

Helpseeking of Immigrant and Native Born Parents: A Qualitative Study from a Montreal Child Day Hospital

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Abstract

Objectives: This qualitative study of the perceptions of native-born Canadian and immigrant parents whose children attended a psychiatric day hospital for significant behavior impairment, focused on parental helpseeking pathways, explanatory models of mental health, and referral or access experiences. **Methods:** A sample of ten immigrant and ten native born parents were recruited for semi-structured interviews analyzed thematically to discern similarities and differences between the two groups. **Results:** The immigrant group more frequently reported barriers and delays in accessing mental health services. They often reported lack of primary care physicians and language barriers. They were less likely to have a biomedical perspective or to use specialized resources for their children prior to admission. Both groups reported apprehension about medication trials, though the immigrant parents were less likely to agree to psychopharmacological treatment. None of the professionals treating parents for mental health problems initiated referral of their impaired children. **Conclusions:** Based on the qualitative analysis of this sample, native born single parents and immigrant parents may feel especially vulnerable to lack of social support. Adjustments of primary care, schools and community resources, as well as promoting best practices of culturally competent child mental health care, may increase access and willingness to pursue treatment in both groups.

Key Words: *helpseeking, immigrant health, access, day hospital, cultural competence*

Résumé

Objectifs: Cette étude qualitative des perceptions de parents canadiens de naissance et immigrants dont les enfants fréquentaient un hôpital psychiatrique de jour pour une déficience significative portait sur les voies empruntées par les parents à la recherche d'aide, les modèles explicatifs de santé mentale, et les expériences d'aiguillage ou d'accès. **Méthodes:** Un échantillon de dix parents immigrants et de dix parents canadiens de naissance a été recruté pour des entrevues semi-structurées analysées thématiquement afin de discerner les similitudes et les différences entre les deux groupes. **Résultats:** Le groupe immigrant rapportait plus souvent des obstacles et des délais pour accéder aux services de santé mentale. Les immigrants déploraient souvent l'absence de médecins de soins de première ligne et les obstacles linguistiques. Ils étaient moins susceptibles d'avoir une perspective biomédicale ou de recourir à des ressources spécialisées pour leurs enfants avant l'admission à l'hôpital. Les deux groupes déclaraient une appréhension au sujet des essais de médicaments, mais les parents immigrants étaient moins enclins à accepter un traitement psychopharmacologique. Aucun des professionnels traitant les parents pour des problèmes de santé mentale n'a initié l'aiguillage de leurs enfants déficients. **Conclusions:** Selon l'analyse qualitative de cet échantillon de chefs de famille monoparentale canadiens de naissance et de parents immigrants, ils peuvent se sentir particulièrement vulnérables à l'absence de soutien social. Des adaptations des soins de première ligne, des écoles et des ressources communautaires, ainsi que la promotion des pratiques exemplaires de soins de santé mentale pédiatriques adaptés à la culture peuvent accroître l'accès et la volonté de suivre le traitement dans les deux groupes.

Mots clés: *recherche d'aide, santé des immigrants, accès, hôpital de jour, compétence culturelle*

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“When he came here, he changed all his life. New family, new home, new languages, new country, everything was new”

(immigrant parent of nine year-old boy)

Introduction

There are a paucity of studies that explore the perceptions of host culture versus immigrant parents who are seeking help for their children’s severe mental health problems (Tharp, 1991; Schwab-Stone, Ruchkin, Vermeiren, & Leckman, 2001; Messant & Murrell, 2003; Yeh, et al., 2005). The present qualitative study undertaken in a child day hospital setting in Montreal, focused on parental help-seeking to understand better the links between culture, immigration, explanatory models, barriers to care and parental support among immigrant and native born families. The objectives of this study were to: (1) describe pathways for helpseeking and support; (2) investigate the family’s framework for understanding their child’s mental health issues; and, (3) consider the referral process through their interactions with the child mental health service system including school, community resources and primary care.

