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It is entitled:
Parental Strategies of Normalization in Account Giving for Child Behavioral Issues

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Parental Strategies of Normalization in Account Giving for Child Behavioral Issues

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Abstract

In the US, many children do not receive the help they need for mental, emotional or behavioral problems. Fundamental to describing parents' help-seeking processes is an understanding of how parents talk about and account for their child's behavior, as children generally depend on their parents or guardians to seek help on their behalf. In this study, 51 interviews were conducted in a Midwest, urban, pediatric, emergency room with mothers whose children screened positive for a behavioral, emotional or mental disorder. The interviews were analyzed for mothers' accounts of their child's behavior. The accounts referenced parents’ cultural understandings of child development; others' assessments (such as the child's teacher's) of the child's behavior; their own parenting as a contributing factor to the behavior; a distressing situation or event as potential cause of problematic behavior; and also used biographical narrative to provide context for an account. These account types suggest that parents view their child's behavior as reflective of the context or situation in which it occurs; as a natural, if sometimes distressing, consequence of normal development; or as reflective of their parenting methods. From the findings, it is suggested that further attention be given to parents' view of their child's behavior as reflective of their own parenting. A suggestion is also made for clinicians to approach behavioral evaluation as a collaborative characterization between themselves and the parent.
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Introduction


Research on the role of parents (or other caregivers) in recognizing their child’s distressing behavior consists primarily of retrospective, questionnaire-based studies, which focus on the portion of parents in a given sample whose recognition of problems most closely matches a professional’s (Roberts, et al. 2005, Sourander, et al. 2001, Teagle 2002, Zwaanswijk, Verhaak, et al. 2003). For example, Teagle (2002) studied parental recognition of distressing behavior in children using a structured survey administered over the phone to the parents of 1420 children from the general rural population of North Carolina. He found that approximately 13% of parents surveyed perceived a problem in their children. When the authors considered only those parents whose children were already diagnosed with a disorder prior to participation in the research, 40% perceived a problem in their children. In another study, Zwaanswijk, Verhaak and Bensing et. al. (2003) reviewed the results of 47 empirical studies from the prior decade involving parental recognition of problems and help-seeking behaviors.
They noted that problems in school, impulsivity, disobedience, inability to concentrate, poor mood and parent’s mental health history contributed to parents’ recognition of problems in their children. Other studies describe the influence of social factors such as culture, economics and politics involved parental recognition of problematic behavior (Pottick, Lerman and Micchelli 1992, Zahner and Daskalakis 1997). Though these studies present influences on parental problem recognition, they do not describe how parents deliberate and discuss their children’s behavior, accept or reject evidence of a problem or problems in their children, or resist the idea that their child may need help. What parents think and say about their child’s behavior when presented evidence of a disorder, such as ADHD, obsessive-compulsive disorder or anxiety, reveals the judgment processes and standards they use and suggests a particular lay-psychiatric view of the child.

Of course, how and when a parent decides that a child’s behavior or mental or emotional state requires outside attention, and what kind, depends on a number of cultural, historical, socio-economic and political factors (Roberts, et al. 2005). For modern societies characterized by pluralistic health care systems, medical anthropologists discuss “hierarchies of resort” and patterns of help-seeking and service utilization of different health sectors (Kleinman 1980, Lane and Millar 1987, Rao 2006). Kleinman (1980) described three sectors that comprise a “local health care system”: popular, folk and professional. This conceptualization of health care systems can also be used to describe forms of ethnopsychiatric knowledge and treatment options. Applied to help seeking for behavioral and mental health issues, popular sector ethnopsychiatric knowledge represents everyday common sense assumptions people make about behaviors that are “normal” and “not normal.” The folk-medical sector reflects elements of popular and medico-religious knowledge such as spiritual and faith healing, as well as, all manner of biological, manipulative and symbolic remedies available through community alternative medicine providers. Professional psychiatric knowledge and expertise is the
knowledge one gains from extensive formal study and training and includes Western biomedicine, Ayurvedic and Chinese natural/herbal medicine.

Professional medical and psychiatric knowledge in the US (i.e. western biomedicine) also holds political, legal and social dominance over the other sectors (Conrad and Schneider 1980, Gaines 1992, Kleinman 1980, Mechanic 1978). Further, there are differences in professional interpretations of illness and its origins, definitions of appropriate treatments, and the role of the professional and his/her knowledge in the patient's health from both popular and folk psychiatric knowledge (Fabrega 1970, Good 1992, Harkness, et al. 1996, Kleinman 1980). For instance, professionals often expect rigid compliance with their prescribed treatment plan, whereas treatments offered from the folk and popular sectors remain largely advice or suggestions (Pfifferling 1981). Kleinman’s model is helpful here because it highlights how parents rely on their own (popular) psychiatric knowledge to assess their children’s behavior and appropriate responses and interventions including when to access the knowledge and expertise of the other sectors.

As Kleinman’s (1980) health care sectors help in understanding people’s ethnopsychologies, what people say about their own or others’ problematic behavior helps in understanding how they think about, recognize and choose to address such behavior in themselves and others. Additionally, such biographical discourse often reflects how they want themselves or that other person to be perceived (Scott and Lyman 1968, Weinstein 1980). The person to whom an individual speaks can also affect how a statement is constructed (Buchbinder 2010, Jacoby and Ochs 1995, Ochs and Capps 1996). Goffman’s (1959) concept of “performance” addresses these issues and is a useful lens through which to better understand how and why parents’ construct their statements about themselves and their children the way they do. For Goffman, when individuals interact with each other, they are “performing.” A performance is, “all the activity [e.g., statements] of a given participant on a given occasion which serves to influence in any way any of the other participants” (Goffman...
For example, a politician may present himself to—and be seen by—his constituency as an upright, trustworthy, noble and moral representative of their interests. He may have moral flaws (e.g. infidelity), but his “performance” as a moral and upstanding individual establishes to his constituency the identity of trustworthy, moral public official (until, of course, his immoralities are exposed). An “identity” can be seen as the “impression fostered before [the audience]” by a performance (Goffman 1959).

