. A chart containing basic demographic information about the participants is included in Appendix C.

## **Data Collection Methods**

The caregiver(s) from each family were interviewed either two or three times between December 18, 2006, and February 20, 2007. Three interviews were requested of each participant, but not all participants could be reached for the final interview. Three participants, Sherry and Felicia and James, could not be located via telephone or postal mail requests for a third

interview. Allowing for a series of interviews rather than a single discussion with each participant deepened understanding of participants' experiences. The first interview occurred as soon as possible after the family was referred by the school counselor for treatment. The second interview took place about three to four weeks after the first, and the third, three to four weeks after the second, at the mutual convenience of both parties. Each interview took about an hour, although the first interview was typically the longest. All interviews were digitally recorded. Interviews followed a semi-structured format (Appendix A).

The purpose of the first interview was to develop rapport with the participant. It was crucial to establish as much of a partnership of equals as possible during this phase so that the participants felt comfortable in sharing personal information (Fontana, 2002). Establishing a warm, respectful relationship was the primary underlying task of this interview. To create an "I-Thou" relationship (Seidman, 1991) with the research participants, the researcher first emphasized how important first hand experiences are to the research process. Participants were asked to choose a name for the written report, which could be either their real name or a pseudonym. All participants were told they will be acknowledged in any publications of this research. The first interview also provided a time for the researcher to answer any questions he or she may have about the study and gather background data. Finally, during the first meeting, participants were asked to begin to tell the story of how he or she came to be referred to counseling, with a focus on events in the past leading up to the present (Seidman, 1991).

The second interview took place a few weeks after the first to allow time to transcribe the first interview. The focus for the second interview was to examine current events in the life of the family surrounding their experiences with the mental health care system, if any (Seidman, 1991). This interview included topics such as; the child's current behavior, any change from the

previous interview and to what the parent attributed the change, how he or she felt about the services at the clinic, how the school worked with the family regarding the child's issues, and the parent's current experiences of treatment. Also during the second interview participants were asked to review the transcript from the first interview and make any changes or clarifications he or she felt necessary in order to bolster the trustworthiness of findings (Kvale, 1996).

During the final interview, the focus was on the future and reflection on the meaning of the process of being referred for mental health care (Seidman, 1991). The final interview took place several weeks after the second one to allow time for transcription. Possible questions for the third interview included: what would you say to summarize your experiences with the clinic, have you seen any changes in your child since we first met, have there been any changes in reports from school, has the treatment (if any) matched your expectations, and what are your plans now? Transcripts from the second interview were reviewed in this session to gather participant feedback and to insure accuracy. Afterwards, the third transcript was made available even though there was not another interview scheduled. Copies of the final product of the research may be sent to the participants upon request.

### **Data Analysis**

Data was analyzed according to Moustakas' (1994) transcendental phenomenological method. Phenomenological analysis of data may be divided into three stages: phenomenological reduction, imaginative variation, and synthesis of meanings and essences (Moustakas, 1994). A list of stages and sub stages of analysis may be found in Appendix B. During all stages of analysis, an audit trail was created to establish the consistency of the findings (Merriam, 1995; Wolcott, 1990). In addition, member checking, both in terms of asking participants to review transcripts, and asking for feedback from other qualitative researchers were utilized to establish the dependability of results (Merriam, 1995).

## **Phenomenological Reduction**

In the process of transcendental-phenomenological reduction, the first step is for the researcher to note all of the unique characteristics of the data, describing the observable information that defines the phenomenon. In interview studies, this usually means transcribing the recorded interviews verbatim. The data is then examined for 'horizons', or "the invariant, unique and defining constituents of the phenomenon" (Moustakas, 1994, p. 97). Horizons are given codes, or titles to make data easier to manage (Wertz, 2005). During this process, it is crucial for the researcher to adopt a posture of wonder and put aside any preconceived ideas of what the participants' experience might include (Moustakas, 1994). Adopting this posture defines the analysis as transcendental, since the researcher is seeking to transcend ordinary, taken for granted explanations of the phenomenon of interest.

Horizons are then clustered into themes, and from the themes, a textural description of the data is written for each individual data set, or interview. The textural description is a coherent description of the participant's report of his or her experience. According to Moustakas (1994), creating a textural description, "uncovers the nature and meaning of the experience" (p. 96). All horizons and individual textural descriptions are considered together, and a coherent description of the experiences of the entire group is created. This composite textural description aims to organize the lived experiences of all participants into a cohesive common description of the phenomenon of interest (Moustakas, 1994).

## **Imaginative Variation**

Once textural descriptions of the data are formed, the researcher then examines the data for the "structural essences of the experience" (Moustakas, 1994, p. 35). In order to identify these structural essences (or meanings and causes of an experience), the researcher employs a form of brainstorming called Imaginative Variation. In this exercise, the researcher imagines all

of the possible explanations and essences of the experience from many different points of view (Moustakas, 1994). Imaginative variation seeks to answer the question, “how did the experience come to be what it is?” (Moustakas, 1994, p. 98). To arrive at answers to this question, the researcher imagines as many explanations as possible, including all possible polarities, juxtapositions, and perspectives as possible.

According to Moustakas (1994, p. 99), there are four stages within Imaginative Variation. These are: 1) systematic varying of the possible structural meanings that underlie the textural meanings, 2) recognizing the underlying themes or contexts that account for the emergence of the phenomenon, 3) considering the universal structures that precipitate feelings and thoughts with reference to the phenomenon, such as the structure of time, space, bodily concerns, materiality, causality, relation to self and others, and 4) searching for exemplifications that illustrate the invariant structural themes and facilitate the development of a structural description of the phenomenon. Using Imaginative Variation allows the researcher to explore some of the endless possible meanings of the experience. Once this exercise is completed, the researcher writes the structural description of the experience of each participant. The structural descriptions are then combined into a composite structural description for all participants, which describe the meanings and causes of the experience.

### **Synthesis of Meanings and Essences**

The final step in transcendental-phenomenological analysis is the synthesis of meanings and essences. According to Husserl (1931), the essence of an experience is the characteristic that makes it what it is, and without which, the experience would not be the same. It is important to note that essences may change over time and context, so that a description of meanings and essences is only applicable at one point in time, in one place, and through the eyes of one person (Moustakas, 1994). However, the intersubjective knowing that is present in the essences as seen

in that situation may illuminate the phenomenon in new and novel ways, such that understanding is widened and enhanced across other settings.

As described by Moustakas (1994, p. 181), a synthesis is achieved by: “Intuitively-reflectively integrate(ing) the composite textural and composite structural descriptions to develop a synthesis of the meanings and essences of the phenomenon or experience.” This is the final step in Moustakas’ (1994) transcendental method and is roughly equivalent to the production of an essence statement in other types of phenomenological analysis (McLeod, 2001). The essence statement is normally a few sentences describing the universal commonalities that make an experience what it is (Wertz, 2005). This is the culmination of the phenomenological reduction, but is not necessarily the only useful product resulting from it. Textural and structural descriptions may also be of use in constructing implications from the data.

### **Validity and Trustworthiness, Reliability and Consistency**

Applying the concepts of validity and reliability to qualitative research is a contested practice among qualitative researchers (Merriam, 1995; Wolcott, 1990). Some researchers follow the quantitative model for establishing validity and reliability while others may eschew these concepts altogether (Wolcott, 1990). In this particular study, the classic quantitative concepts of validity and reliability are not used, but are also not rejected out of hand. Instead, the concepts of trustworthiness and consistency are employed. These concepts are widely, although not uniformly, used in qualitative research.

The first of the two pillars of research evaluation in the quantitative model is validity. In quantitative work, researchers use the term validity to discuss how accurately a study measured what it intended to measure (Merriam, 1995). This concept is predicated on the positivist notion that an external, relatively stable reality exists. However, when working from a phenomenological vantage point, the concept of validity clearly becomes problematic.

Phenomenologists are less concerned with external realities than with how a person describes “a situation just as it has been experienced with all its various meanings” (Wertz, 2005, p. 169). Since phenomenology is concerned primarily with the subjective, changeable perceptions of human beings as they encounter various life experiences, a positivist measure does not fit on an epistemological level.

However, it is important to insure that phenomenological research is rigorous and thoughtful. The concept of trustworthiness is often used in its place in qualitative work to describe thorough, thoughtful work (Glesne, 1999). In Merriam’s words (1995, p. 52), “The question of trustworthiness becomes how well a particular study does what it is designed to do.” In order to create trustworthy qualitative work, researchers need to make their methods of data collection and analysis transparent and show how they arrived at conclusions. Wolcott (1990) terms this process “letting readers ‘see’ for themselves. Creswell (1998, p. 201-203) specifies methods for creating trustworthy and transparent research are numbered below. These methods were implemented in the following manner:

- **Prolonged engagement and persistent observation:** participants were interviewed more than once, several weeks apart.
- **Triangulation:** using multiple sources, theories, investigators, or methods to develop conclusions: during phenomenological reduction, multiple ideas and possible interpretations of data were considered.
- **Peer review and debriefing:** Meeting with member of the dissertation committee provided regular feedback.
- Inclusion of subjectivity statement.
- **Member checking:** Participants read and edited transcripts for accuracy.
- **Create rich, thick descriptions:** The descriptions in Chapter Four are complex and lengthy.
- **External audit:** The dissertation committee and editorial boards of journals will audit the materials.

Although Creswell also mentions searching for ‘negative cases’ to refine ‘working hypotheses’, this particular method is not congruent with phenomenology, hence was omitted in this study.

The second pillar of empirical research evaluation is reliability. In quantitative terms, reliability refers to the likelihood that repeating an experiment will yield similar results (Merriam, 1995). Phenomenology, however, is not concerned with replicable results but in the unique experiences of individuals and in finding commonalities between people (Wertz, 2005). According to Merriam (1995, p. 56), qualitative researchers should be “concerned with whether the results of a study are consistent with the data collected.” Similar to the establishment of trustworthiness, consistency may be achieved in qualitative research by creating detailed, transparent steps of data transformation from raw transcripts to finished product. Merriam (1995) suggests that qualitative researchers use triangulation, peer examination, and an explicit audit trail to establish consistent results. In this study, the steps of data collection and analysis were explicitly described, establishing a clear audit trail. Participants facilitated consistency by reviewing transcripts. Peer reviewers carefully reviewed steps in data analysis and study design in order to insure that the results of the study were consistent with the raw data.

## CHAPTER 4 FINDINGS

"I am a man of substance, of flesh and bone, fiber and liquids—and I might even be said to possess a mind. I am invisible; understand, simply because people refuse to see me." Ellison, R. (1952/2002, p. 3)

This chapter delineates the findings of the research project. Prior to each individual's description, a brief background narrative is provided. The participants' individual textual and structural descriptions open the chapter, followed by the composite textual and structural descriptions and essence statement. The composite descriptions include the voices of all participants. Chapter Four concludes with an essence statement which attempts to answer the primary research question set out in Chapter One.

### • **Textural Description: Anna**

Anna is a single parent of two boys, John who is in his twenties and lives on his own, and George, who is nine. Anna has a clerical job at a local health care facility and works full time. George is in the third grade this year. Anna describes him as bright, sociable, and musically talented.

### **School versus Parent**

Anna described herself as a 'concerned parent'. When her son, George, began to have behavior problems at school during the third grade, she felt she had to take action to 'straighten him out' before things got out of control.

She learned of his problems via negative reports first from his classroom teacher, then from the assistant principal and principal. When she got phone calls or attended meetings at school about his behavior, Anna said she felt that she was being 'attacked' by school staff. When she went to the school for the first meeting about his behavior problems, the staff described his

negative behaviors in detail, but offered no solutions. George was subsequently suspended from school for 10 days, causing his mother to miss work for several days, and pay a sitter on other days.

### **Problem Solving is the Parents' Job**

Anna recalled, "It was true, the things they had been saying, but I felt like, it was caving in on us because there was the counselor, the teacher, the principal, and myself and everybody was sitting there telling me what my son does". She did not deny the facts of the school staff's accusations, but stated that she felt that they expected her to make her son behave on her own, and that they were not taking equal responsibility for the problems. Anna reported the school staff kept 'drilling' her son for answers as to why he had done the things he did. She felt this was unfair because she says children aren't always aware of why they do things. She felt the school staff expected her to correct the problems at home without help from them. She also said she felt they were blaming her for her son's problems and not being supportive of him.

She felt her son was being blamed for not only his share of the problems, but also for problems that may have arisen from classroom management issues. She felt that the school staff was not attempting to help her find solutions to the problems George was having, but were instead blaming her for the problems. She perceived the message to be, "Your child is bad and out of control. We've done all we're going to do. What are you going to do now?" The school staff members were very capable of telling her the details of the problems her son was having, but appeared unable or unwilling to help her find solutions to resolve the problems.

