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Chapter 1: Introduction

Parents' perceptions of adolescent mental health difficulties can have a significant impact on early detection and treatment seeking for adolescent mental health disorders (Abera, Robbins, & Tesfaye, 2015). Adolescents are dependent on their parents or caregivers to recognise psychopathologies, and seek services if mental health concerns arise (Moretti & Peled, 2004). For adolescents, where there is limited access to mental health services and mental health professionals, parental perceptions of mental health problems in their adolescent children plays a critical role in service use (Lindsey, Chambers, Pohle, Beall & Luckstead, 2014). In the last few decades, within the South African context as well as within the global arena, the prevalence rate of adolescent mental health concerns have been increasing, while treatment seeking and service use have remained relatively low (Okpaku, 2014). To date limited emphasis has been placed on the perception and awareness of parents on these issues as well as their preferred treatment options, within the South African context (Kleintjies, Lund & Fisher, 2010). When considering the significance of adolescence as a developmental phase it can be argued that the onset of adolescence presents some risks associated with the development of mental health disorders that can have long-term implications not only for the individual but also for the society at large (Upton, 2011). It has been estimated that 75 percent of mental health disorders have an onset age of younger than 24 years (Kleintjies et al 2010). This statistic highlights the increased predisposition that adolescent children have towards the development of mental health disorders.

The early age-of-onset and increased prevalence rate of adolescent mental health disorders has been well documented within the academic realm, but it remains undetermined whether parents of adolescent children are aware of the susceptibility and severity of adolescent

mental health concerns, specifically within the South African context (Kleintjies et al, 2010; Fryers & Brugha, 2013). A lack of parental knowledge and awareness of adolescent mental health needs can have detrimental consequences associated with a failure and delay of initial treatment contact (Wolfe & Mash, 2006). Adolescent mental health concerns, which do not receive adequate intervention, could lead to the development of psychological disorders in later adulthood (Wolfe & Mash, 2006). Parents of adolescent children are thus faced with the task of ensuring that adolescent mental health needs are identified and managed, in order to ensure healthy psychological development. (Upton, 2011).

The ability of parents to identify and manage adolescent mental health difficulties present numerous challenges associated with the health literacy which parents have regarding the causes, symptoms, and treatment options available to treat these difficulties (Abera et al, 2015). Parents are required to observe their adolescent children's behaviours and emotions and identify any emotions or behaviours that are concerning or threatening to their mental health and well-being (Keck, 2014). It can be argued that parents residing in developing countries such as South Africa, might have limited knowledge and awareness of adolescent mental health concerns, as a result of the lack of emphasis which has been placed on this topic within the broader socio-political sphere (Kleintjies et al, 2010). The challenges resulting from the potential lack of health literacy which parents have is further exacerbated by the characteristic emotional fluctuations and behavioural changes which occur in adolescence (Casey, Jones & Hare, 2008).

As a result of the rapid biological, psychological and socio-environmental changes, adolescents often experience intense and turbulent emotions, adolescent children often present with symptoms associated with anxiety, depression, anger, frustration, jealousy, guilt, loneliness, self-rejection, and insecurity (Wolfe & Mash, 2006). The characteristic emotional and behavioural changes can cause parents great confusion and dismay as these behaviours

often blur the boundaries between normal developmentally appropriate behaviours and abnormal pathological behaviours (Swanson, Edwards & Spencer, 2010). Parents of adolescents face the challenge of distinguishing between normal and abnormal behaviours, with limited knowledge and awareness regarding the complex aetiologies and diagnostic criteria of adolescent mental health concerns.

1.1 Adolescent Mental Health Disorders

Mental health disorders, in both adolescence and adulthood, are typically marked by disruptions in emotional, social, and cognitive functioning (Elia, 2014). The most salient mental health disorders that have an age of onset coinciding with adolescence are, anxiety disorders and depression disorders (Beesto, Knappe & Pine, 2009). Other mental health disorders affecting adolescents include bipolar disorder, conduct disorder, attention-deficit/hyperactivity disorder, learning disorders, eating disorders, autism spectrum disorders, and childhood-onset schizophrenia (Wolfe & Mash, 2006).

In order for parents of adolescents to be able to recognise the symptoms associated with the aforementioned mental health disorders, parents are required to have knowledge on the types of symptoms which are concerning, the duration of the symptoms and the frequency with which symptoms occur (Jensen & Nutt, 2016). Mental health disorders seldom appear with full symptom presentation (Kessler, Amminger, Aguilar-Gaxiola, Alonso, Lee & Ustun, 2007). Instead, they are often preceded by symptoms which are less disruptive and which can be easily attributed to normal life stressors (Kessler et al, 2007). The main underlying differences between developmentally appropriate behaviours and underlying mental health disorders are in symptom severity, frequency of symptom occurrence, and the extent to which the behaviour causes disruption to daily life (Wolfe and Mash, 2006). Adolescent mental health disorders initially present as episodic behavioural instances, but if left untreated can

increase in severity, duration, and level of disruption over time (Wolfe & Mash, 2006). Furthermore, the ways in which symptoms are expressed in adolescence can vary in terms of the types of symptoms expressed and the level of disruption displayed. For example, symptoms of depression in adolescence can be observed through frustration and hostility rather than symptoms of low mood and social withdrawal which is present in adult depression (Thapar, Collishaw, Pine & Thapar, 2012). Similarly, symptoms of anxiety disorders in adolescents are indicated by depressive symptoms such as low mood and substance abuse as opposed to the characteristic physical symptoms which occur in adult anxiety disorders, such as sleep disruptions, heart palpitations and difficulty breathing (Beesdo et al, 2009). These variations in symptom expression can affect how adolescent mental health disorders are detected, and interpreted by parents (Beesdo, 2009). Parents who are unaware of the differences in symptom presentation of adolescent mental health disorders in comparison to those in adult mental health disorders, can have some difficulty identifying these symptoms as related to psychological difficulties (Beesdo, 2009).

1.2 Parental Models for Understanding Adolescent Mental Health

The task of evaluating whether adolescents are experiencing psychological difficulties are thus complicated by the normative disruptive adolescent emotions and behaviours and the initial inconspicuous nature of mental health disorders. Parents who have limited knowledge and awareness of adolescent mental health concerns often rely on evaluating psychological well-being through the presence or absence of mental illness (Pollet, 2007). The emphasis which parents place on mental illness, can be understood as resulting from the internalisation of social norms which are dominated by westernised biomedical ideologies (Abera et al, 2015). Parents who reside in societies which accept westernised models of health, largely understand mental health in similar terms as any medical illness (Abera et al, 2015).

In the contemporary world, adolescent mental health difficulties are understood using a biopsychosocial model (BPS) (Stineman & Streim, 2011). In this regard, mental health disorders are understood as resulting from the complex interaction between biological, psychological and social factors (Gilbert, Selikow & Walker, 2010). These factors can either increase the likelihood of the development of mental health disorders or act as protective factors against the development of mental health disorders (Gilbert et al, 2010). The use of a BPS model highlights the complex nature of mental health disorders, and indicates that mental health disorders rarely result from a clear and single identifiable cause (Urdang, 2008). In this regard, mental health disorders can be understood as resulting from either multiple pathways leading to one disorder (Equifinality), or a single pathway which can lead to multiple outcomes (Multifinality) (Urdang, 2008) These models explaining the development of mental health disorders are unanimously accepted by mental health professionals (Gilbert et al, 2010). This common understanding allows for similarities in diagnosis and treatment of mental health disorders by mental health professionals (Gilbert et al, 2010).

It can however be argued that while the use of a BPS model has been widely utilised by mental health care professionals, parents of adolescent children might not have the knowledge of such frameworks for understanding mental health (Abera et al, 2015). Abera, Robbins and Tesfaye (2015) argue that this is true, even more so in developing countries. Abera et al (2015) state that as a result of the lack of knowledge and awareness of accepted causation models, parents rely on alternative means of understanding mental health disorders. These alternative models include the disease model or a simple causal model of mental health when faced with mental health problems in their adolescent children (Abera et al, 2015).

A disease model describes mental health disorders in similar terms as any medical illness. It assumes that the development of mental health disorders is caused by chemical and physical

changes in the brain, and has specific signs and symptoms which can be diagnosed and verified by test results (Sroufe, 1997). In this regard, mental health disorders can be treated with medical interventions such as medication (Sroufe, 1997). Conversely, a simple causal model describes the development of a mental health disorder as a result of one single identifiable cause (Sroufe, 1997). This model assumes that without a specific cause the illness would not exist (Shirk, Talmi & Olds, 2000). This model thus suggests that if the cause is removed the symptoms will reduce (Shirk, Talmi & Olds, 2000).

The parental reliance on medical models for understanding the causes of adolescent mental health problems could potentially result in a decreased ability to recognize and detect mental health problems (Taddeo, Egedy & Frappier, 2008). The inability to detect adolescent mental health problems could result in a lack of treatment seeking behaviours for adolescent mental health concerns (Taddeo et al, 2008). The ways in which parents understand adolescent mental health concerns thus have a significant impact on the mental health and emotional well-being of adolescents.

1.3 Socio-political influences on parental perceptions

It can be argued that the ways in which parents understand adolescent mental health concerns do not develop solely based on individual parental perceptions, but largely develop based on the broader social norms and political belief systems (Gilbert et al, 2010). Within the South African context various historical and political factors have a prominent influence on the daily lives of its inhabitants. When focusing on the sphere of mental health, it can be said that many South African's have limited access to mental health care facilities, and where these facilities are available they are under resourced and largely inaccessible (Patel & Sumathipala, 2001; Saxena, Paraje, Sharan, Karam, & Sadana, 2006). A limited number of government policies and programs have been developed in order to address this deficit,

however to date these policies have not yet been implemented (Kleintjies et al, 2010). It can be argued that these macrosystemic failures have a trickledown effect whereby the members of the South African population do not possess the necessary knowledge of mental health concerns and if concerns arise they do not have the awareness, or access to, mental health care facilities (Sayal, Taylor & Beecham, 2003; Rickwood, Deane & Wilson, 2007; Logan & King, 2001). Based on these societal constraints parents might not have the necessary knowledge to adopt appropriate behaviours in order to identify and manage adolescent mental health concerns (Sayal, Taylor & Beecham, 2003; Rickwood, Deane & Wilson, 2007; Logan & King, 2001).

This research study, in examining the perceptions of parents of adolescent children, entailed research which explores the thoughts, feelings and beliefs which parents have about their adolescent children's mental health and well-being. In addition, this study focuses on the ways in which parents make sense of the emotional challenges which adolescence children experience, and how they would experience and manage mental health difficulties in their own home.

It is hoped that research on parental perceptions of adolescent mental health and well-being, will yield insightful information on parental mental health cognitions and health seeking behaviours, as related to adolescent mental health. In so doing this study adopted the following aims.

1.4 Research Aim

This research project aimed to explore the ways in which parents understand the causes, symptoms, and treatment options available for adolescent mental health difficulties. In relation to this, this study aimed to focus on not only the proximal relationship between

parent and child but also taking into account the greater community context including culture, religion and ethnic diversity.

1.5 Research Questions

1.5.1 Main Research Question

How do parents' understand adolescent mental health and well-being?

1.5.2 Research Sub-Questions

What concerns do parent's have about mental health difficulties in adolescents?

What existing adolescent mental health services are parents aware of?

What sources of support do parents have?

How do cultural or ethnic issues influence parent's perceptions of adolescent mental health?

1.6 Rationale

Over the past 15 years the rates of suicide completion among children aged 10-14 years has more than doubled and an estimated 20 % of adolescents aged 14-18 years have been found to have thoughts of suicidal ideation (Health Systems Trust, 2016). The high suicide completion and suicidal ideation rates among adolescent children can be seen as a singular representation of vulnerability at this stage of development (Kleintjies et al, 2010). While adolescent suicide rates have received much attention, it is important to note that other adolescent mental health difficulties have also been steadily increasing; these difficulties include drug and alcohol addiction, mood disturbances, eating disorders, anxiety disorders, personality disorders, and neurological disorders (Health Systems Trust, 2016). The increase in adolescent mental health disorders highlights the need for increased emphasis to be placed on the mental health needs of adolescents (Kleintjies et al, 2010).

While adolescents are at the forefront of experiencing these mental health difficulties, neurologically and psychologically they do not yet possess the maturity to understand and manage these feelings (Jensen & Nutt, 2016). It is at this point where the role of the parent becomes paramount. Parents of adolescent children are faced with the task of identifying and managing adolescent mental health difficulties and seeking out support and treatment if adolescent mental health difficulties arise (Davies, 2000; Laxmi & Kudapatti, 2012; DiClemente, Wingood, Crosby, Sionean, Cobb & Harrington, 2001; Fröjd, Kaltiala-Heino & Rimpelä, 2007).

While it is evident that adolescent mental health needs are becoming more demanding, treatment seeking and parental service use remains minimal (Ryan, Jorm, Toumbourou & Lubman, 2015; Gronholm, Ford, Roberts, Thornicroft, Laurens & Evans-Lacko, 2015). It can be argued that the gap between increasing adolescent mental health needs and parental service use, results from the limited implementation of governmental intervention strategies aimed at promoting adolescent mental health and emotional well-being (Kleintjies et al, 2010) This is reflected in the lack of policy development aimed at promoting mental health among parents and adolescents (Kleintjies et al, 2010). Within the realm of academic-based research, a similar trend can be observed, specifically when examining the number of research outputs focussed on adolescent mental health. Currently less than 3% of published research papers focus on adolescent mental health (Patel & Sumathipala, 2001; Saxena, Paraje, Sharan, Karam, & Sadana, 2006). Most of the research conducted on child and adolescent mental health has been motivated by, insufficient skilled human resources, low awareness and low priority, high service load and a greater concern for child mortality and morbidity (Patel & Sumathipala, 2001; Saxena, Paraje, Sharan, Karam, & Sadana, 2006). It can be argued that the lack of government policies and academic research aimed at emphasising the importance of adolescent mental health needs, directly impacts on the

knowledge and awareness which parents have, to identify and manage adolescent mental health difficulties (Kleintjies et al, 2010). Governmental institutions and members of academia have a responsibility to promote the mental health of adolescents, in order to ensure that parents are informed of the causes, symptoms and treatment options available for adolescent mental health concerns (Kleintjies et al, 2010)

Parents or caregivers also bear the same responsibility. As a child enters into the adolescent phase of development, parents take on the role of active facilitators of adjustment and development (Abera et al, 2015). Thus parents of adolescents are required to identify and manage any risk factors which can impede upon healthy adolescent development (Abera et al, 2015). The knowledge and awareness which parents have regarding mental health can greatly impact upon the ways in which parents respond to adolescent mental health difficulties (Abera et al, 2015). The health behaviours which parents adopt as well as the illness behaviours which parents deploy can both act as promoting factors and risk factors to adolescent mental health.

While the knowledge and awareness which parents have regarding, adolescent mental health is crucial for the psychological well-being of adolescents, it is also important to consider the role which social deterrents have on parental perceptions of adolescent mental health. Within the current context of post-Apartheid South Africa many Black South African's are still socio-economically deprived and continue to have limited access to resources such as electricity, water, quality health care, sanitation and education, which are all found to be predictors of mental health (Mfenyana, Griffin, Yogeswaran, Modell, Modell, Chandia, and Nazareth, 2006).

It can be said that within the South African context social deterrents seems to have a significant impact on mental health. When considering the impact of the lack of resources

available to the majority of the South African population and health behaviour, it can be argued that the intention to act in a manner conducive to mental health might not translate into the enactment of these intentions based on the imposing social constraints. The restriction imposed by social deterrents can impact on parents' ability to adopt mental health promoting behaviours. It can be argued that if adolescent mental health needs are not acted upon, these adolescents may experience impairments related to poor academic performance, negative personal relationships, social exclusion, unemployability, limited civil participation, as well as having a high risk of homelessness and contact with the criminal justice system (McDaid, Knapp & Raja, 2008). The negative impacts of social constraints on mental health can thus have long term implications which not only impact on the individual but also on the society as a whole.

The above discussion emphasises the role which social constraints play on mental health. It can also be said that another factor which impacts upon parental health seeking behaviours relates to illness cognitions. It can be said that the illness cognition which parents adopt in order to understand the causes and symptoms of adolescent mental health needs, are formed by a multitude of factors, including the environment and social messages which parents are exposed to (Ballenger et al, 2001). Cross cultural research conducted on the role which social context plays on illness cognitions has consistently found cultural variations in the presentation of psychiatric symptoms such as anxiety, psychosis and depression (Minsky, Vega, Miskimen, Gara & Escobar, 2003; Ballenger, Davidson, Lecrubier, Nutt, Kirmayer, Lepine, Lin, Tajima & Ono, 2001). Cultural variations have been found to not only be specific for symptom identification but also for diagnosis and responsiveness to treatment. These cultural variations have been accounted for by the social messages which are conveyed within a particular social group (Minsky et al, 2003). When faced with a health-related concern, an individual might first consult with lay individuals who are not health

professionals (Taylor & Ogden, 2005). The lay social referral systems which individuals make use of can act as both a risk factors and a protective factor to mental health (Taylor et al, 2005).

Multiple cultural systems coincide within the South African population. Many of these cultural systems have opposing beliefs regarding mental health, both in terms of causation and treatment (Baumann, 2007). It has been estimated that 70 percent of all South Africans consult with a traditional healer at some point, a large percentage of these South Africans do so for mental health concerns (Baumann, 2007). Psychological practises within South Africa are largely considered as furthering westernised concepts and ideals (Baumann, 2007). The multitude of the cultural ideologies which exists in South Africa seems to be in disagreement with the relevance and validity of these western psychological principles (Baumann, 2007). It can be argued that the use of traditional healers when faced with psychological concerns, present some cause for concern, as limited research has focused on the effectiveness of these approaches to managing mental health concerns (Drozdek & Wilson, 2007). Some research has suggested that while mild mental health problems seem to benefit from traditional forms of intervention, more severe mental health disorders remain untreated (Drozdek & Wilson, 2007). This can be problematic when considering whether parents of adolescent children, who subscribe to a traditional African culture, will consider mental illness as a problem deserving of intervention (Baumann, 2007).

Culture can also affect parents' perceptions regarding mental health care facilities (Baumann, 2007). Parents who subscribe to traditional African cultural values may understand mental illness in a differential manner and may not seek out support from westernized mental healthcare facilities, in order to intervene if their child was experiencing mental health difficulties (Baumann, 2007). Parents might consider alternative understandings of their

child's mental health and thus seek out different sources of support, such as traditional healers (Baumann, 2007). When considering the impact which cultural underpinnings have on the illness cognitions of parents of adolescent children, it can be argued that when a lay referral system is contacted for advice, the types of understandings provided and treatment options recommended might not yield the necessary intervention strategies. Conversely the use of traditional cultural practises can act as a compensatory factor against the restrictions imposed by social deterrents. In so doing the cultural illness cognitions may act as a facilitator which increases the likelihood that parents might act in a health promoting way.