Like the politician, parents give a performance when they talk about their child’s behavior, though unlike the politician’s performance, the parent’s performance outwardly concerns their child’s performance, not their own. Despite this “performing-by-proxy”, parents’ statements about their child function to mediate their audience’s (e.g., the research interviewer) impression of the child, just as the politician’s performance mediates his impression on his constituency. For example, a parent may be presented evidence that her child’s constant fighting is indicative of a disorder with potential treatment. To this, the mother might act indignantly, dismiss the evidence, or be open and willing to try a treatment. Any of these would be considered her performance, which could also be said to illuminate her ethnopsychiatric understanding of her child’s behavior. For example, if she responds dismissively by saying, “It’s not really her fault she keeps getting in trouble. It’s the other girls keep picking on her. She just gets caught,” she is revealing an understanding of the behavior as a reaction to other girls bullying her, not a psychiatric disorder.

When a performance, as a statement with social effects, attempts to make a questionable behavior(s) not problematic, that statement is described as an “account” by discourse analysts (Scott and Lyman 1968). “That’s how teen boys are,” a mother might say in reference to her son’s excessive sleep or irritability. Such “accounts” explain actions, behaviors, or statements that are called into question. They are performances that express how the individual wishes to be seen by their audience (Orbuch 1997, Scott and Lyman 1968). The accounts framework has been used to describe individuals’ conceptions of themselves and their
behaviors within a variety of contexts, such as drug use, gambling and students’ excuses for missing class (Kalab 1987, Smith and Preston 1984, Weinstein 1980).

This study uses the accounts framework to examine how parents understand, define and discursively construct “normal” behavior in the context of an opportunistic interview about a child’s psychiatric screening results. After both parent and child completed individual computer-assisted structured surveys about the child, mothers were presented with the results. Mothers receiving results suggesting evidence their children may have one or more behavioral or emotional problems were then interviewed about their child’s behavior. Using the Accounts Framework to describe parents’ discussions of their child’s behavior is a novel application of the Accounts Framework. The general focus of most accounts research has been on how individuals talk about their own behavior (Scott and Lyman 1968, Smith and Preston 1984, Weinstein 1980). This study considers accounting-by-proxy in addressing how parents talk about their child’s behavior — a situation in which one person (the parent) accounts to another (the research interviewer or “quasi-clinician”) on behalf of a third (the child). The idea of accounting is well suited to this set of interviews because, in presenting evidence of a disorder, the interviewer is confronting the mother in the same manner as the constituency confronted the politician about his immoral behavior. A mother’s explanatory response (or account) to the evidence that her child suffers a disorder reflects her efforts at managing the interviewer’s perception of her child and herself. The mother’s efforts to account for her child’s behavior in the face of a professional diagnosis is relevant to clinicians because the account can help the parent rationalize the behavior as not needing professional intervention. As children are dependent on their parents or guardians for recognizing their problematic behavior and seeking help for it on their behalf, learning how parents account for their child’s behavior can give important insight into how they recognize and strategically normalize problematic behavior in their children during a discussion or interview with a professional and how and under what conditions they seek help from professional or other health care sectors.
Background

Past research does not discuss how parents talk about their children’s behaviors as problematic and in need (or not) of other help, whether popular, folk, or professional. Correlations between parental problem recognition and help seeking behavior only illuminate that small proportion of parents’ who have formally entered the mental health system (Flisher, et al. 1997, Kataoka, Laraque and Szilagyi 2009, Sourander, et al. 2001, Zahner and Daskalakis 1997, Zhang and Wells 2002, Zimmerman 2005, Zwaanswijk, Van der Ende, et al. 2003, Zwaanswijk, Verhaak, et al. 2003). How parents verbally convey recognition of their child’s problematic behavior as psychiatric in nature or not, and how they normalize the psychiatric nature of their child’s problematic behavior despite evidence to the contrary are issues in need of attention in the literature. Addressing these issues can improve current understandings of parental problem recognition and its effects on help-seeking behaviors.

Processes in Problem Recognition

Seeking help for a problem is acknowledged in the medical and psychological anthropology literature as a complex process (Gaines, 1992, Kleinman 1980, Mechanic 1978). Researchers have proposed several models to describe the help-seeking process, which generally agree that help seeking begins with problem recognition and ends with seeking help from a professional (DiClemente 1999, Kleinman 1980, Rogler and Cortes 1993, Zwaanswijk, van der Ende, et al. 2007). The barriers encountered and the processes by which families come to decide or not to seek professional mental health help for their child can be understood by considering Kleinman’s (1980) model of health care systems, which makes the distinction between the ‘popular,’ ‘folk,’ and professional health care sectors of a community’s or society’s health care system. In his conceptualization, Kleinman describes the popular health care sector
as representative of the mental health practices and behaviors of individuals whose
ethinopsychiatric knowledge is founded on every day common sense assumptions and
experiences about contextually appropriate and inappropriate behavior that help individuals
distinguish “normal” from “abnormal” behavior.

The professional health care sector in modern western health care systems represents
the knowledge and practices of physicians and psychiatrists after years of study and training in
a university or other formal institution, while the folk health care sector represents individuals
with esoteric knowledge of problems than members of the popular sector, but whose knowledge
is not as institutionalized and standardized as is the professionals' knowledge. While
psychiatric diagnosis is the province of highly trained professionals (Gaines, 1979) the initial
recognition of a behavior as distressing or problematic generally occurs in the popular sector,
and reflects the common sense assumptions, experiences and cultural understanding of
behavior and its appropriateness in relation to particular situations (Kleinman 1980).

