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# Parental ADHD Knowledge in Latinx Families: Gender Differences and Treatment Effects

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## Abstract

### Objective

The current study aimed to extend findings of a study comparing two psychosocial treatments for ADHD in Latinx youth by examining if parental ADHD knowledge improves following treatment and if parental gender differences in ADHD knowledge exist.

## Method

Following a comprehensive ADHD assessment, 58 Latinx families of school-aged children (mean age of 8 years) were randomly assigned to either culturally-adapted treatment (CAT) or standard evidence-based treatment (EBT). Parents completed an ADHD Knowledge measure both pre- and post-treatment.

## Results/Conclusion

Latinx mothers demonstrated greater knowledge of ADHD symptomatology than fathers at pre-treatment. CAT resulted in improvements in parental knowledge of ADHD for both mothers and fathers, whereas standard EBT resulted in no change in maternal knowledge and reduced paternal knowledge of ADHD symptomatology. Clinical implications will be discussed.

## Keywords

ADHD knowledge, parent management training, cultural adaptations, Latinx families, mental health disparities

Research examining the developmental trajectory of youth with Attention-Deficit/Hyperactivity Disorder (ADHD) demonstrates that these youth continue to experience debilitating symptoms and functional impairment into adulthood (Biederman et al., 2012). While effective treatment for ADHD exists, Latinx youth have not been well-represented in treatment outcome studies, resulting in little empirical evidence to support effective treatments for this population (Gerdes et al., 2012; Miranda et al., 2005; Pelham & Fabiano, 2008). This is a public health concern, as nearly one million Latinx youth in the U.S. are estimated to have ADHD (CDC, 2019).

Recently, Gerdes et al. (2019) directly compared a culturally-adapted treatment (CAT) to standard evidence-based treatment (EBT) in Latinx youth with ADHD and found that both treatments resulted in significant improvements in child symptomatology and child and parental/family functioning, but CAT outperformed standard EBT with regards to family engagement and satisfaction. The current study aimed to extend these findings by examining if similar improvements in parental ADHD knowledge are seen following treatment and if parental gender differences in ADHD knowledge exist in Latinx families.

## ADHD

ADHD, one of the most commonly diagnosed mental health disorders in youth, is defined by developmentally inappropriate levels of inattention, hyperactivity, and/or impulsivity that result in functional impairment in at least two settings (American Psychiatric Association, 2013). Research has found that impairment across multiple domains follows youth with ADHD into adolescence and adulthood (Biederman et al., 2012). Fortunately, treatment outcome research suggests that parent management training (PMT) is effective at reducing child symptomatology, improving child functioning, and improving parental and family functioning in youth with ADHD and their families, including Latinx youth (Gerdes et al., 2012, 2019; Pelham & Fabiano, 2008).

## Mental Health Disparities

Despite the availability of effective mental health treatment, ethnic minority youth and their families, including Latinx youth and families, continue to face mental health disparities that prevent them from receiving available treatment (Flores & TCOPR, 2010; Nock & Ferriter, 2005). Many barriers to utilizing mental health services have been identified for Latinx families, including access barriers primarily related to low-income status (e.g., lack of health insurance, limited ability to pay for treatment, and inability to miss work or find reliable transportation to appointments), as well as cultural factors (e.g., limited familiarity with mental health disorders and lack of bilingual mental health providers; see Kapke & Gerdes, 2016 for a review). Unfortunately, treatment outcome research also suggests that when Latinx families engage in mental health interventions, they are at risk of prematurely terminating treatment (for a review, see Kapke & Gerdes, 2016).

Frameworks for help seeking behaviors date back several decades and typically include problem recognition, decision to seek help, selection of service(s), and utilization of the service(s) as stages individuals work through as part of the help seeking process (e.g., Andersen, 1995; Cauce et al., 2002; Eiraldi et al., 2006). In the case of a youth with a mental health disorder, these models suggest that parental recognition of their child's behavior as problematic is essential to parents seeking mental health care.

## Parental Knowledge of ADHD

Despite research documenting the importance of parental knowledge of childhood mental health disorders in help-seeking behavior, limited research into the examination of parental knowledge is available, especially within the context of ADHD (Andersen, 1995; Cauce et al., 2002; Eiraldi et al., 2006). Corkum et al. (1999) found that more parent-reported knowledge of ADHD was related to a greater likelihood of enrolling their child in treatment. Similarly, Haack et al. (2018) reported that "positive reactions to ADHD identification included agreement and motivation to seek help" in their qualitative examination of Latinx parents. Finally, Vander Stoep et al. (2017) suggested that parental knowledge of ADHD gained during treatment may partially explain the reduction in parental distress reported post-treatment. This latter study suggests that parental knowledge of ADHD may not only be related to help-seeking behavior, but also may be partially responsible for improved treatment outcomes.

