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Addressing Racial Disparities in Parent Training Enrollment: An Examination of Help-Seeking for Child Behavior Problems among African American Mothers

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ADDRESSING RACIAL DISPARITIES IN PARENT TRAINING ENROLLMENT: AN EXAMINATION OF HELP-SEEKING FOR CHILD BEHAVIOR PROBLEMS AMONG AFRICAN AMERICAN MOTHERS

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Table of Contents

Abstract

The consideration of African American mothers' mental health help-seeking attitudes and intentions is important when developing culturally sensitive parent training programs and potentially help bridge a critical knowledge and service gap for this population. The purpose of this study is to examine the parental help-seeking for child externalizing behavior problems in order to delineate variables that might influence BPT enrollment among African American families. To address the lack of research considering cultural factors, this study examines the influence of racial group identification, cultural childrearing values, and mental health stigmatization on African American mothers' problem recognition and willingness to engage in behavioral parent training. Participants were 112 African American mothers. Results found that when presented with a child displaying clinically significant externalizing child behaviors, slightly more than half of African American mothers recognized clinically significant child behavior problems. Mothers were more likely to engage in behavioral parent training if problematic behavior was recognized. Additionally, mothers' perception of child behavior, cultural values, and mental health stigmatization were influential to help-seeking. This study supports the importance of considering the cultural variables impactful to problem recognition and treatment utilization among African American families.

Introduction

Childhood externalizing problems are commonly characterized as disruptive, hyperactive, noncompliant, and aggressive. When pervasive, externalizing child behavior is associated with detrimental effects on family and social functioning, academic achievement, and impairment into adulthood (Wehmeier, Schacht, & Barkley, 2010; Scholtens, Diamantopoulous, Tillman, & Rydell, 2012). Therefore, early recognition of child behavior problems and intervention are critical. Decades of research has led to the development of behavioral parent training (BPT), a widely-used treatment for children with behavioral problems. BPT programs teach parents to employ child management practices that reduce misbehavior and improve compliance. BPT techniques include use of clear instructions, contingent praise, ignoring minor misbehavior, timeout and removal of privileges for unacceptable behavior (Sanders, Ralph, Sofronoff, Gardiner, Thompson, Dwyer, & Bidwell, 2008). Numerous studies have demonstrated the effectiveness of BPT programs on reducing behavioral problems, oppositionality, and associated impairment in youth (Evans et al. 2014). However, although BPT has been shown to be effective for improving externalizing child behavior, many racial-minority families fail to enroll in BPT programs (Reyno & McGrath, 2006; Chacko et al., 2016).

African American families have consistently exhibited lower rates of enrollment in BPT programs relative to Caucasian families (Reyno & McGrath, 2006). Ortiz and Del Vecchio (2013) found that between 2004 and 2008, only 14% of parents enrolled in BPT identified as Black or African American. Various factors have been associated with racial disparities in BPT utilization. For example, relative to Caucasian families, African American families tend to be more economically disadvantaged and therefore, experience more barriers to treatment (Webster-

Stratton & Hammond, 1990; Fernandez, Butler, & Eyberg, 2009), including structural barriers (e.g., transportation, distance of services) and sociodemographic barriers (e.g., income level, education). Unfortunately, many of these barriers cannot be readily changed and even when addressed do not ensure BPT enrollment. For instance, BPT interventions that have provided impoverished African American mothers with financial incentives and childcare did not find significant improvements in enrollment (Gross et al., 2011; Dumas et al., 2010). However, culturally-adapted BPT interventions that consider the cultural context of parenting have shown higher rates of engagement among racial-minorities compared to traditional BPT interventions (Bernal, 2006; Lau, 2006). This pattern of outcomes within research suggests that experiencing structural and sociodemographic barriers may be more distal barriers to BPT enrollment among African American families compared to the influence of sociocultural beliefs about child behavior and effective treatment.

Given that parenting occurs within a cultural context, the decisions to seek help for child behavior problems and enroll into a BPT program must be examined from a cultural perspective. Although help-seeking has been consistently linked to service initiation among African American adults (McKay, Pennington, Lynn, & McCadam, 2001; Turner, Jensen-Doss, & Heffer, 2015), few empirical studies have examined factors that influence African American parents' decisions to address their child's behavior problems. Cultural variables associated with help-seeking, such as feelings of stigma related to treatment for childhood disorders (Weisz & Weisz, 1991; Bussing et al., 2005) and beliefs about child mental health problems (Turner et al., 2015) have been identified; however, their influences have not been examined within the context of parental help-seeking for externalizing behaviors. Therefore, this study examines the help-

seeking pathway for externalizing child behavior problems among African American families, with a particular focus on sociocultural factors influential to problem recognition and BPT utilization in order to address disparities in BPT enrollment among this particularly vulnerable group.

Parental Help-Seeking Pathway

Several theoretical models have proposed help-seeking to be a multidimensional pathway composed of distinct phases that lead to treatment utilization (Anderson & Newman, 1973; Srebnik, Cauce, & Baydar, 1996). Cauce and colleagues (2002) delineate three major phases of the help-seeking pathway: (1) problem recognition, (2) decision to seek help, and (3) service selection. The first phase involves recognition of a problem that needs to be addressed. The second phase involves the decision to seek help, while the third phase involves the selection of services to address the problem. Unlike adults seeking help for their own mental health problems, children and adolescents must rely on their parents to initiate help-seeking. Therefore, problem recognition is necessary for parents' decision to seek outside help to address children's mental health problems, which then leads to selection of what parents perceive to be an appropriate treatment. Studies have demonstrated empirical support for this parental help-seeking pathway, as parental problem recognition (Teagle, 2002; Zahner & Daskalakis, 1997) and decisions to seek help (Spoth, Redmond, & Shin, 2000) have been strongly associated with both child and parent service initiation.

Studies utilizing this multidimensional approach have led researchers to expand understandings of the factors influential to parental help-seeking. Overall, substantial research indicates that a parents' response to mental health problems within the context of their larger

social environment may either facilitate or hinder their progress toward service utilization (Cauce et al., 2002). With regard to treatment of child behavior problems, parents' movement along the help-seeking pathway has been found to be affected by illness profile factors (e.g., parents' perception of symptom severity, impairment), predisposing characteristics (e.g., age, gender, race, ethnicity, and beliefs about the causes of the problem), and structural barriers to care (e.g., access to care, availability of services, income). However, investigation of the parental help-seeking pathway has been generally examined within predominantly Caucasian populations (Teagle, 2002). In considering that ultimate service selection is highly influenced by culture and context, attempts to address low BPT enrollment among African American parents may be fruitless without examination of parents' problem recognition and perception of BPT as treatment for problematic child behavior.

Problem Recognition

Parents' recognition of a child's behavior as problematic initiates the help-seeking pathways and is a precursor to BPT enrollment (McKay & Bannon, 2004; Geffken et al., 2006). Yet, fewer than half of the parents of a child with a mental health disorder recognize problems in their child (Sayal, 2006). Studies have found that many parents are hesitant to identify their children's behavior as problematic, thus contributing to delayed treatment-seeking (dosReis et. al, 2010). Therefore, the accuracy with which parents identify their child as demonstrating significant behavior problems is important to understand.

Epidemiological vs. perceived need for treatment. According to the model of help-seeking proposed by Cauce and colleagues (2002), two key factors are influential in predicting parental recognition of a child's behavior as problematic: epidemiologically defined need and

perceived need. Epidemiologically defined need is a symptom-focused approach to conceptualizing problematic behavior (Cauce et al., 2002), and is typically measured by clinicians through diagnostic tools such as the American Psychiatric Association*'s Diagnostic and Statistical Manual of Mental Disorders (DSM)* and standardized clinical rating scales. However, this approach may be incongruent with African American parents' perceptions of their children's problem. For example, Lambert, Rowan, Lyubansky, and Russ (2002) found that less than 1% of 1,605 African American parents described child behavior problems consistent with at least half of the items on the Child Behavior Checklist (CBCL; Achenbach, 1991), a standardized measure often used by professionals to screen for child problem behavior and refer parents for treatment. Many researchers argue that most child assessment measures lack content and cultural validity, in part because the theories of child behavior are based on conceptual frameworks developed largely from European American culture (Cauce et al., 2002). However, in the absence of available alternatives, researchers and clinicians continue to rely on such measures to determine whether a child's behavior is problematic and necessary to treat. Therefore, the discrepancies between epidemiologically assessed need and perceived need among African American families likely reflect a lack of cross-cultural conceptualization of externalizing childhood disorders driven by varying sociocultural interpretations of externalizing behaviors. Subsequently, many of that factors associated with problem recognition among Caucasian families may not predict African American parents' perceived need for treatment.

Child service utilization relies on parents' subjective appraisal of behavior as problematic and important to treat (Cauce et al., 2002). Srebnik, Cauce, and Baydar (1996) found parents' perceived need to be a stronger predictor of problem recognition than epidemiologically assessed

need. However, the rates at which parents of children with epidemiological need perceive their children as exhibiting problematic behavior tends to be low, ranging from 13% to 20% (Teagle, 2002; Verhulst & van der Ende, 1997). Bussing, Zima, Gary, and Garvan (2003) found that 66% of parents of children who met the diagnostic criteria for attention-deficit/hyperactivity disorder (ADHD) did not perceive a service need. In order to understand this disparity, researchers have identified several factors that contribute to parental problem recognition, both contextual and cultural in nature (Alvarado & Modesto-Lowe, 2017; Eraldi et al., 2006; Power et al., 2005).

As previously mentioned, illness profile factors have been found to be associated with parents' perceived need. A review by Zwaanswijk, Van der Ende, Verhaak, Bensing, & Verhulst (2005) found that the presence of child symptomology was insufficient to predict parents' problem recognition and that recognition was enhanced by beliefs about behavior severity and chronicity of the child's problems. Nordstrom, Dumas, and Gitter (2008) found that parents' perception of a child's behavior as only mildly problematic were also associated with low treatment initiation. Tully and colleagues (2017) found parents of children with low levels of externalizing behavior were less likely to endorse their child's behavior as problematic and more likely to deny needing help parenting compared to parents of children exhibited high externalizing behavior. However, illness profile factors may not be sufficient in enhancing perceived need among African American families. For example, Slade (2004) examined parents' perception of their child's need for treatment following a significant school disciplinary event and found that receiving a school suspension or expulsion positively affected parent-reported need for service among Caucasian children but had no effect for African American children.

Further research has found racial/ethnic differences in parents' problem recognition and perceived need for treatment. Weisz and colleagues (1988) provided American and Thai parents a vignette on depicting child behavior problems and found that Thai parents were more likely to rate child problems as less severe, less worrisome, and more likely to improve. Bevaart and colleagues (2012) also examined perceptions of problem behavior among parents of children referred for behavioral problems, finding lower problem perception in racial-minority parents when compared to racial-majority parents. Certainly, research indicates cultural factors such as attitudes about mental health and developmental expectations for child behavior are associated with problem recognition among racial-ethnic minority families (Alvarado & Modesto-Lowe, 2017; Eraldi et al. 2006). Therefore, differential problem recognition across racial/ethnic groups suggests the necessity of examining cultural attitudes of child behavior among African American parents.

The role of cultural values. Cultural values for child behavior guide parents' perceptions and expectations of their child (Keller et al., 2006; Weisz et al., 1988). Differential cultural standards for appropriate versus inappropriate child conduct may result in the perception that symptoms are not problematic and do not warrant professional help. For example, early studies argue that socialization for child compliance is characteristic of economically disadvantaged cultural groups, whereas economically stable groups emphasize child independence (Ogbu, 1981). Compared to Caucasian parents, African Americans have been found to be more collectivistic and emphasize the survival of their families and communities as opposed to the individual (Boyd-Franklin, 1989). Therefore, displays of inappropriate behavior within the context of the family may be poorly tolerated in the African American community.

