Puerto Rican Mothers of Children Diagnosed With Attention Deficit Hyperactivity Disorder

Factors That Impact the Treatment Seeking Process

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Abstract

Although researchers have focused a vast amount of research on Attention Deficit Hyperactivity Disorder (ADHD) with diverse groups, few have addressed specific ethnic groups such as Puerto Ricans. This study explored the concerns of Puerto Rican mothers of children diagnosed with ADHD. This research addressed how factors such as acculturation and cultural beliefs within Bronfenbrenner's Ecological Systems Model impacted the process that Puerto Rican mother experienced while obtaining treatment for their children diagnosed with ADHD. Utilizing a qualitative research method and Bronfenbrenner's Ecological Model, the narratives of ten mothers of Puerto Rican descent with children between the ages of 7 -11 were questioned. The questions consisted of semi-structured interviews to assess how culture and acculturation within an ecological system impacted the process of obtaining mental health services by Puerto Rican mother's children for their children diagnosed with ADHD.

The results yielded eight themes that were embedded within Bronfenbrenner's Ecological System's theory that emphasized the importance of how Puerto Rican culture and acculturation level impacted the process of obtaining services. The mothers narratives exposed the barriers and the fears they faced as Puerto Rican mothers with children diagnosed with ADHD within the Unites States. Recommendation supported the need to address the barriers and fears that Puerto Rican mothers faced as they sought treatment for their children diagnosed with ADHD. Future research suggest further exploration of this research to empower this population and enhance the process to obtain treatment.

KEYWORDS: attention deficit hyperactivity disorder, Puerto Ricans, acculturation,Bronfenbrenner's Ecological System Model, Latinos, treatment process, mothers

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Puerto Rican Mothers of Children Diagnosed With Attention Deficit Hyperactivity Disorder: Factors That Impact the Treatment Process

Chapter 1: Introduction

According to the United States Census Bureau (2010), Latinos are the largest minority group in the United States. Population projections estimate that the Latino population will continue to increase, and by July 2050 one in every three people will be Latino (United States Census, 2011). According to the Pew Research Center (2012), 95% of the Latino population in the United States is made up of Mexicans, Puerto Ricans, Salvadorans, Cubans, Dominicans, Guatemalans, Colombians, Spaniards, Hondurans, Ecuadorians, Peruvians, Nicaraguans, Venezuelans, and Argentineans. Out of these fourteen groups the largest population in the United States are Mexicans, while the second largest group are Puerto Ricans. In 2011 the Census Bureau's American Community Survey estimated that there were 4.9 million Latinos of Puerto Rican origin residing in the United States, slightly greater than the population of Puerto Rico itself in 2011, which was 3.7 million (American Community Survey, 2011). However, what is astounding is that although the Latino population continues to grow and is not homogenous, research that addresses the process of obtaining mental health treatment specific toLatino groups, such as Puerto Ricans is lacking in the literature (Ramos, 2004; Perry, Hatton & Kendall, 2005).

This in itself supports the need to study this population to maximize resources and promote effective mental health interventions that address the specific needs of this growing population. This research seeks to supplement the current literature regarding factors that impact the treatment seeking process for Puerto Rican mothers in the United States with children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD).

Statement of the Problem

The primary purpose of this study was to qualitatively examine the extent that culture and acculturation within an ecological system impact the process of obtaining treatment for mothers with children diagnosed with ADHD. This paper will defineculture as structures of norms within groups that are interrelated and that vary mainly in the degree in which they are systemic (Nescolarde-Selva & Usó-Doménech, 2013). Furthermore, systemic cultural belief systems for the purpose of this research will be defined as Latino cultural characteristics such as *familismo* (family), *personalismo* (personalism), *respecto* (respect), *espiritism* (spiritualism), *simpatia* (sympathy), and *fatalism* (fatalism), which help form a group identity and acculturation levels (Antshel, 2002).Bronfenbrenner's (1979) Ecological Systems Model will be used as a framework to discuss culture and acculturation.

As the literature review revealed Puerto Rican populations merit special attention because, unlike other Latino groups, Puerto Ricans are born United States citizens and have the ability to easily travel between Puerto Rico and the United States (Guarnaccia, Martinez, and Acosta, 2005). Consequently the process of obtaining treatment may be impacted by factors such as culture and acculturation as noted by Guarnaccia, et al. (2005), "While Puerto Ricans have easier access to social ties on the island, their ties to an autonomous culture are more tenuous than other Latino groups, because Puerto Rican culture has been more dramatically transformed by almost a century of American dominance" (p. 25).

A phenomenological qualitative research method was utilized to explore how culture and acculturation impact the process of obtaining treatment because it has proven to be a successful research paradigm with Latino populations (Cauce, Ryan, & Grove, 1998). Questions presented were structured to explore: 1) acculturation levels based on language; 2) recommendations of treatment; 3) cultural beliefs that may influence treatment; and 4) perspectives on the mental

health care system. Demographic data was also collected to determine participant's place of birth; age; length of time residing in the United States; religious belief systems; religiosity; motivations for migrating to the United States; and primary caretakers in the home. Each of these variables were explored and provided a contextual understanding of the factors that contribute to Puerto Rican mother's process of obtaining treatment for their child's diagnosis of ADHD.

Chapter 2: Literature Review

The first to describe behaviors that were aligned with the definition of Attention Deficit Hyperactivity Disorder (ADHD) was Dr. Alexander Crichton, a Scottish physician in 1798 (Palmer & Finger, 2001). Dr. Crichton described symptoms of ADHD in his 1798 medical textbook that made reference to adults and children who experienced symptoms similar to the definition of ADHD in the Diagnostic Statistical Manual, Fourth Edition, (DSM-IV) indicating difficulty with attention (Palmer & Finger, 2001). Then in 1902 Dr. George F. Still described symptoms of what is now termed ADHD as passionateness in children lacking inhibitory volition, "a quite abnormal incapacity for sustained attention" (Laurence, 2008, p. 101). Dr. Still was influenced by cases of impulsive behaviors that he believed were medical disorders and termed Defects of Moral Control (Laurence, 2008, p. 101).

However, in the 1960's and the early 1970's the predecessor to the term ADHD was Minimal Brain Damage or Dysfunction, which was connected to hyperactivity (Lange, Reichl, Lange, Tucha, & Tucha, 2010; Swanson, Wigal, & Lakes, 2009). In 1980, the Diagnostic Statistical Manual, Third Edition, (DSM-III) signified behaviors that included inability to maintain focus and/or staying still as Attention Deficit Disorder (ADD) that included a separate category to signify undifferentiated attention disorder (Lange et al., 2010; Swanson et al., 2009). In 1987 the revised edition of DSM-III-R redefined the term to Attention Deficit Hyperactivity

Disorder (ADHD) and the two subtypes were removed to reflect a single list of symptoms of inattention, impulsivity and hyperactivity (Lange et al., 2010; Swanson et al., 2009). During 1994 DSM-III-R was revised to DSM-IV and although the term Attention Deficit Hyperactivity Disorder remained, three subtypes emerged: predominantly inattentive type, a predominantly hyperactive -impulsive type, and a combined type (Lange et al., 2010; Swanson et al., 2009).

The most recent revision that was released during May of 2013, DSM-5 continues to essentially maintain the core symptoms noted in DSM-IV-TR categorizing individuals into one of the following subtypes, Combined (inattention, hyperactivity-impulsivity); Predominantly Inattentive (inattention is met for 6 months or more, but hyperactivity -impulsivity are not met for 6 or more months); and Predominantly Hyperactive/Impulsive (hyperactivity-impulsivity is met for 6 months or more and inattention is not met for 6 months or more) (Swanson et al., 2009). However, DSM-5 currently places ADHD in the section of Neurodevelopmental Disorder rather than grouping it with disruptive behavioral disorders such as Oppositional Defiant Disorder and Conduct Disorder (CDC, 2010). The DSM-5 also provides examples of the different manners ADHD can manifest including ways it may appear in older adolescents and adults. To warrant a diagnosis of ADHD, unlike DSM-IV that indicates symptoms of ADHD must manifest by the age 7, DSM-5 has increased the onset criteria to the age of 12 and criteria must be met for 6 months or more. Individuals younger than 17 must display at least 6 or more out of the 9 symptoms of inattentiveness, and/or hyperactive impulsivity, individuals 17 and above must display 5 or more symptoms addition to warrant a diagnosis of ADHD.

Attention Deficit Hyperactivity Disorder (ADHD) can also impair academic functioning and may include additional psychosocial symptoms such as oppositional defiant behavior, aggression, and depression (Furman, 2005; Shaw, Mitchell, Wagner, & Eastwood, 2002). The

Center for Disease Control and Prevention (2014) estimated that 11% of children between the ages of 4 -17 years (6.4 million) were diagnosed with ADHD in 2011 and the percentage continued to increase at a rate of 5% per year from 2003 to 2011. In addition the average age of diagnosis was 7 years of age, with boys (13.2%) outnumbering girls (5.6%) in diagnosis. According to the Disease Control and Prevention (2014), ADHD is the most prevalent current diagnosis and most common mental health disorder among children aged 3–17 years. However according to Kataoka, Zhang, and Wells (2002), less than 50% of children diagnosed with ADHD receive professional services.

In particular the rates of Latino children diagnosed with ADHD appear to be lower in comparison to other populations. The prevalence of ADHD diagnosis is also lower among Latino children (5.1%) in comparison to African-American (7.4%), and Euro-American children (7.6%) (Bloom & Cohen, 2007). This data is further supported by Eiraldi, Mazzuca, Clarke, and Power (2006) who cite that "Children of ethnic minority status continue to lag well behind their non-minority counterparts in the rate of diagnosis and treatment of the disorder" (p. 607). This may be due to a number of factors that include the lack of quantitative and qualitative studies available that study the prevalence of ADHD in Latino populations; underutilization of health services by Latinos, low referral rates of Latinos to specialists in comparison to Blacks or whites, and linguistic, attitudinal, and cultural barriers (Gudiño, Lau, Yeh, McCabe, & Hough, 2009; Flores 2002; Yeh, McCabe, Hough, Dupuis, & Hazen, 2003; Phillips, Mayer, & Aday, 2000; Flores, Olson, & Tomany-Korman, 2005; Eiraldi, et al., 2006).

Bronfenbrenner's Ecological Systems Model

This research was informed by Urie Bronfenbrenner's (1979), Ecological Systems Model, this model emphasizes the ecological perspective considering levels of acculturation, culture, and how these factors influence parents perceptions and response to their children's prescribed treatment. It is important not to neglect social constructs because they impact treatment decisions made by mothers and using the ecological approach will help to facilitate our understanding of the complexity of direct experiences that impact mothers' decisions regarding treatment compliance. Puerto Rican mothers lived experiences are influenced by ecology, that include culture, acculturation, family, siblings, neighbors, community organizations, and social and political constructs, therefore, it is important to explore ecological influences regarding treatment compliance.

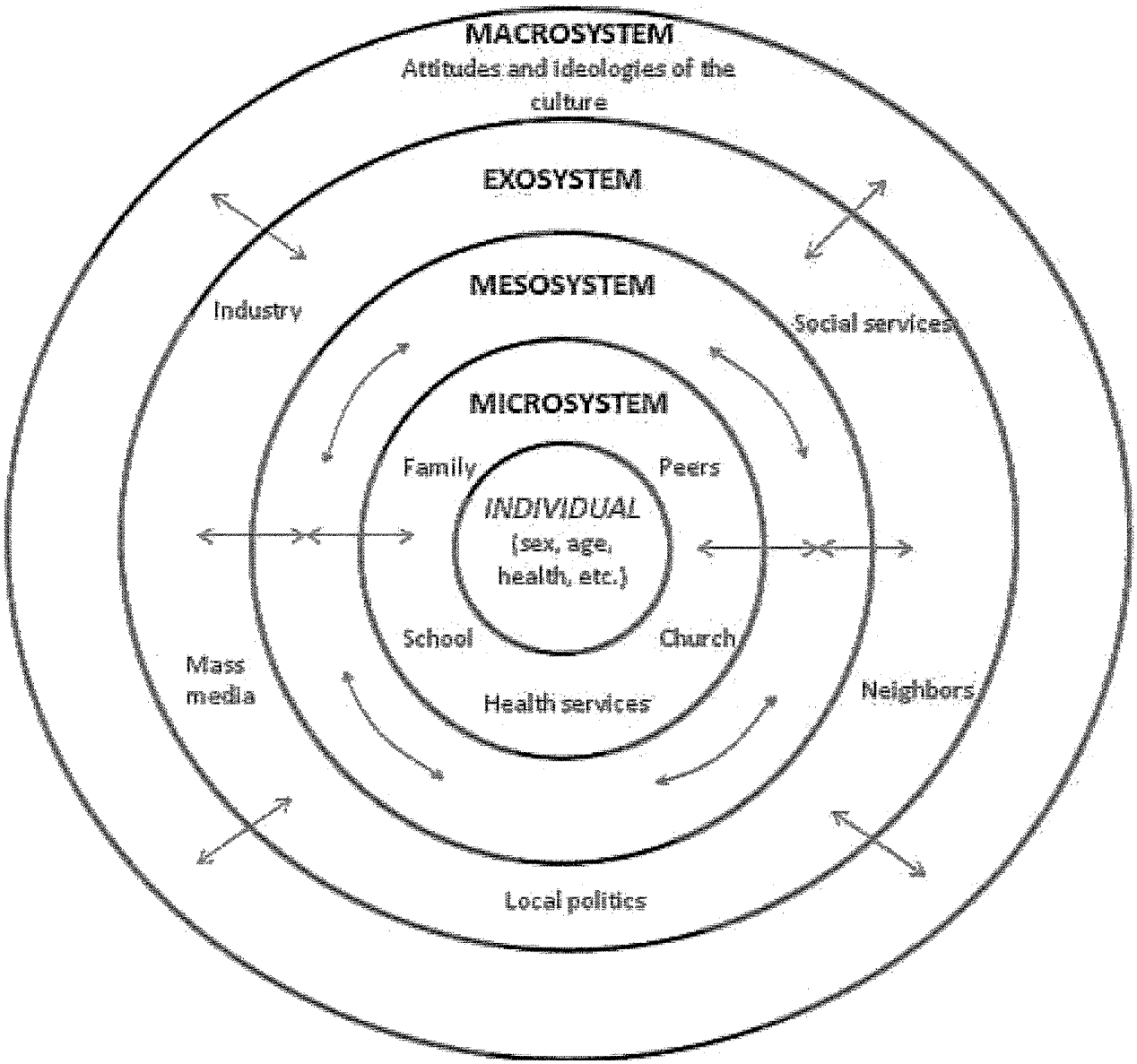
Bronfenbrenner's Ecological Systems Model (see Figure 1) illustrates the five structures-microsystem, mesosystem, exosystem, macrosystem, and the chronosystem. Each structure cascades into the next and is a crucial component that impacts the interaction between the mother and child. According to Bronfenbrenner (1979) the first structure, the microsystemis the setting in which the developing individual resides. Bronfenbrenner (1979) defined it as "a microsystem is a pattern of activities, roles, and interpersonal relations experienced by the developing person in a given setting with particular physical and material characteristics" (p. 22). The individual helps to construct this setting. This system is especially important as it a critical component of mother-child interactions, that helps to produce and sustain development.

