

Parent-Child Interaction Therapy With a Spanish-Speaking Family

Joaquin Borrego, Jr., *Texas Tech University*

Karla Anhalt, *Kent State University*

Sherri Y. Terao, *University of Chicago*

Eric C. Vargas and Anthony J. Urquiza, *University of California, Davis Medical Center*

There is relatively little information on the treatment effectiveness of child behavior-management programs with Spanish-speaking populations. Though there are several empirically supported treatments available in English, research on the applicability of these programs in Spanish is virtually nonexistent. This single-case study discusses the application of Parent-Child Interaction Therapy (PCIT) with a Spanish-speaking mother-child dyad to address the child's externalizing behavior problems. Both observational and parent self-report data are presented. Results suggest that PCIT was effective in increasing positive parent behaviors, decreasing child behavior problems, and reducing parental stress level. Implications for future clinical and research work with Spanish-speaking families are discussed.

There is a strong interest within the mental health field to develop and implement psychosocial interventions that meet the needs of ethnic minority families and children in the United States (National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment, 2001). An identified subgroup of families in need of culturally appropriate interventions is Spanish-speaking Hispanics. One way to meet this need is to make these interventions culturally appropriate for families (American Psychological Association, 1993, 2003). This goal can be accomplished through either developing new psychosocial interventions or taking current efficacious interventions and adapting/modifying them to the specific cultural group (Miranda et al., 2005). Providing a culturally relevant treatment may include making the service readily available and more accessible for Spanish-speaking populations (Rogler, Malgady, Costantino, & Blumenthal, 1987). Along these same lines, different guidelines and recommendations have been proposed regarding what contextual factors should be considered when working with ethnic minority families (e.g., Bernal, Bonilla, & Bellido, 1995; Vera, Vila, & Alegria, 2003).

Providing these services can be difficult given the paucity of psychosocial treatments and limited information on the effectiveness of parenting programs readily available in Spanish. Even more difficult is demonstrating

that treatments offered in Spanish are effective with monolingual or bilingual Hispanics. Though Hispanics comprise the largest ethnic minority group in the U.S. (Ramirez & de la Cruz, 2002; U.S. Census Bureau, 2001), there continues to be a void in the mental health literature with regard to appropriate and effective treatments for this group. This is complicated by the fact that Hispanics tend to underutilize mental health services (Yeh et al., 2002).

Child Behavior Problems

Clinical researchers estimate that 20% to 35% of young children exhibit conduct problems (Webster-Stratton & Hammond, 1998). Like other children, Hispanics are not immune to conduct disorders and other antisocial behaviors (Rodriguez & Zayas 1990). It has been suggested that the prevalence of mental health problems for children from ethnic minority or low-income families ranges from 34% to 50% (Bird, Gould, Rubio-Stipec, & Staghezza, 1991; Tuma, 1989; Zahner, Pawelkiewicz, DeFrancesco, & Adnopo, 1992). Though one third to one half of all mental health referrals consist of children with disruptive behavior problems (Kazdin, 1995), approximately one fifth of children with mental health problems actually receive treatment (Pagano, Murphy, Pedersen, & Mosbacher, 1996).

The Need for Culturally Relevant Parent Education Programs

Currently, there are several empirically supported treatments available in English for parents who have

children with disruptive behavior problems (Brestan & Eyberg, 1998). Despite this, parenting models over the past four decades have shown that the majority of therapeutic techniques, and their demonstrated effectiveness, have been based on Caucasian families (Herschell, Calzada, Eyberg, & McNeil, 2002). Forehand and Kotchick (1996) noted a critical concern in parent training research, namely, a need for recognition of the importance of cultural considerations in parent training programs.

Forehand and Kotchick (1996) noted that multiple issues need to be examined with regard to parenting and child behavior problems. For example, they proposed that researchers examine whether noncompliance and aggression are viewed as equally problematic across ethnic groups, and whether parenting skills typically taught in behavioral parent training programs were as acceptable and effective when evaluated in different ethnic groups.

Capage, Bennett, and McNeil (2001) have begun to address some of these issues with young African American children referred for treatment of disruptive behavior problems. After matching participants on age, gender, income, and treatment location, the authors found no statistically significant differences on the pretreatment and treatment outcome measures administered. There were no statistically significant differences between the African American and Caucasian groups with regard to diagnosis, treatment participation, treatment length, and treatment dropout. Thus, the authors cautioned therapists to refrain from significantly modifying empirically supported treatments based on race alone (Capage et al., 2001).

Still, these authors also have noted that there are unique characteristics of young African American children with disruptive behavior problems that should be considered in parent training (McNeil, Capage, & Bennett, 2002). For example, higher rates of treatment dropout have been concerns in some studies (e.g., Kazdin, Stolar, & Marciano, 1995). Further, positive racial socialization may be an important priority in African American parenting behaviors (McNeil et al., 2002). Of interest, researchers are currently examining the impact of incorporating racial socialization into parent training programs with African American families (Coard, Wallace, Stevenson, & Brotman, 2004). Though there is some promising research with African American families, there is little information on Hispanics.

Hispanics

As stated earlier, Hispanics now comprise the largest ethnic minority group in the U.S. (Ramirez & de la Cruz, 2002). Given that the term *Hispanic* is meant as an umbrella term to encompass different subgroups (e.g., Mexicans, Cubans, Puerto Ricans, etc.), it is difficult to

capture the exhaustive Hispanic socialization and parenting practices that apply to all subgroups. It would also be erroneous to assume that a phenomenon found in one subgroup would generalize to other subgroups. At times, there is greater within-group variability in Hispanics as there are between-group differences such as with Hispanics and Caucasians.

There are, however, some culturally relevant values that apply to many different Hispanic subgroups (Chun & Akutsu, 2003). These values include *familism*, *respeto*, *personalismo*, and *simpatia*. Emphasis on the family (*familismo*) relates to the very close ties that are common in Hispanic families, and how those ties are likely to extend beyond the nuclear family (e.g., mother, father), and include extended family (grandparents, uncles, cousins) as well as close friends of the family that become like family (e.g., *compadre* and *comadre*).

Respeto (respect) is displayed in interactions by showing deference to people of authority or seniority. An illustration of the value that is placed on respect and deference to authority figures pertains to the general notion of “being well-educated” in certain Hispanic subgroups. When used in Spanish (i.e., “*ser bien educado*”), this term refers to a child behaving in a socially appropriate and respectful manner toward others. Children are expected to behave (*ser bien educado*) across different settings, especially in public (Fontes, 2002). Being disobedient is a sign of being disrespectful to the parent. In many instances, if children are identified as *bien educados* (well-educated), this does not refer to academic performance or school-based formal education, but the fact that children may display appropriate social behavior toward adults at home, school, and other public settings.

In professional relationships, people are addressed in a formal manner (*usted*) as opposed to an informal (*tu*) style of interaction. Immigrants from some Spanish-speaking countries may address elders or authority figures in their family (including parents) by using formal language. The use of formal language, including its use within the family, is intended to denote deference and respect toward authority figures. When using names, respect is shown by using the person’s formal title and last name (e.g., Señora Martínez) instead of their first name (e.g., Paula). Along with *respeto*, *personalismo* (developing a relationship that is characterized as being “warm”) and *simpatia* (engaging in positive prosocial interactions) are values that can be seen in parent-child relationships and used in the therapy context. In the context of the parent-child relationship, parents use terms of endearment (i.e., *cariños*). Parents show *cariños* to their children through positive physical touches and terms of endearment such as calling them *Mi reyna/rey* (My queen/king), *mama* (mother), or *mi amor* (my love). *Personalismo* and *simpatia* can be displayed by

engaging the family in informal conversations and asking about family members' well-being.