This is consistent with more recent research that has found that racial-ethnic minority parents have a difficulty accepting child behavioral problems when they are perceived as a lack of manners or disrespect for authority (Perry et al., 2005). In contrast, some research has found that racial-minority parents may be less concerned about inattentive or high energy symptomology due to the belief that these behaviors are more consistent with normal child development (Arcia & Fernández 2003). Indeed, previous studies have shown that racial minority parents may attribute ADHD behaviors to typical child development and feel they are being unfairly targeted when ADHD referrals are provided by professionals (Alvardo & Modesto-Lowe, 2017).

Research indicates that African American families place an extremely high value on respect and obedience (Dixon, Graber, & Brooks-Gunn, 2011). Deater-Deckard and Dodge (1997) hypothesized that a history of racial discrimination has led African American culture to value respect for authority as central to appropriate child behavior, as disobedience could place an African American child in danger in a discriminatory society. In contrast, some inner-city African American children may use aggressive behaviors to preserve and promote self-worth and self-protection within their environment (Guerra & Jaggers, 1998). Unfortunately, among empirical studies, parental values have often been inferred in relation to parenting behavior (Reitman, Currier, & Stickle, 2002), and African American parents have been found to be more likely to employ authoritarian parenting styles in order to convey behavioral expectations (Ogbu, 1981;).

Certainly, social norms for which behavior is undesirable or worthy of concern are important factors impacting the first stage of the help-seeking pathway. When examining problem recognition, it is important to determine whether variability in cultural beliefs about

what constitutes acceptable child behavior contribute to racial disparities in perceived need among African American parents. However, no study has examined cultural values of child behavior in relation to African American parents' problem recognition.

Decisions to Seek Help and Select BPT

In order to understand low BPT enrollment within African American families, it is also important to investigate factors associated with a parent's decision to seek help. Even after a child's externalizing behavior problem is recognized by parents, decisions about whether and how to seek help continue to be influenced by parents' beliefs about their children's behavior and need for treatment. For example, a parent may decide to ignore some behavior problems due to the belief that the behavior will decrease over the course of normal development (Thurston & Phares, 2008). Parental help-seeking is a strong predictor of whether a child with externalizing behavior problems receives treatment (Teagle, 2002), and therefore identifying factors associated with help-seeking may contribute to increased BPT utilization by African American parents.

Attributions. Beliefs about the nature of a child's externalizing has been associated with parents' decision to seek and select help. Research on factors associated with BPT engagement have suggested that parental attributions need to be consistent with the intervention. Investigations examining parental attributional frameworks focus upon two types: causal and responsibility. Causal attributions are parental explanations as to why children misbehave (Geller & Johnston, 1995). For example, if parents believe that their child's problems are biologically based, then they may be more likely to seek medication (Boulter & Rickwood, 2013), whereas parents who believe that their child's problems are due to spiritual issues may then seek a religious leader for guidance (Thurston, Phares, Coates, & Bogart, 2015; Yeh et al., 2005).

Negative causal parenting attributions may lead parents to believe that the child is inherently "bad" and that there is nothing the parent can do to change their child's behavior. Responsibility attributions are parental judgements about their child's accountability for misbehavior. Parents of children who display disruptive behaviors report higher causal and responsibility attributions (Johnston, Reynolds, Freeman, & Geller, 1998; Wilson, Gardner, Burton, & Leung, 2006). With regard to BPT, many argue that parents who do not believe that their parenting practices influence their child's behavior will be less likely to seek parenting interventions. Miller and Prinz (2003) found parents to be more likely to drop out of BPT programs if they attributed their children's misbehavior to factors not under parental control. Similar studies have found that parents who attribute a children's behavior problems to their disposition or temperament are more likely to seek treatment delivered directly to the child rather than BPT (Williford et al., 2009; Tully et al., 2017).

Researchers have speculated that cultural beliefs about the etiology of child behavior problems may be a prominent explanation for the racial disparities in help-seeking and ultimate selection of BPT (Yeh et al., 2005; Schnittker, Freese, & Powell, 2000). Further, parents' attitudes about the cause of their children's externalizing behavior differs depending on cultural values. In qualitative research, many Latino families describe beliefs that ADHD behaviors are caused by family factors, such as a lack of parent discipline (Gerdes et al. 2014). Jacobs and colleagues (2008) found African American parents to be significantly less likely to report their child's emotional or behavior problems to be attributable to physical or biological causes than Caucasian parents. In a mixed-methods approach examining help-seeking among African American families, Bussing and colleagues (2005) found that parents' perceptions regarding the

causes of their child's behavior related to help-seeking and service selection. The authors indicated that when children's behavior has seen as controllable by the child, African American parents relied on behavioral modifications (e.g., spanking and punishment) implemented only by the child's closest family members rather than seeking professional help. This supports previous research that has consistently found African-American parents, compared to their Caucasian counterparts, more likely to seek help from family rather than from health professionals (Boulter & Rickwood, 2013; Bussing et al., 2005).

Stigmatization. The experience, or threat of the experience, of stigma has been linked to help seeking and utilization of formal mental health services. Stigmatization, characterized as thoughts of alienation or feelings of shame regarding treatment, is negatively associated with help-seeking in African American adults (Vogel, Wade, & Hackler, 2007; Corrigan, 2004). Young and Rabiner (2015) examined reported barriers to seeking mental health services within a community sample of 275 parents and found that parents rated stigma-related barriers to be negatively associated with self-reported intent to seek help. Within the context of BPT, stigma may prevent parents of children with behavior problems from seeking help due to fear of being negatively judged by others. For example, parents have been found to worry that their child and/or family will be viewed as 'different', that they are will be judged as a 'bad parent', or that their family would be treated differently if others discovered that the family is engaged in mental health treatment (Dempster, Davis, Jones, Keating, & Wildman, 2015; Corrigan, 2004).

Among African American families, research indicates that there are strong norms that family problems are only discussed within the family or community due to a fear of being labeled and treated in a discriminatory manner (Hinshaw, 2005). For example, African American

parents reported being more likely to turn to family, friends, community, and church members than Caucasian parents, whereas Caucasian parents are more likely to receive help from medical doctors or mental health professionals (Dempster et al, 2015).

Therefore, an important reason that African American families may be reluctant to seek and obtain treatment is the existence of cultural differences in perceptions of BPT as a treatment. Although recent studies have placed a greater emphasis on the role of stigma on parents' willingness to engage in treatment, some studies have found racial differences in perception of stigma when seeking treatment for externalizing child behavior (Turner, 2010) others have not (Young & Rabiner, 2015). However, few studies have looked within African American families to understand the degree to which stigma and other variables uniquely impacts mental health service selection.

Current Study

Despite attempts to address the racial disparities in service utilization (Bussing et al., 2003; dosReis et al., 2006; dosReis et al., 2007; Olaniyan et al., 2007), African Americans families continue to demonstrate low BPT enrollment (Chacko et. al, 2016). Traditionally, underutilization among African American families is assumed to be the result of racial-minority group attitudes toward child behavior and mental health services, which influence parents' movement along the help-seeking pathway. However, this assumption has not been directly investigated, but instead inferred from studies employing a group differences approach between Caucasian and African American parents. Subsequently, little is known about the influence of variables such as racial group identification, cultural childrearing values, and stigma on help-

seeking among African American families. Thus, a gap exists in the literature examining the unique factors that influence African American parents' decisions to utilize BPT.

Therefore, the current study seeks to examine parental help-seeking for child externalizing behavior problems in order to delineate variables that might influence BPT enrollment among African American families. The aims of this study are twofold. First, the influence of cultural variables that may contribute to African American mothers' recognition of an externalizing problem above and beyond those identified in the research was examined. Second, the current study seeks to determine if cultural variables influence African American mothers' intent to utilize BPT to treatment after a child behavior problem has been recognized. Research questions and related hypotheses are detailed below.

Research Question 1: When presented with a child exhibiting clinically significant externalizing behaviors, what variables significantly contribute to African American mothers' problem recognition?

Hypothesis 1a. It is hypothesized that higher ratings of perceived behavior severity and impairment will predict problem recognition. This hypothesis is based on previous research that has found higher levels of externalizing behavior and perceived impairment to be more predictive of problem recognition than low levels of externalizing behavior (Tully et al., 2017; Thurston et al., 2015).

Hypothesis 1b. In order to obtain a more ecologically valid assessment of problem recognition, mothers' ratings of problem recognition will be compared to their own perceptions of their child's externalizing behavior. It is hypothesized that mothers of children exhibiting high rates of externalizing behavior will be more likely to recognize a

problem. This hypothesis is based on previous research that has found prior exposure to psychological disorders to be positively associated with problem recognition (Thurston, Coates, & Phares, 2015).

Hypothesis 1c. It is hypothesized that mothers' SES and self-reported values of child behavior will be associated with problem recognition. This hypothesis is based on previous research that has conjectured that the discrepancy between epidemiological and perceived need within racial-minorities may be due beliefs that behaviors are relatively congruent with cultural norms (Cauce et al., 2002).

Research Question 2: Do cultural variables influence likelihood of utilizing BPT among African American mothers who recognize problematic externalizing behavior?

Hypothesis 2a. It is hypothesized that mothers' willingness to utilize BPT will be associated with mothers' attributions of the child's behavior. This hypothesis is consistent with previous research indicating that parents' conceptualization of the cause of child behavior problems has been shown to influence type of treatment selected (dosReis, Mychailyszyn, Myers, & Riley, 2007).

Hypothesis 2b. It is hypothesized that mental health treatment stigma will explain the relationship between mothers' racial identity and willingness to utilize BPT. This hypothesis is consistent with previous research finding stigma to be negatively associated with intent to utilize child mental health services (Corrigan, 2004) and stronger racial identity to be associated with increased perception of stigma and decreased utilization among African Americans (Richman, John-Wood, & Williams, 2007).

Method

Participants

Participants were one hundred twelve African American mothers with at least one child between the ages of 4 and 17 years living in Southeast Louisiana. Including a broad range of child ages, and therefore parental ages, provided results that were more generalizable to a larger population. Mothers ranged in age from 20 to 49 years old (M = 32.4, SD = 7.11). Approximately sixty-five percent of mothers were married, 26.4% were single, and 9.1% were divorced or separated. Approximately eighty-nine percent of mothers were employed. With regard to education, 22.3% of mothers had only a high school diploma/GED, 14.3% had some college education, 51.8% had a bachelor's degree, and 11.6% had a postgraduate degree. Median income of the sample was $62,144, ranging from $18,000 to $250,000. A total of 12.8% of the sample of mothers reported receiving mental health services in the present or past, while 36.8% of mothers reported that at least one of their children had received mental health services.

Table 1. Demographic Characteristics

	Total Sample
	***N* = 112**
Age (in years)	
Mean (SD)	32.4 (7.1)
Range	20-49
Income	
Mean	$62,144
Range	$18,000 - $250,000
Hispanic Descent	5.7%
Marital Status	
Married	64.5%
Single	26.4%
Divorced/Separated	9.1%
Employment	
Employed	89.6%
Unemployed	10.4%
Education	
High school/GED	22.3%
Some college	14.3%
College Degree	51.8%
Post-graduate	11.6%
Treatment History	
Child mental health treatment	36.8%
Parent mental health treatment	12.8%

Measures

Demographic Questionnaire. Each mother was asked to complete a demographics questionnaire. The demographic variables included mother's age; race as self-identified according to US Census categories; annual household income; marital status; employment status; occupation; years of education; and number of children in the home. Parents were also asked to describe experiences with mental health services received for themselves and their children. See Appendix B.

