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**Behavior and Emotional Problems of
Clinic-Referred Children of the African Diaspora:
A Cross-National Study of African American
and Jamaican Children Ages 4 to 18**

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Societal factors influence the types of problems children of African descent exhibit and the steps adults take to ameliorate them. Cross-national research on children of African descent living in different nations can identify the societal issues associated with problems these children present, but few specifically focus on children of African descent. This article addresses these issues by surveying presenting problems in clinic records of 2,078 children of African descent in the United States and Jamaica. Recorders coded and categorized problems according to eight Child Behavior Checklist syndromes and internalizing (e.g., shyness) and externalizing (e.g., fighting) problems. ANCOVAs revealed significantly more problems for African American than Jamaican youth but the converse was true for severe problems. The findings suggest the need for further studies that test whether lower parental thresholds, a U.S. society that encourages more family openness, widely available treatment services within the United States, and stress associated with minority group membership may cause African American parents to report more child problems than Jamaican parents.

The theoretical and empirical literature base (for review, see Al-Issa, 1982; Marsella, 1979) has implicated sociocultural effects in the development of psychopathology. Recognition that societal customs and practices can

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influence child problems has led researchers to compare children in the United States with children from other societies including Australia (Achenbach et al., 1990), China (Weine, Phillips, & Achenbach, 1995), Holland (Achenbach, Verhulst, Edelbrock, Baron, & Akkerhuis, 1987), Jamaica (Lambert, Weisz, & Knight, 1989), Puerto Rico (Achenbach et al., 1990), and Thailand (Weisz et al., 1989).

Although findings from these cross-national studies are informative, none of the studies specifically focused on children of African descent or addressed the effects of race and other socioethnic factors on their findings. This oversight is problematic, as children's behavior and adults' tolerance and responses toward such behavior may vary according to racial and ethnic group composition within and across the societies surveyed (Malgady & Rogler, 1988). It is therefore possible that findings derived from earlier studies that combined racial groups obscured important variability in parent reports regarding children's problems, particularly of children of African descent.

The inattention to issues associated with race that is present in many national and international studies of child problems (e.g., Achenbach et al., 1987; Lambert et al., 1989) reflects a pervasive problem evident in many studies on behavior and emotional disorders. That is, researchers seldom focus specifically on children from ethnic minority groups within the United States. Researchers' neglect of children of color continues despite the perception that minority youth may have more behavior and emotional problems than their majority counterparts (American Psychological Society, 1996; McLoyd, 1995). Even more alarming is that although most behavioral science research is North American-based, researchers seldom focus on children of African descent even though they form the largest minority group in the United States (McLoyd, 1995).

To better identify and understand environmental effects on the behavior and emotional problems children of African descent present, it is important to study them within and across the different nations in which they reside.

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Historical events have led people of African ancestry to different countries across the world. Different nations in which children of the African diaspora reside usually have their own societal-based customs. The environmentally based mores and the challenges that emerge from these conventions can contribute to the psychological functioning of youth of the African diaspora. For example, the differences in the types of stressors and challenges faced by children and families in developing and industrialized nations like Jamaica and the United States respectively may lead to differences in the number and types of problems children of African descent in each society present.

Parents and children of African descent who reside in Western Eurocentric nations like the United States are often subjected to racism and other types of stress that these societies engender (American Psychological Society, 1996). Also, parents and children of African descent, who live in developing nations like Jamaica, must deal with their own set of stressors. A major source of stress Jamaican children and their families experience is that arising from the severe economic challenges their nation confronts. The stressors in both Jamaica and the United States can lead to psychological dysfunction, which can contribute to child behavior and emotional problems.

Regardless of the types of stressors and the challenges that children of African descent and their families confront, we know that their behavioral and emotional strengths and resiliency (e.g., Boyd-Franklin, 1990) can buffer problematic outcomes. The protective processes arising out of these characteristics may lead to similar outcomes for children of the African diaspora living in different nations. One may also speculate that shared demographic characteristics like age, gender, and the stress and challenges that are associated with these characteristics may override nationality problem differences. The annulling process of these factors may therefore lead to similar outcomes for children of African descent with similar demographic characteristics (e.g., age, gender) across different nations.

Research that focuses on children of African heritage from different nations with different customs, resources, and challenges therefore has the power to identify problems that differ or generalize across children of African descent. By sampling both boys and girls of different ages cross-nationally, this research can also ascertain whether certain problems are evident across one gender versus the other. More specifically, such research can determine whether age and gender effects are generalized across nations. Research on children of African descent in Jamaica and the United States provides a unique opportunity to address questions that are related to these issues.

African American and most Jamaican children are of African ancestry. The countries in which they reside share common European-based heritage (Higman, 1976; Ransford, 1971). However, the Jamaican versus U.S. societies vary in important ways. People of African descent are the majority group in Jamaica, whereas in the United States, they are clearly the largest minority group. In the United States, African American children and their families are bombarded by the cultural mores of the majority culture. Thus, though they may strongly maintain their African-based heritage and customs (Boyd-Franklin, 1989), they may still view child problems differently from families of African descent in Jamaica who are the majority group. That is, Jamaican children and families may more rigidly behave in ways dictated by their African heritage. For example, Jamaican families may more persistently adhere to the African-based perspective of suppressing the existence of externalizing problems (e.g., fighting, stealing). Conversely, they may facilitate internalizing problems (anxiety, depression) by default (Brice-Baker, 1996; Lambert et al., 1989).

