A Parent-Child Therapy Program for Latino Families

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A PARENT-CHILD THERAPY PROGRAM FOR LATINO FAMILIES

by

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ABSTRACT
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This study used a randomized control design with treatment and wait-list conditions to evaluate the efficacy of a culturally-adapted version of the *Early Pathways* program (Fox & Gresl, 2014), an in-home, parent-child therapy program with 137 at-risk Latino children under the age of six referred for severe behavior and emotional problems, such as aggression, oppositional behavior, self-injury and property destruction. *Early Pathways* directly engaged the parent-child dyad, emphasizing parent-directed training and child-engagement activities, such as psycho-education, child-led play, and cognitive-behavioral strategies. Cultural modifications included establishing community partnerships to identify Latino family needs, translation of materials, offering bilingual services, acculturation assessment, and cultural competence training. Multivariate analyses of covariance (MANCOVA) revealed significant differences between the immediate and delayed treatment groups on all post-test measures with the pre-test scores as covariates. After the delayed group completed treatment, repeated measures, multivariate analyses of variance (MANOVA) showed significant improvement for both groups on all measures with maintenance at four- to six-week follow-up. Outcomes included reduced child behavior problems, increased child pro-social behaviors, improved caregiver discipline, enhanced caregiver nurturing, improved parent-child relationships, and a decrease in clinical diagnoses following treatment. This study offers guidance for developing culturally-adapted early intervention services for young Latino children in poverty referred for severe behavior problems.

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CHAPTER I: INTRODUCTION

Statement of the Problem

There is a significant need for appropriate and effective mental health services within Latino communities, particularly for families with young children under the age of six. This need is highlighted by three widely acknowledged premises: (a) a rapid increase in the Latino population and associated increase in poverty and mental health concerns; (b) the unique qualities of Latino cultural values and their impact on effective mental health treatment; and (c) a lack of Parent-Child Therapy (PCT) programs specifically adapted for Latino families.

As the Latino population continues to grow, the poverty rate of Latino families has grown along with it. Between 2000 and 2010, the overall poverty rate for Latinos in the United States increased from 21.2% to 26.6%, reflecting a total increase from 7,155,000 to 13,386,000 Latino individuals living in poverty (U.S. Census Bureau, 2001; U.S. Census Bureau, 2011b). These statistics, however, do not fully capture the enormity of the poverty epidemic among Latino families with young children. In 2011, an estimated 1,147,503 Latino families with children under the age of six were living in poverty, representing 47% of all Latino families living in poverty in the United States. Similarly, 37% of all Latino children under the age of six in the United States – an estimated 2,243,742 children - were living in poverty (U.S. Census Bureau, 2011a).

This increase in poverty along with other factors, such as language and acculturation, represent significant barriers to accessing and adhering to mental health treatment (Altarriba & Santiago-Rivera, 1994; Antshel, 2002). For example, Latinos

have the lowest rate of health insurance coverage in the United States (Halfon, Wood, Valdez, Pereyra, & Duan, 1997; U.S. Census Bureau, 2011b; Vega & Lopez, 2001), and there are significant disparities in the use of mental health treatment for Latino children and adolescents (Flores, 2010). Alegría et al. (2008) examined disparities in treatment for Latino patients with depression and found that 63.7% of Latinos suffering from depression did not have access to appropriate mental health care compared to 40.2% of Caucasian individuals. These statistics serve as a reminder of the challenges facing Latino families, particularly Latino families with young children, as well as the significant need to construct a treatment program that acknowledges these obstacles.

In order to provide effective services for this population, it is necessary to have a thorough understanding of Latino cultural values and their impact on parenting young children. Several constructs have been identified that describe Latino cultural values, including *familismo, machismo, marianismo, respeto, personalismo,* and *simpatía* (Barker, Cook, & Borrego, Jr., 2010). Two meta-analytic reviews found that these cultural values play a significant role in therapy, and being mindful of these values supports effective cultural adaptation of therapeutic treatment programs and strategies (Griner & Smith, 2006; Smith, Domenech-Rodríguez, & Bernal, 2011). For example, *familismo* has been associated with higher levels of maternal nurturing behaviors and emotional support for adolescents (Calderón-Tena, Knight, & Carlo, 2011), as well as providing a protective influence on substance use among adolescents (Unger et al., 2002) and suicide attempts among Latina teens (Peña et al., 2011). In addition, Latino parents have identified *respeto* as an underlying theme of parent-child interactions, with a direct relationship to parental discipline (Arcia & Johnson, 1998). Further, *personalismo* and

simpatía have been found relevant to mental health outcomes given that Latino families tend to identify with their specific health care provider rather than group practice, continue to see their provider despite relocation, and even stop pursuing health care if their provider is no longer available (Grossman, 1994). In fact, Foucault and Schneider (2009) conducted a study in the Dominican Republic and all but one of the mothers who were contacted in person participated in the study while only 47% of mothers who were contacted by school letters participated in the program.

Despite recognition of the influence of culture on therapy, there is a paucity of research examining the impact of cultural values on treatment for children under the age of six. In the past two decades, several PCT programs have been developed for the treatment of child behavior problems, such as *Early Pathways* (Fox & Gresl, 2014), previously known as *Parenting Young Children* (Fox & Nicholson, 2003), *Parent Child Interaction Therapy* (PCIT; Eyberg & Boggs, 1989), *Incredible Years Parenting Program* (IYP; Webster-Stratton, 1992), and *Triple-P Positive Parenting* (Triple P; Sanders, 1999). Research on *Early Pathways*, PCIT, IYP, and Triple P has shown successful outcomes for children with behavior problems (Eyberg et al., 2001; Fox, Mattek, & Gresl, 2013; Roberts, Mazzucchelli, Studman, & Sanders, 2006; Webster-Stratton, Reid, & Hammond, 2004).

While each of these programs has reported success with small portions of Latino populations, only a few have fully adapted a PCT program for Latino families and examined the effects of cultural modifications. Initial studies of culturally-adapted PCIT programs found support for such treatment among Puerto Rican and Mexican American families (Matos, Bauermeister, & Bernal, 2009; McCabe & Yeh, 2009). In addition,

fairly successful outcomes have been found for less well-known program adaptations, such as Parenting Our Children to Excellence (PACE; Dumas, Arriaga, Moreland-Begle, & Longoria, 2011) and Community Parent Education (COPE; Lakes et al., 2009). However, research with Latino children under the age of six is in its incipient stage, and none of these existing studies have evaluated in-home treatment for low-income Latino families to assess whether an outreach format offers the potential for even greater success.

This is particularly concerning given the aforementioned high poverty rate among Latino families with young children, and that these at-risk children have a significantly greater risk for poorer social and emotional outcomes (Ackerman, Brown, & Izard, 2003). Research has found that up to 36% of preschool children from families in poverty exhibit behavior problems (Qi & Kaiser, 2003). These negative outcomes are due, in part, to a lack of availability and accessibility to mental health services (Spencer, Kohn, & Woods, 2002). Research also has shown that families with low socioeconomic status (SES) often drop out of PCT treatment due to contextual factors, such as loss of phone services, child illnesses, and financial and family crises, as well as frequent relocation (Nicholson, Brenner, & Fox, 1999).

In response to these challenges, there has been a gradual increased emphasis on providing treatment for young children in poverty. Reid, Webster-Stratton, and Baydar (2004) reported significant improvement in child behavior problems in a sample of 882 children from Head Start programs. Fernandez, Butler, and Eyberg (2011) conducted a pilot study of PCIT with African American children from low-income families and found successful outcomes for children who completed treatment. Concurrently, there has been

a recent trend to offer school-based services in an attempt to decrease the contextual barriers for at-risk children. For example, Webster-Stratton, Reid, and Stoolmiller (2008) provided group PCT services to parents of children from low-income families who were enrolled in Head Start, kindergarten, and first-grade programs; improved child behavior was reported. Brotman et al. (2011) also examined a school-based group PCT program for children in prekindergarten from low-income families and reported a significant decrease in behavior problems while Breitenstein et al. (2007) reported positive outcomes for a group PCT program that was adapted for at-risk African American Head Start students. These efforts reflect the growing realization that at-risk, young children require services tailored to their specific needs, which requires innovative intervention methods.

Despite their success, each of these programs offered treatment in community organizations or schools, which may not be the ideal settings for low-income families considering the contextual factors (e.g., transportation, maintaining clinic appointments) that may prevent families from regularly attending treatment and may contribute to a high attrition rate. As an alternative treatment setting, Wood, Barton, and Schroeder (1988) pointed out that in-home therapy has several major advantages including the ability to better tailor services to the unique needs of each family, an opportunity to obtain rich information on family dynamics and behaviors as they naturally occur, and the ability to provide services to individuals who would otherwise be unable to attend sessions at a clinic or school. Fox and Holtz (2009) also noted that in-home therapy was particularly efficacious for children with behavioral concerns as the behaviors could be addressed and corrected as they naturally occurred in session. In fact, in-home therapy was just as

effective as residential care for behaviorally troubled children and is a recommended modality due to reductions in restrictiveness and cost (Barth et al., 2007).

The *Early Pathways* program uniquely offers in-home parent-child therapy for young children, focusing on parent-directed training and child behavior activities to decrease child behavior problems. Multiple studies have reported the effectiveness of the *Early Pathways* model for young children with behavior problems, notably including at-risk children living in poverty (Fox & Holtz, 2009; Fox et al., 2013; Nicholson, Anderson, Fox, & Brenner, 2002), children with developmental delays (Holtz, Carrasco, Mattek, & Fox, 2009) and children from different ethnic backgrounds (Gresl, Fox, & Fleischmann, 2014). One study (Carrasco & Fox, 2012) also found that increasing the intensity of *Early Pathways* services did not differentially affect outcomes over a less intense service delivery model.

Purpose of the Study

The purpose of this study was to culturally adapt, implement, and evaluate a PCT program for low-income Latino families with children under the age of six who were referred for severe behavior and emotional problems. The *Early Pathways* program served as the original PCT format because it offered unique, in-home treatment for low-income families. This factor made *Early Pathways* an ideal program format for Latino families considering the aforementioned poverty statistics and related barriers to treatment. In addition, while previous *Early Pathways* research has reported positive outcomes, the present study attempted to determine whether *Early Pathways* was the primary cause of change in child behavior problems by using a waitlist-control group within a randomized controlled design.

Research Questions

This study attempted to answer the following research questions:

1. Did Latino children referred for mental health services decrease the frequency and severity of their challenging behaviors based on the Early Childhood Behavior Screen-Challenging Behavior Scale (ECBS-CBS; Holtz & Fox, 2012) and improve their pro-social behaviors based on the ECBS-Positive Behavior Scale (ECBS-PBS; Holtz & Fox, 2012) following their participation in the culturally-adapted *Early Pathways* program compared to a delayed control group? Did the delayed control group subsequently improve after participation in the program and were these changes maintained at four-six week follow-up in both groups?

2. Did Latino children improve their relationship with their primary caregiver based on direct observation of parent-child interactions using the Parent-Child Play Assessment (PCPA) following their participation in the culturally-adapted *Early Pathways* program compared to a delayed treatment control group? Did the delayed control group subsequently improve after participation in the program and were these changes maintained at four-six week follow-up in both groups?

3. Did Latino children improve their interactions with their primary caregiver based on the Parent-Child Relationship Scale (PCRS) and improve their general functioning based on the Global Assessment of Functioning (GAF) following their participation in the culturally-adapted *Early Pathways* program compared to a delayed treatment control group? Did the delayed control group subsequently improve after participation in the program and were these changes maintained at four-six week follow-up in both groups?

4. Did Latino parents and other primary caregivers (e.g., foster parents, grandparents) improve their parenting skills based on the Discipline and Nurturing scales of the Parent Behavior Checklist (PBC; Fox, 1994) following their participation in the culturally-adapted *Early Pathways* program compared to a delayed treatment control group? Did the delayed control group subsequently improve after participation in the program and were these changes maintained at four-six week follow-up in both groups?

5. Did Latino parents and other primary caregivers (e.g., foster parents, grandparents) exhibit more developmentally appropriate expectations of their children based on the Expectations scale of the Parent Behavior Checklist (PBC; Fox, 1994) following their participation in the culturally-adapted *Early Pathways* program compared to a delayed treatment control group? Did the delayed control group subsequently improve after participation in the program and were these changes maintained at four-six week follow-up in both groups?

6. Did Latino children change their psychiatric status based on the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2000) psychiatric criteria following their participation in the culturally-adapted *Early Pathways* program compared to a delayed treatment control group? Did Latino children in the delayed control group subsequently change their psychiatric status after participation in the program and were these changes maintained at four-six week follow-up in both groups?

7. Were Latino families satisfied with the services based on the Family Satisfaction Survey (FSS) following their participation in the culturally-adapted *Early Pathways* program?

8. What specific factors did participants report as beneficial and not beneficial following participation in the culturally-adapted *Early Pathways* program?

CHAPTER II: REVIEW OF THE LITERATURE

The research questions for this study were developed based on a review of the literature that examined the following four areas: (a) what are the most significant cultural factors (e.g., values, acculturation) of Latino family life? (b) how do these factors impact parenting and treatment with Latino families? (c) would *Early Pathways* be an appropriate treatment intervention for Latino families? and (d) how can *Early Pathways* most effectively be adapted for Latino families based on cultural factors? Ethical considerations, such as variations in adherence to Latino cultural values, also were considered throughout each section of the review.

Latino Cultural Values

Several constructs have been identified that describe Latino cultural values, including *familismo*, *machismo*, *marianismo*, *respeto*, *personalismo,* and *simpatía* (Arcia, Reyes-Blanes, & Vazquez-Montilla, 2000; Barker et al., 2010; Calzada & Eyberg, 2002; De la Cancela, 1986; Ortiz-Torres, Serrano-García, & Torres-Burgos, 2000; Salyers Bull, 1998; Stycos, 1952). Notably, not all constructs will exist within each family structure, and when present, the inherent values of each construct may produce distinct variations in family life. However, a general understanding of these cultural constructs as well as their influence on family life will serve as a foundation for a culturally-adapted *Early Pathways* program.

Rather than the typical North American emphasis on individualism, the importance of collectivism and family has been found evident within Latino culture (Barker et al., 2010). Therefore, *familismo*, generally defined as the Latino emphasis on

family unity and collectivism, will represent the overarching theoretical construct to which other cultural constructs relate (Ayón, Marsiglia, & Bermudez-Parsai, 2010; Harwood, 1992; Marín, 1989). It often is described as the primary cultural construct for Mexican American, Puerto Rican American, Cuban American, Central American, and South American ethnicities (Alvirez & Bean, 1976; Cohen, 1979; Glazer & Moynihan, 1963; Szapocznik & Kurtines, 1980). For instance, while *marianismo*, originally defined by Stevens (1973), typically refers to the role of Latina women from the perspective of gender role expectations, it is inherently tied to a woman's relation to the family. In addition, *personalismo*, the Latino emphasis on warm and trusting interpersonal relationships, is another commonly identified construct that highlights the collectivistic rather than individualistic nature of Latino culture (Marín & Marín, 1991; Okagaki & Frensch, 1998; Oyserman, Coon, & Kemmelmeier, 2002; Triandis, Marín, Lisansky, & Betancourt, 1984). Therefore, while each construct maintains its own distinct meaning, each is derived or related to the overall importance of the collective culture.

Familismo

The previous description of *familismo* oversimplifies its true meaning. *Familismo* includes multiple values related to family and collectivism, such as loyalty and support (financial and emotional), as well as the expectation that each family member respect, participate in, and place family responsibilities above individual desires (Gonzalez-Ramos, Zayas, & Cohen, 1998; Marín & Marín, 1991; Santisteban, Muir-Malcolm, Mitrani, & Szapocznik, 2002; Sommers, Fagan, & Baskin, 1993). This goes beyond the immediate family, as extended and non-blood relatives are often considered family members and treated with similar respect and care (Falicov, 1998; Marín & Marín, 1991).

In terms of practical application of this construct, children are expected to assist with household duties and care for younger siblings while extended family members are called upon to assist with financial and emotional support (Contreras, Mangelsdorf, Rhodes, Diener, & Brunson, 1999; Fuligni, Tseng, & Lam, 1999; Santiago-Rivera, 2003; Sue & Sue, 2003). Even after starting their own families, children tend to remain within the vicinity of extended family because of the strong interdependence and cohesion within Latino families (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002).

Of course, the values associated with the *familismo* construct can and do exist in non-Latino families. Therefore, it is important to determine whether this construct has a significantly greater impact on Latino families to warrant consideration in a culturally-adapted PCT program. Researchers have examined *familismo* and found that it influences Latino more than non-Latino individuals (Calderón-Tena et al., 2011; Harwood, Schoelmerich, Schulze, & Gonzalez, 1999). For example, one study reported that Puerto Rican American mothers of infants expressed significantly greater preference for sociocentrism and collectivism than Caucasian American mothers, who emphasized individualism (Harwood et al., 1999). Further, those results indicated that Puerto Rican American mothers preferred collectivistic values such as respect/obedience and responsibility to family while Caucasian American mothers preferred individualistic values such as creativity, assertiveness, and independence (Gonzalez-Ramos et al., 1998; Zayas & Solari, 1994).

Familismo not only influences preferred values, it also results in distinct perceptions and behaviors. For instance, one study found that Puerto Rican American mothers defined independence as the ability to proactively assist with household

responsibilities while Caucasian American mothers described independence as autonomy and social freedom away from the family (Gonzalez-Ramos et al., 1998). Thus, even when Latina and Caucasian American mothers agreed that independence was an important value, Latina mothers imbued this value with a family-oriented perspective. In terms of behavioral impact, Mexican American adolescents have been found to identify with family-centered beliefs and perform family-related behaviors (e.g., child care, household chores) at a higher rate than Asian American and European American adolescents (Hardway & Fuligni, 2006). These findings on differences between Latino and non-Latino beliefs, perceptions, and behaviors provide initial evidence for *familismo* as a significant factor in Latino family life and a potential factor in a culturally-adapted *Early Pathways* program.

Respeto

Like *familismo*, *respeto* also encompasses a diverse array of values, including obedience to one's parents, upholding family honor through appropriate behavior, and the maintenance of traditional sex roles; it is also typically seen as the foundation for a hierarchical understanding of social relationships within Latino culture (Antshel, 2002; Arredondo et al., 1996; Falicov, 1984; Flores, Eyre, & Millstein, 1998; Lefkowitz, Romo, Corona, Au, & Sigman, 2000; MacPhee, Fritz, & Miller-Heyl, 1996; Parke & Buriel, 1998; Pavich, 1986; Zayas & Solari, 1994). Parents and elders often hold expectations of respectful behavior from children and adolescents in both familial and public domains, and there is an intergenerational passage of these values to children through family processes (Flores et al., 1998). Activities associated with respectful behavior include expectations of obedience, respect for elders, and appropriate manners, which in turn

inform parenting practices (Flores et al., 1998). The expectation of respect even extends to peers and strangers, particularly in public environments (Flores et al., 1998). Other literature highlights this emphasis on respect and proper decorum to aid in building relationships with both family and non-family members (Halgunseth, Ispa, & Rudy, 2006; Harwood, Miller, & Irizarry, 1995; Marin & Marin, 1991). Behaviorally, *respeto* often is manifested through the avoidance of eye contact with authority figures and use of respectful terminology toward elders and authority figures (Arrendondo et al., 1996; Santiago-Rivera et al., 2002). Moreover, children are expected not to argue or interrupt adults (Delgado-Gaitan, 1994), and to obey and respect their parents' wishes (Glass & Owen, 2010). Therefore, while *respeto* identifies its own concept, it also directly relates to the construct of *familismo*.

As with *familismo*, it is imperative to determine the distinct degree of influence that *respeto* has on Latino culture prior to including it in the adaptation process of *Early Pathways*. Calzada, Fernandez, and Cortes (2010) found that *respeto* was identified as being one of the most prominent values of Dominican and Mexican American mothers of preschool-aged children, and considered to have significantly greater importance to Latina mothers as compared to Caucasian American mothers. They also reported that Caucasian American participants promoted a greater emphasis on autonomy and achievement rather than values typically representative of *respeto*. Moreover, Latina mothers of preschoolers have been found to place significantly greater emphasis on respect, obedience, and self-cleanliness than Japanese and European American mothers (Quirk et al., 1986). Finally, Villanueva-Dixon, Graber, and Brooks-Gunn (2008) evaluated maternal-adolescent relationships of Mexican Americans, African Americans,

and Caucasian Americans, and found that expectations of respect were significantly greater for Mexican Americans than Caucasian Americans.

Respeto also appears to engender alternative perceptions. For example, individualism is highly valued in Puerto Rican culture; however, individualism relates to one's self-dignity and self-respect, which in turn builds socially acceptable behaviors and respect between individuals (Hsu, 1972). Essentially, individualism in Puerto Rican culture refers to a collectivistic impact while individualism as a typically North American value refers to achievement and self-sufficiency. Hence, it appears that *respeto* represents a unique construct in Latino culture, which influences beliefs, behaviors, and perceptions, requiring its incorporation into a culturally-adapted *Early Pathways*.

Marianismo

As previously mentioned, *marianismo* refers to the role of Latina women from the perspective of gender role expectations, particularly as complementary to the Latino value of *machismo* (Stevens, 1973). Stevens (1973) identified the origins of *marianismo* in Roman Catholicism; the history of the construct spans five centuries of worship since Juan Diego's vision of the Virgin Mary at Guadalupe, and places great value on those characteristics attributed to Mary (Bracero, 1998; Flores et al., 1998; Gloria & Peregoy, 1996; Kemper, 2009). With its inherent attachment to the Virgin Mary, the construct of *marianismo* has a direct influence on the home environment and Mexican family life, as Latina mothers are expected to embrace those qualities reflected by the Virgin Mary (Kemper, 2009). For example, recent definitions of *marianismo* refer to expectations that Latina women should sacrifice their own needs for those of the family (Castillo & Cano, 2007), as well as be the primary caregivers and nurturers within the home (Rocha-

Sanchez & Diaz-Loving, 2005). Further, Latina women, and Mexican American women in particular, are expected to maintain qualities of the Virgin Mary, such as virtue, chastity, humility, and spirituality (Baca Zinn, 1982; Clifford, 2005; Falicov, 1984; Padilla & Baird, 1991; Padilla & O'Grady, 1987; Pavich, 1986; Tufte, 2000).

The construct of *marianismo* at times is viewed in a negative light, characterized by traits such as naiveté, passivity, and submissiveness to Latino male authority (Julian, McKenry, & McKelvey, 1994; Pavich, 1986). It also has been argued that a mother's expected self-sacrifice for her family is a structural force that restricts Latina women to the home environment (Baca Zinn, 1982). Nevertheless, despite this sometimes negative image of a dependent woman who sacrifices her own well-being for that of her family, *marianismo* also carries a powerful positive vision of women, which focuses on a strong mother who cares for and manages difficulties within the family (Castillo & Cano, 2007). Considering the five centuries of worship to the Virgin Mary, the foundation of *marianismo* centers on devotion and love, and signifies a deep respect for women (Kemper, 2009). By placing the mother of the family on a pedestal, however, Latina women also are burdened with often unattainable expectations (Kemper, 2009). Therefore, the construct of *marianismo* maintains a delicate balance between positive and negative interpretations.

