Acculturation, Religiosity, and Ethnicity Predict Mothers' Causal Beliefs About Separation Anxiety Disorder and Preferences for Help-Seeking

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Abstract:

This study examined causal beliefs about separation anxiety disorder (SAD) and preferences for help-seeking among 117 Indian American, Puerto Rican, and European American mothers. Mothers completed measures of acculturation and strength of religious faith (SORF) and, after reading vignettes describing SAD, made judgments about the etiology of symptoms and the likelihood of various forms of help-seeking for youth SAD symptoms. Hierarchical multiple regressions revealed that acculturation to mainstream American culture and SORF predicted mothers' causal beliefs and preferences for help-seeking. In addition, Puerto Rican mothers were more likely than European American mothers to attribute symptoms to medical causes after accounting for cultural variables. Results highlight the importance of examining cultural constructs that contribute to ethnic group differences. Implications for future research and clinical practice are discussed.

Keywords: Acculturation | religious faith | child anxiety | help-seeking

Article:

Anxiety disorders are among the most common conditions affecting youth (Chavira, Stein, Bailey, & Stein, 2004; Costello, Mustillo, Keeler, & Angold, 2004) and are associated with impairments in school, family, and social functioning (Chansky & Kendall, 1997; Van Ameringen, Mancini, & Farvolden, 2003). Cognitive behavioral therapy often results in meaningful improvements in anxiety and associated impairment (Kendall, Hudson, Gosch, Flannery-Schroeder, & Suveg, 2008; Walkup et al., 2008). Unfortunately, children of Latin American and Asian descent utilize psychological treatments for anxiety and other psychiatric disorders at lower rates than Caucasian children, and these disparities remain even after

accounting for symptom severity and socioeconomic factors (Garland et al., 2005; Kataoka, Zhang, & Wells, 2002; McCabe et al., 1999).

Models of access to health care propose that beliefs about illness and health care influence critical health decisions (e.g., Kleinman, 1980). Indeed, parents' beliefs about the causes of child symptoms predict the likelihood of contacting a mental health professional and the perceived acceptability of behavioral treatments (Morrissey-Kane & Prinz, 1999; Reimers, Wacker, Derby, & Cooper, 1995), and parents' beliefs about psychological treatment for youth externalizing problems predict help-seeking (Nock, Phil, & Kazdin, 2001). Research further suggests that parents' beliefs about child symptoms and mental health treatment differ across ethnic and racial groups (e.g., Hillemeier, Foster, Heinrichs, & Heier, 2007; McLeod, Fettes, Jensen, Pescosolido, & Martin, 2007) and these differences may partially account for ethnic disparities in mental health treatment utilization (Yeh et al., 2005). The majority of research in this area has focused on externalizing disorders, such as ADHD. Despite the documented cross-cultural variability in anxiety disorders (e.g., Hwu & Compton, 1994), including the degree to which somatic symptoms are prominent in the symptom profile (Kirmayer & Young, 1998), little is known about ethnic and cultural variations in parents' beliefs about the causes of youth anxiety symptoms and preferences for help-seeking.

Although researchers often hypothesize about cultural constructs that may be related to ethnic differences in help-seeking beliefs and behaviors, most studies have not directly examined these constructs. The practice of using ethnicity as a proxy for underlying cultural values and beliefs is problematic, as ethnicity is an imprecise approximation of the broader construct of culture and does not take into account vast within-group differences (Okazaki & Sue, 1995). Instead, it has been suggested that ethnic categories should be entered into analyses following the cultural constructs that are hypothesized to account for group differences to evaluate whether these constructs replace ethnic categories as predictors (Helms, Jernigan, & Mascher, 2005; Steinberg & Fletcher, 1998). Two cultural constructs in particular, acculturation and religious faith, have been identified as potentially important for explaining variance in causal beliefs about symptoms and preferences for help-seeking (Harmon, Langley, & Ginsburg, 2006; Hartog & Gow, 2005; Mallinckrodt, Shigeoka, & Suzuki, 2005; Tata & Leong, 1994).

Acculturation, defined as the process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members (Berry, 2006), has been found to be associated with parenting beliefs and child-rearing practices in multiethnic samples (Tajima & Harachi, 2010; Yagmurlu & Sanson, 2009). Because parameters for normal and abnormal behavior and beliefs about appropriate modes of help-seeking are culturally based, it seems likely that these may also shift as one becomes increasingly acculturated to a host culture. Research in the adult literature supports this hypothesis. Acculturation to mainstream American culture predicted greater similarity between the beliefs of Asian American college students and mental health professionals regarding the causes of typical presenting problems (Mallinckrodt et al., 2005). As might be expected, Asian American students who made causal attributions that were most similar to those of mental health professionals tended to attribute presenting problems to psychosocial causes, such as "problems with other people" or "change in life situation." Studies have further suggested that acculturation to mainstream American culture predicts psychological help-seeking (Miville & Constantine, 2006)

and positive attitudes toward mental health treatment (Atkinson & Gim, 1989; Tata & Leong, 1994) among Asian American and Latin American (LA) adults.