Vignettes. Vignettes were created based on criteria from the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; American Psychiatric Association, 2013). Mothers were provided written vignettes describing two externalizing behavior disorders: oppositional defiant disorder (ODD) and attention-deficit/hyperactivity disorder (ADHD), combined presentation. See Appendix C. The ODD vignette described the behavior of the mother's 10-year-old child displaying anger, disobedience, and vindictiveness for the past six months. The below description was used:

> "For the past 6 months, your 10-year-old child's mood often changes throughout the day. One minute your child is really angry and the next minute your child is fine and happy. Your child often ignores and argues with you and teachers. When you ask your child to complete chores, he/she often talks back. But some days your child is helpful around the house without being asked. Your child has recently been reprimanded at school for annoying and calling them names. Your child does not often apologize and hasn't really cared much about getting in trouble. When a classmate is mean to your child, he/she gets even with them."

The ADHD vignette described the behavior of a 10-year-old child displaying inattention and hyperactivity at home and school for the past six months. The below description was used:

> "Your child is a 10-year-old with problems at home and school. For the past 6 months, your child has shown high energy at home and school. Your child's teacher describes him/her as smart and likeable, but difficult to manage. Your child hums and makes noises, blurts answers without raising his/her hand, and always tries to be first when the teacher asks questions. Your child struggles to pay close attention to details, makes a lot of careless mistakes, and often forgets to turn in homework. At home, your child needs to be told many times to stop running, to sit still, and to listen when parents are speaking. Your child also gets distracted while doing chores and usually starts doing a different task."

Mothers were asked to imagine that their child closest in age to 10 years-old was displaying the behavior presented in the vignettes. The order of the vignettes was randomized across participants.

Problem recognition and treatment utilization. After reading each vignette, mothers were asked several questions. Questions were been adapted from previous empirical studies (Chavira et al., 2000; Jacobs, Woolfson, & Hunter, 2017) utilizing vignettes. Mothers were asked about perceived problem severity ("How severe did you feel these behaviors are?"), impairment ("How much do you think these problems would affect your child's daily activities?"), and need for treatment ("How much do you believe these behaviors require treatment?"). Questions will be rated on a 7-point Likert scale (1= *Not at all*, 4 = *Neutral*, 7 = *Very Much*). Mothers will then be asked "If your 10 year-old child were displaying these behaviors, would you believe he/she has a mental health problem?" (Yes or No).

Additionally, two attributional domains for the child's misbehavior were measured: parental attributions or child attributions. The parental attributions domain assessed mothers' perception of their ability to control the behaviors displayed by the child as well as mothers' beliefs about the degree to which they might be blamed for the child's misbehavior. The child attribution domain assessed mothers' perception of their child's ability to control their behavior as well as mothers' beliefs about the degree to which the child might be blamed for their misbehavior. Questions will be rated on a 7-point Likert scale (1= *Not at all*, 4 = *Neutral*, 7 = *Very Much*). Finally, mothers will be provided a short description of parent training and asked to rate the likelihood of initiating a BPT program to address the behaviors depicted in the previous vignette.

Mental Health Service Attitudes. The Stigmatization subscale of the Parental Attitudes Toward Psychological Services Inventory (PATSPI; Turner, 2012) was utilized to measure maternal perceptions of child mental health treatment stigma. This subscale is an 8-item subscale

that measure the extent to which mothers are concerned about what others might think if they knew she were seeking professional help. Items are rated on a 5-point Likert scale (0 = *Strongly Disagree* to 5 = *Strongly Agree*) with higher scores indicating more perceived stigma toward mental health services. See Appendix D. The Stigmatization subscale has demonstrated acceptable internal consistency (α = .91 for African Americans) and test-retest reliability (r = .84; Turner, 2012). In the present sample, the internal consistency reliability for the total scale was .94.

Racial Identity. Mothers' racial identity was measured using the Black Centrality subscale of The Multidimensional Inventory of Black Identity (MIBI; Sellers et al., 1997). The MIBI is an 8-item subscale that measures the extent to which an individual defines themselves with regard to race (e.g., "Being Black is an important reflection of who I am"). Items are rated on a 7-point Likert scale (1 = *Strongly Disagree* to 7 = *Strongly Agree*), with higher scores indicating a stronger Black identity. See Appendix E. The Black Centrality subscale has demonstrated acceptable internal consistency (Vandiver, Worrell, & Delgado-Romero, 2009). In the present sample, the internal consistency reliability for the total scale was .86.

Child Behavior Values. The Goals and Values in Adulthood Questionnaire (GVAQ; Suizzo, 2007) was used to measure mothers' child behavior goals and values. The GVAQ is a 25-item questionnaire that measures the extent to which mothers feel it is important for their child to have certain values or behaviors when they were older. Items are rated on a 6-point Likert scale (1 = *Not Important* to 6 = *Extremely Important*). Two subscales of the GVAQ were utilized for this this study: Agency goals (10 items) pertain to parents' desire for their children to be independent, determined, and self-reliant; Conformity goals (9 items) pertain to parents'

desire for their children to have respect for their parents and those who are senior to him or her, honor family, and conform to cultural or religious values. See Appendix F. The subscales of the GVAQ have demonstrated internal consistencies ranging from acceptable to good (Suizzo, 2007). In the present sample, the internal consistency reliability for was .92 for the Agency subscale and .89 for the Conformity subscale.

Child Behavior. The Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999) was used to measure the intensity of their own child's behavior. This is a 36-item parent report scale that examines externalizing behaviors in children between the ages of 2 and 16. The ECBI measures the frequency of disruptive behavior on a seven-point Likert scale (1 = *Never* to 7 = *Always*). Mothers were asked to think of their child with the most problematic behavior while completing this measure. See Appendix G. Previous research has established that the ECBI has good internal consistency and demonstrates content and discriminant validity (Eyberg & Pincus 1999). In the present sample, the internal consistency reliability for the total scale was .87.

Procedure

Mothers were considered eligible for study if they self-identified as African American and have at least one child between the ages of 4 and 17. Upon Institutional Review Board (IRB) approval, African American mothers were recruited for participation from public libraries, a summer camp, and an after-school program in Southeast Louisiana. Prior to participation, a detailed consent process was completed. Based on preference and accessibility limitations, participating mothers were either given a paper packet containing study materials to be completed in-person or an online link to study materials to be completed through secure survey software. Mothers first completed a demographic questionnaire, then were asked to read two vignettes describing a child

exhibiting clinically significant externalizing behavior. After reading each vignette, mothers were asked to respond to several questions regarding the severity and causes of the child's behavior, as well as the mother's likelihood of addressing the behavior. Finally, parents completed questionnaires on perceptions of stigmatization, racial identity, and self-reported child socialization goals.

Results

Data Screening

Prior to analyses, data were examined using SPSS Statistics 22 software for accuracy of data entry, missing values, and adherence to the assumptions of logistic and multiple regression analyses. Linearity was confirmed by partial regression plots and a plot of studentized residuals against the predicted values. There was independence of residuals and homoscedasticity, as assessed by visual inspection of a plot of studentized residuals versus unstandardized predicted values. There was no evidence of multicollinearity, as assessed by tolerance values greater than 0.1. There were no studentized deleted residuals greater than ±3 standard deviations, no leverage values greater than 0.2, and values for Cook's distance above 1. Across regression analyses, the assumption of dependent variable normality was met.

Problem Recognition

In the overall sample, 52% of mothers (n = 58) recognized the ODD vignette as problematic and 58% of mothers (n = 65) recognized the ADHD vignette as problematic. Refer to Table 2 for correlation coefficients. Mothers who identified problematic ODD behavior were more likely to identify problematic ADHD behavior (r = .483, $p < .01$). Mothers' ODD problem recognition was strongly correlated with mothers' perceived need for treatment (r = .533, $p < .01$). Similarly, ADHD problem recognition was strongly correlated with mothers' perceived need for treatment (r= .521, $p < .01$). Greater years of education was positively correlated with ODD problem recognition (r = .218, $p < .05$) and ADHD problem recognition (r = .204, $p < .05$). Child treatment history was positively associated with ODD problem recognition (r = .354, $p < .01$) and ADHD problem recognition (r = .246, $p < .05$). Mothers' treatment history was

positively associated with ADHD problem recognition (r = .235, $p < .05$); however, no significant association was found between maternal treatment history and ODD problem recognition ($p = .131$). Mothers' income, marital status, and employment status were not correlated with problem recognition for either vignettes.

Table 2. Bivariate Correlations of Demographic Variables and Problem Recognition

	1	**2**	**3**	**4**	**5**	**6**	**7**
ODD problem recognition	—	—	—	—	—	—	—
ADHD problem recognition	.48**	—	—	—	—	—	—
Income	.11	.17	—	—	—	—	—
Years of education	.22*	.20*	.19*	—	—	—	—
Marital status	-.10	-.09	-.04	-.08	—	—	—
Employment status	.06	.09	.04	.11	-.02	—	—
Child treatment history	.35**	.25*	-.03	.23*	.05	-.13	—
Maternal treatment history	.11	.24*	.14	.32**	.15	.04	.39**

Note. *$p < .05$ ** $p < .01$.

Hypothesis 1a. In order to examine the effects of child behavior severity and perceived level of impairment on ODD and ADHD problem recognition, two binary logistic regressions were conducted with problem recognition as the dichotomized outcome variable (i.e., whether the depicted behavior is perceived as problematic) and two continuous predictors: perceptions of behavior severity and perceived level of impairment. Regression coefficients for ODD problem recognition predictors are presented in Table 3. The logistic regression model for ODD problem recognition was statistically significant, $\chi^2(2) = 40.403$, $p < .001$, indicating that the predictors

significantly distinguished between African American mothers who recognized problematic ODD behavior and those who did not. This model explained 40.4% (Nagelkerke $R^2 = .404$, $p < .001$) of the variance in problem recognition and correctly classified 74.1% of cases. These results suggest that African American mothers who perceived higher ratings of ODD behavior severity and greater perception of impairment were more likely to recognize the behaviors as problematic.

The ADHD problem recognition model was also statistically significant, $\chi^2(2) = 21.88$, $p < .001$. This model explained 23.9% (Nagelkerke $R^2 = .239$, $p < .001$) of the variance in problem recognition and correctly classified 69.6% of cases. Contrary to findings for the ODD vignette, results indicated that only ratings of impairment added significantly to the ADHD problem recognition model. Ratings of behavior severity did not add statistical significance to the overall model ($p = .259$). That is, mothers who reported higher ratings of perceived impairment from the depicted ADHD behaviors were more likely to recognize the behaviors as problematic; however, perceived severity did not add significantly to problem recognition over this effect of impairment. Regression coefficients for ADHD problem recognition predictors are presented in Table 4.

Hypothesis 1b: Binomial logistic regression analyses using ECBI ratings were performed to determine if mothers of children exhibiting high rates of externalizing behavior would be more likely to recognize a problem. This analysis was also included in order to enhance ecological validity by assessing problem recognition from mothers who have children with externalizing problems at home. Preliminary analysis revealed that the raw scores of the ECBI ratings obtained from participating mothers were non-normally distributed, with skewness of 1.15. In the overall

sample, only one mother provided child behavior ratings that were above the clinically significant cutoff score of 131 (Eyberg & Pincus, 1999); therefore, the majority of participating mothers did not have children with clinically significant behavior problems. Further, correlational analyses revealed a positive relationship between ECBI ratings and child treatment history ($r = .333$, $p < .001$). Results of the binomial logistic regression indicated that ECBI ratings were not predictive of problem recognition in either the ODD vignette ($p = .267$) or the ADHD vignette ($p = .288$).

