PCIT AS PREVENTION: ATTITUDES OF LATINO PARENTS TOWARDS A PARENT TRAINING PROGRAM

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This is dissertation is dedicated to my family, my husband, and friends.
You have provided invaluable support not only throughout this project but in the many years leading up to it.

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ABSTRACT

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by Emily Abbenante-Honold

Despite the existence of many effective mental health treatments, many families do not receive needed services (Kazdin, 2008). Adaptation of existing treatments, such as parent-child interaction therapy (PCIT), is viewed as one potential method for addressing this service gap. Using a qualitative approach, the purpose of the current study was to gather information regarding Latino parents' beliefs and attitudes regarding PCIT that could potentially be used to adapt the treatment for use within the Latino community. Twenty-five Latino parents participated in focus groups designed to elicit their opinions on parenting intervention and specific components of the PCIT program. Focus group data were transcribed and analyzed for thematic content using a procedure modeled on that described by Marshall and Rossman (1995). Emerging themes suggested parents often disagreed on what parenting programs should include, but indicated a need for parent programs within the community. In terms of Latino parents' response to PCIT, the results of this study suggest many of the components of the program (including behavioral theory and positive attending) would be consistent with community values and beliefs. However, results suggest other aspects of the program (e.g., time out, the use of play to teach skills, and in-vivo coaching) may be viewed ambivalently or negatively by community members. Data was also obtained that may inform the structure of an adapted PCIT Program. Ultimately, results suggested PCIT likely could be adapted to meet some of the needs of Latino parents.

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CHAPTER I

INTRODUCTION AND REVIEW OF THE LITERATURE

It is estimated that a majority of children who need mental health services do not receive them (Kazdin, 2008). The disparity is estimated to be even greater for children from historically underserved groups including ethnic minorities, families living in poverty and rural areas, and immigrants (Kazdin, 2008; NIMH, 2001). In particular, many Latino children who are in need of mental health services do not receive services or do not complete treatment (Yeh, McCabe, Hough, Dupuis, & Hazen, 2003; McCabe et al., 1999). Many factors likely contribute to this disparity. One factor hypothesized to contribute to the mental health disparity for ethnic minorities is the mismatch between minority culture and the culture of the mental health system (e.g., Callejas, Hernandez, Nesman, & Mowery, 2010). Because the mental health system is essentially imbedded in Western European culture, many facets of the existing mental health services, including the treatments used, types of mental health providers, and accessibility, are not compatible with the culture of ethnic minorities (Hernandez, Nesman, Mowery, Acevedo-Polakovich, & Callejas, 2009). This incompatibility makes it less likely that ethnic minorities will use traditional mental health services.

Adapting existing empirically supported treatments for use with minorities is one step to meeting the mental health needs of historically underserved population (e.g., Bernal & Saez-Santiago, 2006; Nagayama Hall, 2001). Adapting interventions for use with minority populations involves modifying psychological constructs, techniques, processes, and interventions to match the culture and context of a desired community or population (Falicov, 2009). To assist in adapting empirically supported interventions for use with ethnic minorities, models of adaptation have been described (e.g., Bernal, Bonilla, & Bellido, 1995). Though there is some contention

regarding the usefulness of cultural adaptations, initial research suggests that adaptations of existing treatments are effective with the populations for which they were adapted (Griner & Smith, 2006).

One domain in which intervention adaptations are sorely needed is the treatment of disruptive behavior disorders. Disruptive behavior disorders are common in young children, and are associated with later mental health problems and substance use (e.g., Burke, 2009; White, Xie, Thompson, Loeber, & Stouthamer-Loeber, 2001). Existing parent management programs, such as parent-child interaction therapy (PCIT), are effective in decreasing disruptive behaviors in young children (Eyberg, Nelson & Boggs, 2008). However, PCIT is an intensive treatment designed to be implemented in a traditional, clinic-based mental health setting. Past adaptations of PCIT suggest it may be successfully adapted for use with Latino families in non-traditional settings (e.g., McCabe & Yeah, 2009). Therefore, future adaptations of PCIT may be useful in addressing disruptive behaviors in children from minority families and bridging the mental health gap.

The purpose of the current study is to gather information from Latino parent regarding their beliefs about parenting programs in general and PCIT in particular. This information will be used to ascertain if there is a perceived need in the community for a parenting intervention, and what a desired intervention would look like. The information gathered from this study will be coded and organized in such a way as to be useful in informing a future adaptation of PCIT. Ideally, the current study will a first step in providing services to underserved families in Michigan by provide information to researchers that will enable them to plan an effective and culturally responsive adaptation of PCIT for use with Latino families in Western Michigan.

Mental Health Service Disparity

Mental illness continues to be a serious problem in the United States with an estimated 28% of the population suffering from a mental disorder (NIMH, 2001). Unfortunately, there is a gap between the number of individuals in the United States who could benefit from mental health services and those who receive mental health services. Recent estimates state that as many as 67% of children who could benefit from mental health services do not receive them (Kazdin, 2008). These estimates indicate that a majority of children who are in need of mental health services are not being reached by the mental health system. When children from ethnic minority groups are considered, the disparity between children who need mental health services and those who receive them becomes even larger (e.g., Kazdin, 2008; NIMH, 2001).

Latinos, defined for the purposes of this study as including any individual residing in the United States who identifies as being of Latino, Hispanic, or other Spanish origin, are the fastest growing segment of the United States population currently accounting for 16.3% of the population (United States Census Bureau, 2010). Almost half of the Latinos in the United States are less than 18 years-old. Due to a lack of consistent, quality research, it is difficult to estimate the unmet mental health needs of Latino children in the United States (Vega & Lopez, 2001). However, several studies indicate a low rate of mental health service use for Latino children (e.g, Algeria, Canino, Lai, Ramirez, Chavez, Rusch, & Shrout, 2004; Chow, Jaffee, & Snowden, 2003). Research using adult Latino samples indicate that there is a great need for mental health services for Latinos, and Latinos who are in need of mental health care are less likely than non-Latinos to receive treatment (Callejas, Nesman, Mowery, & Garnache, 2006; Vega & Lopez, 2001). Additionally, adult Latinos have a higher level of unmet mental health needs (approximately 47.2%) than non-Latino Whites (Yeh e al., 2003). Based on the rates of service

utilization of Latino children and the unmet needs of Latino adults, it is estimated that a large proportion of Latino children who need mental health care do not receive it. Furthermore, Latino parents who seek services for their children may be more likely to prematurely terminate services than White parents (McCabe et al., 1999) so that even those Latino children who initially receive mental health treatment may not receive the full benefits of such treatment.

Culture and Context in the Use and Delivery of Mental Health Services

The underutilization of mental health services by Latino families may be explained in part by the mismatch between the culture and context of the traditional mental health system and the culture and context of Latino families. Culture, the shared thoughts, feelings, actions, beliefs, languages, and institutions of a group (Cauce, Domenech-Rodriguez, Paradise, Cochran, Shea, Srebnik, & Baydar, 2002; Sandstrom, Martin & Fine, 2003), is both a product of and influence on social context. Social context includes the overarching characteristics of an environment such as geography, socioeconomic status, and political climate (Cauce et al., 2002). Culture and context are inexorably entwined as context influences the development of culture and vice versa, confounding the relationships between such factors as culture and socioeconomic status (Cauce et al., 2002). Together, culture and context shape the way in which the individuals sharing a particular culture and context experience life.

Because the traditional mental health model was created primarily under the influence of Western European culture and context (Falicov, 2009), traditional mental health definitions, methods of diagnosis, modes of intervention, and many other facets of mental health may be incongruous or unacceptable to members of historically underserved groups such as Latinos. Several examples will illustrate this point. Traditional mental health practitioners trained in a Western European culture and context may use self-disclosure sparingly in treatment because

this aligns with the culture that practitioners do not share their own personal information with clients (Manoleas, Organista, Negron-Velasquez, & McCormick, 2000). This method of interacting does not align well with the values and styles of interacting shared by many Latinos that emphasize the development of trust through mutual sharing of experiences and life information (Manoleas et al., 2000). In terms of context, fewer mental health services are available in areas where large numbers of historically underserved families live, making it more difficult for those families to access services (Alegria et al., 2002). As a final example, culture and context influence whether behaviors, thoughts, or feelings are considered pathological or "normal" such that an occurrence like receiving information from a deceased relative would be considered pathological or not based on the culture and context in which it occurred (Nagayama Hall, 2001).

The incompatibility between the culture and context of minority populations and traditional mental health services makes it less likely that members of a minority culture or context will use traditional mental health services (Cauce, et al. , 2002; Hernandez, Nesman, Mowery, Acevedo-Polakovich, & Callejas, 2009). In this way, the incompatibility between the culture and context of traditional mental health services and historically underserved populations may contribute to differences in mental health service utilization and increase the disparity (Callejas, Hernandez, Nesman, & Mowery, 2010; Cauce et al., 2002; Hernandez et al., 2009).

A vitally important component in mental health utilization is the initial decision to seek mental health care as opposed to treatment of another variety, and this help-seeking behavior is influenced by individual beliefs and values (Cauce et al., 2002). Two research findings demonstrate how help-seeking attitudes of historically underserved populations contribute to mental health utilization. First, attitudes or stigmas towards traditional mental health care may

prevent individuals from historically underserved groups from seeking help (Vega & Lopez, 2001). Some evidence suggests that Latino attitudes towards mental health services may be negative because of information they receive from their community about the services, or previous negative experiences with mental health services (Vega & Lopez, 2001). Second, the traditional help-seeking patterns of different cultures also influence the likelihood of an individual seeking and receiving traditional mental health services. For example, Latinos are more likely to seek help or advice regarding their children's mental health problems from friends, family, community members, or their medical doctors than to contact a mental health professional (Callejas et al., 2006; McMiller & Weisz, 1996).

Given the state of the mental health disparity and the need to increase accessibility and acceptability of mental health services to historically underserved populations, a shift in mental health research and intervention is needed (Callejas et al., 2010; Kazdin, 2008). If mental health treatment becomes accessible and culturally and contextually acceptable to historically underserved populations, the unmet mental health needs may decrease (Callejas et al., 2010; Hernandez et al., 2009). To accomplish this goal, novel forms and models of treatment delivery are necessary (Kazdin, 2008).

A potential method for decreasing incompatibility in mental health treatment is the adaptation of traditional treatment to better fit within a local culture and context. Cultural adaptation, then, is the process of modifying a psychological construct, technique, process, or intervention to match the culture of a desired community or population (Bernal, Jimenez-Chafey, & Domenech Rodriguez, 2009; Falicov, 2009). Often, traditional constructs or interventions such as empirically supported treatments are adapted for use with a specific group in an attempt to increase effectiveness, retention, and satisfaction of community members (Bernal et al., 2009;

Bernal & Saez-Santiago, 2006). For example, Parent Management Training – Oregon Model has been tailored for use with Latino families, and this adaptation was effective both in producing change in parent and child behavior and satisfactory to parents (Martinez & Eddy, 2005). Community-based and cultural researchers have not simply called for manualized, rigid adaptations, but instead are encouraging a move towards flexible interventions that do not adhere to rigid limitations and procedures that are often imposed by traditional mental health service delivery systems (Callejas et al., 2010).

Cultural Adaptations of Psychosocial Interventions

Cultural adaptations of traditional and empirically supported interventions are described by many researchers as a solution to increase mental health care for historically underserved populations (e.g., Bernal & Saez-Santiago, 2006; Nagayama Hall, 2001). Proponents of cultural adaptations of psychosocial interventions argue that adaptations of treatment are necessary because of the role culture and context play in beliefs about mental illness and the experience and manifestation of mental illness (NIMH, 2001). The argument follows that because cultural minorities experience mental illness differently and may have non-conventional beliefs about the causes and treatments, the treatments they would be most comfortable with and should receive ought to reflect their beliefs and expectations. Similarly, cultural researchers argue that because behavior is learned and occurs within a cultural context, the intervention designed to change the behavior should occur within the same context (Pederson, 2003).

There is evidence supporting the idea that culture and context influence beliefs regarding mental illness and the manifestation of mental illness. The key symptoms that are experienced in association with various diagnoses vary by ethnicity, supporting the idea that culture and context influences how mental illnesses are experienced and manifested (Alegria & McGuire, 2003).

Additionally, research has demonstrated that constructs established in traditional psychotherapy are not necessarily applicable to or descriptive of ethnic and cultural minorities. For example, the four traditional parenting categories (i.e., authoritative, authoritarian, permissive, and uninvolved) have been described as insufficient to adequately capture Latino parenting (Domenech Rodriguez, Davis, Rodriguez, & Bates, 2006).

Ultimately, cultural adaptations are supported because the adaptations are believed to make the intervention more effective for minority clients. A limited amount of research comparing the effectiveness of culturally based interventions to traditional interventions exists, making it difficult to draw firm conclusions about the effectiveness of cultural adaptations in treating and preventing symptoms of mental illness. Insufficient research on mediators and moderators of the efficacy of culturally adapted interventions also makes it difficult to say with certainty that cultural adaptions are better, equivalent, or worse than traditional intervention models.