Interestingly, some of the same studies that highlight the important role of acculturation to *mainstream* American culture have not found a significant relationship between identification with the values of one's *heritage* culture and causal beliefs or help-seeking preferences/behaviors (Mallinckrodt et al., 2005; Miville & Constantine, 2006). Research supports a bidimensional model of acculturation (Berry, 2006; Lara, Gamboa, Kahramanian, Morales, & Hayes-Bautista, 2005), suggesting that individuals can adopt values and behaviors of the mainstream culture without necessarily giving up identification with the culture of origin (e.g., Ryder, Alden, & Paulhus, 2000). Based on this model, identification with mainstream and heritage cultures is an independent construct and should show distinctive and noninverse patterns of correlations with external variables, such as causal beliefs about child symptoms and preferences for help-seeking. When feasible, it is recommended that both dimensions of heritage or native culture and acculturation to mainstream or American culture be examined in relation to outcome variables (Berry, 2006; Lara et al., 2005).

Of additional interest is the role of acculturation with regard to medical/somatic causal attributions and seeking help from a medical, rather than mental health, professional. Although mind and body are often conceptualized as distinct within the United States majority culture, this mindbody dichotomy is thought to be less common among LA and Asian American cultural groups, who may integrate mind-body experiences and express them somatically (Canino, Rubio-Stipec, Canino, & Escobar, 1992; Prathikanti, 1997). Varela et al. (2004) found that Mexican and Mexican American parents expressed a greater proportion of somatic interpretations than Caucasian parents during family discussions of ambiguous situations, although acculturation was not directly assessed. A study of Indian American (IA) adults found that number of years in the United States was negatively associated with the belief that symptoms of schizophrenia were medical in nature, and medical causal beliefs were positively related to the endorsement of treatment seeking from medical doctors (Kumar & Nevid, 2010). Given that children with high levels of anxiety often express their distress through ambiguous symptoms or complaints (e.g., "I don't fell well") and use these symptoms as ways to avoid anxiety-provoking situations (Hofflich, Hughes, & Kendall, 2006), parental interpretations of internalizing symptoms are crucial in determining what type of care children receive.

Religious faith plays a role in the way that individuals conceptualize and respond to life circumstances (Cohen, 2009; Tarakeshwar, Stanton, & Pargament, 2003). Individuals who are highly religious or belong to cultures in which religion plays a prominent role have been found to attribute symptoms to religious causes, such as punishment by God, and to seek help from religious leaders (Abe-Kim, Gong, & Takeuchi, 2004; Hartog & Gow, 2005; Mathews, 2008; Wilcox, Washburn, & Patel, 2007). For example, Christian clergymen in Singapore were found to attribute psychological problems to religious causes more often than psychological or organic causes (Mathews, 2008), and Indian mothers whose children received a diagnosis of ADHD were found to utilize religious interventions more often than professional mental health treatment (Wilcox et al., 2007). A study of Christian adults found that religious beliefs and values were significantly associated with the perceived likelihood that major depression and schizophrenia resulted from religious causes and the perceived helpfulness of religious interventions (Hartog &

Gow, 2005). Although the importance of religious faith in relation to beliefs about youth anxiety disorders and preferred forms of treatment has been emphasized in the literature (Harmon et al., 2006), the nature of this relationship has yet to be examined empirically.

The present study examined the roles of acculturation and strength of religious faith (SORF) in predicting causal beliefs about separation anxiety disorder (SAD) and preferences for helpseeking for youth SAD symptoms among LA, IA, and European American (EA) mothers. Beliefs about SAD in particular, which involves recurrent, excessive distress upon separation from attachment figures, are likely to vary across cultural groups due to variations in expectations regarding separation/individuation and the emphasis on worry and apprehension rather than somatic symptoms in the *Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association [DSM-IV-TR], 2000*; Ginsburg & Silverman, 1996; Iwamasa & Pai, 2003). As recommended (Helms et al., 2005; Steinberg & Fletcher, 1998), the role of ethnic categories was considered only after accounting for the variance associated with the cultural variables. Due to the vast heterogeneity across LA cultures, this group was limited to mothers of Puerto Rican (PR) descent, as they have been understudied as compared to other LA groups, particularly with regard to acculturation (Lara et al., 2005). IAs have been virtually ignored in psychological research, as most studies of Asian Americans tend not to include South Asian participants (Durvasula & Mylvaganam, 1994). Given the absence of this group in mental health clinics and services (Prathikanti, 1997) despite their increasing prevalence rates and current position as the third largest Asian ethnic group in the United States, the importance of studying the cultural views and practices of IAs as they relate to treatment utilization cannot be overemphasized.