Hypothesis 1c. Binomial logistic regression analyses using GVAQ Conformity subscale, GVAQ Agency subscale, and income were used to examine the relationship between maternal values of child behavior, income, and problem recognition. Separate analyses were conducted for ODD problem recognition and ADHD problem recognition. Results indicated that the omnibus ODD problem recognition model was statistically significant, $\chi^2(3) = 10.659$ $p < .05$. This model explained 12.1% (Nagelkerke $R^2 = .121$, $p < .05$) of the variance in problem recognition and correctly classified 63.4% of cases. Results indicated that higher ratings on the GVAQ Conformity subscale were positively predictive of problem recognition ($p < .05$). Additionally, higher ratings on the GVAQ Agency subscale were negatively associated with ODD problem recognition ($p < .05$). Collectively, these results suggest that mothers who held more traditional values of childhood behavior (e.g., obeying and respecting elders, conforming to family traditions) were more likely to perceive the ODD behaviors as problematic. Conversely, mothers who placed a greater value on child demonstrating autonomy and independence were less likely to recognize the ODD behaviors as problematic. Income did not significantly predict ODD problem recognition ($p = .246$).

Table 3. Logistic Regression Analysis for Predictors of ODD Problem Recognition

Predictor	***B***	**Wald χ^2**	**OR (95%CI)**	***p***
Impairment	.809	5.422	2.245 (1.137-4.436)	.020
Severity	.505	6.039	1.656 (1.108-2.477)	.014
ECBI	.010	1.205	1.010 (.992-1.028)	.272
GVAQ Agency	-.052	9.078	.950 (.910 – .991)	.019
GVAQ Conformity	.062	8.098	1.064 (1.005 – 1.126)	.032
Income	.000	2.494	1.00 (1.000 – 1.000)	.246

Results indicated that the omnibus ADHD problem recognition model was statistically significant, $\chi^2(3) = 10.155$ $p < .05$. This model explained 11.7% (Nagelkerke $R^2 = .117$, $p < .05$) of the variance in problem recognition and correctly classified 63.4% of cases. Higher ratings on the GVAQ Conformity subscale were again associated with problem recognition ($p < .05$). Therefore, mothers with stronger traditional values of child behavior were more likely to perceive the ADHD behaviors as problematic. However, higher ratings on the GVAQ Agency subscale were not predictive of ADHD problem recognition ($p = .109$). Income was not a significant predictor of ADHD problem recognition ($p = .099$).

Table 4. Logistic Regression Analysis for Predictors of ADHD Problem Recognition

Predictors	**B**	**Wald χ^2**	**OR (95%CI)**	***p***
Impairment	.743	8.810	2.101 (1.287-3.431)	.003
Severity	.238	1.276	1.269 (.839-1.920)	.259
ECBI	.010	1.094	1.010 (.992-1.028)	.296
GVAQ Agency	-.036	2.565	.965 (.923 – 1.008)	.109
GVAQ Conformity	.061	4.395	1.063 (1.004 – 1.125)	.034
Income	.000	2.719	1.00 (1.000 – 1.000)	.099

BPT Utilization

Bivariate correlations found that recognition of problematic ODD (r = .345, $p < .001$) and ADHD (r = .188, $p < .05$) behaviors were positively associated with willingness to utilize BPT. Additionally, willingness to utilize BPT had a moderate correlation with mothers' perceived need for treatment of ODD behavior (r = .329, $p < .01$) and small correlation with mothers' perceived need for treatment of ADHD behavior (r = .521, $p < .01$). Results also showed a positive association between likelihood of utilizing BPT services to address problematic behavior and parents' marital status and higher years of education. That is, married mothers were more likely to report willingness to engage in BPT services for both the ODD (r = .230, $p < .05$) and ADHD vignette (r = 262, $p < .05$), and mothers with a higher education were more likely to utilize BPT for the ODD and ADHD vignettes (r = .236, $p < .05$, r = .233, $p < .05$, respectively). Maternal income and employment status were not significantly associated with likelihood of BPT utilization.

Table 5. Bivariate Correlations of Demographic Variables and BPT Utilization

	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
BPT utilization for ODD	__	__	__	__	__	__	__	__	__
BPT utilization for ADHD	.52**	__	__	__	__	__	__	__	__
ODD problem recognition	.35**	.11	__	__	__	__	__	__	__
ADHD problem recognition	.07	.19*	.48*	__	__	__	__	__	__
Income	.09	.15	.11	.17	__	__	__	__	__
Years of education	.24*	.23*	.22*	.20*	.19*	__	__	__	__
Marital status	.23*	.26*	-.09	-.09	-.04	-.08	__	__	__
Employment status	.04	.05	.06	.09	-.04	.11	-.02	__	__
Child treatment history	.08	-.13	.35**	.25*	-.03	.23*	.05	-.13	__
Maternal treatment history	.08	.06	.11	.24*	.14	.32**	.15	.04	.39**

Note. **$p < .05$ ** $p < .01$.

Hypothesis 2a. A series of regression analyses were conducted to examine variables that influence African American mothers' likelihood of utilizing BPT. Mothers who failed to recognize the ODD and ADHD vignette behaviors as problematic were excluded from these analyses, leaving a sample of $n = 58$ of mothers who identified ODD vignettes as problematic and a sample of $n = 65$ of mothers who identified the ADHD vignettes as problematic.

A multiple regression was conducted to examine the relative strength of child attribution or parent attributions as predictors of BPT utilization. For the ODD vignette, parent attribution significantly predicted likelihood of BPT utilization, $F(2,55) = 4.457$, $p < .05$, adj. $R^2 = .108$. Attributing the child's ODD behavior to factors within the child's control did not significantly predict utilization of BPT. For the ADHD vignette, the multiple regression model statistically predicted mothers' willingness to utilize parent training, $F(2,62) = 5.142$, $p < .05$, adj. $R^2 = .115$. Child attribution had a significant negative association with likelihood of utilizing BPT ($p < .05$). Regression coefficients and standard errors can be found in Table 6.

Table 6. Multiple Regression Analysis for Attributions and BPT Utilization

Predictor	**B**	**SE**	**β**	***p***
Mothers who recognized problematic ODD				
Child Attribution	-.083	.056	-.188	.148
Parent Attribution	.243	.085	.366	.006
Mothers who recognized problematic ADHD				
Child attribution	-.119	.037	-.440	.002
Parent attribution	.069	.044	.213	.126

Hypothesis 2b: Mediation regression analyses were conducted using the PROCESS Procedure for SPSS Version 3.1 (Hayes, 2018), in which standard errors and bootstrap confidence intervals (CIs) for indirect effects were based on 1,000 bootstrap resamples with replacement (Preacher & Hayes, 2008). This analysis was used to examine the effects of racial identity and mental health stigmatization on mothers' likelihood of utilizing BPT. Mothers' likelihood of utilizing BPT (scale of 0 to 7) was used as the outcome variable, racial identity ratings from the MIBI was used as a predictor, and mental health stigmatization ratings from the PATSPI was used as the mediator variable using model number 4. Again, these analyses excluded all mothers who failed to recognize the ODD and ADHD vignette behaviors as problematic.

The omnibus model was significant, $F(1,56) = 55.07$, $p < .05$, with racial identity and treatment stigmatization accounting for 66.7% of the variance ($R^2 = .667$). Among mothers who identified problematic ODD behaviors, racial identity significantly predicted treatment stigmatization, b = .451, p < .001. That is, mothers with higher racial identity ratings reported higher ratings of mental health treatment stigmatization. Racial identity significantly predicted BPT utilization even with stigmatization in the model, b = -.052, $p < .05$, indicating that as racial identity increased, likelihood of utilizing BPT decreased among mothers who identified problematic ODD behavior. Treatment stigmatization was associated with a significant decreased likelihood of utilizing BPT, b = -.037, $p < .05$. The results found that the standardized indirect coefficient was significant, b = -.0166, 95% BCI = -.0293, -.0034. Therefore, the negative relationship between racial identity and BPT utilization was at least partly due to the

indirect effects through stigmatization. Refer to Figure 1 for the mediation model, containing coefficients, for the ODD vignette.

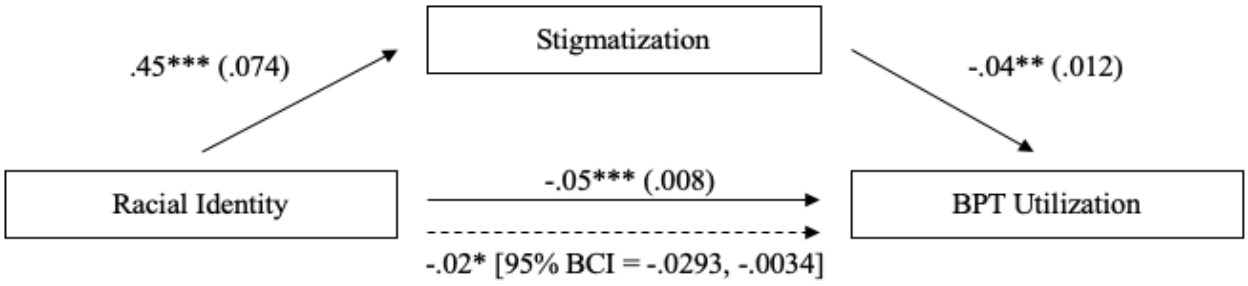

Figure 1. Standardized regression coefficients for the relationship between mother's racial identity and reported likelihood of utilizing BPT to address ODD behaviors, as mediated by mental health stigmatization. Standard error values are in parentheses. *Note*. BCI = bootstrapped confidence intervals. *p<.05, **p<.01, ***p<.001.

The omnibus model was significant, $F(1,63) = 16.75$, $p < .05$, with racial identity and treatment stigmatization accounting for approximately 35.1% of the variance ($R^2 = .3507$). Among mothers who identified problematic ADHD behaviors, racial identity significantly predicted treatment stigmatization, b = .423, $p < .05$. Racial identity significantly predicted BPT utilization even with stigmatization in the model, b = -.027 $p < .05$, indicating that as racial identity increased, likelihood of utilizing BPT decreased. Treatment stigma also added significantly to the model, b = -.0413, p < .05. The indirect effect was significant, b = -.173, 95% BCI = -.0336, -.0008. Therefore, the negative relationship between racial identity and BPT utilization was again at least partly due to indirect effects through treatment stigmatization. Refer to Figure 2 for the mediation model, containing coefficients, for the ADHD vignette.

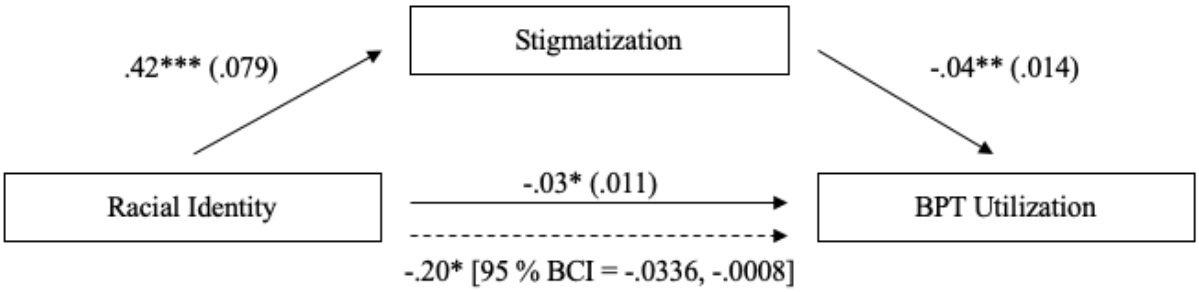

Figure 2. Standardized regression coefficients for the relationship between mother's racial identity and reported likelihood of utilizing BPT to address ADHD behaviors, as mediated by mental health stigmatization. Standard error values are in parentheses. *Note*. BCI = bootstrapped confidence intervals. *p<.05, **p<.01, ***p<.001.

