Parent Training with African American Parents

by

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Abstract

One of the ways in which conduct problems are treated is parent training (Bagner & Eyberg, 2007). Parent training has been primarily designed with Caucasian middle-class parents (Kerig, 2001). Therefore, it may be beneficial to develop a culturally sensitive parent training for African American parents. Participants were parents/guardians of children ages four to eight. A six-part survey assessed demographic information, parents' use and views of parenting practices taught in standard parent training, parents' use and views of racial socialization practices, the saliency of incentives, barriers to treatment, program preferences, and racial identity. Results suggest that certain topics currently taught in parent training, such as time out and planned ignoring, may not be as relevant to African American parents. Additionally, the findings support that African American parents value racial socialization practices. Thus, incorporating them into parent training may be beneficial. The results also emphasize the importance of selecting a convenient location, such as a place of worship or community center. Participants also reported a preference for group formats. Further findings related to designing a culturally sensitive parent training for African American parents are discussed along with limitations and future directions for research.

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Introduction

Conduct Problems (CP) in children are characterized by a heterogeneous group of behaviors ranging from temper tantrums to physical aggression (McMahon, Wells, & Kotler, 2006). CP are represented by Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) in the *Diagnostic and Statistical Manual of Mental Disorders* (4th edition, text revision [DSM-IV-TR]; American Psychiatric Association [APA], 2000). Prevalence estimates for CD (1 to 10 percent) and ODD (1 to 20 percent) are disturbingly high in children (Lahey, Miller, Gordon, & Riley, 1999). CP are associated with negative consequences for the family, community, and child. Research shows that family discord and child CP are positively correlated (Hinshaw & Lee, 2003). Additionally, CP are among the most costly social problems to treat (Guevara, Mandell, Rostain, Zhao, & Hadley, 2003). Children with CP have numerous difficulties, including: academic problems, school dropout, drug abuse, depression, sexual assault, and mental illness during adulthood (Biederman, Faraone, Chu, & Wozniak, 1999; Campbell, 2002; Dretske et al., 2009; Hinshaw & Lee, 2003; Maguin & Loeber, 1996; Rohde, Lewinsohn, & Seeley, 1991; Snyder, 2001). CP are among the most common reasons for seeking mental health services for children and adolescents (Frick & Silverthorn, 2001; Kazdin & Wassell, 1999). Given these critical issues, it logically follows that much time and effort has been expended in developing effective treatments. Parent Training (PT) has emerged as one of the most prevalent interventions for CP, and has shown to be efficacious in improving positive parenting behaviors and decreasing CP (Bagner & Eyberg, 2007; Brestan & Eyberg, 1998; Dretske et al., 2009; McMahon & Forehand, 2003).

PT addresses CP by teaching parents to implement specific positive parenting practices largely based on operant learning and systems theories (Shapiro, Friedberg, & Bardenstein, 2006). Four PT programs, based on the work of Constance Hanf, have become prominent within the field: *Helping the Noncompliant Child* by McMahon and Forehand (2003), *Defiant Children* by Barkley (1997), *Parent-Child Interaction Therapy* by Eyberg (Eyberg & Boggs, 1998), and *The Incredible Years* by Webster-Stratton (2000). All of these approaches, except *Defiant Children*, have strong empirical support (McMahon & Forehand, 2003). These programs share many features, including: time-out, special time, positive attention, labeled praise, planned ignoring, and effective commands. Throughout this review, emphasis is given to these four parenting programs due to the consistency between programs and prevalence within the literature. In a recent meta-analysis, approximately eighty percent of published studies were based on the work of Constance Hanf (Lundahl, Risser, & Lovejoy, 2006). However, it is acknowledged that numerous other PT programs exist.

Although research has found PT to be efficacious, PT was primarily developed with middle-class Caucasian families (Coard, Wallace, Stevenson, & Brotman, 2004). Therefore, it may not generalize to minority groups. Research supports the importance of making culturally sensitive modifications to improve treatment retention and outcomes for minority groups (Lieberman, Weston, & Pawl, 1991; Munoz et al., 1995).

Research on the effectiveness of PT for African American parents is mixed (Gross et al., 2009; Gross, Julion, & Fogg, 2001; Kazdin, Stolar, & Marciano, 1995; Lundahl, Risser, & Lovejoy, 2006; Reid, Webster-Stratton, & Beauchaine, 2001). Despite the mixed results on effectiveness, numerous studies have found that African Americans have higher attrition rates

from PT than Caucasians (Armbruster & Fallon, 1994; Coard et al., 2004; Gottfredson et al., 2006; Kazdin, 1995; National Institute of Mental Health, 1999; Sue, 1977; Sue, Zane, & Young, 1994; Webster-Stratton, 1998; Webster-Stratton & Hammond, 1990; Webster-Stratton, Reid, & Hammond, 2001). Researchers frequently attribute these differences to socio-economic status (SES). However, it is possible that the social validity of PT for African American parents contributes to this disparity (Gottfredson et al., 2006; Gross et al., 2009). Researchers have found significant differences in the parenting practices between ethnicities (Longest, Taylor, Barnett, & Raver, 2007). Furthermore, parenting styles found to be detrimental among Caucasian families are not consistently found to be problematic for African American families (Lansford et al., 2005; Rudy & Grusec, 2001). These differences could partially explain the various findings on treatment efficacy and attrition. Developing a culturally sensitive PT may increase treatment efficacy and decrease attrition among African American parents.

The development of culturally sensitive treatments frequently involves the addition of culturally relevant material to an existing treatment while not modifying the core principles of the treatment (Blume & Lavato, 2010). However, given the differences that can exist between a majority and minority group, it may be beneficial to also modify elements of PT. It is not suggested that we abandon the wealth of knowledge from current PT approaches. Rather, it is important to evaluate how African American parents view current PT and determine if alternative treatment elements would increase the relevancy of PT. Therefore, we will evaluate how African American parents perceive current PT components and determine if they consider alternative parenting practices more pertinent. This information could then be used to develop culturally sensitive PT for African American parents and subsequently assess outcome. Before reviewing how the current literature applies to this study, it is important to recognize that there is

more variability within cultures than across cultures. Therefore, the information presented does not necessarily characterize individuals of any specific ethnicity.

First Generation Research

Practitioners have used conceptual and practical approaches in an attempt to address the higher rates of attrition among African American parents from PT (Dumas, Begle, French, & Pearl, 2010). Conceptual approaches focus on modifying treatment based on theory; practical approaches attempt to reduce barriers to treatment by providing incentives such as childcare or money. However, practical approaches can also be driven by theory (Dumas et al., 2010).

Incentives are used for two primary purposes, to remove obstacles to participation or to entice participation. Examples include: treatment for free or reduced cost, monetary incentives, convenient locations, childcare, transportation, and dinner being provided (Dumas, Nissley-Tsiopinis, & Moreland, 2007; Conduct Problems Prevention Research Group, 1999; Dumka, Garza, Roosa, & Stoerzinger, 1997; Fernandez & Eyberg, 2009; Stoy et al,1995). Studies on incentives suggest that the mode of implementation and saliency of incentives influence their effectiveness (Dirmaier, Harfst, Koch, & Schulz, 2007; Drebing, Van Ormer, Krebs, Rosenheck, & Rounsaville, 2005; Dumas et al., 2010; Irvine, Biglan, Smolkowski, Metzler, & Ary, 1999; Orrell-Valente, Pinderhoughes, Valente, Laird, & Conduct Problems Prevention Research Group, 1999; Stitzer et al., 2007). In addition, incentives can entice individuals to begin treatment (Irvine et al., 1999). Therefore, it is beneficial to know which incentives individuals find most pertinent and any differences that may exist based on ethnicity or SES.

Only one study was found that directly evaluated reactions to incentives in the context of PT (Gross et al., 2001). Gross and colleagues (2001) used a retrospective design in which parents rated the importance of ten different incentives after completing treatment. Participants reported

that the most salient incentives were program location, personality of the recruiter, and free childcare, while they reported that the least important incentives were cab fare home and 30 dollars for completing assessments. Though these rankings are interesting, the retrospective design and sample used limit generalizability. Given these limitations, it is important for future research to determine which incentives parents find most salient.

Incentives may help address some barriers to treatment. However, they are not likely to address issues related to relevancy of the intervention. Research on other disorders suggests that making culturally relevant modifications can significantly improve treatment efficacy and reduce attrition (Lieberman et al., 1991; Munoz et al., 1995). A review of the literature resulted in three programs that have made culturally sensitive modifications to PT to increase its relevance for African American parents: *The Effective Black Parenting Program* (EBPP), *The Chicago Parenting Program* (CPP), and *The Strong African American Families Program* (SAAF)

The EBPP and CPP are modifications to standard PT programs. The EBPP adds topics of racial pride, single parenting, and drug use to standard PT (Myers et al., 1992). The CPP is a modified version of *The Incredible Years*, in which a panel was used to create culturally sensitive videos and examples (Gross et al., 2009). Additionally, the EBPP suggests that African American professionals lead the sessions. Myers et al. (1992) found that EBPP had a modest effect on improving parents' attitudes towards their children, but did not significantly decrease problem behaviors in children. Furthermore, attrition rates for this program were 45%, suggesting that the modifications did not effectively address dropout rates for African American parents. A treatment outcome study on CPP found a reduction in child behavioral problems a year following the intervention as measured by coded observations. However, the effect size was small (.012 to .014 depending on the segment of the observation), and no significant change was

found as measured by the Eyberg Child Behavior Inventory (Gross et al., 2009). This study did not report attrition rates, but the average participant attended 4.3 out of 11 sessions, suggesting that attendance was problematic (Gross et al., 2009). It is difficult to ascertain the utility of these treatment modifications because no research was found that compared the EBPP or CPP to standard PT modalities.

The SAAF was developed with a different approach than EBPP and CPP. The developers reviewed literature about social issues prevalent in African American culture and conducted a focus group with African American parents to select content. This procedure resulted in five target areas: involved-vigilant parenting, communication about sex, parental expectations for use of alcohol, racial socialization, and helping children become more future-oriented (Brody et al., 2004). It is important to note that the SAAF focused on older children and adolescents. Due to the different focus of the SAAF, the results of this study might not be applicable to other research on PT, but some of the suggestions might prove beneficial in improving PT for African American parents. Research conducted at a two-year follow-up found that teenagers whose families participated in the SAAF program displayed less problematic drinking than a control group matched on age and SES. However, risky sexual behaviors did not decrease (Brody et al., 2006). The dropout rates in this study were based on completed research packets rather than on actual group attendance, making it difficult to evaluate attrition (Brody et al., 2005).

In summary, the three programs reviewed have design elements that could address attrition. However, no research was found comparing these groups to other PT programs, making it difficult to ascertain the effectiveness of these modifications. Furthermore, no studies were found that specifically addressed African American perceptions of current PT, illustrating the need for foundational research in order to inform possible modifications to PT.

Barriers to Treatment

The barriers to treatment model (Kazdin et al., 1997) is beneficial for conceptualizing attrition of African American parents from PT. This model divides barriers to treatment into four categories: the experience of stressors and obstacles, treatment demands, relationship with therapist, and relevancy of treatment. These four factors are used to structure further discussion on why African American parents have higher rates of attrition from PT than Caucasian parents.

The experience of stressors and obstacles refers to factors that interfere with participation or treatment attendance, such as work schedules, cost of treatment, and transportation (Nock & Ferriter, 2005). Demographic variables are not included as obstacles to treatment; however, the relationship between these variables and the obstacles to treatment is clear. For example, SES and cost of treatment have a direct relationship. Reviewing demographic variables can be beneficial in understanding the stressors and obstacles to treatment.

SES takes occupation, income, and education into consideration, and is one of the most salient factors in predicting attrition and treatment efficacy (Dumas & Wahler, 1983; Forehand, Middlebrook, Rogers, & Steffe, 1983; Kazdin, 2000; Kazdin, Marciano, & Whitley, 2005; Kazdin & Wassell, 1999; Trefil, Kett, & Hirsch, 2010; Webster-Stratton, 1992). African Americans are over-represented in lower SES (U. S. Census Bureau, 2008). Individuals with lower SES have several plausible barriers to completing PT interventions, including paying for treatment, childcare during services, and transportation. SES can also pose obstacles not commonly recognized. For example, 93% of African Americans reported that location of services is an important factor (Gross, et al., 2001). However, mental health services are frequently located in affluent areas, while many African Americans live in economically disadvantaged areas (Holzer, Goldsmith, & Ciarlo, 1998). SES is so salient that some researchers

have suggested that ethnicity does not have any incremental utility in predicting attrition (Armbruster & Fallon, 1994). However, other studies have found that when researchers control for SES, ethnicity still accounts for a significant percentage of variability in treatment outcome and attrition rates (Coard et al., 2004; National Institute of Mental Health, 1999; Sue et al., 1994).

Single parenthood and younger parenthood are two other demographic variables that are more prevalent among African Americans than the total population (U.S. Census Bureau, 2008). Research has found that these two variables account for a significant amount of the variance in attrition rates from PT and other interventions for CP (Fernandez & Eyberg, 2009; Kazdin & Mazurick, 1994; Kazdin et al., 1993; Peters, Calam, & Harrington, 2005; Werba, Eyberg, Boggs, & Algina, 2006). Stressors associated with single and younger parenthood, such as increased stress, decreased social support, and higher dependence on childcare, could be detrimental to the successful completion of PT (Cunningham & Knoester, 2007).

Kazdin's second classification of barriers is treatment demands. These are the elements of treatment that are particularly difficult or demanding for the individual (Kazdin et al., 1997**)**. Examples include treatment being confusing, too long, or difficult to use in the natural environment. For example, the stressful nature of single and young parenthood might make it difficult to implement some of the strategies taught in PT. One of the principles taught in several PT programs is the importance of consistency (Barkley, 1997; McMahon & Forehand, 2003). Implementing this principle might be very difficult for single parents who may not have as much control over their child's environment as partnered parents. Furthermore, single parents may not have sufficient time to implement the treatment given the multiple demands on their time. Another treatment demand is the degree of behavior change required in both the child and parent.

Research has shown that individuals with lower levels of CP pretreatment are more likely to complete PT, suggesting that when individuals are required to make large changes, treatment demands are increased, resulting in attrition (Kazdin et al., 1993). Research has found that African American children present with higher levels of CP in comparison to Caucasian children (Huizinga et al., 2007). Although this disparity can be explained by variables such as lower SES, it is still possible that these higher rates of CP could partially explain why African American parents have higher attrition rates.

The client's relationship with the therapist is the third group of barriers to treatment. Some of the salient factors in a client's relationship with a therapist include: liking the therapist, perceived support from the therapist, and disclosure with the therapist (Kazdin et al., 1997). However, research has found that a significant proportion of the African American community mistrust mental health professionals in comparison to Caucasians (Gross et al., 2001). Mistrust was reported as a significant barrier to treatment by 66% of African Americans, in comparison to 33% of Caucasians (Jesse, Dolbier, & Blanchard, 2008).

Racism could pose another barrier to developing trusting relationships between therapist and client. In addition to the increased stress that racism places on clients (Corrigan, 2005), past history with racism might make it difficult for African Americans to trust Caucasian clinicians. An even more detrimental barrier could exist if the clinician actually holds prejudiced attitudes towards African Americans. Several older studies have found that clinicians tend to view African Americans more negatively than other groups (Bond, DiCandia, & MacKinnon, 1988; Jenkins-Hall & Sacco, 1991; Whaley, 1997). Additionally, clinicians tend to provide significantly different treatment to African Americans, which is frequently lower in quality (Rost et al., 2000; Wang, Berglund, & Kessler, 2000; Young, Klap, Shebourne, & Wells, 2001).

Research has found that African American clients are more likely to trust an African American than a Caucasian mental health professional (Cooper-Patrick et al., 1999; Keith, 2000). However, only 2% of mental health professionals identify themselves as African American (Holzer, Goldsmith, & Ciarlo, 2000). Furthermore, another study reported that African American clients were significantly more likely to rate their clinician as being highly engaged in their treatment if the clinician was African American, and that attrition increased as perceptions of engagement decreased (Brown & Palenchar, 2004). Three approaches have been suggested to address this possible cause for attrition, including using African American therapists, using community representatives, and cultural sensitivity training for clinicians (Brody et al., 2006; Myers et. al, 1992; Snowden, Hu, & Jerrell, 1995). Though it may be beneficial for African American therapists to implement culturally sensitive PT for African American parents, this may not always be feasible given the small percentage of African American mental health professionals. Therefore, a more probable solution would be to train community members as liaisons, as done in SAAF (Brody et al., 2006), or to train therapists to be culturally sensitive. Cultural sensitivity training has had a significant impact on increasing trust and successful outcomes in other therapeutic settings (Snowden et al., 1995; Yeh, Takeuchi, & Sue, 1994).

Relevancy of treatment is the fourth category of barriers and refers to the degree to which a client perceives a treatment as being relevant and meeting expectations (Kazdin et al., 1997a). As stated previously, PT has largely been developed with middle-class Caucasian families (Kerig, 2001). Therefore, a possible mismatch exists between the culture represented in current PT and the African American culture. For example, Boyd-Franklin (2003) emphasizes the strength that African American families find in their extended family and community. However, current PT does not capitalize on this strength or address the possible difficulties of

implementing treatment with multiple caregivers. The literature on parenting differences between Caucasian and African American parents frequently utilizes measures that have been developed with Caucasian parents. As a result, the strengths associated with African American parents may be overlooked.