To determine the validity of *marianismo* as an extant construct and to better delineate its relevant components, a recently developed *Marianismo* Beliefs Scale (MBS; Castillo, Perez, Castillo, & Ghosheh, 2010) was evaluated with a sample of 377 Latina (primarily Mexican American) participants. Items were developed using in-depth research of cultural values as well as a review by expert clinical practitioners and

professors of Latino counseling. Exploratory and confirmatory factor analyses supported a reasonably reliable and valid measure for the existence of *marianismo* as a multi-dimensional construct consisting of five subscales: (a) family unity, (b) virtuous behavior, (c) support of husband, (d) self-sacrifice for family, and (e) spiritual responsibility. Of primary importance is that each subscale influenced family values individually more than the general *marianismo* construct, with the woman's role of enhancing family unity having the greatest impact on behavioral expectations. That is, different families adhered to different underlying values of *marianismo*. Therefore, whichever value was emphasized had more influence than the overall construct, and family unity (e.g., *familismo*) was the strongest factor because it influenced the most families. This highlights the need to correctly identify each family's adherence to the underlying values of *marianismo*.

Additional recent literature on the *marianismo* construct supports its continued presence in Latino culture. Díaz-Loving et al. (2011) found that self-sacrifice of the mother and virginity until marriage were values still upheld by Latino high school students. Further, research supports the existence of an intergenerational passage of traditional family values where the Latina mother manages the family environment while the father maintains the financial responsibility of the household (Epstein, Dusenbury, Botvin, & Diaz, 1994). Considering the extant literature, *marianismo* appears to be a fairly stable construct within Latino families, with family unity serving as the primary factor considered within this construct. However, individual values of the *marianismo* construct must be evaluated with particular consideration for the positive and negative connotations held within each individual family.

Machismo

Similar to *marianismo*, the *machismo* construct refers to perceptions of the Latino male gender role, and it likewise tends to include multiple divisive definitions. For example, *machismo* is alternately defined as the force of all Latino masculine behavior (Andrade, 1992), the composite of all expected behaviors of Latino men (Panitz, McConchie, Sauber, & Fonseca, 1983), and the combination of both positive and negative characteristics of Latino men (Arciniega, Anderson, Tovar-Blank, & Tracey, 2008). More specifically, *machismo* often is considered to reflect negative qualities, such as rigid sex roles, chauvinistic views, hyperaggressivity, and hypermasculinity (Anders, 1993; Deyoung & Zigler, 1994; Ingoldsby, 1991; Mosher & Tompkins, 1988; Torres, Solberg, & Carlstrom, 2002). Men who personify macho characteristics are described as rude, violent, prone to alcoholism, and incompetent, as well as intimidating and controlling of women (Alaniz, 1996; Anders, 1993; Beaver, Gold, & Prisco, 1992; Imhof, 1979; Mayo & Resnick, 1996; Mosher & Sirkin, 1984; Neff, Prihoda, & Hoppe, 1991). Moreover, men who uphold these characteristics of *machismo* often report greater levels of aggression and antisocial behavior, therefore supporting this definition of *machismo* (Arciniega et al., 2008).

However, many authors argue against this singular focus on hypermasculinity and aggression (Casas, Wagenheim, Banchero, & Mendoza-Romero, 1994; Felix-Ortiz, Abreu, Briano, & Bowen, 2001; Gilmore, 1990; Mirandé, 1977; Mirandé, 1997; Penalosa, 1968; Ramos, 1979; Rodriguez, 1996; Torres et al., 2002). For example, an alternative aspect of *machismo, caballerismo*, has been posited, which refers to chivalry, appropriate manners, as well as a positive connection and affiliation with the family

(Arciniega et al., 2008; Eisenberg, 1991; Mahalik et al., 2003; Torres et al., 2002). This two-factor structure was examined in a study of 477 Latino men; results indicated that stereotypical *machismo* reflected hypermasculinity and chauvinism while *caballerismo* reflected respect for women and family (Arciniega et al., 2008). Further, *caballerismo* was associated with affiliation, nurturing, positive work ethic, and problem-solving rather than aggressive coping behaviors (Arciniega et al. 2008; Casas et al., 1994; Mirandé, 1977; Mirandé, 1997; Ramos, 1979). Therefore, the *machismo* construct represents several underlying values, perhaps with a two-factor structure that cannot be singularly defined. This research signifies that Latino men may adhere to different values associated with the *machismo* construct, which again emphasizes the need for appropriate identification of the underlying values within each individual family.

Personalismo and Simpatía

Two other cultural constructs, *personalismo* and *simpatía*, relate to Latino family life and parent-child relationships. Unfortunately, there is a less robust amount of supporting literature examining these two constructs. The definitions of *personalismo* and *simpatía* tend to intersect, referring to the desire for warm, trusting relationships and a socially amicable persona, respectively (Antshel, 2002; Comas-Díaz, 1994; Griffith, Joe, Chatham, & Simpson, 1998; Marín, 1989; Marín & Marín, 1991; Triandis et al., 1984). Additionally, *personalismo* is described as a close affiliation and interdependent cooperation among family, friends, and relatives, indicating a strong relationship to *familismo* (Bernal & Flores-Ortiz, 1984; Flores et al., 1998; Gloria & Peregoy, 1996). *Simpatía*, however, generally refers to socially polite demeanor, and in particular, the semblance of a comfortable environment rather than conflict (Barber, 1994; Marín,

1989). Often, this requires placing a greater emphasis on positive over negative factors in any given situation (Kagan, Knight, & Martinez-Romero, 1982, Triandis et al., 1984).

Together, these two constructs highlight greater expectations of close, interpersonal relationships and respectful behavior between individuals. This tends to include expectations for mutual self-disclosure of personal experiences rather than less intimate information, such as socioeconomic or occupational information (Donlan, 2011; Triandis et al., 1984). This greater emphasis on internal character and personal experiences can lead to greater comfort with individuals from similar ethnicities who espouse similar values (Marín, 1989). Essentially, these two constructs reflect a general focus on harmonious relationships as well as a preference for self-disclosure. There is a dearth of research comparing the importance of these constructs in Latino and non-Latino cultures. However, considering their relationship with *familismo*, it is likely that *personalismo* and *simpatía* reflect fairly distinct cultural concepts.

Acculturation and Adherence to Cultural Constructs

While the previously reviewed literature supports the existence of these constructs in Latino culture, it must be reemphasized that these constructs may or may not be present in a particular Latino family, and that when present, the constructs also may take alternate forms. Multiple authors underscore the need to consider within-group heterogeneity when evaluating cultural values because cultural differences within Latino subgroups (e.g., Mexican, Puerto Rican) can increase the challenge of identifying shared values (Arbona, 1990; Marín & Marín, 1991; Parham, 1989; Umaña-Taylor & Fine, 2004; Umaña-Taylor & Yazedjian, 2006). Therefore, it is necessary to briefly examine other factors that influence Latino family life, such as acculturation, socioeconomic status

(SES), and education, in order to understand how variations in adherence to cultural constructs may occur.

Acculturation.

In general, acculturation is defined as the changes that occur within one culture as the result of the interaction of two or more cultures (Evenson, Sarmiento, & Ayala, 2004). However, multiple variables are involved in the acculturation process. For instance, acculturation reflects a continuous interaction between two cultures (Crespo, Smit, Carter-Pokras, & Andersen, 2001; Solis, Marks, Garcia, & Shelton, 1990), or in some cases, even a lack of exposure to the previous cultural context and associated cultural beliefs (Landrine & Klonoff, 2004). These components are interrelated, and often a gradual increase in exposure to a new culture occurs alongside a simultaneous decrease in contact with the native culture. Moreover, acculturation is described as an involuntary process that leads to different degrees of cultural adaptation, or within-group heterogeneity (Lara, Gamboa, Kahramanian, Morales, & Hayes Bautista, 2005; Spector, 2000). This acculturation process and subsequent within-group heterogeneity is the result of multiple factors, such as socioeconomic status (SES), education, gender, immigration status, and household composition (Arcia et al., 2000; Casas & Vasquez, 1989; Chilman, 1993; Marín & Marín, 1991; Portes, 1984; Umaña-Taylor & Yazedjian, 2006). As a result, acculturation and its associated variables affect the degree to which any particular individual or family emphasize cultural constructs and their underlying values (Arcia et al., 2000; Umaña-Taylor & Yazedjian, 2006).

Adherence to cultural constructs.

Several studies have examined the relationship between adherence to cultural constructs and acculturation. Their findings indicate varying levels of adherence in Latino families due to acculturation (Santiago-Rivera, 2003) as well as an association between acculturation and a decrease in the perception of obligation and interdependence between family members (Garza & Gallegos, 1985; Grebler, Moore, & Guzman, 1970; Landy, 1959; Mindel, 1980; Sabogal, Marín, Otero-Sabogal, Marín, & Perez-Stable, 1987). In addition, acculturation in successive generations further decreases adherence to such cultural values (Negy & Woods, 1992). Other studies indicate similar results; adherence to traditional gender roles and *familismo* decreases as acculturation and generation level increase (Knight & Kagan, 1977; Knight, Kagan, Nelson, & Gumbiner, 1978; O'Guinn, Imperia, & MacAdams, 1987; Rodriguez & Kosloski, 1998; Soto, 1983; Valentine & Mosley, 1999).

Just as acculturation affects the degree of *familismo* espoused by Latino families, exposure to typical Western traditions of individuality and autonomy tends to conflict with traditional views of *marianismo* (Espín, 1987). Latina women and children may adopt these Western views more readily than Latino men (Ginoria, 1979), and if Latino men adhere more strongly to the typical perception of *marianismo*, it can produce dichotomous cultural beliefs within the family (Espín, 1987). These dichotomous views within Latino households, particularly Mexican American families, may engender barriers to treatment, which makes it imperative for clinicians to recognize where individual family members stand regarding traditional cultural constructs, such as *familismo* and *marianismo*.

Despite the existence of within-group heterogeneity in adherence to cultural values, Sabogal et al. (1987) found that even when acculturation lessened the impact of *familismo*, Latino families still identified greater levels of social support and family interdependence than Caucasian American populations. The values underlying *familismo*, such as obligation and interdependence of family, were described as critical components of the Latino family structure regardless of acculturation, with slight variations in degree of adherence (Sabogal et al., 1987). Further, several studies found that acculturated Latino families, and specifically Mexican American families, were more similar to non-acculturated Latino families than they were to Caucasian American families (Arcia et al., 2000; Gutierrez & Sameroff, 1990; Gutierrez, Sameroff, & Karrer, 1988). Recent surveys conducted as part of the Children of Immigrants Longitudinal Study (CILS) found *familismo* to be a central value of second-generation Latino immigrants despite acculturation factors (Portes & Rumbaut, 2005). Even with this cursory overview of associated variables, it is evident that individual families experience different degrees of acculturation, and accordingly adhere to the aforementioned cultural constructs to varying extents. However, while acculturation and other factors (e.g., SES, education) appear to influence adherence to cultural values, these cultural constructs likely are influential enough to be considered during cultural adaptation of *Early Pathways*.

The literature suggests that these cultural constructs play a significant role in Latino family life, often creating a unique living environment based on variations in the family's interpretation of each cultural construct. Importantly, the heterogeneous nature of Latino populations and the additional factors affecting adherence to cultural constructs,

such as acculturation, must be considered in order to determine the specific values espoused as well as the degree of influence on family life (Santiago-Rivera, 2003). Nevertheless, considering the distinctness and influential qualities of these cultural constructs, they should be examined and integrated when developing and implementing the culturally-adapted *Early Pathways* program.

Cultural Impact on Parenting and Relevance to Treatment

With a foundational understanding of Latino cultural constructs and other pertinent factors of Latino culture, it is now possible to review the impact these factors have on Latino parenting practices, and to examine their relevance to treatment. In general, cultural constructs have been found relevant to parent-child interactions and family structure (Ayón et al., 2010), as well as integral to understanding family roles, parenting preferences, and commonly-used parenting practices (Arciniega et al., 2008; Castillo & Cano, 2007). In addition, research on cultural socialization, which refers to parenting practices that promote and teach racial and ethnic heritage, supports the idea that cultural values impact parenting practices (Flores et al., 1998; Hughes, Bachman, Ruble, & Fuligni, 2006; Hughes & Chen, 1999; Knight, Cota, & Bernal, 1993; Umaña-Taylor & Fine, 2004). A meta-analysis by Hughes et al. (2006) indicated that parents made purposeful attempts to instill a sense of culture in children. Moreover, the extant literature shows that about 85% of Dominican American, Mexican American, and Puerto Rican American parents engage in cultural socialization and the intergenerational transmission of cultural beliefs through parenting practices (Hughes, 2003; Phinney & Chavira, 1995). Examples of cultural socialization include exposing children to cultural music and stories, discussing culturally-historic individuals, celebrating culturally-

specific holidays, and speaking in the family's native language (Hughes et al., 2006).

Based on these studies, it is likely that parents attempt to instill cultural beliefs in children

through parenting practices, making these constructs integral to the culturally-adapted

Early Pathways program.

Before examining how each specific cultural construct influences Latino

practices, this section will provide a brief review of how parenting is most commonly

described in the literature and its relevance with Latino families. Baumrind (1966),

Maccoby and Martin (1983), and Lamborn, Mounts, Steinberg, and Dornbusch (1991)

describe four general parenting styles: (a) authoritarian, (b) authoritative, (c) permissive,

and (d) neglectful. These styles consist of three dimensions: (a) warmth, (b)

demandingness, and (c) autonomy granting. Warmth typically refers to nurturing,

interest in child activities, and being supportive, while demandingness reflects parental

control and patterns of discipline (Broderick & Blewitt, 2003). The third dimension,

autonomy granting, refers to parental allowance of child autonomy and expression within

the family context (Steinberg, Lamborn, Darling, Mounts, & Dornbush, 1994). Each

style represents different combinations of the three dimensions (e.g., authoritarian = low

warmth, high demandingness, low autonomy granting).

While several authors indicate that Latino parents use an authoritarian parenting

style (Chilman, 1993; Darling & Steinberg, 1993; Dornbusch, Ritter, Leiderman, Roberts,

& Fraleigh, 1987; Hammer & Turner, 1990; Harrison, Wilson, Pine, Chan, & Buriel,

1990; Kagan & Ender, 1975; Kearns, 1970; Schumm et al., 1988), other authors suggest

that Latino parents implement parenting practices not typically associated with an

authoritarian style, such as nurturing, egalitarian practices, and permissive parenting

(Delgado-Gaitan, 1994; Durrett, O'Bryant, & Pennebaker, 1975; Escovar & Lazarus, 1982; Levine & Bartz, 1979; Martinez, 1988; Mirandé, 1977; Vega, 1990). A recent study by Domenech-Rodriguez, Donovick and Crowley (2009) evaluated Mexican parenting behaviors of 50 first-generation, low-income Latino parents with children between the ages of four and nine, and found that 61% of parents did not fit traditional classifications of authoritarian, authoritative, permissive, and neglectful parenting styles. Rather, these parents were classified into a "protective" category. This new category reflected similarities to the authoritarian parenting style (e.g., low warmth, high demandingness, low autonomy granting), but with a higher level of warmth and nurturing. Therefore, the impact of cultural constructs on Latino parenting will examine parenting practices across the underlying dimensions (e.g., warmth, demandingness, autonomy granting) rather than the styles (e.g., authoritarian, authoritative, permissive, neglectful) since the dimensions appear more apt for Latino families.

Familismo

Familismo, generally, has been found to have beneficial effects on parenting practices, particularly in promoting warmth and nurturing in family relationships. For instance, greater levels of maternal adherence to *familismo* have been found to directly increase maternal nurturing behaviors, involvement in parent-child activities, and emotional support for adolescent children (Calderón-Tena et al., 2011; Halgunseth et al., 2006; Harwood, Leyendecker, Carlson, Asencio, & Miller, 2002). Further, when Latina mothers incorporate family-oriented activities into parenting practices, adolescents report higher levels of pro-social behaviors, such as completing household chores and caring for siblings (Calderón-Tena et al., 2011; Harwood et al., 2002). In addition, Latino parents,

generally, are more likely to respond to infants and toddlers in distress (Zeskind, 1983) as well as to spend more time comforting children during sleep routines (Korn & Gannon, 1983). Beyond maternal warmth and nurturing, *familismo* also is associated with greater paternal involvement (Glass & Owen, 2010).

In addition, level of adherence to *familismo* is negatively correlated with the demandingness dimension, which relates to parental discipline. For example, one study found that Latina mothers who espoused high levels of *familismo* were less likely to use verbal and corporal punishment with their children than Latina mothers who indicated low levels of *familismo* (Ferrari, 2002). Similarly, Coohey (2001) reported that *familismo* showed an inverse relationship with child maltreatment; that is, Latino parents who were classified as abusive or neglectful by Child Protective Services (CPS) reported lower levels of *familismo* than Latino parents who had no involvement with CPS and had not assaulted their children (e.g., hit with a closed hand or object) in the past year. Other studies have suggested that families with reported child maltreatment lack those values underlying *familismo*, such as social support, contact with extended family, or contact with friends (Coohey, 2000; Coohey & Braun, 1997; Corse, Schmid, & Trickett, 1990; Crittenden; 1985; Giovannoni & Billingsley, 1970; Kotelchuck, 1982; Newberger, Reed, Daniel, Hyde, & Kotelchuck, 1977; Salzinger, Kaplan, & Artemyeff, 1983; Starr, 1982; Wolock & Horowitz, 1979).

In addition to the underlying dimensions, *familismo* even affects the way Latino parents define certain traits or values. For example, while Latino parents often seek to instill and develop autonomy in their children, their definition of autonomy typically refers to children completing family-related activities on their own (Gonzalez-Ramos et

al., 1998). This contrasts with the typical North American definition of autonomy, which reflects the establishment of relationships apart from the family. Latino families that espouse *familismo*, on the other hand, generally de-emphasize peer-related relationships and focus instead on family-related parenting activities and family obligation, such as adolescents caring for siblings (Fuligni et al., 1999).

Relevance to treatment.

Besides impacting parenting practices, *familismo* plays an influential role in mental health outcomes. For example, *familismo* is associated with positive mental health outcomes and providing protection for families suffering from physical and emotional stressors (Gil, Wagner, & Vega, 2000; Grebler et al., 1970; Unger et al., 2002). Moreover, *familismo* can have a protective influence on substance use among Latina adolescents (Marsiglia & Waller, 2002; Parsai, Voisine, Marsiglia, Kulis, & Nieri, 2009) as well as suicide attempts among Latina teens (Peña et al., 2011). That is, Latina adolescents who indicate higher levels of *familismo* are often described as having highly cohesive families with low intra-family conflict. These families in turn show decreased percentages of adolescent substance use and Latina teen suicide attempts. The *familismo* construct also is associated with greater social support, less anxiety, and lower stress levels for pregnant Latina mothers when compared to pregnant European American mothers (Campos et al., 2008; Mannino & Shore, 1976; Miranda, 1980; Valle & Martinez, 1980). This greater perception of social support is associated with increased birth weight among newborns. Finally, some researchers have hypothesized that *familismo* allows Latino immigrants to successfully adapt to North American life and manage the challenges associated with migration (Cohen, 1979; Rumbaut & Rumbaut,

1976; Szalay, Ruiz, Strhol, Lopez, & Turbiville, 1978). While studies on the impact of *familismo* on mental health are in their beginning stages, these initial findings indicate positive effects and support further examination of *familismo* as a potential factor in the culturally-adapted *Early Pathways* program.

Respeto, Personalismo, and Simpatía

Less research exists concerning the impact of *respeto*, *personalismo*, and *simpatía* on parenting dimensions; though, aspects of demandingness are related to the construct of *respeto*. For instance, Latino parents show a greater insistence on appropriate respect for authority and obedience than Caucasian American parents (Florsheim, Tolan, & Gorman-Smith, 1996; Julian et al., 1994). Further, low- and medium-income Puerto Rican American families report a strong emphasis on *respeto* and appropriate obedience (Harwood et al., 1995) as well as the instruction of appropriate decorum and social graces (Gonzalez-Ramos et al., 1998). Two qualitative studies identified respect as an underlying theme of parent-child interactions in Latino families (Arcia & Johnson, 1998; Arcia et al., 2000). These studies indicated that the top five values that mothers instilled in their young children (i.e., under the age of eight) were knowing right from wrong, being a good student, obedience, respect, and responsibility. Arcia and Johnson (1998) further reported that when parental discipline was required, verbal disciplinary instructions tended to be the initial recourse; however, if verbal instructions were ignored, Latino parents who placed greater emphasis on respect and obedience were also more likely to support the use of verbal and corporal punishment (e.g., yelling and spanking). Thus, a relationship between *respeto* and parental discipline in Latino families appears to exist.

There is a dearth of research about the impact of *personalismo* and *simpatía* on parenting. However, Mexican American families report lower levels of intra-family conflict than Caucasian American families (Vega, 1990). This may reflect the previously mentioned desire for harmonious relationships, but otherwise, little information is available for the impact of these constructs on parenting practices.

Relevance to treatment.

Despite this lack of research, *personalismo* and *simpatía* have been found relevant to mental health outcomes based on several studies, in particular through strong relationships with individual providers. As previously mentioned, Latino families identify with their specific health care provider rather than group practice, continue to see their provider despite relocation, and often stop pursuing health care if their provider is no longer available (Grossman, 1994; Trevino, Moyer, Valdez, & Stroup-Benham, 1991). Further, Latina mothers are more likely to participate in research studies when contacted in person rather than by phone (Foucault and Schneider, 2009). Latino families also prefer an emotionally relatable health care provider rather than an impersonal style typically associated with the medical model approach (Christensen, 1992). For example, greater physical distance between individuals during a session and lack of self-disclosure often is viewed as cold and dispassionate (Christensen, 1992). Rather, socially appropriate physical contact and a brief discussion of non-health related activities are considered highly relevant to treatment when considering the construct of *personalismo* (Flores et al., 1998). Similarly, Latino individuals often inquire about personal experiences, not in a confrontational or challenging manner, but simply to better

understand the clinician prior to engaging in discussion of personal issues (Gloria &

Peregoy, 1996).

Despite the scarcity of literature, these studies highlight the importance of

building a strong relationship with Latino families using the following methods: (a)

maintenance of the relationship with a single rather than multiple providers, (b) effective

communication regarding any changes in provider information, and (c) discussion of

topics that promote self-disclosure during treatment. These findings indicate the

significant role of *personalismo* and direct personal contact on the treatment process, and

its importance in a cultural adaptation of *Early Pathways*.