Some evidence indicates that cultural adaptations of previously developed treatments are effective when used with the populations for which they were adapted (e.g., Martinez & Eddy, 2005; Matos, Torres, Santiago, Jurado, & Rodriguez, 2006). Several different parenting programs have been effectively tailored for use with historically underserved populations. For example, Parent Management Training – Oregon Model (PMTO) was tailored for use with Latinos using a flexible, iterative process with built-in feedback loops that resulted in an adaptation with comparable retention rates to that of PMTO with White families (Domenech Rodriguez, Baumann, & Schwartz, 2011). In another study examining the effectiveness of adapted PMTO with Latino families, families were randomly assigned to treatment or a wait-list control (Martinez & Eddy, 2005). Families assigned to PMTO showed a greater improvement in

parent and youth behavior than those families assigned to the wait-list condition, and families assigned to PMTO were highly satisfied with the program (Martinez & Eddy, 2005). A culturally modified version of Parent-Child Interaction Therapy (PCIT) tailored for Mexican American families was compared PCIT and to treatment as usual (non-PCIT therapy with therapists of differing theoretical orientations) through random assignment (McCabe & Yeh, 2009). The results suggested that the culturally modified version of PCIT produced significantly better improvement in child behavior than did treatment as usual, and parents were more satisfied with the modified program than with treatment as usual. However, modified PCIT was not significantly more effective than PCIT, nor did it lead to higher parent satisfaction (McCabe & Yeah, 2009). These examples provide evidence for the effectiveness of a few modified programs, but do not definitively determine whether cultural adaptations are effective in general, nor do they conclusively demonstrate adaptations are more effective than non-adapted versions of the same programs.

Two meta-analytic reviews of culturally adapted mental health interventions have been conducted in an attempt to determine the general effectiveness of culturally adapted models of treatment. Both analyses, including 76 and 65 studies respectively, found that the average effect size of adapted interventions was moderate (d = .45, d = .46 respectively), suggesting that cultural adaptations are effective treatments (Griner & Smith, 2006; Smith, Domenech Rodriguez, & Bernal, 2011). Further meta-analytic findings indicated that studies with a higher percentage of Latinos had larger effect sizes than those studies with a lower percentage of Latinos (Griner & Smith, 2006). Additionally, studies with a large proportion of Latinos with low levels of acculturation had effect sizes almost twice as large as studies with a higher proportion of Latinos with high levels of acculturation, suggesting the effectiveness of cultural

adaptations may vary depending on factors like acculturation (Griner & Smith, 2006). Other factors that increased the effectiveness of cultural adaptations included: 1. therapists speaking the same non-English language as their clients, and 2. having treatment groups with participants from one culture or ethnicity as compared to groups with participants from multiple cultures or ethnicities (Griner & Smith, 2006).

The meta-analyses described above indicate that cultural adaptations are effective, but do not address the question of whether they are more effective than non-adapted treatments. As of this writing, no analysis has been done examining if cultural adaptations are generally more effective than non-adapted interventions; however, studies have compared single adapted interventions with the standard intervention. For example, a culturally adapted, one session exposure treatment for East Asian individuals with specific phobias was compared to a non-adapted version of the same treatment (Pan, Huey, & Hernandez, 2011). In this instance, the adapted treatment was more beneficial for Asian Americans who were not highly acculturated to American society (Pan et al., 2011). Similarly, a cognitive-behavioral group intervention for the treatment of depression was adapted for use with African American women (Kohn, Oden, Munoz, Robinson, & Leavitt, 2002). In a small sample (n = 18), the adapted group treatment reduced self-reports of depressive symptoms more than the non-adapted treatment (Kohn et al., 2002).

The results of modifying existing interventions are not always so positive. A randomized, controlled study comparing a modified version of Parent-Child Interaction Therapy (PCIT) to the standard protocol and treatment as usual found no significant differences between standard and modified PCIT in terms of number of sessions attended, attrition, outcome using parent report and behavioral measures, and parent satisfaction (McCabe & Yeh, 2009). A relatively small

sample (n = 58 families), a single supervisor, and small group of bilingual therapists running all sessions may have decreased the chance of finding differences between the adapted and non-adapted interventions in this study (McCabe & Yeh, 2009).

Cultural adaptations of already existing treatment, such as adaptations of parent management programs, are hypothesized to positively impact factors other than symptom reduction (e.g., Matos, Bauermeister, & Bernal, 2009). Trust, which has been identified as a salient factor in the therapeutic process (e.g., Wampold, Mondin,. Moody, Stich, Benson, & Ahn, 1997), may be more easily fostered in culturally adapted interventions (Griner & Smith, 2006). Additionally, adapted therapies are thought to create fewer conflicts between the client's cultural values (e.g., familismo, the importance of family) and the values associated with mainstream therapy (e.g., autonomy or independence; Nagayama Hall, 2001). This theory has the potential to be significant because assimilation to American culture and conflict between cultures correlates with worse mental health in recent immigrants (Alegria et al., 2008).

Cultural adaptations have been deemed more acceptable than traditional interventions by African Americans, Latinos, Native Americans, and Samoans (Harachi et al., 1997). Similarly, cultural adaptations have been found to increase the completion rate of minority clients (Kumpfer, Alvarado, Smith & Bellamy, 2002). Finally, culturally adapted interventions are believed to lead to high rates of client satisfaction. In a meta-analysis of cultural adaptations, the average effect size for client's satisfaction was large (d = .93) suggesting that cultural adaptations of interventions lead to high client satisfaction ratings (Griner & Smith, 2006). While adaptations may lead to high rates of satisfaction and completion, it is unclear if adaptations result in more satisfaction or higher rates of completion than standard interventions. Evidence suggests that for some interventions, there is no statistically significant difference in satisfaction

or completion rates between the adapted and non-adapted treatments (e.g., McCabe & Yeh, 2009).

Some researchers have focused on adapting existing evidence-based programs and interventions for use with Latinos (Falicov, 2009). The adaptations of evidence-based interventions typically involve modifying the content and delivery of the program while adhering to the core principles (Falicov, 2009).

Preventing Disruptive Behavior Problems in Latino Children

Disruptive behavior disorders such as oppositional defiant disorder (ODD) and conduct disorder (CD) are characterized diagnostically as including rule breaking, non-compliance, violation of the rights of others, aggression, defiance, anger, irritability, and deliberately annoying others (American Psychiatric Association, 2000). These disorders are some of the most frequently diagnosed conditions in young children with prevalence estimates ranging from 1 to 16% in the general population (American Psychiatric Association, 2000). Some risk factors for the development of mental illness and disruptive behaviors are prevalent in historically underserved groups such as Latinos. Living in poverty and exposure to violence are two risk factors for the development of mental illness and disruptive behavior that also affect many Latino families (DeNavas-Walt, Proctor, & Mills, 2004; Nicolaidis, 2011). An additional risk factor for Latino families is acculturative stress, or stress that is a function of changes that occur from direct, ongoing contact with a culture different from one's own (Canino & Alegria, 2009). Latino youth living in the United States whose families perceived experiencing high levels of acculturative stress had higher rates of disruptive behaviors than those families who perceived low levels of acculturative stress or lived in their countries of origin (Canino & Alegria, 2009).

Disruptive behavior disorders are associated with negative outcomes. Oppositional defiant disorder and clusters of symptoms related to the disorder have been associated with later development of anxiety, depression, conduct disorder, and antisocial personality disorder (Burke, 2009; Egeland, Pianti, & Oagawa, 1996; Loeber, Burke & Pardini, 2009). Childhood disruptive behaviors have also been associated with earlier and greater use of substances, including alcohol and marijuana, in adolescence (White et al., 2001). The negative outcomes of disruptive behavior reach into adulthood. Disruptive behavior in childhood has been associated with adult mental health problems, substance dependence, financial and work problems, violence against women, and criminal records (Kratzer & Hodgins, 1997; Moffitt, Caspi, Harrington, & Milne, 2002).

Given that children with disruptive behaviors in early childhood have the potential to experience multiple negative outcomes, it is imperative that early intervention be delivered efficiently and efficaciously (e.g., Loeber et al., 2009). Efficacious treatments, including parent management training, are available to address disruptive behaviors in children (Chambless & Ollendick, 20010: Eyberg, Nelson, & Boggs, 2008). However, many children and families in need of this treatment do not receive it due to the barriers that exist for historically underserved populations at the family and system level (Kazdin, 2008). To prevent negative outcomes associated with the early development of disruptive behaviors, more historically underserved families need to be reached efficiently and effectively.

One method of reaching more historically underserved (e.g., Latino), families efficiently and effectively is through the use of prevention programs. Prevention models are based on a developmental perspective that identifies risk and protective factors and examines the development of mental illness in the context of these factors (Beardslee, Chien, & Bell, 2011). Intervention prior to the onset of a diagnosable mental illness or other serious problem by

eliminating or reducing the impact of risk factors and promoting protective factors (e.g., strong parent-child relationship) may decrease the prevalence of a disorder (Beardslee et al., 2011). Youth are often the target of preventive interventions because half of all mental disorders begin by age 14, but are not diagnosable until two to four years after symptom onset (Beardslee et al., 2011). Therefore, childhood provides preventive interventionists with an opportunity to increase protective factors and decrease risk factors before symptoms develop to a diagnosable level.

Preventive interventions have been developed to target many kinds of mental health issues in a variety of settings, and many of these interventions have been effective at increasing adaptive behaviors and decreasing symptoms of mental illness in children and their families (Albee & Gullotta, 1997; Durlak & Wells, 1997; Nation, Crusto, Wandersman, Kumpfer, Seybolt, & Davino, 2003). For the prevention of disruptive behavior disorders, parent management programs have repeatedly been found to be effective (e.g., Beardslee et al., 2011; Berkowitz, O'Brien, Carter, & Eyberg, 2010; Kumpfer & Alvarado, 2003). While a number of empirically supported preventive interventions exist, many prevention programs within the community continue to be based solely on logic and a belief that the program is effective (Nation et al., 2003). Therefore, there is a continuing need for evidence based, empirically tested preventive interventions including in the area of disruptive behaviors.

To guide the development of preventive interventions, several common principles of effective preventive programs have been identified through a review of the literature. Effective preventive interventions tend to include active or hands-on experiences, booster or follow-up sessions, and opportunities for the development of strong, positive relationships, especially adult-child relationships (Nation et al. 2003). Prevention programs tend to be effective if they are

delivered at a developmentally appropriate time (i.e., before the onset of a problem or illness), and take local culture and context into account (Nation et al., 2003).

Effective prevention programs targeted at disruptive behaviors are desirable for several reasons. First, mental health problems are costly, and cost benefit analyses on effective preventive programs indicate that the cost of programs is outweighed by the savings they incur (Aos, Lieb, Mayfield, Miller & Pennucci, 2004). Second, many preventive interventions assist children and families in developing adaptive skills which contribute to later success (Beardless et al., 2011). Third, effective preventive interventions hypothetically decrease the number of families that need mental health services because they prevent the development of the problems that lead families to seek such services.

Prevention programs can be categorized based on their scope and target population. Universal preventive interventions are designed to target an entire population regardless of individual risk, whereas selective prevention interventions are designed to target a subgroup of a population with an identified risk factor that increases the likelihood of developing a mental illness (Mrazek & Haggerty, 1994). Prevention programs that are intended for high-risk individuals who demonstrate symptoms of a mental illness but do not meet criteria for a diagnosis are indicated preventive interventions (Mrazek & Haggerty, 1994). The goal of this study is to adapt an existing empirically supported treatment, Parent-Child Interaction Therapy (PCIT), for use as a selective prevention program with Latino families. Adapting PCIT for use as a preventive intervention for use with Latino families will help meet the mental health needs of historically underserved families and theoretically prevent the development of significant disruptive behaviors in children.

Parent-Child Interaction Therapy

Parent-child interaction therapy (PCIT) is an empirically supported parent management training program for addressing disruptive behaviors in young children. PCIT is rooted in several theories including Hanf's (1969) two-stage approach to treating disruptive behavior disorders and Baumrind's (1967) theories on parenting styles and child outcome (Bell & Eyberg, 2002; Hembree-Kigin & McNeil, 1995). In addition, PCIT recognizes the benefits of traditional play therapy skills, and incorporates these skills into the program by teaching them to parents (Hembree-Kigin & McNeil, 1995, Niec, Gering, & Abbenante, 2011). Finally, PCIT includes principles of operant conditioning that are designed to teach parents consistent discipline in order to interrupt maladaptive parent-child interactions that feed into a coercive cycle of progressively escalating behavior (Bell & Eyberg, 2002).

Parent-child interaction therapy is a two-phase treatment program. The first phase, called Child-Directed Interaction (CDI), focuses on enhancing the parent-child relationship through the use of traditional play therapy skills and differential social reinforcement (Bell & Eyberg, 2002; Eyberg, 1988; Niec, Gering, & Abbenante, 2011). Specifically, during CDI parents are taught to praise their child, reflect or repeat what the child says, imitate appropriate play, and describe the child's behavior while enjoying the time with their child (Eyberg & University of Florida Child Study Lab, 1999/2010). The goal of this phase of treatment is to follow the child's lead during play and use the skills just described to reinforce appropriate play and behavior while ignoring attention seeking, negative behavior (Bell & Eyberg, 2002).

