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Intention to Seek Mental Health Treatment for Adolescent Girls: Comparison of Predictors in Mothers and Daughters

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Abstract

PROBLEM—To examine predictors of intention to seek mental health treatment for adolescent girls in mothers and daughters.

METHODS—In this cross-sectional study, mothers and adolescent daughters ($n = 71$) completed measures of behavioral attitudes, subjective norms, perceived behavioral control, and intention to seek mental health treatment for the adolescent daughter.

FINDINGS—Behavioral attitude and perceived behavioral control predicted intention to seek mental health treatment among mothers. Behavioral attitude predicted intention among daughters. There were no associations between mothers and daughters on study variables.

CONCLUSIONS—To promote shared decision making and engagement in mental health treatment, clinicians may target interventions to the mother's perceived behavioral control and behavioral attitudes of daughters and mothers. Based upon study results, clinicians should promote shared decision making and concordance between mothers and daughters on attitudes toward mental health treatment.

Search terms

Depression; mothers; daughters

In most families in the western world, mothers make decisions related to the family's use of health care (Gross & Howard, 2001), including health care for their adolescent daughters. However, normative changes and realignments in the parent-child relationship lead to greater adolescent behavioral autonomy over time, including the adolescent's desire for greater involvement in decision making for her health care (Gordon, 1996).

The cognitive capacity for autonomous healthcare decision making has been documented among adolescents 15 years of age (Gordon, 1996). In the United States, most states recognize an adolescent's ability to independently make healthcare decisions for select medical services such as testing and treatment of sexually transmitted infections and obtaining contraception without parental consent (English & Kenney, 2003; Gordon, 1996). However, by law, adolescents cannot independently make decisions to receive mental health treatment (English & Kenney, 2003). Parental consent is required for adolescents under the age of 18 to obtain treatment in nearly all states, making parents the gatekeepers to mental health treatment.

As children mature into adolescents, they tend to be more expressive to their mothers about their healthcare needs and desires, and they attempt to exert influences over their mothers' decisions about their health care (Miller & Harris, 2012). The adolescent's influence on the mother's decisions is impacted by characteristics of the mother-adolescent relationship, including parent-adolescent conflict (Kern, Klepac, & Cole, 1996; Prinz, Foster, Kent, & O'Leary, 1979) and parenting style of the mother (Steinberg, Lamborn, Dornbusch, & Darling, 1992). Promoting concordance and shared decision making between mothers and daughters in respect to mental health treatment is not only essential for seeking care, but also for the adolescent's active engagement in care (Miller & Harris, 2012).

Adolescent girls believe that they have tremendous influence on their mothers' decision making for their health care, and that their perspectives on mental health treatment are similar to that of their mothers (Pinto-Foltz, Hines-Martin, & Logsdon, 2010). Without concurrent and independent assessments of mothers and their adolescent daughters regarding their intention to seek mental health treatment, these assertions by adolescent girls are unfounded. This study fills a gap in scientific knowledge by use of the theory of planned behavior (TPB) and expanded TPB (Hutchinson & Wood, 2006) to examine predictors of intention to seek mental health treatment for adolescent girls, from the perspective of mothers and their adolescent daughters themselves. Roughly 75% of adolescents with mental disorders do not receive mental health treatment at symptom onset, and the usual onset of mental disorders is during the adolescent and young adult years (Kessler, McGonagle, Swartz, Blazer, & Nelson, 1993). Adolescent girls are at highest risk for mood disorders during these early years, and understanding predictors of mothers and daughters' intentions are necessary to promote early treatment and optimize short- and long-term mental health outcomes (Modi et al., 2012; Logsdon, 2004).