The specific relationships to be evaluated were chosen based on empirical findings in the adult literature (e.g., Hartog & Gow, 2005; Mallinckrodt et al., 2005; Mathews, 2008; Miville & Constantine, 2006; Tata & Leong, 1994) and theoretical discussions within the youth anxiety disorders literature (e.g., Harmon et al., 2006). Based on the results of Atkinson and Gim (1989), Mallinckrodt et al. (2005), Miville and Constantine (2006), and Tata and Leong (1994), it was hypothesized that acculturation to mainstream American culture would be positively associated with (a) the perceived likelihood that symptoms resulted from psychological causes (i.e., Psych Causal Beliefs) and (b) the perceived likelihood of seeking help from a mental health professional for youth SAD symptoms (i.e., Psych Help-Seeking). Extrapolating from the results of Varela et al. (2004), it was further hypothesized that acculturation to mainstream American culture would be negatively associated with (c) the perceived likelihood that symptoms resulted from medical causes (i.e., Medical Causal Beliefs) and (d) the perceived likelihood of seeking help from a physician for youth SAD symptoms (i.e., Medical Help-Seeking). Analyses assessing the relationships between identification with one's heritage culture and parental causal beliefs and help-seeking preferences were conducted on an exploratory basis. Identification with Chinese and Mexican heritage cultures did not significantly predict causal beliefs or help-seeking preferences/behaviors in prior studies (Lau & Takeuchi, 2001; Miville & Constantine, 2006); however, these findings may not generalize to the specific cultures included in this study. With regard to SORF, we hypothesized that SORF would be positively associated with (e) the perceived likelihood that symptoms resulted from religious causes, such as God's Will (i.e., Religious Causal Beliefs) and (f) the perceived likelihood of seeking help from a religious leader for youth SAD symptoms (i.e., Religious Help-Seeking) (Hartog & Gow, 2005; Mathews, 2008).

Lastly, it was hypothesized that ethnicity would not be related to any beliefs or help-seeking preferences after accounting for the cultural variables.

Causal beliefs and corresponding help-seeking efforts (e.g., Psych Causal Beliefs, Psych Help-Seeking) were examined separately, as help-seeking may operate independently from causal beliefs given barriers to treatment access for ethnic minority populations or perceived stigma surrounding psychological care. Given the limited psychometric data available for measures of acculturation and SORF in PR and IA samples, the psychometrics of the cultural measures were also assessed.

Method

Participants

Participants were 117 PR (N = 39), IA (N = 39), or EA (N = 39) mothers who live in a large East Coast city in the United States or within the surrounding areas, speak and read English, and have a child between the ages of 7 and 13. Because the vignettes included in this study describe a 7-year-old child, mothers were excluded if they did not currently have a child between the ages of 7 and 13. Mothers of a child younger than 7 years old or those who have not had experience parenting a 7-year-old child in more than 6 years may have judgments that differ from those who have recently parented a child of this age. Table 1 reports demographic information for study participants. A comparison of sample demographics to United States population data indicates that the EA sample is generally representative of EAs with regard to annual household income and marital status but is somewhat more educated (100% of the sample received at least a high school degree versus 82.92% of the population) and is somewhat less likely to speak a language other than English at home (2.6% of the sample speaks a language other than English versus 15.55% of the population) (U.S. Census Bureau, 2000). The IA sample is generally representative of IAs with regard to marital status and languages spoken at home but is somewhat more educated (100% of the sample received at least a high school degree and 87.2% received at least a bachelor's degree versus 86.7% and 63.9% of the population, respectively) and reported a higher annual household income (69% of the sample reported a family income > $80,000 versus a median family income of $70,708 in the population) (Reeves & Bennett, 2004). The PR sample is generally representative of PRs in the United States with regard to education level and languages spoken at home but is less likely to be married (23.1% of the sample versus 56.43% of the population) and reported a lower annual household income (51% of the sample reported a family income < $20,000 versus a median family income of $32,791 in the population) (Ramirez, 2004).

Table 1. Demographic Information for Study Participants

	European American	**Puerto Rican**	**Indian American**
Participant age (M ± SD)	39.0 ± 6.1	33.1 ± 6.4	38.2 ± 3.3
Generations in U.S.			
1st generation	2.6%	30.8%	100%
2nd generation	7.7%	56.4%	0%

3rd generation	35.9%	10.3%	0%
4th or higher generation	53.8%	2.6%	0%
English spoken at home			
100% of time	97.4%	15.3%	0%
> 75% of time	2.6%	56.4%	17.9%
50% to 75% of time	0%	23.1%	23.1%
< 50% of time	0%	5.2%	59%
Marital status			
Married	69.2%	23.1%	97.4%
Divorced/separated	15.4%	23.1%	2.6%
Widowed	2.6%	0%	0%
Never married	12.8%	53.8%	0%
Religion			
Catholic	56.4%	64.1%	0%
Other Christian	12.8%	15.4%	5.1%
Jewish	12.8%	0%	0%
Hindu	0%	0%	28.3%
Sikh	0%	0%	66.7%
Other	15.5%	18%	0%
Missing data	2.6%	2.6%	0%
Education level			
Graduate school	17.9%	2.6%	41.0%
College degree	28.2%	2.6%	46.2%
Some college	20.5%	23.1%	2.6%
High school degree	28.2%	48.7%	10.3%
Did not complete high school	0%	12.8%	0%
Missing data	5.1%	10.3%	0%
Household income			
< $20,000	10.3%	51.3%	0%
$20,000 to $39,000	15.4%	30.8%	15.4%
$40,000 to $59,000	23.1%	12.8%	5.2%
$60,000 to $80,000	17.9%	2.6%	10.3%
> $80,000	33.3%	0%	69.2%
Missing data	0%	2.6%	0%
Child gender			
Males	61.5%	51.3%	43.6%
Females	38.5%	48.7%	56.4%
Child age (*M* ± *SD*)	9.3 ± 1.8	9.2 ± 2.0	8.7 ± 1.6

Measures

Assessment of Demographic Information. Participants completed a questionnaire assessing demographic variables, including race/ethnicity, religious affiliation, socioeconomic status (SES), and age(s) and gender of child(ren)

Assessment of Predictor Variables

SES. The Hollingshead Four-Factor Index (Hollingshead, 1975), a widely used measure of SES that takes into account both education and occupation levels, was used. The Nakao and Treas Socioeconomic Index of Occupations (SEI; Nakao & Treas, 1992), which was derived from educational attainment and income of job incumbents corresponding to the 503 occupational categories in the 1980 census, was used to evaluate the concurrent validity of the Hollingshead Index.

