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Using vignettes describing African American children with internalizing (e.g., withdrawal) versus externalizing (e.g., quarrels) problems, parents, teachers, and clinicians made judgments regarding problem seriousness, prognosis, etiology, referral, and intervention needs. Opinions of parents, teachers, and clinicians differed markedly, especially with regard to judgments about children with externalizing problems. Black raters' ratings significantly differed from those of Whites, especially for seriousness and prognostic judgments with regard to the problems. The findings suggest that interventionists who address problems that African American youth present should attend to the attitudes and judgments of adults who report on such problems. Clinicians can simultaneously harness appropriate judgments and attitudes and decrease counterproductive beliefs and behavior in their interventions with Black children.

Child mental health referrals often involve problems that children exhibit or experience at various points in their development, but children's problems may vary according to factors such as ethnicity, gender, and the sociocultural

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background of the child. Adult attitudes and distress thresholds concerning children's problems may determine whether children get referred for clinical services (Lambert et al., 1992; Weisz et al., 1988). Children rarely refer themselves for professional services (Lambert, Markle, & Francois-Bellas, in press). Therefore, some behavior and emotional problems that are quite distressing to children may not receive clinical intervention if they are not also distressing to significant adults in the child's environment (Achenbach, 1991b, 1991c). For example, in their study of Jamaican and U.S. children, Lambert, Lyubansky, and Achenbach (1998) established that girls from both nations self-reported more problems than did boys. However, in both countries, boys are usually more often referred for clinical services than are girls (Lambert et al., 1998; Lambert & Lyubansky, 1999). The authors inferred that adults' beliefs with regard to what constitute serious behavior problems in girls versus boys may contribute to differential clinic referral rates across genders (e.g., Kashani et al., 1987).

Identification of attitudes and beliefs of adults toward different types of problems children exhibit may determine whether ameliorative steps are needed to ensure that boys and girls with behavior and emotional problems receive the intervention they need. Studies of adult attitudes toward child problems may, therefore, have the potential to identify which types of problems exhibited by different children within or across sociocultural backgrounds are likely to receive professional attention.

Children usually interact with different adults (e.g., parents vs. teachers) and exhibit behavior in different contextual environments (e.g., home, school). Therefore, research on adult attitudes and distress thresholds concerning child behavior and emotional problems should include adults who interact with children in different contexts (Lambert et al., 1998; Weisz et al., 1987). Recognition with regard to the importance of understanding different adults' thresholds of distress and attitudes toward child problems in different populations has motivated researchers to study adults' attitudes and behavior toward child psychopathology across societies. For example, researchers have compared the attitudes of U.S. parents, teachers, and clinicians with those of their counterparts in countries such as Thailand (Weisz et al., 1988; Weisz & Weiss, 1991) and Jamaica (Lambert et al., 1992).

The cross-national studies listed above used vignette procedures to test adult attitudes toward child problems and found striking differences across

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nationalities and adult groups (i.e., parents, teachers, and clinicians). However, the studies did not focus specifically on children or adults of a particular race within or across each society. Inattention to adults' race or the race of the child in each vignette may have been appropriate at those early stages of inquiry. Nevertheless, continued neglect of this issue in contemporary research would represent an oversight because the racial group to which children and adults belong may influence adults' ratings of children's behavior.

People of African descent are the majority group within the Jamaican population and the largest minority group in the United States (Lambert & Lyubansky, 1999; McLoyd, 1999). Similarity in their heritage can lead to important convergence in their attitudes and views and their subsequent ratings with regard to children's problems. Environmental differences between the nations in which they live also may have led to differences in challenges (e.g., racism in the United States vs. poor economic conditions in Jamaica) that adults and children confront. Such differences can influence their child- rearing attitudes and responses to children's problems (Lambert et al., 1998). The earlier cross-national studies that lumped racial and ethnic groups of raters together may have obscured important findings related to the raters' group membership. Such studies may have thus unwittingly obfuscated findings related to the race of children rated and the race of the raters who executed the ratings.

Lack of research focusing on Black children and families is especially apparent in the United States, where Blacks form the largest minority youth group. The paucity of research on African Americans is especially troubling because they are members of a historically persecuted group: Blacks are believed to be at risk for developing psychopathology (American Psychological Society, 1996). Nevertheless, they are less likely than majority groups to seek professional help from mental health practitioners (Neighbors, 1990). Many African Americans are distrustful of mental health care providers and are therefore reluctant to seek mental health care from established mental health systems (Department of Health and Human Services, 1999).

Besides issues related to distrust, African Americans may avoid seeking professional help for their children due to their high threshold for tolerance of behavior and emotional problems their family members exhibit (Boyd-Franklin, 1989). Therefore, African American parents' attitudes toward children's behavior and emotional problems and thresholds for such problems may differ markedly from those of other adults (e.g., teachers) who interact with their children. Many teachers and other adults who have professional relationships with Black youth are from different socioethnic backgrounds than Black youth and their parents (Puig et al., 1999). By nature of their socioethnic backgrounds, adults who are not African American may have

different attitudes, beliefs, and levels of tolerance toward Black children's behavior problems compared with Black parents or other Black adults.