With regard to parenting styles, the literature is mixed as there is considerable disagreement about the consistency of parenting styles/practices displayed by Hispanic-origin families (Hill, Bush, & Roosa, 2003). With regard to discipline, one study found that Hispanic mothers reported greater use of corporal punishment than Caucasian mothers (Cardona, Nicholson, & Fox, 2000). This finding is consistent with other research suggesting that Hispanic parents use corporal punishment (Zayas & Solari, 1994) and are more authoritarian (Zayas, 1992). There are, however, some studies that have not found ethnic differences (Solis-Camara & Fox, 1995). Given the mixed findings, it has been cautioned that mental health professionals working with Hispanic families should not automatically assume that all Hispanic families engage in an authoritarian-based parenting style (Varela et al., 2004). As with other learned phenomena, childrearing and parenting practices in Hispanic communities are greatly influenced by culture and other socialization factors (Fontes, 2002; Zayas & Solari, 1994).

Parenting Programs for Spanish-Speaking Hispanic Families

Mental health research has noted concerns in the availability, accessibility, and utilization of treatment for Spanish-speaking populations in the U.S. (Department of Health and Human Services [DHHS], 2001). Hispanic parents have very limited access to psychological service providers who speak Spanish. This becomes a barrier in mental health treatment, considering that 40% of Hispanics report limited proficiency in English (DHHS, 2001). In addition, underutilization of mental health services by Hispanic families may be compounded by the limited availability of psychosocial interventions in Spanish.

Bernal et al. (1995) noted that language is an essential component of adapting psychosocial interventions to be culturally sensitive for Hispanic children and families. Though there are several parenting books that address parenting and discipline issues in Spanish (e.g., *Niños Desafiante*s, Barkley, 1997a; *PECES*, Dinkmeyer & McKay, 1981; *Padres Eficaces: Lo Básico*, Popkin, 1992), there has been no empirical validation to suggest that the interventions have been effective with Spanish-speaking populations in the U.S.

One promising treatment approach is Parent-Child Interaction Therapy (PCIT). PCIT has different components that may be culturally appropriate for Hispanic families. The focus on enhancing the parent-child relationship in PCIT fits with the "familism" value present in many Hispanic families. This value empha-

sizes loyalty and commitment within family members and it is especially important in parent-child interactions. In addition, the emphasis on discipline and compliance to adult requests is consistent with the value of "respect" for authority figures. Some research also suggests a preference for direct therapy approaches in Hispanic populations (Sue & Sue, 2003). The following section offers a brief description of PCIT.

Overview of PCIT

PCIT is an intensive, short-term parent education program developed to assist parents whose children have disruptive behavior problems such as aggression, noncompliance, defiance, and temper tantrums. The program was developed by Sheila Eyberg and it targets children ages 2 through 7 (Eyberg & Robinson, 1982; Hembree-Kigin & McNeil, 1995). The program aims to decrease young children's oppositional behavior by following a two-stage operant model that was developed by Constance Hanf. In the first stage, parents are taught differential attention skills by providing positive attention for prosocial behavior and ignoring disruptive behavior. The second stage involves compliance training by teaching caregivers to give clear directions, reward compliance, and implement time-out for noncompliant behavior (Hanf, 1969). This two-stage operant model was adopted as a major characteristic of PCIT. However, multiple components were added by Sheila Eyberg and the program evolved into a more prescriptive and detailed intervention (Eyberg & Robinson, 1982; Hembree-Kigin & McNeil, 1995).

PCIT relies heavily on the use of play as a developmentally relevant mechanism to enhance the parent-child relationship. Therefore, the first stage of PCIT aims to increase positive interactions between the parent and the child in addition to teaching differential attention skills. This stage is known as the Child Directed Interaction (CDI) stage. The second stage focuses on increasing child compliance and reducing aggression and destructive behavior by teaching the caregiver to give clear instructions and provide consistent consequences (e.g., labeled praise for compliance, time-out for noncompliance). The second stage of PCIT is named Parent Directed Interaction (PDI; Eyberg & Boggs, 1998; Eyberg, Boggs, & Algina, 1995; Eyberg & Robinson, 1982; Hembree-Kigin & McNeil, 1995).

PCIT is different from other behavioral parent training programs in that both the parent and the child are present during treatment sessions. Other parent education programs focus on teaching skills to parents without the target child being present (e.g., Barkley, 1997b). Also, traditional parent education classes may be conducted in a workshop format where

parents are given lectures on different skills related to parenting (e.g., developmental milestones, discipline, and home safety). With PCIT, parents practice skills with their children during therapy sessions, and they are supported and coached by the therapist. Thus, PCIT encourages the use of social reinforcement between therapist, parent, and child to bring about positive behavior change (Borrego & Urquiza, 1998). Research suggests that in comparison to traditional parenting classes, PCIT is more effective in reducing child behavior problems and parenting stress (Terao, 1999).

In PCIT, feedback to the parent is given by a therapist who coaches the parent to use certain skills with the target child. The coaching takes place behind a one-way mirror with the aid of a "bug-in-the-ear" device that the parent wears during the session. The therapist is able to watch the parent-child interaction and hear verbalizations made by the parent and the child. The parent receives the "coaching" information from the therapist through a hearing aid. If the technology is not available to a therapist or clinic, the clinician can provide feedback to the parent in the therapy room (Hembree-Kigin & McNeil, 1995).

Research Supporting the Effectiveness of PCIT

Treatment studies have shown PCIT to be effective in decreasing child behavior problems (e.g., Borrego, Urquiza, Rasmussen, & Zebell, 1999; Eisenstadt, Eyberg, McNeil, Newcomb, & Funderburk, 1993; Eyberg, 1988; Eyberg & Robinson, 1982; McNeil, Capage, Bahl, & Blanc, 1999; McNeil, Eyberg, Eisenstadt, Newcomb, & Funderburk, 1991; Nixon, Sweeney, Erickson, & Touyz, 2003; Terao, 1999). In addition, PCIT has been effective in improving child compliance to parental requests and increasing positive parent-child interactions (Eisenstadt et al., 1993; Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998). PCIT treatment effects have been shown to generalize across time (Hood & Eyberg, 2003; Newcomb, Eyberg, Funderburk, Eisenstadt, & McNeil, 1990), to the home (Boggs, 1990), to the school setting (McNeil et al., 1991), and to untreated siblings (Brestan, Eyberg, Boggs, & Algina, 1997; Eyberg & Robinson, 1982).

Recently, PCIT has been evaluated with parents who have a history of child physical abuse and who continue to be at high risk for child maltreatment. Borrego et al. (1999) found that PCIT reduced child behavior problems and parental stress in a family with a history of child physical abuse. Further, after conducting a randomized trial, Chaffin and colleagues (2004) found significant decreases in repeated reports of physical abuse in families that participated in the PCIT treatment condition. At follow-up, 19% of parents assigned to the PCIT treatment condition had a re-report for physical abuse. In contrast, 49% of parents assigned to the standard community

group had recurrent reports of child physical abuse (Chaffin et al., 2004).

Though PCIT has been shown to be an effective intervention program for children with behavior problems and for physically abusive parents, the program has not been empirically tested with different linguistic groups. In this single-case study, we discuss the effectiveness of PCIT with a Spanish-speaking family referred to a medical center clinic. Data presented are based on pre-, mid-, posttreatment, and 1-year follow-up. This study used behavioral observation methodology and parent report measures to document progress throughout treatment.