Cultural influences, belief systems, developmental norms, stigma and explanatory models of mental health have been implicated as primary influences in research on helpseeking behaviors (Andersen, 1995; Janz & Becker, 1984; Kleinman, 1987; 1980; Bussing, Gary, Mills, & Garvan, 2003a; 2003b; Surgeon General, 2001, Weisz & Weiss, 1991). These reports indicate that underutilization of mental health services among immigrant groups and cultural minorities is poorly understood (Mental Health Commission of Canada, MHCC, 2009; Andrusis, 2005; Kirmayer et al., 2007; 2012; Janz & Becker, 1984; Andersen, 1995; Whaley, 2001). Studies in an ethnically diverse area of Montreal (Kirmayer et al., 2007; Whitley, Kirmayer, & Grouleau, 2006), to determine health care usage of adult immigrant minorities and their Canadian born neighbours, found that they accessed primary health care at similar rates but minorities and immigrants significantly underutilized mental health services, consistent with several American and British reports (Harris, Edlund, & Larson, 2005; Bhui et al., 2003). Immigrant families in these studies often articulated stigma issues and concerns that clinicians poorly understood or rejected their belief systems. A widening theoretical discourse (Ecklund & Johnson, 2007; Schwab-Stone et al., 2001; McGoldrick & Hardy, 2008; Timimi & Maitra, 2005) on underutilization of mental health resources by minorities, suggests a need for adjustments in health access policies and development of best practices for cultural competency. Positive alliance has been shown to be associated with improved outcomes for this child and family population in a previous study (Guzder, Bond, Rabiau, Zerkowitz, & Rohar, 2011). A large Toronto cohort of Asian immigrants and refugees (Fung & Wong, 2007), had shown that the most significant factor for helpseeking attitudes controlling for other variables, was

perceived access. Their Hong Kong Chinese subjects subscribing to Western stress models of mental illness having more positive attitudes to helpseeking than those subscribing to supernatural belief explanatory models. In a study of stigma and helpseeking for child behavior problems (Dempster, Wildman, & Keating, 2012), child behavior moderated the relationship between stigma and parental helpseeking without stigmatizing their children but rather fearing that their child would be stigmatized in the public space. There is a need to better understand the ways in which patients from diverse ethnic and cultural backgrounds conceptualize mental health problems and identify service needs, in order to reduce health disparities and promote health service utilization.

Methods

The study recruited ten immigrant and ten native born parents of twenty elementary school children (aged 7 to 12) admitted to the Jewish General Hospital Childhood Disorders Day Hospital in Montreal. Immigrant parents had received education in their countries of origin, while the native born parents had been educated in Canada. The majority of the children were diagnosed with complex co-morbid disorders, all had disruptive disorders with significant global functional impairment and some were on medications prior to admission. All children had intake Achenbach Child Behaviour Checklist (CBCL) measures completed by parents and schools to document their profile of externalizing and internalizing symptoms (Achenbach, 1992). The CBCL confirmed that all twenty children had at least one externalizing mental health disorder (attention deficit disorder with hyperactivity (ADHD), oppositional defiant disorder, conduct disorder), and the majority had multiple disorders (internalizing and externalizing disorders), in addition to family related stressors and learning disabilities or delays. All parents were recruited during treatment over a one-year period, and none declined to participate in the study. The study was approved by the hospital Research Ethics Committee, and written informed consent was obtained from study participants.

An in-depth, semi-structured interview with the mother of each child was conducted by a research assistant who was not affiliated with the treatment team (one non-immigrant interview was conducted with both parents). The interview guide was created by the research team with questions focused on parental understanding of their child’s mental health problems, helpseeking process, information seeking, coping mechanisms and experiences with services or support. Analysis of the interviews followed a grounded theory approach (Glaser & Strauss, 1967; Glaser, 1978).