Because their children may be more likely to develop internalizing problems, Jamaican parents may report more of these types of problems to clinicians during intake interviews than African American parents. Inversely, Jamaican parents' thresholds of distress regarding externalizing behavior in their children may be lower than those of African Americans. If the latter statement is true, Jamaican parents should report more externalizing problems to clinicians than African American parents during clinical intake interviews involving their children. The converse should be true for internalizing problems. An alternative perspective is that Jamaican parents may also strongly embrace the African perspective of not reporting problems outside their families (e.g., Lambert et al., 1989). They may therefore report fewer problems to clinicians, irrespective of problem type.

Jamaica's scarce economic resources and its impact on the availability of services for children may also contribute to parents' motivation to seek help for their children. More specifically, limited resources within Jamaica allow the provision of very few child treatment facilities that are scattered throughout the island and are at vast distances from many Jamaican families. The drain on the families' resources (e.g., monetary and time costs to travel vast distances) required to seek these scarce services may decrease Jamaican parents' motivation to seek services for their children. Thus, parents may report and seek help for only the few problems that they consider serious or severe enough to warrant obtaining clinical services for their children. When Jamaican parents report problems during clinical intake interviews, they may

therefore report fewer overall problems than their African American counterparts.

African American families are socialized to engage in behavior that is similar to that of Jamaican families. However, they are bombarded by the media and other cultural forces from the society in which they live. These societal factors may more heavily sensitize African American parents to their children's behavior and emotional problems and encourage them to more readily seek help for these problems. Also, despite the economic adversity many African American families face and the difficulties they often experience in finding culturally sensitive treatment options, they live in a society that affords them easier access to clinical services. These services are usually more readily available and are at a relatively more affordable cost than those Jamaican families receive. Such factors may lower African American parental thresholds to all types of child problems (i.e., internalizing and externalizing) and thus encourage them to report more child problems (i.e., irrespective of problem types) to clinicians than Jamaican parents.

Finally, by virtue of the devastating effects of different types of stressors (e.g., economic and those associated with racism) that each respective group experiences, children from one group may present more problems than the other. Thus, the complexity of sociocultural issues associated with parents and children of African descent residing in different nations with different challenges and stressors can lead to a variety of outcomes.

The present study begins to address these problems by focusing on children of African descent in both Jamaica and the United States. Thus, we surveyed children's problems that parents or guardians (hereafter referred to as parents) of African American and Jamaican children of African descent reported during clinical intake interviews. Although we know that other informant (e.g., teachers) can provide useful information on children's problems, we focused specifically on parents' reports. Parents are instrumental in initiating child referral and they provide critical information (e.g., on home-based problems) to clinicians during child assessment about which other reporters (e.g., teachers) have no knowledge (Achenbach, 1991).

An earlier cross-national study of U.S. and Jamaican children (Lambert et al., 1989) revealed higher numbers of internalizing and lower numbers of externalizing problems for girls compared to boys cross-nationally. It also revealed more overall problems for younger than older children across both nations. This study, however, contained a racially diverse U.S. sample and a predominantly African Jamaican sample. Thus, one could not determine whether the findings observed were applicable to children of African descent across both nations. We therefore explored whether similar findings would

emerge for homogenous racial groups of African descent across Jamaica and the United States.

Because the present study was exploratory, we focused on four primary questions of interest: (a) will there be nationality differences in the number of problems reported? (b) will gender effects emerge (i.e., across the two nations) for total number of problems or for problem type (e.g., internalizing vs. externalizing)? (c) will age effects (i.e., across the two nations) emerge for total number of problems and for problem type? and (d) For children's problems deemed most serious/severe, will parents from one nation versus the other report more of the severe problems than their counterparts?

To address the research questions listed above, we tested for nationality, gender, and age effects and the interactions of age and nationality on each of eight syndromes of the Child Behavior Checklist (CBCL) (Achenbach, 1991) and on internalizing, externalizing, and total problems (see problem classification below for more detailed descriptions of the CBCL and its dimensions) considered separately. Finally, we tested for nationality, gender, and age main effects and for two-way interactions between nationality and gender for a total number of 23 items judged to be most serious of the 118 CBCL problems by three clinicians trained in clinical child psychology.

METHOD

SAMPLE

The native Jamaican sample ($N = 474$) was collected from 12 child assessment and treatment facilities throughout the island of Jamaica during 1995 to 1997. It consists of 291 boys and 183 girls, ages 4 to 18 ($M = 11.58$, $SD = 3.27$). The U.S. sample consists of 1,604 clinic children drawn from 14 child treatment facilities throughout Michigan in 1995. It includes 982 boys and 622 girls, ages 4 to 18 ($M = 10.84$, $SD = 3.71$). The Jamaican sample's mean age was significantly higher than that of the U.S. sample ($p < .001$). Therefore, for all analyses, we not only tested for age effects but concurrently controlled for their effects on the other independent variables.