Method

Participants

The family in treatment consisted of a 49-year-old Mexican monolingual Spanish-speaking foster mother (long-term guardian) and a 3-year-old Mexican-Chilean-Filipina bilingual child (for discussion purposes, we will refer to the foster mother as "the parent" or "the mother" and the child as "Ana"). The mother was born in Mexico and immigrated to the United States as an adult. Given that she was born in Mexico and her preferred language was Spanish, it is reasonable to assume that the mother was not fully acculturated to U.S. culture. There was, however, no way of actually determining the mother's acculturation level because a formal acculturation assessment was not administered to the mother. Her education level was not formally assessed but she was able to read, comprehend, and complete the paperwork given to her. Given the mother's preference and comfort level in using Spanish, all verbal instructions and paperwork were provided in Spanish.

The parent was referred to the medical center by Ana's social worker after she reported numerous child behavior problems. Ana was placed in protective custody (foster care) at birth as a result of her older sibling being physically abused. Information from the social worker's report and an initial assessment session with the foster mother revealed Ana had the following behavior problems: aggression towards peers and caretakers, defiance, resistance to limit setting, temper tantrums (which consisted of whining, screaming, crying, kicking, hitting, and throwing herself on the floor), and not following the caretaker's directions.

Measures

Child Behavior Measures

Eyberg child behavior inventory (ECBI). The ECBI measures behavioral problems exhibited by children ages 2 to 16 years. Parents indicate the frequency of behaviors (Intensity score) and whether they are considered to be problematic (Problem score). Eyberg (1992)

and Eyberg and Pincus (1999) reviewed studies demonstrating the reliability and stability of the ECBI, as well as the validity and sensitivity to change following parent training. The ECBI has been standardized on a number of populations (Eyberg & Pincus, 1999; Eyberg & Robinson; 1982; Eyberg & Ross, 1978). The published cutoff scores for child deviancy are an Intensity score of greater than 131 or a Problem score of greater than 15.

Child behavior checklist for ages 2 to 3 (CBCL/2-3). The CBCL/2-3 is a standardized instrument that lists 113 problem behaviors that children between the ages of 2 to 3 may exhibit (Achenbach & Edelbrock, 1983). When completing the CBCL/2-3, parents indicate whether each item is "not true," "somewhat or sometimes true," and "very true or often true" for their child. Through a factor analytic design, the CBCL/2-3 is comprised of two broad-band scales (Internalizing and Externalizing) and a range of narrow-band scales (e.g., Aggressive, Destructive, Somatic Problems, Sleep Problems, etc). Extensive descriptions of the psychometric properties of the CBCL/2-3 have been provided by Achenbach and colleagues (e.g., Achenbach, Edelbrock, & Howell, 1987).

Parenting Stress Measure

Parenting Stress Index (PSI). The PSI (Abidin, 1990) was designed to identify parent-child dyads who are experiencing stress and who may develop dysfunctional parenting and child behavioral problems. The index consists of 13 subscales grouped into a Child Domain (i.e., Adaptability, Demandingness, Mood, Distractibility/Hyperactivity, Acceptability and Reinforces Parent), a Parent Domain (i.e., Depression, Attachment, Restrictions of Role, Sense of Competence, Social Isolation, Relationship with Spouse, and Parent Health), a Life Stress Scale, and a Total Stress Scale. In his manual, Abidin describes several studies that report psychometric data on the PSI. Alpha reliability coefficients for each scale have been determined, with Child Domain coefficients ranging from .62 to .70; Parent Domain coefficients ranging from .55 to .80; and the reliability coefficient for the Total Stress Score being .95. In addition, Burke and Abidin (1980) provide extensive information about the validity of the PSI, including content validity, overall development of the measure, and development of each scale.

Coding System

Dyadic Parent-Child Interaction Coding System (DPICS). The DPICS (Eyberg & Robinson, 1983) was designed to assess the quality of parent-child social interactions through observations of dyads in a clinic setting. In their standardization study, Robinson and Eyberg (1981) reported interrater reliabilities for different types of

coders (e.g., psychologists, psychology interns, graduate-level research assistants) ranging from .67 to 1.0 (mean = .91) for parent behaviors and .76 to 1.0 (mean = .92) for child behaviors. Interrater reliability was assessed by correlating the frequency of each behavior recorded during the observations. The validity of the DPICS has been demonstrated in studies. It has correctly classified (via discriminant function analyses) 100% of normal families, 85% of treatment families, and 94% of all families (Robinson & Eyberg, 1981).

Statistically significant changes have been noted in child compliance and physical negatives categories created from DPICS codes at pretreatment and post-treatment (Eisenstadt et al., 1993). Eisenstadt and colleagues (1993) observed improved child compliance and reduced physical negatives after PCIT was implemented with 24 mother-child dyads. Child negative behavior and positive parenting summary variables created from DPICS codes also have demonstrated treatment sensitivity. Reduced child negative behavior and increased positive parenting have been observed after intervention for young children with conduct problems (Webster-Stratton, Reid, & Hammond, 2004).

Several additional studies have demonstrated the psychometric properties of the DPICS with other populations, including mothers with a history of child neglect (Aragona & Eyberg, 1981) and children with conduct disorders (Webster-Stratton, 1985). Table 1 lists the codes that were used in the study.

Procedure

During the intake interview, midtreatment, posttreatment, and follow-up, the parent completed measures described above that assessed the child's behavior problems and parental stress level (i.e., CBCL, ECBI, and PSI). The mother and child were also videotaped during two situations to code parent verbalizations and child behaviors during baseline, midtreatment, and posttreatment. These structured observations involved two 5-minute segments. During the first observation, the parent was asked to allow the child to select the play activity and follow the child's lead. This was the "child-directed play situation." The second observation was the "clean-up situation" and the parent was asked to instruct the child to put away the toys without parental assistance (Hembree-Kigin & McNeil, 1995). Both observations are typical components of the intake process; however, these observations also were performed at midtreatment and posttreatment to evaluate treatment gains over time.

The standard protocol for PCIT was implemented with this family. That is, PCIT was conducted in two phases: CDI, or the *Relationship Enhancement Phase*, and PDI, or the *Discipline Phase*. At the beginning of each

Table 1
DPICS codes

Parent behaviors	
<i>Praises</i>	A nonspecific (unlabeled praise) or specific (labeled praise) verbalization that expresses a favorable judgment on an activity, product, or attribute of the child.
<i>Descriptions</i>	A declarative sentence or phrase that gives an account of the objects or people in the situation or the activity occurring during the interaction.
<i>Questions</i>	A descriptive or reflective comment expressed in question form.
<i>Criticisms</i>	A verbalization that finds fault with the activities, products, or attributes of the child.
<i>Direct command</i>	A clearly stated order, demand, or direction in declarative form.
<i>Indirect command</i>	An order, demand, or direction for a behavioral response that is implied, nonspecific, or stated in question form.
Child responses to commands	
<i>Compliance</i>	When the child obeys, begins to obey, or attempts to obey a direct or indirect parental command.
<i>Noncompliance</i>	When the child does not obey a direct or indirect parental command.
<i>No opportunity</i>	When the child is not given an adequate chance to comply with command.

phase (i.e., CDI and PDI), the parent participated in a therapist-led didactic session that provided an overview of skills that would be practiced in future sessions. During the didactic sessions, concepts were discussed, modeled by the therapist, and practiced by the parent. The didactic sessions were followed by coaching sessions with the parent and child in a play therapy room, where the therapist coached the parent behind a one-way mirror. Communication between the parent and the therapist during coaching sessions took place through a bug-in-the-ear device. The mother and child participated in four CDI coaching sessions and three PDI coaching sessions and a final posttreatment session. The mother was required to meet *mastery criteria* in CDI before proceeding to the PDI (Discipline) portion of PCIT. Mastery criteria during CDI involved the parent emitting 25 descriptions, 15 praises, and minimal questions and commands during a 5-minute observation period (Hembree-Kigin & McNeil, 1995).