While cultural perceptions of adolescent mental health do seemingly allow for adolescent mental health needs to be met, the usefulness of such practises have not been determined and thus the ability of these practises to have a substantial influence on adolescent mental health remains undetermined (Baumann, 2007).

While cultural belief systems significantly impact on parental perceptions of adolescent mental health it can be argued that increased emphasis needs to be placed on the promotion and facilitation of adolescent mental health needs among parents from all cultural orientations. Within the South African context limited emphasis has been placed on parental perceptions of adolescent mental health. Parents of adolescents, who reside in a social context which places limited emphasis on adolescent mental health are indirectly acculturated into adopting similar patterns of neglect.

It can be argued that within the South African context, resources are limited across the health care platform. In this regard, more needs to be done in order to ensure that the detrimental consequences associated with adolescent mental health difficulties are prevented. Increased emphasis on the prevention of adolescent mental health difficulties, among parents, can reduce the strain placed on the already overwhelmed mental health care facilitates in South

Africa. Parents need to be informed of the bio-psychosocial factors which impact on the development of adolescent mental health difficulties, the ways in which symptoms can be identified in terms of frequency and duration as well as the various treatment options available if adolescent mental health concerns arise.

This research project places emphasis on the ways in which parents understand their adolescent children's mental health and emotional well-being. The result obtained from this study could allow for the development of interventions aimed at increasing the knowledge and awareness which parents have regarding adolescent mental health, through identifying any inaccurate or distorted parental beliefs, which may cause adolescent mental health needs to remain untreated. Investigating parental perceptions of adolescent mental health, in terms of the causes, treatment options, sources of support and cultural aspects of mental health, can yield valuable insights into the potential gaps which exist in the understanding of adolescent mental health. Identifying the areas of improvement in parental mental health cognitions can be utilised to conduct further research on the topic. In so doing the overall mental health of adolescents can be increased and the likelihood of detrimental consequences of poor mental health can be reduced.

Chapter 2: Literature Review

Adolescent mental health concerns have been steadily increasing over the past two decades with limited public health strategies implemented in order to reduce its prevalence (Kleintjies et al, 2010). At the forefront of adolescent mental health are parents who are challenged with the responsibility to provide their adolescent children with the required support in order to ensure healthy psychological development (Keck, 2014). The requirements of adolescent mental health needs often stretch beyond parental knowledge and awareness (Abera et al, 2015). The consequences associated with unmet adolescent mental health needs, can have long-term implications, which are detrimental to the emotional well-being of the adolescent and the society at large (Upton, 2011). In order to develop an understanding of the existing knowledge and awareness, which parents have regarding adolescent mental health and well-being, theories of health psychology can be utilised in order to gain insight into the cognitive processes underlying health-seeking behaviour. These theories can be further substantiated to include the influence of social determinants on parental decision-making processes, in this regard, emphasis is placed on psychosocial factors including the role of cultural beliefs systems, prevalent stigmatizations of mental health and the broader influence of political and economic ideological and environmental constraints. In order to develop a framework for understanding parental health decisions and behaviours, the various aforementioned factors will be discussed. The discussion will be introduced through developing an understanding of the role of socio-environmental factors on health and illness, and will then incorporate this understanding into the decision-making processes involved in health related behaviours, these decision-making processes will then be supplemented

through exploring the role of socio-political factors and cultural perceptions on parental decision making.

2.1 Reframing Health and Illness: Bio-Psychosocial Environmental Model

The South African public health system is currently neglecting the increasing mental health needs of adolescent children (Kleintjies et al, 2010). This neglect can be seen as resulting from the accumulation of consequences associated with the use of a bio-medical framework for understanding health and illness (Bowman, Naidoo, Pillay & Roos, 2007). The utilisation of a biomedical model is rooted in the traditional understanding of health and illness, which has historically placed limited emphasis on mental health, through reinforcing a mind-body split (Ogden, 2007).

2.1.1 The Biomedical Model

The biomedical model of medicine assumes that health and illness are separate human conditions, which occur based on the presence or absence of physical symptoms (Yuill, Crinson & Duncan, 2013). In this regard, illness is understood as resulting from physical process which either develop internally or as a result of external pathogens. Illness is construed as the physical embodiment of biological processes, which are out of individual control (Yuill et al, 2013). Individuals can be considered to be afflicted by illness and not as active accumulators of illness; all responsibility is thus placed on forces outside of individual control (Nettleton, 2006). The biomedical model assumes that illness can be treated through prescribing medicine, and in extreme cases utilising medical procedures (Nettleton, 2006). Medical professionals are responsible for the identification of pathogens and the implementation of medical interventions (Nettleton, 2006). The biomedical model adopts a traditional dualist model of the mind-body split (Deacon, 2013). The mind is understood as abstract and related to thoughts and feelings while the body is understood as physical matter

such as organs, muscle tissue, and bones (Deacon, 2013). The biomedical model assumes that the mind and body function independently, and thus consider psychological afflictions to be symptoms of physical illnesses, which have no direct impact on the overall health of an individual (Deacon, 2013).

The biomedical model has received much criticism for its exclusion of psychological factors. Over the past thirty years, various research studies have found evidence for the effects of socio-environmental factors on health and illness (Jones & Moon, 1987; Curtis & Taket, 1996; Wilkinson, 1996; Hart, 1996; Senior & Viveash, 1998; Caceres, 2000; Nettleton, 2006). As a result of the research evidence yielded from these studies, a fundamental shift occurred in the ways in which health and illness are understood. The biomedical model was elaborated upon to include a holistic bio-psycho-social environmental (BPSE) model for understanding health and illness (Gilbert et al, 2010).

2.1.2 The Bio-psycho-social Environmental Model

The BPSE model includes the role of social contexts and individual behaviour, while still acknowledging the role of biological and genetic factors (Stineman & Streim, 2011). This paradigmatic shift has reframed the understanding of health and illness and assumes that individuals are active participants, who are responsible for their own health and recovery (Stineman & Streim, 2011). This approach understands disease as resulting from social and environmental changes, psychological conditions, and biological factors, the combination of which are seen as all contributing to the maintenance, prevention, and promotion of health (Stineman & Streim, 2011).

The development of a BPSE approach to understanding health provides a more holistic understanding of health, which can be utilised to explain both physical illness and mental health concerns (Urdang, 2008). The use of a BPSE model has been widely adopted within

the academic spheres (Urdang, 2008). Specifically within the realm of psychology, most mental health professionals have agreed upon the use of a BPSE model when attempting to understand the development of mental health disorders (Urdang, 2008).

2.1.3 Parental Models of Mental Health

Research conducted by Morrissey-Kane and Prinz (1999), Baden and Howe (1992) and Bradley and Peters (1991) found that in most cases parents tend to believe that there is a specific primary cause for their child's mental health problem, rather than considering a more holistic approach such as the BPSE model.

The evidence indicating that parents rely on a disease model and a simple causal model for understanding their adolescent children's mental health indicates some cause for concern. Parents seem to be adopting a bio-medical framework for understanding adolescent mental health. The reliance on a biomedical model indicates that parents might not have the necessary knowledge regarding the complex aetiologies of different mental health disorders, which can occur in adolescent children. The underlying assumptions, which are rooted within a biomedical approach, could influence parental cognition and decision-making processes when faced with concerns regarding adolescent mental health.

In order to ascertain the underlying theoretical paradigm which parents utilise when confronted with adolescent mental health concerns, it is important to consider the different factors which impose on their construction of beliefs and behaviours. The theoretical models, which are considered to form part of health psychology, can provide insight into the cognitions and behaviours of parents of adolescent children and the threat, which mental health concerns pose.

2.2 Parental Health Seeking Behaviour and Illness Cognitions

Health psychology has recently developed in order to include psychological factors in understanding health (Baum, Revenson & Singer, 2012). The principles of health psychology strongly align with a BPSE model and challenge traditional biomedical approaches, which emphasises the mind-body spilt (Baum et al, 2012). Health psychology thus focuses on the role of the mind in both the causes and treatment of illness. This approach to understanding health suggests that humans are complex social beings and that illness is not linear and thus cannot be attributed to a single causal factor, but rather as a result of a multitude of factors (Baum et al, 2012).

Theories of health psychology have been developed in order to understand, explain, and predict health-seeking behaviour (Abraham, Conner, Jones & O'Connor, 2016). These theories can be classified into three different conceptual models, including Lay Theories of Health, Cognitive Models, and Social Cognition Models. These models provide insight into the ways in which health related decisions are made, through exploring the individual beliefs held regarding health (Lay Theories of Health), the ways in which health information is processed (Cognition Models), and the process of the internalisation of external social factors which produce individual cognitions of health (Social Cognition Models) (Abraham et al, 2016).

While each of these three aforementioned models of health psychology, provide valuable insight into individual health behaviours, it can be argued that utilising each of these theoretical models in isolation, does not provide a holistic understanding of parental health seeking behaviours. Rather, the combination of these models allows for a more integrated and fully encompassing understanding of parental health behaviours.

2.3 Lay Theories of Understanding and Predicting Parental Health Seeking Behaviour

Lay theories of predicting health aim to understand the ways in which people make sense of their health. These theories have developed out of quantitative research studies, which aimed to explore the cognitions, which lay individuals have regarding their health (Abraham et al, 2016). The theoretical approaches which can be considered to explore the lay theories of health include Attribution Theory, Health Locus of Control, Unrealistic Optimism, Self Affirmation Theory and the Stages of Change Model (Abraham et al, 2016). These aforementioned theories emerged in response to the initial research finding identified by Lethenthal, Prohaska and Hirschman (1985). Lethenthal et al (1985) identified and described factors which they believed predicted health behaviours. These factors included social factors (such as learning, reinforcement, modelling, and social norms), genetics, emotional factors (such as anxiety, stress, tension, and fear), perceived symptoms (such as pain and fatigue), the beliefs of the patient, and the beliefs of the health professionals (Lethenthal et al, 1985).

Attribution theory can be considered as forming part of the models aligned to lay theories of predicting health and thus contributes to the works of Lethenthal et al (1985), in order to provide further insight into individual perceptions of health (Abraham et al, 2016). Attribution theory has been extensively elaborated upon since its original conception by Heider (1944, 1958), who proposed that individuals perceive their external social world as predictable and controllable and thus that individuals need to understand the causality of an illness in order to predict the likelihood of developing an illness and also understand how to control the illness. Kelley (1967, 1971) elaborated on these ideas and proposed a clear defined attribution theory, which suggest that attributions about causality can be structured according to causal schemata. Causal schemata can be understood as developing based on specific criteria related to cognitive beliefs (Kelley, 1971). These criteria include;

distinctiveness (the attribution about the cause of behaviour, is specific to the individual acting out the behaviour), consensus (the attribution about the cause of a behaviour is shared by others), consistency over time (the same causal attribution can be made over time), and consistency over modality (causal attributions remain the same across different situations) (Kelley, 1971).

According to Kelley (1971) these attribution criteria can be combined with the attribution made (for example low distinctiveness and high consensus) in order to determine the extent to which the cause of a behaviour is understood as the product of internal or external factors. These criteria have been elaborated upon to allow a distinction to be made regarding self-attributions (internal cognitions) and other-attributions (external social cognitions) (Graham & Folkes, 2014). These elaborations have indicated that causality can be understood as either attributed to external or internal individual factors, stable or unstable factors, global or specific factors, and controllable or uncontrollable factors (Graham & Folkes, 2014).

According to Landly and Bradley (2014) attribution theory can be utilised in order to understand the cognitive process which parents adopt regarding the causes associated with their children's mental health problems as well as the benefits associated with therapeutic treatment options. In a study conducted by Reid, Shanley, Goffin, Brown, Evans, Steward, and Wolfe (2008) it was found that parental attributions regarding the causes of their children's mental health problems significantly impacted on the drop out and success rates of therapeutic intervention plans. Reid et al (2008) state that within the field of developmental psychopathology it has been found that mental health problems develop as a result of the interaction between multiple contextual and developmental factors. Reid et al (2008) however found that parents often view their child's mental health problem as resulting from a single contextual factor. Parents with these perceptions were found to have rigid beliefs regarding the type of treatment which their child should receive. Reid et al (2008) make the argument

that these fixed views on treatment could result in inflexibility when the parent is presented with a treatment option, which does not match their treatment cognitions, and could result in an increased likelihood that these parents drop out of treatment plans.

Furthermore Mattek (2013) conducted a study aimed at investigating the underlying factors associated with early termination of treatment by parents of adolescents with mental health problems. Mattek (2013) highlighted that previous research studies have focused on barriers to treatment, which include race, culture, socioeconomic status, and symptom severity. Mattek (2013) however makes the argument that much has been done to reduce the impact of these barriers on treatment, without yielding positive results. Mattek (2013) stated that parental attributional styles may be one underlying factor, which remains unaddressed. Mattek (2013) found that parents, who view themselves as contributing to their child's mental health problem, were more likely to successfully complete the treatment programme. Conversely, parents who viewed their children as responsible for their own mental health problems demonstrated an increased likelihood of premature treatment termination (Mattek et al, 2013).

The parental attributions regarding adolescent mental health problems can thus significantly impact on the ways in which parents understand the causes of adolescent mental health problems as well as the types of treatment options available and the success rate of the treatment program. The external versus the internal dimension of attribution theory highlighted above indicates that parents who view the cause of their child's mental health problem as internal, are more likely to seek out and complete treatment programs. Conversely parents who view the cause of their child's mental health as external, are less likely to seek out and complete treatment programs.

The external versus internal versus external dimension of attribution theory has also been applied to the concept of health locus of control (Moorhead & Griffin, 2004). Individuals differ in the ways in which they understand events as either resulting from factors which are within their control (internal locus of control) or from factors which are out of their individual control (external locus of control) (Marks, Murray, Evans & Estacio, 2006). The Locus of control model has been found to be linked to the likelihood that a particular health threat is acted upon or ignored (Marks et al, 2006).

While it can be argued that a locus of control model seems limited in its ability to understand and predict parental health seeking behaviours, it can however provide some insight into the ways in which parents frame the causes associated with adolescent mental health problems. The locus of control model can be used in combination with attribution theory in order to gain an understanding of parental causal cognitions as well as treatment seeking behaviour and attitudes. Parental attributions regarding the external vs. internal causes of adolescent mental health concerns, however does not facilitate an understanding of the reasons underlying failures to seek treatment. In order to gain an understanding of the thought process associated with negative attitudes towards treatment seeking the theory of Unrealistic Optimism can be utilised.

Research conducted on parental Health Locus of Control, has indicated conflicting results with some studies suggesting that external locus of control in parents, result in higher levels of adolescent psychological distress and relationship dissatisfaction (Marsiglia, Walczyk, Bubolts, & Griffith-Ross, 2007; Morry , 2003; Muhonen & Torkelson, 2004; Wu, Tang & Kwok, 2004), while other studies have suggested that high levels of internal locus of control

in parents results in negative consequences which could lead to the development of adolescent depression (Pomerantz, 2001; Sokolova, 2014).

The conflicting research evidence yielded regarding the Locus of Control Model as a means of understanding parental cognitions regarding adolescent mental health, align with the criticisms this model has received (Marks et al, 2006). The Health Locus of Control Model has received much criticism based on its lack of engagement regarding whether locus of control is a constant trait or a fluid state (Marks et al, 2006). It has also been questioned whether individuals can have both external and internal locus of control, which is situationally dependent (Marks et al, 2006).

Unrealistic Optimism was first identified by Weinstein (1983, 1984) in order to develop insight into the underlying reasons why individuals fail to act in a healthy manner. Weinstein (1983, 1984) argued that repeated unhealthy behaviours can be associated with inaccurate perceptions of risk and susceptibility. These inaccurate perceptions form the basis of the theory of Unrealistic Optimism. Unrealistic Optimism can be defined as the inaccurate beliefs, which individuals hold true, about the likelihood of contracting a disease (Weinstein, 1987). Weinstein (1987) proposed that individuals believe that they are unlikely to develop an illness based on the presence of four factors. These factors include; a lack of personal experience with the problem, the belief that the problem is preventable by individual action, the belief that no past diagnosis predicts no future diagnosis, and the belief that the problem is infrequent (Weinstein, 1987).

The aforementioned factors identify the inaccurate cognitions, which individuals adopt regarding their health. In order to understand how these cognitions emerge when individuals assess their health, Weinstein (1983) argued that individuals have selected focus. Individuals ignore their own risk-increasing behaviour, by selectively focusing on their risk-reducing

behaviour. The focus that is placed on risk-reducing behaviour is further compounded by egocentrism, whereby individuals place emphasis on their own health promoting behaviours while ignoring the risk reducing behaviours of others (Weinstein, 1983).

Weinstein's (1983) theoretical conception of Unrealistic Optimism has received much criticism, within which it has been contested whether optimistic bias can be more accurately conceptualised as a single personality trait type phenomenon or as a series of semi-independent specific illness factors (Coelho, 2010). Furthermore, it has been argued that research studies conducted on Unrealistic Optimism have been driven by physical illness with limited emphasis placed on mental health (Conversano, Rotondo, Lensi, Della Vista, Arpone & Reda, 2010). The limited number of studies, which have been conducted on Unrealistic Optimism, has focused on the relationship between optimistic bias and the perception of risk for depression (Conversano et al, 2010). The results obtained from these studies have however suggested that the ways in which individuals perceive their personal risk of suffering depression, has the potential to have important implications for public health policy (Conversano et al, 2010). In this regard it has been found that those who do not perceive themselves to be at risk for depression, are less likely to engage in help seeking behaviours (Rosenthal, 1996; Moore & Rosenthal, 1996; Harris & Middleton, 1994).

While research studies aimed at investigating the effects of unrealistic optimism and mental health have not been saturated, it can be argued that a combination of unrealistic optimism and self-affirmation theory can provide useful insight into parental cognitions regarding adolescent mental health.

Self-Affirmation Theory suggests that people are motivated to protect their sense of self and their sense of self-integrity (Howell, 2016). If an individual is presented with information which is perceived as a threat to their sense of self and self-integrity, a defence mechanism is

aroused, which ensures the survival of the perceived sense of self (Howell, 2016). In a study conducted by Raviv, Sharvit, Raviv and Rosenblat-Stein (2008) it was found that parents who had concerns about their children's mental health were more likely to refer other parents who had similar concerns, for professional help, rather than seeking out help themselves. These findings have been rooted in the optimism bias which is held regarding others being seen as more in need than the self (Raviv et al, 2008). The inaccurate belief that the self is impenetrable to mental health problems can be seen as a defence mechanism, which serves to avoid heightened levels of anxiety and fear, which is aroused by a perceived threat to the individual's sense of self and self-integrity (Cohen & Sherman, 2014). The use of such biased cognitions can be seen as a projection of the needs of the self onto the other, which results in lower levels of anxiety and thus serves as a means to uphold a righteousness sense of self. Thus in order to self-affirm individual virtues, unrealistic optimism is utilised, which allows inaccurate beliefs to form regarding the development of health related concerns (Cohen & Sherman, 2014).

