

SCHOOL-BASED CHILD PARENT RELATIONSHIP THERAPY (CPRT) WITH
LOW INCOME FIRST GENERATION IMMIGRANT HISPANIC PARENTS:
EFFECTS ON CHILD BEHAVIOR AND PARENT-CHILD
RELATIONSHIP STRESS

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This quasi-experimental study examined the effects of child-parent relationship therapy (CPRT) with low income first generation immigrant Hispanic parents. Forty-eight parents were randomly assigned by school site to the experimental group ($n=24$) and to the no treatment control group ($n=24$). A two factor (Time x Group) repeated measures analysis of variance was performed to examine the effects of group membership (experimental, control) and time (pretest, posttest) on each of the six hypotheses. Dependent variables for the Spanish version of the Child Behavior Checklist (CBCL) included Externalizing Problems, Internalizing Problems, and Total Problems. Dependent variables for the Spanish version of the Parenting Stress Index (PSI) included Child Domain, Parent Domain, and Total Stress. Results indicated that from pre-test to post-test, parents who participated in the CPRT treatment group reported a statistically significant improvement on their children's behaviors at the alpha .025 level (Internalizing Problems $p < .001$; Externalizing Problems $p < .001$; Total Problems $p < .001$) when compared to children whose parents did not participate in CPRT. Partial eta squared (η_p^2) further indicated that the effects of CPRT treatment on the experimental group compared to the control group from pre-test to post-test was large ($\eta_p^2 = .56$; $\eta_p^2 = .59$; and $\eta_p^2 = .68$, respectively). Similarly, results indicated that from pre-test to post-test, parents who participated in the CPRT treatment group reported a statistically significant improvement on parent-child relationship stress at the alpha .025 level (Child Domain $p < .001$; Parent Domain $p < .001$; Total Stress $p < .001$) when compared to parents who did not participate in CPRT. Partial eta squared (η_p^2) further indicated that the effects of CPRT treatment on the experimental group compared to the control group from pre-test to post-test was large ($\eta_p^2 = .39$; $\eta_p^2 = .51$; and $\eta_p^2 = .42$, respectively).

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CHAPTER 1

INTRODUCTION

Government officials and researchers in the field of early childhood development have stressed the urgency that exists to respond to children's early mental health needs (Brazelton & Greenspan, 2000; Bratton, Ray, & Landreth, in press; Knitzer, 2000; New Freedom Commission on Mental Health, 2003; US Public Health Service, 2000). Indeed, the US Surgeon General Report on children's mental health stated, "The burden of suffering experienced by children with mental health needs and their families has created a health crisis in this country" (p. 1).

Acknowledging the dire need for appropriate mental health services for children, leading authorities in the field have advocated working with parents as a way to alleviate children's socioemotional hardships (Guerney, 1991; Landreth, 2002; Landreth & Bratton, 2006; VanFleet, 2005). This is primarily due to an extensive body of research that has linked children's mental health issues with the quality of the parent-child relationship (Berk, 2003; Deater-Deckard, 1998; Greenspan & Wieder, 1998; Wilson & Ryan, 2000).

A secure attachment between parent and child is seen as the foundation of young children's positive social, emotional, and cognitive development (Ryan & Bratton, in press; Greenspan & Wieder, 2006; Peth-Pierce, 2000; Thompson, 2002). Children who have had fewer stable, positive relationships in early childhood are deemed at significant risk for lifelong adverse consequences, such as poor school performance, inability to manage anger as reflected in higher rates of delinquency and violence, higher proportion of placement in special education, and higher school drop-out rates (Knitzer, 2000). In addition, minority groups are over-represented in these areas (Gibbs, 2003; McWhirter, McWhirter, McWhirter, & McWhirter, 1998; Teplin, 2000), indicating a need to address their socioemotional development. As US continues to

experience the rapid increase of an ethnically diverse population, attending to the mental health needs of young minority children is becoming imperative.

The US Public Health Service (2000) emphasized the need to increase the number of culturally and developmentally appropriate researched-based mental health services for minority children and their families. The President's New Freedom Commission on Mental Health (2003) also highlighted this need and recommended that early mental health interventions should be made available and readily accessible in low-stigma institutions such as schools. Additionally, the US Public Health Service listed as one of its primary goals to "Eliminate racial/ethnic and socioeconomic disparities in access to mental healthcare" (p. 6). Furthermore, this report recognized that even though Hispanic children are referred as much as non-Hispanic children, they are less likely to receive mental health services. Since Hispanics are estimated to be the largest and fastest growing minority group in the US (US Census Bureau, 2006a), it seems vital to study the effectiveness of treatments that can meet the needs of Hispanic children and their families, particularly in settings such as schools that are accessible to these families.

Within the US, statistics show that Hispanics represent the largest minority group at 42.7 million and continue to be the fastest growing (US Census Bureau, 2006b). Indeed, the US Census stated that Hispanics accounted for almost 49% of the 2.8 million of the population growth in the US between July 2004 and July 2005 (US Census Bureau, 2006a). Moreover, 11.9 million of Hispanics in the US are children under the age of 13. According to the US Department of Education, in 2003, 18.8% of children enrolled in public elementary and secondary schools across the US were of Hispanic origin (Hoffman & Sable, 2006). The National Center for Education Statistics (NCE) stated in their 2003 report titled *Status and Trends in the Education of Hispanics* that the number of Hispanic children is increasing faster than any other ethnic

group. The NCE estimated that by the year 2020, one in every five children under the age of 18 will be of Hispanic origin. Thus, it is essential to gain a deeper understanding of the mental health needs of this population.

Several factors have been identified that place Hispanic children and families at greater risk for mental health problems: (a) Discrimination in the areas of education, health care, and employment (Santiago-Rivera, 1995; Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002); (b) poverty (Klebanov, Brooks-Gunn, & Duncan, 1994; La Roche, 1999); (c) language barrier (Padilla, Ruiz, & Alvarez, 1975); and (d) emotional stressors caused by the acculturation process (La Roche). Unfortunately, the US census (2005) indicated that poverty rates for Hispanic families in the US are not improving, having remained at 21.8%.

The National Task Force on Early Childhood Education for Hispanics (2007) associated risk factors affecting Hispanic children with negative outcomes such as academic failure, delinquency and violence. Statistics from the Multicultural and International Outreach center (2003) showed a significant representation of Hispanic youth in suicide rates as well as in the justice system as compared to non-Hispanic White youths. These statistics indicate that the mental health needs of Hispanic children are currently not being met. Despite the fact that these factors have long been identified, the mental health profession continues to note an underutilization of mental health services by the Hispanic population (La Roche, 1999; Padilla et al., 1975; US Public Health Service, 2000). This underutilization of mental health services is particularly alarming given the fact that this population continues to be identified by researchers to be at-risk for mental health problems and for social/academic failure (Santiago-Rivera et al., 2002; National Center for Education Statistics, 2003).

Padilla et al. (1975) provided a thorough review of possible causes for Hispanics' underutilization of services. These factors include: (a) Lack of transportation; (b) language barriers; (c) incongruence between treatments and Hispanics' culture; (d) Hispanics' use of "folk" medicine as a source to solve emotional problems; (e) lack of trust of institutions and people outside from their culture due to past negative experiences such as discrimination; and (f) lack of congruence between clients' social class and the mental health institutions. The hypothesis that Hispanics living in US tend to underutilize counseling services due to social and cultural differences and language barriers is supported by other researchers in the field (Altbach, 1991; Santiago-Rivera, 1995; La Roche, 1999; Andres-Hyman, Ortiz, Anes, Paris, & Davidson, 2006).

In addressing a solution to underutilization of services by the Hispanic population, Altarriba and Bauer (1998), stressed the need to render services that consider and incorporate Hispanic values in their delivery. The authors emphasized the importance of family as one of the primary cultural values shared by Hispanics of various origins. As such, counseling services that address the family needs and works with the family unit have the potential to be more successful with Hispanic population. Other authors have further explained that the Hispanic family unit is child-centered due to the high value placed on the parent-child relationship (Ramirez, 1989; Vlach, 2002). This may indicate that involving parents in addressing their children's mental health needs could be a particular good fit for this population. In fact, researchers in the field have started adapting parenting programs and studying their effectiveness with Hispanic populations (Gorman & Balter, 1997; McCabe, Yeh, Garland, Lau, & Chavez, 2005).

Filial therapy, a research-based intervention, was first developed by Bernard and Louise Guerney in the 1960s as an approach that uses child-centered play therapy principles and

involves parents fully in the therapeutic process, training them to become change agents in their children's lives (Guerney, 1991). The authors based their treatment on the premises that play is the developmentally appropriate method of helping children overcome emotional problems and that parents are more influential in a child's life than therapists. Filial therapy was later refined by Landreth into a 10-session model under the name of child-parent relationship therapy (CPRT; Landreth, 1991, 2002). Landreth and Bratton (2006) formalized the 10-session model with their textbook titled *Child Parent Relationship Therapy (CPRT): A 10-Session Filial Therapy Model*. In order to allow for treatment replication and treatment integrity, a manual specifying the protocol for the 10-session CPRT model has been published (Bratton, Landreth, Kellum, & Blackard, 2006).

CPRT is a researched-based model that has shown statistically significant results with a variety of populations and in diverse settings (Landreth & Bratton, 2006). Furthermore, CPRT has been shown effective cross-culturally with an ethnically diverse population, including: Chinese, Korean, Israeli, and Native Americans (Landreth & Bratton). Chau and Landreth (1997) stated that this model may be effective with "minorities or immigrant families in the United States" (p. 90). Although CPRT has been shown as a suitable treatment modality for non-minority and minority families, an extensive review of literature reveals that no research has been done to study its effectiveness with the Hispanic population. In fact, Landreth and Bratton stated "Although this model has been used with Hispanic...parents, no outcome data has been collected to date" (p. 465). Thus, studying the effectiveness of CPRT with Hispanics living in the US is needed to address the early mental health needs of Hispanic children and to respond to the ethical obligation to be multiculturally proactive within the mental health counseling profession.

Statement of the Problem

Alvy (1994) opens his chapter on culturally adaptive parenting training programs by stating “If the majority group has available parenting programs that seem to help them raise children who succeed in society, shouldn’t minority groups have equal access to this social opportunity?” (p. 124).

The need for culturally appropriate and research based early mental health interventions that involve parents is well documented. This need is particularly compelling for Hispanic families as the largest and fastest growing minority group in the US. Despite this fact, there is a dearth of literature examining the impact of parenting education programs for this population. A review of literature on Hispanic values seems to support that CPRT could be a suitable treatment modality to work with Hispanics. However, an extensive review of literature revealed no studies examining the outcome of this modality with this population. Thus, the present study was designed to study the effects of CPRT with Hispanic parents of young children.

Review of Related Literature

The review of literature concentrates on the following elements: (a) characteristics of Hispanics, (b) at-risk factors affecting Hispanic children’s mental health needs, (c) values encountered in the Hispanic culture, (d) parenting values in Hispanic families, (e) culturally responsive services for Hispanics, (f) parenting programs adapted for Hispanics, (g) child-centered play therapy as a developmentally appropriate treatment for children, (h) filial therapy, (i) CPRT, and (j) rationale for using CPRT with Hispanics.

Characteristics of Hispanic Population Living in the United States

Hispanics living in the US are composed of many different groups with somewhat different backgrounds. Casas and Vasquez (1996) emphasized the importance of differentiating

among Hispanic populations living in US. These populations include Mexicans, Puerto Ricans, Cubans, Central Americans (i.e., Guatemala, Honduras, Costa Rica, El Salvador, Nicaragua, Panama), South Americans (e.g., Colombia, Venezuela, Peru, Chile, Ecuador, Uruguay, Paraguay, Argentina), and Spanish-speaking Caribbean islands (e.g., Dominican Republic). Casas and Vasquez noted that although Hispanics share a similar heritage, history, language, and sociocultural background, in some respects they vary in regards to customs, political and economic situations. Even though the cultural similarities among these groups are recognized by researchers in the field (Andres-Hyman et al., 2006; Vlach, 2002), it is still encouraged to be cautious about differences when conducting research with Hispanics.

Recently researchers appear to be more cautious to separate Hispanic groups in order to have an in-depth understanding of differences among Hispanics from different heritages. An example is found in the book titled *Children of Color: Psychological Interventions with Culturally Diverse Youth* by Gibbs (2003), in which Hispanic population is divided into three chapters, each addressing a specific Hispanic group (Central American, Mexican American, and Puerto Rican). However, although researchers in the field support looking into the different characteristics among the Hispanic population according to their heritage, an extensive review of literature yields a paucity of research investigating Hispanic values according to their country of origin. The paucity of research has been previously identified by researchers in the field (Altarriba & Bauer, 1998). Thus, information presented about Hispanics in the US throughout the rest of this paper concerns Hispanics in general. Whenever possible, I have identified specific groups by country of origin.

At-Risk Factors Affecting Hispanic Children's Mental Health

Investigators in early childhood development have associated early at-risk factors with negative outcomes in the socioemotional development of young children (Duncan, Brooks-Gunn, & Klebanov, 1994; Knitzer, 2000). Furthermore, research has supported that not addressing the mental health of children leads to academic, social, and mental health problems that raise the risk of school drop-out, delinquency, violence and suicide (US Public Health Service, 2000). A special analysis published by the National Center for Education Statistics (2003) stated that Hispanic children are five times more likely than Caucasian children to enter kindergarten facing two or more risk factors. A review of literature corroborates that Hispanic families that live in the US face many risk factors such as discrimination in the areas of education and employment, overrepresentation in poverty levels and in the welfare system, language barriers, and stressors arising from the acculturation process (Gibbs, 2003; Klebanov, Brooks-Gunn, & Duncan, 1994; La Roche, 1999; Santiago-Rivera, 1995).

The National Task Force on Early Childhood Education for Hispanics (2007) released an in-depth report on the risk factors that jeopardize Hispanic children's academic success. The report stated that Hispanic children are at higher risk for academic failure due to low parental educational level, higher poverty levels, living in single-parent homes, and challenges of having English as a second language. The report noted an over-representation of Mexican descendent Hispanics in these at-risk areas as compared to Hispanics of other origins. The report indicated that 27% of Hispanic children live in single-parent households as compared to 15% of white children. This report concluded that 44% of Hispanic children had mothers who had not graduated from high school as compared to only 9% of Caucasian children. Consistent with such low educational level, the report indicated that 58% of Hispanic children lived in poverty as

compared with 27% of Caucasian children. A closer look at these statistics revealed that 26% of Hispanic children between the ages of 0-8 were living below the federal poverty line as compared to 9% of Caucasian children in the year 2000. Most Hispanic parents reported using Spanish as their main language at home; this factor was even higher for Hispanics living in poverty.

The National Center for Education Statistics (NCES) released their report titled *Status and Trend in the Education of Hispanics* (2003) which reported that the majority of Hispanic children start kindergarten without knowing English, putting them at greater risk for academic failure. These findings are supported by Ramey, Lanzi, and Ramey (1998) who examined at-risk factors associated with children's perceptions of school. The authors found that children enrolled in Head Start that came from households where English was not the primary language had more negative perceptions about their school. The NCES also highlighted poverty as one of the main at-risk factors for Hispanic children. Poverty has been associated with negative outcomes in the parent-child relationship (McLoys & Wilson, 1990).

Klebanov et al. (1994) used participants enrolled in the Infant Health and Development Program to examine how neighborhood and family conditions affected maternal characteristics and mother-child interactions. Of the 895 participants, 11.3% were of Hispanic origin. The authors looked at the relationship among the different variables, including neighborhood poverty and maternal warmth/responsiveness. The coefficient of the linear regression revealed that living in a poor neighborhood decreased maternal warmth/responsiveness towards children. The authors explained that negative correlation between these variables have previously been hypothesized by other authors to be an adaptive behavior to prepare children for the harsh environment that poorer neighborhoods represent for these families. However, further analysis

revealed that after separating by race, there was no significant relationship for Hispanics between neighborhood poverty and maternal warmth and responsiveness. The authors did not provide further explanation for this finding.

Hashima and Amato (1994) investigated the relations among poverty, social support, parental punitive behavior, and unsupportive parental behaviors. The authors analyzed data from a sample of 1,035 participants from National Survey of Families and Households. All of the research participants were caregivers of children between ages 0-5. The unsupportive parental behaviors were based on the frequency of behaviors such as praising and hugging. Under punitive behaviors, the authors examined frequency of yelling and spanking. The results indicated that punitive and unsupportive parental behaviors were positively correlated with poverty level. However, as perceived social support increased the use of punitive behavior seemed to decrease for parents living under poverty line. Moreover, after controlling for race, findings suggested that Hispanic Americans were less likely to report punitive behavior, but still likely to report unsupportive parental behaviors. The authors hypothesized that such a finding could be caused by cultural differences in child-rearing and suggested further research that looks at variables such as length of residency in US to better understand these differences.

McLoyd and Smith (2002) took a sample from the National Longitudinal Survey of Youth (NLSY) consisting of 3,053 women from which 401 were of Hispanic origin. Mothers in this sample reported their children's behavioral problems and how frequently they used spanking at 4 different intervals (1988, 1990, 1992, and 1994). Children were 4 or 5 years old at the first data collection interval. The authors used the Behavior Problem Index to analyze changes in children's behaviors; the HOME Observation for Measurement of the Environment to determine maternal emotional support; and an open-ended question to measure the amount of spanking.

These variables were all evaluated at each of the four measurement points. Results from this research indicated a positive correlation between spanking and number of behavioral problems in children over time. This correlation was stronger for Hispanics than for European Americans. However, for all ethnic groups such correlation seemed to be moderated by level of maternal emotional support; indicating that the higher the level of emotional support, the weaker the correlation between frequency of spanking and increase in children's behavioral problems. Further analysis revealed that a decrease in spanking over time was positively correlated to a decrease in children's problem behaviors.