The next structure, the mesosystem was defined by Bronfenbrenner (1979) as "the interrelations among two or more settings in which the developing person actively participates (such as for a child, the relations among the home, school, and neighborhood peer group: for an

adult, among family, work, and social life)" (p. 25). It is the impact of experiences within the family structure that influences outside structures. This component is essential as to how mothers and their children perceive structures outside of the family unit, which affect their relationship; it is an interacting system that relate to the microsystem or connections among contexts such as a child who is struggling academically may become oppositional at home refusing to complete his homework.

The third level, the exosystems refers to larger social systems that impact the individual indirectly. The social setting in which the individual does not have an active role will impact the individual, as an example, state educational initiatives and structures may indirectly hinder the mother's ability to obtain or maintain special educational services needed for their children. While level four, the macrosystem refers to "consistencies in the form and content of lower-order systems (micro-meso-and exo-) that exist, or could exist, at the level of the subculture or the culture as a whole, along with any belief systems or ideology underlying such inconsistencies" (Bronfenbrenner, 1979, p. 26). This system involves the larger cultural context that surrounds the individual, social systems communities, belief system, a shared identity, and heritage that continue to evolve. Bronfenbrenner (1979) also refers to the chronosystem, the impact of how changes such as in the family structure, socioeconomic status, employment, or residency occur over time influences the child as they age.

Figure 1. Bronfenbrenner's Ecological Systems Model



Bronfenbrenner (1979)

Models of Acculturation

Acculturation, also impacts the treatment seeking process, "immigrants adapt to the norms, attitude, and values of the host society or culture" (Schmitz & Velez, 2003, p. 113). Lopez and Guarnaccia (2000) cited the importance of understanding how acculturated the individual is to their host society to fully understand factors that affect treatment compliance. Acculturation barriers such as language and low social economic status have been associated with lower utilization of mental health and medical services and contribute to inadequate treatment compliance (McLeod & Nonnemaker, 2000; Schmitz & Velez, 2003; Shaw, Mitchell, Wagner, & Eastwood, 2002).

Acculturation is a dynamic process that changes and evolves over time; external variables influence individuals to adapt to practices in their host culture while still allowing them to maintain important aspects of their heritage (Hanelsman, Knapp, & Gottlieb, 2005). According to Wallace, Pomery, Latimer, Martinez, and Salovey (2010) "... Latino cultural beliefs about cause of illness, treatment, and ways to prevent illness are significantly affected by religion, fear, and fatalismo. These beliefs in turn influence health care utilization" (p. 38). This indicates that there is a need to fully understand the concept of acculturation and its impact on delivery of appropriate health care interventions.

Two popular models of acculturation cited by Cabassa (2003) and Lara, Gamboa, Kahramanian, Morales, et al., (2005) are the unidimensional model and the bidimensional model. The unidimensional model of acculturation views acculturation as a continuum that begins when one is fully immersed in their culture of origin to full immersion in the host culture. The assumption is that if the host culture does not have an impact on the culture of origin, the

individual will maintain ties to their culture of origin. However, as the individual begins to connect to the host culture they lose aspects of their cultural of origin. The criticism of this model is that it lacks the ability to provide for the balance that can exist as an individual moves from full immersion in the culture of origin to full immersion in the dominate culture, losing aspects of their original culture (Cabassa, 2003).

According to Cabassa (2003), the bidimensional model allows individuals to embrace two cultures simultaneously and benefit from each. At one level, individuals maintain their cultural origin while embracing the host culture; at the second level, individuals may reject their culture of origin completely. This model allows for individual variations and accounts for ways some immigrants come to neglect or continue to express their culture of origin. The bidimensional model uses the processes of assimilation, separation, integration, and marginalization to fully express the process that individuals use to adapt to host cultures. Research indicates that parents who are acculturated in the mainstream Euro-American culture and who demonstrate a bicultural orientation (bidimensional model) tend to utilize health and mental health care services more often (Eiraldi, Mazzuca, Clarke, & Power, 2006). Another key aspect of acculturation is the impact of language on treatment adherence.

According to research by Roth (2005) 3,300 parents of children with ADHD ages 6-17 were surveyed, approximately 1,034 were Latino parents, and out of these parents, 32% acknowledged that their language barriers or low English proficiency levels prevented them from obtaining appropriate treatment. Spanish-only monolingual Latinos are less likely to pursue treatment options without access to a bilingual aprovider (Willerton, Dankoski, & Martir, 2008). Although on August 11, 2000 President Bill Clinton signed an executive order requiring that agencies which receive federal funding must provide individuals with limited English

proficiency with interpretation services, interpretation services may not be readily available to therapist or physicians in small or private practices (Willerton et al., 2008). If they are utilized, interpreters may alter the Latino parent's sense of security and privacy (*confianza*)and therefore the parents may neglect to mention important information needed to obtain an accurate diagnosis of ADHD.

In order to address linguistic concerns, many parents will utilize a family member or their own child as an interpreter. It is common for parents who are monolingual to depend on their children to interpret, but this places pressure on the child, information can be distorted due to inadequate language skills of the child, and some delicate issues may be inappropriate to discuss utilizing a child (Fontes, 2008). The use of children as interpreters can ultimately place the parent and "family member at risk of triangulation and could prevent a client from disclosing their concerns candidly" (Wilerton, et al., 2008, p. 198). Obtaining a qualified interpreter is essential to the success of the interview. Interpreters should be prepared prior to the interview to ensure that they understand the language, dialect, culture, and their role (Fontes, 2008). Skilled use of interpreters helps health care workers obtain accurate data concerning the person seeking treatment.

Cultural Characteristics

Certain cultural characteristics are shared among Latinos of diverse national origins. These cultural characteristics include familism, personalismo, respecto, simpatia, espiritismoand fatalismo, which help form a group identity (Antshel, 2002; Cabassa, 2003). Treatment providers who are familiar with these concepts may have improved communication with their Latino clients (Bauermeister, 2005; Cauce, Paradise, Domenech-Rodriquez, et al., 2002; and Schmitz & Velez, 2003). Each term signifies an aspect of the Latino family that helps form

bonds between families and friends.

The term *familismo* involves a strong identification and attachment to one's nuclear and extended family members that emphasizes the importance of the entire family system (Antshel, 2002; Cabassa, 2003). Extended family members form an integrated support system that relies not on individualism, but on strong and loyal groups. Each member is dependent on loyalty and a sense of solidarity. The eldest male is typically viewed as the authority figure in the family and gender roles tend to be traditional. The value of *personalismo* stresses the importance of personal relationships above business or institutional needs (Antshel, 2002; Cabassa, 2003). Latinos will commonly address authority figures by their title, but will engage in social conversation prior to focusing on business issues. Many Latinos are more apt to trust a provider whom they know personally. *Respecto* focuses on showing respect towards elders and authority figures (Antshel, 2002). Differential behaviors are shown to those who are older or in positions of authority such as doctors due to their experiences and knowledge base. Many Latinos will avoid eye contact with people in a position of authority as a way of demonstrating respect. *Simpatia*this is an also an important cultural characteristic that emphasizes the importance of harmonious relationships and striving to avoid showing anger and aggression (Antshel, 2002; Cabassa, 2003). It is considered inappropriate to demonstrate overt disagreement. It is important to maintain a modesty and privacy. The term *espiritismo* focuses on health including aspects of the mind, body, and spirits that drive illness. Finally,*Fatalismo* is the belief that God determines who is to contract illness, which may be due to sins or lessons that need to be learned (Antshel, 2002; Mazzuca, 2001). Fully comprehending the Latino population is virtually impossible due to the diversity that exists among this group, however these general cultural characteristics, which families and individuals subscribe to in different degrees, provides a helpful orientation.

It is impossible to describe the "typical" Latino family because of great variations in personalities, national origin, social class, religious observation, and acculturation.

Treatments

Bauermesiter's (2005) research focuses on pharmacological treatment of ADHD in Latino children. He utilized an epidemiologic study and a sample of children ages 4 to 17 to explore the variables associated with pharmacological treatment. The objective was to identify a number of barriers that contribute to termination of pharmacological treatment for children with ADHD. Issues such as side effects of medication, risk of having children labeled as unstable, apprehension about long-term outcomes, and school policies towards medication of children, were reviewed. This study noted that Latino mothers and fathers were highly concerned about pharmacological treatment for ADHD. Their concerns were that their children would be labeled as crazy; they would experience loss of employment in the future (blood tests would reveal stimulant use) and would experience long-term effects such as brain damage, Alzheimer's disease, and infertility. These concerns impacted parent's noncompliance with pharmacological treatment. These findings point to the importance for clinicians and medical personnel working with Latinos to ensure that parents receive adequate education on pharmacological treatment to ensure that when treatment is prescribed, the myths that exist can be extinguished.

In addition, the impact of psychosocial treatment such as Parent-Child Interaction Therapy (PCIT) has been examined. PCIT is a promising approach that targets symptoms of ADHD and conduct problems. PCIT is geared towards working with families of young children (2-7 years of age), and is designed to teach parents how to effectively work with their children through play therapy. Parents are given the tools to communicate and manage their children's behaviors more effectively (Matos, Bauermeister, & Bernal, 2009; Matos, Torres, & Santiago et al., 2006).

Matos, Torres, and Santiago et al. (2006) focused on the efficacy of using a PCIT as an intervention with Puerto-Rican families with children diagnosed with ADHD; they found PCIT to be successful. What is most intriguing about their study is that the children who participated were not receiving psychotropic medication or any other form of treatment during the time the study was completed. The results indicated that mothers of Puerto Rican heritage reported "a significant reduction in children's hyperactivity-impulsivity, inattention, and oppositional defiant and aggressive behavior problems...as well as improved parenting practices" (Matos, Torres, & Santiago et al., 2006, p. 246). These results confirm that psychotropic medications are not the only answer to treatment; other forms of treatment such as PCIT may be successfully used to improve the behaviors of Puerto Rican children with ADHD. Overall, a number of variables have been found to contribute to treatment compliance with Puerto Rican mothers of children diagnosed with ADHD that will be explored in this research.

Chapter 3: Research Method

Design

This phenomenological research study explored the factors that contributed to the treatment seeking process for Puerto Rican mothers in the United States with children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). Previous research in this area tended to focus on Latinos in general rather than focusing on specific groups such as Puerto Ricans (Ramos, 2004; Perry, Hatton & Kendall, 2005). Furthermore, the studies that do exist focused on Puerto Rican mothers who resided in Puerto Rico, not those who resided on the mainland in the United States, where ideological and situational factors may impact treatment compliance in different ways.

The phenomenological qualitative research methodallowed the research to be driven by the lived experiences of the participants. The research generates data that will:

a. Investigate the factors that impact the treatment seeking process in all its modalities and aspects rather than those that are conceptualized by the researcher;

b. Use personal experiences as a starting point to uncover themes in participants' descriptions;

c. Provide insight into idiomatic phrases that may be crucial to understanding the participants' worldview;

d. Explore the individual's social and historical life circumstances that impact how they relate to the world in general and specifically to their children, medical providers, extended family and community regarding their children's behaviors.

Participants

Following approval by Union Institute and University's Internal Review Board (IRB), participants were recruited from various mental health agencies, community centers, and through word of mouth within the Hartford County area. Participants were procured through both a convenience sampling approach (Marshall, 1996) and a snowball sampling approach (Heckathorn, 2011). Directors in various mental health agencies and community centers located in Hartford, Connecticut were contacted and provided with a Prewritten Script (Appendix A). A request was then made to post a Recruitment Flyer (AppendixB) in their agencies to enlist potential participants (Puerto Rican mothers) for the study.

All directors were asked to use their networks to engage similar participants. These methods yielded sufficient participants, therefore posting flyers in housing complexes and advertising in local publications, the proposed secondary method of recruitment was not utilized. Participants consisted of 10 heterosexual females who self-identified as Puerto Rican between

the ages of 30 and 52, four out of ten were monolingual (Spanish), and eight out of ten women were single mothers. All participants' primary language was Spanish. Their average educational attainment was tenth grade, and they shared an average of 11 years of residency in the United States.

Procedures

All potential participants were contacted via telephone and provided with a verbal overview of the research. Interested participants were then administered a brief Screening Questionnaire (see Appendix D) to access their feasibility for the research. The following criteria were met: (a) mothers who identified themselves as Latino or Puerto Rican; (b) mothers who were monolingual (Spanish) and bilingual (Spanish/English); and (c) mothers with children between the age of 7 and 11 years of age (male or female) with a diagnosis of ADHD were scheduled to meet fact-to-face with the researcher for approximately a two-hour interview. This study did not include (a) participants who identified their children as a member of an ethnic group other than Latino; (b) parents who have resided in the United States for 25 or more years; and (c) fathers. Puerto Rican mothers were interviewed rather than Puerto Rican fathers because in the Puerto Rican culture, women are the primary caretakers and supervisors of their children (Lamb, 1987; Roopnarine & Ahmeduzzaman, 1993). As Guilamo-Ramos, Dittus, Jaccard, Johansson, Bouris, and Acosta (2007) noted "Latina mothers bear responsibility as the primary source of care for the entire family" (p. 19).

Interviews took place at a location of the participants' choice and included either a public library or the researcher's office located in Wethersfield, Connecticut. During the interview the purpose of the interview and nature of the research was again reviewed. Each participant was then provided with an Informed Consent Form (see Appendix C). In order to

obtain informed consent, the researcher reviewed both verbally and in writing the purpose of the study; time needed for the interview; use of audio-recording equipment and transcription methods; assurances of anonymity; potential risks and benefits; compensation of a $10.00 Wal-Mart gift card; and confidentiality and privacy protections. Participants' questions were addressed prior to their completion of the Demographic Questionnaire (see Appendix E). The Demographic Questionnaire was translated to Spanish, thereby providing participants with the choice to complete the form in their preferred language, Spanish or English. The questionnaire was used to collect demographic information in reference to age, place of birth, primary/secondary language, level of education, marital status, religious affiliation, child's age, gender, and treatment services recommend for their children identified with a diagnosis of ADHD. Participants then took part in a face-to-face, semi-structured interview consisting of twelve interview questions (Appendix F) that were delivered in their preferred language, Spanish and/or English.

