Mixed-methods feasibility study on the cultural adaptation of a child abuse prevention model

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Abstract

The current study utilized mixed-methods analyses to examine the process of adapting a home-based parenting program for a local Latino community. The study examined the: (a) acceptability and cultural congruence of the adapted SafeCare® protocol, (b) adherence to the core components of SafeCare® while adapting to local community culture, and (c) social validity of the new model in addressing SafeCare® target areas (parenting, home safety, and child health). Participants were 28 Latino mothers and eight providers. After training in the adapted model, providers demonstrated improved knowledge and skills. All providers reached national certification standards for SafeCare®, demonstrating fidelity to the core components of the original model. Positive consumer–provider relationships were developed as reflected by the results on the Working Alliance (collaboration between caregivers and parents). Themes from the integrated results of the social validity measures and individual interviews with parents were perceived benefits of the program on targeted areas and cultural congruency of the approach. Recommendations are to consider using adaptation guidelines as outlined to promote local culturally congruent practices.

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Introduction

With an increased recognition of racial disparities in the access and availability of social services, literature has emerged to reduce barriers by creating culturally congruent services (Atkinson, Bui, & Mori, 2001; Bernal & Scharron-Del-Rio, 2001; Whaley & Davis, 2007). Culturally congruent services refer to those services that recognize the importance of the adaptation of interventions to meet the unique cultural needs of communities (Whaley & Davis, 2007). Although cultural and ethnic diversity in the United States continues to grow, there is limited research on the best strategies to achieving cultural congruence. Examining and addressing relevant and unique cultural factors is important to increase treatment acceptability (Rogler, 1999; Vega, 1992).

Culturally congruent approaches may be particularly important for acceptability, initial engagement, and retention in services. Cultural adaptation of engagement strategies and services has improved recruitment and retention rates (Botvin, Griffin, Diaz, Miller, & Ifill-Williams, 1999; Harachi, Catalano, & Hawkins, 1997; McCabe, Yeh, Garland, Lau, & Chavez, 2005;
McKay, Stoewe, McCadam, & Gonzales, 1998). Important next steps are to examine the process of adaptation within the context of the local culture and to assess the cultural congruency of adaptations.

The current study was designed to use mixed qualitative-quantitative methods to examine the social validity, acceptability, and cultural congruency of an evidence-based parenting program adapted for a local Latino community. Social validity refers to the consumers’ perceptions of the social importance and acceptability of treatment goals, procedures, and outcomes (Foster & Mash, 1999). Kazdin (1981) recommends three core aspects of treatment acceptability: appropriateness for the specified problem, alignment with popular beliefs of what treatment should look like, and coherence as just, sensible, and nonintrusive.

Impact of Culture on Service Acceptance and Attrition

Secondary prevention programs for child abuse and neglect target vulnerable and underserved populations who are at high-risk for child maltreatment (Geeraert, Van den Noortgate, Grietens, & Onghena, 2004). Research on the impact of culture within service acceptance and attrition for high risk families has had varied results. Ethnic minority status has been found to be related to improved parental involvement in some research on home visitation programs (Daro, McCurdy, Falconnier, & Stojanovic, 2003; McCurdy et al., 2006; McGuigan, Katzev, & Pratt, 2003a, 2003b), but other research has found opposite results (Ammerman et al., 2006; Raikes et al., 2006). Parent perceptions of service approach matched to family beliefs have been found to have a stronger impact on engagement than ethnic match and most other demographic factors alone (McCabe, 2002). This finding supports adaptations that address consumer perceptions rather than surface-level differences alone.

Cultural Adaptation Framework

A multilevel cultural framework addresses both surface and deep structure (Resnikow, Soler, Braithwaite, Ahluwalia, & Butler, 2000). Surface structure is described as the creation of service materials (e.g., brochures, reading material) that match the observable characteristics of a population, while deep structure refers to the inclusion of cultural factors that influence the target behavior within the proposed population. Deep structure factors can include aspects of the community, its members and history, and other factors that might affect the target behavior (Castro, Barrera, & Martinez, 2004; Kumpfer, Alvarado, Smith, & Bellamy, 2002; Resnikow et al., 2000). For example, within the Latino communities, taking into consideration acculturation levels, cultural values and traditions, as well as cultural practices are key deep structure factors (Broyles, Brennan, Herzog, Kozo, & Taras, 2012).

Lau (2006) highlights creating culturally congruent, evidence-based practices (EBP) through dual approaches for treatment adaptation including contextualizing content and enhancing engagement. Contextualizing content is identifying the distinct cultural context of the presenting problem within the target community and may involve creating innovative treatment adaptations. Enhancing engagement involves adaptations to increase engagement while maintaining fidelity to the intervention (Lau, 2006). Individual-level perceptions of social validity of EBP have significant implications for both engagement and outcomes (Kazdin, 2000; Kazdin, Holland, & Crowley, 1997; Kazdin & Wassell, 1999). The current study examines the social validity and cultural congruency of an adaptation of SafeCare® (SC), a home-based parenting program.