A review of this literature found that African American parents are reportedly less warm, less sensitive, and use higher rates of authoritarian parenting (Ipsa et al., 2004; Pinderhughes, Dodge, Bates, Pettit, & Zelli, 2000). According to Baumrind's (1971) classification of parenting styles, authoritarian parenting is associated with less socially competent children, lower self-confidence in children, and lower levels of positive affect (for reviews, see Baumrind, 1989, 1991; Millstein, Holmbeck, Fischer, & Shapera, 2001). However, research with African American parents has not consistently found the same negative impact of authoritarian parenting on children (Lansford et al., 2005; Rudy & Grusec, 2001). Therefore, when considering current PT, which tends to discourage authoritarian parenting, it is possible that African American parents would find this information to be more dissonant with their current parenting style than their Caucasian counterparts. This could partially explain the higher rates of attrition among African American parents from PT.

A review of the literature revealed one study that was designed to assess the strengths of African American parents (Longest, Taylor, Barnet, & Raver, 2007). Longest and colleagues found that in conjunction with more restrictive parenting behaviors, African American parents tended to have high levels of positive affect towards their children and to be extremely involved in their children's lives. This parenting style of showing high levels of restrictiveness, positive affect, and engagement is much more common among African American in comparison to Caucasian parents (Longest et. al, 2007). It has been hypothesized that African American parents

engage in these parenting behaviors in an effort to help their children cope with specific challenges associated with being African American (Garcia et. al, 1996). These findings, in conjunction with the findings that authoritarian parenting is not consistently linked to negative outcomes among African American children, suggest that there may be significant differences between effective parenting behaviors across cultures.

In addition to considering the relevancy of topics currently taught in PT across cultures, it is important to evaluate topics that are not currently incorporated in PT that are relevant to minority cultures. Incorporating these topics into a culturally sensitive PT could be effective in decreasing attrition while maintaining or improving treatment efficacy. However, before a culturally sensitive PT is developed, it is important for further research to be conducted on what topics are most relevant for African American parents. One possible area is racial socialization.

Racial socialization. Racial socialization is defined as "the transmission from adults to children of information regarding race and ethnicity" (Hughes et al., 2006). An increasing body of research recognizes that children from ethnic minorities encounter unique challenges (Caughy, Nettles, Campo, & Lohrfink, 2006). Parents from different minority groups emphasize different racial socialization practices in an effort to help their children face their unique challenges (Caughy et al., 2006). For example, African Americans experience significant racial discrimination (Sellers, Copeland-Linder, Martin, & Lewis, 2006), which has been correlated with poorer mental health, increased stress, increased CP, and poorer academic performance (Murry, Brown, Brody, Cutrona, & Simmons, 2001; Neblett et al., 2008; Prelow, Danoff-Burg, Swenson, & Pulgiano, 2004; Sellers, Caldwell, Schmeelk-Cone, & Zimmerman, 2003; Wong, Eccles, & Sameroff, 2003). However, research indicates that African Americans who have positive attitudes towards race are significantly more resilient to racial discrimination (Neblett et

al., 2008; Sellers et al., 2006; Wong et al., 2003). Thus, African American parents may engage in racial socialization practices that are designed to improve their children's attitudes towards their race and by so doing ameliorate the negative effects of discrimination.

It is important to define and understand the impact of racial socialization on child behavior in order to understand the place it might have in PT. Due to a high level of inconsistency of definitions and the variety of research methods utilized, information on racial socialization varies greatly between studies. Based on a review of recent articles, we divided racial socialization into four categories: preparation for bias, racial pride, egalitarian racial socialization, and promotion of mistrust (Hughes et al., 2006; Neblett et al., 2008).

Preparation for bias occurs when parents explicitly teach their children coping skills to utilize when faced with bias, such as discrimination (Hughes et al., 2006). Studies suggest that between 67% and 90% of African American parents prepare their children for bias (Caughy, O'Campo, Randolph, & Nickerson, 2002; Coard et al., 2004; Hughes, 2003; Hughes & Chen, 1997, 1999). This is higher than any other minority group (Biafora, Warheit, Zimmerman, & Gill, 1993; Hughes, 2003), suggesting that preparation for bias is more central for African American parents than other minority groups.

Developing racial pride is teaching children to value their racial and ethnic history and current culture (Neblett et al., 2008). Activities include exposing children to culturally relevant experiences such as art, literature, activities, holidays, food, etc. Studies evaluating the prevalence of developing racial pride within African American families have provided a wide range of results, suggesting that anywhere from 23% to 96% of African American parents engage in developing racial pride (Hughes et al., 2006).

Promotion of mistrust is the process of teaching children to be wary of and distrust interracial interactions (Hughes et al., 2006). The use of promotion of mistrust is relatively uncommon among African American parents, research suggesting that only 6% to 18% of African Americans use this practice (Hughes et al., 2006).

The term 'egalitarian racial socialization' refers to two different parenting behaviors, either explicitly teaching children to value individual qualities instead of race, or avoiding all messages about race (Hughes et. al, 2006). For the purposes of this study, reference to egalitarian racial socialization refers to the process of teaching children to value individual qualities instead of race. Egalitarian parenting is common across numerous ethnicities, including African Americans (Hughes & Chen, 1999). Research suggests that approximately 66% of African American parents use egalitarian racial socialization (Hughes & Chen, 1999; Phinney & Chavira, 1995).

Impact of racial socialization. Research on the impact of racial socialization is relatively new, and as such, further research needs to be conducted. However, initial results suggest that when used correctly, racial socialization can decrease CP and increase prosocial behaviors. Stevenson and colleagues (2002) reported that preparing children for bias and encouraging racial pride is associated with less aggressive behavior. Fischer and Shaw (1999) also found that adults who reported receiving greater preparation for bias during childhood were less likely to experience the negative impacts of discrimination on mental health during adulthood. Other research has suggested moderate levels of preparation for bias lead African American children to perceive lower rates of discrimination and experience higher levels of self-esteem. In contrast, children who receive low or high rates of preparation for bias perceive higher rates of discrimination and experience lower levels of self-esteem (Harris-Britt, Valerie, Kurtz-Costes, &

Rowley, 2007). The hypothesis for this occurrence is that preparation for bias is necessary, but overemphasis "may weaken the child's sense of self-efficacy and worth" (Hughes & Johnson, 2001). In addition to the benefits associated with preparing children for bias, teaching racial pride is positively correlated with factual knowledge and problem solving skills, and negatively correlated with behavior problems (Caughy et al., 2002). Additionally, children with high levels of racial pride tend to have increased self-esteem, which decreases the effects of discrimination (Constatine & Blackmon, 2002). High levels of racial pride also appear to be related to more positive academic beliefs (Constatine & Blackmon, 2002; Smith, 1996). Egalitarian messages are correlated with higher academic performance (Browman & Howard, 1985). More recently, Neblett and colleagues (2006) found that egalitarian messages are beneficial in increasing academic curiosity, persistence, and grade-point-averages. Research has also supported that egalitarian messages, in combination with self-worth messages and racial pride, led to fewer behavior problems, increased self-esteem, and greater well-being (Constantine & Blackmon, 2002; Stevenson, Cameron, Herrero-Taylor, & Davis, 2002).

In contrast, promotion of mistrust is related to increased CP (Biafora et al., 1993; Caughy et al., 2006). It has been suggested that promotion of mistrust can increase the negative impact of discrimination. However, it is also possible that those parents who engage in the promotion of mistrust do so as the result of increased discrimination. Therefore, it is difficult to determine if the messages of mistrust are problematic or if they are in response to increased discrimination (Hughes & Johnson, 2001).

Based on the findings above, it appears that correctly applied racial socialization could be beneficial in addressing child behavior problems, improving school performance, and attenuating the negative effects of discrimination. Specifically, teaching children egalitarianism, racial pride,

and preparation for bias messages is associated with better outcomes for children, while teaching children mistrust is associated with negative outcomes. Neblett et al. (2008) verified that when parents use egalitarianism, racial pride, and preparation for bias messages and decrease promotion of mistrust, children have higher levels of well-being and better psychological adjustment.

Racial socialization is a common parenting practice among African American parents (Caughy et al., 2002; Coard et al., 2004; Hughes, 2003; Hughes et al., 2006; Neblett et al., 2008). Therefore, it is possible that including racial socialization in PT could increase its relevancy for African American parents. Racial socialization is taught by using: oral communication, modeling, role playing, and exposure (Coard et al., 2004). These methods are already encouraged in PT programs to teach other skills, suggesting that racial socialization could be incorporated into current PT. However, research has not yet evaluated racial socialization within the context of PT. Several recent studies have suggested that this is an important direction for future research (Bannon, Cavaleri, Rodriguez, & McKay, 2008; Coard et al., 2004; Rodriguez, McKay, & Bannon, 2008). Specifically, it is important to determine if African American parents would find PT more relevant if it included racial socialization.

Other Relevant Issues

Many other elements of therapy, such as the selection of group versus individual therapy, should be evaluated when developing a culturally sensitive intervention. In one study, the amount of one-on-one time spent with the clinician was positively correlated with treatment retention for African Americans, suggesting that an individual therapy format might be best (Keith, 2000). However, other literature emphasizes the importance of community within the African American culture (Boyd-Franklin, 2003), which suggests a group setting might be

preferred. It is important to determine which format the majority of African American parents prefer. Another possible issue to evaluate is the venue for PT. As stated previously, the location of mental health services may not be convenient for African Americans (Holzer et al., 1998). Services provided at a more convenient location may reduce attrition. Based on literature that supports the centrality of the community and religion among African Americans (Boyd-Franklin, 2003), two possible locations would be community centers or places of worship. Gaining a better understanding of seemingly minor issues, such as treatment location, might have important implications for the creation of a culturally sensitive PT for African Americans that could decrease rates of attrition.

Purpose

The purpose of this study is to gain a better understanding of how to formulate a culturally sensitive PT for African American parents with the ultimate goal of decreasing dropout rates among African American parents. Given the preliminary and descriptive nature of this research, specific hypotheses cannot always be made. However, specific hypotheses are provided whenever they are appropriate, and when hypotheses are not appropriate, specific research questions are posited.

Hypothesis One. Given the saliency of SES on parenting behaviors, we hypothesize that SES will be a significant predictor for both racial socialization practices and the elements of traditional PT.

Hypothesis Two. Based on research that shows African Americans engage in more authoritarian parenting practices, but do not experience the same negative outcomes (Lansford et al., 2005; Rudy & Grusec, 2001), it is possible that they do not value the authoritative parenting practices that are the focus of traditional PT. It is hypothesized that African American parents

will report that these parenting practices are less familiar, less similar to their own parenting and not as good of an idea as Caucasian parents. We expect to find these differences after controlling for SES.

Hypothesis Three. Given the positive impact of racial socialization on African American children (Neblett et al., 2008) and the high use of racial socialization among African American parents (Hughes et al., 2006), it is hypothesized that African American parents will report that racial socialization practices are more familiar, more similar to their own parenting and a better idea than Caucasian parents. We expect to find these differences after controlling for SES.

Question One: Do African American parents rate racial socialization practices as being more important than traditional PT practices? Although it is hypothesized that African Americans will rate racial socialization skills as being more important than Caucasians, and they will rate traditional PT as being less important than Caucasians, no literature was found that compares these two categories of parenting skills. Therefore, it is important to determine if one set of skills is valued above the other.

Question Two: Which incentives are most salient? Previous research on incentives within the context of PT with African American parents is limited in scope and generalizability. Thus, it would be beneficial to understand which incentives are viewed as being more salient to the majority of African American parents. However, it is important to evaluate if demographic variables such as SES are better predictors of the saliency of incentives than ethnicity. Regardless of ethnic differences, information on incentives is valuable for PT in general.

Question Three: How should PT be designed in consideration of the preferences of African American parents? Several aspects of this question will be evaluated, including

location of services, if individuals have a preference in the ethnicity of the mental health provider, and if participants prefer individual or group therapy.

Question Four: Which barriers are most salient? It would be beneficial to understand which barriers to treatment are most problematic for parents and if there are any differences between ethnicities. However, it is likely that barriers to treatment are largely influenced by SES and personal preference rather than ethnicity.

Method

Participants

A total of 196 participants were recruited from beauty salons, places of worship, and during a community consignment event located in the Southeast region of the United States in a county with approximately 130,000 residents. Of these residents, approximately 74% are Caucasian, 23% are African American, and 3% represent other ethnicities. We selected specific salons and places of worship in order to obtain approximately equal numbers of African American and Caucasian participants while attempting to consider SES factors. Demographic information is summarized in Table 1. We also evaluated differences in demographic variables between ethnicities. Caucasian participants reported significantly higher levels of education (χ^2 (6, N = 175) = 32.95, $p < .01$). Specifically, 71.2% of Caucasian participants had a college degree or higher, compared to 33.0% of African American participants. There was a significant difference in marital status of participants by ethnicity (χ^2 (6, N = 196) = 68.03, $p < .01$). Specifically, 47.6% of African American parents were single in comparison to 7.7% of Caucasian parents. African American parents were also an average of 4 years younger than Caucasian parents (F(1, 176) = 15.99, $p < .01$) and had lower ratings of SES based on the Hollingshead (F(1, 170) = 23.01, $p < .01$). There was not a significant ethnicity different in the age of children (F(1, 236) = 0.85, p =0.18),gender of children (χ^2 (2, N = 231) = 2.73, p = 0.26) or the relationship to the child (χ^2 (4, N = 195) = 8.88, p =0.06). Of our participants, 80.5% were mothers.

Procedures

Following approval from the university IRB, consent was obtained from the owners of each location prior to beginning data collection. Participants were at least 19 years of age and had at least one child between the ages of 4 and 8. Participants completed a six-part survey (See Appendix B). Participants received ten dollars following the completion of the survey. This survey was developed in consultation with individuals who have expertise in measurement development and PT. Furthermore, the survey was reviewed by African American focus groups to ensure applicability of items and examples provided in the survey. Finally, the survey was reviewed by African American therapists who have extensive experience working with African American families. Following development of the survey, we created five versions using a Balanced Latin Square to control for order effects. Within each section of the survey, another Balanced Latin Square was used to order the items when doing so did not interfere with the logical order of the questionnaire. The Flesch-Kincaid Grade Level was calculated using Microsoft Word 2007 in order to obtain the lowest reading level possible while maintaining meanings of items. This resulted in a fifth grade reading level for the survey.

Female African American research assistants collected data in order to decrease potential participant reactivity. Research assistants completed training on how to conduct research with human participants. They were then given a research script that they practiced until reaching mastery. Additionally, research assistants practiced how to respond to participants' questions without potentially influencing responses. Prior to beginning data collection, research assistants audio-taped administrations of the survey until they were able to administer the survey while following protocol.

Measures

Section One: Demographic Information. Participants reported their age, ethnicity, marital status, level of education, occupation, and relationship to child. We also collected data on child age, gender, and ethnicity. Socioeconomic status was calculated with The Hollingshead Four Factor Index of Social Status (Hollingshead, 1975) based on the update by Nakoa and Treas (1992). Two research assistants coded all Hollingshead occupations. Given the categorical nature of the variable, a Kappa coefficient was calculated to assess inter-rater reliability. The kappa coefficient indicated excellent agreement between raters (mother's occupation, $\kappa = 0.94$, $p < 0.01$; father's occupation, $\kappa = 0.94$, $p < 0.01$). After the Kappa coefficient was calculated, a third researcher reviewed any discrepant data and determined the most appropriate coding. This coding was used in all subsequent analyses.

Section Two: Parenting Behaviors. We modified a survey developed by McMahon and Forehand (2003) designed to assess parents' perception of the difficulty involved in implementing various parenting skills. The Guilford Press granted permission to use and modify this survey. We modified the survey by adding a brief description of each parenting skill, and decreasing the scale from seven to five points. Additionally, we modified some of the labels of parenting behaviors to reflect the broader area of PT (e.g., "effective commands" rather than "clear instructions"). We also added several parenting behaviors not included in the original scale (racial socialization). Parents rated each parenting behavior on three dimensions: familiarity, similarity to own parenting, and if this parenting behavior is a good or bad idea for parents. The final list included eleven parenting behaviors (preparation for bias, racial pride, promotion of mistrust, egalitarian, time out, effective commands, special time, behavior

contracts, rewards, planned ignoring, attending). See Appendix B for a description of each parenting behavior.

Section Three: Program Preferences. We assessed differences in format preferences between ethnicities. Questions covered three general areas: format of the group, location of the group, and characteristics of the presenter (e.g., same versus different ethnicity).

Section Four: Racial Identity. The Multi-group Ethnic Identity Measure-Revised (MEIM-R; Phinney & Ong, 2007) was used to assess racial identity. The MEIM-R was selected for its brevity, applicability across ethnicities, and previously established internal consistency (Cronbach's alpha of .81; Phinney & Ong, 2007). The MEIM-R consists of six items. Respondents use a five-point scale ranging from "strongly disagree" to "strongly agree." The internal consistency estimate of the MEIM-R based on data from the current study was $\alpha = 0.86$. Thus, the combined score was used as a measure of racial identity.

Section Five: Barriers to treatment. We assessed seven barriers to treatment related to childcare, transportation, work, cost, and trust of mental health professionals. Parents rated how problematic each barrier would be to their participation in PT on a five-point scale ranging from "not a problem" to "would prevent me from attending."

Section Six: Incentives. Pertinent items from Gross et al. (2001) were selected, including childcare, location, time of services, dinner, transportation, and monetary incentives. Additionally, we assessed books provided to parents, and additional levels monetary incentive. Participants rated how much each incentive would encourage their participation on a five-point scale ranging from "not much at all" to "very much."

