The GANA Program: A Tailoring Approach to Adapting Parent Child Interaction Therapy for Mexican Americans

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Abstract

The current manuscript describes the process of developing the GANA program, a version of PCIT that has been culturally adapted for Mexican American families. The adaptation process involved combining information from 1) clinical literature on Mexican American families, 2) empirical literature on barriers to treatment access and effectiveness, and 3) qualitative data drawn from focus groups and interviews with Mexican American mothers, fathers, and therapists on how PCIT could be modified to be more culturally effective. Information from these sources was used to generate a list of potential modifications to PCIT, which were then reviewed by a panel of expert therapists and clinical and mental health researchers. The resulting GANA program and ongoing research to evaluate its effectiveness with Mexican American families is described.
Although extensive evidence documents the efficacy of clinical interventions for children in lab settings, few clinical trials have included sufficient numbers of ethnic minority children to permit generalization across cultures (Chambless et al., 1996; Miranda, 1996; Miranda, Azocar, Organista, Munoz, & Lieberman, 1996). According to Chambless et al. (1996), no research currently demonstrates psychotherapy treatment efficacy for ethnic minorities. Although there has been national acknowledgment of the need for effective services for youth, empirical research on treatments for ethnic minority children has lagged far behind the recognition of need for such services (Sue, 1998).

Latinos are currently the largest racial/ethnic minority group in the United States, making up 13.3% of the U.S. population in 2002 (U.S. Census Bureau, 2003). Between 1980 and 1999, the proportion of Latino children in the United States increased from 9% to 16%, a higher growth rate than any other racial or ethnic group (Hobbs & Stoops, 2002). The U.S. Census Bureau (2003) estimates that by 2050, almost 1 in 5 children in the United States will be of Latino origin. Clearly, existing mental health programs must examine how best to serve the mental health needs of this large and growing youth population.

Data suggest that existing mental health services may fall short in meeting the needs of Latino youth. Latino youth are much less likely to receive mental health services than Caucasians, despite rates of mental health problems that are as high as or higher than other ethnic groups (Kataoka, Zhang, & Wells, 2002; McCabe et al., 1999; U.S.D.H.H.S, 2001). When Latino families do enter therapy, they may be more likely to drop out of treatment prematurely than families from other ethnic groups (e.g., Huey, 1998). Dropout rates after the first outpatient therapy session by adult Mexican American clients have been as high as 60% to 75% (Kahn & Heiman, 1978; Miranda et al., 1976). Multiple factors contribute to this pattern of service underuse, but these findings suggest that traditional mental health services may need to be modified to be culturally responsive to Mexican American and other ethnic minority families (Miranda, 1996; Vega, 1992).

Unfortunately, few evidence-based recommendations on how to modify mental health services to be more culturally effective are available. Several methods of improving services for ethnic minorities have been proposed, including modifying service delivery systems (e.g., employing bilingual staff), assigning Latino clients to treatment modalities that are likely to be culturally congruent, and creating new treatments that incorporate cultural values into the treatments themselves (Rogler, Malgady, Costantino, & Blumenthal, 1987). While all of these approaches have promise, they also have limitations in terms of practicality and generalizability.

A New Approach to Developing Culturally Responsive Treatment: Modification of ESTs

We therefore propose a fourth method for developing culturally respon-
sive treatments: that of that modifying Empirically-Supported Treatments (ESTs) to be more culturally responsive for ethnic minority clients. This approach has several advantages. First, building culturally effective treatments on the foundations of previously tested, efficacious treatments is an economical approach that takes advantage of years of research that have gone into developing mainstream treatments. It is likely that although efficacious treatments may need some modifications to be effective with specific ethnic minority groups, their core elements are still valuable for these populations. It is certainly important to test this assumption before we discard the rigorously evaluated treatments that currently exist. Second, modifying various aspects of existing treatments allows us to test some of the recommendations made by experts for improving the cultural responsiveness of treatments for feasibility and for their effect on treatment outcomes. By systematically evaluating different components, we can determine which modifications actually have a positive effect on treatment outcome.

