Community Mental Health Journal (2019) 55:1152–1164
https://doi.org/10.1007/s10597-019-00444-2

ORIGINAL PAPER

"Not Just One, It's Both of Us": Low-Income Mothers' Perceptions of Structural Family Therapy Delivered in a Semi-rural Community Mental Health Center

Addie Weaver[1] · Catherine G. Greeno[2] · Rachel Fusco[3] · Tina Zimmerman[4] · Carol M. Anderson[2]

Received: 19 April 2019 / Accepted: 25 June 2019 / Published online: 19 July 2019

Abstract
Qualitative methods were used to explore mothers' perceptions of structural family therapy (SFT) delivered in a semi-rural community mental health clinic. In-depth, semi-structured interviews were conducted with sixteen mothers who received SFT after seeking services for their children. Thematic analysis suggests mothers found SFT acceptable and valuable. Mothers reported using SFT strategies to regain parental authority, which they believed improved their ability to manage their child's needs and decreased their own stress. SFT also increased some mothers' receptivity to individual treatment. Mothers identified their low dose of treatment and lack of father involvement as impediments to improvement, raising concerns about intervention sustainability.

Keywords High-risk families · Maternal treatment engagement · Qualitative methods · Treatment acceptability

Introduction

Maternal and child mental health are intimately intertwined and have a reciprocal relationship (Diaz-Caneja and Johnson 2004; Goodman et al. 2011; Goodman 2007; Lyons-Ruth et al. 2000; National Research Council and Institute of Medicine 2009). The stress and burden associated with caring for children with psychiatric distress negatively impact mothers' functioning and puts them at increased risk for depression, anxiety, and alcohol consumption when compared to women caring for healthy children (Barkley et al. 1992; Breslau and Davis 1986; Civic and Holt 2000; Elgar et al. 2004; Harrison and Sofronoff 2002; Mclennan et al. 2001; Pfefferle and Spitznagel 2009). Parents seeking mental health services for their children are more likely to perceive caregiver burden and family stress as a result of their children's behavioral health needs (Alegria et al. 2004; Angold et al. 1998; Verhulst and van der Ende 1997).

As a result, mothers, who commonly initiate mental health services for their children (Broadhurst 2003; Logan and King 2001), often have unmet needs themselves. Literature consistently demonstrates that as many as 60% of mothers initiating treatment for their children meet criteria for depression or anxiety (Kaufman et al. 1998; Rishel et al. 2006a, b; Swartz et al. 2005); though less than half of these women receive care or accept referrals for treatment (Ferro et al. 2000; Kaufman et al. 1998; Rishel et al. 2008; Swartz et al. 2005). This is likely due to mothers' view of their needs as related to their children's problems (Anderson et al. 2006; Nicholson et al. 1998a, b). Mothers often believe their own symptoms will improve if their children get better (Anderson et al. 2006). Furthermore, some mothers perceive individual therapy as a risk, fearing the stigmatization of a mental health diagnosis would cause them to be perceived as unfit parents (Anderson et al. 2006; Brockington 1996; Nicholson et al. 1998a). Despite reluctance to seek care for themselves, mothers report an increased desire for involvement in their child's treatment (Anderson et al. 2006).

Carol M. Anderson—who was centrally involved in this study, passed away prior to manuscript submission

✉ Addie Weaver
weaverad@umich.edu

[1] University of Michigan School of Social Work, 1080 S University, Ann Arbor, MI 48109, USA

[2] University of Pittsburgh School of Social Work, Pittsburgh, PA, USA

[3] University of Georgia School of Social Work, Athens, GA, USA

[4] Allegheny Health Choices, Inc., Pittsburgh, PA, USA

If both family members' needs are not addressed, mothers and their children continue to suffer. A substantial body of work suggests that mothers' psychiatric distress negatively impacts their children across a wide range of outcomes, including social, behavioral, developmental, psychosocial, and academic indicators (Beardslee et al. 2003; Coiro 2001; Cummings and Davies 1994; Downey and Coyne 1990; Goodman et al. 2011; Goodman and Gotlib 1999; Hammen and Brennan 2003; Weissman et al. 1997, 2004). Mothers' mental health also affects their children's treatment outcomes, as children whose mothers are ill are less likely to adhere to treatment and more likely to experience recurrence of illness than children of healthy mothers (Dover et al. 1994; Kaufman et al. 1998; Rishel et al. 2006a, b).

While scholarship consistently demonstrates high levels of unmet mental health needs among mothers initiating mental health treatment for their children, it has been particularly challenging to engage these mothers in treatment (Anderson et al. 2006; Ferro et al. 2000; Kaufman et al. 1998; Rishel et al. 2006a, b; Swartz et al. 2005). Offering concurrent care for both mothers and their children is likely to improve outcomes for both family members and appears to align with mothers' views of treatment (Anderson et al. 2006; Nicholson et al. 1998a, b). Meta-analytic reviews present strong evidence for the efficacy of family therapy on a variety of child behavior health outcomes (Carr 2000a; Shadish et al. 1993, 1995). Though systemic family therapy, rooted in general systems theory, posits that mothers will be impacted by the intervention for the same reason children are, studies largely ignored its effect on mothers' mental health symptomatology or functioning (Carr 2000b).

SFT is particularly relevant for families served by the community mental health setting. The intervention was developed for low-income, multi-problem families, who typically seek care from the community mental health system. Additionally, the core elements of SFT are well-standardized, offering a basic, yet robust approach that is widely used by clinicians (Cottrell and Boston 2002; Minuchin et al. 2007). However, despite its relevance, family models like SFT are rarely available to consumers served in community mental health settings (Painter 2009). This is reflective of the well-established gap between what is known about efficacious mental health treatment and what is provided to consumers in routine, community practice settings. This research to practice gap has been identified as one of most critical issues in mental health services research (Proctor et al. 2009), with estimates suggesting that it takes at least 20 years for knowledge generated from efficacy research to be utilized in routine mental health care (Institute of Medicine 2001; Hogan 2003). Given this treatment access disparity, consumers treated in routine outpatient mental health settings are unlikely to receive evidenced-based care (e.g. Bickman 1996; Nathan et al. 2000; Panzano and Herman 2005; Rotheram-Borus and Duan 2003; Torrey and Gorman 2005).

The mental health treatment access disparity is particularly relevant for rural Americans in need of mental health services, as they are significantly less likely to receive any treatment than their urban peers (Fortney et al. 2010; Wang et al. 2005). When rural Americans do receive mental health treatment, they are less likely to receive care consistent with clinical recommendations or guidelines, compared to urban and suburban counterparts (Wang et al. 2005). This is in part due to the lack of available mental health professionals practicing in rural areas of the United States. In fact, 80% of masters-level social workers (MSWs) and 90% of psychologists and psychiatrists exclusively practice in metropolitan areas (Ellis et al. 2009; Sawyer et al. 2006). As a result of the limited mental health providers serving rural communities, over 60% of rural Americans reside in designated mental health provider shortage areas (Health Resources and Services Administration 2019).

