Published in final edited form as:

J Child Adolesc Psychiatr Nurs. 2009 May ; 22(2): 86–98. doi:10.1111/j.1744-6171.2009.00177.x.

A Comparison of Two Types of Social Support for Mothers of Mentally Ill Children

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Abstract

PROBLEM—The purpose of this analysis was to compare social support offered by two telehealth nursing interventions for mothers of children with serious mental illnesses.

METHODS—A randomized, controlled, quantitative investigation is underway to test two support interventions, using the telephone (TSS) or Internet (WEB). Qualitative description was used to analyze data generated during telehealth interventions.

FINDINGS—The behaviors and attitudes of children were challenging for the mothers to manage. Mothers' emotional reactions included fear, frustration, concern, and guilt. They sought to be advocates for their children. The nurses provided emotional, informational, and appraisal support. TSS mothers were passive recipients, while WEB mothers had to choose to participate.

CONCLUSIONS—Mothers in both interventions shared similar concerns and sought support related to their child's problems.

Keywords

Mothers; mental illness in children; social support; telehealth

In the United States, approximately 20% of children have mental health problems, of which only 20% are receiving mental health services (National Institute of Mental Health, 2002; U.S. Public Health Service, 2000) and only about half are receiving appropriate services (Junek & Thompson, 1999; Knitzer, 1993; President's New Freedom Commission on Mental Health, 2003). As with other areas of health care, more and more responsibility for mental health care is being placed on the parents or other primary caregivers (Grey, Knafl, & McCorkle, 2006). Being the mother of a child with mental illness is associated with high levels of distress and depression (Elgar, McGrath, Waschbusch, Stewart, & Curtis, 2004). Efforts to reduce parents' depression and/or distress have been significantly associated with improvement in child mental health problems (Weissman et al., 2006). However, the main focus of care is typically the treatment of the child, and as a result, the parents' needs are rarely addressed (Downey & Coyne, 1990; Elgar et al.). According to the National Mental Health Association and the Federation of Families for Children's Mental Health (NMHA & FOF, 1993), parents who are caring for children with mental illness find it extremely difficult to get their own mental health needs met while trying to meet the mental health needs of their children. The Surgeon General's Conference on Children's Mental Health (U.S. Public Health Service) noted that these children and their families face a healthcare crisis because of a lack of available services. A randomized controlled investigation is being conducted to test two types of social support interventions—TSS and Web-based social support—for mothers of seriously mentally ill children. Mothers recruited for the study have children ranging from 5 to 12 years of age who have been recently discharged from an inpatient psychiatry unit. The ongoing study uses an experimental design with randomization to three groups: a usual care group, a TSS group, and a Web-based social support group. This paper reports the findings from a qualitative portion of the investigation examining the interactions between mothers with the TSS nurses and the chat room nurse facilitator. The purpose of this analysis was to compare the amount and types of support offered via these two different types of telehealth interventions.

Background

Many changes have occurred in inpatient treatment of mentally ill children in the last 30 years. In 1978, common lengths of stays for children in acute psychiatric inpatient settings were 3-4 months or longer. Beginning in the mid-1980s, lengths of stays in community hospitals began decreasing. By 1990, the median length of stay was 12.2 days; by 2000, the median length of stay was down to 4.5 days (Case, Olfson, Marcus, & Siegel, 2007). The median length of stay in public sector facilities has also dramatically decreased. Additional cost containment efforts have reduced outpatient services and out-of-home placements for these children. Parents are increasingly responsible for caring for their more acutely mentally ill children without many resources to assist parents or alleviate parents' distress (Plante, Couchman, & Diaz, 1995; Rose, 1998; Scharer, 2002).

When school-aged children require psychiatric hospitalization, their parents typically experience significant distress (Delaney & Engels-Scianna, 1996; Scharer, 2002). Since most psychiatric hospitalizations for children are currently 5-7 days in duration, little change in the child's behavior is likely to be observed and some parents even complain their children are worse when they return from the hospitalization. Since mothers are the most common caregivers, they are in the position of needing to make follow-up decisions about the child's care, schooling, and behavior management. They may or may not have sufficient information, resources, or skills to make appropriate decisions for their child's needs (Scharer).

According to a study by Barkley, Anastopoulos, Guevremont, and Fletcher (1992), mothers of children with mental illness were two to three times more likely to be depressed than

mothers of healthy children. Factors identified by the mothers which contributed to their emotional state were a lack of support from all involved agencies, a lack of information about managing their child's behavior at home, being blamed for their child's mental health problems by professionals, not being included as part of the treatment team, and the isolation of the family due to the stigma of mental illness (NMHA & FOF, 1993). These factors identified by the mother only compounded the problems mothers encountered daily in caring for their children, such as aggressive behavior, suicidal threats or behaviors, and other negative changes in their child (Simon, 1997). Mothers also have to interact with neighbors, teachers, and others in the community about their child's problematic behaviors (NMHA & FOF).

