

Jamaican and American Adult Perspectives on Child Psychopathology: Further Exploration of the Threshold Model

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Although several factors determine whether children receive psychological intervention, cultural determinants may be particularly influential. Cultural factors may influence adults' levels of concern over child psychopathology. This possibility was explored by comparing adult attitudes in two socioculturally different societies. Jamaican and American parents, teachers, and clinicians (total $N = 382$) judged vignettes of two children, one with overcontrolled (e.g., fearfulness) and one with undercontrolled (e.g., fighting) problems. Regression analyses revealed that although years of education affected some adult ratings, culture had the most profound effect.

Despite the proliferation of literature suggesting that culture may influence psychopathology, most research on the topic continues to be based in Western cultures. Thus, we risk developing an ethnocentric picture of how dysfunction takes shape (Kennedy, Scheirer, & Rogers, 1984). The risk is particularly serious with respect to the study of child psychopathology, which is actually defined in terms of both actual behavior and the lens through which adults in a society view that behavior (Weisz et al., 1988). Children rarely seek help on their own (e.g., Achenbach & Edelbrock, 1978). The distress level experienced by adults (e.g., parents, teachers, clinicians) in response to children's problems may well determine whether treatment will be considered. Given the pivotal role of adults, it is important to

know what contributes to their level of concern. Other investigators (e.g., Weisz et al., 1988) have demonstrated that culture may be a contributing factor.

We further explored this possibility by comparing adults' views in two cultures that differ in theoretically significant ways (i.e., as far as child-rearing attitudes is concerned): Jamaica and the United States. We concentrated on child problems within the two most common empirically derived syndromes of child psychopathology: overcontrolled (e.g., anxiety) and undercontrolled (e.g., lying; see Achenbach & Edelbrock, 1978). As in Weisz et al. (1988), our research design was based on a threshold model of cultural influence. The model holds that culture helps to set adult thresholds for distress over child problems, thus determining whether such problems are considered serious and what action will be taken in response to them. This model has two forms, both relevant to a Jamaican-U.S. comparison (see Lambert, Weisz, & Knight, 1989). A general form of the model holds that cultures may differ in their thresholds for child problems. This may be true of Jamaica and the United States. Jamaican adults tolerate a wide range of child behavior as long as it remains within sometimes vaguely defined socially acceptable limits (Clarke, 1957). A pattern-specific form of the model may also be envisioned: Cultures may differ with respect to behavior type, with certain types of child problem behavior arousing greater concern in some cultures than in others (Weisz et al., 1988). Traditionally, the African-British-oriented Jamaican society, for example, seems to favor quietness and inhibition in children (see Cohen, 1955). One might therefore speculate that (a) overcontrolled behavior may be less distressing to Jamaican adults than undercontrolled be-

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havior and (b) to a greater extent than for American adults, Jamaican adults may view undercontrolled behavior as more distressing than overcontrolled behavior.

In this study we tested both the general and pattern-specific forms of the threshold model. Adults in Jamaica and the United States read vignettes describing two children, one with overcontrolled problems, the other with undercontrolled problems. For each child, the adults made several judgments related to the seriousness of the problems and their own likely level of concern. In this design, the emergence of culture as a predictor in adult ratings of both over- and undercontrolled problems would support the general form of the threshold model. If culture predicted one problem type but not the other, or predicted both problem types in opposite directions, support for the pattern-specific form would be achieved. Within each culture we compared three adult groups whose judgments seemed central to the child-referral process: parents, teachers, and clinicians. We investigated the impact of child gender by featuring boys in half of the vignettes and girls in the other half.

Method

In the 2 (culture) \times 3 (adult group) \times 2 (problem type) \times 2 (sex of child) \times 2 (context information) \times 2 (order) experimental design, problem type was a within-subjects factor. Jamaican and American parents, teachers, and clinicians read two vignettes; one described a child with overcontrolled problems, the other a child with undercontrolled problems. Half the adults received vignettes about boys; half received girl vignettes. For half of the adults the overcontrolled child was placed in Context A and the undercontrolled child was placed in Context B (contextual information provided to make vignettes more naturalistic); for half, this pairing was reversed. Order was counterbalanced; half the subjects received the overcontrolled vignette first, and half the reverse order.

