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Which African American Mothers Disclose Psychosocial Issues to their Pediatric Providers?

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Abstract

Objective—To determine if parent's self-efficacy in communicating with their child's pediatrician is associated with African American mothers' disclosure of psychosocial concerns during pediatric primary care visits.

Methods—Self-identified African American mothers ($N = 231$) of children 2–5 years were recruited from eight urban pediatric primary care practices in the Washington, DC metropolitan area. Visits were audio-recorded and parents completed phone surveys within 24 hours. Maternal disclosure of psychosocial issues and self-efficacy in communicating with their child's provider were measured using the Roter Interactional Analysis System (RIAS) and the Perceived Efficacy in Patient-Physician Interactions (PEPPI) respectively.

Results—Thirty-two percent of mothers disclosed psychosocial issues. Mothers who disclosed were more likely to report maximum levels of self-efficacy in communicating with their child's provider compared to those who did not disclose (50% vs. 35%; $p = .02$). During visits in which mothers disclosed psychosocial issues, providers were observed to provide more psychosocial information ($M = 1.52$ vs. 1.08 utterances per minute, $p = 0.002$) and ask fewer medical questions ($M = 1.76$ vs. 1.99 utterances per minute, $p = 0.05$) than during visits in which mothers did not

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disclose. The association between self-efficacy and disclosure was significant among low-income mothers (OR = 5.62, $p < .01$), but not higher-income mothers.

Conclusions—Findings suggest that efforts to increase parental self-efficacy in communicating with their child's pediatrician may increase parents' likelihood of disclosing psychosocial concerns. Such efforts may enhance rates of identifying and addressing psychosocial issues, particularly among lower-income African American patients.

Keywords

childhood mental health; African American; parent-provider communication; primary care

Introduction

There are significant unmet mental health needs of children in the U.S., especially among racial and ethnic minority children.^{1,2} African American youths are 70% less likely to receive needed mental health services than white youths.¹ Parents are typically the first to identify problems and seek services, therefore understanding which factors impact parental help-seeking may improve the early identification of children's mental health needs and reduce disparities in care. A common component of mental health help-seeking is parents' disclosure of child psychosocial problems to their child's primary care provider (PCP). PCPs can play a vital role in children's mental health service receipt because they are often the first professionals with whom parents discuss concerns about child behavior,³ and are an access point for receiving a mental health diagnosis and referral for services.³⁻⁵ Yet few parents who indicate that their child has a psychosocial problem or that they have concerns about their child's behavior report speaking to a health professional.^{6,7} Thus, it is important to examine parental disclosure of psychosocial problems to PCPs, particularly among African American parents.

A variety of factors can impact parent-provider communication and disclosure of psychosocial problems;⁸ however, those identified tend to be fixed, difficult to modify (e.g., socio-demographic characteristics),^{3,9} or focused on provider characteristics (e.g., question-asking).¹⁰⁻¹² While targeting provider behavior is important, it is also necessary to identify modifiable parent characteristics because active patient participation (i.e., communication) in visits is more likely to be patient-initiated than physician-prompted.¹³ Self-efficacy is an important parent-focused, modifiable aspect of communication that warrants further attention. Research with adults supports the effectiveness of patient-focused interventions in increasing patient self-efficacy for communicating with providers¹⁴ and in encouraging patients to be more active during visits.¹⁵ However, research on parental efficacy in communicating with PCPs, particularly in relation to discussions of child psychosocial concerns, is lacking.

The purpose of this observational, cross-sectional study was to examine the role of African American mothers' self-efficacy in communicating with their child's PCP on their disclosure of psychosocial concerns, in addition to examining relevant child, parent, and provider characteristics. We examined which (1) family, (2) provider, (3) parent-provider relationship and (4) parent-provider communication characteristics were associated with

parental disclosure of psychosocial issues. We also explored the extent to which any effect of parental self-efficacy varies by socio-economic status (SES).

Participants & Methods

Participants

Self-identified African American mothers of healthy children 2 to 5 years of age were enrolled into this study when they presented for a health visit (91% well child) at one of eight participating urban pediatric primary care clinics (one hospital-based health center, two community health centers, five private practices) in the Washington, DC metropolitan area, between September 2007 and December 2010. All providers (pediatric nurse practitioners or pediatricians; $n = 49$) at the eight sites were recruited, and 40 (82%) consented to audio-recordings of their visits with enrolled parents.

