How do New Immigrant Latino Parents Interpret Problem Behavior in Adolescents?

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Abstract:

Parents are gatekeepers for their children's mental-health treatment, yet many are unclear about what behaviors warrant intervention. Seeking treatment is further complicated for immigrant parents whose cultural backgrounds may influence their understanding of mental health. This analysis uses qualitative data from [MASKED], which is a representative study of newly immigrated youth (12–18 years) and their parents, to examine parental perceptions of mental health and to determine patterns of help seeking and service use. Sixteen parents participated in semistructured qualitative interviews that used vignettes to elicit parental beliefs about adolescent behavior and mental health. Findings suggest parents 1) identify behavior that meets diagnostic criteria as problematic; 2) ascribe those behaviors to a range of etiologies; and 3) desire to intervene. Two areas of service delivery emerged as problematic: many parents expect services delivered in ways that conflict with current practice standards, and new immigrant families often encounter cultural and practical barriers to accessing care.

Keywords: Immigration | Mental health | Parents | Adolescents | Latinos

Article:

When adolescents experience mental-health problems, multiple factors often converge to make accessing effective treatment difficult. Although significant percentages of adolescents have mental-health problems serious enough to warrant intervention (Schonert-Reichl, 2003), only one-fifth appear to receive needed services (Simpson et al., 2002). Indeed, accessing treatment has become ever more elusive as funding streams dry to a trickle and privatization erodes the mental health service system. Adolescents caught between the adult and child service sectors face additional barriers such as confidentiality issues, social stigma, and inability to pay for services (Ford et al., 1997). For adolescents who are new immigrants, access may be further complicated by cultural and language barriers.

For all adolescents, parents are critical brokers for mental-health services (Cauce and Srebnik, 2003; Logan and King, 2001). Parents are not only the persons to whom youth are most likely to turn when in distress but also the persons teachers are most likely to contact when an adolescent's behavior becomes problematic. Parents are more likely than others to notice early indications of an adolescent's need for mental-health services. However, Latino parents are less likely to identify a mental-health need in their adolescent compared to non-Latino Whites (Roberts et al., 2005a). This identification disparity may be influenced by cultural norms that affect how behavior is perceived and acted upon (Yeh et al., 2005). For example, Latino parents may have a higher threshold for labeling a particular behavior as problematic (Roberts et al., 2005a&b). Even when parents believe services would help their adolescents, their ability to access care may be limited by stigma, family acculturation gaps, and unfamiliar service systems (Cauce and Srebnik, 2003). Research has demonstrated that regardless of insurance or health status, non-White youth access mental-health services far less than their White peers. In particular, Latino children appear to have high levels of unmet mental health needs (Kataoka et al., 2002). The important role parents play in treatment seeking for Latino families is underscored by research demonstrating that parental perceptions of mental-health needs predicts treatment service use (Vera et al., 1998). This article delineates new immigrant Latino parents' understanding of adolescents' problem behaviors, parental preferences for seeking help, and barriers to parents accessing services for their children.

In 2007, the US Latino population exceeded 45 million, with immigrant Latinos comprising nearly 40 percent of that population (Pew Hispanic Center, 2010). Ample evidence exists that Latino youth need mental-health services. As compared with overall youth in the US population, anxiety, depression, suicidal ideation, and suicide attempts are higher for adolescents self-identifying as Hispanic or Latino (US Department of Health and Human Services, 2001). Moreover, Latino adolescents demonstrate elevated risk for problem behaviors (Centers for Disease Control, 2008). Despite elevated need, a study conducted by Yeh et al. (2005) that accounted for symptom severity and demographic variables found Latino youth were less likely than other racial/ethnic groups to use mental-health services. Many factors have been linked to mental-health care disparities for Latino youth, including physical barriers (e.g. transportation, lack of insurance) and systemic barriers (e.g. lack of appropriate care, no services in native language) (Alegria et al., 2010; Gudiño et al., 2008).

In addition, scholars examining disparities in health service use have focused on cultural understandings of illness (e.g. Yeh et al., 2005). Kleinman et al.'s (1978) seminal work in medical anthropology demonstrated the importance of service providers developing an understanding of patients' health beliefs (i.e. explanatory models). This article draws on Kleinman and colleague's work to elucidate Mexican parents' understanding of adolescent problem behavior, and to explore help-seeking behaviors among new immigrant families.