Values of Hispanics Living in the United States

Altarriba and Bauer (1998) summarized an extensive review of literature to define specific characteristics that distinguish three main Hispanic groups in US: (a) Cuban Americans, (b) Mexican Americans, and (c) Puerto Ricans. The authors explained differences in terms of socio-economic and political history of their country of origin while providing readers a summary of specific cultural values that appear to identify Hispanic culture in general. These values include: strong family orientation, *simpatía*, religion, and *allocentrism*. Recognition of these values among Hispanics has been corroborated by other researchers in the field (Andres-Hyman et al., 2006; Flores, 2000; La Roche, 1999)

Altarriba and Bauer (1998) explained that Hispanics strongly value family cohesiveness and expect family members to show high levels of respect for each other. This value is fostered among extended family and includes non blood-related family members such as *comadres* and *compadres* (godparents). The authors stated "A sense of self-confidence and security arises from the close family bond" (p. 391) when explaining the significance of family cohesiveness for Hispanics. The parent-child relationship is highly valued within Hispanic culture, (Ramirez,

1989; Vlach, 2002), thus researchers recommended counseling approaches that focus on redefining problems in the child-parent interaction (Falicov, 1982). Altarriba and Bauer explained *simpatía* as another shared value that refers to Hispanics' preference for behaviors that promote non-conflicting relationships. This leads to actions that show conformity and avoid confrontations. Similar to this value is *allocentrism*, which emphasizes a need to form "interpersonal relationships in groups that are nurturing, loving, intimate, and respectful" (p. 391). In this manner, Hispanics value trust, empathy, willingness to sacrifice for others, and interdependence in group settings. According to the authors, religion plays an important role in Hispanic families and is often sought as a source to help alleviate mental health issues.

Altarriba and Bauer (1998) mentioned that most Hispanics are affiliated with Catholic religion. However, the authors clarified that within religious beliefs, many Hispanics believe in *santería*, a mixture of Catholic and African traditions. While *santería* is more prevalent among Cubans, other Hispanic groups believe in spiritualism. The authors further explained that for Hispanics, spiritualism symbolizes an invisible world with good and bad spirits. *Curanderos* are people with special powers that can communicate with these spirits and have knowledge of folk medicine. Altarriba and Bauer emphasized that Hispanics are likely to seek help from *santeros* or *curanderos* for emotional and or psychological problems instead of seeking counseling services. The authors recommended for counselors to be aware of these values when working with Hispanic clients. Baez and Hernandez (2001) emphasized the need to be culturally sensitive to religious beliefs when counseling Hispanic clients.

In the same article, Altarriba and Bauer (1998) stated that Hispanics share beliefs that compose their worldview, which divides into four categories through which Hispanics socialize and interact. The authors advised counselors to take into consideration these worldviews when

working with this population and explained each one more in depth. Hispanics view nature as a being more powerful than oneself, thus one has no chance of defeating nature. This leads Hispanics to view life events as caused by natural forces they cannot overpower. Hispanics look at time in terms of present tense. Thus, the past and/or the future have no effect on Hispanics' decision-making. Another worldview refers to a preference for activities based on spontaneous interactions that include expression of emotions and desires. In their view of social relations, Hispanics are likely to look at relations in a hierarchical manner, in which authority figures are respected. Flores (2000) explained that Hispanic clients view health care providers as authority figures and treat them respectfully.

Santiago-Rivera et al. (2002) advocated for the implementation of four core Hispanic cultural values into the development of mental health services that are responsive to their culture. They identified these values as *personalismo*, *familismo*, *respeto*, and *dignidad*. These values have been corroborated by different researchers (Andres-Hyman et al., 2006; Flores, 2000; Perez-Stable, 1987). These authors defined *personalismo* as a “formal relationship” and explained that Hispanic clients expect to develop an affectionate/warm personal relationship with the clinician. *Familismo* refers to the strong loyalty Hispanics have toward their families, including non-biological related friends who are considered part of the family, which leads them to place family's well-being above individual needs. *Respeto* is identified as a cultural value that places an expectation to be respectful to authority figures, including therapists. This cultural value is also expected to be reciprocal by the therapist showing respect toward the client with gestures such as a handshake to salute the client. *Dignidad* refers to the cultural value of being worthy of respect and a expectation to treat others and be treated in a way that strengthens a sense of pride.

Pederson (1987) explained that for Hispanics, the individual's mental health is understood as part of the family's mental health. Gloria and Rodriguez (2000) also emphasized the importance of family and the value of the well-being of the family being placed above the individual welfare. In fact, studies on Hispanics' acculturation process refer to separation from family as one of the greatest sources of stress (Smart & Smart, 1994). As a consequence of this emphasis on groups over the individual, Hispanics have a tendency to feel more comfortable in noncompetitive situations and in group work (Griggs & Dunn, 1996).

Hispanics and Parenting

Parenting is recognized as a powerful influence on children's development (Albright & Tamis-LeMonde, 2002). Leading authorities in the investigation of parenting practices emphasized the importance of understanding the influence of culture in child-rearing (Bronfenbrenner, 1979, 1986). Bornstein, Tal, & LeMonde (1991) emphasized that culture is an essential variable that influences the parent-child relationship, and as a result, children's socialization. The authors explained it is within the context of culture that caregivers will exercise parenting practices, thus affecting children's social, cognitive, and emotional development. They hypothesized that parents will choose parenting practices that leads them to satisfy essential cultural goals, thus, such practices vary depending on family's cultural values. The authors further emphasized that even though there is recognition within mental health professions that culture is central to parenting, researchers in the field often neglect to look at culture when studying parenting.

Darling and Steinberg (1993) argued that in order to gain an understanding of how parenting practices influence children's development, one must look at three different practice factors: (a) parents' goals toward socialization, (b) child-rearing practices used by the parents to

reach such goals, (c) parenting style or environmental factors that influence the manner in which parents socialize their children. Such interaction with the environment has been recognized by other authors who linked the interaction between the family system with outside institutions and society as one influential factor in child-rearing (Harrison, Wilson, Pine, Chan, & Buriel, 1990). Monzo and Rueda (2006) explained that Hispanics living in US tend to seek biculturalism, thus adapting some of the American cultural values while maintaining some of their own values within their parenting practices.

Zayas and Solaris (1994) conducted a summary of the review of literature examining parenting practices among Hispanics and concluded that Hispanics living in US appear to prefer behaviors that enhance intimacy to family, parental authority, and relationships with others. Furthermore, the authors indicated that identified Hispanic parenting values differ from American parenting values and as a result must be taken into consideration and integrated in the delivery of parenting programs. The authors indicated that for Hispanic families living in US, not only their cultural values, but also their status as a minority, play a major role in their parenting practices. The authors noted that parenting practices among low-income Hispanic mothers are affected by the level of perceived support and stress they experience. Specifically, the authors explained that the higher the stress level, the more likely that these mothers will use modeling, which leads to completing tasks for young children. Conversely, higher degree of perceived support correlated with mothers using more autonomous parenting practices. Zayas and Solaris advised practitioners to account for the influence of education level, socio-economic status, and length of residency in US when addressing parenting practices with Hispanic population.

Gonzalez-Ramos, Zayas, & Cohen (1998) studied child-rearing values among 80 low-income, urban Puerto Rican mothers with at least one child under the age of six. The authors

developed the Child-Rearing Values and Behaviors Inventory (MCKV-BI) based on findings from 4 focus groups in order to conduct the study. Participating mothers were asked to rate a total of 13 child-rearing values. Results indicated that participants highly valued honesty, respect and obedience, responsibility, loyalty to family, being affectionate, sharing with others, being independent, getting along with others, valuing older people, humbleness, assertiveness, and creativity. The authors further emphasized that these mothers' understanding of the word independence is different than the concept it has in the Anglo-American culture. For these mothers, independence meant for the child to be more self-sufficient in activities such as dressing or feeding oneself, as opposed to children becoming independent in their relationship with their parents or others.

Gonzalez-Ramos et al. (1998) further cautioned clinicians to understand child behavior within a cultural context and be aware that children are expected to act in accordance to their cultural background. Results from this study also supported that acculturation has an impact on parenting practices. Mothers in this study who were less acculturated ranked humility and respectfulness higher than mothers who were more acculturated. More acculturated mothers, ranked independence and creativity higher than did less acculturated mothers. These results indicated that the level of acculturation influences child-rearing practices. Mothers, who become more acculturated to the Anglo-American society, have a tendency to adopt the mainstream cultural values, which affects their parenting.

The influence of acculturation on Hispanic parenting values was found to be significant in another study conducted by Contreras, Lopez, Rivera-Mosquera, Raymond-Smith, and Rothstein (1999). In this study, Puerto Rican adolescent mothers who were less acculturated showed less stress associated with grandmothers' involvement in their child-rearing than more

acculturated mothers. The authors hypothesized that since family support is highly valued in Hispanic culture, less acculturated young mothers in the study found their mothers' help to actually diminish parental stress. However, as the level of acculturation increased, assistance or dependency on family members became a stressful factor. Other researchers have also associated the level of acculturation to be a significant factor in the parenting practices of Hispanic population (Monzo & Rueda, 2006; Varela & Vernberg, 2004).

Varela and Vernberg (2004) investigated preferred parenting styles among Mexican American, Mexican immigrants living in US, Caucasian non-Hispanic families, and Mexicans living in their country of origin. The sample of 308 parents responded to questionnaires looking at their parenting practices. Statistical analysis indicated that Mexican parents living in their country of origin, and Caucasian non-Hispanic parents appear to be more authoritative than authoritarian, while Mexican immigrants and Mexican Americans were more authoritarians. The authors hypothesized the possibility that being a minority may be a factor influencing Mexican American and Mexican immigrants to be more authoritarian rather than their ethnicity or cultural background. Varela and Venberg explained that Mexican American and Mexican immigrants might use more authoritarian child-rearing practices in response to stressors associated with being a minority group in US.

Harwood (1992) reported the results of a study conducted to investigate differences in Puerto-Rican mothers versus Anglo-American mothers in regards to child attachment and cultural values that influence their responses to their toddlers. The authors used vignettes and open-ended questions to study the groups' perceptions. Further coding analysis allowed categorizing answers in order to utilize ANOVA to study the differences between groups. Results revealed that Anglo-American mothers valued toddlers' behaviors related to the

American cultural value of individualism. Thus, these mothers preferred behaviors that emphasized autonomy, self-control, and activity. Puerto Rican mothers in this study valued behaviors that were congruent with Hispanic cultural value of relatedness, such as, closeness to mothers, respectfulness and affection. Further results revealed that a secure child-mother attachment was highly valued by both groups, but for different reasons. The Puerto Rican mothers focused on whether the child in the vignette was able to be respectful, loving, and exercise self-control in the mother's absence. Anglo-American mothers focused more on the category named by the authors "personal development" in which the mothers seemed more concerned with whether the child had the abilities to cope with the absence of the mother.

Monzo and Rueda (2006) examined the results of a 2 year ethnographic study examining the acculturation variable on Hispanics who live in US and their methods of disciplinary actions. They found that Hispanic parents in this study showed a tendency to negotiate their cultural beliefs with the mainstream society's values and seemed to strive to integrate both cultures within their parenting practices. Further analysis revealed that participants believed spanking to be an acceptable disciplinary action, especially for young children. This perception was found to be influenced by a belief that young children do not have the cognitive abilities to understand verbal directions and as a result spanking provides a means for helping children understand rules. A main cultural factor influencing Hispanic parenting was found to be parents' expectations for their children to behave within an adult context. Interestingly, this expectation was tied to the fact that Hispanic parents rarely leave their children at home with sitters when going to adult functions. Thus, young Hispanic children are usually expected to behave in a socially acceptable manner in adult settings that they might find boring. The mothers in this study stated that they considered it "abuse" (p. 195) leaving their children behind for other adults to take care of them.

Monzo and Rueda (2006) further emphasized that it is important for professionals working with Hispanic parents to be respectful of their parenting practices, to understand how socio-economic status is an influential factor on child-rearing among Hispanics, and to acknowledge that parenting practices among Hispanics in US stem from incorporating Anglo and Hispanic cultural values into their parenting strategies. Moreover, an eminent finding was associated with Hispanic parents' perception of professionals providing parenting classes as an expert. This perception resulted in these parents feeling unable to show disagreement out of respect for such authority. The authors emphasized the importance of trust as a necessary construct before Hispanic parents feel safe to be open to discuss their child-rearing practices.

Spiwak (1982) conducted a dissertation examining parenting attitudes on low and middle socioeconomic Mexican American parents living in US while examining acculturation level. The study looked at 80 middle class Mexican-American parents and at 98 Mexican American parents from low socioeconomic status with at least one preschooler aged child. Both groups viewed love and caring as fundamental values within the family unit and the inclusion of immediate family members as important. Both groups valued the concept of *bien educado* (well-educated). The author highlighted that this concept was not associated with academic success; instead, *bien educado* was defined by these parents as the child's ability to behave respectfully. However, the middle class parents appeared to emphasize more characteristics such as children being fun, enjoyable, and beautiful, as opposed to low socio-economic parents in the study who emphasized more teaching, learning, and moral values. This study found that parents from low socioeconomic class used more punishment, and a strong moral orientation to guide children's behaviors. Middle class parents in the study used a combination of disciplinary actions, including

spanking. It is important to notice that children in the study appeared to respond better to verbal reprimands than to physical ones.

The Center for the Improvement of Child Caring (CICC) conducted research on the parenting practices of Mexican American parents (Alvy, 1994). The sample included parents from middle class, as well as, parents living in poverty. The sample was also representative of different levels of acculturation, including parents who had recently immigrated and Mexican American parents who were born in US. The findings yielded differences and similarities between low income and middle- income parents. Specifically, results revealed that both groups valued children being playful and enjoyable, as well as love and psychological well-being. However, parents from middle class emphasized these areas more than parents from low income. The two areas that were more emphasized by low income parents were learn/teach, and obedience/respect. The author explained that Mexican American parents from low income groups may have a need to teach their children moral values and emphasize education to overcome at-risk factors. The research revealed that for recently immigrated parents, the concept of *bien educado* was the most valued. Further analysis revealed that the concept was related to being respectful and not to academic achievement. The research also revealed that parents from middle class favored the following more than did parents from low socioeconomic class: Spanking as an acceptable disciplinary action, consistency and firmness, love and understanding, talking. Parents from low income valued more punishment. Both groups reported using praise as a response to preschool children.

Culturally Responsive Services for Hispanics

Within the counseling profession, a need to be culturally proactive to reach minorities living in US has been recognized. In fact, the 2005 American Counseling Association (ACA)

code of ethics takes a multicultural proactive stand by considering cultural and social justice issues throughout the code (Glossoff & Kocet, 2006; Kaplan, 2006). Kaplan accentuated that most introductory statements in the 2005 ACA code of ethics highlight counselors' ethical obligation to reflect on how cultural values relate to the different standards in each section. As an example, Kaplan reminded readers that at the end of the introduction statement to Section G, Research and Publications, it is stated "Counselors minimize bias and respect diversity in designing and implementing research programs" (American Counseling Association, 2005, p. 16). However, there seems to be a paucity of research investigating appropriate treatments for Hispanic children living in US (Costantino, Malgady, & Rogler, 1994).

Rogler, Malgady, Costantino, and Blumenthal (1987) provided an in-depth analysis of culturally sensitive/responsive services when working with Hispanic clients by conducting a review of literature. The authors concluded that there are three main ways used by mental health professionals to be culturally sensitive and/or responsive. The first one is based on making traditional treatments more available to Hispanics. The second approach centers on selecting therapeutic treatments that match Hispanic cultural values. The third approach consists of modifying traditional treatments to incorporate Hispanics' cultural values. The authors suggested choosing treatment modalities that are congruent with Hispanic culture and for mental health professionals to remain flexible to modifying the treatment in order to incorporate Hispanics' values as necessary. Santiago-Rivera et al. (2002) cautioned professionals to be aware that even though Hispanics of different origins share many cultural values, one must be careful and take into account the diversity that exists among Hispanics when applying these values into treatment modalities.

Costantino et al. (1994) stated that a review of literature appears to indicate that when Hispanic clients look for mental health assistance, they are likely to receive inappropriate services. The authors stated that the provision of inappropriate services is due to “Cultural dissonance [that] emerges not only in the client-therapist relationship, but also when the Hispanic clients’ language, cultural values, and beliefs contradict the professional orientation embodied in mainstream healthcare system” (p. 14). Thus, the authors conducted a research investigating the efficacy of a story telling modality that incorporated Hispanic cultural elements through the use of pictures.

The study conducted by Costantino et al. (1994) recruited 90 Hispanic students in grades fourth to sixth from a public school in New York. Students in the study scored high in symptomatology related to anxiety, phobic, and conduct problems. The experimental group ($n=45$) and control group ($n=45$) were divided into subgroups that participated in 90 minutes session throughout 8 weeks. The experimental intervention consisted of showing pictures that portrayed Hispanic values such as traditional foods and games. The pictures also showed neighborhoods in urban settings. The pictures formed part of Tell-Me-A-Story (TEMAS), a thematic perception test that past research has showed to incite longer stories in Hispanic children. The control group participated in psycho-educational groups. Results showed that conduct problems decreased for sixth graders who participated in the treatment group as compared to the control group, however, no difference was found for fourth and fifth graders. The self-reported anxiety level decreased for the experimental group about a half standard deviation as compared to the control group. Phobic symptoms decreased for male sixth graders and for female fifth and sixth graders in the experimental group. The authors concluded that the

study supported “the effectiveness of using culturally sensitized modalities to treat Hispanic youngsters’ conduct problems in school and their anxious and fearful symptoms” (pg. 19).