Semi-structured interviews were selected because they provided personal contact, helped dispel mistrust of the researcher, and created a welcoming and personal environment. Direct contact has proven to be effective with Latinos who typically demonstrate low research participation rates (Cauce, Ryan, & Grove, 1998). Studies also indicate that success in retaining mothers in psychology studies is attributed to an individual approach that emphasizes a personal connection of warmth, caring, and a sense of personal rapport (Umana-Taylor, Bamaca, 2004; Miranda, Azocar, Organista, Munoz, & Lieberman, 1996). This approach demonstrates the cultural respect and sensitivity that is critical to successful recruitment and retention of Latino participants. Individual interviews "are particularly suited for studying peoples understanding of the meaning in their lived world, describing their experiences and self-understanding, and

clarifying and elaborating their own perspective on their lived world" (Collingridge & Gantt, 2011, p. 393).

Each interview was recorded. Recordings were used for transcription purposes and were downloaded, transcribed, then deleted from the recording device after the transcription was complete. All recordings were stored on the researcher's password protected computer as a security measure prior to being transcribed. In order to ensure confidentiality, all identifying information was removed from transcriptions including name that were changed to further ensure anonymity. Participants were provided with the researchers contact information via the consent form and encouraged to contact the researcher or researcher's dissertation chair with any questions or concerns they may have following the interview. At the end of the interview each participant received a Wal-Mart gift card in the amount of ten dollars as compensation and was informed that a debriefing interview could be scheduled at their request.

Data Analysis

The researcher utilized an interpretive phenomenological analysis (IPA) approach. IPA emphasizes knowledge obtained through interactions with others and the world, "it attempts to explore personal experience and is concerned with an individual's personal perception or account of an object or event, as opposed to an attempt to produce an objective state of the object or event itself" (Smith & Osborn, 2003, p. 53). Guided by IPA, the researcher analyzed the data according to Smith and Osborn's (2003) method. First the researcher utilized an intensive and detailed analysis of the data by reading and rereading each transcript several times to become familiar with the participant's account. The researcher then marked significant aspects of the transcripts and commented on similarities, contradictions, and aspects of the participants' comments that reflected the importance of their experiences. This process allowed the researcher

to be immersed in the data. Following this, the researcher reread the transcripts several times to extract emerging themes and this process was continued until potential themes were exhausted. Next, the researcher organized the themes to make sense of them, while seeking connections and clusters that emerged, themes that were not supported by participants were discarded (Smith & Osborn, 2003). Finally, the researcher developed a summary table of structured themes noting quotes to support themes that were found across transcripts that captured the shared experience of the participants.

Themes were analyzed considering Bronfenbrenner (1979) ecological systems model (microsystem, mesosystem, exosystem, macrosystem, and chronosystem), Cabassa et al., (2003) models of acculturation (unidimenstional and bidimenstionalmodels), and cultural characteristics that are shared among Latinos (familismo, personalismo, respecto, espiritism, simpatia, and fatalism).

Trustworthiness

To verify the accuracy of the data, the researcher established an external audit. The data was interpreted by a second rater who analyzed and coded the data to ensure a high degree of consensus of the results and validation of the researcher's interpretations. To enhance the creditability of the data, the researcher requested a peer psychology graduate student familiar with ADHD to review the data and written drafts. Furthermore, the researcher maintained reflective notes (field notes) to record observations throughout the entire collection process to enhance learning and help keep track of ideas that could be used in the study. This record documented any problems or limitations that may have occurred while collecting the data. Reflective notes also recorded any bias that may have occurred. According to Fontes (2008) a number of potential cognitive biases may result in incorrect conclusions. They can include: (1)

confirmatory bias, the tendency to focus on our preconceived beliefs of the individual; (2) fundamental attribution errors, the tendency to attribute an individual's behaviors to the individual rather than the effects of the situation; (3) halo effect, allowing external aspects (clothes, physical appearance, and language) of the individual to influence the way the interviewer perceives the individual; (4) in group-bias, this entails giving preferential treatment to individuals that resemble the interviewee internally and externally; and (5) self-fulfilling prophecy, engaging in behaviors that confirm our beliefs about an individual, in a positive or negative way. A careful record of the various steps of the study, from recruitment through data analysis, helped to ensure the uncovering of bias, and opportunities to eliminate it.

Ethical Considerations

Participants were treated in accordance to the ethical guideline of the American Psychological Association (APA) and Union Institute and University Institutional Research Board (IRB). The researcher took steps to ensure that participant's rights were protected. Participant's primary language in this study was Spanish. Four out of the ten participants were monolingual speakers, while the remainder, six were bilingual. Written materials and interviews were delivered in the participant's preferred language. To ensure that informed consent was obtained following ethical principles, prior to the interview participants were fully informed in reference to the purpose and audience of the research. Questions were addressed and the consent form was reviewed to ensure participants fully understood what the research required. The researcher also reminded them that they were able to withdraw at any time without prejudice. The researcher reviewed all potential risks of the research, how these risks would be minimized, and how their privacy and confidentiality would be strictly protected. Participants were also informed that pseudonyms would be used on all written materials rather than their actual names

to protect their privacy. They were also informed that all written material would be secured in a locked cabinet for five years at which time the documents will be destroyed.

Chapter 4: Results

A convenience sample of ten (*N=10*) Puerto Rican born females residing in the United States were recruited through contact with Directors of mental health facilities in the Hartford, Connecticut area. Participants primary language was Spanish, but four out of the ten reported being monolingual speakers (Spanish), while six were bilingual (Spanish/English). Their ages ranged between the ages of 30 and 52 years old (*M=39*), years residing in the United States ranged from four to twenty-four years (*M=11*). Two of the ten participants were married, and educational level ranged between the four years of education to fourteen years of educational attainment (*M=10*). Table 1 reveals the demographic information of participants, all which met the inclusion criterial noted in Chapter three. All participants' identities have been protected by using pseudonyms.

Table 1: Demographic Information of Participants

Participants	*Age*	*YRS In US*	*Primary Language*	*Secondary Language*	*Marital Status*	*Educational Level*
Laura	42	5	Spanish	English	Single	12
Liz	34	4	Spanish	None	Single	4
Naomi	45	24	Spanish	None	Single	14
Maria	43	8	Spanish	None	Single	3
MariCarmen	31	6	Spanish	English	Married	12

Nelli	35	18	Spanish	English	Married	13
Myra	33	12	Spanish	None	Single	9
Mime	52	24	Spanish	English	Single	12
Margarita	49	4	Spanish	English	Single	12
Carmen	30	9	Spanish	English	Single	12

The data revealed eight main themes that were relevant to understanding the factors that impact the treatment seeking process impact treatment by Puerto Rican mothers with children diagnosed with ADHD. The eight themes that emerged were,

- **Theme 1 Maintaining Individual Cultural Identity:**

  mother's continued to maintain their Puerto Rican cultural identity, while embracing the Euro-American culture to ensure their children's needs were met;

- **Theme 2 Preserving Familial Cultural Identity:**

  mother's sought to ensure that their children maintained their Puerto Rican cultural identity within the Euro-American culture;

- Theme 3 Assessing ADHD:

  teacher's observations contribute to initial contact with professionals to assess child for Attention Deficit Hyperactivity Disorder;

- Theme 4 Language Barriers:

  language can become a barrier when seeking treatment;

- Theme 5 Stigmatization:

having a child with ADHD can lead to feelings of being stigmatized;

- Theme 6 Support Services:

  ensuring that children received support services despite obstacles;

- Theme 7 Treatment Utilization:

  psychotherapy treatment utilization was prominent in comparison to use of medications to address symptoms of ADHD, and;

- Theme 8 Trust in Providers:

  mental health care providers Spanish language abilities were not a necessity, but a preference that enhanced trust.

All ten participants endorsed aspects of each theme that was broken down and illustrated as follows:

Theme 1- Maintaining Individual Cultural Identity: Mother's continued to maintain their Puerto Rican cultural identity, while embracing the Euro-American culture to ensure their children's needs were met.

The initial question that participants addressed, how strongly do you identify as a Puerto Rican or with Puerto Rican culture, contributed to the first theme that emerged, which revealed how participant's defined their Puerto Rican identity. They all voiced a number of ways that defined their Puerto Rican identity, which included speaking Spanish, cooking Puerto Rican foods, preserving family connections, and practicing their cultural holiday traditions. Participants noted that their primary language Spanish was spoken in the home, Puerto Rican foods such as *pasteles* (boiled green banana mass with pork filling), *arroz con gandules(*pigeon peas with rice), and *pernil* (roast pork) were prominent foods cooked, and families often gathered to celebrated holiday such *el dia de los Reys Magos* (three kings day). Three kings day is celebrated on

January 6 and marks the day of the Magi arriving bearing gifts for the baby Jesus. Children gather hay or grass that they place in shoe-boxes for the Magi's horses or camels and are rewarded with gifts. Although all participants also celebrated Euro-American customs such as Christmas on December 25.

It was important forparticipants topractice their Puerto Rican traditions, which they viewed this as an important component of their identity as Puerto Ricans.This illustrates the impact of Bronfenbrenner's (1979) microsystem, the impact of the parent's family cultural beliefs that helps to shape the family structure. Participants maintained their Puerto Rican culture and obtaining treatment services with mental health care providers who were Puerto Rican, spoke Spanish, or were able to understand them as Puerto Rican was crucial for them to feel that their voice was heard as noted by Naomi (*pseudonym*), "I feel more trust in someone who is Spanish. They understand what I am saying, they understand me" (personal communication October 24, 2014). Participants noted the importance of practicing their Puerto Rican culture as revealed in the following examples:

Carmen:

> The food, Hispanic food is very different from other countries. If you are from another country and I cook something from my country you would say this is good, I have never ate this at my country, and if taste something from your country I will say the same, you know. Also the beliefs, dressing way, the way to do things, we all are different, we can't have the same thoughts or the same brain, so whatever I go they can tell I am Puerto Rican.

Liz:

> Speaking the language, festivals are celebrated like three kings day, Christmas the family celebrates because there are many, my grandmother had 12 (*children*) and they all go to my mother's house, and those children had children so the house becomes so full tis pack. We all celebrated together, we make food, pasteles, arroz con gandules, pernil, we make everything.

Mime:

> Well, speaking Spanish, cooking foods like arroz, things like that. We celebrate holidays like my family gets together for Christmas and three-kings and we all cook together, it's fun we get to see everybody and eat, we eat a lot. The kids get to decorate the tree for Christmas, but we celebrate three kings day too. They get small toys for three-king day, but it's important to celebrate it; you know we are Puerto Rican.

Theme 2-PreservingFamilial Cultural Identity: Mother's sought to ensure that their children maintained their Puerto Rican cultural identity within the Euro-American culture.

Six of the participants reported wanting to maintain their culture of origin. Although they embraced the Euro-American culture, they were mindful of their connections and their children's connection to their culture being preserved. These participants wanted to maintain their ties to their culture of origin while continuing to embrace Euro-American culture, which characterizes the bidimensional model (Cabassa, 2003; Lara, et. al., 2005). Conversely, their children who were introduced to their cultural ties through the participants, were fully immersed in the host culture, which illustrates the unidimensional model (Cabassa 2003; Lara, et. al., 2005).

Participants feared that their children would become fully immersed into the Euro-American culture and lose their culture of origin. This also illustrated Bronfenbrenner's (1979) microsystem as participants viewed a critical component of parenting as shaping their children's immediate environment to ensure that their children retained their Puerto Rican culture, but also acknowledging the impact of the dominate Euro-American influences such as the school environment that also impacted children's development. One significant fear that participants disclosed was that their children would lose an important aspect of their culture, their Spanish speaking language skills. They all reported that their children's ability to speak fluent English, but not Spanish was a concern, which they addressed. This contributed to the struggle that they faced as they realized that while their children spoke English fluently and were able to receive mental health services in English, they preferred Spanish speaking providers for their children. This was a realization that contributed to their need to ensure that their children spoke Spanish, which allowed them to seek out bilingual (Spanish/English) mental health providers. As the following examples demonstrated, sustaining their children's cultural of origin was essential:

Laura:

> I try like my son and my daughter is like they are like a little Americanized, I try to teach both of them their still Boricua (*native Puerto Rican*) no matter what... and I try to tell them what I went through and that not all Puerto Ricans you know like there are successful Puerto Ricans. I want her to know her customs her culture, it's very important to know Spanish especially when you're working in the hospital (*participant noted daughter wanted to be veterinarian*) you know it's good to know both languages.
>
> Ya like the customs, like I make sure I do the rice the beans the pernile, the carne (*meat*), I do all that, I keep it, you know, the bodega (*a shop that caters to Spanish items*). I teach

them you know like stuff like that. I teach them the Spanish even if their Spanish is not good, but I teach them that to talk so they know to get by.

Margarita:

I speak in the house you know Spanish all the time so he don't forget where we come from, I try to tell him a lot of stories from Puerto Rico like, where San Juan Puerto Rico, El Fuerte San Cristobal, Ponce, a la yunke (*militarily fort; rain forest*). I tell him there is some beautiful stuff, there is a lot of stuff, you can go and visit Puerto Rico it is beautiful. Sometimes if I got the time to go back home, I take him with me so we go to the beaches, yunka, San Juan to places where this a lot of places where there are a lot of traditions there. He speaks more English, but he does understand Spanish. He gets confused because it's not the same, it's like when you are in Puerto Rico and you're in social studies and they talk about let's say where Puerto Rico came from, over here they talk about where United states came from, see there is two different stories and he could get confused, but when its bilingual it's easier because then your letting him understand that there are two different worlds and two different traditions, and like that he would understand it.

Theme 3 – Assessing ADHD: Teachers observations contribute to initial contact with professionals to assess child for ADHD.

Frequently participants reported that the first professionals to report problematic behaviors (*hyperactivity, impulsiveness, and disrupted behaviors*) were their child's teachers. Teachers often contacted the participant about their child's disruptive behaviors in the classroom, but did not offer assistance or referral services to assess behaviors. Although participants reported they did not understand why teachers did not direct them to specific resources for

assistance, which was upsetting, they did not confront the teachers. This need to respect authority figures without question and maintaining a harmonious relationship with the teachers illustrates Puerto Rican cultural characteristic ofrespect (*respecto*) and kindness (*simpatia*). This alsoelucidatesa loss of power as participants did not voice their needs due to these cultural beliefs, and sought other avenues to obtain services such as using their child's primary medical providers.