Latino understandings of mental health

Researchers have identified important cultural factors among Latino parents that predict treatment seeking. For example, Alegria and colleagues (2004) found the parents most likely to seek treatment for their children were those whose children had disruptive behavior disorders

and parents who rated their children as having more functional impairment. The authors argue that many Latino parents may be unaware of the threshold that marks when it is appropriate to seek help and may be unclear of what type of help would be useful. Other studies support this conclusion as Latino parents reported fewer mental-health problems in their adolescents than non-Latino Whites and also demonstrated a smaller concordance in symptom endorsement with their adolescents (Roberts et al., 2005a; Roberts et al., 2005b). A recent review of pediatric mental-health disparities concluded that parental education regarding the identification of mental-health needs will be necessary to reduce disparities in treatment (Alegria et al., 2010). Thus, parental labeling and understanding may likely be a source of mental-health care disparities.

There is also evidence that Latino parents may hold different explanatory mechanisms for mental-health problems compared to non-Latino Whites. Latino parents are less likely than non-Latino Whites to endorse biopsychosocial causes of mental-health symptoms in youth (Yeh et al., 2004) which partially mediates the relationship between ethnicity and services use (Yeh et al., 2005).

Familial cultural values may also play a role in how parents view their adolescents' behavior. Familism is a Latino cultural value that dictates family cohesion and harmony as well as filial obligations and obedience (Lugo Steidel and Contreras, 2003). Familism may lead parents to rely on their adolescents to perform important household tasks (e.g. caretaking, preparing meals, providing economic assistance). In an immigrant family this may include interpreting or attending appointments with parents. Because parents are relying on their adolescents, they may have greater tolerance for problem behavior because the adolescent is necessary for family functioning. Second, as familism dictates family harmony, adolescents may not disclose their distress to their parents so as not to disrupt family functioning. This hypothesis falls in line with past research on other family oriented culture and problem-suppression theory that argues that in collectivistic cultures, children are more likely to internalize their distress (Weisz et al., 1993). Thus, these cultural processes may make it less likely that parents view their adolescents as demonstrating behavior problems that require assistance.

Together, these studies suggest that the way in which Latino parents' perceive the etiology and type of a disorder and their child's impairment may influence their treatment-seeking behavior. However, no studies have examined how Latino parents view disorders as described by the Diagnostic and Statistical Manual of Mental Disorders-IV (American Psychiatric Association, 2000). Elucidating how parents understand and explain abnormal behavior as conceptualized in the DSM-IV is critical as Latinos in the US will encounter Western diagnostic criteria in their path to treatment seeking. The current research focuses on parental perceptions of their children's behavior without describing the mental-health symptoms the parents are attempting to understand. Latino parents may focus on specific behaviors as problematic (e.g. defiance) and their etiological explanations may be centered around that specific symptom (Calzada et al., 2010). In fact, among Latinos, there is a greater disparity in mental-health treatment for internalizing problems compared to externalizing ones (Gudiño et al., 2009). Thus, it is critical to examine whether Latino parents perceive certain types of behavior as more or less problematic and whether their explanatory mechanisms change depending on the nature of the problem (e.g. depression versus oppositional disorder). It is also important to clarify if parents consider mental-

health symptoms as problematic but do not seek treatments because of barriers or cultural beliefs that encourage parents to view mental symptoms as normative.

Many authors have addressed traditional perspectives of health and illness in immigrant populations that were assumed to interfere with help seeking. For example, the belief a person's health comes from luck, God, or good behavior (Sandoval, 1998; Spector, 2004) may also be the basis for stigmatizing persons with mental disorders, which in turn, prevents those in need of treatment from either seeking help or remaining in treatment. Further, researchers have noted the influence of immigrants' culture on help seeking; specifically, the sources from which help is sought. Garcia and Saewyc (2007: 41) stated, 'Like all categories of illness, treatment in Latino culture is primarily sought from a curandero, a folk healer.' Although comparisons of cultural differences usually end with a call for cultural competence, in practice, these comparisons may serve to give providers an excuse for not serving a given population. Rather than promoting provision of accessible, culturally competent care, some providers may find it convenient to maintain the status quo based on the misconception that Latinos will not seek services because of stigma or will accept care only from traditional healers.