Parents who have concerns about their adolescent children's mental health might adopt external attributions regarding the susceptibility of adolescent mental health problems. Parents might develop unrealistic optimism, within which it is believed that others are more susceptible than their own children. These unrealistic attributions thus serve as a means to ensure the survival of a moral sense of self and the perseverance of their perceived identity as a good parent.

In conclusion, the theories exploring the ways in which lay individuals conceptualise health and illness can provide some insight into the ways in which parents understand adolescent mental health. The various explanatory phenomenon which these theories represent indicates that the attributions which parents have regarding the likelihood that their adolescent children might develop a mental health problem is dictated by their personal experience and exposure

to adolescent mental health problems, and the knowledge and awareness which they have regarding the causes of adolescent mental health problems. Furthermore, the ways in which attributions are made regarding the causes of adolescent mental health problems can significantly affect the likelihood that therapeutic treatment options are utilised if causes for concern were to arise. Parents who have an external locus of control have been found to be less likely to seek out treatment for adolescent mental health concerns, while parents who have an internal locus of control will be more likely to seek out support. It has also been argued that parent might develop unrealistic optimism about their own adolescent children's mental health, in order to self-affirm their integrity and sense of self as righteous and moral.

While these aforementioned theories have received much criticism, it can be argued that the core principles identified in each theoretical model, present some understanding of the thought patterns and behaviours which parents adopt regarding their adolescent children's mental health. Cognition models have integrated these lay theories of health in order to gain a more structured and holistic understating of health behaviour (Ogden, 2007).

2.4 Cognition Models of Understanding Parental Illness Cognitions

Cognition Models aim to understand and explore the precursors of health behaviour. These models have been developed from the theory of Subjective Expected Etility (SEU). The theory of SEU was first proposed by Edwards (1956), who stated that behaviour results from rational information processing, whereby the cost and benefits of certain behaviours are compared in a rational manner, before a behaviour is enacted. Social Cognition Models have adopted this framework, placing emphasis on cognitions, and thus assume that individuals are rational information processors (Corcoran, 2007). The main theories contained within Cognition Models include the Health Belief Model (HBM) and the Protection Motivation Theory (PMT) (Corcoran, 2007).

The HBM assumes that individuals have certain core beliefs regarding health and illness. These core beliefs can be seen as either facilitating or hindering the enactment of health related behaviours (Glance et al, 2008). The HBM outlines that these core beliefs can be understood as the individual perceptions, which are considered to be true regarding health (Glance et al, 2008). Furthermore, the HBM assumes that individual perceptions of health and illness are shaped by demographic variables such as age, gender, socio-economic status, race, cultural orientation and geographic location (Hayden, 2014). While demographic variables impact on individual beliefs, the HBM argues that individuals acquire these beliefs based on certain factors (Hayden, 2014). These factors include the perception of susceptibility to a particular illness, the severity of the illness, the cost involved in carrying out a health promoting behaviour, the benefits of carrying out the behaviour, and the cues to action (which may be internal) (Hayden, 2014).

In the event that an individual is confronted with concerns regarding a particular health threat, the individual might firstly assess his/her susceptibility to the illness (Edberg, 2010). Research conducted on the topic of parental beliefs, regarding the susceptibility of their children developing a mental health disorder, has indicated that stigma surrounding mental health significantly affects the beliefs held regarding susceptibility (Mukolo, Heflinger, & Wallston, 2011). Parents often view their children as extensions of themselves (Mukolo et al, 2011). In this regard, parents view the development of mental health problems in their children as caused by them (Mukolo et al, 2011). Mental health disorders are often characterised in a negative light, afflicting those who are viewed as immoral and insane (Mukolo et al, 2011). As a result of the stigmatised beliefs held regarding adolescent mental health disorders parents are less likely to perceive their adolescent children to be susceptible to the development of mental health disorders, in order to ensure that their integrity as parents and individuals remain intact. In this regard it can be argued that parents develop unrealistic

optimism in order to self-affirm their parental abilities, and thus deny the likelihood that their adolescent children might be susceptible to mental health problems, and thus avoid being stigmatised.

The second factor, which parents might consider when faced with concerns regarding their adolescent child's mental health, is that of the severity of the disorder (Manasco, 2008). Research conducted on parental severity ratings of adolescent mental health concerns has indicated that parents often perceive mental health problems as less severe. In one particular study, conducted by Capitelo, Puddu, Piga, Cuttini, Gentile and Milani (2014) parents of children and adolescents who have received a clinical diagnosis of mixed specific developmental disorder (MSDD) were asked to rate the symptoms and behaviours of their children using a Child Behaviour Check List. The results obtained from this study indicated that parents rated their children's behaviour as normal regardless of the observable behavioural difficulties (Capitelo et al, 2014). Capitelo et al (2014) makes the argument that these parents had limited previous knowledge regarding MSDD and as a result either, denied its existence or reduced the symptom severity to normal behaviour. These research findings indicated that parents, who have limited knowledge regarding the symptoms of adolescent mental health disorders, are unaware of the presence and severity of the symptoms, and thus are limited in their capacity to identify causes for concern (Capitelo et al, 2014).

The third factor, which shapes parental beliefs regarding adolescent mental health, relates to the benefits of carrying out mental health behaviours (Norman, Abraham & Conner, 2000). The risk associated with stigma have been found to significantly impact on the likelihood that parents seek out treatment if they were to have concerns related to their children's mental health. In a study conducted by Kleintjies et al (2010) it was found that parents fear being victimized on the basis of having mental health problems in the family, parents fear being physically and verbally assaulted based on their child's mental health problem as well as

having a fear of being socially excluded from the community. These negative perceptions are shaped by the greater community context and can greatly affect whether an adolescent child with mental health difficulties receives adequate treatment (Kleintjies et al, 2010). Kleintjies et al (2010) found that because of a fear of being stigmatized parents of adolescent children with mental health disorders were unlikely to seek out assistance either from the community or from health care facilities. Thus it can be said that the high cost of stigmatisation involved in carrying out a mental health promoting behaviour reduces the likelihood that the behaviour is enacted by parents of adolescent children (Kleintjies et al, 2010).

The fourth factor impacting on parental perceptions, is associated with the benefits of carrying out a mental health promoting behaviour. Stewart-Brown and Schrader-McMillan (2011) state that the promotion of mental health has widely been adopted based on evidence highlighting the importance of mental health for children and adolescents. Stewart-Brown et al (2011), however state that much of this promotion has been conducted within the academic realm, with limited policies and programs being implemented in order create widespread knowledge and awareness of child and adolescent mental health. In a study conducted by Stewart-Brown et al (2011), it was found that providing parents with information and practical skills to enhance child and adolescent mental health, significantly improved parenting strategies as well as the overall mental health of children. It can be argued that providing parents with the knowledge and necessary skills to facilitate mental health promoting behaviours, parents are more likely to perceive benefits associated with mental health interventions and strategies.

The findings provided by Stewart-Brown et al (2011), can also be utilised for the fifth component of parental perceptions, which is cues to action. Cues to action can be understood

as the ability to identify symptoms that are problematic (Orji, Vassileva & Mandryk, 2012). Identifying problematic symptoms creates awareness in the individual which indicates that an action is required in order to address these symptoms (Orji et al, 2012). Cues to action can either be generated based on the experience of symptoms or as a result of receiving health information (Orji et al, 2012). It can be argued that in order for parents to be able to identify cues of action, they are required to possess some knowledge about adolescent mental health concerns, and the symptoms associated with each (Glanz, Rimer & Viswanath, 2015). The awareness of symptoms can serve as a cue to parents that a particular behaviour is required to reduce the symptoms or the future development of a mental health disorder (Glanz et al, 2015). When considering cues to action in response to physical illness, the symptomology can be relatively easy to identify without much knowledge regarding the symptoms associated with a particular illness (Glanz et al, 2015). Breathlessness for example is associated with multiple health concerns; however an individual does not necessarily have to possess the knowledge of these illnesses, and rather can rely on the discomfort of the physical symptom to cue action (Glanz et al, 2015). Parents however might have some difficulty with identifying cues to action regarding their adolescent children's mental health. When confronted with adolescent mental health concerns, parents are not experiencing these symptoms first hand but rather as observers of the symptoms (Glanz et al, 2015).

Research studies conducted on the neurodevelopment of adolescent children, has found that adolescents do not yet possess the language necessary to communicate what they are feeling (Jetha & Segalowitz, 2012). Results yielded from these studies indicate that parents often observe changes in the behaviour, mood and affect of their adolescents children, which they deem concerning, however as the parent attempts to confront the adolescent, the adolescent becomes frustrated by their inability to express their difficulties and often respond with

dismissive phrases (Jetha & Segalowitz, 2012). The cognitive inability of the adolescent to communicate psychological distress, present numerous challenges to parents (Jetha & Segalowitz, 2012). Furthermore, many mental health disorders, such as mood and anxiety disorders, present with symptoms which can also be associated with normal adolescent behaviour (National Institute of Health, 2007). The lack of visible symptoms associated with mild forms of mental health disorders, is often experienced internally, and are often not visible externally (National Institute of Health, 2007). The limited symptom expression can result in a decreased likelihood of cues to action, and thus treatment seeking.

The above discussion highlights the ways in which parental beliefs are formed regarding adolescent mental health and well-being. Based on the HBM, parents assess the susceptibility, severity, costs, benefits, and cues to action when attempting to understand adolescent mental health. The HBM has however been criticised based on the lack of acknowledgement which is placed on the interrelationship between the different core beliefs. It has been questioned whether these core beliefs occur in a linear manner, each occurring as a result of the previous belief, or whether the model should be understood as multifactor model. It has also been criticised for the emphasis, which is placed on individual factors, without the consideration of environmental factors such as the economic climate, social-political structure and cultural considerations.

The Protection Motivation Theory (PMT) was developed by Rogers (1975, 1983, 1985) in order to expand on the HBM and address some of the criticism which it has received. The original components of the PMT presented similarities to the HBM and include four components (Salovey & Rothman, 2003). These four components included severity, susceptibility, response effectiveness, and self-efficacy (Salovey & Rothman, 2003). These

components can be utilised to predict behavioural intentions. Rogers (1985), included a fifth component to account for emotional responses which arise when health information is received. The emotional response of fear was identified as resulting from receiving health information, which threatens individual health (Salovey & Rothman, 2003). The emotional response of symptoms severity and fear can be described as relating to threat appraisal and response effectiveness and self-efficacy as relating to coping appraisal (Salovey & Rothman, 2003). Threat appraisals arise as a result of external threats while coping appraisals result from internal coping strategies (Salovey & Rothman, 2003).

According to PMT there are two types of information sources, environmental information is acquired through verbal persuasion and observational learning, and interpersonal information which result from personal experience (Thirlaway & Upton, 2009). These sources of information impact on the five components which result in either an adaptive/coping response (such as the behavioural intention to increase health-seeking behaviour) or a maladaptive coping response (for example avoidance and denial) (Thirlaway & Upton, 2009).

The application of PMT on parental behavioural intentions regarding adolescent mental health problems, can provide insight into the ways in which parents utilise information regarding adolescent mental health. Parental responses can either act as a facilitating factor which increases the likelihood that parents understand and acknowledge adolescent mental health concern and thus act in accordance to the promotion of their mental health. Alternatively parents can respond to threatening information by avoiding and denying any mental health concerns and in so doing avoid treatment seeking behaviour.

In a study conducted on the referral sources of adolescents with mental health problems, it was found that only 17 percent of parents independently consult with mental health care professionals if they have concerns regarding their adolescent children's mental health (Pedrini, Sisti, Tiberti, Preti, Fabiani, Ferraresi, Palazzi, Parisi, Ricciutello, Rocci, Squarcia, Trebbi, Tulli, & De Girolamo, 2015). The majority of adolescents with mental health concerns, are referred to mental health care facilities by teachers and medical professionals (Pedrini et al, 2015). These findings further indicate that most referrals are made based on externalising adolescent mental health disorders, while internalising adolescent mental health disorders are only referred once severe withdrawal is perceived by others outside the home environment (Pedrini et al, 2015). These findings can be linked to the previously discussed research findings proposed by Capitelo et al (2014), who found that parents avoid or deny adolescent mental health problems in order to reduce negative emotional responses such as fear and anxiety.

These findings obtained by both the aforementioned studies align with the theoretical components of PMT. Parents might adopt a fear appraisal when threats arise regarding the susceptibility and severity of adolescent mental health concerns. Parents might react with a fear response which either facilitates treatment seeking, or results in denial and avoidance of the concern presented.

The use of HBM and PMT when attempting to understand parental perceptions of adolescent mental health and well-being can provide valuable insight into the ways in which beliefs are formed through cognitive perceptions and information processing. The formation of parental beliefs are based on the knowledge and information which parents have regarding adolescent mental health, these beliefs can influence the types of responses yielded by parents when

confronted with such concerns. The HBM and the PMT provide an understanding of the development of internal cognitions and emotional responses to adolescent mental health, in order to gain insight into the role with social factors play. The HBM and PMT however focus on the internalised cognitions regarding adolescent mental health, and neglect to account for the role which cultural and contextual factors in the construction and internalisation of mental health cognitions. Social cognition models attempt to account for these contextual factors, in order to understand how mental health cognitions are shaped by societal factors.

2.5 Social Cognition Models of Understanding Parental Perceptions of Adolescent Mental Health

Social cognition models examine factors that are aimed at understanding and predicting individual health cognitions and behavioural intentions (Augoustinos, Walker, & Donaghue, 2014). Social cognition theory was first developed by Bandura (1977, 1986) and suggests that health behaviour is governed by, health expectancies, incentives and social cognitions. Social cognition models, similarly to cognition models, assume that individuals are rational information processors (Augoustinos et al, 2014). A significant difference can however be found between cognition models and social cognition models in that, social cognition models emphasise the role of individual cognitions of health and illness (Augoustinos et al, 2014). Social Cognition Models thus focus on measuring individual representations of their social world, in so doing these models attempt to place the individual within the context of other people and the broader social world (Augoustinos et al, 2014). In order to measure individual social cognitions, focus is placed on developing an understanding of the normative beliefs which individuals are exposed to, and which influence their cognitive thought processes (Augoustinos et al, 2014).

The Theory of Planned Behaviour (TPB) aligns within Social Cognition Models, and it assumes that behaviour results out of the combination of several individual beliefs (Glanz et

al, 2015). The TPB states that attitudes and beliefs held regarding particular behaviours are composed of either positive or negative evaluations of the behaviours and the beliefs about the outcomes of the behaviours (Glanz et al, 2015). In a study conducted by Abera, Robbins and Tesfaye (2015) on parental perceptions of child and adolescent mental health problems and their treatment choice, it was found that parental beliefs regarding the utilisation of mental health services, was significantly impacted upon by parental knowledge of concerning psychological symptoms and socio-economic status. The majority of parents who took part in this study indicated that concerning behaviours are composed of externalising symptoms, rather than internalising symptoms (Abera et al, 2015). Parental beliefs seem to indicate that parents find externalising behaviours more concerning than internalising behaviours, such as suicidal ideation (Abera et al, 2015). The beliefs regarding problematic behaviour were further impacted upon by socio-economic status (Abera et al, 2015). Parents of low-income households were more likely to recognise externalising behaviours and psychotic symptoms, and act in accordance to traditional explanatory and treatment modalities (Abera et al, 2015). Internalising symptoms were not regarded as problematic and these symptoms were considered as normal behaviours, and thus parents were less likely to act upon such symptoms (Abera et al, 2015).

The above research findings indicated that parental beliefs regarding symptom severity significantly impacts on their evaluations of different treatment modalities, symptoms which are not considered as disruptive are not acted upon, while disruptive externalising symptoms are regarded as more serious and are more likely to be acted upon. The TPB has however been criticised for its omission of a temporal element, which results in a lack of understanding regarding the order of different beliefs and the directionality of causality.

The health action process approach (HAPA) was developed by Schwarzer (1992), which attempts to include a temporal element in the understanding of beliefs and behaviour. The main contribution of HAPA, was its utilisation of the aforementioned theoretical components, in a more structured and inclusionary manner, which allows for an understanding of the relationship between beliefs and behaviour (Brannon, Feist & Updegraff, 2014). According to the HAPA two stages occur prior to the enactment of a particular behaviour, these two stages include the motivational stage and the action phase (Brannon et al, 2014). The motivation stage precedes the action phase, as the individual is initially confronted with the decision of whether or not to carry out a behaviour (Brannon et al, 2014). During this stage the individual evaluates his or her self-efficacy and thus their ability to manage the behaviour (Brannon et al, 2014). Research studies conducted on the topic of parental self-efficacy, has indicated that self-efficacy significantly impacts on parenting quality (COMPI, 2015). Efficacious parental beliefs increase parent-child interactions, parental warmth and responsiveness, and parental involvement and monitoring of adolescents (COMPI, 2015). These parental characteristics have been found to act as protective factors, which decrease the likelihood of child and adolescent anxiety, depression and behavioural problems through fostering high self-esteem, school performance and social functioning (COMPI, 2015).

Once the individual has acknowledged their self-efficacy to manage a difficulty, the expected outcomes of a particular behaviour is explored, these outcomes are evaluated through individual and social outcome expectancies (Brannon et al, 2014). As previously discussed, the stigmatisation of mental health can have dire consequences related to the acknowledgement and identification of mental health concerns and the decision to seek out help and support (Brannon et al, 2014). It can be argued that parents, who are confronted with concerns regarding their adolescent children's mental health, face many negative outcome expectancies based on the potential of being stigmatised and devalued for their children's

mental health concerns (Brannon et al, 2014). These negative outcome expectancies are inherently associated with threat appraisals (Brannon et al, 2014). Parents who have concerns regarding their adolescent children's mental health might reduce the likelihood of susceptibility, and normalise the severity of symptoms, which results in a lack of treatment seeking (Brannon et al, 2014).

It can however be argued that while parents might have low motivation for acting upon a certain cause for concern, that it might still result in some form of action . Once a motivation has been evaluated, the action phase is entered (Brannon et al, 2014). The action phase is composed of cognitive, situational and behavioural factors (Brannon et al, 2014). The interaction of these factors determines the extent to which behaviour is initiated and maintained (Brannon et al, 2014). The cognitive factors of this phase are comprised of action plans (which behaviours should be adopted) and action control (how are these behaviours going to be maintained) (Brannon et al, 2014). The situational factors consist of social support (for example the existence of friends, family and partners who are supportive) and the absence of situation barriers (for example financial support to seek out treatment and the availability and accessibility of mental health care services) (Brannon et al, 2014).