Adult attitudes and beliefs with regard to what constitutes a serious problem also may vary according to characteristics other than the race of the child. Such attributes include the child's gender and the type of behavior problems the child exhibits. Knowledge of similarities and differences in attitudes between different adult groups that interact with African American children in different contexts may inform policy or intervention decisions. On one hand, research may reveal that adults may report that they are likely to seek help for African American children with behavior problems despite problem type, adult's relationship with the child (e.g., parent, teacher, clinician), and the child's characteristics (e.g., gender). If such findings emerge, intervention or policy changes that target adult help-seeking behavior for children may be unnecessary. On the other hand, adults' reports concerning the possibility that they might obtain help for Black children could vary according to any of the above-mentioned dimensions. Findings that vary accordingly may indicate a need to design and implement programs that ensure appropriate referral of African American boys and girls who present various types of problems.

To begin addressing the issues outlined above, the present study used vignettes of African American children with different types of behavior and emotional problems to assess the beliefs of adults who are important in making decisions with regard to child mental health referral. It employed established methodology (see Lambert et al., 1992; Sonuga-Barke & Balding, 1993; Weisz et al., 1988; Weisz & Weiss, 1991) in surveying the attitudes of parents, teachers, and clinicians toward problems that African American children may exhibit. Therefore, vignettes that describe African American children with various types of behavior and emotional problems were presented to three sets of adults: parents, teachers, and clinicians of African American children. These adults were selected because they interact closely with African American children and may be regarded as their gatekeepers of referral for professional services. More specifically, the study was designed to test whether the three groups of adults differed in their ratings of seriousness of the problems and their level of worry concerning the problems if they placed themselves in the role of the child's parent or teacher and their prognosis with regard to such problems. All questions below addressed whether the adults' ratings varied according to internalizing (e.g., shyness, sadness) versus externalizing (e.g., argues, fights) problems children presented, the gender of the child, and whether child gender interacted with problem type.

The present study was designed to answer three questions of interest: (a) Will parents' ratings of African American children described in the

vignettes differ from the ratings of clinicians and teachers who are predominantly White as far as their views with regard to the cause of the problems, prognosis, their level of worry if they place themselves in the role of the child's teacher or parent, and their proposed home-based intervention methods? (b) Will the internalizing versus the externalizing child be viewed as more in need of professional help and will this rating vary according to the type of rater (i.e., parent, teacher, and clinician)? and (c) Because all parents and some teachers and clinicians were Black, if the ratings were contrasted according to the race of the raters, will differences emerge for judgments according to the race of the rater?

The three research questions were explored by presenting vignettes describing African American children with behavior and emotional problems to African American parents and to teachers and clinicians who work directly with Black children. Therefore, we tested whether adult attitudes toward problems African American children exhibit vary according to the adult's relationship with the child (i.e., parent, teacher, clinician). To test problem-type effects, we presented vignettes of two different children to each adult. One child in each pair of vignettes was described as presenting internalizing problems and the other as exhibiting externalizing problems. Both types of problems reflect the two most common empirically derived groupings of problems children present. These groupings emerged from earlier research (e.g., Peterson, 1965) and more recent empirical work (e.g., Achenbach, 1991a, 1991b, 1991c, 1991d).

METHOD

PARTICIPANTS AND PROCEDURES

Parents and teachers of African American elementary school children were selected from urban and suburban areas of Michigan with high concentrations of Black families. Nine elementary schools were chosen from seven cities and their suburbs. All selected schools chose to participate and all teachers from these elementary schools received the survey. To randomly select parents, teachers chose every third African American child on their class list and asked selected children to take the survey to their parents.

Clinicians were recruited from mental health clinics in the same regions as the schools and served large proportions (i.e., 50% of their caseloads or greater) of Black youth. Surveys were mailed individually to 150 parents and 150 teachers and combined in one package to a contact person in each clinic

who distributed them among all clinicians (total $N = 115$) who work with African American children. All participants were asked to mail their completed forms in self-addressed stamped envelopes to the researchers. We offered each participant $20 for their contribution to the study. Although most participants (80%) accepted payment, some participants (11%) returned the payment to the researchers, noting that they considered the research to be extremely important and that they did not want to be paid. Another 9% donated their payment to the school or the child treatment facility in which they worked. All completed surveys were individually returned by mail.

Sample demographics. Of the clinicians, 51 (44%) were psychologists, 3 (2%) were psychiatrists, 45 (38%) were social workers, and 19 (16%) were from other professions (e.g., nurses and substance abuse counselors). All clinicians and teachers worked professionally with children, and 73% of parents reported having worked professionally with children. Sixty-four percent of clinicians and 66% of teachers who participated in the study reported having their own children.