The limited availability of rural providers, combined with substantial barriers related to cost (Proctor et al. 2016; U.S. Department of Agriculture Economic Research Service 2017), insurance status (National Advisory Committee on Rural Health and Human Services 2014; Newkirk and Damico 2014), and travel burden (Amundson 2001; Gjesfjeld et al. 2012; Hogan 2003), make it increasingly difficult for rural consumers to access needed mental health care. Family therapy may provide an important opportunity to increase rural residents' access to empirically supported care within community mental health settings. Simultaneously treating multiple family members has the potential to maximize the efficiency and capacity of the mental health professionals who are scarce in rural settings, while likely reducing cost and travel burden for rural families who attend one appointment but obtain needed care for multiple family members. Furthermore, evidence suggests family therapy does not increase overall healthcare costs and that it may reduce healthcare use, especially among high utilizers (Crane 2008).

It is critical to extend the reach of evidence-based mental health treatments, like SFT, in underserved communities and within community mental health settings. As mothers represent an important stakeholder group whose perceptions likely impact treatment engagement of both themselves and their children, it is imperative to identify and offer interventions that align with mothers' views of their mental health needs and treatment. Given the demonstrated reciprocal relationship between child and maternal mental health, as well as the emphasis that mothers place on the interrelated status of their own and their children's symptomatology, family therapy provides an important opportunity to simultaneously address both family members' mental health needs.

However, mothers' perspectives of family treatment are rarely elicited.

Structural Family Therapy (SFT)

Structural family therapy (SFT), specifically developed to treat low-income families experiencing multiple problems, is grounded in family systems theory and places central importance on establishing a healthy organizational hierarchy within the family system (Minuchin 1984; Minuchin et al. 2007). This systemic family model emphasizes child management strategies and attends to mothers' needs, and, as a result, is likely helpful for mothers who are experiencing mental illness or serious mental health symptoms while caring for children with behavioral health needs.

The SFT model contends that presenting symptoms or behavior problems experienced by one member of the family system can be understood as stemming from the family's underlying patterns of transactions and that these transactions are governed by a clear set of hierarchical organizing principles, with parents in charge (Minuchin 1974; Minuchin et al. 2007). The Structural approach maintains that healthy families are characterized by three distinct subsystems: the parental subsystem, the parent/child subsystem, and the sibling subsystem (Minuchin 1974). The parental subsystem holds the authority for the care and safety of children, fulfills major socialization requirements within the family, and, in two parent families, maintains a clear coalition that stresses teamwork and negotiates conflict (Minuchin 1974; Minuchin and Fishman 1981; Vetere 2001). Within the parent/child subsystem, parents provide nurturance, limit setting, and promote the internalization of cultural values and prepare children for gradual emancipation, while children learn to develop a degree of autonomy within unequal power relationships (Minuchin 1974; Vetere 2001). The sibling subsystem provides the context in which children learn to cooperate, compete, resolve conflict, and prepare for peer relationships as they mature (Minuchin 1974). Each subsystem has clear roles and boundaries. However, boundaries cannot be so rigid that natural adaptation, necessary as families move through the life course, is prohibited. SFT asserts that families adopt dysfunctional patterns when generational boundaries are not maintained or when a family's stress exceeds their ability to adapt.

In the Structural Family model, the therapist joins the family system and encourages families to enact problems in session (Colapinto 1982; Vetere 2001). This allows the therapist to explore the family structure, and assess the family's flexibility and potential for change (Minuchin 1974; Minuchin and Fishman 1981). The therapist then pushes the limits of the family system, altering their patterns of transaction and increasingly their capacity to tolerate stress, while making sure not to exceed their ability to innovate and adapt (Colapinto 1982; Minuchin et al. 2007; Vetere 2001). Particularly, the therapist collaborates with the family to increase their understanding of the presenting child's needs and to restore the family's organizational hierarchy. Once dysfunctional patterns of transaction are outgrown, individual behaviors identified as presenting problems, lose their support in the system and become unnecessary (Minuchin 1974; Minuchin et al. 2007).

For this study, the SFT model was adapted in situ for implementation within a semi-rural community mental health setting. The core therapeutic elements of SFT, described above (e.g., joining; restoring organizational hierarchy via family subsystems and boundaries, enacting transactions in session) remained unchanged. Adaptations were made to increase maternal engagement, modernize the intervention's approach to gender roles making it more applicable for single mothers, and for delivery in a low-intensity treatment setting. Adaptations included: (1) structuring the treatment around four session, renewable contracts; (2) adopting a strengths-based, collaborative orientation to treatment; (3) strengthening the focus on engagement, especially of the mother; and (4) emphasizing elements of treatment that directly address the children's problems as well as the mothers' problems. These adaptations overtly solicited mothers' perceptions of their own and their children's problems in order to collaboratively set goals and explore any inconsistencies between maternal and clinician perceptions. Clinicians solicited maternal feedback throughout therapeutic efforts to restructure the family and utilized treatment to provide enhanced support for maternal functioning. It is of note that although adaptations encouraged maternal engagement, fathers were included and encouraged to participate in SFT sessions as well.

Study Purpose

SFT, designed for low-income families experiencing multiple needs, is likely relevant for the community mental health system, as simultaneously addressing children's and mother's needs may provide a cost-effective way to increase access to care in resource constrained rural environments; however, no identified work has qualitatively explored consumer perspectives of SFT delivered in this setting. This study takes a first step toward addressing this gap by exploring the following research question: What are mothers' perceptions of SFT delivered in a semi-rural community mental health center? As knowledge of consumer perspectives can increase access to care, exploring mothers' treatment experiences with SFT is of particular importance given their high levels of need and low levels of help seeking, as well as their primary role in initiating child treatment. Understanding mothers' perceptions of SFT also provide insight to whether family treatments may offer an acceptable strategy

for increasing access to care in underserved, rural communities. Mothers' perceptions of SFT provide stakeholders within the public mental health system insight to facilitators and barriers impacting the intervention's implementation within the community mental health setting.

Methods

Setting and Participants

Mothers were recruited from a semi-rural community mental health center located in an economically disadvantaged area of Southwest Pennsylvania. Mothers who elected to receive SFT when initiating mental health services for their children between January 1, 2009 and December 31, 2009, were eligible for this study if they were over the age of 18, were the biological, step-, or adoptive mother living with the child presenting for services and had no mental or physical condition that precluded their understanding of study procedures. To be included in the analytic sample, families had to attend at least three SFT sessions over the 6-month study period. Inclusion criteria focused on families who attended at least three SFT sessions over the 6-month study period to ensure families had enough exposure to the SFT model to be able to provide perceptions and feedback specific to the treatment modality rather than about aspects of the community mental health system itself.

One hundred and eighteen families initiating child services at the community mental health center were approached about this study, 54 families agreed to participate, and 31 families received at least three sessions of SFT with multiple family members attending. A subsample of mothers whose families received at least three SFT sessions were randomly selected to participate in in-depth, semi-structured interviews about their treatment experiences that were conducted approximately 6 months after initiating services. Mothers received $50.00 for completing the interview.

Sixteen mothers completed qualitative interviews. On average, these mothers and their families received 6.06 ($SD = 0.892$) Structural Family Therapy sessions over a 6-month period. These mothers had ages ranging from 26 to 64, with a mean age of 39 ($SD = 9.81$), and the majority of mothers identified as non-Hispanic White (n = 14; 88%). Fifty-six percent of the mothers were married or living with a partner (n = 9); 63% reported working outside of the home (n = 10). Half of the mothers (n = 8) were high school graduates, had a GED equivalent, or had completed some college. The majority of mothers were economically disadvantaged (n = 11; 69%), reporting annual household incomes less than $30,000. Twenty five percent of mothers (n = 4) reported living on household incomes under $15,000 per year, while supporting an average of three children under the age of 18. Although mothers did not have to meet diagnostic criteria to be eligible for this study, 68% met established clinical cutoffs for depression or anxiety based on the Beck Depression Inventory (Beck, Steer, and Brown) and the Beck Anxiety Inventory (Beck and Steer 1990) when initiating treatment.