The ethnopsychiatric knowledge represented by each sector in Kleinman’s (1980) model
is influenced in part by the other sectors. Non-professionals commonly adopt professional
terminology, but often, new meanings and understandings are attached to them. Folk sector
knowledge draws from ideologies and understandings of both popular and professional sector
knowledge. Parents' recognition of their children's behavior as normal, distressing or
problematic is, as discussed above, culturally informed and so too are their decisions to seek
help in addressing their children's distressing or problematic behavior. Many studies also note
that parents identify problems in their children using different criteria than professionals
(Zwaanswijk, Verhaak, et al. 2003) that take into account such factors as the burden of stress
on themselves, the family as whole, or the community, and that also consider their own beliefs
about problematic behavior (Logan and King 2001, Zahner and Daskalakis 1997). On the other
hand, health professionals, such as physicians and psychiatrists, consider a variety of
epidemiologically significant factors, such as, child’s age, parents’ marital status, sex of the child and nature of the visit, e.g. well-child vs. acute care (Kelleher, et al. 2000, Stiffman, et al. 1997).

In Kleinman’s (1980) tripartite model of a society’s health care system, individuals address most of their health concerns, including mental health, primarily within the popular sector, with parents and other family, friends and other community members such as police, judges, and teachers. Consequently, most instances of distressing or problematic behavior are not presented either at first or at all to the professional or folk sectors; therefore, interaction with the folk or professional sectors by members of the popular sector can be highly variable in modern societies.

For example, Eguchi (1991) talks about Japanese mountain villagers’ process of turning to Western psychiatry for problematic behaviors they normally characterize in supernatural terms as Kitsune-tsuki (fox possession). Eguchi describes an afflicted individual’s behavior as, at first, tolerated until the family or the community (popular sector) can no longer suffer the individual. Then the local religious leader, as folk healer, is sought for intervention. When the spiritual interventions prove ineffective, the community turns to professional psychiatry, though the spiritual interventions are not necessarily abandoned and often continue in tandem with the psychiatric care. Gaines also describes a case in which “one woman was brought to the emergency room by her family (mother, father, and siblings) when they realized that the patient’s problems, which they noted had been present for some time, became severe and beyond their means of coping and understanding” (1979:385).

In contrast to the above examples, the professional assessment in this study often preceded mothers’ recognition of their child’s behavior as in need of professional psychiatric care. How she talks about her child’s behavior in the context of such an evaluation is a topic of this paper.
Responding to questioned behavior

How people talk about themselves and their behaviors has long been a topic of interest to social scientists. Mills’ (1940) idea of motive vocabularies posited that what people say motivated their behavior may not have actually done so; rather, what they give as motives represents how they want others to see them. Sykes and Matza (1957) presented their concept of techniques of neutralization, which went beyond motives to include all statements given to neutralize others’ negative perceptions of the individual. Goffman, in discussing his concept of performances, noted that behaviors, as well as statements, could be given to influence how one’s self is viewed, in general, by another and not necessarily given to mitigate a negative impression (1959), while attribution theory seeks to describe how individuals go about presenting themselves to others by investigating how people think about their actions and the impressions those actions might leave upon another (Orbuch 1997). The last concept in need of mentioning that describes a form of identity management like the above examples of motive vocabularies, techniques of neutralization, performances and attributions is the narrative. The narrative is an autobiographical statement given to an audience that exhibits the elements of a story, including plot structure and a theme (Franzosi 1998, Ochs and Capps 1996, Orbuch 1997). These sociolinguistic concepts (motive vocabularies, techniques of neutralization, performances, narratives) are also reflected in the accounts framework, which specifically looks at how people answer to their questionable behavior (Orbuch 1997).

Description of Accounts

Scott and Lyman (1968) offered the concept of the account as a “linguistic device employed whenever an action is subjected to valuative inquiry… [and which] prevent conflicts from arising by verbally bridging the gap between action and expectation” (46). Accounts are
statements given to appraise a behavior when that behavior is called into question. Three types of accounts have been described: excuses, justifications and disclaimers.

Excuses are “for mitigating or relieving responsibility when conduct is questioned” (Scott and Lyman 1968:47). They divert all responsibility away from the speaker. Weinstein (1980) presents an example of an excuse offered for drug use,

Persons might excuse their drug use by pointing to a character flaw that cannot be changed. A young man questioned by Goode (1970:129) said: ‘I took it (marijuana) because I’m a chump for a broad. Anything she suggested was okay.’ Or such uncontrollable traits or actions as anxiety, moodiness, insecurity, and impulsive tendencies may be held responsible (581).

Justifications are “accounts in which one accepts responsibility for the act in question, but denies the pejorative quality associated with it.” (Scott and Lyman 1968:47). This description follows closely from the work of Sykes and Matza (1957), who described as “techniques of neutralization” the “justifications” individuals give for their behavior when their behavior is brought under scrutiny. To illustrate Scott and Lyman’s justification-type account, Weinstein (1980) presents soldiers’ accounting for their drug use:

The term self-sustenance is applied to justifications that suggest drugs are taken to cope with uncomfortable situations…army psychiatric patients have remarked they ‘can’t live’ without cannabis or need it to be a good soldier (Weinstein 1978: 895). ‘To get through the day’ was the most frequently cited reason for both opiate and amphetamine use by Navy drug addicts (Nail et al., 1974: 133) (583).

In these examples, the individuals who are accounting are accepting that they use drugs, but they do not accept that using drugs, in their particular cases, is wrong (Weinstein 1980). Their justification that the behavior is not wrong is the “self-sustenance” described by Weinstein– their daily activities would otherwise cause them suffering if they did not take the drugs, so, the soldiers justify, excuse otherwise render their drug use socially acceptable.