The current study employs this approach by adapting Parent Child Interaction Therapy (PCIT), an EST that has been demonstrated to be highly effective for young children with behavior problems, to be more culturally effective for Mexican American families (Eisenstadt, Eyberg, McNeil, Newcomb, & Funderburk, 1993; Eyberg, Boggs, & Algina, 1995; Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998). Although PCIT has demonstrated its efficacy with Caucasian children, parent training approaches have not been tested with minority children, despite theoretical considerations that suggest the success of parent training may be dependent on the parenting norms of a particular cultural group (Forehand & Kotchick, 1996). While PCIT includes features that suggest that it might be amenable to Mexican American culture (i.e., inclusion of both parents, structured, time-limited) other features may require modification.

This manuscript describes the process through which we developed a culturally modified version of PCIT, called Guiando a Ninos Activos (Guiding Active Children, or GANA). The current study’s approach to identifying modifications to PCIT that might improve its cultural effectiveness is provided below, followed by a description of the resulting, adapted PCIT program. It is hoped that the detailed descriptions of the study methodology as well as the modified intervention can serve as a model for future adaptations of ESTs for Mexican Americans as well as for other cultural groups.

Approach to Cultural Modification

Because the empirical literature provides limited guidance on how to adapt treatments for ethnic minority families, we developed a modification process that included three steps:

1. Survey of Relevant Information: We gathered information re-
garding potential cultural adaptations to PCIT from a number of different sources: the clinical literature, the empirical literature, expert opinion, and qualitative data collected from Mexican American parents and therapists.

2. Development of Proposed Modifications: Information from all of these sources was combined to arrive at a set of proposed modifications to PCIT that should increase the cultural effectiveness of the program.

3. Review of proposed Modifications: Finally, these proposed modifications were reviewed by three groups of experts: a group of researchers with expertise in the adaptation of mental health treatments, a panel of Mexican American therapists that work clinically with Mexican American families, and Sheila Eyberg, the creator of PCIT. In this review, final decisions were made about the acceptability of the full package of proposed modifications both from a practical and theoretical perspective. Below, the information gathered in our survey of relevant information used to arrive at the proposed modifications is reviewed.

Clinical Literature

We conducted a comprehensive review of the clinical literature on the treatment of Latino families. This literature points out several modal (although not universal) characteristics of Latino families that are important to consider when adapting PCIT for Mexican American populations. First, Mexican Americans are described as placing a stronger emphasis on familism, or the importance of relations with family relative to friends or co-workers in comparison with European Americans, particularly in matters of childrearing and child discipline (Zuniga, 1997). Familism is a source of assistance and support, but may also be a source of stress. For example, grandparents may provide a great deal of assistance with childrearing, but may also be openly critical of a parent’s childrearing techniques. Thus, treatment approaches will be more effective if they are successful at engaging extended family members in treatment. Second, Mexican American families have been described as valuing “personalismo,” or warm interpersonal relations, over individual achievements (Martinez, 1993). This suggests that Mexican American families may require more attention to rapport building and an interpersonal style that is congruent with cultural norms (e.g., including more use of touch and proximity, self-disclosure, etc.) than is typical among European Americans; (Zuniga, 1997). Third, Mexican American culture has been described as collectivistic, and thus families are likely to emphasize affiliation and cooperation, and avoidance of confrontation and competition (Kashima, Yamaguchi, Kim, Choi, Gelfand & Yuki, 1995). Mexican American families are likely to be motivated by childrearing goals that emphasize communication, cooperation,
and sharing over individual achievement. Fourth, Mexican Americans are described as placing a strong value on relationship hierarchy and respect for authority (Martinez, 1993; Zayas & Solari, 1994). Thus, Mexican American families are likely to be respectful towards the therapist, who is viewed as an authority figure. Families may also be reluctant to express disagreement with the therapist directly, which can prevent the identification of weaknesses in rapport or engagement. This value on respect is also reflected in relationships within the family, and suggests parents may be very comfortable with interventions that emphasize exerting control over child behavior, but may also feel less comfortable with interventions that require them to let the child lead interactions. Finally, Mexican American families are more likely to adhere to traditional gender roles in which the mother is primarily responsible for childrearing and the father for providing financial support (Koss-Chioino & Vargas, 1999). Thus, clinicians treating child behavior problems may face a particular challenge in engaging fathers in treatment, which they may view as the mother’s responsibility.