Discussion

The purpose of this study was to examine factors associated with problem recognition and BPT utilization among African American mothers. The results of this study found that when presented with a child displaying clinically significant externalizing child behaviors, slightly more than half of African American mothers recognized clinically significant ODD (52%) and ADHD (58%) behavior problems. These findings are only somewhat higher than previous studies, which have found that a majority of parents who have a child with a mental health problem do not recognize their symptoms (Sayal, 2006) and are consistent with externalizing problem recognition rates in previous studies that have utilized vignettes (Thurston et al., 2015). Importantly, 42-48% of African American mothers in this sample did not identify externalizing behavior depicted in the vignettes as problematic. These results are particularly striking when considering that the mothers in this study who did recognize problematic behavior were significantly more likely to report willingness to engage in BPT.

Problem Recognition

Numerous studies have showed that importance of problem-recognition within the help-seeking pathway. Previous studies examining parental problem-recognition have found perceptions of behavior severity and impairment to be significantly associated with parental problem recognition of both childhood internalizing and externalizing problems (Tully et al., 2017). However, these studies have utilized largely Caucasian populations and few have investigated parental help-seeking among African American families. One purpose of the current study was to confirm the influence of factors commonly associated with problem recognition within Caucasian samples.

The current study found African American mothers' perception of ODD behaviors as severe and impairing to the child's daily functioning significantly predicted problem recognition. Interestingly, perceptions of behavior severity did not significantly predict problem recognition for ADHD behaviors among African American mothers. This finding suggests that although ADHD behaviors may be seen as severe by African American mothers, problem recognition of clinically significant inattentive and hyperactive behaviors relies more on mothers' perception of impairment rather than symptom severity. Not only does functional impairment seem to be a relevant construct for all families, the results of this study suggests it may be an even more culturally appropriate diagnostic criterion than ADHD symptom severity among African American families. It may be that parents attribute the ADHD behaviors described in the vignette as fairly typical to child development, regardless of their severity. Therefore, African American families may have different expectations or thresholds for acceptable versus unacceptable child beahvior that are strongly associated with the effect the behaviors have on their child's daily functioning.

This study also sought to examine whether African American mothers' own child's externalizing behavior problems would predict problem recognition. It was hypothesized that this would provide a more ecologically valid assessment of true problem recognition, as it is important to understand whether mothers who have their own child with externalizing problems would recognize problematic child behavior. Although this study did not find behavior ratings to be significantly related to problem recognition, few mothers in the present sample reported high levels of child behavior. Further, only one mother rated their own child's behavior as clinically significant. Therefore, it is important to note that the investigation of factors associated with

problem recognition and BPT utilization occurred within a population of mothers with children who do not currently demonstrate significant behavior problems.

Although many studies have hypothesized that parental beliefs about appropriate child behavior influence parental help-seeking, no study has examined the effect of specific cultural values on parents' problem recognition. Instead, the majority of research has made inferences on parenting values through parenting practices. The results of this study demonstrated that African American mothers who reported placing a higher value on child conformity were significantly more likely to recognize ODD and ADHD behavior as problematic. Conversely, African American mothers who placed a higher value on child's independence were significantly less likely to recognize problematic ODD behavior; however, this was not the case for ADHD problem recognition. It is apparent that these values play a significant role in perceiving child externalizing behaviors as problematic.

There are several possible explanations for the strong relation between externalizing behavior problem recognition and the values of child conformity and child independence. Oppositional behavior is inherently categorized as defiant, and therefore they may be more easily viewed as problematic among African American mothers that place a high value on traditionalism and obedience. Therefore, high problem recognition when a child appears argumentative and deliberately annoying toward others likely reflects the intolerance that African American families have for behavior that defies their values of respect and reflects poorly on the family. However, ODD behaviors may not be seen as problematic in African American families who expect their children to demonstrate individuality and hold their own beliefs, even if they are different from those of the family. With regard to ADHD problem

recognition, behaviors such as failure to complete tasks or tendency to interrupt others' conversations may be viewed by African American mothers as noncompliance toward authority and therefore easily viewed as problematic by mothers who value child conformity.

The findings of this study shed light on relationships that were only inferred in previous studies. For example, African American parents tend to engage in authoritarian parenting techniques that place a greater emphasis on child obedience and conformity (Lambert et. al, 2001). However, with respect to commonalities in parenting practices among African American parents it is important to note that the results of this study suggest the existence of within-group differences in childrearing values that they have differential effects on recognition of problematic externalizing behavior. Ultimately, social norms for which behaviors are undesirable, deviant, or worthy of concern are important contextual factors that have bearing on problem perception. Therefore, understanding that mothers who place a higher value on child agency will be less likely to recognize oppositional and defiant behaviors provides further support for the argument that clinician-assessed need may be incongruent with the way parents view their children's problem.

BPT utilization

Despite substantial research indicating racial disparities in BPT engagement, few studies have examined factors that influence African American parents' decision to utilize BPT after recognition of problematic child behavior. In order to understand movement along the help-seeking pathway, toward treatment selection, the current study examined the role of mothers' attributional framework for ODD and ADHD behaviors. Results indicated that mothers who recognized ODD behavior as problematic reported a greater willingness to utilize BPT, a parent-

oriented treatment, if the behaviors were attributed to problems within the parent's control. Those mothers who recognized problematic ADHD behavior were significantly less likely to utilize BPT if behavior problems were believed to be within the child's control or due to a lack of control by parent or child.

Although parental attributions and efficacy have been shown to be related to acceptability and BPT program outcomes, few studies have specifically assessed the relation between parenting attributions and enrollment in BPT programs—an important understudied area of investigation. The findings of this study suggest African American mothers who perceive their parenting as unrelated to the cause of problematic child behavior are less likely to engage in interventions that focus on parenting. Further, African American parents may need to believe that they have some level of effectiveness in addressing their child's recognized problem to engage in BPT as a treatment. Therefore, it may be critical to assess mothers' perception of the cause of their child's behavior and the relevance of their parenting strategies, before BPT enrollment. It may be that these factors relate reciprocally—having low parenting efficacy may be due to attributions that their child's behavior is not controllable and vice versa.

The present study also examined the relationships among perceived mental health stigma, racial identity, and BPT utilization. As previously mentioned, for parents of children with behavior problems, stigma may prevent parents from seeking help. However, the degree to which stigma impacts parental help-seeking has received little attention in empirical research. The results of this study found that among African American mothers who identified ODD or ADHD behavior as problematic and had a stronger racial identity reported greater mental health treatment stigma. Specifically, mental health treatment stigmatization was found to partially

mediate the relationship between racial identity and BPT utilization; that is, mental health stigmatization accounts for some, but not all, of the variance associated with decreased likelihood of African American mothers with high racial identity to utilize BPT. The results of this study support the notion that stigma is a powerful barrier to psychological help-seeking in general and provide further justification this may be especially be the case for African American parents with a stronger racial identity.

A unique strength of this study is the examination of the role mothers' racial identity plays in treatment utilization for child behavior problems. In this study, racial identity was strongly associated with increased mental health stigmatization and decreased likelihood of engaging in treatment. Several explanations may exist for the nature of this relationship. Normative beliefs that African American parents hold about their racial identity about having a mental illness (Ajzen, 1991) may be influential to BPT utilization. Additionally, substantial research has found that African Americans perceive higher levels of stigma from others in their day-to-day lives compared to their Caucasian counterparts. For example, Gary (2005) described a concept called "Double Stigma", which denotes the synergistic effect of experiencing discrimination due to both having a mental health disorder and being a member of a racial minority group. The findings of the current study highlight the experience of the African American mother, who recognizes a mental health problem in their child and yet may be unwilling to engage in an effective treatment due to fear of discrimination within not only a professional context, but also from their community.

It is important to note that mental health treatment stigmatization only partially mediated the relationship between racial identity and BPT utilization. Therefore, the results of this study

suggest the importance of considering other factors proximal to racial identity that influence African American mothers' likelihood of utilizing BPT. One possible hypothesis is that African American mother may be resistant to engaging in a treatment that is perceived to be inconsistent with their Black identity. Examining BPT utilization becomes difficult when one recognizes attempts to get help for childhood social and behavioral problems within African American families often happens informally within the context of the family's social, community, and religious network (Cauce et al., 2002; Cauce & Srebnik, 1989). Certainly, if African American mothers' norms are perceived as incongruent with those of BPT, they may not be willing to utilize mental health services in favor of having their needs met within their network. Therefore, it may be that nature of BPT does not appear relevant to this sample of African American mothers. This is important to consider, given that most BPT programs were developed using Caucasian cultural norms, beliefs, and values for parenting and optimal child development (Forehand & Kotchick, 1996).

Overall, the findings of this study support the importance of examining the established and unique factors that influence African American mothers' help seeking, as this is a particularly important step in addressing treatment engagement and addressing disparities in mental health treatment. The goal of the study presented here is to encourage and inform research seeking to identify factors contributing to the disparity in diagnosis and treatment among ethnic minority children and adolescents exhibiting significant externalizing problems. While the results of this study support patterns found in previous research conducted with majority Caucasian parents, it is important to note the unique contribution these findings lend to the literature. The current study's investigation of cultural factors, such as African American

mothers' child behavior values and racial identity, provides vital information regarding within-group variability that cannot be gained from studies employing a group differences approach. Additionally, the results of this study highlight the influence culturally-informed attitudes toward clinically significant child behavior problems and mental health services have on African American parents' movement along the help-seeking pathway. Ultimately, by identifying predictors of BPT service use, researchers will be able to improve problem identification and treatment for African American families.

Limitations, Future Directions, and Implications

This study provides much needed information regarding factors influential to the help-seeking process among African American mothers', a particularly vulnerable group. Nevertheless, these findings should be interpreted in light of some limitations, which can inform future research. First, although this study assessed parent problem recognition using vignettes, only parental help-seeking intentions were assessed and not actual help-seeking behavior. Although strongly correlated (Ajzen, 1991), intentions do not always predict actual parent behavior. To address this limitation, this study attempted to utilize a more ecologically valid strategy by asking mothers to complete questionnaires based on the vignette closest to their own child's age and through measurement of mothers' own child's behavior. However, a limitation of this study was the lack of range in behavior problems according to maternal report, as only one mother reported having a child with behavior problems that met clinical significance. Future studies would likely benefit from gaining ratings from mothers with a wider range of externalizing behaviors in order for results to be more generalizable to actual African American mothers' help-seeking behaviors.

A second limitation of the present study was the conceptualization of the depicted behaviors being a mental health problem. Recent studies have measured problem recognition through conceptualization of internalizing or externalizing symptoms as a mental health problem (Thurston et al., 2015); however, this may be influential to parents' ratings. African American parents may be less likely to conceptualize their child's behavior as a mental health problem due to stigma related to mental health diagnoses. Future iterations examining problem recognition among African American parents use different language to measure problem recognition and determine if conceptualization of behavior as specifically a mental health problem influences rates of recognition.

Thirdly, although design of the vignettes did allow for examination of clinically assessed versus parental perceived need in a 10-year-old child, threshold differences in behavior severity and the impact of child age were not addressed. Previous studies have found threshold differences in help-seeking for child mental health problems by race and ethnicity (Weisz & Weiss, 1991; Weisz et al., 1988). Future research might utilize different versions of the same vignettes varied by age of depicted child or externalizing behavior severity. Additionally, construction of vignettes in future work could might take into consideration cultural variations in labeling of mental health symptoms to determine if this improves parental problem recognition for parents from African American families (Lambert et al., 2002). Finally, the sample size utilized to address the second research question of this study was relatively small and therefore lacked statistical power. Although there was no way to anticipate how many mothers would recognize a problem, future studies should seek to gain a larger sample size with a wider range of family income.