During CDI, the parent was coached to use specific positive and relationship-enhancing skills (e.g., statements and behaviors) including the following: *descriptions* (provide a verbal description of the child's appropriate play), *reflections* (repeat verbatim or paraphrase an appropriate verbal statement of the child), *imitation* (copy appropriate child behaviors in the context of play), and *praise* (provide positive verbal statements for appropriate behavior).

During CDI, the parent also was instructed to *avoid criticizing* the child because critical statements may negatively affect the parent-child relationship and the child's self-esteem (Hembree-Kigin & McNeil, 1995). In order to allow Ana to lead the play during the CDI sessions, her parent was also coached to avoid *using questions and instructions*. See Eyberg and Boggs (1998), and Hembree-Kigin and McNeil (1995), for a detailed description of the CDI phase of PCIT.

Once the parent met mastery criteria for CDI skills, the PDI portion of PCIT was introduced. During the PDI didactic, the parent was taught to use clear, positively stated, direct commands and consistently follow through with consequences for positive and negative behavior (e.g., praise for compliance, time-out for noncompliance; Hembree-Kigin & McNeil, 1995). During the PDI phase, the mother went through several practice drills involving the application of discipline skills.

A unique aspect of PCIT that was implemented with this family was the structured teaching of the time-out procedure. Both the parent and the child receive an overview of the expectations for compliance and consequences for noncompliance. For example, during the PDI didactic, the parent received a flow chart describing the discipline procedure. During the first PDI coaching session, the parent practiced the time-out procedure with Ana so that Ana was aware of how to prevent going to time-out. New behavioral expectations were also explained to Ana, including the expectation to stay seated and quiet during time-out. The parent was asked to avoid using the time-out procedure at home until several successfully coached time-outs took place during PDI sessions. Finally, time-out as implemented in PCIT did not end until the child complied with the original instruction. Thus, noncompliance ceased to be maintained by escaping tasks (see Hembree-Kigin & McNeil, 1995, for a complete description of the PDI phase).

The first 5 minutes of each treatment session were also videotaped and coded prior to any coaching. This was done in an effort to document if treatment progress from the previous session carried over to the following week (i.e., generalization across time). To continue enhancing the parent-child relationship throughout treatment, the parent was instructed to be nondirective and follow the child's lead in play during the first 5 minutes of each session. We refer to this component of the sessions as "child-directed play situations." Specific DPICS variables were coded with frequency counts used for data analysis. The DPICS observational data assisted in monitoring treatment progress.

Coding

Coders were two bilingual (English/Spanish) doctoral students in clinical psychology trained in the DPICS.

The primary coder was a native Spanish-speaking doctoral student who was not involved in treatment delivery in order to reduce bias in coding. Both coders had extensive knowledge of the DPICS and PCIT, had previously coded a minimum of ten 5-minute segments, and reached at least 85% reliability on DPICS codes (i.e., mean reliability for the last two coding tapes). Both coders coded each 5-minute segment. Reliability between coders was assessed as agreements divided by the sum of the number of agreements and disagreements with the results giving a percent agreement. The mean reliability for the coders was 85%. The data presented are from the primary coder.

Assessment and Treatment Integrity

When conducting psychotherapy treatment outcome research in general, and in Spanish in particular, one concern is maintaining assessment and treatment integrity to ensure that the intervention is delivered as intended. Specific steps were taken to preserve assessment and treatment integrity in this case study. First, in accordance with the procedures established by Marin and Marin (1991), all materials were made available in Spanish (the parent-report measures used were originally standardized in English). The CBCL and PSI were made available in Spanish from their respective authors. The ECBI was translated into standard Spanish and then back translated several times by different people (e.g., parents and mental health professionals) to ensure accurate linguistic and functional equivalency. To ensure the cultural appropriateness and ecological/social validity of the treatment components in Spanish, protocols were reviewed through meetings held with Spanish-speaking parents, social workers, and therapists. As with the ECBI, all CDI and PDI materials were translated into Spanish and back translated by independent raters for accuracy. Meetings were also held with people from the community to ensure that the materials were appropriate.

Within the treatment setting, the sessions were conducted by a Mexican-American bilingual therapist who had conducted PCIT numerous times and worked closely with a supervisor. The therapist also followed a week-by-week treatment session checklist that monitored attendance and intervention completion tasks (e.g., focusing on praises for one particular segment in therapy).

Results

Self-Report and Parent-Report Measures

Table 2 shows the pre-, mid-, posttreatment, and follow-up scores for the CBCL/2–3, ECBI, and PSI.

Table 2
Standard measures: Pre-, Mid-, Post-, and follow-up scores

Measures	Pre	Mid	Post	Follow-up ^a
<i>Eyberg child behavior inventory</i>				
Intensity score	194 ^b	143 ^b	84 ^c	128 ^c
Number of problems score	33 ^b	26 ^b	15 ^b	7 ^c
<i>Parental stress index (in percentages)</i>				
Child domain score	98 ^b	95 ^b	69	63
Parent domain score	30 ^c	19 ^c	37 ^c	49 ^c
Total stress score	84 ^b	63 ^c	64 ^c	53 ^c
<i>Child behavior checklist–Parent report</i>				
Externalizing behaviors TS	69 ^b	65 ^b	45 ^c	56 ^c
Aggressive behavior TS	69 ^b	67 ^b	50 ^c	57 ^c
Destructive Behavior TS	67 ^b	61 ^c	50 ^c	51 ^c
Internalizing behavior TS	68 ^b	61 ^c	40 ^c	39 ^c
Anxious/Depressed TS	61 ^c	58 ^c	50 ^c	50 ^c
Sleep problems TS	51 ^c	50 ^c	50 ^c	57 ^c
Somatic problems TS	55 ^c	50 ^c	50 ^c	50 ^c
Withdrawn TS	72 ^b	62 ^c	50 ^c	50 ^c
Total TS	67 ^b	60 ^c	39 ^c	48 ^c

Note. TS = T score.

^a 1-year follow-up.

^b Clinically significant scores.

^c Normal limits scores.

There was a notable decrease in the parent's rating of the child's behavior problems with the CBCL and ECBI. Ana's frequency of behavior problems (as indicated by the parent's ECBI Intensity score) was clinically significant during pre- and midtreatment. However, Ana's ECBI intensity score fell to within normal limits during the posttreatment phase. At follow-up, the parent reported a Problems score that was within normal limits.

Ana's externalizing behaviors as identified by the CBCL/2–3 decreased to within normal limits as treatment progressed. The Externalizing, Aggressive, and Destructive behavior scales were clinically significant at pretreatment and changed to within normal limits at posttreatment and follow-up. The mother's stress level surrounding parent-child relationship issues decreased as treatment progressed. This was evidenced by decreases in the Child Domain and Total Stress scores of the PSI. These PSI scores were clinically significant at pretreatment and within normal limits at posttreatment and follow-up (see Table 2).