Although the clinical literature provides important information about the modal characteristics of Mexican American family that is firmly grounded in knowledge of Mexican American culture and makes theoretical sense, this information must be translated into practical treatment recommendations and tested empirically (Malgady, Rogler, & Costantino, 1990; Sue & Zane, 1987). Empirical tests of these recommendations are necessary to establish whether or not they result in “culturally effective” treatment, meaning that they contribute to improved outcomes for ethnic minority youth. When such evidence is available, clinicians will be able to make informed decisions about which recommendations to adopt.

**Empirical Studies**

A growing body of empirical literature provides information about the practical and cultural barriers that Mexican Americans face when seeking treatment for a child with an emotional or behavioral problem. This literature documents barriers that must be overcome by Mexican American families seeking treatment, as well as cultural and attitudinal factors that influence the likelihood of seeking services, remaining in services, and benefiting from existing mental health treatments. Knowledge gained from these studies provides a second source of information on what kinds of modifications may be necessary to improve the cultural effectiveness of PCIT. Below, we review the information gained from these studies.

**Practical barriers.** Latinos face a disproportionate number of practical barriers to receiving mental health services. For example, Latinos are overrepresented among the poor and uninsured (Trevino et al., 1991). However, financial barriers do not fully explain service underuse. Studies have found that Latinos are less likely to use mental health services even when insurance coverage and socioeconomic status are held constant (Scheffler & Miller, 1989; Padgett et al., 1994). A study of parental perceptions of
health care access for Latino children concluded that practical problems such as language issues, cultural differences between health care staff and the family, transportation, and lengthy waiting times were major barriers to health care access for this population (Flores, Abreu, Olivar, & Kastner, 1998). Thus, culturally sensitive programs must contain explicit protocols for identifying and addressing the unique set of practical barriers that may discourage individual families from participating and engaging in the program.

**Cultural and attitudinal barriers.** Second, although practical barriers play an important role in discouraging service use among Latino families, research clearly demonstrates that cultural and attitudinal barriers also make a contribution. One qualitative study of 30 Mexican American families of children with mental health problems found that extended family members were highly influential in decisions on how to handle a child’s behavior problems (McCabe, 2002). On average, parents reported that four people were involved in their decision to seek treatment for their child, most often spouses, grandparents, aunts/uncles, and teachers. Parents reported a great deal of urging to bring their child for treatment from teachers and family members. However, over half of parents bringing their child in for treatment experienced disapproval from another family member, often a parent or a spouse who felt that the problem was not a mental health problem, treatment would not work, or that seeking treatment meant that the parent had failed. When asked why Latino families were less likely to bring children in for therapy than other racial/ethnic groups, parents emphasized the strong stigma associated with mental health treatments, lack of knowledge about where to find treatment, lack of information about what treatments are and how they work, and a tendency to “keep problems within the family.” Finally, many parents felt that most Latinos would be embarrassed to seek treatment for their child.

In one large study (N = 372) of the barriers experienced by Latino families who had a child with significant mental health needs (Yeh et al., 2003), 64% of families reported that they were discouraged from seeking treatment because of concerns about what might happen in treatment (e.g., services would not be confidential). Approximately 57% of families reported that they did not think services would be helpful or effective, and 55% were discouraged by practical barriers such as lack of transportation or child care. Another 48% of families felt that that they would not be able to afford services. Families reported concerns about the effectiveness of services or concerns that characteristics of the providers would not meet their needs in 45% of cases. Approximately 43% of cases reported that they were concerned about the effect that services might have on their family (e.g., fear of what family and friends might say). Finally, 18% of families were discouraged from seeking services by language barriers. Parents who do not feel supported in seeking treatment or who are ambivalent about treatment may be difficult to engage and more likely to dropout of treatment or not follow through on treatment recommenda-
tions. Therefore, culturally sensitive treatment programs must thoroughly assess family support for treatment and make vigorous efforts to engage family members in the treatment process. In addition, explicit protocols are needed to assess and address parents’ attitudes towards treatment so that misconceptions can be addressed at the outset of treatment.