For the U.S. sample, parents and teachers of elementary school children were randomly selected from urban and rural areas of the mid-Atlantic region. Participation rates were 81% ($n = 58$) for parents and 86% ($n = 62$) for teachers. Psychologists serving elementary-school-aged children were randomly selected from the regions named above. Their participation rate was 72% ($n = 113$). Jamaican teachers and parents of elementary-school-age children were randomly selected from 12 schools in urban and rural areas. The whole population of child clinicians (because few psychologists practice in Jamaica, the sample also included other child practitioners such as psychiatrists, clinical social workers, etc.) were recruited. The 55 teachers, 47 parents, and 47 clinicians represented 90%, 90%, and 100% participation rates, respectively. Demographics of the respective samples reflected characteristics of the respective populations. For example, mean age was higher for the U.S. sample than for the Jamaican sample ($M_s = 43.35$ and 35.31), $p \leq .0001$. The U.S. sample reported more years of education than did the Jamaican sample ($M_s = 18.45, 14.05$), $p \leq .0001$. As for religious affiliation, there were no significant differences.

Each adult received a three-page packet. Pages 1 and 2 each contained a vignette, then questions, concerning a 9-year-old school child. One vignette described a child with overcontrolled problems, the other described a child with undercontrolled problems. Both problem clusters were derived from the empirical work of Achenbach and Edelbrock (1983; see Weisz et al., 1988 for detailed description of vignettes). After each vignette, several questions were posed, using 7-point Likert scales. Questions of interest here included (a) "How serious is this child's problem?" (b) "If you were this child's parent, how worried would you be about his/her behavior?" (c) "If you were this child's

teacher, how worried would you be about his/her behavior?" (d) "Do you think this child's behavior will improve in a year or two?" and (e) "Compared to other primary school students in general, how unusual is this child?"

Results

All analyses focused on responses to the preceding questions.

As a preliminary step, we carried out $2 \times 3 \times 2 \times 2 \times 2 \times 2$ (Culture \times Adult Group \times Sex of Child \times Problem Type \times Context Combination \times Vignette Order) repeated-measures analyses of variance (ANOVAs), with problem type as the within-subjects factor. To minimize the risk of chance findings, we applied a Bonferroni correction (Neter, Wasserman, & Kutner, 1985); this set the alpha level for these five complex analyses at .001. Vignette order and context entered into a four-way interaction indicating that component simple effects and lower order interactions were stronger when the overcontrolled child was in Context A and undercontrolled in Context B. Establishment of this fact was useful methodologically, demonstrating that adults read the vignettes carefully, but the effect was of little theoretical interest. Also no significant sex effects occurred. Hence, context, order, and sex were excluded from the subsequent analyses.

We wanted to assess the possible effects of socioeconomic status (SES) on our findings. No reliable SES classification system (e.g., Hollingshead, 1975 for United States) exists for Jamaican society. However, because years of education are highly correlated with SES in most cultures, we included education in our multiple regression analyses. Three series of simple multiple regression analyses were conducted for each adult group.¹ In each series, the adult rating for each question (e.g., how serious for the overcontrolled child) was entered as the criterion variable, with culture and education as predictors. Table 1 indicates that culture had the more profound effect on adult ratings. Education was a significant predictor primarily for parents, particularly for their ratings of overcontrolled behavior. Education was also a significant predictor of clinicians' ratings of improvement for over- and undercontrolled problems. It was also significantly related to teacher ratings of seriousness for undercontrolled problems and to their ratings of improvement for overcontrolled problems. Education was negatively related to all ratings involving significant effects for clinicians and teachers and positively related to all ratings involving significant effects for parents. Jamaican clinicians' ratings of parent worry and seriousness of over- and undercontrolled problems and teacher worry for undercontrolled problems were significantly higher than those of U.S. clinicians. However their ratings of unusualness in undercontrolled vignettes were significantly lower. Jamaican teacher ratings of unusualness of over- and undercontrolled behavior were significantly lower than

¹ For comparison with the Weisz et al. (1988) Thai-United States adult attitude study, we conducted a series of $2 \times 3 \times 2$ (Culture \times Adult \times Over- vs. Undercontrolled) ANOVAs with Over- versus Undercontrolled as a repeated-measures factor; education was controlled by including it as a covariate in the model. Interested readers may obtain the results of these analyses from Michael Canute Lambert.

their U.S. counterparts. The converse was true of their ratings of improvement for undercontrolled behavior. Jamaican parent ratings of improvement in over- and undercontrolled vignettes were significantly higher than those of U.S. parents. Their ratings were lower for all other significant effects.