Table 1. Demographic characteristics of interviewed immigrant and non-immigrant parents		
	Immigrant (n = 10)	Non-immigrant (n = 10)
Maternal average age in years	37.5 ± 7.4	38.8 ± 5.7
Child's average age in years	8.2 ± 1.2	8.6 ± 1.5
Maternal education		
High school	10%	30%
College/university	50%	60%
Trade school	40%	10%
Maternal marital status		
Single	40%	20%
Married/common law	40%	50%
Separated	10%	20%
Divorced	10%	10%
Number of children in the family		
One child	20%	50%
More than one child	80%	50%
Annual household income		
<20,000	50%	30%
20,000-40,000	40%	40%
40,000-80,000	10%	20%
>80,000	0%	10%
CBCL scores		
Mean internalizing score	69.7 ± 8.0	59.4 ± 13.5
Mean externalizing score	70.1 ± 4.9	69.4 ± 5.5
Mean total score	69.3 ± 6.63	66.9 ± 9.5

The interviews were coded using Atlas-ti data analysis software and analyzed for emergent themes related to the study objectives of identifying similarities and differences in perceptions of mental health problems and helpseeking experiences.

Results

Demographic data were collected from the medical charts, in order to contextualize some of the results by providing a description of the children and their families (see Table 1).

The immigrant and non-immigrant groups were similar in terms of maternal age, child age, maternal education and marital status, and income level. Half of the non-immigrant group versus only 20% of the immigrant group had a single child. The impairments reflected by CBCL on entry and Child Global Assessment Functioning (CGAS) on discharge scores indicate that the groups are clinically comparable. Country of origin for the immigrant group varied with five of Caribbean origin (Trinidad, Jamaica and Guyana), three participants from the Middle East (Egypt, Israel and Lebanon), one from Morocco and one from Bangladesh.

Three significant areas of difference emerged from the analysis of themes in parental narratives, indicating frequent reporting of experiences of barriers to care for immigrant parents with children eventually referred to day hospitals, including perceptions of impediments to access, stigma, barriers at school or social support levels, and divergences of explanatory models from their familial, cultural or professional networks.

1. Delays in access

For both immigrant and non-immigrant families, the first recognition of behavior or social skills problems and referral often occurred through feedback from school or daycare settings. Primary care physicians or community care clinics in this sample were reported as less likely to suggest child psychiatry referral to immigrants versus native born parents. (NIP refers to a non-immigrant parent, IP to an immigrant parent.)

Most in the non-immigrant group reported a relatively short waiting period between the parent's recognition of the problem and referral to specialized child psychiatry services. Among the non-immigrant group and rarely in

Table 2. Child global assessment functioning (CGAS) scores of immigrant and non-immigrant parents		
	Immigrant (n = 10)	Non-immigrant (n = 8)
Mean	63.50	63.13
Standard deviation	7.09	10.67
Minimum score	50	45
Maximum score	70	75

the immigrant group, parents would seek private services, or conduct independent research including internet, public seminars and recommended books. They also actively sought specialized services (such as a hospital-based ADHD clinic, social skills training groups, special camps), and they often reported enrollment of their children into sports activities to promote their children's socialization skills with their peers.

Mental health professionals working with both non-immigrant and immigrant parents or families (e.g. for treatment of anxiety, depression, bipolar disorder), made no direct referral or advised on their children's treatment needs. Some immigrant parents agreed to their own therapy as a result of the child day hospital admission.

IP: "It's funny that my son came here and spent a year here without the Ritalin, and I'm the mother, the one who was in therapy for a year, who needed therapy, was me."

IP: "My son's father is, is clinically violent, schizophrenia, and he's presently at the hospital, so I always thought it had some connection."