*Acculturation.* Third, acculturation, defined as “the changes in behaviors and values made by members of one culture as a result of contact with another culture” (Burnam, Telles, Hough, & Escobar, 1987), has been examined as a gross indicator of the effect of cultural and attitudinal barriers on service utilization among Mexican Americans. Acculturation is likely to have a strong impact on belief structures about psychological problems and the seeking of appropriate treatments. Less acculturated Mexican Americans are six times less likely to utilize specialty mental health services than more acculturated Mexican-Americans (Wells et al., 1987), despite similar rates of psychological distress. Unacculturated clients who do enter therapy are likely to be unfamiliar with the mental health system and may come to therapy with different expectations for what will occur. Clients with little knowledge of the mental health system may have difficulty understanding mental health interventions that are alien to their culture. This may lead to frustration with treatment or a lack of compliance with treatment recommendations. One study has found that less acculturated Mexican Americans are more likely to drop out of treatment (Miranda et al., 1976). Thus, special efforts may be necessary to engage less acculturated families in treatment. However, programs must make accommodations that will be suitable for the full range of acculturation levels, as methods for engaging less acculturated families may not be equally as effective with more acculturated families.

*Attitudes and expectations about treatment.* Fourth, studies of the predictors of treatment dropout among Mexican Americans suggest that attitudes and expectations about therapy are among the most powerful predictors of which families will drop out of treatment. Studies have found that while demographic factors are not good predictors of dropout, families who expect services to be effective and that are more acculturated are more likely to complete treatment (Huey, 1998; Miranda et al., 1976).

In one study of treatment dropout among Mexican American families with young children (McCabe, 2002), parents who were less educated, who felt that emotional/behavioral problems should be handled within the family, and who felt that increased discipline was the appropriate response to children’s emotional/behavior problems were more likely to terminate therapy after one session. In addition, parents who had more perceived barriers to treatment, and who expected their child to recover quickly were more likely to drop out of treatment. Contrary to predictions, therapist-client ethnic match, household income, acculturation, perceptions of stigma, and expectations of therapist directiveness were unrelated to treatment dropout. These findings suggest that targeting families’ attitudes and expectations about treatment at the outset may be one avenue to decrease
treatment dropout. Therefore, culturally sensitive programs should make a thorough assessment of families’ expectations for treatment so that any misconceptions can be addressed at the outset of therapy. In addition, thorough orientation procedures are necessary so that families will have accurate information to guide their expectations for treatment.

**Beliefs about problem causes.** Finally, understanding parents’ beliefs about what has caused their child’s mental health problems is crucial to building rapport with the family and to presenting a rationale for treatment that is congruent with their belief system. Research on parents’ beliefs about their child’s problems has revealed that Latinos draw upon many of the same explanatory beliefs as do Non-Hispanic Whites. However, for individual Latino families, identification of beliefs about their child’s problem causes is essential for tailoring treatment to the families needs. Yeh et al. (2004) surveyed a heterogeneous group of Latino parents of children with emotional and behavioral problem about their beliefs about the causes of their children’s problems (N = 372). Latino families most commonly identify the child’s temperament or personality as the major source of mental health problems (65%), with large proportions also attributing causes to relationships with family (60%) and friends (50%) or traumatic events (41%). A substantial number of families felt that problems could be attributed to economic conditions (28%) or physical causes such as a chemical imbalance (22%). Finally, smaller percentages of families attributed the problem to other environmental factors such as American culture or prejudice (15%), or to spirituality or disharmony with nature (9%). A recent extension of this work has found that beliefs about problem causes (e.g., physical causes, relational issues, prejudice) explain a portion of service underuse for Latino families (Yeh et al., in press), suggesting that beliefs play a role in discouraging service use for Latino families. Programs that seek to improve cultural sensitivity must make a thorough assessment of beliefs about problem causes an initial step in treatment. Gathering this information allows therapists to communicate with the family about their child’s problems within the framework of the parents own belief system.

**Focus Groups and Individual Interviews**

The clinical and empirical literatures provide important background information that can be used to generate recommendations for modifying ESTs. However, the information is general and has not been translated into specific recommendations that can guide clinicians using a specific treatment approach. Therefore, our next step was to conduct a qualitative study examining parent and professional perceptions of how the PCIT program could be improved for Mexican American families. The study consisted of a series of focus groups and individual interviews with Mexican American parents of youth with behavior disorders and with Mexican American therapists (N = 24). During these focus groups and interviews, the PCIT program was described and participants were invited to com-
ment on features that they found appealing or unappealing, and to make suggestions on how to improve the program.