DATA COLLECTION PROCEDURES

The Jamaican and U.S. data were collected from intake assessment records. Six trained reviewers in each nation reviewed the entire clinic record

of each child sampled. They then recorded verbatim each youth's problem as reported to admitting clinicians during clinical intake interviews.

PROBLEM CLASSIFICATION

Appropriate coding of clinic-referred items required the use of a well-validated measure with empirically based classification categories. The CBCL and its classification system were chosen for this task, as it is well researched and widely used in national and international research including the United States and Jamaica (Achenbach, 1991; Lambert & Lyubansky, 1999; Lambert, Lyubansky, & Achenbach, 1998; Lambert et al., 1989).

CBCL. The CBCL comprises demographic items (e.g., age, gender, grade in school), 7 social competence items (e.g., sports activities, hobbies), and 118 problem items. Parents rate their children on each problem item according to 3-point Likert scales (e.g., 0 = *not true*, 1 = *sometimes or somewhat true*, and 2 = *very true or often true*). For the present study, only the problem items of the CBCL were employed. The clinic records of Jamaican and African American children contained little demographic or competence information other than age and gender, making it impossible to focus on other important demographic variables (e.g., socioeconomic status [SES]) or social competence.

Principal components analyses of parent ratings of their clinic-referred children on the CBCL problem items have yielded eight syndromes labeled Withdrawn (e.g., rather be alone, won't talk), Somatic Complaints (e.g., dizzy, headaches), Anxious/Depressed (e.g., cries, fearful), Social Problems (e.g., acts too young, clings), Thought Problems (e.g., hears things not there, sees things not there), Attention Problems (e.g., can't sit still, impulsive), Delinquent Behavior (e.g., swears, steals), and Aggressive Behavior (e.g., mean, attacks others). Second-order principal factor analyses of the syndromes have yielded the internalizing and externalizing groupings of the syndromes.

Method of problem classification. Four coders coded each child's presenting problems as matching or not matching the CBCL. Prior to formal coding, each coder first reviewed and coded items from a sample of 50 cases. They then checked their coding and reconciled differences when they occurred. During formal coding, all coders coded a separate set of 50 cases without the knowledge that those cases were selected as reliability check cases. Agreement between the coders was good, as the mean agreement between each set

of possible pairs was 83%. For presenting problems on the 50 reliability cases that were deemed to have a CBCL match, the coders agreed 70% of the time as to which CBCL item each presenting problem appropriately matched.

DATA ANALYSES

Each syndrome and internalizing versus externalizing groupings had different numbers of item loadings. Specifically, the number of items loading on Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent Behavior, and Aggressive Behavior were 9, 9, 14, 8, 7, 11, 13, and 20, respectively. For internalizing and externalizing, the item loadings were 32 and 33, respectively. To provide a common metric across the different problem categories, we converted the number of items each child presented under each category to percentages. Therefore, we first divided the number of items each child presented that matched a given category by the total number of items loading on that category. Second, we multiplied that number by 100 to convert it to percentages. For example, the total number of items on the Withdrawn syndrome is 9. Therefore, each child's number of problems on this syndrome was divided by 9 and multiplied by 100. Similar procedures were applied for the seven other syndromes and for the internalizing and externalizing problems.

The main set of analyses consisted of 2 (nationality) \times 2 (gender) analyses of covariance (ANCOVAs) with age entered into the model as a continuous variable and covariate. Therefore, age effects were simultaneously tested and partialled out within the model. The ANCOVAs were performed on each of the eight syndromes, internalizing problems, externalizing problems, and total problems as dependent variables considered separately. Thus, we performed 11 separate analyses. We applied the Bonferroni alpha correction criterion (Cliff, 1987) to reduce the chance of Type 1 error. Thus, only effects with an alpha of .0045 or less were deemed significant.

Also, we used Cohen's (1988) criteria that consider ANCOVA effect sizes (ES) as small, medium, and large if they account for 1% to 5.9%, 5.9% to 13.8%, and greater than 13.8%, respectively, to judge the size of significant effects. For analyses involving total problem scores, we conducted two waves of analyses. The first wave included all problems that had a CBCL equivalent. The second wave of the analyses included non-CBCL problems. The two waves of analyses yielded similar results. Thus, we report only the total problem scores that included the CBCL items only.

