

## ABSTRACT

Title of Document: LATINO PARENTS' PERCEPTIONS OF, AND RESPONSE TO, CHILD ATTENTION DEFICIT/HYPERACTIVITY DISORDER AND OPPOSITIONAL DEFIANT DISORDER: AN ECOLOGICAL PERSPECTIVE

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Attention and behavior problems occur at high rates among Latino children in the United States; however, Latino children are less likely than children from other racial/ethnic groups to receive treatment for these problems. Efforts to understand and address these disparities should include research to understand how Latino parents perceive and respond to child behaviors within an ecological framework, as broad contextual factors are known to influence parenting and help-seeking. To this end, the present study utilized grounded theory methodology to analyze in-depth interviews conducted with a community sample of 25 ethnically-diverse Latino mothers of varying levels of socioeconomic status (SES). The primary aims for the study were: (1) To examine parental understanding and perceptions of DSM-IV ADHD and ODD symptoms; (2) To explore and describe self-reported parenting and help-seeking

responses to clinical levels of child ADHD and ODD behaviors, as depicted in hypothetical behavioral vignettes; and (3) To explore general childrearing values and socialization goals among Latino mothers. Each of these aims were examined from an ecological perspective by considering demographic and psychosocial factors, including SES, level of acculturation, and maternal levels of depression and social support.

Four major findings emerged. First, Latino mothers did not experience significant difficulty understanding DSM-IV symptoms of ADHD or ODD and the way they perceive these behaviors is largely consistent with the respective clinical disorders. Second, parental responses to clinical levels of ADHD and ODD behaviors were linked to external versus internal causal attributions across both disorders. Third, parental socialization goals, which reflected strong values on educational/professional goal attainment and positive interpersonal skills, were associated with reported parental responses to ADHD and ODD, respectively. Finally, there were trend differences in results by level of SES. The theoretical model that emerged from this study extends existing models related to parental beliefs, parenting, and help-seeking behavior. Findings suggest important clinical implications with respect to assessing ADHD and ODD among Latino children and engaging Latino parents into parenting and school-based interventions. Results of this study will inform future research and intervention-development efforts ultimately aimed at increasing mental health service use and improving outcomes among Latino children.

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## Dedication

This work is dedicated to my family, friends, and mentors, who have loved, supported, and encouraged me during every step of this journey.

To my father, and in loving memory of my mother. El amor y el apoyo que ustedes siempre me han dado es lo que me motivó llegar hasta este punto y lo llevo conmigo siempre. Las palabras no alcanzan para poder decirle gracias suficientemente.

To my brother and sister for providing me with love, support, and never-ending laughter. “Los tres juntitos”, as mami would say, and we surely are. More importantly, thank you for bringing Yamalis, Robert, Alycia, Alexys, and Adriana into my life, and for allowing me to be a special part of the village that raises them.

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## Chapter 1: Introduction

Attention and behavior problems account for a significant number of referrals to mental health professionals among children (Alessandri, 1992; American Academy of Child and Adolescent Psychiatry, 1997; Loeber, Burke, Lahey, Winters, & Zera, 2000). In fact, attention, hyperactive/impulsive and oppositional behaviors are estimated to affect 5-10% of children and adolescents (American Psychiatric Association [APA], 2000). Clinical levels of these problems are typically classified as Attention-Deficit/Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder (ODD), which commonly co-occur with other psychological conditions (e.g., mood and anxiety disorders). Moreover, risk for increasing levels of impairment and negative outcomes is heightened in the presence of comorbid ADHD and ODD, which co-occur up to 60% of the time (Hinshaw & Lee, 2003). The constellation of attention and behavior problems noted among children with comorbid ADHD and ODD also increases the propensity for the development of the more serious delinquent behaviors associated with Conduct Disorder (CD; Loeber, 1990; Loeber et al., 2000), and thus serves as a developmental precursor to increasingly problematic behavioral outcomes.

Child attention and behavior problems are associated with impairment in multiple domains, including academic and social functioning (APA, 2000). Additionally, research focusing on long-term outcomes of children with attention and behavior problems suggests they have an increased likelihood of school drop-out, higher rates of juvenile delinquency, drug use, and significant occupational impairment as adults (Biederman, Faraone, Milberger, & Jetton, 1996; Hinshaw & Lee, 2003; Mannuzza & Klein, 1999; Loeber, 1990; Mannuzza, Klein, Bessler, & Malloy, 1993). As such, research aimed at

understanding factors that influence the emergence and developmental course of these problems is of great importance at the individual and societal levels.

The majority of the extant literature on environmental risk factors for child attention and behavior problems has established that negative parenting (e.g., harsh or inconsistent discipline) is one of the most important influences in their development and persistence (Campbell, Pierce, March, & Ewing, 1991; Dodge, 1990; Conger et al., 1992; Wahler, 1990) and that positive parenting serves as a protective factor against their emergence and persistence (Chronis et al., 2007; Gardner, Sonuga-Barke, & Sayal, 1999; Pettit, Bates & Dodge, 1997). While parenting has been directly linked to these negative child outcomes, it is necessary to examine the ways in which family-level variables interplay with broad contextual factors to influence child outcomes. Notably, consideration of socioeconomic status (SES) is imperative in light of research suggesting that low-SES has a significant negative impact on parenting, particularly as a result of increased levels of parental stress and depression (Conger et al., 1992; Lempers, Clark-Lempers, & Simons, 1989; McLeod & Shanahan, 1993; McLoyd, 1990).

Socioeconomic status has been linked more broadly to child attention and behavior problems as a function of community-level variables. In fact, research demonstrates higher prevalence rates of child attention and behavior problems in low-SES environments (McLoyd, 1990; Rutter, 1978; Scahill et al., 1999; Velez, Johnson, & Cohen, 1989). This association has been attributed to factors such as high rates of community violence, increased exposure to deviant peers, lack of social services, and attendance at low-quality schools with inadequate resources (Eamon & Mulder, 2005; O'Keefe & Sela-Amit, 1997; Pinderhughes, Nix, Foster & Jones, 2001). Thus,

consideration of the larger context in which child development occurs is critical to a more complete understanding of the emergence and course of attention and behavior problems.

This discussion is especially relevant to Latino children and families who are disproportionately represented in low socioeconomic positions, with 28% living below the poverty line (Fry & Gonzales, 2008). Moreover, results of the Supplement to the Surgeon General's Mental Health Report, focusing on culture, race, and ethnicity (2001) concluded that Latino children and adolescents have higher rates of behavior problems and delinquency, compared to rates found among Caucasian youth. In addition, research suggests that Latino youth may be at particularly high risk for the serious outcomes associated with attention and behavior problems, including school drop-out, arrests and incarceration (Martinez, Eddy, & DeGarmo, 2003). Despite demonstrated mental health needs, Latino youth underutilize services for these, and other, mental health problems (Bui & Takeuchi, 1992; Kataoka, Zhang, & Wells, 2002; McCabe et al, 1999).

While low rates of mental health service use may be partly attributable to instrumental access barriers (e.g., lack of health insurance; Stevens, Harman, & Kelleher, 2005), it has been suggested that culturally-relevant factors (e.g., beliefs and values regarding child behavior) also play an important role in the way members of various ethnic and cultural groups view and respond to child misbehavior (Arcia & Fernandez, 2003a; Eiraldi, Mazzuca, Clarke, & Power, 2006). For example, relative to Caucasian and African American families, Latino children are less likely to be diagnosed with ADHD (Cuffe, Moore, & McKeown, 2005; Rothe, 2005), particularly as a function of low levels of parent-reported symptoms (Stevens et al., 2005). Thus, it is argued that in order to formulate an accurate conceptualization of the emergence, identification of, and

parental response to, child attention and behavior problems among Latino families, research must examine these problems within the context of socioeconomic status and culture.

Census data indicate that the Latino population accounts for more than half of the growth in the total U.S. population over the last decade (Fry, 2008) and that 22% of Latinos are under the age of 18 (Fry & Passel, 2009), highlighting the need for research among this growing population. Further, it is estimated that approximately 50% of the immigrants in the U.S. today are from Latin American countries (U.S. Census Bureau, 2000), and that 35% of Latino children and adolescents are immigrants (Fry & Passel, 2009). Indeed, immigration was the second largest contributor to the increase in the U.S. Latino population over the last decade, behind births (U.S. Census Bureau, 2000). These statistics suggest that a large proportion of Latinos living in the U.S. today are recent immigrants, calling attention to the importance of examining factors associated with the process of immigration and acculturation to the U.S. culture (i.e., adoption of U.S. mainstream values and behavioral norms and English-language proficiency) among this population. Research focusing on Latino children and families that considers broad contextual factors will aid in the development of culturally-sensitive intervention programs aimed at addressing problematic child behavior *and* at decreasing critical mental health disparities within Latino families.

#### *Present Study Aims*

The present study utilized grounded theory methodology to analyze in-depth qualitative interviews regarding parental perceptions of, and response to, DSM-IV ADHD and ODD behavior, as well as general child-rearing values and socialization

goals, which were conducted with a community sample of 25 Latino mothers. The primary aims for the study were:

- (1) To examine parental understanding and perceptions of DSM-IV ADHD and ODD symptoms in a community sample of Latino mothers;
- (2) To explore and describe self-reported parenting and treatment-seeking responses to clinical levels of child ADHD and ODD behaviors, as depicted in hypothetical behavioral vignettes, among Latino mothers; and
- (3) To explore general childrearing values and child socialization goals among Latino mothers.

Each of these aims was examined from an ecological perspective by considering SES and other demographic factors, level of acculturation, and parental level of depression and social support, all of which are known to influence the way parents perceive and respond to child behavior.

## Chapter 2: Literature Review

The following discussion will begin with a review of general theoretical paradigms regarding contextual influences on parenting and child behavior. This is followed by a review of research that examines cultural childrearing values, perceptions of child behavior, and parenting within Latino families specifically, concluding with the theoretical perspective that will guide the present study.

### *Theoretical Models*

*Developmental psychopathology perspective.* Numerous theoretical and empirical models, consisting of a wide range of biological and environmental factors, have been proposed to explain the development and course of child attention and behavior problems. Early research on child psychopathology placed emphasis on single risk factors, both within the child (e.g., difficult temperament, emotion dysregulation, poor impulse control, neurological/cognitive deficits), and within their immediate environmental contexts (e.g., harsh/inconsistent parenting, parental psychopathology, socioeconomic disadvantage; Mash & Dozois, 2003). While these early models certainly contribute to current knowledge regarding the role of individual factors in the development of child attention and behavior problems, they fail to capture the complex ways in which multiple contextual factors interact over time to influence child development (Kazdin & Kagan, 1994; Mash & Dozois, 2003). Indeed, a single theory is unlikely to explain the multiple factors influencing the development of child psychopathology. Instead, it has been argued that integrative models that consider child, family, and contextual (e.g., cultural, sociodemographic) factors together is a more

comprehensive approach to understanding the interactive processes that influence child developmental outcomes.

The developmental psychopathology perspective provides a “macroparadigm” (Mash & Dozois, 2003) that integrates a broad range of theories, each placing different emphasis on specific sets of variables or processes (e.g., biological, behavioral, social-learning, affective) and proposing various mechanisms by which they influence child development. Subsumed under the developmental psychopathology perspective, they share a common focus on examining the complex and reciprocal interactions among these factors over the course of development. Moreover, emphasis is placed on understanding the role of broader contextual factors that influence and interact with child and family variables in the development of *both* normative and “deviant” child behavior (e.g., ADHD and ODD). Models based on this perspective underlie most of the contemporary research and provide the most complete understanding of the development of child psychopathology (Cicchetti & Cohen, 1995; Mash & Dozois, 2003).

*Ecological models of parenting and child development.* Consistent with the developmental psychopathology perspective, ecological models, based largely on the seminal work of Urie Bronfenbrenner (1979), suggest that child development takes place within the context of multiple, interacting ecological (i.e., contextual) systems that are embedded within one another, ranging from micro- to macro-levels (i.e., microsystem, mesosystem, exosystem, macrosystem). From this perspective, child development is thought to be the result of repeated, reciprocal interactions between the child and these ecological systems over time, with interactions growing increasingly complex as you move from micro- to macro-level systems. As such, the model suggests that the most

influential determinants of child development occur within the microsystem (i.e., the family), representing the most proximal context in which children live (Bornstein & Cheah, 2006; Bronfenbrenner & Morris, 1998).

With parent-child interactions at the center of the microsystem, it follows that parenting is a particularly critical component of this ecological system. Indeed, parenting plays a central role in shaping the child's immediate environmental experiences and long-term developmental course (Bornstein & Cheah, 2006; Bronfenbrenner & Morris, 1998). Negative parenting practices (e.g., punitive or physical discipline) have emerged in the empirical research literature as one of the most robust predictors of child attention and behavior problems (Baumrind, 1996; Baumrind, 1997; Chamberlain & Patterson, 1995).

Within the ecological framework, parenting itself is shaped by the environmental context in which the parent lives and is therefore largely influenced by the broader culture (Bornstein & Cheah, 2006; Bronfenbrenner & Morris, 1998; Goodnow & Collins, 1990; Super & Harkness, 1986; 1993), which constitutes more than ethnic group membership. As Roosa and colleagues (2000) astutely point out, ecological niches with shared values are delineated by many factors, including "social address" variables such as social class. Indeed, cultural values and factors associated with SES are both considered part of the macrosystem, suggesting that they interact to a large extent and influence the interactions between other embedded systems. Therefore, examination of parenting is incomplete without consideration of these larger contextual variables that are known to influence parenting.

Expanding on Bronfenbrenner's model, the work of Harkness and Super emphasizes the role of culture in shaping parental "ethnotheories" (Harkness & Super,

1992; 2006). Ethnotheories are considered “cultural models” which represent an “organized set of ideas that are shared by members of a cultural group” (Harkness & Super, 2006). Cultural models influence parents’ conceptualization of the skills and competencies their children should develop in order to function successfully within the culture. Accordingly, ethnotheories help to organize parenting behaviors aimed at socializing children toward different developmental goals (Harkness & Super, 1992; 2006). Further, the authors suggest that parental ethnotheories serve to structure the child’s “developmental niche” (i.e., microenvironment) as a function of the daily activities parents provide for their children (i.e., settings) and the practices they use to socialize them toward specific developmental goals (i.e., customs; Harkness & Super, 1992; 2006). Given that culturally-shaped childrearing values and goals are highlighted as a critical component of parenting, it follows that consideration of parental beliefs is essential to understanding the ways in which members of various cultures evaluate and respond to problematic child behavior (Garcia-Coll, Akerman & Cicchetti, 2000; Rubin, Mills & Rose-Krasnor, 1989; Weisz, Suwanlert, & Chaiasit, 1985).

In addition to cultural values and beliefs, several other contextual variables are known to influence parenting. As outlined in Belsky’s (1984) process model, parenting is highly influenced by contextual sources of stress and support, parental well-being and psychological functioning, and child characteristics. With regard to contextual sources of stress that affect parenting, the model emphasizes employment-related stress, including unemployment, which can arguably be extended to include other socioeconomic stressors. Belsky (1984) posits that contextual sources of stress are believed to have an indirect effect on parenting as a result of their negative effect on parental psychological

well-being (e.g., depression). Further, the availability of social support is believed to serve as an important buffer protecting parents from the negative effects of contextual stress. Finally, this model highlights the effect of child behavior and temperamental characteristics as important determinants of parenting. The relationship between parenting and child behavior is highly reciprocal, such that parenting can *both* influence and be influenced by negative child behavior (Chamberlain & Patterson, 1995; Patterson, 1982). Thus, problematic child behavior can also affect parental stress and depression. For example, mothers of children who display disruptive behavior problems report higher levels of parenting stress, negativity, and depressed mood (Johnston & Pelham, 1990; Johnston, Murray, Hinshaw, Pelham & Hoza, 2002; Ross, Blan, McNeil, Eyberg, & Hembree-Kigin, 1998). This process model underscores the need to consider broad contextual factors and child characteristics as important determinants of parenting, but fails to consider the role of parental beliefs.

The information-processing model of parenting behavior proposed by Rubin and colleagues (1989) provides a useful model for the study of parenting beliefs and behavior in response to different forms of child behavior, while considering both socio-ecological and parental “personal-social” factors. The model postulates that parental behavior is largely motivated by parents’ beliefs and expectations about appropriate child behavior and about effective parenting strategies for socializing children. In line with the ecological framework, both parenting beliefs and behaviors are thought to be highly influenced by contextual variables, including socio-ecological (e.g., SES) and “personal-social” factors (e.g., parental psychological functioning and social support; Rubin et al., 1989). Within this model, parental values and parenting are negatively impacted by

stressors associated with low-SES and by poor psychological functioning (e.g., depression) and low levels of social support. Two types of parenting strategies are delineated, namely *proactive* parenting behaviors aimed at socializing children toward specific competencies (i.e., socialization goals) and *reactive* behaviors aimed at modifying or eliminating maladaptive behaviors. Given the challenging nature of child attention and behavior problems, *reactive* parenting is of particular relevance to the current discussion because they are likely to be elicited by these behaviors. Moreover, reactive parenting strategies are thought to be motivated by “reactive information processes” in which attributions about the cause of the child’s behavior and affective reactions (e.g., feelings of anger, disappointment) are believed to collectively influence the parenting strategies they use in response to the child’s maladaptive behavior.

In order to fully understand how parents might respond to significantly problematic child behavior such as ADHD and ODD, parental help-seeking, and the ways in which help-seeking is influenced by parental beliefs and contextual factors, should also be examined. The help-seeking behavior model of Eiraldi and colleagues (2006) suggests that problem recognition (i.e., recognition of behavior as a significant problem) is the first step in parental help-seeking for child behavior. This model extends previous mental health help-seeking models that also note problem-recognition as the first step (e.g., Cauce et al., 2002; Goldsmith et al., 1988; Pescosolido, 1992a, 1992b; Srebnik, Cauce, & Baydar, 1996) and focuses specifically on help-seeking for ADHD among low-income and ethnic minority youth. Eiraldi and colleagues (2006) posit that contextual and demographic factors, such as culture, SES, and various parent characteristics, play an important role in problem-recognition and in subsequent help-seeking. Thus, similar to

the information-processing model of parenting behavior (Rubin et al., 1989), this model highlights the role of parental perceptions of behavior, and views these perceptions specifically as a determinant of help-seeking.

Whether parents perceive behaviors as significantly problematic enough to warrant professional help-seeking is highly related to cultural and contextual factors. Indeed, by definition, behaviors that are viewed as “problematic” or “deviant” are those that deviate from cultural and societal norms. In their “threshold model”, Weisz and colleagues (1985; 1988) assert that the overarching culture helps to set adult thresholds for distress (i.e., “distress thresholds”) in response to different forms of child behavior. As a result, parental tolerance for problematic child behavior is influenced by larger cultural values and influences the manner in which parents respond to the child’s behavior (Lambert, Weisz, & Knight, 1989; Weisz, Suwanlert, & Chaiyasit, 1985; Weisz et al., 1988).

The preceding discussion highlights important theoretical models that emphasize links between parental perceptions of behavior and both parenting and help-seeking responses to child behavior, as a function of childrearing values and socialization goals, socioeconomic and psychosocial factors, and affective reactions to child behavior. Despite the availability of these models, surprisingly few empirical studies have examined these complex interactions with regard to clinical-level child behaviors such as ADHD and ODD. The relative lack of research in this area is particularly surprising in light of the overwhelming amount of research highlighting parenting, environmental context, and parental psychosocial factors as important predictors of the development, course, and treatment outcomes of child ADHD and ODD (Campbell, Pierce, March, &

Ewing, 1991; Conger et al., 1992; Dodge, 1990; Eamon & Mulder, 2005; O'Keefe & Sela-Amit, 1997; Pinderhughes, Nix, Foster, & Jones, 2001; Wahler, 1990).

Further, existing models consider parenting and help-seeking responses to child behavior separately, and therefore do not provide a comprehensive understanding of parental response to clinical-level child behavior such as ADHD and ODD. Given the clinical nature of these disorders which warrants treatment, and the fact that evidence-based psychosocial treatments for both disorders center on parenting (Pelham, Wheeler, Chronis, 1998), it is essential to consider the ways in which parenting and help-seeking responses coincide. This is particularly relevant in light of research demonstrating that parents who are not in treatment may employ a variety of negative or ineffective parenting strategies in response to child behavior problems which may actually exacerbate maladaptive child behavior. To address this gap, research is needed to bring developmental and clinical bodies of literature together in order to develop a more comprehensive model regarding parenting and help-seeking.

The literature in this area is particularly limited with respect to Latino children and families. The paucity of research among this population is troubling in light of statistics suggesting that Latino children are at elevated risk for the development of child attention and behavior problems and more serious negative consequences resulting from these problems, primarily as a function of their overrepresentation in low-SES environments (DHHS, 2001; Martinez et al., 2003). Moreover, low-income Latinos demonstrate very low rates of service utilization for these disorders, suggesting high levels of unmet need. Research among this population is sorely needed to address these mental health disparities.

## *Latino Children and Families*

*Childrearing values and socialization goals.* Empirical and theoretical literature describing beliefs, values and socialization goals regarding child behavior among Latino parents has demonstrated the presence of common values and parenting beliefs among Puerto Rican (Gonzalez-Ramos, Zayas, & Cohen, 1998; Harwood, Handwerker, Schoelmerich, & Leyendecker, 2001; Harwood, Leyendecker, Carlson, Asencio, & Miller; 2002; Harwood & Miller, 1991), Mexican (Delgado & Ford, 1998), Cuban (Szapocznik, Scopetta, de los Angeles, & Kurtines, 1978), and Central American (Leyendecker, Harwood, Lamb, & Schoelmerich, 2002) parents. In any discussion pertaining to Latino families, it is essential to keep in mind that Latinos are a heterogeneous population, with large variations in country of origin and in traditions, values and beliefs. Thus, it is not possible to make generalizations that apply to all Latino groups. However, the foregoing discussion may provide a *general* understanding of the context in which Latino children are reared.

Research suggests that many Latino societies demonstrate values that are congruent with a collectivist (i.e., sociocentric, interdependent) value system as opposed to the predominantly individualistic (i.e., egocentric, independent) values noted within American culture (Harwood et al., 2001; 2002). Collectivism emphasizes “the fundamental connectedness of human beings to one another”, whereas the individualistic societies perceive “individuals as... independent, self-contained, and autonomous...” (Harwood et al., 2002, p.24). These constructs reflect cultural values at the broad societal level (Triandis, 1995), and therefore play an important role in organizing family structure

and the beliefs parents hold about childrearing and child behavior within cultural groups (Suizzo, 2007).

Empirical and theoretical research demonstrates family values and parenting beliefs consistent with the collectivist perspective among Latino families. First, a high regard for *familismo* [familism] has been noted among many Latino groups (Fontes, 2002; Harrison, Wilson, Pine, Chan, & Buriel, 1990; Harwood et al., 2002; La Roche, 2002; Organista, 2007). *Familismo* refers to “feelings of loyalty, reciprocity, and solidarity towards members of the family, as well as to the notion of the family as an extension of the self” (Cortes, 1995). Also, the value of *familismo* is reflected by high levels of affiliation, cooperation, and emotional and instrumental interdependence among network members (Organista, 2007). *Familismo* is at least partly displayed by the presence of extensive social networks, made up largely of extended family members (Garcia, 1993; La Roche, 2002; Miller & Harwood, 2001).

An extended family network is an important resource among Latino families, providing assistance in day-to-day functioning and various forms of social support. This emphasis on family loyalty, unity and reciprocity serves a protective role in the development of psychosocial problems in parents (e.g., depression) and children (e.g., internalizing and externalizing problems) by reducing the negative impact of environmental stressors (e.g., acculturative stress) on the family system (Bacallao & Smokowski, 2007; MacPhee, Fritz, & Miller-Heyl, 1996; Sabogal, Marin, Otero-Sabogal, Marin, Perez-Stable, 1987). In addition to social support, an interdependent extended family structure is thought to play an important role in child socialization, providing a “changing cast of caregivers” who are involved in socializing and disciplining children

within Latino families (La Roche, 2002). A high regard for *familismo* also suggests that extended family members may significantly influence the child-rearing values and socialization practices of parents in the network.

In line with this family structure, there is an expectation for children to demonstrate high levels of respect and obedience toward all adult family members, including extended family members such as grandparents, aunts and uncles (Calzada & Eyberg, 2002; Zayas & Solari, 1994). This expectation is emphasized by the value of *respeto* [respect], which refers to the level of obedience Latino children are expected to display toward adult authority figures (Harwood et al., 2002; Zayas & Solari, 1994). This value reflects the collectivistic perspective in that it “assumes appropriate relatedness... [and] involves, by definition, knowing the level of courtesy and decorum required... in relation to people of a particular age, sex, and social status” (Harwood et al., 2001; Harwood, Miller, & Irizarry, 1995, p. 98). Related to this is the expectation that children display “proper demeanor” (i.e., appropriate manners and behavior), particularly in public contexts (Gonzalez-Ramos et al., 1998; Harwood, 1992; Harwood et al., 1995; 2001; 2002; Harwood & Miller, 1991; Miller & Harwood, 2001). This expectation is reflected by the concepts of *bien educado* versus *malcriado* (Organista, 2007). While the term *bien educado* literally translates to being “well-educated”, it is not necessarily related to academic achievement. Rather, it reflects the expectation that children demonstrate behaviors that suggest to others that they are being raised properly versus demonstrating disrespectful behavior that might suggest the opposite (i.e., *malcriado* [poorly raised]; Arcia, Reyes-Blanes, & Vazquez-Montilla, 2000; Borrego, Anhalt, Terao, Vagas, & Urquiza, 2006; Organista, 2007). Although this is similar to *respeto*, this

value is somewhat indicative of the idea that child behavior is a direct reflection of parenting. Therefore, when children misbehave, it may be viewed as a poor reflection on their parents.