The HAPA emphasises self-efficacy, which assumes that individuals are the sole initiators and maintainers of behaviour (Brannon et al, 2014). These processes are regarded as being facilitated and motivated by the beliefs held, regarding mental health concerns, the knowledge of the concerns and the access to support systems (Brannon et al, 2014). HAPA highlights that social factors such as social messages conveyed about the problem, as well as the social support systems available all influences the action plans and action control (Brannon et al, 2014).

The emphasis which both HAPA and TPB place on the influence of social norms on individual health behaviours, indicate that parental beliefs are largely shaped by the beliefs held by the broader social system. Lay theories of predicting health behaviours as well as cognition models can be seen as providing the framework from which social cognition theories have emerged. It can be argued that these theories should be integrated in order to develop a comprehensive understanding of parental perceptions. It can also be argued that these theories should be elaborated upon to include the influence which social determinant have on parental perceptions of adolescent mental health.

The discussed theoretical models which aim to understand and explain health seeking behaviour, focus on providing insight into the beliefs and attitudes which inform individual decision making. These theoretical models assume that individuals develop these beliefs internally based on external social factors. These social factors are understood as the information and support provided by friends, family, health care facilities and other social institutions. The influence of social factors on individual decision making, has however not been emphasised within these theoretical models, specifically in terms of the ways in which social determinants influence individual cognitions. It can be argued that the impact which, social factors have on the formation of health beliefs and attitudes are of paramount importance.

2.6 The Influence of Socio-Political and Cultural Factors on Parental Illness Cognitions

Social determinants such as the political ideologies of a country, the availability of resources, the cultural stratification of the population, and the economic climate, all interact and impact on individual perceptions (Kleintjies et al, 2010). The varying prevalence rates of mental health problems in South Africa, demonstrates the impact which social factors have on individual belief systems (Bowman, Naidoo, Pillay & Roos, 2007). Mental health problems

are often diffusely distributed across large segments of the South African population, where some mental health disorders affect certain population groups to varying degrees (Bowman et al, 2007).

South Africa has a relatively high 12-month prevalence of anxiety and mood disorders, when compared to the global prevalence rates of mental health disorders (Herman, Stein, Seedat, Heeringa, Moomal & Williams, 2009). Twenty six percent of the diagnosed mental health disorders in South Africa are considered severe, with only Belgium, Israel and the Netherlands having higher rates of severe mental health disorders (Herman et al, 2009). Furthermore when comparing South Africa to other African countries, specifically Nigeria, it has been found that South Africans experienced twice as many lifetime anxiety disorders, four times as many lifetime mood disorders and almost six times as many lifetime substance abuse disorders (Herman et al, 2009). When comparing different South African regions, alarming distribution rates can also be observed (Herman et al, 2009). The Western Cape, which is predominantly urban, has the highest lifetime prevalence rate of common mental health disorders in South Africa. Rural provinces, in contrast, demonstrate lower rates of common mental health disorders, with the Eastern Cape, showing the lowest rate of common mental health disorders (Herman et al, 2009).

Furthermore, the prevalence rates of mental health disorders among South African adolescents indicate even more cause for concern. In one study conducted by Seedat, Nyamai, Njenga, Vythilingum and Stein (2004), comparing the rates of post-traumatic stress disorder among grade 10 learners from South Africa and Kenya, it was found that while similar rates of trauma exposure were experienced by both South African and Kenyan adolescents, higher rates of full-symptom post-traumatic stress disorder were observed among South African adolescents. The findings yielded by Seedat et al (2004) and Herman et

al (2009) both indicate that adolescent children residing within the South African context seem to be more vulnerable to developing mental health disorders than adolescents throughout the globe. These statistics highlight that social factors which are ingrained within the South African context are increasing the risk factors associated with mental health disorders in adolescents. One particular explanation, which may be underlying the results yielded, from the aforementioned statistics, is that of a socio-political-economic system which is failing to provide adequate public mental health awareness and support in a context, which is already fraught with strained resources and historical barriers to health (Kleintjies et al, 2010).

Health and illness are shaped by individual accessibility to residential and occupational resources and benefits, as well as the exposure to hazards and risks (Gilbert et al, 2010). These social factors influence the ability of parents to provide care for their children and adolescents. The social stratification within the South Africa context highlights the unequal positions occupied by parents and other individuals (Giddens, 2006). Social stratification refers to the hierarchical ordering of a society with the most privileged at the top and the less privileged at the bottom (Giddens, 2006). The South African context is stratified according to race, class, gender, age, religion, ethnicity, and geographical location. Each of these stratified social groups bears different levels of inequality (Giddens, 2006). The most prevailing social inequalities within South Africa, relates to socio-economic status, limited availability and access to mental health care facilities and racial segregation (Giddens, 2006).

The socio-economic and socio-demographic variables of households, such as the parental level of income and education, can be considered as essential components which underlie the knowledge and awareness which parents have regarding adolescent mental health disorders (Logan & King, 2001). Families with low socio-economic status have been found to be less

likely to utilise mental health care facilities for their children, based on the limited instrumental resources, such as time, money and transport, available at the parents' disposal (Logan & King, 2001). Within the South African context, socio-economic status is inevitably linked to race (Logan & King, 2001). Historical racial divisions, rooted with the Apartheid system, have lasting implications for the economic resources available to many non-white South Africans. These lasting racial inequalities can have a significant impact on the resources available to parents of adolescents with mental health concerns.

Furthermore, a family's social structure can significantly impact on the likelihood of symptom identification and service use regarding adolescent mental health problems (Ryan, Toumbourou & Jorm, 2014). The social support which parents have access to, and the social norms which guide these support systems can either act as enablers of service use, or as deterrents to service use (Ryan et al, 2014). The social guidelines which dictate what mental health symptoms are associated with adolescent mental health problems and the norms regarding how these symptoms should be managed are engrained within the particular community context which the parents reside in (Espelenta, Granero, Osa, Domenech & Guillamon, 2002; Ford, Hamilton, Meltzer & Goodman, 2008; Zwaanswijk, Van Der Ende, Verhaak, Bensing & Verhulst, 2005).

Research conducted on the family norms associated with treatment seeking for adolescent children, has found that help-seeking behaviours are associated with gendered differences, difference based on family structure and paternal involvement (Zimmerman, 2005). These research findings have indicated that adolescent girls are less likely to obtain treatment for externalising behaviour disorders when compared to adolescent boys (Zimmerman, 2005). Conversely, adolescent girls are more likely to receive treatment for internalising disorders than adolescent boys (Zimmerman, 2005). These findings were explained as resulting from

the gendered norms associated with male and female behavioural expectancies within families (Zimmerman, 2005). Zimmerman (2005) also found that the family structure in terms of the number of children in a household and the age ranges of children were significantly likened to service use. Adolescent children who are the first born or last born in a family were more likely to receive the required mental health support than middle children (Zimmerman, 2005).

Furthermore, the structuring of households in terms of parental involvement of mother versus fathers also significantly impacts on service use. In matriarchal households, where mothers are predominantly responsible for decision making, it has been found that two important factors influence maternal help seeking behaviour. These factors relate to the mother's ability to recognise symptoms and ascertain the symptom severity (Raviv et al, 2008). Mothers who are single parents are more likely to seek out professional help for adolescent mental health concerns than their married counterparts (Zimmerman, 2005). Mothers who head household, with passive fathers were also found to be more likely to seek out support. Mothers, from both types of households were found to prefer seeking out support from informal information sources (such as friends and family) rather than mental health care professionals (Raviv et al, 2008).

Studies aimed at investigating parental help-seeking behaviour have extensively focused on mothers, however recent studies have suggested that the role of fathers in help seeking behaviour is an important consideration (Raviv et al, 2008). Over the past century, the structuring of families has undergone extensive social, cultural, and economic changes as well as the place and roles of fathers in families (Parke, 2002). Traditional gender roles, have become less restricted and as a result family structures have become more egalitarian (Hoffman, 2002). This restructuring has been attributed to changes within social norms,

which have altered the perception of masculinity, in order to legitimise father's involvement in their children's lives and family functioning (Parke, 2002). The role of fathers in seeking professional support for their children with psychological difficulties, is of paramount importance to the psychological development of their children (Raviv et al, 2008).

A large body of empirical evidence has indicated that men are reluctant to seek out professional help for medical health problems and mental health problems (Addis & Mahalik, 2003; Good & Wood, 1995; Mansfield, Addis & Courtenay, 2005). Men have been found to seek out professional help to a lesser extent than women, for problems such as depression, stressful life events and physical disabilities (Mansfield et al, 2005). The reluctance of men to seek out psychological support, can be hypothesised to influence help seeking behaviours, in a manner which is not conducive to adolescent mental health needs. The aforementioned hypothesis has however not been substantiated by research evidence and thus should be regarded as theoretically based rather than an empirical fact (Raviv et al, 2008). Limited research findings have however indicated that fathers of adolescent children might experience some barriers to help seeking, as a result of concerns related to privacy and embarrassment (Cochran, 2005; Mansfield et al, 2005).

Thus socio-economic status, race and family structure all impact on the quantity and quality of mental health information received as well as the ways in which this health information is understood and acted upon, all of which influence the healthy psychological development of adolescents, it can also be said that culture similarly impacts on the parental perceptions of adolescent mental health.

The process of developing a working definition of culture, presents numerous challenges to social scientists (Gilbert et al, 2010). Social scientists have contested many of the definitions set out to conceptualise culture (Gilbert et al, 2010). While there is no one agreed upon

definition of culture it has been agreed that culture is a socially constructed framework for identity development, which is acquired after birth through the process of socialisation (Gilbert et al, 2010). Culture shapes behaviour and is closely linked to traditions, customs, and beliefs. Culture is not individually based but rather group-based and takes place within a social context, which defines what is acceptable in a particular community (Gilbert et al, 2010). When considering the impact which cultural orientations have on parents and adolescent mental health, it can be said that culture defines and shapes the ways in which parents make sense of the causes and treatment options for adolescent mental health (Walker, Holling, Carpenter & Kinzig, 2004).

Prevailing concepts about the nature and causes of health and disease, range from the emphasis on scientific and natural causal understandings of mental health to a magical and spiritual one (Walker et al, 2004). These two variants of the prevailing concepts regarding health, each reflect the dominant orientation in a particular culture. In most western cultures, it is common for people to focus on a scientific paradigm in order to understand the causes and treatment of disease, while many traditional African cultures utilise a spiritual framework for understanding health and disease (Cocks & Moller, 2002). The differing approaches utilised for understanding health and disease demonstrates that illness behaviour is a culturally learned response, within which illness is defined according to the norms, values, and beliefs which are most prevalent in a society or a community (Gilbert et al, 2008). Cultural belief systems can influence parental perceptions of adolescent mental health in terms of which symptoms are recognised as abnormal, the ways and time of seeking help, and the reaction response to treatment (Gilbert et al, 2008).

Parental cultural perceptions can impact on the ways on which symptoms are recognised and understood. The ability to recognise symptoms as abnormal is a vital component, in order for

a help seeking action to be induced. It can be argued that the symptoms themselves are not significant in explaining illness behaviour, but rather emphasis should be placed on the ways in which symptoms are defined and interpreted by various groups (Gilbert et al, 2010). Psychological understandings of psychopathology and psychiatric epidemiology adheres to a universalist view, within which psychiatric syndromes and disorders are considered to be universal in its expression of core symptoms which cluster into syndromal patterns (Canino & Alegria, 2008). In this regard a universal perspective assumes that psychological disorders are universal in its prevalence across continents, with the only exception relating to the cultural variations of symptom manifestation and the threshold of what is considered pathological versus normal (Canino et al, 2008). Psychological conditions thus occur globally, but vary in the ways in which symptoms are recognised and understood.

South African parents, regardless of cultural orientation, thus face the possibility of adolescent mental health problems. In this regard South African parents when faced with adolescent mental health concerns, can either adhere to a traditional African medical discourse or to a western scientific medical discourse, depending on their cultural orientation, when identifying normal versus pathological adolescent behaviours. Traditional African medical discourse understands mental illness as rooted in theories of misfortune, ancestry and witchery (Ngoma, Price & Mann, 2003; Maiello, 2008). Symptoms expression within a traditional African discourse might vary significantly from western scientific symptom classification (Maiello, 2008). For example, depressive symptoms within traditional African approaches are identified through physical symptoms, such as the experience of pain in different bodily regions (Maiello, 2008). This symptomatic expression of depression differs from westernised symptom classifications of depression which are identified through emotional discomfort such as feelings of sadness, anhedonia and social withdrawal (Maiello, 2008).

The recognition of which symptoms are considered abnormal, and how these symptoms are understood can significantly impact on the types of treatment sought as well as the timeframe allowed before treatment seeking behaviour occurs (Gilbert et al, 2010). In this regard it can be argued that once parents have identified abnormal adolescent behaviours, an action will follow based on the dominant mode of operation within the particular cultural orientation of the parent, in other words parents will act in accordance to “*the way things are normally done*” (Gilbert et al, 2010: p80). The process of help seeking behaviour initially commences with the use of a lay referral system, in order to ensure social and cultural norms are conformed to. In most communities, individuals and parents are likely to consult with family members, friends, and neighbours, when concerns arise (Gilbert et al, 2010). The decisions which are made regarding the symptoms experienced and the treatment action required, are thus not necessarily made by the person experiencing the symptoms, but rather based on the advice provided by their social network (Gilbert et al, 2010).

Following the referral recommendations made through the lay referral system, the concerned individual, may decide to seek help from traditional healers, modern health professional, approach alternative health sources; or a combination of all the aforementioned options. Thus, the final decision is shaped by cultural expectations and values (Gilbert et al, 2010).

The recognition of abnormal symptoms and treatment seeking, in response to symptoms can be understood as being dictated by the expected norms and values of the cultural system which parents ascribed to, one important factor which transcends cultural differences is that of stigma (Ciftici, Jones & Corrigan, 2012). The stigmatisation of mental health can have implications associated with a lack of acknowledgement of adolescent mental health problems (Ciftici et al, 2012). As mentioned previously parents might often utilise a lay referral system in order to ascertain whether symptoms are abnormal and what behaviours

should be adopted, in response to the symptoms presented . It can however be argued that parents might not consult with such referral systems if they fear being stigmatised, and in so doing be rejected by members of their community (Ciftci et al, 2012).

In an attempt to avoid stigmatised beliefs parents and other individuals might attempt to withhold their concerns, in order to avoid being labelled as the parent of an adolescent with mental health problems (Ciftci et al, 2012). Furthermore parents might also avoid mental health care facilities, in order to ensure that such labelling does not occur. These forms of label avoidance can be understood as an attempt to avoid public stigma (Ciftci et al, 2012). Public stigma occurs when members of the general public sanction stereotypical characteristics associated with mental illness onto an individual seeking help (Ciftci et al, 2012). Parents might hold the belief that if they seek out help for their children's psychological difficulties, they might be victims of public stigma, whereby people will avoid contact with them, employment opportunities might be retracted or they might face other forms of discrimination (Ciftci et al, 2012).

According to Fink and Tasman (1992) parents of adolescents with mental health disorders often, become stigmatized as the cause of their child's mental illness. These parents thus face the risk of being deemed as responsible for their adolescent child's mental illness. Fink and Tasman (1992) also point out that there is an element of shame by association, in which parents of adolescent children who are experiencing mental health difficulties are viewed by the general public as an extension of their child's deviance. Parents of adolescents with mental health disorders may fear being stigmatized by their community, and thus may not speak about or seek out help for their adolescent child who may be experiencing mental health difficulties (Fink & Tasman, 1992).

The stigmatisation of mental health thus significantly impacts on the ability of parents to ensure that their adolescent children received the necessary treatment for their mental health problems.

2.7 Conclusion

Numerous research studies have identified and described the human tendency to avoid help seeking from others, and the psychological costs associated with receiving help. (Chadda et al, 2001; Sayal et al, 2002). The gap which exists between the need for help and the utilisation of supportive resources has been termed the “service gap” (Raviv et al, 2008). The service gap has been observed in several domains in which people need help, these domains include psychological and mental health problems. When the suffering individual is a child of adolescent, in need of mental health help, the process of help seeking is carried out by parents (Raviv et al, 2008). Parents can be considered as the ‘gateway providers’, who mediate children’s access to mental health care services (Zima et al, 2000; Stiffman et al, 2004). Through the exploration of theories of health seeking behaviours and cognitions, it has been found that parental variables influence the likelihood that a child receives mental health interventions. These parental variables include parental beliefs about the causes of the child’s problem and their ability to manage the problem, their perception of the burden which their child’s problem will impose on them, their knowledge and awareness of available services, and their attitudes towards these services (Raviv et al, 2008). Children and adolescents only have access to mental health care professionals once their parents have become aware of the problem, realise the problem is out of their control and after the benefits of seeking professional help outweighs the social implications and costs of help seeking (Raviv et al, 2008).

The referral of adolescent children to mental health care facilities has significant consequences for their, social, emotional and cognitive development (New et al, 2002). It has however been argued that despite the high prevalence of psychiatric mental health problems among adolescent children, many of these adolescents do not receive adequate psychological help (New et al, 2002). The poor prognosis given to child and adolescent mental health problems, which are not appropriately treated, are critical consequences for healthy psychological development (Kleintjies et al, 2010). Parents are responsible for identifying when and how to seek help for their adolescent children. Thus understanding parental health seeking behaviour is central to ensuring healthy adolescent development.

Several theories of health behaviours have been explored in order to understand parental cognitions, beliefs and behaviours of help seeking. The theoretical assumptions proposed by each of these models, provides insight into the phenomenon of health seeking behaviours and the avoidance of such behaviours. These theoretical models can be supplemented to include social determinants of health, specifically within the South African context. Through integrating the assumptions of each of these theoretical models as well as the social factors associated with health seeking behaviour, a holistic understanding of parental perceptions can be achieved.

Parental perceptions of adolescent mental health and well-being can be considered as a complex phenomenon, which is made up of various factors. Parental perceptions of adolescent mental health are by and large shaped by a biomedical model for understanding adolescent mental health needs. It can be said that parents adopt the use of a simple causal model or a disease model for understanding mental health problems. In accordance to the HBM parents considered factors such as susceptibility, severity, costs and benefits of treatment seeking and identifying cues to action. These factors outlined by the HBM can be

impacted upon by the attributions made by parents regarding the causes and treatment options available for adolescent mental health problems.

The attributions made regarding these components of adolescent mental health are impacted upon by the optimistic bias which parents develop in response to adolescent mental health concerns (Kelley, 1971). Parents develop unrealistic optimism, which causes the belief that their adolescent children might not be at risk for the development of adolescent mental health disorders (Weinstein, 1983, 1984). Thus rendering their psychological functioning as impenetrable to the development of mental health concerns. The notion of unrealistic optimism, in accordance to the PMT, can result in the development of threat appraisals in response to adolescent mental health concerns. These threat appraisals have been found to result in maladaptive coping responses, whereby parents avoid and deny the presence of adolescent mental health disorders and in so doing reduce symptom severity to normative adolescent behaviours (Corcoran, 2007). The unrealistic optimism which parents develop can be understood as a defence mechanism which serves to protect the parents sense of self-worth and parental identity (Weinstein, 1983, 1984). This defence mechanism arises as a result of the stigmatised beliefs which parents have regarding adolescent mental health problems. As highlighted through the theories of TPB and HAPA, the social messages which are conveyed to parents regarding adolescent mental health, can significantly impact on the ways in which these concerns are understood and acted upon.

