

Mental Health Problems of Adolescents as Reported by Their Caregivers

A Comparison of European, African, and Latino Americans

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Abstract

This article examines problem recognition across ethnic groups by focusing on parental reports of mental health problems in adolescents. Data were collected from 1 youth (aged 11–17) and 1 caregiver from a community-based sample of households in the Houston metropolitan area. The sample was 4175 youths and their caregivers (37.8% European, 35.00% African, 25.4% Latino, and 1.8% other American). Indicators of mental health were perceived mental health, life dissatisfaction, and whether adolescents had a mental health problem in the past year. European Americans were more likely to rate the mental health of adolescents as fair or poor, were about twice as likely to report that adolescents were dissatisfied with their lives, and that adolescents had a mental health problem in the past year. Interventions to help minority families in the identification of youth's mental health problems may need to address cultural differences in the definition of mental health problems or in the benefit of labeling mental health problems that may serve as barriers to help-seeking.

Introduction

Parental recognition of the child's needs is imperative for appropriate treatment for children's mental health problems.^{1,2} Parental belief that the child needs mental healthcare has been found to be the most significant factor associated with service use.³ Youths usually resist mental healthcare,^{4,5} and families must identify children's mental health needs and overcome their resistance to care. Work by John Weisz and colleagues^{6–9} suggests that there might be divergent thresholds of symptom

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severity at which caregivers label mental health problems. These lower or higher thresholds might be associated with the underidentification or overidentification of mental health problems for certain cultures. It is reasonable to assume that lack of parental recognition, in addition to the usual reported factors, may play an important role in inhibiting the use of specialty services.

By way of illustration, most of the literature documents that African American and Latino youths use specialty mental health services at a lower rate than other groups, although some studies find that in some cases African Americans in particular do not have lower utilization rates.¹⁰⁻¹² However, there also is evidence that the mental health of Latino youths may be worse than that of youths from other groups. On the basis of self-report primarily, Latino youths, particularly Mexican Americans, may be at increased risk for depression and for suicidal behaviors.^{13,14} Hispanic youths from the sixth and seventh grades have been reported to have more delinquent behaviors than their white counterparts.¹⁵

Lower mental healthcare use together with greater or comparable need suggest that parents of minority children may be less likely to recognize and/or label their children's behavior as a mental health problem requiring professional intervention.¹⁶ There appear to be important cultural influences that may need to be considered when examining parental assessment of normative development and recognition of emotional and behavioral problems in children. Wachtel and colleagues, in 2 separate studies,^{17,18} found that African American mothers reported less anxiety in their children than did European American mothers, even with comparable levels of symptomatology. Others report that African American parents of adolescent patients and nonpatients reported fewer and less frequent mental health problems than did European American parents.¹⁹ Most of these studies show lower parental identification of mental health problems by minority caregivers than majority caregivers. However, the studies, by not assessing the presence of psychiatric disorders, do not allow disentangling whether the observed differences are due to differences in the actual level of youth functioning between the ethnic and racial groups or differences in caregiver identification of mental health problems.²⁰ Achenbach and colleagues compared U.S. mainland and Puerto Rican nonreferred samples via the Child Behavior Checklist (aged 4-16), Teacher's Report Form (aged 6-16), and Youth Self Report (aged 12-16). Problem scores were significantly higher in parent and teacher ratings of Puerto Rican than of mainland subjects, but were significantly lower in self-ratings by Puerto Rican adolescents. Adolescents in both cultures reported significantly more problems than their parents or teachers did. Most of the significant cross-cultural differences in parent, teacher, and self-ratings of competencies showed more favorable scores for the mainland subjects. High referral rates, a high prevalence of *Diagnostic and Statistical Manual of Mental Disorders (DSM)* diagnoses, and low scores on the Children's Global Assessment Scale are consistent with the high problem rates reported by Puerto Rican parents and teachers but not with the lower rates reported by adolescents.²¹

There is evidence that, when a different informant than the caregiver does child ratings of mental health problems, the likelihood that minority children will have lower rates of mental health problems is reversed. Indeed, Zimmerman et al²² found that teachers reported more mental health problems for African American adolescents than for Hispanics and fewer still for European American adolescents. However, when parent ratings were compared with teacher ratings, African American parents were least likely to report problems among their youths, followed by Hispanic and then European American parents. It is not clear whether there is lower parental recognition, because there are different interpretations of the construct of mental health problems, or there is lower awareness of mental health problems among minority caregivers in contrast to majority caregivers.