Acculturation. The Vancouver Index of Acculturation (VIA; Ryder et al., 2000) is a bidimensional measure of acculturation, which consists of 10 items assessing identification with heritage culture and 10 items assessing identification with mainstream culture. Each of the 10 item pairs assess a domain relevant to acculturation, namely traditions, marriage, social activities, comfort with people, entertainment, behavior, practices, values, humor, and friends. Items are presented as statements (e.g., "I believe in the values of my heritage culture," "I am interested in having North American friends") to which participants assign a number from 1 (*strongly disagree*) to 9 (*strongly agree*). Because 22 of the 39 EA participants were unable to identify one specific culture that has influenced them aside from American culture, only PR and IA participants were included in analyses involving the Heritage subscale (VIA-H). References within the VIA to mainstream culture as *North American* was changed to *American* as recommended by the test developers. Both subscales have excellent internal consistency (VIA-M as = .85 to .89; VIA-H as = .91 to .92), high mean interitem correlations (VIA-M *r*s = .38 to .45; VIA-H *r*s = .51 to .53), and concurrent validity with variables expected to correlate with acculturation (e.g., generation level) in samples of Asian and European participants (Kennedy, Parhar, Samra, & Gorzalka, 2005; Ryder et al., 2000). In the present sample, the VIA-M and VIA-H were moderately correlated in a positive direction ($r = .26$, $p < .05$).

SORF. The Santa Clara Strength of Religious Faith Questionnaire (SORF; Plante & Boccaccini, 1997b) is a 10-item measure that was developed to assess SORF regardless of denomination.1 Items assess the personal importance of religion (e.g., "My religious faith is extremely important to me"), one's involvement in his or her faith or place of worship (e.g., "I consider myself active in my faith or church"), engagement in faith-related behaviors (e.g., "I pray daily"), and social/ community aspects of religion (e.g., "I enjoy being around others who share my faith"). Items are scored on a 4-point scale ranging from 1 (*strongly disagree*) to 4 (*strongly agree*). This measure has high internal consistency (as = .93 to .97), split-half reliability (*r*s = .90 to .96), and retest reliability (*r*s = .82 to .93) in community and student samples (Lewis, Shevlin, McGuckin, & Navratil, 2001; Plante & Boccaccini, 1997a, 1997b) and is significantly correlated with other existing scales of religiousness (Plante & Boccaccini, 1997a).

Table 2. Questions Posed to Participants and Corresponding Dependent Variables

Dependent Variable (DV)	**Question Posed to Participants**
Psych Causal Beliefs	How likely is it that this child's behavior is due primarily to a psychological, emotional, or mental problem?
Medical Causal Beliefs	How likely is it that this child's behavior is due

	primarily to a medical condition or illness?
Religious Causal Beliefs	How likely is it that this child's behavior is due to God's will (for example, God is punishing you or your family for something that you have done)?
Psych Help-Seeking	If you were this child's parent, how likely is it that you would seek help for this child from a psychologist/counselor?
Medical Help-Seeking	If you were this child's parent, how likely is it that you would seek help for this child from a medical doctor/physician?
Religious Help-Seeking	If you were this child's parent, how likely is it that you would seek help for this child from a religious leader (for example, a priest, minister, guru, sadhu, rabbi)?

Assessment of Dependent Variables. Four vignettes were created to assess causal beliefs about SAD symptomatology and the perceived likelihood of help-seeking for SAD symptoms (for studies using similar methodology, see Lau & Takeuchi, 2001; Weisz et al., 1988). Each vignette described a 7-year-old child exhibiting symptoms characteristic of SAD but varied as to symptom severity and symptom type (i.e., moderate-nonsomatic symptoms, moderate-somatic symptoms, severe-nonsomatic symptoms, severe-somatic symptoms). The decision to include four vignettes describing SAD rather than one was made to account for the variability in symptoms displayed across children with SAD. A panel of expert diagnosticians in the area of child anxiety was consulted during the creation of the vignettes, and the final versions of the vignettes received a probable diagnosis of SAD by all diagnosticians, with confidence-in-diagnosis ratings ranging from 80% to 99%. Prior to initiating data collection, the content validity of the vignettes for the specific cultures being studied was also established through consultation with a PR psychologist familiar with PR culture and an IA psychologist familiar with Indian culture.[2]

Prior to reading the vignettes, mothers were asked to "imagine that you are the parent of this child." After each vignette, three questions assessing the perceived likelihood that symptoms resulted from (a) psychological, (b) medical, and (c) religious causes and three questions assessing the perceived likelihood of seeking help from a (a) mental health professional, (b) physician, and (c) religious leader were posed using 7-point Likert-type scales. Instructions to participants were as follows: "Please answer the following questions, assuming that you are this child's parent. Circle a number from 1 to 7 that corresponds to your opinion as a parent." See Table 2 for the six questions posed to participants following each vignette. The vignettes and questions posed to participants were piloted with two IA mothers and two PR mothers prior to data collection, and slight modifications were made to the wording of the questions based on feedback received.