Participants reported that following a number of contacts from teachers informing them of their child's behaviors, they sought professional assistance to assess their child's behaviors. They sought assistance from school psychologist, social workers, physicians, and therapists to evaluate their children. Following a diagnosis of ADHD, seven out of ten mothers accepted the diagnosis to the degree that they were elated to hear that they did not contribute to their child's diagnosis. Two of the participants reacted in a negative manner, first participant *(Liz)* feared that her child contracted an illness, while (*Margarita)* became tearful when informed of her son's diagnosis because she viewed this as another burden to bear in life. However, all participants sought out mental health care providers for their children and many received information from these providers.This is indicative of Bronfenbrenner's (1979) mesosystem, that emphases the impact of the contextual sources of the home and external environment, which is an interacting system that involves relations between the microsystemor connections among contexts. The behaviors of their childrenoutside of the family structure influences the family and prompted participants to seek assistance, as the following illustrations demonstrate:

Liz:

> Well, the school called me all the time, that he was jumping that he was running that he did not pay attention, that he would stand on the chair, he would leave the room, would

interrupted the teacher when they spoke. The psychologist completed test, she talked to me and my son. Then she worked with my son, I don't know exactly what she gave him. Well when they told me (*diagnosis of ADHD*) and I was not familiar with this, I thought oh my God this one is sick, that is what I thought about quickly, this one is sick. I thought that this was an illness that he caught from someone, and I thought oh my God who gave him this. The doctor told me he didn't catch it from anyone, it was something that could be genetic and I though did I have it, but she said if I wanted to know I needed to take some tests. But I was scared. Um, no I did not know about that illness, but the psychologist told me that my son had that illness that children are hyper.

MariCarmen:

Ya, they (*teachers*) reprimanded him a lot so as a mother I felt uncomfortable and then I watched him at home and he use to rock a lot, or watching television he would throw himself on the floor, he would not stay still he was a disaster, throw his toys, and he would not pick up his toys, and was a bit aggressive but I was strong with him and this started to stop, but he was aggressive. No teachers gave me complaints about him, but I knew.When she (*psychologist*) interviewed him and he ate his nails and I saw that she was watching him, she said take your hands out of your mouth and he began to fidget. I told her, he always does that, and she told him sit straight, and I said he always does that. Then she said, you already know, and I said yes. She said how do you feel, and I said I know my son has that. Then she asked why do you know, and I said I know, that is why I am looking for help. She said the easiest thing is that you accept it. She told me there was a lot of um, organizations that you orient you, a lot of papers that told me of places I

could go that treat kids like that, and papers that explained ADHD, she recommended medication if he got more aggressive

Margarita:

Because it was new for me it was like, you know another problem, I had to struggle with something else in life, he had problems with speech and they tell me he has ADHD. For them (*psychologist*) it was normal, for me it wasn't. For them it was normal because they treat children like this, you know, but for me it was something new, I cried because I thought, well like something else on top of so much like saying to someone you have cancer, but on top of that you have diabetes so you pile everything up, everything is piling. And you think if I do this I'm doing it wrong or I go this way I'm doing it wrong. She said everything is ok, it's just ADHD, but I am his mother it wasn't just ADHD it was my son and I have to help him. I guess doctors do this all the time (tell parent), but for me it was hard.

Theme 4 – Language Barriers: Language can become a barrier when seeking treatment.

As each participant described their experiences, the traditional barrier of language was an important aspect of their ability or inability to communicate their needs effectively to school personnel, medical and mental health providers. The four participants who reported speaking only Spanish (*monolingual*) had difficulty expressing their needs, obtaining clear information, and clearly comprehending the diagnosis of ADHD when receiving services from Euro-Americans who only spoke English. However, those that received services from school or mental health providers in Spanish noted their experiences as positive.

Alternatively, six of the participants who reported speaking both Spanish and English (*bilingual*) reported less struggles communicating with school and mental health providers who

were Euro-American and spoke only English. These participants believed that their child's needs were met, but valued the importance of speaking with someone who spoke Spanish or who was a native Puerto Rican.

Overall, the importance of language, developing rapport, and the ability to relate to the Puerto Rican culture were major components that participants sought out in mental health care providers. As participants sought out services, participants that were provided with interpreters reported fearing that translators were unable to convey their sentiments or address their questions appropriately, which may have led to receiving inappropriate support services for their children. However, due to their cultural beliefs of respect (*respecto*) and kindness (*simpatia*) they did not confront these issues directly, but sought out bilingual providers to ensure they could advocate for their children. This clearly illustrates the impact of the social systems in which participants reside as noted by Bronfenbrenner's (1979) exosystem that posits, the larger social setting in which the individuals resides plays an active role in the individual's life. The examples presented below illustrate responses in reference to interacting with school personnel, medical and mental health personnel. In order to clearly represent the data, participants' responses were separated based on whether they were monolingual speakers or bilingual speakers:

Monolingual Speakers

Liz:

> They (*school*) had a translator there (*PPT meeting*) to help me, she was the secretary she spoke Spanish. During the meeting, the interpreter told me what she (*psychologist)* said, but the school did not agree with the psychologist and she (*psychologist)* stood up grabbed her things and left because she became upset because she said she did her job and informed them what she he and they did not want to accept it, so she stood up closed

her bags and left. At times I wonder what they are saying what I tell them (*via the interpreter*). At times I would go to school and I would be waiting for the principal, they would leave me waiting for a good amount of time there, and I would say what is this this I never seen in any school. I would see other people going ahead of me and they would leave me waiting. If I spoke English they would help me more. Because I did not speak English they would make me wait. Speaking to someone who is Spanish is better because you can express yourself better, the feeling of what you're going through with him. The communication is much clearer, we can understand each other. It's not the same that if I expressed myself in English there are words I can't pronounce well, but if someone speaks my language and can understand it that perfect and much better. My son translates I tell him not to lie to me I don't think he lies to me, he (*son*) knows it's important.

Myra:

Ya only the interpreter she was the school secretary. As they spoke she would tell me what they said I wasn't comfortable because sometimes when they interpret they may miss important things. I want to understand them, but I don't think the interpreter told them everything. I could see sometimes she had problems with what I said, that made me nervous, maybe that she gave me the wrong information. She (*secretary*) was trying to tell me and I don't know if she understood everything, but she did her best. I was mad, but it wasn't her fault, they should give you information in Spanish everything is in English that doesn't help me. They (*school)* gave me some papers that explained it (*ADHD*) but they were in English, I didn't understand them.

Bilingual Speakers:

Mime:

> It's easier to speak to them in Spanish, I'm more comfortable speaking in Spanish. I can speak English, but sometimes I can't say some words in English so it's hard. If I say something wrong I can tell, they just smile, but I can tell so sometimes I ask to speak to somebody in Spanish.

Carmen:

> I speak English because then they don't need an interpreter to talk to me, but I rather prefer someone who speak the same language that way they could understand me better, I can express myself better, I can trust them and I know what they are doing. Is not the same as if an American is talking and there's an interpreter saying something I might not agree, I can't express on my language if I want to talk to them alone, how could I do that if I don't speak English.

Theme 5- Stigmatization: Having a child with ADHD can lead to feelings of being stigmatized.

One important level of Bronfenbrenner (1979) theory, the macrosystem noted the importance of the surrounding cultural setting in which individuals reside. For participants this lead to feelings of being stigmatized as they shared experiences of having strangers and friends direct their attention towards their child's disruptive behaviors. According to Fernandez and Arcia (2004), "Latina mothers may be particularly susceptible to being stigmatizedfor their children's behavior because the Latino culture tends to assign primary responsibility to mothers for determining children's behavior" (p. 358). However rather than confronting these situations, they wanted to maintain harmony, which is a cultural characteristic of demonstrating kindness

(*simpatia*), and they coped by restricting their activities with their children diagnosed with ADHD, but this also led them to seek treatment. To illustrate this, the following examples provide participants reactions to their children's behaviors:

Nelli:

> They say I worry too much. But... some friends say "oh, my God, he can't keep quiet, so I can't go out with him as much as I want to. I never go out, I can't go to my friend's house, I stay at home. No, it's not that. It's just that it bothers me that people say "oh, my God, he can't stay still, he can't stop jumping". So you think you're bothering so you prefer staying at your home, right?

Mime:

> I don't like to tell people about my son, people don't understand. I was in a store and he was jumping and running around, an American said, can't you control him. I was embarrassed because that's what people think, but he is sick it's hard to control him, but they don't know that. I don't take him to the store anymore.

Margarita:

> To tell you the truth we went to a store and he became aggressive, it was Toys R US, he became aggressive, and he threw toys and smashed them, this was embarrassing people probably thought I was a bad mother.

Theme 6- Support Services: Ensuring that children received support services despite obstacles.

Although, participants managed the process of seeking support services for their children diagnosed with ADHD and believed that both Latino and Euro-American mental health providers had their best interest at heart, they reported that cultural differences of the providers

impacted the support services they received for their children. It was clear that this perspective of the larger social systems as noted by the macrosystem according to Bronfenbrenner (1979) impacted participant's perceptions of the services provided. They feared that community agencies such as the Department of Child and Family Services (DCF) in CT would remove their children, if they were perceived by Euro-American providers as being negligent parents due refusing the use of medications or being unable to control their children's behaviors. They noted that they would seek out treatment Spanish speaking providers or advice from Latino parents with children diagnosed with ADHD to ensure that they would receive services without being targeted by agencies such as DCF. Participants noted they did not confront providers although they feared they would view them in a negative light, again which illustrates Puerto Rican cultural characteristic of maintaining harmony (*simpatia*) and respecting (*respecto*) authority figures. As noted in the following examples, participants shared their narratives of their fears of being targeted and comfort level with Spanish speaking providers:

Laura:

> I had to go to a minority clinic for them to listen to me there is something wrong with my daughter. Because Americans they are quick to call DCF (*Department of Child and Family Services, a Connecticut child protection agency*) on you or something. When a child is like that, automatically they think its abuse or something. It's good to have somebody Latino like the doctor someone you know they can understand your culture and where you're coming from, I think that is important you can feel that trust issue. They (*Puerto Ricans*) can open up freely they feel like their respected, you know. The town I was living in (*high Euro-American population*) I felt like because me being Puerto Rican ... I feel like they were stereotyping. Ya so they can understand my daughter

her beliefs and someone she could feel comfortable and you know she don't feel scared and call DCF cause she comfortable with a Spanish therapist. She feels safer, I think she feels safer because over there she had a hard time expressing her feelings I feel like someone around her culture who can understand her.

Liz:

Me, I was the one that said to the school there is something wrong with my son. The school psychologist said that no, he did not have anything, but I said, how can you tell me he doesn't have anything. I see a child who doesn't do his work, is running in the hallways, doesn't sit still and you're telling me he doesn't have anything. Well I wasn't happy, but that's fine, the psychologist (*school psychologist*) told me to go to my son's medical doctor and asked her to give my son some medication to help him relax in class so he could return to school until they passed him. So I went to the doctor and then my son's doctor said she could not do this because this would be illegal she could not do that, give him medicine without knowing what my son had and that she was not a psychologist to prescribe medicine like that. The psychologist completed test, she talked to me and my son. Then she worked with my son, I don't know exactly what she gave him. Well they (*mental health providers*) could be Latino or Puerto Rican as long as he has treatment and received services everything is fine.

Myra:

The school doctor No, they were American, my son speaks English so it was ok. They did an evaluation, then they had me in a meeting with a number of people like the teacher, school social, worker, and special education teacher. They (*school)* gave me some papers that explained it but they were in English. I didn't understand them. They

told me he was hyper, and needed help in school. That's what the translator (*school secretary*) said during the meeting. I did not understand too much. She told me that they were going to give him help, but I didn't understand everything. My friend told me he was going to need help from the school. I needed to get him help she told me to take him to a therapist. She told me to find help outside of school with a psychologist or a therapist at The Village (*mental health agency*) they speak Spanish.

Theme 7- Treatment Utilization: Psychotherapy treatment utilization was prominent in comparison to use of medications to address symptoms of ADHD.

This section addresses treatment recommendations that participants attained for their children. All participants reported that they accepted assistance from mental health care providers and provider's primary language (*Spanish or English*) was not a factor that was considered in acceptance of assistance. However, the treatment recommendations utilized by participants was a factor that participants differed on. Out of 10 participants 6 utilized psychotherapy and medication, while 4 out of 10 participants utilized psychotherapy without medication, but no participants utilized only medication as treatment. It is also important to note that none of the participants reported that their child's therapist utilized parenting programs to assist them with their children. Participants reported that their child's therapist would provide them with periodic advice in reference to disciplining their children, but none referred to specific organized programs such as Child Interaction Therapy (PCIT), which integrates parental supports with therapeutic supports.

The general attitudes that emerged in reference to the use of medication included fears of short and longer term side effects, such as hormonal changes that would enhance breast in boys, neurological damage, and future implications, loss of employment due to testing positive for

substances. While participants who utilized medication as part of treatment, although reluctant at first, found the medication helpful with time. This is indicative of Bronfenbrenner's chronosystem that with time changes may occur, for participantsin this research with time the use of medications proved to reduce their child's symptoms of ADHD and therefore it contributed to their change of heart in reference to the use of medications.The following examples illustrate participants that utilized psychotherapy with medication, and psychotherapy, but no medication:

Margarita:

> She (*psychiatrist*) told me there was a lot of um, organizations that you orient you, a lot of papers that told me of places I could go that treat kids like that, and papers that explained ADHD, she recommended medication if he got more aggressive. No, I don't give him medicine because there's a lot of medications that have side effects and have hormone, I am afraid of that. It's us the woman that we get of age, and we need hormones that changes stuff in us, image in the kids. You know I think the therapist, she has helped me more than a pill. For example in school the nurse is supposed to give the child their pill, but then if she forgets to give the child medication, then what is happening here, the parent gives the nurse the pill because they believe that they will get the pill and they may not. I don't trust her, I trust the therapist.

Laura:

> He (*physician*) did it looked like he was trying ya, but it's good to have somebody Latino like the doctor someone you know they can understand your culture and where you're coming from, I think that is important you can feel that trust issue. She (*child*) won't

sleep she wants to stay up. I could tell her its 2, 3 in the morning go to bed, she was so wired. Till this day, that's why they give her Trazodone to help her sleep. Ya, I asked about the side effects and what and why she's on a high does because you know I said isn't that too high for a child. I questioned them because some of the medication I never heard of and they are always upgrading the medication and there is always new medication. You worry about what you give to your child so I try to ask questions, but some people don't understand. Her behavior is calmer, she goes to bed, like she supposed to she is calmer, she is not so all-over the place. Ya, (*provided medications*) because like was paying attention better like to talk back, I felt like she when I was talking to her she was somewhere else, at least she could focus it helps them focus better, that's very important. I could tell they were helping her; she was doing better than before

Liz:

Well they told me that he could not sit for long periods in the class, could not have a lot of work, because if he had too much work, what he would do is stop get bored, and leave the room. The doctor told me that there was a medication for that illness that he had, and until now he is on medication. They told me that they were going to help and they were going to give him medicine and they would find me a therapist to work with him. Well, I thought well what's best for my son and if he is going to be calmer better for him so I give him the medication and he works with the therapist. It is good, with the treatment they give him I see that he is calm, is getting good grades and since he started he has gotten much better, he not as hyper. They are helping him because he is calmer, he is doing better in school his grades are better and he is now he is able to do his work. He is happier and I am happier, he does his work and is not as hyper.