The last account type, proposed by Hewitt and Stokes (1975) is the disclaimer, which they describe as an account for a behavior yet to occur, but which the speaker recognizes as potentially problematic in the eyes of other participants in the forthcoming situation. The authors
cite several well known phrases as examples, “‘I know this sounds stupid, but…’; ‘I’m not prejudiced, because some of my best friends are Jews, but…’; ‘What I’m going to do may seem strange, so bear with me’” (3).

Capitalizing on the flexibility established by Scott and Lyman (1968) of accounts to apply to a variety of situations, many researchers adapted their typology of accounts to a variety of situations including gambling (Smith and Preston 1984), drug use (Weinstein 1980), and students’ poor class attendance record (Kalab 1987). Smith and Preston (1984) analyzed a collection of studies about gambling motives and formulated a twelve-item typology of gambling motive vocabularies, which as discussed above, are a concept comparable to accounts. Their analysis allowed them to ultimately conclude that respondents used motive vocabularies that would best mediate their and their community’s perceptions of themselves; that is, participants, through what they said about their and others’ gambling behavior, constructed an image of themselves for others that reflected what they perceived as most socially acceptable, given their gambling behavior:

It may well be the case that respondents were supplying interviewers with “proper, socially acceptable” vocabularies of motive to explain their own gambling conduct. A typical respondent was in essence saying, “I do it for play, leisure, and recreation or because I am sometimes bored and seek something exciting in my life.” Conversely, the person avoided the “improper,” socially unacceptable vocabularies of motive to explain their wonton conduct, such as “I did it because I want/need the money, desire the prestige, or have so many frustrations that I need an escape” (1984:342).

Weinstein’s (1980) application of accounts to drug users draws the connection between accounts and culturally normative or sanctioned ideas of “drug user” and “drug non-user.” In his study, he analyzed the transcripts of structured interviews to formulate a typology of accounts based on Scott and Lyman’s (1968). He also delineated types of strategies drug users take to avoid accounting for their drug use and described the use of accounts as a method of identity negotiation. This analysis of drug use discourse illuminated aspects of the cultures and societies
to which users belong and assign themselves. For instance, as Weinstein relates, some users may try and present themselves as different from other users by identifying

...themselves as "heads" as opposed to "freaks." Because a "head" uses drugs selectively for purposes of mind expansion, insight, and enhancement of personality attributes, but a freak uses drugs indiscriminately for kicks or because of habit an advantage may be gained. Identification as a head connotes that the user manifests great spontaneity, openness of manner, sensitivity to his own and other's feelings, and a willingness to face personal problems (1980:590).

As the above applications show, accounts participate actively in identity construction and management and in the construction and negotiation of cultural roles (Orbuch 1997, Scott and Lyman 1968, Weinstein 1980). These actions link them with the concept of narrative as Orbuch (1997) demonstrates when he writes, “Accounts and other related concepts, such as stories and narratives, represent ways in which people organize views of themselves, of others, and of their social world” (455). Like accounts, narratives are devices that establish and mediate identity, though they accomplish this differently (Orbuch 1997). They are so closely related, though, that often authors speak of accounts in terms of narratives or as “narrative accounts” (Buchbinder 2010, Butler 2005, Orbuch 1997). Under circumstances such as those established in this study where a mother is challenged, in a manner, by the researcher to evaluate her child’s behavior, “giving an account…takes a narrative form, which not only depends upon the ability to relay a set of sequential events with plausible transitions but also draws upon narrative voice and authority, being directed toward an audience with the aim of persuasion” (Butler 2005:12). Aim of persuasion, relaying sequential events, and a narrative voice and authority are all characteristics of accounts that are shared by narratives, but they are not necessary features of narratives. Buchbinder (2010) calls attention to how Butler also distinguishes narrative from account despite their similarities, “For Butler, telling a story about oneself is not the same as giving and account of oneself, since giving an account, ‘accepts the presumption that the self has a causal relation to the suffering of others’ where a narrative does not necessarily have to” (115).
Parents’ accounting for their children represents a situation unique to accounting research in that the parents are accounting-by-proxy, where their proxy is their child. In past accounts research, researchers have focused nearly exclusively on individuals accounting for themselves to another individual or group (Butler 2005, Goffman 1959, Hewitt and Stokes 1975, Kalab 1987, Mills 1940, Orbuch 1997, Scott and Lyman 1968, Smith and Preston 1984, Sykes and Matza 1957, Weinstein 1980). But, in the clinical psychiatric setting it is common for an individual to speak, and thus account for, their friend or family member. Further, in the case of child mental health, it is almost always the parent or guardian (and primarily the mother) that seeks help, speaks for, or accounts for the child (Bussing, et al. 2005, Hankinson 2009, Zwaanswijk, van der Ende, et al. 2007).

In the interviews considered in this study, mothers are speaking for their children and, it is hypothesized, accounting for their child’s behavior. The accounts framework is suited to this study because the research interviewer, in presenting the parent with an alternative interpretation of their child’s behavior elicits responses from the parents that justify, excuse or otherwise evaluate their children’s behaviors. The accounts mothers give also reveal their processes of recognizing distressing and problematic behavior in their children. Finally, these interviews address an important scenario for accounts that has been underrepresented in accounts research – that of one individual (in this case, the mother) accounting for another (the child). This study will also address this deficiency.

**Methods**

**Research setting**

This study was conducted between June and September 2006 in an urban pediatric emergency department (ED), in a large, Midwestern city. Fifty-one families of children between
nine and eighteen years of age were enrolled in the study after being screened for unrecognized behavioral, emotional or mental distress in the previous year.

The interviews for this study were restricted to non-urgent patients and were conducted primarily in the examination room. These rooms afforded a space out of the way from general ED traffic and provided a setting that ensured privacy, as the room door could be closed. Efforts were made to ensure that the research did not interfere with emergency care. Some interviews were administered outside of patient rooms for a variety of reasons, but usually because the patient was discharged from care before the interview was complete. If the family wished to continue with the study after discharge, a secluded and private space was selected for any remaining data collection.