Mothers' stress resulted from both the child's behaviors and the mothers' perceptions of those behaviors (Delaney & Engels-Scianna, 1996). When mothers perceive themselves as stressed, they have more difficulty coping with their child's behavior, have increased anxiety or other mood disturbances, and may develop physical problems, such as gastrointestinal upsets or headaches. This increase in maternal stress is particularly important since research has shown that stress plays a role in the development and maintenance of children's emotional/behavioral problems (Lewis, Dlugokinsky, Caputo, & Griffin, 1988) even after a child experiences a psychiatric hospitalization (Veerman, 1995). Studies emphasized the importance of treating the entire family unit during and after child psychiatric hospitalization, not because the family caused the problem but because the whole family is affected by the child's problems (Lewis et al.; Veerman).

Another way to provide help to mothers of mentally ill children is through specialized social support programs (Whittaker, 1992). In a study by Scharer (2002), mothers reported needing increased support, including emotional and informational support, following their child's psychiatric hospitalization. In today's hectic times, few parents are able to find time to attend a support group, especially when that involves finding a babysitter for their child with mental health problems. In rural areas, the difficulties are compounded by long commuting distances to the child psychiatry units, which are typically found in larger urban hospitals.

Theoretical Perspective

The theoretical perspective guiding the larger study is based on the concepts of stress, adaptation, and coping. Lazarus (1991,1999; and with Folkman, 1984) have developed a cognitive-phenomenological model of stress, appraisal, and coping in which the individual's cognition is important in the perception or appraisal of the stressor. The stressor can be any phenomenon that elicits the stress response. A psychological stressor is an association between the individual and the milieu that the individual assesses as a threat. It is the interaction between the person and the environment that influences the adaptation of the individual. There are two types of appraisal: (a) estimation of the risks or benefits and (b) assessment of ways to manage the stressor. Coping is the attempt to manage the stressor (Lazarus, 1991). There are two categories of coping. Emotion-focused coping strategies are employed when acceptance or emotional regulation are needed. Problem-solving coping is used when the problem can be solved. Coping effectiveness can only be evaluated based on its effectiveness in the short and long run (Lazarus, 1991). An important mediator in the stress-adaptation-coping cycle is social support (Lazarus & Folkman, 1984).

Social Support

Expression of positive affect between people, affirmations, providing guidance, giving information, giving of aid (actual or symbolic), and social reinforcement are examples of social support. Social support is usually provided by one's social network. Members of the network provide emotional succor, tangible aid, or information (Schaefer, Coyne, &

Lazarus, 2002). Birch (1998) discussed four types of support: informational, material, emotional, and appraisal. Informational support was sharing knowledge or aiding another in learning to obtain needed information. Material support was providing assistance, such as transportation or money, or physically aiding another. Emotional support was listening, offering sympathy, or being available. Appraisal support was giving feedback, affirmations, or praise (Birch).

Social support is important for good health and well-being (World Health Organization, 1998). In 1999, Vandervoort studied satisfaction with social support and its effect on physical and mental health and found that an individual's satisfaction with social support was significantly correlated with both mental and physical health. In terms of health outcomes, the quality of social support was more important than the amount. It is evident in the literature that highquality social support can make a significant contribution to both mental and physical health (Vandervoort).

Letourneau et al. (2001), conducted a randomized, controlled study with 34 families to test a structured social support intervention for mothers of children who were high risk for mental health problems. After analyzing their data, the researchers discovered that the intervention resulted in an enhanced relationship between mother and child (Letourneau et al.).

While social support can be inappropriately offered or the timing of the social support may be problematic, most of the studies reported have demonstrated the value of social support as a positive mediating variable in the stresscoping cycle. Social support can be delivered face to face, by telephone, or over the Internet.

Web-Based Social Support

Computers and other electronic devices have been used to link individuals with various health problems for Web-based social support (Bass, McClendon, Brennan, & McCarthy, 1998; Dunham, Hurshman, Litwin, Gusella, & Ellsworth, 1998; Kalichman et al., 2003). Both discussion boards (asynchronous) and chat rooms (synchronous) allow interactions of participants over the Internet. The study of Dunham et al. demonstrated that young, single mothers who were more isolated tended to use electronic support more than the mothers who were less isolated. Work with caregivers also demonstrated that increased electronic social support reduced stress and strain on the caregiver (Bass et al.; Brennan, Moore, & Smyth, 1991). However, Web-based interventions have not been reported as a method of providing social support to mothers whose children have mental illness. For a more complete discussion of stress and coping, social support, and Web-based social support, see Scharer (2005b).

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Telephone Social Support

Despite the fact that the telephone has been used to provide support and counseling for more than 50 years, there is limited research on this approach. The telephone has been used to help underserved groups, such as minorities and rural populations, as well as with disenfranchised groups unable or unwilling to use more traditional services (Bartlam, 2000; Masi & Feedman, 2001; Wang, 2000). Support and counseling via the telephone has been typically provided to populations who otherwise would not be able to obtain services for a variety of reasons, including concerns/fears because of stigmatization and fear of discrimination, geographic distance and isolation, physical disabilities, and inability to pay (Bobevski, Holgate, & McLennan, 1997; Rasmussen Cruz et al., 2001; Lynch, Tamburrino, & Nagel, 1997).