By the time of the second meeting, a few weeks after the first, Anna had already thought about taking her son to counseling. She had a friend who had been through a similar experience with her son and counseling had been helpful. She told the school counselor she had been thinking of taking George to counseling, and the counselor gave her a name and number to call.

During that same meeting, Anna told the teacher about strategies that George's previous teachers had used effectively to help him. Even though Anna tried to demonstrate her concern about her son's behavior, she said still felt that the school left all of the solutions in her hands, without offering much help or support. Anna strongly felt that the teacher's ineffective management skills were a part of George's problems, but did not feel that the teacher, or any other school staff members, was willing to attempt to improve the classroom structure to help him. She said that the teacher dealt with children's behavioral problems by, "cutting them off because it was nothing else she could do...she just didn't have any tolerance for them" instead of trying different strategies to help the child.

### **Mom Takes the Initiative**

Anna was aware that there was in fact a problem with her son's behavior and realized she would have to take some action to "straighten it out". She had a friend whose son had similar problems and counseling had helped him. Anna said that although some parents may think that counseling is, "brainwashing", she had no negative perceptions about counseling, possibly due to the positive experiences her friend had.

She decided on her own, without guidance from the school, to seek counseling for George. She did not want him to be expelled, and since it was obvious to her that the school had, "done about all they were going to do" to work with George, she took the initiative to find outside help for him. She recounts, "I sat down and really looked at the whole picture as far as him having a behavior problem and I don't want him to be expelled from school...so I thought, what can I do?"

She said she thought the school counselor was relieved when she said she wanted to take George for counseling, "Since they were probably going to mention it anyway". When she told the school counselor she wanted to go to counseling, she was given a contact number and name.

When Anna told the school staff during the third and final meeting (about six weeks after the first meeting) about George's behavior and that she had called to make an appointment for him with a counselor, "They liked that idea". Although they were glad to hear that she was taking George for counseling, the school staff still complained about his behavior and did not offer any ideas for ameliorating the problems.

### **School Makes the Rules, the Parents must Follow**

Anna said that if she had not demonstrated her concern and willingness to be very involved in her son's schooling, he might not have been allowed to stay at that school. Once the school staff recognized that she was being proactive and involved their judgments of her changed. Anna was careful to make her involvement and concern very evident during all three meetings with the school staff members involved in resolving George's behavioral problems.

During the several weeks when George's behavior was problematic, she often visited the school and sat in the classroom to observe him. Anna was also careful to ask George for his behavior report every day and calls the teacher if he has a bad report. She felt that the school staff observing her "sitting in the classroom, calling the school" gave George a better chance of staying there until 5<sup>th</sup> grade. Anna made it clear to the principal that she wanted her son to stay in that magnet program, and was willing to do whatever she had to in order to help him. She felt that if she had not done this, he would have been expelled. Anna stated that volunteering to take George for counseling was the key to him being allowed to remain at that school.

### **Structural Description: Anna**

#### **School versus Parent**

Although Anna considered herself to be an involved and "concerned" parent, she felt as if the school staff treated her as an adversary instead of an ally. When Anna went to the school to meet with staff about her sons' behavior, she felt "pressured" and "like I was being attacked".

Instead of exploring George and Anna's abilities and resources, the school staff (in particular the administrators) appear to have spent most of the meeting time explaining in detail everything George had done wrong. Anna felt isolated from the school staff and alone in her quest to help her son. She felt that the school staff were "caving in on me", which was very stressful and frustrating.

### **Problem Solving is the Parents' Job**

The school staff, in spite of being educational professionals, did not offer Anna any possible resources or suggestions initially. The result of this approach was to make Anna, a single parent, feel as if she was alone in trying to help her son. She felt as if the school staff "had done about all they were going to do" and that it was now up to her to affect change. She perceived the message from school staff to be, 'Your child is bad and out of control, what are you going to do'.

Even though she generally sees herself as a responsible and involved parent, being set the task of helping George with no support from the school staff was a frustrating and stressful experience for her. She said she kept thinking, "What can I do?" She also felt the teacher ignored her suggestions and "wasn't really trying" to help him.

### **Mom Takes the Initiative**

Once Anna had the idea of getting counseling for George, it seemed that the school staff became more engaged in the process of helping her. When she asked the school counselor about the idea of seeking outside help, the counselor was able to provide a name and phone number for her to call. Whether the counselor would have suggested this at some point later is unknown. However, Anna's perception was that all of the school staff at the meeting seemed "to like that idea". She wondered if they were planning to talk to her about going, and were putting it off, fearing she would not react well to the idea. It may be that the hesitation on the part of the school

counselor in mentioning mental health help contributed to Anna's feelings of isolation and frustration with the process.

After the meeting when she asked about counseling, Anna also began coming to school to observe in George's classroom. She also began a more structured approach to rewarding or punishing him based on his daily behavior report from school. Which, if any, of these actions changed the way the school staff reacted to her is not known. However, Anna felt that the school staff became more receptive and friendly towards her after they saw that she was a "concerned parent". Once she demonstrated her resolve to "keep him in that school", the school staff seemed more supportive and helpful- to a point.

### **School Makes the Rules, Parents Must Follow**

Even after George's behavior began to improve, Anna reports that she had to call the teacher to get information about his behavior, and that no one called to let her know if the strategies they were trying were working. She felt that someone "should have called" but did not. Anna's determination to play along with the school rules, even when staff members refused to listen to her point of view was crucial in keeping her son at that school. She believed strongly that if she had not toed the line, he would have been expelled from the magnet program. Again, Anna felt that the school had an us-versus-them mentality when dealing with her. The staff's inability or unwillingness to support her efforts to help her son was extremely frustrating and difficult for her.

### **Textural Description: Teacie**

Teacie is the single parent of five children, four girls and one boy, Patrick. Patrick has two older and two younger sisters. His father is incarcerated. Teacie was working part time for a private elder care agency, but quit when Patrick's problems at school began to demand much of her time. Teacie describes Patrick as funny, friendly, and smart.

## **The Fight to Keep Her Son Enrolled**

The day of Teacie's first interview, she had just withdrawn Patrick from his first elementary school. She was extremely frustrated with how she and her son had been treated at that school, especially by the principal. She was planning to enroll him in another school the next day and was hoping to be treated better there. For Teacie, withdrawing Patrick was an act of anger and outrage. Until this point, she had been desperately trying to avoid Patrick being "kicked out" of this school.

These feelings of desperation began early in Patrick's kindergarten year (the current school year). Teacie estimates that she had to go to school "ten or fifteen times in six weeks" due to his disruptive behavior. During this time, she reports feeling pressured by the school staff, particularly the principal, to take Patrick to a psychiatrist and have him placed on medication. She allowed Patrick to take medication for a while even though she disagreed with the idea because, "He's a doctor and I'm just a mom." She also felt that if she refused Patrick would be expelled. Teacie remembers thinking, "I did not want him to get kicked out of school and that's what was happening. I was willing to try whatever" to avoid expulsion. Teacie was desperate to keep Patrick in school, and was willing to comply with any suggestions from the faculty in order to accomplish that goal.

## **Anger and Stigma**

When the school principal said, "Don't you think you need some counseling?" Teacie's first reactions were shock and anger. She recalls thinking of saying "some bad words" in response, but her desperation to keep Patrick in the school overrode her initial anger. She agreed to go to counseling.

In spite of her agreement to attend counseling, Teacie remained concerned that the school staff thought her son was "crazy". Even though she acknowledges, "that's not how he (the

principal) said it, that's what I heard". She felt the school staff was judging her and her son and implying that he was "crazy and needed some help".

Teacie attributes her angry reaction to the suggestion of counseling to the fact that she had a negative experience with counseling when she was a child. Teacie had a troubled childhood (she did not remember much of it) and went to counseling at the same facility Patrick was being referred. Although she did not remember what happened in the actual counseling sessions, she does remember being teased by children at her school about being in "the psych ward". The teasing got so severe that she, "moved back to Miami, and that was why".

These childhood experiences are what she believes caused her to be so angry when the principal asked her about counseling. When she reflects on that conversation, Teacie says, "I immediately went into defensive mode when I should have remained calm and heard (the principal) out, but I didn't want to hear it because the truth was hurting".

### **Worries for the Future**

Teacie feels a great deal of pressure to keep Patrick on the straight and narrow path. She explains, "I don't want to ruin his life. I don't want him to ruin his life and I don't want no one else to. I don't want him to be one of those boys on the corner...I want to have him running up and down the field, that loves football like he does already and (is) productive...not that cycle that's already on both sides of his family. I want to stop that." The cycle Teacie is referring to is one of incarceration. Both Patrick's father and several uncles have been in and out of prison. Teacie is very worried that her only son will follow in their footsteps.

She sees the troubles Patrick is having at school as an indication that he may be heading down this path. She said, "By him getting kicked out of school today I felt as if the only thing they wanted me to do...was go to some dope dealer and buy him a package of rocks and a pistol and let him hang with his pants down below his ass and let him stand on the corner". She said

she knows that is not what the school staff wants for Patrick, but she feels strongly that the frequent suspensions over “every little thing” are sending him the message that he is “bad”.

In addition to her concerns about Patrick’s future, Teacie also worries about his health. She describes him as “heavy set”. At age 6, he is 4’3” and weighs about 110 pounds. When Teacie first began giving him stimulant medication for his ADHD this fall, his eating habits “bloomed”. Teacie began to fear that continuing with the medication would lead to obesity and complications. She discontinued the medication because she would, “rather him have a crazy head than a bad heart. At least he can live with a crazy mind, but you can’t live too long with a bad heart”. Her ongoing conflicts with the principal at the first school about medication led to her decision to withdraw him and transfer him to another school.

### **The School Staff Will Not Listen**

Teacie felt as though she got no support from the first school Patrick attended. She felt as though the principal was only interested in helping her if she medicated Patrick, which she did not want to do. She said of the staff there, “I’ve talked all I can talk, but I’m not being heard. Maybe they hear me, but they’re not listening”. Her frustration with Patrick’s behavior and the school staff’s lack of support led to her decision to move him to another school. She said of the first school’s staff, “I’ve tried everything. I’ve tried it your way, I’ve tried it my way, give me something back. I feel as if I’m stuck. I’m really stuck. I don’t know where else to turn.”

She felt that the only solution the first school’s staff had for Patrick’s behavior was either medication or suspension. His frequent suspensions caused her trouble at work and further frustration, “I can’t be at school all the time. I’m the sole provider for my family”.

However, moving Patrick to a new school with “harsher” teachers has not completely ameliorated his behavior problems. She said she had thought, “You tend to him at school, I’ll tend to him at the house, we’ll get along fine....just leave me alone”. She knew that would not be

the case, but was hoping for fewer calls to come pick him up, which has been the case so far. He is not on medication, and his new teacher seems to be managing his behavior with less intervention from the principal or school counselor, which results in fewer calls home. Although the reduced number of calls is helpful, Teacie is still worried and distressed about Patrick's behavior and its impact on his academics. This constant worry is wearing her out. She reports her feelings as, "Sometimes I want to give up. I really do...I feel bad about saying it...but I just get tired".

### **Teacie: Structural Description**

#### **The Fight to Keep Her Son Enrolled**

Teacie is a single mother raising her only son without much family support. The fact that the boy has behavioral problems makes raising him alone even more trying. She says, "Sometimes I want to give up. I really do...I feel bad about saying it...but I just get tired". She seems to put a lot of pressure on herself to raise him to be a "family man" and not continue the family cycle of incarceration. However, the lack of support she feels makes this far more difficult. She felt pressured to do whatever the school staff requested of her in order to keep Patrick in the school, and feared expulsion if she challenged their authority.

#### **Anger and Stigma**

Teacie's past haunted her dealings with Patrick's school. Her own experiences with being teased by classmates for going to the same mental health center where Patrick was referred colored her perceptions of help seeking. Along with her fears about Patrick's health in relation to medication, she also worried about him being teased at school for taking medication or going to counseling. These fears caused her to react negatively to the principal, in particular, whose suggestion of counseling was apparently not very tactful.

Although Teacie was eventually able to realize that her initial reaction was angry and defensive due to her own history, the negative feelings toward the school staff lingered. Their rather abrupt referral of Patrick to mental health services did not take into account the potential for caregivers to have emotional reactions to such news.