The current study provides a clearer understanding of the variables associated with African Americans' mothers' mental health help-seeking attitudes and intentions, which can potentially help bridge a critical knowledge and service gap for this population. Parents have been described as gatekeepers to youth mental health services, and this study showed a significant difference between African American mothers' perceived need and clinically assessed need. Unless parents are able to perceive the need for services, they will neither initiate nor maintain treatment participation for themselves or their children. Given the substantial research conducted within predominantly homogeneous parent populations, it may be argued that Caucasian parents are safe in assuming that mental health recruitment and services have been developed on the basis of their ascribed cultural norms. Through awareness and discussion of the cultural variables impactful to problem recognition and treatment utilization, African American families may begin to feel that the professionals involved in the recruitment for BPT programs have an idea of what is considered problematic or consistent with family values for children growing up in neighborhoods and families like their own.

Appendix A. Consent Form

1. **Study Title**: Addressing Racial Disparities in Parent Training Enrollment: An Examination of Help-Seeking for Child Behavior Problems among African American Mothers
2. **Performance Sites:** Private and public community programs
3. **Name and Telephone Numbers of Investigators:** Mary Lou Kelley, Ph.D. (225) 578-4113
   Anna Long, Ph.D. (225) 578-7605 Kasia S. Plessy, M.A. (225) 578-6731
4. **Purpose of the Study:** This study will examine mothers' perceptions of disruptive child behavior and the cultural factors that may influence their enrollment in parent training.
5. **Participant Inclusion:** African American mothers of children aged 4-17 years.
6. **Number of Participants:** 200
7. **Study Procedures:** Participants will receive study materials that measure their perceptions of disruptive child behavior, beliefs about mental health treatment, strength of racial identity and maternal values, as well as the severity of their own child's behavior. Participants are encouraged to use investigator contact information (provided above) at any time for further discussion and/or questions regarding the study if interested. At the end of the data collection period, a raffle drawing will occur and two participants will win $50 gift cards.
8. **Benefits:** The outcome of this research study will provide practitioners and families with information that will help them better understand African American mothers' help seeking for child disruptive behavior as well as cultural factors that may influence enrollment into parenting interventions.
9. **Risks:** This study poses no foreseeable risk to participants.
10. **Right to Refuse:** You may choose not to complete the measures or quit the study at any time without any consequences.
11. **Right to Privacy:** This study may be published, but you and your child's names will not be included in the publication. No information provided by you will be linked back to you. Once data collection is completed, all identifying information (e.g., contact information) will be replaced by a code and deleted from the data file.

    This study has been discussed with me and all my questions have been answered. I may direct additional questions regarding study specifics to the investigators. If I have questions about participants' rights or other concerns, I can contact Dennis Landin, Ph.D., Chairman of the LSU Institutional Review Board, at (225) 578-8692. I agree to participate in the study described above and acknowledge the researchers' obligation to provide me with a copy of this consent form if signed by me.

_____ _____

Signature of Participant Date

Appendix B. Demographics Questionnaire

CODE: _____ Date: _____

1. What is your gender? _____
2. What is your age? _____
3. What is your racial heritage? (select all that apply)

   ___American Indian/Alaskan Native ___Caucasian/White

   ___Asian/Pacific Islander ___Hispanic/Latino

   ___Black/African American ___Other: _____

4. What is your employment status? ___Employed ___Unemployed
5. What is your marital status?

   ___Married ___Widowed

   ___Divorced ___Living with partner, if yes, how long in

   ___Single relationship? _____

6. Enter your years of education (e.g. High School = 12 years, Four-year college = 16 years, etc.):

   _____

7. What is your annual household income? _____
8. How many children (biological, stepchildren, and other children) are presently living in your home? _____
9. List the ages and gender of the children who are presently living in your home

   Child 1: age ____ gender ____ Child 4: age ____ gender ____

   Child 2: age ____ gender ____

   Child 3: age ____ gender ____

10. In all, how many children (biological, stepchildren, and others) do you have? _____

11. Have any of your children received mental health services (such as therapy, counseling, or medication)? _____ Yes _____ No

    a. If Yes: Please note what type of services were received (e.g., psychiatrist, therapist, religious counseling, etc.), and how long ago the services were received.

    _____

    Evaluate their treatment experiences (i.e. were they positive or negative?)

    _____

    _____

12. Have you ever received mental health services (such as therapy, counseling, or medication)? _____ Yes _____ No

    a. If Yes: Please note what type of services were received (e.g., psychiatrist, therapist, religious counseling, etc.), and how long ago the services were received.

    _____

    Evaluate their treatment experiences (i.e. were they positive or negative?)

    _____

    _____

Appendix C. Child Problem Vignettes

Directions: You will be asked to read two descriptions about child behavior. While reading each description below, please imagine that your child (closest in age to 10) is showing these behaviors at the age of 10. Please think of the same child for both descriptions. After each description, you will be asked to answer questions.

Vignette 1 (ODD): For the past 6 months, your 10-year-old child's mood often changes throughout the day. One minute your child is really angry and the next minute your child is fine and happy. Your child often ignores and argues with you and teachers. When you ask your child to complete chores, he/she often talks back. But some days your child is helpful around the house without being asked. Your child has recently been reprimanded at school for annoying and calling them names. Your child does not often apologize and hasn't really cared much about getting in trouble. When a classmate is mean to your child, he/she gets even with them.

	Not at All			Neutral			Very Much
1. How severe did you feel these behaviors are?	1	2	3	4	5	6	7
2. How much do you think these behaviors would affect your child's daily activities?	1	2	3	4	5	6	7
3. How much do you believe these behaviors require treatment?	1	2	3	4	5	6	7
4. How much are these behaviors caused by something within your control as a parent?	1	2	3	4	5	6	7
5. How much is parenting to blame for these behaviors?	1	2	3	4	5	6	7
6. How much are these behaviors caused by something your child's control?	1	2	3	4	5	6	7
7. How much is your child to blame for these behaviors?	1	2	3	4	5	6	7

8. What was the gender of the child you thought of as you read this description? Male / Female

9. If your 10-year-old child were displaying these behaviors, would you believe he/she has a problem? Yes / No

Directions: Please read the following description of a treatment for these behaviors. Then rate your willingness to begin this treatment for your 10-year-old exhibiting significant behavior problems similar to those as described above.

"The aim of parent training is to lessen or get rid of a child's problem behaviors at home or school and to replace them with positive behaviors with peers, parents and teachers. Parent training focuses on improving parenting skills. The therapist teaches parents to use methods such as rewarding good behavior and removing rewards or giving effective punishments for bad behavior"

10. Imagine that your child is exhibiting the behaviors described earlier. How likely would you be to start services?

Not likely			**Neutral**			**Very Likely**
1	2	3	4	5	6	7

Reminder: While reading the description below, please imagine that your SON or DAUGHTER (closest in age to 10) is showing these behaviors at the age of 10.

Vignette 2 (ADHD): Your child is a 10-year-old with problems at home and school. For the past 6 months, your 10-year-old child has shown high energy at home and school. Your child's teacher describes him/her as smart and likeable, but difficult to manage. Your child hums and makes noises, blurts answers without raising his/her hand, and always tries to be first when the teacher asks questions. Your child struggles to pay close attention to details, makes a lot of careless mistakes, and often forgets to turn in homework. At home, your child needs to be told many times to stop running, to sit still, and to listen when parents are speaking. Your child also gets distracted while doing chores and usually starts doing a different task.

	Not at All			Neutral			Very Much
1. How severe did you feel these behaviors are?	1	2	3	4	5	6	7
2. How much do you think these behaviors would affect your child's daily activities?	1	2	3	4	5	6	7
3. How much do you believe these behaviors require treatment?	1	2	3	4	5	6	7
4. How much are these behaviors caused by something within your control as a parent?	1	2	3	4	5	6	7
5. How much is parenting to blame for these behaviors?	1	2	3	4	5	6	7
6. How much are these behaviors caused by something your child's control?	1	2	3	4	5	6	7
7. How much is your child to blame for these behaviors?	1	2	3	4	5	6	7

8. What was the gender of the child you thought of as you read this description? Male / Female

9. If your 10-year-old child were displaying these behaviors, would you believe he/she has a problem? Yes / No

Directions: Please read the following description of a treatment for these behaviors. Then rate your willingness to begin this treatment for your 10-year-old exhibiting significant behavior problems similar to those as described above.

"The aim of parent training is to decrease or get rid of a child's disruptive or inappropriate behaviors at home or school and to replace them with positive interactions with peers, parents and such authority figures as teachers. Parent training focuses on enhancing parenting skills. The parent training therapist teaches parents to use methods such as rewarding good behavior and removing rewards or giving effective punishments for bad behavior"

Imagine that your child is exhibiting the behaviors described earlier. How likely would you be to start services?

Not likely			**Neutral**			**Very Likely**
1	2	3	4	5	6	7

Appendix D. Parental Attitudes Toward Psychological Services Inventory

Directions: For each item, indicate whether you strongly disagree (0), disagree (1), somewhat disagree (2), somewhat agree (3), agree (4) or strongly agree (5). The term "psychological problems" refer to reasons one might visit a professional. Similar terms include: mental health concerns, emotional problems, mental troubles, and personal difficulties. The term "professional" refers to individuals who have been trained to deal with mental health problems (e.g., psychologist, psychiatrist, social workers, and physicians).

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
0	1	2	3	4	5

1. I would not want others (friends, family, teachers, etc.) to know if my child had a psychological or behavior problem.	0	1	2	3	4	5
2. Having been mentally ill carries with it feelings of shame.	0	1	2	3	4	5
3. Important people in my life would think less of my child if they were to find out that he/she had a psychological or behavior problem.	0	1	2	3	4	5
4. I would be uncomfortable seeking professional help for my child because people (friends, family, coworkers, etc.) might find out about it.	0	1	2	3	4	5
5. I would not want to take my child to a professional because what people might think.	0	1	2	3	4	5
6. I would feel uneasy going to a professional because of what some people would think.	0	1	2	3	4	5
7. Had my child received treatment for a psychological or behavior problem, I would feel that it should be "kept secret".	0	1	2	3	4	5
8. I would be embarrassed if my neighbor saw me going into the office of a professional who deals with mental health concerns	0	1	2	3	4	5

Appendix E. The Multidimensional Inventory of Black Identity: Black Centrality

	Strongly Disagree			Neutral			Strongly Agree
1. Overall, being Black has very little to do with how I feel about myself.	1	2	3	4	5	6	7
2. In general, being Black is an important part of my self-image	1	2	3	4	5	6	7
3. My destiny is tied to the destiny of other Black people.	1	2	3	4	5	6	7
4. Being Black is unimportant to my sense of what kind of person I am.	1	2	3	4	5	6	7
5. I have a strong sense of belonging to Black people.	1	2	3	4	5	6	7
6. I have a strong attachment to other Black people.	1	2	3	4	5	6	7
7. Being Black is an important reflection of who I am.	1	2	3	4	5	6	7
8. Being Black is not a major factor in my social relationships.	1	2	3	4	5	6	7

Appendix F. Goals and Values in Adulthood Questionnaire

Directions: Please rate how important you feel it is for your child to have each of these goals or values when they grow up to be an adult?

