DEVELOPING A LATINO-ADAPTED PARENTING PROGRAM FOR PRIMARY CARE: A DELPHI STUDY

by

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Latino children suffer from many health disparities compared to their non-Latino peers. One way to minimize these health disparities is by empowering Latino parents through parenting support programs. Primary care agencies, the location where most Latino families prefer to have their physical and mental health care needs met, remain an ideal setting for implementing such parenting programs. However, little to no research has been completed on how to adapt existent primary care parenting programs to the beliefs, values, and practices of Latino families. The first manuscript is a conceptual paper which adds to the cross-cultural and community health literature by comparing existing primary care parenting programs, evaluating how well-adapted they are to the cultural needs of Latino families, and offering suggestions for further improvement. The findings from this study demonstrated that parenting programs that are implemented in primary care settings are severely lacking in their Latino cultural adaptations.

Building off the findings from the first manuscript, the second study sought expert consensus on the best ways for adapting or developing a parenting programs for Latino families in a primary care setting. To achieve this goal, a Delphi study was implemented. The purpose of a Delphi study is to develop a consensus among a group of experts on a particular topic. In order

to achieve consensus, researchers administered a series of questionnaires to 28 experts in the field of Latino culture, primary care parenting services for Latino parents, and first-generation Latino parents. After the first survey was taken, a rigorous qualitative analysis was implemented to sort out the overall themes and categories. A second survey was developed based on the seven themes and 89 categories that were discovered. For the second survey, the researchers gave the participants a list of 89 categorical statements and asked the participants to mark how important they felt each statement was to the building of a primary care parenting program for first-generation Latino parents. Descriptive statistics were analyzed and a third survey was given to the participants. For the third and final survey, the researchers listed the participants' statements listed from most important to least important and the researchers asked the participants to mark the extent to which they agreed with the final results. In conclusion, the researchers discussed the strengths and limitations of this study and provided recommendations for building future primary care parenting program for Latino families.

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A Dissertation

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Doctor of Philosophy in Medical Family Therapy

By

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DEDICATION

This dissertation is dedicated to the countless first-generation Latino families who I have had the pleasure to serve for the last 5 years. Many of those families had experienced years of abuse, violence, and poverty in their country of origin and discrimination while in the United States. I also saw how many of these families struggled to stay connected to their children who were growing up in a world that was completely different than the world in which they grew up. As I began looking at the research literature on health and educational outcomes of Latino children, I was surprised by just how many health and education disparities they suffered when compared to their non-Latino counterparts. I knew that those of us who have lived in the United States all of our lives weren't doing a good enough job reaching our Latino brothers and sisters. I wondered if there was some way that I could help.

Having received formal education in marriage and family therapy and having worked in medical settings since 2013, I wondered how I could provide greater support to our Latino families in a primary care medical setting. I knew that these settings helped eliminate many barriers for receiving help in relationships: The cultural shaming of receiving outside help, the limited hours of getting time off work, and the difficulties of organizing transportation. I began to ponder what it would like if we were to provide parenting support to Latino families in these settings and if we could do it in a culturally-relevant way. After many hours scouring the research on primary care parenting programs, I realized that most programs do not fully consider how culture affects parenting. Some of the programs may have talked about the differences in parenting between cultures or may have translated their material in Spanish. But few made cultural adaptations outside of language translation and none built their programs from the "ground-up" – directly with Latino families and those who regularly serve them. I decided that this was my next step – to study how to make an effective primary care parenting program for

first-generation Latino families and to learn how to do it in a culturally-relevant way. This dissertation, therefore, is dedicated to the thousands of Latino families whom I have served thus far in my career and for the thousands more that may benefit from this study in the future.

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First and foremost, I want to publicly thank my Heavenly Father and His son Jesus Christ for all of Their help during these three years at East Carolina University. I can honestly say that these have been the hardest 3 years of my life, and there have been many instances where God has carried me through and given me strength beyond my own. From the start, God placed into my heart the thought that "I can do this." I usually didn't see how it was possible, but I just kept moving forward, trusting that somehow it would work out. And it always did.