TPB Explains Healthcare Decisions

TPB indicates that behavioral intentions directly determine behavior (Ajzen & Fishbein, 1980). Intentions are determined by integrating behavioral beliefs about the consequences of the behavior, subjective norms referring to perceived social pressure to perform/not perform the behavior, and control beliefs about how difficult performing the behavior would be and if the behavior is perceived to be under the person's control (Ajzen, 1985, 1991). Thus, following the TPB, one can predict that the mother would intend her daughter to have mental health treatment if the mother believes that the consequences of receiving mental health treatment would be good, that the mother's significant others believe that she should choose mental health treatment for her adolescent daughter, and that the choice is under the

mother's control (Weber, Hill, Ren, & Beatty, 2010). See Figure 1 for the original TPB (Ajzen, 1985).

An Expanded TPB Explains the Daughter's Influence

Health behavior theories, such as the TPB (Ajzen, 1985, 1991), indicate the factors and mechanisms that predict health promotion decisions and activities. TPB is known for its utility and predictive validity in understanding individual health behaviors. Research with adolescents has identified influences outside of the individual (currently omitted from the original TPB theory) that are needed for greater explanation of behavior when adolescents and parents are involved (Hutchinson & Wood, 2006). Specifically, when addressing healthcare decisions made by a mother for her adolescent daughter, the exclusion of parenting style and the mother-adolescent relationship from the TPB is a significant omission that limits the theory's utility (Hutchinson & Wood, 2006). Conversely, expanding the TPB to include these variables (see Figure 2 for model of expanded TPB) allows utilization of a theoretical framework that provides "empirically adequate descriptions, explanations, or prediction" related to the healthcare decision by a mother to choose mental health treatment for her daughter (Villarruel, Bishop, Simpson, Jemmott, & Fawcett, 2001, p. 158).

Thus, the purposes of this study are (1) to examine predictors of the separate intentions of mothers and daughters to seek mental health treatment for the adolescent daughter using both original TPB and expanded TPB and (2) to identify the degree of concordance between mothers and their daughters on the TPB variables. The study examined the following research questions (RQs).

RQ1: Which variables in the TPB and the expanded TPB significantly predict a mother's intention to seek mental health treatment for her adolescent daughter?

RQ2: Which variables in the TPB and expanded TPB significantly predict the adolescent daughter's intentions to seek mental health treatment for self?

RQ3: What is the degree of concordance between mothers and their adolescent daughters on the TPB variables?

Method

The study design was cross sectional and descriptive. The study was conducted in a metropolitan urban area of the southern United States. A convenience sample of adolescent girls and their mothers ($n = 71$ dyad pairs) was recruited from a pediatric gynecology practice and from a weekly university newsletter. Enrollment criteria for study inclusion were adolescent girls, 13–17 years of age, residing with mother, and able to communicate in English. There were no significant differences in demographics between participants recruited from the pediatric gynecology practice and the university newsletter.

Procedures

University Institutional Review Board approval was obtained prior to initiation of study procedures. Interested mother and daughter pairs contacted the study staff by telephone. During this call, potential participants were provided detailed information about the study. Interested and eligible participants were sent by United States Postal Service mail the informed consent and assent forms prior to a face-to-face meeting with study staff. After informed consent and assent were obtained, mother-daughter pairs were each provided with a unique identifier to impute in the secure online data collection form. Staff from the university technology department created a secure website that was accessed by Ethernet

port. No access was possible for anyone without the unique identifier. All computers were password protected. Mothers and daughters each received a \$25 stipend for study participation.

Data collection was cross sectional. Mother and daughters completed an identical battery of questionnaires independently. Instruments are described in Table 1 and included measures of demographics, TPB variables of attitudes, subjective norms, perceived control, intention, and measures of variables in the expanded TPB of the mother–adolescent relationship and the mother’s parenting style.

Data Analysis Plan

As described previously, parent–adolescent studies have not accounted for variables that describe the nature of the parent–adolescent relationship. This study compared the TPB with the expanded TPB, which included the additional variables of mother–adolescent relationship and mother’s parenting style (Hutchinson & Wood, 2006). To assess the influences of the variables in the TPB and expanded TPB, we conducted two multiple regression analyses for RQs 1 and 2. For these analyses, the 0.05 α level was used for statistical significance. To assess concordance on the TPB variables between mothers and daughters, we performed *t* tests and Pearson’s *r* correlations.