Research examining childrearing values and socialization goals among Latino parents has consistently demonstrated the importance of family relatedness, and obedient and respectful child behavior among Latino families. For example, a study by Gonzales-Ramos and colleagues (1998) asked their sample of low-income Puerto Rican mothers living in urban areas of Puerto Rico (N=80) to rank order the importance of various socialization goals. This study found that mothers rated honest, respectful, and responsible behavior (i.e., congruent with *respeto* and “proper demeanor”) as highly important socialization goals for their preschool children, but ranked values characteristic of U. S. mainstream culture (e.g., independence and creativity), as least important goals. Similarly, a study conducted among low-income Mexican-American ( $n=30$ ) and Caucasian ( $n=30$ ) parents found that Mexican-American mothers were more likely to value conformity, politeness, and obedience more than independence and self-direction, whereas the reverse was true for Caucasian mothers (Rodriguez & Olswang, 2003). These results are consistent with another study comparing the socialization goals of low-income Puerto Rican ( $n=30$ ) and Caucasian ( $n=30$ ) parents enrolled in Head Start programs, in which Puerto Rican parents placed more emphasis on values of respect and obedience toward parents, teachers, and grandparents (i.e., *respeto*), and having close family relationships than did Caucasian parents (Achhpal, Goldman, & Rohner, 2007). Taken together, these studies highlight an emphasis on respect, proper demeanor, and family closeness among the Latino samples. However, all of these studies were

conducted among *low-income* Latino parents, calling into question the degree to which values of respect and proper demeanor are a function of the intersection between culture and SES.

A series of studies by Harwood and colleagues has attempted to address this gap in the literature by comparing desirable and undesirable child socialization goals of low- and middle-income Puerto Rican mothers living in Puerto Rico and in the U.S., to the socialization goals of Caucasian mothers (e.g., Carlson & Harwood, 2003; Harwood, 1992; Harwood & Miller, 1991; Harwood et al., 1996; 1999; Miller & Harwood, 2001). This program of research specifically examines beliefs and parenting behaviors related to parent-infant and parent-toddler interactions and attachment. In general, results of these studies consistently demonstrate that both low- and middle-income Puerto Rican mothers living in Puerto Rico and on the U.S. mainland hold beliefs that are more consonant with the value of “proper demeanor” whereas Caucasian mothers emphasize the value of “self-maximization” to a higher degree (i.e., independent/self-directed; Harwood, 1992; Harwood & Miller, 1991; Miller & Harwood, 2001). Moreover, in a study examining associations between SES and culture (i.e., ethnic group membership) with parenting beliefs and goals (Harwood et al., 1996), results demonstrated that both SES and culture were differentially associated with values. Across levels of SES, Puerto Rican mothers were more likely to emphasize proper demeanor, though there was a trend for middle-SES Puerto Rican mothers to note values associated with self-maximization. On the other hand, differences emerged by SES for the Caucasian mothers, indicating that lower-SES Caucasian mothers were more likely to endorse the value of proper demeanor, whereas middle-SES Caucasian mothers were more likely to endorse values associated

with self-maximization. Results of these studies highlight the presence of overarching cultural values among these samples of Puerto Rican parents consistent with the general literature related to Latino cultural values of *respeto* and proper demeanor; however, SES seems to play an important role in the degree to which mothers emphasize these values.

Considered together with the seminal work of Kohn (1969), suggesting that values of conformity and obedience are more pronounced among low-SES groups, more research is needed to understand the degree to which an emphasis on respect, obedience, and proper demeanor are related to culture versus SES among Latino parents.

Additionally, these studies have not consistently included measures of acculturation, presumably because they attempted to hold culture “constant” by including mothers that had resided in Puerto Rico all their lives. However, given the U.S. citizenship status of all Puerto Ricans and the significant “Americanization” of the island itself, it is likely that mainstream values have permeated the island culture to at least some degree, warranting consideration of level of acculturation in these studies. Finally, given that low-SES and lower levels of acculturation overlap to a high degree, it is important to consider both of these factors in examining parental socialization goals.

The degree to which parents adhere to and emphasize culturally-rooted child-rearing values versus mainstream values will vary as a function of level of acculturation. The link between cultural values and acculturation has been demonstrated in several studies. For example, a study examining values pertaining to child behavioral and cognitive developmental goals in the school setting among Cambodian-immigrant ( $n=62$ ), Mexican-immigrant ( $n=90$ ), Filipino-immigrant ( $n=38$ ), Vietnamese-immigrant ( $n=54$ ), and U.S.-born Mexican (i.e., Mexican-American.;  $n=78$ ) and Caucasian ( $n=37$ )

parents, demonstrated differences between immigrant and U.S.-born parents (Okagaki & Sternberg, 1993). Specifically, immigrant parents from all ethnic groups were more likely than American-born parents to value conformity and obedience versus autonomous behavior, whereas the reverse was true for both Caucasian and Mexican-American parents born in the U.S. (Okagaki & Sternberg, 1993), with Caucasian parents being the most likely to emphasize autonomous child behavior. These results suggest that less acculturated parents placed more emphasis on conformity than do more acculturated parents. Interestingly, all of the immigrant groups included in this study were from highly collectivist cultures, suggesting potential overlap between the broad construct of collectivism and *respeto* and conformity, as discussed above. However, it is again difficult to discern whether the emphasis on respect, obedience, and conformity is related to culture or to SES more generally, considering that recently-immigrated and less acculturated parents are also more likely to be of low-SES positions.

A study examining the value of *familismo* among a diverse sample of Latino ( $n=452$ ) and Caucasian ( $n=227$ ) adults also demonstrated some associations with acculturation (Sabogal et al., 1987). Results suggested that a specific dimension of *familismo*, namely the reliance on family members as “behavioral and attitudinal referents”, was negatively associated with level of acculturation. This finding has important implications for the role of acculturation in the degree to which extended family members influence parenting and child-rearing values, suggesting that more acculturated Latino parents may receive input and advice from a more diverse social network than less acculturated parents, who may largely receive input from within their family network. However, results of this study suggested a higher degree of adherence to

this value *across* all levels of acculturation for Latinos relative to Caucasian adults, suggesting that *familismo* is a core Latino family value, which is present even among the most acculturated parents (Sabogal et al., 1987).

In sum, the cultural values discussed herein are likely to have an important influence on the manner in which Latino parents evaluate and respond to child behavior, but have not yet been directly examined with respect to *problematic* child behavior such as child ADHD and ODD. Additionally, research in this area is limited by the fact that it has largely been conducted among low-SES parents, and when middle-SES parents were included, level of acculturation was not measured as a contributing variable. An understanding of the role of these values in parental perceptions of child attention and behavior problems, and their interactions with SES, level of acculturation, and other contextual variables, would increase our understanding of subsequent parenting reactions. This knowledge may also contribute to a greater understanding of barriers and disparities in service use for ADHD and ODD among Latino families.

*Perceptions of child attention and behavior problems.* Available literature offers limited knowledge about treatment-seeking for ADHD and child disruptive behavior problems among Latino parents. For example, a study including 62 predominantly low-income Cuban ( $n=39$ ), Dominican ( $n=11$ ), and Puerto Rican ( $n=12$ ) mothers of children referred for ADHD/ODD-like behaviors, used qualitative and quantitative methods to explore mothers' paths from "problem-recognition" to treatment-seeking (Arcia & Fernandez, 2003a). Results indicated that the largest proportion of mothers (61%) noted hyperactivity and aggression/temper tantrums as the main behaviors that prompted them to seek services, followed by the presence of school complaints about child behavior

(56%), compared to a much smaller proportion (32%) who noted attention deficits as the reason they sought services.

Examining the concordance between maternal reports of child behavior and subsequent diagnoses suggests a disconnect between the behaviors mothers report and the diagnoses assigned (Arcia & Fernandez, 2003a). For example, reports of oppositional and aggressive behaviors were reported for children with ADHD at a higher rate than might be expected from the number of ODD diagnoses subsequently assigned to the children in this study (Arcia & Fernandez, 2003b). These findings might suggest that parents' perceive some ADHD behaviors (e.g., impulsive behaviors such as interrupting, blurting out *or* inattentive behaviors such as failing to follow through on parental requests) as oppositional or disrespectful, and perhaps report them in that manner. Additionally, if certain behaviors are considered to be particularly contrary to parental expectations or overarching socialization goals, parents may be most bothered by those behaviors and thus be more likely to focus on those behaviors when reporting their concerns.

Findings also indicated that mothers used many anxiety-related descriptions for their child's hyperactive and restless behaviors (Arcia, Castillo, & Fernandez, 2004). While mothers did not emphasize fears *per se*, they made references to the child's "nervios" (nervousness). Although subsequent evaluation of parents' narratives by clinical psychologists suggested that 48% of the children demonstrated clinical levels of anxiety, it is difficult to discern whether the children actually had anxiety disorders, or whether mothers simply perceived and reported ADHD behaviors in that manner. Finally, while inattentive behaviors were largely overlooked by mothers, when they did mention them, mothers tended to characterize inattentive behaviors in terms of shyness (i.e.,

“*timido*”, “*penoso*”). Despite less of a focus on inattentive behaviors, a significant proportion of children were subsequently diagnosed with ADHD-Combined Type, suggesting clinical levels of inattentive behaviors that mothers did not consider among their primary concerns (Arcia & Fernandez, 2003a, 2003b). In sum, parental perceptions of behavior influence the manner in which symptoms are reported and could therefore influence subsequent clinical diagnoses.

Incongruence between the perceptions of family members with more “traditional” values versus the way these behaviors are characterized within the mainstream U. S. culture was emphasized throughout the narratives. This is pointedly illustrated by the statement: “In my country, if children act like this, they are called ‘*malcriados*’, here they are called hyper” (Arcia Fernandez, & Jaquez, 2005, p. 118). This sentiment emerged as a salient theme in another qualitative study among primarily low-income Latino parents of children with ADHD ( $N=24$ ), predominantly of Mexican descent ( $n=13$ ; Perry, Hatton, & Kendall, 2005). When asked to describe their experiences managing their child’s ADHD behaviors within their social environment before and after having their child diagnosed with ADHD, one of the most salient themes parents discussed was feeling as if they were “living between two cultures”. In other words, parents reported that the disruptive behaviors exhibited by their child were not consistent with Latino family expectations of “good behavior” and “manners”. Additionally, they reflected on societal values that Latino parents are expected be able to “handle the children” and a tendency among their peers to “blame the parents for a lack of discipline” (Perry et al., 2005, p. 316). Parents also described feelings of stigma and shame resulting from disruptions in social relationships. For example, mothers reported feeling particularly badly when

friends and family members did not want them to visit if they brought their children (Perry et al., 2005). This is consistent with quantitative analyses from Arcia and Fernandez (2003a), suggesting that mothers who felt stigmatized or socially isolated as a result of their child's behavior were more likely to seek services earlier than mothers who did not feel stigmatized.

Together, results of these studies suggest that parental concern regarding child behavior is at least partly determined by culturally-shaped values and beliefs regarding appropriate child behavior. Following from this discussion, it appears that Latino parents may be particularly disturbed by child behavior that is perceived as disrespectful or highly inappropriate, which are incongruent with the values of *respeto* and *proper demeanor*. Additionally, negative feedback from parents' family members and peers suggesting an inability on the parents' part to control or manage their child's behavior may increase parents' negative evaluations of child behavior, alluding to an emphasis on *familismo*. While extrapolations can be made based on the literature discussed above regarding Latino child-rearing values, caution is taken in drawing conclusions about the role of these cultural values in parental perceptions of child attention and behavior problems because neither cultural values nor level of acculturation were directly examined in these studies.

This body of literature is undoubtedly useful, but is limited by the fact that it represents the perceptions of *parents who have sought treatment for their children's behavior* and therefore, does not necessarily generalize to the large proportion of Latino parents who do not seek mental health services for these child behaviors. This sampling bias represents a significant limitation in the existing literature. Given the notable gap

between high levels of estimated risk for these disorders and needs among Latino children and low rates of service use (Alegria et al., 2002; Bui & Takeuchi, 1992; Hough et al., 2002; Katkaoka, Zhang & Wells, 2002; McCabe et al, 1999), research efforts should focus on better understanding parental perceptions of, and response to, these child behaviors prior to seeking services. In fact, research in this area consistently demonstrates that a significant barrier to mental health service use among racial and ethnic minority parents is a lack of perceived need for professional services (e.g., Bussing, Zima, Gary, Garvan, 2003; Yeh, McCabe, Hough, Dupuis, & Hazen, 2003), suggesting that parents might employ other strategies (e.g., discipline strategies) to address problematic child behavior (Bussing & Garry, 2001; Bussing, Kor-Ljungberg, Williamson, Gary, Garvan, 2006). The perceptions of these non-treatment-seeking parents regarding child ADHD and ODD have not been captured in existing studies.

Another important limitation of existing literature in this area is the lack of consideration of parental psychosocial factors. As outlined in the information-processing model discussed above (e.g., Rubin et al., 1989), maternal psychological functioning and level of social support play an important role in maternal perceptions of child behavior and are believed to mediate the link between beliefs and subsequent parenting response. Specific to ADHD and ODD, mothers of children who display these behaviors report higher levels of parenting stress, negativity, and depressed mood (Johnston et al., 2002; Johnston & Pelham, 1990; Ross et al., 1998), further underscoring the need to examine the role of these parental psychosocial variables. Thus, many questions remain regarding how Latino parents perceive and respond to inattentive and disruptive behaviors, particularly among parents of *non-referred* children.

*Reactive parenting.* It is of particular importance to examine the parenting strategies Latino parents might employ in attempting to address problematic child behavior, in light of research which demonstrates that parenting is one of the most important contextual factors in predicting long-term outcomes for children with ADHD (e.g., Chronis et al., 2007), and given that evidence-based treatments for ADHD and ODD largely focus on parenting skills training (e.g., Barkley, 1997).

Research examining specific parenting responses to problematic child behavior among Latino parents is sparse. As noted above, “parental response” to child attention and behavior problems among Latino families has typically been studied with samples of treatment-seeking parents. While this literature does not adequately assess parenting strategies aimed at addressing child behavior prior to seeking treatment, some information about use of reactive parenting strategies can be drawn from the treatment-seeking literature discussed in the preceding section. For example, in the study by Perry and colleagues (2005) parents reported that prior to learning that their child had ADHD, they often responded to the child’s disruptive behavior by using increasing levels of punishment. Although the use of spanking was alluded to during qualitative discussions, data regarding use of specific parenting strategies was not gathered, so it is difficult to know which forms of punishment (e.g., spanking, removal of privileges, etc.) parents used in response to child behavior (Perry et al., 2005).

The belief that discipline is the appropriate response to child behavior problems was also demonstrated in a study examining predictors of premature treatment termination among 50 Mexican American families seeking outpatient services for child emotional and behavioral problems (McCabe, 2002). Specifically, results indicated that

parents who endorsed the belief that child emotional and behavioral problems should be handled “within the family” and addressed with increased discipline were more likely to terminate treatment after the first session (McCabe, 2002). In this study, data pertaining to the specific types of behavioral problems for which treatment was being sought or the specific forms of discipline parents endorsed were not presented. Therefore, conclusions can not be drawn about the degree to which these results relate to parental response to child ADHD and ODD behaviors or the reasons parents terminated after just one session. Nevertheless, results of this study generally support the notion that Latino parents may hold beliefs regarding the appropriate course of action for addressing child behavior problems that emphasizes increased use of parental discipline. Moreover, Latino parents may be particularly intolerant of perceived disrespect or socially disruptive child behavior, which may be more likely than other forms of behavior to elicit increasingly firm or coercive parental responses (Fontes, 2002; Organista, 2007; Zayas & Solari, 1994). A better understanding of the beliefs Latino parents hold regarding the appropriate parenting response (including both parenting behavior and treatment seeking) could be used to increase the cultural sensitivity of parenting interventions in an effort to increase treatment use, compliance, and retention.

The manner in which Latino parents respond to child attention and behavior problems has important treatment implications, particularly for behavioral parent training interventions, which have been identified as evidence-based treatments for child ADHD and ODD (Brestan & Eyberg, 1998; Pelham, Wheeler, & Chronis, 1998). In general, parenting programs focus on teaching parents various strategies intended to modify the antecedents (e.g., providing structure and clear instructions for task completion) of child

behavior and to provide consistent positive and negative consequences to manage negative child behavior (Chronis, Chacko, Fabiano, Wymbs, & Pelham, 2004). Parenting skills covered in a majority of parent training programs center on *both* responding to negative child behavior using non-physical strategies (e.g., ignoring, time out, response cost), as well as responding to prosocial child behavior with praise and rewards (Miller & Prinz, 1990). However, most of the validated parenting programs have been developed and tested primarily with middle-class, Caucasian families (Forehand & Kotchick, 1996, 2002; Herschell, Calzada, Eyberg, & McNeil, 2002; Wood & Baker, 1999), limiting their generalizability for use with other racial and ethnic minority groups.

The degree to which parents accept and use the recommended behavioral parenting strategies will be highly correlated with their existing parenting ideologies. For example, the emphasis Latino parents place on *respeto* implies high expectations for child compliance to parental requests, which may influence the acceptability of contingent reinforcement strategies if parents are unwilling to reward the child for behavior that is already expected of them. Indeed, focus group data from a pilot study focusing on the adaptation of parent training for Mexican-American families suggests important beliefs about discipline that are incongruent with the behavioral skills taught in parenting programs (McCabe, Yeh, Garland, Lau, & Chavez, 2005). Specifically, this study found that mothers emphasized a strict parenting style and viewed both time out and ignoring child misbehavior as “too mild” (McCabe et al., 2005), suggesting a disconnect between their child-rearing values and some of the core strategies typically included in parenting programs. Given that parenting programs are recommended for the wide range of child ADHD and ODD behavior, it is important to obtain a clearer

understanding of *which* child behaviors motivate parents to employ “stricter” forms of parenting. This would allow clinicians to better understand underlying motivation for their response to child behaviors, which would be valuable clinical information in engaging Latino parents into treatment for ADHD and ODD.

A study examining parenting among a large sample (N=1,056; 80% Caucasian; 12% African American, 6% Latino) of urban mothers with toddler-aged children (Fox, Platz & Bentley, 1995) suggested significant differences in parenting beliefs and practices between lower- SES and higher-SES mothers. Results indicated that lower-SES mothers held higher expectations regarding child development (e.g., child’s ability to feed themselves), were more likely to endorse more frequent use of discipline (e.g., corporal punishment), and displayed lower levels of nurturing behaviors compared to higher-SES mothers. This pattern of results was demonstrated across racial/ethnic groups, suggesting that SES is uniquely related to parenting beliefs and behaviors responses.

Another study, conducted among a sample of 978 Caucasian and African American parents of kindergarten-aged children, found that low-SES parents from both ethnic groups were more likely than higher-SES parents to endorse the belief that physical discipline was useful in addressing negative child behavior, which was associated with greater use of those strategies (Pinderhughes et al., 2000). These results are consistent with the bulk of research in this area which has consistently demonstrated that low-SES parents use higher levels of negative parenting and lower levels of positive practices (see Hoff, Laursen, & Tardiff, 2002, for a review). Given that most of the research conducted among Latino parents has almost exclusively included low-income

parents, SES, ethnicity, and culture are consistently confounded in the literature and make it difficult to disentangle the influence of each on parenting.

Risk for the development of depression is heightened in the context of economic disadvantage and stress (Eamon & Mulder, 2005), suggesting important interactions between SES and maternal depression that may negatively influence parenting. A study examining this association among a sample of Mexican American ( $n=167$ ) and Caucasian ( $n=111$ ) parents with adolescents (ages 11-14) found that economic stressors predicted higher levels of parental depressive symptoms, which in turn predicted higher levels of hostile parenting practices, among mothers and fathers in both ethnic groups (Parke et al., 2004). A similar study by Barrera and colleagues (2002) utilizing a predominantly Mexican-American sample ( $n=175$ ) of 300 parents and adolescents demonstrated an association between economic stress and adolescent internalizing problems, which was accounted for by higher levels of maternal depressive symptoms and a subsequent reduction in use of positive parenting practices. These studies suggest an important mediating role of parental depression in the link between SES and parenting.

Research also suggests that living in disadvantaged neighborhoods may influence parents to develop more restrictive practices in order to promote child behavior that is adaptive in dangerous environments (Dubrow & Garbarino, 1989; Steinberg, Mounts, Lamborn, & Dornbusch, 1991). In fact, this sentiment was expressed in a recent qualitative study conducted among low-income Puerto Rican ( $n=19$ ) and Dominican ( $n=44$ ) parents living in New York City. Parents reported that they needed to exert control over adolescents' behaviors in order to protect them from perceived danger and opportunities to engage in risky behavior within their urban environmental context.

Moreover, parents emphasized the values of obedience and *respeto* among their adolescents in order to *both* protect their adolescents from dangerous situations and to instill *respeto*. This is pointedly noted in an excerpt from one of the focus groups in which mothers commented “you gotta be strict from the beginning and you gotta keep holding on to that strictness... at that age you should be strict, because they’re growing up and you want them to know when ‘no’ is ‘no’ is ‘no’” (Guilamo-Ramos et al., 2007; p. 22). Research suggests that an emphasis on parental control and respect for authority is beneficial within disadvantaged and high crime neighborhoods, while autonomy-granting parenting may be less adaptive in these environments (Lamborn, Dornbusch, & Steinberg, 1996). In line with the ecological and information-processing models discussed above, these studies support the notion that parenting beliefs and behaviors are influenced by the larger socio-economic ecology of the family and motivate the use of specific parenting practices that are congruent with those beliefs.

Following immigration, parents may also be increasingly likely to adopt restrictive parenting strategies. For example, a qualitative study including 10 recently-immigrated Mexican families suggested that parents increased their use of highly restrictive parenting practices following immigration (Bacallao & Smokowski, 2007). This change in parenting was attributed by parents to their concern about perceived environmental dangers, particularly in light of their undocumented status. Immigration was also linked with disruptions in family functioning including increased parent-child conflict, increased use of restrictive parenting strategies, and less time spent together as a family. This was largely related to parents’ need to work long hours outside the home. In turn, the reduction in time with family was associated with adolescent feelings of

loneliness and isolation and engagement in risky behaviors, likely as a result of less parental monitoring (Bacallao & Smokowski, 2007).

Level of acculturation has also been directly linked to parenting. For example, a study comparing parenting practices of Mexican (i.e., living in Mexico;  $n=49$ ), Mexican-Immigrant (i.e., recently immigrated to the U.S.;  $n=37$ ), Mexican-American (i.e., American-born;  $n=13$ ) and Caucasian ( $n=51$ ) parents of 10-12 year old children suggested differences in parenting by level of acculturation (Varela et al., 2004). Specifically, results suggested higher rates of authoritarian (i.e., harsh) parenting among Mexican-Immigrant and Mexican-American (i.e., living in the U.S.) mothers than Mexican mothers living in Mexico. Additionally, while Mexican-American parents reported higher levels of authoritarian parenting compared to Caucasian parents, Mexican parents did *not* differ from Caucasian parents in their use of authoritarian parenting. Of note, no significant group differences emerged with regard to use of authoritative parenting. Although research generally suggests higher levels of authoritarian parenting among Latinos, results of this study suggest that use of harsh parenting strategies may be partly accounted for by the immigration/acculturation process and not wholly attributable to Latino culture. Research efforts in this area should therefore focus on understanding the interactions between SES, acculturation, and parenting.

### *Summary and Conclusions*

This review highlights the complex interactions between sociodemographic and contextual variables, immigration/acculturation status, parental psychosocial factors that collectively influence perceptions of child behavior and parenting among Latino families.

As discussed herein, parents hold specific “ethnotheories” about parenting and child behavior that are culturally-shaped and serve to motivate specific parenting goals and behaviors (Harkness & Super, 1992; 2006; Super & Harkness, 1986; 1993). While ethnic-group membership may represent an important component of culture, it has been argued that other “social address” (e.g., SES) variables also define groups that share broad ecological niches (Roosa et al., 2000). Thus ethnic group membership intersects with other contextual variables to shape culturally-specific parenting values and parenting behavior (Bornstein & Cheah, 2006; Bronfenbrenner & Morris, 2006; Goodnow & Collins, 1990; Super & Harkness, 1986; 1993), and should not be ignored in research examining parenting among diverse groups. Yet, a large proportion of research on Latino families has been conducted with exclusively low-income samples without consideration of cultural versus socio-ecological influences and level of acculturation. Given that most of the research conducted among Latino parents has almost exclusively included low-income parents, SES, culture (as defined by ethnic group membership), and level of acculturation, are consistently confounded in the literature, making it impossible to disentangle the influence of each on parenting.

Moreover, ecological models examining the contextual influences on family processes have consistently included parental stress and depression as an important link between SES, parenting and child outcomes (Barrera et al., 2002; Conger et al., 1992; McLoyd, 1990). Research demonstrates that Latinos are at elevated risk for depression (Dunlop, Song, Lyons, Manheim, & Chang, 2003), suggesting the presence of multiple environmental stressors known to influence parenting and child behavior. On the other hand, the availability of social support, particularly for recently-emigrated mothers who

may have fewer available resources in the U.S., may play an important role in buffering parents from external stressors, and may help to protect psychological well-being among mothers (Belsky, 1984; Hovey, 2000). Despite heightened risk for depression among Latino parents, and the demonstrated link between depression and negative parenting, research examining the role of depression in parental perceptions of, and response to, child attention and behavior problems among Latino families is non-existent.

Child ADHD and ODD are among the most commonly referred childhood disorders. Although Latino children are at elevated risk for these disorders, they demonstrate significantly low service utilization rates. These disparities call attention to the need for research aimed at understanding the manner in which Latino parents perceive and respond to child attention and behavior problems. Based on this review, it is argued that a more ecologically-grounded examination of parenting and child behavior within Latino families is necessary. Specifically, an examination of cultural child-rearing values and their association with Latino parents' perceptions and response to child ADHD and ODD behavior is an important research agenda. When conducting such research, it is important to consider that childrearing values and socialization goals are highly associated with parental SES and acculturation, community context, and psychosocial variables, which also interact with one another.