Whereas all parents were African American, only 7 (13%) of the teachers were African American, 27 (51%) were White, and the remaining 19 (36%) were from other groups (e.g., Asian, Hispanic, Latino, Native American). For clinicians, the ethnic distribution was 15 African American (13%), 83 White (72%), and 17 from other groups (15%). Based on the estimates of a recent study conducted in similar regions (Puig et al., 1999), the ethnic distribution of teachers and clinicians can be considered representative of these professions in the facilities sampled. The gender distribution for each adult group was (a) 40% male and 60% female clinicians, (b) 38% male and 62% female teachers, and (c) 12% fathers and 88% mothers. A 3 (parent, teacher, clinician) × 2 (vignette order) × 2 (context of problems) analysis of variance (ANOVA) with years of education as the dependent variable revealed only a significant rater main effect, $F(1, 208) = 18.6$, $p < .0001$. With alpha set at .05, the Scheffe post hoc tests revealed that clinicians and teachers reported significantly more years of schooling than parents (M years = 17.4, 15.7, and 11.6; SDs = 3.8, 6.8, and 5.9, respectively), but clinicians and teachers did not significantly differ from one another.

MATERIALS AND PROCEDURES

Each adult received a three-page packet. Pages one and two of the material contained one vignette each describing a 9-year-old African American school child. In each packet, one vignette described a child with internalizing

problems, whereas the other described a child with externalizing problems. The vignettes with the externalizing child contained eight of the problems that load on the externalizing grouping of the syndromes of the Child Behavior Checklist (CBCL) (Achenbach & Edelbrock, 1983). The items were arguing, cruelty to others, getting into fights, disobedience in school, lying, physically attacking people, teasing, and threatening. The internalizing child vignettes included the following eight problems loading on the internalizing grouping of syndromes: dependency on adults, fear of school, nervousness, anxiety, refusal to talk, shyness and timidity, sadness and depression, and worrying.

Problems were drawn from earlier work by Achenbach and Edelbrock (1983) and matched those used in recent research (e.g., Lambert et al., 1992; Weisz et al., 1988). All externalizing problems load under the cross-informant (i.e., parent, teacher, and self-report) externalizing grouping of problems documented in Achenbach's (1991a) more recent work. Six of the internalizing problems loaded under Achenbach's (1991a) cross-informant internalizing grouping. The two problems that did not load on the more recent internalizing factor are dependency on adults and fear of school. These items were classified as mixed (i.e., loaded on both groupings) and other (i.e., loaded on neither grouping), respectively. We retained the original eight internalizing problems used in earlier research for the following two reasons: (a) For the most part, they reflect the more recent problem-type groupings (Achenbach, 1991a), and (b) the use of the original item lists permitted reliable interpretation of the present findings in the context of recent adult attitude research (e.g., Lambert et al., 1992; Weisz et al., 1988).

In summary, 16 items were chosen from Achenbach and Edelbrock's (1983) empirically derived classification system of internalizing and externalizing problems. Achenbach's (1991b) most recent work shows that all of the items chosen discriminate between children who are referred for clinical services and those in the general population. Thus, for all problems, clinic-referred children received significantly higher ratings from their parents compared with the parent ratings received by children in the general population. Furthermore, for all but three problems (fears school, shyness, and teases others), the effect sizes of the significant differences were medium to large (Achenbach, 1991b).

Both internalizing and externalizing problems were embedded in either Context A or B. Context A indicated that the child (a) works well alone and takes pride in accomplishments, (b) is a good team player but (c) makes below-ability-level grades, and (d) needs special help from the teacher. Context B indicated that the child (a) has one close friend, (b) tries hard once an activity has been started, (c) gets left out of group activities, and (d) is behind

the class in most subjects. We provided the contextual information to make the vignettes more realistic and naturalistic and, as documented in the results, we tested whether the context (i.e., the presence of other behavior) (see Holden & Edwards, 1989) in which the problems occurred affected adult ratings.

After each vignette, several questions were posed using 7-point Likert scales ranging from 0 to 6. For example, a rating of 0 for question (d) below would represent no likelihood of improvement, and a rating of 6 would indicate that improvement would be extremely likely. The questions were (a) How serious is this child's problem? (b) If you were this child's parent, how worried would you be about his or her behavior? (c) If you were this child's teacher, how worried would you be about his or her behavior? and (d) How likely is it that this child's behavior will improve in 1 or 2 years? Participants also were asked two open-ended questions with regard to the internalizing versus the externalizing child. The questions were as follows: (a) What do you think is the major cause of this child's behavior problems? and (b) What methods could be used at home to help this child? On the last page, the adult was asked to determine which child (internalizing vs. externalizing) was in greater need of help and why. In addition, a section on demographic data was attached at the end of the last page.

Coding open-ended questions. We developed a coding system for the open-ended questions. Answers concerning the major cause of the child's problems were classified as follows: (a) faulty child rearing, (b) diagnostic issues (e.g., attention deficit hyperactivity disorder), or (c) environmental and sociological causes (e.g., living in slums). The proposed methods of intervention in the home were classified as follows: (a) behavioral interventions for the children (e.g., reinforce good behavior) or (b) social or emotional support for parent or child (e.g., parent or child support group). To assess coding reliability, two coders blindly coded the same 50 responses. Across all the categories, the mean kappa was .71 (range = .55 to .87).