Marianismo and Machismo

Since there is only a small amount of literature on the impact of *machismo* and

marianismo on parenting practices and both relate to gender roles, their impact will be

considered together. Ferrari (2002) reported that *machismo* scores were negatively

correlated with nurturing behavior from Latino fathers. Similarly, Coltrane, Parke, and

Adams (2004) found that Mexican American fathers who adhered to less stereotypical

views of gender roles were more likely to be involved in family life and childrearing.

Both of these studies point to a potential decrease in father involvement when *machismo*

is strongly present as well as an increase in father involvement when *machismo* is less

prevalent. Even so, less direct involvement does not necessarily mean less overall

involvement with the family. For example, fathers who report higher *machismo* ratings

may exhibit less involvement with their children because they primarily serve the family

through financial responsibilities (Glass & Owen, 2010). In addition, Coltrane et al.

(2004) reported that even when fathers identified with stereotypical views of *machismo*,

they were still likely to participate in stereotypical activities of the mother (e.g., household chores, child care) when the mother was employed for longer hours or earned more money than the father. These studies reflect variations in the impact of *machismo* on parenting; fathers may be involved with the raising of their children regardless of value adherence as long as other family variables require their participation. This likely reflects the prominence of *familismo* in Latino culture and parenting, as the importance of family may override stereotypical gender role beliefs.

Meanwhile, despite being identified as an aspect of *machismo*, one study found that *caballerismo* has shown no correlation with parental involvement and nurturing (Glass and Owen, 2010). One explanation could be that *caballerismo* only reflects an aspect of *machismo* that occurs when specific family-oriented variables are present. For example, if maternal education is high or financial responsibilities require a mother to seek employment, the values indicative of *caballerismo* may arise. While this is a unitary study, it appears that the impact of *machismo* on nurturing behaviors varies depending on the specific factors of each individual family.

In addition to nurturing, these constructs appear to impact demandingness and autonomy granting. Several studies have reported a positive correlation between *machismo* and punitive parenting techniques, such as verbal and corporal punishment (Bird & Canino, 1982; Deyoung & Zigler, 1994; Ferrari, 2002; Figueroa-Torres & Pearson, 1979). That is, higher *machismo* scores are associated with greater use of verbal and corporal punishment by Latino fathers. Further, traditional views of *marianismo* and *machismo* tend to produce differential gender treatment regarding demandingness and autonomy granting. For instance, one study found that parents who indicated strong

adherence to traditional cultural values showed greater usage of differential practices, such as emphasizing a woman's role within the home and greater social freedom for boys outside the home (Raffaelli & Ontai, 2004). Similarly, Domenech-Rodríguez et al. (2009) reported that Latino parents exhibited greater parental control of girls than boys.

Relevance to treatment.

Several studies argue that it is important to engage fathers in treatment because positive paternal involvement (e.g., literacy, caregiving, and warmth) has a direct influence on child health and behavior outcomes (Amato & Rivera, 1999; Cabrera, Tamis-LeMonda, Bradley, Hofferth, & Lamb, 2000; Gottman, Katz, & Hooven, 1997). Since the impact of *machismo* appears to vary depending on each individual family, if stereotypical values associated with *machismo* are identified during treatment, steps should be taken to circumvent potential barriers to treatment while non-stereotypical aspects of *machismo* should be fostered when present. It also will behoove the culturally-adapted *Early Pathways* program to acknowledge the possibility of different gender-based expectations for children.

Additional Factors

It also is necessary to acknowledge that contextual factors, other than these cultural constructs, can affect Latino parenting practices. For example, Fox, Platz, & Bentley (1995) identified several factors, such as SES, lower education levels, greater number of children, and younger age to all have an impact on parenting practices. Also, higher levels of maternal educational attainment have been found to correlate with greater paternal involvement in the family environment (Coltrane et al., 2004). *Machismo*,

therefore, is unlikely to be the sole factor impacting a father's involvement in family life. Further, studies suggest that maternal age, marriage status, and SES may be more significant to parenting practices than culture, as parenting practices often are similar across cultural groups (e.g., African American, Latino, Caucasian American) when these contextual factors are controlled (Julian et al., 1994; MacPhee et al., 1996; McDade, 1995; Solís-Cámara & Fox, 1995a). That is, families from different cultures use similar parenting practices when SES factors are controlled. For example, while some studies indicate that Latino parents demonstrate higher rates of verbal and corporal punishment than Caucasian Americans, these differences disappear in studies that control for SES (Cardona, Nicholson, & Fox, 2000; Halgunseth et al., 2006; Jambunathan, Burts, & Pierce, 2000; Johnson, Teigen, & Davila, 1983; Julian et al., 1994; Laosa, 1980; MacPhee et al., 1996; Medora, Wilson, & Larson, 2001). Furthermore, research has shown no significant differences in preferred parenting techniques between African-American, Latino, and Caucasian American parents of low-SES (Medora et al., 2001). Finally, Latino parents classified as high-SES tend to exhibit lower discipline scores than low-SES Latino parents (Cardona et al., 2000; Hill, Bush, & Roosa, 2003). These studies support the impact of non-cultural factors, such as SES, on parenting practices.

Additionally, the existence of within-group heterogeneity highlights the significance of non-cultural factors on parenting practices. That is, parenting differences among Latino ethnicities (e.g., Mexican, Puerto Rican) demonstrate that non-cultural variables account for some of the variance in Latino ethnic groups. Foucault and Schneider (2009) evaluated parenting practices in the Dominican Republic by interviewing 375 primary caregivers of children ages three, six, and eight living in two

villages of different SES. This study found that mothers classified as low-SES with lower education levels placed greater emphasis on child conformity and less autonomy granting to children than mothers classified as high-SES. Similar results showed that education and SES served as moderating variables when comparing parenting practices between foreign-born and U.S.-born Mexican American mothers of children ages five to nine (Buriel, Mercado, Rodriguez, & Chavez, 1991). Calzada and Eyberg (2002) also found that Puerto Rican American mothers exhibited less warmth, less verbal instruction, more ignoring, and greater levels of verbal and corporal punishment toward their young children (i.e., under the age of six) than Dominican American mothers. These subtle distinctions among and within ethnicities highlight the difficulty in identifying relevant factors and generalizing parenting practices based on culture.

Ultimately, these results reflect the influence of variables other than cultural values on parenting practices as well as the depth of interaction between variables. While the influence of these additional factors is significant, however, it does not entirely negate the impact of cultural constructs. Rather, it accentuates the need for the culturally-adapted *Early Pathways* program to attend to the nuances of each individual Latino family since adherence to cultural constructs and the use of parenting practices likely will vary based on several factors.

Parenting Practices and Child Behavior Problems

With this understanding of Latino cultural constructs, their impact on parenting, and the additional factors that influence Latino parenting practices, this review will now examine one of the primary areas of focus for PCT programs: the association between verbal and corporal punishment and child behavior problems. As with the cultural

constructs described above, factors other than verbal and corporal punishment also contribute to the development of child behavior problems, and this review will address these additional variables in turn. However, while verbal and corporal punishment do not immediately determine the presence of child behavior problems, they are considered primary factors and will be examined to help explain the general underpinnings of PCT programs.

Verbal and Corporal Punishment

A substantial amount of research indicates that parental use of verbal and corporal punishment (e.g., yelling, spanking) is positively correlated with and predictive of child behavior problems (Brenner & Fox, 1998; Dadds, 1987; Glueck & Glueck, 1950; Hoffman, 1960; MacKenzie, Nicklas, Waldfogel, & Brooks-Gunn, 2012; Nix et al., 1999; Parke & Deur, 1972; Patterson, 1986; Patterson, 1995; Patterson, DeBaryshe, & Ramsey, 1989; Robinson & Eyberg, 1981; Simons & Wurtele, 2010). However, the development of child behavior problems is a complicated relationship between parental cognitions, parenting practices, and challenging behaviors (Azar & Wolfe, 1989; Dix, 1993; Patterson, 1982; Strassberg, 1995; Strassberg, Dodge, Bates, & Pettit, 1992). This refers to a complex developmental and maintenance cycle of child behavior problems in which aggressive exchanges through verbal and corporal punishment often unwittingly reinforce challenging child behaviors (Patterson, Reid, & Dishion, 1992; Sanders, Dadds, & Bor, 1989). As parents implement verbal and corporal punishment in response to challenging child behaviors, a self-perpetuating cycle may develop where the frustrated child reciprocates with aggression (Patterson, 1988; Patterson, 1995; Patterson & Forgatch, 1990; Sanders, Dadds, Johnston, & Cash, 1992; Wahler & Dumas, 1989). That is,

parental use of verbal and corporal punishment when frustrated may teach children to reflect this behavior and respond with physical aggression when they in turn are frustrated. Accordingly, PCT programs emphasize the limitation of verbal and corporal punishment, such as yelling and spanking.

One such study by Brenner and Fox (1998) examined the relationship between parenting practices and child behavior outcomes in a sample of 1,056 primarily Caucasian American mothers of children between the ages of one and five. Results from the Parent Behavior Checklist (PBC; Fox, 1994) indicated that verbal and corporal punishment was the strongest predictor of child behavior problems (20% of variance, 13% of unique variance). This study also showed that only 20% of mothers who reported low levels of verbal and corporal punishment had a child with significant behavior problems while 39% of mothers who reported high levels of verbal and corporal punishment had a child with significant behavior problems. Nicholson, Fox, and Johnson (2005) found similar results using the PBC with Caucasian American parents of children between the ages of two and five; their study suggested that more frequent verbal and corporal punishment was associated with more externalizing child behavior problems (e.g., aggression, temper tantrums).

Lorber and Egeland (2011) observed primarily Caucasian American mothers and their first-born children under the age of six in a longitudinal study to identify predictors of conduct problems upon entry to preschool and kindergarten. Observations of parenting practices and scores on the Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983) indicated that punitive parenting practices (e.g., verbal and corporal punishment) during infancy were positively correlated with conduct problems at entry to

preschool and kindergarten. Further, maternal hostility (e.g., angry verbal responses and punishment) independently predicted conduct problems with an additive effect over time. Basically, as verbal and corporal punishment continues over time, the effect on child behavior problems increases. A relationship also exists between verbal and corporal punishment and conduct disorder in children as well as aggressive home environments and normalization of physical violence (Farrington, 1978; McCord, 1988). That is, the more often physical discipline and violence is implemented in the home, the greater the chance of conduct disorder later in life.

Other factors related to child behavior problems.

While verbal and corporal punishment have been reported as significant factors in child behavior problems, it is important to acknowledge that not all families who engage in verbal and corporal punishment will show associations with child behavior problems, and that other factors also influence the development of challenging behaviors. For example, a literature review of verbal and corporal punishment reported that non-abusive forms of spanking in conjunction with nurturing practices were associated with positive child behavior outcomes (Larzelere, 2000). In addition, a few studies have found beneficial outcomes from moderate levels of spanking in African American families (Deater-Deckard & Dodge, 1997; Gunnoe & Mariner, 1997; Whaley, 2000).

Regarding other contextual factors, Fox et al. (1995) identified several variables that moderated the relationship between frequent use of verbal and corporal punishment and child behavior problems: (a) greater number of children in the family, (b) single mothers (c) lower SES, (d) lower education level, and (e) younger age of mothers. A host of other associated factors have been identified as well, including general life stress,

financial difficulties, child characteristics, and maternal characteristics, such as maternal

perception of child behavior (Abidin, Jenkins, & McGaughey, 1992; Baldwin, Baldwin,

& Cole, 1990; Kazdin & Whitley, 2003). Therefore, while the evidence supports a

connection between verbal and corporal punishment and child behavior problems,

variations in each family may occur based on the degree to which verbal and corporal

punishment is used as well as the interaction of multiple variables.

Verbal and Corporal Punishment in Latino Families

Since these studies were conducted primarily with Caucasian American

populations, it remains unclear whether this interaction pertains to other cultures. In fact,

some authors hypothesize that the link between the negative effects of verbal and

corporal punishment and child behavior problems may only pertain to Caucasian

American families and not to Latino families by extension (García Coll, Meyer, &

Brillon, 1995; Jambunathan et al., 2000). Therefore, it is appropriate to determine if

verbal and corporal punishment exists in Latino families with young children under the

age of six. As in the previous section, moderating variables also will be identified. This

will assist in determining whether *Early Pathways*, originally developed with Caucasian

populations, will be an effective approach for Latino populations.

Early research on parental control and obedience found that Latino parents were

more likely than Caucasian, Indian, Asian, and African parents to use verbal and corporal

punishment when children were aggressive with peers (Minturn & Lambert, 1964).

However, more recent research shows similar rates of verbal and corporal punishment

across populations (Fox & Solís-Cámara, 1997; Solís-Cámara & Fox, 1995a). These

comparative studies evaluated parenting practices of mothers and fathers with children

under the age of five in Mexico and the United States. They reported that when SES, education, and marital status were controlled, no significant differences were found in the use of verbal and corporal punishment. Moreover, the key factor was lower SES, which was associated with more frequent verbal and corporal punishment. Further, a longitudinal examination by McLoyd and Smith (2002) found that Latino parents used a comparable rate of verbal and corporal punishment as Caucasian Americans. Hill et al. (2003), Medora et al. (2001) and Wissow (2001) reported similar findings across cultures (i.e., no differences in verbal and corporal punishment) for families with children under the age of three.

As it becomes clearer that the frequency of verbal and corporal punishment is similar across cultures for families with young children under the age of six, it is necessary to examine whether child behavior problems in Latino families are associated with verbal and corporal punishment. The aforementioned longitudinal study by McLoyd and Smith (2002) found that European American, African American, and Latino children who received corporal punishment at the age of four and had consistent, subsequent spanking until the age of ten showed a significant increase in behavior problems over time across cultures. In addition, a study comparing 30 low-income Latina mothers whose children had been referred for clinical services to 30 mothers whose children had not been referred for services showed more frequent verbal and corporal punishment in the clinical group (Perez & Fox, 2008). A similar study by McCabe, Yeh, Lau, Argote, and Liang (2010) examined differences between referred and non-referred Mexican American families with preschool-aged children (ages three to seven). Results showed that referred families reported more child behavior problems and used more punitive

parenting (e.g., negative talk, criticism, verbal and corporal punishment). This study also found a greater difference in punitive parenting (e.g., verbal and corporal punishment) than positive parenting behaviors (e.g., nurturing and warmth) between referred and non-referred families. This implies that parents who are referred for clinical services use fairly equivalent rates of nurturing as non-referred parents, but implement significantly more punitive parenting (e.g., verbal and corporal punishment). The literature appears to identify verbal and corporal punishment as associated with child behavior problems in Latino populations, which makes the *Early Pathways* program an effective format for Latino families because of the focus on verbal and corporal punishment.

Additional variables.

However, just as with Caucasian American populations, factors other than verbal and corporal punishment are associated with child behavior problems in Latino families. Differences in ethnicity have been difficult to unravel (Cauce & Domenech-Rodríguez, 2002; Roosa et al., 2002), but several factors have been identified recently. One relevant factor in Mexican American families is the inconsistent use of discipline generally, not solely verbal and corporal punishment (Dumka, Roosa, & Jackson, 1997). That is, greater inconsistency in the use of discipline strategies, regardless of type (e.g., ignoring, time-outs, verbal and corporal punishment), is associated with greater frequency of child behavior problems. In addition, SES is correlated both with frequency of verbal and corporal punishment and with child behavior problems in Latino families (Fox & Solís-Cámara, 1997; McLoyd & Smith, 2002; Solís-Cámara & Fox, 1995b). Finally, maternal depression and recent immigration are associated with greater risk of child behavior problems for Central American families (Weiss, Goebel, Page, Wilson, & Warda, 1999)

while social support, financial resources, and stress also are related to child behavior

problems (Uno, Florsheim, & Uchino, 1998). These studies tend to show that frequency

of verbal and corporal punishment and child behavior problems is comparable across

cultures for families with young children, but several other variables also play a role in

this process. Therefore, while the majority of evidence concerning verbal and corporal

punishment supports the use of *Early Pathways* with Latino families, again, nuances need

to be considered during the adaptation process.

PCT Programs and Outcomes for Latino Families

Since *Early Pathways* appears to be a logical choice for Latino families whose

children are referred for behavior problems, it is imperative to determine the specific

adaptations necessary to create the most efficacious program for Latino families. This

section will consist of three subsections: (a) a succinct examination of the relevant

elements of general cultural adaptations with evidence-based treatment (EBT)

interventions; (b) a brief summary of the *Early Pathways* program; and (c) an overview

of current culturally-adapted PCT programs for Latino families with young children.

General Adaptations of Evidence-based Treatments for Latinos

Following the Division 12 report for the Task Force on Promotion and

Dissemination of Psychological Procedures (1995), research evaluating the development

and efficacy of EBT interventions increased significantly. Despite this effort, however,

little research has examined EBT interventions with culturally diverse populations

(Bernal & Scharrón-Del-Río, 2001). In fact, Nagayama Hall (2001), Sue (1998), and Sue

(1999) evaluated research with culturally diverse populations and found that the bulk of

EBT interventions involved Caucasian populations or were based on theories designed for Caucasian populations. As a result, some authors have argued that EBT interventions are invalid for culturally diverse populations, due to their failure to examine differences in language, values, and customs, as well as childrearing practices, expectations of children, parent behavior, and external stressors (Bernal & Scharrón-Del-Río, 2001; Miranda et al., 2003; Weisz, Huey, & Weersing, 1998). In response to these early criticisms, practice guidelines were established for work with culturally diverse populations (American Psychological Association, 2003). Subsequently, the field has begun to realize the need to incorporate culture and context into treatment (American Psychological Association, 2006) and treatment protocol (Whaley & Davis, 2007), which has led to an increase in recommendations for culturally-adapted EBT interventions.

Recommendations.

Several content recommendations have been implemented in culturally-adapted EBT interventions to address potential barriers to treatment. Examples of these recommendations include increased telephone contact, transportation availability, family involvement, and outreach to patients (Dwight-Johnson et al., 2010). Other relevant factors are language, values, and acculturation; an examination of world views and values (Harachi, Catalano, & Hawkins, 1997; Kumpfer, Alvarado, Smith, & Bellamy, 2002; Resnikow, Soler, Braithwait, Ahluwalia, & Butler, 2000); and identification of within-group heterogeneity (Bernal, Bonilla, & Bellido, 1995; González-Castro, 1998; Skaff, Chesla, Mycue, & Fisher, 2002). These variables often engender varying cultural perceptions of mental illness, which must be identified in order to provide appropriate treatment based on an accurate understanding of each family (Bernal et al., 1995).

In addition to content recommendations such as those referenced above, culturally-adapted approaches also have focused on structure (e.g., in-home treatment, integration of family and individual therapy), service delivery (e.g., bilingual counseling, flexible hours), and cultural competence of clinicians to avoid culturally-biased practices (Bernal et al., 1995; Cardemil et al., 2010; González-Castro, Barrera, Jr., & Martinez, Jr., 2004). A literature review by Altarriba and Santiago-Rivera (1994) indicated primary language usage as the most effective mode of service delivery to avoid potential errors in communication with Latino populations, as well as logistical problems with the use of translators. However, translators were found to offer benefits over communication in a family's non-native language, as long as proper training was provided. Interestingly, it was reported that while the use of a non-native language (such as English for Spanish-speaking clients) diminished the depth of communication, it also allowed Latino clients to discuss highly emotional situations with greater ease. Therefore, Altarriba and Santiago-Rivera (1994) suggested the idea of language switching to allow a therapist to switch to the less-dominant language during emotionally intense discussions, such as potential child abuse. A final conclusion reached by Altarriba and Santiago-Rivera (1994) was that ethnic matching did not appear necessary for all clients participating in culturally-adapted programs; only primarily Spanish-speaking clients benefited from ethnic matching while bilingual clients did not.

Since within-group heterogeneity is highly prevalent in Latino populations, one of the most significant variables for culturally-adapted EBT interventions is cultural competence and the ability to identify specific cultural differences between clients. Engebretson, Mahoney, and Carlson (2008) proposed a cultural competency continuum

with the apex of five stages being cultural proficiency. To achieve cultural proficiency, it

is necessary to provide patient-centered care, have sufficient knowledge of EBT

intervention practices, and integrate individual patient characteristics and values into

therapy. Similarly, Zayas, Torres, Malcolm, and DesRosiers (1996) examined definitions

from 150 non-minority therapists and found four dimensions of culturally-competent

therapy: (a) awareness of cultural differences, (b) knowledge of the client's culture, (c)

distinguishing culture from pathology, and (d) accounting for culture during therapy.

These characteristics of cultural competency should be addressed at three levels: (a)

individual provider, (b) agency, (c) and community (Sue, Zane, Nagayama Hall, &

Berger, 2009). That is, individual therapists need to fully comprehend these issues,

agencies need to provide clinical training on culturally-informed practices, and

communities need to be consulted regarding culture-specific interventions. Therefore,

regardless of the type of content modification, cultural competence appears to be a

necessary component to ensure efficacious implementation of a culturally-adapted *Early*

Pathways program.

Theories.

At least nine models have been proposed for how to develop a culturally-adapted

EBT intervention, but only three have established a multidimensional approach to address

the aforementioned content, service delivery, and cultural competency recommendations

for Latino populations (Cardemil et al., 2010; Lau, 2006). The first, introduced by

Rogler, Malgady, Constantino, and Blumenthal (1987), identified three stages to address

while culturally adapting an EBT intervention for Latino populations: (a) accessibility of

treatment, (b) selecting treatment according to Latino cultural features, and (c) modifying

treatment with elements of Latino culture. The first stage involves the engagement of community constituents, matching Latino family needs, the introduction of interpreters and bilingual clinicians, and the use of community consultants. The second stage focuses on the recognition of cultural factors and individualizing treatment through the use of treatment modalities (e.g., psychodynamic, insight-oriented, family centered) that resonate with Latino values. The final stage includes the incorporation of cultural activities (e.g., language switching, folktales) and the use of cultural variables in treatment (e.g., family concerns, impact of gender roles). These stages form the foundation for later conceptualization of developing cultural adaptations for Latino families.

Subsequently, Bernal et al. (1995) conceptualized what they termed "the ecological validity model" for culturally-adapted EBT interventions with Latinos, which incorporated eight dimensions: (a) language, (b) persons, (c) metaphors, (d) content, (e) concepts, (f) goals, (g) methods, and (h) context. These dimensions exhibit the multitude of variables potentially involved in a culturally-adapted EBT intervention. About a decade later, the "cultural adaptation process model" developed by Domenech-Rodríguez and Wieling (2004) updated the ecological validity model by creating three phases of adaptation. The three phases were: (a) to match the intervention model with community need, (b) to adopt measures and create the intervention simultaneously, and (c) to observe and gather data. In sum, the most current adaptation process for Latinos involves matching an EBT intervention with the treatment population, and then concurrently implementing and adjusting the intervention through the analysis of outcomes based on eight to ten content dimensions considered culturally relevant. Of primary importance is

that each of these models recommends that cultural values only be introduced when relevant to the treatment. This detail again reflects the significance of cultural competence in order to appropriately identify the impact of cultural values on treatment.