Drawing from the ecological framework generally, and the information-processing model of parenting behavior, behavioral help-seeking and "threshold" models specifically, the present study examined associations between parental perceptions and responses. Further, sociodemographic, parental psychosocial factors, and socialization goals, were also considered. Such research provides valuable information which

facilitates development of ethnically-sensitive intervention programs for child ADHD and ODD among Latino children and families, thereby addressing disparities in mental health service use among this population.

#### *Contributions to Existing Literature*

The complex pattern of interactions among parental beliefs and behavior, and contextual and psychosocial factors, are difficult to disentangle using traditional research methodology based on quantitative methods, underscoring the utility of grounded theory methodology to examine these factors. This methodology has been used for qualitative research conducted in a wide range of social science arenas (e.g., Parra-Cardona, Bulok, Imig, & Gold, 2006; Bussing et al., 2005) and is particularly well-suited for research aimed at understanding complex processes and the context in which they occur (Strauss & Corbin, 1998)--the overarching goal of the present study. Central to this approach is the development of a theory that is “grounded” in the data. In other words, concepts or themes that emerge from the data are analyzed to form a coherent theory about the constructs under investigation and allow for a more contextualized understanding of the interactions between constructs. Additionally, this methodology provides a unique opportunity to discuss topics that are poorly understood in the existing literature, as is the case with regard to perceptions of child ADHD and ODD behavior and parenting among Latino families, and serves to generate new ideas regarding the topic of interest (e.g., Morgan & Krueger, 1998).

More broadly, qualitative methods have proven to be a successful research paradigm with Latino and other difficult-to-reach populations who typically demonstrate low research participation rates (Cauce, Ryan, & Grove, 1998). Indeed, it has been

argued that fear and mistrust among many ethnic minorities with regard to research participation can be dispelled by more personal contact with the researcher (Cauce et al., 1998; Morgan & Kreuger, 1998; Umana-Taylor & Bamaca, 2004). Moreover, qualitative methods have been suggested as one of very few research methods in which participants of varying levels of literacy can participate (Morgan & Kreuger, 1998), a particularly relevant consideration in light of data suggesting low levels of formal education among recent immigrants in general and specifically among Latinos in the U.S. (U. S. Census Bureau, 2000).

Results of this study extend the current literature in several important ways. First, drawing from existing models that independently consider parenting (Rubin et al., 1989) and help-seeking (Eiraldi et al., 2006) responses to child behavior, the data yielded a more comprehensive model of parental response to child ADHD and ODD behavior among Latino parents. In doing so, the model can be used to generate research questions and hypotheses for future research in this area.

Second, this study examined perceptions of child ADHD and ODD behavior among a *community* sample of Latino mothers. Available research in this area has largely been conducted among Latino parents who have sought mental health services for their children. This represents a significant sampling bias in the available literature. Although certainly useful, existing research fails to provide information regarding the manner in which parents of non-referred children (i.e., non-treatment seekers) perceive and respond to inattentive and disruptive child behaviors, which could impact their willingness to seek services for their children. Additionally, research suggests that *prior* to seeking services for child attention and behavior problems, parents may attempt to address the child's

behavior by using increasingly punitive parenting practices (Bussing et al., 2006), which may exacerbate the child's problem or increase parent-child conflict. Lastly, because Latino parents are likely to receive feedback about their child's behavior from social network members (e.g., Sabogal et al., 1987), a community sample of mothers will provide some insight regarding general attitudes and perceptions that might be conveyed to Latino mothers of children who do have attention and behavior problems. Therefore, it is of particular importance to examine parental beliefs about child behavior and strategies Latino parents might employ to address ADHD and ODD prior to seeking services.

Given the notable gap between high levels of estimated risk and mental health needs among Latino children and of service use (Alegria et al., 2002; Bui & Takeuchi, 1992; Hough et al., 2002; Katkaoka, et al., 2002; McCabe et al, 1999), research in this area is sorely needed. Such research expands the knowledge base regarding the manner in which Latino parents might perceive and respond to child ADHD and ODD. This research has the potential to facilitate the development of ethnic-sensitive outreach strategies and parenting interventions for these clinical child behavior problems. Ultimately, research in this area can inform practices that may reduce mental health disparities among Latino children and families.

### Chapter 3: Method

This study used a mixed-method approach to examine associations between variables of interest. In addition to using in-depth qualitative interviews, quantitative data was collected to allow for triangulation of methods. This entails corroborating findings from one source of data (i.e., qualitative) with data from another source (i.e., quantitative), which has been highlighted as a significant strength of this type of mixed-method approach (Rossman & Wilson, 1985). In the present study, the use of questionnaires and in-depth interviews provided a triangulated, and thus more complete, perspective on Latino parents' perceptions and response in relation to child ADHD and ODD.

#### *Participants and Recruitment*

A total of 25 Latino mothers with at least one child between the ages of 5 and 12 were recruited to participate in this study. Efforts were made to recruit mothers representing a wide range of SES, as measured by level of maternal education, in order to examine study aims from an ecological perspective. Participants were primarily recruited from the Washington, DC metropolitan area. Extensive recruitment support was obtained from a Washington, DC bilingual public charter school, CentroNia, with whom the principal investigator had previously developed a working relationship. This school is unique in that it includes a *Family Institute*, as well as before- and after-school care programs, that serve over 700 predominantly Latino families with children ranging in age from infancy through adolescence.

Prior to the start of the study, CentroNia committed to assist with recruitment. In close collaboration with the director of the *Family Institute*, participants were recruited

via “word-of-mouth” and other methods by which the school typically advertises (e.g., posted flyers). More specifically, flyers and other advertisements regarding the study specified that mothers were being recruited to participate in individual interviews about “child behavior and parenting” and included contact information for the principal investigator and the director of the *Family Institute*. In addition to these efforts, the principal investigator actively recruited mothers in person at the school.

As expected, recruitment efforts were significantly facilitated as a result of the partnership with CentroNia and use of more face-to-face recruitment methods. Indeed, the need to partner with community leaders and use of less formal recruitment strategies (e.g., “word-of-mouth”) have been highlighted as useful recruitment strategies among Latino populations (Umana-Taylor & Bamaca, 2004). These recruitment strategies also proved fruitful in a past research study conducted by the principal investigator at this same location (Diaz, 2005). Although the majority of the sample was recruited through CentroNia, some mothers were also recruited via word-of-mouth through personal contacts of the principal investigator.

Once mothers expressed interest in participating, they were scheduled for individual interviews during available days and times that were convenient for them and the interviewer (i.e., principal investigator). Most interviews were conducted during the day and in the early evening hours at CentroNia. Several interviews were also conducted in participant’s homes.

Participants were compensated with a cash incentive of \$25. In addition, they were given the opportunity to sign up for a free, 2-hour parenting workshop, conducted by the principal investigator, focusing on child behavior management strategies. Most

mothers expressed interest in attending these workshops, which were conducted at CentroNia.

### *Measures*

*Demographic characteristics.* A general sociodemographic questionnaire was used to gather sociodemographic and acculturation information (Appendix A). Maternal education was used as a general indicator of SES. Maternal education is a commonly used indicator of SES and has been found to account for a significant proportion of the effects of SES on parenting and child behavioral outcomes (Bornstein, Hahn, Suwalsky, & Haynes, 2003; Gottfried, Gottfried, Bathurst, Guerin, & Parramore, 2003). Moreover, research suggests that graduating from high school is an important indicator of SES which has been linked to mental health treatment-seeking and outcomes (Keller & McDade, 2000; Rieppi et al., 2002). To examine research aims by SES, the sample was divided into three groups by maternal level of education (less than high school, high school graduate, and at least some college).

Level of acculturation was measured using common indicators, including place of birth (U.S. versus another country), number of years living in the U.S., and an 8-item scale of English- and Spanish-language proficiency (Questions 11-18 of demographic questionnaire; See Appendix A). These items are commonly included on measures of acculturation and are thought to provide a good indicator of exposure to mainstream U.S. culture (Cabrera, Shannon, West, & Brooks-Gunn, 2006; Cuellar, 1998; Cuellar, Harris, & Jasso, 1980; Nguyen, Clark, & Ruiz, 2007). Language proficiency items include speaking, understanding, reading, and writing in each language on a 5-point response set ranging from (1) “poor” to (5) “excellent”. Items of Spanish-language proficiency were

reverse-scored in order to adjust the scale such that higher scores reflect higher levels of acculturation, with scores ranging from 8 to 40.

*Maternal psychosocial characteristics.* Current symptoms of depression were measured using the Boston short form of the Center for Epidemiological Studies Depression Scale (CES-D; Kohout, Berkman, Evans, & Cornoni-Huntley, 1993; Appendix B), which is available in English and Spanish. This is a 10-item scale of depressive symptoms experienced within the previous 7 days scored on a 4-point response set ranging from (0) “rarely or none of the time/<1 day” to (3) “most or all of the time/5-7 days”. Scores range from 0 to 30, with higher scores indicating higher levels of current depression and a cut-point of 10 indicating clinically significant levels of depression (Gryzwacz, Hovey, Seligman, Arcury, & Quandt, 2006). Psychometric data for this scale among Latino samples demonstrates high internal consistency, with Cronbach’s alpha coefficients ranging from .711 to .836 and concurrent validity with anxiety ( $r = .669$ ), acculturative stress ( $r = .426$ ), and social support ( $r = -.308$ ), all of which have been linked to depression across Latino groups (Grzywacz et al., 2006).

Perceived social support was measured using the emotional/informational social support subscale of the Medical Outcome Study Social Support Survey (MOS-SS; Sherbourne & Stewart, 1991; Appendix C). The full 19-item MOS-SS is a multi-dimensional measure developed as part of the Medical Outcomes Study to assess social support among patients with chronic health conditions and was validated on a large ( $N=2987$ ) diverse sample of adults (Sherbourne & Stewart, 1991). Multitrait scaling analyses demonstrated four dimensional scales related to emotional/informational, tangible, and affectionate social support, and positive social interaction each yielding

eigenvalues greater than one and demonstrating high internal consistency (Sherbourne & Stewart, 1991). This instrument has been used in combination with the CES-D in a number of studies assessing the association between depression and social support (e.g., Soskolne, Bonne, Denour, & Shalev, 1996; Surkan, Peterson, Hughes, Gottlieb, 2006) and to assess the role of social support across a wide range of functional domains (e.g., Giurgescu, Penckofer, Maurer, & Bryant, 2006; Grunfeld et al., 2004; Kornblith et al., 2001; Rapp, Shumaker, Schmidt, Naughton, & Anderson, 1998).

The emotional/informational social support subscale used in this study consists of 8 items measuring perceived availability of various forms of emotional support using a 5-point response set ranging from (1) “none of the time” to (5) “all of the time”. Scores were calculated by averaging across items, yielding scores that range from 1-5, with higher scores indicate higher levels of perceived social support. This scale demonstrates high internal consistency (Cronbach’s alpha = .96) and high concurrent validity with measures of “loneliness” ( $r = -.60$ ), general mental health ( $r = .40$ ) and family functioning ( $r = .49$ ; Sherbourne & Stewart, 1991). This scale was available in English and Spanish.

*Parenting practices.* The Parenting Practices Questionnaire (PPQ; Appendix D) is a 14-item measure adapted from the Parenting Styles and Dimensions Questionnaire (PSDQ; Robinson, Mandleco, Olsen, & Hart, 2001). Respondents indicated how often they use a variety of positive and negative parenting practices with their own child on a 5-point scale, ranging from (1) “never” to (5) “always”. For the purposes of this study, items were averaged to create two general clusters representing positive and negative practices that were consistent with the authoritative (i.e., positive) and authoritarian (i.e.,

negative) dimensions of the original 32-item version of the PSDQ (Robinson et al., 2001). This questionnaire was previously available in both English and Spanish.

*Perceptions of child behavior.* General understanding and perceptions of DSM-IV ADHD and ODD symptoms were explored in an open-ended fashion by asking participants to review a list of ADHD and ODD symptoms and to discuss the meaning of each, as well as their ideas about the nature of each behavior (i.e., perceptions; see Appendix E). Additionally, participants were asked to rate the degree to which they perceived each behavior as problematic on a 5-point Likert-scale ranging from “no problem at all” (1) to “very much a problem” (5).

The list of DSM-IV symptoms was adapted from the Disruptive Behavior Rating Scale (DBRS; Barkley & Murphy, 1998; Barkley, Murphy, & Bauermeister, 1998). The 26-item list of ADHD and ODD symptoms on the DBRS was used because it closely resembles the DSM-IV list of symptoms and the manner in which behaviors are described on this instrument is similar to many other behavioral rating scales commonly used to assess child ADHD and ODD. This symptom checklist has been previously translated into Spanish for clinical use with Spanish-speaking parents (Barkley et al., 1998).

Perceptions of behavior severity were also measured using the same 5-point Likert-scale in response to two hypothetical behavioral vignettes, one depicting clinical levels (i.e., 6 symptoms) of ADHD and one depicting clinical levels (i.e., 4 symptoms) of ODD behavior.

*Parental response to hypothetical behavioral vignettes.* The use of behavioral vignette methodology allowed us to standardize the behavior to which parents were asked

to respond and has been used in a wide range of studies with similar aims (e.g., Bickett, Milich, & Brown, 1996; Johnston, Chen, & Ohan, 2006; Johnston & Patenaude, 1994). Parents were asked to describe *how* and *why* they would respond to child behavior depicted in the behavioral vignettes (i.e., “*How would you respond to this behavior if your child actually behaved in a similar manner and why?*”); vignettes are included in Appendix F). These two general questions were adapted from a questionnaire developed by Rubin and colleagues (Rubin & Mills, 1990; Rubin et al., 1989) designed to examine freely-reported parental beliefs, childrearing goals, and parenting in response to various forms of child behavior (e.g., withdrawn, aggressive). Variations of this questionnaire have been used in conjunction with vignette methodology in a series of studies examining cross-cultural parenting beliefs and parenting responses regarding hypothetical child behavior (Cheah & Rubin, 2004; Hastings & Grusec, 1998; Hastings & Rubin, 1999; Mills & Rubin, 1990; Park & Cheah, 2005; Rubin & Mills, 1992). In past research, written responses to these open-ended questions were obtained and later coded based on a pre-existing coding scheme of parenting strategies and childrearing goals.

For the purposes of the present study, responses were elicited verbally in order to facilitate open discussion of ideas and to elicit naturally-occurring responses, thereby generating a broad understanding of parenting strategies and childrearing values and goals Latino parents might emphasize. In addition to qualitative responses, parents were also asked to provide quantitative ratings regarding their likelihood of seeking mental health treatment or using medication for their child’s attention or behavior problems, and their negative emotional reaction, to the depicted behaviors on the Vignette Rating Form (VRF; Appendix G). Mothers were asked to rate 8 specific negative emotions in response

to the question “*How would it make you feel if you saw your child act this way consistently (a lot of the time)?*” All quantitative ratings were provided on a 5-point, Likert-scale ranging from ranging from (1) “not at all” to (5) “extremely”.

*Childrearing values and goals.* The childrearing values and goals interview protocol was designed by the principal investigator to assess the degree to which mothers emphasize 9 specific childrearing values, drawn from literature related to Latino cultural and U.S. mainstream values (Achhpal et al., 2007; Gonzalez-Ramos et al., 1998; Harwood, 1992; Suizzo, 2007; Zayas & Solari, 1994; see Appendix H). Respondents were asked to discuss the importance of each value and why they believe it is important (e.g., How important is it for your child to learn to respect you and other adults [respeto]?).

#### *Procedures*

All interviews were audio-taped and transcribed verbatim. Following transcription, all audio-tapes were destroyed. Participants were identified on the transcription by number only and transcripts did not include any identifying information. This study was approved by the Institutional Review Board (IRB) of the University of Maryland, College Park. A copy of the informed consent form is included in Appendix I.

*Step 1.* Upon arriving, participants were introduced to the general purpose and procedures of the study and the consent form was reviewed and signed. More specifically, mothers were told that the purpose of the study was to gain a better understanding of the way Latino mothers feel about different types of child behavior and the types of parenting strategies they would use in response to such behavior. Prior to the start of the interview, participants completed the demographic and parenting practices

questionnaires, as well as the CES-D and MOS-SS. All questionnaires and interviews were completed in the participant's preferred language (i.e., English or Spanish). Although mothers sometimes switched back and forth between English and Spanish throughout the interviews, the majority of interviews and questionnaires were completed in Spanish (n=18; 72%).

*Step 2.* Once introductory procedures were completed, mothers were given a written list of ADHD and ODD symptoms (DBRS) and were asked to discuss their general understanding and perceptions of each item. Following the discussion of each behavior, mothers rated the perceived severity of the behavior on a 5-point Likert scale, as discussed above.

*Steps 3 and 4.* During the second segment of the interview, mothers were asked to read two vignettes depicting children with clinical levels of ADHD or ODD (Steps 3 and 4) behavior. A written copy of the vignette was provided to the participant and then it was read aloud by the interviewer. Both vignettes were presented to all participants in counter-balanced order across participants. Following each vignette, mothers were asked to respond to open-ended questions regarding their responses to the behavior and to complete the VRF (described above). This sequence was then repeated with the second behavioral vignette (Step 4).

*Step 5.* Following both vignettes, a semi-structured interview was conducted to explore parental childrearing values and socialization goals. First, mothers were asked to discuss their general "expectations" for their child's behavior in an open-ended format, followed by the semi-structured interview regarding 9 specific childrearing values, described above.

*Step 6.* Finally, a brief summary discussion was conducted highlighting major themes and ideas discussed throughout the interview. Additional participant comments and feedback were generated and any participant questions were answered.

### *Data Analyses*

*Quantitative analyses.* Using level of education as a general indicator of SES, the sample was divided into three groups representing low-SES (less than high school education; n=8), middle-SES (high school graduate; n=7) and high-SES (at least some college; n=10). All analyses were conducted for the sample as a whole and by SES.

Descriptive statistics were calculated to examine demographic and psychosocial characteristics (Table 1), as well as self-reported parenting (Table 2). Next, mean ratings of perceived severity for DSM-IV ADHD and ODD symptoms were calculated for ADHD-Combined (i.e., all ADHD symptoms), ADHD-Inattentive (ADHD-I), ADHD-Hyperactive-Impulsive (ADHD-HI), and ODD symptoms by averaging ratings across relevant items (Table 3). Finally, means were calculated for quantitative data obtained on the VRF, including mean perceived severity rating, likelihood of seeking mental health treatment and using medication for child behavior, and negative emotional reactions, in response to each behavioral vignette (Tables 4 and 5).

*Qualitative analyses.* The qualitative analyses for the present study provide in-depth insight into the meanings and schemas of Latino parents specific to perceptions and parenting of child ADHD and ODD behavior, as well as childrearing values and socialization goals, using grounded theory methods (Charmaz, 2003; Fassinger, 2005; Glaser & Strauss, 1967). The purpose of data analyses for the qualitative interviews was to identify concepts and ideas that were repeated across interviews, and the associations

among them, in order to expand existing theoretical frameworks that capture the data generated in this study (Charmaz, 2003; Glaser & Strauss, 1967; Strauss, Corbin, Denzin & Lincoln, 1994).

Qualitative data were also explored by SES by calculating the proportion of responses within groups that were accounted for by a certain theme or by calculating the percent of mothers within groups that endorsed specific responses, depending on the study aim. Examination of main themes using within-group calculations provided an estimate of the relative emphasis placed on each theme within the socioeconomic group, which was then compared across groups. These methods accounted for differences in verbal fluency noted across groups; low-SES mothers were less verbally fluent and consequently had notably shorter interviews) than middle- and high-SES mothers.

An important component of the coding process was to avoid analyzing the qualitative data using predetermined ideas and concepts. While *sensitizing concepts* (e.g., DSM-IV symptoms, child-rearing values) were drawn from the literature to structure the interviews (van den Hoonaard, 1997), the grounded theory approach calls for systematic analysis of the conceptual categories that are drawn from the data. This process begins with a general understanding of simple concepts noted in the data and proceeds by making systematic comparisons between concepts (i.e., *constant comparative method*) until interactions and processes among concepts are detected. Ultimately, this process guides the development of a theory that is “grounded” in the data (Charmaz, 2003; Fassinger, 2005; Glaser & Strauss, 1967).

The concept of *reflexivity* is also an important consideration in qualitative analyses, reflecting the degree to which the researcher conducting the study and analyses

identifies and considers ways in which their own personal characteristics shape their interpretation of the data (Corbin and Strauss, 2008; Creswell, 2009). In the present study, such personal characteristics include the researcher's training in clinical psychology and specialized knowledge of ADHD and ODD. In addition, the researcher is a bilingual, bicultural Puerto Rican female, born in Puerto Rico, but raised in the United States by parents that were minimally acculturated to mainstream U.S. culture and were of modest socioeconomic means. Together, these characteristics provided the researcher with a unique perspective of participant responses that could influence interpretation of data in various ways.

With this in mind, the researcher attempted to guard against potential bias during data collection (i.e., interviews) in several ways. First, to minimize social desirability effects, the interviewer introduced the study to participants by explaining that “there are no right or wrong answers”, emphasizing that the purpose of the study was to learn about the ideas and opinions of “mothers like you... so you are the expert here”. Secondly, to prevent use of “leading questions” that would influence the nature of participant responses, the interview guide was carefully prepared using neutral and standardized language, which was reviewed by research consultants and dissertation committee members. Further, throughout the interviews, the researcher closely adhered to the interview guide and refrained from engaging in *reciprocal* conversation with participants or answering participant questions about any of the interview topics (e.g., ADHD, ODD, parenting strategies, mental health services). During data analyses, the researcher guarded against potential bias by initially coding responses that were not clear and explicit as “unknown” in order to avoid immediately coding the data based on existing knowledge.

These data were re-visited and were ultimately coded by comparing these responses to similar responses within and across interviews, consistent with the *constant comparative method*. Taken together, these measures reduced bias introduced by the researcher's personal characteristics and knowledge.

Using verbatim transcripts of the interviews, the data was coded and analyzed in four general stages based on analysis techniques outlined by Strauss and Corbin (1998) specific to grounded theory. The first stage involved *open coding* to identify main concepts (i.e., conceptual categories) and their basic properties and dimensions (Miles & Huberman, 1994; Strauss & Corbin, 1998). This initial phase of analysis is the primary manner by which data were converted from simple terms and phrases into meaningful conceptual units. Codes were developed for these categories from "chunks" of data made up of sentences and/or short paragraphs (Miles & Huberman, 1994). For example, during open coding, all text in which mothers discussed a parental action taken in response to child behavior was coded as "parental response to behavior" (e.g., "I would punish him...", "I'd see his pediatrician..."). This was done for each segment of the interview related to the three study aims.

In refining initial concepts, the *constant comparative method* was employed (Charmaz, 2003; Glaser & Strauss, 1967). This entailed comparing categories within and across SES groups to examine how they compare to each other, to identify variations within and across concepts, and to ensure that each category is mutually exclusive (Charmaz, 2003; Glaser & Strauss, 1967; Strauss & Corbin, 1998). Open coding was conducted by the principal investigator on all transcripts, refining categories as needed, yielding a final coding scheme.

The second phase of analysis utilized *axial coding*. The goal of this phase of coding was to explore relationships among categories and subcategories based on their individual properties and dimensions (Strauss & Corbin, 1998). More specifically, relationships were explored based on the *conditions, actions, and consequences* associated with each category. During *axial coding*, codes were repeatedly sorted and re-organized to explore the manner in which different properties linked categories to subcategories. For example, parental response to behavior was coded as a function of “location”, such as home-based, school-based, and clinic-based. Parental responses were further categorized with regard to parent-implemented versus professionally-implemented interventions, and were then coded as a function of a “parenting” versus “help-seeking” response. Of note, for Aim 1, axial coding was first conducted for each of the 26 DSM-IV symptoms individually and then codes were aggregated across symptom clusters which represented the actual clinical disorders (i.e., ADHD-I, ADHD-HI, and ODD symptoms).

The third phase of data analysis consisted of *selective coding* (Strauss & Corbin, 1998), during which the emerging associations between categories were explored in a more in-depth manner, working toward development of the theoretical framework. This process began by evaluating *main* categories and promoting them to overarching conceptual categories (such as causal attributions, parental responses, etc.), yielding an initial theoretical framework (Charmaz, 2003; Strauss & Corbin, 1998). This initial model was progressively filled in based on continued analyses of processes and interactions between categories, again employing the *constant comparative method*

central to grounded theory analyses. Definitions of final conceptual categories are provided in Appendix J.

In the final phase of analysis, components of the theory were examined and discussed within the context of existing literature, with a particular focus on detailing the extent to which the final theoretical model confirms or contradicts results of previous research in relevant areas (Charmaz, 2003; Glaser & Strauss, 1967). This process ultimately led to the development of the model proposed below, which emerged from the data collected in this study.

## Chapter 4: Results

The primary aims of this study were: (1) To examine parental understanding and perceptions of DSM-IV ADHD and ODD symptoms in a community sample of Latino mothers; (2) To explore and describe self-reported parenting and treatment-seeking responses to clinical levels of child ADHD and ODD behaviors, as depicted in hypothetical behavioral vignettes, among Latino mothers; and (3) To explore general childrearing values and child socialization goals among Latino mothers. Each of these aims was examined from an ecological perspective by considering SES and other demographic factors, level of acculturation, and parental level of depression and social support, all of which are known to influence the way parents perceive and respond to child behavior.

Sample demographic and psychosocial characteristics, and self-reported parenting practices, are presented below, followed by qualitative and quantitative results for each primary aim.. Results of analyses by SES are also discussed for each aim. The main themes emerging from qualitative data were examined by calculating the proportion of all coded responses that represented specific conceptual categories. To analyze data by SES, main themes were examined within each SES group and were then compared across groups.