Individual interviews followed a semi-structured guide that was comprised of open-ended questions. The interviews were intentionally non-leading and explored mothers' perceptions of their recent service experience with SFT, as well as their views of SFT for addressing their own mental health needs and their children's mental health needs. All but one interview was conducted in participants' homes, at their convenience, offering experiential insight to these mothers' lives. A female doctoral student in social work conducted the interviews. The interviewer had experience interacting with the community mental health system and structure as well as experience engaging with consumers receiving community mental health services. These experiences increased the interviewers' ability to develop rapport with consumers completing interviews and to understand the treatment context. All mothers provided informed, written consent prior to participation. With participants' permission, interviews were audio recorded and transcribed verbatim. All study procedures were approved by the University of Pittsburgh's Institutional Review Board.

Data Analysis

Thematic analysis, as outlined by Coffey and Atkinson (1996), Miles and Huberman (1984), and Strauss and Corbin (1990) was utilized to analyze transcribed qualitative data. Trained research staff coded the transcribed data using methodology outlined by Strauss and Corbin (1990). Thematic analysis, using an inductive approach, provides an appropriate strategy to address our exploratory research question focused on investigating mothers' perceptions of the SFT model. This analytic strategy emphasizes the voices and lived experiences of an underserved, understudied population of rural mothers by identifying codes and themes as they emerge from the data, in women's own words.

All transcripts were reviewed by two study team members, one of whom conducted all of the interviews, to establish an intimate understanding of interview content. Next, one investigator conducted in vivo, or line-by-line, open coding to categorize responses with participants' own language and meanings whenever possible (Strauss and Corbin 1990). The second coder independently completed in vivo coding to ensure concurrence. The open coded passages were then reviewed, and related passages were grouped together to form axial codes based on emergent themes. The axial codes were further refined in order to develop core categories with broader applicability. The coders engaged in ongoing dialogue with the research team to connect open codes

to broader themes, interpret emerging patterns, and identify core codes. An iterative process, in which the research team discussed emerging themes and resolved inconsistencies in the assignment or description of codes, was used to determine the coding scheme.

Additionally, coding occurred within and across transcripts to monitor saturation. Saturation was determined through ongoing review and discussion of data by the research team, following Miles and Huberman's (1984) and Morse's (1995) operationalization of saturation as acquiring a comprehensive understanding by continuing to sample until no new information is obtained (e.g., data adequacy).

Interviews with 16 mothers resulted in informational redundancy and thematic saturation. Although there are no published guidelines for estimating the sample size required for achieving saturation, research suggests between 12 and 26 in-depth interviews are appropriate (Luborsky and Rubinstein 1995), and our sample size falls within that range.

Results

Thematic analysis of the semi-structured interviews yielded two core categories: (1) Reasons for Seeking Care: Children's and Mothers' Mental Health Needs and (2) Reactions to Structural Family Therapy. Mothers' statements reflecting the themes encompassing each category are reported.

Reasons for Seeking Care: Children's and Mothers' Mental Health Needs

Mothers were asked to describe the situation that led to their seeking care, and they provided detailed information about their children's situation and their own mental health needs. The findings revealed that these mothers sought care when their children's needs became extreme. They also described their own significant symptomatology, and clearly saw their own mental health needs as stemming from, or exacerbated by, their children's situation.

Reasons for Seeking Care for Presenting Child

Participants described severe behavior problems with serious potential consequences for the children involved. Mothers' perceived inability to continue managing their children's significant behavioral health needs without help was endorsed as the primary reason for seeking treatment. As has been reported elsewhere, mothers generally seek community mental health care for their children only after the situation has become almost unbearable (Singer 2009). For example, participants identified suicidal ideation and school related sanctions, such as expulsion and suspension as catalysts for seeking care for their children. One mother explained, "These problems started…and we cannot help him…he's not, you know, he's beyond what our capabilities as parents are, so we sought help for him, yes." Another mother shared:

> Well, she was drug addicted to begin with at birth… and I was told to expect behaviors to worsen as she gets older and believe me, they did. She was to the point where she was stealing, she wasn't following house rules, she was abusing her siblings, and not doing well in school, argumentative with teachers. She actually got thrown out of school a couple of times. She got thrown off the bus to go to school and I've had to transport her back and forth…and I was just at the point where I didn't know what to do but take her to get her some help.

Mothers' Needs

Participants shared their own significant mental health symptoms, and clearly linked their children's behavioral health problems to their own mental health. As this mother stated:

> Well, I'm extremely over-stressed and overwhelmed with everything in my life, having all these teenage boys and my oldest son has been a problem…So, by the time I got to this [provider], I was just drained. I just didn't know what else to do anymore. And I felt there was absolutely no way I could help my kids because I was a mess…So I was starting to worry about myself…we were definitely overwhelmed.

Another mother similarly shared:

> You know, it's very hard with everything that's gone on. My husband and I were walking on eggshells, trying to figure out how to deal with her, how to keep everyone safe, what was going on, what started it, where did it come from…I would have moments, where, for no reason, I would just start bawling, and I still, it's like, what am I crying about? I don't even know.

Despite acknowledging their own mental health needs, and in some cases, existing diagnoses, these mothers indicated that they were unlikely to prioritize care for themselves. This is exemplified by a mother who noted:

> I was diagnosed as bipolar, so was my mother. When my mother got ill, my family doctor put me on medication. But after a couple of months of being on it, he wouldn't prescribe it any longer and he said you have to go to a therapist. Well, here's the deal. I need to go to an allergist too. I need to go to a family doctor. I mean, I don't make appointments for myself. I'm lucky to get in once a year to get my teeth cleaned.

Mothers also identified barriers, including time, money, and stigma, that impacted their ability to initiate services. For instance, one mother explained:

> Well, I'm depressed anyway. I don't have any medication so that plays a big part in it. I work all the time. I suffer from depression, just me being stressed out in general, with [presenting child], and not having my medication, and working all the time, and money…I mean, I went to the doctor. They had me on medicine and then, of course, I quit taking it again. I don't know…I really haven't worked through any of it yet.

Reactions to SFT

Mothers were asked to describe their recent treatment experience with SFT. Interviews revealed that mothers felt strong rapport with their family therapists, developed an understanding of SFT's fundamental tenets, and were able to apply the tenets to address their families' needs. Mothers identified the infrequency of treatment sessions in the overburdened community mental health setting as their primary concern. Interestingly, some mothers reported taking their own individual mental health needs more seriously after participating in SFT.

Collaborative Relationship with Family Therapists

Rapport is a crucial part of any therapy. Mothers consistently described having a strong rapport with their therapists and feeling like part of a team. This suggests that therapists' efforts of joining the family during SFT were meeting with some success. Mothers perceived a collaborative learning process where strategies were taught, applied at home, and then reviewed and refined during sessions. Mothers viewed this collaborative relationship as contributing to their families' increased understanding of the presenting child's behavioral health needs, discussed below.