Theme 8-Trust in Providers: Mental health care providers' Spanish language abilities were not a necessity, but a preference that enhanced trust.

An emergent theme with participants was their trust in the mental health care providers. The participants (*10 out of 10*) reported that Spanish was the primary language of their child's mental health care providers, which contributed to their level of satisfaction of services received and trust in the provider. This theme relates back to themes one and two, and Bronfenbrenner's (1979) exosystem that reflects the family systemand the external social systems that also impacts the family.Participants noted the importance of trust in mental health providers who spoke their language and understood their Puerto Rican culture. All the participants shared their experiences of seeking out mental health care providers that could understand their culture and speak with them in their native tongue that helped to enhance treatment.Participants noted that the therapist taught them how to effectively work with their child, accompanied them to the school Planning and Placement Team meetings, contacted the school to advocate for them, and provided their child with services that they believed was successful.

Laura

> Cause they will understand you, ya everybody's culture is different, it's very important it's good to have someone of your nationality when you are in that type of field [mental health], when you are trying to help someone because they will feel more comfortable talking to you, they might express themselves better because for the culture ethnicity I think that the ethnicity the culture (*Puerto Rican*) so the child can feel safe who they speak with.

Liz:

> I have a good relationship with her (*therapist*). She tells me how to help him and calls the school for me, she speaks English. They are helping him because he is calmer, he is doing better in school his grades are better and he is now he is able to do his work. He is happier and I am happier, he does his work and is not as hyper.

Myra:

> She (*therapist)* is nice and talks to my son. She talks to the school, counsels my son, and talks to his teacher for me that helps because his teacher doesn't speak Spanish. I trust her I can understand her since she tells me everything and helps me.

Chapter 5: Discussion

The purpose of this qualitative research was to examine the impact of how culture and acculturation levels influenced the treatment seeking process for Puerto Rican mothers with children diagnosed with ADHD. This research also refers to Bronfenbrenner's (1979) Ecological Systems Theory as the researcher recognized that "individuals co-reside in culturally plural societies, influencing each other, and being influenced in common by the many institutions that are widely shared in the larger society (e.g., public education, mass media, justice), (Berry, Dasen, & Saraswathi ,1997, p. xii). Bronfenbrenner's (1979) theory is an appropriate framework because it examines the multilevel systems that contribute to culture and acculturation. It is impossible to neglect the context in which culture and acculturation is formed and its contributions to the treatment seeking process regarding treatment compliance.

The findings of this research suggest that culture and acculturation, which are embedded in ecological systems impact the treatment seeking process for Puerto Rican mothers with children diagnosed with ADHD. The literature supports the results obtained from this research that treatment

seeking process is impacted by cultural belief systems of Puerto Rican populations. The impact of Puerto Rican cultural beliefs such as familismo, personalismo, respecto, simpatia, espiritismo, and fatalismo, influence treatment compliance (Antshel, 2002; Cabassa, 2003). Furthermore, variations in acculturation levels also were noted to impact mother's treatment seeking process as acculturation is influenced by multilevel ecological systems. Cabassa (2003) and Lara, Gamboa, Kahramanian, Morales, et al., (2005) defined two acculturation models unidimensional model and the bidimensional for the Latino population. In this research the results indicated that participants were adhering to the bidimensional model that allowed them to embrace two cultures simultaneously, their Puerto Rican culture and the Euro-American culture, and benefit from each. As an example, one participant Naomi (*pseudonym*) noted the importance of her children speaking English, but preserving their ability to speak Spanish as well, stating

> He (*child*) expresses himself more in English but I tell him,No, you were born here, but from Puerto Rican parents, and that's good for him to know both languages, even if he knows English, is important to show him Spanish because he needs to now both because in the future, when wants to be working, he might need those languages. In the future, I will teach him the language Spanish, for when he is older; he will know how to use it for work (personal communication, October 24, 2014).

The research also was indicative that Puerto Rican mothers desired to maintain their cultural ties, yet were willing to step out of their comfort zone to obtain treatment for their children diagnosed with ADHD as noted by bilingual participant who stepped out of her comfort zone to attend a parenting session to assist her to work with her child, Margarita (*pseudonym*) stated, " I did a little bit more, I went to places where they teach parents to how to handle a child

like him, and how you can control him and not try to make him when he gets aggressive how to grab him and how to calm him down" (personal communication, October 20, 2014).

Furthermore, Puerto Rican mother's experiencesin the process of obtaining treatment for their children diagnosed with ADHD are molded by a larger ecological system in which they resideas noted by Bronfenbrenner (1994), "the ecological environment is conceived as a set of nested structures, each inside the other like a set of Russian dolls" (p. 39). The interaction between cultural beliefs, acculturation, and ecology in this research was clearly observed. All the participants relocated from the island of Puerto Rico to the Unites State, but many continued to return, thus embracing both the Euro-American culture and the Puerto Rican culture as noted by Cabassa (2003). "Individuals within the community may differ significant in their level of acculturation and vary in the ways they have adapted to American culture" (p. 4).

The findings in this research revealed that treatment seeking process was impacted by the culture and acculturation levels framed within a multilevel system. In order to examine the results of this research Bronfenbrenner's (1979) ecological systems theory was used as a framework from which to demonstrate the impact of culture and acculturation on the treatment seeking process. The following discussion utilizes Bronfenbrenner's (1979) ecological systems theory to illustrate how culture and acculturation were impacted by ecological, which impacted participants' treatment seeking process.

Microsystem

Viewing cultural beliefs from Bronfenbrenner (1979) microsystem, the first level of the ecological systems theory, the microsystem is the setting in which the child resides, it includes the family, neighborhood, peers, and school system, which helps to mold children's development

through direct contact. Although the external environment also impacts the family structures, the mothers are not passive recipients of their experiences, but they also construct their social settings. For the purpose of this research this system level contains cultural influence such as the importance of family (*familismo),* and the bidimensional acculturation model that impacts the decision process in regards to treatment.

The participant's narratives pointed to their desire to maintain strong family ties (*familisimo*) by ensuring that their children continue to practice their Puerto Rican culture, while acknowledging the importance of their children embracing the Euro-American culture, in particular the English language. As an exampleNaomi (*pseudonym*) stated,

> He express himself more in English than Spanish, but I tell him not to do so, I tell him you were born here but your parents are Puerto Ricans. And that's good for him to know both languages, even if he knows English, is important to show him Spanish because he needs to now both because in the future, when wants to be working, he might need those languages (personal communication, October 24, 2014).

Antshel (2002) noted the cultural belief of *familismo* that emphasizes the importance of family systems and relies on strong family connections was important regarding treatment decisions, as one participant Liz, (*pseudonym*) stated in reference to discussing her child's ADHD, "I don't have any friends, just my family, I don't trust too many people. I have a big family (laughs), I just speak to my family..." (personal communication October 21, 2014) The influence of family in the Latino population is strong and endorses a connectedness among family members (Carlo, et. al., 2002). All the Participants noted the impact of the family system and importance that this had on the

process of sharing information about their children's behaviors only with family members.

Preserving their children's Puerto Rican culture that included language was alsoan important factor that contributed to the process of obtaining treatment services. Participantsnoted that they needed to integrate into the Euro-American culture by learning the English language to help them obtain services for their children, which is indicative of the bidimensional acculturation model that would allow them to benefit from both cultures simultaneously (Cabassa, 2003). For monolingual Spanish speaking participants, the importance of speaking English was necessary to protect themselves as noted by MariCarmen (*pseudonym*) "I lived in New Jersey for two years so I can speak (English), not perfect, but I can defend myself" (personal communication October 21, 2014). It was also important to speak English because participants believed it would enhance their ability to acquire services for their children in the dominate culture. They noted that their inability to speak English could lead to receiving mediocre services for their children in comparison to Euro-American children, or being discriminated against. For participants the difficulty they experienced with language contributed to their inability to have a voice, as noted by one participant, Carmen(*pseudonym*) reported,

> If I could speak English at least a little bit better, but I can't so is not the same. As right now I am talking with you, (*in Spanish*) you understand me and I understand you. There are two places I went to, but I have never go back, I think it it's because of the language, they treat you bad (personal communication, October 24, 215).

The need to connect to family for support, maintain their Puerto Rican culture while embracing the Euro-American culture appeared to be a key aspect for participants as they sought services for their children diagnosed with ADHD. However, it is important to note that due to some participant's inability to speak English, they believed that the services they received for their

children were not aligned with services provided to Euro-Americans children. As participant's endorsed, it was necessary to embrace the English language while preserving their culture to attain services, as noted by Pstross, Rodriguez, Knopf, and Paris (2014) "For many immigrant parents, their lack of proficiency in the dominant language has a negative influence on their ability to be involved with their children's school (p. 8). For some participants in this research who did not speak English they struggled to obtain services and often turned to Spanish speaking friends to obtain referrals to mental health providers who also Latino or spoke their language.

Mesosystem

According to Bronfrenbrenner (1994), "the mesosystem comprises the linkages and processes taking place between two or more settings containing the developing person (e.g., the relations between home and school, school and workplace, etc.)" (p. 40). The quality of the relationship between the child's teachers and their parents can influences academic achievement, which reflects the mesosystem in which the teacher's ability to communicate with parents to inform them of their child's behaviors helps to build important relationships between the school and parents (Carlo, et al., 2002). Participants reported that their child's teachers were the first professionals to contact them in reference to their child's inappropriate classroom behaviors, as reported by one of the participants Nelli *(pseudonym),*

> The teacher would call me, he would interrupt the teachers, stand up leave the room. At home he would run, jump, he never stays still. I took him to see a therapist, she told me, she told me he was hyper, I knew that. I didn't know about ADHD, but I knew it was something. She was good to tell me cause now I know (personal communication October 25, 2014).

This correlates with the research: "Symptoms of inattention, perhapsoverlooked in earlier years, are usually reported in elementaryschool and through middle" (Eiraldi, et. al., 2006, p. 613).

Although, participants reported that they were informed about their child's behaviors by the teachers, they did not receive recommendations to direct them to resources that would help them to assess or address the needs of their children. Participants noted their dismay about not receiving initial resources for their children from the schools, but they did not verbalize this to their child's teachers as noted by one of the participants, Myra *(pseudonym)* a monolingual Spanish speaker stated, "They (*school*) gave me some papers that explained it (*ADHD*), but they were in English, I did not understand them" (personal communication October 25, 2014). Myra noted that she did not seek a Spanish speaker to confront the school or teacher about her child's behaviors, or the fact that she could not understand the paperwork she received. This supports the cultural characteristic of simpatia (*kindness*), wanting to maintain a harmonious relationships and avoidance of confrontations, and *respecto* (respect) showing respect to authority figures by not confronting the teachers and seeking assistance from them (Comas-Diaz, 2001). These cultural characteristics of simpatia and respecto can contribute to this population becoming vulnerable and may lead to participants' inability to obtain support services that are not aligned with their child's needs. However, the participants' in this research were resilient and sought services from providers that were Latino or spoke the Spanish language.

Participants sought out the assistance of their child's medical provider who referred them to a psychiatrist to evaluate their children for symptoms of ADHD. Medical providers also referred participants to outside mental health resources. A number of participants noted that they sought out Spanish speaking therapists and psychiatrists. Unfortunately many participants were unsuccessful in finding Spanish speaking psychiatrists, but all were able to obtain Spanish

speaking therapists.

Exosystem

The third level of the ecological systems theory the exosystem, "consists of contexts that the child might not directly interact with, or control, but which may nevertheless influence the child's development" (Carlo, et al., 2001, p. 6). Seeking support services to address their child's needs was a struggle for the participants who were monolingual (Spanish). Many reported encountering challenges that impacted their ability to obtain services. They cited the struggles they experienced obtaining Spanish speaking psychiatrists or being provided professional interpreters to assist them during Planning and Placement Team meetings. According to Fontes (2005) "people with limited English proficiency need to be informed about their right to utilize an interpreter" (p. 161). This research revealed that a number of monolingual (Spanish) participants reported that they were not provided with professional interpreters. Instead they reported that they had to depend on their children diagnosed with ADHD, a school secretary, or English speakers with minimal Spanish language skills to comprehend information in reference to supporting their children's needs, as illustrated by a Myra *(pseudonym),* a monolingual (Spanish) participant who stated,

> Ya only the interpreter she was the school secretary. As they spoke she would tell me what they said I wasn't comfortable because sometimes when they interpret they may miss important things. I want to understand them, but I don't think the interpreter told them everything. I could see sometimes she had problems with what I said, that made me nervous, maybe that she gave me the wrong information (personal communication October 25, 2014).

In addition, one monolingual Spanish speaking participant, Liz reported that her 10-year-old son was her interpreter, "My son translates. I tell him not to lie to me, I don't think he lies to me, he knows it's important" (personal communication October 21, 2014). According to Fontes (2005), the use of untrained interpreters that include children can distort complex information that professional mental health providers convey. Furthermore, the use of secretaries or limited Spanish speakers may contribute to monolingual (Spanish) individuals receiving misinformation or a loss of confidentiality (Fontes, 2005). Although monolingual participants struggled with comprehending information received during school meetings or from mental health providers due to using an untrained interpreter or their children, bilingual participants also noted their challenges working with English speakers. In order to make decisions regarding treatment, it is necessary for participants to fully comprehend their choices for treatment and resources that are available to them, which the research indicated was not readily available to some participants who sought supports from Spanish speakers outside of the school system.

Bilingual participants noted that they also were concerned that while they could understand medical or mental health providers, participants reported that often English speakers lacked cultural competencies. This in turn led to the probability of misunderstandings and poor treatment outcomes. Participants noted that cultural characteristics such as *personalismo*, which requires professionals initially making personal connections to participants to gain their confidence and trust was lacking (Antshel, 2002; Mazzuca, 2001). Both monolingual and bilingual participants noted that cultural competence was significant to meet their needs. They noted that the inability for English speaking school personnel, medical and mental health providers to understand their culture or language influenced their help seeking behaviors.