In deciding whether to analyze the responses to each vignette separately or to create composite measures across the four vignettes, analyses were conducted to assess for interactions between

each of the cultural variables (VIA-M, VIA-H, and SORF), symptom severity, and symptom type. With a set at .05, the relationships between the cultural variables and dependent variables did not significantly differ based on symptom severity or symptom type (i.e., somatic vs. nonsomatic). To minimize the risk of Type I error associated with a large number of analyses, six dependent variables were created by averaging across mothers' responses to the four vignettes. The composite measures evidenced good internal consistency: Psych Causal Beliefs a = .80, Medical Causal Beliefs a = .87, Religious Causal Beliefs a = .92, Psych Help-Seeking a = .84, Medical Help-Seeking a = .89, and Religious Help-Seeking a = .91. As expected, Psych Causal Beliefs was positively correlated with Psych Help-Seeking ($r = .78$, $p < .01$), Medical Causal Beliefs was positively correlated with Medical Help-Seeking ($r = .77$, $p < .01$), and Religious Causal Beliefs was positively correlated with Religious Help-Seeking ($r = .51$, $p < .01$).

Procedure

Sixty-nine percent of participants (39 PR, 39 EA, and 3 IA) were recruited from waiting rooms serving pediatric primary care, adolescent medicine, otolaryngology, and dentistry at an urban medical center. In an effort to include the understudied IA group despite their low representation in the local catchment area of the medical center, the remaining 36 IA mothers were recruited from three South Asian community centers that hold religious services and language/cultural classes for youth (13, 13, and 10 participants, respectively). After providing informed consent, participants completed the demographic questionnaire, the vignettes, and the self-report measures (both randomly ordered). The gender of the child in the vignettes matched the gender of the participant's child closest to the age of 7. Mothers were compensated with a $10 gift card. This study was conducted in compliance with Temple University's Institutional Review Board.

Analytic Plan

Hierarchical multiple regression analyses were conducted. SES and child gender were entered first. The VIA Mainstream subscale (VIA-M) was entered into the second block for analyses predicting Psych Causal Beliefs, Psych Help-Seeking, Medical Causal Beliefs, and Medical Help-Seeking, whereas SORF was entered into the second block for analyses predicting Religious Causal Beliefs and Religious Help-Seeking. The ethnicity variable was dummy coded and was placed in the last block to assess whether the cultural variables replace ethnic categories as predictors of the dependent measures, as recommended by Helms et al. (2005).3 With an expected medium effect size (see Varela et al., 2004; Weisz et al., 1988) and a sample size of 117, hierarchical regression analyses with five predictors are adequately powered (> 0.80, obtained via G*Power; Erdfelder, Faul, & Buchner, 1996).

Exploratory regression analyses, with SES and child gender on the first block and the VIA Heritage subscale (VIA-H) on the second block, were conducted to evaluate the relationships between VIA-H and Psych Causal Beliefs, Psych Help-Seeking, Medical Causal Beliefs, and Medical Help-Seeking. Only PR and IA participants were included in these analyses ($N = 78$), given that 22 of the 39 EA participants were unable to identify one specific culture that has influenced them aside from American culture. Analyses were first conducted with all 78 PR and IA participants, and then separately for PR participants only and IA participants only, as

identification with PR heritage culture is likely a different construct from identification with Indian heritage culture.

Results

Preliminary Analyses

Significant differences were found across ethnic groups on SES, $F(2, 114) = 54.91$, $p < .01$, and participants' age, $F(2, 110) = 12.99$, $p < .01$. IA participants had significantly higher SES than both EA participants, $t(67.59) = 3.77$, $p < .01$, and PR participants, $t(70.69) = 11.2$, $p < .01$, and EA participants had significantly higher SES than the PR participants, $t(75.43) = 6.09$, $p < .01$. PR participants were significantly younger than both EA participants, $t(73.3) = 4.13$, $p < .01$, and IA participants, $t(53.56) = 4.32$, $p < .01$.

Table 3. Means and Standard Deviations for Predictor Variables by Ethnicity

	European American		Puerto Rican		Indian American	
	M	*(SD)*	*M*	(SD)	*M*	(SD)
SES	46.05[a]	(13.68)	27.95[b]	(12.53)	56.10[c]	(9.46)
VIA-M	74.72[a]	(12.72)	68.65[b]	(11.04)	52.08[c]	(15.99)
VIA-H	—	—	67.28[a]	(15.44)	74.77[b]	(13.24)
SORF	28.45[a]	(7.57)	31.31[b]	(5.68)	33.77[b]	(4.95)

Note. Across each row of the table, means identified with the same letter (a, b, c) do not differ significantly from one another. SES = Hollingshead Four-Factor Index; VIA-M = Vancouver Index of Acculturation Mainstream Scale; VIA-H = Vancouver Index of Acculturation Heritage Scale; SORF = Strength of Religious Faith.