Garza and Bratton (2005) conducted a pre posttest comparison group designed to investigate the effectiveness of child-centered play therapy on 29 school-aged Hispanic children with behavioral problems. The study was conducted at children’s schools and the authors used the Behavior Assessment Scale for Children (BASC) as a measurement instrument. In order to be culturally responsive to the needs of Hispanic children, the authors included toys that captured the values of Hispanic children participating in the study. Children were introduced to the playroom in both languages (Spanish and English) and responses during the play sessions were provided by matching the language used by the child. Treatment was provided by bilingual/bicultural counselors. Children in the experimental group ($n=15$) participated in weekly play therapy sessions for 30 minutes for 15 weeks. Children in the comparison group ($n=14$) participated in weekly 30 minute curriculum based small group counseling for 15 weeks. Results indicated a statistically significant reduction in children’s externalized problem behaviors as reported by parents for participants in the experimental group when compared to the control group. Parents’ report of children’s internalized problems showed a moderate treatment effect for the experimental group when compared to the control group. Results from teachers’ response in the BASC Teacher Report Form (TRF) did not reveal statistically significant results. The researchers noted irregularities in the posttest collection of teacher data.

Ramirez, Flores-Torres, Kranz, and Lund (2005) provided an in-depth explanation of the use of Axline’s eight principles of play therapy with Mexican-American children. The authors described each principle while providing specific suggestions as to how to apply them when working with this population. Recommendations for play therapists included an increased

awareness of their cultural values and biases coupled with a deep understanding of the Mexican-American culture. The authors cautioned therapists to be aware of child-rearing practices within Mexican culture that are contrary to some of the principles. These included the permissiveness given in the playroom, allowing the child to take responsibility and the lead on his/her own, introducing the playroom in a task-oriented manner. The authors suggested for therapists to honor the child's cultural value of *personalismo* by engaging in casual conversation at the beginning of the first session. Further suggestions included the use of materials that are culturally familiar to Mexican children; including the parents as an important part of the therapeutic process; and a proficient use of the Spanish language.

Parenting Programs and Hispanics

Alvy (1994) explained that the development of culturally sensitive programs originates from the belief that main differences exist in child-rearing practices between Euro-American and other American parents. Researchers in the field support that culture inevitably affects child-rearing as parents seek to transmit their cultural values through their parenting practices (Alvy; Bornstein et al., 1991). An extensive review of literature corroborates that Hispanic parents living in US differ in their parenting practices from other ethnic groups (Contreras et al., 1999; Gonzalez-Ramos et al., 1998; Monzo & Rueda, 2006; Spiwak, 1982; Varela & Vernberg, 2004; Zayas & Solari, 1994). Thus, in an attempt to attend to Hispanic children's mental health needs, more practitioners are researching the effectiveness of culturally sensitive parenting programs (Alvy; McCabe et al., 2005).

Powell, Zambrana, and Silva-Palacios (1990) surveyed 58 Mexican mothers and 63 Mexican-American mothers to investigate their preferences in parenting programs. Specifically, the authors investigated: preferred delivery method, preferred person as a source of information,

extent of wanting involvement of family members, preference for having familiarity with group members, and preference for program content. Results indicated that Mexican mothers preferred a group format with a combination of home visits as a delivery method and a person with special training or an older parent as a source of information. Mexican mothers also indicated their preference for including extended family members in parenting groups, for having activities that focused on children, and rated reading materials as the least attractive manner in which to learn new information. The authors indicated that this last factor might be associated with participants' reading ability. The major difference occurred in the preference to have familiarity with group members prior to starting the parenting group; 85% of Mexican mothers preferred familiarity versus 59% of Mexican American mothers. Both groups indicated that they preferred having information on child-rearing practices. Specifically, the respondents overwhelmingly rated having information on the item "*Ayudar a su hijo para que tenga una vida mejor que la suya*" "Helping your child to have a better life than yours" as the preferred kind of information wanted from a parenting program. The authors suggested the following recommendations when working with Mexican mothers: (a) use a combination of group and home-visit format; (b) use a trained professional or a parent of older children to deliver the program; (c) invite and be open to allowing extended families to participate and be a part of the group; (d) prior to starting the group, have an informal group gathering to allow members to socialize and familiarize themselves with each other; (e) advertise and link the parenting principles presented to the improvement of the child's future; (f) do not rely on reading materials; and (g) have activities that include the children. Zayas and Solaris (1994) emphasized that in order for parenting programs to be culturally sensitive to Hispanic population, one must link cultural values to the principles being taught and show respect for Hispanic parenting strategies and beliefs.

In the late 1980s the confident parenting program was adapted to Hispanic population after an extensive examination of the group's cultural values that started in the late 1970s. The resulting program was named *los niños bien educados* (Alvy, 1994). The Center for the Improvement of Child Caring (CICC) developed this program and tailored it toward newly immigrated low socioeconomic Hispanic parents. The modified program included pictures to exemplify each of the skills taught to overcome parents' low reading levels. Similarly, the program used Hispanic sayings or *dichos* to help parents remember the skills and create a more familiar cultural and linguistic environment. Acculturation and gender roles were addressed by including them as part of the curriculum. The cultural value of *personalismo* was honored by having instructors use more self-disclosure. Similarly, the value for relationships was incorporated by allowing parents social time to interact with each other during each session with the use of a *cafecito* break or coffee break and the use of rapport-building activities during the first session. According to CICC, the Retrospective Assessment of Family Relationship Questionnaire has been used to evaluate the program. Results showed that parents reported their relationship with their children significantly improved after attending the program. No published quantitative outcome data has been published for this program (Gorman & Balter, 1997).

The parent child interaction therapy (PCIT) was recently culturally adapted to work with Mexican Americans and its' effectiveness is currently being researched (McCabe et al., 2005). The authors based their cultural adaptations on information gathered through a review of literature, qualitative data obtained from focus groups, and consultations with experts in cross-cultural mental health services. The program uses an initial assessment during which cultural variables that may affect parents' participation in the program are assessed. The instructor is then provided with specific recommendations on how to successfully address these variables. The

program was framed as an educational/skill building intervention in order to minimize stigmas associated with mental health services. Thus, the authors named the program *guiando a los niños activos*. The culturally adaptive program encourages the inclusion of extended family members, emphasizing a need to focus on the cultural value of family cohesiveness and respect the preference for family decision-making. The program encourages instructors to spend more time building rapport in order to be sensitive to the cultural value of *personalismo*. Similarly, the instructors are expected to spend more time processing parental concerns, as research has shown Mexican parents are less likely to disagree with the instructor due to the respect they feel toward authority figures. All materials for the program were translated in Spanish and include pictures to overcome barriers due to low reading levels. The authors stated that they are currently conducting a pilot study to examine the effectiveness of the program, but no outcome data has been published yet.

Gorman and Balter (1997) provided a thorough review of literature on parenting programs that have been adapted in order to reach minority groups. They identified three types of culturally sensitive programs: (a) translated program, (b) culturally adapted, and (c) culturally specific. The authors explained that translated programs are not responsive to cultural needs since these programs are not culturally modified. In contrast, a culturally sensitive program is adapted to incorporate the cultural values of a specific population and culturally specific programs are designed to explicitly meet the parenting needs of a specific ethnic group. The authors provided a critique of quantitative literature on culturally sensitive parenting programs targeting Hispanics residing in US.

Gorman and Balter (1997) referred to the Houston parent-child development center program developed for low-income Mexican American parents in head start programs. The

program focuses on enhancing the parent-child relationship and its goal is to be a prevention program. Gorman and Balter reported that four studies have been conducted investigating the effectiveness of the program. After careful analysis of these research outcomes, the authors concluded that results are mixed with effect sizes ranging from -.02 to .68 for changes in children's behaviors. Similarly, results for changes in parents' behaviors yielded effect sizes between -.04 and .45. Gorman and Balter stated that "while their mixed results are somewhat comparable with general findings of parent education efficacy studies, their overall findings...are modest at best" (p. 364). Gorman and Balter explained that since specific details of the program have not been described, it is unknown whether this program is culturally adapted. However, it is known that the program uses bilingual and bicultural staff. The authors mentioned that some programs have only been translated in Spanish and as a result, these cannot be considered to be culturally adapted or culturally specific programs. These include: STEP translated into *PECES*; the nurturing program translated into *crianza con cariño*; and the Hispanic Minnesota early learning design.

Child-Centered Play Therapy (CCPT)

Play therapy is recognized as a developmentally appropriate treatment modality for children by leading researchers in the field (Axline, 1969; Landreth, 2002). Play therapy originated in the early 1900s with Freud recognizing the therapeutic power of play by helping a child overcome his fear through play as a treatment (Freud, 1946). After Freud, other leading authorities in the area contributed to the growth of play therapy. These included Hug-Hellmuth, Klein, Anna Freud, Levy, and Axline (Landreth, 2002). Axline explained that play is the natural medium through which children communicate their feelings, and work out their problems. Piaget's theory (1977) postulated that children lack the cognitive ability to engage in abstract

thinking until the age of 11. Because young children think and express themselves concretely, they have difficulty expressing themselves verbally. Instead, children naturally play out their experiences. Landreth explained, “toys are used like words by children and play is their language” (p. 16). Consequently children will show through their play their perception of the world, including their thoughts and feelings.

The child-centered play therapy approach has its roots on the theoretical constructs of the person-centered therapy developed by Carl Rogers (Landreth, 2002). Thus, the therapeutic process is based on the assumption that the child, as any individual, has an inner drive for self-actualization. Axline (1969) stated that central to child-centered play therapy is the belief that children have within themselves all the resources necessary to solve their problems and to find mature behavior more rewarding than immature behavior. Change occurs when the child is given a safe environment where permissiveness to be himself is granted. As a result, the child is free to be himself, to learn who he is, and to plan his own life. O’Connor and Braverman (1997) explained the process of change in the person-centered approach by stating “When there is a complete absence of any threat to the perception of self, the child is free to revise his or her self-concept to assimilate...experiences previously inconsistent with the self-concept” (p. 20). As the child reconstructs his self-concept, he is able to better adjust to his environment and to form better relationships. In order for growth to occur, a relationship in which the child can find, express and use his inner drive for self-actualization must be created. Thus, an essential element for change in the child-centered approach is the relationship between the therapist and the child. Landreth (2002) emphasized the relationship by stating, “In child-centered play therapy, the relationship, not the utilization of toys or the interpretation of behavior, is the key to growth” (p. 86). The child-centered play therapist does not use specific techniques to provoke change in the

child. Instead, the therapist focuses on relating genuinely to the child. The therapist facilitates change by creating a relationship with the child that is guided by the eight principles proposed by Axline.

Axline (1969) outlined eight basic elements necessary to establish a relationship with the child, so that growth can be facilitated. The relationship is based on the therapist expressing genuine interest and caring for the child. The therapist accepts the child unconditionally; she does not evaluate the child or pressures the child to change. As a result, the child experiences freedom to be himself and to express his inner world of reference without fear of rejection. As the child expresses himself, the therapist remains sensitive to the child's emotions and carefully reflects those emotions, so the child can gain self-understanding. The relationship is based on a fundamental respect for the child as an individual capable of being responsible and of solving his own problems. Thus, the therapist does not direct the child, but allows him to lead the session, trusting that the child will go where he needs to go without guidance. Patience on the therapist's part becomes essential for growth to occur. Moustakas (1959) emphasized this element by stating "The therapist waits for the child to come to terms with himself, to express his difficulties, and to find new ways of relating and living...waiting is a positive force, a commitment of faith actively expressed by the therapist" (p. 1). Thus, the therapist trusts the process without trying to force change to happen. Therapeutic limits are established as needed to facilitate the process for growth. By establishing limits in the playroom, the child is given the opportunity to accept and assume responsibility for his actions. This allows the child to find appropriate ways of relating to others and the environment. It is essential to understand that establishing this kind of relationship is not accomplished through a set of techniques, but through the therapist interacting with the

child according to a set of internalized values. The therapist adheres to a set of values and facilitates growth for the child by relating to him according to such beliefs.

Research shows that child-centered play therapy has been effective in reducing children's externalized and internalized behaviors (Bratton, Ray, Rhine, & Jones, 2005). Moreover, filial therapy, a treatment modality that teaches the above explained child-centered principles to parents in order for them to conduct the play sessions at home with their children, was found to be effective in the meta-analysis conducted by Bratton et al.

Filial Therapy

Mental health professionals have used therapeutic play sessions between parents and children as a means to improve children's mental health since the 1950s (Freud, 1946). However, in the 1960s Bernard and Louise Guerney were the first to develop a structured therapeutic play treatment involving parents. They coined the term filial therapy for their innovative approach (Guerney, 1964). Their development of filial was based on two basic beliefs: (a) parents/caregivers hold a more emotional bond with the children than a therapist does, and (b) parents/caregivers can be trained to use the same therapeutic interventions that child-centered play therapists apply. It was through their novel idea to train parents on the use of child-centered play therapy principles and their published research outcomes that filial started to be used by other therapists in the field (Guerney, 2000).

Stover and Guerney (1967) conducted the first study to examine the effectiveness of training parents in child-centered play therapy skills. The authors concluded that after four play sessions, the mothers showed significant changes in their behaviors toward their children. Similarly, results indicated that children's behaviors changed in response to the play sessions. The findings supported that parents are capable of learning child-centered play therapy skills and

use them effectively to work with their children. In 1961, a landmark study in filial therapy was conducted by Andronico, Fidler, Guerney, and Guerney. The study supported the effectiveness of filial therapy on enhancing the parent-child relationship and reducing children's behavioral and physical problems. Follow-up studies corroborated these findings.

Stover and Guerney (1967) conducted a study with 51 mother/child pairs and found efficacy of filial therapy to be statistically significant in reducing children's behavioral problems and increasing their social skills. Results also indicated that the training increased mothers' empathy toward their children. In 1975, Guerney conducted a longitudinal follow-up study with 42 mothers who participated in Stover and Guerney's research. The author found that 76% of the participants reported their children continued to improve 1 to 3 years after treatment and 86% reported that their children maintained their improvements. Sywulak (1978) trained 19 mothers and 13 fathers to conduct filial therapy with their children. The sample was taken from clinic-referred children and data was gathered at 2 months and 4 months. Results showed a statistically significant improvement in parental acceptance and child adjustment.

Sensue (1981) followed-up on Sywulak's study (1978) by forming a matched no treatment comparison group with parents whose children had not been referred for treatment. Data gathered at 3 months and at 3 years corroborated earlier results found by Sywulak. The author found that parents of the children in the treatment group, who had been referred for clinical services, were as adjusted as children in the control group. Various researchers in the field have corroborated results found in earlier studies conducted by the Guerneys (Boll, 1973; Dematatis, 1982; Kezur, 1981; Payton, 1981; Wall, 1979).

Child Parent Relationship Therapy (CPRT)

Based on the promising results that the Guerneys' research on filial therapy yielded, Landreth developed a 10-session model of filial therapy (Landreth, 2000). This model was formalized by Landreth and Bratton (2006) with their textbook titled *Child Parent Relationship Therapy (CPRT): A 10-Session Filial Therapy Model*. A treatment manual for the CPRT model was published by Bratton, Landreth, Kellum, and Blackard (2006). This manual provides a treatment protocol for each session, including the therapist's notebook, study guide, and a parent notebook. The authors stated that the treatment protocol should be used with clinical judgment and adjustments can be made based on the specific needs of the parents and/or the therapist. Landreth and Bratton clarified that the 10-session model can be adapted to be used in fewer sessions or extended to be used for a longer number of sessions depending on the parents' needs.

CPRT is a 10-session format of filial therapy in which a play therapist trains parents, typically in small group formats, to use child-centered principles with their children during weekly structured 30-minute play sessions. The play therapist uses a variety of methods, including: instruction, role-playing, demonstration of play sessions, and supervision of parents' play sessions to help parents become therapeutic agents in their children's lives. Parents learn reflective listening, recognition of children's feelings, tracking responses, therapeutic limit setting, and self-esteem building responses. These skills are taught to parents to create a nonjudgmental, understanding, and accepting environment that enhances the parent-child relationship, thus facilitating personal growth and change for both child and parent (Landreth & Bratton, 2006).

CPRT has been thoroughly researched throughout the last 14 years showing a strong support for its effectiveness as a treatment to alleviate children's mental health needs, reduce

parental stress, and increase parental empathy toward their children. Bratton et al. (2005) conducted a meta-analysis investigating the overall treatment effect for studies that utilized CPRT. Statistical analysis revealed a large treatment effect ($ES=1.25$) for the 10-session model (Landreth & Bratton, 2006).

Bratton and Landreth (1995) published results of a study conducted to investigate the efficacy of CPRT with single parents. The study included 43 parents, 22 in the experimental group and 21 in the control group. Results indicated statistically significant results at the $<.001$ level in increasing parental empathy and parental acceptance. Results also showed a statistically significant decrease in parental stress at the $<.001$ level. In addition, children's problematic behaviors, as measured by the Filial Problem Checklist, were reduced by an average of 18 points for the experimental group showing statistically significant results.

Glazer-Waldman, Zimmerman, Landreth, and Norton (1992) conducted a pretest-posttest treatment group only, with 5 mothers of children ages of 4 to 8 who were chronically ill. Qualitative results indicated that parents perceived the filial training to have positively impacted their parent-child relationship. Quantitative results revealed that the parents were able to judge their children's anxiety level more accurately. This study was later followed-up by Tew, Landreth, Joiner, & Solt (2002) who conducted a pre- post-randomized control group design with 23 parents of chronically ill children. Results indicated that parents in the experimental group ($n=12$) reported statistically significant results on all measures. These included a reduction in parental stress and children's behaviors and an increase in parental acceptance. Kale & Landreth (1999) randomly assigned 22 parents whose children had been diagnosed with learning disabilities to the experimental group. These parents reported a statistically significant increase

in parental acceptance and a statistically significant reduction in parental stress as compared to the control group.