TABLE 1
Means and Standard Deviation Values
for All Nationality and Gender Effects

	<i>African Americans</i>		<i>Jamaicans</i>		<i>Boys</i>		<i>Girls</i>	
	M	SD	M	SD	M	SD	M	SD
Withdrawn	.26	.53	.10	.36	.20	.49	.26	.53
Somatic Complaints	.02	.14	.03	.17	.02	.15	.02	.14
Anxious/Depressed	.32	.61	.10	.34	.22	.52	.36	.64
Social Problems	.12	.35	.05	.22	.10	.33	.11	.32
Thought Problems	.08	.32	.07	.30	.08	.30	.09	.35
Attention Problems	.77	1.04	.32	.60	.80	1.06	.48	.79
Delinquent	.52	.88	.37	.77	.53	.90	.46	.79
Aggressive	1.40	1.29	.61	.95	1.36	1.29	1.06	1.20
Internalizing problems	.46	.79	.20	.50	.35	.69	.49	.81
Externalizing problems	1.92	1.64	.98	1.30	1.89	1.64	1.52	1.54
Total problems	3.85	2.22	1.75	1.54	3.62	2.22	3.16	2.16

RESULTS

Overall, the ANCOVA analyses revealed that African American parents reported more problems to clinicians during clinical intake interviews than their Jamaican counterparts. Jamaican parents, however, reported more problems that were classified as severe problems even when the analyses controlled for the total number of problems that parents in each nation reported. No two-way interactions (i.e., involving nationality and gender) emerged for the initial set of analyses that tested for nationality, gender, and age effects. Interactions were similarly absent from the next set of analyses that tested for nationality, gender, and age effects on the total number of severe problems. Table 1 lists the means and standard deviations for all nationality and gender effects. All means are adjusted for the age covariate. Therefore, the means presented are least squares means.

NATIONALITY EFFECTS

Nationality main effects emerged for Withdrawn, Anxious/Depressed, Social Problems, Attention Problems, Aggressive Behavior, internalizing and externalizing problems, and total problems. African American parents rated children higher on all dimensions that were significant (see Table 1 for mean percentages). The F values for each significant effect were $F(1, 2009) =$

30.98, 49.38, 12.93, 65.62, 83.96, 33.46, 65.62, and 275.98, respectively. With the exception of Social Problems, which had a p value of .0003, the p values for all significant nationality effects equaled .0001. Except for the total problem score that was a medium ES, all significant effects were small.

Testing for severe/serious referral problems. We were concerned that the significant nationality main effects reflecting more problems for African American children on all dimensions and especially on total problems emerged because Jamaican parents primarily reported problems that might be deemed serious or severe. This procedure required determining which problems on the CBCL might be deemed more severe than others. That is, which items might be severe enough to almost always trigger adults to refer children for professional services. A search of the literature base revealed no studies that classified CBCL problems according to severity.

Two clinicians who have extensive clinical and research experiences with the CBCL were asked to classify independently the problems according to severity. Specifically, they were asked to categorize problems that they judged severe/serious enough to warrant referral versus those that were not severe. The clinicians were a 6th-year doctoral candidate in child clinical psychology and a 3rd-year doctoral student in child clinical psychology. Together they had administered approximately 100 CBCLs in clinical settings and have managed and analyzed data sets with more than 2,000 CBCLs. One clinician had administered the CBCL in both Jamaica and the United States.

The clinicians agreed more than 80% of the time regarding which items were considered severe. For items one clinician considered as severe but the other did not, the ratings of a third clinician who also independently rated the items were considered as a tie breaker. The third clinician is an associate professor of clinical child psychology. This clinician is a Jamaican native who received professional training in both Jamaica and the United States and has more than 20 years of clinical experience in working with African American and Jamaican children and families. If this clinician agreed with either of the original clinicians regarding specific problem items on which they disagreed, the items were classified according to agreement between two of the three clinicians. The method of severe versus less serious problem classification led to the classification of 23 of the 118 CBCL problems as severe. The severe/serious problems are listed in Table 2.

Interestingly, more than half (i.e., 13) of the 23 severe problems are loaded under Delinquent (e.g., sets fires, uses alcohol or drugs), Aggressive Behavior (e.g., physically attacks people, cruelty, bullying or meanness to others) or

TABLE 2
Severe/Serious Child Behavior Checklist (CBCL) Items

<i>CBCL Number</i>	<i>Item</i>
6	Bowel movements outside toilet
9	Can't get his or her mind off certain thoughts (obsessions)
15	Cruel to animals
16	Cruelty, bullying, or meanness to others
18	Deliberately harms self or attempts suicide
21	Destroys things that belong to his or her family or others
26	Doesn't seem to feel guilty after misbehaving
28	Eats or drinks things that are not food
34	Feels others are out to get him or her
40	Hears sounds or voices that aren't there
57	Physically attacks people
59	Plays with own sex parts in public
66	Repeats certain acts over and over (compulsions)
67	Runs away from home
70	Sees things that aren't there
72	Sets fires
78	Smears bowel movements
84	Strange behavior
85	Strange ideas
91	Talks about killing self
97	Threatens people
105	Uses alcohol or drugs for nonmedical purposes
107	Wets self during the day

Thought Problems (hears sounds or voices that aren't there, sees things that aren't there) syndromes. The problems on these syndromes reflect problems that meet the diagnostic categories for two of the most severe syndromes in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994). The syndromes are conduct disorder and schizophrenia, and are stable and have very poor prognoses with and without intervention (for a review, see Wicks-Nelson & Israel, 1991).