Telephone support and counseling have been used for a full range of activities, from health promotion interventions to crisis intervention (Bobevski & McLennan, 1998; Samarel, Tulman, & Fawcett, 2002). The most commonly used intervention strategies were to provide: (a) emotional support (Rasmussen Cruz et al., 2001; Lynch et al., 1997); (b) information (Hellerstedt & Jeffery, 1997; Lynch et al.; Valdiserri et al., 1989); (c) a focus on the individuals' most immediate problems/concerns (Bobevski & McLennan; Bobevski et al., 1997); (d) assistance in cognitive reframing and problem solving (Slap, Plotkin, Khalid, Michelman, & Forke, 1991); and (e) a pathway to obtain care and services through referral (Hellerstedt & Jeffery). Telephone support was less threatening to some people because of the reduced level of intimacy. This was important for individuals faced with a sensitive or embarrassing problem and provided the privacy and confidentiality needed when disclosure of stigmatizing conditions was a concern (Bobevski et al.; DeNardo, Stebulis, Tucker, & Schaller, 1995). Other advantages of telephone support and counseling noted were increased empowerment and control, decreased number of unnecessary clinic visits and costs of providing services convenience and comfort, client sense of safety, and increased number of appropriate referrals (Bobevski et al.; DeNardo et al.; Valdiserri et al.). Another advantage was that contact could be maintained even if the client moved to a different location (Bobevski et al.).

A few well-controlled studies provide a link between telephone support and counseling and therapeutic outcomes or behavior change (Bobevski & McLennan, 1998; Vitaliano, Russo, Carr, Maiuro, & Becker, 1985). Recipients of telephone support and counseling have been reported to have less depression (Turk & Okifuji, 1994), improved adherence (Bobevski & McLennan), fewer stress symptoms (Parikh, Eden, Price, & Robinson, 1988), and reduction in risk behaviors (Bobevski et al., 1997; Bobevski & McLennan; Sarason, Levine, Basham, & Sarason, 1991). Researchers have shown that telephone-delivered social support can be as effective as face-to-face social support, which is an important finding in efforts to reduce healthcare costs in our country (Samarel et al., 2002).

Summary

Telephone support and Web-based social support approaches present options for reaching and supporting mothers of mentally ill children. Emotional and informational support interventions are the most common and appropriate to implement via the telephone or the Internet. There is also evidence that telehealth approaches can be effectively used to promote cognitive reappraisal, problem-solving, and coping strategies. Overall, telehealth support is a viable approach to meeting the needs of rural mothers of mentally ill children, and provides potentially feasible and cost-effective approaches to offset barriers to care that are common with this population.

Methodology

Qualitative description was used to compare the mothers' and nurses' interactions in the TSS intervention with that of the Web-based social support intervention, specifically the chat room discussions (Sandelowski, 2000). In qualitative description, the researcher uses a framework to interpret the data presented (Sandelowski). Analysis of the conversations between the mothers and the support nurses was done to determine any qualitative differences between the support modalities. This analysis is a precursor to statistical analysis and will be helpful in understanding the statistical findings of the larger study.

Sample

The population for this study was mothers or maternal caregivers of children with serious mental illness. For purposes of this paper, all the maternal caregivers are referred to as

mothers. The mothers were recruited from child psychiatric units on which their children were hospitalized, although no data were collected until the child was discharged from the hospital. The children were between 5 and 12 years old at the time of hospitalization, and all had a primary *DSM-IV* diagnosis. The mothers were given a letter by a unit staff person and asked to read it. The letter was written at a low literacy level explaining the study and was used to assess if the mother had enough reading skill to participate in the study. Afterwards the unit staff member asked the mother if she had any questions and if she was interested in hearing more about the study. If so, the mother completed a contact information form. The unit staff member forwarded the contact information to the research team. The research team then called the mother to explain the study further. If mothers were interested in participating, they were randomly assigned to one of three groups: the TSS group, the Usual Care group, and the Web-based Social Support group. Other inclusion criteria included the requirements that mothers could speak English, had telephone service, and could read at a fourth grade level.

TSS was delivered on a one-to-one basis. Therefore, to make the comparison events as similar as possible, interactions for the Web-based group were selected when only one mother was participating in the chat with the Web-based social support nurse facilitator. Several interactions between pairs of mothers and nurses were analyzed.

Sampling procedures for this analysis involved selecting the sessions from the chat room data that involved only one mother, which had happened on several occasions. Sampling of the TSS calls involved selecting randomly from among the tape recordings that had already been transcribed. Multiple sessions with each participant were selected.

Mothers were recruited from four southeastern hospitals with child psychiatric units: two private, not-for-profit medical centers with child psychiatric units and two state-funded psychiatric hospitals child psychiatric units. Forty-one transcripts from the chat room conversations and the telephone conversations with participating mothers were read, and entered into NVivo software, which was used for data management and coding. Twenty-two chat-room transcripts, representing conversations with seven participants, were analyzed. A total of 19 telephone conversation transcripts, representing four participants, were analyzed. Sampling ended when the coding interviews became redundant, i.e., for several interviews no new codes, themes, or differences in content were being found during coding in either mothers' or nurses' data. In qualitative research, this is considered to be data saturation and is the point when sampling concludes (Morse, 2007).