Of the 638 mothers approached, 84% expressed interest in participating ($n = 537$), of whom 255 (47%) were excluded because they did not meet one of the following criteria, established to increase the homogeneity of the target study sample (African American children) and control for possible confounding factors that could affect interactions in the medical setting: child's parent and grandparents were born in the mainland United States,¹⁶ both of child's biological parents were mono-racial African American,^{13,16} and child did not have a moderate to severe medical conditions requiring more than one hospitalization per year or care by more than one sub-specialist (e.g., developmental delay), as the increased interaction with providers could impact self-efficacy or disclosure of psychosocial issues.¹⁷ Consenting mothers were excluded from analyses if their recordings could not be coded ($n = 4$; e.g., difficult to hear voices) or they could not be reached for the telephone survey ($n = 47$), yielding a final sample of 231 mothers. Due to missing data on the Roter Interactional Analysis System ($n = 4$) and Eyberg Child Behavior Inventory ($n = 28$), the sample size for multivariate models was 199.

Procedures

The Children's National Medical Center Institutional Review Board approved and monitored this study. Research assistants (RAs) approached families in the clinic waiting rooms, explained the study, and screened interested mothers for eligibility. After obtaining informed consent, the RA notified the provider that the family had enrolled and placed a digital recorder in the exam room, which could be turned off at any time. Within 48 hours of the visit, RAs called mothers to conduct a 10–15 minute survey (described below).

Variables and Measures

Primary outcome variable—Maternal disclosure of psychosocial issues was assessed using the RIAS, a reliable and valid observational coding tool used to evaluate patient-provider interactions.¹⁸ The RIAS has been used across a wide range of studies, including those with African American populations.^{17,18} A trained RA (blind to participant survey responses) coded each tape. Dual-coding (10% of recordings) indicated adequate inter-rater reliability ($r = .78 - .97$). The RIAS assigns codes to each "utterance," the smallest discriminable speech segment to which a classification may be assigned. Utterances vary in

length and are considered a single unit if they convey only one thought or relate to one item of interest. For each speaker (e.g., provider, parent), the RIAS system classifies every utterance into one of 38 mutually exclusive and exhaustive codes, which are subsumed under 4 categories relating to: information-giving/counseling and question-asking in the areas of medical condition/therapy/prevention and psychosocial/lifestyle behaviors. Consistent with past research using the RIAS¹⁷, disclosure of psychosocial issues was indicated by the presence of any maternal utterance mentioning that one or more of the following issues had occurred within 2 weeks of the visit, was an on-going problem, or a past problem that had been resolved: 1) child behavioral difficulties, 2) troublesome habits (e.g. thumb-sucking), 3) disciplinary problems, 4) child's school or daycare functioning, 5) peer relations, or 6) family problems.

Primary predictor variables—Maternal self-efficacy in communicating with their child's provider was assessed using the Perceived Efficacy in Patient-Physician Interactions (PEPPI)¹⁹, a reliable and valid 5-item instrument that has been used in urban, African American samples¹⁹ was modified for use with parents. Using a 10-point scale (from 'not confident at all' to 'extremely confident'), parents rated their confidence in their ability to: "know what questions to ask your child's provider," "get your child's provider to answer all of your questions," "get the most out of your visits with your child's providers," "get your child's provider to take your chief concern seriously," and "get your child's provider to do something about your chief concern." Due to skew ($M=46.37$, $SD=5.35$), we dichotomized total scores to indicate whether the mother had the maximum score of 50, as the scale's author has done.²⁰ Analyses were conducted with both the dichotomous and continuous self-efficacy variables, and significant results remained the same.

Mother rating of child behavior was assessed via the ECBI,²¹ on which parents rate the frequency of 36 child behaviors and indicate whether or not they consider each behavior to be a problem. T-scores >60 on the problem scale indicate that the mother rated child behavior as a problem. The ECBI, which was standardized and validated on a large sample of children from a range of racial, ethnic, and socioeconomic backgrounds, is a commonly used tool in studies of African American families.^{21,22} In this study, the ECBI problem scale displayed excellent internal consistency ($\alpha = .90$).

Parent distress was assessed via the Parenting Stress Index (PSI)²³ short form, a questionnaire on which parents rate their agreement with 36 statements using a 5-point scale (from 'strongly disagree' to 'strongly agree'). The psychometric properties of the PSI (validity, reliability, factor structure) have been established across diverse populations, including African American families.²⁴ The PSI displayed acceptable internal reliability ($\alpha=.68$) in this sample.