### **Worries for the Future**

Instead of stepping in to support her in her desire to raise her son well, the school staff pressured her to medicate him, which she did not want to do. She said of her experiences meeting with them, “Maybe they hear me, but they’re not listening”. She felt that the principal only wanted Patrick medicated and was not willing to try any other methods of helping him improve his behavior. The continued requests to have Patrick medicated despite his health problems was extremely frustrating to Teacie. She felt that her concerns were ignored and discredited because, “I’m only a Mom”.

She saw the staff at that school as acting only in their own interest, wanting Patrick to comply with the rules. Teacie’s concerns about Patrick’s health and the negative effects of the medication on it were brushed aside. When he was on medication, Teacie saw no real change in his behavior, except for increased appetite and lethargy. She did not feel these results merited the risks involved.

### **School Staff Will Not Listen**

The school staff members were not responsive to Teacie’s suggestions for a different approach to classroom management for Patrick. She repeatedly requested a “firm” teacher for him, but the school administration did not seem to regard her request as a serious possibility. Teacie chose to move Patrick to another school in an attempt to find him a more “firm” teacher. She generally felt disregarded by the staff of the first school.

The frequent phone calls from the first school about Patrick's behavior problems along with the lack of family support have been very frustrating and discouraging for Teacie. Her coping skills seem to be pushed to their limits. As she put it, "Mama is tired".

### **Textural Description: Joy**

Joy is the single mother of three children, two boys and one girl. Tyree is the youngest. He is in the third grade and is nine years old. Both of Tyree's siblings also attend his school. Joy is unemployed. Joy describes Tyree as thoughtful and loving.

### **The Search for Answers**

Joy's search for help for her son began well before he ever entered a public school. Although her story did not begin with a referral from a school counselor, it did end with one, and the journey to that point is poignant and telling. This first section of description gives the reader some further background and insight into Joy's situation leading up to the referral from the school counselor. Joy recounted seeing her son, Tyree; experience long, loud, and frequent tantrums beginning around age two or three. She recalled thinking, "there's something wrong with him, he's not just angry". Around that time Tyree also experienced seizures, but the doctors did not recommend any treatment for him.

Joy was very concerned about her son's behavior, and called the Health Department for help. This was her first step on the long journey to getting help for Tyree. The person she talked to at the county Health Department told her, "he's just angry, spend more time with him". When Joy countered, "He's only 5, what can he be so angry about?" She was told there was nothing the Health Department could do for her.

During the period when Tyree was between 3 and 5, his behavior grew steadily worse. He was aggressive with his older siblings, told his mother he heard voices, ran away from home several times, and grew paranoid, "Everybody's out to get me". Joy could not find sitters or

daycares that could handle Tyree and had to leave several jobs for this reason. Joy repeatedly tried to get health professionals to help her, but was deflected.

When Tyree started kindergarten, his behavior problems (“biting, spitting, hitting”) caused him to be suspended and eventually moved to another class. Apparently during kindergarten, Tyree was evaluated by a school psychologist. Joy said, “I think he was seen by a psychiatrist—some guy from (local university) came and talked with him at school”. She did not understand who this person was or what the outcome of the sessions were until 3 years later, when a counselor at another school explained that Tyree had been identified as Specific Learning Disabled in kindergarten and had an IEP.

In the middle of his first grade year, Tyree moved to a nearby town to live with his father and stepmother. Joy hoped that spending more time with his father would help Tyree, however, “I want to say it was a bad mistake...there was a lot of things going on in that home”. Joy says that his father told her that the school staff in that town “diagnosed him as Manic-Depressive and schizophrenic”. She eventually found out from the current school counselor that he was too young to be diagnosed with either of those disorders. However, Joy did not discount the possibility that Tyree may have a serious mental health disorder. She stated, “His genes are bad”, but “Nobody can tell me what is wrong with him and that’s the part that scares me”.

### **Building the Team**

When Tyree came back from staying with his father (and later, his grandmother, who seemed to do well with him) he started attending the school where he is now. Joy’s quest for help for him at this school began after he got into a fight with his sister one morning during breakfast. She came to the school and met with the staff, including the counselor. It was during this discussion that Joy explained her desire to get help for Tyree, and the counselor gave her a name and phone number to call for a mental health evaluation. Joy said of this counselor “finds an

outlet for every little thing you need. So now, it's like I have somebody on my side...my own little support team building up". Interestingly, two other participants had very different experiences with the same person.

For the first time, Joy had someone who could help her navigate the alphabet soup of educational programs and related services. She learned that her son has had an IEP since kindergarten, and is aware of what that means in terms of services he is able to receive. However, she was still not sure what, if any, mental health disorder he may have or what courses of treatment are possible. When Joy made the personal connection with the counselor at Tyree's school, things began to change for her. The school counselor was able to make helpful referrals and also followed up with Joy to be sure she was able to access the services at the referral sites.

### **The Run Around**

In between the second and third interviews, Joy was finally able to get Tyree's Medicaid card and arrange an appointment for him at the local mental health center. However, as of our last conversation, he still had not been seen. This follows four years of her trying to get help for her son, whom she "want(s) to see him in college, not in prison".

Of the process of getting a Medicaid card, she said, "I had to fight to get him a card". Joy had to be very persistent in calling and checking on the status of the application, and waited two months to receive a temporary card. According to Joy, all of the dead ends she encountered while seeking mental health care for her son constitutes "a big run around". The run around was eased significantly when Joy found an ally in Tyree's school counselor. The school counselor was able to talk with Joy to determine what sorts of services Tyree might need (and Joy might want for him) and was able to help Joy locate service providers. She also helped Joy make appointments, gave her phone numbers to call about various Medicaid problems, and generally helped Joy to make contact with the service providers Tyree needed to access. Without the help of the school

counselor, Joy fears she would have been stuck in an eternal run around. She is now waiting for her appointment at the mental health center. She is, “ready for him to get some counseling, something, anything”.

### **Structural Description: Joy**

#### **The Search for Answers**

Joy has been trying to the best of her ability to get help for her often violent and out of control son for almost five years now. She has been extremely frustrated by the process of help seeking. With the notable exception of the current school counselor, Joy has been dismissed and disempowered by professionals from whom she sought help.

The tangled system has not allowed her son to receive treatment to this point, although she clearly is desperate to find out what is ‘wrong’ with her son. It is possible that if Joy knew more about how the system works, she may well have been able to access services much earlier. For example, she did not know that Tyree had an Individualized Education Plan (IEP) or what that meant. No one had explained the special education process to her in a way that she understood it, even though she most probably received a handbook of parent’s rights when he was initially identified. Further, had she been more able to explain to the staff at the Health Department what sort of evaluation he needed, or was able to pay for a private evaluation, things might have been very different.

#### **Building the Team**

Once Joy was befriended by her son’s school counselor, her situation began to change. The school counselor in this situation acted as one might hope a school counselor would act. She first listened to Joy’s story carefully, asked questions to clarify her understanding, and then offered appropriate referrals to community agencies. She gave Joy telephone numbers and contact names

for each agency, and then asked Joy the next time Joy was at school if she had any difficulty arranging appointments.

The school counselor's intervention was a huge relief to Joy. She was now able to call for appointments, and could rely on the school counselor to help her navigate roadblocks. When Joy needed help getting information for Medicaid, she knew she could count on the school counselor to provide the help she needed. The school counselor provided the first spoke in the wheel of support Joy eventually built.

### **The Run Around**

Although Joy does fear the possibility of the mental health counselors blaming her for his problems, she is adamant that she wants to know what is wrong and what can be done to help Tyree. She is concerned that he will end up in an alternative education program for children with behavior problems, or later, in prison. Her persistence in the face of so many roadblocks and run-arounds is astounding.

Joy's story is a sad, but probably not uncommon, illumination of the gulf that stands between those inside the run around and those needing to break in. She repeatedly gave permission for various people to test and/or counsel Tyree without understanding fully the implications of those actions. She is desperate to get help for him, since she is very aware of the possible negative consequences of Tyree growing up without any intervention. However, she neither understands how to break into the run around, nor what entering that system might entail.

### **Textural Description: Sherry**

Sherry is Darrien's maternal grandmother. She is also caring for two of her granddaughters while another of her daughters is in prison. She also still has a teenage son at home. Darrien is six and is repeating kindergarten. Sherry works fulltime at a clerical job at a major hospital. She is married, but her husband was not present for the interviews. He is also employed full time.

## **School Centered Solutions**

Sherry was the only participant who was a grandparent raising a grandchild. Sherry gained custody of her grandson, Darrien, just prior to his kindergarten year beginning. Sherry had spent a lot of time with Darrien previously, but said she did not understand how serious his behavior problems were until he came to live with her. Darrien's mother (Sherry's daughter) has an unspecified "disability" according to Sherry that made it impossible for her to properly care for Darrien.

When Darrien started attending kindergarten, his behavioral problems were immediately evident. The first day of school, he was sent home for biting other children. Along with biting, Darrien was also hitting other children and defying adults.

After sending him home for the day multiple times during the first two weeks of school, the principal requested a meeting with Sherry about Darrien's behavior. At that meeting, the principal, the counselor, Darrien's teacher, and the Behavior Resource teacher told Sherry that they were going to put Darrien on a half-day schedule. This meant that Darrien would come to school at 10 and leave at 2 with the other children.

Apparently, the school staff had chosen to change Darrien's schedule without input from Sherry. She recalled thinking, "It was terrible. I thought I'd have to give up my shift (at work). I was trying to support them, and I was like, where y'all support for me?" Sherry worked at the local hospital from 6am to 2pm. During the time that Darrien was on half days, she had to leave work, drive across town to get him, take him to school, and return to work. She said of this schedule "It was stressing me; I was missing lots of work".

Sherry finally went back to the school after about two months of half days and met with the team again, and asked them to find another solution. During that meeting, the teacher told Sherry that she thought Darrien might have a learning disability and that she wanted him to be

tested. Sherry agreed to have the testing done for the learning disability. At that same meeting, the school counselor suggested Sherry take Darrien to the local mental health center for an ADHD evaluation and counseling. Sherry said she felt “all up for it, he’s always been real hyper”.

Once the team had decided to further investigate the possible causes of Darrien’s behavior, they also agreed to allow him to start coming to school all day again, with a plan in place for dealing with any misbehavior without sending him home. What baffled Sherry about this process was “why they didn’t do that in the first place” instead of requiring Darrien to attend half days, which was a burden on her, and did not seem to help him.

As it turned out, Darrien was diagnosed with ADHD and was placed on stimulant medication. Sherry said of the medication, “it made a big difference”. She added that his behavior at school improved tremendously. Sherry also reported that Darrien was identified as having a learning disability and was able to get extra help with academics. Again, if the school staff had discussed a broad array of possible solutions to Darrien’s problems in the first place instead of assigning one intervention for their own convenience, Sherry would not have felt so distressed and the underlying issues might have been identified sooner.

### **No Support for Caregivers**

During the first few months of Darrien’s first year at school, Sherry said she felt that the school staff “was out to get me”. She recounted the distress she felt when she would get called at work about Darrien’s behaviors, and the huge problems that the half day schedule caused her. Sherry said of those first meetings, “It was depressing to talk to them”.

Sherry had other children who attended the same school in the past and had never had any behavior problems. She had been a class volunteer with all of the other children, and felt she was a strong supporter of the school. However, when her grandson began exhibiting serious

problems, the school staff did not reciprocate her support. As she put it, “I was trying to support them, and I was like, where y’all support for me?” Sherry felt that her years of volunteering and helping teachers meant nothing in this new circumstance. She had to rely on friends and neighbors to help get Darrien to school during the half day schedule, and felt that she was getting no help at all from the school.

None of the staff members at the school offered her any emotional support while she was trying to find help for Darrien. In fact, one teacher even remarked that if Sherry was so stressed, maybe she should send Darrien back to live with his mother. Sherry found this remark to be hurtful and insensitive.

### **The School Decides which Problems are Legitimate**

When Sherry first enrolled Darrien in kindergarten, she asked the teachers about special education services at the school. She felt there was a good chance that Darrien had a “mental disability” similar to his mothers’. However, she was rebuffed and told that if there was a problem, the teacher would find it later.

Instead of taking Sherry’s concerns seriously, asking for family history or reasons for her questions, the teacher simply assumed Sherry’s point of view to be of no educational value. Obviously, Sherry was right about Darrien’s disabilities. If the first teacher she approached had welcomed Sherry’s input, the school year might have started very differently for Darrien.

In Sherry’s words, “things got a lot better when they realized Darrien had a real problem”. Once the school staff members were convinced, through academic performance measures, psychological testing, and a diagnosis of ADHD that Darrien’s problems were “real” they were much more flexible in working with Sherry. Certainly, the data gathered by the school psychologist, teachers, and psychiatrist shed more light on the exact nature of Darrien’s limitations. However, the staff members lack of response to Sherry’s initial concerns and

discounting of her input set Darrien up to fail during his first days of kindergarten. Their disregard for her concerns also frustrated Sherry and made her feel unsupported.