Other studies investigating the effectiveness of CPRT have adapted the model by reducing or extending the number of sessions to accommodate for parents' needs. Ferrel (2003) investigated the effectiveness of an intensive 4-weekend format of the Landreth model compared to the traditional 10 sessions model. The experimental group ($n=13$) met on 4 consecutive Saturdays for 4 hours in small groups of up to 4 members. In this study, the traditional 10-week curriculum was adapted to teach the same material over fewer sessions. The comparison treatment group parents ($n=13$) received CPRT once per week over 10 weeks. Results revealed no statistically significant differences between the experimental and treatment groups at posttesting on measures of parent stress, parental acceptance, empathic behavior, and child behavior problems.

Smith & Landreth (2003) investigated the use of CPRT as an intensive treatment intervention with mothers residing in a domestic violence shelter. The authors extended the treatment to 12 sessions condensed into a 2-3 weeks period. Statistically significant results were found in reducing children's behavioral problems, increasing children's self-concept, and increasing parental acceptance. In addition, as assessed by trained raters, trained mothers showed an increase in their empathic interactions with their children. A comparison between these results and the results of past studies with a matched population and setting (Kot, Landreth, & Giordano, 1998; Tyndall-Lind, Landreth, & Giordano, 2001) supported that the intensive filial training was equally effective as the non-intense treatment.

CPRT has also been researched with ethnically and culturally diverse groups. Chau & Landreth (1997) investigated the effectiveness of CPRT with Chinese immigrant parents living

in US with children between the ages of 2-10. The parents in the experimental ($n=18$) group showed statistical significant increase in parental acceptance, and empathy and a statistically significant reduction in their levels of parental stress as compared to the control group ($n=12$). Yuen, Landreth, & Baggerly, (2002) replicated this study with Chinese immigrant parents residing in Canada and found the same results as the ones previously reported by Chau and Landreth, showing that CPRT seems to be effective for Chinese immigrant parents.

Two studies were carried out with Korean parents and showed an increase in parental acceptance and empathetic interactions with their children, as well as, a reduction in parental stress. Lee and Landreth (2003) investigated the effectiveness of CPRT with Korean immigrant families living in US with children between the ages of 2-10. The sample in this study was composed of 17 parents in the experimental group and 15 parents in the control group. Results indicated that parents in the experimental group showed a statistically significant decrease in parental stress and a statistically significant increase in parental empathy and acceptance. Jang (2000) investigated the effectiveness of a modified version of CPRT by conducting a total of 8 sessions twice a week for 4 weeks with Korean mothers living in their country of origin. Although not statistically significant, the experimental ($n=14$) group showed an increase in parental empathy, and a decrease in parental stress as compared to the control group ($n=16$). Results also showed that the numbers of problem behaviors as reported by parents in the experimental group decreased as compared to the control group. Qualitative analysis of the data supported that parental acceptance was increased for the experimental group.

Kindron (2004) studied a modified intensive version of CPRT with Israeli parents residing in their own country. Kindron adjusted the 10-session model and conducted 9 training sessions within a 5 week period. Results showed that children of parents in the experimental

group ($n=14$) showed a statistically significant decrease in externalizing behaviors as measured by the parent version of the Child Behavioral Checklist. Parents in the experimental group also showed a statistically significant increase in empathy towards their children and a statistically significant decrease in parental stress levels as compared to parents in the control group ($n=13$).

Glover and Landreth (2000) utilized CPRT with 21 Native American parents. Although not statistically significant, the experimental group ($n=11$) demonstrated marked improvements in parental acceptance, empathic parent-child interactions, and children's self-concept. Results also showed a decrease in parental stress. The authors noted concerns regarding the compatibility of the measurements used in this study with this population.

Rationale for Utilizing CPRT with Hispanics

Mental health providers are facing the challenge of providing evidence-based services that meet the needs of minority groups living in US. Even though Hispanics are the fastest growing minority group in US (US Census, 2006), a review of literature shows that the mental health needs of Hispanic children are not being met (Santiago-Rivera et al., 2002; The National Center for Education Statistics, 2003; US Public Health Service, 2000).

Researchers in the field have advocated for the development of mental health treatment modalities that meet the needs of Hispanic children and their families (Altbach, 1991; US Public Health Service, 2000). Specifically, researchers advocated for evidence-based services that are culturally sensitive to this population (Costantino et al., 1994; Santiago-Rivera et al., 2002; Zayas & Solaris, 1994). CPRT has been found to be effective in reducing parental stress and increasing parental acceptance and empathy with minority populations residing in US (Chau & Landreth, 1997; Glover & Landreth, 2000; Lee & Landreth, 2003). Although the 10-session filial

model has been conducted with Hispanics, no outcome data has been reported to date (Landreth & Bratton, 2006).

Rogler et al. (1987) suggested for mental health practitioners to choose treatment modalities that match the cultural values of the Hispanic population and are adjustable to the population's cultural needs. The child-centered principles taught in CPRT have been recognized by researchers to be congruent with the values of Hispanic children and their families and effective as a treatment modality for this population (Garza & Bratton, 2005; Ramirez, Flores-Torres, Kranz, & Lund, 2005). Bratton et al. (2006) stated "As with any treatment/intervention, therapists are expected to exercise clinical judgment in the use of materials and procedures" (p. viii). The authors further explained that CPRT can be adapted to meet the individual needs of groups of parents. Thus, CPRT presents itself as a treatment modality that can be adapted to meet the unique cultural needs of Hispanic families, while still following the procedures and principles outlined in the protocol.

A thorough review of literature revealed that Hispanic families share various cultural values that are congruent with the principles of CPRT, including the following: (a) Hispanics highly value interpersonal relationships and prefer to be in groups (Altarriba & Bauer, 1998; Griggs & Dunn, 1996; Powell et al., 1990), CPRT utilizes small group formats; (b) cohesiveness within the family is a highly valued cultural trait among Hispanics, thus, it is recommended that mental health professionals use treatment modalities that work with the family unit (Gloria & Rodriguez, 2000; Pederson, 1987). CPRT incorporates the family unit by working with the parent to become the therapeutic agent in the child's life instead of relying on treatment modalities that foster therapist-child interactions; (c) the child-parent relationship is central within the Hispanic family unit. In fact, researchers stated that Hispanic families are "child-

centered” and the parent-child relationship is often placed above the marital relationship (Ramirez, 1989; Vlach, 2002). The main purpose of CPRT is to enhance the parent-child relationship by increasing cohesiveness and empathy. Thus, CPRT presents itself as a modality that fits this cultural value; (d) Hispanics look at time in terms of present-tense and value the immediacy of the moment (Altarriba & Bauer, 1998). One of the child-centered skills taught to parents in CPRT is to be fully present with their child during the play times. Landreth (2002) stated that the relationship established in child-centered play therapy “is always focused on the present” (p. 86). In this respect, CPRT is congruent with Hispanics’ view of time; (e) Hispanics prefer spontaneous interactions where emotions and desires are expressed (Altarriba & Bauer). A main focus of CPRT is teaching parents to allow their children to express their emotions and experiences in the immediacy of the moment through play. The home play therapy sessions allow parents to have spontaneous interactions with their children; (f) according to Powell et al., surveyed mothers preferred parenting classes to be taught by a trained professional. CPRT is led by trained mental health providers; (g) results from this questionnaire also showed that participating mothers favored parenting programs that offer activities focusing on interactions with their children. The main focus of CPRT is for parents to practice the skills during their play sessions at home. Thus, offering parents an opportunity to interact with their children as part of the training.

Purpose of the Study

The present study was designed to examine the efficacy of CPRT with low income first generation immigrant Hispanic parents of preschool children. Specifically, this study examined the effects CPRT has on reducing children’s externalized, internalized, and total behavioral

problems as reported by parents. In addition, the study examined the effects of CPRT on reducing total parent-child relationship stress as reported by parents.

CHAPTER 2

METHODS AND PROCEDURES

This quasi-experimental study used a two-factor repeated measures, control group design to investigate the effectiveness of child parent relationship therapy (CPRT; Landreth & Bratton, 2006) with low income first generation immigrant Hispanic parents and their children identified as experiencing behavioral problems. A sample from Head Start, pre-kindergarten, and kindergarten children in the Southwestern US was randomly assigned by school site to participate in CPRT, a 10-session filial therapy model developed originally by Landreth (1991, 2002). In CPRT parents learn child-centered play therapy principles and procedures to use in play sessions with their children in order to enhance the parent-child relationship. In this chapter the definition of terms, hypotheses, instrumentation, participant selection, details of treatment, data collection, and analyses of data are discussed.

Definition of Terms

For the purpose of this study, the following terms were operationally defined:

Child-parent relationship therapy (CPRT). Landreth and Bratton (2006) defined this term as:

A unique approach used by professionals trained in play therapy to train parents to be therapeutic agents with their own children through a format of didactic instruction, demonstration play sessions, required at-home laboratory play sessions, and supervision in a supportive atmosphere. Parents are taught basic child-centered play therapy principles and skills including reflective listening, recognizing and responding to children's feelings, therapeutic limit setting, building children's self-esteem, and structuring required weekly play sessions with their children using a special kit of selected toys. Parents learn how to create a nonjudgmental, understanding, and accepting environment that enhances the parent-child relationship, thus facilitating personal growth and change for child and parent. (p. 11)

A protocol for CPRT can be found in the treatment manual, *Child Parent Relationship Therapy (CPRT) Treatment Manual: A 10-session Filial Therapy Model for Training Parents* (Bratton et al., 2006).

Hispanics. For the purpose of this study, Hispanics was operationally defined as first generation Hispanic immigrants and whose primary language is Spanish.

Parents. For the purpose of this study, a parent is operationally defined as the biological mother or father who is also the primary caregiver of the child.

Low income. For the purpose of this study, low income is defined in accordance to the US poverty guidelines used by the Department of Health and Human Services Federal Register (2007). These guidelines define poverty level based on size of family unit, income, and geographical location.

Internalizing behaviors. For the purpose of this study, internalizing behavior was operationally defined as the overall score on the Internalizing Problem scale on the Spanish version of the CBCL for ages 1½-5. These behaviors include: (a) Emotional Reactions, (b) Anxious/Depressed, (c) Somatic Complaints, (d) Withdrawn, and (e) Sleep Problems (Achenbach & Rescorla, 2000).

Externalizing behaviors. For the purpose of this study, externalizing behavior is operationally defined as the overall score on the Externalizing Problem scale on the Spanish version of the CBCL for ages 1½-5. These behaviors include: (a) Attention Problems, (b) Aggression, (c) Affective Problems, (d) Anxiety, and (e) Pervasive Developmental Problems (Achenbach & Rescorla, 2000).

Total problems. For the purpose of this study, Total Problems was operationally defined as the sum of scores of the Internalizing Problems, Externalizing Problems, and Sleep Problems scales on the Spanish version of the CBCL for children 1½-5 (Achenbach & Rescorla, 2000).

Parent-child relationship stress. Degree of reported parental stress based upon characteristics of both the child and the parent. For the purpose of this study, parent-child relationship stress was operationally defined as the Total Stress and two domains of the Parenting Stress Index (PSI; Abidin, 1995): Child Domain and Parent Domain.

Research Hypotheses

The following hypotheses were formulated for this study:

1. From pretest to posttest, parents of children in the experimental group will report a statistically significant decrease on the Internalizing Problems scale of the Spanish Parent version of the Child Behavior Checklist when compared to parents of children in the control group.
2. From pretest to posttest, parents of children in the experimental group will report a statistically significant decrease on the Externalizing Problems scale of the Spanish Parent version of the Child Behavior Checklist when compared to parents of children in the control group.
3. From pretest to posttest, parents of children in the experimental group will report a statistically significant decrease on the Total Problems scale of the Spanish Parent version of the Child Behavior Checklist when compared to parents of children in the control group.

4. From pretest to posttest, parents in the experimental group will report a statistically significant decrease on the Child Domain of the Spanish version of the Parenting Stress Index when compared to parents in the control group.
5. From pretest to posttest, parents in the experimental group will report a statistically significant decrease on the Parent Domain of the Spanish version of the Parenting Stress Index when compared to parents in the control group.
6. From pretest to posttest, parents in the experimental group will report a statistically significant decrease on the Total Stress Domain of the Spanish version of the Parenting Stress Index when compared to parents in the control group.

Instrumentation

Spanish Version Child Behavior Checklist – Parent Version (CBCL). The CBCL 1½-5 measures parents' reports of children's behavioral and emotional problems based on children's social relationships, activities, and school performance. This instrument uses a Likert scale that gives respondents three possible answers (0) Not True, (1) Sometimes True, and (2) Very True on a total of 99 items that describe children's different behaviors. The CBCL takes approximately 15 minutes to complete. The CBCL is composed of seven syndrome subscales. The syndrome subscales are categorized into one of the following two categories: Internalizing Problems or Externalizing Problems. Internalizing Problems refers primarily to problems within self and it is measured through the Internalizing Problems syndrome subscales: (a) Emotionally Reactive, (b) Anxious/Depressed (c) Somatic Complaints, and (d) Withdrawn. Externalizing Problems refer to behaviors that are expressed outwardly and are in conflict with adults' expectations of children. The Externalizing Problems syndrome subscales include: (a) Attention Problems and (b) Aggressive Behavior. Sleep Problems is an additional syndrome

scale that is not included in either the Externalizing Problems scale or the Internalizing Problems scale, but is included under the Total Problems scale. A decrease in scores indicates improvement in the targeted behavior (Achenbach & Rescorla, 2000).

The normative population for the CBCL was based on a diverse sample, including children referred for clinical and special education services, and children enrolled in various preschool, prekindergarten, and childcare settings. Children were residents of the US, Canada, Australia, and Jamaica. The mean score of the test-retest reliability for the CBCL is strong ($r = .85$). The test-retest reliability for each syndrome subscale of the CBCL is as follows: emotionally reactive ($r = .87$); anxious/depressed ($r = .68$); somatic complaints ($r = .84$); withdrawn ($r = .80$); sleep problems ($r = .92$); attention problems ($r = .78$); aggressive behavior ($r = .87$); internalizing problems ($r = .90$); externalizing problems ($r = .87$); and total problems ($r = .90$). The content validity of the problem scales were strong, as was supported by research that determined that all, but two items, discriminated between referred and non-referred children. The criterion-related validity of the problem scales were also supported by the differentiation between referred and non-referred children (Achenbach & Rescorla, 2000).

Gross, Fogg, and Young (2006) examined the equivalence of the CBCL 1½-5 across race/ethnicity, family socio-economic status, and English versus Spanish language. A total of 682 parents of children between 2 and 4 years old were recruited. Hispanics represented 46.8% of the sample: 218 (32%) classified as low-income and 101 (14.8%) classified as middle/upper class. Furthermore, 102 Hispanic parents in the low-income group completed the Spanish version of the CBCL. Results of the study indicated that the CBCL 1½-5 is equivalent across ethnicities. In addition, the authors concluded there were no significant scale score differences between

Hispanic parents who filled-out the Spanish version and Hispanic parents who filled-out the English version of the CBCL.

Spanish Version Parenting Stress Index (PSI). The PSI is designed to identify parent-child systems that are under significant stress and at-risk for problematic parent and/or child behavior. The PSI can be used with parents of children ranging from 1 month to 12 years. This instrument uses a Likert-type scale on a total of 120 items. The PSI is divided into two domains, the Child Domain and the Parent Domain. In addition, the PSI offers a Total Stress score that combines Child Domain and Parent Domain scores.

Abidin (1995) explained high scores in the PSI Child Domain as being associated with children's qualities that contribute to difficulties in the parent-child relationship. The Child Domain measures parent's perception in the following areas:

Distractibility/Hyperactivity: This subscale measures parent's perception of child's behaviors associated with ADHD. In addition, high scores could indicate parent not able to keep-up with the child's energy level, older parents who are having difficulty adjusting to the child, and/or parents having unreasonable expectations of their children's behaviors.

Adaptability: This subscale measures parent's perception of child's ability to adjust to changes in his or her social environment.

Reinforces Parent: This subscale measures parent ability to experience his or her child as a source of positive reinforcement.

Demandingness: This subscale measures parent's perception of child's demandiness level upon him or her. It is measured through parent's perception of behaviors such as crying, physically hanging on the parent, frequently requesting help, or having a high frequency of minor problem behaviors.

Mood: This subscale measures parent's perception of children's affective functioning by looking at behaviors such as crying and/or displaying signs of happiness.

Acceptability: High scores are produced in this area when the child possesses physical, intellectual, and emotional characteristics that do not match parents' expectations.

Abidin (1995) indicated that high scores in the Parent Domain indicate parents feeling "overwhelmed and inadequate to the task of parenting" (p. 10). The Parent Domain measures parent's perceived parental competency by measuring the following subscales:

Competence: This subscale measures parent's self-perception of their level of parental competency. High scores in this subscale might be the result of parents lacking developmental knowledge about their child, and/or parents who do not find the parenting role as rewarding as they had previously expected. This subscale also measures parent's perceived level of acceptance and criticism from their child.

Isolation: Parents who score high in this area are often socially isolated from their peers, relatives, and emotional support systems.

Attachment: This subscale measures parent's level of emotional closeness to the child, and parent's perceived ability to observe and understand the child's feelings and/or needs accurately.

Health: High scores are suggestive of deterioration in parental health that may be the result of either parenting stress or an additional independent stress in the parent-child system.

Role Restriction: This subscale measures the extent to which parent experiences the parental role as restricting his or her freedom and ability to maintain own identity.

Depression: This subscale measures the presence of depression in the parent.

Spouse: Parents who earn high scores on this subscale are those who are lacking the emotional and active support of the other parent in the area of child management.