Culturally-adapted EBT interventions.

Several successful EBT interventions have occurred with Latino populations, for a wide range of issues including depression and substance use (Cardemil et al., 2010; Chavez-Korell et al., 2012). Chavez-Korell et al. (2012) adapted an EBT intervention protocol by incorporating cultural modifications based on target population (e.g., elderly Latinos) and setting (e.g., community center). The program developers consulted with community partners and professional experts, reviewed literature, and considered client well-being. Specific modifications included using a community center instead of a primary care setting, offering bilingual services, addressing illiteracy in materials (e.g., visual aids), decreasing clinician to client ratio, and implementing activities related to cultural values. Miranda et al. (2003) also adapted a depression treatment program for Latino individuals by translating materials to Spanish, offering treatment in Spanish, adding culturally-diverse individuals to educational videos, disseminating knowledge of cultural beliefs and barriers to clinicians, and maintaining oversight with culturally diverse investigators.

A third culturally-adapted EBT intervention was examined by González Castro et al. (2004). This study identified two factors of effective cultural adaptations: (a) fidelity to EBT intervention and (b) matching EBT intervention components with community needs in order to develop modifications. For example, if the original language was English and the community was primarily Spanish-speaking, adaptations to materials and

bilingual availability was required; moreover, if the community had several potential

barriers but the original treatment did not address those barriers, the treatment was

adapted in a manner consistent with addressing those barriers. Most significantly, each

of these three adaptations was effective at increasing successful outcomes with Latino

populations by maintaining the original EBT intervention protocol and matching the

specific needs of the community to determine specific content modifications. In addition,

several other culturally-adapted EBT interventions have used this basic formula of

adapting an established EBT intervention with needs that match the clientele; examples

include treatment for schizophrenia and substance abuse (Santisteban, Suarez-Morales,

Robbins, & Szapocznik, 2006; Weisman, Duarte, Koneru, & Wasserman, 2006).

In addition to the demonstrated efficacy of these programs, the three largest meta-

analyses of culturally-adapted EBT interventions have reported positive results, albeit

with some contradictions which will be examined. Griner and Smith (2006) found that

culturally-adapted EBT interventions aimed at adult and adolescent populations were four

times as effective as non-EBT programs, and offering treatment in the participant's native

language was twice as effective as interventions conducted in English. In addition,

culturally-adapted EBT programs modified for one specific cultural group had greater

effect sizes than culturally-adapted EBT models for mixed-cultural groups (Smith et al.,

2011). That is, a targeted approach for Latinos was more successful and had greater

impact than a general cross-cultural adaptation for Latinos, Asian Americans, and

African-Americans. Smith et al. (2011) also emphasized that as the number of cultural

modifications increased, the efficacy of the program increased as well; the two most

significant aspects of treatment were matching treatment with the client's specific goals

and using metaphors/symbols that matched with the client's cultural perspective. Miranda et al. (2005) also reported that outcomes of culturally-adapted EBT interventions for children, adolescent, and adult populations were significantly better than non-EBT treatment (e.g., general individual and family therapy).

Despite these significantly better outcomes of culturally-adapted EBTs compared to non-EBT programs, Miranda et al. (2005) and Huey and Polo (2008) determined that culturally-adapted EBT interventions did not provide a substantial improvement over original EBT treatment models for youth and children. For example, treatment of depression in children and adolescent populations was equally effective for a culturally-adapted cognitive-behavioral therapy (CBT) and an original CBT format with similar effect sizes (Huey & Polo, 2008; Miranda et al., 2005). Further, other culturally-adapted EBT programs, such as cuento therapy (i.e., storytelling) and PCIT, only showed slightly better outcomes over the original EBT models (Huey & Polo, 2008; Miranda et al., 2005). However, a closer examination of these results revealed that Latino children and adolescents in the culturally-adapted EBT interventions often improved in areas other than the clinical goal. For instance, while the original and culturally-adapted CBT models showed similar outcomes on depression, other measures, such as self-esteem and general functioning, revealed significant improvements for Latinos in the culturally-adapted CBT program (Miranda et al., 2005). One possible explanation could be that EBT formats are effective across cultures for their specific target (e.g., CBT targeting depression), but cultural adaptations offer a more well-rounded treatment approach for Latinos.

In addition, while several studies did not find statistically significant differences, participants in the culturally-adapted EBT programs often exhibited non-statistically significant improvements over participants in the original EBT models (Huey & Polo, 2008). Perhaps original EBT models already implemented cultural modifications, which created confounding variables in these comparisons. For example, several original EBT programs previously translated their materials, and translation is one of the primary modifications in culturally-adapted EBT programs (Griner & Smith, 2006; Huey & Polo, 2008; Miranda et al., 2005). This would limit the potential improvement of a culturally-adapted EBT program compared to an original EBT model. When comparisons between culturally-adapted and original EBT models were conducted, there were two consistent limitations: (a) a failure to recognize cultural sensitivity of the original EBT model and (b) a failure to identify level of acculturation in the family (McCabe & Yeh, 2009; Miranda et al., 2005). The former presents a confounding variable because if the original EBT used bilingual clinicians, it already provided one of the most pertinent cultural modifications to a culturally-adapted EBT program. The latter also is significant considering the influence of acculturation on the generational decrease of adherence to cultural constructs (Knight & Kagan, 1977; Knight, Kagan, Nelson, & Gumbiner, 1978; Negy & Woods, 1992; O'Guinn, Imperia, & MacAdams, 1987; Rodriguez & Kosloski, 1998; Soto, 1983; Valentine & Mosley, 1999). That is, second and third-generation children and adolescents may not adhere as strongly to cultural constructs, thus decreasing the impact of a culturally-adapted EBT program.

Overall, the literature indicates that while culturally-adapted EBT interventions often lead to positive outcomes with culturally diverse populations, they may not

necessarily enhance the outcomes when compared to the original EBT interventions (Bernal, Jiménez-Chafey, & Domenech-Rodríguez, 2009; Griner & Smith, 2006; Huey & Polo, 2008; Miranda et al., 2005; Nicolas, Arntz, Hirsch, & Schmiedigen, 2009; Sue et al., 2009). As explicated, however, the majority of studies have failed to assess three significant factors in this process: (a) direct comparison of culturally-adapted and original EBT models, (b) acknowledgement of cultural modifications already enacted by original EBT models, and (c) assessment of acculturation and the associated decrease in adherence to cultural constructs. Therefore, culturally-adapted EBT interventions with individualized cultural adaptations appear to function at least as well as general EBT interventions, and also are likely more effective. As a result, culturally-adapted EBT interventions should be attempted to offer the possibility of enhanced services by maintaining fidelity to the EBT intervention and implementing content modifications based on community need.

Early Pathways Program

While other PCT programs exist, this review will focus on *Early Pathways* (Fox & Gresl, 2014). Several studies have reported the efficacy of the *Early Pathways* model for young children with behavior problems, including among Latino populations (Fox & Holtz, 2009; Holtz et al., 2009; Fox, Keller, Grede, & Bartosz, 2007; Fox et al., 2013; Nicholson et al., 2002; Nicholson et al., 1999; Nicholson et al., 2005). Nicholson et al. (1999) conducted one of the earliest studies of this model in a community-based organization with families and children under the age of five. Findings showed that parents who participated in this precursor to the *Early Pathways* program exhibited decreased levels of verbal and corporal punishment, which was associated with a

significant improvement in child behavior problems. Nicholson et al. (2002), subsequently, evaluated 26 parents of children under the age of five who used excessive verbal and corporal punishment within a low-income context. Results again showed significant reduction on multiple measures, including verbal and corporal punishment, anger, stress, and reported child behavioral problems for parents who participated in the program as compared to a control group. Since that time, multiple studies have reported the effectiveness of *Early Pathways* for young children with behavior problems, notably including at-risk children living in poverty (Fox & Holtz, 2009), children with developmental delays (Holtz et al., 2009), and children from different ethnic backgrounds (Gresl et al., 2014). In addition, a mental health clinic providing in-home PCT services to at-risk children with developmental delays and severe behavior problems reported successful treatment outcomes for the past decade (Fox et al., 2007).

Fox and Holtz (2009) examined outcomes of the current *Early Pathways* program, which was used as part of an in-home treatment program for 102 toddlers with behavioral problems living in impoverished conditions. Based on direct observation and parental self-report using the Early Childhood Behavior Screen (ECBS; Holtz & Fox, 2012) and the Parent Behavior Checklist (PBC; Fox, 1994), families who completed the program (*M* = 12.76 sessions) demonstrated improved parent-child interactions from pre-test to post-test, as well as increased child compliance and a greater amount of parental compliments of child, with moderate effect sizes for all results (.41-.53). Parental satisfaction level with the program was high with an average score of 44.40 out of 49. In addition, positive results also were found when *Early Pathways* was evaluated in Mexico (Fox & Nicholson, 2003; Solís-Cámara, Fox, & Nicholson, 2000). Mexican parents showed

similar improvements in parenting practices as non-Latino parents in the United States, which resulted in improved child behavior. With this foundation and preliminary evidence of efficacy with Latino populations, *Early Pathways* serves as an appropriate EBT intervention for Latino families whose children are referred for behavior problems.

Culturally-adapted PCT Programs for Latino Families

Following this overview of *Early Pathways*, this review will examine existing culturally-adapted PCT programs for Latino families to identify potential adaptations to use in *Early Pathways*. Six PCT programs have undergone the cultural adaptation process: (a) Parent-Child Interaction Therapy (PCIT), (b) Parent Management Training Oregon (PMTO; Domenech-Rodríguez, Baumann, & Schwartz, 2011), (c) Parent Management Training (PMT; Martinez, Jr. & Eddy, 2005), (d) Incredible Years Parenting (IYP), (e) Parenting Our Children to Excellence (PACE), and (f) Community Parent Education (COPE). While not always explicitly stated, each of the following culturally-adapted PCT programs appears to follow the previously described guidelines established by Bernal et al. (1995) and Domenech-Rodríguez & Wieling (2004). These programs will be compared in five categories: (a) program design and demographics, (b) content, (c) protocol modifications, (d) in-session modifications, and (e) adaptation success.

Program design and demographics.

Culturally-adapted PCT programs for Latinos can be divided into individual and group formats. Individual treatment formats (i.e., individual therapy for parent-child dyads) were used for the cultural adaptations of PCIT in clinic settings (Borrego, Jr.,

Anhalt, Terao, Vargas, & Urquiza, 2006; Matos et al., 2009; Matos et al., 2006; McCabe and Yeh, 2009) while the group formats included ten to fifteen parents per group and took place in daycare centers, learning centers, preschools, and churches (Domenech-Rodríguez et al., 2011; Dumas et al., 2011; Lakes et al., 2009; Martinez, Jr. & Eddy, 2005). None of the cultural adaptations for Latinos used the in-home format implemented by *Early Pathways* and only one (PCIT) offered an individualized treatment model similar to *Early Pathways*.

Demographic information was fairly similar across studies. For example, average income status ranged from $15,000 to $26,000, and the majority of participants spoke only Spanish or identified Spanish as their first language. Marriage rates varied somewhat (40% to 76.2%), but mothers were the primary participants in each study (82% to 92%). Unemployment rates ranged from 30% to 59%, and a wider range of education was reported, with as little as 20% to as much as 59% having some college education. Acculturation was not measured in all studies, but when it was, between 71% and 98% were first-generation Americans. Despite a wider range on some variables, these demographics are somewhat comparable to the population served by *Early Pathways*.

Content.

The culturally-adapted PCIT program consisted of child-directed interaction (CDI) and parent-directed interaction (PDI) stages (Borrego, Jr. et al., 2006; Matos et al., 2009; Matos et al., 2006; McCabe & Yeh, 2009). The CDI stage focused on developing the parent-child relationship through play activities, and the PDI stage highlighted consistent discipline to decrease challenging behaviors. Both stages involved the parent and child in the process. On the other hand, the programs that took place in large-group

settings typically engaged only the parents. For example, the culturally-adapted PMTO

model provided educational materials and scripts to parents in order to improve parenting

skills, limit setting, problem solving, positive involvement, and appropriate monitoring

(Domenech-Rodríguez et al., 2011). The remaining culturally-adapted PCT programs

(PACE, PMT, IYP, COPE) used discussion, role playing, and videotapes to examine

similar topics, such as limit setting, problem solving, routines, child encouragement,

academic support for children, and anticipating challenges (Dumas et al., 2011; Lakes et

al., 2009; Martinez, Jr. & Eddy, 2005). Of these programs, the two-stage format of PCIT

is most similar to the *Early Pathways* program that will be adapted, in particular because

it involves both the parent and child in the process using child-focused and parent-

directed activities. The majority of activities (e.g., discipline strategies, limit setting,

positive involvement, routines) from all of the culturally-adapted programs match with

Early Pathways activities, which makes them appropriate comparisons for a culturally-

adapted *Early Pathways* program.

Protocol modifications.

A significant aspect of the adaptation process for each of these culturally-adapted

PCT programs was to involve community members in the process. The majority of the

programs established focus groups or advisory councils with families, counselors, experts

in the field, and psychologists around the world (Borrego, Jr. et al., 2006; Domenech-

Rodríguez et al., 2011; Dumas et al., 2011; Martinez, Jr. & Eddy, 2005; Matos et al.,

2006; McCabe, Yeh, Garland, Lau, & Chavez, 2005). During these sessions, individuals

helped to identify family needs and potential barriers, which typically were followed by a

review of culturally-adapted materials to confirm appropriate changes. Only one

culturally-adapted model, COPE, did not involve community members in the process; however, it did incorporate feedback following community presentations in local venues, such as schools and churches (Lakes et al., 2009).

As a result of these community efforts, each study recognized that translation of materials and bilingual services were necessary adaptations. The culturally-adapted PCIT programs used forward-backward translation to translate their materials into Spanish, and also introduced bilingual therapists for sessions (Borrego, Jr. et al., 2006; Matos et al., 2009; Matos et al., 2006; McCabe et al., 2005). Ethnicity was accounted for in the samples, and two of the studies translated materials specifically for Puerto Rican American families (Matos et al., 2009; Matos et al., 2006) while the other two targeted Mexican American families (Borrego, Jr. et al., 2006; McCabe et al., 2005). In addition, the group PCT programs used bilingual group leaders along with Spanish-translated materials, often simplifying language to assuage literacy issues (Domenech-Rodríguez et al., 2011; Dumas et al., 2011; Lakes et al., 2009; Martinez, Jr. & Eddy, 2005).

Other protocol modifications were aimed at improving treatment adherence. These included persistent telephone calls between sessions, as well as incentives. For instance, clinicians in one of the culturally-adapted PCIT programs were allowed unlimited phone contact with primary caregivers to discuss any concerns prior to the first session, as well as unlimited contact with extended caregivers who were identified as potential barriers to treatment (McCabe et al., 2005). In addition, three of the group PCT programs used consistent phone calls to primary caregivers between sessions to discuss home assignments and answer questions or concerns (Domenech-Rodríguez et al., 2011; Dumas et al., 2011; Martinez, Jr. & Eddy, 2005). A variety of incentives also were

offered, including monetary (e.g., $15/session, $30/assessment session), free childcare, drinks, snacks, and dinner during groups (Dumas et al., 2011; Lakes et al., 2009; Martinez, Jr. & Eddy, 2005; Matos et al., 2009; Matos et al., 2006; McCabe & Yeh, 2009). The non-monetary incentives were added to address cultural values of *familismo* and *personalismo* and in turn improve treatment adherence. In sum, interaction with community members, forward-backward translation of materials, use of bilingual clinicians, increased phone contact, and incentives were universal protocol modifications.

In-session modifications.

Besides the protocol changes, there were also significant in-session additions to three of the culturally-adapted PCIT programs. One of the major adaptations was the allotment of structured time at the beginning of the session (approximately 15-20 minutes) for discussion of cultural-specific or acculturation-related stressors, such as immigration and racism (Matos et al., 2009; Matos et al., 2006; McCabe et al., 2005). This discussion time attempted to build rapport between the clinician and family as well as offer a chance to discuss ways to involve other family members. While discussion time was already part of the group models, specific focus on cultural values and stressors was a new development (Domenech-Rodríguez et al., 2011; Dumas et al., 2011; Lakes et al., 2009; Martinez, Jr. & Eddy, 2005). These attempts to build rapport were aimed at limiting attrition and improving outcomes.

Videotapes also were added based on expressed parent preference for videos of themselves and other parents who successfully completed the program. Vignettes and videotaping of role-play during sessions were implemented to enhance parental

understanding of strategies (Borrego, Jr. et al., 2006; Dumas et al., 2011; Lakes et al., 2009; Martinez, Jr. & Eddy, 2005; Matos et al., 2009; Matos et al., 2006).

Other less universal modifications were recommended by each study. For example, Dumas et al. (2011) recommended an emphasis on family rather than individual activities, using stories to explain information, interaction with several caregivers, explicit use of cultural-specific terminology, greater use of physical affection than verbal praise, and increased focus on academic services. McCabe et al. (2005) reported in-session modifications of psychoeducation about treatment to alleviate concerns, greater latitude for clinician self-disclosure, elicitation of complaints about the program, referring to time-outs as punishment chairs, and structured plans to involve extended family (Matos et al., 2006; McCabe & Yeh, 2009; McCabe et al., 2005). Further, multiple studies referred to clinicians as teachers, child behavior experts, or coaches to avoid mental health terminology (Martinez, Jr. & Eddy, 2005; McCabe & Yeh, 2009; McCabe et al., 2005). Finally, Lakes et al. (2009) separated men and women to address the constructs of *marianismo* and *machismo* in group sessions while Borrego, Jr. et al. (2006) offered flexible blocks of time (e.g., three to eight hours) for families to arrive for sessions. Overall, two in-session modifications were universal (allotted discussion of cultural-specific stressors and videotaping) while others were less universal and more related to the specific community needs of each program (e.g., emphasis on physical praise rather than verbal, flexible blocks of time for sessions, clinician self-disclosure).

Adaptation success.

Before determining which of the aforementioned cultural modifications should be incorporated into the *Early Pathways* model, their outcomes should be addressed.

Individual treatment models (PCIT) were successful, reporting significant improvement in child behavior problems (e.g., aggression, opposition) and parenting practices (e.g., improved discipline strategies, increased nurturing) from pre- to post-test (Borrego, Jr. et al., 2006; Matos et al., 2009; Matos et al., 2006; McCabe & Yeh, 2009). Effect sizes for the individual PCIT treatment models were large, ranging from 1.39 to 3.38 (Cohen's d) on measures of aggression and externalizing behaviors, and ranging from 1.01 to 2.31 (Cohen's d) on measures of parent-child interaction and parenting practices (Borrego, Jr. et al., 2006; Matos et al., 2009; Matos et al., 2006; McCabe & Yeh, 2009). These results indicated significant clinical change for the individual PCT models. The group PCT programs also were successful; children exhibited fewer externalizing child behaviors during playtime following group sessions (Domenech-Rodríguez et al., 2011; Dumas et al., 2011; Lakes et al., 2009; Martinez, Jr. & Eddy, 2005) while parents used less verbal and corporal punishment as well as showed improved parent-child communication at post-test (Dumas et al., 2011; Lakes et al., 2009). Typical post-test was between one and three months while follow-up ranged from three months to one year; results were maintained at follow-up sessions in both individual and group formats. However, effect sizes were lower than the individual PCT formats, ranging from .24 to .46 (Cohen's d) for parenting practices and .46 to .64 (Cohen's d) for child behavior problems (Lakes et al., 2009). These results indicate only low to moderate effect sizes compared to large effect sizes for the individual PCT formats. This supports the use of *Early Pathways* because of its individual parent-child dyad structure.

Assessment measures of behavior and parenting practices were equivalent, although not identical to each other. For example, the majority of the programs (Borrego,

Jr. et al., 2006; Martinez, Jr. & Eddy, 2005; Matos et al., 2009; Matos et al., 2006; McCabe & Yeh, 2009) used the Early Child Behavior Inventory (ECBI; Eyberg, 1992), Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983), Dyadic Parent-Child Interaction Coding System (DPICS; Eyberg & Robinson, 1982) and the Parent Practices Inventory (PPI; Salas-Serrano, 2003). Only two programs used other measures, though they were comparable. For example, Dumas et al. (2011) used measures with similar reliability and validity (coefficient alpha = .70 - .92), such as the Social Competence and Behavior Evaluation Scale-Short Form (SCBE30; LaFreniere & Dumas, 1996), the Behavior Assessment System for Children-2nd ed. (BASC2; Reynolds & Kamphaus, 2005), and the Parenting Practices Interview (PPI; Webster-Stratton, Reid, & Hammond, 2001). Finally, Lakes et al. (2009) used the Strengths and Difficulties Questionnaire (SDQ), which has good concurrent validity with the CBCL (Goodman & Scott, 1999). The similarity between established measures indicates that the fairly universal positive outcomes likely assess analogous behaviors. In addition, the ECBS and PBC assessments used in the *Early Pathways* program are comparable to these programs' measures based on type of measure (i.e., self-report), as well as validity and reliability norms.

In addition to primary outcomes, several studies measured satisfaction. A majority of parents found each program beneficial. Examples of satisfaction results included a five-point Likert scale with a mean of 4.75 (Dumas et al., 2011), qualitative examination of focus groups and open-ended questions (Domenech-Rodríguez et al., 2011; Matos et al., 2009; Matos et al., 2006; McCabe & Yeh, 2009), 98% satisfaction on a yes-no questionnaire (Lakes et al., 2009; Martinez, Jr. & Eddy, 2005), and a mean of 47.80 out of 50 on the Therapy Attitude Inventory (TAI; Eyberg, 1993; Matos et al.,

2009; Matos et al., 2006). These satisfaction findings appear comparable to current *Early Pathways* satisfaction reports.

Other supplementary measures of success included an examination of attrition rates and participation to determine whether cultural adaptations improved over non-adapted programs. Results showed that culturally-adapted PCT programs did not differ from non-adapted programs in participation and attrition rates (Domenech-Rodríguez et al., 2011; Dumas et al., 2011; Lakes et al., 2009; Martinez, Jr. & Eddy, 2005; Matos et al., 2009; McCabe & Yeh, 2009). Approximately 71% of participants attended at least six of eight group sessions of the culturally-adapted PMTO program, which was similar to PMTO with Caucasian American populations (Domenech-Rodríguez et al., 2011). Martinez, Jr. and Eddy (2005) also reported attendance statistics comparable to non-Latino samples of their culturally-adapted PMT program (30% attrition). Dumas et al. (2011) reported 49% attrition prior to session three, and Matos et al. (2009) reported a 30% attrition rate. While there is a paucity of research on Latino attendance in PCT programs, these attrition rates appear comparable to PCT programs with low-income individuals (Nicholson et al., 1999). Considering this similarity of attrition rates, perhaps the attempts to improve adherence to treatment (e.g., consistent follow-up phone calls and incentives) were not as effective as initially assumed.