Observational Data

As mentioned previously, a 5-minute child-directed play situation was videotaped at the beginning of each session. These 5 minutes were purely observational; the parent was not "coached" during these situations. These videotapes were then coded and parent verbalizations were plotted on graphs to document treatment progress. As shown in Figure 1, the number of labeled and

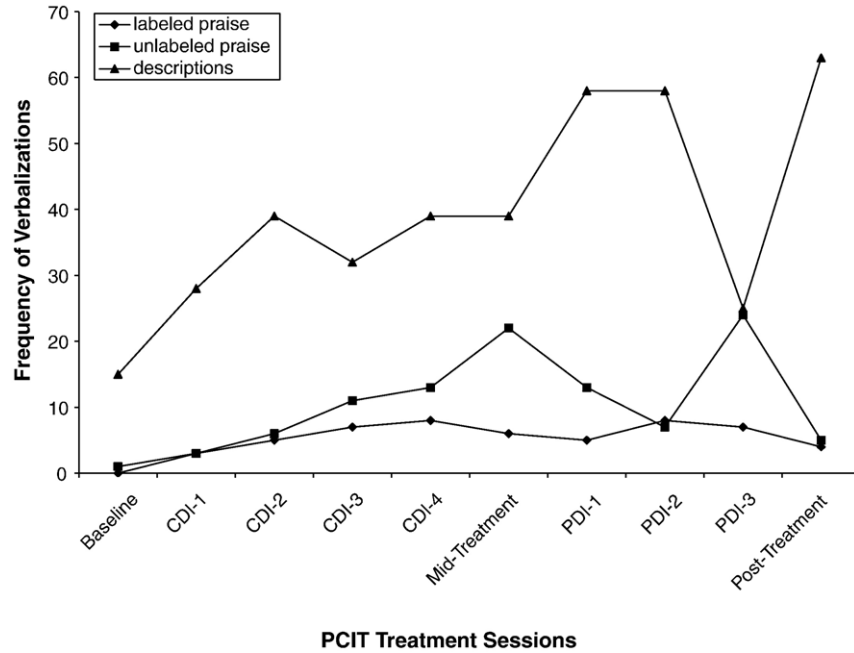


Figure 1. Parent praises and descriptions during child-directed play situations.

unlabeled praises, as well as descriptions, increased as treatment progressed. Frequent use of these positive parent verbalizations was hypothesized to provide an environment in which the child felt attended to and affirmed when the dyad was playing together.

The critical statements and questions the parent directed toward Ana during the child-directed play situations at the beginning of sessions also were coded.

Figure 2 illustrates how critical statements and questions during child-directed play situations decreased dramatically throughout treatment. Parental criticisms toward Ana during the situations coded decreased to zero from the fifth session to the end of treatment.

The number of questions the parent asked Ana from midtreatment to the end of treatment was five or less per 5-minute child-directed play situation. The parent had

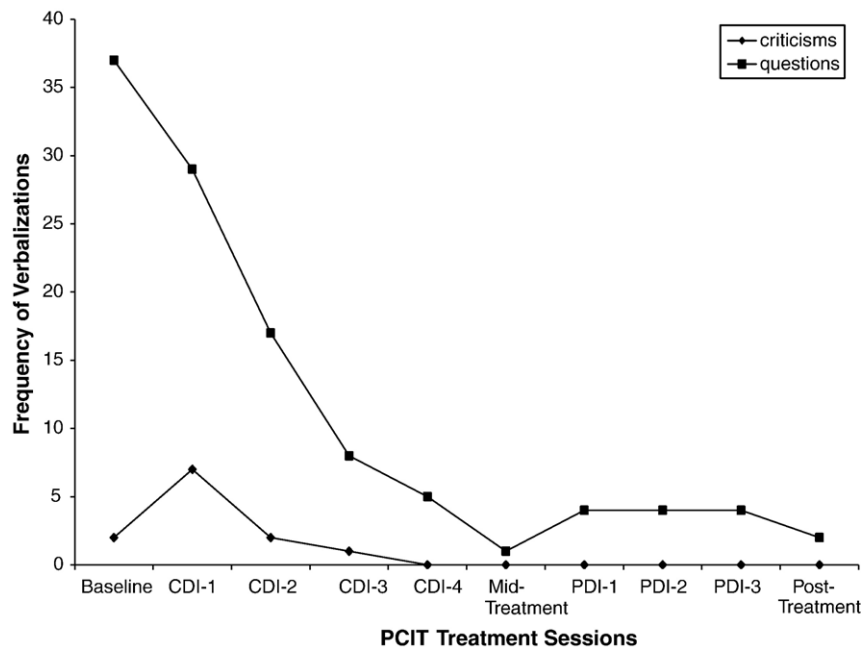


Figure 2. Parent criticisms and questions during child-directed play situations.

asked over 35 questions during the 5-minute baseline play situation. The decrease in questions asked by the parent is significant because questions tend to take away the lead from the child, they may function as indirect commands, or they may suggest disapproval of the child's play choices (Hembree-Kigin & McNeil, 1995). The reduction of critical statements and questions throughout treatment was replaced by a greater use of parent praises and descriptions, facilitating a more positive parent-child interaction.

During baseline, midtreatment, and posttreatment, parent instructions were coded during a 5-minute cleanup situation. Ana's mother did not receive coaching from the therapist during the cleanup situations. The number of commands issued by Ana's mother during the cleanup situations decreased over time (see Figure 3). To illustrate, Ana's mother issued 31 instructions during the baseline cleanup situation. At midtreatment, the number of instructions issued decreased to 13. At posttreatment, Ana's mother issued 6 instructions during the cleanup situation. Thus, Ana's mother had fewer directives over time and she used more effective instructions as PCIT progressed (see Figure 3). Most of the instructions that were issued during the posttreatment cleanup situation resulted in compliance on the part of Ana.

Overall, there were significant improvements in reported and observed target behaviors for both Ana and her mother by the end of the PCIT intervention. Behavior rating scales completed by Ana's mother indicated decreases in disruptive behaviors to within

normal limits by the end of treatment. In addition, during behavioral observations Ana's mother increased her use of positive verbalizations toward Ana. Further, Ana's mother decreased her use of inefficient instructions and her directives became more specific and selective. Ana's mother also reported that Ana's behavior was easier to manage at home and in public settings. The mother also stated during clinic sessions that other family members had noticed an improvement in the child's social functioning.

Discussion

As the Spanish-speaking population continues to grow, the demand for culturally appropriate services will continue to increase as well. One way of meeting this need is through the empirical validation of treatments in Spanish. As has been noted by other researchers, there is a need for empirical data to guide psychosocial interventions with ethnic minority populations (Dumka, Roosa, & Jackson, 1997). The results of this single-case study are promising in demonstrating the appropriateness and effectiveness of PCIT in Spanish. The effectiveness of PCIT with this family can be seen through substantial increases in observed positive interactions between the mother-child dyad. Also, the mother's report of her decreased total stress and her child's behavioral improvement are indicators that PCIT was helpful to this family. Furthermore, the instruments given to the mother in Spanish appeared to have face validity and were sensitive to treatment changes.

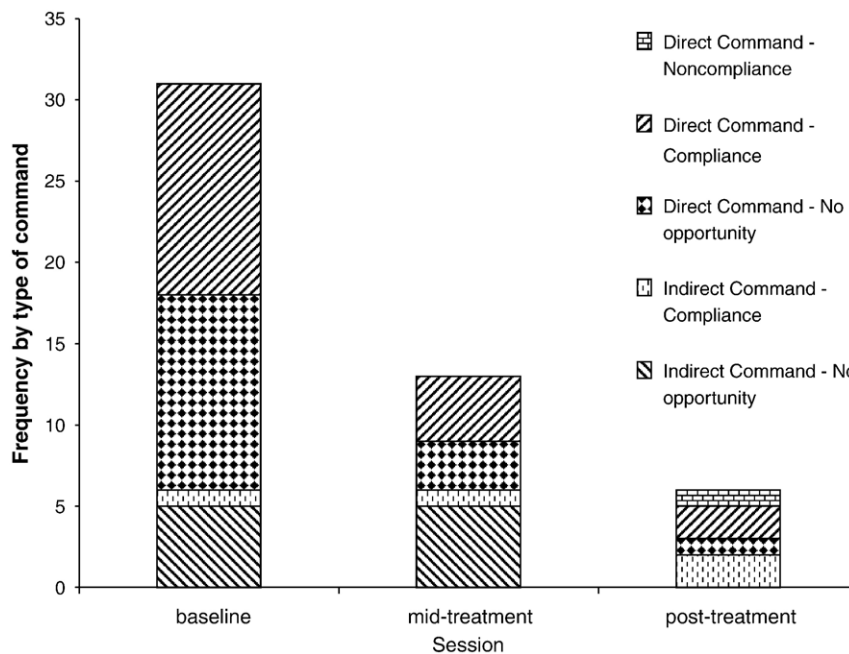


Figure 3. Instructions issued by the parent during clean-up situations.