The second phase of treatment, termed Parent-Directed Interaction (PDI), teaches parents to give effective commands and implement consistent discipline practices for misbehavior and

noncompliance (Bell & Eyberg, 2002; Eyberg, 1988). During the PDI phase of the program, parents build on the skills learned in CDI and learn how to give effective commands, when to give commands, to set up house rules, manage behavior in public, and to provide consistent consequences for noncompliance or misbehavior such as a time out (Eyberg, 1988; Eyberg & University of Florida Child Study Lab, 1999/2010). The goal of the PDI phase is to help parents balance the use of child-directed skills and parent-directed skills to increase desired and pro-social child behaviors while decreasing undesirable child behavior (Bell & Eyberg, 2002).

Like in other parent management programs, therapists in PCIT interact primarily with the parents of the target child. In traditional PCIT, parents and children attend weekly, one-hour sessions that follow two basic formats. The first CDI and PDI sessions are didactic or teaching sessions where the therapist teaches and models for parents the skills that will be the focus of that treatment phase (Bell & Eyberg, 2002; Eyberg & University of Florida Child Study Lab, 1999/2010). Following each teach session is a series of coaching sessions. During coaching sessions, the therapist briefly discusses concerns or barriers to treatment with the parents and then spends the majority of the session coaching each parent interacting with their child through the use of a one-way mirror and a bug-in-the-ear device (Bell & Eyberg, 2002). Coaching sessions allow parents to watch their partners use the CDI and PDI skills with the child and receive immediate feedback on their use of the skills. Parents practice the skills learned in session at home with their child during daily play periods (Eyberg, 2003). The number of sessions it takes to complete PCIT varies by family. The average length of treatment in PCIT is 13 sessions, but families do not move on to the second phase of treatment until they have demonstrated mastery of the CDI skills, and the program is not complete until mastery of PDI

skills is demonstrated and the child's behavior is rated within the average range as compared to peers (Eyberg, 2003).

Parent-Child Interaction Therapy is an assessment-driven intervention where assessment is used to define the initial problem, guide the course of each session, and determine when treatment has been completed (Eyberg, 1988). The Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999) is a parent-report measure used to compare the child's behavior to a normative sample (Bell & Eyberg, 2002). The ECBI is frequently given at pre-treatment, post-treatment, and weekly throughout treatment to track changes in the child's behavior. Brief measures of parent mental health and stress such as the Parenting Stress Index (Abidin, 1995) are also frequently used to examine the parents' level of functioning. Finally, PCIT involves directly observing and coding the parent-child interaction at intake, during weekly sessions, and at post-treatment using the Dyadic Parent-Child Interaction Coding System (DPICS; Eyberg, Nelson, Duke, & Boggs, 2005). The DPICS coding system quantifies the parent-child interaction during a child-lead period, a parent-led period, and cleanup. Results from the DPICS observations drive treatment in two ways. First, these observations are used to assess if parents have mastered the skills presented. Second, the results of the weekly DPICS observation inform coaching such that therapists can quickly identify parent strengths and weaknesses and coach accordingly.

As an evidence based treatment, PCIT has been labeled a probably efficacious treatment for young children (ages two to six) with disruptive behavior problems (Eyberg, Nelson & Boggs, 2008). PCIT has been shown to be superior to a wait-list condition for improving disruptive behaviors (Nixon, Sweeny, Erickson & Touyz, 2003; Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998). In addition, when compared to siblings in a wait-list control condition, siblings of children who received PCIT were reported to have less problematic and less frequent

behavior problems suggesting the effects of the treatment generalize to non-target siblings (Brestan, Eyberg, Boggs, & Algina, 1997). Positive changes in behavior following PCIT also generalize to the school setting (McNeil, Eyberg, Eisenstadt, Newcomb, & Funderburk, 1991).

The improvements in child behavior and other treatment gains have been shown to maintain over time. Families that completed PCIT had better outcomes up to two years post-treatment than treatment drop-outs (Boggs, Eyberg, Edwards, Rayfield, Jacobs, Bagner, & Hood, 2004), and evidence suggests that families can maintain post-treatment gains for at least two years after treatment is completed (Eyberg, Funderburk, Hembree-kigin, McNeil, Querido, & Hood, 2001; Nixon et al., 2004). Treatment gains may last even longer than a few years as changes in mother's beliefs about the control they have over their children and their children's reported improvements in behavior have reported been maintained for three to six years post-treatment (Hood & Eyberg, 2003).

PCIT for Latinos

Parent-Child Interaction Therapy is well-suited to be adapted as a prevention program for use with Latino families for several reasons. First, PCIT includes mechanisms of change associated with decreases in disruptive behaviors. Second, PCIT has previously been adapted for use as a brief prevention program with a general population. Third, PCIT addresses risk factors associated with the development of disruptive behaviors. Fourth, PCIT is compatible with Latino values, and includes components identified by ethnic minorities as being important in parenting programs. Finally, PCIT has already been successfully adapted for use with Latino families as an intervention for treating disruptive behaviors.

Parent-child interaction therapy is a good intervention to be adapted for use with Latinos as a prevention program because it produces change in parent and child behavior. As described

above, PCIT is an effective treatment for disruptive behaviors in children, and treatment gains can be maintained for several years after treatment termination (e.g., Boggs et al., 2004; Eyberg, Nelson, & Boggs, 2008). Parent-child interaction therapy includes many components that have been identified through meta-analysis as being associated with greater decreases in disruptive behaviors in children including increasing positive parent-child interaction, improving parent-child communication skills, teaching parents to use time out, enforcing the importance of consistent discipline, and requiring parents to practice skills learned in session with their children (Kaminski, Valle, Filene, & Boyle, 2008). Of particular relevance to working with historically underserved families, practicing parenting skills in session has been more effective for families of a lower socioeconomic status than discussion or reading (Knapp & Deluty, 1989).

Parent-child interaction therapy has already been adapted for use as a prevention program, making it a good choice for a preventive adaptation for Latinos. A brief, prevention model of PCIT has been adapted and used with a primarily Caucasian population (Berkovits, O'Brien, Carter, & Eyberg, 2010). The prevention model included four weekly one and a half hour group sessions and was comprised of a CDI didactic, a CDI coaching session, a PDI didactic, and a PDI coaching session (Berkovits et al., 2010). This abbreviated prevention model was effective in decreasing problematic disruptive behaviors and ineffective parenting techniques (Berkovits et al., 2010). Evidence from this preliminary study suggests that the mechanisms of change that are embedded in PCIT result in reliable change in as few as four group sessions making PCIT an appropriate intervention to be adapted for brief, preventive treatment (Berkovits et al., 2010).

Parent-child interaction therapy is a good candidate for adaptation and use with Latino families as a prevention program because it addresses risk factors associated with the

development of disruptive behavior disorders. Negative maternal control, low amounts of positive maternal control, lax parenting, and coercive parent-child relationships have been identified as risk factors for the development of disruptive behaviors (Campbell et al., 1996; Deater-Deckard, 2000; Burke, Pardini, & Loeber., 2008; Patterson, 1986). Parent-child interaction therapy addresses these risk factors by teaching skills that enhance the parent-child relationship, increase positive parental control, and assist parents in using consistent, authoritative discipline (e.g., Bell & Eyberg, 2002). Additionally, PCIT addresses these risk factors during the preschool years, and early prevention of the development of disruptive behaviors is imperative (Moffitt et al., 1996).

Some of the characteristics of PCIT allow the program to be easily tailored to fit with Latino values while retaining the integrity of the intervention, making it an appropriate program for cultural adaptation. Various researchers have identified *familismo* as a Latino value (Calzada, 2010; Gonazelez-Ramos, Zayas, & Cohen, 1998). *Familismo* can be described in terms of attitude and behavior, with attitudinal *familismo* including the beliefs that family is prioritized above the individual, the interconnectedness of families is important, families help one another, and family honor is important. Behavioral *familismo* can be exhibited by families sharing responsibility, like child-rearing (Calzada, 2010; Gonazles-Ramos et al., 1998; Lugo Steidel & Contreras, 2003). Parent-child interaction therapy allows for multiple caregivers from each family to be involved in treatment, and this characteristic matches the value of *familismo*. The initial focus of PCIT on enhancing the parent-child relationship through the use of child-directed skills also aligns with *familismo* and the importance of the parent-child relationship. *Respeto,* or the value of respecting family members and behaving obediently, has also been identified as a

Latino value (Barker, Cook, & Borrego, 2010). Parent-child interaction therapy aligns with this value as one of the foci of the program is increasing child obedience.

Latino parents have identified the importance of a group setting and feelings of community and support in parenting programs (McCabe & Yeh, 2009; Parra Cardona et al., 2009), and PCIT can meet this need. Parent-child interaction therapy has previously been delivered as a group intervention and as a group prevention program (Berkovits et al., 2010; Niec, Yopp, Hemme, & Brestan, 2002). As PCIT can meet many of the value and logistical needs of Latinos, it is well-suited for use with Latino families.

Lastly, PCIT has already been successfully adapted and used with Puerto Rican and Mexican American families (Matos et al., 2009; Matos et al., 2006; McCabe, Yeh, Garland, Lau & Chavez, 2005). The Puerto Rican adaptation reduced children's behavior problems and parent stress, and left parents feeling satisfied with the intervention (Matos et al., 2006). The adaptation for Mexican American families, named Guiando a Ninos Activos (Guiding Active Children or GANA), also decreased disruptive behaviors in children (McCabe & Yeh, 2009.

Both adaptations modified the PCIT protocol in similar ways. In modifying the language of PCIT, both adaptations delivered the intervention in Spanish, and one adaptation (Matos et al., 2006) translated the manual into Spanish (McCabe et al., 2005). In an additional effort to adapt the language of PCIT, Matos and colleagues (2006) revised examples provided in the manual and handouts to match the experiences of Puerto Ricans, and simplified some of the terms used. Similarly, the GANAS adaptation translated and simplified handouts provided to parents (McCabe et al., 2005). The metaphors of PCIT were addressed by one adaptation through ensuring that therapists used idiomatic expressions to discuss behavior that were applicable to the target population (Matos et al., 2006).

Both adaptations addressed the role of the people involved in treatment. Both programs encouraged therapists to spend additional time with families building rapport, and the Puerto Rican adaptation set aside time specifically to address parents' concerns not related to child behavior (Matos et al., 2006; McCabe et al., 2005). Additionally, in the GANA program the role of therapist was redefined to be a teacher to better match the expectations parents had for the therapist role (McCabe et al., 2005).

In terms of content, the GANA adaptation added an engagement protocol specifically designed to engage many caregivers in the treatment program and respect Mexican American's value of extended family (McCabe et al., 2005), whereas the Puerto Rican adaptation built time into sessions to discuss how family members not in treatment could use the skills (Matos et al., 2006). Additionally, both programs focused on increasing rapport between therapists and parents and allowed extra time for the discussion of non-PCIT topics (Matos et al., 2006; McCabe et al., 2005). To address the concepts dimension, the GANA program reframed PCIT as a skill building or educational program in an attempt to counteract stigma regarding mental health treatment (McCabe et al., 2005). It was for this reason that the program was renamed.

The Puerto Rican PCIT program found that the goals of the traditional model were aligned with Puerto Rican parents' goals, and so did not make modifications in this area (Matos et al., 2006). However, the GANA program was adapted to include an assessment of parents' expectations for the program so that the program could be individually tailored to meet each parent's expectations and goals (McCabe et al., 2005). Also, some of the treatment terms were modified to align with parents' goals including renaming the Child Directed Interaction phase of treatment Ejercicios de Communicacion ([Communication Exercises]; McCabe et al., 2005).

Adaptations in method were reported in both programs. The Puerto Rican adaptation used a loss of privilege back-up to the time out procedure as opposed to a time out room because that method better matched parents' desires for treatment (Matos et al., 2006). The engagement protocol and assessment of parent expectations were modifications implemented in the GANA program (McCabe et al., 2005). Finally, both adaptations included providing parents with additional information about the program or relevant topics (i.e., ADHD), as well as extra session time for rapport building (Matos et al., 2006; McCabe et al., 2005). Many of these adaptations also addressed the family context. By encouraging the engagement of family members and providing extra time for discussion of non-parenting issues, the programs addressed contextual issues like social support and stress.

The Current Study

As there is a significant need for culturally responsive, preventive parenting programs targeting disruptive behaviors in children, this study took an initial step in developing a culturally tailored, preventive PCIT program for Latino communities in Western Michigan. The primary goal of this study was to explore the opinions and beliefs of Latino parents in Western Michigan regarding parenting programs in general and a selective preventive model of PCIT in particular. Specifically, the study was designed to address the following questions: 1) Is a preventive parent management program needed in this community? 2) What characteristics would make a preventive parent management program useful and appropriate for Latino families in Western Michigan? 3) Do the core components of PCIT meet the needs of Latino families in Western Michigan for a preventive parent management program? 4) Is it feasible to implement PCIT as a preventive parent management program in this community? 5) How can PCIT be tailored to work efficiently and effectively as a preventive program within the community?

To assist the primary investigator and research team in making this study respectful and culturally responsive, the research procedure of the current study borrowed from the community based participatory research tradition. In particular, a community partnership was formed with the Hispanic Center of Western Michigan. The advisory board mentioned above was created through the partnership, and the advisory board made recommendations regarding the research protocol.