Mothers' language demonstrated the rapport that families had with their therapists. Mothers often spoke in the collective when discussing strategies or decisions made in therapy sessions, referring to the family and the therapist as one unit. Typical statements are exemplified by one mother who described being "on the same page" with the therapist and another who explained that her family and the therapist "all just clicked very well together." Other observations clearly show that mothers felt like they were part of a team working together with the therapist. This is exemplified by this mother, who stated, "Things are turning around…Now I still have a problem with the stealing, but she only steals from me. Only me, and we [mother and therapist] don't understand why. We can't get to the root of that." Mothers also believed they had a more important role in therapy due to the collaborative relationship established by the therapist. For example, one mother shared, "…and I felt like I knew what was going on because I was in the circle so that really helped me a lot."

Increased Understanding of Presenting Child's Needs

When receiving SFT, families were learning about the presenting children's disorders together, as a team, which mothers found particularly helpful. Many mothers reported that receiving SFT allowed them to learn about the nature of their children's behavioral disorders. This increased knowledge and understanding was helpful to mothers, who indicated that SFT supported their ability to change dysfunctional patterns of transaction. As this mother noted:

> She can't do big crowds…there's too many people, too much noise, too much everything going on…and she knows it now, where before she didn't. Before, I didn't. So that I would get aggravated, she would get upset, and it would just be a big blowup…now at least we can pick some triggers up.

Mothers reported that this increased knowledge and understanding impacted their own ability to effectively manage their children's needs, as well as siblings' ability to positively engage and interact as a family subsystem. For example, mothers believed that siblings' increased understanding of the presenting child's behavioral health needs allowed them to stop reacting to and reinforcing symptomatic behaviors. As one mother shared:

> The older kids were taught to realize the triggers of the youngest ones with ADHD and last summer they didn't realize that so when those kids was agitating them… the older ones would argue back and…now, they walk away …So rather than letting the little kids engage them, they're able to see that, oh this is something to do with the ADHD, I'm not gonna start something, and then it's not gonna escalate…So, now they're learning that so I'm hoping that this summer is going to be a pretty good one.

Finally, mothers reported that increased knowledge of their family members' needs resulted in greater appreciation and understanding of other family members' perspectives. When describing the impact that SFT had on her family, one mother explained:

> …we're all working on focusing on ourselves as a family…I'm not sure how to say this…we are always interested in each other's views and seeing each other's viewpoints and having a counselor that understands us and listens to everything everyone says…and granted, parenting is still a dictatorship…hint, hint…but we

> still valued their opinions - and listening to value each other's opinions is an on-going process - so I think that's helped us a lot simply because [therapist] cares about what we think and…makes us better at expressing how we feel to each other.

Another participant concisely concurred, noting, "I think we're closer. I think we're a little bit more focused on each other's, um, things that we're all going through separately, so that has helped. We've gotten a little closer."

It is of note that some mothers expressed concern that fathers were not actively participating in SFT; and therefore, mothers perceived that fathers continued to engage in dysfunctional patterns of interaction resulting in part from limited knowledge of their children's behavioral health needs. These mothers felt that fathers' lack of involvement in SFT prevented them from understanding their children's needs, which contributed to continued relationship problems. When describing the relationship between her family members, one mother stated:

> [Presenting child] and my husband are having a lot of friction and [my husband] should be going to more of [child's] counseling appointments too but I can't do anything about that…I've tried but he works third shift and wants to sleep so I understand…

Applying SFT Tenets to Restore Family's Organizational Hierarchy

Mothers perceived substantial improvements in family life as a result of receiving SFT. For example, one mother stated:

> After the first two weeks of her having services I could see a big change in the house. She would come in without an attitude. She would say please and thank you… She keeps her bedroom clean now. Another issue with her was she hated to bathe. Well now she's in that tub every night at 8:00 ready to bathe, washing her hair, and getting ready for school. And it's a good thing. Things are turning around.

Perceived improvements appeared to be directly linked to changes that resulted from mothers' application of the structural model's approach to repairing the parent/child subsystem. The most prominent theme to emerge from the interviews was mothers' large strides in re-establishing their parental authority. Participants clearly linked this to their perceived improvements in family life. When discussing her family's treatment experiences, one mother shared, "It definitely helped me. I mean, it lowered some of my stress. I no longer felt overwhelmed…because of the things that I learnt to do to, you know, control the situation in the house".

Mothers' experiences indicate that they learned to recognize dysfunctional patterns of interaction and inappropriate interaction between family subsystems. Mothers discussed children trying to act on "an adult level" and the need to "take the reins and take control." One mother stated "…[presenting child] thinks he's the head of all of us…We needed to find someone to take him back down to a kid level rather than an adult level." Another mother explained, "…[presenting child] mothers her brother…ok, no offense, ***I*** am the mother…if I want [my son] to do something, ***I*** will tell him…just because you're not his mother doesn't mean you can't love him…but I will tell him what to do…"

The interviews also revealed mothers' renewed ability to perform the main functions of parenting, as described in the SFT model. For instance, this mother demonstrated an understanding of her daughter's need for gradual emancipation, sharing:

> I'm learning patience. I'm learning better communication with my daughter. I'm not treating her like a child anymore. You know, I'm letting her make her own choices more and you know, guiding her but also… realizing she's going to be 18 in October.

As previously mentioned, father participation can be challenging in family therapy (Carr 1998), and these mothers identified it as a challenge as well. Given the limited support from a parental coalition, mothers' comments indicated that, as a result of SFT, they learned and applied techniques to engage in self-care. Mothers reported that prioritizing self-care allowed them to address their own stress, which supported their ability to successfully parent. When discussing some of their self-care strategies, one participant stated, "[I put] myself in time out, or to go take a hot bath, or just remove myself from the area…'Cause if you don't get away, you're just gonna blow." Another mother explained:

> Even in the summertime, I would have my daughter-in-law come up and I would just go outside and get in the pool. I would stay in the pool for half an hour, 45 minutes, just to relax, then come back and deal with the situations…[The therapist's suggestions] calmed me down a lot.

Concern over Infrequent SFT Sessions

Some mothers identified having infrequent SFT sessions as a primary concern and believed that infrequent sessions negatively impacted their treatment experience. These mothers attributed their infrequent treatment to characteristics of the community mental health system; though some acknowledged that their chaotic lives also attributed to the irregularity of treatment sessions. Mothers believed that the treatment would have been more successful had their families received more care. When sharing her family's treatment experience, one mother stated:

> Our services weren't consistent enough - which I shared with our therapist and she agreed - but I guess they're just so overwhelmed and understaffed that we just were not able to be consistent. I really wanted to be able to see her once a week, *at least.* And there would be weeks that would go by and we didn't even see her. So that was a big issue and I think played a big part on things not coming to where I wanted them to be…One time it would be every two weeks and then it would stretch out to four or five weeks and I thought, this isn't gonna work, it's not. And it had nothing to do with our therapist at all. She just didn't have enough hours in her book to see all the families…[Community mental health clinic] is basically the only place we can go [because of our insurance]. And, they're obviously overloaded.

Some mothers acknowledged their own contributions to the difficulty in follow through, when they described hectic lifestyles that prevented them from regularly attending family therapy sessions. This mother acknowledged her family's difficulty in regular attendance and follow up with the treatment, noting, "[we] didn't always live here…and I was bouncing around…So there were a lot of appointments that I had to cancel. And I couldn't attend or make up."