In reality, little is known about how Latino parents view adolescents' behavioral or emotional problems, where those parents would seek help for their children, and what expectations Latino parents hold for treatment. Indeed, information on how parents in general understand their adolescent's behavior is lacking. However, an emerging body of literature in this field supports the notion that Latino youth would first look to their parents for help with health problems (Garcia and Saewyc, 2007), which reinforces the urgency of examining parental beliefs about mental health, mental illness, and mental-health services to understand how to best provide help for Latino adolescents.

We examined mental-health beliefs in a sample of 16 Latino parents. To clarify the mental-health care beliefs of Latino parents, we used a qualitative approach to describe parental perceptions of the causes of common disorders during childhood and adolescence, whether parents thought these symptoms warranted intervention, and what types of interventions parents felt would be effective. To map symptoms onto Western mental-health practices, we presented participants with descriptions of common internalizing (major depressive disorder, post-traumatic stress disorder (PTSD)) and externalizing (oppositional defiant disorder (ODD), conduct disorder (CD)) disorders. By presenting standardized scenarios, we could determine which symptoms were related to etiological and treatment beliefs in this cultural group. Finally, we examined whether participants described significant differences in treatment in the US versus their home country. This study extends past research by using a qualitative approach and having parents respond to specific scenarios.

Method

Data were obtained from The Latino Adolescent Migration, Health, and Adaptation Project (LAMHA), a representative, statewide study of 283 newly immigrant youth, most of whom had arrived within the last five years, and their parents. All data were collected between August 2004, and March 2006. LAMHA used a mixed-methods approach, combining both qualitative and quantitative methods, to understand the well-being of new immigrant Latino youth and their

parents, as well as service use patterns, migration histories, and parent perceptions of mental health in adolescents. LAMHA consists of four data sources, one of which was a qualitative data collection of interviews with parents (n=16) about their understanding of adolescent behavior and their beliefs about mental-health interventions. This article draws exclusively from parent interviews. Additional information about the LAMHA project and participants has been reported elsewhere (Perreira et al., 2008). All data collection procedures were approved by the University of North Carolina at Chapel Hill Institutional Review Board.

Participants

All but one of the 16 parents interviewed were mothers, one parent had completed college, five were high-school graduates, and 10 did not have a high-school diploma or equivalent. Nine parents lived in urban counties and seven lived in rural counties. All but three parents lived with a spouse and worked at least part-time. Eight parents had children who appeared to need further mental-health assessment, and eight did not. This stratification was based on questions in the larger survey questionnaire, 1 and enabled comparison between parents whose children had symptoms that would at least warrant further screening and those that did not. We did not find differences based on this criterion.

Interview procedure and measures

The parent qualitative interview used five scenarios depicting youth with mental health conditions meeting DSM-IV criteria (American Psychiatric Association, 2000). These scenarios, developed by the authors, were based on protocols formulated by Berkman et al. (2005) to examine the mental-health beliefs of older Latinos, and on a questionnaire designed by Kleinman et al. (1978) to explore cross-cultural health beliefs. The scenarios (see Appendix) depicted adolescents with major depressive disorder, ODD, CD, OCD, and PTSD. Drafts were first prepared in English, and English-speaking mental-health professionals from social work, psychiatry, and psychology were asked to read the scenarios and assign a diagnosis. The scenarios were refined, translated to and back-translated from Spanish. Spanish-speaking professionals were then asked to review the scenarios in Spanish and assign a diagnosis. Following this process, we were confident the scenarios expressed symptoms consistent with the target DSM-IV diagnoses.

The parents were interviewed at home by bilingual, bicultural interviewers; all interviews were in Spanish and tape-recorded. The recordings were transcribed into Spanish, and then transcribed into English. Transcripts preserved Spanish idioms, which the research team discussed. The first author and interviewers met bi-weekly to ensure the interview structure was effective, obtain the interviewers' feedback and review completed transcripts.

After obtaining consent, each scenario was read aloud to the parent, followed by the set of 11 questions (see Table 1).