### *Demographic and Psychosocial Characteristics*

Sample characteristics were obtained using self-report measures of general demographics (e.g., age, marital status, level of education), level of acculturation, depression (CES-D), social support (MOS-SS), and parenting practices (PPQ; Tables 1 and 2). A total of 25 mothers participated in the study. Participants were on average 35

years old and had on average 2 children. The majority of participants was single and employed full-time. Level of education was fairly evenly distributed and the largest proportion of mothers had completed “at least some college”. The sample was very diverse with regard to ethnicity, with the largest number of participants being from Puerto Rico, Peru, and El Salvador. The majority of mothers in the sample was born outside the U.S. and was moderately acculturated, as measured by a language proficiency scale.

Mean scores on the depression scale indicated low levels of depression, though 16% ( $n = 4$ ) of mothers reported experiencing clinically significant levels of depression (i.e., CES-D > 10; Gryzwacz et al., 2006). Mean scores on the MOS-SS indicated high levels of social support among mothers in the sample. On the parenting practices questionnaire (PPQ), mothers reported very frequent use of positive parenting practices and occasional use of negative parenting practices (Table 2). More specifically, they reported very frequent use of giving praise and emphasizing the reasons for rules to their child and occasional use of negative practices such as “exploding in anger toward child”, “using threats and punishment with little or no justification”, and “scolding or criticizing child when he doesn’t meet expectations”.

Demographic and psychosocial characteristics varied by SES. First, the majority of both low- and high-SES participants were single mothers, while most middle-SES mothers were married. Groups also differed somewhat in their ethnic composition, with half of the participants in the low-SES group coming from El Salvador, whereas half of the participants in the high-SES groups came from Puerto Rico. The middle-SES group was fairly diverse and had at least one participant from five different countries. In general, low-SES participants reported living in the U.S. the least amount of time and

were less acculturated, compared to middle- and high-SES mothers. Low-SES mothers also reported relatively higher levels of depression compared to middle- and high-SES mothers. Additionally, several mothers in the low-SES ( $n = 3$ ; 37.5%) group reported clinically-significant levels of depression. Reported use of positive parenting practices was similar across the three groups, though low-SES mothers reported more frequent use of negative parenting practices than mothers in the other SES groups.

In sum, participants were ethnically diverse and moderately acculturated, with level of acculturation and time living in the U.S. increasing with SES. Mothers reported low levels of depression and high levels of social support. Mothers also reported frequent use of positive parenting practices and occasional use of negative strategies. Some differences were noted by SES, with mothers in the low-SES group reporting lower levels of acculturation, higher levels of depression, and more frequent use of negative parenting strategies.

#### *Understanding and Perceptions of DSM-IV ADHD and ODD Symptoms (Aim 1)*

Parental understanding and perceptions of DSM-IV ADHD and ODD symptoms were examined by asking mothers to discuss the meaning of symptoms as described on a behavioral rating scale and to discuss their beliefs about the nature of each symptom. Perceived severity of behavior was also assessed via quantitative ratings on a 5-point Likert scale. Results of qualitative and quantitative data are discussed for each aim.

First, with regard to parental understanding of symptoms, mothers did not experience difficulty understanding any of the ADHD-I or ODD symptoms, but had some difficulty understanding the meaning of one ADHD-HI symptom: “seems on the go, as if driven by a motor”. Several mothers initially commented that they were unclear what this

item meant and asked for clarification before responding. For example, one mother asked “what does that mean, ‘on the go’?”, while another mother commented “I don’t understand what that means... acting like a robot?” Their difficulty understanding this symptom was noted on both English and Spanish-language versions. More specifically, in English, mothers had some difficulty understanding the phrase “on the go” and in Spanish mothers reported difficulty understanding the metaphor “as if driven by a motor”, which may not have the same meaning once translated. Thus, it may be best to avoid using U.S.-based phrases and idioms on assessment instruments that are used across ethnically and linguistically diverse populations and/or to translate instruments using specific descriptions of behaviors, as opposed to translating metaphors literally.

*Perceptions of ADHD symptoms.* Qualitative responses regarding perceptions of behavior indicated that mothers accurately described ADHD-I symptoms as various forms of attention-related problems (e.g., “not paying attention to what they’re doing”), with 29.6% of responses falling into this category. Further, when mothers discussed attention problems, they tended to describe them as a *challenge* for the child (e.g., “can’t focus his attention”, “has some type of problem that makes her get distracted”, “just can’t reach a higher level of concentration”, “he doesn’t know how to focus his attention”), consistent with perceptions of a *deficit* in attention.

On the other hand, mothers also discussed some ADHD-I symptoms as being under the child’s control to some degree. Specifically, mothers expressed beliefs that some ADHD-I symptoms (e.g., “fails to give close attention to details or makes careless mistakes in his/her work”; “doesn’t follow through on instructions and fails to finish work”) were primarily related the child’s level of motivation (e.g., “not motivated to do

well”, “doesn’t care about what he’s doing”, “lazy”; 9.5% of responses), particularly with regard to achievement and academic tasks. For example, one mother commented that “this is the type of child that would rather play games than read a book or would rather go outside than do his homework”. Another mother commented that “if they don’t want to do their homework it means they don’t want to be studious, which means they aren’t going to get ahead and they’re not going to become anything in life”. Finally, one mother noted that a child’s reluctance to complete work demonstrates “laziness”, noting that “... she knows when she needs to do something and how to get it done and finish it and if she doesn’t it’s more [about] laziness, she doesn’t want to...”. This theme was noted most often with regard to the symptom “avoids, dislikes, or is reluctant to engage in work that requires sustained mental effort”, with 34.4% of responses for that item falling in this category.

Mothers also discussed beliefs that inattentive symptoms are inherited or caused by a biological problem or disorder (9.2% of responses; e.g., “born that way”, “has a disorder”, “a ‘special’ child”, “challenged mentally...”). Mothers described biological and brain-based problems in very general terms, and only mentioned ADHD or Attention Deficit Disorder (ADD) in approximately 4% of their descriptions. Additionally, when mothers discussed ADHD, they demonstrated minimal knowledge of the clinical disorder. For instance:

“ADHD... is that the one with behavior problems? I think the one with the ‘H’ are kids with behavior problems, right? Like kids with ADD... aren't those kids with like reading problems?”

“That to me, reminds me of a child who has hypertension... hyper-attention disorder... what is that called?...hyperactivity disorder...”

Finally, although mothers were not specifically asked how they would respond to child inattentive behavior during this segment of the interview, mothers discussed ideas regarding their own parental responsibility to prevent or manage these problems, primarily by increasing the structure in the child’s daily routine and their own involvement in the child’s activities (8.8% of responses). For example, mothers discussed beliefs that “a parent has fault in that also, ‘cause they have to be involved with the child...” and noted that “a child needs help getting organized” and “needs someone to give him instructions”. These ideas imply that, in response to ADHD-I symptoms, mothers may increase their role in the child’s activities in an effort to help the child organize and complete tasks.

Examination of perceptions for individual ADHD-I symptoms suggested that two inattentive symptoms were most often perceived as being purposely defiant or disrespectful: “not listening when being spoken to directly” (23.1% of responses for that item) and “doesn’t follow through on instructions and fails to finish work” (16.7% of responses for that item). Mothers commented that when a child does not listen “when being spoken to directly” it indicates that “they don’t want to hear it or they don’t care what you’re saying...” or “wants to ignore me” and noted “that is disobedient... because you’re supposed to listen when a parent is talking to you, give them undivided attention and respect...”

In sum, responses related to ADHD-I symptoms indicated that mothers most commonly perceived these behaviors as an attention-related deficit, consistent with the

nature of ADHD. Considering the most common themes together, mothers discussed ADHD-I behaviors along a continuum related to the perceived degree of control the child or parent may have over behaviors. More specifically, when they discussed attention or biological/inherited problems, behaviors were perceived as a deficit or problem that is internal to the child and outside their direct control. On the other hand, responses related to the child's level of motivation, purposeful defiance or disobedience, or parental responsibility suggest underlying attributions that behaviors are related to external factors that are controllable by the child and/ parent.

With regard to perceptions of ADHD-HI symptoms, mothers most often described these symptoms using the terms "hyperactivity/hyperactive" (25.2% of responses).

Although mothers did not make many specific statements about the underlying nature of "hyperactivity", when they did, they often noted that it is normal for children to be highly active (e.g., "that's hyperactivity... that's normal in kids", "maybe he's just really active, some kids just don't like to sit still", "that's not a problem at all... kids don't know how to do anything quietly"). On the other hand, mothers also described these behaviors as defiant and disrespectful (14.2% of responses), noting that a child displaying ADHD-HI "has problems listening... like to a higher authority" and is demonstrating a "lack of respect".

Mothers also described perceptions related to the impulsive nature of ADHD-HI behaviors, noting that some of these symptoms demonstrate an inability on the child's part to regulate their behavior (10.9% of responses; e.g., "can't wait", "has no patience", "doesn't know what self control is", "does whatever comes to his mind"). Closer examination of responses in this category also indicated that mothers often referenced a

lack of knowledge or adherence to rules and social norms (e.g., “doesn’t know the rules”, “has a problem following rules”, “isn’t aware of the situation [surroundings]... that he can’t stand up [leave his seat], “doesn’t know how to take turns in a conversation”). These ideas are consistent with the value of *proper demeanor* (i.e., demonstration of appropriate manners and behavior, particularly in public contexts), discussed above, and suggested that impulsive behaviors may be perceived as “rude” because they are intrusive and contrary to social rules and norms.

While ADHD-HI symptoms were largely perceived as negative behavior, mothers also perceived these behaviors as being indicative of positive personality characteristics (10.3% of responses), such as “happy”, “expressive”, “intelligent” and “motivated”. Further, when individual items were examined in more depth, it was noted that positive attributions were most often endorsed with regard to several hyperactive symptoms (e.g., “seems ‘on the go’ or ‘driven by a motor’” and “talks excessively”), whereas impulsive symptoms (e.g., “blurts out answers before questions have been completed” and “interrupts or intrudes on others”) were more likely to be perceived as disrespectful.

Overall, ADHD-HI symptoms were most often described simply using the terms “hyperactivity” or “hyperactive” and mothers largely viewed this as normal behavior in children. Along the same lines, mothers also perceived some of these behaviors in a positive light, particularly with regard to several symptoms of hyperactivity. On the other hand, mothers also described some of these behaviors as defiant and disrespectful, and perceived impulsive behaviors as contrary to rules or norms. Further, negative perceptions were endorsed more often in response to impulsive, as opposed to hyperactive, symptoms and mothers discussed these symptoms in a manner consistent

with the expectation that the child should demonstrate *proper demeanor* in line with social norms. Similar to ADHD-I symptoms, themes related to defiance/disrespect and impulsivity suggest underlying beliefs related to the controllability of these behaviors. Notably, mothers rarely mentioned the ADHD/ADD label when discussing underlying causes of ADHD-HI symptoms (1.5% of responses), using this label more often for ADHD-I symptoms (4%).

*Perceptions of ODD symptoms.* ODD symptoms were primarily perceived as being reflective of an emotional problem (33.7% of responses) and mothers often described depression-like problems (e.g., “is really irritable”, “they’re isolated”, “sad” “has an emotional problem... maybe they’re depressed”) and “problems at home” (e.g., “their parents fight a lot”). These perceptions were most commonly endorsed with regard to the symptoms “is touchy or easily annoyed by others” and “is angry or resentful”, both of which are highly similar to a core DSM-IV symptom of depression in children (i.e., irritability).

Secondly, mothers perceived ODD symptoms as highly defiant and disrespectful (19.1%), and most often provided these descriptions in response to symptoms clearly describing active child defiance (i.e., “actively defies or refuses to comply with adults’ requests or rules” and “argues with adults”). For example, mothers commented that these behaviors demonstrate a “lack of respect” and “disobedience”, and are “very disrespectful and very, very rude!” Mothers also discussed beliefs that these behaviors are contrary to the expectation that children should demonstrate a high level of respect for adults, noting: “A child is a child and should always stay in his place rather than him sit there and argue with an adult”, “the child doesn’t follow the rule to ‘respect your elders’”, and “imagine a

child arguing with adults! That's not normal". These responses are aligned with the value of *respeto* (i.e., high regard for children to demonstrate respect toward adults), discussed above.

Mothers also discussed ideas regarding parental responsibility for both causing and preventing ODD behavior (7.2%). More specifically, mothers expressed that parents may cause these behaviors by failing to give the child enough attention, by displaying inappropriate or aggressive behavior in front of the child (e.g., arguing in front of them), and by "spoiling" the child (i.e., giving them "everything" they ask for). Additionally, mothers noted that parents are responsible for preventing or managing these behaviors by using increased or firmer discipline strategies (e.g., "needs to be punished" and "the child is lacking discipline"). With these ideas in mind, mothers may be likely to respond to ODD behavior by attempting to increase parental attention or minimize exposure to negative situations, or by increasing their use of discipline aimed at punishing the child's negative behavior.

Overall, ODD behaviors were largely attributed to either emotional problems or purposeful defiance, consistent with the current conceptualization of ODD as being related to underlying difficulties with emotion and behavioral displays of active defiance (Cole, Michel, & Teti, 1994; Hinshaw & Lee, 2003; Mullin & Hinshaw, 2007). Further, mothers discussed a parent's responsibility to respond to such behavior by increasing their role in promoting a positive environment for the child or by using more discipline, which is consistent with evidence-based treatment for ODD.

*Perceptions of behavior by SES.* Perceptions of ADHD and ODD behavior varied by SES. First, although ADHD-I symptoms were primarily perceived as attention-related

problems across groups, mothers within the three SES groups emphasized different reasons for inattentive behavior. Low-SES mothers most often attributed ADHD-I symptoms to “some type of disorder” or inherited problem (15.1%) or to a learning/developmental problem (11.6%). On the other hand, middle-SES mothers primarily attributed attention problems to some form of emotional problem (18.6%), often noting depression-like symptoms. Lastly, high-SES mothers most commonly attributed these symptoms to a lack of motivation or concern on the child’s part (11.5%) or to a temporary “state” (e.g., tired, bored; 9.8%). This pattern of results suggests that low- and middle-SES mothers endorsed beliefs related to “internal” and uncontrollable causes for ADHD-I symptoms, whereas high-SES mothers discussed beliefs regarding external causes and controllability of ADHD-I symptoms.

Mothers in all groups primarily perceived ADHD-HI symptoms as “hyperactivity”, followed by the perception that these behaviors are defiant or disrespectful. However, consistent with their perceptions of ADHD-I symptoms, middle-SES mothers were more likely to perceive the behavior as an emotional problem (18.4%), compared to low- and high-SES mothers (1.2% and 3.3%, respectively). Moreover, they primarily described anxiety-related problems (“feels anxious”, “nervous about something”) as opposed to the depression-like concerns described for ADHD-I symptoms. Anxiety-related problems were most commonly endorsed in response to the ADHD-HI symptoms “fidgets with hands or feet or squirms in seat” and “seems restless”, which are both non-specific symptoms that may also reflect DSM-IV anxiety disorders. Considered together with results related to ADHD-I symptoms, middle-SES mothers were more likely than low- and high-SES mothers to attribute ADHD symptoms to

underlying emotional problems, which are presumably viewed as internal to the child and difficult to control.

ODD symptoms were perceived as being associated with or caused by an emotional problem, primarily depression-like concerns, and low-SES mothers were more likely to emphasize concerns related to depression (40.1%) than middle- or high-SES mothers (30.6% and 33.3%, respectively). It is interesting that middle-SES mothers did not endorse this belief most often, given that they attributed ADHD symptoms to emotional problems more often than mothers in the other groups. Consistent with their tendency to perceive ADHD symptoms in ways that suggest that the behavior is under the child's control, high-SES mothers perceived ODD symptoms as purposefully defiant or disrespectful (21.9%), more often than low- and middle-SES mothers (12.7% and 9.7%, respectively). High-SES mothers also discussed these as simple attention-seeking behaviors (10.5%) more often than low- and middle-SES mothers (3.8% and 3.2%, respectively). These results suggest that, similar to responses for ADHD, low-SES mothers attributed ODD symptoms to factors that are internal to the child and not highly controllable, whereas high-SES mothers most often attributed them to situational and controllable factors.

*Quantitative ratings of perceived behavior severity.* Qualitative data were further clarified when quantitative ratings of perceived severity were examined, indicating that mothers perceived ODD symptoms as more problematic than ADHD symptoms (Table 3). Further, ADHD-I symptoms were rated as more problematic than ADHD-HI symptoms. Thus, ADHD-HI symptoms were rated as least problematic, which is consistent with qualitative results suggesting neutral and sometimes positive perceptions

of some ADHD-HI symptoms. Quantitative ratings of perceived severity did not vary notably by SES.

In sum, mothers did not experience difficulty understanding DSM-IV symptoms of ADHD or ODD, with the exception of one ADHD-HI symptom (“acts as if driven by a motor”). ADHD-I and ADHD-HI behaviors were primarily perceived as attention problems and hyperactivity, respectively, suggesting that the most commonly endorsed perceptions are consistent with the actual clinical disorder. Along the same lines, impulsive symptoms were discussed in ways that are consistent with the underlying nature of these symptoms, namely an inability on the child’s part to regulate their behavior in a manner consistent with social rules or norms. Interestingly, a difference in the way mothers perceived hyperactive versus impulsive symptoms was noted. While hyperactive symptoms were largely perceived as normal and/or a positive child characteristic, impulsive symptoms were largely perceived as disrespectful and rude. Lastly, mothers primarily perceived ODD symptoms as some form of emotional problem, followed closely by the perception that the behaviors were defiant and disrespectful. Given the overlap between symptoms of ODD and symptoms of depression, as well as the inherently defiant nature of ODD, these perceptions are also relatively consistent with the clinical disorder.

Closer examination of qualitative responses further indicated that mothers discussed attributions along a continuum related to the perceived degree of control a child or parent may have over ADHD and ODD behaviors. More specifically, some symptoms were attributed to an underlying problem or deficit that is internal to the child and is not within his or her control (e.g., biological, emotional problem), while other symptoms

were attributed to situational factors within the child's or parent's direct control (e.g., lacks motivation, defiant/disrespectful, lacks discipline). Further, perceptions and attributions differed by SES such that low- and middle-SES mothers most often attributed ADHD and ODD to "internal" and uncontrollable causes, while high-SES mothers were more likely to attribute ADHD and ODD to "external" and controllable factors.

Finally, mothers discussed some parental responsibility for preventing or managing ADHD and ODD behaviors, though there was a difference in the role parents are believed to play in managing the two disorders. With regard to ADHD, they discussed the parent's responsibility to provide more structure and be more involved in the child's completion of tasks, which is in line with their perceptions of an attention *deficit*. On the other hand, with regard to ODD, they discussed the need for parents to increase their level of attention toward the child and to decrease exposure to negative stressors, in line with their beliefs that these behaviors are caused by an emotional problem. They also suggested parents should prevent or manage ODD behavior by using more discipline with the child, consistent with their perceptions of this behavior as purposefully defiant and disrespectful.

#### *Parental responses to clinical-level ADHD and ODD symptoms (Aim 2)*

To review, during the second segment of the interview, mothers read two vignettes depicting children with clinical levels of ADHD or ODD behavior and were asked to describe how and why they would respond to the behavior if it was their own child. Quantitative data regarding perceived severity of ADHD and ODD behavior, likelihood of seeking mental health treatment or using medication for child behavior, as well as negative emotional reaction to behavior, was obtained via 5-point Likert-scale

ratings on the Vignette Rating Form (VRF). Qualitative data provided in response to each behavioral vignette are presented in turn, first for the entire sample and then by SES, followed by results of quantitative data.

*Parental responses to ADHD.* During open-ended discussions, mothers emphasized a variety of parenting and help-seeking responses to the ADHD behavior depicted in the behavioral vignette. Given the broad nature of the interview question (i.e., “How would you respond to this behavior if your child actually behaved in a similar manner and why?”), all mothers discussed use of various parenting strategies. Mothers were not probed specifically about whether they would seek any professional services for the behavior, but the majority of mothers (76%) reported that they would seek mental health treatment for ADHD and a small proportion also reported that they would consult with the child’s pediatrician (20%). Finally, about half of the mothers reported that they would seek school-based services or assistance for their child’s behavior (52%).

With regard to parenting strategies, mothers discussed use of both proactive and reactive strategies in response to ADHD behavior, and proactive parenting strategies were more commonly endorsed than reactive strategies (59.6% and 26.3% of reported parenting strategies, respectively). As described above, proactive parenting strategies have been defined as those strategies used by parents with the goal of socializing children toward specific competencies and reactive strategies are aimed at modifying or eliminating maladaptive behaviors (Rubin et al., 1989).

In general, proactive parenting strategies reported in response to the ADHD vignette largely focused on ways parents would facilitate the child’s completion of tasks, particularly school-related tasks (e.g., homework). More specifically, mothers expressed

that children displaying ADHD behavior need more structure in their daily routines and a higher level of parental assistance in order to complete tasks. For instance, one mother described that she would “try to create a schedule for him...I would find a specific place for him, like a table, for him to keep all his things from school... and I would help him with his homework”. Another mother described that “having a routine helps you establish discipline... [because] if they don’t finish something on time, there are consequences”.

Reactive strategies endorsed in response to ADHD largely centered on using contingent reinforcement for child behavior (i.e., remove privileges/assign chores for negative behavior and praise/reward for positive behavior), which were also largely focused on addressing school-related behavior (e.g., failing to complete tasks, disrupting class). Mothers discussed using removal of privileges as their primary method of discipline, describing that “if the teacher gives me a bad report, I won’t take him to McDonald’s with the other kids” and “I would take his Gameboy [videogame] and everything he likes, like TV”. Although they emphasized praising/rewarding for appropriate behavior less often than removing privileges, they did endorse this strategy as well, noting that “kids need to be stimulated too... give them a little prize for doing well”.

Of note, no mothers endorsed use of physical discipline in response to ADHD behavior. In fact, when probed about whether they would use physical discipline (e.g., spanking) to address ADHD behavior, mothers expressed concerns about using more punitive forms of discipline, commenting that “I don’t know about discipline for this... because the behavior you describe sounds like a child who needs more than punishment...”.

As noted above, the majority of mothers reported that they would seek help for their child, in the form of mental health services, primarily from a psychologist, or through school-based support/services. Mothers discussed reasons they would seek mental health services and noted concerns that the child could have an emotional disturbance (e.g., problems with self-esteem, “internal conflicts”) and “needs someone to talk to” or having the child “evaluated” to “understand what the problem is” as the primary reasons they would see a mental health professional. Additionally, several mothers noted concerns regarding the extreme nature of the behavior as the motivation for seeking mental health treatment. For example, mothers commented that “there’s just too many things going on here [in the vignette]... too many” and “I would ask for professional help because this doesn’t seem like a normal problem... a normal behavior problem, the parents can resolve it... but not this”.

Mothers also reported that they would seek help for ADHD behavior through their child’s school and described various types of school-based interventions or assistance. For example, mothers discussed that they would ask the teacher to send home some form of daily or weekly communication regarding both the child’s academic tasks and behavior. For instance, mothers described requesting “a note from Monday through Friday with all his homework”, “[asking] the teacher to send me a report about his behavior every week”, and “ask[ing] for a daily report from the teacher”.

In addition to this form of communication, mothers also reported that they would try to speak to teachers and school administrators directly (e.g., “I would talk to his teacher”, “request a meeting with the teachers”, “talk to the director of the school”). During this discussion, mothers alluded to the responsibility of teachers to help the child

in order to prevent academic consequence (e.g., “the teacher’s job is to help the child learn... they have to help him so he can learn”) and that they would request more teacher involvement with the child (e.g., “ask the teacher to take more time with him”). Further, mothers also noted that it is important for there to be collaboration and communication between parents and teachers, expressing “ we are all involved in this [problem]... the child is in school the majority of the day, so we have to do this together”.

Concerns regarding the academic and school-related consequences of the ADHD behavior were endorsed as the primary reason mothers would seek services at school. For instance, mothers expressed that “the child needs help so he can learn, because if not, he’s not going to learn anything”. Further, mothers discussed concerns about the disruptive nature of the hyperactive behaviors described in the vignette (e.g., “the teachers say that this disturbs the other students and makes it difficult for the teacher to teach”) and noted that these behaviors would be problematic because “[they are] bothering others in class... affecting other students” and the teachers “would probably be calling me all the time... to come to meetings”.

Overall, concern regarding ADHD behavior was largely related to behaviors that would affect the child’s academic/school functioning, which would prompt the use of proactive parenting strategies aimed at facilitating academic task completion, reactive parenting strategies aimed at addressing failure to complete tasks and disruptive classroom behavior, and school-based help-seeking such as more frequent contact and collaboration with teachers and school personnel. Of note, the ADHD behavioral vignette depicted problem behaviors in the school setting, consistent with DSM-IV criteria, which may have specifically elicited these concerns.

Examination of parenting and help-seeking responses to ADHD by SES indicated no notable differences in reported parenting strategies, with mothers in all groups emphasizing the use of proactive parenting strategies to address ADHD behavior. However, there was one notable difference with regard to help-seeking. The majority of mothers in each group reported that they would seek mental health services for ADHD; however, most low-SES mothers (87.5%) also reported that they would seek school-based services, while this was reported less often among middle- and high-SES mothers (14.3% and 50%, respectively). Furthermore, low-SES mothers emphasized seeking school-based services as their “first response” to ADHD, while middle- and high-SES mothers most commonly reported seeking mental health services as their “first response” to ADHD.

To summarize, mothers reported proactive parenting strategies more often than reactive strategies in response to ADHD behavior. Proactive strategies were largely focused on providing more structure in the child’s daily routine and increasing parental involvement in the child’s activities with the goal of facilitating task completion. Further, contingent reinforcement of child behavior was the most commonly reported reactive parenting strategy in response to ADHD behavior. Mothers also commonly endorsed help-seeking responses for ADHD and specified that they would either seek mental health treatment or school-based services for their child. Furthermore, mothers reported a variety of reasons for help-seeking, emphasizing concerns about the child’s emotional and behavioral functioning as the primary reason they would seek mental health services, while emphasizing concerns regarding academic functioning as the primary reason they would seek school-based services. Responses were similar across SES, with the

important exception that low-SES mothers reported that they would seek school-based services more often than mothers in the other group, and emphasized seeking school-based services as their “first response” to ADHD.