Interventions

Nurses who were providing social support were psychiatric nurses who had worked on inpatient psychiatric units with either children or adults. These nurses received both didactic training and participated in practice sessions. The training was 2 days in length and the didactic portion was focused on Lazarus and Folkman's theory. Emotional, informational, appraisal, and material social support, as described by Birch (1998), were discussed as well as their application. It was noted that because of the delivery systems for the interventions, tangible material support could not be provided. In addition, problem-solving coping and emotional coping were reviewed along with strategies for promoting both and appropriate situations in which each should be used. Differences between therapy and the intervention were made clear. The nurses were taught when to refer mothers to other resources and the nurses were provided with a list of available resources as well as a current drug book. Then nurses role-played sessions, using real situations provided from the primary investigator's (PI) clinical experiences. The PI was doctorally prepared and had many years of inpatient child psychiatric nursing experience, working with children and their parents, running parent groups, and providing family therapy and individual therapy for parents. The nurses

practiced using different vignettes with the PI portraying various mothers with a wide range of problems. The TSS nurses were also taught how to document their sessions to facilitate subsequent sessions and as a back-up in case a session failed to tape properly. The typical oral conversation during these interactions lasted about 15-20 min.

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The chat room was 1 hr in length but with the additional time it took to type and read the responses, communication took longer. Each chat room session was automatically recorded and stored in an MS Excel file. The transcripts of the TSS sessions were approximately the same length as the chat-room transcripts.

In addition, nurses were supervised by the PI. Supervision occurred for the TSSNs through listening to tape-recorded sessions and providing feedback. For the chat room, written transcripts were read.

The TSSN called the mother every 2 weeks at a time agreed upon. During the first call, the TSSN collected some history of the mother's situation and found out what difficulties the mother was experiencing. In subsequent calls, the TSSN followed up on problems the mother had mentioned in previous sessions and discussed coping strategies, and provided informational and emotional support,

The Web Nurse (Web RN) facilitated the chat room weekly for an hour. The chat room was used to provide peer support among the mothers, but on occasion, only one mother entered the chat room. In that case, the Web RN chatted with the mother, provided informational, emotional, and appraisal support, and encouraged appropriate coping. Mothers who participated in the Web intervention either used their own computers or were given an MSN TV© device. Approximately two thirds of the mothers owned computers. The study also paid the Internet service provider fees for the study period. The Web site was developed and tested in a pilot study, using feedback from mothers in earlier studies and from studies found in the literature (Scharer, 2002; Scharer 2005a,b). Improvements were made based on the pilot data, including the addition of the chat room. The site was password protected so that only mothers who were involved in the study could access the site and the chat room during their 6 months of participation. Mothers were trained on using the Web site and the chat room during their introduction to the study. Because of the nature of the chat room, no one paid much attention to typos or misspellings and they were quite common—even the Web RN made mistakes and purposefully did not correct them. Not all of the mothers in the ongoing study use the chat room aspect of the Web site and they select when to participate. However, there are many other features of the Web site that are available to the mothers in addition to the chat room and these are described elsewhere (Scharer).

Data Collection Procedures

Data used in this paper were collected with other data during the larger study. All participants gave informed consent. The TSS conversations with the mothers were tape recorded, and then transcribed verbatim, except that any names used were changed to initials or (*my child*) when a child's name was used. The transcript was then converted to a rich text file for coding. Calls were made every other week for 6 months. The TSS nurses also kept more focused, written records of their conversations so they could refer to them prior to and during each phone call. The written record allowed the nurse to follow-up on issues raised in the previous session or to check on a problem the mother was trying to resolve.

Data from the chat room were also collected for data purposes. Transcripts of sessions were downloaded as MS Excel files. Data from the MS Excel file were then imported into a rich

text file for coding. Since only aliases were used in the chat room, the identity of the participants was protected. However, if a child's name was used by a mother, (*my child*) was inserted in place of the child's name in the text file.

The chat room was available once a week in the late evening for 1 hr. This time was selected so that younger children would have already gone to bed and there would be fewer interruptions for the mothers. Of course, many times there were multiple mothers in the chat room. At other times, however, only one mother entered the chat room. The nurse facilitator was always available when the chat room was open so on these evenings, more in-depth written conversations were held. While the time set aside for the chat was significantly longer than for the telephone calls, the process of writing and posting responses, and waiting for data to be sent over dialup Internet service providers resulted in about the same amount of interaction time as in the telephone calls.

Data Analysis

Demographic data for the specific mothers in this group were analyzed using descriptive statistics. The qualitative data were first coded at a descriptive level by a nurse doctoral candidate not involved in either intervention or in the main study. Initial codes were naturally occurring in the data. The goal was to describe what was seen in the data through identification of similarities and differences and to label these with codes. Then the codes were grouped into larger categories to describe the experience of the phone calls and chat rooms. Finally, major concepts were developed for organizing and reporting the data. The coding process and analysis was supervised by the PI, who has conducted many qualitative studies and has many years of clinical practice with the population being studied. In addition, the outcomes were reviewed by the entire research team for coherence of the results.