CHAPTER II

METHOD

This project used qualitative methodology to obtain information that can be used to inform PCIT adaptations. The worldview of the primary investigator in the proposed study is a conglomeration of constructivist, participatory, and pragmatic beliefs as described by Creswell (2003). Borrowing from constructivism, the researcher and the goals of the study place an emphasis on understanding the meaning of phenomena (e.g., parenting) in terms of participant context, suggesting a bottom up, or qualitative, approach is necessary for understanding the themes present in the community (Creswell & Plano Clark, 2007; Crotty, 1998). The researcher also shares some beliefs with the participatory worldview in that an emphasis in this study was placed on collaboration with the community through a community partnership, and participants were involved in at least part of the research process (Creswell & Plano Clark, 2007; Crotty, 1998).

Qualitative methods in general and focus groups in particular were selected as the method to explore Latino/a values and beliefs regarding parenting and parenting programs for a number of reasons. Qualitative methods such as focus groups match the worldview of the researcher because they allow for participant involvement and an in-depth exploration of knowledge, experiences, and context (Creswell & Plano Clark, 2007; Kitzinger, 1995). Focus groups in particular were selected because they have the potential to provide information regarding values and norms while using the participants' own language and conceptual framework in a way that quantitative research does not allow (Kitzinger, 1994; Kitzinger, 1995). Focus groups may often provide more information than quantitative measures such as surveys. When compared to surveys, focus groups have been found to provide more information than surveys on up to 42%

of variables (Ward, Bertrand, & Brown, 1991; Morgan, 1996; Saint-Germain, Bassford, & Montano, 1993) These characteristics of focus groups are valued in the proposed study because there was a genuine desire to learn about the community's values and beliefs in an in-depth fashion with minimal research bias. Individual interviews have many of the characteristics described above; however, research suggests that focus groups are a more efficient means of gaining similar information (Fern, 1982; Morgan, 1996).

An additional reason focus groups were selected as the primary method in the proposed study is because focus group methodology matches well with some of the potential characteristics of the study population. Focus groups discriminate less than written measures for individuals who are illiterate or have difficulty reading or writing in the language of the researcher (Creswell & Plano Clark, 2007). Because the participants had varying levels of English literacy, focus groups seemed like a good fit. Focus groups may also encourage participation through group discussion from people who do not feel like they have much to contribute and might skeletally complete a quantitative measure (Creswell & Plano Clark, 2007). The potential for participants to be wary of providing information to an "outsider" or not believing they have knowledge to contribute was hopefully ameliorated by the use of focus groups.

Participants

To be eligible for recruitment in this study, participants had to be self-identified as Latina/o and parents of a child age two to seven. Recruitment was limited to current parents of young children because the proposed prevention program will target families with young children. Recruitment guidelines were provided to the Hispanic Center of Western Michigan, and this community partner recruited all participants from an urban area in Western Michigan.

Twenty-five participants engaged in this study as members of one of three focus groups. Participants were divided into groups based on convenience; participants were invited to attend the group that fit with their schedule and language preference. A majority of participants (*n* = 21) were female. By design, participants were required to be parents; however, one participant reported having no children but indicated she was pregnant; and one participant declined to provide information regarding offspring. Therefore, 23 participants reported having at least one child between the ages of two and seven. Participants reported raising an average of 2.80 children (*SD* = 2.47) and currently caring for an average for 1.67 children (*SD* = .96) between the ages of two and seven. Thirty-six percent of participants were single parents, 32% were married, and 32% were living with a partner. A majority (*n* = 13) of participants reported that at least one other caregiver (in addition to a mother and/or father) for their child/dren lived in their home.

Participants were asked to provide information about their race and their cultural background/ethnicity. Participants were allowed to identify as many races or ethnicities as they wished. Twenty-four participants identified as belonging to one race whereas 23 participants identified as belonging to one ethnicity or culture. A majority of participants identified their race as Hispanic/Latino, and their first listed ethnicity/culture as Mexican. For additional information regarding the race and/or ethnicity/culture of participants, please see Tables 1 and 2.

Table 1. *Participants' Identified Race*

Race Reported	Percentage of Sample that Listed First	Percentage of Sample that Listed Second
Hispanic/Latino	40%	0%
White	16%	0%
Did not Report	16%	0%
Native American	12%	0%
Other	12%	0%
Black	4%	4%

Table 2. *Participants' Identified Ethnicity/Culture*

Ethnicity/Culture Reported	Percentage of sample that listed First	Percentage of Sample Listed Second	Percentage of Sample Listed Third
Mexican	64%	0%	0%
Guatemalan	12%	0%	0%
Puerto Rican	8%	0%	0%
Mexican American	4%	0%	0%
Multicultural	4%	4%	0%
Latino (Non Specific)	4%	0%	0%
Salvadorian	4%	0%	0%
American	0%	4%	0%
Native American	0%	4%	0%
French	0%	0%	4%

In addition to information about participants' race and ethnicity, information was gathered regarding participants' immigration history. A majority of participants (*n*=16) stated they were immigrants to the United States. Participants reported emigrating from Mexico (48%), Guatemala (8%), and El Salvador (4%). In terms of their language preference for a parenting

class, 48% of participants reported preferring Spanish, 32% indicated they would attend a class in English or Spanish, and 16% reported preferring an English class.

Participants' educational attainment ranged from completing elementary school to obtaining a college degree. A large minority of participants (44%) completed some high school and 20% of participants reported earning a high school degree. Please see Table 3 for complete educational information of the sample. Participants were asked to estimate their annual household income as a marker of SES. A large minority (40%) of the sample reported earning less than $10,000 per year. Please see Table 4 for additional information regarding participants' income.

Table 3. *Educational Attainment of Sample*

Highest Grade or Degree Completed	Percentage of Sample
Elementary School	4%
Middle School	4%
Some High School	44%
High School Diploma	20%
GED	4%
Technical School/Certification	4%
Some College	8%
College Degree	4%

Table 4. *Breakdown of Annual Household Income*

Income Range	Percentage of Sample
Less than $10,000	40%
$10,000 to $20,000	20%
$20,000 to $30,000	20%
$30,000 to $40,000	12%
$40,000 to $50,000	0%
$50,000 to $60,000	4%
Did not Respond	4%

Measures

The measures used in this study can be classified into two groups based on design and purpose: background measures and the focus group guide. A description of the background measures will be provided followed by a description of the focus group guide. None of the measures listed below requested any identifying information such as name or date of birth. All participants were identified using a numerical identifier.

Demographics Questionnaire

A demographics questionnaire (see Appendix A) developed by the primary investigator and reviewed by the advisory board was administered to each participant. Participants were asked to report their age, level of education, ethnic and racial background, family immigration status, and approximate family income. Participants were also asked to provide information about their partners and children. The demographics questionnaire was available in English and Spanish. Participants selected the version they felt most comfortable completing.

Cultural Information Form

A cultural information form (see Appendix B) was administered to each participant. The cultural information form was based on two pre-existing measures: the Multigroup Ethnic Identity Measure (MEIM; Phinney, 1992) and the Bicultural Involvement Questionnaire – Short Version (BIQ-S; Szapocznik, Kurtines, & Fernandez, 1980). The MEIM was originally developed to assess ethnic identity across all ethnic groups. The MEIM demonstrated good reliability in the development sample, a group of ethnically diverse high school and college students, with Cronbach's alpha ranging from .81 to .90 (Phinney, 1992). Factor analysis of the MEIM suggests an underlying structure with two factors: ethnic identity search and an affective component that includes affirmation, belonging, and commitment (Roberts, Phinney, Masse, Chen, Roberts, & Romero, 1999).

Unlike the MEIM, the BIQ-S was originally developed to assess the extent to which a person feels comfortable in American and Hispanic cultures independent of one another (Szapocnik et al., 1980). Using a samples consisting of Cuban-Americans and non-Cuban Hispanic-Americans, the original BIQ demonstrated good internal reliability, $\alpha = .93$ and $\alpha = .89$, for the Hispanic and American scales, respectively (Szapocznik et al., 1980). Test-retest reliability for the measure varied by subscale with the reliability for all subscales except the Cultural Involvement Scale reaching statistical significance. Criterion validity for the original BIQ was established by demonstrating a significant relationship between ratings of students' "biculturalism" as rated by "bicultural" teachers and results from the measure (Szapocznik, et al., 1980). In terms of theoretical structure, exploratory and confirmatory factor analyses support a four-factor structure of the BIQ-S with the following factors: comfort with use of Spanish language, comfort with use of English language, enjoyment of Hispanic cultural activities, and

enjoyment of American cultural activities (Guo, Suarez-Morales, Schwartz, & Szapocznik, 2009).

The cultural information form assessed participant's preference in language when speaking with to their children and children's comprehension of parent's speech using modified questions from the BIQ-S. To assess participant's involvement in American and Hispanic culture, 14 items from the BIQ-S were borrowed and modified. The items were modified to assess participants' *involvement* in Hispanic or American oriented activities as opposed to their *enjoyment* of the activities. Participants rated their involvement on a four-point scale where (1) indicated no time spent involved in the activity and (4) indicated much time spent in the activity. An American Involvement and a Hispanic Involvement scale score was calculated from the 14 modified BIQ-S items.

To assess ethnic group and American identity, the six items from the MEIM were modified. Each item from the MEIM was used twice – once in regards to ethnic group culture and once in regards to American culture. Participants rated their agreement with item using a five point scale from (1) *strongly disagree* to (5) *strongly agree.* Four scales were calculated from the modified MEIM items: the Ethnic Group Exploration Scale, the Ethnic Group Commitment Scale, the American Exploration Scale, and the American Commitment scale.

Focus Group Guide

A focus group guide, or outline, developed to assist in leading the focus groups, was developed for the purpose of this study (see Appendix C). The guide was modeled after focus group guides that have been previously used by researchers examining parenting beliefs (e.g., Parra Cardona et al., 2009), but was significantly altered to collect information specific to parents' attitudes about PCIT. The focus group guide began with an introduction to the study

purpose and procedure, and emphasized the importance of honest participant feedback. The initial portion of the focus group guide cued parents to discuss children with behavior problems to ensure that all participants had some understanding of the types of children the proposed PCIT prevention program would help. The remainder of the focus group guide was designed to introduce components of PCIT to the participants and then elicit feedback regarding each component. To assist in the introduction of some components of the program, such as coaching and using time out, brief videos were shown to participants. Finally, the focus group guide included questions designed to elicit discussion about factors that might make the proposed PCIT program more accessible or desirable for Latino families.

Procedures

Participants were recruited by the Hispanic Center of Western Michigan and asked to participate in one of three parenting focus groups. Participants were not assigned to groups but were allowed to select which group they wished to participant in based on convenience and language preference. Group one was conducted primarily in English; groups two and three were conducted in Spanish. All focus groups were conducted at the Hispanic Center of Western Michigan by trained members of the research team and supervised by a bilingual researcher experienced in running focus groups. Each group lasted 90 to 120 minutes. All participants received $30 compensation for their time.

Upon arrival, participants were greeted by a member of the research team, guided through the consent procedure, and asked to complete the background and cultural information forms. Groups were conducted following the focus group guide, and all groups were audio recorded. Each group was transcribed in the language in which it was conducted, and then verified for accuracy.

CHAPTER III

RESULTS

Ethnic Identity and Cultural Involvement

Data obtained from the cultural information form were used to compute scores representing the involvement, exploration, and commitment of participants to American and Hispanic/Ethnic Group culture. Prior to calculating scores across all participants, independent samples *t* tests were computed to determine if there was a significant difference in ethnic and cultural variables between the participants in the English-spea**k**ing group and the Spanish-speaking groups. Assuming equal variances, there was a significant difference in scores for American Involvement between participants in the English group, $M = 3.20$, $SD = .70$, and participants in the Spanish groups, $M = 2.50$, $SD = 66$) with the participants from the English group reporting significantly more American involvement than participants from the Spanish groups, $t(18) = 2.38$, $p < .05$. As there were no other significant differences in ethnic and cultural variables between language groups, the rest of the data obtained from the cultural information form was considered across all participants. See Table 5 for mean scores and standard deviations for the Hispanic Involvement, American Involvement, Ethnic Group Experiences, Ethnic Group Commitment, American Experiences, and American Commitment scales.

The Hispanic Involvement Scale and American Involvement Scale scores are comprised of seven items each. Participants rated their involvement on a four-point scale where (1) indicated no time spent involved in the activity and (4) indicated much time spent in the activity. The score for each scale was obtained by calculating the mean of these items. Due to the small number of items on each scale, the total score for each scale was calculated only if participants

had responded to at least six of the seven items. Using these parameters, scores for the Hispanic Involvement Scale were calculated for 21 participants and scores for the American Involvement Scale were calculated for 20 participants. The mean score for Hispanic Involvement across participants, $M = 2.82$, $SD = .82$, indicated participants are somewhat involved in Hispanic activities such as watching Hispanic TV programs and listening to Hispanic radio stations. As reported above, all participants indicated some level of involvement in American activities with the participants in the English-speaking focus group reporting significantly more involvement in American activities than those in the Spanish-speaking focus groups.