All the participants noted that they sought out Spanish speaking medical and mental health care providers because it presented them with a level of comfort that Euro-American or non-Spanish speakers were unable to provide, as one participant Margarita *(pseudonym),* reported she sought mental health services from an agency with a Spanish speaking therapist.

> For me yes, it's *(Spanish)* better because you can express yourself better, the feeling of what you're going through with him. The communication is much clearer, we can understand each other. It's not the same that if I expressed myself in English there are words I can't pronounce well, but if someone speaks my language and can understand it that perfect and much better (personal communication, October 20, 2014).

Out of the ten participants, only one bilingual speaker conveyed their dismay with their medical providers' recommendations. This illustrated participant's cultural characteristic of *respecto* and *simpatia.* Due to *respecto* participants did not express their concerns becauseby virtue of their education and training medical and mental health care providers are afforded with a high level of respect (Antshel, 2002). Furthermore, *simpatia* the need to maintain harmony through agreement is also an important aspect that prevented some participants from questioning their providers or disagreeing with recommendations as one of the participants noted, Liz *(pseudonym),* noted she was informed of medication and did not question this, "The doctor told me that there was a medication for that illness that he had, and until now he is on medication" (personal communication, October 21, 2014). As noted previously participants need to maintain harmony (simpatia) and not question authority figures (respecto) may impact services they receive and disempower them.

However, in spite of the hurdles the participants encountered, they sought multiple treatments with Spanish speaking providers. Six participants (two monolingual/four bilingual)

obtained both a therapist and psychiatrist to prescribe medication. Four participants (two monolingual/two bilingual) obtained therapy and did not want to pursue medication to supplement therapeutic services. All participants sought Spanish therapists to address their children's needs. Participants who had difficulty comprehending English speaking professionals sought out Spanish speaking service providers or connected with other Puerto Ricans who provided references to Spanish speaking providers. It was clear that participants had to become their child's primary advocate, and their desire to comply with recommendations was strengthened by obtaining support services from mental health care providers who were Latino or spoke Spanish. All participants complied, but they obtained resources through other Spanish speaking contacts they trusted and felt comfortable due to their cultural connections.

Macrosystem

Bronfenbrenner's fourth level of ecological systems, the macrosystem describes the ideology, and customs of the culture in which individuals reside, as Carlo, et al. (2002) cited, "one critical aspect of this layer entails learning the language the majority culture" (p. 7). Ten out of ten participants reported that their therapists were Spanish speakers, which attributed to their comfort level and trust in their mental health care providers. Their motivation to comply with recommendations may be attributed to their connection with Spanish speaking medical and mental health care providers, "When Latinos distrust a health care provider, they are less likely to comply with the recommended treatment" (Christensen, 1992, p. 49).

All participants noted their comfort level with Spanish speaking providers and the importance of having a Spanish speaking provider that they could trust. They noted that they believed these providers could comprehend their needs and work effectivity to provide them with the resources they sought. As stated by Carmen *(pseudonym)* who noted,

> Because then they would need an interpreter to talk to me and I rather prefer someone who speak the same language that way they could understand me better, I can express myself better, I can trust them and I know what they are doing. Is not the same as if an American is talking and there's an interpreter saying something I might not agree, I can't express on my language if I want to talk to them alone, how could I do that if I don't speak English (personal communication October 21, 2014).

This also illustrates how positive relationships with providers are facilitated by *personalism*. The importance of *personalism*, the importance of personal relationships above business or institutional needs must be present for Puerto Ricans to connect with their providers and feel safe.

Chronosystem

The last multilevel system of Bronfenbrenner's ecological theory, the chronosystem holds that the variables within the ecological theory are in constant flux and for Latinos this can be seen in the acculturation level of the individual as Cabassa (2003) stated, "Acculturation has a dualistic effect; it affects the culture of a group as well as changes the psychology of an individual" (p. 129). The level of acculturation as two cultures engage takes time and is a factor that reflects the chronosystem. The two levels of acculturation that are most subscribed to by the Latino population is the bidimensional model and unidimensional models.

Participants in this research adhered to the bidimensional model. They all cited the importance of maintaining their primary culture, but embracing the host culture to ensure their children received appropriate services. While in contrast participants noted that their children adhered to the unidimensional model, they embraced the host culture and were losing aspects of their culture. In order to maintain their culture, participants imparted information that would

ensure that their children also embrace their Puerto Rican culture. They noted that they maintained traditions such as three king's day and taught their children Spanish to sustain the language, which they viewed as part of cultural identity as Margarita *(pseudonym)* noted,

> He (son) gets confused because it's not the same, it's like when you are in Puerto Rico and you're in social studies and they talk about let's say where Puerto Rico came from, over here they talk about where United states came from, see there is two different stories and he could get confused, but when its bilingual its easier because then your letting him understand that there are two different worlds and two different traditions, and like that he would understand it (personal communication October 20, 2014).

In addition social stigmatization also impacted participants. Participants' reactions to perceived stigma influenced their behaviors, "Stigma results when people find others different from their definition of self and conceptualize that being different, they are inferior" (Fernandez & Arcia, 2004, p. 358). Participants noted that due to their child's disruptive behaviors (*hyperactivity, impulsivity, and aggression*) in public and social arenas they felt "embarrassed," as they were exposed to negative remarks from others, "Latina mothers may be particularly susceptible to being stigmatized for their children's behavior because the Latino culture tends to assign primary responsibility to mothers for determining children's behavior" (Fernandez & Arcia, 2004, p. 358).

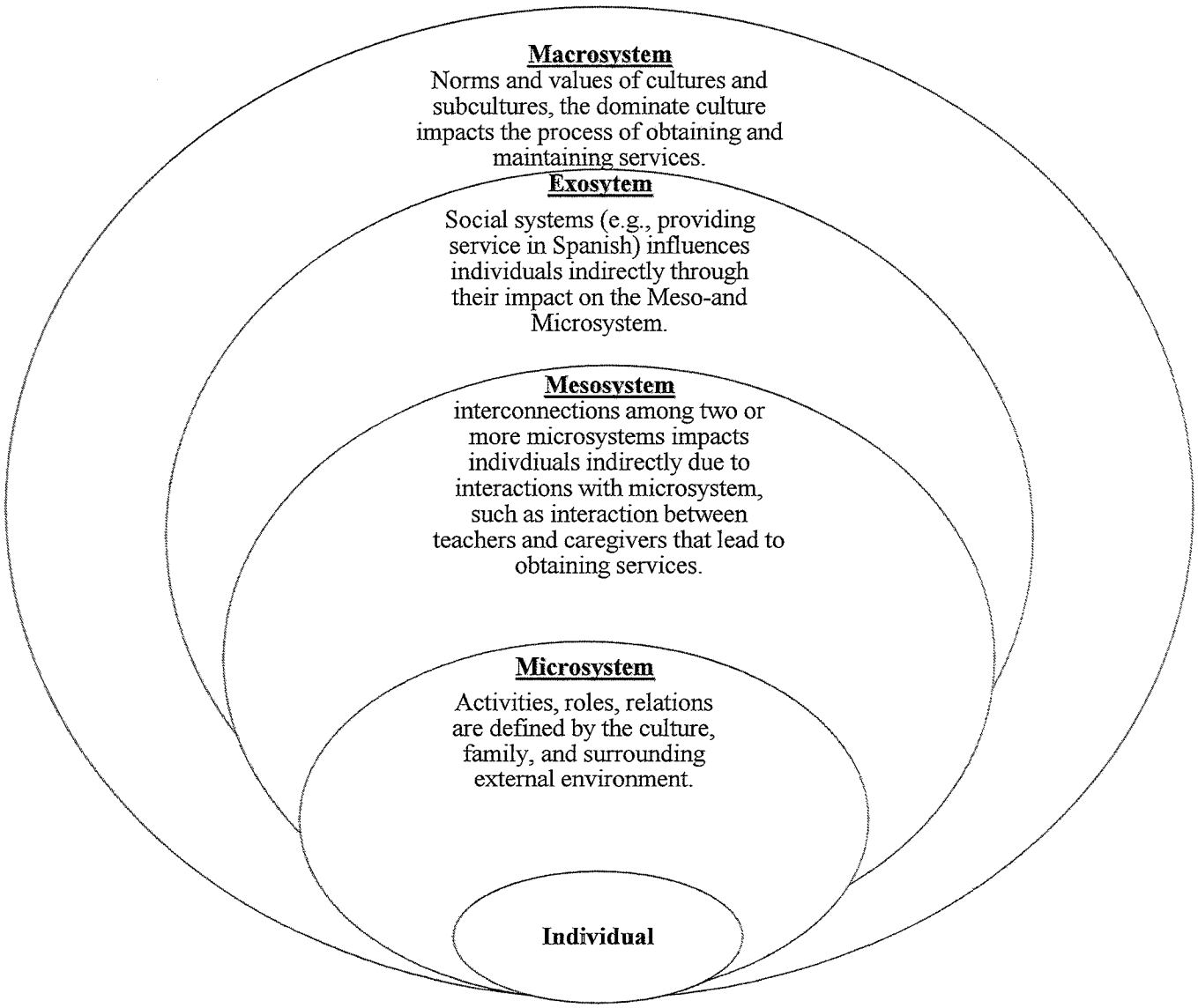
These experiences caused some participants to remove themselves from social situations that would expose them and their children to settings where they believed others would critique their children's behaviors. They also feared that this could result in being targeted by a child protection agency such as The Connecticut Department of Child and Family Services (DCF).

DCF has a duty to investigate cases of child abuse that are called in to their child protection hotline. Participants feared that DCF would be contacted if they were viewed as a "bad" parent and they could lose custody of their children. This fear surfaced from communication with others who experienced being contacted and investigated by DCF due to their child's disruptive behaviors as Laura (*pseudonym*) stated,

> Ya because, how you say that their American and they so quick to call DCF on you or something, some teachers they don't I don't know how to explain this. When a child is like that automatically they think its abuse or something. They misdiagnosed or something (personal communication September 23, 2014).

Due to these misconceptions it is important that providers be cognizant of the health related cultural beliefs and acculturation levels of Puerto Rican populations, "When treating Hispanic patients, assessing the degree of acculturation is important because it often provides clues to patients' health-related beliefs and practice and may predict if these practices stem from the culture of origin or from the American culture" (Guilamo-Ramos, 2007, p. 27). The use of Spanish speaking providers will ultimately improve compliance of treatment. The need to comprehend the language and cultural belief systems of this population cannot be understated in providing culturally competent treatment and reducing the disparities that contribute to the reduction of service utilization among Puerto Ricans (Arcia & Fernandez, 2003, Eiraldi et. al., 2006).

Figure 1: Proposed Ecological Systems Model as applied to treatment adherence



Chronosystem
Changes in systems over time in society via mutual accommodations impact culture, acculturation levels, attitudes, and level of stigmatization

Table 2: Summary of Research Results

Themes	Bronfenbrenner's Ecological Systems	Cultural & Acculturation Factors	Treatment Implications
1: Maintaining Individual Cultural Identity: Mother's continued to maintain their Puerto Rican cultural identity, while embracing the Euro-American culture to ensure their children's needs were met. **2: Preserving Familial Culture Identity:** Mother's sought to ensure that their children maintained their Puerto Rican cultural identity within the American culture.	**Microsystem** The family structure is influenced by family members and the ecological system. While the family also influences the ecological system.	▪ Family *(Familisimo)* ▪ Bidimensional Model ▪ UnidimensionalMode	1. School and mental health providers should have knowledge of the Puerto Rican culture (cultural competence). 2. Respect that child resides within the Puerto Rican culture and family's belief systems should be acknowledged. 3. Observe acculturation level of parents, unidimensional or bidimensional to enhance communication and treatment compliance. 4. Ensure that child's needs are addressed utilizing a family systems approach.
3: Assessing ADHD Teacher's observations contribute to initial contact with professionals to assess child for Attention Deficit Hyperactivity Disorder.	**Mesosystem** Linkages between two settings, relationship between parents and teachers.	▪ Simpatia (Kindness) ▪ Respecto (Respect) ▪ Bidimensional Model	1. School personnel including teachers should provide verbal or written information that will assist parent to obtain services. School often do not provide information as it also binds them to the financial responsibility of paying for evaluation for child.

Themes	Bronfenbrenner's Ecological Systems	Cultural & Acculturation Factors	Treatment Implications
4:LanguageBarriers: Language can become a barrier when seeking treatment Participants reported that their inability to speak English or limited fluency of English created a barrier for them to obtain services for their children. **8:Trust in Providers** Mental health care providers Spanish language abilities were not a necessity, but a preference that enhanced trust.	**Exosystem** External social systems that impact family indirectly	▪ Mother's language Barriers ▪ Comprehension of information ▪ Personalismo(*Person -alism*) ▪ Kindness *(Simpatia)* ▪ Respect *(Respecto)*	1. Fear of being stigmatized and discriminated due to lack of education. Mental health providers should consider providing accurate information to dispel inaccurate information about social service agencies such as the Department of Child and Family Services. 2. Providing psychoeducation in clients preferred language to enhance treatment. 3. Create support groups where this population can voice their concerns and questions and create an environment where they will feel empowered.
5: Stigmatization: Having A Child With ADHD Can Lead To Feelings Of Being Stigmatized. Have a child with ADHD can lead to fears of being stigmatized within a larger social setting. **6: Support Services:** Ensuring that children received support services despite obstacles.	**Macrosystem** Norms and values of cultures and subcultures impacts the family system. The dominate culture also impacts the process of obtaining and maintaining services.	▪ Stigmatization ▪ Trust of mental health professional ▪ Kindness (*Simpatia*) ▪ Personalism (*Personalismo)*	1. Psychoeducational services should be provided to address the treatment process and put an end to misconceptions of 2. Address with Puerto Rican parents how to address their children's behaviors in public. 3. Provide structured parenting programs as part of the therapeutic process.

Themes	Bronfenbrenner's Ecological Systems	Cultural & Acculturation Factors	Treatment Implications
7:Treatment Utilization: Psychotherapy treatment utilization was prominent in comparison to use of medications to address symptoms of ADHD.	**Chronosystem** Changes in the family system is influenced by family changes and external environmental changes.	▪ Bidemensional Acculturation Model ▪ Kindness (*Simpatia*) ▪ Personalism (*Personalismo*)	1. Provide psychoeducationalto address mediation use and dispel fears and allow clients to have the information needed to make educated decisions.