Finally, McCabe & Yeh (2009) conducted the most comprehensive comparison of culturally-adapted PCT programs to date, which deserves a more detailed description. It compared a culturally-adapted PCIT program, the original non-adapted PCIT program, and non-EBT intervention formats for families with young children (e.g., general behavioral therapy, family systems). It found that both the culturally-adapted and non-

adapted PCIT programs were more effective than the non-EBT formats. Moreover, the

culturally-adapted PCIT program was significantly better than the non-adapted PCIT

program on some, but not all, of the parent, child, and participation outcomes (McCabe &

Yeh, 2009). Specifically, the culturally-adapted PCIT model showed significantly

greater improvement on the ECBI measure of child behavior problems (M = 84.30, SD =

34.40, Cohen's d = 2.84) than the non-adapted PCIT model (M = 95.44, SD = 45.20,

Cohen's d = 2.14), but only non-statistically significant improvement on the CBCL

measure of child behavior problems (M = 45.83, SD = 11.28, Cohen's d = 1.97)

compared to the non-adapted PCIT model (M = 48.82, SD = 13.31, Cohen's d = 1.41).

However, while the non-adapted PCIT program did not implement the majority of

cultural modifications, it used bilingual therapists who were familiar with Mexican

American culture. Since the provision of bilingual counseling is the primary cultural

modification for culturally-adapted PCT programs, this presents a significant

confounding variable in this comparison. This likely led to the similarity in results

between the two PCIT programs. Further, an examination of the results showed that even

the non-statistically significant differences on measures of child and parent behavior were

slightly better for the culturally-adapted PCIT model than the non-adapted model, all

with larger effect sizes ranging from 1.01 to 3.38 (Cohen's d) compared to a range of .54

to 2.14 (Cohen's d) for the non-adapted PCIT model.

Based on these outcomes, it appears that culturally-adapted PCIT programs are

significantly more effective with Latino populations than non-EBT programs; moreover,

culturally-adapted PCIT programs are significantly better than non-adapted PCIT

programs on some, and potentially, all variables. This indicates that the use of an EBT

intervention (e.g., *Early Pathways*, PCIT, PMTO) and the provision of culturally

competent bilingual therapists appear to be the most significant factors affecting

outcomes while specific cultural modifications also may provide a boost in efficacy.

With an EBT intervention and bilingual counseling as the foundations for treatment,

individualized modifications can be made to appropriately address cultural differences for

Latino families that will engender a highly efficacious culturally-adapted *Early Pathways*

program. Considering that these are the only existing studies of culturally-adapted PCT

programs, these results are preliminary and additional studies need to be conducted.

Interpretation of culturally-adapted PCT programs.

Based on the current culturally-adapted PCT programs, three major

determinations can be made regarding a potential adaptation of *Early Pathways*: (a) the

demographics, content, and measures of these programs are sufficiently comparable to

Early Pathways to assume that a cultural adaptation is possible and can produce positive

outcomes, particularly considering the individual format employed in *Early Pathways*;

(b) an EBT intervention with individualized modifications based on community/family

preferences likely will produce the most efficacious outcomes; and (c) certain

modifications (e.g., translation, bilingual clinicians, cultural competence training) appear

to be of primary importance while others (e.g., allowing a block of hours to attend

sessions) are not viable for the *Early Pathways* format because they are based on target

population need. Universal protocol modifications include interaction with community

constituents, forward-backward translation of materials, and availability of bilingual

treatment while universal in-session modifications comprise discussion of cultural-

specific stressors and videotaping of sessions. Finally, follow-up phone calls and

incentives do not appear to significantly impact treatment, though likely do not hurt efficacy either.

Conclusion

Based on increasingly severe poverty levels for Latino families with young children, the distinct nature of Latino culture, and significant barriers to treatment for Latino families, the need for culturally-adapted PCT programs has become an essential step in the field of mental health. To assist with this process, the literature identifies a diverse array of Latino cultural constructs that are pertinent to successful intervention outcomes of underserved Latino families with young children. The constructs of *familismo, respeto, marianismo, machismo, personalismo,* and *simpatía* appear integral to understanding Latino family interactions and parenting practices. Further, recognition of these values is vital in order to identify the most effective ways to culturally adapt the *Early Pathways* program. Equally significant, however, is the recognition that adherence to cultural values is not universal and a culturally-adapted *Early Pathways* program must account for other variables (e.g., acculturation, SES, education) and within-group heterogeneity.

The literature also indicates that child behavior problems are related to verbal and corporal punishment, and addressing this interaction traditionally has been the focus of PCT programs. Of course, various factors (e.g., acculturation, SES, education) are associated both with verbal and corporal punishment as well as child behavior problems, and these must be addressed in the cultural adaptation process of *Early Pathways*. Overall, *Early Pathways* seems to be a viable choice to address child behavior problems in Latino families based on Latino family parenting practices.

The general process to develop a culturally-adapted EBT intervention involves interaction with the community, a review of cultural values, and protocol changes based on specific cultural content areas. Though culturally-adapted EBT interventions are in their incipient stages, several have been successful and the most influential variables appear to be: (a) fidelity to an EBT intervention, (b) matching modifications to community need, and (c) training of culturally competent clinicians. This process provides a structured foundation to which cultural adaptations can be made.

Besides general EBT interventions, six PCT programs around the country have developed culturally-adapted PCT programs. Based on a review of these programs, the following steps appear necessary to developing, implementing, and evaluating a culturally-adapted *Early Pathways* program. Since *Early Pathways* is based on an EBT intervention, maintaining fidelity to this model is the first essential step in the cultural adaptation. This is evident in the literature on general culturally-adapted EBT interventions as well as culturally-adapted PCT programs. Second, as with other culturally-adapted programs, matching the *Early Pathways* intervention to community/family need is vital. To achieve this process for Latino families, the following protocol modifications appear most likely to benefit the *Early Pathways* model: (a) interaction with community experts and families to match the *Early Pathways* model to specific community needs and barriers; (b) forward-backward translation of materials to Spanish; (c) facilitation by bilingual clinicians; (d) enhancement of clinician cultural competence through appropriate training; and (e) inclusion of an acculturation measure to identify adherence to cultural values. Clinician cultural competence is particularly relevant because this will allow clinicians to appropriately adapt treatment to

each individual family's needs. As demonstrated, adherence to cultural constructs may vary depending on each family, making cultural competence a significant factor in positive treatment outcomes for Latino families.

Since the remaining in-session modifications appear to be specific to each target population, the protocol modification to improve clinician cultural competence should be sufficient to address in-session modifications on an individualized basis. That is, as their cultural competence is enhanced, clinicians should better be able to identify family adherence to cultural values and specific family needs. The clinician, therefore, can determine appropriate in-session modifications, such as using culturally-sensitive descriptions of program strategies, self-disclosing, and determining when and how to engage extended caregivers to appropriately build rapport with each individual family. Ultimately, clinician cultural competence will determine whether potential modifications, such as the discussion of cultural-specific stressors, videotaping of sessions, follow-up phone calls, and incentives are incorporated into the treatment based on each family's needs.

Based on positive outcomes from *Early Pathways* in Mexico (Fox & Nicholson, 2003; Solís-Cámara et al., 2000), *Early Pathways* appears to have promise for use with Latino families in the United States. This coupled with the research indicating that EBT interventions offer substantial success with cultural populations regardless of cultural adaptation gives initial hope to a culturally-adapted *Early Pathways* format. It is likely that cultural modifications will enhance these initial effects. In addition, a home-based PCT program, which has not yet been evaluated, may provide an additional increase in efficacy, as the in-home visitation format resonates with treatment for Latino families

since it meets the parent and child at their most comfortable and intimate location. There is good reason to believe that the modifications determined by this review of Latino cultural constructs, culturally-adapted EBT interventions, and culturally-adapted PCT programs will engender successful outcomes for Latino families in the culturally-adapted *Early Pathways* program.

Limitations

The primary limitation of this literature review is the relative paucity of culturally-adapted PCT programs for Latino families. With only six culturally-adapted PCT programs and only one comparison study between a culturally-adapted PCT program and its original EBT, the findings must be interpreted with caution until additional studies can be conducted. Further examination will help clarify the effects of cultural modifications on PCT programs. A second limitation is the difficulty in assessing the importance of cultural values due to the heterogeneity within the Latino culture. Several contradictions arose in the literature regarding the impact of culture on treatment, in part because of different levels of adherence to cultural values. This limitation guided the present study to examine the cultural values of each individual family rather than focus solely on race and ethnicity.

CHAPTER III: METHODOLOGY

Participants

Early Pathways participants were 137 Latino children under the age of six from low-income families who were referred for severe behavior and emotional problems. Services were provided in participant homes, which were located within a large urban community in the upper Midwest. Eligibility criteria for this study included: (a) the child was under 72 months of age at time of intake; (b) the child was referred for a significant mental health concern such as aggression, destructiveness, hyperactivity, self-injury, or separation anxiety; (c) the child did not have a serious physical disability, significant health concern, or meet the criteria for moderate to profound intellectual disability or autistic spectrum disorder; however the child may have had a developmental delay; (d) at least one of the child's parents was Latino; (e) the family met the federal criteria for living in poverty (e.g., eligible for public assistance programs); (f) the primary caregiver signed an IRB-approved informed consent form (see Appendix A) for the child and family to participate in this study. If the parent or caregiver declined to participate in the study, they still received the full *Early Pathways* treatment program but their information was omitted from this study.

Of the 137 participants, there were 100 boys (73%) and 37 girls (27%). Child ethnicities included Mexican (48.5%), Puerto Rican (27.2%), other (14.7%; e.g., Dominican, Central American, Spanish), and mixed ethnicities (9.6%; e.g., Mexican/Puerto Rican, Mexican/Dominican). The majority of caregivers were mothers (94.9%), and 60.6% of primary caregivers were unemployed. Fifty-six percent of

primary caregivers were single, 35% were married, and 9% were separated/divorced. Of

the participants, 47.4% completed the treatment program in Spanish, 44.5% in English,

and 8% in Spanish and English. Average primary caregiver age was 28.87 years ($SD =$

6.88) and average child age was 3.89 ($SD = 1.11$). A total of 46.7% of the children were

diagnosed with a developmental delay, of which 82% were language disorders. At

intake, 88.7% of children received an initial psychiatric diagnosis. Disruptive Behavior

Disorder NOS was the most common primary diagnosis at intake (45.1%); additional

primary diagnoses included Oppositional Defiant Disorder (23.8%), Adjustment Disorder

(9.8%), other (8.1%; e.g., Separation Anxiety, Reactive Attachment Disorder), Parent-

Child Relationship Problem (6.6%), Post-Traumatic Stress Disorder (4.1%), and

Attention Deficit Hyperactivity Disorder (2.5%).

Procedure

This project was approved by the Internal Review Board of Marquette University

(see Appendix B). A convenience sample of consecutive Latino children referred from

over 50 agencies and individual providers to the *Early Pathways* program was used. A

random-number generator assigned 1000 numbers (0 or 1) to a Microsoft Access case

management database. Children were entered into the database in the order that they

were scheduled for an intake session and determined to be eligible to participate in the

study, thus ensuring random assignment to either the immediate (n = 80) or delayed

treatment groups (n = 57). However, if children were identified at intake as having a

significant trauma history, they were provided immediate treatment regardless of

randomization protocol to ensure participant safety.

Project data were collected in participants' homes over an 18-month period from April 2012 to September 2013. All participants signed an informed consent form describing the purpose, risks, and benefits of treatment prior to completing the intake evaluation. Caregivers also were asked to sign a contract agreeing to actively participate in treatment, which included being present with their child at all sessions, actively implementing treatment strategies in and out of treatment sessions, and providing 24-hour notice for session cancellations (see Appendix C).

The immediate treatment group completed an intake, treatment, post-test, and four-six week follow-up sessions. The delayed treatment group completed an intake, waited four to six weeks ($M = 5.86$, $SD = 1.82$), and repeated the pre-test measures during a second intake before following the same treatment and assessment protocol as the immediate treatment group. Booster sessions were provided at the request of families after the follow-up session. A total of 26 booster sessions for eight families were provided.

Instruments

Intake Form

Following referral, families were contacted to schedule an initial intake session. At this session with the family in the child's home, the intake form (IF; see Appendix D) was used to collect demographic information about the referred child (e.g., gender, date of birth, siblings), and the family and others who were living in the child's home and/or providing care for the referred child (e.g., grandmother, aunt, preschool, day care center). The IF also was used to collect information about the child's birth history, current health,

previous involvement with protective services, and medications, if any. In addition, the

IF helped determine the frequency and nature of the child's referral concerns, possible

contributing factors, and how the caregivers were presently responding to the referral

concerns. The IF was updated regularly as new information became available (e.g.,

family moved to new address, parents separated).

Early Childhood Behavior Screen

The Early Childhood Behavior Screen (ECBS; Holtz & Fox, 2012) is a 20-item

self-report screening instrument developed specifically for very young children (0 to five-

years-old) from low-SES backgrounds. The ECBS includes 10 positive behavior items

(e.g., "listens to you," "shares toys") and 10 challenging behavior items (e.g., "hits

others," "has temper tantrums") and is written at a 3.9 grade level. The scale instructions

ask caregivers to rate each item based on their perception of their child's behavior over

the past week using a three-point Likert rating scale (1 = almost never, 2 = sometimes, 3

= often). Total scores on the Positive Behavior Scale (PBS) range from 10 to 30 with

higher scores indicating a greater frequency of pro-social behaviors. Total scores on the

Challenging Behavior Scale (CBS) range from 10 to 30 with higher scores indicating a

greater frequency of challenging behaviors. The ECBS-CBS was administered at pre-

test, all individual treatment sessions, post-test, and follow-up. Field-testing of the ECBS

was conducted with a representative, diverse sample of 439 parents from a low-SES

urban community. Internal consistencies using coefficient alphas were reported for the

CBS (.87) and PBS (.92). The CBS demonstrated adequate levels of concurrent validity

($r = .75$) with the Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999). In

addition, the CBS demonstrated adequate levels of sensitivity (82%) and specificity

(80%) based on its relationship with the ECBI cutoff scores for clinical significance.

Parent Behavior Checklist

The Parent Behavior Checklist (PBC; Fox, 1994) is a 32-item rating scale that is

designed to measure the behaviors and expectations of parents of young children between

the ages of one and five. The PBC was administered at pre-test, post-test, and follow-up.

For this project, all three subscales were used from the PBC. The Discipline subscale

consisted of 10 items that assessed parental responses to the child's problem behaviors

that primarily consisted of verbal and corporal punishment (e.g., "I yell at my child for

whining"). The Nurturing subscale consisted of 10 items that measured specific parent

behaviors that promoted the child's psychological growth (e.g., "My child and I play

together on the floor"). The Expectations subscale consisted of 12 items that measured

specific parent developmental expectations of the child's behaviors (e.g., "My child

should be able to ride a tricycle"). Items were rated using a four-point frequency scale (1

= almost never/never, 2 = sometimes, 3 = frequently, and 4 = almost always/always).

Total scores for Discipline ranged from 10 – 40, with higher scores indicating more

frequent use of verbal and corporal punishment (e.g., yelling, spanking). Total scores for

Nurturing ranged from 10 – 40, with higher scores suggesting more frequent use of

positive nurturing activities (e.g., reading with child, playing with child). Total scores for

Expectations ranged from 12 – 48, with higher scores suggesting greater expectations of

child behaviors compared to the child's developmental level (e.g., expecting a two-year-

old child to dress himself/herself). From a representative sample of 1,140 mothers, the

following internal consistencies using coefficient alphas were reported: Discipline = .91,

Nurturing = .82, and Expectations = .97. Test-retest reliabilities for each of the three

subscales were: Discipline = .87, Nurturing = .81, and Expectations = .98.

Parent-Child Play Assessment

Parents were instructed to play with their child with toys they had in the home

while the clinician observed and rated the quality of the parent-child interaction. If no

toys were available, the clinician provided them. The Parent-Child Play Assessment

(PCPA) was administered at pre-test, post-test, and follow-up sessions. Based on the

work of Crawley and Spiker (1983), five dimensions of the child's behavior and six

dimensions of the parent's behavior were rated using a three-point frequency scale (1 =

poor, 2 = fair, 3 = good). For 142 observations of parent-child interactions (72 African

American, 44 Latino, 19 Caucasian, 7 Mixed) from a previous study (Fung, Fox, &

Harris, 2014), two clinicians independently completed the play assessment. Kappa

coefficients were computed and yielded the following results: child behaviors – positive

affect = .78, negative affect = .80, interest in play = .80, initiates interactions = .82, social

responsiveness = .83; parent behaviors – parent leads = .84, parent engagement = .73,

sensitivity to child = .85, expectations of child = .85, sets appropriate limits = .82, and

reciprocity = .83. The sizes of these coefficients indicated good agreement between

observers (Viera & Garrett, 2005). Separate total scores were computed for the five

dimensions of the children's behaviors and the six dimensions of the parents' behaviors.

Coefficient alphas for the sample were computed for the child behavior scale (.85) and

the parent behavior scale (.82) for the present sample.

Diagnostic and Statistical Manual of Mental Disorders

Children who met the criteria for one or more primary diagnoses at intake (Axis I) had this information added to their intake report. In addition, the other four Axes of the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2000) were completed for each child, including the Global Assessment of Functioning (GAF). For this study, the GAF score was completed at pre-test, post-test, and follow-up. When two clinicians were present, each completed an individual GAF score. Based on 100 cases, the kappa coefficient for inter-rater reliability was .56. This indicates moderate agreement between observers (Viera & Garrett, 2005).

Parent-Child Relationship Scale

The Parent-Child Relationship Scale (PCRS) provided a subjective and quantitative global assessment of the parent-child relationship on a scale of 0-100 with five behavioral anchors (poor, below average, average, good, and exceptional) at 20-point intervals (Fox & Nicholson, 2003). For example, scores suggestive of a good relationship (e.g., thoughtful interactions, typically appropriate parental expectations, parent responsiveness, appropriate limit setting, and limited use of verbal or corporal punishment) ranged from 60-80. For the study, the PCRS score was completed at pre-test, post-test, and follow-up. When two clinicians were present, each completed an individual PCRS global score. Based on 101 cases, the kappa coefficient for inter-rater reliability was .57. This indicates moderate agreement between observers (Viera & Garrett, 2005).

Family Satisfaction Survey

At the completion of the treatment program, a 7-item anonymous survey was used to assess caregiver satisfaction with the treatment services. On a 7-point Likert rating scale, caregivers were asked to rate: the quality of services received (1 = poor, 3 = fair, 5 = good, 7 = excellent), how the services contributed to their child's improvement (1 = not at all, 3 = a little, 5 = quite a bit, 7 = a lot), how the clinic helped them to improve management of their child (1 = not at all, 3 = a little, 5 = quite a bit, 7 = a lot), if caregivers would use the clinic again if needed (1 = no, definitely not, 3 = no, I don't think so, 5 = yes, I think so, 7 = yes, definitely), current status of the child's referral concern (1 = considerably worse, 2 = worse, 3 = slightly worse, 4 = the same, 5 = slightly improved, 6 = improved, 7 = greatly improved), if caregivers would recommend the clinic to others (1 = no, definitely not, 3 = no, I don't think so, 5 = yes, I think so, 7 = yes, definitely), and the caregiver's confidence in managing their child's behavior in the future (1 = not at all confident, 3 = somewhat confident, 5 = more confident, 7 = very confident). The internal consistency for these seven items was r = .82 for the present sample.

Short Acculturation Scale for Hispanics

This scale (Marín, Sabogal, Marín, Otero-Sabogal, & Perez-Stable, 1987) is a 12-item acculturation scale that is designed to measure the acculturation status in Latino populations. This scale was administered only at intake to obtain descriptive information regarding each family's level of assimilation into American culture. The scale contained three factors: Language Use (e.g., "In general, what language do you read and speak?"),

Media (e.g., "In what languages are the T.V. programs you watch?"), and Ethnic and Social Relations (e.g., "Your close friends are…"). Scores ranged from 1 to 5 for items one through eight (1 = Only Spanish, 3 = Both Spanish and English equally, 5 = Only English) and for items 9 to 12 (1 = All Latinos/Hispanics, 3 = About half and half, 5 = All Americans). The norms for this scale were developed using 363 Hispanic and 228 non-Hispanic males and females. The Hispanic group ranged from 15-75 years of age ($SD = 11.6$). This 12-item scale has been found to correlate highly with the following validation criteria: generation, length of residence in the U.S., age at arrival in the U.S., ethnic self-identification, and acculturation index. The coefficient alpha for the overall scale is .92. Coefficient alphas for the three subscales are .90 ("Language"), .86 ("Media"), and .78 ("Ethnic Social Relations").

Qualitative Interview Protocol

This qualitative assessment (see Appendix E) was administered during follow-up sessions to identify the impact of cultural modifications on treatment. Sample questions included "Was the clinician able to address your cultural values?" and "Was anything unhelpful during treatment?" While four questions were initially developed, general follow-up probes were used based on participant responses. For example, if parents identified family values as important during treatment, a follow-up probe was "How did the clinician address your family values."

<center>**Early Pathways Program**</center>

The *Early Pathways* program (Fox & Gresl, 2014) was adapted for home-based use with individual families in poverty from the evidence-based Parenting Young

Children program (Fox & Nicholson, 2003). Key treatment components were maintained across families with minor adaptations in content to tailor the information and strategies to each family's unique situation (e.g., clarification of details, order of activities, pace information was presented). Intake duration was approximately 90-120 minutes and treatment sessions typically lasted 60-90 minutes. During early stages of treatment, caregivers were taught child-led play, a non-directive interaction that allows the child to choose and lead play while the caregiver follows along and offers positive comments on child activities. The goal was to strengthen the parent-child relationship, and caregivers were encouraged to participate in this play at least 15 minutes each day outside of the treatment sessions. There were five additional components to *Early Pathways*. First, psychoeducation regarding child development and reasonable parent expectations as well as information about the development and maintenance of challenging behaviors was offered to caregivers. Second, caregivers were taught the STAR technique (Fox & Nicholson, 2003), a cognitive-behavioral strategy to manage parental responses to challenging behavior in a more reasonable and thoughtful manner. Caregivers were instructed to stop (S) before reacting to their child's challenging behaviors, think (T) about their thoughts and emotions, ask (A) themselves what a developmentally appropriate response would be, and finally respond (R) to the child in a thoughtful manner. Third, appropriate developmental expectations based on the child's developmental age were discussed with caregivers. Fourth, caregivers were taught to effectively implement behavioral strategies, such as positive reinforcement and structured routines, in order to increase children's positive behaviors. Finally, strategies to manage challenging behaviors were introduced, including ignoring, redirection, limit setting,

natural consequences, and time-outs; all forms of verbal and corporal punishment were strongly discouraged. Clinicians provided caregivers with individually-developed, behavior treatment plans and a daily checklist to facilitate caregiver practice each week, which families completed and returned at the beginning of the subsequent session.