For this particular Spanish-speaking family, besides delivering the intervention in Spanish, there were very minor modifications made to the protocol. Efforts were made throughout the entire process to keep the integrity of the PCIT treatment protocol. Given that the therapist was bilingual and bicultural, he had knowledge of some cultural values that applied to Hispanics. For one, the therapist was aware that *respeto* (i.e., respect) is important to Hispanics and this was displayed by showing deference toward the mother (addressing her in a formal *usted* vs. an informal *tu* when speaking with her). The mother was never addressed by her first name. She was always addressed by her title and formal last name (e.g., Mrs./Señora Z).

The therapist was also aware of other Hispanic values such as *personalismo* (developing a warm professional relationship with the mother) and *simpatía* (engaging in positive social interactions with others). This was displayed to the mother by not only showing interest and asking how she and the child were doing but also inquiring how the rest of their family was doing as well. Thus, a form of informal chit-chat was carried out throughout the therapy process especially before and after coaching. Since this was not systematically applied throughout treatment, it is not known how much these modifications had on the effectiveness of PCIT with this family.

Another modification that was made was that of referring to *cariños* throughout treatment. In the Hispanic culture, *cariños* literally means using *terms of endearment* for the child (e.g., Nena/Nene). Though the English version of PCIT discusses unlabeled and labeled praises, there is little mention of terms of endearment. Though both types of praises were taught to the mother, the use of *cariños* occurred throughout treatment. *Cariños* can serve as social reinforcers and they can be incorporated when teaching the parent to verbally praise prosocial behaviors. *Cariños* can serve as social reinforcers and they can be incorporated when teaching the parent to verbally praise prosocial behaviors. *Cariños* can also be incorporated when trying to increase the frequency of physical positives in PCIT. This was not systematically manipulated either so it is not known to what extent this contributed to a culturally relevant application of PCIT.

In summary, minor modifications were done to the English-based PCIT protocol. We were interested in keeping the integrity of the PCIT protocol to examine if this particular treatment could be applied effectively in Spanish. Related to this, there were also minimal deviations in the translations of the PCIT handouts for the CDI and PDI phases. Translation procedures were followed that are standard in the field. As with the protocol, we were interested in achieving a balance between literal and functional equivalence in the materials that were presented to the mother.

A strength of this case study was the use of multiple outcome criteria to assess parent and child changes. Both standard paper-and-pencil measures and behavior observation data to document change during treatment were included. Both methods of documenting change add to the validity of PCIT in Spanish. Paper-and-pencil measures completed by the mother indicated that, at the end of treatment, the child had fewer problematic behaviors. The discipline component of PCIT (i.e., PDI) appeared to be effective in teaching the parent how to manage the child's behavior problems. From the mother's report, PCIT seemed to be effective in reducing negative behaviors (e.g., child's whining, yelling, destructive behavior, aggression) and teaching her how to reinforce appropriate behavior (e.g., descriptions and praises given by the parent).

Behaviorally, it took the mother quite a few sessions to turn her unlabeled praises into labeled praises. Another noticeable change was that the mother decreased the number of questions she asked Ana in a rather sudden manner. This facilitated the process of the child being in control of the play situation and it also allowed the mother to focus on other verbalizations (e.g., giving descriptions and praises).

There are several clinical implications from this study. First, this study suggests that PCIT may hold promise when delivered in Spanish. Second, teaching Spanish-speaking parents behavior modification (i.e., child management) techniques appears to have social validity. Third, a didactic and hands-on therapy coaching style can be successfully implemented in Spanish. Further, an approach that emphasizes modeling of skills lends itself well to families that may have a difficult time reading materials and applying concepts if they are only explained verbally. Finally, PCIT was accomplished in a relatively short period of time (12 one-hour sessions).

There are important future research recommendations regarding PCIT with Spanish-speaking families. First, because this was a single-case study, research needs to focus on overall group effects to address the issue of treatment generalization. Since relatively few data are available, a single-case design was chosen because it allowed for the intensive examination of the parent-child dyad and documentation of treatment progress through the use of repeated measurement (Follette & Compton, 1999). The emphasis was on gathering multiple data points throughout different stages of treatment. Second, PCIT should be compared to other treatments that are available in the community (e.g., comparing PCIT to traditional parenting classes). Third, reliability and validity data needs to be gathered on the instruments that clinicians may use in Spanish. Fourth, the DPICS should be validated in Spanish to ensure that there is agreement on what constitutes certain codes (i.e.,

validity) and that the same behaviors are being coded consistently across time (i.e., reliability).

Fifth, though this was not formally done with this parent, it is important to consider acculturation level when working with Hispanics. Differing levels of acculturation can impact the parent-child relationship. For example, researchers have found that level of acculturation has an impact on *familism* (Chun & Akutsu, 2003). Finally, since parent satisfaction with the process and outcome of PCIT was not directly assessed, future studies with Hispanics and other ethnic minority groups should incorporate measures related to social validity (e.g., treatment acceptability). The mother in the study reported being satisfied with the outcome of PCIT but this information was collected through conversation at the termination of therapy.

Though there is a wealth of information regarding social validity with parents (especially related to treatment acceptability), there are very few studies that have examined issues related to social validity with ethnic minority populations (Boothe, Borrego, Hill, & Anhalt, 2005). Further, a recent study has suggested that Mexican-American parents find treatment components used in PCIT as acceptable (Borrego, Spendllove, Pemberton, Ibañez, & Jackson, 2004). Assessing for social validity gives clinicians valuable information such as whether the parent agrees with the treatment goals and the procedures involved to reach those goals.

A couple of limitations are worth noting in this study. A limitation of this study is that all treatment sessions occurred in the context of a playroom in a clinic setting. Since home visits were not offered during treatment, we do not know whether the skills practiced improved child and parent behaviors at home and if new patterns of interaction generalized to other settings (e.g., the home environment). Some research has shown that PCIT generalizes across settings (e.g., Boggs, 1990; McNeil et al., 1991). Also, because this was a single-case study, the treatment effects cannot be assumed to work with all Spanish-speaking Hispanics. Future studies should focus on more single-case designs to maximize needed treatment modifications. Experimental studies (e.g., single-subject and group design research) are needed to examine the effectiveness of particular treatments in Spanish.