*Parental responses to ODD.* In response to the ODD vignette, all mothers discussed using various parenting strategies, but reported minimal help-seeking for ODD behavior. In contrast to what they reported for ADHD, mothers emphasized use of reactive parenting strategies in response to ODD more often than proactive strategies (45.3% and 33.3% of all parenting responses, respectively) in response to ODD behaviors. Moreover, mental health treatment seeking was endorsed less often for ODD (48% of mothers), compared to ADHD (76% of mothers), and school-based help-seeking was only noted by 8% of mothers, compared to 52% of mothers endorsing school-based services for ADHD.

Mothers primarily reported that they would use reactive parenting strategies, mainly taking away privileges (28.8% of reactive parenting responses) and sending the child to his or her room (i.e., time out; 11.9% of reactive parenting responses) in response to ODD behaviors, in order to teach the child some type of lesson (e.g., respect, the consequences of their behavior) or to punish the child’s behavior. For example, mothers discussed that they would want to “teach them that you are the mother and you deserve respect and they have to do what you say the majority of the time” and that they would “take away everything he likes... so he learns that that behavior is not OK”. Specific to giving the child a time out, mothers described that “I would send her to her room so she can think about what she did”, “I would put them in their room a good while and explain why they have to stay there” and “he would be in time out, at that moment”. Thus,

removal of privileges and time out were described as the primary methods for punishing the child's ODD behavior.

Although less commonly reported, some mothers reported that they would consider using physical discipline “for this type of [disrespectful] behavior” (6.8% of reactive parenting responses). As emphasized by one mother saying “oh no... that's disrespectful and disobedient...for that type of behavior, I would spank him, there's nothing to talk about [with the child]”. However, when the interviewer probed further about the use of physical discipline, mothers noted concerns that this approach might actually intensify the child's negative behavior (e.g., “I think that would just make them more angry...”, “maybe that would make it worse”) and would probably not be effective.

Mothers reported some potential use of proactive parenting strategies in response to ODD, but placed less emphasis on these strategies than reactive strategies. The most commonly endorsed proactive strategy was “talk to [the child]”. Mothers discussed this primarily as a way to increase communication with the child in order to help the child express him or herself and to meet the child's emotional needs, and this was commonly discussed in conjunction with attributions regarding an underlying emotional cause for ODD behavior. For example, one mother discussed that it would be important “to communicate a lot so that they express themselves... so they know that they can tell me what's bothering them” and another commented that ODD behavior indicates that “they're looking for more attention from me... I would have to focus on our relationship so that they feel better”. Compared to parenting responses provided for the ADHD vignette, the goals underlying parenting strategies differed for ODD, with a primary focus on punishing misbehavior or talking to the child to encourage appropriate expression of

emotions or increase parental attention as a means of improving the parent-child relationship.

Though mothers generally reported less help-seeking in responses to ODD, when they did endorse help-seeking, they primarily reported that they would seek mental health treatment for this behavior. Mothers reported that the primary goal of seeking mental health treatment would be to get help for the child's "emotional problems" by finding them "someone to talk to". For instance, one mother noted that she would seek treatment because "something is bothering him... maybe he's having problems at school with their friends or something..." Another mother commented that she would seek treatment because the child likely "has a 'mental' problem... a psychological problem..." and added that they may display ODD behaviors because "they haven't received affection, love, or support..." Lastly, mothers also reported some help-seeking specifically related to getting help with parenting (i.e., parent training; 8% of mothers), and this was related to beliefs that ODD behavior is reflective of a parent's inability to manage their child's behavior (e.g., "something is missing in me... if my child doesn't obey [defies] me"). Taken together, both reported parenting and help-seeking responses are consistent with mothers' primary perceptions of ODD behavior as being related to an underlying emotional problem, such as depression, and their beliefs that parents are at least somewhat responsible for preventing or manage these behaviors by increasing communication with and/or disciplining the child (discussed above).

Several differences were noted in reported parenting and help-seeking responses to ODD by SES. First, while mothers in the low- and high-SES groups emphasized the use of reactive versus proactive strategies in response to ODD behavior, mothers in the

middle-SES group emphasized the use of proactive strategies more than reactive parenting strategies. Secondly, similar to results related to the ADHD vignette, 25% of low-SES mothers reported that they would seek school-based services to get help with their child's ODD behavior, while no middle- or high-SES mothers reported that they would seek school-based services for this behavior. Additionally, the majority of high-SES mothers reported that they would seek mental health services for ODD behavior (60%), while this was less commonly endorsed by mothers in the low- and middle-SES groups (37.5% and 14.3% of mothers, respectively). Further, mothers in the high-SES group were the only ones to specifically report that they would seek treatment to get help with parenting (i.e., parent training; 20% of high-SES mothers).

Overall, mothers primarily discussed that they would use various reactive parenting strategies to address ODD behavior, and reported minimal help-seeking for this behavior. Reactive parenting strategies were endorsed with the overarching goals of teaching the child a "lesson" or punishing the child. The most commonly reported proactive parenting strategy was talking to the child, with the goal of improving the child's level of emotional functioning and the parent-child relationship. Examination of data by SES indicated that low-SES mothers reported that they would seek school-based services in addition to mental health treatment for ODD, while middle- and high-SES mothers only reported that they would seek mental health services for ODD. High-SES mothers discussed seeking mental health services slightly more often than mothers in the other groups and mothers in the high-SES group were the only ones to report that they would seek help with parenting (i.e., parent training).

*Quantitative ratings in response to hypothetical behavioral vignettes.* To provide a more in-depth understanding of parental perceptions and responses to clinical levels of ADHD and ODD behavior, quantitative ratings regarding perceived behavior severity, likelihood of seeking mental health treatment and using medication for the depicted child behavior, and negative emotional reactions were obtained on the VRF (Appendix G).

These quantitative data were in line with themes discussed throughout the qualitative interviews. Ratings of perceived severity indicated that mothers rated the ADHD behavior depicted in the vignette as more problematic than the ODD vignette. Interestingly, these ratings differed from mean ratings of perceived severity provided in response to DSM-IV symptoms in which mothers rated DSM-IV symptoms of ODD as more problematic than ADHD (see Table 3). This difference in perceived severity may be accounted for by the additional contextual information provided in the vignettes, particularly with regard to the school-based problems depicted in the ADHD vignette, about which mothers expressed significant concerns during interviews.

Mothers reported being slightly more likely to seek mental health treatment for ADHD than for ODD (see Tables 4 and 5), as noted in their open-ended responses; however, ratings were moderately high for both disorders. Similarly, mothers uniformly reported a low likelihood of using medication for both ADHD and ODD, but possible medication use was rated higher for ADHD than for ODD. This is consistent with evidence-based treatment approaches, with medication used more often and demonstrating higher effectiveness in treating ADHD compared to ODD (DuPaul & Weyandt, 2009). Likelihood of seeking mental health treatment for ADHD and ODD was notably lower among low-SES mothers compared to middle- and high-SES mothers. This

is consistent with results suggesting that low-SES mothers may be more likely than middle- and high-SES mothers to seek school-based services, particularly for ADHD.

With regard to the emotional reaction mothers would reportedly experience if their child displayed ADHD or ODD behavior (see Tables 4 and 5), mothers reported a moderate level of negative emotions overall, and mean ratings were higher in response to ODD compared to ratings provided in response to ADHD. Closer examination of emotional reaction ratings indicated that mothers would feel a moderate amount of disappointment, guilt, anxiety and sadness if their child displayed behavior similar to that in the ADHD vignette and a moderate amount of anger, disappointment, embarrassment, guilt, anxiety and sadness in response to ODD. Furthermore, the item regarding “how hurt [would you feel]?” was also rated at a moderate level in response to ODD.

Comparison of specific emotional reactions to ADHD versus ODD suggests that mothers reported several similar emotions in response to both, but endorsed relatively more anger, embarrassment, and “hurt” feelings in response to ODD compared to ADHD. These data are consistent with the level of reactive parenting mothers discussed in response to the ODD vignette, suggesting greater use of reactive parenting for behavior that elicits a stronger emotional reaction. This pattern of results was demonstrated among low- and high-SES mothers, while middle-SES mothers reported similar levels of negative emotional reactions to both ADHD and ODD. This may be due to the fact that middle-SES mothers perceived ADHD and ODD similarly, primarily attributing both to an underlying emotional problem.

Quantitative data were consistent with primary themes emerging from qualitative data, indicating higher levels of perceived severity of ADHD behavior compared to

ODD, as well as a slightly higher likelihood of seeking mental health treatment for ADHD than ODD. Finally, mothers endorsed a moderate amount of negative emotions in response to both ADHD and ODD vignettes, but ratings of the intensity of negative emotions were higher for ODD than for ADHD.

*Parental Socialization Goals (Aim 3)*

The final segment of the interview consisted of open-ended and semi-structured questions regarding child-rearing values and socialization goals. The semi-structured interview included questions related to nine values typically considered “traditional/cultural” and “U.S. mainstream” values (e.g., Harwood et al., 2001; Harwood et al., 2002). During the semi-structured interview, there was a consensus among all mothers that each value we discussed was “important” or “very important”. Open-ended responses varied by SES and those results are discussed below.

In general, mothers emphasized four values or characteristics most often throughout this discussion: (1) being a “good person” with positive personality characteristics (e.g., honest, kind; 31.9% of responses); (2) being respectful, well-behaved, and demonstrating good manners (20.6% of responses); (3) being academically-oriented, intelligent and educated (18.6% of responses); and (4) achieving high professional goals (e.g., “getting ahead in life”, “having a professional title”; 16.5% of responses). Additionally, mothers commonly discussed a link between educational achievement and professional goal attainment. For example, one mother noted “I want them to become something, to have a professional title... I’m always talking to them about [the importance of] education... that they should study a lot”.

When open-ended responses were examined within and across SES groups, minimal differences were noted (see Table 6). First, low- and high-SES mothers emphasized educational achievement and being respectful/well-behaved more often than middle-SES mothers. Secondly, low- and middle-SES mothers emphasized professional goal attainment more often than high-SES mothers. Further exploration of these results within groups clarified the differences with regard to educational achievement and professional goal attainment. First, low-SES mothers highly valued *both* educational achievement and professional goal attainment and consistently discussed them together, highlighting the idea that educational achievement facilitates professional goal attainment. Middle-SES mothers also emphasized professional goal attainment, but discussed both educational achievement *and* leadership skills as important components of reaching professional goals. Lastly, high-SES mothers emphasized educational achievement, but not professional goal attainment. Similar to mothers in the other groups, high-SES mothers discussed education as the method for achieving professional goals, but they did not discuss professional goal attainment as a primary “aspiration” for their children; rather, this may be an “expectation” among this group of mothers. Despite these subtle differences in relative emphasis, mothers in all groups highly valued the same socialization goals for their children.

*“Cultural” versus “mainstream U.S.” values.* All mothers agreed that the nine “cultural” and “mainstream” values included in the semi-structured interview were “important” or “very important”, with one notable exception. The notion of unquestioned obedience (i.e., “obey all adults”) was rejected by all mothers to some degree. Mothers commonly distinguished between respect and obedience and noted that they expect their

children to be respectful, but not necessarily to “obey”. For example, one mother commented, “well, respect yes, obey *everyone*, no” and another mother noted “I don't know about obey *all* adults... my child isn't a dog, you know, he doesn't have to *obey*, but he has to respect.” Mothers voiced concerns about their child following all directives without using their own judgment and noted specific concerns regarding the potential for the child to be sexually abused by an adult or to face peer pressure to engage in inappropriate activities (e.g., drug use).

Consistent with these ideas, mothers emphasized the value of respect (*respeto*), but did not simply describe it as “obedience toward adult authority figures”, as it has been most commonly defined in some of the existing literature focused on cultural values among Latino parents (e.g., Zayas & Solari, 1994). While these ideas were discussed, mothers largely emphasized the importance of demonstrating respect in order to facilitate strong and positive relationships and in order to get respect from others. For example, one mother explained that it is important for her child to show respect because “...the adults in his life will want to help him... for example, if he is disrespectful to his teacher, that teacher is not going to want to do things to help him, go that extra step for him... so he needs to show her respect to get her on his side”. Other mothers commented on the importance of mutual respect, saying that “if she respects others, she will be respected herself...” and “if I don't respect them, they won't respect me”. In short, mothers primarily endorsed beliefs that demonstrating respect will be important in their children's ability to form positive and mutually respectful social relationships.

Mothers also emphasized a high regard for social relatedness when they were asked about the importance of getting along with others and being loyal to family, and

commonly noted that they value a high degree of interdependence among friends and family. For example, one mother discussed how important it is for her child to learn to get along with others so that he can then count on people when he needs them. Other mothers commented that learning to get along with others is important because “he’ll be able to communicate with other people and build relationships” and because “I want my child to learn how to make friends and be part of a group”. With regard to family loyalty, mothers often noted that the “family comes first” because it forms the child’s “foundation”, giving them “security” and comfort in “always know[ing] that he belongs somewhere”.

On the other hand, mothers also highly endorsed “independence” and viewed it as being especially important for the child’s “future”. More specifically, mothers discussed valuing independence in their children and discussed this mostly with regard to not wanting the child to be overly dependent on parents as they get older. For example, mothers noted “I won’t be around forever, so I feel like a mom’s job is to teach her kids how to do what they need for themselves” and that “this is important because say something happens to me and I’m not here tomorrow and can’t help them, they’ll already be independent”.

Similarly, having “confidence” was viewed as important to the child’s future development and was linked specifically to the child’s ability to pursue their goals. For example, mothers noted that “if he feels sure of himself, whatever he decides to do, he’ll do it well” and “if she’s confident, she’ll be good at things... if she’s confident in what she’s doing even if she fails or falls in whatever she’s trying to achieve, she’ll always try to get back up and go for it versus giving up”.

Ideas related to being independent and confident were highly similar to what mothers discussed in relation to “a child’s ability to freely express themselves even if they disagree with you”. The majority of mothers highly endorsed this and reported that this would help the child learn to confidently express their ideas, which would help them navigate various situations. For example, mothers commented that “everyone has an opinion... he should be able to tell me what he thinks... that will make him a really independent man later...” and “[that] will help them in the future to be able to help themselves in any situation”.

Finally, mothers also noted that learning to express their opinions is important for children because it facilitates open communication and conflict resolution with parents, noting that “this is the way to [engage in] a dialogue and communication” and “they should be able to tell me why they didn’t agree with me and then we can work on that”. Consistent with ideas discussed above, many mothers emphasized the need for such disagreements to be expressed in a respectful manner. For example, mothers noted “that’s important, as long as he knows *how* to speak his mind... I think communication is very important. I want him to be able to tell me how he feels, but to do it the right way” and “he has to say it with respect, he can't just be all disrespectful, but if he's respectful about it, he can disagree with me”.

Taken together, these results indicate that Latina mothers highly emphasized child characteristics that would facilitate the child’s ability to form strong relationships with family and friends and endorsed a high regard for educational achievement and professional goal attainment. Considered in light of ADHD and ODD symptoms, it is likely that mothers would perceive ADHD behavior as highly disruptive to the child’s

academic functioning, while perceiving ODD behavior as disruptive to their child's interpersonal functioning. As such, parental socialization goals, including both educational/professional goal attainment and relationship development, may play an important role in the manner in which parents perceive and respond to these behaviors. Finally, mothers in all SES groups largely endorsed the same broad values and socialization goals; though there were some minor differences in the relative emphasis they placed on each.

Results related to "cultural" and "mainstream" values were consistent with these socialization goals and indicated that mothers highly emphasized *both* cultural (e.g. *respeto*) and mainstream U.S. (e.g., independence) values. In addition, cultural values were most commonly discussed as important components of the child's "foundation" that facilitate the child's ability to form strong relationships, whereas characteristics associated with mainstream U.S. values were viewed as important to their pursuit of educational and professional goals.

### *Summary of Results*

In sum, results indicated that, with few exceptions, mothers did not experience significant difficulty understanding DSM-IV symptoms of ADHD or ODD as described on a commonly-used DSM symptom scale and that the way they perceive these behaviors is largely consistent with the respective clinical disorders. Further, in describing their perceptions of ADHD and ODD symptoms, a notable theme emerged with regard to causal attributions of behavior and the perceived level of control mothers believe they or their children might have over the behavior. For both ADHD and ODD, mothers endorsed attributions regarding internal/uncontrollable causes of behavior (e.g.,

biological problem), as well as external/controllable causes (e.g., purposeful defiance). In addition, causal attributions varied notably along this continuum by SES, with low- and middle-SES mothers most commonly discussing internal and uncontrollable causes, while high-SES mothers primarily discussed factors that were external and controllable by the parent or child, for both ADHD and ODD behavior.

With regard to parental response to behavior, mothers reported differential parenting and help-seeking responses for ADHD versus ODD that seemed to align with causal attributions and parental socialization goals. Mothers reported more proactive parenting (e.g., setting structure, supervision) and both mental health and school-based help-seeking in response to ADHD compared to ODD, for which they primarily reported more reactive parenting (e.g., punishment). Further, results suggest that parental socialization goals may motivate parental responses to behavior that are aimed at preventing or addressing perceived disruption to the child's functioning in associated domains. Specifically, parenting and help-seeking responses to ADHD may be highly motivated by perceived academic impairment, which is contrary to parental aspirations for their child to reach high educational and professional goals. On the other hand, parental response to ODD may be motivated by the importance mothers place on the child's ability to form and maintain positive interpersonal relationships, which could be negatively impacted by the poor emotion and disrespectful behavior characteristic of ODD (Cole et al., 1994; Hinshaw & Lee, 2003; Mullin & Hinshaw, 2007). Finally, while reported parenting responses did not vary notably by SES, help-seeking responses did vary by SES, with low-SES mothers endorsing more school-based help-seeking than mothers in other groups, who reported more mental health treatment-seeking.

## Chapter 5: Discussion of Results and Implications

Four major findings emerged from this study. First, Latino mothers did not experience significant difficulty in understanding DSM-IV symptoms of ADHD or ODD and the way they perceive these behaviors is largely consistent with clinical disorders. Second, self-reported parenting and help-seeking responses to clinical levels of ADHD and ODD behaviors were linked to external versus internal causal attributions across both disorders. Third, parental socialization goals which reflect strong values on educational/professional goal attainment and positive interpersonal skills were associated with reported parenting and help-seeking responses to ADHD and ODD, respectively. Finally, trend differences in results by level of SES showed that low-SES mothers reported a greater tendency to seek services from their child's school than from mental health providers. Overall, results suggest important clinical implications for assessment practices and recruitment and engagement of Latino families into treatment for child ADHD and ODD. Higher use of treatment by Latino families for these childhood disorders could contribute to reducing service use disparities among this underserved population.

In this chapter, these four major findings are discussed within the context of existing literature. Using the grounded theory approach, current models of factors that are associated with parental response to child behavior are extended based on emerging constructs from the current study to propose a model that can be tested in future studies with Latino families. Clinical implications for working with Latino parents in the assessment and treatment of child ADHD and ODD are also presented. The chapter concludes with important limitations of the present study.

Mothers in this study did not experience difficulty understanding the meaning of most DSM-IV symptoms of ADHD and ODD, and endorsed perceptions that are consistent with the underlying conceptualization of the respective clinical disorders. Indeed, primary perceptions endorsed for ADHD-I and ADHD-HI items were primarily perceived as “attention problems” and “hyperactivity”, respectively. Similarly, mothers accurately described ODD behaviors in terms of poor emotion regulation and active defiance, which is in line with characteristics of ODD (Cole et al., 1994; Hinshaw & Lee, 2003; Mullin & Hinshaw, 2007). This suggests that the current language used to define ADHD and ODD is understandable and relevant to the way that Latino mothers perceive and identify these behaviors, which has implications for assessment practices.

An interesting pattern of results emerged when perceptions of ADHD symptoms were examined more closely. Specifically, there was a difference in the way mothers perceived hyperactive versus impulsive symptoms and hyperactive versus inattentive symptoms. Whereas hyperactive behaviors were sometimes perceived as normal or representative of *positive* personality characteristics, impulsive behaviors were largely perceived as “rude” and contrary to social rules and norms, suggesting that mothers would likely respond to these two types of behaviors differently. The finding that mothers perceived hyperactive behaviors as normal or positive child characteristics is not consistent with findings of a qualitative study among a small group of Latino mothers who sought treatment for their child’s ADHD, which found that “hyperactivity” was among the primary reasons mothers ultimately sought mental health treatment for their child (Arcia & Fernandez, 2003a). Additionally, mothers in Arcia’s study reported that school complaints about the child’s disruptive classroom behavior were among the

primary reasons they would seek mental health treatment. In light of the fact that hyperactive and impulsive behaviors in the classroom are common complaints about students with ADHD among teachers and school staff, results of Arcia's study may actually represent parental concerns regarding school-based problems, as opposed to hyperactive behavior itself.

Considered together with results of the present study which suggested a neutral or positive perception of hyperactive behavior, it may be the case that Latino mothers perceive hyperactive behavior as problematic only in the context of school-related impairment, but may be less concerned about these behaviors at home. Therefore, efforts among teachers and school staff to collaborate with Latino parents in addressing these behaviors in the classroom may be more successful if teachers emphasize concerns about the specific academic and social consequences associated with the child's behavior, rather than simply describing the child's behavior regarding their level of "activity" (e.g., child leaves seat), which may be perceived by parents as normal child behavior. Framing behaviors within the academic context may highlight for parents the importance of addressing such behaviors to enhance educational achievement, and therefore motivate parents to actively participate with school-based interventions in order to reduce impairment.

Mothers also discussed perceptions of an underlying emotional problem for ADHD symptoms, perceiving anxiety-related problems for hyperactive symptoms and depression-like problems for inattentive symptoms. Results of a previous study among Latino mothers of children with ADHD similarly indicated that mothers used many anxiety-related descriptions for their child's hyperactive and restless behaviors (Arcia et

al., 2004). In contrast, mothers in that study characterized inattentive behaviors as shyness, rather than “sadness”, as was found in the present study. Nevertheless, results of the present study suggest that Latino parents may perceive, and subsequently respond to, some ADHD behaviors based on their perception of an underlying emotional problem. These perceptions are not completely inaccurate given that DSM-IV symptoms of depression include concentration problems and symptoms of anxiety include restlessness and behavioral agitation. However, symptoms are intrinsically different when manifested as a result of ADHD versus depression or anxiety. This finding has important implications for conducting ADHD assessments with Latino parents, during which it will be crucial to thoroughly assess emotional problems. Careful assessment of both ADHD and internalizing disorders in Latino children will enable clinicians to disentangle parental perceptions which may lead parents to report “emotional problems” that may be better accounted for by ADHD or vice versa.

To my knowledge, this is the first study that has examined perceptions of *each* individual DSM-IV symptom of ADHD in this manner. Previous studies have failed to distinguish between hyperactive and impulsive symptoms, and the majority of studies have also not distinguished between inattentive and hyperactive/impulsive symptoms when assessing perceptions of ADHD. While examining these ADHD symptom clusters is consistent with the theoretical conceptualization of the disorder, it does not allow for a clear understanding of parental perceptions of specific child behaviors, and may therefore mask associations between perceptions and parental response. For example, Gerdes and Hoza (2006) examined parental attributions for “inattentive-impulsive” symptoms depicted in a behavioral vignette. Results revealed that parents viewed these behaviors as

less controllable, but intentional, which was associated with more power assertive parenting among mothers of children with ADHD. In contrast, results from the present study suggest that several symptoms of inattention were perceived as an uncontrollable *deficit* that presented a challenge for the child, to which parents would likely respond differently than the inattentive and impulsive symptoms that were perceived as controllable and purposeful (e.g., not listening when spoken to directly, interrupting).

In light of this, research that only examines perceptions of symptom clusters (e.g., Gerdes & Hoza, 2006), may not accurately describe the link between parental attributions and parental response to specific behaviors. Present results help clarify parental perceptions of ADHD and ODD symptoms among Latino mothers, which is especially helpful in understanding which behaviors they may find most bothersome, their differential parenting responses to these behaviors, and the target behaviors they would prioritize in applying behavior management strategies recommended in parent training or in school-based interventions.

Overall, these results suggest good parental understanding of items used on behavior rating scales to assess parent report of ADHD and ODD symptoms and generally accurate perceptions of behavior that are consistent with the nature of the clinical disorders. Considered together with quantitative ratings indicating high levels of perceived severity and moderate levels of likelihood of help-seeking for both ADHD and ODD behavior, these results challenge the argument that Latino parents may demonstrate differential “distress thresholds” (Weisz et al., 1985; 1988) in perceiving child behavior as problematic. Indeed, present results indicate that Latino parents are likely to perceive ADHD as problematic enough to motivate help-seeking responses, though less so for

ODD. Overall, mothers endorsed both mental health and school-based help-seeking at a level that is higher than what might be expected based on existing research demonstrating low levels of perceived need for and actual service use among Latino parents (Alegria, Canino, Lai, Ramirez, Chavez, Rusch, et al., 2004).

These findings are important because they suggest that Latino mothers have some knowledge of these disorders and perceive them as problematic enough to motivate professional help-seeking, which is considered the first step in the help-seeking process (Eiraldi et al., 2006). However, given the demonstrated lack of service use among Latino parents (Alegria et al., 2002; Bui & Takeuchi, 1992; Hough et al., 2002; Katkaoka, et al., 2002; McCabe et al, 1999), an important area for future research would be to examine barriers to help-seeking among parents of children who have already been identified as being at risk or formally diagnosed with ADHD, but have not received treatment. Such research may help identify ways to engage parents who are between the first (i.e., problem-recognition) and second (i.e., decision to seek help) steps of help-seeking (Eiraldi et al., 2006) and may elucidate barriers that play an important role in help-seeking (e.g., lack of knowledge regarding available services). Moreover, efforts should be made to identify sources of information that Latino families regularly use and effective outreach methods aimed at increasing knowledge and awareness of the need to seek treatment for ADHD and ODD and available services.