Responses to each scenario were analyzed within a narrative framework.

Table 1. Adapted Klienman Questions.

1. How do you understand this young person's behavior?
2. What do you call this type of behavior?
3. What do you think has caused the behavior?
4. Why do you think it started when it did?
5. If this were [(you) your son or daughter], how worried would you be about this behavior?
6. What would scare you the most about this behavior?
7. What would you do to try and stop it?
8. If that did not change anything what would you try next?
9. If you were living in Mexico, where would you go for help with this problem? What would the people there do to help?
10. Are there people you would go to here for help if you/your child were behaving like this? How do think these people would help?
11. Do you think the helpers in your home country or in this country would be most effective?

Although narrative analysis is considered an umbrella term (Mishler, 1999), our methods fit this approach for two reasons: (a) participants responded to scenarios that were essentially stories of behavior, and (b) participants expanded on the story, elaborating on the scenario by describing what was happening and why. Bruner (2001) described the elements of what and why as central to narrative analysis. The semi-structured interview protocol allowed participants to respond through their own experience. Moreover, participants were not told the scenarios represented particular diagnoses, but that 'young people sometimes behave in these ways' and we were seeking their opinions.

We began analyzing the transcripts using a priori codes drawn from the literature on culture, health beliefs, and help seeking. In particular, we built on Yeh and Hough's (1997) measure of parental beliefs. Using a constant comparative method, we identified additional codes and themes that emerged in the data.

The transcripts were grouped by scenario to enable review of all responses to a scenario at once. The authors independently immersed themselves in the data, reading responses multiple times. The authors then met to compare codes and to discuss and reach consensus on discrepancies (Codes are listed in Table 2). The interview structure suggested the overarching themes by which codes were grouped and interpreted.

Results

During the analysis, themes emerged that illustrated participants' understanding of adolescent behavior, likely response to such behavior, likely sources for seeking help, and expectations from treatment in the United States versus their country-of-origin.

Table 2. Qualitative Analysis Codes.

A Priori	**Data-derived**
Causes of behavior	
Family relationships	Adolescent development
Nature/Temperament/Illness	Parent modeling

Religious explanations	
Events/Acculturative stress	
Lack of discipline	
Peer influences	
Help-seeking behavior	
Mental-health professional	Parent intervention support
Traditional healer	Parent intervention monitoring
Spiritual	Parent intervention systemic
	Police/legal system
	Reform school

Recognizing problem behavior

Parents provided nearly unanimous interpretations of four of the five scenarios, describing the behavior as warranting parental concern. Almost all parents perceived the depression, ODD, CD, and PTSD scenarios as worrisome situations requiring some sort of intervention. Responding to the depression scenario one mother stated, 'Because one knows her children and sees that they are happy or friendly, introverts, one knows them. And suddenly one sees that they are changing and one is worried . . .'

The trauma scenario elicited similar concern as reflected in a parent's comments:

> Everyone gets traumatic by watching an accident or a fight or whatever. What happened to this kid is that he saw with his own eyes and he had not heard from others. And he saw when they stabbed the other kid and he didn't want to talk about it to avoid problems . . . because they asked him, what happened . . . He said, 'Better be quiet and act like I didn't see anything.' But that is psychological and it stays in his mind. And when he is calm and reading a magazine, it comes back through his mind. This is traumatic . . . I will be worried about him . . .

Similarly, a father responded to the conduct-disorder scenario saying, 'This situation is very serious and it's something to be alarmed about . . .'

The exception to the consistent parental reaction was the reaction to obsessive compulsive behavior scenario. Respondents provided mixed interpretations, as illustrated by the following quotes:

> The kid behaves very well . . .A lot of times parents help them to be organized. Many times, kids are restless, and they are very disorganized. But, there are those . . . they are very organized by themselves . . . they are like that on their own . . . I think that he was always organized from the beginning . . . He was a very good kid. In the future, he will be a good kid . . . perhaps, one of the best ones, who excels . . . He will be someone in this life.

> Yes, I would be worried . . . because this, this is not a normal thing, for children to wash their hands constantly. Now, if I had taught him this, then I would say, 'Okay, I taught him this,' right? But, if I had not taught him this, the very exaggerated, washing his hands once in a while for whatever reason is good, but not so exaggerated that he is compulsive that all the time he is thinking that he is going to get sick or that someone is going to hurt him, this is something bad.