To the authors' knowledge, no research examining if participation in treatment improves parental knowledge of ADHD or other mental health disorders exists; however, given that psychoeducation about ADHD directly and indirectly occurs during PMT, it seems plausible that participation in treatment may result in improved ADHD knowledge. Further, treatments designed to maximize parental engagement, such as CAT that includes greater parental involvement via the school intervention and the addition of home visits, may result in even greater, indirect knowledge gains.

Research examining if parental gender differences exist in parental knowledge of ADHD also is very limited. In a community sample of Australian parents, Gilmore (2010) found that mothers were significantly more knowledgeable about ADHD than fathers. This is not surprising given that mothers still serve as the primary caregivers in most families and are the parent most often responsible for seeking mental health treatment for their child (Boulter & Rickwood, 2013). Although only indirectly related, treatment outcome research examining PMT in families of youth with ADHD also suggests that mothers may possess greater knowledge of ADHD than fathers given that mothers consistently demonstrate improvements in more parental domains than fathers following treatment (Gerdes et al., 2010, 2019). This suggests that mothers of youth with ADHD may have greater knowledge of or involvement with their child, at least as it pertains to their mental health.

## Current Study

The current study aimed to examine parental knowledge of ADHD in a treatment-seeking sample of Latinx families of youth with ADHD. Aim 1 was to examine parental gender differences in pre-treatment knowledge of ADHD symptomatology. It was predicted that Latinx mothers would correctly identify more ADHD symptoms, miss fewer ADHD symptoms, and have a higher total ADHD score (correctly identified minus missed ADHD symptoms) than fathers. Aim 2 was to examine if CAT and standard EBT result in improvements in parental knowledge of ADHD symptomatology and to examine if CAT results in greater improvements than standard EBT. It was predicted that both treatments would result in improvements in maternal and paternal ADHD knowledge across all three outcomes (i.e., correctly identified, missed, and total ADHD symptoms), but CAT would outperform standard EBT across all three outcomes.

## Method

### Participants

Participants included 58 families. Forty-eight mother-father dyads completed pre-treatment data; fifty-seven mothers and 26 fathers participated in treatment and completed both pre- and post-treatment data. Families were recruited within a mid-sized Midwest city via partnerships with local schools and community organizations, as well as word of mouth referrals. Eligibility criteria included youth and parents self-identifying as Latinx, and youth being 5 to 13 years-old at the time of study enrollment and receiving a diagnosis of ADHD. Exclusion criteria included symptoms suggestive of Intellectual Disability, Autism Spectrum Disorder, or psychosis.

Most youth were male (74%) with a mean age of 8 years ( $M = 7.98$ ,  $SD = 2.55$ ). Twenty-five were diagnosed with ADHD, Predominantly Inattentive Presentation, six were diagnosed with ADHD, Predominantly Hyperactive-Impulsive Presentation, and 27 were diagnosed with ADHD, Combined Presentation. Eighteen received comorbid diagnoses, including conduct, mood, and anxiety disorders. Twelve were taking ADHD medication, with doses maintained throughout the course of treatment. The mean age of mothers was 35 years ( $M = 35.39$ ,  $SD = 5.06$ ), 88% identified Mexico as their country of origin, 49% predominantly spoke Spanish, 44% had at least a high school education, and 65% were working outside of the home. The mean age of fathers was 39 years ( $M = 38.92$ ,  $SD = 9.68$ ), 85% identified Mexico as their country of origin, 35% predominantly spoke Spanish, 19% had at least a high school education, and 85% were working outside of the home. Families fell in the mid- to low-range of socioeconomic status based on Hollingshead's Four Factor Index of Social Status (Hollingshead, 1975). Both mothers and fathers were more oriented towards traditional Latinx culture than mainstream U.S. culture based on two self-report measures of acculturation (Acculturation Rating Scale for Mexican Americans-II; Cuellar et al., 1995; Mexican American Cultural Values Scale for Adolescents and Adults; Knight et al., 2010).

### Procedure

After obtaining consent from parents and teachers and assent from youth, a multi-method, multi-informant assessment of ADHD, including parent, teacher, and youth interviews and measures, was conducted for each youth (see Gerdes et al., 2019 for more description of the assessment process). As part of the assessment, parents completed the ADHD Knowledge Measure, which is described in greater detail below. Parents and teachers received gift cards upon completion of the assessment.