Results

Hierarchical Regressions

Multicollinearity was assessed because it is possible that SES, racial identity, and ethnicity are highly correlated. Allison (1999) suggested using a stringent Variance Inflation Factor (VIF) of 2.5 when working with models that have small effect sizes. The 2.5 cut-off was used to assess for multicollinearity because several of our regressions have small to moderate effect sizes. In our regressions the VIF did not exceed 2; indicating that multicollinearity is not problematic for this data set. Hierarchical Regressions (HRs) were used to evaluate the impact of ethnicity, SES, and racial identity on multiple variables including the different parenting behaviors (familiarity, similarity, and good/bad idea: see Tables 2-4), incentives (see Table 5), and barriers to treatment (see Table 6). HRs were selected due to the literature that has found a significant impact of SES on treatment efficacy, attrition, and outcomes. After SES was entered into the regression, racial identity scores and ethnicity were entered simultaneously.

Hypothesis One

HRs were conducted to assess the impact of SES on both traditional PT behaviors and racial socialization practices. In general, we did not find a significant impact of SES on most parenting behaviors. We assessed 3 aspects of 11 different parenting behaviors, resulting in 33 areas that SES could significantly predict parenting behaviors. Of those 33, only 4 were significant. Specifically we found that as SES increased parents were more likely to endorse

effective commands as a good idea for parents. Additionally, we found that as SES increased parents were less likely to report that preparing children for bias and teaching children to mistrust other ethnicities was similar to their parenting. Also, as SES increased, parents were less likely to endorse the promotion of mistrust as a good idea for parents (See Figures 1-3).

Hypothesis Two

Mixed results for differences in parenting behaviors across ethnicities were obtained (See Tables 2-4). With the effect of SES accounted for, ethnicity and racial identity were entered simultaneously into a series of hierarchical regressions. Differences were found for three of the traditional PT behaviors. Specifically, Caucasian parents were more likely to endorse attending as a good idea for parents. African American parents reported significantly lower rates of familiarity for planned ignoring, and were not as likely to endorse it as a good idea. Furthermore, African American parents reported that time out was not as similar to their parenting as Caucasian parents, and also reported feeling as if it was not as good of an idea for parents. (See Figures 1-3 for a summary of parenting differences by ethnicity).

Hypothesis Three

Hierarchical regressions were also conducted to assess if African American parents endorse racial socialization practices at a higher rate than Caucasian parents (Tables 2-4). African American parents reported being more familiar with preparing their children for bias and reported that it was more similar to their own parenting behaviors than Caucasian parents. However, there was no significant difference between ethnicities in rating preparing children for bias as a good or bad idea. There was no difference between ethnicities for familiarity, similarity to own parenting, and if the parenting behavior is a good or bad idea for egalitarian messages. In regards to mistrust of other ethnicities, there were no differences in familiarity between

ethnicities. Additionally, both ethnicities reported it was not like their own parenting and not a good idea for parents. However, there was a significant difference between ethnicities. Specifically, compared to Caucasian parents, African American parents reported that the promotion of mistrust was more similar to their parenting and a better idea. In addition to the differences between ethnicities, when individuals had higher rates of racial identity, they were more likely to be familiar with racial pride. They also reported that it was more similar to the parenting and a good idea for parents.

Question One: Do African American parents rate racial socialization practices as being more important than traditional PT practices?

An average score was calculated for racial socialization practices (excluding mistrust) and traditional PT for each of the three questions about each parenting behavior. F-tests were conducted to determine if there was a significant difference between racial socialization practices and traditional parenting training parent behaviors. We found a significant difference between racial socialization practices and traditional parent training for familiarity, similarity to own parenting, and if the parenting behavior is a good or bad idea across both African American and Caucasian parents. Specifically, we found that African American parents reported higher levels of familiarity, similarity to own parenting, and that the parenting behavior is a good idea for racial socialization practices than for traditional parenting training parent behaviors. Caucasians parents reported higher levels of familiarity, similarity to own parenting, and that the parenting behavior is a good idea for traditional PT practices compared to racial socialization practices (See Table 7).

Question Two: Which incentives are most salient?

Hierarchical regressions were conducted to understand the saliency of incentives and to determine if there was a significant difference based on SES, ethnicity, or racial identity (Table 5). SES did not significantly predict how salient participants found incentives. We found a significant impact of ethnicity on the saliency of transportation and childcare. Specifically, relative to Caucasian parents, we found that African American parents reported that transportation is more salient. However, both ethnicities reported transportation as the least enticing incentive. We also found that Caucasian parents reported that childcare is a more salient incentive than did African American parents (See Figure 4)

Question Three: How should PT be designed in consideration of the preferences of African American parents?

Chi-square analyses were used to assess program preference differences between ethnicities. We assessed what location parents prefer for services (e.g., place of worship, community center, or clinic). A significant difference between ethnicities for preference of location (χ^2 (3, N = 191) = 9.66, p = .02) was found. Specifically, Caucasian parents were most likely to prefer places of worship for treatment, and African American parents were most likely to prefer community centers. However, a disproportionate amount of Caucasian participants' data was collected from places of worship (See Table 8). Therefore, these findings should be interpreted with caution. However, it was clear that overall, parents preferred community centers and places of worship compared to either in home or at a clinic. In regards to ethnicity of the provider, there was no difference between ethnicities as to whether they preferred a provider of similar or different ethnicity (χ^2 (2, N = 194) = 1.44, p = .49). The majority of participants reported that the ethnicity of provider was not important. There was a significant difference

between ethnicities on preference of group or individual format (χ^2 (1, N = 192) = 4.52, p = .03). Specifically, a larger percentage of African American parents reported preferring an individual format (36%) than Caucasian parents (22%). However, both ethnicities reported preferring group to individual formats. Both African American and Caucasian parents reported that it is important for the clinician to have their own children. However, Caucasian parents (82%) found it to be more important than African American parents (66%; χ^2 (1, N = 190) = 5.11, p = .02).

Question Four: Which barriers are most salient?

Hierarchical regressions were used to assess any differences between ethnicities for which barriers to treatment are most problematic (Table 6). Overall, very few differences were found. We found a significant impact of SES on the barriers of transportation, cost of program, and child being too busy. Specifically, we found that as SES decreased parents were more likely to report that the cost of the program and transportation were barriers to treatment. We also found that as SES increased parents were more likely to report their child being too busy as a barrier to treatment. We found significant differences between ethnicities for cost of program and for childcare. These differences were above and beyond the variance accounted for by SES. Specifically, we found that Caucasian parents were more likely to endorse the cost of a program and childcare as problematic to treatment participation. Additionally, we found that racial identity significantly predicted if parents found the cost of a program to be problematic. This difference remained significant after accounting the variance accounted for by SES and ethnicity was removed. We found that as parents identified more with their ethnicity they reported that cost of the program was a greater barrier (Figure 5).

Discussion

The purpose of this study was to gain a better understanding of how to formulate a culturally sensitive PT experience for African American parents, which may have a secondary effect of decreasing attrition. Our survey, developed in consultation with African American focus groups and therapists, addressed four areas for clinicians to consider when developing PT for African American parents: understanding barriers and incentives, characteristics of the treatment, parenting behaviors covered in PT, and specific recommendations for a culturally sensitive PT. Although the focus of this study was to identify elements of a culturally sensitive PT, it is important to note that many of the findings are also applicable for PT across ethnicities. Finally we will address limitations and future directions for research.

Barriers and Incentives

When considering why African American parents have higher rates of attrition from PT than Caucasian parents, it is important to understand what barriers they face, as well as what incentives would encourage participation. Participants reported that the three most salient barriers to treatment were childcare, cost of program, and conflicting work schedule. These were followed by parents being too busy, children being too busy, mistrust of counselors, and transportation. Thus, across ethnicities, providing services at a reduced cost, selecting a convenient time, and providing childcare may all be important factors. In particular, selecting a convenient time might be especially important when working with individuals from low SES, given the higher probability of varying work schedules.

Previous research on the use of incentives with PT found that parents reported that the location of services and childcare are the most salient incentives and that small monetary incentives and transportation were not as salient (Gross, 2001). We confirmed this pattern in parental preference. However, we also assessed a larger monetary incentive ($30 for attending each session), which was also salient to parents and was rated as being just slightly less important than the location of services. Previous studies that have evaluated the efficacy of monetary incentives have found mixed results (Drebing, Van Ormer, Krebs, Rosenheck, & Rounsaville, 2005; Dumas et al., 2010). The finding that participants found $30 to be more enticing than $10, suggests that the disparity in previous research may partially be explained by the size of monetary incentives.

Several researchers have suggested that differences in attrition rates between ethnicities are the result of SES (Armbruster & Fallon, 1994; Kazdin, 1995). If the same logic holds for incentives and barriers to treatment, the differences in which incentives and barriers are salient should largely be accounted for by SES. After controlling for differences in SES, few differences remained between ethnicities in how they viewed barriers to treatment or incentives. This suggests that in general, when clinicians select incentives it may be more important to consider the SES of the target population rather than ethnicity. However, some differences still exist between ethnicities.

We found that SES significantly predicted if cost of program, transportation, and child being too busy were significant barriers. It is logical that individuals from lower SES would report that the cost of a program is a significant barrier. By combining this information with the finding that SES did not predict differences in the saliency of monetary or free treatment as incentives, it can be deduced that monetary incentives are enticing to individuals from various

SES. However, when working with individuals from low SES, the cost of program may be detrimental to participants' ability to engage in treatment. Additionally, with the effect of SES controlled, African American parents reported that cost of the program was a less significant barrier than Caucasian parents.

We found that African American parents were not as likely to report that childcare was a significant barrier to treatment, and they did not value childcare as an incentive to the same degree as Caucasian parents. This may reflect a cultural difference, in that African Americans tend to have more extensive support networks (Boyd-Franklin, 2003), which may make childcare easier to obtain, and thus, less of a barrier to treatment.

Aside from childcare, we also found differences in the way participants responded to transportation as both a barrier and an incentive. We found a small effect of SES on if transportation was a significant barrier to treatment. We also found that African American parents were more likely to rank transportation as being a salient incentive than Caucasian parents. However, it is important to note that overall, transportation was the least enticing incentive for both ethnicities. Although parents did not rank transportation as being a salient incentive, it may actually be an important factor in helping parents with lower SES remain in treatment. Previous researchers have attempted to address issues with transportation by paying for public transportation. However, participants from economically disadvantaged areas reported that this was not an effective intervention because public transportation did not have services in the areas of town where they lived (Gross et al., 2001). Given that transportation was the least enticing incentive and that it may be difficult for participants to access, clinicians may be better able to address concerns related to transportation by selecting a convenient location that decreases transportation demands rather than attempting to provide transportation. As previously

mentioned, African American parents tend to live in economically disadvantaged areas (Holzer, Goldsmith, & Ciarlo, 1998). Therefore, selecting a location in an economically disadvantaged area that is comprised primarily of African American residents may contribute to decreasing treatment attrition.

Extending our findings that location of services was the most salient incentive, we further assessed what location individuals would prefer. Participants reported preferring community centers and places of worship over a clinic or their home (See Table 8). Therefore, selecting the former venues may help decrease attrition among African American parents. Although the current study did not address the impact of religiosity, such a factor may help clinicians choose between the two venues. That is, a non-religious individual may be uncomfortable going to a place of worship for mental health services, but a religious individual may not have the same hesitation in going to a community center.

We found one other difference between participants' ratings on barriers to treatment. Specifically, as the SES of parents increased, they were more likely to endorse that their child was too busy with activities that would make it difficult to engage in PT. Research has shown positive benefits for children who engage in extracurricular activities (Feldman & Matjasko, 2007). Therefore, clinicians should attempt to provide services in a manner that will not conflict with children's extracurricular activities. For example, clinicians may want to purposefully select times for treatment that are less likely to interfere with extracurricular activities.

Interestingly, we did not find ethnicity differences related to mistrust of counselors. Previous research has indicated that mistrust of counselors is a significant barrier for African American parents (Gross et al., 2001). There are several possible explanations for this finding. It is possible that a shift has taken place within the African American community towards

acceptance of mental health services. However, research conducted as recently as 2008 still finds a significant level of mistrust of counselors among African Americans (Jesse, Dolbier, & Blanchard, 2008). Another explanation could be that meeting with a counselor for PT may not elicit mistrust in comparison to seeing a counselor for more personal mental health needs, such as treatment for depression. This result might also be influenced by collecting data in a community centered around a university, where the population may have higher rates of education about mental health services, resulting in a more positive view of mental health professionals.

Treatment Characteristics

After a clinician has selected the incentives to use in an effort to minimize the impact of barriers to treatment and decrease attrition, it is important to consider how to format the treatment. These include both characteristics of the treatment and the provider. There are many treatment characteristics that can be considered, such as the use of psycho-education and role playing in treatment. Given the established importance of including these elements in PT (Shapiro et al., 2006), we focused on participants preference for a group or individual format. We found that the majority of parents reported preferring group (70%) to individual (30%) formats. Research suggests that individual formats may result in more extensive changes (Hampson, Schulte, & Ricks, 1983), although group formats have also been found to be efficacious (Webster-Stratton, 2000). Research has found that a good predictor of treatment outcome is the amount of personal attention clients get from the clinician (Brown & Palenchar, 2004). Therefore, if a group format is used, it is important for clinicians to make sure that each parent is engaged in the group process. Recent research has confirmed that African Americans tend to prefer a more interpersonal approach over an instrumental approach (Mulvaney-Day,

Earl, Diaz-Linhart, & Algeria, 2011). A group format may be especially effective for facilitating an interpersonal approach by giving members of the group an opportunity to interact with each other while discussing parenting.

In regards to the clinician, previous culturally sensitive PT programs have emphasized the importance of having a clinician of the same ethnicity as the target group (Brody et al., 2006). Therefore we assessed if participants preferred a provider of their same ethnicity. We found that the majority of participants (81%) did not consider this to be an important factor. However, having a provider of the same ethnicity was still important for 17% of our sample. Thus, ethnic similarity still seems to be important when trying to maximize client engagement. Unfortunately, only 2-4% of service providers are African American (American Psychological Association, 2009; Holzer et al., 2000). This suggests the need for continued attention to cultural sensitivity training among current and future practitioners. The American Psychological Association created the Committee on Ethnic Minority Affairs (CEMA) to help improve services for underserved minorities (American Psychological Association, 2011). CEMA provides several references that are beneficial in providing cultural sensitivity training for clinicians.

Research has found that when given the option, participants prefer a clinician that is similar to them on multiple dimensions including gender and ethnicity (Garcia, Paterniti, Romano, & Kavitz, 2003). Similarly, the majority of parents felt that it is important for the clinician to have a child (73%). Although having a child is not necessary for a clinician to be effective in conducting PT, having a child may help clients feel as if the counselor is more credible or can relate more readily to the role of a parent. In a similar fashion to cultural sensitivity training, it may be beneficial for clinicians who don't have children to have training that will help them take the perspective of parents and thus improve their treatment delivery.

Parenting Behaviors

In regards to parenting behaviors commonly taught in PT, parents reported being very familiar with all of these skills. This indicates that PT does not introduce new concepts for most parents, though it is not clear how accurate or complete their knowledge of these different skills is. For example, it is feasible that time out has very different meaning across participants. We attempted to partially address this likelihood by adding brief descriptions and examples of parenting behaviors, but it is likely that differences in participants' understanding remained.

There was much more variability in parents' reports of engaging in these behaviors and if they believed the behavior to be a good or bad idea. Overall, parents were likely to rank a parenting skill as a good idea for parents, but then not rate the skill as being very much like their parenting. Therefore, it may be beneficial for clinicians to utilize therapy techniques such as motivational interviewing designed to improve motivation (Miller & Rollnick, 2002).

In reviewing participants' rankings for similarity of parenting skills to their own behavior and how good of an idea the skill is for parents, it became clear that skills with a positive connotation, such as attending, special time, and rewards were viewed more positively than planned ignoring, behavior contracts, and time out. These findings could be the result of parents engaging in positive impression management and being reticent to report engaging in parenting behaviors that could be viewed as negative. It could also be that participants did not pay attention to the written descriptions of the parenting behaviors, and assumed that skills such as planned ignoring are undesirable based on name only. With these limitations aside, if parents do have a more negative view of planned ignoring, behavior contracts, and time out, they may view the treatment as less relevant, which is one of the barriers to treatment that frequently predicts attrition (Kazdin et al., 1997a). Further research points out that parents create schemas about

their parenting style (Azar, Nix, & Makin-Byrd, 2005). Whenever a skill is promoted that is not part of a parent's current schema, the application of the new skill is more difficult (Azar, Nix, & Makin-Byrd, 2005; Young, Klosko, & Welshaar, 2003). To help parents address parenting skills that are not easily accepted, Azar and colleagues (2005) recommend that the clinician assign the parent homework of keeping a daily diary about their reaction to the parenting skills. In addition, they recommend role-playing the skill while having the parents verbalize their reactions to it. In this way, clinicians can better address concerns that may occur.

For the parenting strategies of behavior contracts, effective commands, rewards, and special time, there were no significant differences between ethnicities for the familiarity, similarity to own parenting, and if the parenting behavior was a good or bad idea. This suggests that African American parents may hold similar schemas about these behaviors as Caucasian parents. This suggests that it may not be necessary to modify these skills when conducting a culturally sensitive PT. However, it should be noted that an African American focus group and African American therapists were consulted when creating the examples used in the survey. The examples used in the survey were selected for their cultural relevance to African Americans. Therefore, even though African American parents did not have significantly different responses from Caucasian parents, it may still be beneficial to keep African American culture in mind when selecting examples to use when teaching these skills in PT. Thus, when the skills of behavior contracts, effective commands, rewards, and special time are presented in a culturally sensitive way, the response of African American parents to these skills may not be significantly different from treatment with Caucasian parents.