SafeCare®

SC is an evidence-based model designed to prevent child maltreatment and increase protective factors, including positive parent–child interactions. It emphasizes training caregivers in three areas to reduce child neglect: home safety, infant and child health care, and parent–child bonding (Lutzker & Bigelow, 2002; Lutzker, Bigelow, Doctor, & Kessler, 1998). SC is provided in the family’s natural environment, targets proximal skills and behaviors, utilizes a structured skills-based approach with ongoing measurement of observable behaviors, skill modeling, practice and feedback, and trains parents to criterion in observable skills. This approach is also used in the training, supervision, and coaching of the providers.

SC has demonstrated support for child maltreatment prevention, reduced recidivism, and parent behavior change across a series of studies (Chaffin, Hecht, Bard, Silovsky, & Beasley, 2012; Lutzker, 1984; Lutzker & Bigelow, 2002; Lutzker et al., 1998; Lutzker & Rice, 1984, 1987; Silovsky et al., 2011). SC augmented (supplemented with Motivational Interviewing and safety planning for intimate partner violence) meets the Department of Health and Human Services (DHHS) criteria for Home Visiting Evidence of Effectiveness (homeee.acf.hhs.gov). SC is rated as both highly relevant for child welfare and is supported by research evidence by the California Evidence-Based Clearinghouse for Child Welfare (www.cebc4cw.org). Additional details can be found on the SC website (www.nstrc.org).

Previous qualitative research has examined providers’ impressions of the cultural sensitivity of SC and need for adaptation for other cultures (Self-Brown et al., 2011). Self-Brown et al. (2011) interviewed 11 SC providers from six states to determine the possible need for adaptation. Overall, SC was perceived to be readily accepted by diverse families. Themes emerged regarding the importance of providers being knowledgeable about aspects of the culture and community in relation to program targets. Specific suggestions for working with families in the Latino community were to spend more time developing relationships with family members, understanding local home remedies and health care practices, lowering literacy level
of materials, and improving translation of information. Additionally, practices to support providers’ application of cultural adaptation to improve EBP by maintaining fidelity while enhancing cultural congruency was recommended.

**Rationale for Current Study**

The present study uses a mixed-methods approach to examine the social validity and acceptability of the culturally-adapted services of SC for providers and parent consumers. The steps in the cultural adaptation of service models while balancing implementation fidelity to core components of the EBP are outlined. The current study seeks to respond to previous research on cultural adaptations of home-based parenting programs by implementing recommendations from previous research and examining cultural congruency and provider fidelity of an adapted SC model for a local Latino community.

**Overview of the Current Study**

The quantitative portion of the study was designed to understand the adapted model of SC for a Latino community through determining: (a) provider response to training in the adapted model, (b) acceptability of the model for parent consumers (i.e., completed visits, working alliance, satisfaction surveys), and (c) cultural competency of the adapted model.

The first hypothesis was that providers trained in the adapted model would achieve fidelity to the SC model and would successfully engage caregivers, as reflected on the Working Alliance. The Working Alliance refers to the collaboration between caregivers and parents based on the nature of their agreement toward the goals of services (Bordin, 1979). The second hypothesis was that the adapted version of SC would be accepted by families and viewed as useful and culturally congruent in both the approach of the provider and the content of the program material.

The qualitative portion of the study was designed to enhance the understanding of the cultural congruency of an adapted model of SC with proposed hypotheses including that interviewees would articulate themes of: (a) an overall impression of acceptability of the model and (b) importance of the aspects of the program that were modified to achieve cultural congruency.

**Procedures Prior to Intervening and Collecting Data**

**Cultural Adaptation of the SafeCare Program.** The first step was to adapt the SC program for the local Latino community. SC augmented, as approved by HOMVEE, was used for this study. Focus was placed on deep structure adaptation because of the need for successful modifications to include in-depth understanding of culture, community members, and historical context that can influence target parenting behaviors. To conduct the adaptation, a collaborative team of the program developer, university researchers, and parents in the local Latino community was formed.

The goal of the adaptation was improving receptivity to the program while maintaining all core approaches and components of the SC model. Acknowledging and respecting values and contextualizing the content to the community guided this adaptation, following recommendations of the Workgroup on Adapting Latino Services (2008). Specific adaptation areas targeted were: (a) language, (b) extended family, (c) acculturation, (d) traditional beliefs, (e) relationship development, (f) preferred learning style of incorporating storytelling and proverbs, and (g) racism, stereotypes, and discrimination.