Mothers made several important suggestions for how PCIT could be improved to meet their needs. Mothers reported that they preferred the program to be presented as educational rather than therapeutic in order to avoid stigma associated with mental health treatments. They reported feeling isolated from other families, and even from their own family members, who they often perceived as blaming them for their child’s problems. They stressed that interventions need to be careful to adopt a non-blaming attitude toward the parent and to reduce parents’ feelings of guilt and blame. They also reported that they would like to see an emphasis on communication skills for use with children and spouses, and they requested help in encouraging participation of fathers and extended family members. Mothers also reported that they and other family members preferred a more strict disciplinary style, and they perceived both ignoring minor misbehavior and time-out procedures as being too mild. They suggested making ignoring procedure as active as possible so that parents feel they are disciplining, and to frame time out as a more severe punishment. Mothers requested more orientation to treatment that includes the perspectives of families similar to themselves and makes clear how certain activities, such as play, can be used a therapeutic tool. Mothers wanted to see an immediate change in their child’s behavior, and would like assistance in addressing practical barriers to treatment. Finally, mothers reported that they would like the therapist to be knowledgeable about characteristics of the Mexican American family, including the use of strict discipline and collectivism.

We also conducted one focus group with fathers. We found that it was much more difficult to recruit fathers to participate in the focus groups, in contrast to the mothers who were eager to participate and seemed to genuinely enjoy the sessions. Therefore, we chose to conduct seven additional individual interviews with fathers, with the same content as the focus groups. This allowed us to get the perspective of fathers who were reluctant to participate, as these fathers would also presumably be less likely to participate in treatment programs. The fathers made several important suggestions. First, fathers pointed out several features of the PCIT program that they found appealing including coaching of parenting skills and teaching non-abusive discipline. Fathers recognized that they would like to participate more in treatment, but pointed out that due to gender roles and demanding work schedules, there will be many fathers that will not participate fully in treatment. They suggested that father participation could be increased by sharing testimonials from similar other fathers, encouraging wives to invite them to participate, and motivating them by pointing out the consequences of inaction. Some fathers also reported that they were uncomfortable with the one-way mirror used in PCIT, which they perceived as “artificial” or “laboratory like.” Finally, fathers echoed mothers’
comment on ignoring, the need for more orientation to treatment, the need to reframe the intervention as educational rather than mental health oriented, and the desire to learn communication skills to use with their children.

Finally, a focus group was conducted with an expert panel of Mexican American therapists who specialize in children and families. The therapists echoed many of the parents' ideas and also suggested that we provide additional time for “venting” and rapport building, address acculturation and immigration related stressors, emphasize the connection between homework and outcomes, and assess satisfaction directly because parents may report that things are improving when they are not out of deference to the therapist.

*The GANA Program*

Based on information gathered from the clinical literature, empirical literature, and qualitative data, a theoretical approach and a list of specific modifications to PCIT were derived. The adaptation approach and a description of the modifications were then reviewed by the expert panel of Mexican American therapists described earlier, by a group of consultants with expertise in cross-cultural and mental health services research (N = 12), and by Dr. Sheila Eyberg, the creator of PCIT. The final version of the GANA program was revised according to their recommendations to arrive at a version that was considered both culturally acceptable and faithful to the original intervention. The program philosophy and details are described below.

*GANA and the public health approach.* The GANA program adopts a public health approach to mental health problems (Bruce, Smith, Miranda, Hoagwood, & Wells, 2002; U.S.D.H.H.S., 2001). This view runs counter to traditional views in the mental health system that patients are primarily responsible for initiating and maintaining participation in mental health services. The public health approach recognizes that the individuals who are most in need of such services are also likely to face multiple practical and cultural barriers to engaging in those services. In this approach, the program provider plays an active role in engaging families in the program, addressing barriers to participation, and preventing treatment dropout. Families that need treatment but have not been successful at obtaining it are not viewed as resistant or as unable to benefit from treatment. Rather, providers seek ways of increasing access to and engagement in services for such families and reducing or removing the barriers they face (Miranda, Lawson, & Escobar, 2002). Although this approach may require greater expenditure of resources in terms of provider time and effort, it also holds the promise of reducing racial/ethnic disparities in mental health service use.
A Tailoring Approach to Cultural Sensitivity: The Initial Assessment

To ensure that parenting experts are able to tailor the GANA program to the needs of individual families, a key component of the intervention is the assessment during the first session of a number of culturally influenced concepts that may have an important effect on how parents respond to the program. Information from this assessment is referred to throughout treatment so that concepts can be presented in ways that are congruent with the parents’ belief system about the causes of their children’s problems and the types of intervention that they believe will be helpful. In addition, some constructs are assessed continuously throughout treatment because they may change, and a therapist that is aware of those changes will be able to address them as they occur and before a family drops out.