Gateway to Individual Treatment

Participating in SFT appeared pivotal in some mothers' decision to seek their own care. Individual therapy is a very important avenue for people with mental health disorders. Five of the sixteen mothers (31%) described seeking therapy for themselves after receiving SFT, and appeared to link their ability to care for themselves to their family therapy experience. Although it was painful to her, this mother described how participating in SFT opened the door for her to consider the potential benefit of individual therapy for herself, explaining:

> At first I kind of was like, um, not offended, but kind of like, wow, we're here for [presenting child], not me, you know, um, and then I'm thinking I can't afford it anyway so it doesn't matter but at first I kind of almost was offended but then sitting back thinking about it, oh my god, this is just not one, it's both of us, so…

Interviews suggest that SFT helped mothers acknowledge their own mental health needs while establishing a comfort level with treatment. For example, one mother explained:

> Yeah, I started going to therapy myself here too. [Individual therapy] helped me deal with stuff that I was dealing with personally on top of the parenting stuff so it took a bit of the edge off of everything that was going on. So it was a lot better. Yeah.

Despite mothers' increased receptivity to individual treatment, access remained a problem for this low-income sample. Mothers explained that while SFT was covered under their children's insurance, they either did not have insurance or did not have a plan that provided adequate mental health coverage. One mother shared:

> Oh yeah, [individual treatment] would be majorly helpful. It's just, right now, I don't have medical. That's coming out of pocket. I'm the only one working right now, my husband's working jobs that really aren't that great. You can't afford to do stuff. That where I'm at.

Discussion

This study reported results of in-depth qualitative interviews with 16 mothers whose families received SFT when seeking community mental health services for their children. Interviews focused on mothers' perceptions of SFT as a treatment modality to address their children needs and their own needs. Findings reveal important implications for SFT's implementation within community mental health settings. Mothers' perceptions of their treatment experiences suggest they found SFT acceptable for addressing both their mental health needs as well as their children's, but also revealed concerns related to their inability to receive consistent care due to low treatment intensity and limited treatment engagement among fathers and partners, which reflect threats to the intervention's sustainability.

Acceptability

Acceptability, following Proctor et al. (2011) definition, refers to the perception among implementation stakeholders that a given treatment is agreeable, palatable, or satisfactory, based on stakeholders' direct experience or knowledge of that particular treatment. Findings suggest that SFT may offer an acceptable way to increase access to care for women initiating treatment for their children, a population unlikely to receive treatment despite consistent documentation of high need. Mothers perceived SFT as appropriate for addressing their reasons for seeking care and described applying central tenets of the SFT model to restore their families' organizational hierarchy and improve their ability to parent effectively. It is of interest that participating in SFT, and finding it helpful, seemed to have opened some mothers to consider individual treatment as well.

Mothers indicated that they sought care when their children's behavioral health needs became severe, and they no longer felt equipped to manage their children's needs. As a result, mothers reported experiencing high levels of stress and chaos in their own lives. This finding, consistent with

existing literature indicating that mothers perceive their own stress as related to their children's behavioral challenges (Anderson et al. 2006; Ferro et al. 2000; Kaufman et al. 1998; Nicholson et al. 1998a, b; Rishel et al. 2008; Swartz et al. 2005), likely impacted these mothers' decision to receive SFT. SFT focuses on mothers in relation to their children and addresses the stress of caregiving, which seems to align with mothers' views. Given mothers' perception of the interrelationship between their own and their children's needs, as well as concerns about their ability to effectively address their children's needs, it is likely that they viewed SFT as not only acceptable, but value-added, when compared to individual child treatment or individual treatment for themselves.

Additionally, mothers endorsed central tenets of the SFT model and described applying techniques taught by their family therapist outside of sessions. Mothers particularly emphasized the importance of regaining parental authority and described their use of techniques to regain appropriate authority in order to more effectively manage their children's behavioral health needs. As many reported limited support from partners, these mothers also described strategies to support their self-care as particularly relevant. Mothers frequently discussed applying techniques for self-care, and reporting using self-care to reduce their own stress while supporting effective management of their children's needs.

Furthermore, mothers' experiences suggest that SFT may have offered an important opportunity to reduce barriers associated with seeking care for their own mental health needs. Mothers commonly described lifestyles in which they juggled appointments and activities for their children around their work schedules, and had no time or energy left to address their own needs. Some mothers also shared that while insurance covered their children's services, they did not have insurance, or adequate coverage, for treatment for themselves. Attending family treatment with their children likely mitigated the challenges mothers face when attempting to factor in services for themselves, including time, cost, and the need for childcare. Additionally, the SFT model allows mothers to continue prioritizing their children's needs, while supporting their own needs as well.

Despite the barriers to care described by many mothers, it is of interest that SFT acted as an important gateway to individual treatment for some mothers. As previously noted, almost one-third (n = 5; 31%) of mothers participating in this study initiated individual treatment after receiving SFT. It may be that attending SFT sessions brought mothers' feelings to the surface while also making them more comfortable with the community mental health service system. Mothers overwhelmingly described developing strong rapport and collaborative relationships with their family therapists. This positive experience may have provided encouragement to seek individual treatment and further speaks to the acceptability of SFT as a way to engage and retain mothers in treatment.

Sustainability

Mothers' experiences with SFT also indicate potential challenges related to the intervention's sustainability within the community mental health setting. Following Aarons et al. (2011) definition, sustainability is defined as the continued use of an innovation, in this case SFT, in practice. The primary potential challenge to sustainability relates to the concern participants raised over the low dose of treatment they received. Some mothers believed their quality of care suffered as a result of infrequent care. Mothers attributed their infrequent treatment sessions to both the overburdened community mental health system as well as their own hectic lifestyles. Although research suggests clinicians working in community mental health settings typically maintain caseloads of 40-50 consumers (Hromco et al. 2003), clinicians at this community mental health clinic commonly maintained caseloads of eighty to ninety consumers and could only schedule therapy sessions every 3 to 4 weeks. This necessarily affects the consistency, and perhaps the quality, of treatment that is offered, as literature consistently demonstrates a positive, clinically significant relationship between session frequency and psychotherapy outcomes (Cuijpers et al. 2013; Erekson et al. 2015). Although these mothers were very positive about their therapists, with many mothers describing a strong rapport and collaborative relationship with therapists, the long periods between appointments remained a problem for families. Given the low intensity of treatment, it is impressive that these families remained in treatment over a 6-month period. This may further support SFT's acceptability among this sample; though it may also indicate that these families were desperate for service and had limited treatment options.

Although the infrequent sessions arose as a potential challenge to sustainability, the fact that mothers found SFT to be helpful indicates that families may be able to apply and benefit from a low dose of this treatment. This is an interesting finding, given that, on average, consumers in routine mental health treatment settings receive 4.3 sessions, yet most efficacy trials suggest 13–17 sessions are required to address mental health needs (Hansen et al. 2002). Further research is necessary to assess the effect of low-dose SFT on outcomes for both mothers and their children in community mental health and other routine practice settings; however, it may be that there is an unexplored benefit to systemic, low-dose SFT, especially among mothers. If effective, offering low-dose SFT, perhaps monthly sessions or multi-family group models, would support the intervention's sustainability within community mental health settings.