	Not Important	A little Important	Important	Very Important	Extremely Important
1. Have respect for those who are older	1	2	3	4	5
2. Be able to get along on his/her own	1	2	3	4	5
3. Be well-mannered	1	2	3	4	5
4. Be obedient towards parents and older family members	1	2	3	4	5
5. Have gratitude, appreciation	1	2	3	4	5
6. Be able to do things on his/her own	1	2	3	4	5
7. To maintain close family relations	1	2	3	4	5
8. Be able to bounce back from setbacks	1	2	3	4	5
9. Have cultural or ethnic pride	1	2	3	4	5
10. Have a desire to help people in difficulty	1	2	3	4	5
11. Be clean and orderly	1	2	3	4	5
12. Strive to better himself/herself	1	2	3	4	5
13. Able to forgive others	1	2	3	4	5
14. Honor religion or faith	1	2	3	4	5
15. To preserve and enhance family honor	1	2	3	4	5
16. Be determined and persevere in the face of difficulty	1	2	3	4	5
17. Have kindness and compassion	1	2	3	4	5
18. Be true to himself/herself	1	2	3	4	5
19. Be comfortable with self	1	2	3	4	5

20. Have own views even if they differ from the views of others	1	2	3	4	5
21. Have a sense of purpose	1	2	3	4	5
22. Able to integrate into social groups	1	2	3	4	5
23. Not boastful or proud	1	2	3	4	5
24. Develop unique individual strengths	1	2	3	4	5
25. Have respect for those who are different than him/her	1	2	3	4	5

Appendix G. Eyberg Child Behavior Inventory

Below are a series of phrases that describe children's behavior. Please (1) circle the number describing how often the behavior currently occurs with your child **closest to the age 10**, and (2) circle either "yes" or "no" to indicate whether the behavior is currently a problem.

How often does this occur with your child, aged closest to 10-years-old?

	Never	Seldom	Sometimes	Often		Always		Is this a problem for you?	
1. Dawdles in getting dressed	1	2	3	4	5	6	7	Yes	No
2. Dawdles or lingers at mealtime	1	2	3	4	5	6	7	Yes	No
3. Has poor table manners	1	2	3	4	5	6	7	Yes	No
4. Refuses to eat food presented	1	2	3	4	5	6	7	Yes	No
5. Refuses to do chores when asked	1	2	3	4	5	6	7	Yes	No
6. Slow in getting ready for bed	1	2	3	4	5	6	7	Yes	No
7. Refuses to go to bed on time	1	2	3	4	5	6	7	Yes	No
8. Slow in getting ready for bed	1	2	3	4	5	6	7	Yes	No
9. Refuses to go to bed on time	1	2	3	4	5	6	7	Yes	No
10. Does not obey house rules on own	1	2	3	4	5	6	7	Yes	No
11. Refuses to obey until threatened with punishment	1	2	3	4	5	6	7	Yes	No
12. Acts defiant when told to do something	1	2	3	4	5	6	7	Yes	No
13. Argues with parents about rules	1	2	3	4	5	6	7	Yes	No
14. Gets angry when doesn't get own way	1	2	3	4	5	6	7	Yes	No
15. Has temper tantrums	1	2	3	4	5	6	7	Yes	No
16. Sasses adults	1	2	3	4	5	6	7	Yes	No
17. Whines	1	2	3	4	5	6	7	Yes	No
18. Cries easily	1	2	3	4	5	6	7	Yes	No
19. Yells or screams	1	2	3	4	5	6	7	Yes	No

20. Hits parents	1	2	3	4	5	6	7	Yes	No
21. Destroys toys and other projects	1	2	3	4	5	6	7	Yes	No
22. Is careless with toys and other objects	1	2	3	4	5	6	7	Yes	No
23. Steals	1	2	3	4	5	6	7	Yes	No
24. Lies	1	2	3	4	5	6	7	Yes	No
25. Teases or provokes other children	1	2	3	4	5	6	7	Yes	No
26. Verbally fights with friends own age	1	2	3	4	5	6	7	Yes	No
27. Verbally fights with sisters and brothers	1	2	3	4	5	6	7	Yes	No
28. Physically fights with friends own age	1	2	3	4	5	6	7	Yes	No
29. Physically fights with sisters and brothers	1	2	3	4	5	6	7	Yes	No
30. Constantly seeks attention	1	2	3	4	5	6	7	Yes	No
31. Interrupts	1	2	3	4	5	6	7	Yes	No
32. Is easily distracted	1	2	3	4	5	6	7	Yes	No
33. Has short attention span	1	2	3	4	5	6	7	Yes	No
34. Fails to finish tasks or projects	1	2	3	4	5	6	7	Yes	No
35. Has difficulty entertaining self alone	1	2	3	4	5	6	7	Yes	No
36. Has difficulty concentrating on one thing	1	2	3	4	5	6	7	Yes	No
37. Is overactive or restless	1	2	3	4	5	6	7	Yes	No
38. Wets the bed	1	2	3	4	5	6	7	Yes	No

Appendix H. IRB Approval

ACTION ON PROTOCOL APPROVAL REQUEST

Institutional Review Board
Dr. Dennis Landin, Chair
130 David Boyd Hall
Baton Rouge, LA 70803
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TO: Mary Lou Kelley
Psychology

FROM: Dennis Landin
Chair, Institutional Review Board

DATE: January 4, 2018

RE: **IRB#** 3990

TITLE: Addressing Racial Disparities in Parent Training Enrollment: An Examination of Help-Seeking for Child Behavior Problems among African American Mothers

New Protocol/Modification/Continuation: New Protocol

Review type: Full ___ Expedited _X_ **Review date:** 12/19/2017

Risk Factor: Minimal ___X___ Uncertain _____ Greater Than Minimal_____

Approved_____X_____ **Disapproved**_____

Approval Date: 1/4/2018 **Approval Expiration Date:** 1/3/2019

Re-review frequency: (annual unless otherwise stated)

Number of subjects approved: 200

LSU Proposal Number (if applicable)**:**

Protocol Matches Scope of Work in Grant proposal: (if applicable)

By: Dennis Landin, Chairman _____

PRINCIPAL INVESTIGATOR: PLEASE READ THE FOLLOWING –
Continuing approval is CONDITIONAL on:

1. Adherence to the approved protocol, familiarity with, and adherence to the ethical standards of the Belmont Report, and LSU's Assurance of Compliance with DHHS regulations for the protection of human subjects*
2. Prior approval of a change in protocol, including revision of the consent documents or an increase in the number of subjects over that approved.
3. Obtaining renewed approval (or submittal of a termination report), prior to the approval expiration date, upon request by the IRB office (irrespective of when the project actually begins); notification of project termination.
4. Retention of documentation of informed consent and study records for at least 3 years after the study ends.
5. Continuing attention to the physical and psychological well-being and informed consent of the individual participants, including notification of new information that might affect consent.
6. A prompt report to the IRB of any adverse event affecting a participant potentially arising from the study.
7. Notification of the IRB of a serious compliance failure.
8. **SPECIAL NOTE: When emailing more than one recipient, make sure you use bcc.**

**All investigators and support staff have access to copies of the Belmont Report, LSU's Assurance with DHHS, DHHS (45 CFR 46) and FDA regulations governing use of human subjects, and other relevant documents in print in this office or on our World Wide Web site at http://www.lsu.edu/irb*

References

Achenbach, T.M. (1991). Integrative Guide for the 1991 CBCL/4-18, YSR, and TRF Profiles. Burlington, VT: University of Vermont, Department of Psychiatry.

Alvarado, C., & Modesto-Lowe, V. (2017). Improving treatment in minority children with attention deficit/hyperactivity disorder. *Clinical Pediatrics, 56*(2), 171–176.

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed., text rev.). Washington, DC: Author.

Anderson, R., & Newman, J. (1973). Societal and individual determinants of medical care utilization in the United States. *Milbank Memorial Fund Quarterly, 51*, 95–124.

Arcia, E., & Fernández, M. C. (2003). From awareness to acknowledgement: The development of concern among Latina mothers of children with disruptive behaviors. *Journal of Attention Disorders, 6*, 163–175.

Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes, 50*, 179–211.

Bernal, G. (2006). Intervention development and cultural adaptation research with diverse families. *Family Process, 45*, 143-151.

Bevaart, F., Mieloo, C., Donker, M., Jansen, W., Raat, H., Verhulst, F., & Oort, F. (2014). Ethnic differences in problem perception and perceived need as determinants of referral in young children with problem behaviour. *European Child & Adolescent Psychiatry, 23*(5), 273-281.

Boulter, E., & Rickwood, D. (2013). Parents' experience of seeking help for children with mental health problems. *Advances in Mental Health, 11*(2), 131–142.

Boyd-Franklin, N. (1989). Black families in therapy. New York: Guilford.

Bussing, R., Koro-Ljungberg, M. E., Gary, F., Mason, D. M., & Garvan, C. W. (2005). Exploring help-seeking for ADHD symptoms: a mixed-methods approach. *Harvard Review of Psychiatry, 13*(2), 85–101.

Bussing, R., Zima, B. T., Gary, F. A., & Garvan, C. W. (2003). Barriers to detection, help-seeking, and service use for children with ADHD symptoms. *The Journal of Behavioral Health Services & Research*, 30, 176–189.

Cauce, A. M., Domenech-Rodríguez, M., Paradise, M., Cochran, B. N., Shea, J. M., Srebnik, D., & Baydar, N. (2002). Cultural and contextual influences in mental health help seeking: A

focus on ethnic minority youth. *Journal of Consulting and Clinical Psychology, 70*(1), 44–55.

Chacko, A., Jensen, S. A., Lowry, L. S., Cornwell, M., Chimklis, A., Chan, E., Pulgarin, B. (2016). Engagement in Behavioral Parent Training: Review of the Literature and Implications for Practice. *Clinical Child and Family Psychology Review, 19*(3), 204–215.

Chavira, V., Lopez, S. R., Blacher, J., & Shapiro, J. (2000). Latina mothers' attributions, emotions, and reactions to the problem behaviors of their children with developmental disabilities. *Journal of Child Psychology and Psychiatry, 41*(2), 245–252.

Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist, 59*, 614–625.

Deater-Deckard K, Dodge KA (1997). Externalizing behavior problems and discipline revisited: Nonlinear effects and variation by culture, context, and gender. *Psychological Inquiry, (8*), 161–175.

Dempster, R., Wildman, B., & Keating, A. (2013). The Role of Stigma in Parental Help-Seeking for Child Behavior Problems. *Journal of Clinical Child and Adolescent Psychology, 42*(1), 56–67.

Dixon, S. V., Graber, J. A., & Brooks-Gunn, J. (2008). The Roles of Respect for Parental Authority and Parenting Practices in Parent–Child Conflict Among African American, Latino, and European American Families. *Journal of Family Psychology: JFP: Journal of the Division of Family Psychology of the American Psychological Association (Division 43), 22*(1), 1–10.

dosReis, S., Barksdale, C. L., Sherman, A., Maloney, K., & Charach, A. (2010). Stigmatizing experiences of parents of children with a new diagnosis of ADHD. *Psychiatric Services, 61*, 811–816.

dosReis, S., Mychailyszyn, M. P., Myers, M., & Riley, A. W. (2007). Coming to terms with ADHD: How urban African-American families come to seek care for their children. *Psychiatric Services, 58*, 636–641.

Dumas, J. E., Begle, A. M., French, B., & Pearl, A. (2010). Effects of monetary incentives on engagement in the PACE parenting program. *Journal of Clinical Child & Adolescent Psychology, 39*, 302–313.

Eraldi, R. B., Mazzuca, L. B., Clarke, A. T., & Power, T. J. (2006). Service utilization among ethnic minority children with ADHD: A model of help-seeking behavior. *Administration and Policy in Mental Health and Mental Health Services Research, 33*, 607–622.