**Language.** Within cultural competence guidelines, translation of language is described as linguistic competence (American Psychological Association, 1993, 2003). Translation is considered necessary to obtain cultural competence but not solely sufficient (Whaley & Davis, 2007). A formal Spanish translation approach (i.e., standard) rather than informal was followed to reach many anticipated dialects and to demonstrate respect to caregivers (Owora, Silovsky, Beasley, Demoraes-Huffine, & Cruz, 2012). Sensitivity to detect and correct misunderstandings was incorporated in provider training.

A specific area of linguistic translation deemed important was reading level (Self-Brown et al., 2011). Reading level needed to be lowered to make materials usable for a larger number of participants. Further, visual and learning cues were determined to be vital for understanding.

Provider training was delivered in English and Spanish due to provider preference in learning information. Modules were practiced in Spanish. Translation of training materials was designed to ease training and increase usefulness of the material in the home with families.

**Extended Family.** Family is a vital part of the Latino culture and is characterized by traditional family values often referred to as familismo (Marin & Marin, 1991). Family within the Latino culture includes both nuclear and extended family. The Latino culture values collectivism, interdependence, and cooperation, all of which can impact treatment (Andrés-Hyman, Ortiz, Añez, Paris, & Davidson, 2006). This familial network provides support and assistance in creating change during services to Latino individuals (Delgado, 1998). Providers were trained in the importance of family within the Latino culture and to incorporate the extended network directly and indirectly into services.

**Acculturation.** Acculturation has been broadly defined in the literature (Thomson & Hoffman-Goetz, 2009) and is considered important in service delivery (Aponte & Barnes, 1995). Literature has reported the importance of provider inquiry about ethnic identity, generational status, immigration circumstances, native and preferred language, and level of acceptance.

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and adherence to cultural scripts (Andrés-Hyman et al., 2006). Initial provider training and ongoing supervision addressed acculturation to better understand and support families.

Traditional Beliefs. Traditional health beliefs, practices, and spirituality are crucial components within the Latino culture. Due to implications to the child health module, an extensive literature review of home remedies used within the Latino culture was conducted. Local parenting professionals supplemented this with local traditional beliefs and practices. The adaptation team developed culturally sensitive materials to utilize during the health module of SC to facilitate communication and understanding of beliefs and healing practices, assess family illness and health behaviors, help families identify when modern medical approaches may be warranted or when home remedies may cause adverse effects, and integrate home remedies and modern approaches. This included identifying and addressing barriers to modern medical approaches such as access to services and understanding of fatalismo, respeto. The understanding and importance of spirituality and receptivity to spiritual diversity was also stressed.

Relationship Development. Personalismo has been found to be crucial in recruiting, engaging, and retaining Latino families (Miranda, Azocar, Organista, Muñoz, & Lieberman, 1996). Relationship components included treating older Latinos with respect and using formal titles while maintaining a warm and personable demeanor (Antshel, 2002; LaRoche, 2002). Relationship development focused on teaching providers strategies to form quality relationships with families. This included understanding the nature of relationships, how and when to disclose personal information, remembering children and important events, and managing the sharing of food and gifts.

Incorporation of Storytelling and Proverbs. A strong tradition within the Latino culture is the use of storytelling to answer questions, preserve history (Shapiro, 1998), and promote healing (Anderson & Jack, 1991). Spanish proverbs or dichos are used to address life problems (Aviera, 1996; Zuniga, 1991, 1992). Dichos have been characterized as being a “succinct and effective” way of teaching (Cabos, 1985) through providing short phrases that articulate values and beliefs. Cultural adaptation included understanding and incorporating storytelling (i.e., cuento/dichos) through teaching providers the meaning and importance of stories and helping providers incorporate storytelling into modules. This involved identifying proverbs that would readily teach portions of the SC modules.

Racism, Stereotypes, Discrimination. Provider training addressed racism, stereotypes, discrimination, and the impact of immigration laws on the local community. Topics included impact on the provider–parent relationship, willingness to seek services, access to services in the community, and access to employment. Further, training integrated provider understanding of their own biases and assumptions and how this may impact service delivery.

Quantitative Study

Method

Setting and Sample. The SC program took place in an urban area with providers delivering SC in home-based settings. All providers were bilingual (Spanish and English) with services provided in the language most comfortable for the family. Most participants preferred services to be provided in Spanish, with one family requesting both English and Spanish.

The parent consumer participants consisted of 28 Latino mothers who were the primary caregiver of at least one child under the age of six. Country of origin included Mexico (82%), Guatemala (7%), United States (4%), El Salvador (4%), and Colombia (4%). Participant age range was 17–41 (M = 29, SD = 6) years (Table 1).