This comprehensive assessment protocol is administered to families as part of the intake procedure. GANA teachers are provided with a computerized report summarizing the families’ responses and with specific recommendations on how to address issues that may be problematic, and how to tailor the treatment to the characteristics of individual families. The full list of constructs can be found in Table 1.

Table 1
Constructs Assessed During GANA

<table>
<thead>
<tr>
<th>Assess at Intake Through Questionnaire Measures</th>
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<tr>
<td>Do parents perceive child’s problem to be a mental health issue?</td>
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<td>Do parents favor strict discipline, or do they favor permissive parenting?</td>
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<tr>
<td>Are parents skeptical of play as part of therapy?</td>
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<td>Do parents feel comfortable praising their children?</td>
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<tr>
<td>Will fathers and grandparents participate?</td>
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<tr>
<td>Do the parent and other family members feel comfortable with the one-way mirror?</td>
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<tr>
<td>Do the parent and other family members feel comfortable being coached?</td>
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<tr>
<td>What do parents believe to be the cause of their children’s behavior problems?</td>
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<tr>
<td>Do parents feel they should be able to solve their problems without help from outside the family?</td>
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<tr>
<td>Do parents believe that behavior problems simply require more strict discipline?</td>
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<tr>
<td>Do parents feel guilty or responsible for child’s behavioral problem?</td>
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<tr>
<td>Do parents perceive mental health services as stigmatizing?</td>
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<tr>
<td>What are parents’ expectations about the frequency and duration of sessions?</td>
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<tr>
<td>How quickly do parents expect to see improvements in their child’s behavior?</td>
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Assess Continuously Through Unstructured Interview

| Are parents skeptical/dissatisfied with aspects of the program (e.g., time-out, ignoring, praise)? |
| Are family members supportive of treatment? |
| What are the barriers to mother coming to treatment? |
| What are the barriers to the participants of father and grandparents? |
This tailoring approach was adopted because focus groups conducted with Mexican American parents of children with behavior disorders revealed a great deal of variability in attitudes among families. The variation in attitudes among the families suggests that a one-size-fits-all “Mexicanized” program would alienate as many families as it would attract. Instead, a “tailoring approach” was adopted (Ayala et al., 2001). A tailoring approach involves including more assessment of constructs that may be particularly relevant to Mexican American families so therapists can tailor the treatment based on the characteristics of the individual family. This tailoring approach is consistent with the philosophy of PCIT, which recognizes that a structured treatment manual cannot be applied mechanically, but rather must be adjusted to meet the needs of individual families. For example, the PCIT manual emphasizes the use of the therapeutic relationship and rapport building in order to tailor the treatment to families (Eyberg, 2004).

To illustrate, many Mexican American families are not familiar with time-out, and do not consider this a reasonable form of punishment. Instead, parents reported using much harsher forms of discipline with their children, and were skeptical that asking a child to sit in a chair would work if harsher forms of punishment had already failed. One approach would be to have therapists present time-out to all Mexican American families as a more “severe” form of punishment than is typical. For example, the time out chair could be referred to as a “punishment chair” (silla de castigo). However, presenting time-out in this way for all families is likely to alienate families who would be open to time-out or have difficulty with the idea of any kind of punishment for a young child. A tailoring approach entails assessing constructs particular to Mexican American families in the first session, and checking in periodically with families to assess how their views may be changing throughout the course of treatment. In this manner, the presentation of time out and other concepts can be adapted to the parents’ particular point of view. For example, with one family we may describe time-out as a punishment, and refer to the chair as a punishment chair, but for another family we may choose to de-emphasize punishment and refer to the chair as a “thinking chair” (silla pensativa).

Another advantage to the tailoring approach is that it is highly flexible, and thus can be applied to multiple ethnic groups (including Caucasians) and, at least in part, to other treatment approaches. Thus, the adaptation of PCIT for Mexican Americans can serve as a general model for adapting evidence based treatments for a variety of ethnic minority groups or for groups that differ in some significant way from the population with which it was initially developed.