EXPERIMENTAL DESIGN

Patterning Weisz et al. (1988) and Lambert et al. (1992), our design was a 3 (adult group) × 2 (internalizing vs. externalizing) × 2 (child's gender) × 2 (problem type) experimental design, with problem type (i.e., internalizing vs. externalizing) as the within-subjects factor. As described in the Results section, we first tested for vignette order and problem context effects and removed them from the model because they were not significant. Unlike the earlier studies that did not include the race of the child in the vignettes, the

present study specified that the child was African American. Parents, teachers, and clinicians (collectively referred to as raters) of African American children read two vignettes; one vignette described a child with internalizing problems, whereas the other vignette portrayed a child with externalizing problems. To afford the testing of vignette gender effects, half of the adults received vignettes about boys and half received vignettes about girls. For half of the adults, the internalizing child was placed in Context A, whereas the externalizing child was placed in Context B (see Materials and Procedures for further description of, and reason for, contexts). This pairing was reversed for the remainder of the sample. Similarly, order was counterbalanced; half of the subjects received the internalizing vignette first and half received the externalizing vignette first.

RESULTS

CHARACTERISTICS OF THE SAMPLE

The sample included 42 parents of African American children ages 6 to 11, 53 teachers who teach African American children ages 6 to 11, and 115 clinicians who treat African American children in this age range; thus, the total sample was 210 adults. No significant age difference existed between adult groups. Mean ages for the three adult groups of clinicians, teachers, and parents were 40.42 (*SD* = 10.21), 41.00 (*SD* = 9.32), and 38.40 (*SD* = 8.18), respectively.

RATINGS OF SERIOUSNESS, UNUSUALNESS, WORRY, AND LIKELIHOOD OF IMPROVEMENT

Preliminary analyses. Prior to conducting the main analyses, we tested for normality of the distribution of each dependent variable. Thus, we examined indices of skewness and kurtosis. Considering that distributions are normally distributed if indices of skewness are less than 2 and greater than –2 and those of kurtosis are less than 4 and greater than –4 (Tabachnick & Fidell, 1996), all dependent variables were normally distributed. That is, indices of skewness and kurtosis for all dependent variables ranged between –1.56 and .46. For kurtosis, the range was –.67 to 2.48. Thus, log transformation of the scores was unnecessary and the raw scores were used in the analyses described next.

For all analyses subsumed under this broad heading, years of education was entered as a covariate in the model factor. As documented under Sample

Demographics above, significant differences in years of education existed across parent, teacher, and clinician raters. Also, we used years of education as a proxy for socioeconomic status (SES) because we had no data (e.g., occupation) that matched standard SES systems (e.g., Hollingshead, 1975). Earlier research has demonstrated that SES is related to adults' ratings of children's functioning (Achenbach, 1991a). Other research has demonstrated not only a strong link between standard measures of SES and years of education (Hollingshead, 1975) but that the former may be an even better predictor of adult ratings on children's functioning than the latter (Auerbach, Lerner, Barasch, & Palti, 1998; Greenberg, Lengua, Coie, & Penderhughes, 1999; Hauser, 1994; McGrath, Sullivan, & Seifer, 1998).

As documented under Materials and Procedures, adults' ratings were based on two vignettes, each describing children with one of two types of problems. One vignette described a child with internalizing problems and another depicted a child with externalizing problems. Reflecting the design of the study, all analyses described under this broad heading included problem type as a repeated-measures factor.

The first set of analyses focused on adult ratings of the following five dependent variables considered separately: (a) the seriousness of the children's problems, (b) the unusualness of such problems, (c) how worried the adults would be about the children's problems if they were placed in the role of the child's parent, (d) the adults' magnitude of worry if they were the child's teacher, and (e) the children's prognosis (i.e., likelihood of improvement). Prior to conducting the analyses that addressed each question, we tested for the effects of context and vignette order by using them as the only independent variables in a separate wave of analyses. Thus, for ratings on each question as separate dependent variables, we conducted 2 (context) $\times$ 2 (order) repeated-measures analyses of covariance (ANCOVAs). Context and vignette order main and interaction effects were nonsignificant for all sets of analyses. Thus, for the sake of parsimony, we removed these two independent variables from all subsequent ANCOVA analyses.

The next set of analyses addressed whether parents', teachers', and clinicians' ratings differed from one another for each dependent variable considered separately. Thus, the analyses were a series of 3 (rater: parent, teacher, clinician) $\times$ 2 (child gender in vignette) $\times$ 2 (problem type) ANCOVAs, with years of education as a covariate and problem type (i.e., internalizing vs. externalizing) as the within-subjects (i.e., repeated measures) factor. To minimize the risk of chance findings, we applied the Bonferroni correction (Cliff, 1987), which set the alpha for these analyses at .01. We interpreted the sizes of the significant effects (ES) via Cohen's (1988) criteria. Cohen classifies effect sizes as small if they account for 1% to 5.9% of the variance, as

medium if they account for 5.9% to 13.8%, and as large if they account for more than 13.8%.