Qualitative data revealed a notable theme regarding causal attributions of behavior endorsed by mothers in response to both individual DSM-IV symptoms and behavioral vignettes. For both ADHD and ODD, mothers endorsed attributions along a continuum of perceived level of child and/or parental control over behavior (i.e., locus of

control) and discussed both internal/uncontrollable causes of behavior as well as external/controllable causes for both ADHD and ODD. To briefly review, mothers attributed ADHD-I symptoms to an attention *deficit* or biological/inherited problems that are internal to the child and outside their direct control, which is consistent with the nature of ADHD. On the other hand, for both ADHD-I and ADHD-HI symptoms, mothers also discussed perceptions and attributions related to the child's level of motivation, purposeful defiance or disobedience, or parental responsibility to manage these behaviors, which suggest underlying perceptions that behaviors are related to external factors that are controllable by the child or parent. Mothers primarily attributed ODD behaviors to underlying emotional problems, which are presumably internal to the child and uncontrollable, or at least difficult for the child to manage on his or her own. On the other hand, mothers also viewed ODD behavior as actively defiant and disrespectful, suggesting they also perceived this behavior as purposeful, and therefore controllable.

These findings are highly consistent with existing models of parental attributions for child behavior which postulate that parents make attributions along three general dimensions: "locus address" (i.e., whether cause of behavior is internal or external to child), locus of control (i.e., extent to which cause of behavior is controllable), and stability (i.e., whether cause of behavior is transient or stable; Bugental & Johnston, 2000; Joiner & Wagner, 1996; Weiner, 1986; 1993). Specific to ADHD and ODD, previous research, conducted primarily among middle-class Caucasian mothers, has demonstrated that parents of children both with and without these disorders attribute ADHD symptoms to less controllable factors, while attributing ODD to more controllable

factors (Freeman, Johnston, & Barth 1997; Johnston et al., 2006; Johnston & Freeman, 1997;) and that parents attribute ADHD-I symptoms to more internal, uncontrollable, and stable factors than ADHD-HI symptoms (Chen, Seipp, & Johnston, 2008). Latino mothers in the present study endorsed similar attributions for child behavior as those endorsed in the general body of literature. These findings are important given the relative lack of research examining parental attributions for ADHD or ODD among Latino parents.

Studies related to causal attributions for ADHD and ODD behavior among other racial and ethnic groups is also limited and has yielded inconsistent results (e.g., Bussing, Schoenberg, & Perwien, 1998; Mah & Johnston, 2007). For example, a study examining parental attributions of ADHD, conducted among middle-class Chinese-immigrant and Euro-Canadian mothers of non-problem children, mothers in both groups similarly attributed negative child behavior to factors outside the child's control and differences in parental attributions were not found between ethnic groups (Mah & Johnston, 2007). On the other hand, another study found differences in causal attributions between African American and Caucasian parents, with African American parents being significantly less likely to attribute ADHD to genetic causes, while being more likely to attribute it to external factors such as the child's diet (i.e., too much sugar), compared to Caucasian parents (Bussing et al., 1998). While these results remained significant in statistical analyses in which SES was controlled, this study did not specifically examine how causal attributions varied as a function of SES.

Results of the present study contribute to this limited body of research and underscore the need to examine the role of SES and other contextual factors in parental

perceptions of behavior. Indeed, qualitative data indicated that parental attributions varied by SES, such that attributions endorsed by low-SES mothers indicated lower levels of parental sense of control over both ADHD and ODD behavior, while attributions endorsed by high-SES mothers indicated a higher sense of parental/child control. This finding is consistent with a wide body of literature suggesting that low-SES populations, across racial and ethnic groups, are more likely to attribute various facets of both physical and mental health to factors outside their own control, whereas the reverse has been found among higher-SES groups (e.g., Caplan & Schooler, 2007; Lever, Piñol & Uralde, 2005; Maher & Kroska, 2002; Ross & Sastry, 1999; Wardle & Steptoe, 2003).

A possible explanation for these differences in attributions may be related to parental level of depression, which was reportedly higher among low-SES mothers. As discussed above, contextual sources of stress among lower-SES parents are known to impact general parental psychological well-being and level of depression. Further, research has demonstrated that problematic child behavior also significantly impacts parenting stress, negativity and depressed mood (Johnston & Pelham, 1990; Johnston et al., 2002; Ross et al., 1998). Thus, low-SES mothers of children with behavior problems may be especially likely to demonstrate high levels of stress and depression which may promote a sense of helplessness over their child's behavior. Indeed, higher levels of depression are typically accompanied by a sense of helplessness and hopelessness consistent with an external locus of control, which may lead mothers to feel less competent in managing their child's behavior, ultimately leading to parental withdrawal and lower levels of responsiveness that may further exacerbate negative child behavior (Chronis et al., 2007; Gerdes et al., 2007; Leckman-Westin, Cohen, & Stueve, 2009).

The role of causal attributions in parental response to child behavior has been highlighted across numerous models, which argue that parents attempt to understand the reasons for their child's behavior in order to determine the most appropriate parenting response (Dix & Grusec, 1983; Dix, Ruble, Grusec, & Nixon, 1986; Rubin et al., 1989). Drawing on these models, the information-processing model (Rubin et al., 1989) specifically delineates proactive parenting strategies aimed at increasing a specific skill or competency versus more "power assertive" reactive parenting strategies aimed at modifying or eliminating maladaptive behavior. Research in the area of parental attributions and parenting has demonstrated that parents react with more harsh and power assertive parenting strategies in response to problematic child behavior when they perceive the behavior as purposeful and under the child's control (Dix, Ruble, & Zambarano, 1989; Gerdes & Hoza, 2006; Johnston & Ohan, 2005).

In the present study, parental attributions regarding locus of control aligned with reported parenting response in expected ways. Mothers reported more proactive parenting strategies in response to ADHD (e.g., increasing parental involvement in academic task completion), which was generally viewed as less controllable, while reporting more reactive parenting strategies in response to ODD (e.g., time-out), which was generally viewed as more purposeful and controllable. Moreover, when they reported proactive parenting strategies in response to ODD (e.g., talking to the child), they were primarily focused on the child's perceived "emotional" problems, which are presumably viewed as less controllable by the parent or child. These results should be considered together with findings regarding parental perceptions and attributions of individual DSM-IV symptoms of ADHD and ODD, indicating differential causal attributions across symptoms of

inattention, hyperactivity, impulsivity, active defiance and emotional dysregulation, which may underlie differential parental responses across these behaviors.

Few studies have been conducted among Latino groups in the area of parental attributions and parenting. Drawing from a broader body of literature, only one study examined the associations between parental attributions of negative child behavior and parenting among 149 Latino mothers of children with developmental disabilities (Chavira, López, Blacher, Shapiro, 2000). Results of this study were similar to those found in the present study, with mothers viewing the child as being more responsible for problem behaviors characterized as a “behavioral excess” (e.g., temper tantrums), while viewing behaviors characterized as a “behavioral deficit” (e.g., lack of speech) as less controllable by the child. Results of this study also indicated that mothers who perceived the child to be more “responsible” for the behavior (i.e., in control) were more likely to report using more aggressive and harsh parenting strategies in response to those behaviors. Results of the present study contribute to this limited body of literature and provide valuable insight into the association between causal attributions and parental responses to *specific* behaviors associated with ADHD and ODD among Latino parents.

When it comes to child misbehavior in particular, existing models also argue that the negative affect elicited by child behavior plays an important role in determining the parents’ subsequent reaction (Rubin et al., 1989). In the present study, parents reported that they would experience moderate levels of negative emotions in response to both ADHD and ODD behavior in their own children, but reported higher levels of negative emotion for ODD. More specifically, mothers reported that they would feel moderate to high levels of anger, disappointment, and embarrassment if their child displayed ODD

behavior, which have been linked to increasingly coercive and directive reactive parenting strategies (e.g., Mills & Rubin, 1990; Johnston & Pelham, 1990; Johnston et al., 2002). Thus, results of this study are consistent with a large body of literature suggesting that parenting in response to child misbehavior is directly linked to parents' causal attributions for, and affective reactions to, the behavior.

Existing models of parenting beliefs and behavior note that, in addition to causal attributions, general socialization goals and parental expectations guide parenting efforts such that when faced with child behavior that is contrary to parental expectations and goals, parents will react by using parenting strategies they believe will be effective in directing the child's behavior toward their expectations (Dix & Grusec, 1983; Dix et al., 1986; Rubin et al., 1989). The present study extends these models by more clearly elucidating specific socialization goals among Latino mothers that may underlie their parenting, help-seeking, and emotional reactions to ADHD and ODD.

In this study, mothers highly emphasized socialization goals related to educational and professional achievement and positive interpersonal skills that promote strong social relationships. Qualitative analyses indicated that perceived disruption to socialization goals associated with ADHD and ODD behavior may directly underlie parental response to child behavior. Specifically, mothers reported concerns about the potential academic impairment associated with ADHD behavior, which is consistent with the goals they hold for their children with regard to high academic and professional achievement. This may be particularly true for low-SES mothers, who highly emphasized the view that academic achievement is important to their child's attainment of professional goals and "getting ahead" in the U.S. These values are very much in line with the proactive parenting

strategies mothers reported in response to ADHD, which centered on promoting task completion and academic functioning.

With regard to ODD, mothers reported a high level of concern over the child's poor emotional control and high level of disrespectful behavior. Considered together with the emphasis mothers placed on interpersonal relationships, it is argued that Latino mothers may respond to ODD behavior with the primary goal of preventing disruption in the social domain. This socialization goal may also underlie parental reaction to ADHD-impulsive behaviors which may be perceived as "rude". Indeed, when mothers discussed the importance of *respeto*, they emphasized the need to demonstrate mutual respect that will promote positive social relationships. Thus, Latino parents may be motivated to respond to behavior that is perceived as disrespectful with this particular socialization goal in mind.

Perceived disruption to socialization goals may also underlie parental help-seeking responses. For example, concerns regarding academic impairment and other school-related problems (e.g., disrupting class) were linked to the endorsement of seeking school-based services for ADHD, while mothers who attributed ADHD to an underlying emotional problem subsequently reported that they would seek mental health care to evaluate and address these concerns. Similarly, when mothers reported that they would seek help for ODD, they primarily reported that they would seek mental health services to address "emotional concerns" by finding the child "someone to talk to," focused on improving the child's ability to express themselves appropriately to others (i.e., interpersonal functioning). These data therefore provide a clearer understanding of the manner in which socialization goals promote specific parenting *and* help-seeking

responses to clinical-level child behavior among Latino mothers. Moreover, these results suggest that parental socialization goals must be examined within a broad socio-ecological context in order to understand the multiple factors that influence those goals, rather than simply linking socialization goals to “culture” as defined by ethnic group membership. To my knowledge, this is the first study to explicitly link specific socializations goal to perceptions of, and response to, child ADHD and ODD, and to assess differences by SES and other contextual factors for these childhood disorders in a sample of Latino parents.

When help-seeking responses were examined by SES, low-SES mothers were more likely than middle- and high-SES mothers to indicate that they would seek school-based services and noted this as their “first response” to ADHD, whereas middle- and high-SES mothers most commonly reported mental health services as their “first response”. This is a particularly relevant finding with regard to Latino children and families in light of recent data suggesting that approximately 1 in 5 public school children are Latino, accounting for 60% of the increase in public school enrollments between 1990 and 2006 (Fry & Gonzales, 2008). Moreover, existing research has demonstrated that children living in low-SES environments, as is the case for approximately 28% of Latino youth (Fry & Gonzales, 2008), and whose mothers have lower levels of education are more likely to utilize school-based services than traditional mental health services (e.g., Mann, McCartney, & Park, 2007; Zahner & Daskalakis, 1997), particularly for ADHD (Leslie, Lambros, Aarons, Haine, & Hough, 2008).

These data suggest that, for low-SES Latino parents in particular, school-based services may serve as a primary “access point” for ADHD, and perhaps general mental

health, services. Yet, the availability of mental health services or general behavioral health support is significantly limited in public schools, particularly those within low-SES communities. Fortunately, development of more comprehensive school-based programs has recently become the focus of public health and mental health research agendas (Atkins, Frazier, Adil, & Talbott, 2003; Atkins et al., 2006; Walrath, Bruns, Anderson, Glass-Siegel, & Weist, 2004). With this in mind, future research examining help-seeking patterns and access to mental health services among low-SES, Latino communities should consider availability and use of school-based mental health services to get an accurate understanding of help-seeking among this population.

### *Grounded Theory*

A grounded theory approach was used in order to assess whether the data collected in the present study could *extend* current theoretical models related to parental perceptions and responses, and the ways in which child rearing values and socialization goals influence parental perceptions and responses, specifically for child ADHD and ODD. The primary goal of this grounded theory examination was to increase our understanding of the multiple factors beyond those measured in existing models that capture the “lived experiences” of Latino families from an ecological perspective. The theoretical goal was to develop a more comprehensive model related to these domains for Latino parents, drawing from several existing models which were used to guide this study. Constructs were drawn from broad ecological models (Bronfenbrenner, 1979; Cicchetti & Cohen, 1995; Harkness & Super, 1992; 2006; Mash & Dozois, 2003) generally, and specifically from the information-processing model of parenting behavior (Rubin et al., 1989), the help-seeking behavior model (Eiraldi et al., 2006) and the

“threshold model” (Weisz et al., 1985; 1988). Further, constructs were drawn from theoretical models that consistently highlight the role of parental stress and depression as important links between SES, parenting and child outcomes (Barrera et al., 2002; Conger et al., 1992; Feder et al., 2009; McLoyd, 1990). These constructs are important in the study of parental attributions and response to child behavior since research demonstrates that Latinos are at elevated risk for depression (Dunlop, Song, Lyons, Manheim, & Chang, 2003) and are overrepresented in low-SES communities (Fry & Gonzales, 2008). Prior studies suggest the presence of multiple environmental stressors known to influence parenting and child behavior among low-income Latino families.

Together, these models suggest that the broad ecological context, particularly SES and related factors, and maternal psychosocial characteristics, are associated with parental beliefs about child behavior, namely their causal attributions and perceived severity of behavior. Furthermore, the interactions between ecological context, parental psychosocial characteristics, and parental perceptions and attributions, play a significant role in the parental responses parents employ to address their children’s misbehavior.

Causal attributions have been highlighted in existing models of parenting behavior (e.g., Dix & Grusec, 1983; Dix et al., 1986; Rubin et al., 1989) and have consistently been linked to parenting responses among mothers of children with and without ADHD and disruptive behavior problems in particular (e.g., Mah & Johnston, 2007; Gerdes & Hoza, 2006; Chen, et al., 2008; Johnston & Freeman, 1997; Seipp & Johnston, 2005), yet research in this area on Latino parents is almost non-existent.

Results of the present study provide additional information that extends existing models in several important ways to assure accurate and meaningful data on Latino

families. First, causal attributions of behavior, particularly with regard to locus of control, are central to the manner in which parents perceive and respond to ADHD and ODD and causal attributions vary by SES. Secondly, results show that parental socialization goals reflected strong values related to educational and professional goal attainment and positive interpersonal skills, and that perceived disruption to these parental socialization goals (i.e., perceived impairment) as a result of ADHD and ODD behavior may directly motivate parental responses to behavior. Proactive parenting strategies were endorsed more often in response to inattentive behaviors and the ADHD vignette with the goal of increasing skills and competencies that will facilitate academic and occupational success and in response to ODD behaviors that are perceived as emotionally-rooted (e.g., seems angry or resentful), with the goal of promoting the child's competency in self-expression and the parent-child relationship toward the development of interpersonal relationships. On the other hand, mothers described being more likely to use reactive parenting strategies in response to inattentive, hyperactive, and impulsive behaviors that are perceived as a lack of motivation or laziness, disrespectful or rude, and actively defiant with the goal of preventing disruption to the child's functioning in domains associated with these parental socialization goals (e.g., school-based disruptive behavior, active defiance).

These results inform existing literature by elucidating specific associations between parental socialization goals and the manner in which Latino mothers perceive *both* individual symptoms and clinical-level ADHD and ODD behavior, as well as their negative emotional reactions and parental responses to behavior. For example, a behavior perceived as disruptive to the child's academic functioning (e.g., difficulty completing

assignments) may lead mothers to feel increasingly worried about the child's long-term academic and professional success, which may motivate them to increase their own efforts to help the child in this area and to seek help through the child's school, thereby facilitating the child's academic progress. Further, an important contribution of this study that extends prior theories is the understanding that socialization goals must be examined within a broader context of family and school environments, thereby necessitating measurement of parental SES and other indicators of resource availability, to more fully assess the role of specific socialization goals in motivating parental responses. Such information is clinically-useful and may provide an important avenue for engaging Latino families into treatment by framing treatment goals in a manner that aligns with these socialization goals.

Finally, results of this study underscore the need to examine the *interactive* effects of ethnic group membership, SES and other contextual variables in studies examining the manner in which parents perceive and respond to child behavior disorders such as ADHD and ODD. Existing research demonstrates that ethnic *identity* (i.e., culture) of a given ethnic group varies by national origin, number of years in the United States, education level and other variables associated with level of acculturation (Bayard, 1978; Mattar, 2004; Roosa et al., 2000). However, prior studies have failed to acknowledge differences within and across Latino ethnic groups by SES, acculturation level, as measured by English-language proficiency, and contextual stressors and resources (Hector, 2009; Roosa et al., 2000). Moreover, acculturation has frequently been confounded with low-SES, with low-SES Latinos having lower levels of English-language proficiency and higher-SES Latinos demonstrating higher levels of English-language proficiency. Future

studies should measure ethnic subgroup membership and examine how SES intersects with acculturation (English-language proficiency) and contextual factors to shape parental “ethnotheories” about parenting and child behavior (Bornstein & Cheah, 2006; Bronfenbrenner & Morris, 2006; Goodnow & Collins, 1990; Leyendecker et al., 2005; Super & Harkness, 1986; 1993).

As observed in this study, Latino subgroup ethnic identifiers and SES need to be measured explicitly and ethnic / cultural values on child rearing must be assessed within a specific context such as home, school or community, to assure accurate measurement of parental child socialization goals. As argued by Roosa and colleagues (2000), consideration of ethnic/cultural background alone does not provide accurate understanding of parenting beliefs and behavior because it fails to acknowledge the fluidity of parental beliefs and behavior in response to contextual demands. Thus, it is argued that culture cannot be considered as a static construct, but rather should be considered as a fluid and dynamic entity that varies within and across the multiple Latino subgroups in the United States, by SES, country of origin, and other ethnic-specific factors (e.g., historical relationship between country of origin and the U.S., citizenship status, etc.) that together influence ethnic/cultural parental childrearing and socialization values.

Data from the present study show that ethnicity SES, as it intersects with other contextual factors, was most associated with variations in parental perceptions of, and parental responses to, ADHD and ODD. Indeed, Latino mothers in this study endorsed very similar perceptions, parental responses, and socialization goals as those found in the general literature conducted primarily among Caucasian parents, indicating similarities in

these domains. However, parental attributions and help-seeking varied by SES, highlighting the importance of considering SES when conducting research in this area. SES is directly related to the availability of resources that parents need in order to actively engage in both parenting and help-seeking efforts aimed at addressing problematic child behavior. Prior models that make implicit assumptions based solely on ethnic group membership, which are often defined as a cultural group, need to be extended to include SES and broader ecological factors in order to accurately interpret research conducted among Latino families. This is particularly relevant with regard to research that examines the role of parental socialization goals in parenting and help-seeking responses to child behavior. A more nuanced understanding of Latino parenting strategies, help-seeking responses, and parental socialization goals will provide an important source of information for effectively treating ADHD and ODD in Latino children.

Taken together, these results suggest that existing models can be extended to more fully capture factors which are relevant to understanding how Latino mothers perceive and respond to ADHD and ODD behaviors in their children. Bringing together aspects of both the information-processing model of parenting behavior (Rubin et al., 1989) and the help-seeking behavior model (Eiraldi et al., 2006), the proposed model inserts additional factors that influence parental causal attributions, particularly with regard to locus of control, and socialization goals in parental perceptions of behavior (i.e., perceived impairment) and suggests specific links to parental responses.

Specifically, Figure 1 shows that the ecological context has multiple dimensions that include ethnic group membership and ethnic/culture, socioeconomic status, and

community-level resources, which are associated with maternal psychosocial characteristics. Further, the model suggests that the interactions between ecological context and maternal psychosocial characteristics influence parental perceptions of behavior and causal attributions, negative affective reactions, and socialization goals that influence perceived impairment associated with child behavior and, together, are involved in the identification and treatment of ADHD and ODD among Latino children.

Based on this model, several hypotheses are proposed that can be tested in future research with Latino families. First, parental perceptions and causal attributions of ADHD and ODD will vary by SES, such that lower-SES parents will demonstrate an external locus of control and will be more likely to attribute ADHD and ODD to more uncontrollable factors than higher-SES mothers. Second, hypotheses regarding the association between socialization goals and perceived impairment of child behavior are: higher levels of perceived impairment related to ADHD will be positively associated with strong parental socialization goals regarding academic success; and higher levels of perceived impairment related to ODD will be positively associated with strong parental socialization goals regarding interpersonal functioning. Lastly, it is hypothesized that help-seeking among low-SES parents will be associated with availability of community-level resources, including school-based services, whereas high-SES parents, who are more likely to have private insurance, may be more likely to seek private mental health services. In sum, the associations depicted in this model and the resulting hypotheses, extend prior models and can provide a deeper insight into the multiple and complex factors that contribute to parental perceptions of, and responses to, ADHD and ODD among Latino children.

The following design improvements are also suggested for future research using similar methodology as that used in the present study. First, in order to elicit natural responses about parental perceptions of behavior, positive behavior descriptors should be included throughout the interview so that participants do not “catch on” to the fact that the behaviors on the list are descriptors of *negative* behaviors. Related to this, questions should be included about *additional* behaviors that participants would find problematic or concerning enough to prompt various parenting strategies or help-seeking. This is particularly relevant for research aimed at examining perceptions of clinical disorders across diverse populations given that diagnostic criteria were largely developed in the United States. Finally, degree of existing knowledge of disorders under study and exposure to media and U.S. culture should be carefully measured and considered in future research in order to examine the role of factors such as level of education, English-language proficiency, and length of residence in the U.S. among immigrant parents.

### *Clinical Implications*

Results regarding perceptions and causal attributions of behavior for both ADHD and ODD have important implications with regard to assessing child ADHD and ODD among Latino children, and especially underscore the need for careful assessment of emotional problems when discussing inattentive and oppositional behaviors, as mothers may inaccurately perceive and report symptoms of ADHD and ODD this way. This should not present an additional burden to clinicians, as careful assessment of potentially comorbid conditions such as depression and anxiety should routinely be included in standard clinical practice. On the other hand, this may be slightly more difficult when using behavior rating scales because such scales leave no room for clarification of items

or examination of parental perceptions that underlie the problems they endorse. Perhaps this could be easily accomplished by including an open-ended “perception and attribution screening” question (e.g., “what do you think is causing your child’s problems?”) or several direct questions to assess parental concerns about the possibility of existing emotional problems.

Perceptions of behavior and causal attributions emerged as underlying predictors of the *type* of services mothers would seek. For example, concerns regarding academic impairment and other school-related problems (e.g., disrupting class) were linked to the endorsement of school-based services for ADHD, while mothers that attributed ADHD to an underlying emotional problem subsequently reported that they would seek mental health care to evaluate and address emotional concerns. Similarly, when mothers reported that they would seek help for ODD, they primarily reported that they would seek mental health services to address the child’s “emotional concerns” by finding the child “someone to talk to”. This pattern of results suggests that mental health treatment was endorsed specifically for perceived emotional problems, as opposed to what might be considered a behavioral problem (i.e., ODD). If mothers believe their child is experiencing emotional problems, they may be more likely to seek “child-focused” mental health services in which the child receives one-on-one counseling or therapy, which is not an empirically-supported treatment for ADHD or ODD.

Qualitative responses from mothers with child-focused versus parent-focused beliefs highlight this point. Mothers that discussed ideas emphasizing that “something is wrong with [the child]” were more likely to report that they would seek services to help the child with concerns such as “internal conflicts”, “self-esteem”, and “what’s going on

with her that makes her behave this way”. Although focusing on the child’s emotional functioning may indeed be helpful for a child that has an emotional disturbance, it is not an evidence-based treatment for either ADHD or ODD. On the other hand, mothers who reported that they would seek parenting help (i.e., parent training), endorsed beliefs regarding the parent’s responsibility for managing child behavior. Thus, parental perceptions of behavior and their causal attributions have direct implications for the type of treatment mothers are likely to seek and may influence subsequent engagement in treatment.

Similarly, causal attributions regarding parental locus of control also has important implications for treatment, and this may vary by SES. The finding that low-SES mothers demonstrated a high external locus of control, and demonstrated higher levels of depression, also has implications with regard to participation and engagement in parenting and school-based interventions. Considering the high level of active participation required in both, with the goal of modifying ineffective parenting practices and increasing parental monitoring and involvement in classroom behavior, parents who have higher levels of depression and a high external locus of control may demonstrate lower levels of engagement and consistency in their application of recommended behavior management strategies. Further, the interaction between low-SES, depression, and locus of control should be considered in light of the fact that low-SES mothers have less access to mental health insurance and quality services, which may further intensify feelings of helplessness and hopelessness in addressing their child’s problems. Considered together, lower perceived control over behavior and higher levels of

depression may be particularly important considerations among low-SES mothers, especially with regard to treatment use.

On the other hand, results indicated that high-SES mothers endorsed attributions for both ADHD and ODD behavior that demonstrate a high internal locus of control, congruent with the nature of behavioral interventions, which may partly explain why higher-SES mothers, across racial/ethnic groups, are more likely to participate in parent training (Heinrichs, Bertram, Kuschel, & Hahlweg, 2005; MacKenzie, Fite, & Bates, 2004). High-SES mothers in this study were the only ones to specifically discuss that some of their help-seeking would focus on getting help with parenting, discussing that they would pursue this treatment “to learn ways to handle his problems better”. On the other hand, high-SES mothers also endorsed more beliefs and attributions regarding the *purposeful* and controllable nature of ADHD and ODD behavior, which may undermine parent training goals. Research in this area could elucidate how parental attributions about child misbehavior influence parent training outcomes with the goal of improving the fit between parental beliefs and treatment goals.