Limitations of Research

This study was not without limitations, due to limited sample size, limited geographic area, and because all the participants who volunteered for the research were concurrently seeking or in treatment, this research cannot be generalized to the overall Puerto Rican population. This study was concerned with a small group of Puerto Rican women in a particular geographic region of Hartford, Connecticut. Due to the geographic areas, and limited availability of large scale mental health agencies in the area that cater to Puerto Rican populations, all the participants were, or had received services from the same mental health agency. Also, it is possible that Puerto Rican fathers or even mothers in other parts of the mainland and on the Island might respond differently. Because of these and other limitations to the study, the conclusions were presented modestly and intended to provide a snapshot of this samples shared experiences.

However, despite these limitations the research met the researcher's goal of understanding the factors that lead to treatment compliance by Puerto Rican mothers with children diagnosed with ADHD. It is recommended that further large scale studies are

conducted to replicate this study and expand on finding to include the impact of father's contribution to compliance, the impact of socioeconomic status, and degree of treatment adherence to provide Puerto Rican families with improved medical and mental health care services. It would also be beneficial to develop a study to gauge the number of Spanish speaking medical and psychiatric personnel in regions where large Puerto Rican populations reside. This may be used to recruit service providers to these areas to enhance services. Further research that compares medical and mental health services delivered on the island of Puerto Rico in comparison to services in the United States may shed some light on key services that may lacking in the United States for this population. Although this research did not interview children to access their response to the process of obtaining treatment, this may be an area to explore as children's response to providers and treatment may influence parental behaviors and attitudes.

Future Recommendations

Future recommendations to enhance parental knowledge and treatment compliance for mothers with children diagnosed with ADHD include (1) increasing Spanish speaking medical and psychiatric providers, (2) development of educational seminars that focus on comprehension of Puerto Rican cultural beliefs systems and the impact of levels of acculturation to enhance communication and trust between Puerto Rican clients and providers, (3) providing Spanish speaking parents with a liaisons in the schools to help Puerto Rican parents comprehend the needs of their children and school protocols, (4) providing professional Spanish interpreters during school meetings, such as Planned Placement Team meetings to ensure that parents are able to communicate what their needs are, (5) psychoeducational services in Spanish and materials written in Spanish that provide resources that they can access to support the needs of

their children, (6) providing Puerto Rican mothers with resources to help empower them such as referring them to free English as a second language courses, (7) creating support groups to address the needs of this population and provide them with a forum where their voices can be heard to empower them, and (8) reducing feelings of stigmatization by provided accurate information in reference to social service agency such as Department of Children and Family Services and psychopharmacology. These recommendations are central to creating an environment where Puerto Rican parents feel respected and are able to obtain appropriate services. These recommendations will also assist in creating partnerships between parents and providers, allowing Puerto Rican parents to become advocates for their children without feeling stigmatized.

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Appendix A: Prewritten Script

As a doctoral candidate at Union Institute and University in Cincinnati, Ohio, I am in the process of conducting my dissertation research titled, *Puerto Rican Mothers of Children Diagnosed with Attention Deficit Hyperactivity Disorder: Treatment Compliance*. This study will investigate how factors such as acculturation, cultural differences, parental perceptions of child behaviors and treatment modalities affect overall compliance, noncompliance, or inadequate adherence to treatment prescribed for ADHD. I am asking for your help to obtain participants for my study. I am seeking women who were born in Puerto Rican with child/children between the ages of 7 and 11 diagnosed with Attention Deficit Hyperactivity Disorder who may be interested in participating in my study. Involvement in this study includes completion of a demographic questionnaire and participation in a one two hour taped interview, in which participants will be asked to share their experiences of caring for a child diagnosed with ADHD. Participation is voluntary and confidential. Attached you will find a flyer(Appendix B), I would appreciate it if you would post this flyer (Appendix B), in your agency, give it to friends and colleagues and also pass along my contact information if you know of anyone who may be interested in participating in my research. I can be reached by phone at 860-904-3444 or by email at psy1515@yahoo.com. My dissertation chair, Dr. Jennifer Ossege, can also be contacted at 513-487-1170 or by email at Jennifer.Ossege@myunion.edu.

Lilliam Martinez, MA, LPC

Appendix B: Recruitment Flyer

ENGLISH/SPANISH VERSION

Mothers Who Have Children Diagnosed with Attention Deficit/ Hyperactivity Disorder (ADHD) are needed for a research study.

If you meet the following criteria, you are eligible to participate in this study.

- Born in Puerto Rico
- Have a child age 7 to 11 years old, diagnosed with ADHD

I, Lilliam Martinez, am conducting a research study for my Doctor of Psychology degree at Union Institute & University in Cincinnati, Ohio. I would like to know how you feel about your child's diagnosis, how you cope with the diagnosis, how it may have changed your family, and what you think will help your child. I would also like to know what you think about ADHD and what you think will help improve your life and your child's. Your stories will help me understand the kinds of services you need to support you and your family. Any information that you provide will be confidential. You will receive a $10.00 Walmart gift card for your participation in the study, but you will not incur any costs because of your participation in this study.

You will be asked to:

1. Review and sign a consent form to agree to participate in the study.
2. Complete a demographics questionnaire that may take 30 minutes.
3. Participate in a 2 hour audio-recorded interview.
4. Review a printed transcript of your interview.
5. Participate in a debriefing interview lasting about I hour if needed.

If you have questions about the study or want to volunteer to help with the study, please call Lilliam Martinez at 860.372.4811, or send an e-mail to Lilliam.Martinez@myunion.edu who will ask you some questions to make sure that you are eligible for the study.

SPANISH VERSION

Las Madres Que Tienen Niños Diagnosticados Con Trastorno Por Déficit De Atención / Hiperactividad (TDAH)

Son Necesarios Para Un Estudio De Investigación .

Si usted cumple con los siguientes requisitos , usted es elegible para participar en este estudio.

- Nacido en Puerto Rico
- Pida a un niño de 7 años de edad a 11 años y diagnosticados con TDAH

Soy, Lilliam Martínez, y estoy llevando a cabo un estudio de investigación para mi título de Doctor en Psicología en la Universidad, Unión Institute & University en Cincinnati, Ohio. Me gustaría saber cómo te sientes sobre el diagnóstico de su hijo, ¿cómo hacer frente a la diagnosis , ¿cómo es posible que haya cambiado su familia , y lo que crees que va a ayudar a su hijo . También me gustaría saber lo que piensa sobre el TDAH y lo que crees que va a ayudar a mejorar su vida y la de su hijo. Sus historias le ayudarán a entender el tipo de servicios que necesita para ayudarle a usted ya su familia. Cualquier información que usted proporcione será confidencial. Usted recibirá una tarjeta de regalo de $ 10.00 Walmart por su participación en este estudio y no se le ocasionará gastos a causa de su participación en esta investigación.

Se le pedirá que :

1 . Revisar y firmar un formulario de consentimiento para aceptar participar en el estudio.

2 . Completar un cuestionario de datos demográficos que pueden tardar 30 minutos .

3 . Participar en una entrevista de audio grabada de 1 a 3 horas .

4 . Revise una transcripción impresa de su entrevista.

5 . Participar en una entrevista informativa que dura unos 30 minutos si es necesario .

Si tiene alguna pregunta sobre el estudio o quiere ser voluntario para ayudar con el estudio, por favor llame a Lilliam Martínez al 860.372.4811 , o envíe un e- mail a Lilliam.Martinez @ myunion.edu . Voy a hacerle algunas preguntas para asegurarse de que usted es elegible para el estudio.

Appendix C: Informed Consent Form

Project Title: *Puerto Rican Mothers of Children Diagnosed with Attention Deficit Hyperactivity Disorder: Treatment Compliance*

Principal Investigador (PI): Lilliam Martinez

PI Telephone Numbers: 860-904-3444

PI E-mail: psy1515@yahoo.com

Faculty Advisor/ Faculty PI/ Dissertation Chair: Dr. Jennifer Ossege

Faculty Telephone Numbers: 513-487-1170

Faculty E-mail: jennifer.Ossege@myunion.edu

Location of Study: Hartford, Connecticut

You are being asked to participate in a research study conducted by Lilliam Martinez. The researcher conducting this study will describe this study to you and answer all your questions. Please read the following information and ask any questions you might have before deciding whether to take part in the study. Your participation is entirely voluntary. You can refuse to participate without any penalty or loss of benefits to which you are otherwise entitled. You can refuse to participate at any time, and you can decline to answer any questions at any time. Simply tell the researcher that you wish to stop participating. All data collected before you stop will be destroyed and not used in the data analysis or results of this study. The researcher will provide you with a copy of this consent form for your records. A summary of the study results will be provided to you upon request.

The purpose of the study is to investigate if treatment compliance by Puerto Rican mothers is impacted by their belief system of psychotherapy or psychopharmacology?

If you agree to be in this study, you will be asked to do the following during a 2-3 hour time-frame:

- Complete a demographic questionnaire
- Participate in a 2 hour, audio-recorded interview
- Review the transcript of the interview (1 hour) for accuracy and/or clarification, but this is optional

The total estimated amount of time that you will be involved in this study is a maximum 2-3 hours (2 hour interview, 1 hour to review transcripts of your interview for accuracy and/or clarification, however this is optional).

Potential risks of being in this study:

- Loss of confidentiality if your name is associated with your responses.
- This potential risk is minimized through the use of pseudonyms that will be written onto interview tapes and used in the transcript of your interview tape.
- If recalling certain events during the interview causes you to become emotional, you may take a break for a few minutes. You may choose to continue, reschedule, or withdraw from the study. All data collected before your withdrawal will be destroyed and not used in the data analysis and written report.

Potential benefits of being in this study:

- The opportunity to make suggestions that may help others in similar situations in the future.
- The opportunity to contribute to research that may enhance medical and mental health care treatment.
- The opportunity to offer information that may help others in similar situations in the future.
- As a result of the interview you may also have an insight due to your sharing that impacts your life, perspective, etc., in a positive way.

Compensation/ Costs:

- You will receive a $10.00 Wal-Mart gift card for your participation in this study and will not incur any costs because of your participation in this research.

Confidentiality and Privacy Protections:

Your identity in this study will be treated as confidential. Results of the study, including all collected data, may be published in my dissertation, in future journal articles, professional presentations, and Internet sites, but your name or any identifiable references to you will not be included. However, any records or data obtained as a result of your participation in this study may be inspected by the persons conducting this study and/or Union Institute & University's Institutional Review Board (IRB), provided that such inspectors are legally obligated to protect any identifiable information from public disclosure, except where disclosure is otherwise required by law or a court of competent jurisdiction. These records will be kept private in so far as permitted by law. All study

data will be retained for a minimum of three years as required by the IRB, but this will be extended to five years as stipulated by the American Psychological Association for Psy. D. students, and then destroyed.

If we communicate by e-mail during this study, please be aware that e-mail is not a secure form of communication. However, my computer has security software, and I am the only person who has access to my e-mail account. No one else will read our communications.

Termination of Study

Your participation in the study may be terminated by the investigator without your consent under the following circumstances: You fail to appear at a scheduled time for participation or fail to respond to a request to set up a time for your participation on two occasions. This study may need to be terminated without prior notice to, or consent of, participants in the event of illness or other pertinent reasons.

Subject and Researcher Authorization

I have read and understand this consent form, and I volunteer to participate in this research study. I understand that I will receive a copy of this form. I voluntarily choose to participate, but I understand that my consent does not take away any legal rights in the case of negligence or other legal fault of anyone who is involved in this study. I further understand that nothing in this consent form is intended to replace any applicable federal, state, or local laws.

Signatures

Participant Name (printed): _____

Participant Signature: _____

Date: _____

Principal Researcher's Name (printed): _____

Signature of Principal Researcher: _____

Date: _____

Note: You may contact the individuals listed at the top of this form with any questions about this study. You may also contact the IRB Director at Union Institute & University with any questions about your rights as a participant at 800.861.6400, ext. 1153, or at irb@myunion.edu. In the event of a study-related emergency, contact the individuals listed at the top of this form and the IRB Director within 48 hours.

Appendix C: Formulario De Consentimiento Informado

Título del proyecto: Madres puertorriqueñas con niños diagonistados con ADHD

Investigadora Principal(PI): Lilliam Martínez

PI Número de Teléfono: 860-904-3444

Coreo electrónico de PI: psy1515@yahoo.com

Consejero de facultad: Dr. Jennifer Ossege

Teléfono de Facultad: 513:487-1170

Coreo electrónico de facultad: Jennifer.ossege@union.edu

Local del estudio: Hartford, Connecticut

Le pedimos que usted participe en este estudio conducido por Lilliam Martínez. Ella le explicará el estudio y le dará información en cualquier preguntas que tenga. Por favor de leer la siguienta información and déjanos saber si tiene preguntas antes de decidir en su participación. Su participación es totalmente voluntaria. Usted puede decidir en no participar sin penalti o pérdida de beneficios en que usted esta recibiendo. Usted puede decidir en parar su participación en cualquier tiempo y no tiene que responder en las preguntas. Simplemente comuníquese que quiere para . Toda la información será destruida y no será usada en el estudio. Le daremos una copia del formulario dando permiso para el estudio. Le daremos un resumen del estudio si lo solicita.

El propósito de este estudio es investigar si los impactos del Sistema de creencias de su decisión de cumplir o no cumplir recomiendan tratamiento médico y/o terapéutico para su niño que ha sido diagnosticado con ADHD.

Si usted está de acuerdo con este estudio, le pediremos lo siguiente:

- Participe en una entrevista grabado durante 2-3 horas
- Completar preguntas demográficas

El tiempo total que le pedimos para este estudio es 2 horas máxima (1 hra de entrevista, 1 hora para revisar la entrevista para ver que no tenga errores.

Riesgo posibles en participar en este estudio:

- Perdida de confidencial si su nombre está mencionada en sus respuestas.
- Riesgo de que cosas similares pueden estar escritas en las cintas contenido en la grabación de la entrevista.
- Si usted se siente mal o le molesta algo durante la entrevista usted puede pausar unos minutos. Usted pude continuar, hacer otra sita o puede retirarse de la entrevista. Toda la información será destruida y no será usada para el estudio.

Beneficios que pueden ser beneficiares sí usted decide en participar con el estudio:

- La oportunidad de hacer sugerencias que ayudara a otros que tengan la misma situación
- La oportunidad de contribución al estudio que pueda ayudar mejorar el tratamiento medicinal y de salud mental.

- La oportunidad de contribuciones al estudio que puede resultar en situaciones simulares que tenga otra gente en el futuro
- Usted puede recibir información que le dará perspectiva en su vida de manera positiva

Compensación/gastos

Usted recibirá una tarjeta de regalo de $ 10.00 Wal-Mart por su participación en este estudio y no se le ocasionará gastos a causa de su participación en esta investigación..