Following completion of the assessment, each family participated in a feedback session and was randomly assigned to one of two treatment conditions. The feedback session included brief psychoeducation about ADHD. Twenty-seven families participated in standard EBT, consisting of eight group PMT sessions, as well as an individualized classroom intervention in the form of a daily report card (DRC). Sessions were co-led in Spanish by bilingual clinicians, lasted 2 hr, and were held in a university-based ADHD Clinic with childcare and snacks provided. Thirty-one families participated in CAT. CAT consisted of eight group PMT sessions, all of which were newly created and/or culturally adapted to be more culturally-appropriate and acceptable to the Latinx community, an individualized DRC with weekly parental involvement, and two home visits to practice skills; weekly parental involvement with the school intervention and home visits for skill practice were specific to CAT. Sessions were co-led in Spanish by bilingual clinicians, lasted 2 hr, and were held in a community center with childcare and dinner provided. Following the completion of treatment, parents again completed the ADHD Knowledge Measure, in addition to other measures. See Gerdes et al. (2015, 2019) for more detail, including the development of CAT.

## Measures

### *ADHD knowledge measure*

The ADHD Knowledge Measure is a 36-item, parent-report measure consisting of the 18 DSM 5 symptoms of ADHD, as well as 18 DSM 5 symptoms of childhood disorders other than ADHD. Specifically, the non-ADHD items are made up of symptoms of Oppositional Defiant Disorder (e.g., often losing temper), anxiety disorders (e.g., feeling constant worry), and mood disorders (e.g., feeling hopeless). Parents were instructed to put a check mark next to all items that are symptoms of ADHD. For purposes of this study, three subscales were created—correctly identified ADHD symptoms (a sum of all ADHD items correctly identified), missed ADHD symptoms (a sum of all ADHD items that were missed or not correctly identified), and total ADHD symptoms (correctly identified minus missed ADHD symptoms).

## Results

### Missing Data and Sample Sizes

All measures were returned to research staff in person and were examined immediately, resulting in virtually no missing data from parents and teachers who completed pre- and post-treatment measures. Analyses for Aim 1 include data from all mother-father dyads who completed pre-treatment measures. Analyses for Aim 2 include data from all parents who participated in treatment and completed both pre- and post-treatment measures.

### Primary Analyses

#### *Aim 1—Pre-treatment maternal versus paternal ADHD knowledge collapsed across treatment group*

Paired-samples *t*-tests were employed to examine if mothers and fathers differed in their ADHD knowledge at pre-treatment. Specifically, *t*-tests compared ADHD knowledge in mothers and fathers across three outcomes: correctly identified ADHD symptoms, missed ADHD symptoms, and total ADHD symptoms (correctly identified minus missed ADHD symptoms). As Table 1 indicates, significant parental gender differences emerged for correctly identified, missed, and total ADHD symptoms. Examination of the means demonstrated that collapsed across treatment condition, mothers correctly identified more ADHD symptoms, missed fewer ADHD symptoms, and had a higher total ADHD symptom score than fathers at pre-treatment. The effect sizes for all significant findings were small.

**Table 1.** Results of Paired Samples *t*-Tests for Pre-Treatment Maternal Versus Paternal ADHD Knowledge Collapsed Across Treatment Group.

	Mother			Father					
	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>t</i>	<i>df</i>	Cohen's <i>d</i>
CAS	13.15	4.13	48	11.25	4.43	48	3.39**	47	0.44
MAS	4.85	4.12	48	6.75	4.43	48	-3.39**	47	-0.44
ADHDTOT	8.29	8.25	48	4.50	8.86	48	3.39**	47	0.44

Note. CAS = sum of correctly identified ADHD symptoms; MAS = sum of missed ADHD symptoms; ADHDTOT = ADHD total score (correctly identified minus missed ADHD symptoms).

\*\**p* < .01.

#### *Aim 2—Pre-post treatment change in parental ADHD knowledge*

Paired-samples *t*-test were employed to examine if CAT resulted in improvements in ADHD knowledge. Specifically, *t*-tests compared pre-post treatment scores on six outcomes: mother- and father-correctly identified ADHD symptoms, missed ADHD symptoms, and total ADHD symptoms (correctly identified minus missed ADHD symptoms). As Table 2 indicates, significant findings emerged for mother- and father-reported

correctly identified, missed, and total ADHD symptoms. Examination of the means demonstrated that following CAT, mothers and fathers correctly identified more ADHD symptoms, missed fewer ADHD symptoms, and had a higher total ADHD symptom score relative to pre-treatment. The effect sizes for all significant findings were small to medium.