There were eight provider participants, with a mean age of 29 (SD = 3) years. Most providers were Latino (87.5%) with one provider being European American (12.5%). In terms of education, 37.5% had some college with no degree, 12.5% had an associate’s degree, 37.5% had a bachelor’s degree, and 12.5% had a master’s degree. All home-based providers of the model completed training in the adapted SC protocol. The providers completed three phases of training and certification: project specific training, national SC training certification, and observation of implementation of all three modules to fidelity. One provider is not included in our study analysis due to lack of study consent. Providers were not randomly assigned to consumers; assignments were based on caseload and availability. The number of providers employed over the two-year evaluation of the cultural congruence phase varied from one to four due to turnover for various reasons including: health issues (1), termination (1), relocation (1) and leaving the field for a different profession (1).

Procedures. Participant quantitative data was derived from paper questionnaires. Trained data collectors were present to assist with questions or problems. All provider measures and participant satisfaction measures were administered via face to face interactions. Research methods were approved by Institutional Review Board.

Measures.

Provider. Service Training Knowledge and Satisfaction Questionnaires. Training questionnaires were designed to collect feedback on provider training, including module knowledge (health care, home safety, parent interaction), cultural sensitivity

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Table 1
Study participant characteristics (N=28).

<table>
<thead>
<tr>
<th>Characteristic (SD, standard deviation)</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of mother in years (Average = 29; SD = 6)</td>
<td>28(100%)</td>
</tr>
<tr>
<td>Race (Latino)</td>
<td>28(100%)</td>
</tr>
<tr>
<td>Number of children per household (Average = 3; SD = 1)</td>
<td>1(4%)</td>
</tr>
<tr>
<td>Annual household income (Average = 14,800; SD = 7,000)</td>
<td>1(4%)</td>
</tr>
<tr>
<td>Less than or equal to $3,000</td>
<td>28(100%)</td>
</tr>
<tr>
<td>$6,001–$9,000</td>
<td>2(7%)</td>
</tr>
<tr>
<td>$9,001–$12,000</td>
<td>7(25%)</td>
</tr>
<tr>
<td>$12,001–$15,000</td>
<td>2(7%)</td>
</tr>
<tr>
<td>$15,001–$20,000</td>
<td>6(21%)</td>
</tr>
<tr>
<td>$20,001–$30,000</td>
<td>6(21%)</td>
</tr>
<tr>
<td>Gender</td>
<td>28(100%)</td>
</tr>
<tr>
<td>Referral sources</td>
<td>1(4%)</td>
</tr>
<tr>
<td>Current client</td>
<td>1(4%)</td>
</tr>
<tr>
<td>Faith based organization (Catholic Charities)</td>
<td>7(25%)</td>
</tr>
<tr>
<td>Friend/relative</td>
<td>2(7%)</td>
</tr>
<tr>
<td>Hospital</td>
<td>1(4%)</td>
</tr>
<tr>
<td>Police</td>
<td>1(4%)</td>
</tr>
<tr>
<td>Other sources including prevention programs/agency</td>
<td>7(25%)</td>
</tr>
<tr>
<td>School</td>
<td>2(7%)</td>
</tr>
<tr>
<td>Self referral</td>
<td>5(18%)</td>
</tr>
<tr>
<td>WIC</td>
<td>5(18%)</td>
</tr>
<tr>
<td>Country of origin (Average years in US = 9, SD = 3)</td>
<td>2(7%)</td>
</tr>
<tr>
<td>USA</td>
<td>1(4%)</td>
</tr>
<tr>
<td>Mexico</td>
<td>23(82%)</td>
</tr>
<tr>
<td>Guatemala</td>
<td>1(4%)</td>
</tr>
<tr>
<td>El Salvador</td>
<td>1(4%)</td>
</tr>
<tr>
<td>Colombia</td>
<td>1(4%)</td>
</tr>
<tr>
<td>Marital status</td>
<td>15(54%)</td>
</tr>
<tr>
<td>Married</td>
<td>3(11%)</td>
</tr>
<tr>
<td>Single never married</td>
<td>3(11%)</td>
</tr>
<tr>
<td>Divorced/separated</td>
<td>7(25%)</td>
</tr>
<tr>
<td>Living with a partner</td>
<td>7(25%)</td>
</tr>
<tr>
<td>Work status</td>
<td>21(74%)</td>
</tr>
<tr>
<td>Not working</td>
<td>17(61%)</td>
</tr>
<tr>
<td>Part time or full time work</td>
<td>9(32%)</td>
</tr>
<tr>
<td>Education</td>
<td>17(61%)</td>
</tr>
<tr>
<td>Completed high school education (or equivalent)</td>
<td>17(61%)</td>
</tr>
<tr>
<td>Have not completed high school education</td>
<td>10(36%)</td>
</tr>
<tr>
<td>Pregnant at time of consent to participate</td>
<td>3(11%)</td>
</tr>
<tr>
<td>Type of public assistance received</td>
<td>17(61%)</td>
</tr>
<tr>
<td>Temporary Assistance for Needy Families (TANF)</td>
<td>3(11%)</td>
</tr>
<tr>
<td>Medicaid (Parent): SoonerCare</td>
<td>3(11%)</td>
</tr>
<tr>
<td>Medicaid (Child): SoonerCare</td>
<td>3(11%)</td>
</tr>
<tr>
<td>Food Stamps</td>
<td>25(89%)</td>
</tr>
<tr>
<td>Social security benefits</td>
<td>12(43%)</td>
</tr>
<tr>
<td>WIC</td>
<td>4(14%)</td>
</tr>
<tr>
<td>Government subsidized child care</td>
<td>2(7%)</td>
</tr>
<tr>
<td>Other government programs</td>
<td>4(14%)</td>
</tr>
</tbody>
</table>