Data Collection Procedures

All procedures were approved by the hospital’s institutional review board. Parents of children presenting to the ED with medical problems were approached to participate. After giving informed consent, consenting parents and children were administered the DISC Predictive Scales (DPS), a computer assisted diagnostic screening instrument. If the child, by either their own or their parent’s answers screened positive for any disorders, the child was then administered the Child Global Assessment Scale (C-GAS) questionnaire, after which, the parent was interviewed about their child’s behavior and their thoughts and feelings in reaction to the positive results of the screening instrument. The interviews were voice-recorded and transcribed for analysis.

Non-urgent and patients with a parent or guardian were approached by research staff and explained the goals of the study. If parent/guardian and child agreed to the study, a consent form was read aloud, explained to both and signed. The first procedure began by administering a computer assisted DPS survey; parent and child completed their surveys simultaneously on separate computers. The DPS was used for its reliability and accurate screening of DSM-III-R
disorders (Lucas et. al. 2001). Upon completion of the DPS, the researcher reviewed the results. The session was concluded if no positive evaluations were returned.

If positive evaluations were returned, the researcher reviewed these with both parent and child and the researcher then conducted a short C-GAS assessment with the child, during which, the child’s responses were written in note form and later transcribed. Following administration of the C-GAS, a 30-45 minute interview was conducted with the parent concerning the parent’s initial reactions to the DPS results, their recognition of any problems, experience with behavioral or emotional health problems in children and several other topics outlined below.

Measurements

DPS: Diagnostic Interview Schedule for Children (DISC) Predictive Scales

The DPS was administered on separate laptops simultaneously to parent and child. Each item was displayed on-screen, while audio-recorded readings of each item were played over headphones. Simple keystroke or mouse click generally enabled yes/no responses. Upon completion, the researcher reviewed the results. If the DPS did not return any positive evaluations, the session was concluded. Any positive screening results prompted the interviewer to administer the C-GAS interview.

C-GAS-I: The Child’s Global Assessment Scale – Interviewer Interpreted

Each child screening positive for at least one disorder on the DPS was interviewed to assess general social functioning during the last month. The C-GAS has been shown to be a useful “compliment to syndrome-specific scales” (Shaffer, et. al. 1983), such as the DPS, and as a useful and reliable “measure of overall severity of disturbance” (Shaffer, et. al. 1983). Each child was asked to describe social relations over the last month with friends and family, favorite recreational activities, a recent pleasant memory and three wishes. These responses along with
the DPS results were reviewed in 1-2 paragraphs at the conclusion of the session by the interviewer and rated for general functionality on a scale of 0-100, where 100 indicates no functional impairment and rating of 80 or below indicated clinically significant functional or emotional health impairment.

**C-GAS-P: The Child’s Global Assessment Scale – Psychiatrist Interpreted**

A psychiatrist colleague also reviewed the DPS results and C-GAS responses and provided an alternative general functionality rating on the same scale of 0-100 as used by the interviewer for their interpretation of the C-GAS.

**Qualitative Interview**

After administering the DPS and C-GAS, the researcher then conducted an approximately 30-45 minute, voice recorded, semi-structured, open-ended interview with the parent that was later transcribed for analysis. Questions and follow-up probes addressed the parent’s general impressions of their child, impressions of the DPS results, experience with behavioral, emotional and mental disorders in their family, and familiarity with mental health diagnoses and services. The questions’ purpose was to gain a better understanding of parental problem recognition and willingness to seek treatment for any potential or recognized problems.

**Selection and Analysis of quotes and subgroups**

Considering the DPS, both C-GAS interpretations and the interview data, cases appeared to range from relatively mild to relatively severe. No cases were excluded from initial analysis; however, only a few were selected to illustrate the findings. All interviews were assigned descriptive codes representing the found variation in accounting statements. As such, no accounting typology was established before analysis; rather, patterns of accounting were allowed to emerge. Analysis of the verbatim transcripts considered; 1) parental recognition of
problematic behavior; 2) parental accounting for or normalizing of problematic behavior to the interviewer; 3) parental accounting for their own behavior; and 4) themes reflected in parents’ accounts. Cases were then chosen to illustrate these topics by means of select quotes.

Results

Results from the interview transcript analyses are presented below and illustrated by key excerpts from selected interviews. It was found from these interviews that mothers’ accounts each cited a perceived source of the problematic behavior. The sources described are conceptions of child development; parenting methods; and a situation or event that is perceived to have influenced the child’s behavior or is whose influence is anticipated due the nature of the situation. The sources can be broadly interpreted as near to the child (i.e., conceptions of child development), removed from the child (i.e., parenting), or distant to the child (i.e., situation based accounts such as those utilizing narratives or providing disclaimers for anticipated questionable behavior). One type of account does not quite fit this ordering and that is the account type that draws on others’ assessments of the child’s behavior. As others’ assessments can, in nature, be near, removed or distant and are co-opted just as they were given to account for a behavior, it is appropriate to avoid classifying this account type as near, removed or distant; therefore, it will be discussed at the end.

Sources near the child

Sources are defined by the conceptual distance the cited source is from the child. In this case of a child-near source, parents discuss a culturally determined time frame in the course of the child’s development in which certain questionable or problematic behavior is anticipated. The perceived cause of the behavior being the natural process of development is appropriate to consider as near to the child as it is not generally held as a function of other individuals’ actions.
Sources of accounts that are described as removed or distant to the child have in common that they involve other individuals’ direct influence on the child. How parents talk about age or the process of growing up does not seem to implicate the involvement of others in the same way that removed and distant sources do. As discussed below, problematic behavior conceptually linked with development in parents accounts seem to portray development as culturally understood to be an inherent property of being a child.