Other studies extend the role of culture in labeling mental health problems, suggesting that it relates to the behaviors that parents value within their context. Parent and teacher reports of child problem behaviors in the United States and Puerto Rico find that Puerto Rican mothers were more likely to perceive externalizing problem behaviors in their children, controlling for level of externalizing problems. Given the importance Puerto Ricans place on calmness, active behaviors were seen as negative, whereas white mothers perceived these behaviors as exhibiting independence and curiosity.²¹ Whether these differences are reflected in service use in this study is not clear, but

clearly in this case thresholds for problem recognition appear to be lower among Puerto Ricans for externalizing symptoms. Other studies similarly demonstrate that culture influences whether a child's behavior is considered normal or pathological.²³⁻²⁵ Consequently parents' culture-specific interpretations of children's behavior may be influenced by the goals set by effective child rearing, affecting the possibility of undetected or untreated mental health problems.^{6,7}

However, there have been few studies examining ethnic differences in reports of mental health problems among youths as reported by parent informants. There is evidence that suggests minority parents are less likely to recognize and report mental health problems of their adolescents than are their majority group counterparts, but direct evidence on this question is sparse. That is the focus here: Are there systematic ethnocultural differences in reports by caregivers of mental health problems in their adolescents? This article is the first in a series that will examine factors affecting receipt of services for mental health problems by adolescents from different ethnocultural groups. As a first step in this program of research, the focus here is on recognition by parents or other primary caregivers of emotional or mental health problems among adolescents, and how problem recognition may vary across different ethnic groups. The data are taken from Teen Health 2000, a community-based study of adolescent functioning and healthcare behaviors.

Methods

Teen Health 2000 was designed as a 2-wave, prospective study of the prevalence of psychiatric disorder among adolescents in managed care and use of services for both psychiatric and somatic complaints. The sample was selected from households in the Houston metropolitan area enrolled in local health maintenance organizations. One youth 11–17 years of age was sampled from each eligible household, with oversampling for African and Latino American households. Wave 1 data collection ended in early 2000. Data were collected at baseline on sample youths and the primary adult caregiver using computer-assisted personal interviews and self-administered questionnaires. Interviews were usually collected in the household, although some interviews were done at other sites if the home interview could not be done. Complete data were available for 4175 youths in Wave 1. Data from Wave 1 are presented here.

The sample was diverse. The youth cohort was 50.8% male at baseline. In terms of age distribution at baseline, 43.4% were 13 or younger, 45.8% were 14–16, and the rest were 17 or older. The sampling strategy used selected families with youths aged 11–17, but a few (40 or 1%) had turned 18 by the time interviews were done (9.8% were 17). In terms of ethnic status, the cohort was 37.8% European American, 35.0% African American, 25.4% Latino, and 1.8% other American. For caregivers, the vast majority (93.3%) were biological mothers. Regarding education level of the primary caregiver, 10.8% had not completed high school, 20.5% had completed high school, and 38.8% had some education beyond high school. Comparisons of caregivers across ethnic groups are presented in Table 1 for parental status, gender, education, income, and self-reported mental health status. As can be seen, minority caregivers are slightly younger, less educated (particularly Latino Americans), and have lower income. Slightly more African American caregivers reported their mental health status as better than the other comparison groups.

Data were collected on a broad array of indicators drawn from four domains: status attributes, personal and social resources, stressors, and psychological dysfunction (see, eg, references 13, 26, and 27). Here the focus is on parent reports of child mental health problems using 3 constructs: perceived emotional health, life satisfaction, and perception that the adolescent suffered from an emotional or behavioral problem.

In studies of adolescent mental health an item on perceived mental health is always included: "Would you say your child's emotional or mental health is excellent, good, fair or poor?" Also included was an item on life satisfaction: "Overall, how satisfied does your child feel about his or her life as a whole: very satisfied, pretty satisfied, equally, pretty dissatisfied, or very dissatisfied?" A single