Parents often rely on a lay referral system, within which members of the social context are approached for advice (Gilbert et al, 2010). The advice which is provided to parents are often reflections of the cultural norms, which parents are expected to adhere to. In this regard negative and stigmatised social message can result in the lack of acknowledgement of adolescent mental health concerns (Gilbert et al, 2010).

Parental perceptions of adolescent mental health needs are thus products of the social setting within which parents resides. The service gap can be understood as a product of the socialised cognitions which individuals hold true regarding adolescent mental health. The barriers which exist between the need for service use and the lack of service use can potentially be attributed to the influence of cultural ideologies and stigmatisations of mental health which shape parental cognitions and beliefs in such a manner which ensures that the norms and values of a society are upheld by parents. This can however have a significant impact on adolescent mental health, and indicates that increased emphasis needs to be placed on the topic.

Developing an understanding of parental perceptions of adolescent mental health can allow for a deeper understanding of the gaps, which exist in parental perceptions of adolescent mental health, and in so doing to ensure the healthy psychological development of adolescents, through creating increased awareness on the topic with the hopes of reducing stigmatised threat appraisals.

Chapter 3: Methods

3.1 Research Design

This research study adopted a qualitative approach, utilising one-to-one semi-structured interviews. The research design was non-experimental (Rosnow & Rosenthal, 2005).

3.2 Procedure

The University of the Witwatersrand, Department of Psychology (School of Human and Community Development) was approached in order to obtain ethical clearance to conduct the research project. Once ethical clearance was obtained, the researcher compiled a referral list of potential parents of adolescent children, who were interested in taking part in the research project. The referral list was compiled by the researcher, through informing members within her social network of the project, who were then asked to advertise the research project to any potential participants. Potential participants were identified based on specified sampling criteria, which had been determined prior to the onset of the recruitment process. The sampling criteria outlined that participants were required to be parents of adolescent children aged between the ages of 12-18 years of age, and who resided within the greater Johannesburg area. The potential participants, who met the sampling criteria were provided with the contact details of the researcher. Based on the sampling procedure, this research project utilised a purposive snowball sampling strategy whereby an existing referral base of participants were utilised to identify and contact potential future participants. The participants were also purposefully selected based on sampling criteria. The parents, who were interested in taking part in the study, either contacted the researcher directly or were contacted and then provided with verbal information regarding the nature, topic and aims of the project. Once the parents agreed to take part in the project, they were provided with a participant information sheet (Appendix B) which included comprehensive information regarding the nature of the

project and what their participation in the project would entail as well as a participant consent form (Appendix C) and permission for audio-recording slip (Appendix D). Once parents signed and completed the participant information sheet and consent form, and written consent for audio recording was obtained, interview times and dates were arranged based on the availability of the parents and the researcher.

The interview process unfolded, through the use of a semi-structured interview schedule (Appendix A). The semi-structured interview schedule was comprised of a list of clear questions, this list was also flexible in that the researcher could add any questions which she felt necessary, and allowed participants to go as in-depth as they wished, without being constrained by the questions asked (Greenstein, Robert & Sitas, 2003). The interview process took place over 3 weeks in the month of February 2016. The interviews took no more than 60 minutes to complete, and were conducted in a quite/private environment, in order to ensure that the interview process would not be disturbed. The interview process unfolded by firstly establishing rapport with the parents; this was achieved through discussing the topic of parenting, the ages of their children and their interest in the research project. The interview process was terminated once the required interview questions were completed, and any unanswered questions were clarified. All audio recordings were password protected and stored on the researcher's personal computer. Once the interview process was completed the researcher transcribed the audio-recorded interviews and then analysed the data obtained. After the research project is concluded, the data will be stored for a period of two years after which it will be destroyed.

3.3 Participants

The researcher interviewed six parents of adolescent children, who resided within the greater Johannesburg area. All parents, with the exception of one parent, were female. One

participant was parenting only one child, while the remaining participants were parents of more than one child. All parents, with the exception of two parents had more than one adolescent child residing in their household. The age ranges of the parents' adolescent children were between 12 to 18 years of age. The parents who took part in this study were aged between 35-60 years. Three parents were married to the biological father of the adolescent, one parent was a widower, and two parents were divorced from the biological father of the adolescent. Four participants were white Afrikaans speaking females, one parent was a coloured Afrikaans female, and one parent was a black isiZulu speaking male. Most parents indicated that their adolescent children were psychologically healthy and they had not experienced any major causes for concern regarding the mental health of their adolescent children. One parent indicated that her adolescent child had previously received a diagnosis of ADHD and Bipolar Disorder, by a mental health care professional.

Table 1: Demographic Information of Parents

Participant	Gender	Race	Age	Home Language	Marital Status	Number of children	Gender and AGE of children
Parent A	Male	Black	35-45	IsiZulu	Married	1	• Female: 14
Parent B	Female	Coloured	35-45	Afrikaans	Divorced	3	• Male: 11 • Female: 13 • Male: 15
Parent C	Female	White	55-60	Afrikaans	Widowed	3	• Female:14 • Male: 20 • Male: 23
Parent D	Female	White	55-60	Afrikaans	Married	2	• Male:13 • Female: 19
Parent E	Female	White	45-55	Afrikaans	Divorced	2	• Male: 12 • Male: 18
Parent F	Female	White	45-55	Afrikaans	Married	2	• Male:14 • Female:17

3.4 Instrument (Appendix A)

Interviews are the most common form of qualitative data collection (Mason, 1994). Qualitative researchers make use of interviews in order to gain an in-depth understanding of individual experiences (Gray, 2009). Semi-structured interviews are in-depth interviews, which require participants to respond to pre-set open-ended questions (Corbin & Strauss, 2008). The open ended nature of semi-structured interviews allowed the participants to respond genuinely and spontaneously rather than being forced into certain answers (Marks & Yardley, 2004). A semi-structured interview was conducted individually with each participant (Gray 2009). The one-to-one nature of the interviews allowed the researcher to adjust the interview questions and probes according to the responses of each participant (Gray, 2009).

The semi-structured interview schedule was designed based on literature regarding adolescent mental health and well-being and was focused on the main research questions. The interview questions were designed in order to gain insight into ways in which parents understand adolescent mental health, specifically in terms of their perceptions regarding the causes, treatment options, existing sources of support and cultural conceptualizations of adolescent mental health and well-being. The semi-structured interview schedule consisted of eight questions. Probes were identified for each question, in order to assist participants with providing a comprehensive response or in the event that a participant was experiencing difficulty responding to a particular question. The use of probes also facilitated the process of uncovering information which might not have been within the conscious awareness of the participant, at the time of the interview, but which increased the richness of the information yielded (Gray, 2009).

3.5 Data Analysis

Phenomenography is a qualitative research methodology, which aligns with an interpretative paradigm (Bowden, 2005; Marton & Booth, 1997). This approach is aimed at investigating the differing perceptions and perspectives which frame individual experiences (Bowden, 2005). Phenomenography's ontological assumptions are subjectivist, and agree with a non-dualist viewpoint, within which individuals are understood as constructing singular lived realities (Bowden, 2005). This research project aligns with a phenomenographical approach and thus adopted an intersubjective ontology and an interpretivist epistemology. An intersubjective ontology refers to a shared understanding, taking into account that one's position is based on reference and that it is socially mediated through interaction (Anderson, 2008). Interpretivism agrees with an intersubjective ontology and assumes that realities are not fixed but rather multiple, fluid and constructed, and furthermore that knowledge is a result of the negotiation between the observer and the participant (Borelli-Montigny, 2010).

Phenomenographic data analysis requires that the perceptions held by the participants be sorted into specific categories of description (Marton, 1986; Åkerlind, 2005; Uljens, 1996). The categories which emerge from the data become the phenomenographic essence of the phenomenon (Bowden, 2005). These categories thus reflect the primary outcome of the research project (Bowden, 2005). The emergent categories are analysed, in a process which is both recursive and comparative, and thus the categories are continuously sorted and resorted, as comparisons arise within the categories as well as between categories (Bowden, 2005). An essential component of phenomenographic data analysis relates to the theory of variation, which specifies that the analysis seeks to describe, analyse and understand the experiences of both the participant and the researcher (Bowden, 2005). The perceptions of the participants,

in line with their experience with the phenomenon are also experienced and described by the researcher, this allows for a collective analysis of individual experiences (Bowden, 2005).

In order to facilitate a phenomenographic approach, a method of a thematic content analysis was utilised. A thematic content analysis focuses on identifying, analyzing and reporting patterns (themes), in order to produce a compressed and rich description of the data set (Braun & Clarke, 2006). This method of data analysis, proposes that themes are the most important units of data (Reis & Judd, 2000). A theme can be defined as a level of patterned meaning which provides an encapsulated response to the research question posed (Braun & Clarke, 2006). The process of conducting a thematic content analysis can be considered a laborious process which unfolds in several phases throughout the data analysis procedure (Braun & Clarke, 2006). The thematic content analysis is initiated once data collection has been completed (Braun & Clarke, 2006). This research project entailed that the researcher personally collected the data. According to Braun and Clarke (2006) when the researcher is personally involved in the data collection process, the first phase of the thematic content analysis is entered with some knowledge and awareness of the data set and thus the conceptualization of themes has preliminarily emerged. This initial phase of the analysis procedure required the researcher to immerse herself in the data, through actively and repeatedly reading through the data, placing emphasis on searching for meaning and patterns (Braun & Clarke, 2006). The second component of this phase of the thematic content analysis was initiated by the researcher through the process of transcribing the data. The process of transcribing the data can be seen as an interpretive act, which is an essential feature of any interpretive qualitative methodology (Bird, 2005). This phase of the data analysis is complete once the researcher had completed the transcription process, and the preliminary coding schemas had been identified.

The second phase of the thematic content analysis involved the process of generating initial codes. Codes are basic elements contained within the raw data, which can be utilized to make meaning of the experiences of the participants in relation to the phenomenon (Braun & Clarke, 2006). It is important to note that codes differ from themes, in that themes are broader unit of analysis (Braun & Clarke, 2006). This phase of the thematic content analysis thus required the researcher to read and reread the transcribed data, in order to organize the information obtained into meaningful groups.

Once the researcher had compiled a list of codes the third phase of data analysis was entered. This phase of analysis involved a focal shift, during which the researcher placed emphasis on the broader scope of the research project (Braun & Clarke, 2006). The researcher analyzed the identified codes in order to develop an understanding of how the codes interact, in so doing overarching themes were developed (Braun & Clarke, 2006). The researcher made use of a visual thematic map, in order to establish the relationship between codes, themes, and the differing levels of themes. This phase of data analysis was completed once the researcher had compiled a collection of potential themes and sub-themes.

The fourth phase of the thematic content analysis involved reviewing the potential themes (Braun & Clarke, 2006). The aim of this phase of analysis was to identify which themes were in accordance to the data obtained; this was achieved through reexamining the codes contained in each theme in order to establish that a coherent pattern is present within each theme and between themes (Braun & Clarke, 2006). In order to facilitate this process the research relied on the Patton's (1990) dual criteria for judging categories, the dual criteria was utilized to evaluate the internal homogeneity of each theme and the heterogeneity of all identified themes in relation to the overarching research question. This phase was completed once the identified themes and subthemes had been finalized. The fifth component of the thematic content analysis began when the finalized themes were re-examined, in order to

develop a definition and name for each theme (Braun & Clarke, 2006). The essence of each theme was analyzed alongside the entire thematic scope in order to ensure that the themes were in accordance with the data obtained. The main focus of this phase was to ensure that the themes presented an accurate representation of the data as well as being in accordance to the overarching aim of the research project (Braun & Clarke, 2006). This phase was concluded once each theme had a clear and concise name and working title.

The last phase involved the final analysis and the production of a report (Braun & Clarke, 2006). In order to write-up the final report the researcher consulted numerous research publications, for example Ellis and Kitzinger, 2002; Kitzinger and Willmott, 2002 and Toerien and Wilkinson, 2004, which utilized thematic content analyses as their main data analysis procedure. This provided the researcher with a knowledge base regarding the essential components of a completed thematic analysis.

3.6 Ethical Considerations

When conducting research which utilises human subjects, it is essential to consider any ethical issues which may arise during the course of the research process. The nature, topic and aims of this research project, focus on exploring the everyday thoughts feelings and beliefs of parents regarding adolescent mental health and well being. The questions posed to the parents during the interview process did not require the participants to divulge any sensitive or traumatic information and thus posed minimal risk for psychological consequences to the participants. It can be said that the content of the information provided by participants cannot be entirely regulated and thus, while the study does not present any risk of psychological distress, an element of risk is always present to some extent, and therefore the researcher took the following measures to ensure that the psychological well-being of the participants was not affected by their participation in the research project.

Firstly the researcher reviewed the faculty code of ethics and all ethical considerations mentioned within were taken into account. Once the faculty code of ethics was reviewed the researcher submitted the research proposal to the Department of Psychology. The research proposal was reviewed in accordance to the departmental code of ethics and ethical clearance was granted, allowing the research project to commence.

The researcher approached parents of adolescent children who indicated an interest in participating in the research project, and provided them with information regarding the purpose of the study and what their participation in the study would entail. It is important to note that the participants were in no way coerced into partaking in the study and to this extent the participants were informed that their participation would be voluntary and that they would be free to withdraw from the study at any time, with no negative consequences. Furthermore it was emphasised that there would be no benefits associated with their participation in the research project. The researcher also clarified that confidentiality would be assured and that no identifying information would be included in the reporting of research findings. The participants were however informed that the researcher would be making use of direct quotations, in order to substantiate claims made, but that the identifying information of the participants would not be disclosed, and that the researcher would make use of numerical coding techniques when reporting findings. The participants were also informed that the raw interview data would only be accessible to the researcher and the research supervisor. The researcher informed the participants that she would provide feedback in the form of an executive summary to the institution, should they wish to review the findings of the research project.

The participants were also provided with a participant information sheet, consent form and permission slip for audio recording prior to the commencement of the interviews. The consent form provided information regarding the nature and purpose of the study as well as

all ethical and procedural information. The participants were required to read and sign the participant information sheet and consent forms prior to the commencement of the interviews. In the event that the researcher noted any causes for concern, during the interview process, regarding the psychological well-being of any of the participants, the researcher would provide the participant with the contact details of a free psychological service provider. The designated service provider was the South African Depression and Anxiety Group (SADAG), which could be contacted at any time, free of charge on 011 234 4837 or 0800 20 50 26.

The process involved in obtaining informed consent as well as the nature of the interviews as face-to-face, caused some restraints to anonymity. The researcher needed to access the names and contact information of the participants for practical reasons. Thus it was not possible to guarantee anonymity. However, to this extent, the researcher assured the participants that she would do everything in her power to ensure confidentiality and privacy. The participants were informed that no identifying information would be included in the research report and that access to raw interview data would be limited to the researcher and the research supervisor. The recorded interviews would be stored on the researcher personal computer with password protection. The researcher also made use of alphabetical and numerical codes when referring to the participant's responses. Thus while anonymity could not be guaranteed confidentiality was ensured. After completion of the research project, all the raw data would be kept for the period of two years, after which it would be permanently destroyed.

The participants were not provided with feedback on an individual basis, but the institution will be provided with an executive summary of the results of the project via e-mail. The participants were informed at the start of the project that the report would be available in the library at the University of the Witwatersrand, and that it would be accessible to anyone wishing to read it.

Chapter 4: Findings

The literature reviewed has identified that individual perceptions of health, and the behavioural responses associated with these perceptions, are complex and dynamic phenomenon. The complex nature of health perceptions and health behaviours is further exacerbated when directed towards understanding parental perceptions of adolescent mental health and well-being. The following section addresses the findings obtained from the analysed parent interview responses. The themes constructed, through the process of a thematic content analysis, provides some insight into the thoughts, feelings and behavioural patterns, which parents adopt when confronted with adolescent mental health concerns. This chapter identifies, as themes, parental perceptions of adolescent mental health as related to: 1) parental causal attributions 2) symptom identification, 3) treatment seeking and sources of support, and 4) sociocultural beliefs and stigma. The presentation of each theme displays the dominant system of sense making for parents of adolescent children.

4.1 Parental Causal Attributions

The main aim of this research project was to understand the ways in which parents make sense of adolescent mental health and well-being. In this regard, the first theme emerged when parents were asked to describe their understanding of adolescent mental health. The descriptions which followed, indicated that for most parents (P1, P2, P3, P4, P5, P6) the topic of adolescent mental health is one framed by causation of “*mental illness*” (P4) rather than emotional health and well-being.

The emphasis placed on 'cause' and 'illness' was prominent in all parents' responses. Parents seemed to understand adolescent mental health in linear terms, whereby the presence or absence of certain behaviours were associated with reactive symptomatic illness behaviours.

"Well if the mother is a drunkard the child will certainly have a deficiency mentally." (P1)

Most parents seemed to attribute the causes of adolescent mental health problems as rooted in the type of parenting style and parenting behaviours adopted, specifically in terms of parenting styles characterised by absenteeism, inconsistency, and emotional disregard. These factors were attributed as the causes of adolescent mental health problems, the presence of which was considered to result in specific pathological emotional symptoms and the absence of which results in emotional well-being.

"Sometimes I think it's how a mother acts towards her children" (P6 on the causes of adolescent mental health problems)

The symptoms resulting from pathological parenting styles included symptoms such as social withdraw (P1, P2, P3, P4, P5, P6) changes in eating patterns (P2, P3, P4, P5, P6) and loss of interest (anhedonia) (P2, P3, P4, P5, P6). Two parents (P4, P6) discussed suicidal ideation and completion as the most severe symptoms of mental health problems in adolescents. The aforementioned factors indicate that the causal attributions made by most parents, where characterised by high levels of distinctiveness, where the attribution about the cause of the concerns is specific to the individual acting out the behaviour i.e. detached parent-child relationships cause emotional difficulties.

"If mom and dad is too busy and doesn't try to make an effort... mentally I think it can do a lot of damage if the parents are absent" (P5)

The causal schemata adopted by parents highlight two important facets of parental perceptions of adolescent mental health. Firstly, parents seem to adopt a biomedical approach for understanding adolescent mental health, whereby specific causes are associated with specific symptoms. Parent thus inadvertently agreed that if the cause is removed or is not present then symptoms will reduce or fail to occur. This indicates that parents perceived adolescent mental health concerns in similar terms as any medical illness.