It was found that African American parents have less favorable attitudes towards time out, attending, and planned ignoring, compared to Caucasian parents. In regards to time out, we

found that African American parents reported that time out is less similar to their own parenting than Caucasian parents. They also did not view time out as favorably as Caucasians. This suggests it is possible that when we teach African American parents to engage in time out, we are asking them to implement a skill that is more likely to be foreign to their culture, but when we ask Caucasian parents to implement time out, we are simply asking them to modify a familiar practice. The information presented earlier on schemas and how to adjust schemas would also apply to helping African American parents adopt time out into their parenting repertoire. Furthermore, additional research suggests that the more exposure children have to a parenting skill the more likely they are to believe that the skill is effective and just (Grusec & Goodnow, 1994). Furthermore, the more effective and just the child believes the skill to be, the more likely that the parenting behavior will result in a long term behavior change rather than a more temporary behavior change (Grusec & Goodnow, 1994; Vittrup & Holden, 2010). Thus, given that African American parents reported that time out is less similar to their parenting practices than Caucasian parents, it logically follows that their children are less likely to have experienced time out. If the pattern follows that was found by Vittrup and Holden, time out would initially be less effective for African American children than Caucasian children due to a previous exposure effect. Thus, when African Americans first adopt time out as a parenting skill, it may take additional effort and time before they see the positive outcomes in child behavior.

Research has found that the outcome of parenting behaviors is closely tied to a parent's belief about the parenting practice (Lansford et al., 2004; McLoyd & Smith, 2002). For example, research has shown that one of the strongest predictors of negative outcomes for corporal punishment is if parents view it as a bad parenting practice (McLoyd et al., 2007). Parents who did not view corporal punishment as negative had children who did not respond negatively to the

practice. It is hypothesized that the reason behind this difference is that when parents did not believe that corporal punishment was a good parenting practice, they were more likely to use it when angry or frustrated (McLoyd et al., 2007). If a similar pattern holds true for time out, and parents who initially did not endorse it as being a good idea or being similar to their own parenting only use it when frustrated or angry, it is possible that the time out may be implemented incorrectly. Therefore, when approaching time out with African American parents, it may be important to de-emphasize the importance of time out in favor of other discipline strategies that are more congruent with the African American culture. However, given the strong empirical support for the effectiveness of time out, a more reasonable step may be to implement the additional therapy skills suggested earlier (Azar et al., 2005) to address parental concerns.

In regards to the parenting practices of attending and planned ignoring, similar arguments as those made concerning time out apply. In addition, research has found that a common parenting pattern in African Americans is to be highly engaged in their children's lives and to use higher amounts of authoritative parenting mixed with an increase of warmth (Longest et al., 2007). This parenting practice may be in conflict with the use of planned ignoring. Thus, a culturally sensitive PT for African American parents may want to focus on how to best address problem behaviors when parents are not willing to use this strategy. Clinicians may also need to understand parents' concerns related to planned ignoring and attending, and when appropriate address those concerns or use alternative parenting practices to address problem behaviors. Furthermore, as research progresses on how to best engage in PT with African American parents, we may find that these skills are not as central to success as we have found in the research conducted with Caucasian parents. Therefore, in the future, it may be possible to deemphasize these skills when working with African American parents.

In addition to being more vigilant when teaching African American parents how to use time out, attending, and planned ignoring, it is possible that adding racial socialization practices to current PT may increase its efficacy for African American parents and decrease attrition. As stated previously, the racial socialization practices of preparation for bias, racial pride, and egalitarian messages have been found to decrease CP and increase prosocial behaviors (Stevenson et al., 2002). Additionally, these skills are related to better coping with discrimination (Fischer & Shaw, 1999), better self-image (Constatine & Blackmon, 2002), higher academic performance (Browman & Howard, 1985; Neblett et al., 2006), and better well-being and psychological adjustment (Neblett et al., 2008). We found that African American parents are more familiar with racial socialization practices than traditional elements of PT. Additionally, our participants reported that racial socialization practices are more congruent with their current parenting practices and they believe them to be a good idea at a higher rate than traditional elements of PT. Given the congruence with established parenting behaviors and the positive beliefs about these practices, it is likely that African American parents and children will respond positively to these practices. It is possible that by adding these components to PT, African American parents will find treatment to be more culturally relevant and effective. This could lead to a decrease in treatment attrition, which could improve the likelihood that African American parents would utilize the more traditional components of PT that could also be taught. Furthermore, given the benefits of engaging in racial socialization practices, it is possible that African American parents who complete a modified treatment that includes both racial socialization and traditional PT would have better treatment outcomes than those parents who completed just a traditional PT. This remains an empirical question.

Conclusion

In summary, we found that when creating a culturally sensitive PT for African American parents it may be especially important to select a convenient location such as a place of worship or community center. Also providing services for free or reduced cost may be especially important when working with African American parents. In regards to the therapist, it may be beneficial to have a therapist of the same ethnicity. However, when individuals from other ethnicities are conducting PT it may be especially important for them to receive cultural sensitivity training. When selecting a treatment format, the majority of parents reported preferring a group format. When conducting the treatment, it is important to be cognizant of which skills are viewed less favorably by African American parents so appropriate steps can be taken. Furthermore, our findings support that African Americans responded positively to the concept of racial socialization. Therefore, encouraging parents to increase racial pride, preparation for bias, and egalitarian messages, while decreasing the promotion of mistrust, may be beneficial.

Limitations and Future Directions

Our findings must be interpreted in the context of study limitations. Our sample may not be representative of the general population due to collecting approximately 30% of our participants from places of worship. Additionally, limits of our sample include collecting participants from the Southeast region of the United States and a higher rate of single parents and lower SES among African American participants. This study was exploratory in nature. Thus, numerous analyses were conducted, increasing our family wise error and increasing the likelihood that some of our findings are the result of chance. Another limitation of this study is the design used. Because survey data were collected from parents who have not participated in PT, it is unknown how well this information will generalize to actual PT. The results of this

study are also restricted by the limitations of self-report measurement, such as the risk of the participants engaging in positive impression management and careless responding. Furthermore, due to wanting to collect a broad overview of PT across ethnicities, some of our constructs were assessed with few questions or brief measures that may not evaluate all aspects of the given construct. Therefore, future research may want to utilize more in depth measures and behavioral observations.

Given the exploratory/descriptive nature of this study, future research is needed to further evaluate how to improve PT for African American parents. Specifically, researchers may want to focus on each parenting skill and determine how they are currently being used across ethnicities. Additionally, researchers may want to specifically study which parenting behaviors lead to the most effective dissemination of racial socialization. Finally, research is needed to determine how to present these parenting behaviors within the therapeutic context. The effectiveness of future clinical services may depend on more closely considering culturally sensitive aspects. Researchers can then evaluate the efficacy and the impact on retention of culturally sensitive PT in comparison to standard PT.

References

Allison, P. D. (1999). *Logistic regression using the SAS system*: *Theory and Application.* Cary, NC: SAS Institute, Inc.

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders (4th ed.), Text Revision.* Washington, DC: Author.

American Psychological Association (2009). Tables showing characteristics of division members including education, employment, demographics, and more. Retrieved July 18, 2011, from http://search.apa.org/search?query=2009+APA+membership+ directory +and+employment+update+Division+53

American Psycholgoical Association (2011). Committee on ethnic minority affairs (CEMA). Retrieved June 17, 2011, from http://www.apa.org/pi/oema/committee/index.aspx

Armbruster, P., & Fallon, T. (1994). Clinical, sociodemographic, and systems risk factors for attrition in a children's mental health clinic. *American Journal of Orthopsychiatry, 64,* 577-585.

Azar, T. S., Nix, R. L., & Makin-Byrd, K. N. (2005). Parenting schemas and the process of change. *Journal of Marital and Family Therapy, 31*, 45-58.

Bagner, D. M., & Eyberg, S. M. (2007). Parent-child interaction therapy for disruptive behavior in children with mental retardation: A randomized controlled trial. *Journal of Clinical Child and Adolescent Psychology, 36*, 418-429.

Bannon, W. M. Jr., Caveleri, M. A., Rodriguez, J., & McKay, M. M. (2008). The effect of racial socialization on urban African American use of mental health services. *Social Work in Mental Health, 6,* 9-29.

Barkley, R. A. (1997). *Defiant children: A clinician's manual for assessment and parent training* (2nd ed.). New York: Guilford Press.

Baumrind, D. (1989). Rearing competent children. In W. Damon (Ed.), *Child Development Today and Tomorrow* (pp. 349-378). San Francisco, CA: Jossey-Bass.

Baumrind, D. (1991). The influence of parenting style on adolescent competence and substance use. *Journal of Early Adolescence, 11,* 56-95.

Bernal, G., & Scharro´n-del-Rio´, M. R. (2001). Are empirically supported treatments valid for ethnic minorities? Toward an alternative approach for treatment research. *Cultural Diversity and Ethnic Minority Psychology, 7,* 328–342.

Biafora, F. A., Taylor, D. L., Warheit, G. J., & Zimmerman, R. S. (1993). Cultural mistrust and racial awareness among ethnically diverse Black adolescent boys. *Journal of Black Psychology, 19,* 266–281.

Biederman, J., Faraone, S. V., Chu, M. P., & Wozniak, J. (1999). Further evidence of a bidirectional overlap between juvenile mania and conduct disorder in children. *Journal of the American Academy of Child and Adolescent Psychiatry, 38,* 468-476.

Blume, A. W., & Lovato, L. V. (2010). Empowering the disempowered: Harm reduction with racial/ethnic minority clients. *Journal of Clinical Psychology, 66,* 189-200.

Bond, C. F., DiCandia, C. G., MacKinnon, J. R. (1988). Responses to violence in a psychiatric setting: The role of patient’s race. *Personality and Social Psychology Bulletin, 14,* 448–458.

Boyd-Franklin, N. (2003). *Black families in therapy (2nd Ed.*). New York: Guilford Press.

Bosworth, H. B., Parsey, K. S., Butterfield, M. I., McIntyre, L. M., Oddone, E. Z., Stechuchak, K. M., & Bastian, L. A. (2000). Racial variation in wanting and obtaining mental health services among women veterans in a primary care clinic. J*ournal of the National Medical Association, 92*, 231-236.

Brestan, E. V., & Eyberg, S. M. (1998). Effective psychosocial treatment of conduct-disordered children and adolescents: 29 years, 82 studies, and 5,272 kids. *Journal of Clinical Child Psychology, 27,* 179-188.

Brody, G. H., Murry, V. M., Gerrard, M., Gibbons, F. X., Molgaard, V., McNair, L., et al. (2004). The Strong African American Families program: Translating research into prevention programming. *Child Development, 75,* 900-917.

Brody, G. H., Murry, V. M., Kogan, S. M., Gerrard, M., Gibbons, F. X., Brown, A. C., et al. (2006). The Strong African American Families program: A cluster-randomized prevention trial of long-term effects and a mediational model. *Journal of Consulting and Clinical Psychology, 74,* 356-366.

Brody, G. H., Murry, V. M., McNair, L., Chen, Y., Gibbons, F. X., Gerrard, M., et al. (2005). Linking changes in parenting to parent-child relationship quality and youth self-control: The Strong African American Families program. *Journal of Research on Adolescence, 14*, 47-69.

Brown, C. & Palenchar, D. (2004). Treatment of depression in African American primary care patients. www.rcgd.isr.Umich.edu/prba/pers. Retrieved 05/05/10.

Bowman, P. J. & Howard, C. (1985). Race-related socialization, motivation, and academic achievement: A study of Black youths in three-generation families. *Journal of the American Academy of Child Psychiatry, 24*, 134-141.

Campbell, S. B. (2002). Follow-up and outcome studies. In *Behavior problems in preschool children: Clinical and developmental issues* (2nd ed., pp. 241-275). New York: Guilford.

Caughy, M. O., O'Campo, P. J., Randolph, S. M., & Nickerson, K. (2002).The influence of racial socialization practices on the cognitive and behavioral competence of African American preschoolers. *Child Development, 73*, 1611–1625.

Caughy, M. O., Nettles, S. M., Campo, P. J., & Lohrfink, K. F. (2006). Neighborhood matters: Racial socialization of African American children. *Child Development, 77,* 1220-1236.

Coard, S. I., Wallace, S. A., Stevenson, H. C., Jr., & Brotman, L. M. (2004). Towards culturally relevant preventive interventions: The consideration of racial socialization in parent training with African American families. *Journal of Child and Family Studies, 13,* 277-293.

Conduct Problems Prevention Research Group. (1999). Initial impact of the Fast Track prevention trial for conduct problems: The high risk sample. *Journal of Consulting and Clinical Psychology, 67,* 631-647.

Constantine, M. G., & Blackmon, S. M. (2002). Black adolescents' racial socialization experiences: Their relations to home, school, and peer self-esteem. *Journal of Black Studies, 32*, 322–335.

Cooper-Patrick, L., Gallo, J. J., Gonzales, J .J., Vu, H. T., Powe, N. R., Nelson, C., et al. (1999). Race, gender, and partnership in the patient–physician relationship. *Journal of the American Medical Association, 282,* 583–589.

Corrigan, P. W. (Ed.) (2005). *On the stigma of mental illness: Practical strategies for research and social change.* Washington, DC: American Psychological Association.

Cunningham, A., & Knoester, C. (2007). Marital status, gender, and parents psychological well-being. *Sociological Inquiry, 77,* 264-287

Dirmaier, J., Harfst, K. U., Koch, U., & Schulz, H. (2007). Incentives increased return rates but did not influence partial nonresponse or treatment outcome in a randomized trial. *Journal of Clinical Epidemiology, 60,* 1263-1270.

Drebing, C. E., Van Ormer, E. A., Krebs, C., Rosenheck, R., & Rounsaville, B. (2005). The impact of enhanced incentives on vocational rehabilitation outcomes for dually diagnosed veteran. J*ournal of Applied Behavior Analysis, 38,* 359-372.

Dretzke J., Davenport C., Frew E., Barlow J., Stewart-Brown S., Bayliss S., Taylor R. S., Sandercock J. & Hyde C. (2009) *Child and Adolescent Psychiatry and Mental Health, 3,* 3-7.

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

Dumas, J. E., & Wahler, R. G. (1983). Predictors of treatment outcome in parent training: Mother insularity and socioeconomic disadvantage. *Behavioral Assessment, 5,* 301-313.

Dumas, J. E., Nissley-Tsiopinis, J., & Moreland, A. D. (2007). From intent to enrollment, attendance, and participation in preventive parenting groups. *Journal of Child and Family Studies, 16,* 1-26.

Dumka, L., Garza, C., Roosa, M., & Stoerzinger, H. (1997). Recruitment and retention of high-risk families into a preventative parent training intervention. *Journal of Primary Prevention, 18,* 25-39.

Eyberg, S. M., & Boggs, S. R. (1998). Parent-child interaction therapy for oppositional preschoolers. In C.E. Schaefer & J.M. Briesmeister (Eds.) *Handbook of parent training: Parents as co-therapists for children's behavior problems* (2nd ed., pp. 61-97). New York: Wiley.

Faul, F., Erdfelder, E., Lang, A. G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods, 39,* 175-191.

Feldman, A. F., & Matjasko. J. L. (2007). Profiles and portfolios of adolescent school-based extracurricular activity participation. *Journal of Adolescence, 30,* 312-332.

Fernandez, M. A., & Eyberg, S. M. (2009). Predicting treatment and follow-up attrition in parent-child interaction therapy. *Journal of Abnormal Child Psychology, 37,* 431-441.

Fischer, A. R., & Shaw, C. M. (1999). African Americans' mental health and perceptions of racist discrimination: The moderating effects of racial socialization experiences and self esteem. *Journal of Counseling Psychology, 46,* 395-407.

Forehand, R., Middlebrook, J., Rogers, R., & Steffe, M. (1983). Dropping out of parent training. *Behavioral Research and Therapy, 21,* 663-668.

Frick, P. J. & Silverthorn, P. (2001). Behavior disorders in children. In H.E. Adams & P.B. Sutker (Eds.), *Comprehensive handbook of psychopathology* (3rd ed., pp. 879 - 919). New York: Plenum.

Garcia, C. C., Lamberty, G., Jenkins, R., McAdoo, H. P., Crnic, K., Wasik, B. H., et. al. (1996) An integrative model for the study of developmental competencies in minority children. *Child Development, 67,* 1891-1914.

Garcia, J., Paterniti, D., Romano, P., and Kravitz, R. (2003). Patient Preferences for Physician Characteristics in University-Based Primary Care Clinics. *Ethnicity and Disease 13*, 259-67.

Gottfredson, D., Kumpfer, K., Polizzi-Fox, D., Wilson, D., Puryear, V., Beatty, P., et al. (2006). The Strengthening Washington DC Families Project: A randomized effectiveness trial of family based prevention. *Prevention Science, 7*, 57–74.

Gross, D., Garvey, C., Julion, W., Fogg, L., Tucker, S., & Mokros, H. (2009). Efficacy of the Chicago Parent Program with low-income African American and Latino parents of young children. *Prevention Science, 10,* 54-65.

Gross, D., Julion, W., & Fogg, L. (2001). What motivates participation and dropout among low-income urban families of color in a prevention intervention? *Family Relations, 50,* 246-254.

Grusec, J., & Goodnow, J. (1994). Impact of parental discipline methods on the child's internalization of values: A reconceptualization of current points of view. Developmental Psychology, 30, 4−19.

Guevara, J. P., Mandell, D. S., Rostain, A. L., Zhao, H., & Hadley, T. R. (2003). National estimates of health services expenditures for children with behavior disorders: An analysis of the medical expenditure panel survey. *Pediatrics, 112,* 440-446.

Hampson, R. B., Schulte, M. A., & Ricks, C. C. (1983). Individual vs. group training for foster parents: Efficiency/effectiveness evaluations. *Family Relations, 32,* 191-202.