Family poverty status was calculated using the Health and Human Services federal poverty level (FPL) thresholds for the year in which the interview was conducted, maternal reports of household size, and annual income. The 200% FPL cut-off, a common standard for Medicaid eligibility, was used to create poverty status categories.

Mothers' trust in their child's provider was measured using a modified version of the 10-item Wake Forest Physician Trust Scale, a reliable and valid measure.²⁵ Responses (provided on a 5-point scale) were summed to create a total trust in provider score (range: 10–50; $\alpha = .97$).

Providers' communication was assessed using the RIAS, in which providers' communication is coded according to 9 variables/categories: question-asking (medical and psychosocial), information-giving (medical and psychosocial), positive talk (e.g., approval, laughter), negative talk (e.g., disagreements, corrections), emotional talk (e.g., empathy, reassurance) social talk (i.e., non-medical chit chat), and partnership-building (e.g., paraphrasing, requesting opinions). For each variable/category, the number of individually coded utterances is divided by the length of the visit to yield a standardized summary score (utterances per minute) for each participant on all of the provider communication categories. Because very few instances of provider negative talk were observed (M utterances/minute=0.05, $SD=0.10$), this variable was recoded as any instance of negative talk versus none.

Provider sociodemographic characteristics, including gender, race/ethnicity (recoded as 'African American' or 'other' to reflect racial concordance with the parent), and years in practice, were gathered via a provider questionnaire.

Covariates—Based on previous literature reporting associations with parental disclosure of child behavior problems, child (age, sex) and mother (age, marital status, number of children, and highest level of education) characteristics were included as covariates.^{3,5,26}

Data Analysis

First, we generated descriptive statistics for family and provider characteristics, parent-provider relationship characteristics, observed provider communication, and maternal disclosure of child behavior problems. Next, we conducted univariate analyses using one-way Analysis of Variance (ANOVAs) for continuous variables (difference in means) and chi-square tests for dichotomous variables (difference in proportions) to compare mothers who did versus did not disclose psychosocial problems. In a final multi-level logistic regression model (model 1), in which participants were nested within providers, we retained predictors theoretically-driven (e.g., mother rated child behavior as a problem, poverty status) or significant ($p < .01$) at the univariate level to determine their independent effects on maternal disclosure of child behavior problems, which is useful for understanding the relative strength of predictors. (A two-level model, with providers nested within recruitment sites, yielded the same results.) As a second step in the multi-level logistic regression model (model 2), we included an interaction term for poverty status x parental self-efficacy. We examined any significant interaction using within-group multi-level logistic regression (same as model 1) for each poverty category separately. All analyses were conducted using Stata statistical software (Version 11).

Results

Sample Characteristics

On average, children in this sample were 3 years old (Table 1). Mothers, most of whom were single with more than one child, ranged from 18 to 57 years of age. Over half of the mothers had at least attended college, and almost half were living above 200% poverty. Thirteen percent of mothers rated their children's behavior as a problem. PCPs were mostly White and female with a wide range of experience (4–40 years). Just under half the parents reported high self-efficacy in communicating with their child's provider. Average provider medical information-giving was more frequent than medical question-asking; both were more frequent than psychosocial information-giving or question-asking. Over a third of providers uttered some form of negative talk; however, positive talk was also frequent. Close to a third of mothers disclosed psychosocial issues.

Predictors of Maternal Disclosure of Psychosocial Issues

Table 2 shows comparisons between mothers who did versus did not disclose psychosocial issues on each of the primary predictor variables and covariates. There were no significant differences in terms of family characteristics or demographic covariates. Mothers who disclosed were less likely to be seen by female providers compared to mothers who did not disclose. There was no difference in likelihood of disclosure based on provider race. Mothers who disclosed were more likely to have high self-efficacy scores relative to mothers who did not disclose. Mothers who disclosed psychosocial issues experienced higher rates of psychosocial information giving by their providers and were more likely to see a provider who used negative talk than mothers who did not disclose psychosocial concerns.