Category Development and Coding

The transcripts were read several times to familiarize the reader with the types of conversations and general ideas being discussed. The data were entered into NVivo software to facilitate coding and management of the data. The program allowed coding, sorting, writing memos, comparing categories, and easy recoding as categories were collapsed.

Conversations included common problems and actions identified by the participating mothers and nurses. Initial descriptive codes were assigned to problems and actions described and discussed by the mothers and to the interactions of the nurses with the mothers. These were then grouped into categories and finally into descriptive concepts that illustrate the problems and processes of these mothers' experience as well as the contributions of the nurses. All the participating mothers discussed similar challenges in providing mothering for their child. During analysis, several concepts emerged from the conversations.

Verification

Creswell (1998) used the term *verification* to describe the process of ensuring credibility and dependability of qualitative studies. Several methods were employed in this study to assure credibility and trustworthiness. First, members of the research team have years of involvement with the population being studied and the duration of the intervention and multiple sessions transcripts over time contribute to prolonged engagement and persistent observation, two methods of increasing credibility. In addition, peer debriefing is an external check on the research process. Peer debriefing was used through the PI's supervision of the nurse who was conducting the analysis. In addition, the software used to facilitate analysis maintains an audit trail that can be used for verification.

Results

Results include the analyzed demographic data as well as the qualitative analysis of the transcripts. Results of the qualitative analysis are reported using both summary statements and portions of transcripts, with an alias rather than the mother's name. Care has been taken to protect the mother's confidentiality. For the sake of clarity, the participants will be referred to as "chat mothers" and "phone mothers" and their own words will be used to illustrate the concepts derived from the data.

Sample Demographics

Eleven mothers' interactions with the support nurses were used in this analysis. The educational attainment of the mothers varied from a grade school education to college graduate. Five of the mothers were homemakers, one was a laborer, two were in service occupations, two were in executive/managerial positions, and one was in a professional or specialist position. Incomes ranged from less than \$15,000 (five mothers) to between \$75,000 and \$100,000 (two mothers). The other four mothers' incomes were in between the high and low amounts.

Nine of the 11 children who had been inpatients in the child psychiatric unit had more than one diagnosis. Six children had a bipolar disorder diagnosis, eight had an attention-deficit/hyperactivity disorder (ADHD) diagnosis, two had an oppositional defiant disorder diagnosis, two had major depressive disorders, and one had a pervasive developmental disorder.

The two groups—Web-based social support intervention and TSS intervention—were also compared on certain demographic variables to determine similarities of the two groups. Tables 1-3 show that the Web-based social support group ($N = 7$) had almost twice as many mothers as the TSS group ($N = 4$). The most apparent difference is in the mothers' ages. The mothers in the TSS group were older than the mothers in the other group. However, the smaller number of mothers in the telephone group means that one grandmother in the group has more impact on the mean than the grandmother in the Web group. The children are close in age in both groups. Racial/ethnic characteristics are varied in both groups and both groups include more minorities than are in the general population in the region. In terms of educational attainment, in both sets of mothers, about half have a high school education or less and about half have some college or higher.

Challenges and Processes

It was obvious from the transcripts that all the participating mothers faced many problems in mothering their children with mental health difficulties. Three major concepts emerging from the data were the "emotional strains" experienced by the mothers and the role of the mother as an "advocate" for her child. The role of the mental health nurse was identified as a "facilitator" fostering the mothering abilities of the mother in providing the advocacy for her child.

Experiencing Emotional Strains

All of the mothers reported problems that complicated their mothering. Many problems resulted from the behaviors and attitudes exhibited by their children. These problems were a major source of the mothers' emotional strains.

Behaviors

The behaviors exhibited by the children ranged from lack of attention and self-control to behaviors of violence toward self and others both in school and at home. Both the chat-room

mothers and phone mothers indicated that the child's erratic behaviors were a problem they had to deal with continually. "I have tried from the very beginning to teach him that hitting, kicking, biting, choking is not the way to resolve conflict," said chat mom Barb. Phone mom Deb described her child's behavior and her concerns about his safety: "That's why when he was getting into so much trouble at school, jumping out of desks and jumping where he landed in the aquarium and all. He did not see the concept that he could get hurt." Another mother, chat mom Teri, reported her problems this way:

My child is smaller than I am by a lot but when he gets enraged, he is VERY strong. He has hurt me. He will most likely do it again. I will deal with it when it happens while taking as many precautions to help avoid it.

Attitudes

The problem of the child's attitude was another topic that mothers discussed. Many of the children were unable to cope with changes and were unable to control their emotional responses to situations. Others appeared to ignore and distance themselves from the consequences of their interactions with others. The attitudes and related emotions of their children were difficult for the mothers to understand and to deal with.

For example, chat mom Teri related: "It started long ago and has not let up. He acts like consequences mean nothing to him." Describing the scene before school, chat mom Barb said: "He was teary at breakfast and a bit belligerent. He told his brother to keep the shorts. By the time I picked him up from school he apologized and had the right attitude." And phone mom Cara described picking up her son one day: "And he got into the car—I picked him up from school and he got in the car and he was just madder than mad. He could have spit nails."