and congruency, and quality of SC training. Providers rated skills before and after training on a seven-point scale ranging from very little skill (1) to great deal of skill (7), as well as answered open-ended questions on module training and overall program evaluation. Additionally, providers rated training on a five-point scale ranging from poor (1) to excellent (5). Specific to cultural training, providers were asked to rate their training experience and relevance of material on a four-point scale ranging from poor to excellent.

**Engaging of Extended Family.** Providers completed a question post-service to determine if extended family members were engaged in home visiting services. This question specifically asked if anyone in the family, in addition to the primary caregiver, was involved in the home services and, if so, to indicate the relationship of those individuals.

**Caregiver Participant.** *Client Cultural Competence Inventory (CCCI).* The CCCI is a 12-item scale designed to assess a client’s perceptions of the care provided by therapists in terms of cultural competency (Switzer, Scholle, Johnson & Kelleher, 1998). An example item is “The caregiver respects my family’s beliefs, customs, and ways that we do things in our family.” The CCCI was adapted to nine questions most salient to home-based programs. The first item in the scale was rated “no”
or “yes,” with the remaining eight items rated on a five-point scale, ranging from never true (1) to always true (5). Internal consistency of the measure for the current study was high (\(\alpha = .76\)).

**SafeCare Satisfaction Surveys.** Social validity and satisfaction surveys were created by the National SafeCare Training and Research Center (NSTRC) and were modified for the current population to better understand participant feedback on adaption of SC modules. Social validity measures are module specific (health, home safety, and parent child interaction). Surveys consisted of eight questions on the impact of training material; six questions on services received, and nine questions on the provider. Items about impact of training and providers were rated on a five-point scale ranging from strongly agree (1) to strongly disagree (5), service questions were rated on a five-point scale ranging from useful to useless.

**Provider and Caregiver Participant. Working Alliance Inventory.** The 12-item Working Alliance Inventory Short Form (WAI-S; 1994), by Tracey and Kokotovic (1989), modified by Santos (2005) for home visiting, was used to assess the working alliance between home providers and caregivers according to Borduin’s (1979) formulations. Items for the WAI-S were obtained from a factor analysis. Tracey and Kokotovic (1988) selected the four highest loading items from the subscales: bond, tasks, and goals. The WAI-S exists in provider and client forms. Items are rated on a seven-point, anchored-response scale ranging from never (1) to always (7). Internal consistency ratings for the WAI-S were high with Cronbach’s alpha ratings of .83–.98.

**Statistical Analysis.** Descriptive statistics were used to describe the demographic characteristics of the family dyads and service staff. Univariate and bivariate analyses were performed to assess the associations between WAI-S, consumer satisfaction, and service attributes (number of completed home visits, usefulness, and acceptance of adapted model and social provisions). The strength of the linear relationships between consumer satisfaction, service provision and working alliance were assessed using non parametric correlation analyses (Spearman’s rank correlation coefficient). The consumer–home visitor working alliance was assessed by the composite score on the WAI-S and its three subscales. Descriptive frequencies were used to describe participant responses to the satisfaction surveys and training questionnaires. Further, the interquartile range (IQR) was used as a measure of spread for the distribution of the WAI-S item ratings. The IQR is the width of the interval that contains the middle (median) of the values in this distribution (Q3–Q1). The IQR is a robust measure of spread and is not influenced by usually large or small values (WAI-S item ratings) and is therefore more useful as a measure of spread than the range (maximum–minimum) given the nature of the WAI-S data (i.e., based on participant ratings).