The PSI takes less than 30 minutes for parents to complete. The norm sample for the PSI consisted of 2,633 mothers with an average age of 30.9 years. The participation of ethnic groups in the sample was as followed: 76% White, 11% African American, 10% Hispanic, and 2% Asian. The children of focus for the sample varied in age from 1 month to 12 years. Further validation of PSI with the Hispanic population was carried out with another sample of 223 Hispanic parents of different origin. Coefficients for test-retest reliability were obtained from four different studies. For parent domain, coefficients ranged between .69 and .91. For child domain, coefficients ranged between .55 and .82. For total stress score, coefficients ranged from .65 to .96. The instrument has been validated with diverse populations in the US as well as in other countries. The Spanish version of the PSI was validated in one study carried by Solis & Abidin in 1991. The instrument has also been validated with at-risk populations including battered women, negligent mothers, parental drug exposure, teenage parents, and families at-risk for parenting problems.

Participants Selection

Human subjects approval from the University of North Texas Institutional Review Board was obtained prior to contacting potential participants. Principals at Head Start, pre-kindergarten, and kindergarten schools in two suburban school districts in the Southwestern region of the US were contacted to discuss potential benefits of providing CPRT at their schools. Once permission was obtained from the principals, I attended Spanish speaking parenting meetings, including registration for preschool programs and open house for elementary schools, at the beginning of

the school year. During these meetings, prospective participants were explained the purpose of the study.

I collaborated with social workers, educational specialists, school psychologists, and teachers of participating schools to recruit additional participants for the study. In addition, a flyer explaining the purpose of the study was sent to parents' homes.

Parents had to meet the following criteria to participate in the study:

1. Parent identified himself/herself as first generation immigrant of Hispanic origin.
2. Parent reported living at or below poverty level in accordance to the US Department of Health and Human Services (2007) guidelines.
3. Parent identified Spanish as the primary language spoken at home and as the primary language of the child.
4. Parent consented to participate in CPRT.
5. Parent's report on the CBCL obtained one or more scores at the borderline or clinical range on internalizing, externalizing, and/or total problem scale.

Parents who expressed interest in participating and signed the consent form (Appendix A) to participate in the study filled out the family background form (Appendix B) and were interviewed to ensure they met criteria for participation. Parents who met criteria were contacted to fill out the Spanish version of the PSI. Parents whose children did not meet the criteria to participate were contacted to explain they did not qualify for the study. These parents were offered the opportunity to participate in CPRT after completion of the study.

Participating schools included two schools in District A (one Head Start school and one Title 1 elementary school) and one Head Start/Pre-K school in District B. All three schools were similar in demographics regarding Hispanic enrollment (55%, 55%, and 65% respectively).

Parents of all participating children reported living at or below poverty level (US Department of Health and Human Services Federal Register, 2007), thus qualifying for free or reduced lunch.

Qualified participants ($n=62$) were randomly assigned by school site to the no treatment control group ($n=31$) or the experimental group ($n=31$). Parents attended CPRT training at their child's school. Based on parents' schedules, parents were divided into five groups (5 to 7 parents per group) in keeping with CPRT methodology (Bratton et al., 2006). In school District A, two groups were conducted at the Head Start site and one group at the Title 1 elementary school. In school District B, two groups were conducted at the Head Start/Pre-K site. Of the 31 parents assigned to the experimental group, 24 completed the study, and 7 dropped out due to various reasons including geographical relocation and conflicts with work schedules. Of the 31 parents assigned to the control group, 24 parents completed posttesting while the remaining 7 parents did not complete posttesting due to various reasons including, having disconnected phone numbers, geographical relocation, and other unknown reasons. Parents in the control group were offered treatment at the end of the study. All parents were offered a stipend for completing the instruments. Table 1 summarizes demographic information of participating parents and Table 2 summarizes demographic information of participating children.

Table 1

Demographic Information for Parents in Experimental (n=24) and Control Groups (n=24)

		Experimental Group	Control Group
Gender	Male	1	0
	Female	23	24
Age	20-29 years	11	12
	30-39 years	12	12
	40-49 years	1	0
	Mean	30	29
Years in the USA	1-5	8	6
	6-10	11	13
	11-15	3	4
	16-20	2	1
	Mean	7.7	7.8
Educational Level	Elementary	9	9
	High School	10	10
	Some College	3	0
	College	5	5
Employment Status	Employed	8	6
	Unemployed	16	18
Origin	Mexican	18	22
	South America	3	2
	Central America	3	0
Marital Status	Married	20	19
	Living with Partner	1	2
	Single	1	2
	Separated	2	0
	Divorced	0	1

Note: Most mothers who checked unemployed do stay at home by choice

Table 2

Demographic Information for Children in the Experimental (n=24) and Control Groups (n=24)

		Experimental Group	Control Group
Gender	Male	13	14
	Female	11	10
Age Mean		4.12	4.42
Living Arrangements	Both Biological Parents	21	20
	Biological Mother	3	3
	Biological Mother/Step Father	0	1

Experimental Treatment

Parents of children assigned to the experimental group ($n=24$) participated in CPRT training and supervision. CPRT facilitates the enhancement of the child-parent relationship by training parents to become therapeutic agents in their children's lives. Parents learn child-centered therapeutic play skills, such as reflective listening, therapeutic limit setting, and building children's self-esteem, to use with their child in a 30-minute weekly play session. The curriculum content and procedures utilized during the training were based on the CPRT 10-session treatment protocol (Bratton et al., 2006). I provided the treatment, I am a bilingual (English and Spanish) and bicultural Hispanic doctoral level student, experienced in play therapy and trained in the CPRT treatment protocol. I translated the parent handbook located in the CPRT treatment manual to Spanish.

To abide by the American Counseling Code of Ethics (2005) to be culturally responsive and in accordance with Landreth and Bratton (2006), who stated that CPRT is to be used with clinical judgment to accommodate the needs of the parents, I incorporated recommendations made by leading authorities in culturally responsive counseling for Hispanics (Altarriba & Bauer, 1998; Alvy, 1994; Powell et al., 1990; Santiago-Rivera et al., 2002). Based on such

recommendations, the CPRT format was extended to 11 sessions in order to incorporate Hispanics' values for socialization and interpersonal relationships (Altarriba & Bauer; Griggs & Dunn, 1996; Santiago-Rivera et al.). Based on results from a survey conducted to investigate Hispanic mothers' preferences in parenting programs, Powell, Zambrana, and Silva-Palacios (1990) recommended to have an informal group gathering to allow members to socialize and familiarize themselves with each other prior to the first session of parenting programs. Thus, for this study, the focus of the first CPRT session was to allow members to socialize and familiarize themselves with each other.

No modifications were made to the actual content and procedures presented in the CPRT treatment manual (Bratton et al., 2006). In order to assure adherence to the protocol, I was supervised by Dr. Sue Bratton, co-author of the CPRT text and treatment manual throughout the study. Consistent with CPRT methodology, parents met in groups of 5-7 parents per group to facilitate small group interactions. All groups met at their children's school weekly for 2 hours. At parents' request, 3 groups were conducted during the school day, and the other 2 groups met late afternoon and early evening. The latest group began at 5:00 p.m.; no parents were willing to meet later than that time. Consistent with CPRT procedures, parents conducted 7 weekly play sessions with their child during the last 7 weeks of CPRT.

Parents had the choice to conduct play therapy sessions in playrooms located at the school sites or at their homes. For parents who conducted play sessions at the school sites, I provided assistance with childcare and ensured videotaping of sessions. For parents who conducted play sessions at home, I provided video cameras and play session toy kits. I ensured that parents who missed sessions had one-on-one make-up sessions by meeting with these parents prior to the following CPRT group.

No Treatment Control Group

Parents of children assigned to the no treatment control group ($n=31$) were offered CPRT upon completion of the study. Same procedures followed for parents in the experimental group were offered to parents in the control group.

Data Collection

After IRB approval and parental consent were obtained, the CBCL Spanish was administered to screen children for participation. I offered parents the option of completing the documents by themselves or utilizing an interview format. The interview format consisted of me reading the questions to the parent and marking the answers on the documents. This option was provided to allow parents with low reading ability to receive help without having to disclose their reading difficulty and in order to ensure accuracy of parent responses. To ensure integrity of data collection, parents completed questionnaires in a controlled environment, free from distractions. Parents were provided free childcare at school while they completed the Spanish versions of the CBCL and the PSI. I was present during all stages of data collection to ensure data integrity. In a few cases, due to parental preferences, I collected data at the parents' homes. Prior to visits, I took measures to provide the same level of integrity for data collection. The CBCL and PSI were administered again immediately after treatment following same procedures used at pretesting. To ensure confidentiality, participants were assigned random code numbers for use in all data collection. Data was stored in a locked filing cabinet in a secure location.

Analyses of Data

Results were obtained from the pretest and posttest data of the CBCL and PSI Spanish versions completed by parents. The data was statistically analyzed in order to examine the effects of the experimental treatment on children's behaviors and parents' stress when compared to the

control group over time. To ensure accuracy, both pretest and posttest data for the CBCL were scored by a research assistant using computer software scoring for the CBCL, which requires all data be entered twice. Pretest and posttest for PSI scales were scored twice by hand in order to ensure accuracy. The investigator sought consultation through a qualified statistician to ensure the validity and appropriateness of all statistical analysis.

First, prior to analysis, data was examined to determine appropriate statistical analysis. To examine whether the sample data was representative of a normal distribution, a box plot test was conducted to inspect individual scores. The box plot test revealed a few extreme scores. Hinkle, Wiersma and Jurs (2003) defined an outlier as, “an unusual score in a distribution that is considered extreme and may warrant special consideration” (p. 64). Thus, each score identified as an outlier was inspected individually. Kutner, Nachtsheim, Neter, and Li (2005) stated "A safe rule frequently suggested is to discard an outlier only if there is direct evidence that it represents an error in recording, a miscalculation, a malfunctioning of equipment, or a similar type of circumstance" (p. 108). Wilcox (1998) expanded by explaining that simply eliminating outliers without careful examination of each one is not a viable procedure because “if extreme values are thrown out, the remaining observations are no longer independent” (p. 305). For this study, after careful examination of the outliers, I was not able to identify any theoretical rationale for eliminating the extreme scores.

Dependent variables were analyzed to screen data for normality, sphericity, and homogeneity of covariance. Kurtosis and skewness values for the dependent variables were examined to ensure data reflected a normally distributed population and were found to be within the accepted range. For this study, since there were only two points of measurement, sphericity was assumed.

A Box's test of equality of covariance was conducted to assure homogeneity of covariance. Results revealed this assumption was met for the Internalizing Problem and Total Problem scales of the CBCL and for the Child Domain of the PSI. However, for the Total Stress and Parent Domain of the PSI, and for the Externalizing Problem scale of the CBCL, the data failed to meet this assumption. According to Leech, Barrett, and Morgan (2005) "if *N*s for the various groups are approximately equal, then the box test should be ignored" (p. 167). The authors suggested reporting the more robust Pillai's trace test when the group sizes are equal and the homogeneity of covariance matrices assumption is violated. Other authors corroborated that violation of this assumption is not significant when sample sizes are equal (Hinkle, Wiersma, & Jurs, 2003). Given that sample sizes in this study are equal (experimental=24, control=24), a two factor (time x group) repeated measures ANOVA was conducted for all dependent variables using Statistical Package for Social Sciences (SPSS). Dependent variables included the CBCL ratings for Externalizing Problems, Internalizing Problems, and Total Problems scales and the PSI ratings for Child Domain, Parent Domain, and Total Stress. A reduction in scores on the CBCL and PSI indicate improvement. Results for all dependent variables were interpreted using Pillai's trace analysis. To avoid a Type I error resulting from the testing of multiple hypotheses, a .025 alpha level was established to either reject or accept hypotheses.

CHAPTER 3

RESULTS AND DISCUSSION

This chapter presents the discussion, results, and limitations of this study, as well as implications for practice and research. Results of the data analysis are presented in the order in which the hypotheses were tested.

Results

As discussed in Chapter 2, after examining data for assumptions, a two factor (time x group) repeated measures analysis of variance was performed to examine the effects of group membership (experimental, control) and time (pretest, posttest) on each dependent variable. Dependent measures for the Spanish version of the Child Behavior Checklist (CBCL) included Externalizing Problems, Internalizing Problems, and Total Problems (Achenbach & Rescorla, 2000). Dependent variables for the Spanish version of the Parenting Stress Index (PSI) included Child Domain, Parent Domain, and Total Stress (Abidin, 1995).

The CBCL and PSI were administered prior to treatment and at the end of treatment. A reduction in scores on the CBCL and PSI scales indicated improvement in the targeted behavior. Pillai's trace was utilized to interpret results. Partial eta squared effect sizes were calculated to assess the magnitude of difference between the two groups and to better understand the practical significance of the study (Kazdin, 1999). The following guidelines proposed by Cohen (1988) were used to interpret η_p^2 effect size: .01= small, .06= medium, and .14 = large.

Results for Hypotheses 1 to 3

Table 3 presents the pretest and posttest means and standard deviations for the experimental ($n=24$) and control group ($n=24$) on the Externalizing Problems, Internalizing Problems, and Total Problems scales of the Spanish version of the CBCL.

Table 3

Mean Scores on the Internalizing Problems, Externalizing Problems and Total Problems scales on the Spanish Version of the Child Behavior Checklist (CBCL)

	Experimental Group <i>n</i> = 24		Control Group <i>n</i> =24	
	Pretest	Posttest	Pretest	Posttest
Internalizing Problems				
Mean	67.25	52.63	65.04	65.71
<i>SD</i>	6.95	5.93	9.29	9.87
Externalizing Problems				
Mean	65.38	50.67	62.00	63.67
<i>SD</i>	12.27	6.94	8.88	9.15
Total Problems				
Mean	68.00	51.29	65.04	65.71
<i>SD</i>	8.38	6.95	8.74	7.92

Note: A decreased in mean scores indicates an improvement in behavior.

Hypothesis 1

Parents of children in the experimental group will report a statistically significant decrease from pretest to posttest on the Internalizing Problems scale of the Spanish parent version of the Child Behavior Checklist when compared to parents of children in the control group.

Results of 2 factors repeated measures analysis of variance indicated that the dependent variable, Internalizing Problems, revealed a statistically significant interaction effect of time (pretest, posttest) x group membership (experimental, control); Pillai's trace = .56, $F(1, 46) =$

58.75, $p < .001$, $\eta_p^2 = .56$. These results indicate that parents who participated in the experimental group reported a statistically significant decrease in children's internalizing problems from pre-test to post-test, when compared to parents who were in the no treatment control group. On the basis of these results, Hypothesis 1 is retained. Results further indicate that the effects of CPRT treatment on the experimental group compared to the control group was large ($\eta_p^2 = .56$).

Hypothesis 2

Parents of children in the experimental group will report a statistically significant decrease from pretest to posttest on the Externalizing Problems scale of the Spanish parent version of the Child Behavior Checklist when compared to parents of children in the control group.

Results of 2 factors repeated measures analysis of variance indicated that the dependent variable, Externalizing Problems, revealed a statistically significant interaction effect of time (pretest, posttest) x group membership (experimental/control); Pillai's Trace = .59, $F(1, 46) = 66.42$, $p < .001$, $\eta_p^2 = .59$. These results indicate that parents who participated in the experimental group reported a statistically significant decrease in children's externalizing problems from pre-test to post-test, when compared to parents whose children were in the control group. On the basis of these results, Hypothesis 2 is retained. Results further indicate that the effects of CPRT treatment on the experimental group compared to the control group was large ($\eta_p^2 = .59$).

Hypothesis 3

Parents of children in the experimental group will report a statistically significant decrease from pretest to posttest on the Total Problems scale of the Spanish parent version of the Child Behavior Checklist when compared to parents of children in the control group.

Results of 2 factors repeated measures analysis of variance of the dependent variable, Total Problems, revealed a statistically significant interaction effect of time (pretest, posttest) x group membership (experimental/ control); Pillai's trace = .67, $F(1, 46) = 95.43$, $p < .001$, $\eta_p^2 = .68$. These results indicate that parents who participated in the experimental group reported a statistically significant decrease in children's total problems from pre-test to post-test, when compared to parents whose children were in the control group. On the basis of these results, Hypothesis 3 is retained. Results further indicate that the effects of CPRT treatment on the experimental group compared to the control group was large ($\eta_p^2 = .68$).

Results for Hypotheses 4 to 6

Table 4 presents the pretest and posttest means and standard deviations for the experimental and control group on the Child Domain, Parent Domain, and Total Stress of the Spanish version of the PSI.

Table 4

Mean Scores on the Child Domain, Parent Domain, and Total Stress on the Spanish Version of the Parent Stress Index (PSI)

	<i>Experimental Group n= 24</i>		<i>Control Group n=24</i>	
	Pretest	Posttest	Pretest	Posttest
Child Domain				
Mean	138.21	100.08	130.42	129.88
<i>SD</i>	28.68	17.44	21.729	20.29
Parent Domain				
Mean	158.96	124.88	143.54	149.58
<i>SD</i>	30.93	20.35	22.39	26.79
Total Stress				
Mean	293.00	224.71	273.96	279.67
<i>SD</i>	61.84	32.31	34.53	40.00

Note: A decreased in mean scores indicates an improvement in behavior.

Hypothesis 4

Parents in the experimental group will report a statistically significant decrease from pretest to posttest on the Child Domain of the Spanish version of the Parent Stress Index (PSI) when compared to parents in the control group.

Results of 2 factors repeated measures analysis of variance the dependent variable, Child Domain, revealed a statistically significant interaction effect of time (pretest, posttest) x group membership (experimental/control); Pillai's trace = .39, $F(1, 46) = 29.95$, $p < .001$, $\eta_p^2 = .39$. These results indicate that parents in the experimental group who received CPRT reported a statistically significant decrease in the Child Domain from pre-test to post-test, when compared

to parents in the control group. On the basis of these results, Hypothesis 4 is retained. Results further indicate that the effects of CPRT treatment on the experimental group compared to the control group was large ($\eta_p^2 = .39$).