To examine if the TPB and expanded TPB variables predict a mother’s intention to seek mental health treatment for her adolescent daughter (RQ1) and adolescent daughter’s intention to seek mental health treatment for self (RQ2), we performed two multiple regression analyses for each RQ. The first regression analysis examined the influence of variables included in the original TPB model regressing behavioral attitude, subjective norms, and perceived behavioral control on the outcome (mother’s intention to seek mental health treatment for adolescent daughter and the daughter’s intention to seek mental health treatment for self). For the second regressions, we examined the influence of the additional variables included in the expanded TPB, adding the variables of mother–adolescent relationship and mother’s parenting style for both the mother’s intention to seek mental health treatment for adolescent daughter and the daughter’s intention to seek mental health treatment for self. To examine concordance between mother and daughter scores on intention to seek mental health treatment and the TPB variables, we performed paired *t* tests and Pearson’s *r* coefficient.

Results

Participants

On average, adolescent daughters were 15 ($SD = 1.29$) years of age, Caucasian (75%), and in the 9th grade (50%). On average, the mothers were 44 years old ($SD = 6.15$), Caucasian (75%), and married (61%).

RQ1

As shown in Table 2, behavioral attitude and perceived behavioral control significantly predicted the mother’s intention to seek mental health treatment for her adolescent daughter, accounting for 40% of the explained variance. When additional variables (parenting style and mother–adolescent conflict) of the expanded TPB were entered into the model, behavioral attitude and perceived behavioral control remained significant. There was little and no significant contribution of these additional variables.

RQ2

As shown in Table 3, behavioral attitude significantly predicted the daughter's intention to seek mental health treatment for self, accounting for 55% of the explained variance. When the variables of the expanded TPB parenting style and mother–adolescent conflict were entered in the model, behavioral attitude remained significant. There was little and no significant contribution of these additional variables.

RQ3

Mean scores for mothers and adolescent daughters are displayed in Table 4. Because the original TPB model was most predictive of both the mothers and daughters' intentions (results of analysis of RQs 1 and 2), we compared the results of mothers and their adolescent daughters on these variables using *t* tests and Pearson's *r* coefficient. Using *t* tests to compare TPB variables between mothers and adolescent daughters, there was a significant difference between mothers and adolescent girls on all TPB variables. To further verify this discordance between mothers' and adolescent girls' scores, Pearson's *r* coefficient was used. There was no significant correlation between mothers and their adolescent daughters on any TPB variables.

Conclusions and Implications of the Study

Results of the study have important clinical and public health implications. Adolescents are an underserved population (Lawrence, Gootman, & Sims, 2008), particularly in the area of mental health services (Petersen et al., 1993). Depression in adolescent girls is of specific concern (Logsdon, 2004; Nolen-Hoeksema & Girgus, 1994). As the gatekeeper to mental health services, the mother's perspective is important to understand. For example, a clinician might ask a mother what she perceives her own role to be in obtaining mental health treatment for her adolescent daughter (perceived control). Another question might be: "tell me what you have heard about mental health treatment for teens" (attitude). Support for public health initiatives to improve community attitudes toward mental health treatment should also be provided, such as "In Your Own Voice" by the National Alliance for Mental Illness.

In this study, the original TPB as conceptualized by Ajzen (1985, 1991) was superior in explaining the intentions of mothers and their adolescent daughters when compared to the expanded TPB model in this study. In other words, the expanded TPB, which included parent–adolescent conflict and the mother's parenting style, did not influence the mother or adolescent daughter's intentions to seek mental health services.

Behavioral attitude and perceived behavioral control had a nearly identical and significant influence on the mother's intention to seek mental health treatment for her adolescent daughter. For an adolescent daughter, behavioral attitude was the only significant predictor of her intention to seek mental health treatment for self. Given that adolescence is a time of strong concern with maintaining status and the good opinion of one's peers (Lerner & Steinberg, 2004), it is surprising that subjective norms were not influential to an adolescent daughter's intention to seek mental health treatment. Because there is a stigma associated with mental health treatment, adolescents tend to refrain from disclosing mental health treatment seeking from peers, potentially making subjective norms less influential in this study (Pinto-Foltz et al., 2010).