Cultural Adaptations

Cultural modifications followed the guidelines established by the ecological validity model (Bernal et al., 1995) and the process model of Domenech-Rodríguez & Wieling (2004). The adaptation focused on eight culturally-relevant content areas (e.g., language, concepts, context) while also matching *Early Pathways* with the treatment population through partnership with a community organization to identify family needs and barriers along with concurrent implementation and adjustment of the intervention. Based on these guidelines and feedback from Latino families, the following protocol modifications were made: (a) established a community partnership with a large, non-profit organization in the area; (b) forward-backward translation of program materials to Spanish; (c) addition of bilingual clinicians and a Spanish interpreter to the clinical staff; (d) inclusion of an acculturation measure to identify adherence to cultural values; and (e) cultural competence training for clinicians.

The community partnership involved meetings with community pediatricians, nurses, and social workers at a large non-profit, health care organization to identify community needs, barriers, and program goals. Two formal meetings occurred while implementing initial cultural modifications. During meetings, handouts about *Early Pathways* were provided and discussed with medical providers, and feedback was solicited regarding potential adjustments, such as engaging multiple caregivers in

treatment. Subsequently, annual meetings were conducted to identify ongoing challenges and adjust initial modifications throughout program duration.

The Spanish interpreter was trained to maintain client confidentiality and interpreter familiarity with mental health terminology. Prior to conducting visits with non-Spanish speaking clinicians, the interpreter shadowed the primary bilingual clinician and discussed treatment protocol and terminology to ensure accuracy of translation. The interpreter also met with the bilingual doctoral student to review facilitation and analysis of assessment protocol, as well as appropriate incorporation of assessment data to adapt treatment strategies. In addition, the primary bilingual clinician, bilingual doctoral student, and interpreter met weekly for six sessions to discuss the implementation of cultural factors into treatment sessions. Following initial sessions, clinicians and the interpreter met informally to discuss individualized family concerns as they arose during treatment.

Cultural competence training for all staff and students included a review of Latino cultural constructs and their potential impact on Latino parenting. For example, clinicians were instructed that Latino caregivers may place a greater emphasis on familial rather than non-familial relationships, and treatment may involve extended family members, including grandparents, aunts, and uncles. In addition, clinicians were informed that they may need to spend additional time building a strong relationship with the family at the outset of treatment due to the Latino preference for close, personal relationships with treatment providers. Clinicians also were instructed that they may have to implement unique treatment strategies, such as physical rather than verbal forms of praise, as well as focus on the potential impact of gender roles during treatment.

Finally, cultural competence training emphasized that while understanding these cultural values is necessary, adherence to cultural values is not universal and clinicians must attend to individual participant differences.

Clinician Training

One full-time bilingual licensed professional counselor and one bilingual doctoral student served as the primary clinicians on the project. In addition, three full-time licensed professional counselors, three full-time counselors-in-training, two doctoral psychology students, and five master's level graduate students who were completing practicum or internship placements served as clinicians for the project. For non-Spanish speaking clinicians, a Spanish interpreter attended sessions to translate materials and ensure the appropriate implementation of treatment protocol. A consulting psychologist and clinical director provided supervision while senior clinicians and doctoral students trained novice clinicians on the treatment protocol using a three-step process: (a) novice clinicians received didactic training and read an extensive training manual on the *Early Pathways* program, (b) they shadowed senior clinicians on in-home visits, and (c) they gradually implemented in-home treatment protocol under supervision. At that point, they began to lead cases. Additionally, incoming clinicians were trained on how to competently interact with a diverse racial and ethnic population within an urban setting, with low-income backgrounds, particularly emphasizing Latino cultural values and their impact on treatment. Once novice clinicians demonstrated appropriate professional demeanor, showed cultural sensitivity, and completed administrative documentation based on a treatment fidelity checklist completed by their supervisors, they subsequently were allowed to facilitate individual cases. Each clinician received individual

supervision and attended weekly case management meetings to discuss client progress, address concerns, and receive feedback on clinician performance.

Data Analyses

The IBM SPSS Statistics for Windows, Version 21.0 (IBM Corp., 2012) program was used to conduct the statistical analyses for this study. Intent-to-treat (ITT) analyses were used by including all families who had available data regardless of whether they dropped out of treatment prematurely. This analysis is more conservative than a dose-effect comparison. Treatment completers and dropouts were compared on demographics and pre-test measures.

Immediate and delayed treatment groups then were compared on demographic, acculturation, and treatment adherence variables. Independent-group *t*-tests were used to identify any statistically significant differences at pre-test on continuous variables (e.g., child age, acculturation score, treatment adherence) while chi-square tests were used to assess significant differences on categorical variables (e.g., child gender, caregiver employment status).

For research questions one through four, multivariate analyses of covariance (MANCOVA) were computed to determine if the immediate treatment group differed from the delayed treatment group on post-test measures with the pre-test scores as covariates. The MANCOVA procedures were chosen because this study used a randomized, waitlist design with the pre-test occurring prior to treatment. Further, pre-test scores were found to be predictors of post-test scores on each measure, and therefore controlling for pre-test scores accounted for this relationship. Effect sizes were examined using Cohen's *d* (Cohen, 1988). It was hypothesized that the immediate treatment group

would be significantly different at post-test compared to the delayed control group on all measures.

After the delayed treatment group completed *Early Pathways*, repeated measures, multivariate analysis of variance (MANOVA) were conducted to determine if significant change was made from pre-test to follow-up for the combined sample of both groups. Three points in time were used for both groups (pre-test, post-test, and follow-up). Effect sizes were examined using Cohen's *d* (Cohen, 1988). It was hypothesized that following treatment, both groups would show statistically significant change over time and would not be significantly different from each other.

For research question five, participant scores on the PBC Expectations scale were separated into low (score < 40), medium (score between 40 and 60), and high (score > 60) groups. Low scores at pre-test were expected to increase at post-test and follow-up, high scores were expected to decrease, and medium scores were expected to remain static. A chi-square test of pre-test scores was analyzed to determine any initial between-group differences. Subsequently, a chi-square test after the immediate group received treatment was run. It was hypothesized that the immediate treatment group would be significantly different from the delayed group. After the delayed group subsequently received treatment, a chi-square test at post-test was run. It was hypothesized that the two groups would not be significantly different after they both received treatment.

For research question six, the number of children who received a diagnosis at pre-test and post-test were compared to identify whether participation in the treatment program led to a decreased rate of psychiatric diagnoses in the sample. In addition, a chi-square test of pre-test scores was analyzed to determine any initial between-group

differences. Subsequently, a chi-square test after the immediate group received treatment

was run. It was hypothesized that the immediate treatment group would be significantly

different from the delayed group. After the delayed group subsequently received

treatment, a chi-square test at post-test was run. It was hypothesized that the two groups

would not be significantly different after they both received treatment.

For research question seven, scores on the seven questions from the Family

Satisfaction Survey were summed to provide an aggregate total. All participant scores

were combined, and an average score was assessed.

Finally for research question eight, qualitative interviews were completed with 12

participants as part of the *Early Pathways* follow-up sessions. During these follow-up

sessions, each participant responded to a brief four-question protocol. One bilingual

research assistant and one bilingual clinical interpreter completed the qualitative

interviews. Seven interviews were audiotaped while the other five participants declined

to be audiotaped. These questions attempted to address the relevance or lack of relevance

of cultural factors during the culturally-adapted *Early Pathways* program.

A grounded theory method (GTM; Glaser & Strauss, 1967) qualitative approach

was used. Adaptations based on Rennie, Phillips, and Quartaro (1988) also were

included. A bottom-up, inductive process was used by first examining interview data to

establish meaning units (MU). The literal text was read and coded to derive specific

MUs based on the general meaning of the passage. Passages could be grouped into more

than one MU. For example, if the researcher determined that a passage referred to two

distinct MUs (e.g., *familismo, respeto*), this passage was grouped into both MUs.

Subsequently, the MUs were grouped by similarity to create categories. Finally, these

categories were compared for similarity of meaning to determine general overarching constructs (core categories).

Constant comparative analysis was used throughout these stages. The preliminary category development process involved examining the literal text to establish MUs, followed by comparing one MU to another and combining MUs if similar. This process continued for all MUs until none were remaining and all categories had been developed. Once all MUs had been organized into categories, they were resorted and the process was repeated beginning with a different MU. Eventually, a hierarchical structure was established with the MUs as the foundation, categories as the second tier, and core categories as the most abstract group.

Prior to conducting the interviews, a review of the literature and bracketing of researcher bias was completed through examination of thoughts regarding the impact of Latino cultural factors on PCT treatment (e.g., expectations about extended family involvement in treatment). The goal of bracketing researcher bias was to avoid leading participants during the interviews as well as limit searching for expected findings during the analysis phase. In addition, saturation determined when the last interview was conducted. When no new MUs could be derived from additional interviews, the saturation point had been reached. Theoretical memos were maintained throughout the interview and analysis process. These memos were kept in a packet of protocol forms, and included thoughts about MUs, categories, interview data, and anything else relevant to the process.

Following data analysis, participants were provided with their interviews and researcher interpretations to determine if there were any discrepancies between

participants' and researchers' perspectives. Participants were given the opportunity to

clarify their comments and offer any concerns. Feedback on interpretation of interviews

and the subsequently developed model were incorporated into the analysis process. The

eventual conceptualization and theoretical model accounted for all of these processes and

gathered information.

CHAPTER IV: RESULTS

All results reflect intent-to-treat (ITT) analyses as described in the data analysis section. A total of 26 (32.5%) participants from the immediate group and 18 (31.6%) participants from the delayed group dropped out prior to completing a post-test evaluation, and 18 participants from the immediate group and 16 participants from the delayed group did not complete a follow-up evaluation (see Figure 1). Treatment completers and dropouts were compared on demographics and pre-test measures. No differences were found on pre-test measures. On demographics, dropouts were more likely to be single [$\chi^2(2) = 9.52, p < .01$] and also more commonly spoke English [$\chi^2(1) = 7.16, p < .01$].

Immediate and delayed treatment groups were then compared on demographic, acculturation, and treatment adherence variables. The immediate treatment group had a larger number of employed parents [$\chi^2(1) = 7.02, p < .01$]. Otherwise, there were no differences between groups on demographic or acculturation variables. Average program duration was 2.7 months ($SD = 1.58$) for the immediate treatment group and 3.25 months ($SD = 1.25$) for the delayed treatment group while treatment attendance was 81% for both groups. No significant differences between groups were found for any treatment adherence variables.
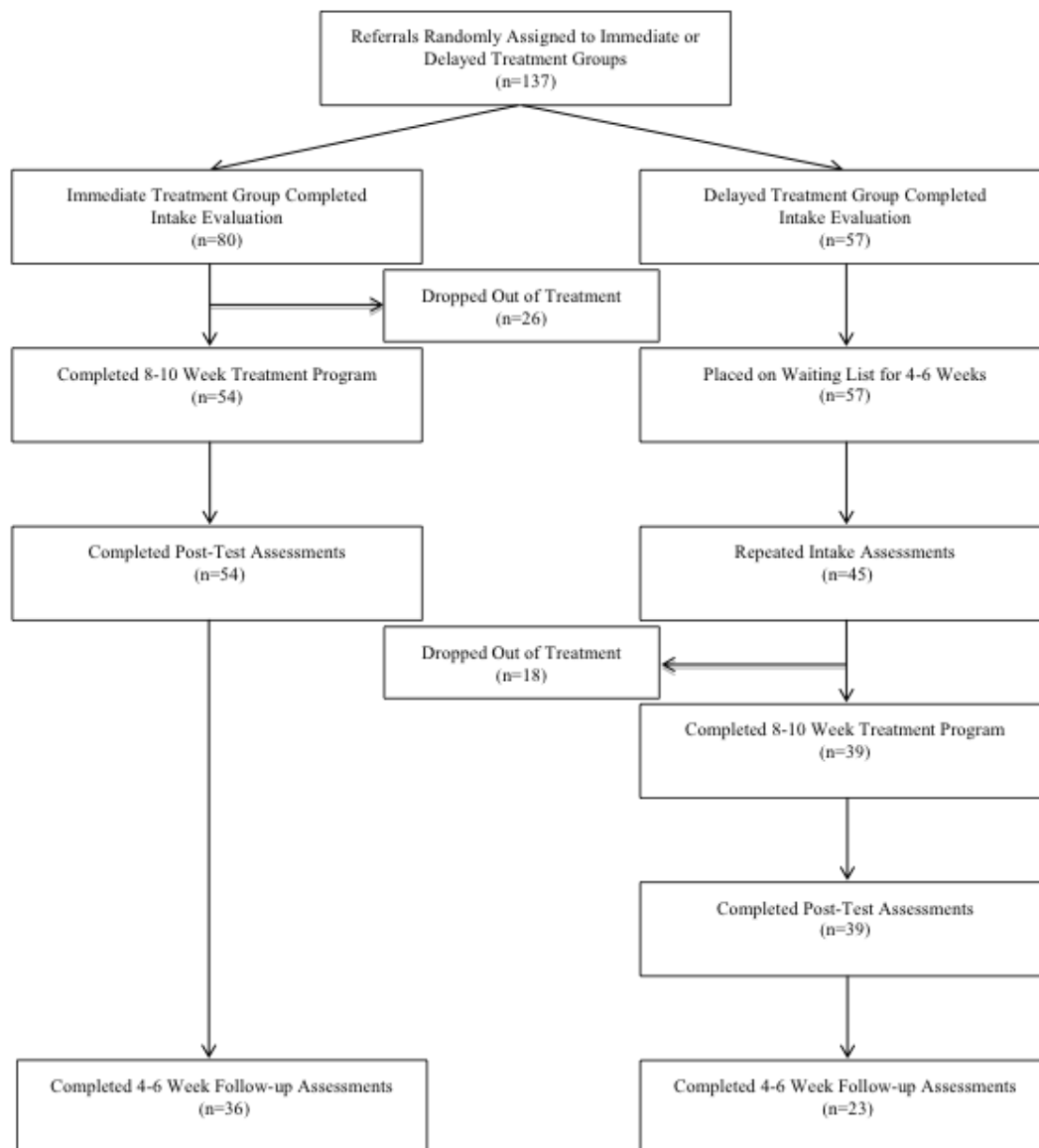
Figure 1

Participant Flowchart from Random Group Assignment through Short-Term Follow-Up Evaluations

For research questions one through four, MANCOVA results (see Table 1) showed a significant difference between the immediate and delayed treatment groups on the ECBS measure with a large effect size [$F(2,81) = 39.79$, $p < .001$, Cohen's $d = 1.98$]. A review of univariate tests revealed significant differences on the ECBS-PBS with a large effect size [$F(1,82) = 19.02$, $p < .001$, Cohen's $d = .96$] and the ECBS-CBS with a large effect size [$F(1,82) = 72.32$, $p < .001$, Cohen's $d = 1.88$]. Results also revealed a significant difference between the immediate and delayed groups on the overall PCPA measure with a large effect size [$F(2,73) = 24.96$, $p < .001$, Cohen's $d = 1.65$]. A review of univariate tests revealed significant differences on the PCPA child scale with a large effect size [$F(1,74) = 20.96$, $p < .001$, Cohen's $d = 1.07$] and the PCPA parent scale with a large effect size [$F(1,74) = 50.14$, $p < .001$, Cohen's $d = 1.65$]. For the PBC discipline and nurturing scales, a significant difference between the immediate and delayed groups was found with a large effect size [$F(2,81) = 8.75$, $p < .001$, Cohen's $d = .93$]. A review of univariate tests revealed significant differences on the PBC discipline scale with a large effect size [$F(1,82) = 14.61$, $p < .001$, Cohen's $d = .84$] and the PBC nurturing scale with a medium effect size [$F(1,82) = 7.38$, $p < .01$, Cohen's $d = .60$]. MANCOVA tests also revealed a significant difference between the immediate and delayed groups on the overall GAF and PCRS measures with a large effect size [$F(2,77) = 97.16$, $p < .001$, Cohen's $d = 3.18$]. A review of univariate tests revealed significant differences on the individual GAF measure with a large effect size [$F(1,78) = 143.09$, $p < .001$, Cohen's $d = 2.71$] and the individual PCRS measure with a large effect size [$F(1,78) = 132.92$, $p < .001$, Cohen's $d = 2.61$].

Table 1

MANCOVAs with Pairwise Comparisons for Immediate vs. Delayed Groups at Pre-test, Post-test/Pre-test 2, and Follow-up

Measures	Immediate Pre-test		Delayed Pre-test		Immediate Post-test		Delayed Pre-test 2			Immediate Follow-up		Delayed Follow-up	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*d*	*M*	*SD*	*M*	*SD*
ECBS													
Pro-Social	21.61	3.34	22.32	2.69	25.15*	2.92	23.18	2.80	.96	25.19	3.18	24.83	3.11
Challenging	22.76	4.48	22.72	4.14	16.74*	4.25	21.96	4.12	1.88	16.14	3.93	17.91	4.76
PCPA													
Child	7.27	2.27	6.76	2.44	9.13*	1.07	6.93	2.44	1.07	8.69	2.32	8.18	2.65
Parent	8.26	2.10	7.50	2.31	10.84*	1.26	7.63	2.37	1.65	10.10	2.12	10.00	2.83
PBC													
Discipline	14.93	4.78	14.93	4.58	12.76*	3.34	14.57	4.62	.84	12.56	2.36	13.48	3.65
Nurturing	28.80	5.53	28.98	5.56	30.57*	5.77	28.18	6.14	.60	31.69	4.60	29.91	4.03
GAF	56.44	7.64	56.81	8.68	74.83*	8.75	57.24	7.36	2.71	78.17	7.72	76.26	11.60
PCRS	54.57	12.28	56.84	11.94	77.74*	11.00	57.68	9.69	2.61	80.28	7.92	77.83	9.02

Note: $*p<.001$. The notation d refers to effect size of MANCOVA comparisons at post-test with pre-test scores as covariates.

Subsequently, repeated measures, multivariate analyses of variance (MANOVA) were conducted to determine if significant change was made from pre-test to follow-up for the combined sample of both groups. Results showed a significant time effect on the overall ECBS measure with a large effect size [$F(4,54) = 38.22$, $p < .001$, Cohen's $d = 3.37$]. A review of univariate tests revealed significant time effects on the ECBS-PBS with a large effect size [$F(2,114) = 33.96$, $p < .001$, Cohen's $d = 1.54$] and the ECBS-CBS with a large effect size [$F(2, 114) = 97.95$, $p < .001$, Cohen's $d = 2.62$]. Results for the PCPA measure also showed a significant overall time effect with a large effect size [$F(4,39) = 13.75$, $p < .001$, Cohen's $d = 2.37$]. A review of univariate tests revealed significant time effects on the PCPA child scale with a large effect size [$F(2,84) = 15.58$, $p < .001$, Cohen's $d = 1.22$] and the PCPA parent scale with a large effect size [$F(2,84) = 28.16$, $p < .001$, Cohen's $d = 1.64$]. A significant overall time effect with a large effect size was found on the combined PBC discipline and nurturing scales [$F(4,54) = 13.45$, $p < .001$, Cohen's $d = 2.00$]. A review of univariate tests revealed significant time effects on the PBC discipline scale with a large effect size [$F(2,114) = 28.25$, $p < .001$, Cohen's $d = 1.41$] and the PBC nurturing scale with a medium effect size [$F(2,114) = 4.26$, $p < .05$, Cohen's $d = .55$]. There also was a significant time effect on the overall GAF and PCRS measures with a large effect size [$F(4,53) = 54.47$, $p < .001$, Cohen's $d = 4.05$]. A review of univariate tests revealed significant time effects on the GAF measure with a large effect size [$F(2,112) = 152.36$, $p < .001$, Cohen's $d = 3.30$] and the PCRS measure with a large effect size [$F(2,112) = 132.45$, $p < .001$, Cohen's $d = 3.08$]. No differences between groups or interaction effects were found on any of the measures ($p > .05$).

Pairwise comparisons of all measures revealed significant change from pre-test to post-test and maintenance of change from post-test to follow-up (see Table 2).

For research question five, an initial chi-squared test of PBC Expectations scores at pre-test for the immediate and delayed treatment groups was not significant ($p > .05$). However, after the immediate group received treatment, a chi-squared test also was not significant ($p > .05$). That is, participants in the immediate treatment group did not change their position from the low and high groups to the medium group at a statistically different rate than the delayed treatment group. Further, while neither the immediate nor delayed group demonstrated significant change from pre-test to post-test on chi-squared tests ($p > .05$), a chi-squared test of the combined sample revealed significant change from pre-test to post-test [$\chi^2(4) = 10.8, p < .05$]. Review of data showed that 11 participants moved from the low and high groups to the medium group, and 18 participants moved from the medium group to the low and high groups.

For research question six, of the 85.7% of children in the immediate treatment group who received a primary diagnosis at intake, 58.9% no longer met the criteria for a psychiatric diagnosis at post-test. Meanwhile, of the 92.9% of children in the delayed treatment group who received a primary diagnosis at intake, 90.9% still met the criteria for a psychiatric diagnosis at the second pre-test. A chi-square test revealed no differences between groups at pre-test ($p > .05$). However, after the immediate group received treatment, the percentage of children with diagnoses was significantly greater in the delayed group [$\chi^2(8) = 34.23, p < .001$]. After they both had received treatment, 67%

Table 2

Repeated Measures MANOVAs with Pairwise Comparisons for Both Groups Combined at Pre-test, Post-test and Follow-up

Measures	Pre-test		Post-test		Short-term Follow-up		
	M	SD	M	SD	M	SD	d
ECBS							
Pro-social	22.05	2.91	25.31***	2.57	25.05***	3.13	1.54
Challenging	23.22	4.07	16.68***	4.06	16.83***	4.32	2.62
PCPA							
Child	6.89	2.47	8.75***	1.86	8.45***	2.36	1.22
Parent	7.82	2.49	10.64***	1.73	10.16***	2.36	1.64
PBC							
Discipline	16.32	5.28	12.73***	3.38	12.92***	2.94	1.41
Nurturing	28.49	5.83	29.92*	6.05	31.00*	4.44	0.55
GAF	57.62	9.46	75.71***	9.13	77.36***	9.44	3.30
PCRS	58.28	12.79	78.36***	8.81	79.40***	8.43	3.08

Note: *$p<.05$, **$p<.01$, ***$p<.001$. The notation d' refers to overall effect size from pre-test to short-term follow-up.

of the delayed group no longer met criteria for a psychiatric diagnosis at post-test and a chi-square test between groups was not significant ($p > .05$).