The scores of all children sampled across the two nations were totaled according to the 23 severe problems. We tested for nationality, gender, and age effects and for interactions between the nationality and gender independent variables on total severe problems. Thus, we ran a 2 (nationality) \times 2 (gender) ANCOVA with age entered as a continuous variable and covariate in the model and total severe problems as the dependent variable. As we predicted, Jamaican parents reported more severe child problems than their African American counterparts, $F(1, 2015) = 135.59, p < .0001$. The means for the

African American sample was .23 versus .76 for Jamaicans. No gender, two-way interaction effects between nationality and gender emerged, but a significant age effect emerged across the two nations for problems classified as severe, $F(1, 2015) = 10.86, p < .0001, r = .07$, reflecting that parents of older children reported more severe problems.

To address whether the findings may have emerged simply because U.S. parents reported higher numbers of all child problems than their Jamaican counterparts, we repeated the ANCOVA analysis controlling for total number of problems reported (i.e., entering it as an additional covariate with age) in the model. The nationality effects remained significant, $F(1, 2015) = 29.28, p < .0001$, but the differences between the means (African American = 47%, Jamaican = 71%) were smaller than those that did not control for total problems. Age effects also remained significant, but with a higher (i.e., with total problems partialled out) correlation coefficient ($r = .12$).

AGE EFFECTS

Significant age main effects were found for Withdrawn, Anxious/Depressed, Thought Problems, Attention Problems, Delinquent Behavior, Aggressive Behavior, internalizing problems, and total problems. $F(1, 2009) = 66.41, 39.46, 23.57, 65.62, 31.04, 33.87, 35.94, \text{ and } 23.57$, respectively (all $p < .0001$, and all ESs small). The parents of younger children reported more Attention Problems, Aggressive Behavior, and total problems for their children than older children's parents reported. However, the parents of older children reported more Withdrawn, Anxious/Depressed, Delinquent Behavior, and internalizing problems in their children than the parents of younger children reported.

GENDER EFFECTS

Significant gender main effects emerged for Anxious/Depressed, Attention Problems, Aggressive Behavior, internalizing and externalizing problems, and total problems. $F(1, 2009) = 34.21, 128.81, 27.29, 18.73, 24.08, \text{ and } 21.08$, respectively (all $p < .0001$, and all ESs small). Boys obtained higher numbers of problems for all but Anxious/Depressed and internalizing problem dimensions.

MOST COMMON PROBLEMS

Although we conducted analyses on the composite syndromes, internalizing, externalizing, and total problems, we tallied the number of children in

TABLE 3
Twelve Most Common Referral Problems
in African American and Jamaican Samples

<i>Problem</i>	<i>Problem Type</i>	<i>United States^a</i>	<i>Jamaica^b</i>	χ^2	<i>p</i>
African American sample					
1. Uncooperative	N	24.4	7.9	69.6	< .001
2. Temper tantrums	E	23.5	3.7	107.38	< .001
3. Can't sit still	E	21.2	7.9	49.76	< .001
4. Often fights with others	E	21.1	6.0	64.85	< .001
5. Cruel or mean to others	E	20.1	2.19	99.7	< .001
6. Disobedient at home	E	19.5	17.2	1.49	<i>ns</i>
7. Disobedient at school	E	18.3	6.6	43.25	< .001
8. Cannot concentrate or pay attention	O	17.5	3.3	69.31	< .001
9. Poor school work	O	16.1	11.3	7.25	.007
10. Unhappy, sad, or depressed	I	14.3	2.4	58.25	< .001
11. Impulsive, acts without thinking	O	13.1	2.2	52.38	< .001
12. Mischievous or naughty	N	10.0	3.3	24.44	< .001
Jamaican sample					
1. Disobedient at home	E	19.5	17.2	1.49	<i>ns</i>
2. Poor school work	O	16.1	11.3	7.25	< .001
3. Lying or cheating	E	9.3	9.9	.15	<i>ns</i>
4. Can't sit still	O	21.2	7.9	49.76	< .001
5. Uncooperative	O	24.4	7.9	69.6	< .001
6. Steals at home	E	2.9	7.4	22.72	< .001
7. Disobedient at school	E	18.3	6.6	43.25	< .001
8. Stubborn, sullen, or irritable	E	5.0	6.2	1.28	<i>ns</i>
9. Often fights with others	E	21.1	6.0	64.85	< .001
10. Plays too much	N	.2	6.0	85.10	< .001
11. Stays away from home without permission	N	1.4	5.1	24.11	< .001
12. Poor hygiene	N	.7	4.6	37.62	< .001

NOTE: I = internalizing problems, E = externalizing problems, O = other Child Behavior Checklist (CBCL) problems (i.e., not loading exclusively on either internalizing or externalizing), and N = not included on the CBCL.

a. Percentage of African American children for whom parents reported each problem in the column.

b. Percentage of Jamaican children of African descent for whom parents reported each problem in the column.

each sample for whom each individual problem was reported. We focused on the 12 most common problems in the two samples. The 12 most frequently reported problems for children in both nations are listed in Table 3. Each problem in the table is identified as I (reflecting the item loaded under the internalizing dimension), E for loading under externalizing problems, O for

other (meaning that they did not load exclusively under either dimension), and N depicting that the items were not listed on the CBCL.