Emotional Strains

The behaviors and attitudes of these children evoked many emotions in their mothers. Four repetitive emotions were identified and coded in the conversations between the mother and the nurse. These emotions included the mother's reported concerns, fears, frustrations, and guilt in dealing with the child's behaviors and attitudes. The concept of "emotional strains" illustrates the described experience of these mothers in dealing with their children.

Concerns

Mothers expressed many concerns about their child and the problems resulting from the child's special needs. One concern was the erratic or worsening behaviors and the long-term consequences for the child. One mother described her concern this way,

She's almost 11. Her grades have been slipping and all and she's an A student too. And she just hasn't been doing it. And she's stealing and lying a little bit. Not a little bit, getting worse, getting pretty bad about it.

Chat-room mom Teri said: "My son is very violent and will need help for years and years to come."

Some mothers expressed concerns that they might be contributing to the problems experienced by their child. "I need to ask you a question. My son is acting out only a bit at [school name]. Could I be a toxic parent?" chat mom Teri asked during one chat session.

Knowing that their children have especially difficult adjustments to changes in their lives, mothers discussed concerns about moving to another area, changing schools and grade levels, and locating new counselors and mental and physical healthcare providers. For example, chat-room mom Nan wrote: "When he [husband] retires we will move to Texas to

settle down but having to find new doctors and counselors will be tough. More scary for the kids. They don't do well with change."

Medication effects and exposure to negative influences were other expressed concerns. An example of one such interaction between phone mom Deb and the TSS nurse follows.

Mom said: "He came in from school today, he lay down on the porch outside—babysitter picked him up, and he went outside and laid down on the porch when he came in and went to sleep on the porch for an hour." The nurse responded: "Oh my goodness. That's just not like him, is it?" And the mom replied: "No, that's not like him. That's what I'm saying. A clonidine at lunchtime and one in the morning, he doesn't—you know, that's why I told them."

Fears

Numerous mothers disclosed a familial history of mental health issues and the fears for what the child's future could hold. Phone mom Bette described it this way: "A bit of both [symptoms], more so manic behavior. We have a significant history of mental health issues in our family." Many of the child's erratic behaviors and wild imaginations caused mothers to fear the repercussions both for themselves and their child's future. Another chat mom, Teri, was concerned if her child's distorted thinking could cause legal complications for her:

I go with [child's name] to [social service agency] Tuesday. Is there any chance I could go to jail depending on what he says? I am use to [his distortions], but the unknown is dreadful. He is telling people that man and women climb in the house through the window and have sex with him and his sister. He hits, kicks, punches and bites when he can. I am scared for [child] and what his future holds.

Frustrations

Dealing with the needs of a child with special mental health needs created physical and financial disturbances for these mothers. Not being able to continue some activities with siblings was disappointing. One phone mom Deb, a grandmother who was the maternal caregiver, stated: "Well, I just don't have the money or the energy to, you know, like, we use to do granny days. She [child's sister] and I would go, when I had [child] with the babysitter, or in daycare. She and I would go to [the city] and shop and junk and whatever. But we just can't do that anymore."

Interfacing with community agencies and bureaucracy delays on behalf of a special child increased these mother's frustrations. Chat room Bette mom noted: "It just means further delays. The atty [attorney] 'forgot' that TPR [Temporary Protective Restraining order] had been filed and that a hearing date still needs to be scheduled, just more frustration."

Guilt

Mothers expressed guilt in allowing other problems and responsibilities to detract from a concentrated focus on the child and his or her special needs. "I feel I was spending more time trying to deal with my estranged husband's illness and how to cope with it." Chat mom Beverly said guilt was also expressed in not being able to meet the child's and society's role expectations. Phone mom Deb explained her feeling of guilt this way:

You know, it's like, well, you know, you're supposed to—she told me the other night that grannies are supposed to be fun. You know, I have to enforce the rules and make the bedtimes and—make them eat right and all that.

The concerns, fears, frustrations, and guilt that these moms expressed indicated the emotional strains that they experienced in trying to provide mothering for their special child.

The chat room support or telephone support from the mental health nurse provided the opportunity for these mothers to share their experiences. Although the mothers expressed the concept of emotional strains that accompany raising a child with mental health problems, they also provided illustrations of the problem-solving coping mothers used when being an advocate for their child. Throughout the transcripts the mothers demonstrated this concept of “advocate” for their child. Codes that illustrated the mothers’ advocacy role included protecting, positive, planning, and gaining insights about the child.

Advocating

Mothers demonstrated the role of child advocate through being perceptive, protective, positive, and planning for the child’s benefit. Many of the mothers’ discussions about their child were coded with affirmative statements and indicated the advocacy role that the mother assumed.

Perceiving

The mothers of these children disclosed perceptions into the child’s behaviors, attitudes, and problems. These insights enabled the mothers to be more tolerant, positive, and protective of their special child. For example, chat mom Amy described her child’s responses to his father this way: “[child] has not seen his father all summer and he gets better every day. Yea! His doctor mentioned his name and [child] shut down completely, stopped smiling and talking.” For another child, being asked to talk about his biologic mother was very stressful. His maternal caregiver, phone mom Cara, reported: “And I think that’s what prompted him being put in the hospital because the counselor was going to get him to talk about her. He pressured him in to talking about her.” The mothers’ ability to perceive what was going on with their children helped mothers in tolerating the emotional strains of parenting these children as well as in learning to manage the problematic behaviors.