Fathers' limited treatment engagement emerged as a sustainability challenge as well. Mothers who had partners, often perceived fathers as disengaged, indicating that fathers were not attending SFT sessions and therefore unable to support and apply treatment strategies. Although adaptations developed in situ for delivery in the community mental health setting included a focus on maternal engagement and acknowledged of a variety of family structures, including single mothers, fathers were invited and encouraged to participate in SFT as well. Given that family systems theory provides the theoretical underpinnings of SFT and that SFT identifies the parental subsystem as a key element of restoring the family organizational hierarchy, it is a problem that mothers perceived a lack of engagement and participation among fathers. Fathers' limited engagement in SFT is consistent with literature suggesting that, in general, fathers are less involved in children's treatment and research related to children's behavioral health problems (Phares et al. 2005, Zimmerman et al. 2000). The current study suggests that fathers' engagement should be a target for community mental health services. Engaging fathers may be particularly important as there is a small literature suggesting fathers' involvement in their children's treatment has been associated with better long-term gains (Bagner and Eyberg 2003; Phares 1996). Further, future research of family treatment in the community mental health setting should consider father's perceptions of treatment in order to better understand factors that may impact their willingness to participate.

Limitations

This study has limitations that must be acknowledged. First, as with all qualitative findings, our results represent the perceptions of this specific group of mothers and are not generalizable. Second, mothers self-selected to receive SFT when initiating community mental health treatment for their children. It may be that these mothers were more receptive to family treatment approaches to begin with, which may have influenced their treatment engagement and perceptions of treatment. Finally, our sample represented an underserved group of women whose children had substantial behavioral health needs. Whereas mothers' perspectives suggest SFT was helpful for both their own needs and managing their children's needs, there is no way to know if this sample of women would have found another type of therapy equally valuable.

Conclusion

Although delivering evidence-based practices within the public mental health system is complex and impacted by a variety of factors, consumer values and consumer concerns have been identified as key factors related to the implementation of evidence-based treatment in community mental health settings (Aarons et al. 2009). This study examined mothers' perceptions of SFT delivered in a semi-rural community mental health clinic and findings suggest SFT is likely an acceptable intervention for families whose children present for treatment within the community mental health setting and may provide a promising way to engage and increase service utilization among mothers. Results provide agency administrators and clinicians with an innovative approach for engaging mothers and children with co-occurring mental health needs in treatment. The potential to simultaneously engage mothers and children in SFT is particularly salient for the rural context, as it may reduce barriers to care associated with the shortage of mental health providers, cost, lack of insurance, and travel burden.

Mothers' perceptions of SFT suggest that it is important for clinicians in community mental health settings to have skills needed to work with families. Mothers receiving SFT reported gaining knowledge of their children's behavioral health needs and applying techniques necessary to restore their families' organizational hierarchy, which they perceived as decreasing their own stress and supporting effective parenting. The hereditary nature of mental health needs, the demonstrated link between mothers' and children's mental health needs, and mothers' positive reaction to family treatment suggest that families could benefit if SFT was offered in the community mental health setting. Assessing community mental health clinicians' current understanding of family systems and family development and providing professional development opportunities in these areas when needed, could strengthen the community mental health workforce's ability to practice effectively with families.

Results of this study also lead to questions regarding the sustainability of SFT within the community mental health setting. Even with the development of adaptations in situ, aimed at providing the best chance at sustainability within this community mental health clinic, there were challenges to providing consistent care. These challenges suggest the importance of staffing resources, as well as system readiness and capability when implementing evidence-base treatment in community mental health settings (Aarons et al. 2009). However, results also suggest that SFT can be delivered at a low-dose within a community mental health setting, with perceived benefits to families. Currently, efficacious systematic family approaches built upon SFT's central theoretical underpinnings, such as brief strategic family therapy (Szapocznik et al. 2003) and multisystemic family therapy (Henggeler et al. 1998) are intensive, community-based interventions often requiring low caseloads (4–6 families) and expensive training, and are rarely available to consumers served by the community mental health system (Painter 2009). Findings from this study indicate potential

opportunities to extend the reach of SFT to low-income, multiple families it was originally developed to treat. Results suggests that implementing SFT within community mental health settings may be feasible, even with existing structural barriers associated with low treatment intensity.

Future research is needed to examine both the effectiveness and implementation of SFT within community mental health settings. Agency administrators and clinicians must be aware of the challenges, opportunities, and complexities around implementing evidence-based practices (Aarons et al. 2009), and also actively advocate for structural changes and treatment innovations, such as tele-mental health, integrated healthcare models, and partnering with community health workers, that will facilitate the implementation of efficacious care for community mental health consumers, ultimately ensuring that the most vulnerable mental health consumers are able to receive effective, acceptable treatment.

Funding The authors disclosed receipt of the following financial support for the research, authorship, and or publication of this article: NIMH R24 MH 0066872: Collaboration to promote engagement of low-income clients, Carol Anderson, PI.

Compliance with Ethical Standards

Conflict of interest The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

References

Aarons, G., Hurlburt, M., & Horwitz, S. (2011). Advancing a conceptual model of evidence-based practice implementation in public service sectors. *Administration and Policy in Mental Health and Mental Health Services Research, 38,* 4–23.

Aarons, G. A., Wells, R. S., Zagursky, K., Fettes, D. L., & Palinkas, L. A. (2009). Implementing evidence-based practice in community mental health agencies: A multiple stakeholder analysis. *American Journal of Public Health, 99,* 2087–2095.

Alegria, M., Canino, G., Lai, S., Ramirez, R., Chavez, L., Rusch, D., et al. (2004). Understanding caregivers' help-seeking for Latino children's mental health care use. *Medical Care, 42,* 447–455.

Amundson, B. (2001). America's rural communities as crucibles for clinical reform: Establishing collaborative care teams in rural communities. *Families, Systems, & Health, 19,* 13–23.

Anderson, C. M., Robins, C. S., Greeno, C. G., Cahalane, H., Copeland, V. C., & Andrews, R. M. (2006). Why lower income mothers do not engage with the formal mental health care system: Perceived barriers to care. *Qualitative Health Research, 16,* 926–943.

Angold, A., Messer, S. C., Stangl, D., Farmer, E. M. Z., Costello, E. J., & Burns, B. J. (1998). Perceived parental burden and service use for child and adolescent psychiatric disorders. *American Journal of Public Health, 88,* 75–80.

Bagner, D. M., & Eyberg, S. M. (2003). Father involvement in parent training: When does it matter? *Journal of Clinical Child and Adolescent Psychology, 32,* 599–605.

Barkley, R. A., Guevremont, D. C., Anastopoulos, A., & Fletcher, K. F. (1992). Acomparison of three family therapy programs for treating family conflicts in adolescents with ADHD. *Journal of Consulting and Clinical Psychology, 60,* 450–462.

Beardslee, W. R., Gladstone, T. R. G., Wright, E. J., & Cooper, A. B. (2003). A family-based approach to the prevention of depressive symptoms n children at risk: Evidence of parental and child change. *Pediatrics, 112,* e119–e131.

Beck, A. T., & Steer, R. A. (1990). Manual for the Beck anxiety inventory.

Bickman, L. (1996). A continuum of care: More is not always better. *American Psychologist, 51,* 689–701.

Breslau, N., & Davis, G. C. (1986). Chronic stress and major depression. *Archives of General Psychiatry, 43*, 309–314.

Brockington, I. (1996). *Motherhood and mental health*. New York: Oxford University Press.