The non-immigrant group generally found the school system to be supportive. The immigrant group often had a difficult time communicating, doing homework with their child, and creating alliances with the school, especially at the stage of interacting with "classe d'accueil" or welcome classes providing child immigrants initial French language skills. Language barriers (child and maternal languages were neither English nor French), and lack of access to testing or specialized services were reported as particular difficulties. In contrast, many of the non-immigrant group had accessed consultation with school psychologists and individualized learning plans, though some found private psychologists such as school psychologists difficult to access, i.e. "not available" or had long wait lists. Both groups often resisted teachers' feedback, questioning the teachers' capacity to "diagnose" problems. Some parents in the non-immigrant group wanted the teachers to make earlier referrals for psychological testing. Both sets of parents expressed concerns that teachers were unable to attend to their child's needs with large class sizes.

Many immigrant parents with better English language skills had tried to transfer schools, applied for English school eligibility, or sought private schooling when the law permitted this option, to reduce their child's stress in dealing with language barriers. Language barriers were not mentioned among the non-immigrant group, who often had the choice of English or French schooling in Quebec.

IP: "The English and French, the language was very important for him to learn because he couldn't communicate. And with all his trouble not to communicate was a big, big punishment...I'm confessing...for the first year, I didn't have time or the opportunity or...to handle it, to think about it, to know what to do. I was myself still adjusting and learning."

2. Stigma and support

Among the non-immigrant group the support received from the family often entailed empathic listening or seeking advice from a family member. The immigrant group often referred to family as supportive or involved, even though these relatives remained in countries of origin. They often did not share information on mental health issues either for stigma reasons or fear of overburdening their families. It was not clear whether physical proximity or intra-familial issues were factors in support. While some non-immigrants overtly stated that they were not emotionally close to their family, this disclosure was not often made by immigrant parents.

Some non-immigrant parents also felt stigma and isolation, though mostly these were within intra-familial systems.

NIP: "Like everybody knew I had learning disabilities, like, dyslexic, just because of all the tests, and because of the way I read when I was younger...it's not that they don't care, it's just, my mom has no understanding about learning disabilities...and my dad, he just, you know, like, I think he just like shushes it..."

Spousal support was most commonly reported by mothers from intact nuclear families in the non-immigrant group. These couples were reluctant "to burden" extended family with their problems, and tended to work as a couple

supporting each other. The immigrant group rarely referred to spousal support, whether they were single mothers or living with a partner.

IP: (extended family in another country) "...well, my husband is very (busy)...he's not involved in raising M. like me..."

The immigrant group often reported that they sought and received outreach and instrumental support from new contacts, community or religious organizations. One single parent in the non-immigrant group approached her priest for advice. The immigrant group reported receiving instrumental support such as locating food banks, accessing housing or using public transport though not for mental health resources.

Some of the non-immigrant single parents conveyed social isolation and alienation with limited support from family or any social network including friends; this was not explicitly stated by the immigrant group. Immigrant parents may have had fewer expectations in the post-migration resettlement process. These parents emphasized connection to family or community support and need for financial resources or instrumental help such as daycare. Their child's behavioral problems were less of a family priority until the school was unable to manage their child.

3. Parental explanatory models of child mental health care and acceptance of psychopharmacologic therapies

Parents in the non-immigrant group tended to align with a biomedical perspective, suggesting that constitutional, genetic or biological factors or "chemical imbalances" influence children's behavior. Immigrant parents did not tend to accept a biomedical model. Despite exposure to biopsychosocial frameworks to which a few agreed, many parents in the immigrant group continued to describe their child's illness in non-biomedical terms such as possession states, curses or evil eye. Immigrant parents often stated that their family and communities did not accept the concept of child mental disorders nor treatment in psychiatric programs. Many non-immigrant parents felt diet might be a reason for the child's disorder.

IP: (who believed her child was possessed by a demonic spirit)...: "Yeah, oh my, if he would just listen...But for whatever reason it's like somebody in there do not listen...It's like somebody in his head going, don't, don't, don't...and he's sticking to that, no, no, no, and it gets more angry."

IP: "she (the teacher) said he needed the Ritalin to calm down,...that's not...my concern... 'cause you see where I come from, the Caribbean, I never heard that word ADHD, really. Well, and also I heard a lot of beatings, so maybe that was Ritalin

for the kids that were 'ADHD'...When they're hard-headed kids."