Table 1
Characteristics of caregivers

	% (<i>n</i>)			<i>P</i>
	European Americans	African Americans	Latino Americans	
Relationship				
Biological mother	93.2 (1472)	92.7 (1354)	94.2 (999)	<.001
Biological father	2.2 (35)	1.0 (14)	1.8 (19)	
Others	4.6 (73)	6.3 (92)	4.0 (42)	
Gender				
Male	2.3 (36)	1.2 (17)	2.1 (22)	NS
Female	97.7 (1544)	98.8 (1444)	97.9 (1038)	
Age, y				
16–35	11.8 (184)	20.8 (303)	25.5 (270)	<.001
36–45	60.9 (962)	58.8 (857)	57.6 (611)	
46–71	27.5 (434)	20.4 (298)	16.9 (179)	
Education level				
Did not complete high school	3.9 (62)	2.7 (39)	26.8 (284)	<.001
Completed high school	20.8 (328)	19.0 (277)	30.7 (325)	
Some education beyond high school	36.3 (574)	51.0 (745)	31.2 (331)	
College degree	21.7 (343)	16.4 (240)	6.6 (70)	
Some postgraduate education	17.3 (273)	11.0 (160)	4.7 (50)	
Total annual household income				
\$24,999 and below	3.9 (58)	15.5 (208)	15.0 (146)	<.001
\$25,000–\$44,999	17.3 (257)	35.5 (476)	36.2 (352)	
\$45,000–\$64,999	25.2 (375)	23.7 (318)	28.1 (273)	
\$65,000–\$99,999	35.5 (529)	20.5 (275)	17.4 (169)	
\$100,000 and more	18.1 (270)	4.8 (64)	3.4 (33)	
Perceived mental health				
Excellent	22.7 (355)	27.5 (398)	22.2 (232)	<.001
Very good	43.7 (684)	40.5 (587)	40.4 (423)	
Good	25.6 (400)	25.8 (374)	27.9 (292)	
Fair or poor	8.0 (125)	6.1 (89)	9.6 (100)	

item inquired whether during the past 12 months caregivers thought their child had an emotional, behavioral, drug, or alcohol problem (yes/no). Studies of this topic have used diverse indicators of mental health functioning of children and adolescents. Hence, there is no consensus regarding assessment strategies. Several recent papers on parent reports have used structured psychiatric interviews with children and parents.²⁸ Unfortunately, while adolescents were interviewed concerning a broad array of psychiatric disorders, parents were interviewed only about youth disruptive behaviors (attention deficit–hyperactivity disorder, conduct disorder, oppositional defiant disorder). Rather than focus on a single class of disorders, the decision was made to focus on more global, generic indicators. Single-item indicators of psychological functioning or well-being have a long history in psychiatric epidemiology.^{29,30} Items inquiring about worry, happiness, and life satisfaction, for example, have been used to characterize the well-being of population subgroups, including ethnic groups. In this particular study, there was no external validation of the perceptions of adolescent mental

health functioning by parents or caregivers. However, we were able to examine the associations among the individual indicators themselves. All were significantly associated—for the overall group, and for the 3 ethnic groups (all P s < .001). For example, the correlation between poor perceived mental health and life satisfaction was 0.53 and with perception of an emotional, behavioral, or drug problem was 0.39, and the correlation between this latter measure and life dissatisfaction was 0.32 for the total sample. In addition, 2 other measures were examined, which are not included in this article. Poor perceived mental health was correlated 0.46 with youth unhappiness, and this was correlated 0.54 with life dissatisfaction (both P s < .001).

The analytic strategy consists of contrasting prevalence rates (percentages) of these 3 indicators of adolescent mental health reported by adult caregivers by ethnic group. For these analyses, European, African, and Latino Americans are compared. This latter group consists of those who self-identified as being of Mexican origin born in the United States, born in Mexico, or of other Latino origin (Puerto Rican, Cuban, Central American, etc).

Differences in the crude prevalence rates are then examined adjusting for the effects of several covariates: age and gender of youths, education level of caregiver, family income, and presence of psychiatric disorder in the youth, functional impairment of the youth, and mental health of parents. Youth's age was categorized as less than or equal to 13, 14–16, and 17 or more. This categorization of age allowed testing whether the effect of age on parental reports of children's mental health problems was linear or not. Education level of caregivers (see above) was classified as "did not complete high school," "completed high school," "some education beyond high school," "college degree," and "some postgraduate education." Education level was used as the indicator of socioeconomic status of caregivers for 2 reasons: there were fewer missing cases than with income and the 2 indicators are strongly correlated, of course. For example, the correlation between caregiver education level and family income was 0.40 for European, 0.40 for African, and 0.38 for Latino Americans. Logistic regression models were run using family income instead of caregiver education, and the results were virtually identical (data not shown). For that reason, the models are presented with education as the socioeconomic status measure. Psychiatric disorders were assessed with the Diagnostic Interview Schedule for Children (DISC-IV), a highly structured instrument³¹ designed to be administered by lay interviewers. Studies suggest the DISC has acceptable levels of test-retest reliability.^{31,32} Research with European, African, and Latino American adolescents indicate no systematic differences among these groups in terms of test-retest concordance.³³ In Teen Health 2000, anxiety disorders (agoraphobia, generalized anxiety, panic, social phobia, posttraumatic stress disorder), affective disorders (major depression, dysthymia, mania, hypomania), disruptive disorders (conduct, oppositional defiant, attention deficit–hyperactivity disorders), eating disorders (bulimia, anorexia nervosa), and substance use (alcohol, marijuana, and other substance disorders) were included. The measure here is one or more *DSM-IV* disorders in the previous 12 months. That is, a case was defined as anyone who met diagnostic criteria for at least 1 disorder in the past year. In Wave 1, 15.6% of the youths met diagnostic criteria for 1 or more disorders. There were no ethnic differences in the prevalence of any DISC-IV diagnosis in the past year as reported by the youths in the present study. The prevalence of at least 1 of 17 DISC-IV diagnoses was 16.1% for European, 14.3% for African, and 16.7% for Latino American youths (NS).