“...you try and treat the cause and you move on” (P4)

Secondly, parents associated factors within parental control as causal factors, these factors included open communication, problem solving and nurturance. These factors propose that adolescent mental health is controllable and preventable.

“I had an incident last year where the au-pair kind of made my son to feel like he was being bullied... those kinds of things you can deal with and I actually said to her that she should stop it, because it makes my son feel like he is being bullied and he is not. Eventually he believes that with every push or every shove he is being bullied and it really made him soft and we had to work on him to get him stronger. I came and told him that when you walk up and down the stairs you're going to bump into people... so we told him to just bump back and move on full stop.” (P4)

Most parents seemed to understand the causes of adolescent mental health problems as rooted within individual parenting styles or parenting behaviours. Parents could identify pathological parenting styles and healthy parenting styles, with relative ease. Healthy parenting styles were rooted in supportive, nurturing, rule-governed and authoritarian parenting behaviours. The justification for these behaviours as healthy, was rooted in the necessity to allow adolescents to be independent while guiding them through the challenges associated with increased independence. On the contrary pathological parenting styles, were

based on parenting styles which adopted a general disregard towards the adolescent, which most parents believed caused feelings of loneliness, isolation and anger.

“They will start to feel that they don’t belong anywhere, and then it’s a mental thing, it affects them, they feel that they don’t fit in, that they are not loved, they don’t have friends, and then they start to ask themselves: What am I even doing here?” (P6, on how absent and detached parents can cause suicidal ideation).

The above parental response indicates that parental behaviours and parenting styles are accepted as the main causal factors which increases the susceptibility of adolescent mental health problems. Other factors such as *“they don’t have friends”* (P3) are either denied or avoided. The avoidance of socio-environmental causal factors demonstrates a reductionists approach to understanding adolescent mental health concerns.

The causal attributions which parents made indicate that parents indirectly attempt to reduce causal factors of adolescent mental health concerns, to ensure that the causes remained stable and consistent across most mental health concerns. Thus ‘all’ mental health disorders and the symptoms associated with each were considered to have similar aetiologies, with only one parent noting genetic factors (P6) and one parent (P1) noting contextual factors such as violence and poverty. Parents noted that *“eating disorders”* (P4), *“depression”* (P6), *“suicidal ideation”* (P2, P4, P5, P6) *“hearing voices”* (P6), *“ADHD”* (P4, P5) and *“bipolar”* (P5, P6) can all be attributed to parenting styles and behaviours.

In most cases the discussion of causes and symptoms of adolescent mental health problems was accompanied by a blunted affect. Parents seemed to feel the need to distance themselves from their responses. The affectless and distant response styles in conjunction with an illness mentality and a reductionist causation model can be interpreted as an expression of the

parental need to control the risks associated with the development of adolescent mental health problems.

The ability to identify adolescent mental health problems, seemed to provide parents with the capability to predict adolescent mental health problems, which in turn allows for the potential prevention of these problems. The need to control adolescent mental health problems can be understood as a resulting from the unrealistic optimism bias adopted by parents. The affectless emotional responses of parents in conjunction with the heightened need to control and predict adolescent mental health problems indicates the potential arousal of defence mechanisms such as denial and avoidance. Parents seemed to unconsciously attribute a lack of control over the causes and symptoms of adolescent mental health disorders to increased susceptibility. Parents seemed to not only deny the potential that their adolescents could be susceptible to mental health problems, but also avoided discussing any risk factors which are damaging to their parental self-image.

“I always believe that any mental illness or disturbance, should not be nurtured, because the minute you nurture them you breed something and you tamper with something” (P4)

Furthermore, parents seemed to adopt fear appraisals when threats arose regarding the susceptibility and severity of adolescent mental health concerns. The emotional responses which were evoked when parents were confronted with adolescent mental health concerns, seemed to cause parents to not only avoid and deny their own adolescent children’s impenetrability but also increased the likelihood that parents displaced their fears onto ‘other’ parents.

“As a parent, I would think nothing more than to assist, but at the same time other parents might see their children’s problems as being small and things that are just going to blow over as they grow up.” (P3)

The ways in which parents framed their responses indicated that while the causes and symptoms of adolescent mental health problems are understood, they were understood based on observations made of parents who were perceived as parents of adolescent with emotional difficulties. The distinction made between pathological parenting styles of the 'other' and the protective parenting styles of the 'self', indicates that most parents seemed to have an unrealistic optimism bias towards their adolescent child's susceptibility to mental health problems. Thus, by avoiding factors outside of parental control parents avoid threats to their adolescent's emotional well-being.

This phenomenon was specifically demonstrated when the threat posed to parental integrity was reduced. When parents were asked to indicate the causes of adolescent mental health problems in 'other' adolescent children, parents broadened their causal attributions to include social factors outside of the home environment. Parents noted that factors such as "*social media*", "*peer pressure*", "*bullying*" and increased "*exposure to information*", presented threats to their adolescent children's emotional well-being.

The conflicting causal attributions highlight the complex ways in which parents understand adolescent mental health. The complexity of causal attributions was further demonstrated in the distinctions which parents made between mental illness and emotional difficulties. While the former was considered to be pathological and related to parenting styles, the latter was considered to be aspects of normal adolescent development. Normal adolescent behaviour is understood as not posing any threat to the psychological well-being of the adolescent and thus does not invoke a defensive response. Parents were able to acknowledge these challenges as well as the emotional difficulties which they cause, in such a manner as to ensure that their integrity as parents of psychologically healthy adolescent children is preserved.

“If a person is depressed then you would think that there something wrong, that's one thing but when we're talking about this child who is hearing voices and seeing things and making up stories and believing funny things then I would think that there is a bigger problem” (P6)

The conflicting perceptions which parents held true regarding normal adolescent behavior versus abnormal pathological behavior, seemed to be less orientated towards health and more orientated towards avoiding their adolescent children's susceptibility to developing emotional difficulties. This is further demonstrated by the emphasis which parents placed on simplified controllable causal factors, as opposed to the complex interactions between biopsychosocial factors. Through creating distinctions between normal and abnormal behavior, parents inadvertently created distinctions between threatening and non-threatening causes of adolescent mental health concerns. Non-threatening causal factors seemed to be exclusively related to parental behaviors and parenting styles, while threatening causal factors were associated with socio-environmental deterrents, such as interpersonal conflict, social pressure and physical and/or emotional violence. Threatening causes of adolescent mental health problems were displaced onto uncontrollable social factors, which are challenging to predict, identify and manage. Non-threatening causes were associated with parenting behaviors, which were restricted to occurring within the realm of the 'other', thus rendering these causal factors as within individual parental control and thus non-threatening to their adolescent children's emotional well-being.

The casual schemata adopted by parents thus seemed to be rooted in the necessity to control and predict stable causes of adolescent mental health problems, which are easy to identify and which remain stable across disorders. This framework for understanding adolescent mental health is aimed at reducing the susceptibility and severity of adolescent mental health concerns. Parents seemed to consider their own parenting styles to be protective and

enhancing of adolescent mental health, thus reducing the likelihood of the development of mental health problems in their adolescent children.

4.2 Symptom Identification

The causal attributions made by parents regarding the specific aetiologies of adolescent mental health concerns indicate that parents indirectly avoid and deny the potential threat posed by adolescent mental health concerns. Parents placed emphasis on causal factors which are within the realm of individual control. The dominant patterns of parental sense-making seemed to be rooted in causation. Symptoms were discussed in broad terms, and the identification of problematic emotional symptoms seemed to be understood in a less concrete manner than the causes associated with the symptoms. Thus, the emphasis placed on causes seemed to deflate the importance of symptom identification and treatment seeking. The parental responses indicated that for most parents, symptoms of emotional difficulties were largely ignored or displaced onto normal adolescent behaviour.

Most parents indicated that they had not noticed any concerning emotional difficulties in their adolescent children's behaviour.

“We have actually not had any problems; both our children do their best with academics and they are also fine on other levels” (P6)

Conversely most parents did however indicate that their adolescent children had experienced symptoms including, anxiety, disruptive sleep patterns changes in eating habits, social withdrawal, heightened emotional responses and low mood.

“Uhm you know they start to become quiet uhm its almost as though they become quiet uhm and they are miserable, they withdraw themselves completely, and then I always fear for the worst. (P6)

The conflicting parental accounts of their adolescent children's experiences of emotional difficulties, indicates that parents indirectly distinguished between internal and external symptom expression. The internalised emotional difficulties which most parents noted in their adolescent children, were largely attributed to normal adolescent development. Conversely external symptom expression was considered as problematic and deserving of intervention. Parents noted that academic difficulties and symptoms associated with ADHD (Attention Deficit Hyperactivity Disorder) were more likely to be acted upon, while symptoms associated with mood and anxiety disorders were less likely to be acted upon.

"I think so because unless it's a real problem it's just normal teenagers on an emotional rollercoaster." (P4)

Parents indicated that "*real problems*" such as those exhibited through externalised emotional symptoms, act as cues to action. The emphasis which parents placed on externalised symptom expression can be understood as resulting from the adverse social reactions which occur in response to disruptive emotional behaviours. Most parents indicated that symptoms expressed within the school environment evoked negative reactions in teachers and peers. These negative reactions were in the form of referrals made to mental health care professionals.

"...they informed us that Brandon has got ADHD and referred him for medication" (P5)

The above quotation highlights that treatment actions which were queued by externalised emotional difficulties seemed to be less motivated by internal parental health seeking drives, and more motivated by forced social referral.

Most parents indicated that the observable element of externalising adolescent disorders caused adverse social reactions within their broader social sphere. Parents seemed to believe that their self-efficacy as parents were directly challenged when others observed emotional difficulties in their adolescent children. The belief that externalising adolescent behaviours were indicative of parental inefficacy seemed to be internalised by parents. Parents indicated that externalised emotional behaviours were indicators of a lack of discipline, respect and rules within the adolescent's home environment.

"I've got a friend who's got a child with a learning disorder and whatever and I think that people tend to undersee basic discipline because they think their child is disordered and they feel sorry for their child and because he's like that we leave him and we allow him to say and do bad things" (P4)

The parental belief that a lack of discipline attributes to the development of symptoms indicates that parental self-efficacy is directly challenged. Parents thus view externalised symptoms as demonstrating their inability to control their adolescent children's behaviour.

Parents noted that while internalised emotional difficulties were easily identifiable, they were less severe and disruptive than externalised difficulties. Internalised mental health difficulties were also considered to reach a peak after which symptoms would reside, while externalised emotional difficulties were more pervasive and enduring. Factors such as frequency of symptom occurrence and the duration of symptom expression were noted by most parents but did not seem to impact on their decision to act upon symptoms.

"... they become so withdrawn. And then you just have to wait and hope that it improves, and then then suddenly one morning they just wake up early, they ask questions, they chat. Sometimes they will talk about what bothered them but then other times they will just say that they got over it." (P6)

Internalised emotional difficulties, thus seemed to be understood as time limited and as managed by the adolescent's internal resilience and their ability to self-regulate their emotions. Parents seemed to understand internalised emotional difficulties as not posing any threat to the overall emotional well-being of the adolescent.

The parental belief systems regarding the symptomology of adolescent mental health concerns, seemed to be dominated by the level of disruption caused by the symptoms and the abilities of the parents to manage the symptoms. Internalised emotional behaviours were thus considered to be less severe as they were less visible to others. Furthermore, internalised emotional difficulties were also considered to be easily managed within the home environment. Parents thus seemed to display a level of self-efficacy in their ability to manage internalised disorders such as anxiety and depression. The evaluations made by parents regarding the severity of symptoms thus largely depend on the perceived self-efficacy of the parent to manage these difficulties.

"I think in my situation I'm strong enough to try and sort things out first" (P5)

The parental evaluations of their self-efficacy to manage emotional difficulties seemed to have a significant impact on the ways in which these symptoms are managed.

The outcomes associated with emotional difficulties are evaluated through individual and social outcome expectancies. It can be argued that parents, who are confronted with concerns regarding their adolescent children's emotional difficulties, whether internal or external, face many negative outcome expectancies. These negative outcome expectancies seemed to be inherently associated with negative social reactions. In order to limit the development of negative social reactions, parents seemed to normalise the severity of symptoms.

"...kids are naughty and it's normal for them to be like that at school" (P3)

The symptoms identified by parents were, normalised not only in terms of the developmental stage of adolescence, but also in terms of gender norm expectancies. Most parents seemed to distinguish between symptom expression in adolescent females and adolescent males. Parents indicated that adolescent females were more likely to display internalised emotional symptoms, such as low mood and low self-esteem, while adolescent males were more likely to exhibit externalised emotional difficulties such as aggression and social withdrawal.

“Definitely for women, definitely PMS... uhm ja uhm that time of the month, you are more vulnerable and your emotions work overtime” (P6)

“I think girls might show by being tearful and boys might show by being angry.” (P3)

The gender differences in symptom expression seemed to indicate that most parents believed that males were more likely to display externalised symptoms, while female adolescents were more likely to display internalised symptoms. Anger and frustration seemed to be the main symptoms expressed by adolescent males, while emotional fluctuations were more prominent in female adolescents. The genderisation of adolescent mental health difficulties may indicate stereotypical gender socialisation patterns. The responses provided by parents seemed to indicate that if the symptoms are normalised then they are less severe. This was further demonstrated in parents' responses, which indicated that despite the accepted gender norms, both male and female adolescents were vulnerable to mood and behavioural emotional difficulties.

“It can also lead to eating disorders. Ja and suicide in those cases, uhm and I think what people don't always realise is that your child is going through a phase.” (P6)

The need for parents to normalise emotional difficulties can be attributed to the negative outcome expectancies associated with adolescent mental health difficulties. The threat

appraisals made by parents seemed to illicit defence mechanisms, such as denial and avoidance to reduce the severity of symptoms.

4.3 Treatment seeking and sources of support

The outcome expectancies which parents held true regarding the treatment of adolescent mental health concerns directly impacted on the health seeking behaviours of parents. The topic of preferred treatment modalities and sources of support, seemed to be challenging for most parents.

“I must say I don't think there's an easy answer” (P3)

The challenges which parents faced regarding potential intervention strategies, seemed to be rooted in the costs associated with acknowledging their concerns of adolescent's emotional difficulties. The negative outcome expectancies of actively seeking out help and support for adolescent mental health difficulties, seemed to be evaluated as having more costs than benefits. The cost associated with treatment seeking included the potential adverse reactions of other parents, teachers and their adolescent children's peers. The most concerning social reactions which parents noted was that of shame. Parents indicated that if they were to seek out help and support from others, that their adolescent children would be treated as mentally ill.

“Ja, ja because this one and that one, talks about this other one's problems, and they point fingers.” (P5)

The negative outcome expectancies associated with treatment seeking seemed to influence the types of support systems and treatment option available to parents. Most parents identified medical doctors and mental health care professionals as treatment providers. Parents thus seemed aware of these professionals but indicated that they would only consider

approaching these professionals as a last resort. Parents indicated that when they are faced with concerns regarding their adolescent's emotional well-being they relied on their spouse or partner for support and guidance.

"...we find it quite intimate and we are personal with our stuff. I would first talk to my husband about my concerns and then see what happens from there" (P4)

The reliance on spousal support, can be understood as resulting from the parents' need to ensure privacy and limit embarrassment. Most parents indicated that other support systems such as family members and friends, presented numerous threats. Most parents indicated that if they were to confide in others, they were likely to be ridiculed for their concerns. The perceived threat of ridicule seemed to be premised on the notion of vindictiveness and gossip. Parents indicated that their private concerns would become public if they were to share their concerns with others. Interpersonal and familial support systems thus posed the threat of exposure.

"I would think no, oh no what happened there... luckily I haven't been in such a situation, but I think it comes from the male way of thinking, that your child can't be seen as having an emotional problem." (P6)

In conjunction with the need for their concerns to remain private, most parents also seemed to justify their lack of treatment seeking based on the belief that the emotional difficulties experienced by their adolescent children would subside as they mature. Parents seemed believe that the severity of emotional symptoms which their adolescent children experienced is low, and that the likelihood that these symptoms are indicative of psychological disorders is limited. Parents thus agree that their adolescents are not susceptible to psychological difficulties, and the psychological difficulties which they do face are not severe and thus do not require intervention.

“...we never believed in that and there are ways to deal with it so that you don't need to make it an illness, you can suffer from something but you can work around it.”

The discussion surrounding support systems and treatment seeking evoked strong emotional responses in parents. Most parents seemed to identify with the emotional difficulties faced by their adolescent children. The discussion surrounding treatment seeking seemed to bring up memories of the parents' past personal experiences with mental health difficulties. Most parents reported that they had experienced emotional difficulties such as depression, anxiety and self-devaluation. The memories which were evoked centred on the lack of support which they had received for their own emotional struggles.

“I was depressed for years and years and years and years and not even one person could help or even wanted to help, if only one person could have said come talk to me. But you are expected to behave a certain way because you are a girl so you just carried on with your life and it was bloody hard.” (P3)

The heightened emotional responses of parents indicated that parents were strongly identifying with the emotional difficulties faced by their adolescents. Parents however noted that their experiences with emotional difficulties as adolescents, were managed privately. Parents noted that they never communicated their difficulties to their parents. Most parents noted that while they had never openly discussed their difficulties, that they had hoped that their parents would have acknowledge their struggles. While parents indicated their own personal need for intervention, these needs were not projected onto their adolescent children. Parents thus seemed to replicate their experiences, in so doing they indirectly avoided acknowledging the emotional difficulties faced by their own adolescent children. Treatment seeking thus seemed to be reliant on temporal elements of past experiences and how these experiences were managed.

“I suffered with depression for a long time, And it’s not nice. It’s something that happens, that everyone goes through, and luckily I came out of it, and then you realise that everyone goes through it, but no one realises it and no one acknowledges it.” (P6)

Furthermore, in addition to the threat of exposure and the replication of unmet emotional needs, parents also noted that they had concerns regarding the effectiveness of available treatment options. All parents seemed to agree that the dominant accepted treatment options were based on medicating symptoms. Parents noted that health care professionals often prescribe medication to treat emotional difficulties.

“Yeah there was this one I called for James he was a psychologist, but he got sick of listening and he gave him medicine and whatever but it didn't go away” (P5)*

Most parents disagreed with the use of medication as a viable treatment modality. The justification for their concerns for the use of medication, was rooted in the belief that medication treats the symptoms associated with mental health difficulties, but neglects to address the causes associated with the symptoms.

“...in my personal experience doctors just give medication and it doesn’t really solve the problem, sometimes it can make it worse. I don’t think it addresses the real problem.” (P3)

All the parents seemed to agree that emotional problems stemmed from deep rooted difficulties. Parents indicated that if these difficulties are not addressed at the core, then despite treatment seeking, the problem will persist. Parents thus seemed to have a lack of trust in the treatment options available to them. The lack of trust which parents had towards mental health care professions, can be understood as resulting from the inability to distinguish mental health care professionals from medical doctors. Parents seem collate mental health care professionals and medical professionals into one treatment modality.