Discussion

Jamaican and American adults judged identical patterns of child behavior, and our findings suggest that they viewed behavior from different perspectives. Although culture was not a significant predictor in all ratings given by the adults, it played a significant role in a number of ratings. On five occasions across the 3 adult groups, significant culture effects, in the same direction for both over- and undercontrolled problems, provided some support for the general form of the threshold model discussed in the introduction. On four occasions across the 3 adult groups, significant culture effects were found for undercontrolled but not for overcontrolled problems; such findings are consistent with the pattern-specific form of the threshold model. These findings are somewhat consistent with those of others (e.g., Weisz et al., 1988), suggesting that cultures and adult groups within them may differ in their thresholds for child problems in general. Our finding that Jamaican parents and teachers rated child problems as less unusual than did their American counterparts is consistent with Clarke's (1957) observation that Jamaican adults may be tolerant of a wide range of behavior problems in their youngsters. Moreover, they also indicate that such tolerance may be based in the Jamaican adult attitude that maladaptive behavior reflects a transient and not an ingrained personality state. Jamaican parents, for example, were indeed more confident than their American counterparts that problem behavior would improve. Interestingly, the impact of culture on adults' concern was reversed when we moved from parents and teachers to clinicians; Jamaican clinicians expressed *more* worry and *higher* levels of perceived seriousness

than did Americans. This suggests that professional training may modify the impact of culture on adults' attitudes.

We also found some cross-cultural similarities that might aid us in interpreting recent data on clinic referral problems among Jamaican and U.S. youngsters (see Lambert et al., 1989). Although undercontrolled problems were more often noted as a reason for referral than were overcontrolled problems among clinic-referred Jamaican and American youths, overcontrolled problems were more often reported by parents of Jamaican youngsters than by their American counterparts. The converse was true for undercontrolled problems. These clinic findings might have resulted from differences in the prevalence rates of over- and undercontrolled problems in each nation or differences between Jamaican and American judgments about the types of problems that are worthy of referral. The findings from the clinic-referral study and the current study suggest that the clinic referral findings may not have been heavily influenced by cultural differences in adult attitudes. Table 1 indicates that on those occasions where culture emerged as a significant predictor for only one problem type (i.e., over- or undercontrolled), Jamaicans seemed more concerned about undercontrolled problems than did American adults.

Two limitations of this study should be noted. First, although reliable classification systems for SES (e.g., Hollingshead, 1975) exist in the United States, no such systems exist in Jamaica. It was therefore impossible to directly address the effects of SES per se on our findings. However, when we included educational level (which is typically highly correlated with SES) in our regression model, it primarily predicted the ratings of parents only. This is not surprising because the range in years of education was greater for parents than for clinicians and teachers. Second, our vignette method may have been affected by our subjects' reading ability or a tendency to give socially desirable responses. These method-specific problems may be circumvented in the future by use of videotaped vignettes or by recently developed methods that compare clinic referral rates

Table 1
Simple Regression Weights for Culture and Education

Variables	Clinicians		Teachers		Parents	
	Culture	Education	Culture	Education	Culture	Education
Parent worry						
Overcontrolled	2.03*	1.76	-0.02	0.56	0.22	3.59***
Undercontrolled	2.16*	1.11	-1.31	-1.86	-0.32	-0.96
Teacher worry						
Overcontrolled	1.29	1.01	-1.63	-0.24	-0.38	3.51***
Undercontrolled	2.16*	1.11	-1.31	-1.86	-4.76****	-0.58
Unusualness						
Overcontrolled	-0.64	1.45	-2.70**	-0.46	-6.85****	3.17**
Undercontrolled	-2.04*	0.28	-2.45**	-1.85	-6.00****	0.10
Seriousness						
Overcontrolled	2.91**	1.82	-0.64	0.61	-0.45	2.43*
Undercontrolled	3.87***	1.06	-0.56	-1.95*	-1.32	0.70
Improvement						
Overcontrolled	0.61	-3.51***	1.84	-3.14**	2.42*	-1.05
Undercontrolled	-0.65	-5.01****	5.15****	1.17	4.76****	-0.57

* $p < .05$. ** $p < .01$. *** $p < .001$. **** $p < .0001$.

with the general population prevalence rates of various child problems (Weisz & Weiss, 1991).

Despite its limitations, this study provides some support for both forms of the threshold model and raises additional questions for future research. Problems of clinic-referred children may indeed reflect tolerance thresholds of referring adults. As the data suggest, the thresholds may be affected by the socio-cultural arena in which child problems occur. The clinician may therefore need to address both the individual child's problem and the response of the social milieu to such problems.

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