Other Modifications in the GANA Program

Framing program as an educational/skill building intervention. Our focus groups and other qualitative data have suggested that seeking mental health
services may carry a great deal of stigma in the Mexican American community (McCabe, 2002). This may be a particular concern for parents of young children, who worry that seeking services will mean “labeling” their child as having a mental health problem at a very early age. In the focus groups conducted with family members, parents repeatedly emphasized their preference for educational interventions, and the stigma attached to terms such as “therapy,” “therapist,” and “mental health.” Therefore, we chose to rename the program Guiando a Ninos Activos, or Guiding Active Children, which emphasizes the parent training aspect of the program, and avoids any suggestion that children enrolled in the program are suffering from a mental disorder. The acronym, GANA, also means to win or to earn in Spanish, and has positive connotations that fit well with the philosophy of PCIT. In addition to changing the name of the program, we also refer to the therapist as a GANA Teacher (maestro) or Child Behavior Expert (experto en comportamiento de los niños) rather than as a therapist. Several other terms in the program have been changed to fit with the parents’ viewpoints. For example, both mothers and fathers emphasized their desire to improve their communication skills with their young children. Communication is already a strong component of PCIT, but is not discussed implicitly as such in the program. In the GANA program, we refer to the Child Directed Interaction phase of treatment as Ejercicios de Comunicacion (Communication Exercises, or ECO), in order to emphasize the CDI goal of improving parent-child communication. The acronym ECO also means echo in Spanish, and fits nicely with the idea of parents following the child’s lead in play by “echoing” what the child is saying and doing. We also refer to Parent Directed Interaction as Disciplina Consistente (Consistent Discipline, or DISCO), which is consistent with parents desire to learn non-abusive discipline techniques.

Engagement protocol for mothers, fathers, and extended family members. Research indicates that Mexican American families who have unrealistic expectations about treatment are more likely to terminate treatment prematurely (McCabe, 2002). Previous research (Azocar et al., 1996; McKay, Stoewe, McCadam, & Gonzalez, 1998; Miranda et al., 1996; Szapocznick et al., 1988) also indicates that increased attention to engagement in initial telephone and in-person contacts with families can dramatically reduce treatment dropout rates. Furthermore, our qualitative research indicates that for Mexican American families, engagement of mothers alone (who typically make initial contact with the program staff) is likely to be insufficient. As mentioned previously, fathers and grandparents often object to the child being brought to any form of treatment, and Mexican American mothers are unlikely to disregard these opinions given the collectivistic family decision making that is predominant in this cultural group. Therefore, we developed a comprehensive engagement protocol based on McKay et al.’s (1998) approach that explicitly targets mothers, fathers, and grandparents. The engagement process begins with the very first telephone con-
tact, and has the following goals: (a) clarify the need for mental health care, (b) increase caretakers’ investment and efficacy in relation to help seeking, (c) provide a basic description of GANA program, (d) assess familial support for treatment and create engagement plan for other family members, (e) identify attitudes about previous experiences with mental health care, and (f) Overcome concrete obstacles to access to services. The initial engagement phone call lasts from a half hour to one hour depending on the needs of the family. At the first face-to-face session, these issues are revisited, and the engagement plan is modified as needed. GANA teachers are encouraged to outreach to the family, and can use unlimited telephone contact prior to the first session, home visits to the family prior to the first session, and as needed up to three times throughout treatment, and unlimited telephone contact with mother and family members during the intervention. GANA teachers focus on identifying and removing practical and cultural barriers for participating families at program entry and on a continuous basis throughout the intervention.

In addition, the engagement protocol includes specific methods for engaging fathers and other extended family members that are involved in child rearing or in decision-making about the child. GANA teachers attempt to make contact with fathers and grandparents even when (or especially when) fathers and grandparents have not expressed interest in attending GANA sessions. This is important because if these family members have negative attitudes towards the program or do not understand the program, they are less likely to attend sessions or support the mother in her efforts to participate. They also may actively discourage the mothers’ participation in the program. We have developed specific written materials designed to address concerns that parents and grandparents may have about the program, and enlist the mother’s help in making a plan for engaging these family members. Depending on the recommendations of the mother, we may call fathers or grandparents directly, send literature home to be given to them, or provide them with videotapes of their child’s sessions. Engagement of fathers and grandparents is a focus throughout the course of treatment, and does not stop with the initial contact.