### **Structural Description: Sherry**

#### **School Centered Solutions**

One of the most frustrating aspects of the entire situation with Darrien was, for Sherry, the fact that the school staff members initially created an intervention plan without any input from her. Worse, the plan was a serious infringement on Sherry's ability to do her job, and did not seem to make any changes in Darrien's behavior.

Sherry readily acknowledged that Darrien's behavior was unacceptable and stated she was willing to work with the teacher to help him. However, before she had a chance to make any suggestions, a plan was decided on and she was told how the situation was going to be handled. Her exclusion from the decision making process made Sherry feel unwelcome and angry. The imposition on her of an amended schedule for Darrien was highly inconvenient and left her feeling "depressed".

#### **No Support for Caregivers**

Sherry's interactions with the school in years past had always been very positive. She had always volunteered to help in her children's classrooms and was hoping to do so again for Darrien. However, when his first year of kindergarten started with numerous suspensions and calls about behavior problems, she found that the friendly atmosphere at the school changed, and that she suddenly felt like an unwelcome interloper.

Instead of treating Sherry like a valued part of a problem solving team, the school staff treated her as if she was causing Darrien's problems, or was holding back the key to solving them. As she said, "I felt like they were out to get me".

### **The School Decides which Problems are Legitimate**

Sherry warned the teacher prior to school starting that she thought Darrien might have a learning problem. Although he did not bite or hit other children at home, he was “real hyper”. The teacher dismissed Sherry’s concerns until Darrien started to misbehave in her classroom.

Instead of referring Sherry to the school counselor to prevent potential problems at school, the teacher waited until she saw the proof. Even then, when Darrien was biting and hitting other children, it took more than one meeting of the behavior intervention team at the school for anyone to refer Sherry to a mental health clinic for Darrien. Perhaps the school staff members were being cautious about making a referral for an ADHD evaluation, but the delay cost everyone valuable time. Darrien is now repeating kindergarten, partially because he missed so much time last year due to suspensions. It seems reasonable that if Sherry had been given the name and number of a mental health clinic sooner, Darrien’s behavior might have improved more quickly.

### **Felicia and James: Textural Description**

Felicia and James are co-parenting Felicia’s adopted son, Jaquan, who is 10 years old and is in the fourth grade. Felicia adopted Jaquan as an infant. James, her fiancé, has been a father figure to Jaquan for three years now. James has children from a previous marriage who live with their mother. Felicia asked James to participate in the interviews because he was present at most of the meetings at school about Jaquan. Felicia and James run a small business together.

### **No Compassion**

The fourth grade has been a very trying year for Jaquan and his parents. Jaquan has had some difficulty during each year of school, but this year has been the worst to date. Felicia and James attribute Jaquan’s increased problems to his fourth grade teacher’s lack of compassion. James said flatly, “she’s a grouch”.

They feel that the teacher is exaggerating Jaquan's behavior problems, and is referring him to the administrators at the school over "little stuff". They describe this teacher as being "all by the book" and inflexible. They say she has, "one way of seeing Jaquan. She thinks he's just messing up."

Unfortunately, once Jaquan is in the office and his parents are called, this "straight and narrow" attitude continues. When Felicia and James come to the school to discuss Jaquan's behavior, they feel that, "they've already made up their minds before they get the whole story...I wish the school would be more open instead of judgmental." They feel that as parents, they have very little impact on the decisions of the school staff regarding Jaquan's discipline or his education in general.

When the school counselor suggested that Jaquan might need an ADHD evaluation, Felicia was in agreement. As she says, "he's very hyper". Jaquan was prescribed medication, and is taking it. However, he still has some (although fewer) behavior problems at school. When Felicia suggested that perhaps he needed a "more sympathetic teacher", the principal asked if he was taking his medication every day.

Felicia and James found this remark offensive. They readily acknowledge that Jaquan does have ADHD, and are treating him for it, but do not think that ADHD is the only problem. They see the teachers' lack of compassion and unwillingness to accommodate his differences as a major impediment to Jaquan's education. The school's staff as a whole does not acknowledge that any changes need to be made to help Jaquan. Now that he is on medication, their answer is always, "have his meds adjusted". To that, James replied, "He doesn't need more meds; they need to fix what's going on in school." He said he would prefer for the teacher to, "See that he has some problems, work with him, be more understanding".

## **Failure to Communicate with Parents**

During the many visits they made to the school this past fall (which they estimated to number around three or four per week), Felicia and James felt that even though they had a lot of conversations with school staff members, the communication was largely one-way. The school staff told Felicia and James their version of events and expected them to agree. They expressed frustration at only being contacted when Jaquan was having a bad day, never when he was improving.

Both of Jaquan's caregivers were under what they called "tremendous stress" with their small business and felt that the schools frequent phone calls and demands to come pick Jaquan up early added to their frustration. Although they tried to give the teacher suggestions for dealing with Jaquan more effectively, she was not open to their ideas. James perceived that the teacher simply wanted, "Jaquan out of her class, period" and that she was unwilling to hear his suggestions.

In spite of James and Felicia's high level of concern and involvement, they both still felt as if the school staff had a "biased view...they have one way of thinking about Jaquan...no matter what we tell them." They felt that their repeated requests for accommodations fell on deaf ears until the mental health counselor told Felicia that Jaquan would qualify for a 504 plan. Felicia had never heard of Section 504. She and James were upset that no one at the school had ever mentioned this as one way for Jaquan to get accommodations for the FCAT. James said, "We don't have the information...or the knowledge of what's available, and that bites everybody." He went on to say that after they met with the teacher to request a 504, she agreed to write a plan for Jaquan, but several weeks had gone by with no follow up. James was very frustrated at the lack of communication from the school, and even more frustrated at their lack of willingness to listen to him and Felicia. As he put it, "everything is about communication".

## **No Flexibility**

In addition to not taking the caregivers' input seriously and not appearing to have compassion for Jaquan, the school also maintained extremely rigid expectations. James said he felt that the principal and teacher in particular took a "tough love, my way or the highway" approach with Jaquan. According to Felicia and James, the school staff did not seem willing to work with Jaquan and make allowances for his ADHD.

Felicia said of the school staff, "We got mad with them...we felt like they were giving up on him." At one point, the principal mentioned the possibility of sending Jaquan to an alternative school if his behavior did not improve. James felt that the principal was "trying to force him (Jaquan) out" of the school. Both James and Felicia relayed that they felt the school staff would rather send Jaquan to an alternative school rather than to be flexible in their expectations for his behavior. Even in light of Jaquan's ADHD diagnosis and medication, the school staff did not seem willing to try to accommodate his needs. Rather, they expected Jaquan to conform to the school's way of doing things.

This rigid expectation seemed to apply to the parents as well. James said he felt that the school expected parents to come when called but not to have an equal voice in the decisions that were made. He said of the school staff, "They take us seriously, but then they want us to understand their biased thinking about how he's a mess up."

### **Structural Description: Felicia and James**

## **No Compassion**

Felicia and James expressed strong feelings about Jaquan's teacher's lack of compassion in the classroom. They perceived her as being "biased" in her appraisal of the boy and unwilling to make any changes in her approach to meet him halfway. Felicia and James thought that the

teacher did not like Jaquan, had no patience with him, and made discipline referrals for minor rule infractions.

Their perception of a lack of compassion also extended to their dealings with other school staff members. They did not feel that anyone on the faculty was interested in joining with them to help Jaquan succeed. Rather, they were treated with professional detachment and a lack of warmth. Felicia and James felt the school staff “took us seriously” and were respectful, but did not make allowances for their work schedules or for providing any new ideas for helping Jaquan. Their approach was very business like and rigid. This was frustrating to both caregivers, who perceived the school staff as unfriendly and only interested in “forcing him out” and not helping Jaquan.

### **Failure to Communicate**

The lack of communication Felicia and James discussed was two fold. First, the school staff only provided one-way communication, following the separation paradigm of parent involvement in schools (Amatea, 2007). The school staff members were quick to call Felicia or James if Jaquan was having a problem, but never reported any progress he was making. They also expected Felicia and James to agree with any and all requests from the school.

Secondly, the school staff members did not adequately explain to Felicia and James what resources might be available to help Jaquan. Although the school counselor did give them information for making an ADHD evaluation appointment, she did not provide any information on educational resources, such as Section 504, special education, or other locally available services. This reflects the school centered mindset discussed in other participants’ interviews.

All in all, the dearth of two- way communication between the school staff and the caregivers was not only frustrating to Felicia and James; they also felt that it impeded their ability to help Jaquan. Not having open communication and sharing of ideas, “bites everybody”

as James put it. If the school staff had used a more open, friendly communication style, Jaquan's needs might have been met sooner and with less frustration.

### **No Flexibility**

The third major source of frustration for Felicia and James was the school staff's lack of flexibility. They described the classroom teacher "straight and narrow" in her dealings with students. This approach clearly did not work for Jaquan, whom his parents describe as a child who needs a "sympathetic teacher" who can be flexible in approaching Jaquan. They said they knew he needed to be responsible for his actions, but that this teacher's inflexibility "discouraged him".

The pattern of inflexibility applied to the rest of the school staff and their dealings with Felicia and James. They recalled feeling that the overall message from the school staff was "our way or the highway". They also felt that school staff, particularly the principal and the teacher, had a "biased" view of Jaquan and only saw him as "a mess up" and were unwilling to recognize him as a child with special needs in need of a less rigid environment.

## **Composite Textural Description**

### **School Centered Perspective**

All of the caregivers who participated in this study felt that the staff at their son's schools expected the family to find and carry out solutions to the boys' problems, mostly without any assistance from school. Prior to, during, and after the actual referral to a mental health agency was made, the caregivers felt that they were being blamed for their sons' problems, and that they alone were responsible for "fixing it". There was a sense that the school staff developed ways of dealing with the boys' misbehaviors that were most convenient for the school staff without taking into account the needs or wishes of the caregivers. As Felicia and James pointed out, their son's school staff "are biased...they have one way of thinking of Jaquan. They think he's

messing up. No matter what we tell them, they say we're not seeing the teacher's side, and we say you're not looking at Jaquan's!"

This bias seemed to lead the school staff to make decisions that were sometimes extremely difficult for caregivers to manage. In Sherry's case, the school staff decided Darrien could only attend school from 10-2 since his worst behavior occurred in the mornings. This schedule was implemented while Sherry was waiting for an appointment at the mental health center, which she had made at the request of the school counselor. Sherry missed a lot of work because of this new schedule and recalls, "It was terrible. I was thinking I'd have to give up my shift".

In Teacie's case, the insistence that her son Patrick be medicated in spite of her misgivings about the health implications of using stimulants for him led her to believe the school staff was not listening to her. She felt this pressure to medicate Patrick inferred that he was "crazy and needed some help". She said of the staff at the school, "I've talked all I can talk, but I'm not being heard. Maybe they hear me, but they're not listening". Her frustration with Patrick's behavior and the school staff's lack of support led to her decision to move him to another school. She said of the first school's staff, "I've tried everything. I've tried it your way, I've tried it my way, give me something back. I feel as if I'm stuck. I'm really stuck. I don't know where else to turn."

In a similar vein, Anna perceived the message from George's school to be, "Your son is bad and out of control. We've done all we're going to do. What are you going to do now?" Anna describes feeling as if "they were all caving in on us because here was the teacher, the principal, and myself, and everybody was sitting there telling me what my son does." Anna did not feel the school staff were willing to help her find solutions to George's problems, and in fact, ignored her request that different strategies be used with him in the classroom. She felt his teacher had "no

tolerance” for him and was not willing to work with her. She said she simply felt as if she were “being attacked” by the school’s staff.

Felicia and James had a similar feeling about Jaquan’s teacher. They felt that her lack of compassion for Jaquan led to him being sent to the office for “little stuff” they felt could have been handled in the classroom. After several meetings with the school staff, Felicia and James came to the conclusion that Jaquan needed “a better classroom” and not more effective medication. Teacie felt that Patrick’s school was also blaming her for problems created or at least fueled by their handling of his behavior. She reported that her requests for different management strategies also went unfulfilled, while she was being pressured to medicate Patrick.

### **Lack of Compassion for Caregivers**

All of the participants also reported feeling alone in their search for solutions, as well as feeling blamed for their son’s problems. As Sherry put it, “I thought they were out to get me. I was trying to support them and I was like, where’s y’all support for me?” Participants relayed feelings of disappointment in the level of practical and emotional support they received from school staff members. Most of the participants (all except for Felicia and James) are parenting the boys alone and reported feeling “tired” (Teacie), “depressed” (Sherry) and “stressed” (Anna) when faced with the daunting task of finding mental health care for their sons. Anna was the only participant who consciously built a social support network for herself and her son during these trying times. She asked male friends from church and the community center to help her get and keep George “on track” by checking in with him about his progress.