The Ethnic Group Experiences, Ethnic Group Commitment, American Experiences, and American Commitment scales are comprised of three items each. Participants rated their agreement with each item using a five point scale from (1) *strongly disagree* to (5) *strongly agree*. Thus, higher scores indicate a greater involvement and/or commitment. The score for each scale was obtained by calculating the mean of these items. Due to the small number of items on each scale, the total score for each scale was calculated only if participants had responded to all of the items for that scale. Using these parameters, scores for these scales were calculated for 24 participants. The mean scores across participants for Ethnic Group Experiences, $M = 3.47$, $SD = 1.1$, and Ethnic Group Commitment, $M = 3.74$, $SD = .87$, suggest participants are somewhat involved in experiences that are related to ethnic group membership and are somewhat committed to their ethnic group. The mean scores across participants for American Experiences, $M = 3.50$, $SD = .91$, and American Commitment, $M = 3.54$, $SD = .96$, suggest participants are also somewhat involved in experiences related to American culture and are somewhat committed to American culture.

Table 5. *Ethnic/Cultural Involvement, Experiences, and Commitment*

Variable	Mean (*SD*)
Hispanic Involvement	2.82 (.82)
American Involvement (Spanish)	2.46 (.66)
American Involvement (English)	3.20 (.70)
Ethnic Group Experiences	3.47 (1.11)
Ethnic Group Commitment	3.74 (.87)
American Experiences	3.50 (.91)
American Commitment	3.54 (.96)

Note. Hispanic Involvement $n = 21$, American Involvement (Spanish) $n = 12$, American Involvement English $n = 8$, Ethnic Group Experiences, Ethnic Group Commitment, American Experiences, and American Commitment $n = 24$.

Parent Focus Groups

Coding Rules

Following the transcription of each focus group, the transcripts were qualitatively analyzed for thematic content using a procedure modeled after that described by Marshall and Rossman (1995). To keep coding consistent between coders, a list of coding rules was developed first. As the transcripts being analyzed were not pre-divided into codeable units, many of the guidelines were developed to improve reliability in terms of which portions of the transcript to code. The first guideline stated coders were to code an instance where the meaning of the theme began, not necessarily at the beginning of a sentence or paragraph. Additionally, coders were to code another instance of a theme every time a new participant began speaking of the theme or every time a participant spoke about one theme, spoke about another topic, and then returned to the theme. Coders were allowed to assign multiple codes to segments of text. Finally, rules were developed regarding how to code verbal agreement or verbal place fillers. Coders were to code "yes" or "yeah" as instance of a theme if it was clear what the participant

was speaking about. Coders were not to code "mmhmm," "right," or other verbal agreements or noises.

Interrater Agreement

Two coders, both fluent in English and Spanish, independently reviewed the transcripts identifying themes, defining themes, and recording specific instances of the themes. The coders then combined their identified themes and reached a consensus regarding the definition of each theme. Additionally, the coders looked for convergent instances (i.e., when both coders agreed an instance of the theme was present) and non-convergent instances (i.e., when only one coder indicated an instance of a theme). Following this discussion, the coders reached an agreement on all recorded instances. After round one of coding, the coders were convergent on 241 instances out of a possible 377 (63.9% convergence).

After the initial round of coding, a mutually agreed upon list of 47 themes was developed. This list of themes was reviewed by the research team for content and clarity. Once all themes definitions were deemed to be clear, the coders independently reviewed the transcripts using the agreed upon list of themes and definitions. The coders then met to review convergent and non-convergent instances and reached a consensus on the instances of all themes. During the second round of coding, the coders were convergent on 450 instances out of a possible 511 (convergence estimate of 88%).

Cohen's kappa (Cohen, 1960) was also calculated as an estimate of inter-rater agreement. Cohen's kappa estimates the agreement between two raters when they are classifying specific items into categories (Cohen, 1960). Slight modifications were made in the calculation of this statistic due to the design of the current study. Because coders were qualitatively analyzing transcripts of extended discussions, there were no pre-formed units to specify the total number of

instances that should be coded. Each coder independently reviewed the transcripts and made a decision about whether or not a particular section of the transcript was codeable. As a result, sometimes Coder A would indicate an instance of a theme in a location where Coder B did not code anything. To account for this occurrence while calculating Cohen's kappa, a "no code" category was developed. When one coder did not code an instance that was ultimately believed to be an instance of a theme, it was recorded as an instance of a "no code" theme. After the second round of coding, a kappa of .89 was achieved. The pre-determined minimally acceptable kappa for this project was .70. As this criterion was exceeded during the second round of coding, the themes were considered to be adequately reliable and no further coding was performed.

Coded Themes

A subset of the research team including the primary investigator, an expert in parent-child interaction therapy, a community-based researcher, and graduate students familiar with Latino culture reviewed the themes and instances looking for overarching patterns or categories. Based on this review, the 47 themes were grouped into eight categories: Need for and Availability of Parenting Help, Parenting Beliefs and Practices, Fathers and Parenting, Parent Reaction to Specific Program (PCIT) Components, Program Suggestions, Barriers to Parenting and/or Parenting Programs, Cultural Considerations, and Physical Punishment and Abuse. All themes and the number of instances of each can be found in Table 6 and will be discussed below.

Table 6. *Themes and Instances*

Category	Theme	Instances
Need for and Availability of Parenting Help		
	Acting Out Kids Exist	23
	Parenting is Challenging	39
	Public Behaviors are Challenging	32
	Caregivers' Discrepant Parenting	28
	Need for More Parenting Services	22
	Teen Parents are in Need of Parenting Services	4
	Help is Available in the Community	14
Parenting Beliefs and Practices		
	Terms for Acting Out Kids	17
	Parents are the Authority and Children Should Obey	10
	Parents Model Behaviors	6
	Parents Need to be Consistent	10
	Parents Need to Set Limits	14
	Parental Attention is Important	9
	Children Act Out to Get Their Way	6
	Ignoring Is Used	19
	Positive Reinforcement Works	2
	Parents use Time Out	11
Fathers and Parenting		
	Fathers Would Benefit From a Parenting Program	4
	Fathers Have Limited Involvement With Children	5
Positive Reactions to Specific Program (PCIT) Components		
	Positive Reactions to PRIDE Skills/Phase 1 (CDI)	14
	Concerns with Ignoring	2
	Coaching would be Helpful for Some People	19
	Negative Reactions to Coaching	15
	Positive Reactions to Didactics	5
	Positive Reactions to PCIT Commands	14
	Positive Reactions to Mr. Bear	11
	Negative Reactions to Mr. Bear	10
	Negative Reactions to Time Out	7

Program Suggestions		
	Alternatives to Coaching	7
	Home Visits Could Increase Accessibility	2
	Other Caretakers Should be Included in Treatment	14
	Only Parents Should be Involved in Treatment	1
	There Should be Group and Individual Sessions	5
	Community Members Should Teach Parenting Groups	14
	Professionals Should be Parent Group Leaders/Coaches	5
	Benefits to Group Treatment	4
Barriers to Parenting and/or Parenting Programs		
	Immigration Issues are a Source of Stress	11
	Barriers to Participating in a Child's Life	7
	Lack of Follow-Through with Parent Training	4
	Use of Information to Promote the Group	5
Cultural Considerations		
	Time Out is not Common in Latin America	2
	Education is Important	16
	Treatment Needs to be Tailored to Each Family	5
Physical Punishment and Abuse		
	Corporal Punishment/Harsh Parenting Practices Exist	23
	Negative Reactions to Corporal Punishment/Harsh	6
	Desire to Learn How to Use Physical Punishment Legally	5
	Parents are Worried about being Called Abusive	5

Need for and Availability of Parenting Help. This category includes seven themes related to parents needing assistance with parenting and the availability of existing services to address this need: (1) Acting out kids exist, (2) Parenting is challenging, (3) Public behaviors are challenging, (4) Caregivers' discrepant parenting, (5) Need for more parenting services, (6) Teen parents are especially in need of parenting services, and (7) Help is available in the community for parents.

Acting out kids exist. This theme encompasses the idea that children with acting out behaviors exist in the Latino community and are known or observed by Latino parents (e.g.,

"…like out in public you see a kid acting out…") This theme also includes Latino parents identifying their children as "acting out" (e.g., "Mine fit that description,") or describing particular acting out behaviors in which their children engage (e.g., "You know, I can't get him to eat. He doesn't listen.")

Parenting is challenging. This theme encompasses the idea that parenting is difficult (e.g., "…being a mom, it's not easy.") and parents are sometimes not sure how to handle difficult child behaviors (e.g., You don't know if you should like, yell at him, you know?"). Also included in this theme is the idea that parents occasionally lack the patience or skills to manage challenging behaviors (e.g., "No sabemos estas técnicas, nadie nos las ha tratado de enseñar.") [We don't know these techniques, nobody has taught us]

Public behaviors are challenging. Included in this theme is the idea that managing child misbehavior in public is challenging because of parents' concern about judgments from other people (e.g., "…but if my son does act out in public I feel like people's judging me saying I'm a bad parent or something;" and "Adelante de otras personas es más difícil, corregirlos.") [In front of other people it is harder to correct them.] Also included in this theme is the idea that parents do not know how to manage public misbehavior. One parent stated, "Y por ejemplo ¿Si una niña así de dos años hace un berrinche en una tienda porque quiere algo? ¿Que haría uno?" [And for example, if a little two-year-old girl has a tantrum in a store because she wants something? What should one do?] Additionally, this theme encompassed parents' positive responses to queries about addressing public behaviors as part of a parenting program.

Caregivers' discrepant parenting. This theme encompasses the idea that different caregivers or parents do not agree on parenting techniques (e.g., "I'm not with his mother, and when he goes with her, she might allow something different.") Furthermore, this theme includes

the concept that differing parent techniques can lead to problems or conflict (e.g., If you have multiple, uh adults, trying to be the authority figure in the child's life they get confused."; "…because if I yell at my son then my mom gets mad and she say, 'Don't talk to him like that.'")

Need for more parenting services. Included in this theme is any mention of the need for additional parenting services or support for parents. When describing the availability of parenting resources, one participant said, "Creo que nunca va a ver suficientes." [I don't think we will ever see enough.], and another added, "Mi punto de vista, necesitamos más." [My point of view, we need more.]

Teen parents are especially in need of parenting services. Instances of this theme suggested teen parents are an especially vulnerable population who could benefit in special ways from parenting services. For example, in response to a question about the need for parenting help, one participant said, "…yes, especially for teen moms…" Another participant further explained, "…young guys 18-years-old or 17-years-old that's gots a kid…he doesn't really know what to, you know, how to approach interaction with the child."

Help is available in the community for parents. This theme includes any mention of existing services available to Latino families that are designed to help parents with parenting. Two existing programs were mentioned: Baby Scholars and Pailalen. This theme also included potential locations at which participants might be able to find parenting help. Participants listed the Hispanic Center of Western Michigan as one potential option (e.g., "Maybe here at the center?")

Parenting Beliefs and Practices. This category includes ten themes that describe different beliefs parents have about children's behavior, what factors are important in parenting,

how to parent, what techniques work or do not work, and how parents refer to children with acting out behaviors. The following themes are included in this category: (1) Terms for acting out kids, (2) Parents are the authority and children should obey, (3) Parents model behaviors, (4) Parents need to be consistent, (5) Parents need to set limits, (6) Parental attention is important, (7) Children act out to get their way, (8) Ignoring is used, (9) Positive reinforcement works, and (10) Parents use time out. Each of these themes will be described in more detail below.

Terms for acting out kids. Instances of this theme were coded when parents described, discussed, or named a term that is used in their family or community to refer to acting out children. For example, when asked what terms participants had heard used to refer to acting out children, participants responded with "hyper" and "bad kids." Participants in the Spanish speaking group reported hearing or using the terms "malcriados," "groseros," "hiperactivoes," and "inquitos" to describe acting out children.

Parents are the authority and children should obey. This theme encompasses the belief that children should obey parents because parents are the boss. The theme includes the idea that this type of authoritarian belief is present in the Latino culture and/or community. When discussing interacting with his or her child, one participant said, "…you go do it. I'm the boss. That's why." Another participant emphasized, "I just want him [the child] to know that I'm the boss."

Parents model behaviors. Included in this theme are discussions or examples that highlight how parents influence their children's behavior by modeling positive and negative behaviors (e.g., "You guys [the parents] taught 'im to say shut up." Participants also discussed how modeling works, an example of which is the following exchange:

Participant A: El niño siempre va a seguir el ejemplo de uno. [The child is always going to follow your example.]

Participant B: Si. [Yes.]

Participant A: Si uno actua mal el niño va a actuar mal. [If you act bad the child is going to act bad.]

Parents need to be consistent. This theme includes the concept that consistency in implementing consequences and consistency in routine are important for children. Also included in this theme are instances when participants indicated that consistency should be taught as part of a parenting program, (e.g., "…teaching consistency," as a response to things that should be included in a parenting program.

Parents need to set limits. This theme encompasses the idea that limits are important for children's healthy development and parents are responsible for setting limits. For example, when discussing parenting, one participant said, "Es poner limites." [It's giving limits.] The idea that parents standing firm with their guidelines is part of parenting/limit setting was also stated (e.g., "Porque uno tiene que mantenerse firme.") [You need to stay firm.]