*Increased orientation to treatment.* Because unrealistic expectations are a strong predictor of treatment dropout for Mexican American families, every effort to inform the parent about what will happen in treatment, as well as explaining their role, the role of their child, and the role of their teacher must be made. The GANA program addresses this in several ways at the outset of treatment. First, parents are asked to report on their expectations about treatment during the initial assessment. The results of this assessment are passed on to GANA teachers, so that if parents endorse expectations that do not fit well with the program (e.g., expecting their child to show dramatic improvement after a single session), therapist can address these misconceptions immediately. Second, parents are given a description of the GANA program during their first telephone contact with their GANA teacher. Third, parents are given a more detailed description
that includes verbal and written information as well as two 15-minute videotape presentations that describe the CDI/ECO and PDI/DISCO phases of the program and show examples of families in PCIT sessions (Stille, Urquiza, & Zebell, 2000; Urquiza & Zebell, 2001; Zebell & Urquiza, 2002a, 2002b). Finally, parent's attitudes towards each of the elements of the program are assessed in a self-report questionnaire (e.g., "How interested are you in being coached by a teacher on parenting skills"). GANA teachers are then aware program elements that are likely to be difficult for the parents, and can focus increased effort on explaining those elements and reframing them to fit the parents' beliefs.

*Increased attention to rapport building.* As mentioned previously, the clinical literature suggests that Mexican American parents are likely to value "personalismo," or warm interpersonal relationships (Martínez, 1993). In addition, Mexican American therapists on our expert panel emphasized the need to accommodate this value by spending more time building rapport with families. For example, Mexican American parents may be more likely to expect to engage in casual conversation with their teachers rather than settling down to the "business" of the session right away. They may expect teachers to share more about themselves, and may expect the teachers to indicate that they value their personal relationship with their clients in addition to the professional relationship. GANA teachers are informed about Mexican American cultural norms, and are given extra time during each session to focus on rapport building with families.

*Eliciting complaints.* Mexican American parents are more likely to place a strong value on "respeto" or respect for authority (Martínez, 1993; Zayas & Solari, 1994). Mexican American parents and therapist both reported in our focus groups that Mexican American parents would be unlikely to challenge the authority of the GANA teacher when they disagree with a recommendation are unhappy with the program. Rather, families who are dissatisfied are more likely to simply stop coming to sessions or to fail to follow through on recommendations without giving an indication that they feel they are not benefiting. Thus, GANA teachers spend time each session discussing parental concerns about the program and encouraging parents to voice any complaints they may have.

*Translation and simplification of written handouts.* The linguistic appropriateness of written materials is particularly important for Latino families (Bernal, Bonilla, & Bellido, 1995). The PCIT program relies on a relatively large number of written handouts so that parents can review them at home and share them with other family members that may not be participating in the sessions. Thus, the GANA program spent a great deal of time translating written materials to Spanish, and also simplifying the language used in the handouts to accommodate individuals with lower levels of education. In addition, we have increased the use of visual cues on the handouts so that family members with low reading levels can more easily grasp the meanings. We have also included pictures of Mexican
American families engaged in PCIT so that they can more readily identify with the examples.

Pilot Effectiveness Trial and Future Directions

Although the GANA program has been based on the best information currently available on how best to modify PCIT for Mexican American families, it is unclear whether these modifications will confer advantage to families in terms of treatment retention, outcomes, and satisfaction with services. Thus, we are currently conducting a pilot effectiveness trial, which will randomly assign 75 Mexican American children with behavior problems to the GANA program, Standard PCIT, or treatment as usual. This trial is being conducted at a community clinic based in a largely Mexican American community. The results of the final phase are expected by 2006 and will provide preliminary data to answer two questions: Is standard PCIT more effective than treatment as usual for Mexican American families? And do the cultural modifications described above boost treatment retention, treatment outcomes, or client satisfaction beyond Standard PCIT? If both of these questions are answered in the affirmative, the process used to design the GANA program will provide a model for the cultural modification of treatments for a range of ethnic minority groups. If, however, PCIT is superior to treatment as usual, but GANA is not superior to PCIT, it will suggest that we simply need to make high quality treatment more available to Mexican American families. We believe that either outcome will provide useful information to the field and inform the allocation of scarce resources.

References