**Qualitative Study**

**Methods**

**Sample.** A convenient sample of nine families was recruited from the 28 families described above to participate in qualitative data collection. Families were contacted by their provider or a supervisor to determine their interest. Every family contacted...
agreed to be in the qualitative portion of the study. Families had either graduated from services or had completed relevant modules. Individual interviews were conducted by the director of prevention programs who did not have previous direct contact with families, with her introducing herself as member of the team. Interviews were conducted in person with follow-up interviews completed by phone if families had not completed the SC Health module at the time of the first interview.

**Procedures.** Individual interviews lasted approximately one hour with follow up interviews (if needed) lasting approximately 30 min. All interviews were conducted in Spanish and audio-recorded. Transcriptions were conducted by a Spanish-speaking professional with transcripts and translations checked for accuracy by the interviewer. Research methods were approved by the Institutional Review Board.

**Interview Guide.** A semi-structured interview guide was developed to assess content, engagement, cultural congruency, and usefulness of SC content. Early questions were organized to be module-specific with questions focusing on understanding program experience. Later questions focused engagement and attrition and the role of culture in accepting a home visiting program.

**Statistical Analysis.** Analysis of qualitative data was conducted with NVivo 10 software. A template approach (Patton, 2002) was used for thematic analysis with hierarchical coding used to define broad themes. Specific themes emerged which related to broad themes. Themes were endorsed by at least 80% of participants. Further, data was coded and compared by two qualitative researchers.

**Results**

**Provider Satisfaction and Acceptance of the Adapted Model**

It was hypothesized that the providers trained in the adapted model would readily achieve fidelity to the SC model and successfully engage caregivers, as reflected on the Working Alliance. All providers in the study reached SC certification requirements. Further, results indicated that provider knowledge of health care, home safety, parent–child interactions, and parent–infant interactions prior to and after training showed improvement. In terms of cultural sensitivity and congruency, training responses ranged from mean scores of 3.7 to 4.0 with 4.0 being excellent. Ratings included overall experience (M = 3.7), didactic lecture (M = 3.7), relevance (M = 3.8), amount learned (M = 3.8), and value of time (M = 4.0). Ratings of the quality of SC training ranged from mean scores of 4.5 to 4.7 with 5.0 being excellent. Specific modules rated were health (M = 4.5), safety (M = 4.7), and parent–child interaction (M = 4.7).

**Engagement of Families in Services**

With regard to service provision, the number of completed home visits per consumer ranged from three to 60 with an average of 36 visits per consumer (SD = 16). The monthly caseload of the home visitors varied between one to 15 consumers per home visitor during the study. For 26% of the families, extended family members (primarily spouses/partners) were directly involved in service delivery. Of the remaining families, 24% were single without a partner (Table 2).

Service attributes indicated there was a statistically significant relationship between the completion of at least 36 visits (the average visits per consumer among the 28 consumers in the study) and successful graduation from the SC program (Fisher exact test (α = .1): p > .06); 75% (14) of the graduates had at least 36 visits.

Table 3 shows median scores and correlations between consumer and provider responses to the WAI-S. Although none of the correlations were significant (95% CI of the correlations include zero), using the average of question scores with a one point difference criterion, the percentage of consumer–home visitor pairs with shared expectations on the goal setting subscale were 97%, on the tasking subscale were 91%, and on the bonding subscale items were 91%.

**Consumer Satisfaction and Acceptance of Adapted Model**

The second hypothesis was that the adapted version of SC would be accepted by families. With regard to health (N = 20), 100% of participants strongly agreed or agreed that caring for their child’s health and recognizing their child is ill was easier since completing the health module and that the written materials were useful. For home safety (N = 23), 100% of participants indicated that they strongly agreed or agreed that their home was safer and that they were better able to identify and get rid of hazards in their home since completion of the home safety training. There was also 100% agreement that the written materials were useful. Within Parent Child Interaction training (N = 22), 100% of participants indicated that they strongly agree or agree that interacting with their child and routine activities were improved and written materials were useful.

The adapted version of SC was hypothesized to be considered culturally congruent with the current practices of the family. Using the CCCI, it was found that participants (N = 19) rated providers and their approach to services as high regarding cultural competency. For example, 100% of participants indicated that their provider almost always (highest possible

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rating) involved the right family members in services and respected their family’s beliefs, customs, and ways. Participants also indicated that providers almost always or most of the time accepted the family as important and treated them with respect.

Retention of Families

Service attrition in the current study was 33%. It is important to note that most of the total study attrition was due to gaining employment (18%) or health concerns (3%), with the remaining 12% (N = 3) not being able to locate, excessive missed appointments, or a desire to end services.