Parental attention is important. Instances of this theme were coded when participants communicated that parents need to give their children positive attention such as playing or talking with them. Some instances of this theme were from the perspective that children want attention (e.g., "…porque, muchos niños quieren que uno juegue con ellos.") […because many children want you to play with them.] Other instances were described from the perspective of parents knowing children need attention (e.g., "Una mamá, ya sabe que todos los días, este, se debe de poner a jugar o que ya tiene una hora que se debe de, de poner a jugar con su hija.") [A mom already knows that everyday, that she should play with her daughter.]

Children act out to get their way. Included in this theme is the idea that children behave in ways that are consistent with "acting out" (i.e., misbehaving) in order to get something they want such as attention or a tangible reward. When discussing acting out behaviors, participants stated, "…like the child is, is just developing…how much they can get away with," and, "Yeah, testing to see how much he can get away with." One participant described children's motivation for acting out in the following way, "They're doing it for attention. So you give them that attention they'll keep doing it."

Ignoring is used. This theme encompasses the idea that parents use ignoring as a child management strategy (e.g., "I do it."), ignoring works in some situations, and some parents view the strategy of ignoring positively. This theme also included instances where participants described using ignoring to manage child behavior (e.g., They're gonna sit there and I'm gonna pretend like I don't see it.")

Positive reinforcement works. This theme encompasses the concept that positive reinforcement is an effective parenting technique to modify child behavior, and parents like the technique or like using it. For example, one participant described success with positive reinforcement, "High fives definitely work."

Parents use time out. Instances of this theme were coded when parents described using various forms of time out with children (e.g., "I just started doing time out with my son.")

Fathers and Parenting. This category includes two themes that describe particular challenges fathers face in terms of parenting and particular needs of fathers. Themes included in this category are: (1) Fathers would benefit from a parenting program and (2) Fathers have limited involvement with children.

Fathers would benefit from a parenting program. This theme covers the concept that fathers need help with parenting skills for various reasons including a lack of involvement with their children and/or not knowing how to manage child behavior. One participant described how fathers' responsibilities take away from time with children, "…even more so in Hispanic families it seems like the man, he works, and then he doesn't have a lot of interaction with the kids so much. So you know, I think it's a good thing, that you know, have that kind of training." Included in this theme is the idea that fathers need parenting programs. When describing the need for parenting groups for fathers, a participant stated, "Pero necesitamos un programa especialmente que llegue a los hombres." […but we need a group that especially reaches the men.] Particular challenges for fathers that could be addressed in a parenting program were also mentioned (e.g., "Que alguna vece lo padre no tiene la pacien—la paciencia.") [Sometimes fathers lack patience.]

Fathers have limited involvement with children. Instances of this theme were coded when participants discussed how fathers spend less time with their children or are less involved in parenting than female caregivers (e.g., "Porque no se involucran.") [Because they are not involved]. Instances of this theme were also coded when participants spoke about how fathers are less likely to attend events related to the child such as school functions or parenting classes (e.g., "…porque simper hay reunions y puras mamas. Raro el papa que llega.") […because there are always meetings and pure moms. Rare that a father comes].

Parent Reactions to Specific Program (PCIT) Components. Throughout the focus groups, participants were provided with verbal descriptions of PCIT and were asked to watch video clips demonstrating parts of the program. This category includes nine themes that describe parents' reactions to specific components of the program including the skills taught and the methods of

teaching. Parent reactions to the program components can be divided into the following themes: (1) Positive reactions to PRIDE skills/Phase 1(CDI), (2) Concerns with ignoring, (3) Coaching would be helpful for some people, (4) Negative reactions to coaching, (5) Positive reactions to didactics, (6) Positive reaction to PCIT commands, (7) Positive reactions to Mr. Bear, (8) Negative reactions to Mr. Bear, and (9) Negative reactions to timeout.

Positive reactions to PRIDE skills/phase 1 (CDI). This theme encompasses participants' opinion that PRIDE skills and building the parent-child relationship – the focus of the first part of the proposed program—are important techniques for parents to learn or use. Most participant reactions were to praises (e.g., "Eso está perfecto lo de los elogios;") [This is perfect, these praises;] and, "Pero que es, de eso de los elogios si está muy bien porque, este, los enseñan a, a e, a ellos los hace sentirse importantes." [But, that is, this thing of praises is very good because it teaches them to ah, and to feel important.]

Concerns with ignoring. This theme was coded each time a participant expressed a concern about using ignoring as a parenting technique or expressed that ignoring as a strategy is/would be difficult to execute properly. For example, a participant described trying to ignore her children by saying, "A veces es un poco dificil ignorarlos." [Sometimes it's a little hard to ignore them.]

Coaching would be helpful for some people. This theme includes the opinion that coaching may be helpful for some people, and explicated the situations in which coaching may be helpful. Participants tended to state that coaching would not be helpful for them personally, but could be helpful for someone else (e.g., "I wouldn't need it, but uh, you know, I think it's a good thing.")

Negative reactions to coaching. This theme encompassed all participants' negative reactions to coaching (e.g., "De eso del guía como que no me gusto." [This thing with a coach, I didn't like it.]), including the reasons they gave for disliking coaching. Participants described how they would not like to be told what to say (e.g., "…I wouldn't have a coach tell me what to do.") Also, participants described how it might be uncomfortable and unnecessary for parents, "So it's like, it's kind of weird having someone having – having someone tell you to oh, say this….you should know you have to say those things to you, you know. To your kid."

Positive reactions to didactic. This theme was coded when participants responded positively to the description of a didactic (teaching) session or to the video of the didactic session. Instances of this theme primarily occurred when participants agreed in the affirmative to questions about didactics being helpful. Occasionally a participant would say they liked the format (e.g., "A mi me gustaria.") [I would like it.]

Positive reaction to PCIT commands. This theme describes participants' positive reactions to watching a video of a didactic session during which parents are being taught how to phrase commands effectively. Participants liked the teaching section generally (e.g., "I think that section was pretty good."), and expressed appreciation for the specific techniques taught (e.g., "It's a very good point in that it's not exactly what you say, but how you say it that could make all the difference.")

Positive reactions to Mr. Bear. This theme was coded each time participants reacted positively to a description or video of the process of parents using Mr. Bear to teach time out to children. For example, after viewing a video of this process one participant said, "I think it's effective…" Other participants reacted positively but with qualifications regarding the situation in which Mr. Bear would work best (e.g., "I can see it being beneficial for the right age group.")

Negative reactions to Mr. Bear. This theme was coded when participants reacted negatively to a description or video of the process of parents using Mr. Bear to teach time out to children. Some participants were concerned with how they would feel using the Mr. Bear process (e.g., "I would feel so goofy doing it."), whereas other participants expressed concern with how children would react to the process (e.g., "…she'd pick up that this is all pretend or something.") Specifically in reaction to the concern that children might view Mr. Bear as "pretend" or "play time," one participant suggested, "It's better for us to see it in reality, like make it seem real…"

Negative reactions to time out. This theme encompasses participants' opinion that time out is not an effective discipline method (e.g., "…but the chair thing doesn't really work for my son.") This theme also includes participants' concerns about using time out and/or past difficulties in using time out (e.g., "El 'timeout' a mi no funciona.") [Time out doesn't work for me.]

Program Suggestions. Focus group participants were encouraged to suggest alternatives to the PCIT program components, and were also specifically asked to provide suggestions for how the program should be set up to meet the needs for Latino families. The category Program Suggestions includes the following eight themes: (1) Alternatives to coaching, (2) Home visits could increase accessibility, (3) Other caretakers should be included in treatment, (4) Only parents should be involved in treatment, (5) There should be group and individual sessions, (6) Community members should teach parenting groups, (7) Professionals should be parenting group leaders/coaches, and (8) Benefits to group treatment.

Alternatives to coaching. This theme includes alternatives to live coaching suggested by participants. Participants suggested being videotaped and then reviewing the videotape with a

coach and receiving feedback in that manner. A participant explained how this process works for other programs stating, "Entonces te graban con tu bebe, okey y ya okey, luego este video se va al grupo de, de padres, y lo estamos viendo y este, entonces, este, uno mismo dice, "U me faltó hacer mas esto."" [So they videotape you with your baby, ok and now ok, later this video – they go the parent group and we are watching, and this, so this, with yourself you say, "Oh I need to do this more."] Another suggestion given by participants was to have a discussion with feedback after a parent-child interaction. One participant described how this might be accomplished saying, "Another um, approach to the coaching, instead of having the coach talk to the parent, uh as the parent is playing with the child, maybe taking notes and then having like a conference with the parent afterwards."

Home visits could increase accessibility. This theme states offering home visits to families might increase participation in a parenting program. One participant said, "Una forma también, que pueden llevar es para, llevarlo a las casas." [Another format also, you could take it to, take it to the homes.]

Other caretakers should be included in treatment. This theme encompasses the opinion that in addition to parents, other caretakers such as grandparents, siblings, teachers, neighbors, etc. should be included in a parenting program (e.g., "I think, you know, that would be very realistic to consider the grandparents, siblings, and things like that.") Also included in this theme is the idea that relatives are important in childcare, so that is why they should be included (e.g., "También pueden ir abuelas y tías porque también, ya ves que a veces los tíos cuidan también a las niñas y los hijos y también las abuelas las cuidan.") [Also grandparents can go and aunts because also, you see, that sometimes aunts and uncles also take care of the girls and the sons, and sometimes grandparents take care of them.]

Only parents should be involved in treatment. In direct contrast to the previous theme, this theme encompasses the opinion that only parents should be included in a parenting program. For example, a participant responded "Todos por parejo," [Everything for the couple.] in response to the question, "Should we invite everyone [to the group] or just the couple?"

There should be group and individual sessions. Included in this theme is the preference that parenting programs include a combination of group and individual sessions to best meet parents' needs. One participant described the benefits of combining both formats by saying, "…because you want to hear what other people have to say, you know. What they're doing. Their problems they're experiencing, but then you want some focus on your family."

Community members should teach parenting groups. This theme developed in response to a question about who should lead future parenting groups for Latino families. This theme includes the opinion that community members would be good parenting group leaders or coaches. Participants suggested several categories of community members that might be good leaders including the police (e.g., "…even if there was somebody from, like, law enforcement."), community elders, and grandparents (e.g., "If they look up to their own parents or to have their own parent come in to coach them through so that they're more comfortable.")

Professionals should be parenting group leaders/coaches. A second theme that was developed in response to the question about who should lead future parenting groups, this theme includes the opinion that "specialists" (i.e., "Los Psicólogos" [Psychologists], "Trabajadores Sociales" [Social Workers]) should be group leaders or coaches.

Benefits to group treatment. This theme communicates the opinion that group sessions are preferable to individual sessions because parents can learn from one another in a group (e.g.,

"Mas personas porque asi uno de más ejemplos que dan las otras.") [More people because that way one learns from examples that others give.]

Barriers to Parenting and/or Parenting Programs. This category includes four themes that describe barriers parents might face in terms of parenting their children or in terms of attending and benefiting from a parenting program. The following themes are included in this category: (1) Immigration issues are a source of stress, (2) Barriers to participating in a child's life, (3) Lack of follow-through with parent training, and (4) Use of information to promote the group.

Immigration issues are a source of stress. This theme encompasses the idea that people in the Latino community fear immigration enforcement and immigration laws, which leads to family stress. Fear was one adverse effect of immigration rules described by participants (e.g., "Orita[1] la, la población mexicana o de inmigrantes estamos casi viviendo con miedos." [Right now, the, the Mexican population or immigrants are living in fear.)

Barriers to participating in a child's life. Included in this theme is the idea that parents face a number of barriers that limit their involvement with their children and/or involvement in parenting groups. Participants described how being busy limits involvement with their children (e.g., "…but I'm always multi-tasking, doing a lot of things at the same time. Trying to, you know, clean up or organize stuff or... And I barely give my focus like that to my kids, you know…"). Another participant described how work responsibilities can interfere with a parent's involvement with their child, "Pero como el mío ahorita no puede venir porque él está trabajando." [But like mine [husband] can't come because he's working.]

[1] Ahorita

Lack of follow-through with parent training. This theme describes how parents often do not apply skills learned in parenting classes to their parenting. This theme is exemplified in the following exchange:

> Participant D: "Pues, está bien pero falta que lo usemos, y no todos lo ponemos en práctica. ¿Verdad? Es como hay veces que uno se lleva los papeles que nos dan y l, l, l, que pa' leer, y llega uno y— y ya después limpia uno y ya quedan quien sabe dónde." [Well it's good but the problema is do we use it? We don't all put it into practice. Right? It's like there are times when you take the papers they give and uh, uh, uh that are to read, and you arrive, and and later you clean and then they are, who knows where.]
>
> Participant C: "Y también los lee y tampoco practican." [And also you read them but you don't practice.]

Use of information to promote the group. Included in this theme is the participants' belief that informational or introductory sessions that provide parents with information about a parenting program are needed to promote the program. To promote the group, participants suggested an introduction day (e.g., "I think that it would be more beneficial to have uh, kind of a, like an introduction day.") Another suggestion put forth by participants was to host an informational teaching session to promote the group (e.g., "…do like a seminar.")

Cultural considerations. The category of Cultural Considerations includes themes that highlight differences in parenting practices by culture, and cultural values in the Latino Community of Western Michigan. The following themes are included in this category: (1) Time out is not common in Latin America, (2) Education is important, and (3) Treatment needs to be tailored to each family.