The younger single mothers in the group, Teacie and Joy, seemed to lack any support from their own families and reported feeling especially let down by the initial response from the schools regarding their sons. Joy was eventually able to find an ally at school, but Teacie was still searching at the time of the last interview. She reported feeling “alone” and “pressured” to

get help for her son, while not getting any help for herself. Both Joy and Teacie reported feeling intense internal pressure to see their sons “go to college and not prison” (Joy) and to “end the family cycle” of going to prison (Teacie). The referral to the mental health center was especially stressful for Teacie, who had negative memories of going to the same center when she was a child. Joy, however, saw the referral as the key to finding out “what is wrong with” Tyree, something she had been searching for many years.

The other participants also felt isolated and blamed by the schools, but seemed more able than the younger single mothers to access other forms of support. Anna found church and community members to help George, Sherry relied on her adult children, and Felicia and James have each other to lean on for support. However, these participants were also distressed by the process of finding out their son had a problem and being referred for treatment. All four of these participants also mentioned increased strain at work due to frequent trips to school. Joy does not work, and Teacie left her job due to pressures from her boss to resolve her “son problems”. All participants felt at least some sense of isolation and lack of support from the schools.

The lack of support for families manifested a different way for Joy, who has spent hours seeking help for her son, Tyree. She reports that she has repeatedly told Tyree’s teachers that she thinks “there’s something wrong with him” but got no help. This began to shift when Tyree got in a fight at school and was going to be suspended for ten days. When Joy got to school to pick him up, she met the school counselor. Following their conversation, Tyree was not suspended, and for the first time was given the name and phone number for a mental health center that takes Medicaid. Sadly, out of all of the participants in this study, only Joy felt helped and supported by the school staff.

In Joy's case, the school counselor acted as a link between her and various services the school and mental health system could offer for Tyree. Not only did the counselor provide Joy with the name and telephone number of a mental health counselor, she also began the special education paperwork for academic testing for Tyree and helped Joy fill out Social Security paperwork. This multi-layered help is in contrast to Felicia and James' situation where they say their mental health counselor advised them to request a 504 plan for Jaquan, and the school counselor has not returned their phone calls. They are bewildered at the school counselor's lack of intervention on Jaquan's behalf. As James put it, "He doesn't need more meds; they need to fix what's going on in school".

### **Schools are Rigid Systems**

Another sentiment shared by all participants was the schools expectation for caregivers and their sons to conform to the school's plans, with no room for compromise. The schools' "our way or the highway" (James) mentality was especially frustrating for the caregivers who were aware that their sons had medical diagnoses that influenced their behavior at school. Sherry's frustration with the school's expectation that Darrien behave exactly like all of his classmates was expressed as, "a child with ADHD is going to be fidgety and you can't punish him for it". Sherry had already taken Darrien to the psychiatrist, had him diagnosed, and was giving him the medicine as prescribed. The staff at Darrien's school did not seem to make any allowances for his condition.

The lack of flexibility was extremely frustrating for Sherry. However, once Darrien was placed in exceptional student education classes for a developmental delay, she felt the staff became more willing to forgive his behavior. Sherry had tried to convince the school staff earlier in the year that Darrien had a "disability like his mother" but this notion was not given any credence until formal testing was carried out near the end of the school year.

This dual ordeal of knowing the child has a problem and not getting any help from the school and the school not yielding to the child's needs is echoed in Felicia and James' story. Felicia's son, Jaquan, was adopted as an infant from a birth mother who was using drugs. When Jaquan started school, Felicia told the school staff that she felt his mother's drug use had affected Jaquan. She felt the school ignored this information until Jaquan began having serious academic and behavioral problems. Felicia took Jaquan to have him assessed for ADHD. He was diagnosed and prescribed medication. Although Felicia gives Jaquan his medication as prescribed, she feels the school pressures her to ask the psychiatrist to increase his medication any time he has a behavior problem rather than to work with him to find other solutions. Felicia says she wishes the school staff would. "Work with him, be more understanding". She feels that they are trying to push Jaquan into an alternative school to avoid having to help him succeed where he is. James said he feels that the school is "unbending, all by the book, straight and narrow". This approach is not working for Jaquan. Both Felicia and James feel that if the school staff were more "sympathetic" he would have more success.

Teacie experienced similar frustrations with Patrick's first school. She did take him to the mental health center as requested, but refused to put him on medication. The ensuing struggle between her and the school principal over the medication led to her decision to move Patrick to another school. Again, Teacie had explained to the teacher early in the year that she felt Patrick would respond better to a different style of discipline than the teacher was using. She felt her input was discounted, and that the school staff was only interested in seeing Patrick medicated. This frustrated Teacie, "I have never in all my many little years seen a principal encourage a mother to put their child on something they disagree with...and I felt she wasn't in the best interest of my child, so I blew up and withdrew him."

Anna and Joy also experienced the round hole, square peg phenomenon. When Anna first met with the school staff she strongly felt they were trying to expel her son. She felt that, “if you don’t say the right things, you’re out the door.” Again, her suggestions about how the school could help her son were ignored. When Anna said she would take her son to counseling, she felt “they (the school staff) liked that idea.” They were happy for Anna to take action, but were not willing to make any changes themselves. Joy also feared her son would be expelled or sent to an alternative school. She had been trying to get help for Tyree for years for his “anger” problem and had repeatedly been told by educators and medical professionals that she should “spend more time with him, he’s just mad.” However, when his problems became more visible at school, he was quickly referred for mental health intervention.

### **Parents as Advocates**

The struggles the caregivers faced in finding help for their sons left them exhausted, but also helped them become more effective advocates for their children. The advocacy skills they have acquired were born out of necessity. Once the caregivers recognized that the schools were not going to “bend”, they began looking for other sources of support. Anna decided to take George for counseling before the school counselor mentioned it, although Anna says, “I think they were going to talk to me about it anyway”. The counseling George received was “really helpful” in helping him “get himself back on track”. Anna also recruited friends from church and the community center to help support George in his behavior changes.

Felicia and James learned from Jaquan’s mental health counselor that he might be able to get accommodations on the FCAT through a 504 plan. They contacted the school and requested a 504 meeting. They said they have learned now that “We don’t have all of the information...of what’s available...and that bites everybody.” James added that he has learned “it’s all about

communication”, and that they now realize they have to “stay on top of the school to get anything done”.

Joy and Sherry had similar experiences with advocacy. Joy said, “Tell me where to go from here...I’m ready for him to get some counseling, anything, something.” She and Sherry both asked repeatedly for help until the counselor gave them the number for the mental health center. They both also later asked for academic help from the school, and both boys are now placed in special education. Joy characterized the entire process of getting mental health help for Tyree as “a big run around” and often felt “angry and embarrassed” about Tyree’s behavior, but she was able to persist and eventually got help.

Teacie had a more difficult time communicating her concerns to her son’s school, and realizes now that switching schools may not have been the best idea. She said, “I immediately went into defensive mode when I should have remained calm. I didn’t want to hear it because the truth was hurting” when the first school’s principal said “Think you might need some counseling?” However, she changed schools in an effort to help Patrick be successful and not become “one of those boys on the corner.” She continues to advocate for him at the new school even though she admits she is “tired...and frustrated.”

### **Composite Structural Description**

#### **Alienation of Caregivers**

A sense of “us versus them” ran through all of the stories in the study. Of all participants, only one was eventually able to forge supportive relationships within the school to assist her in her search for help for her son. All of the others were left with the feeling that, “If you don’t say the right things, you’re out the door.” Participants talked of feeling attacked, judged and snubbed by educators. These feelings were fueled by the school staff’s creation of untenable interventions, ignoring caregiver input and refusal to make needed modifications.

Therefore, when the school counselors made referrals to mental health, some of the caregivers were skeptical of its usefulness. Some only complied with the referral out of desperation to avoid having their sons expelled. “Anything to keep him in school” was a common reply. None of the caregivers initially saw the school as a place of refuge or help for their son’s problems. Only one came to see the school as a place of hope and help after interaction with the school staff (and in particular, the counselor).

Most of the participants viewed themselves as involved parents and were shocked by the lack of compassion they received from the school staff during the meetings about their son’s misbehavior. Several caregivers reported having been active volunteers at the school prior to the behavior problems developing and were dismayed by what was described as the attacking posture of the staff during meetings. This lack of respect for the caregiver’s input lead to further feelings of alienation and divisiveness. Some participants were able to “prove we were concerned” after several meetings, and after complying with staff suggestions. However, they still felt that the school staff saw their sons as “bad and out of control” and felt the school staff “just want him out...don’t want to work with him”. All but one of the caregivers retained feelings of being disrespected and isolated throughout the process. They reported feeling frustrated and exhausted by the end of the interviews. This deep sense of isolation and disenfranchisement did nothing to help caregivers, boys, or schools. In fact, one speculation that could be made here is that the caregivers’ sense of isolation from school staff during their child’s elementary school years may be a factor contributing to low parent involvement at the secondary education level.

### **Fear and Guilt**

One of the most prominent emotional states in the caregiver’s accounts of the referral process was fear. The caregivers expressed fear that their sons would be suspended or expelled

from school, that he would end up in prison, and that their decisions now would hurt their sons later in life. Perhaps because the boys in this study are from low-income African-American families, and their chances of being incarcerated are higher than their chances of going to college, their caregivers are more vigilant about keeping them on the “straight and narrow” than they might have been if the boys were of another social class or race and had experienced similar problems at school.

All of the participants reported that the school staff had mentioned the possibility of the boys being transferred to an alternative school, which all of them saw as a negative place. Caregivers were worried that if their sons were reassigned to an alternative school, the negative peer pressure from the other students would make their behavior problems worse. They expressed a desire for the regular education setting to be adapted to meet the needs of their children, not to have their children sent away for specialized services.

This sense of fear drove them to feel even more distressed and isolated. Many participants shared strong concerns that their sons would follow in their fathers’ footsteps and go to “prison instead of college” They also expressed concerns about the long term effects of medication, particularly the possibility of addiction.

One of the greatest fears expressed by participants was that they would never find the answers they sought about their sons’ problems: “No one can tell me what’s wrong with him, and that part really scares me.” In searching for answers, participants also feared they might be blamed for the boys’ condition: “I just don’t want somebody to say, ‘It’s all your fault’ because then I have to deal with the guilt and I already feel guilty enough, like if I had done this or if he hadn’t been in that situation, but I mean, he needs help.”

Although each of the participants had unique fears, the common thread of being afraid was clear throughout the group. They all feared negative outcomes for the boys, and were all aware that these fears were not far-fetched, since many of the caregivers mentioned male relatives who had suffered similar life outcomes. The caregivers feared that if they were not able to find adequate help for the boys early in life, they would not succeed in school, and would be as one parent put it, “one of those boys on the corner with his pants hanging below his ass selling rocks.” These fears were realistic and palpable in the group. Their initial experiences with the school system had not done much to allay their fears or give hope for alternative outcomes without a lot of perseverance from the caregivers.

### **Powerlessness and Transformation**

The final common thread running through the participants’ experiences was their perceived lack of power. Caregivers felt themselves to be in a one-down position in relation to school staff and mental health professionals. Several caregivers talked about feeling pressured to follow the school’s recommendations about behavior management. Others were threatened with their son’s expulsion from Magnet programs if they did not stop their son’s negative behaviors. Two felt pressure to medicate their sons, even though neither of them saw the benefit of using medication. While one of them was able to deflect the pressure to medicate, the other gave in, saying, “He’s a doctor, I’m only a Mom.” She later stopped the medication due to her concerns about complications.

Participants also talked about their lack of information about available services at school. They saw their lack of “knowledge about what’s there” as a stumbling block for their sons and in their negotiations with the school staff. Another caregiver talked about the school counselor explaining to her that her son was identified with a disability and had an IEP. Apparently, he had been placed two years previously, but she was not aware of the disability or the accommodations

in the IEP. She did not know the name of the disability he had, nor did she know what services for which he was eligible. One caregiver also talked about “testing for something” that had been conducted at school, but was unclear about the outcome. Only two of the caregivers were able to say what their sons were diagnosed with (both were diagnosed with ADHD) and seemed to understand the diagnosis. The lack of knowledge about the inner workings of the school and mental health care systems added to the sense of powerlessness and inequality for the caregivers.