In the multi-level multivariate logistic regression model (Table 3, Model 1), parental self-efficacy in communicating with their child's provider was significantly and independently associated with maternal disclosure. Mothers were almost twice as likely to disclose if they had the maximum score for self-efficacy. There was also a trend level effect of providers' psychosocial information-giving such that mothers who disclosed psychosocial concerns experienced higher rates of psychosocial information giving by their providers (OR = 1.34).

The second step of the logistic regression (Table 3, Model 2) indicated that the association between high self-efficacy and maternal disclosure was significantly moderated by poverty status. Follow-up multi-level logistic regression testing the effects of self-efficacy within each poverty group (Table 4) revealed that, among families living below 200% FPL, mothers with high self-efficacy ($n = 57$) were more than five times more likely to disclose psychosocial issues than mothers with lower self-efficacy ($n = 44$). Self-efficacy was not significantly associated with maternal disclosure among families above 200% FPL ($n = 102$ lower self-efficacy, $n = 63$ max self-efficacy).

Discussion

In this sample of African American mothers, disclosure of psychosocial issues to their child's PCP was uniquely associated with parent self-efficacy in communicating with their

child's PCP and providers' psychosocial information-giving. The effect of high self-efficacy appears specific to lower-income African American parents.

Mothers with higher self-efficacy scores were more than twice as likely to disclose psychosocial issues than mothers with lower self-efficacy scores. Research supports the association between self-efficacy in communicating with providers and various communication and health behavior outcomes, including greater satisfaction with providers and care received^{27,28} and greater participation in treatment decision-making,^{20,29} although this research has been mostly limited to adult populations with health problems. To our knowledge, no other study has examined the role of parental self-efficacy in communicating with providers and parental disclosure of psychosocial problems.

Although causality cannot be inferred from the findings of this study, that the association between high self-efficacy and maternal disclosure was moderated by poverty status suggests that interventions aimed at increasing efficacy in communicating with pediatric providers may be especially valuable for low-income families. Research has documented a positive correlation between socioeconomic status and self-esteem,³⁰ and physicians tend to use less participatory communication (e.g., less information giving and partnership-building) with lower income patients.³¹ Interventions with adult populations typically occur just before the appointment and they teach/encourage behaviors, such as increased question-asking, discussion of concerns, and requests to clarify information to increase patient self-efficacy in communicating with the provider.¹⁵ Research on interventions that aim to increase *parents'* self-efficacy in communicating with their child's provider is scarce. Findings from the present study suggest that low-income mothers, who may feel less efficacious in speaking with physicians, may benefit from such brief empowerment interventions completed within the pediatric practice aimed at increasing their feelings of efficacy and that these efforts could increase the identification of children's unmet mental health needs.

Provider communication was also an important correlate of mothers' disclosure of psychosocial issues. Specifically, provider psychosocial information-giving was higher during visits in which mothers disclosed psychosocial problems. This finding is consistent with previous research documenting associations between provider information-giving and maternal discussions of psychosocial issues.¹⁷ Given that visits were not coded sequentially, it is unclear whether disclosure occurred before or after provider information-giving. Information-giving may have encouraged maternal disclosure or maternal disclosure may have prompted providers to offer more information. Interestingly, the effect of provider gender in unadjusted models seems to be confounded with psychosocial information-giving and thus not a significant unique predictor in multivariate models. Female providers exhibited significantly less psychosocial information-giving than male providers ($M=1.13$ vs 1.62 , $F=6.09$, $p=.01$).

More research is needed to this finding and to clarify the direction of the association between psychosocial information-giving and maternal disclosure of psychosocial issues. More research is also needed to clarify the finding that provider negative talk was higher during visits in which mothers disclosed psychosocial problems. This finding stands in

contrast to previous research indicating that parents are more likely to disclose psychosocial concerns when pediatricians are more patient-centered (e.g., asking questions, showing empathy).¹² However, it may be that providers used negative talk *in response to* maternal disclosure. Indeed, previous research has documented that physicians often provide inadequate responses to parent disclosure of concerns (e.g., fail to respond with information or referral).¹⁰ Moreover, in one study of parent-provider communication, maternal disclosure of problems was the most powerful predictor of provider discouraging responses.¹⁰

Null findings from this investigation are also interesting. The likelihood of maternal disclosure of psychosocial issues was not significantly associated with maternal ECBI problem score ratings. Although associations between disclosure and aspects of the child's behavior (e.g., severity, impact on family functioning) have been noted in other studies,^{3,5,26} research, particularly with young children, documents that, even among parents reporting high levels of problem behaviors, a large proportion report minimal worry.³ Given documented associations between parental worry and seeking professional help,³ parents of young children (as in the present study), may be less concerned about their child's behaviors and therefore less likely to disclose concerns to the pediatrician. Furthermore, we examined disclosure of issues related to child behavior *and* other aspects of child and family functioning. Thus, mothers in this study may have expressed concern about psychosocial issues (e.g., family problems) that would be less strongly correlated with child behavior scores. It may also be that factors not measured, such as parental norms for child behavior or child competency scores, influenced maternal disclosure.