Latino caregivers were given the option of completing both interviews and questionnaires in either Spanish or English. The DISC was developed in English and in Spanish by the National Institute of Mental Health. The non-DISC components of the interview and the questionnaire for the caregivers were translated using independent forward- and back-translation adjudication and pilot testing. Only 8.4% of Latino caregivers opted for the Spanish instruments. All youths opted to complete their assessments in English. Regarding gender, female was chosen as the reference class. Age was grouped as a categorical variable with 3 levels (≤ 13 , 14–16, and ≥ 17), with the younger category chosen as the reference class. Education level of caregivers (see above) was a categorical variable with 5 levels. The level of "did not complete high school" was chosen as the reference class.

Presence of psychiatric disorder was a binary variable (the level Yes for at least 1 of the 17 DISC-IV diagnoses; the level No as none of the 17 assessed DISC-IV diagnoses.)

To assess functioning, the lay-administered version of the Child Global Assessment Scale (C-GAS) was used,³⁴⁻³⁶ completed by interviewers after the interview was completed. For the purposes of the analysis, the C-GAS was scored so that 0 to 79 was low, 80 to 89 was moderate, and 90 or above was high functioning. The mean C-GAS score was 83.7 (SD = 11.5) in Wave 1. There were ethnic differences in C-GAS scores assigned by the interviewers. For example, 39.0% of the European, 38.7% of the African, and 43.4% of the Latino American youths were assigned C-GAS scores of 90 or more ($P < .05$), indicating a tendency for the third group to be rated as functioning slightly better. A score of 90 or above represented the reference group.

Given that family dysfunction³⁷ and parental psychopathology³⁸ can affect problem recognition, parent ratings of their own mental health functioning (excellent, very good, good, fair, or poor) were included. The reference group was excellent/good.

Statistical analysis

Differences in mental health functioning of adolescents reported by the 3 ethnic groups of caregivers were examined using χ^2 analyses, with α set at .05. Sequential logistic regression techniques³⁹ were employed to assess the explanatory role of ethnic group for adolescent mental health problems with and without adjustment for other possible covariates, including history of any psychiatric diagnoses in the child. Thus, 3 sets of sequential logistic regression analyses were performed using SPSS (SPSS 7.5, SPSS Inc., Chicago, Ill). to assess the prediction of caregivers' recognition of children's mental health problems, first on the basis of ethnic group, then sequentially with the inclusion of adolescents' gender, age, primary caregiver's education level, 1 or more *DSM-IV* youth disorders in the previous 12 months, and youth C-GAS rating score and parents' mental health. The total sample for each set of analyses was limited to adolescents with complete data on each outcome variable and all the covariates. For the multivariate analyses of perceived mental health, 94.9% ($n = 3963$) of the total sample was included. For the multivariate analyses of perceived life satisfaction, 93.1% ($n = 3888$) of the total sample was included. For the multivariate analyses of perceived drug, alcohol, and behavior problems, 94.3% ($n = 3938$) of the total sample was included. A comparison between those retained and those excluded across the 3 sets of analyses showed that caregivers' ethnic status and education level were associated with the nonresponses. Youths excluded were more likely to have Latino American caregivers ($P < .001$) and caregivers who had not completed high school ($P < .001$).

Results

Table 2 presents data on the associations between selected caregiver characteristics and the 3 indicators of adolescent mental health functioning. For worse perceived mental health, only caregiver mental health was significant, with worse caregiver functioning positively related to worse adolescent functioning. For life dissatisfaction, the same pattern held. For feeling that adolescents had experienced an emotional, mental, behavioral, or drug problem in the past year, there was a tendency for older caregivers and better-educated caregivers to endorse this item, as well as caregivers who rated their own mental health as worse.