The Byzantine labyrinth of forms and procedures was also disempowering to caregivers. Joy called the help seeking process, “a big run around”. One caregiver admitted feeling “like giving up” after trying for two years to find help for her son. The others all reported feeling “frustrated” about school rules and procedures. This lack of knowledge seemed to fuel the caregivers’ view of themselves as outsiders in the school system: outsiders who were not necessarily welcomed, but who were expected to play by the rules and “fix” their sons’ behavior.

However, in spite of the exhaustion and oppression they felt, none of the caregivers gave up on their sons. They persisted and found ways to either convince the educators involved to hear them, or they found ways around the system. Moving the child to a new school for a fresh start was one example of going around a school’s rigid power structure. These caregivers were passionate about advocating for appropriate care education for their sons. The rigid, blaming, and often isolating school power structures did not deter them from seeking what they felt the boys needed in order to surmount the odds against them.

### **Textural – Structural Synthesis**

The most consistent, pervasive thread within the data was the lack of collaborative communication in the schools, which resulted in caregivers feeling excluded from and unwelcome in encounters with educators. Caregivers felt alienated from the decision-making process when working with educators in schools that employed the remediation paradigm of

communication (Amatea, 2007). Caregivers felt that the school staff members were not listening to them when deciding on interventions for problem behaviors.

Low-income African-American caregivers felt disconnected from the school community during the time when their sons were experiencing behavioral difficulties. Caregivers expressed feelings of frustration with and alienation from the people in the school who had the power to determine their son's educational future.

Caregivers felt that they were not viewed as equal partners in their sons' education. Caregivers talked about not understanding what services were available at school for their sons, or what services might be appropriate. Caregivers were desperate to do anything necessary to keep their sons at their current schools but did not feel empowered to demand that the school staff make any changes. Instead, the caregivers felt pressured to fix their sons. Some participants felt added pressure to find help for their sons in order to break a cycle of negative outcomes for men in their families.

However, the caregivers were persistent in their support of their sons and in their quest to find help for them. Caregivers were able to transform their negative feelings about staff members and school policies into a catalyst for learning to advocate for their sons.

### **Essence Statement**

The essence of the phenomenon of being referred for mental health care for their sons by the school counselor was the caregivers' experiences of alienation and powerlessness in the face of a rigid, hierarchical system for parent involvement in educational decision making. Caregivers felt that school staff members were not interested in listening to their opinions or relevant past experiences. Caregivers felt that they had no power or voice in decisions concerning their sons' futures, and that the school staff members expected them to quietly acquiesce to all

recommended interventions. The caregivers wanted to advocate for their children by opposing interventions they perceived to be either impractical or inappropriate, but feared negative repercussions for disagreeing with or questioning educators. Caregivers clearly felt disempowered and unwelcome during meetings with school staff members.

## CHAPTER 5 DISCUSSION

### **Introduction**

This study was undertaken to answer one primary research question: What are the lived experiences of low-income African-American caregivers referred for mental health services for their sons? The question was subdivided into two parts: a) What are the initial reactions (thoughts, feelings, and actions) of the caregivers to the school counselor's referral of their child to mental health services, and, b) How do the caregivers perceive the school staff making the referral during and after the referral meetings? Chapter Five addresses the findings of the study in relation to the original questions, links the findings to current literature, and outlines potential future research related to this topic. Limitations of the study design and application are also examined.

### **Overview of Findings**

The experience of having a son referred for mental health treatment by the school counselor was generally a negative one for the study participants. The actual referral itself was difficult for the caregivers to separate from the surrounding events; such as being contacted by the administrators and /or teachers about discipline problems, and having to go to school for meetings with various school staff members. The phenomenon in its totality was difficult for the caregivers. However, in this particular group of people, the hardships they encountered caused them to find inner and community resources they had not previously tapped. The transformative power of the experience in creating advocacy skills in the caregivers is a credit to their resiliency and strength.

### **Alienation of Parents**

The caregivers in the study, many of whom were long time school volunteers, were severely disappointed by how they were treated by school staff during meetings regarding their sons' behavioral problems. They described feeling attacked, blamed, and isolated. School staff members were apparently frustrated with the actions of the boys and took out their frustrations

on the caregivers. Instead of asking the caregivers to join with school staff to find mutually agreeable solutions, educators instead assigned total responsibility for finding help for the boys' problems on the caregivers. This way of handling parent relations resulted in feelings of anger and alienation for the caregivers and did nothing to aid the boys.

More often than not, the caregivers would go along with the requests of school officials to avoid possible negative consequences (suspensions, expulsion, and alternative school) not because the caregiver was engaged with the intervention. Erford (2003) calls this passive behavior in parents the "don't make waves" role. Erford contends that parents often agree with school staff members in order to avoid negative outcomes that might derive from their active resistance to interventions. The perception by parents that they should remain quiet and do as they are told by school officials comes from a power imbalance. In contrast, when school staff members work with parents collaboratively, power is shared equitably between both parties. Collaboration results in the creation of interventions palatable to both parties, and eliminates feelings of alienation of caregivers

### **Feelings of Fear and Guilt**

To varying degrees, all of the caregivers expressed feelings of fear and guilt. Many also experienced feeling that they were blamed for their sons' problems by school staff members. These fears were initially related to not understanding why their sons were acting out at school (and sometimes at home as well) and fears that their son's problems would get worse. During the process of negotiating possible consequences of their sons' behaviors with the school staff members, a second set of fears emerged; the fear of their sons being expelled, sent to an alternative school, or suffering other negative consequences.

The blaming stance of most of the educators seemed to cause these later fears. As African-American parents of boys, all of the study participants were aware of the potential for their sons to face negative outcomes in school and in later life. The perceived intolerant, unfriendly stance of the school staff brought these worries to the fore and caused the caregivers to become seriously concerned about their sons being lost to prison, drugs, and school drop out as the long term consequence of early negative school experiences.

### **Powerlessness and Transformation**

Low-income, minority caregivers negotiating with the formal power structure of a public school often perceive themselves as powerless (Brantlinger, 1993; Friere, 1970/2003; Kozol, 1991; Majors, 2001; Winters, 1993). This appeared to be true of the caregivers who participated in this study. Caregivers reported that they felt desperate to comply with the wishes of the school staff, no matter how inappropriate they thought those interventions were. Participants saw the school as the gatekeeper to better life opportunities for their sons, and did not want to endanger their futures by resisting the school staff's demands.

In spite of their fears, feelings of alienation, and sense of powerlessness, all six caregivers managed to find ways to make their voices heard with the school staff members. Their transformations from powerless spectators to advocates took many paths. Some parents took matters in their own hands, pre-empting the school staff in recommending treatment for their sons. Others found allies in the community or within the school to bolster their leverage. Yet others chose to move their children to other schools. All of these acts required bravery and persistence. What is compelling about these caregivers' transformations into advocates is that the educators involved seemed not to appreciate their efforts to intervene on behalf of their children. Some educators apparently would have preferred the parents to have remained passive and

compliant, while others seemed to ignore the caregivers' change. None were reported to congratulate the caregivers on their persistence, bravery, or caring.

Paulo Freire (1970/2003), although he was referencing impoverished Brazilian farmers in this quote, sums up the experience well; "Education either functions as an instrument which is used to facilitate integration... into the logic of the present system and bring about conformity or it becomes the practice of freedom, the means by which men and women deal critically and creatively with reality and discover how to participate in the transformation of their world." (p. 35). Certainly, the caregivers in this study learned to "deal critically and creatively" with their sons' problems and the education system. Each of them were all able to point out shortcomings in the educational system, yet were also able to navigate within or around it in order to meet the needs of their children.

### **Links to Current Literature**

The findings in the study have strong links to current professional literature in three major areas; family-school communication, minority disenfranchisement in mental health care, and the experiences of African- American males in public schools. This section will highlight relationships between this study and previous research. Links between the findings of the current study and various theories of education, culture, and social class will also be examined.

#### **Family-School Communication**

The professional literature regarding effective communication between families and schools is very consistent in its emphasis on the importance of open, non-judgmental, two-way communication (Amatea, 2007; Apter, 1992; Christenson & Sheridan, 2001; Finders & Lewis, 1994; Lareau, 2000; Martin & Hagan-Burke, 2002; McCaleb, 1994; Shockley, Michalove & Allen, 1995). This follows a large and growing body of research which indicates that parent

participation in education is a key to student academic achievement (Amatea, 2007; Christenson & Sheridan, 2001; Swap, 1995).

Although the professional literature clearly show a strong link between student achievement and family involvement in schooling, many schools in the United States remain biased against low-income and minority families (Dodson, 1998; Kozol, 1991; Lott, 2001). In their qualitative study of low-income Hispanic parents who were not visibly active in their children's schooling, Finders and Lewis (1994) found that parents generally wanted to be present at school, but were not sure how to go about getting involved. This lack of cultural insight may make reaching low-income and minority parents more difficult for educators. In an extensive review of the literature, Lott (2001) concluded that there is a lack of research about how educators and low-income parents communicate, but the available research indicates that, "low-income and working-class parents, as compared with middle-class parents, receive less warm welcomes in their children's schools; their interventions and suggestions are less respected and attended to; and they are less able to influence the education of their children" (p. 249).

Adults who are members of marginalized groups often have negative histories with schooling and are often suspicious of educators' motives. Overcoming their negative past experiences requires a conscious effort on the part of the school faculty to invite caregivers to be involved in explicit and consistent ways (Blair, 2001; Finders & Lewis, 1994; Lott, 2001; Winters, 1993). Brantlinger (1994) found that middle school students perceive their teachers biases about social class: students from upper-income families were almost twice as likely to think their teachers liked them as were their low-income peers. In a related study by the same author, low-income parents were found to be deeply interested in their children's education, but reported feeling "powerless" to impact educators (Brantlinger, 1993, p. 143).

The current study clearly showed a disconnect between low-income African-American caregivers and middle class educators parallel to the findings in previous research. Interestingly, this was true in cases where the school counselor was African-American just as often as when the school counselor was White. In both instances, the race of the school counselor seemed not to be as important as his or her methods of connecting to parents. The school counselor who helped Joy connect to community services was White. That school counselor was effective in her communications with Joy largely because she took the time to listen to Joy's point of view regarding her son's behaviors and did not immediately construct school-centric interventions for him.

The grave importance of treating low-income and minority caregivers with respect and giving credence to their points of view is emphasized over and over in the professional literature from the fields of education, counseling, and psychiatry (Amatea, 2007; Bemak & Chung, 2005; Boyd-Franklin, 1989; Brantlinger, 1993; Brunious, 2002; Christenson & Sheridan, 2001; Dogra, 2005; Lott, 2001; Noguera, 2007; Smith, 2004). In order to effectively reach low-income and minority caregivers, educators are encouraged to take the following steps:

- Acknowledge and build on wisdom already present in the family.
- Treat the caregivers as equals, not subordinates.
- Avoid blaming the caregiver for the students' difficulties.
- Establish consistent, two-way communication that is not problem-based (Amatea, 2007).

Creating a social climate in the school where effective family-school communication with low-income and minority families is possible requires a shift in the paradigm guiding the schools' leadership, including the school counselor (Amatea, 2007; Christenson & Sheridan, 2001; Lott, 2001; Senge, Cambron-McCabe, Lucas, Smith, Dutton & Kleiner, 2000). All of the schools in this study appeared to operate under a paradigm called "remediation" by Amatea

(2007, p. 8). In the remediation paradigm, educators acknowledge the importance of parental involvement in their children's education, but place strict limits on the level of engagement they foster with parents. Parents are seen as non-experts whose primary role in schooling is to help the teacher support his or her curriculum and provide for the child's basic needs. Communication within the remediation model is primarily problem-centered: Caregivers are called only when there is a problem. Once caregivers are contacted about a problem by the school staff, caregivers are then expected to fix the problem right away in the way prescribed by the school staff. There is little give-and take in the remediation paradigm, it is school-centric and hierarchical.

The paradigm prescribed in the literature as being more effective in partnering with families, particularly low-income and minority families, is called "collaborative" by Amatea (2007, p. 11). School faculties using a collaborative approach to engaging caregivers establish consistent, two-way communication prior to problems developing so that if and when they do develop, the teacher and caregivers have already established trust. Collaborative communications also require that the educators view caregivers as experts on their own children. Had the educators in this study been operating under a collaborative model, intervention would have been far less adversarial and caregiver input would have been more highly valued. A collaborative frame would have also helped ease the caregivers' concerns about being blamed for their son's problems and would have replaced alienation with a sense of team work and community.