Maternal disclosure was also not found to be directly associated with child or family socio-demographic characteristics, parental distress, parent trust in the child's provider, or provider race. Previous studies have also failed to find significant associations between family socio-demographic characteristics and parental disclosure of psychosocial problems.^{3,5} The finding regarding provider race also aligns with previous research indicating that racial concordance between patients and providers does not influence communication in the pediatric setting.³² Previous research suggests that trust in providers may enhance health behavior (e.g., preventive service use)³³ and is enhanced by provider's partnership-building communication style.³⁴ There is also some research to suggest that maternal trust in their child's provider may be associated with willingness to discuss parenting stress and depression,³⁵ but we know of no research that has found an association between trust in the provider and disclosure of psychosocial concerns. All African American mothers in our sample reported high levels of trust, and this limited variation may have precluded differentiating between mothers who did versus did not disclose psychosocial problems. Future research should therefore incorporate more sensitive measures of trust that can better document variability in this domain and therefore examine the extent to which trust may play a role in discussion of psychosocial problems.

Findings should be considered in light of the study's limitations. The RIAS disclosure of psychosocial issues variable captures a wide range of problem areas (from thumbsucking to domestic violence), which makes results interpretation challenging. Future research that more specifically examines type of concern disclosed would be beneficial. Additionally,

parent-provider communication data were not coded sequentially because that is not a feature of the standardized RIAS coding system. Thus, we cannot speak to transactional aspects of parent-provider communication, such as whether parental disclosure preceded or followed certain provider utterances, which would be an interesting direction for further research. We also do not have information about non-verbal aspects of the visit, such as facial expressions and body language, which may have played a role in discussions and disclosure of concerns. These as well as other theoretical factors, such as parent health literacy skills, may influence parent's decision to disclosure behavior problems to a greater degree than factors measured in this study, which only accounted for a small proportion of variance in disclosure. The fact that participants were recruited via convenience sampling at pediatric practices and that many were either deemed ineligible or failed to complete all study components also limits our ability to generalize findings. Finally, further research is needed to determine whether parent disclosure leads to increased diagnoses, referrals, service receipt, or other differences in child outcomes.

Conclusion

Findings from this study may have important implications for practice, research, and intervention development. Lower-income African American mothers with higher self-reported ratings of self-efficacy in communicating with their child's pediatrician were more likely to disclose psychosocial concerns. While causality cannot be inferred from this association, it suggests that parental self-efficacy may be an important and potentially modifiable factor that can serve as a target for intervention and future research investigating the nature of this association would be beneficial. Interventions aimed at improving parent-provider communication about psychosocial issues and reducing disparities in care have tended to target providers¹¹ who are less likely to elicit concerns from parents of underrepresented backgrounds.⁹ While this should remain a priority within the field, findings suggest that efforts to empower parents and increase their feelings of efficacy in communicating with health providers could be fruitful. Such efforts could ultimately improve mental health outcomes for socio-economically disadvantaged African American children.

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References

1. Coker TR, Elliott MN, Kataoka S, et al. Racial/Ethnic disparities in the mental health care utilization of fifth grade children. *Acad Pediatr*. Mar-Apr;2009 9(2):89–96. [PubMed: 19329099]
2. Flores G. Technical report--racial and ethnic disparities in the health and health care of children. *Pediatrics*. Apr; 2010 125(4):e979–e1020. [PubMed: 20351000]
3. Ellingson KD, Briggs-Gowan MJ, Carter AS, Horwitz SM. Parent identification of early emerging child behavior problems: predictors of sharing parental concern with health providers. *Arch Pediatr Adolesc Med*. Aug; 2004 158(8):766–772. [PubMed: 15289249]
4. Policy statement--The future of pediatrics: mental health competencies for pediatric primary care. *Pediatrics*. Jul; 2009 124(1):410–421. [PubMed: 19564328]