As can be seen in Table 3, European Americans were more likely than African or Latino Americans to rate the mental health of their adolescents as fair or poor. European American caregivers were about twice as likely to report that their adolescents were more dissatisfied with their lives in comparison to the other groups (Table 3). Finally, European American caregivers were about twice as likely to have thought their adolescents had an emotional, behavioral, drug, or alcohol problem in the past year than their minority group counterparts (Table 3).

In Table 4, results of the multiple logistic regression analyses examining the association between ethnicity, age, and gender of youths; education level of caregiver; psychiatric disorders among youths;

Table 2

Caregiver reports of youth mental health functioning by caregiver characteristics, total sample

	Worse mental health	<i>P</i>	Dissatisfied	<i>P</i>	Behavior or drug problems	<i>P</i>
Age, y		NS		NS		<.05
16–35	5.8 (44)		4.7 (34)		10.9 (82)	
36–45	5.6 (135)		3.6 (86)		11.5 (277)	
46–71	7.8 (71)		4.8 (43)		14.7 (132)	
Income		NS		NS		NS
\$24,999 and below	5.8 (23)		3.6 (14)		9.3 (37)	
\$25,000–44,999	7.4 (80)		4.7 (49)		14.0 (151)	
\$45,000–64,999	5.4 (52)		4.1 (39)		11.7 (113)	
\$65,000–99,999	5.6 (55)		3.4 (33)		12.3 (120)	
\$100,000 and more	4.3 (16)		4.0		11.3	
Education		NS		NS		<.001
Did not complete high school	6.0 (22)		3.2 (11)		7.2 (26)	
Completed high school	6.9 (63)		3.8 (34)		10.6 (97)	
Some education beyond high school	5.3 (88)		4.1 (66)		12.5 (205)	
College degree	7.6 (50)		4.8 (31)		13.6 (89)	
Some postgraduate degree	5.5 (27)		4.3 (21)		15.1 (74)	
Caregiver's mental health		<.001		<.001		<.001
Excellent	1.5 (15)		1.1 (11)		5.6 (55)	
Very good	3.1 (53)		2.6 (43)		10.4 (176)	
Good	9.1 (97)		5.9 (61)		17.2 (182)	
Fair or poor	27.0 (84)		16.2 (48)		25.0 (76)	

Table 3

Perceptions by caregivers of youths' emotional health, life satisfaction, and emotional, behavioral, drug, or alcohol problem in the past year

Measures	% (<i>n</i>)			
	European American	African American	Latino American	Total
Worse emotional health				
Better health	91.5 (1441)	95.7 (1377)	95.0 (977)	93.9 (3795)
Worse health*	8.5 (134)	4.3 (62)	5.0 (51)	6.1 (247)
Life dissatisfaction				
Satisfied	94.0 (1464)	97.7 (1372)	96.7 (970)	96.0 (3806)
Dissatisfied [†]	6.0 (94)	2.3 (32)	3.3 (33)	4.0 (159)
Emotional, behavioral, drug, or alcohol problem				
No [‡]	83.2 (1307)	90.6 (1294)	91.7 (934)	88.0 (3535)
Yes	16.8 (264)	9.4 (134)	8.3 (84)	12.0 (482)

*Fair or poor perceived mental health, $\chi^2 = 26.29$ ($df = 2$), $P < .000$.[†]Dissatisfied, very dissatisfied, $\chi^2 = 28.85$ ($df = 2$), $P < .000$.[‡] $\chi^2 = 57.15$ ($df = 2$), $P < .000$.

Table 4

Association between mental health functioning of adolescents and ethnic status as reported by their caregivers (sequential logistic regression models)