Harris-Britt, A., Valerie, C. R., Kurtz-Costes, B., & Rowley, S. J. (2007). Perceived racial discrimination and self-esteem among African American youth: Racial socialization as a protective factor. *Journal of Research on Adolescence, 17,* 669-682.

Hinshaw, S. P., & Lee, S. S. (2003). Conduct and oppositional defiant disorders. In E. J. Mash & R. A. Barkley (Eds.), *Child Psychopathology* (2nd Ed., pp. 144-198). New York: Guilford Press.

Holzer, C.E. III, Goldsmith, H. F. & Ciarlo, J.A. (2000). The availability of health and mental health providers by population density. *Journal of the Washington Academy of Sciences, 86,* 25-33.

Hughes, D. (2003). Correlates of African American and Latino parents' messages to children about ethnicity and race: A comparative study of racial socialization. *American Journal of Community Psychology, 31,* 15–33.

Hughes, D., & Chen, L. (1997). When and what parents tell children about race: An examination of race-related socialization among African American families. *Applied Developmental Science, 1,* 200–214.

Hughes, D., & Chen, L. (1999). The nature of parents' race-related communications to children: A developmental perspective. In L. Balter & C. S. Tamis-Lemonda (Eds.), *Child psychology: A handbook of contemporary issues* (pp. 467–490). Philadelphia: Psychology Press.

Hughes, D., & Johnson, D. J. (2001). Correlates in children's experiences of parents' racial socialization behaviors. *Journal of marriage and the Family, 63,* 981-995.

Hughes, D., Rodriguez, J., Smith, E. P., Johnson, D. J., Stevenson, H. C., & Spicer, P. (2006). Parents' ethnic-racial socialization practices: A review of research and directions for future study. *Developmental Psychology, 42,* 747-770.

Huizinga, D., Thornberry, T. P., Knight, K. E., Lovegrove, R. L., Hill, K., & Farrington, D. P. (2007). Disproportionate minority contact in the juvenile justice system: A study of differential minority arrest/referral to court in three cities. A report to the Office of Juvenile Justice and Delinquency Prevention (NCJ Rept. No. 219743). Retrieved from National Criminal Justice Reference System Web site: http://www.ncjrs.gov/pdffiles1/ojjdp/grants/219743.pdf

Irvine, A. B., Biglan, A., Smolkowski, K., Metzler, C., & Ary D. (1999). The effectiveness of a parenting skills program for parents of middle school students in small communities. *Journal of Consulting and Clinical Psychology, 67,* 811-825.

Ipsa, J. M., Fine, M. A., Halgunseth, L. C., Harper, S., Robinson, J., Boyce, et al., (2004). Maternal intrusiveness, maternal warmth, and mother-toddler relationship outcomes: Variations across low-income ethnic and acculturation groups. Child Development, 75, 1613-1631.

Jenkins-Hall, K. D., & Sacco, W. P. (1991). Effect of client race and depression on evaluations by white therapists. *Journal of Social and Clinical Psychology, 10,* 322–333.

Jesse, D. E., Dolbier, C. L., & Blanchard A. (2008). Barriers to seeking help and treatment suggestions for prenatal depressive symptoms: Focus groups with rural low-income women. *Issues in Mental Health Nursing, 29,* 3-19.

Kazdin, A. E. (1995). *Conduct disorder in childhood and adolescence* (2nd Ed.). Newbury Park, CA: Sage.

Kazdin, A. E. (2000). Perceived barriers to treatment participation and treatment acceptability among antisocial children and their families. *Journal of Child and Family Studies, 9,* 157-174.

Kazdin, A. E., Holland, L., & Crowley, M., (1997a). Family experience of barriers to treatment and premature termination from child therapy. *Journal of Consulting and Clinical Psychology, 65,* 453-463.

Kazdin, A. E., Holland, L., Crowley, M., & Breton S., (1997b). Barriers to treatment participation scale: Evaluation and validation in the context of child outpatient treatment. *Journal of Child Psychology and Psychiatry, 38,* 1051–1062.

Kazdin, A. E., Marciano, P. L., & Whitley, M. K. (2005). The therapeutic alliance in cognitive-behavioral treatment of children referred for oppositional, aggressive, and antisocial behavior. *Journal of Consulting and Clinical Psychology, 73,* 726-730.

Kazdin, A. E., Mazurick, J. L., & Bass, D. (1993). Risk for attrition in treatment of antisocial children and families. Journal of Clinical Child Psychology, 22, 2-16.

Kazdin, A. E., & Mazurick, J. L. (1994). Dropping out of child psychotherapy: Distinguishing early and late dropouts over the course of treatment. *Journal of Consulting and Clinical Psychology, 62,* 1069-1074.

Kazdin, A. E., Stolar, M. J., & Marciano, P. L. (1995). Risk factors for dropping out of treatment among white and black families. *Journal of Family Psychology, 9,* 402–417.

Kazdin, A. E., & Wassell, G. (1999). Barriers to treatment participation and therapeutic change among children referred for conduct disorder. *Journal of Clinical Child Psychology, 28,* 160-172.

Keith, V. M. (2000). A profile of African Americans' health care. In C. Hogue, M.A. Hargreaves, & K. S. Collins (Eds.), *Minority health in America* (pp. 47–76). Baltimore, MD: Johns Hopkins University Press.

Kerig, P. K. (2001). Children's coping with interparental conflict. In J. H. Grych & F. D. Fincham (Eds.), *Interparental Conflict and Child Development* (pp. 213-235). Cambridge, UK: Cambridge University Press.

Lahey, B. B., Miller, T. L., Gordon, R. A., & Riley, A. W. (1999). Developmental epidemiology of the disruptive behavior disorders. In H. C. Quay & A. E. Hogan (Eds.), *Handbook of disruptive behavior disorders* (pp. 23-48). New York: Plenum Press.

Lansford, J. E., Chang, L., Dodge, K. A., Malone, P. S., Oburu, P., Palmerus, K., et al. (2005). Physical discipline and children's adjustment: Cultural normativeness as a moderator. *Child Development, 76,* 1234-1246.

Lansford, J. E., Deater-Deckard, K., Dodge, K. A., Bates, J. E., & Pettit, G. S. (2004). Ethnic differences in the link between physical discipline and later adolescent externalizing behaviors. *Journal of Child Psychology and Psychiatry, 45,* 801-812.

Lieberman, A. F., Weston, D. R., & Pawl, J. H. (1991). Preventive intervention and outcome with anxiously attached dyads. *Child Development, 62,* 199–209.

Longest, K. C., Taylor, L. C., Barnett, M. A., & Raver, C. C. (2007, August). *Parenting Styles in African American and White Low-Income Families: Findings from an Observational Study.* Paper presented at the annual meeting of the American Sociological Association, New York.

Lundahl, B., Risser, H. J., & Lovejoy, M. C. (2006). A meta-analysis of parent training: Moderators and follow-up effects. *Clinical Psychology Review, 26,* 86-104.

Maguin, E., & Loeber, R. (1996). Academic performance and delinquency. In M. Tonry (Ed.) *Crime and justice* (Vol. 20, pp. 145-264). Chicago: University of Chicago Press.

McLoyd, V. C. & Kaplan, R., Hardaway, C. R., & Wood, D. (2007). Does endorsement of physical discipline matter? Assessing moderating influences on the maternal and child psychological correlates of physical discipline in African-American families. *Journal of Family Psychology, 21,* 165-175.

McLoyd, V. C., & Smith, J. (2004). Physical discipline and behavior problems in African-American, European-American, and Hispanic children: Emotional support as a moderator, *journal of Marriage and Family, 64,* 40-53.

McMahon, R. J., & Forehand, R. L. (2003). *Helping the noncompliant child: Family-based treatment for oppositional behavior* (2nd Ed.). New York: Guilford Press.

McMahon, R. J., Wells, K. C., & Kotler, J. S. (2006). Conduct problems. In E.J. Mash & R.A. Barkley (Eds.), *Treatment of childhood disorders* (3rd ed., pp. 137-268). New York: Guilford Press.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change.* New York: Guilford Press.

Millstein, R. B., Holmbeck, G.N., Fischer, S. N., & Shapera, W. E. (2001). Parenting styles. In J. V. Lerner, R. M., Lerner, & J. Finkelstein (Eds.), *Adolescence in America: An encyclopedia* (Vol. II, 484-489). Santa Barbra, CA: ABC-CLIO.

Mulvaney-Day, N. E., Earl, T. R., Diaz-Linhart, Y., & Algeria, M. (2011). Preferences for relational style with mental health clinicians: A qualitative comparison of African American, Latino, and Non-Latino White patients. *Journal of Clinical Psychology, 67,* 31-44.

Munoz, R. F., Ying, Y. W., Bernal, G., Perez-Stable, E. J., Sorensen, J. L., Hargreaves, W. A., et al. (1995). Prevention of depression with primary care patients: A randomized controlled trial. *American Journal of Community Psychology, 23*, 199–222.

Murry, V. M., Brown, P. A., Brody, G. H., Cutrona, C. E., & Simons, R. L. (2001). Racial discrimination as a moderator of the links among stress, maternal psychological functioning, and family relationships. *Journal of Marriage and Family, 63*, 915–926.

Myers, H., Alvy, K., Arrington, A., Richardson, M., Marigna, M., Huff, R., et al. (1992). The impact of a parent training program on inner-city African-American families. *Journal of Community Psychology, 20*, 132-147.

Nail, P. R., Harton, H. C., & Decker, B. P. (2003). Political orientation and modern versus aversive racism: Tests of Dovidio and Gaertner's (1998) Integrated Model. *Journal of* Personality and Social Psychology, 84, 754-770.

Nagayama-Hall, G. C. (2001). Psychotherapy research with ethnic minorities: Empirical, ethical, and conceptual issues. *Journal of Consulting and Clinical Psychology, 69*, 502–510.

Nakoa, K., & Treas, J. (1992). The 1989 Socioeconomic Index of Occupations: Construction from the 1989 Occupational Prestige scores. *General Social Survey Methodological Report No. 74*. Chicago: University of Chicago, National Opinion Research Center.

National Institute of Mental Health. (1999). *Strategic plan on reducing health disparities.* Rockville, MD: Author.

Neblett, E. W. Jr., White, R. L., Ford, K. R., Philip, C. L., Nguyen, H. X., & Sellers, R. M. (2008). Patterns of racial socialization and psychological adjustment: Can parental communications about race reduce the impact of racial discrimination? *Journal of Research on Adolescence, 18,* 477-515.

Neblett, E. W. Jr., Philip, C. L., Cogburn, C. D., & Sellers, R. M. (2006). African American adolescents' discrimination experiences and academic achievement: Racial socialization as a cultural compensatory and protective factor. *Journal of Black Psychology, 32,* 199–218.

Nock, M. K. & Ferriter, C. F., (2005). Parent management of attendance and adherence in child and adolescent therapy: A conceptual empirical review. *Clinical Child and Family Psychology Review, 8,* 149-166.

Orrell-Valente, J., Pinderhoughes, E., Valente, E., Laird, R., & Conduct Problems Prevention Research Group. (1999). If it's offered, will they come? Influences on parents' participation in a community-based conduct problems prevention program. *American Journal of Community Psychology, 27,* 753-783.

Peters, S., Calam, R., & Harrington, R. (2005). Maternal attributions and expressed emotion as predictors of attendance at parent management training. *Journal of Child Psychology and Psychiatry, and Allied Disciplines, 46,* 436-448.

Phinney, J. S., & Chavira, V. (1995). Parental ethnic socialization and adolescent coping with problems related to ethnicity. *Journal of Research on Adolescence, 5,* 31–54.

Pinderhughes, E. E., Dodge, K. A., Bates, J. E., Pettit, G. S., & Zelli, A. (2000). Discipline responses: Influences of -parent's socioeconomic status, ethnicity, beliefs about parenting, stress, and cognitive-emotional processes. *Journal of Family Psychology, 14,* 380-400.

Prelow, H. M., Danoff-Burg, S., Swenson, R. R., & Pulgiano, D. (2004). The impact of ecological risk and perceived discrimination on the psychological adjustment of African

American and European American youth. *Journal of Community Psychology, 32,* 375–389.

Price, D. D., Finniss, D. G., & Benedetii, F. (2008). A comprehensive review of the placebo effect: Recent advances and current thought. *Annual Review of Psychology, 59,* 565-590.

Reid, M. J., Webster-Stratton, C., & Beauchaine, T. P. (2001). Parent training in Head Start: A comparison of program response among African American, Asian American, Caucasian, and Hispanic mothers. *Prevention Science, 2,* 209-227.

Rodriguez, J., Mckay, M. M., & Bannon, W. M. Jr. (2008). The role of racial socialization in relation to parenting practices and youth behavior: An exploratory analysis. *Social Work in Mental Health, 6,* 30-54.

Rohde, P., Lewinsohn, P., & Seeley, J. (1991). Comorbidity of unipolar depression: Comorbidity with other mental disorders in adolescents and adults. *Journal of Abnormal Psychology, 100,* 214-222.

Rost, K., Nutting, P., Smith, J., Coyne, J. C., Cooper-Patrick, L., & Rubenstein, L. (2000). The role of competing demands in the treatment provided primary care patients with major depression. *Archives of Family Medicine, 9,* 150–154.

Rudy, D., & Grusec, J. (2001). Correlates of authoritarian parenting in individualist and collectivist cultures and implications for understanding the transmission of values. *Journal of Cross-Cultural Psychology, 32,* 202-212.

Sellers, R. M., Caldwell, C. H., Schmeelk-Cone, K. H., & Zimmerman, M. A. (2003). Racial identity, racial discrimination, perceived stress, and psychological distress among African American young adults. *Journal of Health and Social Behavior, 43*, 302–317.

Sellers, R. M., Copeland-Linder, N. C., Martin, P. P., & Lewis, R. L. (2006). Racial identity matters: The relationship between racial discrimination and psychological functioning in African America adolescents. *Journal of Research on Adolescents, 16,* 187-216.

Sellers, R. M., & Shelton, J. N. (2003). The role of racial identity in perceived racial discrimination. *Journal of Personality and Social Psychology, 84,* 1079–1092.

Shapiro, J. P., Friedberg, R. D., & Bardenstein, K. K. (2006). *Child and adolescent therapy: Science and art.* Hoboken, NJ: John Wiley and Sons.

Simons, R. L., Murry, V., McLoyd, V., Lin, K., Cutrona, C., & Conger, R. D. (2002). Discrimination, crime, ethnic identity, and parenting as correlates of depressive symptoms among African American children: A multilevel analysis. *Development and Psychopathology, 14,* 371–393.

Smith, E. P. (1996, March). Racial-ethnic socialization: Family, school, and community influences. Paper presented at the biennial meeting of the Society for Research in Adolescence, Boston, MA.

Snowden, L. R., Hu, T., & Jerrell, J. M. (1995). Emergency care avoidance: Ethnic matching and participation in minority-serving programs. *Community Mental Health Journal, 31,* 463–473.

Snyder, H. (2001). Child delinquents. In R. Loeber & D. P. Farrington (Eds.), *Risk factors and successful interventions.* Thousand Oaks, CA: Sage.

Stitzer, M. L., Peirce, J., Killeen, T., Hamilton, J., Sterling, R., Kolodner, K, et al. (2007). Effectiveness of abstinence-based incentives: Interaction with intake stimulant test results. *Journal of Consulting and Clinical Psychology, 75,* 805-811.

Stevenson, H. C. Jr., Cameron, R., Herrero-Taylor, T., & Davis, G. Y. (2002). Development of the teenager experience of racial socialization scale: Correlates of race-related socialization frequency from the perspective of Black youth. *Journal of Black Psychology, 28,* 84–106.

Stoy, D., Curtis, C., Dameworth, K., Dowdy, A., Hegland, J., Levin, J. et al. (1995). The successful recruitment of elderly black subjects in a clinical trial: The CRISP experience. *Journal of the National Medical Association, 87,* 280-287.

Sue, S. (1977). Community mental health services to minority groups: Some optimism, some pessimism. *American Psychologist, 32*, 616-624.

Sue, S., Zane, N., & Young, K. (1994). Research on psychotherapy on culturally diverse populations. In A. Bergin & S. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th Ed., pp. 783–817). New York: Wiley.

Thornton, M. C. (1997). Strategies of racial socialization among black parents: Mainstream, minority, and cultural messages. In R. J. Taylor, J. S. Jackson, & L. M. Chatters (Eds.), *Family life in Black America* (pp.201–215). Thousand Oaks, CA: Sage.

Townes, D. L., Chavez-Korell, S., & Cunningham, N. J. (2009). Reexamining the relationships between racial identity, cultural mistrust, help-seeking attitudes, and preferences for a black counselor. *Journal of Counseling Psychology, 56,* 330-336.

Trefil, J., Kett, J. F., & Hirsch, E. D. (Eds.) (2010). *The new dictionary of cultural literacy* (3rd ed.). Chicago, IL: Houghton Miffin Harcourt.

Uebersax J. S. (1987). Diversity of decision-making models and the measurement of interrater agreement. *Psychological Bulletin, 101*, 140 – 146.

U.S. Census Bureau (2001). *The black population in the United States: March 2000* (Update) (Report No. PPL-146). Washington, DC: Author.

U. S. Census Bureau (2008). *American community survey: 3-year estimates.* Washington, DC: Author.

Vittrup, B., & Holden, G. W., (2010). Children's assessments of corporal punishment and other disciplinary practices:The role of age, race, SES, and exposure to spanking. *Journal of Applied Developmental Psychology, 31,* 211-220.

Voss Horrell, S.C. (2008). Effectiveness of cognitive-behavioral therapy with adult ethnic minority clients: A review. Professional Psychology: *Research and Practice, 39*, 160–168.

Wang, P. S., Berglund, P., & Kessler, R. C. (2000). Recent care of common mental disorders in the United States. *Journal of General Internal Medicine, 15,* 284–292.