Seriousness. For the question on how serious the child's problem is, a 3 (rater) × 2 (vignette child gender) × 2 (problem type) repeated-measures ANCOVA with years of education as the covariate and problem type as a within-subjects factor revealed a rater main effect, $F(2, 192) = 5.72$, $p = .0039$, ES = 6%, which is medium. However, this effect was moderated by a Rater × Problem Type interaction effect, $F(2, 192) = 4.88$, $p = .007$, ES = 6%, which is medium. With alpha set at .05, we used the Scheffe statistic to conduct post hoc analyses of the components of this and other interactions. Table 1 indicates that when they rated children described as exhibiting externalizing problems, teachers and parents viewed such problems as significantly more serious than did clinicians. Parents' and teachers' ratings, however, did not significantly differ from one another. For adult ratings of vignettes describing children with internalizing problems, no significant rater effects emerged.

Unusualness. The 3 (rater) × 2 (vignette child gender) × 2 (problem type) repeated-measures ANCOVA with years of education as the covariate and problem type as the repeated-measures factor revealed no significant main or interaction effects for unusualness.

Parent worry. Main and interaction effects for 3 (rater) × 2 (vignette child gender) × 2 (problem type) repeated-measures ANCOVA with years of education as the covariate and problem type as a within-subjects factor focused on the question asking how worried the rater would be if he or she placed himself or herself in the role of the child's parent were nonsignificant.

Teacher worry. A 3 (rater) × 2 (vignette child gender) × 2 (problem type) repeated-measures ANCOVA with years of education as the covariate and problem type as the repeated-measures factor focused on the question concerning how worried raters would be if they were the child's teacher revealed no main effects. However, a Rater × Problem Type interaction emerged, $F(2, 192) = 11.11$, $p = .0014$, ES = 6%, which is medium. Post hoc analyses revealed no significant differences between type of rater (i.e., parent, teacher, clinician) for the internalizing vignettes. Nevertheless, for the externalizing vignette, Table 1 shows that the Scheffe test revealed that teachers noted that they would be more worried than clinicians. However, no significant differences emerged between parents and the other two raters. No other interactions emerged for analyses on this question.

TABLE 1
Means Derived From Repeated-Measures Analyses of Covariance Adjusted for Years of Education as a Covariate in the Model

	Clinician	*Teacher*	*Parent*
Seriousness (internalizing)	5.69	5.80	5.94
Seriousness (externalizing)	5.44_a	6.25_b	6.28_b
Unusualness (internalizing)	4.87	4.78	4.64
Unusualness (externalizing)	4.87	4.78	4.64
Parent worry (internalizing)	6.21	6.21	6.30
Parent worry (externalizing)	6.07	6.47	6.51
Teacher worry (internalizing)	5.75	5.98	6.03
Teacher worry (externalizing)	5.99	6.47_a	6.33
Improvement (internalizing)	3.02	3.24	4.00
Improvement (externalizing)	2.95_a	2.96	3.71_b

NOTE: Subscripts in each row that differ from one another indicate significant group differences according to the Scheffe post hoc test. Scheffe tests were performed only on analyses of ratings that revealed significant main or interaction effects.

Improvement. The 3 (rater) × 2 (vignette child gender) × 2 (problem type) × 2 (problem type) repeated-measures ANCOVA with years of education as the covariate and problem type as the repeated-measures factor analysis focused on improvement revealed no main or interaction effects.

ADULTS' RESPONSES CONCERNING WHICH CHILD NEEDS MORE HELP, PROBLEM CAUSES, AND INTERVENTION METHODS THEY PROPOSED FOR THE HOME

We then focused on the question asking whether the internalizing or the externalizing child had a greater need for help, the major causes of the problem, and the proposed interventions in the home. For all these questions, we used the log-linear method that uses chi-square distribution to test main and interaction effects. The chi-square statistic was used to determine whether rater differences existed concerning which child had a greater need for help. Only three variables were included in each log-linear model: rater, problem type, and the dependent variable in question.

Adults' ratings concerning which child needed more help. Log-linear analyses of 2 (rater) × 2 (problem type) frequency tables indicated that significantly more clinicians than parents thought the internalizing child had a greater need for help. Of clinicians, 74% reported that children with intern-

alizing problems had a greater need for help, as compared with 50% of parents reporting this, $\chi^2(1, 98) = 4.78$, $p < .05$. There were no significant differences between parents and teachers or between teachers and clinicians. No significant effects emerged for ratings of externalizing problems.

Adults' ratings concerning the major cause of each child's problems. Environmental causes were excluded from analyses that focused on problem causes because insufficient raters selected this option to allow reliable comparisons. A Rater × Problem Type interaction emerged for adult ratings concerning the causes for externalizing problems, $\chi^2(2, 115) = 9.33$, $p < .05$. A significantly larger proportion of parents (86%) than clinicians (55%) attributed externalizing problems to faulty child rearing, $\chi^2(1, 115) = 8.4$, $p < .004$. No significant differences emerged between teachers and the other two raters. For internalizing problems, no significant rater differences emerged for the major causes of the child's problems.