Hypothesis 5

Parents in the experimental group will report a statistically significant decrease from pretest to posttest on the Parent Domain of the Spanish version of the Parent Stress Index (PSI) when compared to parents in the control group.

Results of 2 factors repeated measures analysis of variance the dependent variable, Parent Domain, revealed a statistically significant interaction effect of time (pretest, posttest) x group membership (experimental/control); Pillai's Trace = .52, $F(1, 46) = 49.10$, $p < .001$, $\eta_p^2 = .52$. These results indicate that parents in the experimental group who received CPRT reported a statistically significant decrease in the Parent Domain from pre-test to post-test, when compared to parents in the control group. On the basis of these results, Hypothesis 5 is retained. Results further indicate that the effects of CPRT treatment on the experimental group compared to the control group was large ($\eta_p^2 = .52$).

Hypothesis 6

Parents in the experimental group will report a statistically significant decrease from pretest to posttest on the Total Stress Domain of the Spanish version of the Parent Stress Index (PSI) when compared to parents in the control group.

Results of 2 factors repeated measures analysis of variance the dependent variable, Total Stress, revealed a statistically significant interaction effect of time (pretest, posttest) x group membership (experimental/control); Pillai's Trace = .42, $F(1, 46) = 33.12$, $p < .001$, $\eta_p^2 = .42$. These results indicate that parents in the experimental group who received CPRT reported a

statistically significant decrease in the Total Stress domain from pre-test to post-test, when compared to parents in the control group. On the basis of these results, Hypothesis 6 is retained. Results further indicate that the effects of CPRT treatment on the experimental group when compared to the control group was large ($\eta_p^2 = .42$).

Clinical Significance

According to Kazdin (2003), clinical significance refers to the benefit the treatment offers to the client in real life. To better understand if the CPRT intervention helped children and parents improve day to day functioning, their individual pre and post scores for each dependent variable were examined. Specifically, clinical significance was assessed by determining the number of experimental children ($n=24$) and parents ($n=24$) who moved from clinical/borderline levels of concern at pretesting into the normal range of functioning following treatment.

Child Behavior Outcomes

To determine clinical significance, children's T-scores on the Internalizing Problem, Externalizing Problem, and Total Problem scales of the Child Behavior Checklist (CBCL) were analyzed to assess if functioning was improved from pre to post. T-scores above 64 are considered in the clinical range, T-scores between 60 and 63 are considered in the borderline range, and T-scores below 60 are considered in the normal range. Consistent with Achenbach and Rescorla's (2000) report regarding the comorbidity of presenting concerns in young children, children in the present study demonstrated clinical levels of behavioral problems in multiple areas.

A total of 20 of the 24 treatment group children demonstrated clinical/borderline levels of concern for internalizing problems at pre-test. Of 16 who presented in the clinical range, 13 improved to normal levels after treatment, 2 moved to borderline and 1 child stayed in the

clinical range, but showed a 13 point decrease. The additional 4 children that scored in the borderline range prior to the intervention were functioning in the normal range by the end of treatment. Thus, of the 20 children demonstrating clinical/borderline levels of internalizing problems prior to treatment, 17 (85%) moved into the normal range of functioning after their parents participated in CPRT.

Clinical/borderline levels of concern for externalizing problems were reported for 17 of the 24 children at pretest. Of the 11 who scored in the clinical range, 9 improved to normal levels after treatment, 1 child moved to borderline, and 1 continued to show a clinical level of concern post treatment but demonstrated a 21 point decrease. All 6 children who began treatment in the borderline range moved to the normal range after CPRT. Hence, 15 of the 17 children (88%) whose parents reported pre-treatment externalizing behavior problems in the clinical to borderline range improved to normal levels of concern following CPRT.

Pretest scores from the Total Problem scale indicated that 20 of the 24 children were demonstrating clinical to borderline levels of behaviors. Of the 17 children scoring in the clinical range, 15 improved to normal functioning and 2 continued to show clinical concerns with a decrease of 17 and 21 points respectively. All 3 children who began treatment with borderline range of concern moved into the normal range after treatment. Thus, 18 of 20 children (90%) demonstrating clinical to borderline levels of total behavior problems prior to CPRT improved their scores into the normal range after treatment.

In summary, for child behavioral problems, approximately 22 (85%) of the 24 children whose parents received the CPRT intervention ($n=22$) moved from clinical/borderline levels of behavioral concern on one or more of the CBCL scales to normative functioning. Of the remaining 4 children, 2 moved from clinical to borderline concern and 2 remained in the clinical

level but showed notable improvement. These findings demonstrate the clinical significance of the CPRT intervention on internalizing, externalizing, and total behavior problems of low income Hispanic children.

Parent-Child Relationship Stress Outcomes

Clinical significance of treatment on parent-child relationship stress was determined by examining the change in parents' pre to post scores on the Child Domain, Parent Domain, and Total Stress Domain of the Parenting Stress Index (PSI). The PSI reports raw scores, with scores above the 85th percentile considered in the clinical range. Scores of 258 or higher qualify parents in the clinical range for Total Stress. For the Parent Domain, clinical levels are indicated by a score of 148 or higher, while a score of 116 or higher on the Child Domain is considered clinical.

Of 18 treatment group parents scoring on the clinical level on the Child Domain at pretest, roughly 75% (13 parents) moved in the normal level after treatment. An inspection of the pre to post scores for the 5 parents who remained in the clinical range showed that all 5 improved, with 4 showing marked improvement (18 to 42 point decrease). Although the remaining 6 parents scored in the normal range at pretest, all 6 showed a posttest decrease in parenting stress related to child characteristics, ranging from 9 to 41 points.

An examination of scores on the Parent Domain revealed 15 parents demonstrated clinical level of stress prior to treatment. Of these, 66% ($n=10$) improved to normative functioning after the CPRT treatment, and 5 continued to report clinical levels of concern. The 5 parents who remained in the clinical range post treatment showed a decrease in their scores ranging from 6 to 31 points. While the remaining 9 parents reported normal levels of parent-child stress related to parent characteristics at pretesting, they also showed decreases in scores ranging from 1 to 33 points.

Of the 16 parents scoring in the clinical range on the Total Stress Domain at pretest, 10 (62%) reported normal levels of parent-child relationship stress after treatment, while 7 remained in the clinical range of functioning but showed marked post-treatment decreases ranging from 43 to 75 points. For the 8 parents scoring in the normal range of parent-child relationship stress prior to treatment, all 8 showed a decrease following CPRT, with decreases ranging from 15 to 65 points.

In summary, 66% of the 24 experimental group parents ($n=16$) moved from clinical levels of parenting stress on one or more of the PSI domains to normative functioning following their participation in CPRT. Of the remaining 8 parents, all 8 showed decreases in their stress related to parenting following treatment. These results demonstrate the clinical significance of the CPRT intervention on reducing parental-child relationship stress for first generation immigrant Hispanic parents.

Discussion

This study investigated the effectiveness of CPRT on low income first generation Hispanic immigrant parents. Specifically, this study examined the effect of the treatment on reducing low income Hispanic children's externalized, internalized, and total problem behaviors as measured by the Spanish version of the CBCL. In addition, this study examined the effect of the treatment on reducing Child Domain, Parent Domain, and Total Stress Domain scores as measured by the Spanish version of the PSI. Treatment outcomes for children's internalizing, externalizing, and total behavior problems were measured through parental ratings of children's behaviors. Treatment outcomes for parents' Child Domain scores, Parent Domain scores, and Total Stress domain scores were measured through parents' self-report. All six hypotheses were retained at the .025 alpha level of significance, indicating an improvement in the experimental

group when compared to the no treatment control group. Partial eta squared (η_p^2) was calculated to assess the magnitude of the treatment effect. Following Cohen's (1988) guidelines for interpreting effect size, the CPRT treatment demonstrated a large treatment effect on all six dependent variables.

Internalizing Behavior Problems

Achenbach and Rescorla (2000) defined the Internalizing Problems scale on the CBCL form as consisting of children's behavioral problems that are expressed internally. These behaviors include scales for emotionally reactive, anxious/depressed, somatic complaints, and withdrawn.

Results of Hypothesis 1 indicated that from pre-test to post-test, parents who participated in the CPRT treatment group reported a statistically significant ($p < .001$) improvement on the Internalizing Problems scale of the CBCL when compared to parents who did not participate in CPRT. A visual inspection of group means in Table 3 shows that while control group children demonstrated a slight increase in internalizing problems, children in the CPRT group demonstrated a notable 15 mean point reduction. The finding regarding CPRT's large treatment effect ($\eta_p^2 = .56$) on the experimental group compared to the control group demonstrates its practical significance, or its therapeutic value as an intervention. Furthermore, the finding that 85% of the children moved from the clinical/borderline levels of concern to the normal range of functioning following treatment shows strong support for the clinical significance of the CPRT intervention on children's everyday lives.

These findings are comparable to results from other controlled studies that demonstrated a statistically significant reduction in children's internalizing behavioral problems as a result of CPRT training conducted with caregivers (Smith, N. & Landreth, 2003; Smith, D. & Landreth,

2004). Additionally, findings from a meta-analysis examining the efficacy of play therapy, including CPRT and other filial therapy studies, reported similar treatment effects on children's internalizing behavioral problems (Bratton, Ray, Rhine, & Jones, 2005). In two additional studies conducted with teachers, CPRT demonstrated a moderate treatment effect on the internalizing behaviors of preschool children (Helker, 2007; Morrison, 2006).

CPRT teaches parents to be sensitive to and understanding of their children's feelings and needs. Thus, parents' increased understanding and ability to respond to their child's internalized behaviors may in part explain the significant impact that CPRT had on children. Similarly, Morrison (2006) explained that the treatment effect on children's internalizing problems could have been a result of teacher's increased sensitivity and responsiveness to children.

Internalizing behavior problems are associated with anxiety, depression, and withdrawn behaviors. Statistics from the Multicultural and International Outreach Center (2003) demonstrated a significant representation of Hispanic youth in suicide rates. This statistic highlights the need to identify effective treatments that can positively impact internalizing behavior problems in Hispanic children and that can be offered in highly accessible settings such as schools. Early intervention and treatment, particularly those involving families, can offer additional protective factors by preventing the onset of more serious problems that can develop across the life span. Thus, the statistical, practical and clinical significance of findings support CPRT as a viable treatment for low income Hispanic children exhibiting internalized behavior problems are noteworthy.

Externalizing Problems Behaviors

Achenbach and Rescorla (2000) defined the Externalizing Problem scale on the CBCL as consisting of behaviors that affect children's relationships with others, as well as, others' expectations of children. These behaviors include attention problems and aggressive behaviors.

Results of Hypothesis 2 indicated that from pre-test to post-test, parents who participated in the CPRT treatment group reported a statistically significant ($p < .001$) improvement on the Externalizing Problem scale of the CBCL when compared to parents who did not participate in CPRT. A visual inspection of group means in Table 3 shows that while control group children demonstrated a slight increase in externalizing problems, children in the CPRT group demonstrated a 15 point mean reduction. The finding regarding CPRT's large treatment effect ($\eta_p^2 = .59$) on the experimental group when compared to the control group demonstrates its practical significance, or its therapeutic value as an intervention. Furthermore, the finding that 88% of the children moved from the clinical/borderline levels of concern to the normal range of functioning following treatment shows strong support for the clinical significance of the CPRT intervention on children's day-to-day functioning.

These results are consistent with prior controlled studies that demonstrated statistically significant improvements in children's externalized problems with parents trained in CPRT (Kidron, 2004; Smith & Landreth, 2003). Other studies investigating the effectiveness of CPRT conducted by teachers found statistically significant reductions in externalizing behaviors of pre-school children (Morrison, 2006; Smith & Landreth, 2004). Additionally, findings from a meta-analysis examining the efficacy of play therapy, including CPRT and other filial therapy studies, reported similar treatment effects on children's externalizing behavioral problems (Bratton, et al.).

The skills taught during CPRT, such as therapeutic limit setting, reflection of feelings, and choice giving teach children to express their emotions in acceptable ways and foster the development of self-control. The use of CPRT skills by parents in weekly play sessions with their children offers a plausible explanation for the significant reduction in children's externalized behaviors.

Literature suggests that externalizing behaviors, such as aggression, appear in early childhood and have a tendency to be stable and resistant to change over time (Bernazzani, Cote, & Tremblay, 2001; Tremblay, 2000). In addition, Webster-Stratton and Reid (2003) suggested a link between externalized behaviors in preschoolers and long-term effects such as violence, drug abuse, juvenile delinquency and anti-social personality disorders. Statistics from the Multicultural and International Outreach Center (2003) showed a significant representation of Hispanics youths in the juvenile system, suggesting the need to identify early intervention and preventive treatments to treat externalizing problems in Hispanic children. Early detection and treatment can prevent unnecessary suffering and related costs that may result from delays in treatment. The statistical, practical and clinical significance of findings support CPRT as a viable treatment for low income Hispanic children exhibiting externalized behavior problems. This finding is especially important when considering that researchers have identified externalizing behavior problems in children as being particularly resistant to treatment (Hinshaw, 1992).

Total Problems Behaviors

Achenbach and Rescorla (2000) defined the Total Problems scale on the CBCL form as consisting of a combination of children's internalizing and externalizing behavioral problems in addition to a scale that measures sleep problems.

Results of Hypothesis 3 indicated that from pre-test to post-test, parents who participated in the CPRT treatment group reported a statistically significant ($p < .001$) improvement on the Total Problems scale of the CBCL when compared to parents who did not participate in CPRT. A visual inspection of group means in Table 3 shows that while control group children demonstrated a slight increase in Total Problems, children in the CPRT group demonstrated a significant 17 point reduction. The finding regarding CPRT's large treatment effect ($\eta_p^2 = .68$) on the experimental group when compared to the control group demonstrates its practical significance, or its therapeutic value as an intervention. Furthermore, the finding that 90% of the children qualifying as clinical prior to treatment moved from the clinical/borderline levels of concern to the normal range of functioning following treatment shows strong support for the clinical significance of the CPRT intervention on children's day to day functioning.

Results from this study are consistent with findings from other controlled CPRT studies that showed statistically significant decreases on scores for the Total Problem scale of the CBCL (Bratton & Landreth, 1995; Kidron, 2003; Landreth & Lobaugh, 1998; Smith & Landreth, 2003). In addition, a study conducted to investigate the effectiveness of the CPRT model with teachers, also showed a statistically significant reduction on children's total problem scores (Morrison, 2006).

CPRT teaches parents basic child-centered play therapy (CCPT) skills that can have an impact on children's internalizing and externalizing problems. CCPT skills used by parents including recognizing and responding to children's feelings, building children's self-esteem, choice-giving and therapeutic limit setting have been shown to positively impact children's internalizing, externalizing and combined behavior problems (Bratton et al., 2005). Parents' use

of these skills in weekly play sessions with their child offers a possible explanation for the experimental group children's significant reduction of scores on the Total Problem scale.

The statistical, practical, and clinical significance of findings for CPRT's effects on total behavior problems are particularly noteworthy due to the fact that the majority of children displayed clinical/borderline levels of concern on multiple scales of the CBCL. The literature supports the notion that young children often present signs of comorbidity, making single diagnosis a difficult task (Achenbach & Rescorla, 2000). This view seems in opposition to the current trend in child mental health research to focus on one specific diagnosis to determine the effects of a particular intervention on that diagnosis. The present study corroborates the idea that young children present with a range of behavioral difficulties and supports targeting treatments that are responsive to a broad spectrum of problem behaviors. Findings from the present study provide strong support for CPRT as an effective intervention to treat a combination of behavioral problems in young Hispanic children.

Parenting Stress Outcomes Related to Child Characteristics

Abidin (1995) explained high scores in the PSI Child Domain as being associated with children's qualities that contribute to difficulties in the parent-child relationship. Thus, when scores for child domain are high, it is advised to focus on treatments that can positively impact children's behaviors.

Results of Hypothesis 4 indicated that from pre-test to post-test, parents who participated in the CPRT treatment group reported a statistically significant ($p < .001$) improvement on the Child Domain of the PSI when compared to parents who did not participate in CPRT. A visual inspection of group means in Table 4 shows that while control group parents demonstrated a slight decrease in the Child Domain, parents in the CPRT group demonstrated a notable 38 point

reduction. The finding regarding CPRT's large treatment effect ($\eta_p^2=.39$) on the experimental group when compared to the control group demonstrates its practical significance, or its therapeutic value as an intervention. Furthermore, the finding that roughly 75% of parents who reported clinical levels of concern at pretest moved to normal functioning levels following treatment shows strong support for the clinical significance of the CPRT intervention on reducing parenting stress related to child characteristics. These results are consistent with other CPRT controlled studies that showed a statistically significant reduction on scores for the Child Domain of the PSI (Chau & Landreth, 1997; Kidron, 2003; Yuen, Landreth, & Baggerly, 2002).

Hastings (2002) suggested that children's problem behaviors and parental stress influence one another, creating a reciprocal cycle. The Child Domain is designed to measure the influence that children's behavioral problems have on parental stress. According to Abidin (1995) high scores on the Child Domain emphasize a need to focus interventions on children's behaviors. The present study found a statistically significant decrease in children's problem behaviors (internalizing, externalizing, and total) as measured by the CBCL. It is possible that the statistically significant decrease on the scores of the Child Domain is a reflection of parents' reactions to the decrease in their children's behavioral problems. In addition, CPRT focuses on increasing parental empathy and helping parents normalize their concerns in light of their children's developmental level. These factors could have positively impacted parents' ability to accept their child, resulting in the significant decrease on the Child Domain scores. These findings support that CPRT is a viable treatment to reduce parent-child relationship stress associated with child characteristics.