	OR (95% CI)		
	Worse emotional health	Life dissatisfaction	Emotional, behavioral, drug, or alcohol problem
Model 1 (Crude)			
European Americans*	1.00 (—)	1.00 (—)	1.00 (—)
African Americans	0.48 [†] (0.35, 0.65)	0.37 [‡] (0.24, 0.55)	0.51 [†] (0.41, 0.64)
Latino Americans	0.55 [‡] (0.39, 0.78)	0.51 [‡] (0.33, 0.76)	0.43 [†] (0.33, 0.56)
Model 2 (Model 1 + child's age + child's gender)			
European Americans	1.00 (—)	1.00 (—)	1.00 (—)
African Americans	0.49 [†] (0.36, 0.67)	0.37 [†] (0.25, 0.56)	0.53 [†] (0.42, 0.66)
Latino Americans	0.56 [‡] (0.40, 0.79)	0.51 [‡] (0.34, 0.78)	0.44 [†] (0.34, 0.57)
Model 3 (Model 2 + education of caregiver)			
European Americans	1.00 (—)	1.00 (—)	1.00 (—)
African Americans	0.50 [†] (0.36, 0.68)	0.37 [†] (0.24, 0.55)	0.52 [†] (0.42, 0.66)
Latino Americans	0.54 [‡] (0.37, 0.78)	0.56 [§] (0.36, 0.88)	0.49 [†] (0.37, 0.65)
Model 4 (Model 3 + any DISC one-year diagnosis for child)			
European Americans	1.00 (—)	1.00 (—)	1.00 (—)
African Americans	0.51 [†] (0.37, 0.70)	0.38 [†] (0.25, 0.57)	0.53 [†] (0.52, 0.66)
Latino Americans	0.53 [‡] (0.36, 0.70)	0.56 [§] (0.36, 0.87)	0.47 [†] (0.35, 0.63)
Model 5 (Model 4 + interviewer CGAS score of child)			
European Americans	1.00 (—)	1.00 (—)	1.00 (—)
African Americans	0.49 [†] (0.35, 0.68)	0.37 [†] (0.24, 0.56)	0.50 [†] (0.39, 0.64)
Latino Americans	0.54 [‡] (0.37, 0.79)	0.58 [§] (0.38, 0.91)	0.48 [†] (0.36, 0.65)
Model 6 (Model 5 + caregiver's mental health)			
European Americans	1.00 (—)	1.00 (—)	1.00 (—)
African Americans	0.48 [†] (0.34, 0.67)	0.37 [†] (0.24, 0.57)	0.50 [†] (0.40, 0.65)
Latino Americans	0.50 [‡] (0.34, 0.74)	0.57 [§] (0.36, 0.90)	0.48 [†] (0.35, 0.64)

*European Americans as the reference group.

[†] $P < .001$.

[‡] $P < .01$.

[§] $P < .05$.

C-GAS scores for youths; parent's mental health; and each of the 3 parent-reported indicators of youth mental health functioning are presented. In each set of analyses, Model 1 presents ethnic contrasts, Model 2 introduces controls for age and gender, Model 3 adds education of caregiver, Model 4 adds DISC-IV diagnoses reported by youths, Model 5 adds interviewer C-GAS rating score

of youth's functioning, and Model 6 adds parent's mental health. As can be seen, the crude ethnic differences are little changed in the multivariate analyses. In each model, European American parents are significantly more likely to rate the mental health of their adolescents as worse than Latino and African American parents do, with no differences between the latter 2, even after controlling for youth's psychiatric disorder and functioning. That is, minority parents are less likely to report mental health problems in their children as compared to their majority counterparts.

Discussion

To summarize, European American caregivers were more likely than the 2 groups of minority parents to (1) rate the mental health of their adolescents as worse, (2) rate their life satisfaction as worse, and (3) report they thought their adolescents had an emotional, behavioral, drug, or alcohol problem in the past year. These differences were large, with the prevalence reported by European American caregivers about twice those of the 2 minority groups. Introduction of statistical controls for age and gender of youths, education of caregiver, youth-reported DISC-IV disorders, ratings of youth functional impairment and parent mental health did not alter this pattern appreciably.

How do these results compare with other studies? As noted in the introduction, there have been few attempts to examine ethnic differences in parent or caregiver assessments of the mental health functioning of children and adolescents. The finding that, in general, African American caregivers were less likely to report a variety of adolescent mental health problems than their European American counterparts corroborates earlier research.¹⁷⁻¹⁹ The finding that parents of Latino adolescents report low rates of mental health problems also appear to support findings by Zimmerman et al.²² However, in that study, both teachers and parents reported the fewest mental health problems among European American adolescents. By contrast, in this study both groups of minority parents reported substantially fewer problems than majority parents.

Although there was a clear pattern of higher reporting of youth problems by European American caregivers, there were no systematic differences in reporting between African and Latino American caregivers. Several potential explanations may account for the observed ethnic differences in parental reports of youth's mental health problems.