SES was significantly associated with Medical Causal Beliefs ($r = -.27$, $p < .01$), Religious Causal Beliefs ($r = -.20$, $p = .03$), Medical Help-Seeking ($r = -.25$, $p < .01$), and Religious Help-Seeking ($r = -.20$, $p = .04$). Child gender was significantly associated with Medical Causal Beliefs, $F(1, 115) = 4.73$, $p = .03$, with mothers of girls endorsing a higher likelihood of medical causes than mothers of boys. Participant age, child age, and recruitment site (IA group only) were not significantly associated with any of the DVs. Significant differences across ethnic groups were found for VIA-M, $F(2, 114) = 29.79$, $p < .01$, VIA-H, $t(76) = 2.3$, $p < .02$ (PR and IA only), and SORF, $F(2, 113) = 7.21$, $p < .01$ (see Table 3).

Psychometrics of the Measures

The VIA-M (a = .89), VIA-H (a = .87), and SORF (a = .94) demonstrated good internal consistency. Convergent validity was established for the Hollingshead Index, VIA-M, and VIA-H. The Hollingshead Index was significantly and positively correlated with the SEI and with total household income with *r*s > .85 and $p < .01$. The VIA-M was significantly and positively correlated with number of generations in the United States ($r = .48$, $p < .01$) and percentage of time English is spoken at home ($r = .58$, $p < .01$) and significantly and negatively correlated with the age at which one moved to the United States ($r = -.45$, $p < .01$). The VIA-H was significantly correlated with number of generations in the United States ($r = -.23$, $p < .05$) and marginally

correlated with percentage of time English is spoken at home (r = -.21, p = .07), both in the expected directions. Divergent validity for the SORF was not established (see Table 4). When the SORF total score was compared across the four most frequently reported religious affiliations in the present sample (e.g., Catholic, Other Christian, Hindu, Sikh; N = 97), significant differences were observed, $F(3, 93) = 5.05$, $p < .01$: Catholic participants scored significantly lower on SORF than did Other Christian participants, $t(93) = -3.06$, $p < .01$, or Sikh participants, $t(93) = -3.16$, $p < .01$. These results suggest that the SORF may be measuring aspects of religious faith specific to one or more religions rather than those applicable to all religions (see Cohen, 2009; Tarakeshwar et al., 2003, for a discussion of variations across groups in what it means to be religious). To address this issue, exploratory regression analyses examined whether the SORF total score remains a significant predictor when religious affiliation is entered into the regression equation and whether religious affiliation additionally predicts the dependent variable.

Role of Acculturation

Perceived likelihood of psychological causes and help-seeking. Demographic variables in the first block did not significantly improve the ability to predict Psych Causal Beliefs. The addition of VIA-M significantly improved the model, $F(1, 113) = 5.94$, $p = .02$, which accounted for 5% of the variance. Acculturation to mainstream American culture was positively related to the perceived likelihood that symptoms resulted from psychological causes ($\beta = .23$). The addition of ethnicity did not significantly improve the ability to predict Psych Causal Beliefs. VIA-H was also not found to be a significant predictor of Psych Causal Beliefs in exploratory analyses.

Table 4. Divergent Validity of the Strength of Religious Faith Scale

	Catholic		Other Christian		Hindu		Sikh	
	M	(*SD*)	*M*	(*SD*)	*M*	(*SD*)	*M*	(*SD*)
SORF Total	29.91[a]	6.31	35.31[b]	4.73	31.91[a,b]	4.44	34.27[b]	5.10

Note. Means identified with the same letter (a, b) do not differ significantly from one another. SORF = Strength of Religious Faith.

Demographic variables in the first block did not significantly improve the ability to predict Psych Help-Seeking. The addition of VIA-M significantly improved the model, $F(1, 113) = 4.62$, $p = .03$, which accounted for 7% of the variance. Acculturation to mainstream American culture was positively related to the perceived likelihood of seeking help from a mental health professional for child SAD symptoms ($\beta = .20$). The addition of ethnicity did not significantly improve the ability to predict Psych Help-Seeking. VIA-H was also not found to be a significant predictor of Psych Help-Seeking in exploratory analyses.

Perceived likelihood of medical causes and help-seeking. Demographic variables in the first block significantly improved the ability to predict Medical Causal Beliefs, $F(2, 114) = 8.03$, $p < .01$, accounting for 12% of the variance. SES was negatively related to Medical Causal Beliefs ($\beta = -.29$, $p < .01$). Child Gender was also related to Medical Causal Beliefs ($\beta = .22$, $p = .01$) in that mothers of girls endorsed a higher likelihood of medical causes than mothers of boys. When VIA-M was entered into the equation, the ability to predict Medical Causal Beliefs was not

significantly improved. However, the addition of ethnicity significantly improved the model, $F(2, 111) = 4.09$, $p = .02$, which accounted for 19% of the variance. Being of PR as compared to EA ethnicity was associated with a significantly higher perceived likelihood of medical causes ($\beta = .33$, $p < .01$), and being of PR as compared to IA ethnicity was associated with a marginally higher perceived likelihood of medical causes ($\beta = .28$, $p = .06$). VIA-H was not found to be a significant predictor of Medical Causal Beliefs in exploratory analyses.