Second of all, I would like to thank my wife and children for their love and support during this journey. My wife, Emily, has been my constant companion, my strongest advocate, and my hope when I thought all was lost. She has been so merciful with me and all my late nights away from home. She has done a magnificent job caring for our five beautiful children and keeping our house clean and safe. She has also spent countless hours listening to me complain, moan, and just about give up. She simply gave, gave, and gave some more. I told her over and over that one day I would "make it up to you" (Imagine Dragon's song). My five children; Asher, Bridger, Titus, Hazel, and Vance; have also been a tremendous support throughout this process. There have been countless nights where I could not make it home before they went to sleep at night or times when I could not attend their activities. There are many hours of daddy time that are owed to them.

Thirdly, I would like to thank my two dissertation chairs, Drs. Jennifer Hodgson and Andy Brimhall, as well as my committee members, Drs. Eboni Baugh and Sharon Knight. Jennifer is the most available person I know and one of my strongest advocates. She has fought for me to finish over and over again, many times going out of her way so I could finish an assignment or turn in a paper. She has spent late nights, early mornings, and weekends to meet with me and provide feedback on my papers. I am in absolute wonder at her willingness to

sacrifice so much for me, particularly when I have been, at times, so ungrateful for her help. Words are not adequate for describing just how grateful I am for her. Andy is one of the most ethical, thoughtful, and thorough person that I know. He always helped me look at the ethics of every decision that I made, and challenged me to think of others over myself. He is an exquisite writer and provides feedback that is so poignant and meaningful. He does not let you get by with mediocre work – if you work with him your assignments will be of the highest quality possible. He has been a great friend and supervision mentor for me throughout this process. Sharon is an expert in qualitative research who was always challenging me to think more critically about the words that I use in my papers. Her qualitative know-how was an invaluable asset throughout this process. Eboni is a leader in social justice and inclusiveness. Her comments always reflected her desire to make programs and policies that were inclusive and culturally sensitive. Her attention to culture and social justice helped to make my paper more culturally attuned.

Finally, I would like to thank all of my friends and family members who walked this journey with me. Particularly, I would like to thank those from the 1st and 2nd year cohorts and those from the Master's program. They took me in and accepted me when I felt excluded from those of my own cohort. They saw value in my contributions and welcomed my input. My parents, brother and sisters, and my in-laws were also a great support for me throughout this journey. In particular, at one point, my entire family fasted and prayed for me that I could finish an important paper and that I would stay in this program. Their prayers and words of encouragement were invaluable to me.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

PREFACE

While working on my Master's degree at Colorado State University, I completed a study which examined the emotional attachment participants formed with drugs. I found a significant portion of participants felt emotionally attached to their drug and that they were experiencing the grief of missing that drug while they received treatment. When I first came to East Carolina University, I planned to do a study on a similar topic as my Master's thesis – this time it would be on bariatric surgery and the grieving process that patients possibly go through when they undergo major changes to their post-surgery diet. However, after learning that East Carolina University was going to lose their only bariatric surgeon soon and that replacement may take many months, I decided to change topics. This was a big change because all of my papers, up this point, were centered on bariatric surgery.

I decided, at this time, to explore other areas of interest. While working in Colorado, prior to coming to North Carolina, I taught Parenting with Love & Logic® classes at a primary care medical clinic. While there, I attempted, on my own, to adapt their English curriculum to Spanish in order to help the Latino families I saw at our clinic. I quickly realized that my own adaptations were not very effective and that I was having difficulty keeping Latino parents engaged in my parenting class. While reflecting on my parenting program experiences in Colorado, I realized that I was trying to teach a parenting program that was developed by white, non-Latino developers to Latino parents, most of which were the first of their families to live in the United States. Although I taught the class in Spanish, I noticed that the parents were not as engaged in the class, nor did they report the same of sort of improvement in their child's behavior that I had seen in the English parenting class.

This discovery led me to read research articles on Latino culture and Latino parenting practices and how, if at all, their practices were different than non-Latino parenting practices. I also read several articles on how researchers attempted to adapt popular parenting programs to Latino language and culture. I discovered that, while there are many similarities between Latino and non-Latino parenting practices, there are also unique differences that are important to consider – differences in the roles and purposes of family generally and parenting specifically. I also discovered that, while there were some parenting programs that had been developed with Latino families in mind, most of these programs had few adaptations beyond Spanish translation and even fewer had been administered in a primary care medical setting.