The TPB model demonstrates multiple potential influences on the mother's intention to seek mental health treatment for her adolescent daughter, and all influences are potential targets for family teaching interventions and tailored social marketing by psychiatric nurses. Because mothers are gatekeepers to mental health treatment, the mother's behavioral

attitude and perceived behavioral control should be a focus for nursing interventions. Yet, to promote shared decision making and engagement in treatment, adolescent daughters should not be ignored in this process. Health outcomes can be optimized when adolescents are engaged in their health care, and this engagement may have lasting effects (Modi et al., 2012). Promoting early positive interactions with mental health treatment influences later care-seeking behaviors (Jones, DeMore, Cohen, O'Connell, & Jones, 2008). Although behavioral attitudes were influential predictor of both mothers and daughters' intentions to seek mental health treatment, differences in scores between mothers and daughters hint that behavioral attitudes may be different among mothers and adolescent girls and require different approaches for nursing interventions.

When mental disorders are not treated in adolescence, they tend to become chronic, and a harbinger of a long trajectory of decreased quality of life and diminished productivity (Pine, Cohen, Johnson, & Brook, 2002). Although there are a variety of effective treatments for mental disorders, early detection and entry into treatment is critical. Attention to the mother's role in the process of identification and treatment cannot be overemphasized.

Further study is needed to determine how well the model applies to various family types, diverse cultures and nationalities, and in longitudinal studies. The study is limited by the small sample, the limited demographics, and the use of a community sample in which the history of mental disorders and mental health treatment in mothers and their adolescent daughters was not assessed. This study is an initial step in understanding influential factors that predict intention to seek mental health treatment for adolescent girls from the mothers and adolescent daughters' perspectives. Furthermore, this study establishes discordance between mothers and adolescent daughters in TPB variables. Findings should be interpreted with caution and further assessments with clinical populations and diverse groups of adolescents should be performed before the application of findings.

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Figure 1.
Application of Theory of Planned Behavior to Intention to Receive Depression Treatment

Figure 2.
Expanded Theory of Planned Behavior

Table 1

Instruments

Instrument name	Author	Construct(s)	No. of items and description	Reliability and validity
Attitude and behavioral beliefs				
Health Behavioral Belief Instrument	Gerend, Lee, & Shepherd, 2007	<ul style="list-style-type: none"> Perceived safety, effectiveness, and benefits of getting the vaccine 	<ul style="list-style-type: none"> 9 items on a 6-point Likert scale The higher the score, the more positive beliefs held about the vaccine 	
Health Behavioral Belief Instrument	Taylor & Newnan, 2000	<ul style="list-style-type: none"> Comfort with vaccines in general 	<ul style="list-style-type: none"> 1 item on a 6-point Likert scale The higher the score, the less comfort in vaccines in general 	
Control beliefs				
Health Self-Determinism Index and Health Self-Determinism Index for Children	Cox, 1985; Cox, Cowell, Marion, & Miller, 1990	<ul style="list-style-type: none"> Self-determinism in health judgment Competency in health matters 	<p>Adult index:</p> <ul style="list-style-type: none"> Judgment: 6 items Competency: 3 items <p>Children index:</p> <ul style="list-style-type: none"> Judgment: 6 items; competency: 7 items that ask about "other kids" Scored on ordinal scale (1–4). Score of 1 indicates max intrinsic motivation and score of 4 indicates max extrinsic motivation. 	<p>Adult index:</p> <ul style="list-style-type: none"> Internal consistency for the entire scale = 0.85 (Cox, 1985) Internal consistency for judgment scale = 0.75, and competency scale = 0.67. Children index: <ul style="list-style-type: none"> Test-retest after 5 months = 0.58–0.76 Internal consistency of judgment subscale = 0.75–0.83 Competency = 0.54–0.78 Factorial, discriminant, predictive, and construct validity demonstrated (Cox et al., 1990)
Mother–adolescent relationship				
Conflict Behavior Questionnaire	Prinz, Foster, Kent, & O'Leary, 1979	<ul style="list-style-type: none"> Perceived conflict Negative communication between parent and adolescents 	<ul style="list-style-type: none"> 16 items scored either true or false. Higher score indicates higher levels of negative communication. 	<ul style="list-style-type: none"> Internal consistency = 0.79 in adolescent sample ($n = 133$) (Barker, Bornstein, Putnick, Hendricks, & Suwalsky, 2007)
Parenting style				