As noted in the introduction, cultural factors may influence whether parents recognize problems in their children^{6,7,21,23-25,40} Parent's ethnocultural background may affect both their interpretation of and response to their youth's symptoms of mental health problems. Normative standards in minority groups may provide more latitude in labeling youth as having mental health problems even when these same behaviors would be automatically labeled as mental health problems in European American groups. As noted earlier, Weisz and colleagues⁶⁻⁹ have posited a threshold effect for understanding cultural differences in parent reports. In this case, the threshold for labeling youth's symptoms and behaviors as mental health problems might be higher among Latino and African American caregivers than their European American counterparts, even when the youths exhibit the same level of problems or symptoms. The boundaries of what is pathological and what is normal in minority families may be more related to being an asset or deficit in that neighborhood, particularly if these behaviors are adaptive rather than maladaptive in their communities.

A second potential explanation involves what might be considered reporting bias. For example, the threshold for what is considered a mental health problem may be the same across ethnocultural groups but minority parents may reframe these problems as a way to lower stigma, particularly if the consequences are going to be negative. Minority caregivers may believe that the consequences of identifying their youth's mental health problems might be uncertain and more difficult to predict than would European American caregivers.⁴¹ Mental health utilization among children in foster care varies more dramatically between ethnic groups at the lowest level of symptom severity while service use is more similar at the highest symptom severity.⁴² In other words, when need is high, caregivers might seek care for their youth, independent of the cost of labeling, but not when need is low. Minority

parents may also anticipate that mental health problems may lead their youth to more restrictive care (eg, juvenile justice) and, in response, attempt to minimize the labeling of certain behaviors or symptoms as mental health problems. The overrepresentation of minorities in restrictive care and their underrepresentation in more voluntarily entered mental care¹² makes this a plausible conjecture.

Another example of possible biased reporting is that the cost-benefit of labeling their youths with a mental health problem may be different for minority than for majority caregivers. If minority parents, in comparison to majority caregivers, are less clear on what the mental health system can do for them or anticipate that the mental health system is likely to be ineffective in improving the outcomes of their youth, they may feel reluctant to identify their youths' problems. On the contrary, if the nature and outcomes of service delivery are more obvious and perceived to be effective, independent of ethnicity or race of their youths, as in the primary care sector, ethnocultural factors may play an insignificant role in labeling. This might explain the lack of a relationship between the ethnic status of children and adolescents and their receipt of services for psychosocial problems in primary care offices.⁴³ Identification of problems may be more closely linked to the perceived benefit of care.

A third potential reason for the observed differences may be tied to greater openness in the expression of difficulties between majority families and their youth as compared to minority families. Minority families may favor youth self-reliance more than majority families,⁴⁴ leading to less communication of problems between minority youths and their caregivers. Or, the more authoritarian role of minority parents with their children, in comparison to European American caregivers,⁴⁵ may lead minority youth to refrain from expressing their problems or articulating their mental health symptoms. As a consequence, minority caregivers may be less aware of their youth's difficulties and, as a result, less likely to identify mental health problems than majority caregivers.

A fourth alternative explication may be that minority parents are more likely to interpret youth mental health problems as attributable to their own failures than are majority parents. Identification of youth mental health problems may be seen as being blamed on their child rearing or discipline, which might not be the case for European American caregivers. Or, it may be associated with minority parents' taking more responsibility for solving these problems than European American caregivers. African American and Latino caregivers may feel that the problem is more endogenous to the family than would European Americans and, therefore, needs to be solved within the family.

Several limitations must be kept in mind. First, assessment of psychiatric disorders and youth's functioning was not assessed by a clinician, so the observed ethnic differences in problem recognition may reflect a methodological artifact of content nonequivalence in the interpretation of the questions assessing mental health problems rather than differences in youths' perceived need by ethnicity/race of informants. While caregivers rated whether their youths had mental health problems, youths self-reported on psychiatric diagnoses and interviewers rated youth's functioning. Lack of agreement between multiple informants is so problematic for ascertaining "caseness" in epidemiologic research that recent papers have presented estimates of prevalence separately for youth and parent reports.^{32,46} Results from such studies demonstrate that prevalence based on parent versus child reports differ by diagnostic category and also that there often is little overlap between caseness status based on separate assessments by parent and child concerning the presence and type of disorder affecting the children. The observed differences may correspond to less overlap among informants for minority children than for majority children.