Two parents saw this young person as very organized and likely to be successful, whereas the others focused on the extreme nature of the behavior and decided it was outside of the normal range. This discrepancy mirrors findings in the general population that suggest adolescents' symptoms of OCD are more likely to be overlooked than other behavioral symptoms (Flament et al., 1988).

Causes of behavior

Parents distinguished disorders based on possible causes. Parents made multiple attributions of cause for depression, ranging from adolescent development to difficult life events, problems with peers or family relationships. However, even when other difficulties were mentioned, family relationships and communication were dominant issues associated with the cause of depressive symptoms.

> I think it's the lack of communication between parents and children. I mean in adolescence, the children have another mentality and sometimes parents do not understand them. Well, in my case, I tried to place myself to their place, in their level, but . . . the parents, we have other thoughts, like the need to work and to provide and to buy them what they need. And, we are worried about the electric bills and other costs. And they feel ignored.

Acculturative stress was mentioned as an etiology in response to the depression scenario:

> Since we are immigrants, they make us feel that we are third-class citizens. A person from a third class and that we are not worth the same as someone from here. These things could affect her [the girl in the scenario]. The racism that exists between races here . . .

Although parents viewed depression as being caused by multiple stressors, parents identified a single event as the cause of the PTSD behavior and understood that witnessing the violent event was enough to cause the symptoms. Parents articulated understanding of the symptoms in ways quite consistent with the trauma literature, such as noting re-experiencing the trauma, hypervigilance, and avoidance behaviors.

> He is traumatized because of what he saw. It gets recorded in their mind, right? . . . it can disturb one's mind and people can stay traumatized . . . It can change [their lives] because they won't have the thoughts they used to have. They won't be calm; they will have fear and be alert (*pendiente*) that something similar will happen. And they won't be able to go outside . . . This is why I think their lives will change and they won't be the same.

However, the ODD and CD scenarios were perceived inconsistently across the sample. While most highlighted family relationships as important, responses reflected a greater diversity of potential causes for ODD and CD than for other behaviors. In discussing these scenarios, parents often used the words ‘crazy’ and ‘mentally ill.’ Many parents mentioned possible causes as traumatic life histories or innate aggressive traits. Parents described ODD and CD behaviors as having multiple or complex origins, and did not prefer one explanation over others.

Parental role in intervention

Regardless of the behavior or perceived causes of behaviors, all parents reported parental intervention was the first line of defense. Parents expressed a need to move closer to their children emotionally and physically when a child was in distress. Enhancing family unity to face a challenge was expressed by one mother: ‘First I would talk to her and try to figure out what was going on.’ Another parent emphasized support of the child, ‘Well, if my daughter is behaving like this, . . . I will put all of my attention or try to talk to her so that she will tell us the ‘‘why’’ of her behavior.’ In addition to offering empathy and support, parents emphasized intervention with other systems such as the child’s school or peers.

> One needs to investigate why she is reacting this way. If they are sick, then one takes them to the doctor . . . if she is experiencing discrimination at school, then one must investigate why this is happening and one can go talk to the teacher.

Monitoring their child’s peer relationships was a common strategy to understanding sudden changes in behavior: ‘First of all, when the children have friends, then one needs to investigate what kind of friends they are . . . You need to select your kid’s friends.’ Another parent commented on negative peer influences saying, ‘Well, you will keep them from going out with them [problematic friends].’ If these tactics were unsuccessful in resolving the adolescent’s behavior problems, most parents said they would seek help from a physician or mental-health professional.

> Sometimes we don’t know how to answer our children or how–we don’t know how to guide them and how to help them. And sometimes they don’t feel absolute confidence in us either. Yes, I would look for someone professional because this person is specialized in these subjects and these cases, right? So, I think yes, I would look for professional help.

Similarly, parent responses to the PTSD scenario indicated willingness to seek professional mental-health services. The supportive comments of one parent were typical of the parent responses:

> I think [mental-health professional] will need to give him treatment . . . to recover the security because he lost this in the shock. That it was traumatic . . . And to let him know that there is always danger and that he is capable to ride one and the other [that he can handle life with all its uncertainty]. Even if he falls, then to carry him so that he doesn’t get hit . . . that it [trauma] will not take him down.