Protecting

Mothers demonstrated protective mothering in many ways. Sometimes they had to be assertive and intervene on their child’s behalf to gain appropriate resources for their child. Phone mom Deb described protecting her child by making a choice for a special education program that other family members did not see as the answer. She described her experience this way:

It was up to me basically. I had to counteract the rest of them. I’m going to put him into a special program next year. I don’t know what they call it. They have a term for it. But they’ll only be like eight to ten kids and three or four teachers. This way, they can’t suspend him. If he has a tantrum or a bad day and you know, something happens, they’ve got people right there that can handle him and they’re more trained.

Chat room Ann went above a staff member’s head to the CEO to make sure her child was properly cared for: “It seems like since I called the CEO of the place, things are happening.”

Being Positive

Most of the mothers expressed very optimistic views of the child. They found positive and affirming characteristics in their child despite the difficulties. Several examples of such comments follow. “I never regret having him with the man I did because [child] would not be the sweet boy I love when he’s doing okay,” chat room mom Alice said. Phone mom Cara described her son’s talent: “Oh, and see he is the first one in the family to play the instrument. So, it’s like, [child’s name] you’re doing a lot and showing us up.” And Chat mom Ann noted: “It is hard on my heart to know how messed up the kid is yet he lightens it

with his smile.” No matter how many emotional strains mothers felt, the joys they felt with their children showed in their conversations.

Planning

Planning for the benefit of the child was a part of the mothering that these women provided. Strategies included interfacing with institutional personnel, setting up routine meetings for continuity of care, and pressing for evaluations to provide for the various physical, emotional, and educational needs of their children. “I asked just the right questions and in just the right order, including who was paying his bill. Then I called the CEO of the hospital and by God, the next night, he had a mattress,” said Chat mom Ann. Chat mom Barb reported: “The immediate plan for my younger son is to get him settled into school and work with his therapist. We are set up on a biweekly schedule. He seems to really like him [the therapist] and I do too.” Phone mom Jen notes: “I was really frustrated with that lady. And I was really about ready to give up with mental health. But, I’m going to go up there this time, but I’m trying my best to get back in with [former doctor’s name]”.

Nurse Facilitator

Interactions with the nurse through chat room or telephone conversations were coded. The nurses’ responses provided the mothers with information, clarification, encouragement, and affirmation. The transcripts indicate that the mothers anticipated and were pleased with the nurse interactions. Although the mothers had other social support available, the nurse, in providing consistent information, clarification, encouragement, and affirmation, facilitated the ability of the mother to “mother” and “advocate” for her child. The concept of the nurse as “facilitator” emerged from the narratives. The exemplars are organized using the framework of support described by Birch (1998). TSS RN provided the telephone support and Web RN provided the chat room support. Any differences between telephone support versus chat room support interactions were attributable to the personality of the intervention nurse rather than the type of interventions. Both nurses offered encouragement and affirmation equally. However, the chat room nurse (Web RN) provided more emotional and appraisal support and waited for the mother to seek guidance and information before providing information while the telephone nurse (TSS RN) was more proactive and directive in providing guidance and information, and provided less emotional and appraisal support. Some examples of affirmation and support are given below.

The nurses’ responses provided the mothers with information, clarification, encouragement, and affirmation.

Informational Support

Information support is providing of knowledge and information or helping someone learn how to get information needed. TSS RN gave a mother some feedback about the best way to help her child learn how to do things:

Well, just try and give him one direction at a time. You know, like you said, go get the bucket. Or, pick up this. Because when you tell him to do two or three things, you don’t get none of it done because they can’t remember. So, you pretty much have to say, like, pick the clothes up off the floor-then after he does that, then come back and say, make up your bed. It’s like you have to tell him one thing.

In a discussion with another mother, TSS RN suggested a method for the mother to remember the issues to bring to the therapist:

Yeah. Definitely make a list of these things so that you don’t forget them when you have your next appointment. Just jot them down because today’s been a day that’s

been trying for you and so just write some of these problem areas down today and take that little list with you so you can bring those up and let them know, you know, what you've been dealing with on the difficult days. Because, you know, people have good days, people have bad days, but it's important that you document well so that you can explain.

Both nurses provided teaching about medications, behavior management, and suggestions for navigating the healthcare system in their sessions.

Emotional Support

When the nurses listened, provided empathy, or were present to the mother, they were providing emotional support. For example, the chat-room nurse listened to a mother discuss her plan for managing a situation and responded with emotional support: "I think that sounds like a good idea—hopefully you will all get something out of it." In a telephone support session, the mother said: "I find that I'm dealing with two ADHD children, not just one." The nurse responded with empathy: "And that's very trying." Emotional support helped the mother feel understood and cared about by the nurses.

Appraisal Support

The nurses gave appraisal support by giving praise, affirmations, or feedback. In one chat session, the mother was talking about dealing with her own bipolar disorder as well as that of her child. The chat-room nurse supported her by giving affirmation. "It is difficult to struggle with bipolar disorder but it sounds like you have been trying hard to manage this—kudos to you for all of your efforts to care for yourself and your children."