Second, the problem recognition questions are broad, so it is not possible to identify the elements that may lead to different interpretations of the same question. How the measures were related to each other was examined in an attempt to explore this, by determining the Spearman rank order correlation among the 3 measures within each ethnic group. The average ρ coefficient was 0.48 for European, 0.35 for African, and 0.36 for Latino American caregivers. All individual correlations were significant ($P < .001$). The data suggest that majority group parent ratings are slightly more consistent across measures, and differed little between the 2 minority groups. Attempts were also made to examine whether there were differences in how parents reported their own functioning, reasoning that if

cultural differences in understanding and labeling mental health problems are present, they should operate for self-reports as well as reports about children. As can be seen in Table 1, there was a tendency for European American caregivers to perceive their mental health as worse in comparison to their minority counterparts. Reports of happiness by caregivers (data not shown) were examined and there was a tendency for minority groups to report less unhappiness. These results, coupled with corroboration of the findings by previous studies (noted earlier), does not preclude ethnocultural differences in interpretation of the stimulus questions as a potential confounder, but it does suggest consistency in patterns of responses across groups. It should be noted that research using a bicultural family design suggests minimal effects of parent culture on reports of child psychopathology.²⁰

Third, both African Americans and Latinos are grouped as if they were homogeneous groups, although it was recognized that they are not. Limited sample size for many of the groups included (Puerto Ricans, African American Caribbean, Central Americans) does not permit the disaggregation into more refined racial and ethnic categories. Fourth, other important variables, such as mental health literacy, perceived effectiveness of mental healthcare and fear of disclosing mental health information, were not collected in the present study. This underlines the need to have additional variables, besides ethnicity and race, that may explain the problem recognition differences among ethnic and racial groups.

Future research should address the mechanisms responsible for the observed ethnic and racial differences in caregiver and youth identification for youth mental health problems. Are there specific factors attributable to ethnic culture that may account for parent-child discrepancies in reports of mental health functioning? In this report, the role of ethnicity was examined as measured by ethnic self-identification. However, ethnicity is a complex phenomenon, going well beyond ethnic status.^{7,4} Conceptually, ethnicity is manifested across 3 domains—natal, behavioral, and subjective.^{47,48}

Future research on this issue should incorporate measures from the broader context of the cultural experience. Such measures might assess, for example, constructs such as salience of ethnicity, perceived power of the group, perceived prejudice and discrimination, ethnic esteem and ethnic identity, and cultural beliefs about mental illness and its treatment.^{13,49,50}

As noted earlier, the available literature suggests that African American and Latino youths use specialty mental health services at lower rates than other groups.¹⁰⁻¹² Other research suggests that parental recognition of the child's mental healthcare needs is a powerful predictor of service use.¹⁻³ The findings reported here suggest that 1 possible reason for apparent differential use of mental health services by minority youths may be attributable to lower perception of need for care on the part of parents. Why this may be so is a question in need of further exploration.

Implications for Behavioral Health

Understanding factors affecting decisions to seek help for child mental health problems is important. It is generally parents who refer children for help.⁵⁰ It appears that psychological factors (attitudes, beliefs, intentions) are relatively more important than practical considerations (financial costs, availability, time) when making the decision to seek care.⁵¹⁻⁵⁵

As noted in the introduction, there appear to be cultural influences affecting recognition of mental health problems among minority youths.^{7,21-25,40} The results of this study strongly suggest that differential threshold effects^{6,7} are one such factor. Minority parents appear to have higher thresholds for problem recognition in the present study. Logically, and empirically, one would predict such a threshold effect to have an effect on use of mental health services. There is evidence indicating this is so.

The literature documents that African and Latino American youths are more likely to use specialty mental health services at a lower rate than other groups.^{10,16} Unpublished data from the present study also document such ethnic differentials. For specialty mental health services, there was a strong tendency for European American youths to receive such services, contrasted with African and Latino American youths.¹³ For example, European Americans were 2 times as likely to use any outpatient

services ($P < .001$), $2^{1/2}$ times more likely to see a mental health professional ($P < .001$), 2 times as likely to see a primary care physician for mental problems ($P < .001$), and $1^{1/2}$ times more likely to see a primary care physician for mental problems ($P < .001$), and $1^{1/2}$ times more likely to use school-based mental health counseling or therapy ($P < .01$) than were African or Latino American youths. Thus, in Teen Health 2000, ethnic differentials in parent reports or mental health functioning parallel differentials in use of specialty mental health services.

These data, along with data from other studies, suggest that there may be strong ethnocultural differences in factors promoting or inhibiting help-seeking for child emotional or behavioral problems. As noted above, barriers to services use may be both psychosocial and practical. At this point, neither clinicians nor researchers fully understand how these factors play out in parental decisions to seek, and receive, services from the specialty mental health sector.

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