Although parents emphasized they would attempt to intervene with ODD and CD behaviors, their responses expressed less sympathy for the youth in these scenarios. Moreover, when considering ODD and CD behaviors, most respondents indicated that if parental intervention was ineffective, they would move quickly to other options such as juvenile justice and law enforcement: 'If they don't listen, you need to send them to a reformatory.' The ODD and CD scenarios evoked despair, and parents' responses indicated little hope of remedying the situation without extreme measures; thus, they chose restrictive interventions. For example, 'They say there are jails where they keep kids like that . . . they can be sent there to be taught good things,' or 'I will call the police because I won't be able to deal with him . . . They can subdue him and they have strategies for the kids to change.' These parents seemed to believe that by the time young people were exhibiting these behaviors their parents had lost all ability to influence their young people; therefore, the best option was to isolate these children from society. One parent said, 'I think that I would look for a way to lock him up because this would be better, that he wouldn't hurt anyone or make the issue worse.'

Professional roles

When the parents were asked about the role of the professional mental-health care provider, they had difficulty articulating their expectations for professional services. Those with specific expectations described the mental-health professional as providing the parent with guidance on how to help the adolescent. These parents were clear that they would seek treatment for their child, but viewed the professional's role as helping them to be better parents rather than having extensive direct intervention with the adolescent. These parents perceived their role as an active intermediary in mental-health treatment, whereas the professional's interaction with the adolescent was not necessary, much less the focus of such care. One parent's comment summarized many:

> In this case, we will both go [parents], when it comes to the children, one needs to go as a couple . . . because it is both of our problems . . . then to see what he [professional] can tell us and in case [emphasis added] he needs to talk to our son or daughter, we will take them.

Another parent's comments reflected an expectation that the mental-health care professional would be consulted as a collaborative partner working with the parent to address the adolescent's behavior or emotional problems. 'To a specialist first, before anything, a doctor that would tell me about his change from a child to a young person, adolescent. And we [emphasis added] would look for a solution.' Given the literature reports that Latinos enter treatment at similar rates to other US racial/ethnic groups but prematurely leave treatment at significantly higher rates, this finding demonstrates the need to investigate treatment expectations for different cultural groups (Yeh et al., 2005).

Treatment in the US versus Mexico

When asked how mental-health services differed between the United States and Mexico, responses varied based on the rurality of parents' home communities. Parents from rural

communities in Mexico reported little, if any, mental-health care was available in Mexico for the problems portrayed in the scenarios.

> In . . . [Mexico] because we are from a small village, we have to go very far and then we have to pay for where we sleep and everything. It is very hard there, life there.

However, parents who had emigrated from urban environments seemed to have greater familiarity with mental-health services and greater knowledge about how to access services in their home country. A parent from Mexico City described the seeking help from a government agency. 'We will probably go to the DIF . . . it's a government institution that works with families. So, they advocate about families and family-related problems, youth gangs, and they have professionals.' In contrast, some parents indicated that although they would seek help by talking with a mental-health professional, barriers existed to accessing such services. Some of these respondents indicated they did not know how to find or access mental health services in the United States, whereas others indicated that the mental health services in the United States were too cumbersome or too expensive.

> It's easier to go see a doctor [in Mexico]. You don't have to make an appointment like here. If you are sick, then you go. They don't charge what they charge here. There are many places one can go and it's practically free. [But] there are many people; we have to wait in line. But here, if you don't have health insurance, if you don't have Medicaid or if you don't have this, it's very difficult and they don't examine you well.

> I had better medical experience in Mexico. Here, there is more technology, but they need to put more heart into it. In my country, the doctors also have their things, but it's more simple. If one cannot pay for the prescription or the following consultation, they will say, 'Don't worry. You go and don't worry.'