Demographic variables in the first block significantly improved the ability to predict Medical Help-Seeking, $F(2, 114) = 4.43$, $p = .01$, accounting for 7% of the variance. SES was negatively related to Medical Help-Seeking ($\beta = -.26$, $p < .01$). The addition of VIA-M further improved the model, $F(1, 113) = 7.97$, $p < .01$, which accounted for 13% of the variance. Acculturation to mainstream American culture was positively related to the perceived likelihood of seeking help from a medical professional for child SAD symptoms ($\beta = .26$). The ability to predict Medical Help- Seeking was not significantly improved after adding ethnicity into the regression equation. VIA-H was also not found to be a significant predictor of Medical Help-Seeking in exploratory analyses.

Role of SORF

The overall model for Religious Causal Beliefs was not significant with the addition of each block of variables. Demographic variables in the first block did not significantly improve the ability to predict Religious Help-Seeking. However, when SORF was entered into the equation, the ability to predict Religious Help-Seeking was significantly improved, $F(1, 112) = 13.71$, $p < .01$, and the model accounted for 15% of the variance. SORF was positively related to the perceived likelihood of seeking help from a religious leader for child SAD symptoms ($\beta = .32$). The ability to predict Religious Help-Seeking was not significantly improved after adding ethnicity into the regression equation. However, when religious affiliation was entered into the equation after SORF, the relationship between SORF and Religious Help-Seeking was maintained ($\beta = .40$, $p < .01$) but having a Catholic as compared to Sikh religious affiliation was additionally associated with a higher likelihood of seeking help from a religious leader for child SAD symptoms ($\beta = .28$, $p = .02$). The addition of religious affiliation to the model significantly improved its ability to predict Religious Help, $F(3, 90) = 3.70$, $p = .02$, and the overall model accounted for 23% of the variance.

Discussion

Acculturation to mainstream American culture and SORF predicted maternal causal beliefs about SAD and preferences for help-seeking for youth SAD symptoms in this multi-ethnic sample. Ethnicity was not found to be a strong predictor of maternal beliefs and preferences for help-seeking after accounting for variance associated with cultural factors, with the exception of medical causal beliefs. These results support the measurement of cultural constructs in addition to the sociopolitical categories of race and ethnicity and the usefulness of analytic strategies recommended by Helms et al. (2005) to evaluate whether cultural constructs replace ethnic categories as predictors.

Consistent with hypotheses, acculturation to American culture predicted the likelihood of endorsing psychological causes for symptoms and of seeking help from a mental health professional for SAD symptoms. This may reflect a greater familiarity with Western beliefs about psychology and mental health treatment among participants who identify strongly with American culture. The hypothesis that participants who were less acculturated to the mainstream culture would be more likely to endorse medical causes for SAD symptoms and to seek help from a physician was not supported. Whereas mainstream acculturation was found to have no relationship with medical etiological beliefs, it was positively related to the likelihood of seeking help from a physician for SAD symptoms. It may be that mothers who strongly identify with American culture are more confident in their ability to seek help for their child from any professional, whether from a physician or a mental health professional. Certainly, seeking professional help within a culture that is not entirely familiar or comfortable is likely to be intimidating and confusing, particularly when language barriers are present.

In contrast to the important role of identification with mainstream American culture, identification with heritage culture did not predict parents' causal beliefs or preferences for help-seeking. This is consistent with prior research with Chinese American parents and Mexican American college students (Lau & Takeuchi, 2001; Miville & Constantine, 2006) and provides further support for the bidimensional model of acculturation. It is of note that the moderate correlation between the Mainstream and Heritage subscales of the VIA was a positive one, suggesting that those parents for whom it is important to maintain heritage cultural practices and relationships may also place a high value on adopting aspects of the mainstream culture. Taken together, these results indicate that the process of adopting mainstream American values, practices, and social relationships is a key construct in predicting parents' causal beliefs and preferences for helpseeking, as opposed to the process of relinquishing aspects of the heritage culture.

Participants with strong religious faith were more likely to seek help from a religious leader for youth SAD symptoms than those who were less religious, which is consistent with findings in the adult literature (e.g., Hartog & Gow, 2005). Religious affiliation additionally predicted the likelihood of seeking help from a religious leader, with Sikh participants being less likely than Catholic participants to endorse seeking help from a religious leader after accounting for SORF. One Sikh participant mentioned informally that Sikh mothers turn to religious leaders for religious guidance but not for parenting advice due to the perception that the religious leaders have old-fashioned views on childrearing. Perhaps Sikh religious leaders play a different role in the lives of families than do Catholic religious leaders, who often give guidance on family matters (i.e., premarital counseling). This finding highlights the importance of studying SORF as it relates to individual religions, rather than generalizing results found with one religious group to others. There is certainly a need for additional studies examining the role of religious faith in parenting and help-seeking behaviors within the Hindu and Sikh communities.