**Accounting using conceptualizations of development**

Mothers accounted for their child’s behavior by attributing their actions and attitudes to the developmental process – both the physical/hormonal changes of puberty and the socialization and enculturation processes. Statements such as “he’s just at that age” or “she’ll grow out of it” exemplify this type of account. For instance, in one interview, the mother’s account referenced comments made by the child’s teacher, in which the teacher attributed the child’s problematic behavior to his “transition” from the fourth to fifth grade and also to his age: “that may be because…the age”. Accounting for behavioral problems due to age was common in the interviews, but how aged was referenced varied.

**Puberty**

One mother, whose relationships with her thirteen-year-old daughter and ex-husband were tense, described her daughter as being very angry all the time and possibly wanting to physically lash out: “She get’s so angry she wants to hit you – angry.” She goes on to discuss some trust issues with her daughter, also. She accounts for these distressing behaviors in the following statement:

P: She thirteen, you know. The typical thirteen-year-old um going through issues, but I mean she’s very smart, she’s outgoing, she’s athletic. She’s just going through the typical thirteen-year-old emotional issues, you know, changes in her body…
This account presents the behavior as an almost normal consequence of physically developing into adulthood; a situation over which neither daughter or mother has complete control, thus resulting in distressing, albeit easily normalized behavior. Age, as a cultural construction, in this account, functions as the source of the problematic behavior.

*Age-difference*

In another interview with a mother who was physically abused by her husband and in the process of seeking a divorce, age was referenced differently. She relates that her teenage daughters are close in age and this distance is a source of intermittent conflict: “[They] are only fourteen months apart, so they have that conflict every so often,” she begins. When they do have conflicts, the mother describes them as “normal arguments the sisters have like over clothes or you were in my room or stuff like that.”

These references to age are different in two ways: one makes reference to a specific age, while the other references the age difference between the siblings. A parent’s account referring to a specific age, as in the phrasing “he’s just at that age,” or and account referring to an age difference, as in the phrasing “he’s so much older, so…” indicates the behavior is seen, culturally, as not necessarily a product of the child’s personality or identity, but rather more a part of the process and nature of growing up. In American culture, the “terrible two’s” are a well-known illustration of this perspective. Age, as an account, allows for the behavior to be distressing, but not necessarily in need of professional help because of the expectation of improvement. Therefore, the seeking of professional help can be suspended for a time.

**Sources removed from the child**

It was common in the interviews for a parent to account for their child by citing their own behavior or parenting methods as the source of the child’s problematic behavior. This type of accounting can be described as removed from the child because the behavior is presented as
reflexive of another individual's (the mother's) behavior (her own actions and attitudes or her own, self-identified, parenting methods). Unlike the child-near source presented above, this source implies that the behavior is the result of an interaction with another individual. What makes this source “near” that the other individual is first, a mother can be considered socially “near” her child by virtue of being the mother and second, is that mother’s accounts of this kind generally suggest that questioning their child’s behavior, by extension, questions their own parenting behaviors.

**Mom accounting by diverting responsibility back onto herself**

In this type of account, the mother presents the child’s behavior as resultant directly from her own behavior or attitude—a situation over which she sees herself as holding considerable control. Due to her own failure (conscious, subconscious, inevitability, or ignorance) at managing herself or her situation, she sees herself as partly responsible for influencing the actions of her child. In one interview, the mother responds similarly to an inquiry concerning her reaction to her son’s positive screening results for problems with mood, anxiety and paying attention:

P: That I don’t know my child. That I didn’t know that he felt that way cuz I usually try – I talk to them. I have an open relationship with my kids and I want them to tell me what they feel. The only thing I can say…I do, I fuss a lot, so that maybe why he doesn’t tell me things. Cuz I’m always fussing about something.

This example shows the mother accounting for her child’s affirmative responses as a consequence of her own behavior: “I fuss a lot, so that maybe why he doesn’t tell me things.” Her account implies the reasoning that the disorders the screening identified might not have shown up if she did not “fuss” all the time and thus interfere with their communication (so that maybe why he doesn’t tell me things”). Simply, in her view, her “fussing” contributed to his “not
telling her things” which thus may have inhibited her ability to address his “feelings” (“I did not know he felt that way”).

Scott and Lyman classified this type of account as “scapegoating,” noting that the account places responsibility for the questioned behavior on another. In this case, however, the person doing the accounting (the mother) is actually taking responsibility upon herself. This still accomplishes the purposes of accounting: to mitigate negative impressions; however, by reflecting that responsibility back onto herself (“that I don’t know my child”; “I fuss a lot”), she potentially opens her parenting and herself to inquiry by illuminating her “fussing” behavior as possibly having a negative affect on her child. As she has now brought her own behavior (“fussing”) into question, she provides a preemptive account for herself: “I usually try – I talk to them. I have an open relationship with my kids and I want them to tell me what they feel.”

**Sources distant to the child**

The following types of accounts utilize sources that are here described as “distant” from the child because they refer to larger, more public social situations or events surrounding the child and influencing their behavior; or, they rely on the assessment of another who is further socially removed from the child than the parent, such as a teacher, friend, or neighbor. Sources distant to the child describe the actions of others that create a context, which, for the mother, conceptually accounts for her child’s behavior (i.e., accounting via biography and by-proxy disclaimers), or the thoughts and interpretations of a third party that are then adopted by the mother as representing her own interpretation of her child’s behavior (accounting via others’ assessments).

**Accounting via biography**

Parents often use a story or narrative format in accounting for a behavior(s). For instance, one mother tells of her teenage daughter:
P: Um, last year it was she, we got a phone call from [local] police, saying that had my daughter, [was arrested] and so my ex-husband went tout to get her. Well she stole a bottle of vodka from the house and she drank it. She was puking. Um, her friend who took um a drug for seizures and so they had to take her [the friend] and put her in an ambulance and send her to children's. So it was pretty serious. So, um, this was in the midst of the divorce. You know separation… I was very upset. Um, one because, um, you know nobody wants their daughter or son to drink before their age, you know. And you think that you know thank God neither one of them were driving. Um, but you know a cop calling your house. I mean that's scary. I'm scared for her. And then I was, I was upset because I realized what this [the separation/divorce] was doing to my family.