5. Briggs-Gowan MJ, Horwitz SM, Schwab-Stone ME, Leventhal JM, Leaf PJ. Mental health in pediatric settings: distribution of disorders and factors related to service use. *J Am Acad Child Adolesc Psychiatry*. Jul; 2000 39(7):841–849. [PubMed: 10892225]
6. Horwitz SM, Gary LC, Briggs-Gowan MJ, Carter AS. Do needs drive services use in young children? *Pediatrics*. Dec; 2003 112(6 Pt 1):1373–1378. [PubMed: 14654612]
7. Blanchard LT, Gurka MJ, Blackman JA. Emotional, developmental, and behavioral health of American children and their families: a report from the 2003 National Survey of Children's Health. *Pediatrics*. Jun; 2006 117(6):e1202–1212. [PubMed: 16740820]
8. Cooper LA, Roter DL, Johnson RL, Ford DE, Steinwachs DM, Powe NR. Patient-centered communication, ratings of care, and concordance of patient and physician race. *Ann Intern Med*. Dec 2; 2003 139(11):907–915. [PubMed: 14644893]
9. Guerrero AD, Rodriguez MA, Flores G. Disparities in provider elicitation of parents' developmental concerns for US children. *Pediatrics*. Nov; 2011 128(5):901–909. [PubMed: 22007017]
10. Wissow LS, Larson S, Anderson J, Hadjiisky E. Pediatric residents' responses that discourage discussion of psychosocial problems in primary care. *Pediatrics*. Jun; 2005 115(6):1569–1578. [PubMed: 15930218]
11. Wissow LS, Gadomski A, Roter D, et al. Improving child and parent mental health in primary care: a cluster-randomized trial of communication skills training. *Pediatrics*. Feb; 2008 121(2):266–275. [PubMed: 18245417]
12. Wissow LS, Roter DL, Wilson ME. Pediatrician interview style and mothers' disclosure of psychosocial issues. *Pediatrics*. Feb; 1994 93(2):289–295. [PubMed: 8121743]
13. Street RL Jr, Gordon HS, Ward MM, Krupat E, Kravitz RL. Patient participation in medical consultations: why some patients are more involved than others. *Med Care*. Oct; 2005 43(10):960–969. [PubMed: 16166865]
14. Kravitz RL, Tancredi DJ, Grennan T, et al. Cancer Health Empowerment for Living without Pain (Ca-HELP): effects of a tailored education and coaching intervention on pain and impairment. *Pain*. Jul; 2011 152(7):1572–1582. [PubMed: 21439726]
15. Harrington J, Noble LM, Newman SP. Improving patients' communication with doctors: a systematic review of intervention studies. *Patient Educ Couns*. Jan; 2004 52(1):7–16. [PubMed: 14729285]
16. Yin HS, Johnson M, Mendelsohn AL, Abrams MA, Sanders LM, Dreyer BP. The health literacy of parents in the United States: a nationally representative study. *Pediatrics*. Nov; 2009 124(Suppl 3):S289–298. [PubMed: 19861483]
17. Wissow LS, Larson SM, Roter D, et al. Longitudinal care improves disclosure of psychosocial information. *Arch Pediatr Adolesc Med*. May; 2003 157(5):419–424. [PubMed: 12742876]
18. Roter D, Larson S. The Roter interaction analysis system (RIAS): utility and flexibility for analysis of medical interactions. *Patient Educ Couns*. Apr; 2002 46(4):243–251. [PubMed: 11932123]
19. Maly RC, Frank JC, Marshall GN, DiMatteo MR, Reuben DB. Perceived efficacy in patient-physician interactions (PEPPI): validation of an instrument in older persons. *J Am Geriatr Soc*. Jul; 1998 46(7):889–894. [PubMed: 9670878]
20. Maly RC, Umezawa Y, Leake B, Silliman RA. Determinants of participation in treatment decision-making by older breast cancer patients. *Breast Cancer Res Treat*. Jun; 2004 85(3):201–209. [PubMed: 15111757]
21. Eyberg, S.; Pincus, D. *Eyberg Child Behavior Inventory & Sutter-Eyberg Student Behavior Inventory - Revised*. Odessa, FL: Psychological Assessment Resources; 1999.
22. Gross D, Fogg L, Young M, et al. Reliability and validity of the Eyberg Child Behavior Inventory with African-American and Latino parents of young children. *Res Nurs Health*. Apr; 2007 30(2): 213–223. [PubMed: 17380522]
23. Abidin, R. *Parenting Stress Index: Professional Manual*. 3. Lutz, FL: Psychological Assessment Resources, Inc; 1995.
24. Reitman D, Currier RO, Stickle TR. A critical evaluation of the Parenting Stress Index-Short Form (PSI-SF) in a head start population. *J Clin Child Adolesc Psychol*. Sep; 2002 31(3):384–392. [PubMed: 12149976]