**Table 2.** Results of Paired Samples *t*-Tests for Maternal and Paternal ADHD Knowledge at Pre-Treatment (Time 1) and Post-Treatment (Time 2).

	CAT			ST						
	Time 1			Time 2						
	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>t</i>	<i>df</i>	Cohen's <i>d</i>	
M CAS	13.20	4.12	30	15.07	4.00	30	-2.31*	29	0.46	
M MAS	4.80	4.12	30	2.93	4.00	30	2.31*	29	-0.46	
M ADHDTOT	8.40	8.24	30	12.13	8.00	30	-2.31*	29	0.46	
F CAS	11.65	3.57	17	14.24	4.24	17	-2.13*	16	0.66	
F MAS	6.35	3.57	17	3.76	4.24	17	2.13*	16	-0.66	
F ADHDTOT	5.29	7.14	17	10.47	8.47	17	-2.13*	16	0.66	
	Time 1			Time 2						
	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>t</i>	<i>df</i>	Cohen's <i>d</i>	
M CAS	12.11	3.98	27	12.00	4.95	27	.11	26	-0.02	
M MAS	5.89	3.98	27	6.00	4.95	27	-.11	26	0.02	
M ADHDTOT	6.22	7.97	27	6.00	9.91	27	.11	26	-0.02	
F CAS	13.00	4.64	9	9.22	4.58	9	3.51**	8	-0.82	
F MAS	5.00	4.64	9	8.78	4.58	9	-3.51**	8	0.82	
F ADHDTOT	8.00	9.27	9	.44	9.15	9	3.51**	8	-0.82	

Note. CAT = culturally adapted treatment; ST = standard evidence-based treatment; M/F CAS = mother/father sum of correctly identified ADHD symptoms; M/F MAS = mother/father sum of missed ADHD symptoms; M/F ADHDTOT = mother/father ADHD total score (correctly identified minus missed ADHD symptoms).

\*\**p* < .01. \**p* < .05.

For comparison, paired-samples *t*-tests for standard EBT also are presented in Table 2. No significant findings emerged for mothers; however, significant findings emerged for fathers across all three outcomes: correctly identified, missed, and total ADHD symptoms. Examination of the means demonstrated that following EBT, fathers correctly identified fewer ADHD symptoms, missed more ADHD symptoms, and had a lower total ADHD symptom score relative to pre-treatment. The effect sizes for all significant findings were large.

Finally, repeated-measures ANOVAs were employed to examine if CAT resulted in greater improvements in ADHD knowledge than standard EBT. Specifically, pre-post change was the within subjects factor, treatment condition was the between subjects factor, and time × treatment condition was the interaction term. Given that the focus of these ANOVAs was to examine significant interaction effects, only those findings are reported.

For mothers, no time by treatment condition interactions emerged. For fathers, significant interactions emerged for all three outcomes: correctly identified,  $F(1, 24) = 11.79, p < .01$ , missed,  $F(1, 24) = 11.79, p < .01$ , and total ADHD symptoms,  $F(1, 24) = 11.79, p < .01$ . Correct identification of ADHD symptoms and total ADHD symptoms significantly increased and missed ADHD symptoms significantly decreased in fathers following participation in CAT. The opposite pattern emerged for fathers in standard EBT; correct identification and total ADHD symptoms

significantly decreased and missed ADHD symptoms significantly increased in fathers after participation in standard EBT. The effect sizes were large.

## Discussion

The current study aimed to examine if parental gender differences in ADHD knowledge exist in Latinx families, and if improvements in parental ADHD knowledge are seen following treatment. In brief, Latinx mothers demonstrated greater knowledge of ADHD symptomatology than fathers at pre-treatment. CAT resulted in improvements in parental knowledge of ADHD for both mothers and fathers, whereas standard EBT resulted in no change in maternal knowledge and reduced paternal knowledge of ADHD symptomatology.

### Parental Gender Differences in Knowledge of ADHD Symptomatology

The first aim was to examine parental gender differences in pre-treatment knowledge of ADHD symptomatology. Our prediction that Latinx mothers would correctly identify more ADHD symptoms, miss fewer ADHD symptoms, and have a higher total ADHD score (correctly identified minus missed ADHD symptoms) than fathers was fully supported. Although research examining parental knowledge of ADHD symptomatology is quite limited, this finding is consistent with Gilmore's (2010) work with a community sample of Australian parents and with research identifying mothers as the primary caregivers in most Latinx families (Miranda et al., 2006). Given their greater involvement and likely greater familiarity with their children, it is not surprising that mothers were better able to identify ADHD symptoms than fathers.