This is important because parental expectations of what treatment will entail have been shown to be significantly associated with treatment engagement, compliance and retention. For example, research by Nock and Kazdin (2001; 2005) suggests that parents are more likely to drop out of treatment for child behavior problems when their expectations are incongruent with treatment goals. Thus, if parents have the expectation that treatment for ADHD or ODD will be primarily implemented directly with the child and will focus on the child’s emotional functioning, they may be less likely to complete parent training or participate in school-based interventions because they are highly

incongruent with these expectations. To address this, clinicians should provide psychoeducation related to the nature of treatment during the initial assessment visit so that parental misconceptions regarding their role in treatment can be addressed early on, with the goal of increasing the likelihood that parents will follow through with treatment (Nock & Kazdin, 2001).

Results of the present study indicated that the parenting strategies and school-based interventions endorsed by mothers most often in response to ADHD and ODD are largely consistent with evidence-based behavioral treatment approaches (e.g., Barkley, 1997; DuPaul & Power, 2009; DuPaul & Weyandt, 2009). For instance, mothers commonly reported that they would increase the structure in the child's daily routines in order to minimize some of the attention and organizational deficits associated with ADHD, which are commonly included in behavioral interventions. Additionally, in response to ADHD, mothers often mentioned that they would ask the teacher to begin sending home some form of "behavior report" or "note" on a daily or somewhat regular basis in order to monitor the child's school behavior and to increase communication with the child's teacher. This is consistent with a "Daily Report Card" (DRC) or School-Home Note, often used to address problem behaviors in the school setting (e.g., Kelley & Jurbergs, 2009).

Primarily in response to ODD, mothers also endorsed disciplinary strategies such as removal of privileges and time out, both of which are core components of evidence-based behavioral parent training and classroom-based programs. Although mothers primarily endorsed taking away privileges to address misbehavior, they also discussed use of praise/rewarding in combination with this strategy (i.e., contingent reinforcement)

with the goal of “motivating” the child to meet behavioral expectations. This is also a key component of behavioral interventions in both home and school settings, though clinical experience suggests that mothers focus more on discipline and less on strategies for increasing prosocial behavior.

With regard to “time out”, mothers that discussed using this strategy by sending the child to their bedroom, which is contrary to the time out methods described in behavioral parent training. Indeed, parents are often discouraged from using the child’s bedroom for time out, primarily because it may be *more* reinforcing for the child because the child’s bedroom contains toys and books which the child may play with while serving their “time out”, undermining the effectiveness of “time out *from positive reinforcement*”. However, previous research among Latino parents indicated that Latino mothers viewed time out as excessively punitive and negative when the child was asked to sit in a chair while the mother ignored him/her (McCabe et al., 2005) and several mothers in the present study echoed similar concerns. Thus, mothers may view sending the child to his/her room more positively because they believe it accomplishes the goal of punishing the child while eliminating the feeling that they are actively rejecting their child. Thus, the time out strategy described in parent training could be modified to incorporate these parental ideas, rather than discouraging parents from using the child’s room for time out (e.g., Barkley, 1997).

Mothers also commonly reported that they would “talk to my child” as a primary strategy for addressing perceived “emotional” problems, which is less consistent with evidence-based treatments approaches. While parent training certainly does not discourage parents from communicating with their children, several strategies emphasize

*decreasing* parental attention to avoid reinforcing negative behavior when the child is actively misbehaving with the goal of obtaining parental attention. Indeed, one of the strategies most commonly included in parent training is actively *ignoring* the child when they are engaging in minor misbehavior and applying negative consequences without excessive explanation or discussion. Previous research suggests that this strategy is generally not acceptable to Latino parents (e.g., McCabe et al., 2005) because it is viewed as unresponsive to the child's behavior. With this in mind, it may be useful to include a discussion regarding the appropriate time to discuss misbehavior and/or parental concerns with the child when presenting the active ignoring strategy. Moreover, parents may be more receptive to this strategy if clinicians also discuss ways that parents can teach their children how to express themselves *appropriately* in order to facilitate the child's ability to communicate with others, thereby promoting skills that will help the child develop more positive interpersonal relationships.

Additionally, given the emphasis mothers place on promoting strong interpersonal relationships and facilitating positive parent-child communication, parent training may be more acceptable to Latino parents if it includes a problem-solving/communication-focused component. This could easily be incorporated into existing parent training programs that include "special time" (i.e., positive, relaxed, non-problem-focused time between parent and child) specifically aimed at improving the parent-child relationship (e.g., Barkley, 1997). Overall, these findings suggest that core strategies that comprise evidence-based parenting programs for children with ADHD and ODD will generally be acceptable to Latino parents, with minor modifications to the manner in which the strategies are presented.

As illustrated by this discussion, and consistent with the proposed theoretical model, it is argued that engaging Latino parents in both parent training and school-based interventions may be best accomplished by eliciting and framing treatment in a way that closely aligns with parental concerns about their child's impairment and possible disruption to long-term socialization goals (i.e., motivation for seeking treatment). This approach is consistent with techniques used in motivational interviewing (Miller & Rollnick, 1995; 2002), which has been demonstrated to be highly effective for engaging Latino and other difficult-to-engage patients into psychotherapy (Miller & Rollnick, 1995; 2002). Motivational interviewing techniques focus on building the patient's motivation to change by eliciting and discussing discrepancies between current behavior and desired outcomes, then emphasizing the patient's competence in changing problematic behaviors. This has been applied to parents participating in parent training and was shown to be an effective technique for increasing participation in, and completion of, parent training (Nock & Kazdin, 2005).

In sum, results of the present study have important implications with regard to assessing and treating ADHD and ODD among Latino children. In terms of assessment, these results suggest that, across SES, Latino parents generally understand the DSM-IV symptoms of ADHD and ODD as presented in most DSM-IV rating scales and diagnostic interviews. Parental perceptions regarding a potential emotional problem underlying child behavior should be carefully assessed and parents should be provided with psychoeducation about the nature of ADHD and ODD behaviors. This initial psychoeducation should also focus on the nature of treatment for these disorders, and emphasize the parents' active role in treatment, which will improve congruence between

parental expectations and treatment goals, thereby promoting subsequent treatment engagement and compliance.

Finally, an important implication of the present study is that many parenting responses endorsed by mothers are highly consistent with behavior management strategies included in evidence-based parent training and school-based interventions. Thus, it may be the case that Latino mothers generally find strategies acceptable, with only minor modifications. Together with results regarding parental socialization goals, results also suggest that Latino parents may be increasingly engaged into treatment by framing treatment goals in ways that align with their emphasis on academic/occupational achievement and interpersonal functioning. Overall, these results are especially useful to efforts aimed at increasing treatment use for ADHD and ODD among Latino parents and reducing mental health disparities.

#### *Limitations*

Results of the present study should be interpreted while considering several study limitations. First, by nature of the study design, a small sample of mothers was included in the study, which may limit the generalizability of results. However, the utility of grounded theory methodology employed here is centered on conducting *in-depth* examination of research questions in order to develop a comprehensive theory that promotes the formulation of future research questions that can then be explored using larger samples.

The majority of mothers in this study did not have a child that exhibits clinical levels of either ADHD or ODD symptoms. As such, these results may not represent the perceptions of parents whose children display clinical levels of attention and behavior

problems, which have been found to differ from parents of children that do not display behavior problems (e.g., Gerdes & Hoza, 2006; Johnston & Freeman, 1997). For example, when talking about problems with their own children, mothers may have more intense emotional reactions than they would in response to a hypothetical situation. However, given the high level of demonstrated need and low level of service use among Latino children, research which examines perceptions of parents who have sought treatment does not represent perceptions of parents who may be less likely to seek treatment.

Thus, research among non-referred Latino parents is needed to examine factors which may impact parental perceptions and response to these child problems *prior* to seeking services. Indeed, research suggests that Latino parents are more likely to seek input from within their social networks prior to, or perhaps instead of, seeking mental health services (e.g., McMiller & Weisz, 1996). Therefore, this research provides information regarding general perceptions among Latino parents which may be communicated to Latino parents of children who do have ADHD and/or ODD, thereby influencing their subsequent responses to their child's behavior. Future research should compare the help-seeking responses of Latino parents whose children are *at risk* for ADHD and ODD prior to seeking treatment and those who have already sought treatment in order to understand factors influencing parental decision to seek help. Further, as suggested by the proposed model, research in this area should specifically explore the role of perceived impairment and disruption to long-term socialization goals in parental help-seeking.

Parental perceptions and reported responses were elicited using written descriptions of ADHD and ODD that likely did not elicit the same reactions as actual child behavior, particularly if parents were responding to their *own* child's actual behavior. This raises questions about the validity of the reported perceptions and responses; however, use of behavioral vignettes is one of the most common methods for assessing parental attributions regarding behavior (e.g., Bickett, Milich, & Brown, 1996; Johnston & Patenaude, 1994; Johnston et al., 2006), particularly because it allows us to standardize the behavior to which parents were asked to respond, thereby minimizing variability as a function of child behavior. While this research paradigm is useful, parental perceptions of specific child behaviors may be masked when examined using a behavioral vignette depicting a cluster of symptoms. Other studies have attempted to address these limitations by asking parents to watch or listen to live or taped child behavior and to verbalize their thoughts or provide ratings of attributions (e.g., Mah & Johnston, 2007; Gerdes & Hoza, 2006; Chen et al., 2008; Johnston & Freeman, 1997). Going one step further, future studies could more accurately assess associations between attributions and parenting by asking parents to *first* name the behavior and discuss why they believe the child is behaving in that manner (e.g., "not following rules because he likes to be bad"), followed by a brief verbal description of how they would respond to the behavior. This approach may be more appropriate for understanding specific links between parents' perceptions and attributions of behaviors and their subsequent responses.

The order of interview questions also presents an important limitation of the present study. First, individual DSM-IV items were discussed in the same order for each

interview, as presented on an existing behavioral rating scale, beginning with all ADHD symptoms, followed by the ODD symptoms. Therefore, parental perceptions of behavior toward the end of this segment of the interview may have become increasingly negative as a result of the *cumulative* discussion of preceding behaviors. Similarly, individual DSM-IV items were always discussed prior to the behavioral vignettes, which may have had a similar effect on parental perceptions of the behavior depicted in vignettes. Future studies should counterbalance segments of the interview in order to minimize this cumulative effect.

Finally, given the small size and exploratory nature of the study, interviews were not double-coded by an independent coder to assess the reliability of final codes. However, emerging themes were repeatedly discussed by the principal investigator and a senior research consultant in order to determine final codes. Furthermore, consistent with a grounded theory approach, themes and codes were developed using a rigorous level of “constant comparison” and were finalized based on existing literature. Thus, the final themes discussed throughout are believed to be an accurate representation of the data collected in this study.

### *Conclusions*

Despite these limitations, results of this study contribute to the general literature on child ADHD and ODD by examining and extending current models regarding parenting beliefs and behavior among Latino mothers. More specifically, the present study brings together models that separately examine parenting (Rubin et al., 1989) and help-seeking responses (Eiraldi et al., 2006), and proposes a more comprehensive model regarding parenting and help-seeking responses specifically related to ADHD and ODD

in Latino children. Based on a grounded theory approach, the theoretical model that emerged underscores the role of causal attributions regarding locus of control in motivating parenting responses (i.e., proactive vs. reactive) and elucidates specific socialization goals that underlie both parental perceptions and responses.

Further, this study highlights the importance of examining SES in this line of research, as it directly impacts the overarching “cultural context” and socioecological niche in which families live. Moreover it is argued that focusing exclusively on ethnic group membership to explain “cultural” differences between groups will mask associations between important ecological variables. Among low-SES mothers in particular, results suggest important considerations with regard to perceived locus of control, school-based help seeking for ADHD, and level of depression, highlighting the importance of considering broader contextual variables in understanding both parenting and help-seeking among low-SES populations. Additionally, findings suggest important clinical implications with regard to parental socialization goals and development of school-based services that may serve as avenues by which to engage Latino families into treatment for ADHD and ODD.

Table 1

*Sample demographic and psychosocial characteristics*

	Low-SES (n=8)	Mid-SES (n=7)	High-SES (n=10)	Total (N=25)
Age	33.62 (6.05)	38.86 (6.28)	32.80 (2.62)	34.76 (5.48)
Number of children	2.88 (1.36)	2.14 (1.07)	1.50 (.97)	2.12 (1.24)
Marital status (%)				
Single	5 (62.5%)	2 (28.6%)	7 (70%)	14 (56%)
Married	3 (37.5%)	5 (71.4%)	3 (30%)	11 (44%)
Employment status (%)				
Full-time	4 (50%)	3 (42.9%)	7 (70%)	14 (56%)
Part-time	2 (25%)	3 (42.9%)	1 (10%)	6 (24%)
Unemployed	2 (25%)	1 (14.3%)	2 (20%)	5 (20%)
Highest level of Education				
Less than high school	8 (100%)	--	--	8 (32%)
High school graduate	--	7 (100%)	--	7 (28%)
Some college	--	--	5 (50%)	5 (20%)
College graduate	--	--	2 (20%)	2 (8%)
Graduate School	--	--	3 (12%)	3 (12%)
Ethnicity				
Cuba	0	0	1 (10%)	1 (4%)
El Salvador	4 (50%)	1 (14.3%)	0	5 (20%)
Honduras	2 (25%)	1 (14.3%)	0	3 (12%)

México	1 (12.5%)	2 (28.5%)	1 (10%)	4 (15%)
Perú	1 (12.5%)	2 (28.5%)	3 (30%)	6 (24%)
Puerto Rico	0	1 (14.3%)	5 (50%)	6 (24%)
Born in U.S. (% yes)	0	1 (14.3%)	3 (30%)	4 (16%)
Number of years in U.S.	12.50 (6.14)	14.29 (7.93)	19.60 (12.83)	15.84 (9.94)
Acculturation <sup>a</sup>	13.88 (3.27)	16.86 (7.93)	24.40 (8.32)	18.92 (8.19)
Depression (CES-D) <sup>b</sup>	9.12 (5.59)	3.29 (2.56)	4.40 (2.72)	5.60 (4.45)
Social support (MOS-SS) <sup>c</sup>	3.97 (1.07)	3.66 (1.15)	4.33 (.53)	4.02 (.92)

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*Note:* Standard deviations of mean scores are enclosed in parentheses.

<sup>a</sup> Acculturation scores range from 8 to 40 and higher scores reflect higher levels of acculturation.

<sup>b</sup> CES-D = Center for Epidemiological Studies Depression scale (Brown-Short Form). Scores range from 0 to 30, with higher scores indicating higher levels of current depression and a cut-point of 10 indicating clinically significant levels of depression.

<sup>c</sup> MOS-SS = Medical Outcome Survey – Social Support scale. Scores range from 1 to 5, with higher scores indicating higher levels of perceived social support.

Table 2

*Means and standard deviations of self-reported parenting practices on Parenting Practices Questionnaire.*

	Low-SES (n=8)	Mid-SES (n=7)	High-SES (n=10)	Total (N=25)
Positive parenting strategies (all items)	4.14 (.72)	4.37 (.51)	4.60 (.37)	4.39 (.56)
Responsive to child's feelings and needs.	4.12 (.99)	3.57 (1.81)	3.90 (.99)	3.88 (1.24)
Explain to child how feel about the child's good and bad behavior.	3.88 (1.13)	4.43 (.79)	4.60 (.52)	4.32 (.85)
Encourage child to talk about his/her troubles.	4.00 (.93)	4.43 (.79)	4.90 (.32)	4.48 (.77)
Encourage child to freely express self even when disagreeing with me.	3.75 (1.03)	4.57 (.54)	4.70 (.48)	4.36 (.81)
Emphasize the reasons for rules.	4.37 (.74)	4.43 (.54)	4.70 (.48)	4.52 (.59)
Give praise when my child is good.	4.50 (.54)	4.86 (.38)	4.80 (.42)	4.72 (.46)
Help child to understand impact of behavior by encouraging child to talk about the consequences of his/her own actions.	4.38 (1.06)	4.29 (1.11)	4.60 (.52)	4.44 (.87)
Negative parenting strategies (all items)	2.60 (1.09)	1.83 (.62)	1.87 (.51)	2.09 (.82)

Use physical punishment as a way of disciplining my child.	2.12 (1.55)	1.71 (.76)	1.30 (.48)	1.68 (1.03)
Spank when my child is disobedient.	2.12 (1.55)	1.57 (.79)	1.30 (.48)	1.64 (1.04)
Yell or shout when my child misbehaves.	2.38 (.06)	1.57 (.79)	1.90 (.32)	1.96 (.79)
Explode in anger towards child.	3.00 (1.69)	2.71 (1.89)	2.50 (1.58)	2.72 (1.65)
Use threats as punishment with little or no justification.	3.00 (1.69)	1.57 (.54)	2.40 (1.17)	2.36 (1.32)
Scold or criticize when child's behavior doesn't meet expectations.	3.00 (1.19)	1.86 (1.07)	1.80 (.42)	2.20 (1.04)

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*Note:* Standard deviations of mean scores are enclosed in parentheses. Scores indicate self-reported frequency of using each parenting practice and range from (1) “never” to (5) “always”. Items were averaged to create two general clusters representing positive and negative practices.

Table 3

*Mean perceived severity ratings of DSM-IV symptoms of ADHD and ODD*

	Low-SES (n=8)	Mid-SES (n=7)	High-SES (n=10)	Total (N=25)
ADHD (all symptoms)	3.66 (.64)	4.16 (.61)	3.91 (.45)	3.89 (.57)
ADHD-I	3.75 (.56)	4.43 (.40)	4.12 (.31)	4.09 (.49)
ADHD-HI	3.57 (.77)	3.89 (.87)	3.69 (.67)	3.71 (.74)
ODD	4.45 (.49)	4.61 (.32)	4.60 (.34)	4.56 (.38)

*Note:* Standard deviations of mean scores are enclosed in parentheses. ADHD =

Attention Deficit/Hyperactivity Disorder. ADHD-I = ADHD-Inattentive symptoms.

ADHD-HI = ADHD-Hyperactive/Impulsive symptoms. ODD = Oppositional Defiant

Disorder. Mean perceived severity ratings range from (1) “no problem at all” to (5) “very

much a problem”. Scores were averaged across relevant symptoms to obtain mean

perceived severity ratings of symptom clusters.

Table 4

*Quantitative ratings on the Vignette Rating Form in response to the ADHD behavioral vignette*

	Low-SES (n=8)	Mid-SES (n=7)	High-SES (n=10)	Total (N=25)
Perceived severity of behavior	4.62 (.52)	4.86 (.38)	4.90 (.32)	4.80 (.41)
Likelihood of seeking mental health treatment	3.88 (1.36)	5.00 (.00)	4.40 (1.35)	4.40 (1.19)
Likelihood of using medication	3.12 (1.81)	2.86 (1.68)	3.20 (1.62)	3.08 (1.63)
Negative emotional reaction	2.83 (1.01)	3.07 (1.09)	2.56 (.74)	2.79 (.91)
Angry	3.25 (1.17)	3.00 (1.29)	2.40 (.84)	2.84 (1.10)
Disappointed	3.50 (1.41)	3.43 (1.27)	2.70 (.82)	3.16 (1.18)
Disgusted	2.12 (1.55)	2.00 (1.56)	1.30 (.48)	1.76 (1.13)
Embarrassed	2.00 (1.41)	3.29 (1.38)	2.40 (1.43)	2.52 (1.45)
Pleased	1.75 (1.17)	1.71 (1.49)	1.00 (.00)	1.44 (1.04)

Hurt	1.87 (1.36)	2.29 (1.38)	2.80 (1.14)	2.36 (1.29)
Guilty	3.00 (1.51)	3.29 (1.25)	2.80 (1.14)	3.00 (1.26)
Anxious	3.00 (1.41)	3.43 (1.51)	2.80 (1.14)	3.04 (1.31)
Sad	3.88 (1.46)	3.86 (1.22)	3.30 (1.25)	3.64 (1.29)

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*Note:* Standard deviations of mean scores are enclosed in parentheses. ADHD = Attention Deficit/Hyperactivity Disorder. Perceived severity of behavior, likelihood of seeking mental health treatment, and likelihood of using medication were rated on 5-point scale, ranging from (1) “no problem at all”/”not at all likely” to (5) “very problematic”/”very likely”. Negative emotional reactions were rated on a 5-point scale indicating how much mothers would experience each emotion in response to behavior depicted in the behavioral vignette ranging from (1) “not at all” to (5) “extremely”.

Table 5

*Quantitative ratings on the Vignette Rating Form in response to the ODD behavioral vignette*

	Low-SES (n=8)	Mid-SES (n=7)	High-SES (n=10)	Total (N=25)
Perceived severity of behavior	4.50 (.76)	4.14 (1.22)	4.80 (.42)	4.52 (.82)
Likelihood of seeking mental health treatment	3.88 (1.46)	4.29 (1.49)	4.50 (.71)	4.24 (1.20)
Likelihood of using medication	2.62 (1.77)	2.43 (1.90)	2.60 (1.71)	2.56 (1.71)
Negative emotional reaction	3.70 (.90)	3.25 (1.36)	3.41 (.81)	3.46 (.99)
Angry	3.88 (.99)	3.71 (1.49)	3.50 (.85)	3.68 (1.07)
Disappointed	4.00 (1.07)	3.14 (1.35)	3.60 (.84)	3.60 (1.08)
Disgusted	2.88 (1.36)	2.43 (1.39)	2.20 (1.03)	2.48 (1.23)
Embarrassed	3.88 (.99)	3.71 (1.60)	3.30 (1.25)	3.60 (1.26)
Pleased	1.62 (1.19)	2.43 (1.90)	1.10 (.32)	1.64 (1.29)

Hurt	3.62 (1.30)	2.71 (1.49)	3.50 (.97)	3.32 (1.25)
Guilty	3.62 (1.19)	3.14 (1.68)	3.50 (1.08)	3.44 (1.26)
Anxious	3.50 (1.31)	3.29 (1.49)	3.70 (.82)	3.52 (1.16)
Sad	4.25 (1.04)	3.86 (1.68)	4.00 (1.05)	4.04 (1.21)

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*Note:* Standard deviations of mean scores are enclosed in parentheses. ODD = Oppositional Defiant Disorder. Perceived severity of behavior, likelihood of seeking mental health treatment, and likelihood of using medication were rated on 5-point scale, ranging from (1) “no problem at all”/“not at all likely” to (5) “very problematic”/“very likely”. Negative emotional reactions were rated on a 5-point scale indicating how much mothers would experience each emotion in response to behavior depicted in the behavioral vignette ranging from (1) “not at all” to (5) “extremely”.