Qualitative Findings: Themes

Theme One: Overall SafeCare Program. (a) Opinion of the program. Participants were pleased with the overall program and specific modules. Some representative quotes were: “It’s a good program, it has helped me a lot,” and “Very helpful program.” (b) Most helpful part of the program. Families felt that the parenting module was the most helpful. Specifically parents reported: “I learned how to speak with my children, how to treat them better.” and “(I learned) how to play with children, how to treat them.” (c) Reading material. Participants reported material to be understandable, appropriate, and engaging. Parents explained that: “Yes, it was understandable, it’s practical and understandable.” (d) Cultural congruency. Families felt that material was culturally appropriate and they liked that material was adapted for their culture. Specific information provided was: “Good that they are working with our way of thinking.”

Theme Two: Safety Module. (a) Opinion of safety module. Families found the safety module to be helpful and indicated that they learned a lot from the material. A representative quote was: “I have things in my house that I didn’t know were bad for my children.” (b) Improvements to safety module. Participants explained that they would make no changes to the safety material. Specifically, families reported: “nothing, I find it good as it is.”

Theme Three: Parenting Module. (a) Opinion of parenting module. Families found the parenting module to have a positive impact on the way they spoke and interacted with their children. An example from participants included: “It was very good because when she was going to explain something she would put herself on the level of the child or would tell me do this or pretend I’m not here and do this. So I would do this and if I didn’t do it well she would tell me how to do it. Or have to do things in this form, speak with him in this manner. I think that she explained things well.” (b) Culturally sensitivity to parenting module. Participants reported that even though the values and strategies suggested in the parenting module were different from their own culture, they found them very useful. An example is: “They (my culture) spank, they scold loudly. I started to raise my children that way and when I started the program the lady that came taught me how to have patience and that I didn’t have to get to the striking point for a child to understand.”

Theme Four: Health Module. (a) Opinion of health module. Participants found the health module to be helpful and to be a good resource for child health material. Example of what a family disclosed is: “I find it as a recipe book, if you’re going to make a soup, what does it need? If you have a wound, what can you do for it?” (b) Improvement to health module. Families felt that the material was complete with no improvements needed. Specifically, families reported: “I liked the module as it is.” (c) Cultural

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congruency of health material. Families rated the health material very positively and liked that the health manual addressed culturally-specific disorders. Some representative quotes are as follows: “Yes, it talked about many cultural illnesses like for example what we commonly know in our countries as ‘el ojo’ (evil eye), ‘el empacho’ (indigestion) things like those, yes, it included many illnesses.” and “I never imagined that they would be included in the manual, but I think it’s great because I tell my family to call and get enrolled because it’s going to help you a lot. You think what can I do when I have an empacho? Is it something that I can do at home? Do I have to call the doctor? Or should I go to the ER? And it’s something I speak to my family about and say I would’ve never thought that this would have been in here.”

**Theme Five: Attrition and Engagement.** (a) Reasons for engagement. Families reported reasons for engagement were parents needing help with a variety of family issues (i.e., stress, needing social support, and wanting to improve parenting). Families said: “I was going through a tough situation. I was even emotionally unstable.” and “I think the most important thing is my children...” (b) Reasons for attrition. Participants explained that reasons why families might drop out of services were due to time conflicts or lack of motivation in changing parenting style. An example given is: “Majority of the women that are like me and are at home would say I don’t have time...”

**Theme Six: Overall Opinion of Program.** (a) Recommend program to others. Families reported that they have and will recommend the program due to the positive impact that the program made in their life. Representative quotes are as follows: “Yes, I have recommended it to several people because they say ‘I can’t believe it, why do those children behave that way?’ (due to the child’s drastic improvement in behavior)” and “Of course! It would be unfair if people didn’t have it, that is, it would be good to have it since, as I told you, there are many mothers who are not ready to know...they need to have this type of basic knowledge.”

**Discussion**

The current study utilized mixed-methods analyses to examine the process of adapting a home-based parenting program for cultural congruency, specifically: (a) acceptability and cultural congruence of the adapted SC protocol, (b) adherence to the core components and approach of SC while adapting to local community culture, and (c) social validity of the new model in addressing SC target areas (parenting, home safety, and child health). Providers successfully reached national certification for implementing SC with fidelity to the core components and approach. Provider ratings of knowledge and skills gained and cultural congruency of the training were high. Quantitative and qualitative data from consumers indicated high levels of satisfaction, usefulness, and cultural congruency of the approach.