Time out is not common in Latin America. This theme represents the cultural phenomenon that time out is typically not used in Latin America; therefore, it is often a new parenting strategy for immigrants. For example, in response to discussions about time out, one participant said, "Eso está bien porque pues allá en nuestro países no se usa mucho eso." [This is good because there in our countries they don't use that much.]

Education is important. This theme includes the idea that academic issues and educational achievement are important in Latino families. Also included is the opinion that these issues should be addressed in parenting programs because of their importance and because Latino parents may struggle to help their children with academics. Participants described one specific area in which parents may need help, "Los padres tenemos que tener más comunicación con los maestros." [Parents need to communicate more with teachers.]

Treatment needs to be tailored to each family. This theme expresses the concept that parenting programs should be tailored to meet the needs of individual families and not "Latino culture" because of the variety of cultures from which Latinos originate and the distinctive needs of each family. Participants shared various ways that tailoring might occur (e.g., "I think you kinda gotta have to have a, uh, evaluation maybe with the uh, family and be able to kind of tailor it [the program] to their family;" and, "Maybe incorporating some of that, uh, like what we hold as like family values…").

Physical Punishment and Abuse. The final category derived from the data encompasses the opinions and beliefs surrounding the use of corporal punishment and harsh parenting practices. This category includes reactions to the use of corporal punishment/harsh parenting, and ways in which these types of discipline might be addressed in a parenting group. Included in this category are the following themes: (1) Corporal punishment/harsh parenting practices exist,

(2) Negative reactions to corporal punishment/harsh parenting practices, (3) Desire to learn how to use physical punishment in legal ways, and (4) Parents are worried about being called abusive.

Corporal punishment/harsh parenting practices exist. This theme includes the idea that harsh parenting (e.g., calling children names, threatening children) and physical punishment are accepted and used by some members of the Latino community. In addition to descriptions of some of the harsh parenting practices participants have used (e.g., "I put him in a corner make him stand straight up, his arms straight to the side, nose right in the middle of the corner."), this theme also included the beliefs and thought processes behind these types of discipline (e.g., "If a kid pushes you, you better beat his ass, you know?"). Also included in this theme were discussions of the cultural component of corporal punishment (e.g., "Allá en nuestro países …solo es, nalgadas, jalones.") [There in our countries it is only spanking and marking.]

Negative reactions to corporal punishment/harsh parenting practices. This theme was coded when participants indicated displeasure with corporal punishment or harsh parenting practices. Some participants were vocal about their negative response to physical punishment (e.g., I'm like, well, you don't just go hitting on kids, you know what I mean?"), whereas other participants were more vague in their negative reaction to harsh parenting (e.g., "Y yo miro como la mama, o sea, como trata a la niña así bien bien mal. Y ella dice que la niña es mala. Pero la que yo miro que es mala es ella.") [And I like how the mom, or that is, how she treats her daughter very poorly. And she says the girl is bad, but I see that the bad one is her.]

Desire to learn how to use physical punishment in legal ways. Some participants expressed a desire to learn how to discipline using physical punishment in ways that would not be against the law or get them in trouble with Child Protective Services. That concept is included in this theme. One participant responded to a question about including spanking in

parent training by saying, "What type of hitting is ok…maybe a thump or a spank, is that ok, you know?" Also captured in this theme is the concept that physical punishment should be included in a parenting program (e.g., "…because it's unrealistic to teach parents don't ever hit your child, because it's going to happen.")

Parents are worried about being called abusive. This theme encompasses a worry participants expressed: that parents will be labeled as abusive or get into trouble with Child Protective Services. One participant said, "Yeah, society has people scared to discipline their children physically because they're scared that CPS is going to get called."

Author

All research, particularly that conducted within a community context and designed to examine cultural beliefs, is impacted by the subjectivity of the primary investigator and research team. Reflexive exploration of subjective bias followed by a written account of this process can assist researchers in examining how their experience may have impacted data, and allows readers to place research results in the context provided by the primary investigator and/or research team (Parker, 2005). With these purposes in mind, the following information about the first author is offered.

The primary investigator is a Caucasian, female graduate student pursuing a Ph.D. in Clinical Psychology at a Midwestern university. She identifies as American with an Irish and Italian background. She has lived her entire life in the Midwestern portion of the United States and speaks English. The author was raised in a two-parent household where both parents participated in disciplining the children. In the author's household, physical punishment and harsh parenting were rarely used; time out was frequently used.

The author has several biases related to her background that are relevant to the study. For her, a prototypical family consists of two parents equally participating in raising their children with little assistance from extended family members. This perception may not match the reality of many Latino families in which one parent is the primary disciplinarian and/or where extended family members are significantly involved in childcare. Additionally, the author believes that corporal punishment is not an effective method of disciplining children. This bias may lead to her to believe that families who report using physical punishment are not using "good" discipline strategies and should be discouraged from using such punishments.

The author has been receiving training in PCIT for approximately four years, and has used PCIT with many families in a clinic setting. Additionally, she has assisted in training community therapists in the use of PCIT. Based on these experiences, she conceptualizes PCIT as a useful, empirically-supported treatment for families who have children with disruptive behavior disorders. This positive bias towards the usefulness and efficacy of PCIT may impact her interpretation of data gathered and may lead her to ignore or down-play information that suggests PCIT is not an appropriate intervention for Latinos in Western Michigan.

The author has limited experience with the Spanish language consisting of two college courses. She also has little experience with the Latino culture outside of the academic literature and a week-long trip to Mexico in 2003. Her inexperience with the Spanish language and culture may impact her interpretation of data gathered during the focus groups and her ability to identify and conceptualize themes. She may be unfamiliar with phrases, concept, and colloquialisms frequently used in the Latino community. Additionally, because she is not fluent in Spanish, she may have difficulty interacting with study participants. This could lead participants to view the researcher as an outsider and may result in participants feeling reluctant to share information.

Despite the limitations of the author's experience with Latino families, she has a sincere interest in working with the Latino community. The experiences she has had with the Spanish language and Latino culture have proved interesting, and have resulted in the author's desire to learn more information about Latino culture. An additional reason for wanting to work with this population is the value for family that many Latinos have (e.g., Calzada, 2010). The author also values and appreciates the benefits that may arise from having extended family participate in child rearing. Finally, Latinos are a group that is in need of mental health services (e.g., NIMH, 2001). The author has a desire to work with this population in order to help bridge the gap and make additional mental health services available in communities that need them.

CHAPTER IV

DISCUSSION

Many families and children in the United States, including some Latino families, do not receive the mental health services they need or do not complete mental health treatment (Yeh et al., 2003; McCabe et al., 1999). One potential method for addressing this need is culturally adapting existing treatments to meet the needs of historically underserved populations (Nagayama Hall 2001). A second potential method for addressing this need is to provide preventive programs to communities (Beardless et al., 2011). The current study took a step in meeting the mental health needs of the historically underserved by merging these two methods and examining the desirability and feasibility of modifying a preventive parent-child interaction therapy program for use with Latino families.

Overall, participants indicated a need for additional programs addressing parenting in the community, and expressed pleasure with some aspects of PCIT. Based on data from this study, cultural adaptation of PCIT prior to implementation in the Latino community may be beneficial as parents did not respond positively to all aspects of the program and indicated community needs that are not typically included in the original PCIT format. Perhaps the most important finding of the current study is that Latino parents often disagreed on what a parenting program should include or look like, reminding us that individual preference and meeting family need may be as or more important than attempting to meet global community needs. Despite the reminder that individual families have individual needs, many themes emerged from the data that could inform adaptation of a PCIT prevention program for Latinos.

Consistent with epidemiological data that suggests there is a need for mental health services for underserved populations (e.g., McCabe et al., 1999), the results of the study suggest

a need exists for parenting services in the Latino community of Western Michigan. In particular, a need for services targeting teen parents and Latino fathers was expressed. These findings suggest a preventive PCIT program could meet a need of Latino families with young children.

Several findings emerged in terms of language use. First, it was clear that many parents would need or want parenting resources in Spanish. However, it was also clear that some parents would not benefit from Spanish groups and would require English resources. As has been done in past adaptations (e.g., Matos et al., 200), the results of this study suggest some words and phrases would need to be adapted and/or translated when used with Latinos or Spanish speakers.

A goal of the study was to determine not only if the technical components of PCIT would be acceptable to Latino families, but if the underlying theories (i.e., behaviorism, attachment theory, Hanf's two part model; Bell & Eyberg, 2002; Hembree-Kigin & McNeil, 1995) would match the beliefs and expectations of Latino parents. Seemingly, some Latino parents hold beliefs that are consistent with the foundation of PCIT. Parents expressed beliefs consistent with behavioral theory such as the importance of consistency, limits, and obeying. Parents also discussed how behavioral modeling significantly impacts child behavior – a concept that is routinely discussed with parents in PCIT. Additionally parents identified attention towards children as important in modifying behavior and healthy development, a belief that is consistent with the two part model of PCIT that places emphasis on relationship building and positive attention as well as discipline.

Parents in this study also responded positively to some PCIT program components. Specifically, parents' responses to positive reinforcement, the use of ignoring, teach sessions, learning how to give commands, time out, and using Mr. Bear to teach time out were at least partially positive. Additionally, parents highlighted the importance of knowing how to manage

public misbehavior, a procedure that is often included in PCIT. These responses suggest Latino parents may already be familiar with or using many of the core components of PCIT. For parents who are not using these components, these results suggest Latino parents may be open to learning these techniques.

However, some integral components of PCIT elicited an ambivalent or negative response from Latino parents. While time out was used and viewed favorably by some parents, other participants expressed displeasure with the practice and discussed how time out is not a prevalent discipline strategy in many Latin American countries. In a similar way, some parents thought Mr. Bear a useful technique for teaching time out while others were concerned with the "fantasy" or "play" attitude he might evoke in children. Perhaps the biggest concern raised by parents was related to in vivo coaching. In vivo coaching is one of the key components of PCIT that sets it apart from other parenting programs, but unfortunately parents in this study were likely to dislike coaching, find it useless and uncomfortable, and suggest alternatives that do not involve live feedback.

An additional goal of this study was to find out if there are issues not typically addressed in PCIT that could be included in a program tailored for use with Latino families. Several cultural or contextual issues arose that may be necessary to include or address in a modified PCIT program. The issue of immigration and the fear surrounding immigration may need to be included in treatment as this study suggests it is a source of stress for many families and a potential barrier to participation. Families also expressed the importance of education and academic achievement, and explicit inclusion of education and parenting behaviors related to achievement could be included in PCIT. These findings are consistent with past PCIT

adaptations that spent time in session addressing family and context issues (Matos et al., 2006; McCabe et al., 2005).

A category of themes that emerged from the data related to physical punishment and abuse. The results of the study suggest physical punishment is commonly used and often viewed as positive in Latino families, a result that is supported by previous studies (e.g., Calzada, Basil, & Fernandez, 2012). Data also suggest that ignoring physical discipline as a strategy or failing to address the difference between what is considered abuse and punishment may be a mistake. Participants in this study expressed a desire to have this discussion and the belief that assuming physical discipline does not or will not continue to happen is naïve and ignorant.

Another area in which this data may be helpful in adapting PCIT for use in the community is the logistics and set-up of the program. Data suggests involving extended families and other caregivers in a prevention program may be important. Past adaptations have attempted to address this desire by explicitly including extended family (McCabe et al., 2005) Consistent with previous data (e.g., Parra Cardona et al., 2009), some parents expressed a desire to have the program include a group component where parents from different families can come together. Conversely, the data simultaneously suggests that for some parents, having individual sessions with only parents and not extended family may be important. In sum, it seems as though who should be included in treatment and who should attend sessions is dependent on individual preference.

Participants also had ideas about who should run a PCIT prevention program, but here again the data suggests mixed results. While some parents seemed to think having community members run the groups would be a good idea, others expressed a desire for professionals, like psychologists or social workers, to run the program.

Regardless of the format of the program, the results suggest parents face a number of barriers to participation (e.g., busyness, work schedules) and benefiting from the program. In particular, data suggests that even if the program is fantastic, parents may not follow through with the program or truly learn the skills. A suggestion for improving accessibility was to offer home visits as opposed to solely a center-based approach.

Conclusions

Parent-Child Interaction Therapy may be a good choice for adaptation into a prevention program for Latino families. Previous adaptations of PCIT have been accepted by Latino families (Matos et al., 2006), and data from this study suggests that the goals and techniques of PCIT could match with the goals and desire of Latino families. However, adaptation should be carefully considered. Several aspects of PCIT may not match well with Latino culture and values (e.g., coaching, use of time out), and traditional PCIT likely does not address some issues that would be of vital importance to Latino families (i.e., immigration, educational achievement). While adaptation may be beneficial, the efficacy of such an adaptation should be closely examined. Additionally, the bottom line remains that even the best adaptation will not meet every need of every family, and flexibility with adherence will be an important component of any future PCIT adaptations for use with Latino families in Western Michigan.

APPENDICES

APPENDIX A

BACKGROUND INFORMATION FORM: PARENTS

(Please feel free to use the ruled space at the end of the form if necessary.)