25. Hall MA, Zheng B, Dugan E, et al. Measuring patients' trust in their primary care providers. *Med Care Res Rev.* 2002; 59(3):293–318. [PubMed: 12205830]
26. Brown JD, Wissow LS, Riley AW. Physician and patient characteristics associated with discussion of psychosocial health during pediatric primary care visits. *Clin Pediatr (Phila).* Nov; 2007 46(9): 812–820. [PubMed: 17641120]
27. Maliski SL, Kwan L, Krupski T, Fink A, Orecklin JR, Litwin MS. Confidence in the ability to communicate with physicians among low-income patients with prostate cancer. *Urology.* Aug; 2004 64(2):329–334. [PubMed: 15302489]
28. Thind A, Maly R. The surgeon-patient interaction in older women with breast cancer: what are the determinants of a helpful discussion? *Ann Surg Oncol.* Jun; 2006 13(6):788–793. [PubMed: 16614883]
29. Tarini BA, Christakis DA, Lozano P. Toward family-centered inpatient medical care: the role of parents as participants in medical decisions. *J Pediatr.* Dec; 2007 151(6):690–695. e691. [PubMed: 18035155]
30. Twenge JM, Campbell WK. Self-esteem and socioeconomic status: A meta-analytic review. *Personality and Social Psychology Review.* 2002; 6(1):59–71.
31. Willems S, De Maesschalck S, Deveugele M, Derese A, De Maeseneer J. Socioeconomic status of the patient and doctor-patient communication: does it make a difference? *Patient Educ Couns.* Feb; 2005 56(2):139–146. [PubMed: 15653242]
32. Horn IB, Mitchell SJ, Joseph JG, Wissow LS. African American parents' perceptions of partnership with their child's primary care provider. *J Pediatr.* 2011; 159(2):262–267. [PubMed: 21429513]
33. O'Malley AS, Sheppard VB, Schwartz M, Mandelblatt J. The role of trust in use of preventive services among low-income African-American women. *Prev Med.* Jun; 2004 38(6):777–785. [PubMed: 15193898]
34. Horn IB, Mitchell SJ, Wang J, Joseph JG, Wissow LS. African-American parents' trust in their child's primary care provider. *Acad Pediatr.* Sep-Oct;2012 12(5):399–404. [PubMed: 22858071]
35. Heneghan AM, Mercer M, DeLeone NL. Will mothers discuss parenting stress and depressive symptoms with their child's pediatrician? *Pediatrics.* Mar; 2004 113(3 Pt 1):460–467. [PubMed: 14993535]

What's New

In this study, low-income African American mothers were more likely to disclose child psychosocial problems to providers if they had high self-efficacy. Enhancing minority parents' self-efficacy in communicating with providers could improve access and utilization of child mental health services.

Table 1

Sample descriptive statistics (N=231)

	Mean (SD)	%
<i>Family Characteristics</i>		
Child age (years)	3.30 (1.17)	
Child gender (female)		51
Mother age (years)	31.14 (6.97)	
Marital status (single)		68
Mother has more than 1 child		63
Mother education		
Less than high school (HS)		9
HS/General Education Development test (GED)		33
Attended some college		32
College degree or more		27
Mother rated child behavior as a problem ¹		13
Poverty status (>200% Federal Poverty Level)		48
Parenting stress ²	72.84(16.06)	
<i>Provider Characteristics</i>		
Gender (female)		82
Race/ethnicity		
White/Caucasian		52
African American		37
Years in practice	18.08(10.01)	
<i>Parent-Provider Relationship Characteristics</i>		
Parental self-efficacy in communicating w/ child's provider ³	46.37(5.35)	
Max score		40
Parental trust in provider ⁴	44.23(4.56)	
<i>Observed Provider Communication (# utterances/minute)⁵</i>		
Medical question-asking	1.91(0.84)	
Psychosocial question-asking	1.43(0.96)	
Medical information-giving	3.26(1.51)	
Psychosocial information-giving	1.22(1.09)	
Positive talk	2.70(1.23)	
Emotional talk	1.14(0.70)	
Negative talk (% any)		39
Social talk	0.26(0.32)	
Partnership	3.00 (1.28)	
Mother disclosed child psychosocial issues ^e		32