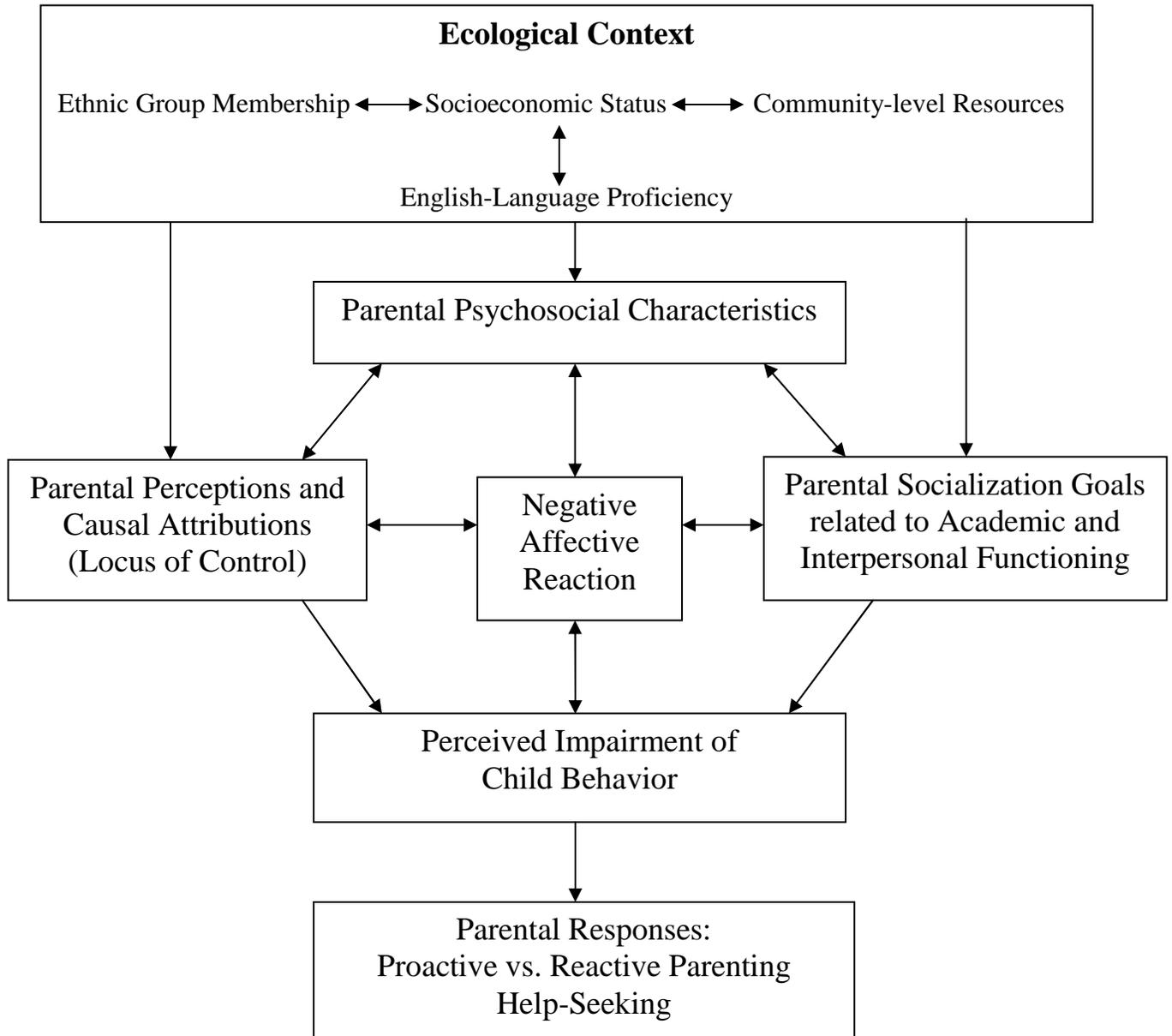
Table 6

*Percentage of responses related to the most commonly endorsed socialization goals during the open-ended interview, and number of respondents endorsing each category, by SES*

	Low-SES (n=8)	Mid-SES (n=7)	High-SES (n=10)	Total
Positive personality ("good person")	24.1 (5)	32.0 (6)	37.2 (8)	31.9 (19)
Respectful ("well- behaved")	20.7 (7)	12.0 (2)	25.6 (7)	20.6 (13)
Educated ("academically- oriented")	20.7 (6)	12.0 (3)	20.9 (7)	18.6 (16)
Professional ("get- ahead")	24.1 (7)	24.0 (5)	6.9 (3)	16.5 (15)

Figure 1

Proposed theoretical model of parental perceptions and attributions in parenting and help-seeking responses to ADHD and ODD among Latino parents



Appendix A: Demographic Questionnaire

1. Age: \_\_\_\_\_ 2. How many children do you have? \_\_\_\_\_
3. How old are your children (list all ages): \_\_\_\_\_
4. What is your employment status? [*Circle one*] 5. What is your marital Status:  
[*Circle one*]
- |               |              |
|---------------|--------------|
| a. Full Time  | a. Single    |
| b. Part Time  | b. Married   |
| c. Unemployed | c. Divorced  |
| d. Student    | d. Separated |
| e. Homemaker  | e. Widowed   |
6. What is the highest level of school that you completed? [*Circle one*]
- a. Grade School (6<sup>th</sup> grade or less)
  - b. Some High School (11<sup>th</sup> grade or less)
  - c. Graduated from High School
  - d. Some College
  - e. Graduated from College
  - f. Graduate/Professional School
7. What is your total family income per year? [*Circle one*]
- |                        |                        |
|------------------------|------------------------|
| a. less than \$10,000  | b. \$10,000 - \$19,999 |
| c. \$20,000 - \$29,999 | d. \$30,000 - \$39,999 |
| e. \$40,000 - \$49,999 | f. \$50,000 - \$59,999 |
| g. \$60,000 - \$69,999 | h. \$70,000 - \$79,999 |
| i. \$80,000 - \$89,999 | j. \$90,000 - \$99,999 |
| k. \$100,000 +         |                        |
8. What is your ethnicity? [*Check all that apply*]
- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Argentinean                           | <input type="checkbox"/> Honduran     |
| <input type="checkbox"/> Belizean                              | <input type="checkbox"/> Mexican      |
| <input type="checkbox"/> Boliviana/o                           | <input type="checkbox"/> Nicaraguan   |
| <input type="checkbox"/> Chilena                               | <input type="checkbox"/> Panamanian   |
| <input type="checkbox"/> Columbian                             | <input type="checkbox"/> Paraguayan   |
| <input type="checkbox"/> Costa Rican                           | <input type="checkbox"/> Peruvian     |
| <input type="checkbox"/> Cuban                                 | <input type="checkbox"/> Puerto Rican |
| <input type="checkbox"/> Dominican                             | <input type="checkbox"/> Spanish      |
| <input type="checkbox"/> Ecuadoran                             | <input type="checkbox"/> Uruguayan    |
| <input type="checkbox"/> El Salvadoran                         | <input type="checkbox"/> Venezuelan   |
| <input type="checkbox"/> Guatemalan                            |                                       |
| <input type="checkbox"/> Other country (please specify): _____ |                                       |
9. Were you born in the United States?  No  Yes

9a. If No, where were you born? \_\_\_\_\_

10. How many years have you lived in the United States? \_\_\_\_\_ *years*

	Poor (1)	(2)	(3)	(4)	Excellent (5)
11. How well can you speak Spanish?					
12. How well can you understand Spanish?					
13. How well can you read Spanish?					
14. How well can you write Spanish?					
15. How well can you speak English?					
16. How well can you understand English?					
17. How well can you read English?					
18. How well can you write English?					

19. During the rest of the interview, we want you to respond to questions thinking about only *one* of your children (between 5 and 12 years old). Decide which one you will think about and **write their age and gender here:** \_\_\_\_\_

19a. Has this child ever been diagnosed with Attention Deficit/Hyperactivity Disorder (ADHD) or another type of attention or behavior problem?

No       Yes (please specify: \_\_\_\_\_)

19b. Has this child ever received medication or therapy for attention or behavior problems?

No       Yes

Appendix B: Center for Epidemiological Studies Depression Scale (Boston Short Form)

Below is a list of some of the ways you may have felt or behaved. Please indicate how often you have felt this way during the **past week**: (circle one number on each line)

During the past week ...	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
1. I was bothered by things that usually don't bother me	0	1	2	3
2. I had trouble keeping my mind on what I was doing	0	1	2	3
3. I felt depressed	0	1	2	3
4. I felt that everything I did was an effort	0	1	2	3
5. I felt hopeful about the future	0	1	2	3
6. I felt fearful	0	1	2	3
7. My sleep was restless	0	1	2	3
8. I was happy	0	1	2	3
9. I felt lonely	0	1	2	3
10. I could not "get going"	0	1	2	3

Appendix C: Medical Outcome Study Social Support Survey (Emotional Support Scale)

Next are some questions about the support that is available to you. People sometimes look to others for companionship, assistance, or other types of support.

How often is each of the following kinds of support to you if you need it?

	(1) None of the time	(2) A little of the time	(3) Some of the time	(4) Most of the time	(5) All of the time
1. Someone you can count on to listen to you when you need to talk.					
2. Someone to give you good advice about a crisis.					
3. Someone to give you information to help you understand a situation.					
4. Someone to confide in or talk to about yourself or your problems.					
5. Someone whose advice you really want.					
6. Someone to share your most private worries and fears with.					
7. Someone to turn to for suggestions about how to deal with a problem.					
8. Someone who understands your problems.					

## Appendix D: Parenting Practices Questionnaire

**Instructions:** For each item, indicate how often you use each strategy with your child by writing the number that corresponds with your answer on the line next to the item.

### I EXHIBIT THIS BEHAVIOR:

- 1 = Never
- 2 = Once In Awhile
- 3 = About Half of the Time
- 4 = Very Often
- 5 = Always

- \_\_\_\_\_ 1. I am responsive to my child's feelings and needs.
- \_\_\_\_\_ 2. I use physical punishment as a way of disciplining my child.
- \_\_\_\_\_ 3. I explain to my child how I feel about the child's good and bad behavior.
- \_\_\_\_\_ 4. I spank when my child is disobedient.
- \_\_\_\_\_ 5. I encourage my child to talk about his/her troubles.
- \_\_\_\_\_ 6. I find it difficult to discipline my child.
- \_\_\_\_\_ 7. I encourage my child to freely express (himself)/(herself) even when disagreeing with me.
- \_\_\_\_\_ 8. I emphasize the reasons for rules.
- \_\_\_\_\_ 9. I yell or shout when my child misbehaves.
- \_\_\_\_\_ 10. I give praise when my child is good.
- \_\_\_\_\_ 11. I explode in anger towards my child.
- \_\_\_\_\_ 12. I use threats as punishment with little or no justification.
- \_\_\_\_\_ 13. I help my child to understand the impact of behavior by encouraging my child to talk about the consequences of his/her own actions.
- \_\_\_\_\_ 14. I scold or criticize when my child's behavior doesn't meet my expectations.

Appendix E: Interview guide regarding perceptions of DSM-IV ADHD and ODD symptoms

**Verbal instructions to participant:** We will be discussing each of the behaviors you see listed here. First I will ask you what each one means to you and then other words you would use to describe each behavior. I will also ask you to describe what comes to mind when I read each one. Finally, I will ask you to indicate how problematic each behavior would be if your child behaved that way most of the time. [Instructions should be repeated throughout as needed; each item will be read aloud to participant]

	(1) No problem at all	(2) Somewhat of a problem	(3) Neutral	(4) Moderately a problem	(5) Very much a problem
1. Fails to give close attention to details or makes careless mistakes in his/her work					
2. Fidgets with hands or feet or squirms in seat					
3. Has difficulty sustaining his/her attention in tasks or fun activities					
4. Leaves his/her seat in classroom or in other situations in which seating is expected					
5. Doesn't listen when spoken to directly					
6. Seems restless					
7. Doesn't follow through on instructions and fails to finish work					
8. Has difficulty engaging in leisure activities or doing fun things quietly					
9. Has difficulty organizing tasks and activities					
10. Seems "on the go" or "driven by a motor"					
11. Avoids, dislikes, or is reluctant to engage in work that requires sustained mental effort					
12. Talks excessively					

13. Loses things necessary for tasks or activities					
14. Blurts out answers before questions have been completed					
15. Is easily distracted					
16. Has difficulty awaiting turn					
17. Is forgetful in daily activities					
18. Interrupts or intrudes on others					
19. Loses temper					
20. Argues with adults					
21. Actively defies or refuses to comply with adults' requests or rules					
22. Deliberately annoys people					
23. Blames others for his/her mistakes or misbehavior					
24. Is touchy or easily annoyed by others					
25. Is angry or resentful					
26. Is spiteful or vindictive					

Appendix F: Interview guide regarding parental responses to hypothetical behavioral vignettes

**Verbal instructions to participant:** I am going to tell you a brief story. Please listen carefully to the behaviors I describe and imagine that it is your child I am describing. After I tell you the story, I will ask you to answer some questions.

**ADHD Vignette**

Imagine your child a lot of trouble getting his/her chores done and completing his/her homework because he/she gets easily distracted and has difficulty following instructions. Imagine that they have a lot of trouble paying attention in school too. As a matter of fact, the teachers have been complaining about your child and say that h/she often makes careless mistakes when he/does does his schoolwork and tries to avoid doing things that require him/her to focus for too long. When he/she sits down to do his/her schoolwork, he/she has trouble staying in his/her seat and moves around a lot. The teachers say that this disturbs the other students and makes it difficult for the teacher to teach. Also, he/she runs around a lot and makes a lot of noise, even when he's/she's playing by himself/herself.

**ODD Vignette**

Imagine that your child disobeys you and other adults a lot. He/she often refuses to do things you ask him/her to do, such as picking up his/her toys or cleaning up his/her room. When you ask him to do something he/she often has a temper tantrum which includes yelling and throwing things. If anything breaks during a temper tantrum he/she sometimes yells at and blames other people. He/she argues with you a lot, especially when he/she doesn't get his/her own way. Also imagine that he/she does things to bother other kids, such as poking them over and over to make them cry. Every time you try to talk to him/her about his/her behavior, he/she gets touchy and annoyed.

**Open-ended question (to be asked following each vignette):**

1. How would you respond to this behavior if your child actually behaved in a similar manner and why?
2. What kind of discipline would you use to address this behavior, if any?



## Appendix H: Interview guide regarding childrearing values and goals

**Open-ended question(s):** Now, I'd like to ask you some questions about what you expect from your child. What are your expectations for your child? How do you expect them to behave or act? What characteristics do you want them to develop?

**Semi-structured interview:** I am going to ask you about specific expectations parents sometimes have for their children. Please tell me how important each one is to you and why you think it is important.

1. How important is it to you for your child to show you and other adults respect?
2. How important is it to you for your child to learn to get along with other people?
3. How important is it to you for your child to be close to the family and be loyal to the family?
4. How important is it to you for your child to obey all adults?
5. How important is it to you for your child to behave appropriately in public places?
6. How important is it to you for your child to learn to speak his mind freely, even if they disagree with you?
7. How important is it to you for your child to learn to be independent and make their own decisions?
8. How important is it to you for your child to learn to be confident in himself/herself and develop his/her own talents and abilities?
9. How important is it to you for your child to learn not to behave in ways that embarrass you or make you look bad.

## Appendix I: Informed Consent Form

### **INFORMED CONSENT FORM**

**Identification of Project/Title:** Perceptions of, and parenting response to, child attention and behavior problems among Latino mothers.

#### **Why is this research being done?**

This is a research project being conducted by Yamalis Diaz, M.A., Andrea M. Chronis, Ph.D., and Ruth E. Zambrana, Ph.D. at the University of Maryland, College Park. We are inviting you to participate in this research because we want to learn about the way Latino mothers like yourself think and feel about different types of child behavior. We are also interested in learning about the ways you would respond to certain types of child behavior, such as inattention, hyperactivity, and defiance. The purpose of the research is to gather information that will help us develop parenting programs for Latino parents and children.

This form gives you information about the study. We will talk to you about the study and answer any questions you may have. We will ask you to sign this form to show that you understand what you will be asked to do in this study and we will give you a copy of this form to keep. It is important for you to know that:

- You do not have to join the study;
- You may change your mind and drop out of the study any time you want and you will not be penalized;

#### **What will I be asked to do?**

First, you will be asked to complete questionnaires about basic demographic information, your parenting, your mood and the amount of emotional support you receive from friends and family. You will also be asked to participate in an interview in which you will describe your opinions and feelings about different types of child behavior. Throughout the interview, you will also be asked to complete several brief questionnaires that also ask for your opinion about child behaviors such as inattention, hyperactivity, and defiance. In addition, you will be asked to answer some questions about how it would make you feel and how you would respond if your own child displayed some of the behaviors we will be discussing. Finally, you will be asked to answer some questions about the expectations you have for your own child's behavior and the qualities you hope they will develop in the future. Altogether, it should take you between 1 ½ to 2 ½ hours to complete the questionnaires and the interview.

The interview will be audio-taped and you will be asked to sign the consent to be audio-taped at the end of this document. The tapes will be stored in a locked cabinet when they are not in use by research staff, and they will be destroyed after we transcribe the interview.

You will receive \$25 today for completing the questionnaires and the interview. In addition, you are eligible to sign up for a 2-hour parenting workshop that will discuss

different parenting strategies for managing child misbehavior. This parenting workshop is free and is completely optional. You do not have to participate in the workshop.

**What about Confidentiality?**

All information collected in this study is confidential. The information discussed during the interview and the responses you give on the questionnaires will not be discussed with anyone other than members of the research staff. The questionnaires and the audio-tapes will be identified by a number and will not be kept in the same place with your personal information, such as your name and phone number/email. Finally, only the people working on the study will know your name. To keep your identity private, we will ask you not to say your last name once the tape recorder is turned on.

There are two exceptions to confidentiality that you should be aware of. First, if you provide information that suggests child abuse or neglect, we are required by law to report it to Child Protective Services. This includes, but is not limited to, any reports of using any type of object to spank/hit your child, including a belt and any situations in which you left a visible mark or bruise on your child while disciplining them.

Another exception to confidentiality is if you tell us that you have a plan to hurt yourself or other people. If you tell us about having this plan, the interviewer will contact her supervisor, Dr. Chronis, immediately and we will take the necessary steps to ensure your safety and the safety of others.

**What are the risks of this research?**

There are some risks involved in participating in this study. For example, you may become mildly annoyed, frustrated, or upset by some of the questions you will be asked. If this occurs, you are encouraged to discuss your concerns with the interviewer. The interviewer and her supervisor, a Maryland licensed psychologist, are trained to help participants deal with these feelings. Also, you are free to stop answering questions at any time and can withdraw from the study if you choose.

**What are the benefits of this research?**

As part of this study you will receive \$25 and you are eligible to sign up for a free 2-hour parenting workshop that will discuss different parenting strategies for managing child misbehavior.

**Do I have to be in this research? May I stop participating at any time?**

You are free to ask questions or to withdraw from participation in this research study at any time. In addition, you may choose not to answer any questions that you do not feel comfortable answering. If you decide that you no longer wish to participate in the study, you will still be eligible to enroll in the free parenting workshop.

**Is any medical treatment available if I am injured?**

The University of Maryland does not provide any medical or hospitalization insurance for participants in this research study. The University of Maryland will not provide any compensation for any injury sustained as a result of participation in this research study, except as required by law.

**What if I have questions?**

This research is being conducted by researchers at the University of Maryland, College Park. If you have any questions about the study, please contact: Yamalis Diaz, M.A., Graduate Student, Department of Psychology, 2109K Biology/Psychology Building, College Park, MD 20742, (301) 405-4606, [ydiaz@psyc.umd.edu](mailto:ydiaz@psyc.umd.edu). Andrea M. Chronis, Ph.D., Assistant Professor, Director, Maryland ADHD Program, Department of Psychology, 1123G Biology/Psychology Building, College Park, MD 20742, (301) 405-9640, [achronis@psyc.umd.edu](mailto:achronis@psyc.umd.edu). Ruth E. Zambrana Department of Women's Studies, 2101 Woods Hall, University of Maryland, College Park, MD 20742, (301) 405 – 6877, [rzambran@umd.edu](mailto:rzambran@umd.edu).

If you have additional questions about your rights as a research participant or wish to report a research-related injury, you should contact: Institutional Review Board Office, University of Maryland, College Park, Maryland, 20742; (e-mail) [irb@deans.umd.edu](mailto:irb@deans.umd.edu); (telephone) 301-405-4212.

**Statement of Electronic Recording Consent:** I, \_\_\_\_\_, give permission to be audio-taped during my interview. I understand that these recordings will be used only for the purposes of research and that only researchers involved in the study will hear these tapes for research related purposes. I also understand that everything I say will be transcribed into a written document and then the tapes will be destroyed.

\_\_\_\_\_ I agree to be audio-taped during my participation in this study.  
\_\_\_\_\_ I do not agree to be audio-taped during my participation in this study.

**Statement of Age of Subject and Consent:**

Your signature indicates that:

- you are at least 18 years of age;
- the research has been explained to you;
- your questions have been answered; and
- you freely and voluntarily choose to participate in this research project.

**NAME OF SUBJECT** \_\_\_\_\_

**SIGNATURE OF SUBJECT** \_\_\_\_\_

**DATE** \_\_\_\_\_

Appendix J: Coding Manual

Main themes/codes for DSM-IV ADHD-Inattentive Symptoms	Definition
ADHD/ADD	Participant uses the terms ADHD, ADD or Attention Deficit Hyperactivity Disorder to describe the behavior.
Attention problem	Response specifically includes the word “attention” and implies a deficit or problem with attention
Defiant/Disrespectful	Behavior described as purposefully defiant or disrespectful toward adults or authority figures or describes purposeful “rule-breaking” behavior
Emotional problem	Attributes behavior to underlying emotional problem, including depression/sadness and anxiety
Hyperactivity/Hyperactive	Response specifically includes the terms “hyperactivity” or “hyperactive” or clearly describes excessive level of activity
Biological/“Internal” problem or disorder	Response implies that the child’s behavior is caused by a biological or brain-based problem or disorder
Learning problem	Behavior described as a learning-related problem, such as a learning disorder, or inability to understand things.
Negative consequence of behavior	Response includes description of a specific negative consequence resulting from the behavior
Normal Behavior	Response describing behavior as “normal” among children.
Not motivated/Lazy	Behavior described as a general lack of motivation or as “laziness” on the part of the child
Parental responsibility	Response implies or explicitly discusses a parent’s responsibility for preventing or managing child’s behavior
Teacher responsibility	Response implies or explicitly discusses a teacher’s responsibility for preventing or managing child’s behavior
Transient state	Behavior is attributed to a transient state or situation such as child’s mood or ongoing task.

Main themes/codes for DSM-IV ADHD-Hyperactive/Impulsive Symptoms	Definition
ADHD/ADD	Participant uses the terms ADHD, ADD or Attention Deficit Hyperactivity Disorder to describe the behavior.
Attention problem	Response specifically includes the word “attention” and implies a deficit or problem with attention
Attention-seeking behavior	Behavior is attributed to a child’s desire to obtain attention from adults, peers, or others
Defiant/Disrespectful	Behavior described as purposefully defiant or disrespectful toward adults or authority figures or describes purposeful “rule-breaking” behavior
Emotional problem	Attributes behavior to underlying emotional problem, including depression/sadness and anxiety
Hyperactivity/Hyperactive	Response specifically includes the terms “hyperactivity” or “hyperactive” or clearly describes excessive level of activity
Impulsive/poor control	Response includes the word “impulsive” or explicitly implies difficulty or inability on the part of the child to control their behavior, but does not imply purposeful behavior
Biological/“Internal” problem or disorder	Response implies that the child’s behavior is caused by a biological or brain-based problem or disorder
Negative consequence of behavior	Response includes description of a specific negative consequence resulting from the behavior
Normal behavior	Response describing behavior as “normal” among children.
Not motivated/Lazy	Behavior described as a general lack of motivation or as “laziness” on the part of the child
Parental responsibility	Response implies or explicitly discusses a parent’s responsibility for preventing or managing child’s behavior
Positive attribute	Response discusses the behavior in a positive light or suggests that behavior represents a positive personality characteristic
Transient state	Behavior is attributed to a transient state or situation such as child’s mood, diet or ongoing task.

Main themes/codes for DSM-IV ODD Symptoms	Definition
Emotional problem	Attributes behavior to underlying emotional problem, including depression/sadness and anxiety
Defiant/Disrespectful	Behavior described as purposefully defiant or disrespectful toward adults or authority figures or describes purposeful “rule-breaking” behavior
Parental responsibility	Response implies or explicitly discusses a parent’s responsibility for preventing or managing child’s behavior or being a poor role model
Attention-seeking behavior	Behavior is attributed to a child’s desire to obtain attention from adults, peers, or others
Normal behavior	Response describing behavior as “normal” among children.
Poor control of emotions/ inability to express emotion	Response discusses or explicitly implies difficulty or inability on the part of the child to control their emotions or express their emotions, but does not imply purposeful behavior
Biological/“Internal” problem or disorder	Response implies that the child’s behavior is caused by a biological or brain-based problem or disorder
Hyperactivity/Hyperactive	Response specifically includes the terms “hyperactivity” or “hyperactive” or clearly describes excessive level of activity
Learned behavior	Response discusses the learned nature of behavior (e.g., from media, peers, parents, etc.)
Positive attribute	Response discusses the behavior in a positive light or suggests that behavior represents a positive personality characteristic

Main themes/codes for parental response to behavior in Hypothetical Vignettes	Definition
Parenting response	An action by a parent, directed at the child that is focused on addressing the child's behavior.
Proactive parenting	Parenting strategies aimed at increasing or improving a specific area of child functioning (e.g., academic or interpersonal)
Reactive parenting	Parenting strategies aimed at reducing or addressing child <i>misbehavior</i> and is punishment-focused
Help-seeking response	An action by a parent aimed at obtaining support or services to address child behavior or perceived impairment.
School-based help-seeking	An action by a parent aimed at obtaining support or services through the child's school to address child behavior or perceived impairment.
Mental health help-seeking	An action by a parent aimed at obtaining therapy, medication, or other mental health services from a mental health professional (e.g., psychologist) to address child behavior or perceived impairment
Other professional help-seeking	An action by a parent aimed at obtaining support, services, or information from a professional other than a mental health provider.
Talk to child/increase communication	Parental response to behavior specifically described as a means for increasing level of communication between parent and child.
Other response/reaction	Parental reaction to behavior that is not related to parenting or help-seeking (e.g., emotional response, talk to a friend).

Main themes/codes regarding reasons for parental response to behavior in Hypothetical Vignettes	Definition
Punish child	Goal of parental action is to “punish” the child for their behavior
Teach child “lesson” or value	Goal of parental action is to “teach” the child a lesson about the consequences of their behavior or an overarching value (e.g., respect for authority)
Improve parent-child relationship	Goal of parental action is improve parent-child relationship
Improve child’s academic functioning	Goal of parental action is to address, improve, or monitor the child’s academic functioning
Improve child’s emotional functioning	Goal of parental action is to improve child’s ability to control or express negative emotions
Improve child’s interpersonal functioning	Goal of parental action is to improve or address child’s ability to form and maintain positive interpersonal relationships

Main themes/codes for responses from open-ended and semi-structured interview regarding values	Definition
Believe in God/Religious/Spiritual	Response related to parent's desire for child to demonstrate belief in God and a high level of religiosity and spirituality
Educated/academically-oriented	Response related to parents' desire for child to reach high educational goals and have a strong desire to do well in school
"Good person"/positive personality characteristics	Response related to parent's desire for child to demonstrate positive personality characteristics (e.g., kind, honest)
Leadership skills (strong, leader not follower)	Response related to parent's desire for child to demonstrate strong leadership skills in daily and/or future tasks and interactions
Perseverant/motivated/ambitious	Response related to parent's desire for child to demonstrate resilience in difficult situation and motivation/ambition to pursue goals
Professional/"get-ahead"	Response related to parent's desire for child to achieve professional goals
Respectful	Response related to parent's desire for child to demonstrate respect toward authority and/or others (explicit use of the word respect)
Well-behaved/good manners/follow rules	Response related to parent's desire for child to be well-behaved, to demonstrate manners across social settings, and adhere to rules
Promotes social relatedness/interpersonal functioning	Response related to characteristics viewed as important or necessary to social relatedness and interpersonal relationships or which expresses the importance of ability to count on family /others when needed and/or importance of building relationships
"Respect begets respect"	Response discussing the idea that children should display respect in order to promote <i>mutual</i> respect
Respect for elders	Response discussing the idea that children should display a high level of respect toward adults
Characteristic will help child "get ahead"	Response related to the importance of child having specific skills or attributes that will help them in the future (e.g., to "get ahead", to take care of themselves, to develop their own identity, etc.)
Appropriate/positive self-expression	Response related to the importance of developing the ability to express negative and/or positive emotions openly and appropriately.

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