Basic Information about You

1. Age: _____ 2. Gender: _____

3. Your ethnic, national, or cultural background. Please write down all that apply (e.g., Mexican, Puerto Rican, Guatemalan, Cuban, Dominican, French, etc.): _____

_____

4. Your race (select all that apply):

___ White ___ Asian (Specific Group(s):_____)

___ Black ___ Pacific Islander (Specific Group(s):_____)

___ American Indian ___ Other (Specific Group(s):_____)

5. Please circle a number that corresponds to the highest grade you've completed:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Elementary	Middle School	High School/ GED	College/Associates/ Technical School	Graduate/ Professional

6. Select all choices that describe you:

___ I am an immigrant to the United States (US).

I was born in the country of _____.

I have lived in the US for _____ years.

___ I am in the first generation of my family born in the US (i.e. my parents immigrated)

___ I am in the second generation of my family born in the US (i.e. my grandparents immigrated)

___ I am in the third or higher generation of my family born in the US

7. If you had to attend a course that would help you improve your parenting, in what language would you prefer to receive it?

___ Spanish ___ Either English or Spanish

___ English ___ Other: _____

Basic Information about Your Family

We are interested in learning how many children you have raised, whether they are your own or other people's children.

8. How many children have you raised? _____

9. How many children between two and seven-years-old are you currently raising? _____

10. Please select one: I am…

__ Single (go to question 16) __ Married (go to question 11) __ Living with a partner (go to quest 11)

You have already answered these questions about <u>yourself.</u> Please answer questions 11-15 about the <u>second parent/partner</u> in your home

11. Age _____ 12. Gender _____

13. Ethnic and cultural background Please write down all that apply (e.g., Mexican, Puerto Rican, Guatemalan, Cuban,Dominican, French, etc.)_____

_____

14. Race (select all that apply):

___ White ___ Asian (Specific Group(s):_____)

___ Black ___ Pacific Islander (Specific Group(s):_____)

___ American Indian ___ Other (Specific Group(s):_____)

15. Please circle a number that corresponds to the highest grade you've completed:

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Elementary					Middle School				High School/ GED			College/Associates/ Technical School					Graduate/ Professional		

16. Besides you and a partner, are there any other people who help to raise your children (e.g., your mother, sister, etc.)?

___ YES ___ NO

17. If YES, please list the relationship of the person(s) to you (for example, your mother):

_____

_____

18. When you think of all the different people who contribute income to your household, which range best describes the total amount of income your household receives in a year?

___ Less than 10,000	___ 60,000 to 70,000
___ 10,000 to 20,000	___ 70,000 to 80,000
___ 20,000 to 30,000	___ 80,000 to 90,000
___ 30,000 to 40,000	___ 90,000 to 100,000
___ 50,000 to 60,000	___ More than 100,000

19. How many people (including children and adults) live in your home? _____

Notes/Comments: _____

_____

_____

_____

_____

APPENDIX B

CULTURAL INFORMATION: PARENTS

1. When interacting with your children, do you prefer to speak (select one)

____ Spanish ____ English
____ Both Spanish & English ____ Other language: _____

2. Do your children understand you better in (select one)

____ Spanish ____ English
____ Both Spanish & English ____ Other language: _____

Using the following scale for this first set of items, please circle the option that best matches your <u>involvement</u>:

1 ----- ------ ----- ----- 2 ------ ----- ----- ----- 3 ------ ----- ----- ----- 4

(Not at All) (A Little) (Enough) (Very Much)

How much time do you spend involved in:

1. Hispanic music	1	2	3	4
2. Hispanic dances	1	2	3	4
3. Hispanic-oriented places	1	2	3	4
4. Hispanic-type recreation	1	2	3	4
5. Hispanic TV programs	1	2	3	4
6. Hispanic radio stations	1	2	3	4
7. Hispanic books and magazines	1	2	3	4
8. US American music	1	2	3	4
9. US American dances	1	2	3	4
10. US American-oriented places	1	2	3	4
11. US American-type recreation	1	2	3	4
12. US American TV programs	1	2	3	4
13. US American radio stations	1	2	3	4
14. US American books and magazines	1	2	3	4

Using the following scale for each of the items on this page, please circle the option that best matches your <u>agreement</u>:

1 ----- ------ ----- ----- 2 ------ ----- ----- ----- 3 ------ ----- ----- ----- 4 ------ ----- ----- ----- 5

(strongly disagree) (neutral) (strongly agree)

15. I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs.	1	2	3	4	5
16. I have a strong sense of belonging to my own ethnic group.	1	2	3	4	5
17. I understand pretty well what my ethnic group membership means to me.	1	2	3	4	5
18. I have often done things that will help me understand my ethnic background better.	1	2	3	4	5
19. I have often talked to other people in order to learn more about my ethnic group.	1	2	3	4	5
20. I feel a strong attachment towards my own ethnic group.	1	2	3	4	5
21. I have spent time trying to find out more about the history, traditions, and customs of U.S. Americans.	1	2	3	4	5
22. I have a strong sense of belonging in the U.S. American culture.	1	2	3	4	5
23. I understand pretty well what my belonging in U.S. American culture means to me.	1	2	3	4	5
24. I have often done things that will help me understand my background as a U.S. American better.	1	2	3	4	5
25. I have often talked to other people in order to learn more about U.S. Americans.	1	2	3	4	5
26. I feel a strong attachment towards being a U.S. American.	1	2	3	4	5

APPENDIX C

PARENT FOCUS GROUP PROTOCOL

I. INTRODUCTION AND CONSENT

__ Thank you for coming to our group today

__ We have asked you here to get your opinion on a parent training program that we hope will be useful for some of the Latina/o families like yours or families that you know.

__ Your feedback will help us tailor this parent training program to work well for families like yours or other Latina/o families you know

__ Our goal is to develop a program that will work well for Latina/o families in your community, address your main parenting concerns, and be led by a person from your community.

__ For that reason, we will want to get your opinions on how to make the program work well for families like yours and other families you know. We will also want to get your opinion on what are main concerns you have about parenting your children.

__ We are also conducting focus groups with people who work in your community, such as at churches or community centers, to get their opinions on the parenting program.

__ We appreciate your participation and your willingness to share your thoughts with us. There are no right and wrong answers and all of your opinions are valuable to us. You have the right to stop participating in this group at any time and to not participate in any question that you do not want to answer. If any questions are confusing, please ask us to make them more clear to you.

__ In order to ensure that everyone feels comfortable participating, we would like to ask you to not share any opinions that were shared today with anyone else.

___ Although we will be recording the group, we will only keep the recording until we've created a written transcript of the tape that does not include any information that can be used to identify you. After that transcript is written, we will erase the recording and any future mention of anything that was shared in this group will only include a participant reference code (e.g., participant one).

__ Are there any questions before we begin?

II. WHO THE PROGRAM IS FOR

__ The parenting program that we will describe could benefit any young child, we are particularly interested in how it might help kids between the ages of 2 and 7 who act out.

__ We want to make sure everyone knows the kind of kids we're talking about.

__ Kids who act out often do not follow rules at home or at school and are often in trouble,

__ Because these children are quite stubborn, disciplining them can be very difficult for parents.

__ Kids who act out are sometimes aggressive and hit, kick, bite, scratch, or in other ways hurt their parents, siblings, and pets.

__ They are more likely to do what they want to do, rather than what they are told to do. They may talk back or whine about having to do something

__ Kids who act out often have more energy than a typical child and will run around in the house, try to climb on furniture and objects, and sometimes act very dangerously.

__ Kids who act out are often stubborn, and it can be difficult for parents to discipline them

__ Any questions about the types of children we are interested in?

Probes:

- ☐ Do you know children who act like this?
- ☐ What do you or other families you know call children like this?
- ☐ How do parents handle these children? Do they seem to know what to do?
- ☐ Are there places where Latina/o parents of kids who act out can get help?
- ☐ Do parents need more places to go to get help with these children?

II. PROGRAM INTRODUCTION - COACHING

___ We'd now like to begin introducing you to the parent training program.

___To do this, we will show you video clips that demonstrate the main parts of the program, and then ask your feedback.

___Remember, there are no right or wrong answers. Your honest opinions are very important to us. If anything is confusing, please let us know and we will do our best to explain them more clearly.

___ This program uses a coaching approach where a coach teaches families by giving parents feedback as they are playing with their children.

___ Coaching helps parents to learn parenting skills because they get feedback right away.

___ Coaches are supportive of parents and help parents to use the strengths they already have and help them to learn more skills to manage their children's acting out.

___ *Show video sample of coaching.*

Probes

- ☐ How would you feel about a parenting program where a coach gave you feedback on how you play with your child?
- ☐ Would this type of coaching be useful for parents who have children who act out?
- ☐ If you dislike/have concerns about coaching, what are they, and what might be done to make better?

III. Child-Directed Interactions

(Praises, Reflections and Descriptions)

___ There are two types of skills that parents are taught in our program. The first type strengthens the relationship between the parent and child and reduces annoying child behaviors.

___For example, parents are taught to praise their children when they are doing something well. Things like completing chores, obeying parents, and sharing.

___Parents are also taught special way of listening to their children and a way to follow their children's lead to help their child stay focused. We call these listening and following skills "reflections" and "descriptions."

___ *Show video of CDI coaching, with particular emphasis on LPs.*

Probes:

- ☐ What are your reactions to this part of the program?
- ☐ Would you be interested in learning these relationship-building skills?
- ☐ If you dislike/have concerns about these relationship-building skills, what are they, and what might be done to help make it better?

(Ignoring)

___ As part of this first set of skills, we also teach parents a special kind of ignoring that helps to get rid of attention-seeking behaviors like whining, throwing temper tantrums, and talking back. Parents are taught to completely ignore the negative attention-seeking behaviors (e.g., whining), while focusing on their children's positive behaviors (e.g., talking respectfully). Although this special kind of ignoring is not helpful for children's dangerous or destructive behaviors, it can be very effective at stopping attention-seeking behaviors.

___ *Show video of ignoring*

Probes:

- ☐ What are your reactions to this part of the parent program?
- ☐ Would you be interested in learning this special type of ignoring?
- ☐ If you dislike/have concerns about these ignoring skills, what are they, and what might be done to help make it better?

IV. Didactics and Parent-Directed Interactions

(Didactics and Commands)

___ In each section of the program, before we begin coaching a specific set of skills, we provide parents with information about how to properly do these skills.

___ We spend an hour explaining different skills, like the ones you have already seen, and the reasons for using them, so that parents can learn about the skills and ask questions if they need to before practicing. We give lots of examples during these teaching sessions and model the use of the skills, too.

___The video clip you will see next shows a teaching session where coaches are explaining the second set of skills to parents. This set of skills teaches parents how to manage their kids' acting out. Parents are taught how to give commands in a way that their children are more likely to follow and to provide immediate consequences if their children do not obey the commands. Important points about giving commands include telling the child what *to do* instead of what not to do, giving only one command at a time, and making sure that the child is looking at you and paying attention to you when you give it.

Probes:

- ☐ What are your reactions to this part of the program?
- ☐ Would you be interested in coming to teaching sessions where a coach teaches you skills before you practice with your children?
- ☐ Would you be interested in coming to a teaching session where a coach teaches you new ways to give commands to your children?
- ☐ Do you have concerns about learning new ways to give commands to children? If you do, what might the program do to address those concerns.

(Time Out)

___ In our parent training program, parents are taught to provide consequences when children act out by not following home or school rules.

___ When other things don't work to get a child to do what they're told, parents are taught to use a time out procedure where the child sits alone in a time out spot for three minutes.

___The coaches help parents to teach time out to the child using Mr. Bear, a stuffed animal. Parents show their children what happens when Mr. Bear does not follow a command and

has to go to time out. Using Mr. Bear has been helpful for children to learn the new rules about discipline.

___ This video clip will show you how Mr. Bear is used in our program and how coaches help parents use time out.

Probes:

- ☐ What are your reactions to this part of the program?
- ☐ What are your reactions to using Mr. Bear to help children learn about time out?
- ☐ What are your reactions to having a coach help parents use time out as a form of discipline when children don't obey commands?
- ☐ Do you have concerns about using time out with children? If you do, what might the program do to address those concerns?

V. Service Characteristics

___ We are interested in making this program as useful as possible for Latina/o families who need it. Your answers to the next set of questions will help us do this.

Probes:

- ☐ Who should be included in the program? (Parents? Extended family? Other children in the home?)
- ☐ If other people should be included in the program, how do we encourage them to come?
- ☐ Would you prefer to be in the program alone or to be in the program with other families?
- ☐ Where would you prefer the program be held?
- ☐ Are there any cultural or community values (things that are important to many Latina/o families you know) that we should include in the program?
- ☐ What types of people do you think would be leaders/coaches for this program?
- ☐ What are the most important goals of a parenting program like the one we described?
- ☐ How long do you think meetings for this program should be, and how often do you think they should happen?
- ☐ How important is it to include information about stress, finding support outside of group, or other topics in the program?

VII. Wrap up

___ Thank you very much for your time and help today.

___ After we have finished analyzing the information we learn from this group and others, we will be making any needed changes to our parent training program.

___ At that point, we will ask you to join us again for a large group forum, where we present you with the proposed program and ask for your feedback again.

___ In the mean time, if you have any questions or further comments, please speak with me now or contact me at this number/email/etc.

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