We also conducted chi-square tests of association on the 12 most frequently reported items in each sample. Thus, we determined whether the proportions of parents from one sample versus the other reported significantly more problems. Table 3 also lists the results of these analyses. It indicates that, of the 12 most common problems for the African American sample, significant effects emerged for 10 items. These effects indicated that significantly larger proportions of the African American parents reported these 10 problems to clinicians during clinical intake interviews. This finding contrasts with analyses of the 12 most common items for the Jamaican sample. Significantly larger proportions of Jamaican parents reported only 3 of the 12 most frequently occurring Jamaican items. Interestingly, significantly larger proportions of African American parents reported 5 of the 12 most common problems that Jamaican parents reported. By contrast, for the 12 most common problems African American parents reported, no proportions of Jamaican parents who reported those problems were significantly larger than proportions of their African American counterparts that reported the same problems.

DISCUSSION

African American parents reported significantly more child problems on most problem dimensions and reported more total problems than Jamaican parents. However, for 23 child problems coded as most severe, Jamaican parents reported significantly more of these problems than their U.S. counterparts. This finding emerged even when the analyses controlled for the total number of all problems that parents across both nations reported. The findings suggest that due to Jamaican parents' tendency to withhold childhood problems from outsiders (e.g., clinicians; see Lambert et al., 1989), they may have reported significantly fewer problems than their African American counterparts.

The findings should, however, also be interpreted within the context of knowledge pertaining to the limited access most Jamaican families have to child clinical services. Jamaican parents seemed more likely than their African American counterparts to seek services mainly for severe problems. The severe problems that Jamaican parents reported may be reflective of problems that reach or surpass these parents' thresholds of distress for their children's problems and trigger help-seeking behavior. Thus, Jamaican parents

may mostly report severe problems to clinicians during intake interviews and lead to the findings observed in the present study.

The higher number of internalizing and externalizing problems and total number of problems African American parents reported may be indicative of their lower thresholds for child problems in general compared to the high thresholds of their Jamaican counterparts. However, the higher rates of child behavior and emotional problems African American parents reported may also be related to the effects of stress African American children experience as members of a minority group within the United States (McLoyd, 1990). The high levels of stress experienced by African American children may lead them to exhibit more behavior and emotional problems than their counterparts in Jamaica. Despite Jamaica's status as a developing nation and the challenges that accompany countries with this label, children of African descent represent Jamaica's majority group. More specifically, the absence of race-related stress may buffer Jamaican youth from the devastating psychological problems African American children experience.

Having discussed cross-national differences, we now turn to similarities in cross-national findings. Though there is value in establishing the existence of cross-national differences, most cross-cultural researchers (e.g., Weisz et al., 1987) agree that recognizing the presence of cross-national similarities is equally important. Like earlier research that compared racially diverse U.S. child samples with Jamaican (Lambert et al., 1989) and Thai children (Weisz et al., 1987), age and gender differences emerged for total number of problems and problem type, respectively. Parents across both nations reported more externalizing and less internalizing problems for boys than for girls and more problems for younger than older children. The results suggest that the age and gender effects observed in research on racially heterogeneous cross-national groups (e.g., Weisz et al., 1987) may be evident in the racially homogeneous groups of children of African descent who reside in two different nations. However, the present findings contrast with earlier cross-national racially heterogeneous studies (e.g., Lambert et al., 1989; Weisz et al., 1987) that found no gender difference in the number of problems reported. In the present study, parents across both nations reported significantly more problems for boys than girls of African descent.

The present findings suggest that some gender-related findings may differ when research focuses exclusively on the two international groups of children from the African diaspora versus cross-national research that surveys ethnically heterogeneous groups of children. The gender effects observed in the present study also suggest that, like older African American males (Harris, 1995), boys of African descent in both nations are at greater risk for

developing psychopathology. Boys may therefore exhibit more behavior and emotional problems than their female counterparts.

The type of informant may be another contributing factor to the findings observed in the present study. Like other socioethnic groups (see Achenbach, 1991), mothers of African descent most often accompany and report on children's problems during clinical assessment. Mothers may have lower thresholds of distress for all types of problems that boys exhibit. Differences in mothers' gender-related child problem thresholds may lead them to report more problems to clinicians when they seek clinical services for their sons. The gender-related differences in total problems may also reflect the possibility that the problems girls present may be expressed in less severe magnitude than when boys exhibit the same problems. Parents may therefore more readily refer boys for clinical intervention than their female peers, even though children of both genders present similar problems.

Although the findings from the present study are intriguing, they must be interpreted with caution. Part of the sample was drawn from most regions of Jamaica, but the other portion was drawn from Michigan. Therefore, it is not representative of the entire United States, which makes it difficult to generalize across all areas of both countries. Also, most clinics from which we sampled were located in urban areas. Therefore, we know that the largest proportion of children in both samples were urban dwellers. Nevertheless, the archival nature of the study precluded us from obtaining reliable information on which children resided in urban versus rural areas of each nation. We also had no reliable information on the sources of referral in both nations. Thus, we could not test whether problem type, total number of all problems, or severe problems differed according to referral source or urban versus rural area of residence.