R: now, what’s ‘upset’?

P: what’s upset to me? (A: yeah) just, you know, I was down, depressed, sad. Sad for the fact that I felt that she needed to go out and drink. But you know I guess she was letting off some steam to some degree.

This mother’s story begins with a narrative about her teenage daughter’s night out drinking with friends. Her child’s behavior was distressing for the mother (“I was upset…I’m scared for her”), but despite her distress, she accounts for the behavior as a consequence of the stressful divorce (“I realized what this was doing to my family”) and presenting it, metaphorically, as coping behavior (“she was just letting off steam”). The narrative here is sets up the account of “letting off steam” by providing context for it. This context makes the account easier to accept than it would otherwise be.

This example indicates the importance of context in formulating an account on behalf of another. Because the parent perceives her divorce (a product of the mother’s own choices and actions) as ultimately responsible for her child’s behavior, she then construes that both she and her child are implicated when the child’s behavior is called into question. The context provided by a narrative functions as a source from which parents can draw information to account for their own and their child’s behavior. The account can then mitigate identity perceptions and even shift concern from one individual to another, such as from child to parent. Narratives, being descriptive in nature and functioning to establish identity, compliment accounts as they correct, mitigate or otherwise change the audience’s perception of the child. It is important to note about the narratives that mothers give that they commonly function to orient the child as a sort of tragic hero because such presentation can generate sympathy for the child being in such a
predicament and make the ensuing account more acceptable to the audience. In the case
presented, the mother’s narrative carries a tone that mitigates negative perceptions of the child
by presenting the child’s behavior as an unfortunate reaction to a distressing situation over
which the child had no control. Through this tone and presentation, the narrative makes
acceptable an account that protects the child’s identity as “good kid” while still allowing her
behavior to be problematic.

**Disclaiming-by-proxy – accounting for future problematic behavior**

The following examples share similarities with a type of account described by Hewitt and
Stokes (1975) as “disclaimer,” in which a person accounts for a behavior they are about to
perform. In the context of these interviews, these mothers can be described as disclaiming-by-
proxy; they are accounting for their children’s problematic behavior before it is interpreted or
accepted as problematic. One mother, after describing her son’s regular fighting with other kids
on their street and the violent nature of the neighborhood in which she lives, relates:

P: Cuz my kids can be walking down the street, I won’t know if somebody gonna try to shoot my
kids or not. That’s how bad it is over there. And then it’s get, becoming a depression thing and
eventually he gonna end up getting depressed – getting into it with the same, about the same
thing, a person get tired of it, fighting about the same thing, especially if you don’t know the real
reason why you fighting. See we [sic] don’t even know the real reason, the real reason he is. I
guess they [other teenagers] see new faces or whatever. That’s the only thing I can think of. Cuz
other than that, I don’t see no sense in it.

For this mother, the fighting is not necessarily the primary concern; rather, she is
concerned by specific characteristics of the fighting; first, that it is constant (“eventually, he
gonna end up getting depressed”), and second that it seems senseless (“a person get tired of it,
fighting about the same thing, especially if you don’t know the real reason why you fighting”).
Due to the apparently violent nature of the neighborhood in which they live, she expects the
constant fighting to take a toll on her son and result for him in depression. Her description of the
neighborhood and fighting is her account for any depressive symptoms that might emerge in him later.

In another interview, a mother also anticipated some distress in her child. In this case the mother stated that her ex-husband had physically abused her and that her daughter witnessed the abuse. When the mother was later asked what behaviors in her daughter would, in her opinion, warrant professional help, her response was:

P: I mean, I guess just when they start changing their behavior. Plus, I mean, her behavior hasn’t really changed a whole lot, it’s just I know what they’ve been through. And I know in myself I need to get them help. You know, I – they’re really wasn’t a change or anything pointing a finger – like ‘ah, that’s, you know’ it was just because I know what I’ve been through and I know that they’ve seen all that they probably shouldn’t have seen. So, it’s my doing and not any way they’re acting.

Earlier in the interview, this mother related that she had noticed a small change in her daughter’s behavior, but it was not worrying her. It was intermittent and not serious – just “attitude.” When, in the above statement, the mother says, “her behavior hasn’t really changed a whole lot, it’s just I know what they’ve been through,” she is further affirming that the problematic behavior she has already seen in her daughter is, in her view, not related to the domestic violence. In fact, the mother asserts she has seen no evidence of problems resulting from the violence (“there really wasn’t a change or anything pointing a finger – like ‘ah, that’s, you know –“) but anticipates such problems to eventually emerge (“it was just because I know what I’ve been through and I know that they’ve seen all that they probably shouldn’t have seen. So, it’s my doing and not any way they’re acting”).

**Accounting via other’s assessments/impressions**

Several instances were found in which parents relied on teachers’ assessments in their decision to not seek help. In one case, a parent described her child’s behavior thus:

P: School for fourth grade, he passed to fifth grade, but fourth grade was kind of rough for him. Um grades were good, but the behavior was horrible. Um he was not getting along with some of peers in his class and the teacher said that may be because that transition, the age whatever.
Towards the end of the year he got better. He’s starting to get along with people and you know, hopefully that’s over.

In this statement, the “horrible” behavior at school is accounted for by adopting the teacher’s own accounting for the behavior: “The teacher said that may be because that transition, the age, whatever.”