Parenting Stress Outcomes Related to Parent Characteristics

Abidin (1995) explained that high scores in the Parent Domain indicate parents feeling “overwhelmed and inadequate to the task of parenting” (p. 10). This domain includes scales measuring parental depression, competence, isolation, and spouse among others.

Results of Hypothesis 5 indicated that from pretest to posttest, parents who participated in the CPRT treatment group reported a statistically significant ($p < .001$) improvement on the Parent Domain of the PSI when compared to parents who did not participate in CPRT. A visual inspection of group means in Table 4 shows that while control group parents demonstrated an increase in the Parent Domain, parents in the CPRT group demonstrated a 34 point reduction. The finding regarding CPRT's large treatment effect ($\eta_p^2 = .51$) on the experimental group when compared to the control group demonstrates its practical significance, or its therapeutic value as an intervention. Furthermore, the finding that 66% of parents who reported clinical levels of concern at pretest moved to normal functioning following treatment shows strong support for the clinical significance of the CPRT intervention on reducing parent-child relationship stress related to parent characteristics. These results are consistent with other CPRT controlled studies that showed a statistically significant reduction on scores for the Parent Domain of the PSI (Chau, and Landreth, 1997; Kale & Landreth, 1999; Kidron, 2003).

The CPRT format provides both didactic and supportive group experiences in a safe environment. This environment provided parents with the opportunity to offer support for each other as they shared not only child-rearing problems, but also marital and family problems as they related to their parenting practices. In addition, parents shared feelings of loneliness and isolation in regard to being immigrants in US. It seems plausible that the supportive environment was conducive to parents lowering their feelings of isolation and depression. It makes sense that

as parents felt accepted and that they were not alone in their struggles that they were able to develop a more positive view of themselves.

CPRT treatment provides parenting skills that can positively influence feelings of parental competence. Moreover, CPRT focuses on strengthening the child-parent relationship, thus it would be expected that as parents experienced a closer relationship with their children that they experienced higher levels of attachment, which is one of the factors examined in the Parent Domain. Interestingly, many parents reported experiencing a positive change in their marital relationship as a result of learning the CPRT skills, which is another factor that the PSI Parent Domain measures. In summary, the statistical, practical and clinical significance of these findings support CPRT as a promising intervention to reduce parenting stress related to parent qualities.

Total Parenting Stress Outcomes

The Total Stress Domain reflects the combination of the Child Domain and Parent Domain (Abidin, 1995). Treatment effects for this study showed that parents who participated in CPRT showed a statistically significant decrease in the scores of Parent Domain.

Results of Hypothesis 6 indicated that from pre-test to post-test, parents who participated in the CPRT treatment group reported a statistically significant ($p < .001$) improvement on the Total Stress Domain of the PSI when compared to parents who did not participate in CPRT. A visual inspection of group means in Table 4 shows that while control group parents demonstrated a slight increase in the Child Domain, parents in the CPRT group demonstrated a marked 69 point reduction. The finding regarding CPRT's large treatment effect ($\eta_p^2 = .42$) on the experimental group when compared to the control group demonstrates its practical significance, or its therapeutic value as an intervention. Furthermore, the finding that 62% of parents who

reported clinical levels of concern at pretest moved to normal functioning levels following treatment shows strong support for the clinical significance of the CPRT intervention on reducing total parenting stress. These results are consistent with other CPRT controlled studies that showed a statistically significant reduction on scores for the Total Stress Domain of the PSI (Bratton & Landreth, 1995; Chau & Landreth, 1997; Costas & Landreth, 1999; Kale & Landreth, 1999; Kidron, 2003; Landreth & Loubough, 1998; Lee & Landreth, 2003; Tew, Landreth, & Solt; Yuen, Landreth, & Bagerly, 2002).

Many Hispanics in the US experience stressors associated with living in poverty and the acculturation process (Santiago-Rivera, 1995; Klebanov, Brooks-Gunn, & Duncan, 1994; LaRoche, 1999; Gibbs, 2003). Hughes and Barad (1983) explained that mothers under stress have a tendency to become easily frustrated with their children's behaviors. The cyclical relationship between parental stress and child behavior problems is often cited in the literature. Higher levels of parenting stress have been associated with negative effects on the parent-child relationship and problematic behaviors in children (Abidin, Jenkins, & McGaughey, 1992; Deater-Deckard, 2005; Kazdin & Whitley, 2003; Teti, Nakagawa, Das, & Oliver, 1991). Kazdin and Whitley (2003) explained that parental stress intertwines with the development and maintenance of children's aggressive and oppositional behavioral problems. The authors added that parental stress increases "parent irritability and attention to deviant behavior and the likelihood that parents initiate or maintain aversive interchanges with their children" (p. 504). Participants in the present study showed high scores on both the PSI and the CBC, thus providing support to the reciprocal relationship between parental stress and children's problem behaviors. The statistical, practical, and clinical significance of these findings indicates that

CPRT is a promising treatment modality that can positively impact both parent-child relationship stress and children's behaviors in low-income immigrant Hispanic families.

Observations

Throughout the course of this study, I observed what seemed important cultural considerations for providing CPRT to first generation Hispanic parents: 1) socialization and social support; and 2) significance of therapists embracing Hispanics' values. My observations seem consistent with cultural considerations suggested in the literature (Altarriba & Bauer, 1998; Alvy, 1994; Griggs & Dunn, 1996; Powell et al., 1990; Santiago-Rivera et al., 2002; Vlach, 2003). Additional observations were noted regarding logistics of training that seemed important considerations for working with this population. Furthermore, information gathered through informal group interviews with parents is shared.

Socialization and Social Support

Dedicating the first session of CPRT for socialization purposes appeared to create a sense of closeness and *familiarismo* among participants. Parents reported feeling very comfortable with each other at the end of the first session and looking forward to coming back, specifically commenting that they appreciated and enjoyed the opportunity to get to know each other. At the end of the first session, in response to the question "how did you feel today?" parents reported "Being here feels like being surrounded by friends, I will definitely come back." "I like this group, we got to meet each other instead of going straight to teaching." These observations support recommendations in the literature to provide an informal meeting for parents to socialize prior to beginning parenting trainings (Alvy, 1994; Powell et al., 1990). I also observed what authors have termed *allocentrism*, generally viewed as a value of great importance for Hispanics (Altarriba & Bauer, 1998). According to Altarriba and Bauer *allocentrism* emphasizes a need to

form “interpersonal relationships in groups that are nurturing, loving, intimate, and respectful” (p. 391). In this manner, one can infer Hispanics value trust, empathy, willingness to sacrifice for others, and interdependence in group settings. Based on parents’ interactions, it appeared that the first session served to incorporate this value and foster a sense of connection among group members.

In keeping with recommendations in the literature for Hispanics’ preference for socialization and *allocentrism* (Alvy, 1994) refreshments were provided during CPRT group sessions. Parents stated they liked having *el cafecito* or the coffee and food as part of the group. Having refreshments provided more opportunities for the parents to socialize among themselves during the sessions. Parents often stood up during sessions to get refreshments for each other, and at times, talked about how they wanted the coffee made or the food served. In 4 out of the 5 groups, parents spontaneously decided to bring food to celebrate holidays. Similarly, in 3 of the 5 groups, parents brought food from their country of origin during the last session as a way to terminate the groups. Parents reported that having food made them feel “like being at-home.” I observed that food seemed to bring a sense of “family gathering” to the group sessions, a concept highly valued by Hispanics. In addition, the serving and receiving of refreshments contributed to parents creating opportunities to deepen interpersonal relationships with each other. This seemed to create group cohesion that parents reported enjoying.

Consistent with literature suggesting group treatment modalities are more appropriate for Hispanics than individual services (Powell et al., 1990), I observed that parents enjoyed and seemed to benefit from the supportive atmosphere that CPRT group format offered. Parents disclosed feeling “very comfortable” and “supportive” by group members; one mother said “it’s like having conversations with a group of friends. I really like that.” Parents reported feeling that

the group was a place for them to share not only about their children, but also about their marriage and other issues impacting their parenting and it helped them not to feel as isolated or lonely. Participants also shared feelings associated with being first generation immigrants and their struggles related to the acculturation process. This is important because the acculturation process has been identified as one of the stressors that place Hispanics at greater risk for emotional problems (Gibbs, 2003; Klebanov et al., 1994; LaRoche, 1999; Santiago-Rivera, 1995).

CPRT treatment was facilitated by a first generation Hispanic immigrant. Consistent across all groups, parents seemed to identify with me with such comments as “you know what is like to live far away from home” when talking about being immigrants; or “you know how it is in our countries” when talking about child-rearing practices. These statements appear to indicate that having a group leader who understood Hispanic cultural values, especially as they relate to child-rearing practices, allowed parents to feel an immediate sense of affiliation with the group facilitator. This sense of affiliation was most evident when parents expressed their views regarding differences in child-rearing practices between American and Hispanic cultures. Many parents stated a sense of safety to talk openly about spanking and to express disagreements concerning American parenting practices. Some parents said they would have not shared these feelings and opinions to someone who did not understand and embrace Hispanic culture. This supports past research that found client-therapist ethnic, cultural, and language match appears to be important for Hispanic clients (Sue, Fujino, Hu, Takeuchi, & Zane, 1991). It was observed that regarding the use of spanking, toward the end of CPRT treatment, parents reported having more patience with their children resulting in less spanking. One parent said “I have a lot more

patience now. Now I am not quick to spank her.” Across all groups, parents reported feeling more patience and feeling more in control of their own stress level.

Rendering services in Spanish was important for participants. Even the parents who spoke English said they felt “much better” when they realized the training was offered in Spanish. Several parents expressed feeling uncomfortable calling my office for fear that the phone call would be answered in English. In addition, because I was bilingual, parents seemed to view me as an advocate, someone who could provide support for matters unrelated to the training. For instance, one parent asked me to translate a letter she received from the court regarding a traffic violation. On a few occasions, parents asked me to translate homework their children received at school or to translate conversations with school personnel. Groups were led at the schools where their children attended, thus I had regular contact with school staff. More importantly, parents seemed to appreciate the leader taking the time and effort to be an advocate for them. This phenomenon can be a reflection of parents’ *allocentrism* and *personalismo*. *Personalismo* is a value researchers in the field identify as important when rendering services to Hispanics (Andres-Hyman, Ortiz, Anes, Paris, Davidson, 2006; Flores, 2000). This value refers to Hispanic clients expecting to develop an affectionate/warm personal relationship with the clinician.

I observed that most group members arrived late to group meetings. In fact, it became an unspoken rule to start groups between 15 to 30 minutes after the agreed starting time. The belief that Hispanics tend to focus on the present rather than on past or future in terms of decision making (Altarriba & Bauer, 1998) may explain the fact that group members arrived late to groups. Parents may have been more focused on the issue delaying them at that moment than with arriving on time to the group sessions. I did not view being late as a sign of resistance or as

disrespect to the group and I reassured members that it was better to come to group late than to miss a session. Across all groups, parents made comments such as “I am glad you don’t mind me coming late” or “I am always late, it feels good to know you don’t mind and that everyone else is late.” It appeared that embracing this phenomena allowed group members not to feel embarrassed or rejected. Accepting this unspoken rule seemed to have prevented parents from dropping out of the group. It is important to mention that parents were not concerned with ending the group on time either. In fact, in some occasions, they asked me to stay longer if not all material for that day had been covered entirely.

I observed that most parents preferred the groups to be conducted during school hours and did not want to schedule group times later than 5:00 pm. Parents that worked wanted to meet in the early evening and reported wanting to finish CPRT groups on time to enjoy family dinner, indicating a preference to end groups before 7:00 pm. Flexibility in scheduling meeting times is another consideration in providing parent training to Hispanic families.

Another observation across all groups was the difficulty in covering all the material in the CPRT treatment protocol each week as thoroughly as I wanted to. The fact that groups started late and spent more time socializing resulted in less time to cover the content. This observation is consistent with the literature (Santiago-Rivera et al., 1995) and suggests that practitioners consider extending the program to 12 weeks instead of 10 weeks for this population or extend the group time to 2 ½ hours instead of 2 hours per week. Further research is necessary to investigate how CPRT can become more culturally responsive to Hispanic parents, including the number of sessions needed to ensure proper covering of all training material while balancing their preference for social activities.

An interesting phenomenon that occurred across most groups was the participation of family members, especially fathers and grandparents, but not on a regular basis. Even though the CPRT model dictates a closed group and was explained as such at the beginning of treatment, parents occasionally asked the leader if they could bring their family members. All group members appeared to be open to this idea and in fact encouraged each other to feel free to bring others. It was noted that group members did not feel restricted to share when different people came to the group sessions and that confidentiality was not an issue for them. This is consistent with past research that shows Hispanics prefer to include family members in parenting classes (Powell, et al., 1990) and with recommendations to embrace Hispanics' value of *familismo* when providing mental health services for this population (Santiago-Rivera et al., 1995).

Additional Considerations

Participants in this study lived at or below poverty level. Thus, some accommodations were made to help alleviate some of the stressors that might adversely impact parents' participation in treatment. Throughout training, parents were offered free childcare during the time they participated in sessions. All parents reported that offering this service was a decisive factor for them to attend the groups.

I made weekly phone contact with each parent. Initially, the purpose of the calls was to develop a sense of *personalismo* with parents and to minimize stressors that might impede attending. In the process, it became apparent that parents not only appreciated the extra support but that the contact served as a reminder. Parents specifically reported that their lives were so chaotic that they sometimes forgot appointments. One mother reported "I like when you call me because it makes me feel that you care about me." Other members of this group expressed feeling the same way after this mother's disclosure. These comments could reflect members

viewing the phone calls as part of the leader incorporating *personalismo*. In addition, Hispanics' view of time in present tense when making decisions (Altarriba & Bauer, 1998) could also impact parents forgetting to come to sessions. Thus, the weekly telephone calls could serve as a factor to help parents with consistency.

Informal Group Feedback

During the last session, parents in all groups were asked to share either verbally or in writing feedback about their experience in CPRT training. The main recommendation made by parents was to allow more time to cover the training material in greater depth. Another recommendation was providing more activities for them to do with their children and with their entire family. Similarly, Powell, et al. found that Hispanic mothers prefer parenting programs that provides them with parent-child activities (1990). This preference is congruent with parents reporting that they enjoyed conducting the home play sessions.

Additionally, parents' comments focused on their learning from CPRT. One parent stated:

About the training what I liked the most is that I learned...to value more the time I spent with my daughter...that does not come about by giving her food, a bath, taking care of her, instead, as a mom I have to have special times with her, demonstrate that I am listening to her, that I am with her, that I can notice what she feels.

Another mother wrote "I have learned that he is an independent person and even though I will always be with him, he needs to be autonomous." Other parents reported that their relationship with their children changed, specifying that towards the end of the training, they felt closer to their children and they were more aware of the importance of spending quality time with them. During the last session, one mother approached the leader and stated:

I didn't tell you before because I was too embarrassed, but before we started the training I was feeling so overwhelmed and frustrated that I had gotten to the point to where I looked at my child's eyes and told him I hated him, and 11 weeks later, last night, we

were hugging each other and I was telling him how much I love him...this training changed our lives.

These quotes reflect the impact that CPRT had on the participants' lives, their children's lives, and on the parent-child relationship.

Feedback from School Staff

Because groups were conducted in the schools, I had the opportunity to interact with school personnel on an ongoing basis. Towards the end of the treatment, teachers and administrators spontaneously commented on noticeable change in children's behaviors. This feedback is noteworthy when considering that this study used parents as the only source to report improvement in children's behaviors. Administrative staff noticed children behaving better in the classroom, engaging in less power struggles, and relating better to peers. The school counselor at one site reported "I went to observe him and he seems to be better at handling limits in the classroom, he did not throw a tantrum as he usually did when the teacher instructed him to sit down." These comments provided anecdotal support that children's changes in behaviors were also noticed by school personnel.

Limitations of the Study

While this study offers valuable information for mental health practitioners, it has limitations that should be considered when interpreting results. Participating parents volunteered to be part of the research project. These parents' motivation to participate may be a factor that differentiates them from parents in the general population who did not volunteer to participate. Although the study includes participants from South and Central America, the majority of participants were of Mexican descent, limiting the generalizability of the results to Hispanics from different origins.

The real world setting of the study validates its applicability in school settings; however, it also contributes to limitations. The school districts where the training took place offer parenting classes on a regular basis and parents are highly encouraged to assist. In addition, the schools offer counseling services for children as well as referrals for mental health services outside of the school. I was able to control this confounding variable for the experimental group by asking members every week during the training. None of the experimental parents reported receiving any other mental health service during training. During postdata collection, parents in the control group were asked if they had attended parenting classes or if they or their children had participated in any kind of counseling intervention. Some parents reported attending to parenting classes that were taught once a month at the schools, but not receiving any other type of treatment for themselves or their children.

One limitation of the study is the use of a non treatment control group. The statistical difference found between the experimental and control group could have been caused by the fact that the experimental group received a treatment independently of whether it was CPRT or not. A research design comparing CPRT to a proven parent treatment program would increase confidence that the findings were due to the actual CPRT treatment protocol.

Participants became aware of their treatment group membership when they signed the consent form. The Hawthorne effect (Gay & Airsian, 2003) may have affected participants' reports. In addition, I conducted all CPRT groups. While this helped to strengthen the internal validity of the study, it could have introduced certain degree of my bias.

Another limitation was the use of only one report measure to examine the effects of CPRT on children's behaviors. Since parents who participated in the training served as reporters of their children's behaviors, it is possible that such reports reflected parents' changed

perceptions towards their children and not true behavioral change. The use of multiple sources of measurements would have added more validity to the findings.