### Pre-post Treatment Change in Parental Knowledge of ADHD Symptomatology

The second aim was to examine pre-post treatment change in parental knowledge of ADHD symptomatology. Our prediction that both treatments would result in improvements in maternal and paternal ADHD knowledge across all three outcomes (i.e., correctly identified, missed, and total ADHD symptoms) was only supported for CAT, and our prediction that CAT would outperform standard EBT across all three outcomes was only supported for fathers. Following CAT, both mothers and fathers correctly identified more ADHD symptoms, missed fewer ADHD symptoms, and had a higher total ADHD symptom score relative to pre-treatment. Interestingly, mothers' knowledge of ADHD symptomatology did not significantly change following standard EBT relative to baseline, and fathers' knowledge of ADHD symptomatology actually worsened across all three outcomes following standard EBT relative to baseline, with significant interaction effects emerging for fathers across outcomes.

Given that psychoeducation about ADHD was provided in standard EBT and CAT, we predicted that both treatments would result in improvements in parental ADHD symptomatology knowledge; however, we predicted greater improvement with CAT, primarily because primary treatment outcomes revealed greater family engagement with CAT relative to standard EBT (Gerdes et al., 2019). We expected that this greater engagement or investment in the treatment process would likely result in families taking away more of the treatment content and integrating it into their lives, which appears to have occurred with regards to knowledge of ADHD symptomatology.

Another possibility may be related to the fact that parents who participated in CAT had much greater involvement with the teacher than parents in standard EBT. Specifically, one of the cultural adaptations involved having parents attend weekly teacher meetings with the clinician to discuss their child's progress on the DRC. Parents who participated in standard EBT only attended the first and last teacher meeting with the clinician. Additionally, families participating in CAT engaged in two home visits, a cultural adaptation that was not offered to families participating in standard EBT (Gerdes et al., 2019, for more detail). These home visits also may have contributed to increased parental engagement in treatment. Thus, it is possible that greater exposure to and involvement with their child's teacher and his/her concerns in the classroom, as well as additional therapeutic



time in the home setting resulted in parents gaining greater knowledge of ADHD symptomatology over the course of CAT.

Although we predicted greater improvement with CAT, we did not expect mothers in standard EBT to demonstrate no improvement in ADHD knowledge and fathers' ADHD knowledge to actually worsen following treatment. Perhaps these parents would have responded similarly to those in CAT if provided with the same cultural adaptations. CAT may have been better suited to address some of the underlying cultural beliefs and biases that ultimately impact parental engagement and knowledge of ADHD in youth. This needs further examination.

## Clinical Implications, Limitations, and Future Directions

The current study is one of a few studies examining parental knowledge of ADHD symptomatology and is the only study to examine if knowledge improves following treatment. This study is especially important, as it demonstrates that the benefits of a culturally-adapted treatment extend beyond traditional treatment outcomes, such as child symptomatology and impairment. Perhaps as a result of greater involvement and engagement in treatment, both mothers and fathers who participated in CAT demonstrated greater knowledge of ADHD symptomatology following treatment. Quite a different picture emerged for parents who participated in standard EBT. Research suggests that assessing parental knowledge of ADHD, as well as working to address potential misconceptions, may have implications on family attitudes regarding treatment, help-seeking behavior, and engagement in treatment (Sayal et al., 2006; Sciotto, 2015; Taylor & Antshel, 2019). Clearly, this is an important area of research that needs further examination. If similar findings emerge in future work with diverse groups of families, clinicians may want to consider if providing more direct psychoeducation about ADHD or increasing parental involvement via school interventions and/or home visits should be an essential component of standard EBT across cultural, ethnic, and racial groups.

Despite the important clinical implications, several limitations should be improved upon in future studies. The current sample consisted of treatment-seeking, Latinx parents residing in an urban area within the Midwestern U.S.; most faced economic challenges and identified Mexico as their country of origin. Therefore, these findings cannot necessarily be generalized to all Latinx parents, especially given the significant heterogeneity that exists within the Latinx population. The current sample also was small, especially with regards to fathers, which resulted in uneven group comparisons. Unfortunately, this limitation has been noted throughout much of the behavioral parent training literature (see Fabiano, 2007 for a comprehensive review). It will be important to replicate the current findings with a larger sample of mothers and fathers from diverse Latinx backgrounds. Similarly, future research should examine parental ADHD knowledge across various cultures, as well as racial and ethnic groups.

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