“The GP we met with, just wanted my son to take medicine, that’s what psychologists do they just prescribe medicine” (P2)

The conflation of differing treatment modalities seemed to have caused parents to adopt the belief that adolescent mental health problems are untreatable. The perceived ‘untreatable’ nature of adolescent emotional difficulties, thus seemed to be rooted in the lack of viable professional treatment options. The lack of efficacy of treatment options, seemed to have caused parents to adopt their own mechanism for treating emotional difficulties. Internalised and externalised symptom expression seemed to be managed within the home environment. While these difficulties were managed within the home environment, differing parental treatment modalities were adopted for internalised and externalised symptoms. Parents noted that internalised symptoms were self-regulated by the adolescent. Parents noted that the self-efficacy of the adolescent to manage the difficulty was enhanced by communicating possible coping strategies to the adolescent. These strategies included positive thinking, parental generativity and active problem solving.

“I think we just get through life to try and see the positive in everything” (P4)

“To grow and to understand that it's going to go away but it doesn't go away overnight it doesn't go away until it's done” (P3)

Externalised emotional difficulties were managed through varying forms of punishment. The most commonly used form of punishment was corporal punishment. Parents noted that corporal punishment was the only viable form of treatment for externalised emotional difficulties.

“There is nothing like a good hiding, cause even if you take away their toys and their iPhones

and their games at the end of the day only a good hiding will solve the problem.”

The justification for this form of treatment was rooted in the parents’ personal experience of receiving corporal punishment for “*naughty behaviour*”. Externalising symptoms thus seemed to be understood by parents as rooted in socially unacceptable boundary testing.

4.4 Sociocultural norms and Stigma

Parental perceptions of adolescent mental health seemed to be dominated by illness cognitions. Parents seemed to be less orientated towards enhancing mental health and emotional well-being, and more orientated towards avoiding mental illness. The illness cognitions adopted by parents were focused on framing adolescent mental health in terms of the causes, symptoms, and treatment of adolescent mental health difficulties. The beliefs which parents held true regarding these mental health difficulties, seemed to be rooted within the broader sociocultural norms which encompasses these beliefs, and the stigma attached to adolescent mental health difficulties. Sociocultural norms and stigma thus seemed to be overarching factors which directly influence the ways in which parents understand adolescent mental health difficulties.

4.4.1 Socio-cultural Norms

All parents discussed generational differences. Generational differences were emphasised as containing the culturally accepted patterns of behaviour for managing adolescent mental health concerns. The cultural belief systems which parents ascribed to, regarding adolescent mental health difficulties, were conveyed in a manner which is both in agreement with these cultural understandings, but also resistant to these belief systems.

The predominant cultural beliefs systems adopted by parents, seemed to strongly align with a westernised medical approach for understanding adolescent mental health concerns. The

westernised framework adopted by parents, seemed to be rooted in a simple causal model. The utilisation of a simple causal model, provides an explanation for the emphasis which parents placed on avoiding illness rather than facilitating health. The cognitive framing of illness as rooted in a single identifiable cause, was applied in a widespread manner to encompass both medical ailments and emotional difficulties.

“The funny thing is, that everyone is sort of westernised” (P6)

The parents who took part in this study were predominantly white, Afrikaans speaking females who identified themselves as modern westernised parents. The reliance on a westernised medical model for understanding adolescent mental health concerns was not only demonstrated through the causal attributions made, but also through the externalisation of symptom expression and the coagulation of mental health care professionals and medical doctors as ascribing to the same treatment modality. This was demonstrated through the parents utilisation of words such as “*doctor*”, “*psychologist*”, and “*psychiatrist*” in an interchangeable manner.

The utilisation of a biomedical model for understanding adolescent mental health difficulties, seemed to be challenging for most of the Afrikaans speaking parents. The parental responses associated with a medical approach was neither accepted nor rejected. Parents seemed to identify that emotional difficulties are deep rooted and stem from unknown causes. Conversely however, while parents seemed to have this insight most still ascribed to culturally accepted belief systems to understand and manage adolescent mental health difficulties.

“...they would either think that one the child is dumb or two, I remember my brother had epilepsy as a child and my grandfather used to just say he is just playing get the belt he is just trying to get attention and stuff like that” (P3)

The conflicted responses provided by parents, can be understood as rooted in the dissatisfaction which parents felt towards their cultural beliefs systems, which largely avoided their own need for a more holistic model. The need for a more holistic model was demonstrated through the unmet past parental desires for emotional support. These desires were communicated in an unconscious manner, through the defensive responses provided by parents as well as the emotional responses indicating feelings of resentment towards past generations. The emphasis which cultural practices placed on treating externalised symptoms, while neglecting internal turmoil, was strongly rejected by parents. Parents, however seemed unable to dismiss these belief systems. The need to resist these beliefs and provide a corrective experience through their adolescent children, seemed challenging for most parents. The impact which these beliefs systems have, resulted in conflicted feelings, as parents desired to act on mental health concerns but lacked the social approval to do so. Parents thus inadvertently reproduced their own past experiences.

One parent strongly disagreed with the westernised medical model for understanding adolescent mental health difficulties. This parent was a black isiZulu speaking male who strongly identified with traditional African medical discourse for understanding adolescent mental health. This parent noted that adolescent mental health difficulties are associated with misfortune, ancestry and wizardry which should be treated through spiritual interventions.

“I will give you an example of a long-established practice which has been running for more than 100 years in our communities. Children of a certain age when he or she is sleeping urinates in bed, someone who is trained elsewhere would immediately take the child to a medical doctor but in families that have got a strong connection with how it was done in the past they would slaughter a goat. The reason for it is that it is understood in our communities that something needs to be done culturally, and I don't know whether you might say it's a psychological thing that affects the person, to stop them wetting themselves when they are

sleeping. In as much as that happens in our communities it is viewed as a spiritual incident and it needs a spiritual intervention but generally I might add, you a psychologist, would say it's more of a psychological intervention” (P1)

The above quotation illustrates the perception of a father who is orientated towards a traditional African understanding of adolescent mental health concerns, but who is challenged by broader westernised psychological ideals. This parent seemed to have a strong emotional response to the fact that the researcher was a white, female, intern psychologist, who he perceived as questioning his traditional spiritual beliefs.

While this parent seemed to be strongly aligned with a traditional spiritual orientation, it can be said that he noted causal attributions related to violence and trauma, and identified treatment resources including psychologists and counsellors. The conflicting responses provided by this parent can be understood as resulting from the feelings of imposed westernised social norms on his traditional belief system. This parent demonstrated similarities to the Afrikaans speaking parents, as he seemed to have a need for a more inclusive model for understanding adolescent mental health concerns, without being restricted by broader social norms which dictate the validity of a westernised medical model.

Both Afrikaans speaking parents and the isiZulu parent had differing belief systems. Both parental cultural groups presented similar challenges, including the impact of social norms and expected parental behaviours. The differing understanding of adolescent mental health concerns, indicate that sociocultural factors have a direct impact on parental perceptions of adolescent mental health.

In terms of the broader social system parents enacted many of the widespread social norms regarding adolescent mental health concerns. Gender norm expectancies were noted by most parents. All parents agreed that adolescent females and adolescent males are susceptible to

gender specific emotional difficulties. The parental responses also seemed to indicate that adolescent males were more likely to receive treatment than adolescent females. This was demonstrated through the differences in treatment seeking behaviours of parents of adolescent males versus adolescent females. The parents of adolescent males indicating that they have interacted with a psychologist, while parents of adolescent females indicated limited to no interaction with mental health care professionals. Societal norms which dictate gender roles thus seemed to have an impact on the ways in which parents understand the expression of adolescent mental health difficulties.

“Aag I think it’s just how they were raised, they were raised, we were raised thinking that men shouldn’t cry” (P6)

Parental perceptions of adolescent mental health can be understood not only in terms of the causes and symptoms themselves, but also the way in which these causes and symptoms are defined and interpreted by parents. The social norms and cultural belief systems which parents adopt significantly impact on these definitions and interpretations of what constitutes as a concern.

The similarities in the approaches utilised by parents, demonstrates that illness behaviour is a culturally learned response, within which illness is defined according to the norms, values, and beliefs which are most prevalent in a society or a community. Cultural belief systems thus seemed to influence parental perceptions of adolescent mental health in terms of which symptoms are recognised as abnormal, the ways and time of seeking help, and the reaction response to treatment.

4.4.2 Stigma

Overarching the cultural belief systems and widespread social norms, is stigma. The stigmatisation of mental health, seemed to have a significant impact on parental perceptions

of adolescent mental health concerns. Stigma seemed to manifest in different forms but was present in all the parents' responses. The threat posed by stigma can be understood as affecting both parents and adolescents.

The discussions which took place on the topic of stigma seemed to occur spontaneously. While most parents utilised the term "*stigma*" (P1, P3, P5, P6), other subtler indicators of stigma were observed in the response styles and diction used by parents. The subtle references to stigma was prominent in the parents utilisation of the term such as "*illness*" and "*disorder*".

Stigma seemed to be the root cause for many of the challenges faced by parents. One of the main challenges faced by parents was that of the threat posed by public stigma. Parents seemed to elude any actions which could indicate the presence of adolescent emotional difficulties. In this regard parents seemed to avoid seeking out help and support for any concerns related to the emotional well-being of their adolescent children. Most parents' responses indicated that their adolescent children were seen as extensions of themselves. Thus, any indication of emotional difficulties would be directly attributed to parental failures. These failures included, a lack of parental self-efficacy to control adolescent emotional difficulties, which was understood to result from ineffective parenting styles.

"I think a lot of the time as a parent you feel that there is something that you can do or should be doing... your children would undergo a stigma if you want them to see a psychologist so also it's not that easy" (P3)

Parents seemed to believe that any form of disclosure whether within private social circles or consultations with mental health care professionals, would result in negative outcomes. The perceived negative outcome expectancies were believed to not only result in parental stigma but also the stigmatisation of their adolescent children. Most parents indicated that while they

are resistant to seeking out support and treatment, their adolescent children were equally as resistant to treatment seeking.

“No they don't, they don't because if you want to go to a teacher and you really don't know if you can trust the teacher. I personally wouldn't trust the teacher it's very difficult because you don't know who they will be communicating with, it is very difficult and it would be very difficult to trust anybody” (P3)

The above quotation highlights the strong emotional response which was invoked when this parent discussed stigma and help seeking. The use of the word “*difficult*” was utilised multiple times to emphasize the challenges posed by actively seeking out support. Most of the parents responses similarly demonstrated strong negative emotional reactions in response to help seeking behaviour.

Parents indicated that their avoidance of treatment seeking, occurred as a result of the perceived effects of labelling. Most parents stated that any communication of adolescent emotional difficulties would cause their adolescent children to be labelled as ‘mentally ill’. These labels were understood to develop not only from mental health care professionals but also from teachers and peers. Labelling was considered to occur regardless of the presence or absence of mental health difficulties.

Most parents indicated that the school environment, presented numerous threats. Parents noted that teachers are often quick to label any adolescent who disrupts classroom activities. Parents noted that teachers often single out adolescent children who have mental health difficulties. The negative outcome expectancies which parents associated with seeking out support from teachers, was associated with wider implications of stigmatisation, whereby peers would avoid contact with adolescents who are perceived to be ‘mentally ill’. Parents indicated that teachers expose adolescent mental health difficulties, to peer groups and other

parents. The exposure of these difficulties was perceived to result in stigmatised behaviour towards their adolescent child. Parents indicated that their children would bear the negative social consequences associated with stigma.

“... with James when he needed to take his medication he would go to the principal’s office and they would put them in a row and because of that he was pushed out of his friend groups and that kind of thing” (P5)*

In order to avoid being victims of public stigma parents adopted various measures to ensure that any concerns regarding their adolescent children’s mental health, remained private. The main methods adopted by parents included the utilisation of defence mechanisms such as denial and avoidance. Parents denied and avoided any indications that their adolescent children were susceptible to mental health concerns. The severity of these concerns was also reduced and mostly ascribed to normal adolescent development.

Most parents seem to disagree with the stigmatised views of adolescent mental health concerns. Conversely parents however seemed to directly contribute to the reinforcement of these stigmatised beliefs. Parents seemed to have internalised the widespread stigmatised beliefs associated with adolescent mental health difficulties. These internalised beliefs were evident in the parental attributions regarding the causes of adolescent mental health concerns as rooted in poor parenting styles, a lack of discipline and a lack of parental control over external threats. Parents also seemed to attribute negative characteristics to children who they perceived as having mental health difficulties, these characteristics emphasised a lack of adequate value systems.

“...if you look at my son he has to wear a blazer and they wear school shoes and the way they look generally is better because in other primary schools the kids don’t care about it and

they don't wear blazers and my phone is always on, I think it's because of a lack of discipline.” (P4)

The stigmatisation of adolescent mental health difficulties, resulted in non-disclosure of any concerns which parents had. Parents limited their communication of concerns to such an extent that no support was sought after.

“You don't want to be seen there, because no, then people will think there is a big problem”
(P6, on consulting with mental health care professionals).

The above quotation highlights the concerns which parents have regarding the potential of stigmatisation. The threat which stigma posed seemed to occur regardless of the presence or absence of emotional difficulties. Parents seemed to avoid any support seeking behaviours, and instead displaced their concerns onto other parents and adolescents. The displacement of concerns seemed to reduce the threat posed by stigma and thus reduced the anxiety which parents felt towards the inability to seek out help and support. Most parents indicated that they had a desire to seek out support but felt restricted to act on their desires. The threat posed by stigma seemed to override the internal drive to ensure the emotional well-being of their adolescent children in the hope that the avoidance of stigma would ensure social safety and security. The potential threat of stigma thus seemed to overarch the individual parental perceptions of adolescent mental health and emotional well-being.

5. Discussion and Conclusion

Parental perceptions of adolescent mental health and emotional well-being are complex and dynamic. The developmental stage of adolescence presents many challenges associated with the identification and management of adolescent mental health difficulties. The challenges which parents are confronted with result from the perplexing similarity in the presentation of normal developmentally appropriate behaviours and abnormal pathological behaviours, and how these behaviours should be differentiated. The evaluation of which symptoms are deserving of intervention, seemed to be understood in a contradictory manner. The contradicting ways in which parents understood the severity of adolescent mental health difficulties can be understood as resulting from the intersectionality between internal parental health beliefs, social expectancies and the threat posed by stigma. Social norms and cultural belief systems dictated the ways in which parents understood adolescent mental health concerns. The internalised social norms and culturally learned behavioural expectancies, seemed to result in the avoidance and denial of the susceptibility and severity of adolescent mental health difficulties. In addition to this, it was found that adolescent mental health concerns were perceived as afflicting those who do not ascribe to these social norms and beliefs systems. Thus, the presence of adolescent mental health difficulties was associated with social non-conformity. The threat of non-conformity was found to be triggered by parental failures to control the causes and symptoms of adolescent mental health difficulties.

Parental perceptions of adolescent mental health difficulties can be understood as resulting from the complex interaction between individual health cognitions and the impact of broader societal norms and cultural belief systems. The interaction between individual beliefs systems and societal norms can be understood as interwoven, whereby individual parental beliefs can

be understood as being both shaped by societal norms, and as contributing to the development and reinforcement of these social norms.

5.1 Parental Causal Attributions

The social context within which parents reside was framed by westernised ideological principles. In this regard parents adopted a westernised bio-medical framework for understanding adolescent mental health. This finding agreed with the works of Abera et al (2015) and Cocks and Moller (2002) who proposed that parents are likely to adopt a causal biomedical model for understanding mental health problems. The utilisation of a biomedical model places emphasis on the presence of external causal pathogens which result in the presence of observable physical symptoms (Yuill, 2013; Nettleton, 2006; Deacon, 2013). As a result of the reliance on a biomedical model, parents placed emphasis on causality and illness rather than health and well-being. Parents thus understood adolescent mental health difficulties in similar terms as any medical illness, where the presence or absence of causal factors results in either the presence or absence of symptomatic illness behaviours.

The emphasis which parents placed on causes and illness as opposed to health and well-being, can be understood as not only resulting from the use of a biomedical model, but also as a result of the parental need to control and predict adolescent mental health difficulties. Heider (1944, 1958) stated that individuals have an inherent need to control and predict their external social environment. In agreement with Heider (1944, 1958) parents of adolescent children seemed place emphasis on identifying controllable causal factors which result in predictable symptomatic illness responses. In this regard, the utilisation of a biomedical model was dually beneficial, as parents could ascribe to the socially accepted biomedical model for understanding adolescent mental health difficulties which also facilitated the controllability and predictability of these difficulties. In this regard, the utilisation of a

biomedical model aligned with both the internal health cognitions of the parents and the broader social cognitions regarding illness.

The need for parents to understand their external environment as predictable and controllable, was directly challenged by the developmental stage of adolescence and the potential threat posed by adolescent mental health difficulties. Parents of adolescent children seemed to face many challenges associated with the predictability and controllability of mental health problems. The main concerns which parents had, related to the inability to distinguish between which emotions and behaviours were indicative of mental health problems and which can be explained as normal adolescent behaviours. Parents noted that their adolescent children displayed various emotions and behaviours which can be attributed to mental health difficulties such as mood, anxiety and personality disorders. The difficulty experienced, as a result of an inability to distinguish between normal and abnormal behaviours seemed to elicit a fear response. The emotional response of fear can be understood as resulting from perceived threat posed by the susceptibility and severity of adolescent mental health concerns.

In an attempted manage the threat posed by mental health difficulties, parents reduced the susceptibility and severity of adolescent mental health concerns. In order to reduce the threat of susceptibility parents adopted various strategies to control for the exposure of causal factors. Parents ensured that causal factors were within their individual parental control. Parents identified parenting styles and parenting behaviours as the main cause of adolescent mental health difficulties. In most cases parents perceived their own parenting styles as protective and other parenting styles as maladaptive. The parental belief that their parenting styles acted as immunogens against adolescent mental health difficulties, demonstrates that parents had an unrealistic optimism bias regarding their adolescent's susceptibility to mental health difficulties. In agreement with the theory of unrealistic optimism, proposed by

Weinstein (1983), the inaccurate beliefs which parents hold true, can be understood as resulting from selective focus. In this regard parents ignored their own risk increasing behaviours, by selectively focusing on their risk-reducing behaviour. The focus which parents placed on their risk-reducing behaviour was further compounded by the lack of acknowledgment of the health promoting behaviours of others.