Similarly, parent-child relationship stress was measured through parents' self-report. Holden and Edwards (1989) cautioned readers about the use of self-reporting methods. The authors cited Anderson (1931) who suggested complementing self-reports with other sources of measurements due to the difficulty distinguishing between opinions and facts. However, Abidin (1992) recognized that even though self report instruments have limitations, research shows that measurements that include questions directly related to particular belief systems can predict and aid to define factors associated with parenting behaviors.

Recommendations for Further Research

Based on the limitations and findings of this study, several recommendations for future research can be made:

- 1- The present study is confined to reporting the immediate effects of CPRT on children's behaviors and parental stress. A follow-up study to investigate the long-term effects of treatment is needed.
- 2- The participants from the present study were largely representative of Mexican descent. In addition, this study had 1 male participant only. It is recommended to replicate the study with samples representative of different Hispanic origin and with more male participants to further validate generalization of current findings.
- 3- The present study had a relatively small sample size of 48 participants. Replicating the study with a larger sample size is necessary to increase the power of statistical measures and to allow for greater generalizability of findings.

- 4- The present study relied solely on parental report to assess change in children's behaviors. Conducting a study that measures children's behavioral changes through a variety of sources such as teachers' report and/or direct observations of children's behaviors by objective raters would further validate findings.
- 5- My observations revealed Hispanic cultural values and preferences seemed important to embrace in the CPRT treatment delivery. Further investigation of the impact of incorporating these values and preferences into the traditional CPRT format is needed.
- 6- The present research limited findings to children's behaviors and parental stress. Future research could investigate other variables such as parents' skills attainment and correlate findings with children's improvement.

Implications and Conclusion

The most recent US Surgeon General's report on the status of children's mental health (US Public Health Service, 2000) highlighted the critical need for early intervention services provided in highly accessible settings, especially for minority children and their families. Hispanics are the largest minority group in US (US Census Estimates, 2006a) and according to the National Center for Education Statistics (2003); Hispanic children represent the fastest growing demographic group in US. Researchers in the field identify Hispanic children to be at risk for long term negative effects such as violence, suicide, and school drop-out (The National Task Force on Early Childhood Education for Hispanics, 2007), making it even more urgent to target early mental health interventions focused on prevention as well as intervention. However, the literature shows an underutilization of mental health services by the Hispanic population (LaRoche, 1999; Padilla, Ruiz, and Alvarez, 1975; US Public Health Service, 2000). Thus, it is

imperative to identify effective mental health services that are culturally responsive as well as developmentally responsive for early intervention with this population. CPRT is a developmentally responsive intervention that involves parents fully in their children's treatment. The high value Hispanics place on *familismo* and their preference for interventions that focus on the family (Pederson, 1987; Vlach, 2002), make interventions such as CPRT particularly suited to this population. The statistical, practical and clinical significance of the present study's findings provide strong support for the use of CPRT with first generation immigrant Hispanic parents and their young children exhibiting behavioral problems.

The findings in this study indicate that CPRT can significantly reduce stress in the parent-child relationship for Hispanic families living in poverty. Families living in poverty experience additional stressors that can have a negative effect on the parent-child relationship. Research corroborates a positive correlation between poverty rates and parental punitive behaviors (Hashima & Amato, 1994), making it even more imperative for mental health practitioners to identify treatment modalities that help Hispanic parents living in poverty to reduce stress related to the parent child dyad. The findings in this study are noteworthy, as results indicate that CPRT can significantly decrease parent-child relationship stress while helping to strengthen the relationship. Results also demonstrate CPRT's effectiveness in reducing children's problematic behaviors. Consistent with play therapy/filial therapy findings (Bratton et al., 2005), the results from the present study support the idea that parents can successfully learn the skills and become therapeutic agents of change in their children's lives. The efficacy of the CPRT treatment on both parental stress and children's behavioral problems seems especially important in light of literature supporting that parental stress intertwines with the development and maintenance of children's behavioral problems (Kazdin & Whitley, 2003).

The fact that this study was conducted in a school setting answers the call for providing early mental health services for minority children and families in low-stigma settings that are highly accessible to all children (New Freedom Commission on Mental Health, 2003) and increases its utility for school professionals. In addition, this study answers the call to conduct outcome research to investigate treatment modalities for minority groups (ACA, 2005), thus contributing to the counseling profession by identifying culturally responsive services for Hispanic immigrants in the US. Sue, Fujino, Hu, Takeuchi, and Zane (1991) found that for non-English speaking Hispanic clients, ethnic and language match between clients and therapists was important to reduce premature termination and achieve positive outcomes. However, researchers in the field report a shortage of Spanish speaking counselors (Altaribba & Bauer, 1998; Garza, 2005). The group format of CPRT not only responds to Hispanics' preference for group settings, but also allows mental health professionals to effectively reach more parents and children. Because CPRT focuses on helping parents become therapeutic agents in their children's lives, the training has an impact on all children in the household. As a result, CPRT helps Spanish speaking mental health professionals to respond more effectively to the high demand that exists to offer services to non-English speaking Hispanic parents. An additional strength of this study was to identify a treatment modality that offers a solution to the shortage of Spanish speaking mental health professionals trained to work with young children and their parents.

In summary, CPRT shows strong promise as an effective intervention to positively impact parenting stress and young children's problem behaviors with low income immigrant Hispanic families. Based on an exhaustive review of the literature, the present study represents the largest controlled CPRT/filial therapy study to date and appears to be the first filial therapy or play therapy study conducted with first generation Hispanic immigrants. As such, the study

contributes to the broader field of play therapy by adding to its evidence base, particularly related to the cross-cultural application and effects of child-centered play therapy/filial therapy.

Additionally, the use of a manualized treatment protocol ensures confidence in the integrity of the treatment and allows practitioners and researchers to replicate the intervention. As with all research, the present study has limitations that must be considered; however, adherence to accepted research methodology, along with the statistical, practical and clinical significance of findings, adds confidence to results and informs practitioners and researchers.

APPENDIX A
CONSENT FORM

FORMULARIO DE CONSENTIMIENTO

Nombre del Participante: _____ Fecha: _____

Título del estudio: Una intervención temprana para la salud mental de niños minoritarios de edad elemental: Los efectos del entrenamiento de la terapia filial/terapia de juego de familia en el comportamiento y en el éxito académico de los niños.

Investigador principal:

La Dra. Sue Bratton, profesora asistente del programa de Counseling, y directora del Centro para la Terapia del Juego.

Antes de que usted decida participar en este estudio de investigación, es importante que usted lea y entienda la siguiente explicación acerca de los procedimientos que se proponen. Este documento describe los procedimientos, las ventajas, los riesgos y posibles molestias que el estudio puede ocasionar. Es importante que usted entienda que no se le puede dar ninguna garantía o asegurarle cuales serán los resultados de este estudio.

Su participación es voluntaria y usted puede elegir retirarse en cualquier momento durante el estudio sin ningún tipo de penalidad. Su firma indica que usted cumple con todos los requisitos para participar en este estudio, que usted ha decidido participar y le han dicho que usted recibirá una copia firmada de esta forma de consentimiento. La situación de su niño(a) en la escuela no será afectada por su decisión de participar o no participar en este estudio. Al terminar este estudio, un resumen de resultados será puesto a la disposición de todos los padres y maestros interesados.

Propósito del estudio y cuánto tiempo durará:

Este proyecto está diseñado para examinar los efectos de la terapia de Relación Entre Padres e Hijos (CPRT), también llamada terapia filial o terapia de juego familiar, en los niños minoritarios que atienden escuelas primarias en Denton, Texas y que están en riesgo de no alcanzar éxito académico en la escuela. Proveer servicios de conserjería en las escuelas para niños minoritarios a la edad más temprana posible es crítico para tratar problemas prematuramente y ayudarles a alcanzar el mayor éxito en la escuela. Investigaciones anteriores demuestran que entrenar a los padres en la terapia de relación entre padres e hijos es altamente eficaz en mejorar los problemas de comportamiento de los niños y en reducir el estrés en la relación entre padres e hijos. Además, el propósito del entrenamiento de CPRT es ayudar a padres a aprender maneras más apropiadas de responder a los problemas de comportamiento de los niños jóvenes y de crear una relación más positiva entre padres e hijos. Este estudio requiere que los padres participen en 11 sesiones de entrenamiento y supervisión.

Descripción del estudio incluyendo los procedimientos que se utilizarán:

Si usted elige participar, se le asignará participar en el grupo de entrenamiento de la fase uno o en el grupo de entrenamiento de la fase dos, el cual servirá como el grupo de control durante el estudio. Los padres seleccionados para participar en la fase dos no recibirán ningún entrenamiento durante la fase uno, pero recibirán el entrenamiento durante la fase dos. El entrenamiento de Relación Entre Padres e Hijos es un modelo que entrena a los padres a usar

aptitudes como empatía, estímulo, límites terapéuticos, y el uso de opciones. Estas aptitudes se enseñan para ayudar a los padres a manejar los comportamientos de los niños con eficacia y a mejorar la relación entre padre e hijos. Los padres seleccionados participarán una vez a la semana por un total de 11 semanas en el entrenamiento y supervisión. A estos padres se les pedirá llenar el cuestionario sobre el comportamiento de niños (CBCL) dos veces, al principio y al final del entrenamiento, para evaluar los efectos del entrenamiento en los comportamientos de los niños. El CBCL tomará aproximadamente 20 minutos para completar. Adicionalmente, para proveer supervisión, a los padres se les pondrá a la disposición una cámara de vídeo para grabar las sesiones de juego con su niño(a) que serán llevadas a cabo en la casa. El investigador también está interesado en las interacciones entre el padre y el niño(a), específicamente la capacidad del padre de comunicar empatía y aceptación así como también la capacidad del padre de usar las aptitudes enseñadas durante el entrenamiento. Por lo tanto, los videos serán utilizados para examinar los efectos del entrenamiento en la relación del padre con el niño(a). Para examinar el impacto del entrenamiento en los comportamientos de los niños en el salón de clase, se les pedirá a los profesores de los niños cuyos padres estén participando en el entrenamiento que completen el cuestionario sobre el comportamiento de niños (versión C-TRF de maestros) dos veces, al principio y finalizar el entrenamiento. El C-TRF tomará aproximadamente 20 minutos para completar. El entrenamiento y la supervisión serán dados por consejeros profesionales que tienen entrenamiento avanzado en terapia de juego y en el modelo de Relación Entre Padres e Hijos. Los coordinadores principales del proyecto de investigación y el investigador principal se asegurarán de que toda la información sea mantenida confidencialmente.

El entrenamiento de relación entre padres e hijos (CPRT)

CPRT es un modelo de entrenamiento para los padres que se ha demostrado ser altamente eficaz en ayudar a los padres a aprender maneras más eficaces de responder a las necesidades de sus niños y maneras más eficaces de disciplinar a sus niños. Los padres atienden a un grupo semanal con otros padres que también están interesados en aprender aptitudes y métodos más eficaces. El entrenamiento requiere que los padres practiquen con su niño las nuevas aptitudes que están aprendiendo durante un tiempo de juego especial de 30 minutos cada semana. Investigaciones anteriores sugieren que estos tiempos especiales de juego semanales ayudan eficazmente a reducir problemas de comportamiento en los niños y a mejorar la relación con los niños como resultado de ayudar a los padres a crear y mantener un ambiente familiar positivo usando disciplina positiva. También se ha demostrado que este entrenamiento ayuda a los niños en la escuela al reducir los problemas de comportamiento.

Descripción de los procedimientos/de los elementos que pueden dar lugar a malestar o incomodar:

No hay riesgos personales implicados directamente con este estudio con excepción de esos riesgos asociados con interrupción de sus actividades normales diarias debido a tener que asistir al entrenamiento. Usted puede escoger retirarse del estudio en cualquier momento sin tener que sufrir ninguna penalidad.

Ventajas para los participantes y para otros:

La relación entre padres e hijos es esencial para el desarrollo de niños pequeños. Debido al significado tan importante de esta relación, los padres tienen el potencial de contribuir considerable en el desarrollo de sus hijos. Por lo tanto, entrenar a los padres a responder a los

niños de una forma apropiada de acuerdo al nivel de desarrollo del niño y de una manera que aliente al niño puede beneficiar ciertos aspectos del desarrollo de su niño, incluyendo: cognoscitivo, comportamiento, social y emocional.

Confidencialidad de los expedientes de la investigación:

La información que usted proporcione al contestar el cuestionario será mantenida confidencialmente y no será divulgada en ninguna publicación o discusión que se haga acerca de este estudio. Todos los datos incluyendo los cuestionarios y las cintas de video serán asignados un número de código y mantenidos en un gabinete cerrado con llave para mantener la confidencialidad. Solamente el investigador principal y los asistentes tendrán acceso y podrán ver las cintas de video. Para cumplir con los propósitos de la investigación, solamente el investigador principal y los coordinadores del proyecto de investigación tendrán acceso a la lista de nombres de participantes con los números de código. Al final de este estudio la lista de nombres será destruida.

La única excepción para romper confidencialidad es basada en la autorización del padre o el guardián legal del niño(a) quien puede autorizar una petición y hacer disponible la información sobre los resultados de C-TRF y/o de CBCL.

Revisión para la protección de participantes: Este proyecto de investigación ha sido revisado y aprobado por el comité examinador de la universidad de North Texas. Contacte UNT IRB en el teléfono 940-565-3940 si tiene cualquier pregunta con respecto a cuáles son sus derechos como participante en este estudio de investigación.

Los derechos de los participantes:

Yo he leído o alguien me ha leído a mí todo lo escrito en este documento.

El investigador principal o los coordinadores principales del estudio me han explicado el estudio y han contestado todas mis preguntas. Me han dicho que no hay riesgos o malestares previsibles implicados directamente con este estudio a excepción de molestias asociadas con la posible interrupción de actividades normales diarias. También me han informado las posibles ventajas de participar en este estudio. Entiendo que no tengo que participar en este estudio, y mi consentimiento para participar o mi decisión de no participar no resultara en ninguna penalidad ni en ninguna pérdida de mis derechos o de cualquiera de los recursos legales a los cuales tengo derecho. El personal del estudio puede elegir terminar mi participación en cualquier momento.

En caso de que haya problemas o tenga preguntas, me han dicho que puedo llamar a Dr. Sue Bratton al número de teléfono (940) 565-3864.

Yo entiendo todos mis derechos como participante de este estudio de investigación, y mi consentimiento para participar es voluntario. Yo entiendo de qué se trata el estudio y las razones por las que se hace este estudio. Me han dicho que recibiré una copia de este formulario.

Firma Del Participante

Fecha

Para el Investigador o Designado:

Yo certifico que he revisado el contenido de este formulario con la persona que ha firmado arriba, quien, en mi opinión, entendió la explicación dada. Yo he explicado los posibles riesgos y beneficios que pueden esperarse de este estudio.

Firma del Investigador Principal o del Designado

Fecha

APPENDIX B
FAMILY BACKGROUND FORM

Información Familiar

Su Nombre: _____ Relación con su Hijo(a): _____

¿Cuántos años tiene usted? _____ ¿Cuál es su raza? _____

¿Cuál es el nombre de su hijo(a)?: _____ La Raza de su Hijo(a) _____

¿Dónde Nació usted? _____

Si nació en otro país: ¿Cuantos años lleva viviendo en los Estados Unidos? _____

¿Qué idioma se habla en su casa? _____ ¿Cuál es el idioma principal de su hijo(a)?

Su Teléfono: _____ ¿Qué Días y a Qué Hora Prefiere el Grupo? _____

Información Básica

¿Esta su hijo(a) recibiendo algún tipo de terapia? No ___ Si ___

¿Esta su hijo(a) recibiendo educación especial u algún otro servicio? No ___ Si ___
Si respondió si, por favor explique _____

¿Ha recibido su hijo(a) alguno de los siguientes servicios (psiquiátrico, psicológico, o orientación)? No ___ Si ___

Si respondió Si, por favor escriba el nombre y la dirección de la agencia

La Situación Familiar Actual de su Hijo(a): ¿Con quién vive actualmente su hijo(a)? (escoja una):

___ Madre solamente ___ Padre Solamente ___ Padres Naturales

___ Madre natural y Padraastro ___ Padre Natural y Madrastra

___ Familia combinada (ambos padres con hijos de relaciones anteriores) ___ Padres adoptivos

___ Abuelos ___ Familia no vinculada al hijo(a)

___ Otro (especifique _____)

Incluyendo a su hijo(a) ¿Cuántos niños menores de 17 años viven en la casa? _____

Esta usted en este momento en una disputa legal por los derechos de su hijo(a)? No ___ Si ___
Si respondió Si, por favor explique: _____

¿Cuál es el nivel de educación más alto que usted ha obtenido? Indique con un número el grado más alto:

Primaria _____ Bachillerato _____ Universidad _____

¿Está usted empleado(a) en este momento? Si _____ No _____

Si respondió si ¿Cuál es su trabajo actualmente? _____

¿Cuánto es el salario anual en su casa en dólares? (escoja uno)

___ Menos de \$15,000	___ 20,001 – 22,000	___ 28,001 – 30,000
___ 15,001 – 16,000	___ 22,001 – 24,000	___ 30,001 – 32,000
___ 16,001 – 18,000	___ 24,001 – 26,000	___ 32,001 – 34,000
___ 18,001 – 20,000	___ 26,001 – 28,000	___ 34,000+

¿Cuántas personas son soportadas bajo ese salario? _____

¿Está usted actualmente participando en una clase para padres/madres? Si _____ No _____

¿Le preocupa algo acerca de su hijo(a)?

¿Su hijo(a) ha recibido algún diagnóstico físico o psicológico? Si _____ No _____

Si usted respondió Si, por favor explique

¿Algo más que a usted le gustaría decir acerca de su hijo(a)?

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