Discussion

These findings speak to a host of issues for those working with Latino parents and youth. Most important, the findings affirm that new immigrant Latino parents not only recognize problem behavior in adolescents but are willing to seek help from mental-health professionals to treat the behavior. The parents in our study were aware of many potential etiologies of problem behavior, and clearly viewed intervening as a parental responsibility. Parents spoke with great empathy about their teenagers and the struggles young people face. Parents interviewed for this study repeatedly stressed the importance of parents setting an example for children, and parents being mentors and guides for their adolescents. A nearly universal theme among parent responses was that good parent-child relationships prevent problems and should be the first line of defense when problems occur. However, when mental-health treatment is sought, parental focus on themselves as the mechanism for helping their children may conflict with prevailing views in the mental-health community. For example, biomedical explanations for behavior were not present among the various etiologies suggested by parents in this sample. The absence of a biomedical explanation for problematic behavior may indicate that these parents would feel at odds or, at least, surprised by helping professionals that advise psychopharmacology as an integral part of treatment. Although parents did not speak specifically about medication positively or negatively,

the complete absence of conversation about a widely used form of mental-health intervention would indicate that practitioners should be cautious when advocating for medication use and that this is an area for future research. Likewise, some immigrant Latino parents suggested that their consultation with a mental-health professional would be more focused on improving their parenting approach than on the young person engaging in a personal, private relationship with a therapist. This concept of the role of the mental-health professional differs from the typical notion of what is entailed in the mental-health treatment of an adolescent in the United States. Most literature about therapy with adolescents gives considerable attention to issues of confidentiality and privacy as essential elements of the therapeutic relationship. However, little attention has been given to the clash of client expectations with therapeutic practices. Although these parents did not talk specifically about confidentiality, their comments implied an expectation for significant treatment involvement. Providers' typical commitment to adolescent confidentiality, while well-intended, may leave new immigrant Latino parents feeling they have been shut out of their child's care. This point is made not to suggest that confidentiality is not important, rather to underscore that a difference in expectations may contribute to the high rate of treatment discontinuation in Latino populations reported in the literature. Future research should investigate this finding on treatment expectations.

Notably, this study suggests parents may expect different types of interventions for internalizing versus externalizing disorders. Primarily, parents felt that counseling and improving parent-child relationships would help youth struggling with depression or trauma, but parents described a more punitive intervention (e.g. jail) as necessary for scenarios describing CD and ODD symptoms. Given that interventions for CD and ODD in large part are centered around the family and improving relationships, providers need to be prepared to discuss this mismatch between parent expectations and the intervention that would be offered. This finding is consistent with a recent cultural adaption to Parent-Child Intervention Therapy for Mexican Americans where the time out chair was renamed the 'punishment' chair to meet the parents' need for a more punitive intervention (McCabe et al., 2005).

Although our findings underscore the role of culture in influencing parental perceptions, our findings do not affirm the idea that traditional healers are the treatment of choice among new immigrant Latino communities – at least not for the adolescent behavior problems considered in this study. No participants in the study mentioned seeking help from traditional healers for mental-health problems for adolescents. This finding warrants further investigation. Possibly, parents seek traditional healers in addition to professional mental-health care or traditional healers may be used in situations that our scenarios did not represent. Nevertheless, the findings are clear that significant barriers exist in accessing professional mental-health services in an unfamiliar system and in a new community. Barriers including treatment costs and lack of knowledge about locating a mental health provider are likely to prevent many parents from accessing care for a troubled adolescent. In sum, our findings affirm these parents' commitment to their adolescents' well-being and their interest in seeking care that is accessible and culturally synchronous. Meeting this need may mean delivering services in non-traditional settings, providing more family-oriented services, and paying particular attention to parental expectations for treatment.

Strengths and limitations

This article presents findings from a small sample of new immigrant Latino parents and is not intended to be generalizable to all new immigrant parents. Although every effort was made to include a range of parents who represented differing attitudes about difficulties in adolescence as well as help seeking, other groups of new immigrant parents might interpret the scenarios differently and reach different conclusions. Trustworthiness of the findings was enhanced by a number of factors. First, all participants in the qualitative interviews had been involved with our project in the quantitative segment of the LAMHA project and voluntarily agreed to participate in a second round of research, indicating a level of trust in our research team. The authors represent both an insider and an outside perspective. The first author is an outsider to the Latino community whereas the second author is a native of Mexico whose first language is Spanish. These dual perspectives allowed for bias checking related to our cultural backgrounds in our analysis of the interviews, and allowed a native speaker to review how words were used and interpreted. In addition, the authors represent different disciplines within the helping professions.