Webster-Stratton, C. (1992). Individually administered videotape parent training: "Who benefits?" *Cognitive Therapy and Research, 16,* 31-52.

Webster-Stratton, C. (1998). Preventing conduct problems in Head Start children: Strengthening parenting competencies. *Journal of Consulting and Clinical Psychology, 66*, 715-730.

Webster-Stratton, C. (2000). *The incredible years training bulletin.* Washington, DC: U. S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

Webster-Stratton, C., & Hammond, M. (1990). Predictors of treatment outcome in parent training for families with conduct problem children. *Behavior Therapy, 21,* 319-337.

Webster-Stratton, C., Reid, M. J., & Hammond, M. (2001). Preventing conduct problems, promoting social competence: A parent and teacher training partnership in Head Start. *Journal of Clinical Child Psychology, 30,* 283-302.

Werba, E., Eyberg, S. M., Boggs, S. R., & Algina, J. (2006). Predicting outcome in parent-child interaction therapy. *Behavioral Modification, 30,* 618-646.

Whaley, A. L. (1997). Ethnic and racial differences in perceptions of dangerousness of persons with mental illness. *Psychiatric Services, 48,* 1328–1330.

Whaley, A. L., & Davis, K. E. (2007). Cultural competence and evidence-based practice in mental health services: A complementary perspective. *American Psychologist, 62,* 563–574.

Wong, C. A., Eccles, J. S., & Sameroff, J. S. (2003). The influence of ethnic discrimination and ethnic identification on African American adolescents' school and socioemotional adjustment. *Journal of Personality, 71,* 1197–1232.

Yeh, M., Takeuchi, D. T., & Sue, S. (1994). Asian American children seen in the mental health system: A comparison of parallel and mainstream outpatient service centers. *Journal of Clinical Child Psychology*, *23*, 5–12.

Young, A. S., Klap, R., Shebourne, C. D., Wells, K.B. (2001). The quality of care for depressive and anxiety disorders in the United States. *Archives of General Psychiatry, 58,* 55–61.

Young, E. J., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide.* New York, NY: Guilford Press.

Table 1

Demographic Information

	African American Mean (*SD*)	Caucasian Mean (*SD*)
N	105	91
Age of participant (Years)	30.32 (7.26)	34.20 (5.81)
Age of Mother	30.22 (7.44)	33.75 (5.96)
Age of Father	32.93 (8.55)	36.16 (6.85)
SES (Hollingshead)	39.35 (12.12)	48.31 (12.32)
Relationship to Child		
Mother	77	80
Father	11	8
Grandparent	8	1
Guardian/Other	8	2
Level of Education of Participant		
9^{th} Grade or Less	2	1
10^{th} Grade – High School Graduate	24	5
Some College/Certificate Course	33	19
College Graduate	24	45
Graduate or Professional Degree	5	17
Marital Status		
Single	50	7
Married	28	76
Separated/Divorced/Widowed	7	5
Living with Someone	4	0
Children (ages 4-8)		
N	133	121
Age (Years)	5.55 (1.60)	5.47 (1.49)

Table 2

Hierarchical Regression Analyses for Familiarity of Parenting Behaviors

Variables	*B*	*SE B*	β	R^2	*F* for R^2 change
Attending					
Step One					
SES	<0.01	0.01	-0.06	<0.01	0.63
Step Two					
SES	-0.01	0.01	-0.12		
Ethnicity	0.09	0.06	0.16		
Racial Identity	<0.01	0.01	-0.01	0.03	1.96
Contracts					
Step One					
SES	0.01	0.01	0.07	0.01	0.86
Step Two					
SES	0.01	0.01	0.09		
Ethnicity	-0.02	0.07	-0.02		
Racial Identity	0.02	0.02	0.09	0.02	0.88
Commands					
Step One					
SES	<0.01	0.01	0.02	<0.01	0.07
Step Two					
SES	<0.01	0.01	0.04		
Ethnicity	-0.02	0.05	-0.04		
Racial Identity	0.01	0.01	0.09	0.01	1.12
Ignoring					
Step One					
SES	<0.01	0.01	0.01	<0.01	0.28
Step Two					
SES	<0.01	0.01	-0.05		
Ethnicity	0.26	0.08	0.28**		
Racial Identity	0.03	0.02	0.13	0.06	4.91**
Rewards					
Step one					
SES	<0.01	0.01	-0.03	<0.01	0.11
Step Two					
SES	<0.01	0.01	-0.07		
Ethnicity	0.07	0.05	0.12		
Racial Identity	<0.01	0.01	0.02	0.01	0.95

Variables	*B*	*SE B*	β	R^2	*F* for R^2 change
Special Time					
Step One					
SES	<0.01	0.01	-0.02	<0.01	0.10
Step Two					
SES	<0.01	0.01	0.02		
Ethnicity	-0.09	0.06	-0.13		
Racial Identity	-0.01	0.02	-0.03	0.01	1.00
Time Out					
Step One					
SES	<0.01	0.01	-0.01	<0.01	0.01
Step Two					
SES	-0.01	0.01	-0.08		
Ethnicity	0.14	0.07	0.18		
Racial Identity	-0.01	0.02	-0.03	0.04	3.09*
Bias					
Step One					
SES	-0.01	0.01	-0.11	0.01	1.96
Step Two					
SES	<0.01	0.01	0.02		
Ethnicity	-0.30	0.08	-0.35**		
Racial Identity	0.02	0.02	0.08	0.15	13.32**
Egalitarian					
Step One					
SES	0.01	<0.01	0.12	0.02	2.54
Step Two					
SES	0.01	<0.01	0.16		
Ethnicity	-0.04	0.04	-0.08		
Racial Identity	0.01	0.01	0.07	0.03	1.37
Mistrust					
Step One					
SES	-0.01	0.01	-0.12	0.01	2.29
Step Two					
SES	-0.01	0.01	-0.08		
Ethnicity	-0.09	0.10	-0.08		
Racial Identity	0.04	0.02	0.13	0.05	2.86

Variables	*B*	*SE B*	β	R^2	*F* for R^2 change
Racial Pride:					
Step One					
SES	-0.01	0.01	-0.12	0.01	2.27
Step Two					
SES	<0.01	0.01	0.01		
Ethnicity	-0.22	0.06	-0.28**		
Racial Identity	0.06	0.02	0.30**	0.24	24.99**

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

Table 3

Hierarchical Regression Analyses for Similarity of Parenting Behaviors

Variables	*B*	*SE B*	B	R^2	*F* for R^2 change
Attending					
Step One					
SES	<0.01	0.01	-0.06	<0.01	0.59
Step Two					
SES	-0.01	0.01	-0.12		
Ethnicity	0.11	0.06	0.17		
Racial Identity	<0.01	0.01	-0.01	0.03	2.18
Contracts					
Step One					
SES	<0.01	0.01	-0.05	<0.01	0.34
Step Two					
SES	<0.01	0.01	-0.04		
Ethnicity	<0.01	0.08	-0.01		
Racial Identity	0.01	0.02	0.05	0.01	0.25
Commands					
Step One					
SES	<0.01	0.01	0.02	<0.01	0.05
Step Two					
SES	<0.01	0.01	0.02		
Ethnicity	0.01	0.06	0.01		
Racial Identity	0.02	0.01	0.12	0.01	1.09
Ignoring					
Step One					
SES	-0.01	0.01	-0.05	<0.01	0.42
Step Two					
SES	-0.01	0.01	-0.10		
Ethnicity	0.14	0.09	0.14		
Racial Identity	<0.01	0.02	0.02	0.02	1.32
Rewards					
Step One					
SES	<0.01	0.01	-0.01	<0.01	0.03
Step Two					
SES	<0.01	0.01	-0.05		
Ethnicity	0.07	0.07	0.10		
Racial Identity	-0.02	0.02	-0.09	0.02	1.95

Variables	*B*	*SE B*	B	R^2	*F* for R^2 change
Special Time					
Step One					
SES	<0.01	0.01	-0.05	<0.01	0.45
Step Two					
SES	<0.01	0.01	-0.05		
Ethnicity	<0.01	0.07	<0.01		
Racial Identity	0.01	0.02	0.05	0.01	0.21
Time Out					
Step One					
SES	-0.01	0.01	-0.07	0.01	0.80
Step Two					
SES	-0.02	0.01	-0.15		
Ethnicity	0.20	0.09	0.21*		
Racial Identity	-0.02	0.02	-0.10	0.07	5.98**
Bias					
Step One					
SES	-0.02	0.01	-0.21**	0.05	7.91**
Step Two					
SES	-0.01	0.01	-0.11		
Ethnicity	-0.24	0.07	-0.28**		
Racial Identity	0.01	0.02	0.06	0.13	8.34**
Egalitarian					
Step One					
SES	0.01	0.01	0.13	0.02	2.63
Step Two					
SES	0.01	0.01	0.12		
Ethnicity	0.04	0.06	0.07		
Racial Identity	0.03	0.01	0.17*	0.04	1.99
Mistrust					
Step One					
SES	-0.02	0.01	-0.27**	0.07	13.13**
Step Two					
SES	-0.02	0.01	-0.17*		
Ethnicity	-0.24	0.07	-0.31**		
Racial Identity	-0.01	0.02	-0.03	0.15	7.26**

Variables	*B*	*SE B*	B	R^2	*F* for R^2 change
Racial Pride					
Step One					
SES	-0.01	0.01	-0.11	0.01	2.21
Step Two					
SES	<0.01	0.01	-0.02		
Ethnicity	-0.13	0.07	-0.16		
Racial Identity	0.09	0.02	0.42**	0.27	28.60**

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

Table 4

Hierarchical Regression Analyses for Good/Bad Idea

Variables	*B*	*SE B*	B	R^2	*F* for R^2 change
Attending					
Step One					
SES	<0.01	<0.01	-0.04	<0.01	0.25
Step Two					
SES	-0.01	<0.01	-0.13		
Ethnicity	0.12	0.04	0.29**		
Racial Identity	<0.01	0.01	0.04	0.07	6.02**
Contracts					
Step One					
SES	<0.01	0.01	-0.03	<0.01	0.12
Step Two					
SES	<0.01	0.01	0.01		
Ethnicity	-0.05	0.08	-0.06		
Racial Identity	<0.01	0.02	<0.01	<0.01	0.23
Commands					
Step One					
SES	0.01	0.01	0.18*	0.03	5.88*
Step Two					
SES	0.01	0.01	0.16		
Ethnicity	0.04	0.05	0.07		
Racial Identity	-0.01	0.01	-0.06	0.05	1.05
Ignoring					
Step One					
SES	0.02	0.01	0.14	0.02	3.35
Step Two					
SES	0.01	0.01	0.05		
Ethnicity	0.31	0.09	0.31**		
Racial Identity	0.05	0.02	0.21*	0.09	6.45**
Rewards					
Step One					
SES	-0.01	0.01	-0.09	0.01	1.32
Step Two					
SES	-0.01	0.01	-0.08		
Ethnicity	-0.04	0.05	-0.06		
Racial Identity	-0.03	0.01	-0.18*	0.03	2.25

Variables	*B*	*SE B*	β	R^2	*F* for R^2 change
Special Time					
Step One					
SES	<0.01	<0.01	-0.01	<0.01	0.02
Step Two					
SES	<0.01	0.01	-0.01		
Ethnicity	-0.01	0.05	-0.02		
Racial Identity	-0.01	0.01	-0.05	<0.01	0.19
Time Out					
Step One					
SES	-0.01	0.01	-0.09	0.01	1.32
Step Two					
SES	-0.02	0.01	-0.17*		
Ethnicity	0.18	0.08	0.21*		
Racial Identity	-0.02	0.02	-0.10	0.08	6.27**
Bias					
Step One					
SES	-0.01	0.01	-0.10	0.01	1.57
Step Two					
SES	<0.01	0.01	-0.05		
Ethnicity	-0.07	0.06	-0.12		
Racial Identity	0.01	0.01	0.04	0.03	1.61
Egalitarian					
Step One					
SES	<0.01	<0.01	0.06	<0.01	0.60
Step Two					
SES	<0.01	<0.01	0.06		
Ethnicity	0.01	0.04	0.02		
Racial Identity	0.01	0.01	0.09	0.01	0.56
Mistrust					
Step One					
SES	-0.03	0.01	-0.30**	0.09	16.38**
Step Two					
SES	-0.02	0.01	-0.22**		
Ethnicity	-0.17	0.07	-0.21*		
Racial Identity	0.02	0.02	0.11	0.16	7.06**

Variables	*B*	*SE B*	β	R^2	*F* for R^2 change
Racial Pride					
Step One					
SES	<0.01	0.01	-0.01	<0.01	0.03
Step Two					
SES	<0.01	0.01	0.05		
Ethnicity	-0.09	0.06	-0.12		
Racial Identity	0.05	0.02	0.26**	0.11	9.97**

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

Table 5

Hierarchical Regression Analyses for Incentives

Variables	*B*	*SE B*	β	R^2	*F* for R^2 change
$10 for Attending					
Step One					
SES	-0.01	0.01	-0.06	<0.01	0.54
Step Two					
SES	-0.01	0.01	-0.08		
Ethnicity	0.06	0.10	0.05		
Racial Identity	-0.01	0.02	-0.03	0.01	0.38
$30 for Attending					
Step One					
SES	<0.01	0.01	-0.03	<0.01	0.12
Step Two					
SES	<0.01	0.01	-0.03		
Ethnicity	-0.02	0.09	-0.02		
Racial Identity	-0.02	0.02	-0.06	<0.01	0.25
Free Treatment					
Step One					
SES	<0.01	0.01	-0.01	<0.01	0.03
Step Two					
SES	<0.01	0.01	-0.04		
Ethnicity	0.04	0.09	0.05		
Racial Identity	-0.02	0.02	-0.10	0.02	1.21
Location					
Step One					
SES	-0.01	0.01	-0.13	0.02	2.85
Step Two					
SES	-0.01	0.01	-0.15		
Ethnicity	0.05	0.07	0.06		
Racial Identity	0.01	0.02	0.04	0.02	0.20
Childcare					
Step One					
SES	<0.01	0.01	<0.01	<0.01	<0.01
Step Two					
SES	-0.01	0.01	-0.07		
Ethnicity	0.15	0.09	0.16*		
Racial Identity	-0.02	0.02	-0.10	0.05	3.97*

Variables	*B*	*SE B*	β	R^2	*F* for R^2 change
Transportation					
Step One					
SES	-0.01	0.01	-0.11	0.01	2.03
Step Two					
SES	<0.01	0.01	-0.03		
Ethnicity	-0.37	0.10	-0.33**		
Racial Identity	-0.89	0.02	-0.32**	0.12	9.71**
No Work Conflict					
Step One					
SES	<0.01	0.01	0.02	<0.01	0.08
Step Two					
SES	0.01	0.01	0.07		
Ethnicity	-0.10	0.08	-0.11		
Racial Identity	0.02	0.02	0.07	0.02	1.88
Dinner Provided					
Step One					
SES	-0.01	0.01	-0.11	0.01	2.16
Step Two					
SES	-0.01	0.01	-0.11		
Ethnicity	-0.05	0.09	-0.05		
Racial Identity	-0.03	0.02	-0.14	0.03	1.41
Books Provided					
Step One					
SES	-0.01	0.01	-0.10	0.01	1.75
Step Two					
SES	-0.01	0.01	-0.12		
Ethnicity	0.07	0.08	0.08		
Racial Identity	0.03	0.02	0.13	0.02	1.06

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

Table 6

Hierarchical Regression Analyses for Barriers to Treatment

Variables	*B*	*SE B*	B	R^2	*F* for R^2 change
Work Conflict					
Step One					
SES	-0.02	0.01	-0.13	0.02	2.94
Step Two					
SES	-0.01	0.01	-0.10		
Ethnicity	-0.12	0.09	-0.12		
Racial Identity	-0.01	0.02	-0.06	0.03	0.84
Mistrust Counselor					
Step One					
SES	<0.01	0.01	0.03	<0.01	0.12
Step Two					
SES	<0.01	0.01	0.04		
Ethnicity	-0.03	0.09	-0.03		
Racial Identity	-0.01	0.02	-0.04	<0.01	0.09
Cost of Program					
Step One					
SES	-0.03	0.01	-0.26**	0.07	12.51**
Step Two					
SES	-0.04	0.01	-0.33**		
Ethnicity	0.23	0.08	0.25**		
Racial Identity	0.04	0.02	0.18*	0.12	4.28*
Transportation					
Step One					
SES	-0.02	0.01	-0.18*	0.03	5.58*
Step Two					
SES	-0.01	0.01	-0.14		
Ethnicity	-0.10	0.07	-0.14		
Racial Identity	-0.01	0.02	-0.05	0.05	1.17
Childcare					
Step One					
SES	<0.01	0.01	<0.01	<0.01	<0.01
Step Two					
SES	-0.01	0.01	-0.09		
Ethnicity	0.26	0.10	0.25**		
Racial Identity	<0.01	0.02	-0.01	0.06	5.22**

Variables	*B*	*SE B*	B	R^2	*F* for R^2 change
Parent too Busy					
Step One					
SES	0.01	0.01	0.09	0.01	1.20
Step Two					
SES	<0.01	0.01	0.04		
Ethnicity	0.15	0.08	0.17		
Racial Identity	0.03	0.02	0.13	0.03	1.84
Child too Busy					
Step One					
SES	0.02	0.01	0.17*	0.03	4.71*
Step Two					
SES	0.01	0.01	0.14		
Ethnicity	0.07	0.08	0.08		
Racial Identity	0.01	0.02	0.02	0.03	0.42