In determining successful adaptation, the current study used a mixed-methods approach. The WAI-S results indicate high agreement in home visiting expectations between provider and consumer in all areas measured (goal setting, tasking, bonding) ranging from 91% to 97%. This is indicative that model presentation was well received, with the provider presenting material to the consumer in a way that shared expectations were reached. The overwhelmingly positive qualitative results echo the success of the provider in developing a working relationship and implementing a culturally sensitive model. Social validity data on the model results were quite positive with 100% of consumers strongly agreeing or agreeing with targets of the program, the benefits, and the usefulness of the home visitors’ approach in all areas of the home visiting program (health, home safety, and parent child/infant interaction).

In terms of qualitative data that reflected successful adaptation of the SC model, many themes emerged. Some specific areas discussed include: (a) acceptance of the health manual with positive feedback on the incorporation of home remedies and cultural factors, (b) acceptance of the parenting approach, even though participants reported it did not reflect how they were raised, (c) acceptance of the home safety approach with minimal changes, (d) understandable and useful reading material, and (e) overall useful modules. Other quotes highlighted that the adapted model was positive in engaging families and creating positive relationships. A strong focus of adaptation that did not emerge as a theme was the use of storytelling or proverbs and the focus on acculturation. We believe that this reflects a success in blending these elements in a manner that felt natural to clients and therefore might have been unnoticed. Therefore, participants did not comment specifically, but we believe these elements contributed to the overall success in clients reporting cultural congruency.

The SC model has been found to have success over standard approaches in engaging and keeping families in services (Damashek, Doughty, Ware, & Silovsky, 2011). In the current study, service attrition was 32% and was primarily a result of gaining employment (18%). There is a history of difficulties with attrition within home visitation (Duggan et al., 2000; Gomby, Culross, & Behrman, 1999; McGuigan et al., 2003a; Naviae-Waliser et al., 2000). The current results may suggest a larger issue of carefully measuring attrition. Often, home visiting programs assist the consumer with self-sufficiency. It is inevitable that through encouraging consumers to become employed this can negatively impact engagement as a result of time constraints.

With the goal to improve engagement of the extended family, providers were successful with 26% of the families. It is unclear the extent to which the remaining caregivers requested that other family members not be directly involved. Providers noted that the spouses/partners often had competing work demands and couldn’t participate directly. Strategies that integrated other family members indirectly (e.g., caregivers following up with family members between sessions) were not assessed. When incorporating cultural aspects of the program, extended family engagement is significant to understand.
as many families may have difficulty finding social support due to English as a second language, cultural differences, and other barriers. Other strategies by the providers to engage additional extended family and community members may be beneficial. Through understanding these barriers, providers can assist in linking families to outside support and increasing engagement and providing longevity of social support after program completion. Qualitative data was blended with these findings to provide further clarity with respect to engagement, with participants indicating that program engagement was not only related to need for social support, but more specifically to family stress and the desire for improved parenting skills.

Limitations of the Current Study

Although all of the caregiver report data indicated strong agreement that the culturally adapted model was well received, there has been some indication within research that social desirability biases can occur, even with data collectors independent from the providers (Hopwood, Flato, Ambwani, & Morey, 2009). To assist in creating a clearer understanding of the quantitative data and to determine if possible reporting biases occurred, individual interviews also captured the caregiver–participant perspective. The qualitative data not only mirrored the self-report measures, it provided rich examples of the benefits, usefulness, and cultural congruency of the model and specific components. Social desirability may have also influenced the interview data and has to be considered, though the pattern of results and low level of attrition due to program dissatisfaction does not support that interpretation.

The current study was designed to serve as a feasibility trial for the cultural adaptation, with the study indicating a positive response from the families (N = 28). Conducting a controlled trial to examine the impact on key outcomes is a critical next step to determine if the adapted model does not interfere with, but rather maintains or enhances outcomes.

The current adaptation and study was limited due to the specific adaptation to the local Latino community. This limitation is indicative of a greater issue within cultural adaptation of modules. That is that culture is complex and there are difficulties in creating adaptations that are general yet specific. Successful adaptation involves looking closely at the local community to ensure the fit and potential need for adaptation. This in turn assists in establishing participant engagement and understanding the community context in application of skills. Given the complexity of families and culture, focus on provider characteristics, training, consultation and close supervision for adapting models to fit specific family’s preferences and approach while remaining true to the core components is equally important.

Conclusions

The results support deep level adaptation of prevention services for Latino communities to assist with acceptability and cultural congruency. The study outcomes outline the success of a framework for cultural adaptation. The study adaptation framework stresses the importance of focusing on factors most salient to cultural congruency for the community to be served. The current project focused on a local Latino community but the process to identify key aspects of adaptation and the approach used can be applied to other communities. Specific to this process is establishing adaptation guidelines through determining relevant cultural aspects and topics and creating provider training and consumer material that reflect cultural context and consumer engagement while maintaining fidelity to core components of the evidence-based model.

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