Intervention methods that adult raters proposed for the home. A Rater × Problem Type interaction also emerged for adult ratings concerning the intervention methods proposed for the home, $\chi^2(2, 200) = 7.29$, $p < .05$. A significantly greater proportion of teachers (76%) than parents (44%) endorsed behavioral intervention methods for externalizing problems, whereas parents (56%) were significantly more likely than teachers (24%) to suggest social or emotional support, $\chi^2(1, 66) = 6.80$, $p < .01$. Clinicians (70%) also were significantly more likely to endorse behavioral methods than were parents (44%), $\chi^2(1, 112) = 5.77$, $p < .05$. Teachers and clinicians did not significantly differ in their recommendations for externalizing problems. Only one significant difference emerged for internalizing problems, where a significantly greater proportion of teachers (60%) suggested behavioral interventions compared with only 32% of parents who suggested this intervention rather than social or emotional support.

RACE EFFECTS

The small number of Black clinicians and teachers in our sample precluded adding race as a dependent variable in the design described above. To address whether adult ratings varied according to race, the three adult groups in the sample were collapsed and the sample was divided into Black versus White adults. All analyses were repeated. Before conducting the analyses of interest, we tested whether each group of Black adults (i.e., parents, teachers, and clinicians) differed from one another according to each dependent variable.

No significant effects emerged between the groups. We were concerned that the number of Black clinicians and teachers was too small to afford sufficient power and thus yield the nonsignificant differences observed. Therefore, we collapsed African American teachers and clinicians into one group and compared their ratings with those of parents. These analyses again resulted in nonsignificant findings. To test for potential differences between the two groups of White raters, we compared White clinicians' ratings with those of White teachers. The results were nonsignificant.

Having completed the preliminary tests described above, we ran a 2 (rater race) × 2 (child gender) × 2 (problem type) repeated-measures ANCOVA. Similar to the repeated-measures ANCOVA analyses reported above, years of education was the covariate and child problem type (i.e., internalizing vs. externalizing) was the repeated-measures factor in the model. Separate analyses were done on ratings of seriousness, parent worry, teacher worry, unusualness, and likelihood of improvement. The ratings of African American adults revealed that they rated children described in both internalizing and externalizing vignettes as more serious than their White counterparts, $F(1, 154) = 6.8$, $p < .01$ (Ms = 5.97 and 5.53; SDs = 1.11 and .98, respectively), ES = 2%, which is small. Nevertheless, Black adults' ratings ($M = 2.04$, $SD = .88$) with regard to the chance of children exhibiting both sets of behavior improving were significantly higher than those of Whites ($M = 1.42$, $SD = .70$), $F(1, 153) = 15.34$, $p < .0001$, ES = 10%, which is medium. Interactions and all other main effects for the analyses reported above were not significant. Nonsignificant main and interaction effects emerged for the 3 (rater) × 2 (vignette child gender) × 2 (problem type) repeated-measures ANCOVAs for parent worry, teacher worry, and unusualness considered separately.

Besides the continuous variables, we also repeated the analyses on the categorical variables. Thus, we tested for race effects in ratings with regard to whether the internalizing or the externalizing child had a greater need of help, the major causes of the problem, and the proposed interventions in the home. As with the previous set of categorical analyses, we used the log-linear chi-square distribution. No race differences were found for which problem type required more help or for the major causes of internalizing and externalizing problems. In addition, no significant race differences were found for proposed home interventions for internalizing problems. However, a significant Race × Problem Type effect emerged for proposed home interventions, $\chi^2(1, 118) = 4.80$, $p < .05$. A significantly greater percentage of Whites (73%) than Blacks (53%) proposed behavioral methods for externalizing problems, whereas significantly more Blacks (47%) than Whites (27%) favored educational support. No other main or interaction effect was significant.

DISCUSSION

Parents of African American children, and teachers and clinicians who work with African American children, judged vignettes that described African American children with behavioral and emotional problems. The answer to the first research question, which focused on whether parents', teachers', and clinicians' ratings would differ, is a qualified yes. Few differences emerged for the three groups of adult ratings with regard to internalizing problems, but parent and teacher ratings for the externalizing vignette differed from those of clinicians. More specifically, parents and teachers viewed the child described with externalizing problems as more serious, but teachers' ratings also indicated higher levels of worry with regard to children with such problems when they placed themselves in the role of parent or teacher.

With regard to the second question, which focused on which child was in greater need for help, more clinicians than parents or teachers stated that the child with internalizing problems had the greatest need for professional intervention. The findings also suggested that the answer to the third question with regard to the race of the raters having an effect on their ratings was a qualified yes. Irrespective of problem type (i.e., internalizing or externalizing), Black raters' (i.e., parents, teachers, clinicians) ratings of seriousness were significantly higher than those of their White counterparts. However, their ratings with regard to the prognosis of the children's problems were more optimistic; Black raters were more likely to rate all children as being more likely to improve than were White raters.

Overall, the findings suggest that perhaps by nature of professional socialization (Weisz et al., 1988) and their race, different groups of adults viewed behavior problems from different perspectives. Similar to their Thai, Jamaican, and racially heterogeneous U.S. counterparts (Lambert et al., 1992; Weisz et al., 1988), teachers rated children with externalizing problems as significantly more serious and warranting significantly more parent and teacher worry than did clinicians. The findings from the present and earlier studies may be viewed in the context of the disruptiveness of children's externalizing behavior in classroom settings. Teachers may have lower thresholds of distress concerning problems than do clinicians, hence, the higher teacher ratings for that problem type.