References

- Abidin, R. R. (1990). *Parenting Stress Index*, 3rd ed. Charlottesville, VA: Pediatric Psychology Press.
- Achenbach, T. M., & Edelbrock, C. (1983). *Manual for the Child Behavior Checklist and Revised Child Behavior Profile*. Burlington: University of Vermont.
- Achenbach, T. M., Edelbrock, C., & Howell, C. T. (1987). Empirically based assessment of the behavioral/emotional problems of 2- and 3-year-old children. *Journal of Abnormal Psychology*, *15*, 629–650.
- American Psychological Association. (1993). Guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations. *American Psychologist*, *48*, 45–48.
- American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist*, *58*, 377–402.
- Aragona, A., & Eyberg, S. (1981). Neglected children: Mothers' report of child behavior problems and observed verbal behavior. *Child Development*, *52*, 596–602.
- Barkley, R. A. (1997a). *Niños desafiantes*. New York: The Guilford Press.
- Barkley, R. A. (1997b). *Defiant children: A clinician's manual for assessment and parent training*, 2nd ed. New York: The Guilford Press.
- Bernal, G., Bonilla, J., & Bellido, C. (1995). Ecological validity and cultural sensitivity for outcome research: Issues for the cultural adaptation and development of psychosocial treatments with Hispanics. *Journal of Abnormal Child Psychology*, *23*, 67–82.
- Bird, H. R., Gould, M. S., Rubio-Stipec, M., & Staghezza, B. M. (1991). Screening for childhood psychopathology in the community using the Child Behavior Checklist. *Journal of the American Academy of Child and Adolescent Psychiatry*, *30*, 116–123.
- Boggs, S. R. (1990). *Generalization of the treatment to the home setting: Direct observation analysis*. Paper presented at the meeting of the American Psychological Association, Washington, DC.
- Boothe, J., Borrego, Jr., J., Hill, C., & Anhalt, K. (2005). Treatment acceptability and treatment compliance in ethnic minority populations. In C. L. Frisby & C. Reynolds (Eds.), *Comprehensive handbook of multicultural school psychology* (pp. 945–972). New York: John Wiley & Sons.
- Borrego, J., Jr., Spendllove, S. J., Pemberton, J. R., Ibañez, E. S., & Jackson, C. T. (2004, November). *Treatment acceptability with Mexican American parents*. Poster presented at the 38th annual meeting of the Association for Advancement of Behavior Therapy, New Orleans, LA.
- Borrego, J., Jr., & Urquiza, A. J. (1998). Importance of therapist use of social reinforcement with parents as a model for parent-child relationships: An example with parent-child interaction therapy. *Child and Family Behavior Therapy*, *20*, 27–54.
- Borrego, J., Jr., Urquiza, A. J., Rasmussen, R. A., & Zebell, N. (1999). Parent-child interaction therapy with a family at high risk for physical abuse. *Child Maltreatment*, *4*, 331–342.
- Brestan, E., & Eyberg, S. M. (1998). Effective psychosocial treatments of conduct-disordered children and adolescents: 29 years, 82 studies, and 5,272 kids. *Journal of Clinical Child Psychology*, *27*, 180–189.
- Brestan, E. V., Eyberg, S. M., Boggs, S. R., & Algina, J. (1997). Parent-child interaction therapy: Parents' perceptions of untreated siblings. *Child and Family Behavior Therapy*, *19*, 13–28.
- Burke, W. T., & Abidin, R. R. (1980). Parenting Stress Index (PSI)—A system assessment approval. In R. R. Abidin (Ed.), *Parent education and intervention handbook* Springfield, IL: Thomas.
- Capage, L. C., Bennett, G. M., & McNeil, C. B. (2001). A comparison between African-American and Caucasian children referred for treatment of disruptive behavior disorders. *Child and Family Behavior Therapy*, *23*, 1–14.
- Cardona, P. G., Nicholson, B. C., & Fox, R. A. (2000). Parenting among Hispanic and Anglo-American mothers with young children. *The Journal of Social Psychology*, *140*, 357–365.
- Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Brestan, E. V., Balachova, T., et al. (2004). Parent-child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology*, *72*, 500–510.
- Chun, K. M., & Akutsu, P. D. (2003). Acculturation among ethnic minority families. In K. M. Chun, P. Balls Organista, & G. Marin (Eds.), *Acculturation: Advance in theory, measurement, and applied research* (pp. 95–119). Washington, DC: American Psychological Association.
- Coard, S. I., Wallace, S. A., Stevenson, H. C., & Brotman, L. M. (2004). Towards culturally relevant preventive interventions: The consideration of racial socialization in parent training with African American families. *Journal of Child and Family Studies*, *13*, 277–293.
- Department of Health and Human Services. (2001). *Mental health:*