For research question seven, scores from each of the seven items (range 1 to 7) on the Family Satisfaction Survey were summed to create an aggregate score ranging from 7 (low satisfaction) to 49 (high satisfaction). The mean score at post-test was 46.67 ($SD = 2.48$) for the immediate group and 46.41 ($SD = 2.67$) for the delayed group, indicating a high level of satisfaction in both groups following treatment. These scores were not significantly different ($p > .05$).

Analysis of interview data revealed nine MUs (see Figure 2). The first four were language, family, respect, and self-disclosure. The language MU referred to participants who discussed the importance of translated materials and being able to clearly decipher and implement the program strategies. The family MU referred to any mention of family inclusion or engagement during treatment (e.g., grandparents involved during treatment) while any references to an emphasis on respect (e.g., importance of respect for elders, clinician respecting parents' culture and discipline preferences during treatment) were included in the respect MU. Finally, the self-disclosure MU included any comment about clinician willingness to discuss personal information (e.g., leisure activities, family interactions). These four MUs were grouped into a "cultural factors" category because of their primary emphases on aspects of culture and their relevance to treatment.

The other five MUs included feelings of comfort, understanding, similarity, sensitivity, and flexibility. Several participants described greater comfort and understanding while speaking to a bilingual clinician rather than through an interpreter. Moreover, many participants reported feelings of similarity toward the clinician as well
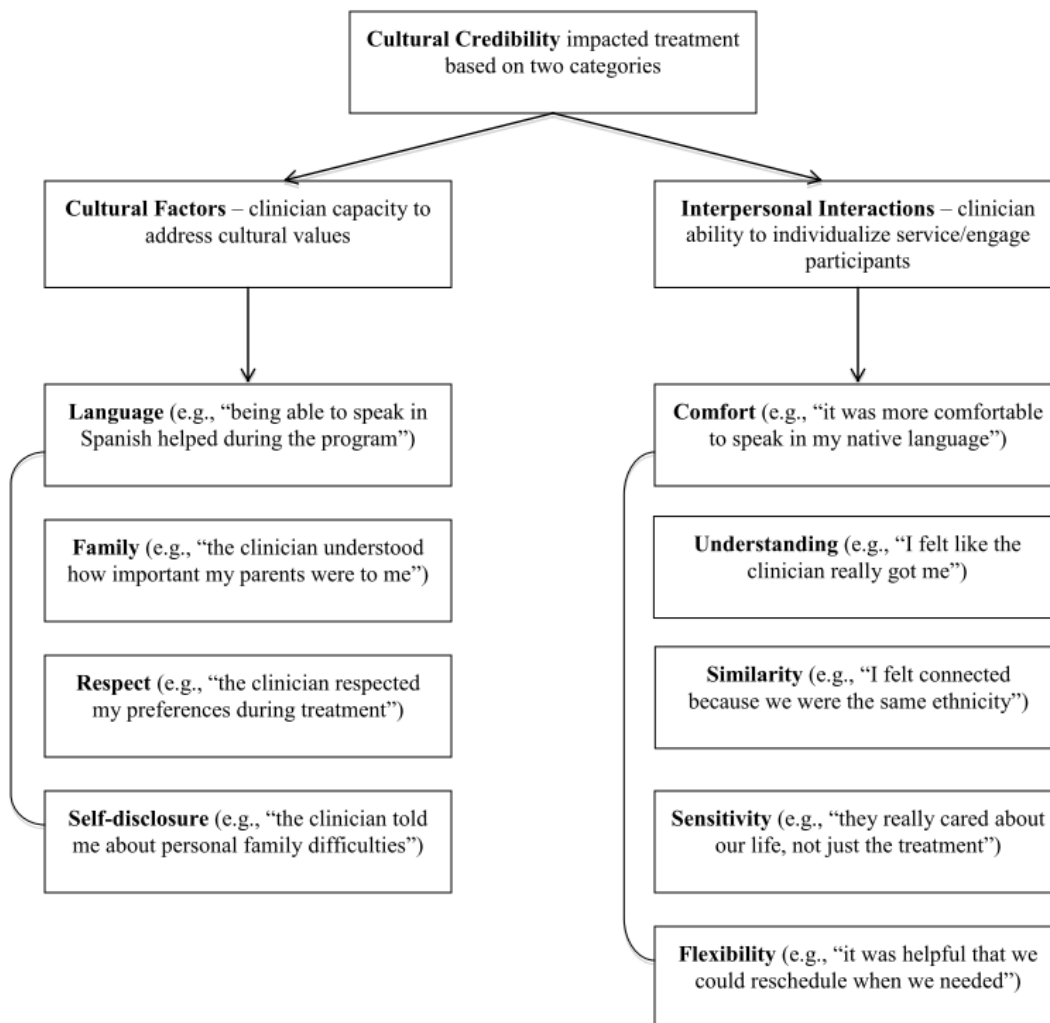
Figure 2

Qualitative Analysis Model

as sensitivity to cultural issues because of the clinician's inherent connection to the participant's primary cultural background. Finally, participants identified clinician flexibility as important during treatment, such as adjusting for scheduling conflicts. These five MUs were grouped together under an "interpersonal interactions" category because each MU seemed to highlight the importance of clinician-participant rapport related to cultural values.

Notably, rather than being mutually exclusive, the two categories showed significant overlap. For example, self-disclosure was categorized in "cultural factors" based on the literature describing *personalismo* as a relevant cultural value (Foucault and Schneider, 2009). However, self-disclosure also affected "interpersonal interactions" by engendering comfort and sensitivity during treatment. Nevertheless, these two categories were subsumed under a general overarching construct of "cultural credibility," which refers to the combination of understanding Latino cultural factors and their importance within the context of treatment, as well as the ability for clinicians to build rapport and connect with participants. This overarching core category seemed apt to describe the interaction of cultural factors and interpersonal interactions, as both appeared relevant to participants' successful outcomes following treatment. Ultimately, clinician "cultural credibility" impacted treatment based on the clinician's ability to implement cultural factors into treatment, such as respecting family structure and engaging extended family members while performing these activities with an interpersonal style that exhibited characteristics (e.g., sensitivity, flexibility) matching each individual family's needs.

CHAPTER V: DISCUSSION

The present study developed, implemented, and analyzed a culturally-adapted *Early Pathways* program for Latino families in poverty with children under the age of six who had been referred for severe behavior and emotional problems. Results revealed that children showed a significant decrease in the frequency and severity of challenging behaviors (e.g., hitting, kicking) as well as a significant increase in pro-social behaviors (e.g., sharing, listening). In addition, caregivers exhibited significant increases in the use of appropriate discipline strategies and nurturing activities with their children. Based on clinician observation, child interactions during play also improved significantly, suggesting an improvement in the parent-child relationship.

The singular non-significant result on the PBC Expectations scale suggests that either the program was unsuccessful at impacting caregiver expectations or another statistical procedure may be necessary to analyze the scale. The latter seems more likely considering that several participants changed groups in both expected and unexpected directions, indicating that caregiver expectations were affected by treatment. Given the nature of the scale, it also was likely that confounding variables played a role. For example, caregivers in the medium group may have raised or lowered their expectations once they learned that their child was functioning at a higher developmental level or if a developmental delay was identified, respectively, thus helping to explain the variable movement between groups.

Important clinical implications were noted. Sixty percent of participants who received a diagnosis at intake no longer had the diagnosis following treatment. Furthermore, a high level of caregiver satisfaction was reported on the overall Family

Satisfaction Survey. These results support previous studies (Carrasco & Fox, 2012; Fox & Holtz, 2009; Fox et al., 2013; Holtz et al., 2009) highlighting the clinical impact of *Early Pathways* as an early intervention to prevent the development of ingrained behavior patterns during later childhood and adolescence.

The use of a randomized, waitlist-control design highlights the contributory effect of *Early Pathways* to the successful outcomes of Latino children participants. This outcome further strengthens the efficacy of *Early Pathways* with children from different ethnic backgrounds as initially identified by Gresl et al. (2014). Moreover, after the delayed group completed treatment, participants from both the immediate and delayed groups exhibited similar positive outcomes with successful maintenance of gains, importantly highlighting the long-term efficacy of *Early Pathways*. This long-term, sustainable impact is likely a result of the program's requirement that caregivers directly implement treatment strategies and participate fully in the intervention. By the end of treatment, caregivers had developed the necessary skills to manage their children's challenging behaviors independently. Also, younger children's behavior problems are more quickly addressed by consistent implementation of effective strategies than older children, whose behavior often has become more ingrained.

The direct observation of child behavior in the family's natural environment provides compelling support for the in-home treatment format because clinicians were able to directly witness challenging behavior patterns and difficult parent-child interactions. Clinicians then were able to adapt treatment to each family's specific concerns rather than offer generic treatment strategies. The in-home structure also empowered caregivers to address their children's challenging behaviors in the most

pragmatic setting possible while also overcoming the aforementioned barriers to

treatment for families in poverty (Nicholson et al., 1999), resulting in this study's positive

outcomes.

This study also adds to the growing body of literature (Borrego, Jr. et al., 2006;

Domenech-Rodríguez et al., 2011; Dumas et al., 2011; Lakes et al., 2009; Martinez, Jr. &

Eddy, 2005; Matos et al., 2009; McCabe & Yeh, 2009) suggesting that cultural

modifications to evidence-based treatment are beneficial when offering early intervention

services for culturally diverse participants. In addition to cultural competence training

for clinicians and general protocol modifications (e.g., translation of materials, use of

bilingual clinicians), this study's adaptations emphasize building partnerships with

community constituents (e.g., health care organizations, pediatricians) to identify specific

community needs and barriers. Through this inclusion of community recommendations,

Early Pathways was able to more appropriately adapt its services to Latino family needs,

increasing access to care for Latino families in poverty. Importantly, this study reported

large effect sizes ranging from .55 to 4.05 (Cohen's *d*), comparable to the culturally-

adapted PCIT programs that also used an individual parent-child format (Borrego, Jr. et

al., 2006; Matos et al., 2009; Matos et al., 2006; McCabe & Yeh, 2009). These large

effect sizes further highlight the greater efficacy of individual PCT compared to group

PCT formats. Overall, the study findings provide compelling evidence for the

incorporation of cultural modifications into evidence-based treatment to address the

dearth of culturally-adapted services for Latinos, particularly using an in-home parent-

child dyad structure.

Qualitative analysis of follow-up interviews suggests that cultural factors were integral in the *Early Pathways* program's successful treatment outcomes. While no single grounded theory was developed, there appeared to be an interaction of two primary components during the culturally-adapted *Early Pathways* treatment: (a) clinician understanding of Latino cultural factors and (b) the ability of the bilingual clinician to effectively build rapport with participants through the integration of cultural factors into treatment. However, given the significant overlap of the identified variables and relatively arbitrary categorization process, further clarity of this model is necessary.

Nevertheless, these results suggest that there is an additional process beyond cultural competence training and translation of materials, which is related to the bilingual clinician's sensitivity and inherent connection to Latino culture. The term "cultural credibility" was chosen because it better highlights the importance of both cultural competence along with the capacity to effectively engage Latino participants in treatment, perhaps because a bilingual clinician offered greater credibility of cultural competence. These results likely will add to the discussion of cultural competence terminology (e.g., cultural competence, cultural expertise, cultural sensitivity) and the various factors that are subsumed under each term (Sue et al., 2009). However, this preference for bilingual clinicians does not preclude successful treatment when using a bilingual interpreter because positive outcomes were found for the overall sample. Ultimately, the field of mental health should approach treatment for traditionally underserved populations with the understanding that the best services are likely provided with a thorough implementation of cultural modifications, including translation of materials, cultural competence training, and the use of bilingual clinicians.

Limitations

The first limitation of this study was the relatively high attrition rate (32.1%) that occurred, similar to other PCT programs that provide in-home treatment for traditionally underserved populations. Of important note, treatment completers did not differ from non-completers on any of the study's outcome measures at pre-test suggesting that attrition may best be attributed to contextual factors as suggested by Nicholson et al. (1999), some of which included loss of phone services, financial and family crises, and frequent relocation. Second, despite the use of a waitlist-control group, the length of time to complete treatment varied for the immediate treatment group. That is, while the delayed treatment group waited four to six weeks ($M = 5.86$, $SD = 1.82$), the immediate treatment group rarely completed treatment within that four-six week period ($M = 11.7$, $SD = 6.85$), due to treatment-specific needs (e.g., child trauma history, medical issues). Therefore, additional time effects could not be isolated and may be a factor given the relatively short delay before treatment. Similarly, variable length of time between post-test and follow-up was a third limitation of this study. Consistent communication with families is a common challenge of providing treatment for low-income families. Therefore, while a four-six week follow-up was planned, typical duration between post-test and follow-up varied ($M = 6.93$, $SD = 4.16$). A fourth limitation was the use of a convenience sample of self-referred participants, which may limit generalization.

A fifth limitation was the moderate Kappa coefficients for the PCRS and GAF, though given the nature of those measures, moderate Kappa levels may be difficult to exceed. In addition, while acculturation was not the primary focus of this study, the examination of acculturation and its effect on clinical outcomes was a limitation.

Specifically, the limited analysis of the SASH assessment (i.e., as a single continuous scale) did not account for variation across items and scales. That is, participants may have reported greater acculturation on some items or scales than others, which should be further assessed.

Regarding the qualitative analysis, only seven of the twelve interviews were audiotaped, limiting analysis of data, and we lost contact with some families who were interviewed before they were able to provide feedback about their interview results. Moreover, the qualitative analysis was completed by a single researcher without the use of either a team or an auditor.

Conclusion/Implications for Future Research

The successful outcomes of this study add two primary findings to the current literature: (a) evidence for the efficacy of a culturally-adapted *Early Pathways* program for young Latino children and (b) support for the contributory effect of the *Early Pathways* in-home format as an effective treatment for child behavior problems through the implementation of a randomized waitlist-control design. The cultural modifications implemented in this study offer potential avenues for further development of culturally-adapted treatment models. In light of these positive results, future research should further identify how cultural factors play a role in treatment with particular focus on clinician effects, perhaps examining interpreter and bilingual clinician outcomes to clarify the initial findings of this study. A comprehensive mixed methods approach with a team of researchers and an auditor would be beneficial to identifying these differences. Given the within-group heterogeneity of Latino populations, it also will behoove future research to compare Latino ethnicities (e.g., Mexican, Puerto Rican) and acculturation status to

identify any within-group differences. A multidimensional orthogonal approach that isolates scores within each scale on the SASH would more clearly delineate the specific details and impact of acculturation on participant outcomes.

In addition to cultural-specific improvements, further research should attempt to expand the *Early Pathways* program to address two other areas of need. First, 30% of this study's participants reported a history of trauma, which in turn required additional trauma-focused strategies during the treatment process. Second, it quickly became evident during this study that Latino families living in poverty faced a multitude of contextual factors that often served as barriers to treatment (e.g., medical needs, school and academic concerns, financial limitations). While *Early Pathways* clinicians effectively managed both of these challenges by reviewing trauma-focused treatment and providing advocacy efforts for participants, it would be beneficial to incorporate and assess an evidence-based trauma-focused treatment model into *Early Pathways*, as well as examine the impact of clinician advocacy on the treatment process and outcomes.

Finally, while this study's findings suggest that the in-home format is an effective setting for a PCT program, two areas need to be addressed. First, a novel statistical analysis of the PBC Expectations scale should be developed to clarify the impact of *Early Pathways* on caregiver expectations, perhaps focusing on a case-by-case analysis of participants. Second, given that the ITT analysis used in this study was more conservative than a dose-effect comparison, subsequently resulting in a higher attrition rate, future research should develop a more comprehensive definition of treatment adherence to better identify treatment completion. One recommendation comes from Swift, Callahan, and Levine (2009), a multi-dimensional definition of treatment

completion, incorporating treatment attendance, a reliable change index of a primary

outcome measure, and a clinician observation of caregiver participation in treatment.

Such a definition would assess participant outcomes on several facets of treatment. The

Early Pathways program recently took a first step toward developing a multi-dimensional

definition of treatment completion (Fung et al., 2014), and a current study is presently

working to further develop this approach in *Early Pathways* treatment.

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APPENDIX A

Marquette University
Parent Permission Form
Behavior Clinic: Shaw Fund Project
Dr. Robert Fox, Professor of Counselor Education and Counseling Psychology and Director of the Behavior Clinic at
Penfield Children's Center

(stamp: MARQUETTE Approved FEB 1 3 2013 IRB)

You and your child have been invited to participate in this research study. Before you agree to allow your child to participate, it is important that you read and understand the following information. Participation is completely voluntary. Whether or not you choose to allow your child to participate in this project will have no effect on your child's treatment or relationship with the clinic. Please ask questions about anything you do not understand before deciding whether or not to give permission for your child to participate.

Purpose: I understand that the purpose of this research study is to determine if our treatment program is successful in reducing behavior and emotional problems of young Latino children. I understand that my child will be one of approximately 500 participants in this research study and that we have a 50% chance of receiving treatment immediately or after an eight-week waiting period.

Procedures: I clearly understand the following procedures will be part of this project following my initial orientation to the program after my child has been referred: (1) Intake session – I will participate in an interview with my child, be observed interacting with my child, complete surveys, answer interview questions, and have my child's development and behavior assessed. These procedures will require two hours to complete. (2) Treatment sessions – I will meet with clinic staff for eight or more one to one and a half-hour treatment sessions in my home. I will be expected to implement a new form of play with my child and a treatment program including strategies designed to improve my child's behavior and address any relevant trauma-related concerns that will require up to one hour of my time each day in my home. Video recording of portions of some treatment sessions will be offered to supplement the treatment strategies. (3) Post-test session – After the treatment sessions are over, I will meet with a staff member for one hour to repeat a portion of the intake procedures. (4) School readiness program – During the post-test session, I will receive school readiness materials and information from clinical staff about how to implement school readiness activities. I will be expected to perform school readiness activities, such as reading with my child. (5) Short-term follow-up session – About four-six weeks after the post-test session, I will meet again with clinic staff for one hour to repeat the post-test session as well as to discuss my current progress with the school readiness program. At that time, I may request additional services from the Behavior Clinic. (6) Long-term follow-up sessions – Every three months after completion of the initial follow-up session, I will meet again with clinic staff for one hour to repeat a portion of the intake procedures until termination of the third year of the project. (7) Follow-up phone calls – In addition to follow-up sessions, I will speak briefly with clinicians on the phone once a month to discuss current progress and have a chance to ask any questions.

Duration: I understand that my child's participation will consist of either one or two intake sessions, eight or more treatment sessions, a post-test session, one short-term follow-up session, six sessions of the school readiness program, and long-term follow-up sessions until termination of the project. The entire time my child is involved in this project will be three years.

Risks: I understand the risks associated from my participation in this study including, the ongoing parenting stress that I may experience in managing my child's behavior and the emotional discomfort my child may experience as I implement new procedures to improve his/her behavior.

Benefits: I understand the benefits associated with my participation in this study including, I will have an improved understanding of my child and his/her behavior; I will learn effective strategies to better manage my child's behavior; I will have ongoing professional support as I work to improve my child's behavior; I will observe improvement in my child's behavior; and I will learn effective academic preparation activities with my child. I also understand that my participation in this study may assist other parents who are experiencing similar behavior problems with their young children.

Confidentiality: I understand that all information my child and I reveal in this study will be kept confidential. All of my child's data will be assigned an arbitrary code number rather than using my child's name or other information that could identify my child as an individual. When the results of the study are published, my child will not be identified by name. The data for this study will be kept in a locked file cabinet at Penfield Children's Center. I understand that the data will be destroyed by shredding of all paper documents and deletion of electronic files seven years after the completion of the

study. I understand that the research records may be inspected by the Marquette University Institutional Review Board or its designees and (as allowable by law) state and federal agencies. I understand that the clinic staff are mandated reporters and are required by law to report child abuse and neglect to the authorities.

Compensation: I understand that I will receive a framed certificate of completion following initial treatment termination as well as a $25 gift card after each completed follow-up session (thirteen total).

Voluntary Nature of Participation: I understand that participating in this study is completely voluntary and that my child may withdraw from the study and stop participating at any time without penalty or loss of benefits to which my child is otherwise entitled. If I choose to withdraw from this study, my child's research records will be destroyed. I also understand that if I choose not to participate in the study, I can still receive normal treatment services at the Behavior Clinic. If the Behavior Clinic services are not appropriate for my child, I will be referred to alternative services in the community.

Contact Information: If I have any questions about this research project, I can contact Dr. Robert Fox at (414) 345-6351 or email him at robert.fox@marquette.edu. If I have questions or concerns about my child's rights as a research participant, I can contact Marquette University's Office of Research Compliance at (414) 288-7570.

I HAVE HAD THE OPPORTUNITY TO READ THIS PARENT PERMISSION FORM, ASK QUESTIONS ABOUT THE RESEARCH PROJECT AND AM PREPARED TO GIVE MY PERMISSION FOR MY CHILD TO PARTICIPATE IN THIS PROJECT.

Please choose and check the appropriate consent option box, add the date of consent, and obtain the appropriate signatures.

☐ Option A – I, the person signing below, understand the above explanations. On this basis, I consent to participate voluntarily in the Behavior Clinic research study.

_____   _____
Parent/Legal Guardian Signature(s)   Date

_____   _____
Parent/Legal Guardian Name(s)   Child's Name

_____   _____
Researcher Signature   Date

☐ Option B – I, the person signing below, understand the above explanations. On this basis, I do not consent to participate in the Behavior Clinic research study but would like to voluntarily participate in the full range of clinical services offered by the Behavior Clinic.

_____   _____
Parent/Legal Guardian Signature(s)   Date

_____   _____
Parent/Legal Guardian Name(s)   Child's Name

_____   _____
Researcher Signature   Date

Universidad Marquette
Formato de Permiso del Padre
Clínica de Comportamiento: Proyecto de Fondos Shaw
Dr. Roberto Fox, Profesor en Educación de Consejería y psicología y Director de la Clínica de Comportamiento en el
Centro Infantil Penfield

Usted y su hijo/a han sido invitados a participar en un estudio de investigación. Antes de que usted este de acuerdo en que su hijo/a participe, es muy importante que usted lea y entienda la siguiente información. Su participación es completamente voluntaria. Ya sea que usted decida participar o no en este proyecto, esto no afectara el tratamiento de su hijo o la relación que exista con la Clínica. Por favor pregunte todo lo que usted no entienda antes de decidir si da o no el permiso para que su hijo participe.

Propósito: Yo entiendo que el propósito de esta investigación es para determinar si nuestro programa de tratamiento tiene éxito en reducir problemas de conducta y emocionales en los niños Latinos. Yo entiendo que mi niño será uno de aproximadamente 500 participantes en este estudio de investigación y que tendremos un 50% de probabilidad en recibir tratamiento inmediatamente o después de un periodo de espera de ocho semanas.