### **Minorities and Mental Health Care**

The experiences of the participants in this study closely resembled those of the low-income Latina mothers interviewed by Arcia, Fernandez, Marisela, Castillo, & Ruiz (2004). The path from recognition of a problem needing treatment to the actual door of the mental health clinic was often very long and indirect. Two of the participants in this study seemed better able to marshal resources than did the Latina mothers Arcia interviewed, but others struggled to find and

access services. Joy's story of help seeking was extremely similar to those of the Latina mothers. One possible explanation for the difference is that older, more experienced participants fared better than younger, less experienced caregivers, so that maturity and life experience may make finding appropriate care easier.

Caregivers in this study struggled with concerns about the consequences both of not finding mental health care for their sons as well as concerns about the effects of going for treatment. Several participants also expressed concerns about lack of treatment resulting in a downward spiral for the boys, ending in prison and/or substance abuse. Other worried that their sons would be teased by their peers for going to counseling or for taking medication. These concerns are echoed in the professional literature (Black & Krishnakumar, 1998; Brunious, 2001; Winters, 1993).

The professional literature reflects the multiple barriers facing low-income families seeking mental health care for their children, many of which were reported by caregivers in this study. According to the Children's Defense Fund (retrieved 09/01/2007) major barriers to mental health care for low-income families include:

- Lack of agreement among health care providers about when and how to screen children
- Lack of coordination between multiple service providers and funding sources,
- Lack of accessible resources.
- Too few qualified service providers and inadequate reimbursement for services.

Additionally, low-income families face increased stress levels, often have fewer coping strategies and social supports, and may have difficulty getting to service centers even when they exist (Black & Krishnakumar, 1998; Colpe, 2006; French & Reardon, 2003). Joy mentioned encountering the first three items in the list of barriers in seeking care for her son. All of the

caregivers in the study mentioned increased stress levels when trying to find appropriate care for their sons.

A final, but often compelling, barrier to services for low-income families is the fear of losing custody of their children (GAO, 2003). Families with children who have severe mental illness sometimes relinquish custody to the state because they can not afford the high costs of inpatient or group home treatment. One estimate suggests that parents of up to 20% of children with severe and persistent mental illness had to relinquish custody to child welfare agencies in order to have their children qualify for needed services (Children's Defense Fund, 2005). None of the caregivers in this study faced the possibility of losing custody of their sons in order to qualify them to receive services. However, if any of the boys were to develop severe and persistent mental illness, the families interviewed here could very quickly run through all available financial resources, and be forced to choose between retaining custody and obtaining treatment for their sons.

### **African-American Males and Schools**

The African-American boys discussed in this study faced many of the barriers to academic success commonly written about in the professional literature. Two of the five boys were in special education programs due to developmental delays, while all five had suffered negative academic consequences as a result of behavioral problems. All of the boys had been repeatedly suspended from school, often for what their caregivers saw as minor infractions of school rules, which parallels national trends in the over-representation of African-American male students among the total numbers of suspended and expelled students (National Center for Educational Statistics, 2001).

The caregivers' concerns for the futures of their sons are supported by educational research. African-American males comprise a majority of the United States prison population

(U.S. Department of Justice, 2006). The majority (52%) of all African-American males who leave school without a high school diploma have prison records before their thirtieth birthdays (Day-Vines & Day-Hairston, 2005). The caregivers' hopes for their sons to attend college are common among parents of all races in the United States, but the chances for African-American males to enter a four-year college are far less likely than for any other race or gender combination (Noguera, 2003).

The caregivers' perspectives on the ways in which the school staffs chose to intervene with them and their sons also echoes the professional literature. Caregivers felt that their son's teachers did not have enough patience, compassion, or training to appropriately help their sons. This may have resulted from interacting with less well prepared teachers. Day-Vines and Day-Hairston (2005) document the trend of staffing schools in high poverty areas with teachers who are not as well prepared to work with high needs students than their peers in more affluent schools.

Another common conjecture as to why African-American males do not perform well in school seemed to be only partially true in this study sample. The caregivers in this sample were stressed by the demands of raising multiple children (and sometimes grandchildren, nieces, or nephews), working long hours at one or more jobs, and stretching slim financial resources to cover expenses. Some researchers have postulated that these multiple demands, combined with single and/or teenage parenting, can lead to a deficit in family support for academic achievement (White, 1982). However, in this study, the parents were all engaged extensively with the schools their sons attended and reported making time regularly to check homework. The caregivers also talked about having high levels of stress, and the difficulties they faced in finding help and support. In spite of those difficulties, in this group of caregivers, their own perceptions of their

organizational skills, high expectations for achievement, and positive attitudes were very strong and gave them some hope for good academic outcomes for their sons, in spite of problems the sons had experienced in the past. This hope for positive outcomes mirrors findings of other researchers (Clark, 1983; McCaleb, 1994; Swap, 1995) who reported that family functioning appears to be more important than family structure or circumstance in determining the level of engagement of caregivers in children's schooling.

### **Implications for School Counseling Practice and Education**

The findings in this study affirm results of other research that highlights the high frequency of miscommunication between caregivers from low-income African-American families and school personnel, including the school counselor. The roots of this disconnection seem to be cultural; most public schools in the United States appear to operate from a cultural world view based on middle-class White values. The cultural dissonance between the schools and low-income African-American families may cause families and students to feel disrespected and unwelcome in the social system of the school (Applebaum, 2002; Day-Vines & Day-Hairston, 2005; Monroe, 2005; Noguera, 2003; West-Olatunji, Baker, & Brooks, 2007; Winters, 1993). While this disconnection is most likely unintentional, bridging the distance between the White middle-class world of the school and the African-American low-income world of some families and students needs to be examined in an intentional, direct manner in order to improve communication.

The cultural disconnection between low-income African-Americans and the nation's public schools not only skews family-school communications, but also limits academic achievement and students' career options (Carter, 2003; Lee, 2005; Noguera, 2003). School counselors are key figures in the current struggle to close the achievement gap between African-American and White students (Bemak & Chung, 2005). Part of the task of raising African-

American student achievement overall is to better connect with caregivers, which this study clearly highlights as being problematic, at least in these particular cases. As Bemak and Chung (2005, p.197) make clear, the school counselor's role now entails a duty to, "pay close attention to social, political, and economic realities of families, with an aim to simultaneously address these as critical elements within the school counselor's role. For school counselors to ignore the impact of inherent power structures that contribute to the achievement gap is to participate in the insidious cycle of low performance and failure for poor students and students of color". One critical step towards closing the achievement gap for low-income African-American students is to create better working alliances with their families; a need which this research clearly shows was not being adequately addressed.

### **Collaborative Relationships with African-American and Low-Income Families**

Effective communication between families and schools is not a one-size fits all structure. Schools must consider the racial, ethnic, economic, and cultural backgrounds of the families they serve in order to create appropriate programs of communication (Applebaum, 2002; Comer, 1989). To effectively reach low-income African-American families, school counselors should draw from existing literature to better inform their practices of engaging these families.

School counselors can begin to shift the family-school communications paradigm in the schools they serve from one of remediation to one of collaboration by instituting the following changes:

- Acknowledge and build on the wisdom already present in the family.
- Treat the caregivers as equals, not subordinates.
- Avoid blaming the caregiver for the students' difficulties.
- Establish consistent, two-way communication that is not problem-based (Amatea, 2007).

By engaging families in a collaborative, mutual sharing model of communication instead of a more traditional one-way, educator-as-expert mode, school counselors can begin to overcome some of the negative expectations about school staff held by some low-income and minority parents.

Caregivers in this study lamented the lack of input they felt they had in decisions regarding their sons' education. They also talked about feeling that school staff members did not listen to their concerns, and were very distressed by the lack of power they felt they had in meetings to influence the decision making of school staff. Implementing a system of collaborative communication with all parents would help to assuage these feelings. Collaborative communication would help equalize power between low-income minority parents and the middle-class education professionals who serve them. Recalling Liu's (2001) intrapsychic model of classism, school counselors need to be aware of possible internalized classism when working with low-income and/or minority parents. Low-income and/or minority people may have difficulty 'reading' social cues common in middle-class environments, such as schools. Care should be taken to fully explain all school-related issues and avoid professional jargon so that caregivers have a clear understanding of all possible interventions and alternatives.

Sharing power and giving caregivers more voice at school would also help reduce what Erford (2003, p. 197) calls the "don't make waves" role parents sometimes play when they feel they do not have equal power in school decisions. This role, wherein caregivers will agree to anything suggested by school staff for fear of negative consequences, was prominent in participants' responses in this study. Caregivers' fears of potential suspension, expulsion, or transfer to alternative schools led them to agree to interventions they did not feel were

appropriate for their sons. If the schools had been operating from a collaborative model, caregivers might have felt empowered to voice their concerns about these interventions.

Creating collaborative communication with low-income and African-American families is not a one-time exercise (Comer, 1989; Winters 1993). School counselors need to spend time intentionally creating and fostering relationships over a long period of time in order to make a real impact on the alienation and disenfranchisement felt by many parents in that population. In addition to the suggestions from Amatea (2007) about building collaborative communications with parents, Lott (2001, p. 255) suggests the following steps to reach low-income families:

- School personnel must take the initiative in creating relationships with parents. Educators should not expect parents to come to them, but should intentionally find ways to reach out to families.
- Find ways to involve low-income parents other than as “consent-giver”. Invite parents to participate as collaborators, innovators, and critics.
- Encourage informal communication with families.
- Coordinate services with community agencies so that schools can be seen as community centers, or hubs of information and services.
- Provide training for all school personnel on reaching and collaborating with diverse families.

As educational leaders, school counselors should be at the forefront of implementing such changes in how schools interact with low-income and minority families. School counselors have specialized training in interpersonal communication and in systems change issues, therefore making them the ideal agents of change in family-school communications (Erford, 2003).

### **Making Culturally Responsive Referrals**

School counselors making referrals for low-income African-American families, particularly to mental health services need to be aware of cultural stigmas and fears, as well as practical concerns, facing these parents. Caregivers in this study were generally not opposed to

the idea of getting some kind of mental health services for their sons, although some of them had serious concerns about the safety of medications. In fact, some of the caregivers were desperate for answers about their sons' behavioral problems. However, some parents did have memories of negative personal experiences with being teased for attending counseling when they were children which were not addressed by the school counselor during the referral process. Others had concerns about paying for services, finding time to go to appointments, and other practical concerns. To increase the likelihood that the referral is appropriate for the caregivers' view of the problem, school counselors should explore existing concerns with caregivers prior to making referrals in order

The most consistent complaint about the referral process from caregivers in this study was the manner in which the referral was made. In the majority of cases, the caregivers felt either that they were forced to get services in order to avoid punishment (suspensions, expulsion, or transfer to alternative schools) or were expected to go along with suggestions in order to "not make waves" (Erford, 2003). Even the caregivers who wanted help for their sons were put off by the way the school counselor approached the issue of mental health services. Only one caregiver reported a positive experience with the process. Much of the negativity of these interactions was predicated on the poor quality of existing relationships between school staff and parents. Carefully creating warm, egalitarian relationships with caregivers prior to the development of a problem can go a long way to preventing negative outcomes. School counselors need to learn these skills in their graduate programs. Specific training regarding structural constraints of poverty and racial discrimination has been shown to increase counselor trainees' sensitivity to race and class based oppression (Toporek & Pope-Davis, 2005) and should be included in master's level multicultural counseling coursework. Ideally, the thread of multicultural training,

including issues of social class, should be integrated into counseling coursework rather than being isolated in one course (Patton & Day-Vines, 2004).

In addition to creating collaborative relationships with families, school counselors need to insure that caregivers understand precisely what the referral entails. Many times in this study, caregivers remarked that they did not fully understand what services were provided by various agencies, or which person was responsible for which intervention. This was especially true of caregivers whose sons had already been identified as having special needs. Caregivers were baffled by the array of terms and forms they had heard of and seen in meetings, and had no useful working knowledge of what any of it meant in terms of their sons' education. School counselors need to take the time to be sure caregivers understand what is being said in referral meetings, and need to be available for caregivers' answering questions that may come up after the meeting.

### **Recommendations for Parents**

In this study, low-income African-American caregivers revealed that they perceived themselves as alienated from mainstream public education in the United States. They also reported feeling that they had less power in decision making than the school staff members. The caregivers in this study recognized that an imbalance of power existed between themselves and the public school officials. When the caregivers talked about the school staff members, "not listening", "not caring", "stressing me out", and "being biased" they were acknowledging their own lack of power. Even though the caregivers thought of themselves as the less powerful group, they can nonetheless take action to equalize the imbalance of power. Paulo Freire (1970/2003) explains that power can be redistributed in unequal situations in two steps: "In the first step, the oppressed unveil the world of oppression and through praxis commit themselves to its transformation." (p. 54).