Instrument name	Author	Construct(s)	No. of items and description	Reliability and validity
Parenting Style Index	Steinberg, Lamborn, Dornbusch, & Darling, 1992	<ul style="list-style-type: none">• Involvement• Autonomy granting• Strictness/supervision	<ul style="list-style-type: none">• 18 items, strongly agree/disagree• Last 8 options, one item is checked.	<ul style="list-style-type: none">• Internal consistency for the three subscales involvement = 0.78; autonomy = 0.79; strictness/supervision = 0.68 (Slicker, 1998) and 0.76 (Glasglow, Dornbusch, Troyer, Steinberg, & Ritter, 1997)
Demographics				
Demographics		Race, age, education, employment position of primary family breadwinner, private insurance or not, zip code of residence, religion, birth order of daughter	<ul style="list-style-type: none">• 6 items	

Table 2

Regression Results for Predicting Mother's Intention to Seek Mental Health Treatment for Daughter

		B	SE B	β
Model 1	Behavioral attitude	0.299	0.139	0.273*
	Social norm	-0.18	0.123	-0.187
	Perceived behavioral control	0.524	0.212	0.280*
Model 2	Behavioral attitude	0.299	0.143	0.273*
	Social norm	-0.206	0.128	-0.213
	Perceived behavioral control	0.522	0.224	0.279*
	Parenting style (involvement)	-0.025	0.036	-0.104
	Parenting style (autonomy granting)	-0.011	0.026	-0.069
	Mother-adolescent relationship (authoritativeness)	0.194	0.208	0.170
	Mother-adolescent relationship (appraisal of dyad)	0.033	0.051	0.081

Notes. $R^2 = 0.396$, $p = .009$ (Model 1); $R^2 = 0.420$, $p = .079$ (Model 2);

* $p < .05$, two tailed. $N = 71$.

Table 3

Regression Results for Predicting Daughter's Intention to Seek Mental Health Treatment for Self

		B	SE B	β
Model 1	Behavioral attitude	1.266	0.242	0.549**
	Social norm	-0.358	0.186	-0.204
	Perceived behavioral control	-0.044	0.811	-0.006
Model 2	Behavioral attitude	1.286	0.253	0.558**
	Social norm	-0.351	0.196	-0.200
	Perceived behavioral control	-0.198	0.857	-0.026
	Parenting style (involvement)	-0.008	0.032	-0.032
	Parenting style (autonomy granting)	0.000	0.033	-0.001
	Mother-adolescent relationship (authoritativeness)	0.059	0.392	0.020
	Mother-adolescent relationship (appraisal of dyad)	0.038	0.069	0.083

Notes. $R^2 = 0.547$, $p < .001$ (Model 1); $R^2 = 0.556$, $p = .001$ (Model 2);

*
 $p < .05$,

**
 $p < .01$ two tailed. $N = 70$.

Table 4

Comparing Mother and Daughter Perceptions Toward Mental Health Treatment

		M (SD)	t(df)	p	r	p
Intention	Mother Daughter	6.53 (0.86) 2.74 (1.63)	17.45 (70)	<.001	0.02	.86
Attitude	Mother Daughter	4.71 (0.78) 3.79 (0.71)	7.54 (70)	<.001	0.05	.70
Social norms	Mother Daughter	3.88 (0.89) 3.53 (0.93)	2.30 (69)	.02	0.04	.73
Perceived behavioral control	Mother Daughter	3.36 (0.46) 2.35 (0.21)	17.15 (70)	<.001	0.04	.73