¹ Eyberg Child Behavior Inventory (ECBI), T-score > 60 on problem subscale

² Parenting Stress Index (PSI) short form, total score range: 34–170

³ Perceived Efficacy in Patient-Physician Interactions (PEPPI), total score range: 10–50

⁴ Wake Forest Physician Trust Scale

⁵ Roter Interactional Analysis System (RIAS)

Table 2

Univariate associations of primary predictor variables and covariates with maternal disclosure of child psychosocial issues

	Mother disclosed		Mother did not disclose		p
	Mean	%	Mean	%	
Demographic Covariates					
Child age (years)	3.33		3.29		.86
Child gender (female)		54		53	.86
Mother age (years)	30.00		31.66		.91
Marital status (single)		64		70	.32
Mother has more than 1 child		67		64	.70
Mother attended some college		60		58	.90
Primary Predictors					
Family Characteristics					
Mother rated child behavior as a problem (n=203)		21		13	.14
Poverty status (>200% FPL)		47		55	.31
Parenting stress	74.81		71.86		.21
Provider Characteristics					
Gender (female)		76		88	.02
African American		33		41	.15
Years in practice	17.59		18.32		.773
Parent-Provider Relationship Characteristics					
Parental self-efficacy in communicating w/ child's provider	47.5		45.83		.03
Max score		50		35	.03
Parental trust in provider	44.38		44.15		.73
Observed Provider Communication					
Medical question-asking	1.76		1.99		.05
Psychosocial question-asking	1.41		1.44		.73
Medical information-giving	3.12		3.33		.19
Psychosocial information-giving	1.52		1.08		.002
Positive talk	2.67		2.71		.51

	Mother disclosed		Mother did not disclose		<i>p</i>
	Mean	%	Mean	%	
Emotional talk	1.16		1.13		.97
Negative talk (% any)		51		34	.01
Social talk	.24		.27		.20
Partnership	3.05		2.97		.55

Table 3

Multi-level multivariate logistic regression predicting maternal disclosure of child psychosocial issues

	Model 1		Model 2	
	OR	95% CI	OR	95% CI
<i>Family Characteristics</i>				
Mother rated child behavior as a problem (> ECBI cut-off)	2.02	.82 – 4.96	2.04	.79–5.26
Poverty status (>200% FPL)	.90	.46–1.78	1.86	.67–5.16
<i>Provider Characteristics</i>				
Gender (female)	.50	.21 – 1.23	.44	.16–1.24
<i>Parent-Provider Relationship Characteristics</i>				
Max parental self-efficacy in communicating w/ child's provider	2.41 *	1.21 – 4.79	5.19 **	1.77–15.23
<i>Observed Provider Communication</i>				
Psychosocial information-giving	1.33 [†]	.97 – 1.82	1.36 [†]	.97–1.89
Negative talk (any)	1.42	0.72 – 2.81	1.49	.71–3.12
Poverty x High Self-efficacy			.22 *	.05–.94

[†]
 $p < .10$ *
 $p < .05$ **
 $p < .01$

Table 4

Within poverty category multi-level multivariate logistic regression predicting maternal disclosure of child psychosocial issues

	<200% FPL (n=101)		>200% FPL (n=110)	
	OR	95% CI	OR	95% CI
<i>Family Characteristics</i>				
Mother rated child behavior as a problem (> ECBI cut-off)	1.09	.24–4.84	1.65	.53–5.18
<i>Provider Characteristics</i>				
Gender	.39	.09–1.61	.53	.17–1.68
<i>Parent-Provider Relationship Characteristics</i>				
Max parental self-efficacy in communicating w/ child's provider	5.62**	1.86–17.01	1.02	.41–2.57
<i>Observed Provider Communication</i>				
Psychosocial information-giving	1.91*	1.03–3.53	1.24	.87–1.78
Negative talk (any)	1.68	.59–4.80	1.82	.74–4.47

†
p<.10

*
p<.05

**
p<.01