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

Table 7

ANOVAs for Differences Between PT and Racial Socialization Within Ethnicities

	African American Parents			Caucasian Parents		
	PT M *(SD)*	RS M *(SD)*	*F*	PT M *(SD)*	RS M *(SD)*	*F*
Familiarity	4.20 *(0.59)*	4.46 *(0.61)*	3.26**	4.32 *(0.52)*	3.83 *(0.77)*	4.90**
Similarity	3.67 *(0.64)*	4.08 *(0.77)*	1.98*	*3.86 (0.60)*	3.55 *(0.83)*	3.18**
Good/Bad Idea	3.99 *(0.59)*	4.38 *(0.69)*	2.16*	*4.22 (0.48)*	4.19 *(0.59)*	2.96**

Note. PT = Traditional Parent Training. RS = Racial Socialization Practices
*$p < .05$. **$p < .01$

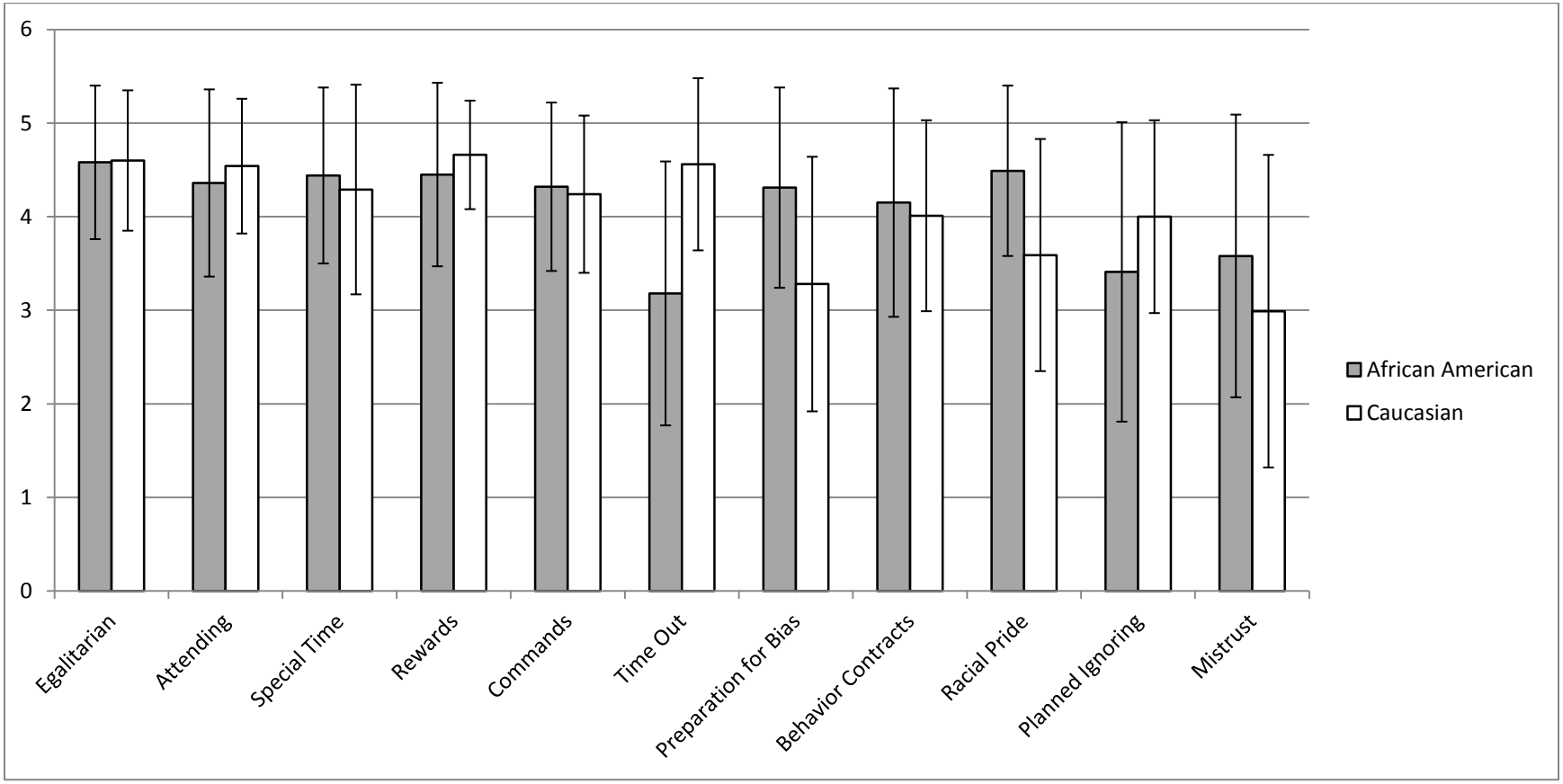
Table 8

Program Preferences

	African American		Caucasian		Combined
Data Collection Location	Place of Worship	Other	Place of Worship	Other	Combined
	N =13	*N*=92	*N* =44	*N* =47	*N* = 196
	%	%	%	%	%
Location					
Home	0	10.0	9.5	13.0	9.9
Clinic	15.4	22.2	9.5	23.9	19.4
Place of Worship	69.2	17.8	52.4	34.8	33.0
Community Center	15.4	50.0	28.6	28.3	37.7
Format					
Group	75	62.2	83.7	72.3	70.3
Individual	25	37.8	16.3	27.7	29.7
Ethnicity of Provider					
Same Ethnicity	30.8	14.3	18.6	14.9	16.5
Different Ethnicity	7.7	3.3	0	2.1	2.5
No preference	61.5	82.4	81.4	83	80.9
Provider has Children					
Not Important	23.1	35.2	23.1	28.3	26.8
Is Important	76.9	64.8	76.9	71.7	73.2

Figure 1

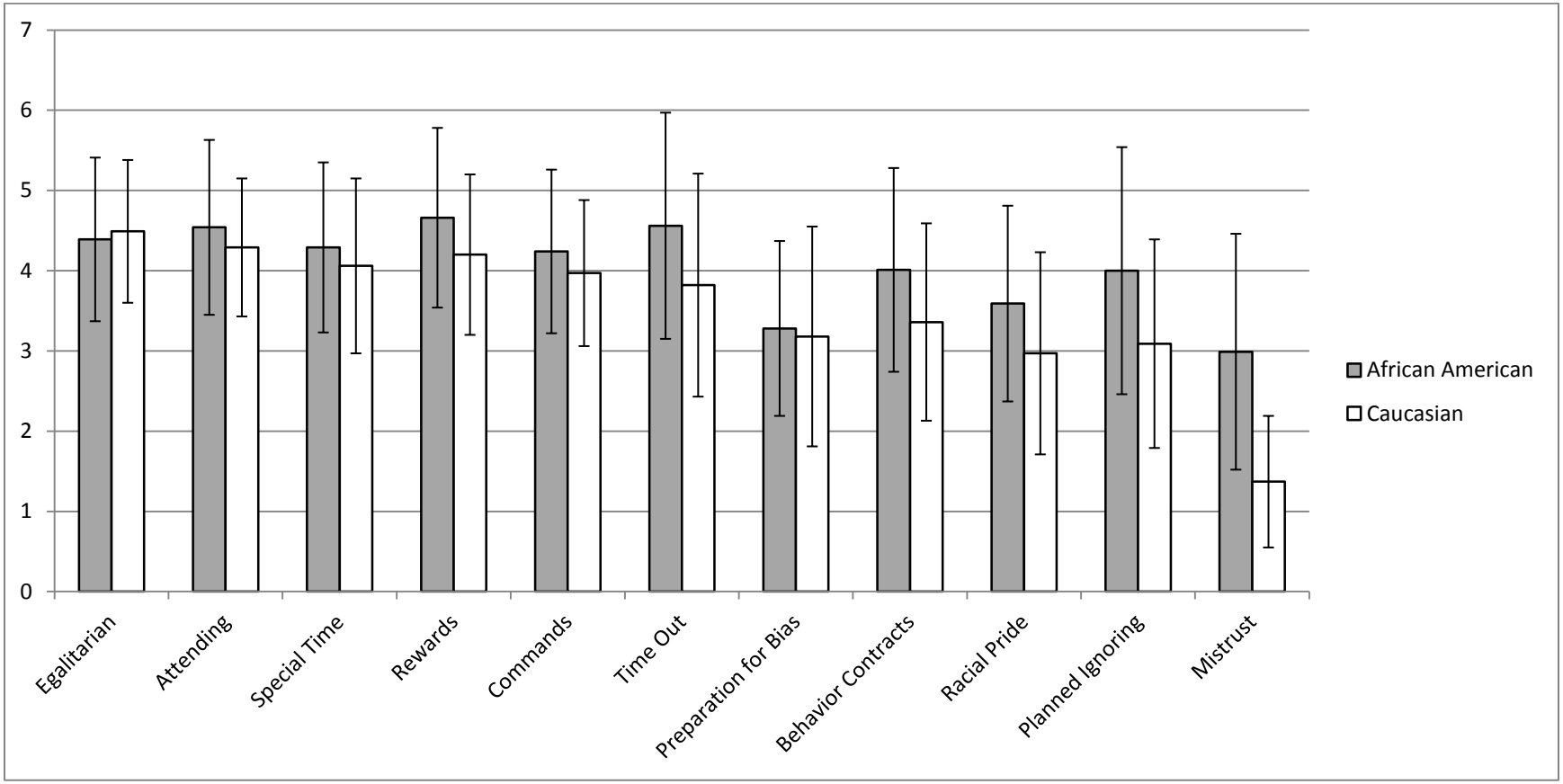
Ethnicity Comparisons for Familiarity of Parenting Behaviors



Note: Error bars are Standard Deviations

Figure 2

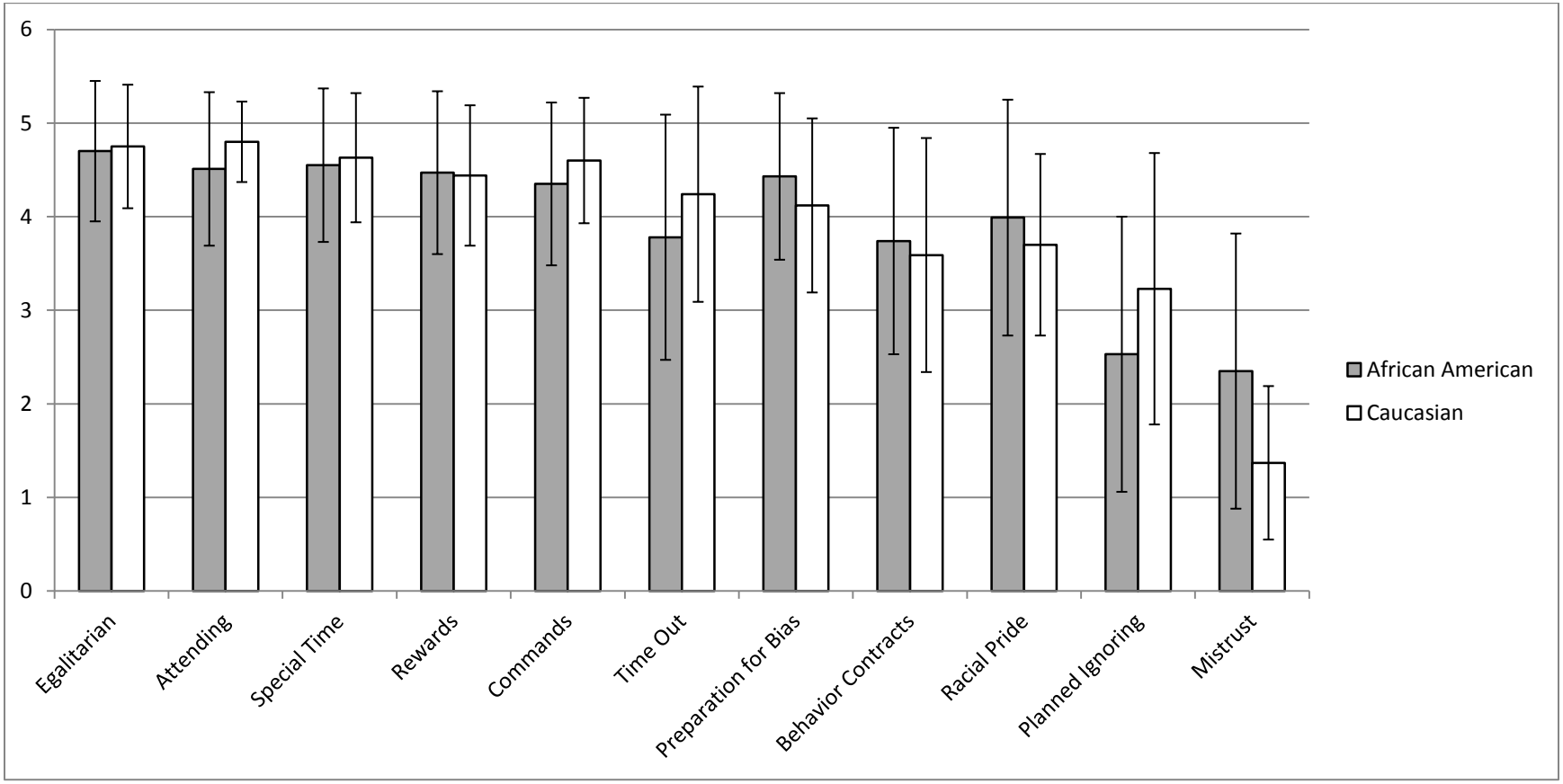
Ethnicity Comparisons for Similarity of Parenting Behaviors



Note: Error bars are Standard Deviations

Figure 3

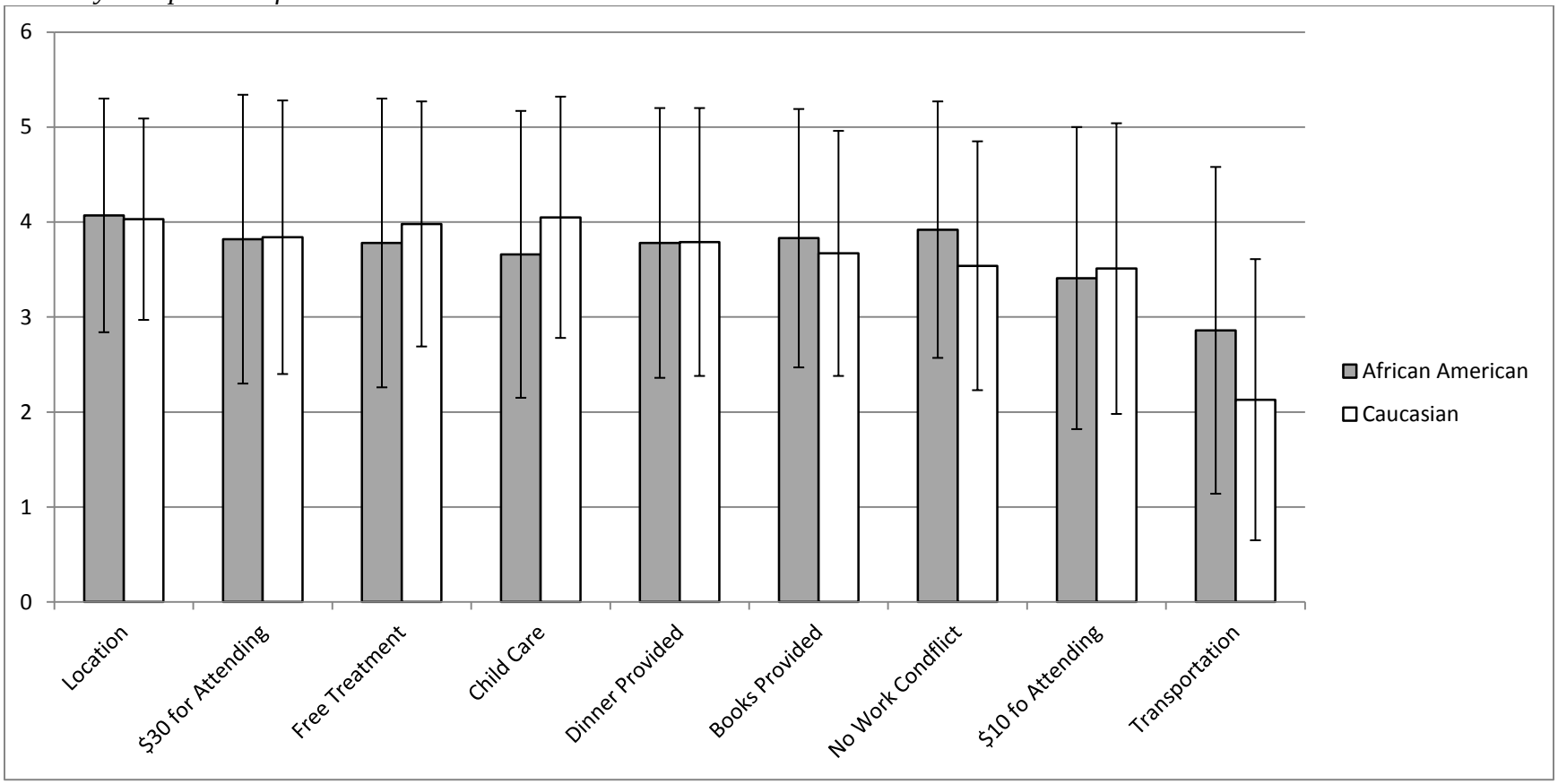
Ethnicity Comparisons for Good/Bad Idea for Parents