It is interesting that African American parents also reported that the children who present externalizing problems are more serious than the children who experience internalizing problems. The sociocultural values that African Americans hold may explain these findings. African Americans are said to be collectivistic in their affiliations with not only members of their immediate

and extended family but those of the Black community in which most of them live (Boyd-Franklin, 1989). Similar to other children who exhibit externalizing problems, Black children with externalizing problems discharge their problems into their environment. The disruptive nature of externalizing problems may not only threaten African American children's alienation from members of the Black community but negatively affect the collectiveness that Blacks highly value. Because this behavior also severely violates the cultural norms most Blacks adhere to and inculcate in their children, it is not surprising that Black parents surveyed view such behavior as the product of faulty child rearing.

Differences between the ratings of African American parents and those of clinicians who treat African Americans are especially intriguing. Similar to teachers' ratings, African American parents view children with externalizing problems as most serious. Parents also viewed the same children as in great need for psychological intervention. One cannot be certain that the beliefs expressed here are suggestive of potential behavior (e.g., seeking professional services) of Black parents when faced with real children who present behavior problems. Nevertheless, the limited levels of concern that Black parents reported for children with internalizing behavior versus that for externalizing behavior may warrant intervention. That is, although not as disruptive as externalizing problems, internalizing problems reflect psychological disturbance and may be very distressing to children who experience them.

At a more microecological level, it may be important to raise African American parents' levels of concern with regard to the distress many children with internalizing problems experience. The importance of seeking clinical intervention for African American children with this type of problem also should be stressed. Clinicians also may be sensitized to the concern that Black parents experience with regard to childhood externalizing problems. They may need to acknowledge this concern when they meet with African American parents and children for intake and evaluation. Employing their knowledge concerning the comorbidity of internalizing and externalizing problems (see Tannock, 1998, for review), clinicians may consider assessing whether internalizing problems are salient. When appropriate, they should consider addressing such problems in Black children referred for externalizing problems.

While joining parents and other family members in treating the externalizing problems of African American youth, clinicians can simultaneously educate parents with regard to the presence and the risks (e.g., depression, suicidal thoughts and behavior) of some internalizing problems. By providing this and other information, clinicians can help African American parents

make appropriate judgments with regard to seeking professional help for their children with internalizing problems. Macroecological intervention may focus on community-based (e.g., religious organizations, community-based groups such as the urban league) presentations in didactic and discussion format with regard to internalizing problems in African American children.

Having focused on adults' beliefs concerning the seriousness and intervention needs of children with problems, it is also important to address the beliefs the different adult groups hold concerning the causes of children's problems. The majority of African American parents viewed faulty child rearing as the primary cause of externalizing problems that African American youth in the vignettes presented. Although responses to vignettes may not be reflective of their responses to real children with problems, the findings indicate that African American parents may be very likely to take responsibility for the externalizing problems children present and in some cases may even blame themselves or other parents when children present such problems.

By engaging Black parents as partners in the treatment process, clinicians who evaluate and treat these children may capitalize on the responsibility most African American parents are likely to assume for their children's problems. A more direct approach to treatment (e.g., behavior therapy, parent training) that directly involves parents may be very appealing to many African American parents. Clinicians should, however, be mindful that some parents may experience their responsibility for their children's problems as more paralyzing self-blame. Such a stance can lead to problems (e.g., depression) for the parents and other family members who attribute the causes of their children's problems to themselves and may warrant clinical intervention.

The findings presented and the inferences drawn thus far should be interpreted in the context of the race effects that emerged across all groups of adults. Black adults viewed African American children with either internalizing or externalizing problems as more serious than their White counterparts. Equally intriguing is the finding with regard to Black adults' tendency to see both internalizing and externalizing problems presented by African American youth as having good prognoses. Most teachers and clinicians who work with Black children in the area of the country sampled are White (Puig et al., 1999). It is important for White professionals in Michigan and other areas of the country to be aware of potential differences between their attitudes toward problems that Black youth present and those held by the youth's parents and other members of the African American community. For example, clinicians and teachers can join parents in adopting a sense of

responsibility for the problems that African American youth present. Embracing the sense of hope that Black adults have for African American youth and combining it with their strong sense of responsibility, professionals and adults in the Black community may more successfully intervene with troubled African American youth.

Turning to the ratings concerning types of home-based intervention that may benefit children with problems, the differences between parents' beliefs and those of teachers and clinicians are noteworthy. By virtue of their more collectivistic philosophy (Boyd-Franklin, 1989), more Black parents viewed intervention that included the whole community as more beneficial. Clinicians and teachers who were primarily of European heritage valued a more individualistic behavioral and child-centered approach. This finding also was upheld when the analyses focused on Black versus White adults, collapsed across the three groups of raters.