Another limitation was our use of clinical vignettes to describe mental-health symptoms. Parents may respond differently to a hypothetical scenario than to their own child. Nevertheless, this strategy enabled a uniform approach of presenting behaviors to participants. Further, presenting hypothetical scenarios allowed us to document the cultural beliefs surrounding multiple types of mental-health problems.

Conclusion

New immigrants from Latin America represent an important group in current American society. Similar to the general population, young Latino immigrants to this country have mental-health care needs that require accessible and effective intervention if these young people are to be successful. To provide services to this population those working with immigrant families must pay particular attention to cultural nuances of providing treatment and ensuring access to services. Among immigrant populations, access to services may mean something quite different than providing phone numbers, Websites, or pamphlets – even if contact information is provided in a family's native language. Access may mean having professionals who are approachable because they are not only aware of cultural differences between expectations of treatment and the way treatment is usually delivered but also willing to make adjustments to overcome these barriers. For providers, cultural competence does not simply mean doing 'business as usual' in another language or with different posters on the wall. Rather, the key to cultural competence may be in carefully listening to clients while practicing cultural humility so that clients from other traditions can communicate what is important to them, what they have tried, what they believe will help, and what that help will look like. When professionals learn this information, they will successfully bridge cultural understandings and expectations in ways that benefit new immigrant youth and their families.

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Note

1. Interviewers made immediate referrals for youth endorsing suicide or other significant symptoms. The research team provided consultation and referrals if parents asked for help.

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Appendix

Behavioral scenarios

Depression

For the last month, Alicia, a 15-year-old girl, has had trouble sleeping. She wakes up at 3 a.m. most mornings and cannot get back to sleep. She is becoming more argumentative with her parents and stays in her room whenever she is home. She has recently quit her after-school activities, saying that she finds them 'boring.' In fact, she does not seem to enjoy much of anything. She used to enjoy doing her friends' hair and talked about owning her own shop after high school. But, her friends have not come over lately and she shrugs when her mother tries to talk with her about her plans for the future.

OCD

Diego is a 12-year-old boy who has always been very neat. Recently, he has had trouble completing his homework because he says he must start over whenever he makes a mistake. His room is quite organized for his age. He keeps shirts, socks, pants, and shoes organized by color. He became very upset with his sister when she did not put his clothes away according to his system. His mother noticed that his hands were red and chafed. When she asked him about it, he told her he was washing his hands many times every day in order to 'keep the germs from getting out of control.' Instead of playing soccer with his friends, Diego now wants to accompany his mother to church on at least a daily basis. He told her he needs to keep praying or terrible things might happen to his family.

PTSD

Enrique is a 16-year-old boy who was present at a neighborhood fight about six months ago. The fight ended in a fatal stabbing. After the incident, the family's priest asked Enrique how he was doing. He said, 'Fine, those guys weren't after me' and changed the subject. Recently, his little brother complained at the breakfast table that Enrique kept waking him up at night with his 'screaming.' Enrique said he had had a few bad dreams lately. He has also been late for supper because he is taking a much longer route home from school. This route avoids the entrance to the apartment complex where the fight took place. His mother has become worried about him because she found a knife in his school backpack.

ODD

Pablo is a 14-year-old boy who is always in trouble. He has a terrible temper and is constantly fighting with his brothers, teachers, and kids in the neighborhood. His parents will ask him to do simple tasks around the house and he ignores them. Whenever he is late for school or curfew, he says it is someone else's fault that he is late. He has started hanging around with a group of boys that everyone considers 'trouble.'

CD

Esteban is a 16-year-old boy who recently was arrested for breaking into a neighbor's home where he had stolen money and electronics. Because of robberies in the neighborhood, the police searched his room and found other stolen goods and the bones of small animals. He explained to the police that he liked dog fighting and described in detail how he enjoyed watching one dog attack and kill another. The bones in his rooms are 'souvenirs' from the dogfights. He has had numerous problems at school through the years, but his teachers usually give him a second chance because he convinces them that he will change his ways.