Another drawback of the present study is that, although we know that strengths are important in buffering stress and its contribution to problem outcomes, the archival data did not permit adequate assessment of strengths within and across the two groups of youth we surveyed. Equally important are the biases associated with reports parents make to clinicians. For example, we cannot be certain that the unstructured reports reflect problem prevalence rates in both populations.

Another shortcoming is our reliance on the CBCL to classify children's problems across both nations. We have no information on whether the factors (i.e., syndromes) identified from the CBCL validation samples (composed primarily of European American children) are appropriate for either of the two samples of African descent surveyed in the present study. Another problematic issue in the present study is the absence of SES variables in our

statistical analyses. We know that SES is negatively correlated with psychopathology (Dohrenwend et al., 1992). The absence of reliable SES data in both samples, however, made it impossible to test and control for its effects. Further compounding this problem is the absence of reliable and valid measures of SES for Jamaican children.

Further studies that design and standardize appropriate SES measures for Jamaicans are needed. Use of a standard child problem measure with a wide variety of items (e.g., the CBCL itself) to survey large samples of urban and rural children from clinical and general populations in both nations is needed. Clinic and general population CBCL data can provide an opportunity to test whether cross-national problem similarities (e.g., gender and age effects) and differences (e.g., nationality effects) identified here are present in both populations. A standard measure can also test whether the problem similarities and differences reported here represent the base rates in general populations of children of African descent in both nations. Larger clinic samples can also allow confirmatory factor analyses to determine whether the original CBCL syndromes are replicated in Jamaican and African American samples. It is also important to address whether problem prevalence and problem type (e.g., internalizing versus externalizing) differ according to urban versus rural place of residence.

Data from a standard instrument with an appropriate rating scale like the CBCL can also allow the testing of magnitudes in severity of the problems parents report for girls versus boys. Problems on rating scales are usually not only recorded as present or absent but are also rated according to severity. Data from these measures can therefore provide an opportunity to test for gender differences in the severity or magnitude of problems parents report for boys versus girls. By comparing data derived from male and female parents on the instruments, one can also test whether parent reports vary in number, type, and severity according to the gender of the parent who reports the problems and the gender of the child on whom the report is given.

Also important is research that directly tests stress levels in African American versus Jamaican children. This research should also address whether the stressors that children in both nations experience are mediated by their majority versus minority status. If this research proves that group status mediates stress, further research might assess the contributions of stressors and their mediating variables to the types and magnitude of problems that youth of African descent in both Jamaica and the United States present. Combining this research with studies that assess behavioral and emotional strengths and resiliency in African American and Jamaican children may

provide important insight into the interrelation of both sets of factors on children's strengths and difficulties. Future research may also address the effects of these predictors on the number and types of child behavior problems, and whether they interact with children's ages and gender.

Research that tests the effects of children's problems on Jamaican and African American parents' distress thresholds is also needed. This research should also focus on parents' tolerance for problems that their children present and whether their distress thresholds vary according to children's gender and the availability and proximity of clinical services. Other projects that investigate the steps parents take to ameliorate their children's problems, and how they deliberate their help-seeking options and arrive at a decision to refer their children for professional services, are also important. The results from such studies can extend and further elucidate the findings of the present study. Specifically, these studies can identify both the factors that contribute toward psychopathology and those that buffer problems in Jamaican and African American youth. The studies can also determine whether adults who are charged with the task of being primary caretakers of children differ in attitudes and thresholds according to the nations in which they and their children live.

As discussed above, the present research possesses some limitations (e.g., reliance on archival data, absence of SES information). Nevertheless, it is the first study we know that compares problems presented by children of the African diaspora from an industrialized country and those in a developing nation. The study has generated important information on problems presented by clinic-referred children of the African diaspora and provides a foundation on which future research efforts can be built. Furthermore, the results suggest important issues that clinicians who treat children in both nations or who treat immigrants from either nation might consider. Clinicians should be mindful of the impact of cultural mores (e.g., willingness to report behavior and emotional problems) on the types (e.g., severe vs. less severe) of problems parents of the African diaspora report when they seek clinical services for their children. Additionally, the inferences drawn from the study indicate that in assessing and treating children of African descent, clinicians from both nations should consider the unique stressors (e.g., economic and race-related) that affect these children. Finally, they should bear in mind the presence and magnitude of factors that possibly buffer or contribute to the stress Jamaican and African American children experience and how the stressors influence the problems that these children present.