Broadhurst, K. (2003). Engaging parents and carers with family support services: What can be learned from research on help-seeking? *Child and Family Social Work, 8,* 341–350.

Carr, A. (1998). The inclusion of fathers in family therapy: A research based perspective. *Contemporary Family Therapy, 20,* 371–383.

Carr, A. (2000a). Evidence-based practice in family therapy and systemic consultation: Child-focused problems. *Journal of Family Therapy, 22,* 29–60.

Carr, A. (2000b). Evidence-based practice in family therapy and systemic consultation II. *Journal of Family Therapy, 22,* 273–295.

Civic, D., & Holt, V. L. (2000). Maternal depressive symptoms and child behavior problems in a nationally representative normal birthweight sample. *Maternal and Child Health Journal, 4,* 215–221.

Coiro, M. J. (2001). Depressive symptoms among women receiving welfare. *Women and Health, 32,* 1–23.

Coffey, A., & Atkinson, P. (1996). *Making sense of qualitative data: Complementary research strategies*. Thousand Oaks, CA: Sage Publications Inc.

Colapinto, J. (1982). Structural family therapy. In A. M. Horne & M. M. Ohlsen (Eds.), *Family counseling and therapy*. Itasca, IL: F.E. Peacock.

Cottrell, D., & Boston, P. (2002). Practitioner review: The effectiveness of systemic family therapy for children and adolescents. *Journal of Child Psychology and Psychiatry, 43,* 573–586.

Crane, D. R. (2008). The cost-effectiveness of family therapy: A summary and progress report. *Journal of Family Therapy, 30,* 399–410.

Cuijpers, P., Huibers, M., Ebert, D. D., Koole, S. L., & Andersson, G. (2013). How much psychotherapy is needed to treat depression? A metaregression analysis. *Journal of Affective Disorders, 149,* 1–13.

Cummings, E. M., & Davies, P. (1994). *Children and marital conflict: The impact of family dispute and resolution*. New York: Guilford Press.

Diaz-Caneja, A., & Johnson, S. (2004). The views and experiences of severely mentally ill mothers. *Social Psychiatry and Psychiatric Epidemiology, 39,* 472–482.

Dover, S. J., Leahy, A., & Foreman, D. (1994). Parental psychiatric disorder: Clinical prevalence and effects on default from treatment. *Child: Care Health & Development, 20,* 137–143.

Downey, G., & Coyne, J. C. (1990). Children of depressed parents: An integrative review. *Psychological Bulletin, 108,* 50–76.

Elgar, F. J., McGrath, P. J., Waschbusch, D. A., Stewart, S. H., & Curtis, L. J. (2004). Mutual influences on maternal depression and child adjustment problems. *Clinical Psychology Review, 24,* 441–459.

Ellis, A. R., Konrad, T. R., Thomas, K. C., & Morrissey, J. P. (2009). County-level estimates of mental health professional supply in the United States. *Psychiatric Services, 60,* 1315–1322.

Erekson, D. M., Lambert, M. J., & Eggett, D. L. (2015). The relationship between session frequency and psychotherapy outcome in a naturalistic setting. *Journal of Consulting and Clinical Psychology, 83,* 1097–1107.

Ferro, T., Verdeli, H., Pierre, F., & Weissman, M. M. (2000). Screening for depression in mothers bringing their offspring for evaluation or treatment of depression. *American Journal of Psychiatry, 157,* 375–379.

Fortney, J. C., Harman, J. S., Xu, S., & Dong, F. (2010). The association between rural residence and the use, type, and quality of depression care. *Journal of Rural Health, 26,* 205–213.

Gjesfjeld, C. D., Weaver, A., & Schommer, K. (2012). Rural women's transitions to motherhood: Understanding social support in a rural community. *Journal of Family Social Work, 15,* 435–448.

Goodman, S. H. (2007). Depression in mothers. In S. Nolen-Hoeksema, T. D. Cannon, & T. Widiger (Eds.), *Annual review of clinical psychology* (Vol. 3, pp. 107–135). Palo Alto: Annual Reviews.

Goodman, S. H., & Gotlib, I. H. (1999). Risk for psychopathology in the children of depressed mothers: A developmental model for understanding mechanisms of transmission. *Psychology Review, 106,* 458–490.

Goodman, S. H., Rouse, M. H., Connell, A. M., Broth, M. R., Hall, C. M., & Heyward, D. (2011). Maternal depression and child psychopathology: A meta-analytic review. *Clinical Child and Family Psychology Review, 14*(1), 1–27.

Hammen, C., & Brennan, P. A. (2003). Severity, chronicity, and timing of maternal depression and risk for adolescent offspring diagnosis in a community sample. *Archives of General Psychiatry, 60,* 253–258.

Hansen, N. B., Lambert, M. J., & Forman, E. M. (2002). The psychotherapy dose–response implications for treatment delivery services. *Clinical Psychology: Science and Practice, 9,* 329–343.

Harrison, C., & Sofronoff, K. (2002). ADHA and parental psychological distress: Role of demographics, child behavioral characteristics, and parental cognitions. *Journal of the American Academy of Child and Adolescent Psychiatry, 41,* 703–711.

Health Resources and Services Administration. (2019). Designated health professional shortage areas. Bureau of Health Workforce. U.S. Department of Health and Human Services. Retrieved from https://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Smry_HTML&rc:Toolbar=false.

Henggeler, S. W., Shoenwald, S. K., Bourdin, C. M., Rowland, M. D., & Cunningham, P. B. (1998). *Multisystemic treatment of antisocial behavior in children and adolescents*. New York: Guilford.

Hogan, M. F. (2003). The President's New Freedom Commission: Recommendations to transform mental health care in America. *Psychiatric Services, 54,* 1467–1474.

Hromco, J. G., Moore, M. W., & Nikkel, R. E. (2003). How managed care has affected mental health case management activities, caseloads, and tenure. *Community Mental Health Journal, 39,* 501–509.

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academy Press.

Kaufman, J., Birmaher, B., Brent, D., Dahl, R., Bridge, J., & Ryan, N. D. (1998). Psychopathology in the relatives of depressed-abused children. *Child Abuse & Neglect, 22,* 171–181.

Logan, D. E., & King, C. A. (2001). Parental facilitation of adolescent mental health service utilization: A conceptual and empirical review. *Clinical Psychology: Science and Practice, 8,* 319–333.

Luborsky, M. R., & Rubinstein, R. L. (1995). Sampling in qualitative research: Rationale, issues, and methods. *Research on Aging, 17,* 89–113.

Lyons-Ruth, K., Wolfe, R., & Lyubchik, A. (2000). Depression and the parenting of young children: Making the case for early preventive mental health services. *Harvard Review of Psychiatry, 8,* 148–153.

Mclennan, J. D., Kotelchuck, M., & Cho, H. (2001). Prevalence, persistence, and correlates of depressive symptoms in a national sample of mothers of toddlers. *Journal of the American Academy of Child & Adlolescent Psychiatry, 40,* 1316–1323.

Miles, M. B., & Huberman, A. M. (1984). Drawing valid meaning from qualitative data: Toward a shared craft. *Educational Researcher, 13,* 20–30.

Minuchin, S. (1974). *Families and family therapy*. Cambridge, MA: Harvard University Press.

Minuchin, S. (1984). *Family kaleidoscope*. Cambridge, MA: Harvard University Press.