In a telephone support session the nurse responded to a mother:

Well, good. Good. Well that's good news. Well I'm glad you guys are having a great summer and that he seems to be doing better with his behaviors and following directions and stepping up and, you know, trying some new things too. That's good. It sounds like you've been praising him and encouraging that behavior, so that's excellent.

In another chat session the nurse responded to a mother who was describing the positive side of her child by saying: "Well, no child or adult is ever perfect—It is good that you can enjoy his sweet self and not just focus on his episodes. It must be easier when the episodes are fewer."

Summary

The mothers described their emotional strains in caring for a child with mental illness. In some cases the mother was dealing with more than one child with mental illness or with another family member with a mental illness, which complicated the situation even more. Mothers showed problem-focused coping through their advocacy efforts for their children. The nurses facilitated the work of the mothers through informational, emotional, or appraisal support.

Discussion

Behaviors and attitudes exhibited by their children created emotional strains that participating mothers encountered in caring for their children with mental health troubles. These mothers identified similar problems in mothering their difficult children. The concept of emotional strains was embedded within each mother's experience. These emotional strains were daily stressors for these moms. The experiences of these mothers fits with the

work of Delaney and EngelsScianna (1996) and Scharer (1999), who reported that mothers of children with mental illness were stressed by the child's behaviors. In addition, mothers' spoke about stressors, such as difficulty in dealing with agencies involved with the family and being blamed for their child's problems as was noted by Barkley et al. (1992).

Despite these strains, the moms expressed a positive attitude and worked to provide the best care, treatment, and educational opportunities for their child. These mothers were proactive advocates for their special children. This role was enhanced through the facilitation provided by the consistent availability of the intervention nurse. The encouragement, affirmation, information, and clarification assisted the mother in her advocacy role. Four types of social support have been noted in the literature, including informational, material, emotional, and appraisal support (Birch 1998). In these conversations, informational, emotional, and appraisal support were noted. Material support was not given because there was no person-to-person contact between mothers and nurses.

Providing support through two opportunities for communication, about the problems, concerns, and questions inherent in mothering a child with special mental health needs, was an appropriate strategy. Most women are communicators and use communication interactions to help cope with problems and stressors in their lives. The participating mothers were able to ventilate some of the stressors and concerns of mothering a special child with the nurse. The nurses provided not only a listening ear but the encouragement and affirmation that these mothers needed to continue to mother their children with special needs. Both types of support were effective for these mothers. However, some differences were apparent.

Differences in the type of support, whether phone or chat room, depended upon both the personality of the nurse and the motivation of the mother. The proactive approach of the phone call intervention enabled mothers a consistent opportunity to discuss problems and concerns. The mothers in the phone intervention group received consistent support whether they were passive or active in discussing their problems and actions on behalf of their child.

The chat-room mothers, however, needed to be active in their pursuit of support, having to sign in to the chat room to access the nurse. This may have hindered some of the chat-room mothers from receiving consistent nursing support. Mothers who were under more strain may have actively sought the counsel of the nurse. Or it may have been those mothers who needed it the most who did not have the energy or time to seek out the chat-room help.

One concern with using a chat room as part of an intervention was that the need to type responses would interfere with communicating the empathy and caring of the nurse toward the mother. However, judging by the comments of the mothers, this was not a problem.

While this is a small sample with multiple contacts between nurses and mothers, this qualitative description of the interactions between nurses and mothers demonstrates that social support can be offered effectively over the phone or through an Internet chat room. Mothers in both groups described similar issues with emotional strains. In addition, mothers in both groups served as advocates for their child. Nurses were able to provide informational, emotional, and appraisal support through both mediums of communication.

This qualitative description of the interactions between nurses and mothers demonstrates that social support can be offered effectively over the phone or through an Internet chat room.

Implications

Clearly, these mothers are in need of social support. They articulate the problems in raising children with mental illness and the increased efforts needed to parent these children. However, the best way to provide the needed social support is still under study. Since this is a small sample, it is premature to base changes in practice on these data. However, these findings do suggest that the two interventions do provide social support to the mothers. The larger study should add to these findings when it is completed.

Acknowledgments

This work was supported by a grant from the National Institute for Nursing Research (R01 NR08580 Social Support for Mothers of Mentally Ill Children; Dr. Kathleen Scharer, principal investigator).

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Table 1

Race

Group	American Indian/Alaskan Native	African American	White	Other
Total	2	1	7	1
Web-based social support	1	0	5	1
Telephone social support	1	1	2	0

Table 2**Age of Mothers/Children in Years**

	Mean	SD	Minimum	Maximum
Group: Mothers				
Total	39.91	11.12	28	61
Web-based social support	38.14	9.94	28	55
Telephone social support	43	13.95	31	61
Group: Children				
Total	9.82	1.83	7	12
Web-based social support	10.14	1.95	7	12
Telephone social support	9.25	1.71	7	11

Table 3**Mothers' Educational Attainment by Group**

Group	Grade school	Some high school	High school graduate	Some college	College graduate
Total	1	3	1	5	1
Web-based social support	0	2	1	3	1
Telephone social support	1	1	0	2	0