If adults' vignette ratings are indicative of their potential behavior when they confront real children with similar problems, specific steps should be taken to ensure that African American children who present behavior and emotional problems receive the help they need. Such steps could involve the achievement of two goals. One goal is to make professional services available for African American children and their families within the context of the school and other community-based systems (e.g., parent training and/or prevention programs). A second goal is to empirically focus on the attitudes and beliefs that African American families possess with regard to organized mental health treatment through further research. If this research reveals problematic attitudes and beliefs, one may address such attitudes and beliefs via education. The education process may be more successful if it is executed in the context of places of worship and other community groups where African Americans congregate and receive support.

The present findings also suggest a need for clinicians and teachers who work with Black youth to be more mindful of the collectivistic or more community-based intervention that Black adults value. A wraparound approach that uses resources in the Black community while respecting and including parents' collectivistic value for micro (family) and macro (community) systems might be most appropriate. However, simultaneously employing the individualistic approach when necessary also may be beneficial to the psychologically troubled Black youth and their families. For example, the behavioral approach may be an appropriate intervention to engage the Black family and African American youth in reducing self-destructive behavior (e.g., poor school performance, suicidal ideation or behavior). This method of intervention may be similarly effective when clinicians address problems that are harmful to others (e.g., verbal and physical aggression).

Despite the reasons for different ratings within or across different groups of adults, the differences in perspectives between clinicians and teachers and parents may be reason for concern. Unlike majority children, larger percentages of minority children (including African American) are referred for clinical intervention from the school system. Moreover, many clinicians who evaluate and treat African American and other children obtain information from both parents and teachers and in some cases conduct treatment within the school setting. Parental permission often is required for treatment initiation and their cooperation is needed for continuation of treatment. Similarly, teachers' cooperation often is necessary for referral, evaluation, and in some cases intervention (e.g., addressing classroom-based behavior). Slight differences in opinions between clinicians and the other groups of adults with regard to the severity of children's problems are not likely to inhibit successful assessment and intervention. However, marked disagreement might lead to lack of cooperation between clinicians and the other two sets of adults who are extremely important in African American child referral, assessment, intervention, and successful treatment outcomes.

Focusing on clinicians' beliefs concerning the seriousness of behavior problems that children described in the vignette presented is also important. Unlike teachers and parents who are the primary sources of child mental health referral, clinicians viewed the internalizing child as in greater need of help than their externalizing counterparts. Because research (e.g., Kazdin, 1987) has demonstrated poorer outcomes for children with externalizing behavior (see Capsi & Mofitt, 1995, for further review), the clinicians' belief that the child with internalizing problems needs more help defies empirical evidence. Several factors may account for this finding. First, clinicians' perspectives with regard to the severity of problem behaviors in African American children may differ from those that pertain to other racial-ethnic groups. Second, the training and experience that clinicians receive also may contribute to this view. Clinicians may receive more training in treating the internalizing child and the emphasis of their training may color their views. In addition, because children with internalizing problems have better outcomes than their externalizing counterparts, clinicians may obtain more gratification when they treat these youngsters. This gratification may positively bias clinicians' view toward the internalizing child.

The inferences drawn from the present study should be interpreted in the context of its shortcomings. One of its drawbacks is the low return rates for parents and teachers. We had no information on persons who did not respond and thus cannot be certain that their demographic and other important characteristics are represented in the participants who returned the survey. Thus,

one cannot be certain that the parent and teacher samples are entirely representative of the regions sampled. Although our sample of clinicians is highly representative of clinicians who treat Black youth, we collected no information on their training foci. Therefore, we could not test whether the foci influenced the results we obtained. The small number of Black clinicians and teachers sampled also made it impossible to test whether the opinions of these professionals varied according to their race. A final drawback is linked to the medium in which the material was presented to the participants. Similar to the findings of earlier research (e.g., Lambert et al., 1992; Weisz et al., 1988), we cannot be certain that the adults would respond exactly the same way to real children having the same constellations of problems presented in the vignettes.

An effective way of addressing this problem is through research that employs methods developed by Weisz and Weiss (1991). They developed a referability index statistic that tests adult referral behavior for different types of children's problems given their prevalence in the general population. Bolstering or refuting some of the inferences drawn from the above study would, nevertheless, require additional research using methodology similar to that used here. For example, sampling a larger group of adults across the nation and hypersampling Black clinicians and teachers may address problems associated with national representativeness. Such a sample also would allow more reliable comparisons of the professional attitudes and beliefs of African versus European heritage. To address the problems related with low return rate, it may be beneficial to use methodology suggested by Cauce, Ryan, and Grove (1998). This methodology includes investing more resources in establishing and maintaining personal contact with potential participants and in substantial payment for completing the surveys.

To summarize, although the present study possesses some shortcomings, it is the first study we know that specifically targets adult attitudes toward problems exhibited by African American children. It underscores the need for further research that addresses adult attitudes and behavior when they confront real African American children with behavior problems. However, the present study indicated marked differences in the attitudes that different adults have toward problems presented by hypothetical African American children, especially toward externalizing problems. Most important, it suggests that clinicians who treat African American children and families should be mindful of their own perspectives and be simultaneously cognizant of those held by Black parents. Recognizing and addressing biases that may hinder intervention while capitalizing on the strengths of African American children and their families (e.g., sense of responsibility and hope concerning

children's problems) may enhance clinicians' effectiveness in assessing and treating African American children and their families.

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