Confidencial y protección de privacidad :

Su identidad en este estudio será tratado confidencialmente. Resultados de este estudio, incluyendo todos los datos, puede ser escrito en mi deserción/tesis/documento final, en artículos en el futuro, presentación Professional y páginas del internet, pero su nombre ni referencias de identidad de usted no serán incluida. Información y datos obtenido en su participación en este estudio será revisado por personas conduciendo este esté estudio y/o Union Institute & University's Institutional Review Board (IRB) si estos inspectores están obligados legalmente a proteger información de pública excepto donde la información está requerida legalmente o por la corte de jurisdicción competente. Esta información será mantenido privado en cuanto permitido por ley. Toda información será mantenido por lo menos tres años como requerido por IRB, pero puedes ser mantenido por 5 años si requerido por American Psychological Association de Psy. D estudiantes, y entonces destruidos. Si nos comunicamos por correo electrónico durante este estudio, por favor de entender que un correo electrónico no es bastante segura forma de comunicación. Mi computadora tiene seguridad, y yo soy la única persona que tiene acceso a mi correo electrónico. Ninguna otra persona tendrá acceso a nuestra comunicación.

Terminando el estudio

Su participación en este estudio puede ser terminada por el investigador si su permiso bajo la siguientes circunstancias. Usted no se presenta a su sita programada o no responde a el requisito de hacer una sita por dos veces. Este estudio podrá ser terminada sin aviso o permiso, por razones de enfermedad o otra razón.

Asuntoe Investigadorde Autorización

He leídoy entiendo estaforma de consentimiento, yme ofrezco como voluntariopara participar en esteestudio de investigación.Entiendoque recibiréuna copiade este formulario.Yo voluntariamentedecido participar, pero entiendoque mi consentimientono le quitaningún derecho legalen el caso denegligencia o deotro fallojudicialdecualquier persona que estéinvolucrada eneste estudio.Además, entiendo queno hay nada eneste formulario de consentimientopretende sustituirningún, leyes estatales olocales aplicables.

Firmas

Nombre: _____

Firma: _____

Fecha: _____

Nombre de la persona principal del estudio : _____

Firma de Principal: _____

Fecha; _____

Nota: usted puede comunicarse con personas referidas en la parte que esta mencionadas al principio de este documento con cualquier pregunta. También pueden comunicarse con RB Director at Union Institute & University con cualquier preguntas hacerca de sus derechos como participante at 800.861.6400, ext. 1153, or at irb@myunion.edu. En el evento que sea una emergencia en relación a este estudio, por favor de comunicarse con personas mencionadas al principio de este documento y IRB director entre 48 horas.

Appendix D: Screening Questionnaire

ENGLISH VERSION

1. How did you hear about this study?
2. What led you to inquire further about the study?
3. Briefly describe your interest in this study?

In order to determine if you meet the criteria to participate in the study I need to ask the following questions:

a. Were you born in Puerto Rico Yes No
b. Do you have a child between the ages of 7 and 11 years of age, who was diagnosed with Attention Deficit Hyperactivity Disorder? Yes No

SPANISH VERSION

1. Como se enteró de este estudio?
2. Qué le intereso de este estudio que le hizo preguntar más del estudio?
3. Brevemente, por que esta interesado en este estudio?

Para determinar sí usted está cualificada para este estudio tenemos que hacer algunas preguntas:

a. Nació en Puerto Rico? Si No
b. Tiene usted un hijo entre las edades de 7 y 11 años y fueron diagonistados con ADHD? Si. No

Appendix E: Demographic Questionnaire

ENGLISH VERSION

1. What is your age? _____

2. What is your place of birth? _____

3. When did you come to live in this country and why? _____

4. In total how many years have you lived in this country? _____

5. What is your primary language? _____

6. What is your secondary language? _____

7. What is the primary language spoken in the home? _____

8. What is the highest level of education you have completed? _____

9. What is your current marital status, are you divorced, married, or single? _____

10. What is your religious affiliation?

Protestant Christian

Roman Catholic

Evangelical Christian

Jewish

Muslim

Hindu

Buddhist

Nonreligious

Other: _____

11. How observant are you of this religion.

Not at all

Mildly religious (Don't attend services, but observe all religious holidays)

Moderately religious (attend services periodically)

Extremely religious (attended services weekly)

12. How do you self-identify in terms of race or ethnicity?

White

White, non-Latino

African American/ Black

Asian-Pacific Islander

Latino

Native American

Arab

Multiracial

Would rather not say

Other: _____

13. Number of biological children in the home?

1-2

2-3

4-5

5-6

7-8

14. Note child/children (between the ages of 7-11) diagnosed with Attention Deficit Hyperactivity Disorder, gender, age, place of birth, date of diagnosis, school, and if the child is receiving special education services.

Gender	**Age**	**Place of Birth**	**Date Diganosed**	**School Name**	**Receiving Special Education Services Yes/No**

15. What recommendation(s) were made to treat your child (ren) diagnosed with ADHD?

Therapy _____ Medication _____

16. Number of guardians in the home? One or Two

If two, who is the second guardian in the home?

Biological father

Step-father

Grandmother

Grandfather

Aunt

Uncle

Sibling

17. Who is the primary caretaker in the home?

Biological mother

Step-mother

Biological father

Step-father

Grandmother

Grandfather

Aunt

Uncle

Sibling

SPANISH VERSION

1. Cual is tu edad? _____

2. Cual es su lugar de nacimiento? _____

3. Cuándo llegó a vivir en este país y por qué? _____

4. En total, cuántos años ha vivido en este país? _____

5. Cual es su idioma principal? _____

6. Cual es su Segundo idioma?_____

7. Cual es el idioma principal que se habla en su casa? _____

8. Cual es el nivel mas alta de educacion que ha completado? _____

9. Cual es su estado civil actual, esta casada or eres soltera? _____

10. Cuál essu religión?

    protestantecristiana

    católico romano

cristiana Evangélica

judío

musulmán

hindú

budista

No religiosos

Otro:_____

11. Cómoestá ustedatentode esta religión.

Nada

Ligeramentereligiosa(noasistir a los servicios, sino queguarden todas lasfiestas religiosas)

Moderadamentereligioso(asistir periódicamentelos servicios)

Extremadamentereligioso(servicios atendidospor semana)

12. Cómo seidentifican a sí mismosen términos de razao etnia?

Blanco

Blanco, no hispanos

Afro Americano / Negro

Asia y las Islas del Pacífico

Hispano

Nativo Americano

Arabe

Multirracial

Prefiero no decir

Otro: _____

13. Número dehijos biológicosen la casa

1-2

2-3

4-5

5-6

7-8

14. Notaniño / niñosdiagnosticados contrastorno de hiperactividad ydéficit de atención, género, edad, lugar denacimiento,la escuela,y siel niño está recibiendoservicios de educación especial.

Género	**Edad**	**Lugar de nacimiento**	**Fecha Diagnosis**	**Nombre de la escuela**	**RecibiendoServicios de Educación EspecialSí / No**

15. Qué recomendación (s) se hicieron para tratar a su hijo (s) con diagnóstico de TDAH?

Terapia _____ Medicación _____

16. Número detutores enel hogar?Uno odos

Sidos, quees elsegundotutoren el hogar?Quién es elsegundotutoren el hogar?

padre biológico

Padrastro

abuela

abuelo

tía

tío

hermano

17. Quién es elprincipal cuidadoren el hogar?

padre biológico

Padrastro

abuela

abuelo

tía

tío

hermano

Appendix F: Interview Guide

ENGLISH VERSION

1. How strongly do you identify as a Puerto Rican or with Puerto Rican culture?
   - What PR beliefs, values, and customs do you espouse?
   - Do you feel that you are raising your child/ren as PR?
   - Do your children speak Spanish?
   - Do your children attend a bilingual program?

2. Who are the people that you interact with the most in your daily life?
   - Are they primarily PR?
   - Are they primarily Latinos?

3. How old is your child who was diagnosed with ADHD?
   - How old was your child when you first suspected that s/he was different from other children?
   - What concerned you about him/her?
   - Who noticed first?
   - What did you do?
   - Whose opinions did you seek at that time? Among family and friends? Among professionals?

4. Tell me how your child was first diagnosed with ADHD.
   - How old was your child when s/he was first diagnosed?
   - What was the process by which he was diagnosed?
   - Where was he diagnosed?
   - By whom was he diagnosed?
   - What kind(s) of evaluation(s) did he receive?
   - Were the professionals evaluating him PR/Latinos
   - Did they speak Spanish?

5. How was your child's ADHD diagnosis explained to you? To your child?
   - What did you initially think of the diagnosis?
   - Did you agree with the diagnosis?

6. What were the recommendations for treatment that they gave you initially?
    - What did you think of the recommendations? Did you follow the recommendations? Why?
    - What treatments has your child/you participated in?
    - Where have you received services?
    - How satisfied are you with the treatment services your child has received?
    - Who are the treatment providers? Are the professionals treating him PR/Latinos/speak Spanish?
    - Tell me about your relationship with your child's mental health care providers.

7. Based on your experience with mental health providers, what would enhance your compliance of treatment for your child?

8. Is there anything you would recommend that would have improved the evaluation or treatment your child has received?

9. Does it matter to you whether the people evaluating/treating him/her are PR/Latinos or not? Why?

10. Do you feel that the fact that your family is PR makes any difference in terms of how your child was evaluated? How so?

11. Do you feel that the fact that your family is Puerto Rican makes any difference in terms of the services your child receives or the services that are available to you? How so?

12. What advice would you want to share with other Puerto Rican mothers of children who have ADHD?

SPANISH VERSION

1. En qué medidase identificacomo puertorriqueñooconla cultura puertorriqueña?
    - Quécreencias, valoresy costumbresPRCómo se adapta?
    - Siente queusted está criando asu hijo/scomo Puertorriqueño?
    - Sus hijoshablanespañol?

- Sushijosasisten a un programabilingüe?

2. Quién sonlaspersonas que interactúancontodos los días?
   - SonprincipalmentePR?
   - Sonprincipalmente latinos?

3. Qué edad tienesu hijoque fue diagnosticado conTDAH?
   - Qué edad teníasu hijocuando ustedsospechaque él / ellaera diferente delos demás niños?
   - Quélepreocupaacerca de él/ella?
   - Quiénse dio cuentapor primera vez?
   - Qué hiciste?
   - Enese momentocuyas opinionesbuscó? Entrelos amigosy la familia?Entre los profesionales?
4. Dime cómosu hijofuediagnosticado conTDAH.
   - Cuántos añosfuesu hijo cuandole diagnosticópor primera vez?
   - Cuál fue elproceso que usaron para el diagnosticó?
   - Donde recibido el diagnostic?
   - Quiénfue que le do diagnosticado?
   - Cuáles fueron losevaluaciones que recibieron?
   - Fueron losprofesionalesloque evalúanPR/ latinos?
   - Ellos Hablabaespañol?

5. Cómo le explicaron el diagnósticodeTDAH? asu hijo?
   - Inicialmente que fue quepensastesobre el diagnóstico?
   - Estuvo de acuerdocon el diagnóstico?

6. Cuáles fueronlasrecomendaciones para el tratamientoquele dieroninicialmente?
   - Qué piensasde las recomendaciones? seguistelasrecomendaciones? por qué?
   - Qué tratamientoshasu/hijoparticipado?
   - Dónde hasrecibido servicios?
   - Qué tan satisfechoestá usted conlosservicios de tratamiento desu hijo harecibido?
   - Quiénes sonlosproveedores de tratamiento? Losprofesionalestratándolo sonPR/latinos/hablarespañol?
   - Hábleme de surelacióncon los proveedores de salud mentalde su hijo.

7. Basado en suexperiencia conlos proveedoresde salud mental, lo quemejorar sucumplimientodetratamiento para su hijo?

8. Hay algoque usted recomendaríaque hubieramejorado laevaluación otratamiento que su hijoha recibido?

9. Esimporta a ustedsi laspersonasque evalúan/tratándolo/ella sonPR/ latinoso no? Por qué?
10. Cree usted queporque su familiaesPRhaceninguna diferenciaen términos de cómosu hijofueevaluado? Cómo?

11. Cree usted queel hecho de quesu familiaesde Puerto Ricohaceningunadiferencia enlosserviciosque recibe su hijoolosservicios queestán disponibles para usted? Cómo?

12. Qué consejo le quiera compartir con otras madres puertorriqueñas de los niños que tienen TDAH?

Appendix G: Confidentiality Agreement

ENGLISH VERSION

I, Lilliam Martinez, will transcribe all audiotapes and documentation for my doctoral study, Puerto Rican Mothers of Children Diagnosed with Attention Deficit Hyperactivity Disorder: Treatment Complianceand I agree to maintain full confidentiality in regards to any and all audiotapes and documentation related to my doctoral study, Puerto Rican Mothers of Children Diagnosed with Attention Deficit Hyperactivity Disorder: Treatment Compliance. Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-taped interviews, or in any associated documents;
2. To not make copies of any audiotapes or computerized files of the transcribed interview texts.
3. To store all study-related audiotapes and materials in a safe, secure location as long as they are in my possession;
4. To delete all electronic files containing study-related documents from my computer hard drive and any backup devices.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audiotapes and/or files to which I will have access.

Transcriber's name (printed) Lilliam Martinez _____

Transcriber's signature _____

Date _____

SPANISH VERSION

Yo, Lilliam Martínez, transcribirá todas las cintas de audio y documentación para mi estudio de doctorado , puertorriqueños Madres de niños diagnosticados con Trastorno de Hiperactividad y Déficit de Atención, Tratamiento de Cumplimiento y estoy de acuerdo en mantener absoluta confidencialidad respecto a cualquier y todas las cintas de audio y documentos relacionados con mi doctorado estudio , puertorriqueños madres de niños diagnosticados con Trastorno de Hiperactividad y Déficit de Atención, Tratamiento de Cumplimiento. Por otra parte , estoy de acuerdo :

1 . Para mantener en estricta confidencialidad la identificación de cualquier persona que pueda ser revelada inadvertidamente durante la transcripción de las entrevistas grabadas en audio , o en cualquiera de los documentos asociados ;

2 . Para no hacer copias de cualquier cintas de audio o archivos informáticos de los textos de entrevistas transcritas .

3 . Para almacenar todas las cintas de audio relacionados con el estudio y materiales en una ubicación segura y segura , siempre y cuando estén en mi poder ;

4 . Para eliminar todos los archivos electrónicos que contienen documentos relacionados con el estudio de mi disco duro de la computadora y los dispositivos de copia de seguridad .

Soy consciente de que puedo ser considerado legalmente responsable de cualquier incumplimiento de este acuerdo de confidencialidad , y por cualquier daño causado a los particulares si revelar información contenida en las cintas de audio y / o archivos a los que voy a tener acceso.

El nombre del transcriptor : Lilliam Martínez

Firma del transcriptor: _____