Evans, S. W., Owens, J., & Bunford, N. (2014). Evidence-based psychosocial treatments for children and adolescents with attention-deficit/hyperactivity disorder. *Journal of Clinical Child & Adolescent Psychology, 43*(4), 527–551.

Eyberg, S.M., & Pincus, D. (1999). Eyberg Child Behavior Inventory and Sutter-Eyberg Student Behavior Inventory: Professional Manual. Odessa, FL: Psychological Assessment Resources.

Fernandez, M. A., Butler, A. M., & Eyberg, S. M. (2011). Treatment outcome for low socioeconomic status African American families in parent-child interaction therapy: A pilot study. *Child & Family Behavior Therapy, 33*(1), 32–48.

Forehand, R., & Kotchick, B. A. (1996). Cultural diversity: A wake-up call for parent training. *Behavior Therapy, 27*, 187–206.

Gary, F. A. (2005). Stigma: Barrier to mental health care among ethnic minorities. *Issues in Mental Health Nursing, 26*, 979-999.

Geffken, G. R., Keeley, M. L., Kellison, I., Storch, E. A., & Rodrigue, J. R. (2006). Parental adherence to child psychologists' recommendations from psychological testing. *Professional Psychology, Research and Practice, 37*, 499–505.

Geller, J., & Johnston, C. (1995). Predictors of mother's responses to child noncompliance: Attributions and attitudes. *Journal of Clinical Child Psychology, 24*, 272–278.

Gross, D., Johnson, T., Ridge, A., Garvey, C., Julion, W., Treysman, A. B., Fogg, L. (2011). Cost-effectiveness of childcare discounts on parent participation in preventive parent training in low-income communities. *Journal of Primary Prevention, 32*(5–6), 283–298.

Hinshaw, S. P. (2005). The stigmatization of mental illness in children and parents: Developmental issues, family concerns, and research needs. *Journal of Child Psychology and Psychiatry, 46*, 714–734.

Jacobs, R. H., Klein, J. B., Reinecke, M. A., Silva, S. G., Tonev, S., Breland-Noble, A., March, J. S. (2008). Ethnic Differences in Attributions and Treatment Expectancies for Adolescent Depression. *International Journal of Cognitive Therapy, 1*(2), 163–178.

Jacobs, M., Woolfson, L. M., & Hunter, S. C. (2015). Attributions of stability, control and responsibility: How parents of children with intellectual disabilities view their child's problematic behavior and its causes. *Journal of Applied Research in Intellectual Disabilities, 29*(1), 58–70.

Johnston, C., Reynolds, S., Freeman, W. S., & Geller, J. (1998). Assessing parent attributions for child behavior using open- ended questions. *Journal of Clinical Child Psychology, 27*, 87– 97.

Keller, H., Lamm, B., Abels, M., Yovsi, R., Borke, J., Jensen, H., et al. (2006). Cultural Models, socialization goals, and parenting ethnotheories: A multicultural analysis. *Journal of Cross-Cultural Psychology, 37*, 155–172.

Lambert, M. C., Rowan, G. T., Lyubansky, M., & Russ, C. M. (2002). Do Problems of Clinic-Referred African-American Children Overlap With the Child Behavior Checklist?, *Journal of Child and Family Studies*, *11*(3), 271–285.

Lau, A. (2006). Making the case for selective and directed cultural adaptations of evidence-based treatments: Examples from parent training. *Clinical Psychology: Science and Practice, 13*, 295-310.

McKay, M. M., & Bannon, W. M. (2004). Engaging families in child mental health services. *Child and Adolescent Psychiatric Clinics of North America*, *13*(4), 905–921.

McKay, M. M., Pennington, J., Lynn, C. J., & McCadam, K. (2001). Understanding urban child mental health service use: Two studies of child, family, and environmental correlates. *Journal of Behavioral Health Services and Research, 28*, 475–483.

Miller, G. E., & Prinz, R. J. (2003). Engagement of families in treatment for childhood conduct problems. *Behavior Therapy, 34*, 517–534.

Nordstrom, A. H., Dumas, J. E., & Gitter, A. H. (2008). Parental attributions and perceived intervention benefits and obstacles as predictors of maternal engagement in a preventive parenting program. *NHSA DIALOG, 11*, 1–24.

Ogbu, J. U. (1981). Origins of human competence: A cultural- ecological perspective. *Child Development, 52*, 413–429.

Olaniyan, O., dosReis, S., Garriett, V., Mychailyszyn, M. P., Anixt, J., Rowe, P. C., & Cheng, T. L. (2007). Community perspectives of childhood behavioral problems and ADHD among African American parents. *Ambulatory Pediatrics, 7*, 226–231.

Ortiz, C., & Del Vecchio, T. (2013). Cultural Diversity: Do We Need a New Wake-Up Call for Parent Training? *Behavior Therapy*, *44*(3), 443–458.

Perry, C. E., Hatton, D., & Kendall, J. (2005). Latino parents' accounts of attention deficit hyperactivity disorder. *Journal of Transcultural Nursing, 16*(4), 312-321.

Power, T. J., Eiraldi, R. B., Clarke, A. T., Mazzuca, L. B., & Krain, A. L. (2005). Improving mental health service utilization for children and adolescents. *School Psychology Quarterly, 20*(2), 187.

Reitman, D., Currier, R. O., & Stickle, T. R. (2002). A critical evaluation of the parenting stress index-short form (PSI-SF) in a head start population. *Journal of Clinical Child and Adolescent Psychology, 31*(3), 384–392.

Reyno, S. M., & McGrath, P. J. (2006). Predictors of parent training efficacy for child externalizing behavior problems - A meta-analytic review. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, *47*(1), 99–111.

Richman, L.S., Kohn-Wood, L.P., & Willliams, D.R. (2007). The role of discrimination and racial identity for mental health service utilization. *Journal of Social and Clinical Psychology, 26*(8), 960-981.

Sanders, M. R., Ralph, A., Sofronoff, K., Gardiner, P., Thompson, R., Dwyer, S., & Bidwell, K. (2008). Every family: A population approach to reducing behavioral and emotional problems in children making the transition to school. *The Journal of Primary Prevention, 29*(3), 197-222.

Sayal, K. (2006). Annotation: Pathways to care for children with mental health problems. *Journal of Child Psychology and Psychiatry, 47*(7), 649–659.

Schnittker J, Freese J, Powell B (2000). Nature, nurture, neither, nor: Black-white differences in beliefs about the causes and appropriate treatment of mental illness. *Social Forces, 78*. 1101–1130.

Scholtens, S., Diamantopoulou, S., Tillman, C. M., & Rydell, A. (2012). Effects of symptoms of ADHD, ODD, and cognitive functioning on social acceptance and the positive illusory bias in children. *Journal of Attention Disorders*, *16*(8), 685–696.

Sellers, R. M., Rowley, S. A. J., Chavous, T. M., Shelton, J. N., & Smith, M. A. (1997). Multidimensional inventory of black identity: A preliminary investigation of reliability and construct validity. *Journal of Personality and Social Psychology, 73*, 805–815.

Slade, E. P. (2004). Racial/ethnic disparities in parent perception of child need for mental health care following school disciplinary events. *Mental Health Services Research*, *6*(2), 75–92.

Spoth, R., Redmond, C., & Shin, C. (2000). Modeling factors influencing enrollment in family-focused preventive intervention research. *Prevention Science, 1*(4), 213–225.

Srebnik, D., Cauce, A. M., & Baydar, N. (1996). Help-seeking pathways for children and adolescents. *Journal of Emotional and Behavioral Disorders, 4*(4), 210–220.

Suizzo, M. A. (2007). Parents' goals and values for children dimensions of independence and interdependence across four US ethnic groups. *Journal of Cross-Cultural Psychology, 38*(4), 506-530.

Tabachnick, B. G., & Fidell, L. S. (2006). Using multivariate statistics (5th ed.). Boston: Allyn & Bacon.

Teagle, S. E. (2002). Parental problem recognition and child mental health service use. *Mental Health Services Research, 4*(4), 257–266.

Thurston, I. B., Phares, V., Coates, E. E., & Bogart, L. M. (2015). Child Problem Recognition and Help-Seeking Intentions Among Black and White Parents, *Journal of Clinical Child & Adolescent Psychology, 44*(4), 604–615.

Tully, L. A., Piotrowska, P. J., Collins, D. A. J., Mairet, K. S., Black, N., Kimonis, E. R., Dadds, M. R. (2017). Optimising child outcomes from parenting interventions: fathers' experiences, preferences and barriers to participation, *BMC Public Health, 17*, 1–15.

Turner, E. A. (2012). The parental attitudes toward psychological services inventory: Adaptation and development of an attitude scale. *Community Mental Health Journal, 48*, 436–449.

Turner, E. A., Jensen-doss, A., & Heffer, R. W. (2015). Cultural Diversity and Ethnic Minority Psychology Ethnicity as a Moderator of How Parents' Attitudes and Perceived Stigma Influence Intentions to Seek Child Mental Health Services Ethnicity as a Moderator of How Parents' Attitudes and Perceived Stigma I. *Cultural Diversity and Ethnic Minority Psychology*, *21*(4), 1–6.

Vandiver, B. J., Worrell, F. C., & Delgado-Romero, E. A. (2009). A psychometric examination of Multidimensional Inventory of Black Identity (MIBI) scores. *Assessment, 16*(4), 337-351.

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

Vogel, D. L., Wade, N. G., & Hackler, A. H. (2007). Perceived public stigma and the willingness to seek counseling: The mediating roles of self-stigma and attitudes toward counseling. *Journal of Counseling Psychology, 54*, 40–50.

Webster-stratton, C., & Hammond, M. (1990). Predictors of Treatment Outcome in Parent Training for Families with Conduct Problem Children. *Behavior Therapy*, *21*, 319–337.

Wehmeier, P. M., Schacht, A., & Barkley, R. A. (2010). Social and emotional impairment in children and adolescents with ADHD and the impact on quality of life. *Journal of Adolescent Health, 46*(3), 209–217.

Weisz, J. R., Suwanlert, S., Chaiyasit, W., Weiss, B., Walter, B. R., & Anderson, W. (1988). Thai and American perspectives on over- and undercontrolled child behavior problems:

Exploring the threshold model among parents, teachers, and psychologists. *Journal of Consulting and Clinical Psychology, 56*, 601-609.

Weisz, J., & Weiss, B. (1991). Studying the referability of child clinical problems. *Journal of Consulting and Clinical Psychology, 59*, 266–273.

Williford, A. P., Graves, K. N., Shelton, T. L., & Woods, J. E. (2009). Contextual risk and parental attributions of children's behavior as factors that influence the acceptability of empirically supported treatments. *Vulnerable Children and Youth Studies*, *4*(3), 226–237.

Wilson, C., Gardner, F., Burton, J., & Leung, S. (2006). Maternal attributions and young children's conduct problems: A longitudinal study. *Infant and Child Development, 15, 109–121.*

Yeh, M., Hough, R. L., McCabe, K., Lau, A., & Garland, A. (2004). Parental beliefs about the causes of child problems: Exploring racial-ethnic patterns. *Journal of the American Academy of Child and Adolescent Psychiatry*, *43*, 605–612.

Young, A., & Rabiner, D. (2015). Racial/ethnic differences in parent-reported barriers to accessing children's health services. *Psychological Services*, *12*(3), 1541–1559.

Zahner, G. E., & Daskalakis, C. (1997). Factors associated with mental health, general health, and school-based service use for child psychopathology. *American Journal of Public Health*, *87*(9), 1440–1448.

Vita

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