Consistent with research suggesting that distress is often expressed somatically among LA youth (Pina & Silverman, 2004) and LA parents are more likely than EA parents to interpret ambiguous symptoms as somatic (Varela et al., 2004), PR mothers endorsed a higher perceived likelihood that SAD symptoms resulted from medical causes in comparison to EA mothers. In this case, acculturation and SORF were not found to underlie ethnic differences, suggesting that

other aspects of culture not measured in the present study (e.g., views about the integration of mind and body) may account for such differences. This finding has important clinical implications. Some research suggests that treatment may be most effective when the client and treatment provider share similar problem perceptions and therapy goals (e.g., Bernal & Sáez-Santiago, 2006; Zane et al., 2005). It may be important for treatment providers working with PR parents and youth to gather information about the beliefs and goals of their clients and incorporate these into treatment. PR participants may benefit less from therapy focused exclusively on psychological causes and symptoms and instead may benefit from an approach integrating mind and body. The treatment setting can also be important. To facilitate greater collaboration between mental health professionals and physicians and to reduce disparities in the receipt of mental health care, psychological services are increasingly being provided within primary care offices and medical centers (Patterson, Peek, Heinrich, Bischoff, & Scherger, 2002). Such services may lead to better outcomes for PR youth, whose parents may seek help from the child's pediatrician due to somatic complaints and who may not otherwise receive mental health services.

Several potential limitations merit attention. First, the vignettes describe hypothetical child behavior. Although useful to assess the beliefs and help-seeking preferences of community participants whose children may not be experiencing psychological distress, responses may differ from actual beliefs or help-seeking preferences in a real situation. On a related note, this study assessed help-seeking preferences rather than help-seeking behaviors; although preferences may predict behavior in many cases, one may not serve as a proxy for the other. Parents who endorsed a high likelihood of seeking help from a mental health professional on a confidential questionnaire may in reality be hesitant to bring their child to a psychologist due to factors such as stigma, cost, or other barriers to treatment access.

Furthermore, although efforts were made to increase the utility of the measures through consultation with cultural experts and minor rewording of items, it is possible that the methods of the present study were not appropriate for all groups. A review of individual items on the SORF would suggest that this measure may be most appropriate for religions in which daily prayer and frequent gatherings at a place of worship are central to the religious experience. It is also possible that questions assessing causal beliefs and help-seeking preferences could be interpreted in different ways depending upon the cultural background or education level of the participants or that different results would have emerged if the questions were reworded. For example, mothers may have responded differently to a question assessing the likelihood of seeking help from only a "counselor" rather than from a "psychologist/counselor." Participants were limited to English speakers, and it is possible that the exclusion of non-English-speaking participants limited the variability of the cultural constructs and produced a sample that was more acculturated or of higher SES than the general population. Different patterns of findings may have emerged were non-English speaking mothers to be included in this study; indeed, previous studies have shown different patterns of results based on the language choice of participants (Pina & Silverman, 2004).

Table 5. Summary of Hierarchical Regression Analysis for Psychological Causal Beliefs

	B	*SE B*	ß	R^2	R^2 Change
Block 1				< .01	< .01

SES	-0.001	0.01	-.01		
Child Gender	-0.04	0.27	-.01		
Block 2				.05	.05
VIA-M	0.02	0.01	.23*		
Block 3				.05	< .01
PR vs. EA	-0.09	0.39	-.03		
IA vs. EA	-0.03	0.41	-.01		

Note. SES = Hollingshead Four-Factor Index; VIA-M = Vancouver Index of Acculturation-Mainstream Scale; PR = Puerto Rican group; EA = European American group; IA = Indian American group. *$p < .05$

Finally, in an effort to include the understudied IA group, it was necessary to recruit from a source different than that of the other two groups, which may have resulted in selection biases. Participants were recruited from a large metropolitan area on the East Coast of the United States and differed somewhat from the overall United States population of EA, PR, and IA mothers with regard to demographics. It is not clear whether the results of this study would generalize to mothers in rural areas or in other regions of the United States. Last, EA, IA, and PR participants differed significantly on SES and generational status, with all IA mothers having immigrated to the United States. Although these demographic differences reflect true differences between the groups related to historical, political, and economic factors (e.g., due to multiple waves of immigration after the late 1970s, the majority of second-generation IAs do not yet have children ages 7 or older), such differences make it difficult to determine which variables are driving the effects. An important future direction would be to further examine socioeconomic and generational differences in parental beliefs about anxiety symptoms and preferences for help-seeking. Despite limitations, this study contributes to our growing understanding of specific cultural variables, often so intertwined with a person's ethnicity, which can play a significant role in parental decisions regarding *when and how* to seek help for child anxiety problems.

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The authors declared that they had no conflicts of interests with respect to their authorship or the publication of this article.

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Notes
1. For the present study, the reference to "church" in Item 5 was changed to "church/temple/gurudwara/mosque" and "God" in Item 7 was changed to "God(s)," as followers of the Hindu religion tend to worship multiple gods.

2. A copy of the vignettes used in this study and detailed information regarding the development and validation of the vignettes are available from the first author at esood@nemours.org.

3. The general regression approach is illustrated in Table 5, which depicts the analysis predicting psychological causal beliefs; all regression models are available from the first author.

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