- Culture, race, and ethnicity—A supplement to mental health: A report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- Dinkmeyer, D., & McKay, G. D. (1981). *Padres eficaces con entrenamiento sistemático (PECES)*. Circle Pines, MN: American Guidelines Services.
- Dumka, L. E., Roosa, M. W., & Jackson, M. K. (1997). Risk, conflict, mothers' parenting, and children's adjustment in low income, Mexican immigrant, and Mexican American families. *Journal of Marriage and the Family, 59*, 309–323.
- Eisenstadt, T. H., Eyberg, S., McNeil, C. B., Newcomb, K., & Funderburk, B. (1993). Parent-Child Interaction Therapy with behavior problem children: Relative effectiveness of two stages and overall treatment outcome. *Journal of Clinical Child Psychology, 22*, 42–51.
- Eyberg, S. (1988). PCIT: Integration of traditional and behavioral concerns. *Child and Family Behavior Therapy, 10*, 33–46.
- Eyberg, S. (1992). Assessing therapy outcome with preschool children: Progress and problems. *Journal of Clinical Child Psychology, 21*, 306–311.
- Eyberg, S., & Boggs, S. R. (1998). Parent-child interaction therapy: A psychosocial intervention for the treatment of young conduct-disordered children. In J. M. Breisemeister, & C. E. Schafer (Eds.), *Handbook of parent training: Parents as co-therapists for children's behavior problems* (pp. 61–97). New York: John Wiley and Sons.
- Eyberg, S. M., Boggs, S. R., & Algina, J. (1995). New developments in psychosocial, pharmacological, and combined treatments of conduct disorders in aggressive children. *Psychopharmacology Bulletin, 31*, 83–91.
- Eyberg, S. M., & Pincus, D. (1999). *Eyberg child behavior inventory and Sutter-Eyberg student behavior inventory: Professional inventory*. Odessa, FL: Psychological Assessment Resources.
- Eyberg, S., & Robinson, E. A. (1982). Parent-Child Interaction Training: Effects on family functioning. *Journal of Clinical Child Psychology, 11*, 130–137.
- Eyberg, S., & Robinson, E. A. (1983). Conduct problem behavior: Standardization of a behavioral rating scale with adolescents. *Journal of Clinical Child Psychology, 12*, 347–354.
- Eyberg, S., & Ross, A. W. (1978). Assessment of child behavior problems: The validation of a new inventory. *Journal of Clinical Child Psychology, 7*, 113–116.
- Follette, W. C., & Compton, S. (1999). *Correcting methodological weaknesses in traditional psychotherapy outcome research*. Unpublished manuscript.
- Fontes, S. A. (2002). Child discipline and physical abuse in immigrant Latino families: Reducing violence and misunderstandings. *Journal of Counseling and Development, 80*, 31–40.
- Forehand, R., & Kotchick, B. A. (1996). Cultural diversity: A wake-up call for parent training. *Behavior Therapy, 27*, 187–206.
- Hanf, C. A. (1969). *A two-stage program for modifying maternal controlling during mother-child interaction*. Paper presented at the meeting of the Western Psychological Association, Vancouver, Canada.
- Hembree-Kigin, T., & McNeil, C. B. (1995). *Parent-Child Interaction Therapy*. New York: Plenum.
- Herschell, A. D., Calzada, E. J., Eyberg, S. M., & McNeil, C. B. (2002). Parent-child interaction therapy: New directions in research. *Cognitive and Behavioral Practice, 9*, 9–16.
- Hill, N. E., Bush, K. R., & Roosa, M. W. (2003). Parenting and family socialization strategies and children's mental health: Low-income Mexican-American and Euro-American mothers and children. *Child Development, 74*, 189–2004.
- Hood, K. K., & Eyberg, S. M. (2003). Outcomes of parent-child interaction therapy: Mothers' reports of maintenance three to six years after treatment. *Journal of Clinical Child and Adolescent Psychology, 32*, 419–429.
- Kazdin, A. (1995). *Conduct disorders in childhood and adolescence*, 2nd ed. Thousand Oaks, CA: Sage.
- Kazdin, A., Stolar, M., & Marciano, P. (1995). Risk factors for dropping out of treatment among White and Black families. *Journal of Family Psychology, 9*, 402–417.
- Marin, G., & Marin, B. V. (1991). *Research with Hispanic populations*. Newbury Park, CA: Sage.
- McNeil, C. B., Capage, L. C., Bahl, A., & Blanc, H. (1999). Importance of early intervention for disruptive behavior problems: Comparison of treatment and waitlist-control groups. *Early Education and Development, 10*, 445–454.
- McNeil, C. B., Capage, L., & Bennett, G. M. (2002). Cultural issues in the treatment of young African American children diagnosed with disruptive behavior disorders. *Journal of Pediatric Psychology, 27*, 339–350.
- McNeil, C. B., Eyberg, S., Eisenstadt, T. H., Newcomb, K., & Funderbunk, B. (1991). Parent-Child Interaction Therapy with behavior problem children: Generalization of treatment effects to the school setting. *Journal of Clinical Child Psychology, 20*, 140–151.
- Miranda, J., Bernal, G., Lau, A., Kohn, L., Hwang, W., & La Fromboise, T. (2005). State of the science on psychosocial interventions for ethnic minorities. *Annual Review of Clinical Psychology, 1*, 113–142.
- National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment. (2001). *Blueprint for change: Research on child and adolescent mental health*. Washington, DC: Author.
- Newcomb, K., Eyberg, S. M., Funderburk, B. W., Eisenstadt, T. H., & McNeil, C. B. (1990). *Parent-Child Interaction Therapy: Maintenance of treatment gains at 8 months and 1 and 1/2 years*. Presented at the meeting of the American Psychological Association, San Francisco, CA.
- Nixon, R. D., Sweeney, L., Erickson, D. B., & Touyz, S. W. (2003). Parent-child interaction therapy: A comparison of standard and abbreviated treatments for oppositional defiant preschoolers. *Journal of Consulting and Clinical Psychology, 71*, 251–260.
- Pagano, M., Murphy, J. M., Pedersen, M., & Mosbacher, D. (1996). Screening for psychosocial problems in 4–5-year-olds during routine EPSDT examinations: Validity and reliability in a Mexican-American sample. *Clinical Pediatrics, 33*, 130–146.
- Popkin, M. H. (1992). *Padres eficaces: Lo basico*. Active Parenting.
- Ramirez, R. R., & de la Cruz, G. P. (2002). *The Hispanic Population in the United States: March 2002 (Current Population Reports, P20-545)*. Washington, DC: U.S. Census Bureau.
- Robinson, E. A., & Eyberg, S. (1981). The Dyadic Parent-Child Interaction Coding System: Standardization and validation. *Journal of Consulting and Clinical Psychology, 49*, 245–250.
- Rodriguez, O., & Zayas, L. H. (1990). Hispanic adolescents and antisocial behavior: Sociocultural factors and treatment implications. In A. R. Stiffman, & L. E. Davis (Eds.), *Ethnic issues in adolescent mental health* (pp. 147–171). Newbury Park, CA: Sage.
- Rogler, L. H., Malgady, R. G., Costantino, G., & Blumenthal, R. (1987). What do culturally sensitive mental health services mean? The case of Hispanics. *American Psychologist, 42*, 565–570.
- Schuhmann, E. M., Foote, R. C., Eyberg, S. M., Boggs, S. R., & Algina, J. (1998). Efficacy of Parent-Child Interaction Therapy: Interim report of a randomized clinical trial with short-term maintenance. *Journal of Clinical Child Psychology, 27*, 34–45.
- Solis-Camara, P., & Fox, R. A. (1995). Parenting among mothers with young children in Mexico and the United States. *Journal of Social Psychology, 135*, 591–599.
- Sue, D. W., & Sue, D. (2002). *Counseling the culturally diverse client*, 4th ed. New York: John Wiley and Sons.
- Terao, S. Y. (1999). *Treatment effectiveness of parent-child interaction therapy with physically abusive parent-child dyads*. Unpublished doctoral dissertation, University of the Pacific.
- Tuma, J. M. (1989). Mental health services for children: The state of the art. *American Psychologist, 44*, 188–199.
- U.S. Census Bureau. (2001). *Statistical abstract of the United States: 2001*, 121st ed. Washington, DC: U.S. Department of Commerce.
- Varela, R. E., Vernberg, E. M., Sanchez-Sosa, J. J., Riveros, A., Mitchell, M., & Mashunkashey, M. M. (2004). Parenting style of Mexican, Mexican American, and Caucasian Non-Hispanic families: Social context and cultural influences. *Journal of Family Psychology, 18*, 651–657.
- Vera, M., Vila, D., & Alegria, M. (2003). Cognitive-behavioral therapy:

- Concepts, issues, and strategies for practice with racial/ethnic minorities. In G. Bernal, J. Trimble, A. Berlew, & F. Leong (Eds.), *Handbook of racial and ethnic minority psychology* Thousand Oaks, CA: Sage.
- Webster-Stratton, C. (1985). Mother perceptions and mother-child interactions: Comparison of a clinic-referred and a nonclinic group. *Journal of Clinical Child Psychology, 14*, 334–339.
- Webster-Stratton, C., & Hammond, M. (1998). Conduct problems and level of social competence in Head Start children: Prevalence, pervasiveness, and associated risk factors. *Clinical Child and Family Psychology Review, 1*, 101–124.
- Webster-Stratton, C., Reid, M. J., & Hammond, M. (2004). Treating children with early-onset conduct problems: Intervention outcomes for parent, child, and teacher training. *Journal of Clinical Child and Adolescent Psychology, 33*, 105–124.
- Yeh, M., McCabe, K., Hurlburt, M., Hough, R., Hazen, A., Culver, S., Garland, A., & Landsverk, J. (2002). Referral sources, diagnoses, and service types of youth in public outpatient mental health care: A focus on ethnic minorities. *Journal of Behavioral Health Services and Research, 29*, 45–60.
- Zahner, G. E., Pawelkiewicz, W., DeFrancesco, J. J., & Adnopoulos, J. (1992). Children's mental health service needs and utilization patterns in an urban community: An epidemiological assessment. *Journal of the American Academy of Child and Adolescent Psychiatry, 31*, 951–960.
- Zayas, L. H. (1992). Childrearing, social stress, and child abuse: Clinical considerations with Hispanic families. *Journal of Social Distress and the Homeless, 1*, 291–309.
- Zayas, L. H., & Solari, F. (1994). Early childhood socialization in Hispanic families: Context, culture, and practice implications. *Professional Psychology: Research and Practice, 25*, 200–206.

Address correspondence to Joaquin Borrego, Jr., Department of Psychology, Texas Tech. University, Lubbock, TX 79409-2051, USA; e-mail: Joaquin.Borrego@ttu.edu.

Received: September 16, 2004

Accepted: September 19, 2005

Available online 13 March 2006