For the majority of both parent groups, medication recommendations created anxiety about negative side effects on their child's development. Despite reporting a positive response to medication with no side effects, many parents expressed reservations about long-term effects. Most of the non-immigrant group reported undesirable or negative information from the press, community or internet associated with Ritalin but were less resistant to long-acting medications with similar pharmacology. In both groups, parents informed by testing and psychoeducation reported that positive alliance in treatment had shifted their resistance to medication trials; this included parents who had used Ritalin as children.

NIP: "...I said drugs would be my last priority, I, you know, if there's nothing else I'll open him on the drugs but right now I'd like to see what's causing it and all that."

IP: "Because...they said medication, they become dependent, um, its not good it mess up their, their thinking, you know the Ritalin...it was on TV, they showed Ritalin did have some things negative effects on some kids...I was afraid, I give him medication, he's going to become stupid...he's going to become retarded then, he's not going to be able to function...his whole head is going to be messed up and all that...(later) I said I'm going to try and see 'cause maybe it could really help."

Discussion

This small, qualitative study found similarities and differences among immigrant and non-immigrant parents in their helpseeking experiences for their children with severe childhood mental health disorders.

The immigrant families reported that they encountered delays and barriers from the beginning of their pathways to access of care. Fewer families in the immigrant group than in the non-immigrant group had a pediatrician or primary care physician. Immigrant parents felt that these systemic issues impeded their high-risk children, while their more resilient siblings could manage these challenges. Many of the children in the immigrant group had experienced recent immigration, absent fathers, and significant pre- and post-migration trauma which their parents felt reluctant to disclose even to family or close members of their community. Some parents perceived institutional racism (Fernando & Keating, 2009) as a factor in their experiences that may have increased the likelihood of their psychological distress. Their child's mental health was reported as a low priority when there were pressing immediate instrumental strains.

Despite the fact that more immigrant than native born parents were single parents, they felt supported by their extended family and communities; this was not the case among the single parents of non-immigrant families. Immigrant families articulated considerable pressure from financial strain. The immigrant family defined cultural support as psychological connection with their families of origin without physical proximity.

Similarities between the groups emerged in discussion of diagnosis and medication, as both expressed significant anxieties and reluctance to use medication for their children with concerns about long-term impact. Stigma fears for the child were lessened by giving long-acting medications at home rather than school. Parents in both groups agreed that their children's behavior problems would not resolve with medication alone but required school, social skill and family management. Both groups commented that neither adult mental health workers nor primary care physicians suggested or inquired about child mental health referral. Many native born parents reported actively seeking social skills resources such as extracurricular groups. As household incomes were comparable, it is not clear if beliefs, networks or access account for this difference in parent reports.

Perceptions of mental illness and types of explanatory models were clearly different between the two groups. Immigrant parents generally did not adhere to a biomedical model or partially accepted this as a parallel alternate framework (Guzder, 2007; Guidino, Lau, Yeh, McCabe, & Hough, 2009; Turner, Wieling, & Allen, 2004), while non-immigrant parents more clearly endorsed genetic or biomedical models though not necessarily accepting diagnosis. Both sets of parents appeared to use divergent multiple explanatory models, with non-immigrant parents often endorsing a dietary basis for disruptive disorders.

Since the study reports perceptions of a selected group who had accepted treatment in a hospital setting, these results may not be applicable to a community sample. The heterogeneous and small sample of the immigrant group limits our ability to comment on culture specific issues for particular vulnerabilities of minority groups.

It appears that strengthening community partnerships with minorities and single parents, as well as raising parental awareness through schools and primary care settings might diminish barriers to service access and support parental willingness to pursue treatment of high-risk children for immigrants and single mothers. Promoting cultural competency (Kirmayer et al., 2012) in providing mental health care to families and children is an additional consideration for schools and mental health service providers.

Acknowledgements/Conflicts of Interest

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