Minuchin, P., Colapinto, J., & Minuchin, S. (2007). *Working with families of the poor* (2nd ed.). New York: The Guilford Press.

Minuchin, S., & Fishman, H. C. (1981). *Family therapy techniques*. Cambridge, MA: Harvard University Press.

Morse, J. M. (1995). The significance of saturation. *Qualitative Health Research, 5,* 147–149.

Nathan, P. E., Stuart, S. P., & Dolan, S. L. (2000). Research on psychotherapy efficacy and effectiveness: Between Scylla and Charybdis? *Psychological Bulletin, 126,* 964.

National Advisory Committee on Rural Health and Human Services. (2014). *Rural implications of the Affordable Care Act outreach, education, and enrollment (Policy brief)*. Retrieved from https://www.hrsa.gov/advisorycommittees/rural/publications/ruralimplications.pdf.

National Research Council and Institute of Medicine. (2009). Depression in parents, parenting, and children: Opportunities to improve identification, treatment, and prevention. In M. J. England & L. J. Sim (Eds.), *Committee on depression, parenting practices, and the healthy development of children*. Washington, DC: The National Academies Press.

Newkirk, V. R. & Damico, A. (2014, May). *The Affordable Care Act and insurance coverage in rural areas* (Issue Brief). Menlo Park, CA: Kaiser Family Foundation. Retrieved from https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8597-the-affordable-care-act-and-insurance-coverage-in-rural-areas1.pdf.

Nicholson, J., Sweeney, E. M., & Geller, J. L. (1998a). Mothers with mental illness: I.: The competing demands of parenting and living with mental illness. *Psychiatric Services, 49,* 635–642.

Nicholson, J., Sweeney, E. M., & Geller, J. L. (1998b). Mothers with mental illness: II. Family relationships and the context of parenting. *Psychiatric Services, 49,* 643–649.

Painter, K. (2009). Multisystemic therapy as community-based treatment for youth with severe emotional disturbance. *Research on Social Work Practice, 19,* 314–324.

Panzano, P., & Herman, L. (2005). Developing and sustaining evidence-based systems of mental health services. In R. E. Drake, M. R. Merrens, & D. Lynde (Eds.), *Evidence-based mental health practice* (pp. 167–187). New York, NY: Norton.

Pfefferle, S. G., & Spitznagel, E. L. (2009). Children's mental health service use and maternal mental health: A path analytic model. *Child and Youth Services Review, 31,* 378–382.

Phares, V. (1996). *Fathers and developmental psychopathology*. New York: Wiley.

Phares, V., Lopez, E., Fields, S., Kamboukos, D., & Duhig, A. M. (2005). Are fathers involved in pediatricresearch and treatment? *Journal of Pediatric Psychology, 30,* 631–643.

Proctor, B. D., Semega, J. L., & Kollar, M. A. (2016). *Income and poverty in the United States: 2015 (Current population reports)*. Washington, DC: U. S. Government Printing Office.

Proctor, E., Silmere, H., Raghavan, R., Hovmand, P., Aarons, G., Bunger, A., et al. (2011). Outcomes for implementation research: Conceptual distinctions, measurement challenges, and research

agenda. *Administration and Policy in Mental Health and Mental Health Services Research, 38,* 65–76.

Proctor, E. K., Landsverk, J., Aarons, G., Chambers, D., Glisson, C., & Mittman, B. (2009). Implementation research in mental health services: An emerging science with conceptual, methodological, and training challenges. *Administration and Policy in Mental Health, 36,* 24–34.

Rishel, C. W., Greeno, C. G., & Anderson, C. (2008). The relationship between maternal and child symptom change in community mental health. *Community Mental Health Journal, 44,* 289–293.

Rishel, C. W., Greeno, C. G., Marcus, S. C., & Anderson, C. (2006a). The effect of maternal mental health problems on child treatment response in the community. *Psychiatric Services, 57,* 716–719.

Rishel, C. W., Greeno, C. G., Marcus, S. C., Sales, E., Shear, M. K., Swartz, H., et al. (2006b). Impact of maternal mental health status on child mental health treatment outcome. *Community Mental Health Journal, 42,* 1–12.

Rotheram-Borus, M. J., & Duan, N. (2003). Next generation of preventive interventions. *Journal of the American Academy of Child & Adolescent Psychiatry, 42,* 518–526.

Sawyer, D., Gale, J., & Lambert, D. (2006). *Rural and frontier mental and behavioral health care: Barriers, effective policy strategies, best practices*. Waite Park, MN: National Association for Rural Mental Health.

Shadish, W. R., Ragsdale, K., Glaser, R. R., & Montgomery, L. M. (1995). The efficacy and effectiveness of marital and family therapy: A perspective from meta-analysis. *Journal of marital and Family Therapy, 21,* 345–360.

Shadish, W., Montgomery, L., Wilson, P., Bright, I., & Okwumabua, T. (1993). The effects of family and marital psychotherapies: A meta-analysis. *Journal of Consulting and Clinical Psychology, 61,* 992–1002.

Singer, J. B. (2009). *Mothers seeking mental health services for their children: A qualitative analysis of pathways to care* (Doctoral dissertation, University of Pittsburgh).

Strauss, A. C., & Corbin, J. M. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Thousand Oaks, CA: Sage Publications.

Swartz, H., Shear, M. K., Wren, F. J., Greeno, C. G., Sales, E., Sullivan, B. K., et al. (2005). Depression and anxiety among mothers who bring their children to a pediatric mental health clinic. *Psychiatric Services, 56,* 1077–1083.

Szapocznik, J., Hervis, O. E., & Schwartz, S. (2003). *Brief strategic family therapy for adolescent drug abuse (NIH Publication No. 03-4751). NIDA Training manual for drug addictions*. Rockville, MD: National Institute on Drug Abuse.

Torrey, W. C., & Gorman, P. G. (2005). Closing the gap between what services are and what they could be. In R. E. Drake, M. R. Merrens, & D. W. Lynde (Eds.), *Evidence-based mental health services* (pp. 167–188). New York, NY: Norton.

U.S. Department of Agriculture Economic Research Service. (2017). *Geography of poverty*. Retrieved from https://www.ers.usda.gov/topics/rural-economy-population/rural-poverty-well-being/geography-of-poverty.aspx.

Verhulst, F. C., & van der Ende, J. (1997). Factors associated with child mental health service use in the community. *Journal of the American Academy of Child and Adolescent Psychiatry, 36,* 901–909.

Vetere, A. (2001). Structural family therapy. *Child Psychology & Psychiatry Review, 6,* 133–139.

Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Twelve-month use of mental health services in the United States: Results from the National Comorbidity Survey replication. *Archives of General Psychiatry, 62,* 629–639.

Weissman, M. M., Feder, A., Pilowsky, D. J., Olfson, M., Fuentes, M., Blanco, C., et al. (2004). Depressed mothers coming to primary care: Maternal reports of problems with their children. *Journal of Affective Disorders, 78,* 93–100.

Weissman, M. M., Warner, V., Wickramaratne, P., Moreau, D., & Olfson, M. (1997). Offspring of depressed parents: 10 years later. *Archives of General Psychiatry, 54,* 932–940.

Zimmerman, M. A., Salem, D. A., & Notaro, P. C. (2000). Make room for daddy II: The positive effects of fathers' role in adolescent development. *Child Development, 78,* 132–147.