Procedimientos: Yo entiendo claramente que los siguientes procedimientos serán parte de este proyecto, seguido de mi orientación inicial a este programa y después de que mi niño/a haya sido referido: (1) <u>Sesión de entrevista inicial</u> – Yo participare en una entrevista con mi hijo, seré observado interactuando con mi hijo/a, llenare encuestas, contestare a preguntas, y entiendo que la conducta y desarrollo de mi hijo serán evaluadas. Este procedimiento tomara dos horas para ser concluido. (2) <u>Sesiones de tratamiento</u> – Yo me reuniré en mi hogar con el personal de la Clínica por ocho semanas o mas, por alrededor de una hora o una hora y media cada sesión. Se espera que yo implemente una nueva forma de juego con mi hijo y un programa de tratamiento incluirá estrategias designadas para mejorar la conducta de mi hijo/a y manejar problemas pertinentes relacionados con el trauma que requerirán una hora de mi tiempo cada día en mi hogar. Grabación de vídeo de porciones de algunas sesiones de tratamiento se ofrecerá para complementar las estrategias de tratamiento. (3) <u>Sesión de prueba de reforzamiento</u> – Después del tratamiento las sesiones se terminaran, yo me reuniré con un miembro del personal por aproximadamente una hora para repetir una porción del procedimiento de la entrevista inicial. (4) <u>Programa de educación prescolar</u> – Durante la sesión de prueba de reforzamiento, Yo recibiré información sobre el programa de educación prescolar. Se esperara que yo desempeñe actividades de educación prescolar, como leer con mi niño/a. (5) <u>Sesión de seguimiento a corto plazo</u> – Aproximadamente de 4-6 semanas después de la sesión de la prueba de reforzamiento, Yo me reuniré de nuevo con el personal de la clínica por aproximadamente una hora para repetir la sesión de prueba de reforzamiento y también para discutir el progreso actual del programa de educación prescolar. Esta vez, yo podre expresar y pedir servicios adicionales a la Clínica de Comportamiento. (6) <u>Sesiones de seguimiento a largo plazo</u> – Cada tres meses después de terminar la sesión de seguimiento inicial, Yo me reuniré una vez mas con el personal de la clínica por aproximadamente una hora para repetir una porción del procedimiento de la entrevista inicial hasta que termine el tercer año del proyecto. (7) <u>Llamadas de seguimiento</u> – Aparte de las sesiones de seguimiento, yo hablare por teléfono con los consejeros una vez al mes para discutir el progreso actual de mi niño/a y tendré la oportunidad de hacer preguntas.

Duración: Yo entiendo que la participación de mi niño/a consistirá en una o dos sesiones de entrevistas iniciales, ocho sesiones de tratamiento o más, una sesión de prueba de reforzamiento, una sesión de seguimiento a corto plazo, seis sesiones del programa de educación prescolar y una sesión de seguimiento de largo plazo hasta la terminación del proyecto. Tres años será el tiempo que mi hijo/a estará envuelto en este proyecto.

Riesgos: Yo entiendo los riesgos asociados con mi participación en este estudio, que incluye el estrés que tal vez experimente como padre al manejar la conducta de mi hijo/a y el malestar emocional que mi hijo/a pueda experimentar al yo implementar nuevas tácticas para mejorar su conducta.

Beneficios: Yo entiendo que los beneficios asociados con mi participación en este estudio incluyen, que yo tendré un mejor entendimiento sobre la conducta de mi niño/a y aprenderé estrategias efectivas para manejar mejor la conducta de mi hijo/a; también tendré apoyo profesional conforme vaya trabajando para mejorar la conducta de mi hijo/a; Notare la mejoría en su conducta; y aprenderé actividades de preparación académica efectiva para mi hijo/a. También entiendo que mi participación en este estudio ayudara a otros padres que estén experimentando problemas de conducta similares con sus hijos.

Confidencialidad: Yo entiendo que toda la información que yo revele mía o de mi hijo/a se mantendrá confidencial. A todos los datos de mi hijo se les dará un número arbitrario, en vez de usar el nombre de mi hijo/a u otra información que pueda identificarlo como individuo. Cuando los resultados de este estudio sean publicados, a mi hijo no se le identificara por su nombre. Los datos de este estudio se mantendrán en un archivero bajo llave en el Centro Infantil Penfield. Yo

entiendo que todos los datos para este estudio serán destruidos por medio de un destrozador de papel y todos los datos capturados electrónicamente serán borrados después de siente años de la finalización del estudio. Yo entiendo que los archivos de la investigación pueden ser inspeccionados por el Comité de Revisión Institucional de la Universidad Marquette o sus representantes y (como la ley lo permita) en las agencias estatales y federales. Yo entiendo que el personal de la Clínica está obligado por la ley a reportar a las autoridades cualquier abuso maltrato o negligencia por parte del padre u otras personas hacia un niño/a.

Compensación: Yo entiendo que recibiré un certificado de Culminación en marco, seguido de la terminación del tratamiento inicial así como un certificado de regalo de $25dolares después que cumpla con cada sesión de seguimiento (trece en total).

Participación Natural Voluntaria: Yo entiendo que participar en este estudio es completamente voluntario y que mi hijo/a en cualquier momento y sin ninguna penalidad o pérdida de beneficios a los cuales mi hijo/a tenga derecho él puede retirarse del estudio y no seguir participando. Si yo decido que mi hijo/a no seguirá participando en este estudio, los archivos de mi hijo se destruirán. También entiendo que si decido no participar en el estudio, todavía puedo recibir servicios de tratamiento normales en la Clínica de Comportamiento. Yo también entiendo que si yo decido no participar en la Clínica de Comportamiento se me referirá a otros servicios alternativos familiares que existan en la comunidad.

Información de Contacto: Si tengo cualquier pregunta acerca de este proyecto, puedo comunicarme con el Dr. Roberto Fox al: (414) 345-6351 o enviarle un correo electrónico a: Robert.fox@marquette.edu. Si tengo preguntas o inquietudes acerca de los derechos que tiene mi hijo/a al participar en esta investigación, Yo puedo comunicarme a la oficina de Cumplimiento en Investigación de la Universidad de Marquette al: (414) 288-7570

YO HE TENIDO LA OPORTUNIDAD DE LEER ESTA FORMATO DE PERMISO DEL PADRE, HACER PREGUNTAS ACERCA DEL PROYECTO DE INVESTIGACION Y ESTOY PREPARADA PARA DAR MI CONSENTIMIENTO PARA QUE MI HIJO/A PARTICIPE EN ESTE PROYECTO DE INVESTIGACION.

Por favor escoja y marque la caja con la opción de consentimiento apropiada, añada la fecha de consentimiento y obtenga las firmas apropiadas.

Opción A – Yo, la persona que firma, entiendo toda la información en este documento. En base a ello, doy mi consentimiento para participar voluntariamente en este estudio de Investigación.

_____   _____
Firma (s) del Padre/Tutor   Fecha

_____   _____
Nombre (s) del Padre/Tutor   Nombre del Niño

_____   _____
Firma Del Investigador   Fecha

Opción B – Yo, la persona que firma, entiendo toda la información en este documento. En base a ello, no doy mi consentimiento para participar en el estudio de investigación de la Clínica de Comportamiento, pero me gustaría participar voluntariamente y en su totalidad en los servicios que ofrece la Clínica de Comportamiento.

_____   _____
Firma (s) del Padre/Tutor   Fecha

_____   _____
Nombre (s) del Padre/Tutor   Nombre del Niño

_____   _____
Firma Del Investigador   Fecha

APPENDIX B

MARQUETTE
UNIVERSITY

Be The Difference.

Office of Research Compliance

Schroeder Complex, 120
PO Box 1881
Milwaukee, Wisconsin 53201-1881

P 414.288.7570
F 414.288.6281
W www.marquette.edu/researchcompliance

March 6, 2012

Dr. Robert Fox
Counselor Education and Counseling Psychology

Dear Dr. Fox:

Your protocol number HR-2350, titled, *"Resolving Significant Mental Health Concerns in Young Latino Children Through a Parent and Child Therapy Program: A Three Year Study"* was expedited on March 5, 2012, by a member of the Marquette University Institutional Review Board.

Your IRB approved informed consent forms are enclosed with this letter. Use the stamped copies of these forms when recruiting research participants. Each research participant should receive a copy of the stamped consent form for their records.

Subjects who go through the consent process are considered enrolled participants and are counted toward the total number of subjects, even if they have no further participation in the study. Please keep this in mind when conducting your research. This study is currently approved for 500 subjects.

If you need to increase the number of subjects, add research personnel, or make any other changes to your protocol you must submit an IRB Protocol Amendment Form, which can be found on the Office of Research Compliance web site: http://www.marquette.edu/researchcompliance/research/irbforms.shtml. All changes must be reviewed and approved by the IRB before being initiated, except when necessary to eliminate apparent immediate hazards to the human subjects. Any public advertising of this project requires prior IRB approval. If there are any adverse events, please notify the Marquette University IRB immediately.

Your approval is valid until March 4, 2013. Prior to this date, you will be contacted regarding continuing IRB review.

A Protocol Completion/Termination Report must be submitted once this research project is complete. The form should be submitted in a timely fashion, and must be received no later than the protocol expiration date.

If you have any questions or concerns, please do not hesitate to contact me. Thank you for your time and cooperation.

Sincerely,

Sean W. Horkheimer, J.D.
Research Compliance Coordinator

cc: Dr. Christopher Okunseri, IRB Chair

Enclosures (2)
AA/rr

APPENDIX C

**Penfield
Children's Center
Behavior Clinic**

Consent for Mental Health Services

Name of Client: _____ Name of Legal Guardian: _____

1. **Evaluate/Treat:** I voluntarily consent that my child will participate in mental health services by staff from the Behavior Clinic. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
   a. The benefits of the proposed treatment
   b. Treatment alternatives
   c. The manner in which treatment will be administered and the proposed length of treatment
   d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable), as well as the possible consequences of not receiving treatment
   e. The rights and responsibilities of the client or guardian in the development and implementation of an individual treatment plan.
   f. The outpatient mental health services that will be offered under the treatment plan
   g. The fees that the client or responsible party will be expected to pay
   h. How to use the clinics grievance procedure under ch. DHS 94
   i. The means by which a client may obtain emergency mental health services during period outside the normal operation hours of the clinic.
   j. The clinic's discharge policy, including circumstances under which a client may be involuntarily discharged for inability to pay or for behavior reasonably the result of mental health symptoms.

2. **Benefits of Mental Health Services:** Mental health services may include clinical interviews and observations, assessment, and parent-child therapy. It may be beneficial to me or my child, as well as the referring professional, to understand the nature and cause of any difficulties affecting me or my child's daily functioning, so that appropriate recommendations and treatments may be offered. Possible benefits to our mental health services include improved child behavior and emotional problems, new and enhanced caregiver skills in child management, and strengthened parent-child relationships.

3. **Charges:** Fees are based on the length of mental health services. I will be responsible for providing information on any insurance that covers my child's mental health services.

4. **Confidentiality, Harm, and Inquiry:** Information from my child's evaluation and/or treatment is contained in a confidential medical record at the Behavior Clinic, and I consent to disclosure for appropriate use by Behavior Clinic staff for the purpose of continuity of my child's care. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions: 1) if you/your child are deemed to present a danger to self or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

5. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

6. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

TREATMENT CONTRACT

Active Participation in Treatment

The Behavior Clinic requires that you and your child actively participate in all treatment sessions. Your child's behavior will only improve if you do the treatment program every day. Remember that it will take time to change your child's behavior, so please be patient.

We expect that you will make your best effort to follow the treatment program. This includes:
- Attend all treatment sessions with your child.
- Be ready and on time for your appointment in your home with your child.
- Eliminate unnecessary distractions such as the TV, phone calls or visitors during treatment sessions.
- Actively participate in the treatment session by doing what is recommended every day.
- Complete the Behavior Treatment Plan each day and turn in to the clinician every week.

- ☻ Your progress in participating in the treatment program will be reviewed at the third treatment session. Services may be terminated if the clinician determines you are unable or unwilling to follow the treatment program. If termination is recommended, you will be provided a list of alternative services that you may wish to contact for your child.

Missed Treatment Session

Missed treatment sessions interfere with reaching your child's treatment goals. **You must contact the Behavior Clinic at (414) 345-6351 at least one day prior to your scheduled appointment time to cancel** your child's treatment session. Missed treatment sessions occur when:

- You do not give 24-hour notice when cancelling an appointment (cancelling that day or at the door).
- You end treatment sessions early.
- For the first and second missed sessions, the clinician will contact you to determine the reason for the missed session, discuss alternative plans if warranted and reschedule a new appointment.
- For a third missed session, you will receive a letter indicating that treatment services are being terminated. You must contact the Behavior Clinic if you wish to continue with treatment. Resuming treatment services may require a significant waiting period and will depend on the availability of Behavior Clinic clinicians. Termination of Behavior Clinic services does not affect your child's participation with other Penfield services or programs.

No Shows
- You and your child are not home when a Behavior Clinic clinician arrives for a treatment session.
- For the first no show the clinician will discuss the reason for the missed session, second know show case will be closed.

- ☻ Excessive cancellations also interfere with treatment success. If cancellations (even with appropriate notice) are impacting treatment, services may be terminated.

Patient Rights and Grievance

Behavior Clinic shall, as part of the intake process, share information with you concerning informal methods for resolving client concerns and formal procedures by which clients may seek resolution of a grievance. At any time a complaint occurs, the client or other complainant shall be provided with a copy of the agency's Client Grievance and Requests for Administrative Review Policies and Procedures. Program staff shall be familiar with client rights and with these agency procedures. The program staff and their supervisor will forward the complaint to the local Client Rights Specialist.

My signature below also indicates that I have been given a copy of this information sheet, the "Client Rights and the Grievance Procedure for Community Services" brochure.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the mental health services. I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

_____   _____
Signature of parent/legal guardian   **Date**

_____   _____
Signature of witness   **Date**

CLINICA DE COMPORTAMIENTO
CONTRATO DEL TRATAMIENTO

Participacion Activa en el Tratamiento

La Clinica de Comportamiento requiere que usted y su niño/a participe activamente en todas las sesiones del tratamiento. El comportamiento de su hijo/a mejorara solamente si usted hace el tratamiento todos los dias. Recuerde que cambiar el comportamiento de su hijo/a tomara tiempo, por favor sea paciente.

Nosotros esperamos que usted haga su mejor esferzo para seguir el programa de tratamiento. Que incluye:
* Estar en todas las sesiones de tratamiento con su hijo/a
* Estar listo/a y a tiempo en su casa con su hijo/a
* Eliminar distracciones inecesarias tales como: Television, llamadas y visitas durante las sesiones.
* Participar activamente en las sesiones de tratamiento haciendo lo que sea recomendado diariamente.
* Completar el Plan de Comportamiento todos los dias y regresarlo a el terapeuta.

❇ Su Progreso de participacion sera repasado en la tercera sesion de tratamiento. Los servicios seran terminados si el terapeuta determina que usted no esta disponible o no desea seguir con el programa de tratamiento.

Sesiones Perdidas del Tratamiento

Sesiones perdidas del tratamiento interfieren con la meta de tratamiento que su hijo debe alcanzar. **Usted necesita comunicarse a la Clinica de Comportamiento al: (414) 345-6351 por lo menos un dia antes de su cita** para cancelar la sesion de tratamiento de su hijo/a. Sesiones perdidas del tratamiento ocurren cuando:

* Usted no dio un aviso de 24 horas de anticipacion para cancelar la cita programada (Cancelo el mismo dia de la cita o en la puerta).
* Usted no estaba en casa cuando los terapeutas de la Clinica de Comportamiento llegaron a su casa para dar la sesion.
* Usted termino los servicios de tratamiento antes de lo programado.

Los siguientes pasos aplican a las sesiones perdidas del tratamiento:

1. Para la primera y segunda sesion perdida, el terapeuta se pondra en contacto con usted para determinar la razon por la cual se perdio la sesion, discutiran planes alternativos para garantizar y reprogramar una nueva cita.
2. Para la Tercera sesion perdida, usted recivira una carta indicando que los servicios de tratamiento han sido terminados. Usted debera contactar a la Clinica de Comportamiento si usted desea continuar con el tratamiento. Resumir servicios del tratamiento tal vez requiera un significante periodo de espera y todo dependera de la disponibilidad de los terapeutas de la Clinica de Comportamiento. Terminacion de servicios de la clinica de Comportamiento no afectara la participacion de su hijo/a con otros servicios o programas de Penfield.
❇ Cancelaciones execivas tambien interferiran con el éxito del tratamiento. Si las cancelaciones (aunque sea con previo aviso) dan impacto a el tratamiento y los servicios pueden ser terminados.

_____   _____
Nombre del Niño/a   Fecha

_____   _____
Nombre del Padre o Tutor   Firma del Terapeuta

APPENDIX D

Intake Form

Intake Date: _____   Clinician (s): _____

Spanish-speaking family   Y   N   Interpreter:_____

Child's Medicaid/BadgerCare Number:_____

(Number must be 10 digits)

Child & Family Information

Child: _____ Date of Birth: _____ Age: _____

School/Childcare name: _____Phone: _____

Days/Times attend: _____

Mother: _____ Age: _____ Race: _____

Highest Education Obtained: _____ Time spent with child:_____

Employer: _____ Phone: _____Shift: _____

Health: _____

Father: _____ Age: _____ Race: _____

Highest Education Obtained: _____ Time spent with child:_____

Employer: _____ Phone: _____Shift: _____

Health: _____

Additional Caregiver: _____ Age: _____ Race: _____

Relationship to child:_____ Time spent with child:_____

Employer: _____ Phone: _____Shift: _____

Health: _____

Does a primary caregiver receive public assistance: (WIC, rent assistance, SSI, W2, food stamps)   Y   N

Household Income (circle one) $0-$9,999 $10,000-$14,999 $15,000-$22,999

$23,000-$33,999 $34,000-$49,999 $50,000-$74,999 $75,000 or more   Unknown

Who lives in the home (names, ages, relationship):_____

_____

_____

Significant family mental health history: _____

Child Health

Birth weight:_____Weeks gestations: _____

Drug use during pregnancy: Y   N (If yes, please describe_____

Tobacco use during pregnancy: Y   N (If yes, please describe_____

Alcohol use during pregnancy: Y   N (If yes, please describe_____

Medications used during pregnancy: _____

Pregnancy or delivery complications: _____

Significant past health problems: _____

Current health concerns: _____

_____

Medications: _____

Prescribing Physician:_____Phone Number:_____

Lead tested: Y   N   Date: _____   Level: _____

Referred for an Evaluation/Test: Y   N   Concern(s): _____

Areas of concern:

Hearing: Y   N   Vision: Y   N   Dental: Y   N

Activity level: _____

Comments:_____

Assessed for developmental delay: Y   N If no, concerns: _____

        Agency: _____ Date: _____

        Results: No Delays   Cognitive Delay   Language Delay   Motor Delay

        Type of services: ST   PT   OT   Spec. Ed   Other: _____

        Frequency of services: _____ Location: Home   Center

Referred for a developmental evaluation? Y   N   Evaluation Source: _____

2

Any additional Multi-Agency contacts (IEP, Outpatient Therapy, Child Protective Services, etc.)? _____

_____

Name: _____ Phone # _____

Name: _____ Phone # _____

Name: _____ Phone # _____

Involvement with the Bureau of Milwaukee Child Welfare (BMCW) current, past?_____

_____

_____

Child Daily Living Skills and Routine

Eating (Good/Picky Eater; # Meals/Snacks/ Mealtimes; Sugar/Caffeine): _____

_____

Bedtime: _____ What time does child fall asleep: _____Wakes up?_____

Nap: Y N Time put down for nap: _____Total nap time: _____Total hour's sleep/day (24 hours):_____

Where does child sleep and with whom:_____

　　　　Bedtime routine: _____

　　　　Bedtime problems:_____

Toilet Trained:　Y N　In process　　Problems:

Stressful/difficult times of day: _____

How caregiver spends time with child: _____

Child's likes/reinforcers: _____

Referral Concerns

Challenging Behavior 1: _____

How long has it been occurring?_____How often does it occur? _____

Where does it occur? _____How long does it last? _____

Antecedents? _____

How do you respond? _____

_____

How does other caregiver respond? _____

How do daycare/teachers respond? _____

Why do you think your child does this behavior? _____

_____

Challenging Behavior 2: _____

How long has it been occurring? _____How often does it occur? _____

Where does it occur: _____How long does it last? _____

Antecedents? _____

How do you respond? _____

_____

How do other caregivers respond? _____

How do daycare/teachers respond? _____

Why do you think your child does this behavior? _____

_____

Do these behaviors present a danger to him/herself or others at this time?   Y   N   _____

_____

Prosocial Behaviors

What behavior do you want to see more of? _____

_____

How often does this behavior occur (% of time) now?_____

How often would you like to see this behavior occur (%)?_____

What do you do when your child does this behavior? _____

_____

What do you do when your child does not do this behavior?_____

_____

Why do you think your child does not display this behavior as much as you would like?_____

_____

Treatment Goals

What do you think will happen if you don't address your concerns?_____

_____

What do you think **you** will have to change in order to improve your child's behavior?_____

_____

What are your child's strengths? _____

_____

What are your families' strengths?_____

Can you meet every week for treatment? Y   N   Can you practice treatments strategies every day? Y   N

Availability for treatment, day of week/time of day, etc.):_____

Are there any possible barriers to meeting weekly/consistently? _____

Is there anything that I did not ask that would be important for us to know?_____

_____

Trauma Questionnaire

Describe incident(s): _____

Frequency of Abuse (how many times):_____

Duration (time frame):_____

Was abuse by family member/stranger /isolated event? Explain: _____
_____

Please list trauma stress symptoms (affect regulation, re-experiencing, avoidance, numbing, or increased arousal):

1. Does the child speak about it?_____

2. Does the child ask questions?_____

3. What is his/her affect like when discussing/asking?_____

4. Do you see these events in their play? Rough play? Refusal to play? _____
_____

5. Does the child have nightmares? How many a night? How many nights a week? How do you respond? What does the child do (run to caregiver, hide under bed, etc.)?_____
_____

6. Do you see blank stares? How often? How long do they last? How do they stop?_____
_____

7. Any changes to eating habits, sleeping habits, toilet training problems?_____
_____

8. How do they respond when the topic is brought up? Avoidance? No reaction? Anger? Sadness?_____
_____

9. For visitation: How does the child behave before the visit? After the visit? Does your child talk about their visits and if so, what do they say?_____
_____

10. Hypervigilance? Does she/he become scared easily? What scares him/her?_____
_____

APPENDIX E

Qualitative Interview Protocol

1. As part of our research, we have been trying to make our program more useful for Latino families. For example, we hired bilingual clinicians and tried to integrate Latino cultural values into the treatment activities. How do you think we did?
2. Was anything particularly helpful? For example, was your clinician able to address your cultural values?
3. Was anything unhelpful during treatment?
4. What could we do better to improve our program for Latino families?