Note: Error bars are Standard Deviations

Figure 4

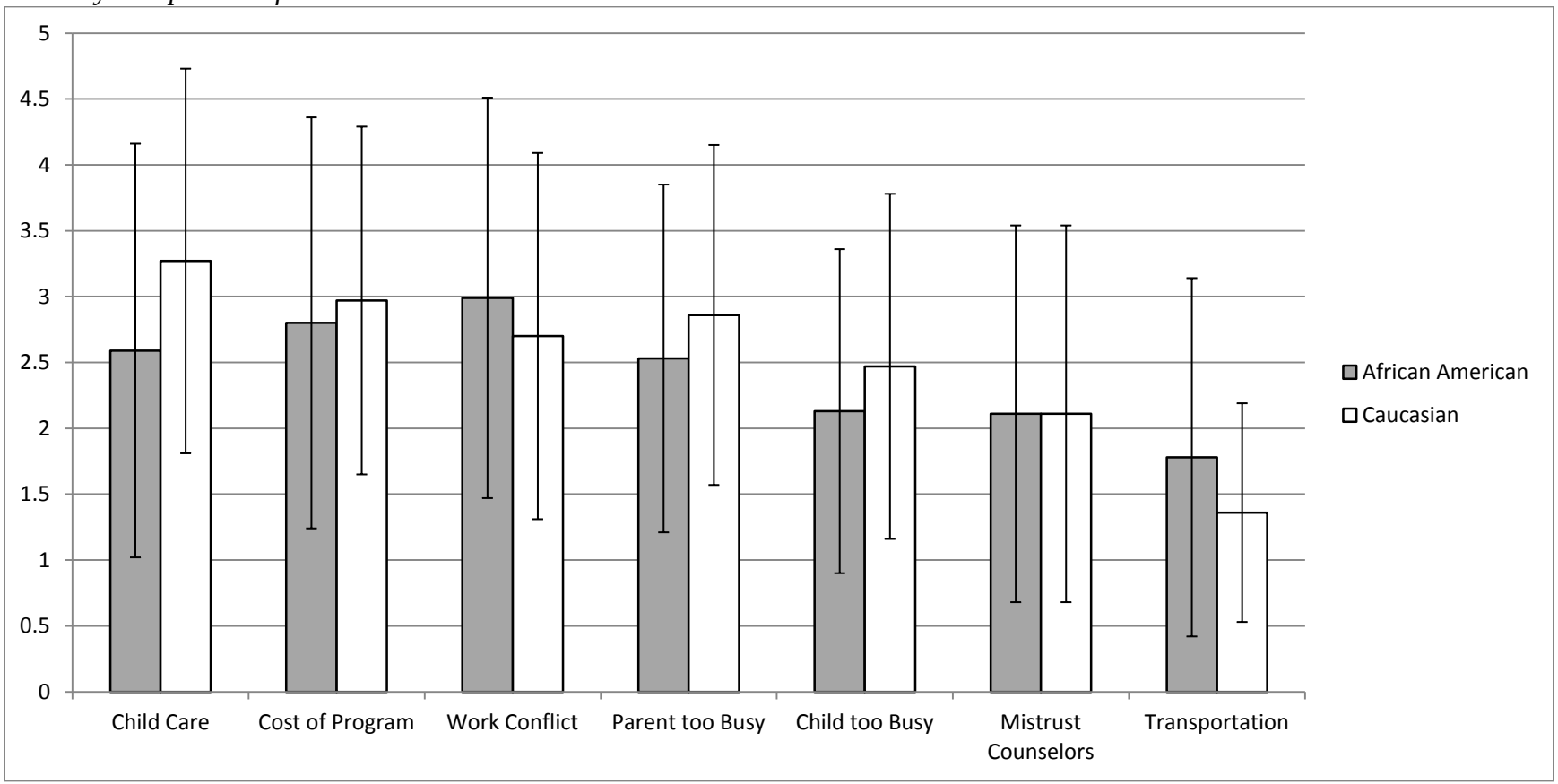
Ethnicity Comparisons for Incentives



Note: Error bars are Standard Deviations.

Figure 5

Ethnicity Comparisons for Barriers to Treatment



Note: Error bars are Standard Deviations.

Appendix

What is your relationship to this child (please check and/or circle)?

☐ Mother, Step Mother ☐ Grandmother ☐ Guardian
☐ Father, Step Father ☐ Grandfather ☐ Other _____

INFORMATION ABOUT MOTHER OF CHILD	INFORMATION ABOUT FATHER OF CHILD
Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Separated ☐ Living with someone	Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Separated ☐ Living with someone
Highest Level of Education: ☐ 6th grade or less ☐ 7th-9th grade ☐ 10th-12th grade ☐ High school graduate ☐ Some college or certification course ☐ College Graduate ☐ Graduate or Professional Degree	Highest Level of Education: ☐ 6th grade or less ☐ 7th-9th grade ☐ 10th-12th grade ☐ High school graduate ☐ Some college or certification course ☐ College Graduate ☐ Graduate or Professional Degree
Occupation/Job Title: _____	Occupation/Job Title: _____
Age of mother now: _____	Age of Father now: _____
Ethnicity or Race of Mother: ☐ Black, Non-Latino ☐ Asian or Pacific Islander ☐ Mexican/Latino ☐ White, Non-Latino ☐ American Indian or Alaskan Native ☐ Other _____	Ethnicity or Race of Father: ☐ Black, Non-Latino ☐ Asian or Pacific Islander ☐ Mexican/Latino ☐ White, Non-Latino ☐ American Indian or Alaskan Native ☐ Other _____

INFORMATION ABOUT THE CHILD (Please provide information for children between ages 4-8)

Child One: Age of child _____ Gender: ☐ male ☐ female
Ethnicity or Race: ☐ Black, Non-Latino ☐ Mexican/Latino ☐ American Indian or Alaskan Native
☐ White, Non-Latino ☐ Asian or Pacific Islander ☐ Other_____

Child Two: Age of child _____ Gender: ☐ male ☐ female
Ethnicity or Race: ☐ Black, Non-Latino ☐ Mexican/Latino ☐ American Indian or Alaskan Native
☐ White, Non-Latino ☐ Asian or Pacific Islander ☐ Other_____

Child Three: Age of child _____ Gender: ☐ male ☐ female
Ethnicity or Race: ☐ Black, Non-Latino ☐ Mexican/Latino ☐ American Indian or Alaskan Native
☐ White, Non-Latino ☐ Asian or Pacific Islander ☐ Other_____

I would describe most of the people in my neighborhood as being

☐ Black, Non-Latino ☐ Mexican/Latino ☐ White, Non-Latino ☐ A mixture
☐ Other _____

Parenting Program

Parenting Program: These programs teach parents ways to manage child behavior. These programs can take place in the community or as part of counseling and can be called by other names.

Have you attended a Parenting Program?	If yes, did you complete the program?
☐ NO ☐ YES	☐ NO ☐ YES

Parenting Behaviors
Please read the description of each parenting behavior and the examples of that parenting behavior. Then circle the ratings for each of three questions about that parenting behavior.

Equality: Teaching your child to value people for "who they are" (personal qualities) instead of valuing race or ethnicity. Example: Helping your child learn that what makes people valuable is "not the color of their skin, but who they are."
Question 1: How familiar are you with Equality? Not familiar with 1 2 Somewhat familiar with 3 4 Very familiar with 5
Question 2: Is the parenting behavior (teaching Equality) like the way you parent your child? Not like my parenting 1 2 Somewhat like my parenting 3 4 Very like my parenting 5
Question 3: Do you think teaching Equality is a good or bad idea for parents? Bad idea 1 2 Neutral 3 4 Good Idea 5
Time Out: When your child misbehaves (i.e. hitting, biting, or not following a command) you place her on a chair or in a separate location where she can no longer have fun and she sits there until you tell her "you are done with time out." Example 1*:* Your child is upset and hits you. You take her to a chair where she has to sit for 3 minutes. At the end of three minutes, you tell her she can get off the chair. Example 2: You tell your child to clean up her toys. She says "NO!" You then take your child to a separate room, where she has to wait for 5 minutes. Afterwards she is again asked to clean up his toys.
Question 1: How familiar are you with Time Out? Not familiar with 1 2 Somewhat familiar with 3 4 Very familiar with 5
Question 2: Is the parenting behavior (Time Out) like the way you parent your child? Not like my parenting 1 2 Somewhat like my parenting 3 4 Very like my parenting 5
Question 3: Do you think Time Out is a good or bad idea for parents? Bad idea 1 2 Neutral 3 4 Good Idea 5

Effective Commands: There are several parts to an effective command, including:

- Getting your child's attention
- Using a firm, but nice voice
- Make it simple and specific
- Tell your child what to do, instead of what not to do

Example: Instead of saying "clean up your room" you say "place your dirty clothes in the hamper." After your child places her dirty clothes in the hamper, you then say "put your blocks in the box."

Question 1: How familiar are you with Effective Commands?

Not familiar with		Somewhat familiar with		Very familiar with
1	2	3	4	5

Question 2: Is the parenting behavior (Effective Commands) like the way you parent your child?

Not like my parenting		Somewhat like my parenting		Very like my parenting
1	2	3	4	5

Question 3: Do you think Effective Commands are a good or bad idea for parents to use?

Bad idea		Neutral		Good Idea
1	2	3	4	5

Special Time: Reserving playtime and letting your child choose the activity. You then play with your child while the child leads the play.

Example: Letting your child pick an activity. Then play for 10-15 minutes the way he wants to. You try not to tell him what to do while playing. If he is coloring a picture, you would also color a picture. You also describes what he is doing. Special Time ends after the 10-15 minutes or if he misbehaves.

Question 1: How familiar are you with Special Time?

Not familiar with		Somewhat familiar with		Very familiar with
1	2	3	4	5

Question 2: Is the parenting behavior (Special Time) like the way you parent your child?

Not like my parenting		Somewhat like my parenting		Very like my parenting
1	2	3	4	5

Question 3: Do you think Special Time is a good or bad idea for parents?

Bad idea		Neutral		Good Idea
1	2	3	4	5

Behavior Contracts: Making a promise with a child that certain behaviors will result in rewards.
Example 1: To help your child do well at school, you could make a "deal" that if she does well on a test, she can earn $2.
Example 2: To help a child with bed-wetting, you and your child make a contract that if she can go a week without wetting the bed, you will take her to the store to buy a new shirt.

Question 1: How familiar are you with Behavior Contracts?

Not familiar with		Somewhat familiar with		Very familiar with
1	2	3	4	5

Question 2: Is the parenting behavior (Behavior Contracts) like the way you parent your child?

Not like my parenting		Somewhat like my parenting		Very like my parenting
1	2	3	4	5

Question 3: Do you think Behavior Contracts are a good or bad idea for parents?

Bad idea		Neutral		Good Idea
1	2	3	4	5

Rewards: Providing your child with an activity or object as a reward for good behavior.
Example 1: Your child cleans up his room so you reward him by letting him pick what to have for dinner.
Example 2: Your child goes a week without getting in trouble with school so you let him rent a movie.
Example 3: Your child eats all of his vegetables so he gets dessert after dinner.

Question 1: How familiar are you with Rewards?

Not familiar with		Somewhat familiar with		Very familiar with
1	2	3	4	5

Question 2: Is the parenting behavior (Rewards) like the way you parent your child?

Not like my parenting		Somewhat like my parenting		Very like my parenting
1	2	3	4	5

Question 3: Do you think Rewards are a good or bad idea for parents?

Bad idea		Neutral		Good Idea
1	2	3	4	5

Mistrust: Teaching children to **not** trust individuals from other ethnicities/races.
Example 1: Specifically teaching your child that people from other ethnicities might lie, hurt, or cheat. "Don't trust them because they are _____."

Question 1: How familiar are you with Mistrust?

Not familiar with		Somewhat familiar with		Very familiar with
1	2	3	4	5

Question 2: Is the parenting behavior (Mistrust) like the way you parent your child?

Not like my parenting		Somewhat like my parenting		Very like my parenting
1	2	3	4	5

Question 3: Do you think Mistrust is a good or bad idea for parents?

Bad idea		Neutral		Good Idea
1	2	3	4	5

Ignoring Bad Behavior: Not giving your child attention for bad behavior.

Example 1: You are at the grocery store and your child begins to whine because he wants candy. Instead of correcting him, you simply ignore his whining. After he quits whining, you give him attention.

Example 2: Your child repeatedly yells "MOM/DAD!" to get your attention. Instead of responding, you do nothing until he says "excuse me" in an appropriate voice.

Question 1: How familiar are you with Ignoring Bad Behavior?

Not familiar with		Somewhat familiar with		Very familiar with
1	2	3	4	5

Question 2: Is the parenting behavior (Ignoring) like the way you parent your child?

Not like my parenting		Somewhat like my parenting		Very like my parenting
1	2	3	4	5

Question 3: Do you think Ignoring is a good or bad idea for parents?

Bad idea		Neutral		Good Idea
1	2	3	4	5

Attending: Giving your child attention for good behaviors.

Example 1: You are working on a project and notice your child is quietly playing by herself. You take a brief moment to let her know that you appreciate her letting you work and playing quietly.

Example 2: While playing next to your child you play the same way your child does to let her know you approve of how she is playing.

Question 1: How familiar are you with Attending?

Not familiar with		Somewhat familiar with		Very familiar with
1	2	3	4	5

Question 2: Is the parenting behavior (Attending) like the way you parent your child?

Not like my parenting		Somewhat like my parenting		Very like my parenting
1	2	3	4	5

Question 3: Do you think Attending is a good or bad idea for parents?

Bad idea		Neutral		Good Idea
1	2	3	4	5

Racial/Ethnic Pride: Teaching children to value her race/ethnicity.
Example 1: An African American mother teaches her children about Martin Luther King Jr., and his contributions to equality.
Example 2: Teaching children how to cook food that is specific to one's culture, such as a Hispanic mother teaching her child how to make Tamales.

Question 1: How familiar are you with Racial/Ethnic Pride?

Not familiar with		Somewhat familiar with		Very familiar with
1	2	3	4	5

Question 2: Is the parenting behavior (teaching Racial/Ethnic Pride) like the way you parent your child?

Not like my parenting		Somewhat like my parenting		Very like my parenting
1	2	3	4	5

Question 3: Do you think teaching Racial/Ethnic Pride is a good or bad idea for parents?

Bad idea		Neutral		Good Idea
1	2	3	4	5

Preparation for Bias: Teaching your child how to deal with racism.
Example 1: Because your child might be treated poorly because of his race, you teach him how to cope. For example, teaching your child to talk to you if somebody calls him a racist name.

Question 1: How familiar are you with Preparation for Bias?

Not familiar with		Somewhat familiar with		Very familiar with
1	2	3	4	5

Question 2: Is the parenting behavior (teaching Preparation for Bias) like the way you parent your child?

Not like my parenting		Somewhat like my parenting		Very like my parenting
1	2	3	4	5

Question 3: Do you think teaching Preparation for Bias is a good or bad idea for parents?

Bad idea		Neutral		Good Idea
1	2	3	4	5

Program Preferences

If you were to attend a parenting program, would you prefer _____? (check only one box)
☐ A mental health professional of your same ethnicity
☐ A mental health professional of a different ethnicity
☐ No preference

If you decided to attend a parenting program, which format would you prefer? (check only one box)
☐ Individual (One-on-one with a mental health professional)
☐ Group (With a group of other parents and a mental health professionals)

If you were to attend a parenting program, which setting would you prefer? (Check only one box)
☐ Clinic (In the mental health provider's clinic) ☐ Community Center
☐ Place of Worship ☐ In Home (A mental health professional comes into your home

Is it important for the mental health professional to have children?
☐ NO ☐ YES

Ethnic Identity: Please circle the answer that best describes you. (You may also consider your racial identity while answering these questions).	**Strongly Disagree**		**Neutral**		**Strongly Agree**
I have often done things that will help me understand my ethnic background better.	**1**	**2**	**3**	**4**	**5**
I have a strong sense of belonging to my own ethnic group.	**1**	**2**	**3**	**4**	**5**
I have often talked to other people in order to learn more about my ethnic group.	**1**	**2**	**3**	**4**	**5**
I feel strong attachment towards my own ethnic group.	**1**	**2**	**3**	**4**	**5**
I feel as if I have experienced discrimination on a regular basis as result of my ethnicity/race.	**1**	**2**	**3**	**4**	**5**
I have spent time trying to find out more about my ethnic group, such as history, traditions, and customs.	**1**	**2**	**3**	**4**	**5**
I understand pretty well what my ethnic group membership means to me.	**1**	**2**	**3**	**4**	**5**

If you wanted to attend a Parenting Program, how difficult would the following items make it for you to attend?	**Not Difficult**		**Somewhat Difficult**		**Very Difficult**
Work schedule conflict	**1**	**2**	**3**	**4**	**5**
Do not trust counselors	**1**	**2**	**3**	**4**	**5**
Cost of program	**1**	**2**	**3**	**4**	**5**
Need transportation to and from program	**1**	**2**	**3**	**4**	**5**
Need childcare during program	**1**	**2**	**3**	**4**	**5**
I am too busy with other activities	**1**	**2**	**3**	**4**	**5**
Child is too busy with activities that I need to attend	**1**	**2**	**3**	**4**	**5**
Other: Please Specify: _____					

How much would each of the following encourage you to attend a Parenting Program?	**Not Much At All**		**Somewhat**		**Very Much**
$30 given each time you attend	**1**	**2**	**3**	**4**	**5**
Books provided to assist in your parenting	**1**	**2**	**3**	**4**	**5**
Transportation to and from the program	**1**	**2**	**3**	**4**	**5**
Childcare provided during parenting program	**1**	**2**	**3**	**4**	**5**
Program offered when not at work	**1**	**2**	**3**	**4**	**5**
$10 given each time you attend	**1**	**2**	**3**	**4**	**5**
Treatment for no cost	**1**	**2**	**3**	**4**	**5**
Convenient location	**1**	**2**	**3**	**4**	**5**
Dinner provided for both parent and children	**1**	**2**	**3**	**4**	**5**