The next part of Freire's (1970/2003, p. 54) first step, "through praxis commit themselves to action" would follow. There are many ways the caregivers could make a commitment to action to resolve the imbalance of power they perceive in the schools. Some possibilities would include; developing formal or informal groups of concerned parents that could organize a reform effort, networking with other institutions in the African-American community such as churches and civil rights organizations to lobby the schools on their behalf, and taking individual action as needed.

Once the caregivers chose to take some action to correct the imbalance of power in the schools, the stage is set for the second step. According to Freire (1970/2003, p. 55) the second step of the pedagogy of the oppressed is, "the expulsion of the myths created and developed in the old order, which like specters haunt the new structure." In this stage, the transformation of the relationship between oppressor and oppressed has occurred, and now the two sides can engage in egalitarian dialogue to negotiate a new relationship.

This step can also be framed as a shift in the mental model of how schools work (Senge, Cambron-McCabe, Lucas, Smith, Dutton, & Kleiner, 2000). Shifting the mental model of how schools and parents interact entails "bringing tacit assumptions and attitudes to the surface so people can explore and talk about their differences with minimal defensiveness" (p. 67). Senge and his colleagues also talk about a two step process of transformation, which they call "reflection and inquiry" (Senge, Cambron-McCabe, Lucas, Smith, Dutton, & Kleiner, 2000, p. 68). The reflection process requires people to think about their thinking, to carefully consider how they have formed the opinions they hold about a situation, while inquiry requires a dialogue between various members of a community or organization to identify and bridge miscommunications and imbalances of power. This effort may be begun by school counselors or

other staff members or by the caregivers themselves. For example, school counselors could conduct workshops for parents on communication skills, child advocacy, and their rights under special education law. School counselors could also conduct small group or individual coaching sessions with caregivers about how to negotiate with school staff on behalf of their children.

Caregivers, as the oppressed group in this scenario, may have less formal power than do school staff members, but they are certainly not completely powerless. Many of them showed evidence of great personal power in the course of recounting their struggles to obtain appropriate care for their sons. If they were to apply this personal strength to the larger context of family-school relationships, the caregivers could initiate large scale changes in the mental models and practices of the schools in their communities.

### **Training for Administrators and Teachers**

Although school counselors may lead the change in family-school communication, they can not do it all (Bryan, 2005). School counselors are, of course, not present during every interaction between a caregiver and educator at any given school. However, they can work to insure that all educators at their school are trained to interact in a culturally responsive way with all caregivers. This may be accomplished by conducting regular in-service workshops for teachers and administrators on culturally congruent communication skills (Bryan, 2005) and by modeling good communication skills.

Training all school personnel, including administrators, to use collaborative communication methods with parents is especially important in working with disenfranchised caregivers. Low-income parents are more likely than middle class parents to have negative assumptions about school personnel (Lott, 2001) and are more likely to stay away from the school if they perceive the atmosphere to be unwelcoming (Winters, 1993). School counselors can help other school staff members to understand the conflicting mental models of caregivers

versus school personnel. By framing the imbalance of power as a culturally driven disconnection in mental models, school counselors can lay the groundwork for less blaming and divisive discussions of these issues.

In this study, caregivers were unable to differentiate between various roles of school staff members. They understood the role of the classroom teacher, but many of them did not understand the role of the school counselor versus that of assistant principal or principal. To these caregivers, the school personnel were a homogenous seeming group, not distinct individuals. This perception underscores the importance of all school personnel being trained to work in a collaborative manner with diverse families.

### **Limitations of the Study**

Qualitative research of this variety is limited in its generalizability, which is not the goal, but which may be desired by some readers. This study aimed to describe the lived experiences of a certain group of people within a specific time, place, and context. Descriptions are rich and thick, full of possible essences and meanings. However, what was essential about an experience in 2006 in the southern United States may or may not be essential about the same experience in a different place and time, or for a different group of people (Wolcott, 1990).

My race (white) may or may not have limited disclosure by participants. Special care was taken to develop rapport with participants, however, due to a long history of oppression and mistreatment of African-Americans by Whites, participants may have remained reluctant to fully disclose thoughts and feelings. There is also a possibility I did not understand subtle language and posture clues due to difference in culture.

According to Gibson and Abrams (2003), White qualitative researchers interviewing African-American people are likely to have difficulty getting access to participants and building trust. However, Gibson and Abrams (2003) also found that African-American participants take

extra effort to help White researchers understand what they intend to communicate, while when African-American researchers interview them, the African-American respondents may assume the researcher already understands their experiences. Thus, gaining access is a greater chore for White researchers, while participants may be more careful to fully explain their thoughts and feelings. This finding seemed to be valid with this study. However, access was made easier due to the pre-existing relationships between school personnel and participants. The phenomenon of African-Americans assuming researchers of their own race may understand more than White researchers is certainly worthy of further thought and study.

Bracketing all preconceived ideas about the referral of young African-American males to mental health services by school counselors was difficult for me, since I have worked as both a school counselor and a mental health service provider. However, all attempts were made to leave prior knowledge out of the interview and analysis process in order to allow for the participants' experiences to drive the formation of the essence statement.

Two participants, Sherry and Felicia, were not available for final interviews. However, they provided substantial information in earlier interviews. Ideally, all participants would have been interviewed three times, but due to the heavy work and parenting responsibilities of these participants, three interviews were not always a possibility.

### **Recommendations for Further Research**

Further studies examining low-income African-American caregivers' perspectives on both schooling and on mental health care are needed. Social class in particular, is not a well understood construct as it relates to counseling theory and practice. The education and mental health professions would benefit from both more theoretical writing and research into how social class functions as a variable in people's decision making. Research on social class as it relates to race and ethnicity is also needed. Combinations of low or middle class status among African-

American males and how membership in various social classes might impact their academic performance would be of help to educators and policy makers working to close the Achievement Gap between African-American and White students.

The ability of the caregivers in this study to transform the negative experiences into a lesson in advocacy was fascinating to witness. Whether this ability was borne out of their shared African-American culture or some other factor was not made clear. However, studying the ability of low-income African-Americans to overcome and transform trying experiences would be of great use to the helping professions.

## APPENDIX A POSSIBLE INTERVIEW QUESTIONS

Interview 1: History of the family and child leading up to the referral that shape the caregiver's perceptions and reactions, story of the referral.

As you know, I'm curious about what you thought about and how you felt when your son was referred to \_\_\_\_\_ for help. Today, I'd like to talk with you about how you felt when \_\_\_\_\_ was referred. I'd like to hear a little about your son, and his history at school so far. Then we can talk about the process of being referred for mental health help.

1. Now let's talk a little about your son, \_\_\_\_\_. Tell me a little about what kind of a child he is—what he likes to do, what he's good at, who he favors.
2. How has his school experience been so far? What does he like about school? What's been tough for him?
3. Describe what happened the day that the school counselor talked to you about your son getting help.
4. How did you feel? What thoughts went through your head?
5. How did you decide what to do about the referral? Did you talk to anyone? Who? What advice did they have?
6. If you could go back in time to the day of the referral, is there anything you'd like to change about how it was handled?
7. Between that day and now, what kinds of things have you thought about regarding the idea of going to \_\_\_\_\_?

Interview 2: Caregivers' current perceptions of the referral of the child to mental health services by the school counselor.

I will send the transcript from interview one to the participants in advance of interview two, and will check with them about the accuracy of the transcription before we continue.

Last time, you told me some of your family's past experiences. Today, I'd like to talk about what's going on now with the referral to \_\_\_\_\_.

1. Have you seen any changes in your son? Can you give me some examples?
2. How has school been for \_\_\_\_\_ since then?
3. How are you feeling about all that now?

4. Is there anything else you want to be sure I know? Do you have any questions for me?

Interview 3: Referral of the child to mental health services and future plans.

I will send the transcript from interview two to the participants in advance of interview three, and will check with them about the accuracy of the transcription before we continue.

Today, as a way of wrapping up our time together, I'd like to focus on your thoughts and feelings about how you're feeling about the referral in light of our previous talks, and find out what your plans are for the near future.

1. Let's review some of how you were thinking about the referral last time. Has anything changed in your mind since then?
2. How have things been going for you and your son since last time I saw you?
3. How (if at all) has this referral process affected your family or yourself?
4. Describe how you're feeling about your son's schooling today.
6. What are your hopes for your son for the rest of the school year?
7. How would you like the school to interact with you in the future?
8. Is there anything you'd like to be sure I know? Do you have any questions for me?

## APPENDIX B STEPS IN DATA ANALYSIS

Steps for performing transcendental phenomenological analysis of data (Moustakas, 1994):

- 1) Scouring data for meaning units. Meaning units are discrete, non-repetitive, non-overlapping statements.
- 2) Connected meaning units are grouped together into themes.
- 3) Each individual participant's data is reviewed for themes. A textual description is written which describes the individuals' 'objective' statements about the experience. Quotes are used liberally to support contentions.
- 4) Each participant's data is then reviewed for structural descriptions. These are the researcher's interpretation of the internal subjective experiences of the participant. During this step of analysis, the researcher considers 'imaginative variations' or possible explanations and theories about the internal processes at work.
- 5) Once all of the individual data sets are described, group portraits are constructed. Composite textual and composite structural descriptions are written, compiling the experiences of all group members, while still referring back to original sources.
- 6) A textual-structural synthesis is written, combining essential elements of the composite structural and textual descriptions.
- 7) Finally, an essence statement is derived from the synthesis. This is a brief statement of the essential nature of the phenomenon at study.

APPENDIX C  
CONSENT FORM AND IRB APPROVAL

**University of Florida  
Department of Counselor Education  
1212 Norman Hall  
Gainesville, FL 32611**

Dear Parent,

I am a doctoral student in the Department of Counselor Education at the University of Florida. I am conducting research on low income African-American parents' experiences of the being referred to mental health services by school personnel. I am hoping that what I learn will help school and mental health counselors better understand how African-American parents make decisions about their children's care.

Parents who choose to participate will be interviewed three times, for about an hour each time. I can do the interviews in any quiet place where we can talk, like your home, the school, or in an office at the University. I will tape record the interviews in order to transcribe them later. I will ask several questions about your experiences with being referred to mental health services. Whether or not you decide to go anywhere for services will not affect your ability to participate in the interviews. I am interested in how see the referral process, not what you decide. These interviews are not mental health therapy, although I am a licensed counselor, I will not be conducting therapy with you. I will only be learning from you about the referral process.

The information I gather will be used to help counselors better understand how African-American parents make decisions regarding their children's health care. The people I interview will not be identified by name nor will any information that could be used to identify them be shared. Your confidence will be protected as provided for under the law. I will use your answers when writing my dissertation, and in possibly in journal articles, but will not use your name or other identifying information.

Participation in the study is completely voluntary. It will not affect your child's grades, placement, or status with school staff in any way. There are no known risks or immediate benefits known to participants. There is compensation for participation. After the first interview, you will receive a \$10 gift card from a grocery store; for the second, \$10, and \$20 for the third. You may request group results of the study next March, if you wish. You may withdraw your consent at any time. If you have any questions about the research, you may contact me at 359-1258. Questions about your rights as a research participant may be directed to the UFIRB Office, Box 112250 Gainesville FL 32611, or call 392-0433.

Thank-you,  
Catherine Tucker

Approved by  
University of Florida  
Institutional Review Board 02  
Protocol # 2006-U-0864  
For Use Through 10/01/2007

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DATE: October 3, 2006

TO: Catherine Tucker, PhD  
3324 W. University Avenue #226  
Gainesville, FL 32607

FROM: Ira S. Fischler, Chair *ISF*  
University of Florida  
Institutional Review Board

SUBJECT: Approval of Protocol #2006-U-864

TITLE: Low Income African-American Families Experiences of Being Referred to Mental Health Services by School Counselors

SPONSOR: Chi Sigma Iota Excellence Grant

I am pleased to advise you that the University of Florida Institutional Review Board has recommended approval of this protocol. Based on its review, the UFIRB determined that this research presents no more than minimal risk to participants. Given your protocol, it is essential that you obtain signed documentation of informed consent from each participant. Enclosed is the dated, IRB-approved informed consent to be used when recruiting participants for the research.

It is essential that each of your participants sign a copy of your approved informed consent that bears the IRB approval stamp and expiration date.

If you wish to make any changes to this protocol, *including the need to increase the number of participants authorized*, you must disclose your plans before you implement them so that the Board can assess their impact on your protocol. In addition, you must report to the Board any unexpected complications that affect your participants.

If you have not completed this protocol by October 1, 2007, please telephone our office (392-0433), and we will discuss the renewal process with you. It is important that you keep your Department Chair informed about the status of this research protocol.

ISF:dl

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