The reasons underlying the development of unrealistic optimism, can be understood as resulting from the parental need to protect their sense of self and self-integrity as good parents. This was in agreement with self-affirmation theory (Steele, 1988), which proposes that individuals are motivated to protect their perceived sense of self. In this regard parents developed a defensive reaction to any stimulus which threatens their sense of self as good parents. According to Steele (1988) defence mechanisms such as denial and avoidance, are often utilised to disarm threats and ensure survival of the perceived sense of self. This was found to be true, even more so for parents of adolescent children. The ways in which parents perceived causal factors which were outside of their individual control demonstrated the defensive avoidance and denial of threatening stimuli. Concerning causal factors such as increased exposure to information, peer pressure and bullying, were acknowledged by parents, but managed in such a way as to eliminate the threat posed by these factors. These socio-environmental causal factors were often restricted to afflicting 'other' adolescent children, specifically adolescents who are exposed to poor parental behaviours.

The inaccurate beliefs that the parental self and the adolescent self, is impenetrable, can be seen as a defensive reaction, which serves to reduce feelings of anxiety and fear, which is aroused when the parents' sense of self and self-integrity is threatened. The biased cognitions can be seen as a projection of the individual parental fears onto the other, in order to reduce feelings of anxiety, and thus serves as a means to uphold a sense of self and self-integrity.

Thus in order to self-affirm parental virtues, unrealistic optimism was utilised, which allowed inaccurate beliefs to form regarding the development of adolescent mental health concerns.

One aspect which the theories of unrealistic optimism (Weinstein, 1983) and self-affirmation (Steele, 1988), did not account for was the role of the broader social belief systems and the stigmatisation of mental health. While parents did display unrealistic optimism, which resulted in defensive reactions, these defensive reactions can be also attributed to the threat posed by stigma. Stigma seemed to significantly impact on the ways in which parents perceived adolescent mental health. In agreement with the work of Mukolo et al (2011) parents saw their adolescent children as extensions of themselves and thus parents viewed the development of mental health problems in their children as caused by them. The beliefs held that adolescent mental health concerns resulted from parental failures can be understood as presenting a threat to the social perception of their self-efficacy in conjunction with the individual internal perceived self-efficacy. The theories of unrealistic optimism (Weinstein, 1983) and self-affirmation (Steele, 1988) thus, excluded the role of a social sense of self which is distinct from an internal sense of self. Parents, seemed to develop unrealistic optimism as a result of the threat which adolescent mental health difficulties posed to both their individual internal sense of self and their external social sense of self.

5.2 Symptom Identification

The threat posed by stigma impacted on the ways in which parents perceived and managed the causes of adolescent mental health concerns. The social norms, cultural belief systems and the threat posed by stigma also seemed to significantly impact on the ways in which parents understood the symptoms of adolescent mental health difficulties. As mentioned previously parents experienced difficulties related to the blurred boundary between normal and abnormal adolescent emotions and behaviours. In order to evaluate which behaviours are

deserving of intervention, parents created distinctions between internalising and externalising behaviours. The distinctions which parents made between internalising and externalising symptom expression, was based on the social norms regarding acceptable and non-acceptable adolescent behaviours.

Internalising symptoms were understood as resulting from mood and anxiety difficulties, while externalising symptoms were understood as relating to developmental disorders such as ADHD. In agreement to the research work of Abera et al (2015) and Pedrini et al (2015), parents perceived internalising symptoms as less threatening than externalising symptoms. Internalising symptoms were considered to form part of normal adolescent development and were understood to reduce as the adolescent matures. Internalising symptoms were also considered to be less observable and as predominantly occurring within the private realm. Externalising symptoms were considered to be more severe as they were perceived to increase without treatment and intervention. Externalising symptoms were also considered to be more observable within the social realm, as these symptoms caused social disruptions which were viewed as negative by others. The disruption caused by externalising disorders were considered to result in negative social appraisals and thus posed a greater threat.

In this regard the ways in which parents distinguished between normal and abnormal behaviours was dependent on the visibility of the behaviours. The severity of adolescent mental health difficulties was thus based on the social threat which the behaviour presented rather than the actual psychological severity of the behaviour.

The parental belief that externalising disorders were more severe, inadvertently resulted in increased treatment seeking behaviours for externalising disorders. These treatments seeking behaviours were facilitated through a social referral system whereby parents were referred to seek out treatment for their adolescent children disruptive behaviours. In this regard parents

were not the initiators of treatment seeking, but rather passive recipients of forced social referral.

The normalisation of internalising symptoms and the normalised treatment reactions for externalising symptoms highlight the emphasis which parents placed on social conformity. In this regard parents thus only reacted to symptomatic behaviours if these behaviours were socially unacceptable. The reliance on social norms, was further demonstrated through the behavioural expectancies for adolescent girls and adolescent boys. Parents perceived adolescent girls to be more susceptible to internalising disorder and adolescent boys to be more susceptible to externalising disorders. The rationale for these inaccurate beliefs were rooted in the social norms which dictated that adolescent girls are more emotional than adolescent boys. These findings were in agreement with the research work of Zimmerman (2005), who found similar gender specific symptoms classifications.

Parental perceptions of symptom expression thus indicate that parents placed considerable emphasis on the ways in which symptoms are interpreted within the broader social realm. One factor which was not addressed related to the importance of symptom occurrence and symptom duration. Parents placed limited emphasis on the timeframe required before treatment seeking occurs, this factor was also not emphasised within the theories of health psychology including Lay Theories, Cognition Models and Social Cognition Models. It can be argued that parental perceptions as well as theoretical orientations are more orientated towards medical health cognitions rather than psychological health cognitions. Medical symptoms are often identified immediately based on physical discomfort. Mental health difficulties however might be more challenging to identify as the discomfort experienced is emotional rather than physical. The utilisation of a medical approach thus neglects the complex nature of psychological difficulties through focusing on symptoms which are time limited. Parents of adolescent children who reside in a social context which fails to

acknowledge mental health difficulties, inadvertently become acculturated into similar patterns of neglect.

The ways in which parents distinguished between normal and abnormal adolescent behaviours indicate that the broader social system within which parents reside, significantly impacted on the ways on which symptoms are recognised and understood. It can be argued that parents of adolescent children placed considerable emphasis on avoiding illness. In this regard parents ensured that causal factors are eliminated and that symptomatic behaviours are reduced to normal developmentally appropriate behaviours. In agreement with the Health Belief Model, treatment seeking is unlikely to occur if the perceived susceptibility is low, there is no assumed threat and there are more risks than benefits associated with help seeking (Glance et al, 2008). Through avoiding causal factors and reducing symptom severity, parents inadvertently eliminated the need for treatment utilisation. Parents of adolescent children seemed to have many concerns related to treatment seeking. For most parents' treatment utilisation would only be considered in extreme cases, where all attempts to eliminated causal factors and reduce symptoms, have failed.

5.3 Treatment Seeking

The major concerns which parents had regarding treatment seeking was related to a lack of trust in the available treatment options and the potential stigma associated with treatment seeking behaviour. Parents indicated that mental health care professional often rely on medication as the main form of treatment for adolescent mental health difficulties. Parents strongly disapproved of the use of medication as it was considered to reduce symptoms without treating the cause. A possible explanation for the inaccurate beliefs which parents had regarding the effectivity of treatment options can be related to the lack of knowledge and awareness which parents had regarding the different treatment modalities available. Parents

seemed to categorise mental health care professionals and medical doctors into one treatment modality. Parents thus demonstrated a lack of awareness regarding the differing available treatment options, such as psychodynamic psychotherapies, cognitive behavioural therapies, dialectical therapies, family therapy, play therapy etc. The lack of knowledge regarding the various treatment options available resulted in the perception that treatment options are ineffective and that ultimately adolescent mental health difficulties are untreatable.

It can be argued that past parental experiences significantly impacted on the ways in which current treatment options are understood. Furthermore these past experiences which are rooted in emotional neglect were reproduced by parents through the lived reality of their adolescent children. The cultural *modus operandi* regarding the management of adolescent mental health, emphasised the avoidance of treatment seeking behaviour. Past generational beliefs systems dictated that adolescent emotional difficulties be managed within the privacy of the home environment. In this regard, parents relied on the sole support of their partners, when confronted with concerns regarding their adolescent children's mental health. Parents indicated that social support systems such as friends and family members were unapproachable and were thus not considered as viable support systems. Parents indicated that social support systems present the threat of exposure within the broader social system. The imminent threat posed by stigma thus hindered social support seeking. This finding seemed to be in contradiction to the works of Gilbert et al (2010) who state that the process of help seeking behaviour initially commences with use of a lay referral system, whereby parents first consult with family members, friends, and neighbours when concerns arise. The findings generated from this research project indicated that parents avoid any form of help seeking behaviour, which falls outside of the immediate spousal dyad. It can be argued that while parents did not rely on a lay referral systems, parents did however subscribe to the culturally accepted form of behaviour.

The lack of support seeking behaviours and treatment utilisation can be understood as resulting from the interaction between past-unmet emotional desires and the internalisation of social norms and stigmatised beliefs. Parents of adolescent children seem to be caught in a cycle of replication, whereby the past unmet emotional needs of the parent are continuously being relived. The continuous replication of behaviour can be understood as resulting from the internal needs of the parents to seek out help and the social pressure to avoid help seeking. The cultural requirement of the private management of adolescent mental health difficulties is replicated as a result of the lack of viable alternatives. It can be argued that parents have limited knowledge and awareness regarding adolescent mental health concerns and thus rely on socially learned knowledge systems. Parents do not have an alternative template for understanding and managing adolescent mental health needs, and thus have no choice but to rely on the “*way things are normally done*” (Gilbert et al, 2010: p80).

5.4 Conclusion

The complex nature of parental perceptions of adolescent mental health difficulties, seemed to be in agreement with the theoretical models of health psychology in a manner which is both aligned with the theoretical principles, while also affirming of the criticism of these models. The main criticism of these theoretical models, which was confirmed in this research project, was associated with the lack of emphasis which these models placed on the of role social deterrents on individual parental perceptions of adolescent mental health and emotional well-being. Parental perceptions of adolescent mental health is shaped by the complex interaction between internal health cognitions and socio-cultural belief systems. The socio-political context within which parents reside can be seen as an environment, which does not provide input in the realm of adolescent mental health, and as a result, parents indirectly adopt similar patterns of neglect. The ways in which parents understand the causes,

symptoms and treatment options available for adolescent mental health concerns, demonstrate that parents have limited of knowledge and awareness regarding the complex nature of adolescent mental health.

The limited knowledge that parents have regarding adolescent mental health and emotional well-being resulted in the development of various inaccurate beliefs. Parents understood adolescent mental health in similar terms as any medical illness. The medicalisation of adolescent mental health concerns resulted in an increased emphasis being placed on causes and symptoms of illness rather than the facilitation of mental health. Parents adopted various strategies to avoid illness connotations as a result of the fear of being stigmatised as parents of mentally ill adolescents. In this regard, parents perceived causal factors as predictable and controllable, and symptom expression as resulting from normal adolescent development. Parents seemed to adopt these inaccurate beliefs regardless of the presence or absence of adolescent mental health disorders. This indicated that parents were less concerned with the mental health of their adolescent children and more concerned with the label avoidance. The inaccurate beliefs which parents held true can be understood as a protective mechanism, which ensures the survival of parental self-efficacy and self-integrity. Implications in this regard inadvertently resulted in a lack of support seeking behaviours and treatment utilisation by parents.

5.5 Limitations

The purpose of any research design is to ensure that the research question is achieved through collecting data which is of good quality and which provides the most accurate findings (Jensen & Laurie, 2016). While this research project has achieved its aim to develop insight into parental perceptions of adolescent mental health and well-being, it can be argued that various limitations relating to the research design immersed throughout the unfolding process

of the research project. The first shortcoming relates to the reliability of the data, given the small sample size utilised in this research project, the findings obtained cannot be generalised to account for the entire population of parents of adolescent children. According to Jensen and Laurie (2016) qualitative research does not aim to produce generalizable data but rather data which is qualitatively rich and in depth. Although generalizable results were not the goal due to the qualitative nature of this project, the sample comprised of predominately white, married, Afrikaans speaking females, thereby limiting the exploration of diverse family structures, genders differences, and ethnic and cultural variations.

The second limitation, relates to the subjective nature of qualitative research, specifically as it relates to the utilisation of a thematic content analysis. A thematic content analysis requires a significant level of subjectivity in terms of theme generation (Jensen & Laurie, 2016). In this regard the researcher is required to develop themes based on her interpretation of the responses provided by the parents. The researcher thus inevitably forms part of the research instrument (Jensen & Laurie, 2016). The researchers own ideological framework may have had an impact on the types of themes constructed and the ways in which the themes were interpreted. Thus the findings obtained from this data might present some constraints in terms of replication, as the findings obtained may not be easily replicated to produce the same results.

5.6 Implications for Future Research

Despite the above limitations, this research project provides valuable information, which has implications for future research into parental perceptions of adolescent mental health and emotional well-being. Research on the topic of parental belief systems and adolescent mental health, is a critical subject, which has received little attention within the South Africa context. Accordingly, this study has been able to delineate the ways in which parents understand their

adolescent children's mental health and well-being, both at an individual level as well as a societal level. The themes which emerged in this research project, including the ways in which parents understand the causes and symptoms of adolescent mental health concerns as well as the health seeking behaviours of parents. In view of the fact that demographic variables were not included in this study, further research examining the impact of certain variables such as parental race, age, gender, educational background, age and socio-economic status can be further explored. The impact that these variables have on parental perceptions of adolescent mental health and well-being is both valuable and interesting to research. In addition to exploring the impact of demographic variables, future research can also endeavour to explore the ways in adolescent mental health and emotional well-being can be promoted amongst parents. In view of the fact that the participants who took part in the study were parents of psychologically healthy adolescent children future research can also aim to explore the perceptions of parents of adolescents with mental health difficulties. Furthermore, this study identified that parents have limited of knowledge and awareness of adolescent mental health difficulties, in this regard it can be suggested that more mental health services be made available, to parents within the public health sector. Individual counselling and support groups for parents of adolescent children can provide parents with more support to enable them to cope with the many challenges of adolescent mental health difficulties. This study was able only to make qualitative comments on the parental perceptions of adolescent mental health. In this regard future research could adopt a quantitative or mixed methods design, which looks more closely at, the ways in which parental perceptions of adolescent mental health are shaped, in order to increase the reliability and validity of the research study and, thus, facilitate the more effective deduction of both comparisons and conclusions.

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Appendix A: Semi-Structured Interview Schedule

1. What does childhood emotional well-being mean for you?
2. How do you understand the causes of mental illness in adolescents?
3. What do you think causes mental illness in adolescents?
4. What existing adolescent mental health services are you aware of?
5. If your adolescent has an emotional problem, who will you turn to for support?
6. Which professionals or non-professionals would you choose for the treatment of your adolescent?
7. How do cultural or ethnic issues influence your understanding of the problems and choice of treatment of adolescent mental health?
8. Are there any myths and stigmas about mental health that you are aware of?

Appendix B: Parent Information Sheet

UNIVERSITY OF THE
WITWATERSRAND,
JOHANNESBURG



Zhel-Ann Delport

Dear Mr/Mrs/Miss

Request for Participation in Research Project

Good day. My name is Zhel-Ann Delport, I am currently doing my Masters degree in Community based Counseling Psychology in the department of Psychology, in the faculty of Humanities at the University of the Witwatersrand. I am conducting a research project on the ways in which Parents of adolescent children (children between the ages of 12-18 years of age) understand the mental health needs of their children. This paper will look at how parents understand what is important when it comes to the emotional well being of their children. This project will also try to understand what parents of adolescents know about the causes of mental problems for adolescents as well as what existing services and sources of help and support are available to parents when it comes to their adolescent child's mental health. The report will be submitted as part of the course requirements for my Master of Arts in Community based Counseling Psychology.

This research will help to understand adolescent mental health needs, through the eyes of the parents. In developing a better understanding of adolescent mental health and well being we

can prevent poor mental health among adolescents as well as preventing long term mental health difficulties.

Your participation in this study is completely voluntary, there will be no reward provided for participating or penalty for not participating. Involvement in this study would require you to participate in a semi-structured interview, which will be scheduled at a time and place that is suitable to you. You will not be obliged to answer any questions with which you are uncomfortable with and therefore have the option to decline to respond to any of the questions asked. You will also have the option of terminating your participation at any stage during the interview. Should you require any counseling as a result of your participation in the research, please feel free to contact the following counseling service (note that they are free and no payment will be required),

Lifeline (Toll free): 0861 322 322

All the information you give will be treated with the strictest confidentiality. Your name or any identifying information will not appear in the report. All interview transcripts and reports will be appropriately coded to ensure that you remain anonymous in my reporting. You will also be provided with a one page summary of the research report if requested. The results of the research will be submitted as part of the course requirements for my Masters degree in Community Counseling Psychology. My research report will also form part of the university archives and might be published in a psychological journal. The audio-recordings of the interviews will be kept in a password protected file and will form part of my data archive, no names will be linked to the recordings.

Your participation in this research project will be greatly appreciated. It is my understanding that the study will not pose any risks or result in any direct benefit to you. However, if you feel that you have concerns regarding the study or if you require any additional information,

please contact me Zhel-Ann on 072 847 9970 or my supervisor Vinitha Jithoo on vinitha.jithoo@wits.ac.za to discuss any questions or concerns. If you would like to participate, please contact me directly on zhel.delpport@gmail.com or phone me at any time on 072 847 9970.

Kind regards

Zhel-Ann Delpport (Researcher)

072 847 9970 or zhel.delpport@gmail.com

Dr Vinitha Jithoo (Supervisor)

Vinitha.jithoo@wits.ac.za

Appendix C: Parent consent form

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WITWATERSRAND,
JOHANNESBURG



I _____ confirm that I have read the participant information sheet. I confirm that I understand what participation in this research project requires, I understand that my participation is voluntary, and will not be rewarded or punished in any way, shape or form. I understand that I have the right not to answer any questions which I do not feel comfortable with; I also have the right to withdraw from the research at any time. I acknowledge that my identity will remain anonymous and that the researcher will do her best to keep my identity anonymous and the information I have shared confidential. I understand that any information I share will be held in the strictest confidence by the researcher. I confirm that I am aware of the fact that the results of the research will be used as part of the course requirements for my Masters degree in Community based Counseling Psychology and will form part of the university archive. The research report might also be published in a psychological journal.

Signature of Participant

Appendix D: Permission for Audio Recording

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JOHANNESBURG



I _____ hereby allow the researcher to audio record all conversations and responses which occur during the interview. I agree that the audio recordings will be used as part of the research, and may be presented within the research findings. I acknowledge that I have the right to remain anonymous and that the researcher will do everything in her power to ensure my anonymity in the reporting of the results. I agree to the researcher making use of direct quotes from my interview, as part of study. I also acknowledge that I have the right to withdraw any statement which I have made, if I feel the need to do so. I acknowledge that I will inform the researcher of any such statements which I feel I want to withdraw from the research directly after or during the interview. I acknowledge that my interview recordings will form part of the researchers archival data and will be stored in a password protected file on the researchers personal computer and that no names will be associated with the recordings.

Signature of participant