This example addresses the child’s problematic behavior during school, as reported by the teacher. Despite the DPS results, the mother expresses little remaining concern for her child’s behavior. Additionally, from this account it appears the teacher was suggesting a conceptualization of the effects of an age-behavior relationship on social development similar to the parents. This similarity between social development concepts of parent and teacher reflects their shared culture. Most importantly, the mother’s re-use of the teacher’s account demonstrates the importance of the teacher’s role in the parent’s recognition and interpretation of degree of problematicity. The teacher’s account was enough to convince the mother that no professional help seeking was immediately necessary. The teacher’s assessment seemed to further confirm for the mother a lessening disturbance by the improvement in the child’s behavior. Lastly, this account demonstrates the collaborative nature accounts can take. Parent and teacher were both involved in formulating this account; the teacher provided its source, “age”, while the mother accepted it and upheld it against the screening results.

**Discussion and Conclusions**

The goal of this study was to describe how parents account for their child’s behavior when it is brought into question in a clinical setting. To accomplish this 51 parents were interviewed in an urban mid-west pediatric emergency room regarding their responses to their child’s positive screening results for various mental and behavioral disorders. From these interviews, it was found that not only do parents account for their child’s behavior by referencing
situations such as divorce or neighborhood social conditions, but they also account by referencing characteristics of the child such as age, culturally informed developmental stage, and their own parenting behavior. Additionally, it was found that they anticipate distressing behavior from their child given various narrative contexts such as witnessing domestic violence.

In addition to those sources such as age and parenting, similarities and differences between accounts and by-proxy accounts were also noted from parents’ statements. It was found that the by-proxy account was similar to accounts described in previous research (which shall be referred to as direct accounts). The direct account and by-proxy account are similar in that they both mitigate the identity of the individual whose behavior is called into question, they both are affected by the situational context of the inquiry (in this case, the medical setting) and the identity of the inquirer (the researcher as quasi-clinician) and they both can be organized into typologies. Despite these similarities, they differ in that by-proxy accounts are also collaborative between the account-er and the accounted-for, and the by-proxy account mitigates potential identity changes for both the accounted-for and the account-er.

Another finding was that parents seem to conceptualize problematic behavior as reflective of the context or situation in which the behavior occurred. For instance, one mother characterized her child’s frequent fighting as defensive and consequential living in an apparently violent neighborhood. In some cases, the parents offered narratives that set a context for the account, which functioned to make the account more acceptable to the audience. The richer description offered in the narrative suggests to the audience that the situation had a direct influence on the child’s behavior such that the more distressing the situation, the more distressing or problematic the behavior. In addition to making the account acceptable to the audience by establishing a vivid context, the mother’s narrative also helps mediate the child’s identity by making the problematic or distressing behavior a consequence or reaction to the distressing situation rather than a consequence of some character flaw inherent to the child.
Another type of account was also found to rely on a description of a distressing event their child suffered. These accounts, here referred to as by-proxy disclaimers, suggest some of the mother’s own ethnopsychiatric knowledge in that they imply an understanding of certain situations or events, such as divorce, domestic violence or living in violent area, to be potential causes of questionable or distressing behavior in children. Using this knowledge, she is able to preemptively address problematic behavior.

Parents were also found to account for their child’s behavior as reflective of the process of growing up. The cultural perceptions of age in these accounts mitigates any potential negative interpretations of the child’s identity by presenting the behavior as common to a culturally determined point or stage in the child’s development. Such accounts are normalizing because they conform the child to the general cultural understanding of child development that certain behavior can be expected at particular ages or age-ranges. Likewise, accounting for problematic or distressing behavior between siblings by citing their age difference points to a culturally informed understanding of family dynamics. From such accounts, it seems mothers anticipate differences in age to sometimes be a source of distressing behavior. This anticipation normalizes to some degree any distressing behavior as culturally understood to be a consequence of birth order and spacing, and not necessarily in need of professional intervention.

In addition to accounting for their child’s behavior by referring to their own culturally informed understanding of child development and presenting the behavior as consequential to a distressing situation, parents also referenced their own parenting as in some way deficient to account for their child’s behavior. Suggesting some fault on the part of their parenting diverts responsibility for the behavior away form the child onto themselves and thus protects the child’s identity to some degree. This kind of accounting calls attention to the mothers’ cultural understanding of their relationship to their child by implicating their parenting as a potential cause of the child’s behavior suggesting that their child’s behavior may reflect their own
behavior and quality of their parenting. As such, when the child’s behavior is brought into question, mothers may interpret this as a questioning of their own parenting methods and perhaps their role as parent.

This study was limited in that it only addressed parents’ accounting within a clinical context. Future research directed at parents’ accounting for their child’s behavior in other contexts such as at school to teachers, school counselors or other school officials; at home to family, friends, or neighbors; or among the community to police, religious leaders or other community members may contribute further understanding of this topic. Additional consideration for parents’ utilization of their conceptualizations of their child’s development and the role of age in accounting for and thereby normalizing their child’s behavior to an audience could also address questions surrounding the ethnopsychiatries of parents regarding their children. Further, how questioning or medicalizing a child’s behavior impacts their parent’s self-perception as “parent” and their conceptions of “good” parenting is also a topic suggested for further inquiry.

Clinically applied, these findings could positively impact parental help seeking for problematic behavior in children in several ways. For example, parents could be more likely to pursue and engage in professional help if treatments were presented as a collaboration between the parent and clinician. Not only would such an approach parallel the collaborative nature of help seeking and receiving in the popular sector, it may also alleviate any sentiments the parent may have that their parenting is, somehow, inadequate or at fault. Additionally, as bringing the child’s behavior into question can also cause the parent to question their own parenting to possible deference of seeking help for the child in favor of addressing their own, perceived inadequacies, inquiring about the parent’s own interpretation of the child’s behavior, as well as, discussing the parent’s parenting techniques may lessen any inferred negative impact to their identity as parent or to their child’s identity by the clinical identification of a behavioral problem.
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