REFERENCES

- Achenbach, T. M. (1991). *Integrative guide for the 1991 CBCL/4-18, YSR, and TRF profiles*. Burlington: University of Vermont, Department of Psychiatry.
- Achenbach, T. M., Bird, H., Canino, G., Phares, V., Gould, M. S., & Ruubio-Stipek, M. (1990). Epidemiological comparisons of Puerto Rican and U.S. mainland children: Parent, teacher, and self-reports. *Journal of the American Academy of Child and Adolescent Psychiatry*, 29, 84-93.
- Achenbach, T. M., Hensley, V. R., Phares, V., & Grayson, D. Problems and competencies reported by parents of Australian children. *Journal of Child Psychology and Psychiatry*, 31, 265-286.
- Achenbach, T. M., Verhulst, F. C., Edelbrock, C., Baron, G. D., & Akkerhuis, G. W. (1987). Epidemiological comparison of American and Dutch children: II: Behavioral/emotional problems reported by teachers for ages 6-11. *Journal of the American Academy of Child and Adolescent Psychiatry*, 26, 326-332.
- Al-Issa, I. S. (1982). *Culture and psychopathology*. Baltimore, MD: University Park Press.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- American Psychological Society Human Capital Initiative. (1996). Reducing mental disorders: A behavioral science research plan for psychopathology [Special issue]. *APS Observer*, (3).
- Brice-Baker, J. (1996). Jamaican families. In M. McGoldrick, J. Gordon, & J. K. Pearce (Eds.), *Ethnicity and family therapy* (pp. 85-96). New York: Guilford.
- Boyd-Franklin, N. (1989). *Black families in therapy: A multisystems approach*. New York: Guilford.
- Boyd-Franklin, N. (1990). Five key factors in the treatment of Black families. In G. W. Saba, B. M. Karner, & K. V. Harvey, *Minorities and family therapy* (pp. 53-69). New York: Haworth Press.
- Cliff, N. (1987). *Analyzing multivariate data*. New York: Harcourt Brace Jovanovich.
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). New York: Academic Press.
- Dohrenwend, B. P., Levav, I., Schrot, P. E., Schwartz, S., Naveh, G., Link, B. G., Skodol, A. E., & Stueve, A. (1992). Socioeconomic status and psychiatric disorders: The causation-selection issue. *Science*, 225, 946-952.
- Harris, S. M. (1995). Psychological development and Black male masculinity: Implications for counseling economically disadvantaged African American male adolescents. *Journal of Counseling and Development*, 29, 279-287.
- Higman, B. W. (1976). *Slave population and economy in Jamaica*. New York: Cambridge University Press.
- Lambert, M. C., & Lyubansky, M. (1999). Behavior and emotional problems of children and adolescents in urban and rural Jamaica: Teacher, parent, and self reports for ages 6-18. *International Journal of Intercultural Relations*, 56, 1-25.
- Lambert, M. C., Lyubansky, M., & Achenbach, T. M. (1998). Behavioral and emotional problems among adolescents of Jamaica and the United States: Parent, teacher, and self reports for ages 12-18. *Journal of Emotional and Behavioral Disorders*, 6, 180-187.
- Lambert, M. C., Weisz, J. R., & Knight, F. (1989). Over- and undercontrolled clinic referral problems of Jamaican and American children and adolescents: The culture general and culture specific. *Journal of Consulting and Clinical Psychology*, 57, 465-472.
- Malgady, R. G., & Rogler, L. H. (1988). Reply to "The empirical basics of ethnocultural and linguistic bias in mental health." Evaluations of Hispanics. *American Psychologist*, 43, 1097.

- Marsella, A. J. (1979). Cross-cultural studies of mental disorders. In A. J. Marsella, R. J. Tharp, & T. J. Ciborowski (Eds.), *Perspectives in cross-cultural psychology* (pp. 233-262). New York: Academic Press.
- McLoyd, V. C. (1990). The impact of economic hardship on Black families and children: Psychological distress, parenting, and socioemotional development. *Child Development, 61*, 311-346.
- McLoyd, V. C. (1995). Methodological and conceptual issues in the study of children of color. In H. E. Fitzgerald, B. E. Lester, & B. Zuckerman (Chairs), *Children of color: Research, health, and public policy issues*. Round table conducted at the biennial meeting of the Society for Research in Child Development, Indianapolis, Indiana.
- Ransford, O. (1971). *The slave trade: The story of transatlantic slavery*. London: John Murray.
- Weine, A. M., Phillips, J. S., & Achenbach, T. M. (1995). Behavioral and emotional problems among Chinese and American children: Parent and teacher reports for ages 6 to 13. *Journal of Abnormal Child Psychology, 23*, 619-639.
- Weisz, J. R., Suwanlert, S., Chiayasit, W., Weiss, B., Achenbach, T. M., & Trevathan, D. (1989). Epidemiology of behavioral and emotional problems among Thai and American children: Teacher reports for ages 6-11. *Journal of Child Psychology and Psychiatry, 3*, 471-484.
- Weisz, J. R., Suwanlert, S., Chiayasit, W., Weiss, B., Achenbach, T. M., & Walter, B. R. (1987). Epidemiology of behavioral and emotional problems among Thai and American children: Parent reports for ages 6 to 11. *Journal of the Academy of Child and Adolescent Psychiatry, 20*, 190-197.
- Wicks-Nelson, R., & Israel, A. C. (1991). *Behavior disorders of childhood* (2nd ed.). Englewood Cliffs, NJ: Prentice Hall.