For the past 5 years, I have worked almost exclusively as a medical family therapist within a primary care medical setting. I worked at a pediatrics, a geriatrics, school-based, and a family clinic where I have primarily served first-generation Latino families (in both Colorado and North Carolina). In these settings I helped Latino families with a variety of health challenges – depression, anxiety, attention problems, oppositional behavior, substance use, pain management, and many others. At the root of many of these problems I saw unhappy families – families that had been torn apart by trauma, abuse, addictions, deportation, miscommunication, acculturation stress, poverty, and many other issues. I found myself often wondering how I could bring more family-centered care to these families. How could I help heal the pain and suffering that came from family disconnection, grief, and loss? One way that I could do this was by implementing a parenting program within a primary care setting. I knew, however, that I needed to make sure that this program was both relevant to Latino families and applicable to a primary care environment.

After discussing my ideas and experiences with my dissertation chairs, we made a decision to move forward with me doing a study on parenting, Latino culture, and primary care. As I dove into the literature around primary care parenting programs, I soon learned that little to no research had been completed on cultural adaptations for Latino families. While a few studies examined the effectiveness of primary care parenting programs, none of them mentioned if and how they were adapting their services to Latino families. This was concerning to me because I knew that unless these programs were making adaptations to the needs of first-generation Latino families, they were not going to reach this population and affect the necessary changes. I knew that their challenges were significantly different than the challenges of those from other ethnic groups, and that adaptation beyond language was essential. I knew at that point exactly what I needed to do: Start the process of developing a parenting program in primary care setting that was relatable and engaging to Latino families.

Before developing a Latino-relevant program, I knew I needed to find out, for certain, what primary care parenting programs were already doing to adapt their services to Latino families. This led me to my first manuscript where I compared existing primary care parenting programs on number of facets: Length, format, costs, training needed, and most importantly, cultural adaptations. I discovered that most programs had few, if any, cultural adaptation outside of Spanish translation and those that did were limited in their parenting scope (e.g., one program was a reading program for parents and children). After this manuscript was written, I turned my focus toward the main manuscript of my dissertation: A study that involved asking Latino parenting experts what it would take to make primary care parenting programs relevant to Latino parents. This study involved recruiting experts in three distinct, yet overlapping areas: Latino parenting research, primary care programming for Latino parents, and first-generation Latino

parents. The results demonstrated that a one-size-fits-all approach will not work with Latino families and that there are a lot of similarities between the needs of Latino and non-Latino parents. At the same time, this program highlighted the need for several adaptations to a program for first- generation Latino parents: A greater focus on face-to-face connection, family loyalty and connection, trauma, and the process of acculturation, to name a few. I believe that this was an important first step toward developing a "ground-up" parenting program – one that is developed by both Latino parents and those who care for them. I believe that this study adds to the parenting, integrated care, and cross-cultural literature by taking the first step toward the creation of a culturally-relevant parenting program in the place where most Latino families prefer to have their healthcare needs met – primary care.

CHAPTER 1: INTRODUCTION

Latinos are the fastest growing ethnic group within the United States, accounting for more than 17% of the total population (Pew Research Center, 2015). Latino children make up approximately 25% of all children within the United States (Child Trends, 2014a). In response to the growing population of Latino Americans and immigrants from other countries, healthcare programs that are delivered in languages other than English have dramatically increased (Hseish, 2016). More healthcare agencies today are hiring bilingual staff and providing training on Latino culture than ever before (Callahan & Gandara, 2014). Despite these achievements, many Latino families continue to live on the borders of society (Aldama, Sandoval, & García, 2012; Anzaldúa, 1999), have access difficulties to health insurance (Center for Disease Control and Prevention, 2017), and suffer from many healthcare disparities when compared to their white, non-Latino counterparts (Center for Disease Control & Prevention, 2017). The purpose of this dissertation is to investigate better ways for delivering culturally-relevant parenting programs within primary care by comparing existent parenting programs and asking Latino and primary care experts about the best ways for developing a culturally-sensitive primary care parenting program. To begin this investigation, it is important to establish what is meant when referring to those from Latin decent.

A Definition of Latino

It is important to define what is meant by the term Latino, a term that has changed and evolved over the years. Rodriguez and colleagues have argued that Latino refers to any person who is originally from Central America, South America, or the Caribbean, regardless of what language(s) they speak (Rodriguez, Parrish, & Parks, 2017). Others have defined Latino as individuals from Central or South America, or the Caribbean whose predominant language is Spanish (Varela & Hensley & Hensley-Maloney, 2009). The United States Census uses the

terms Latino and Hispanic interchangeably and allows all individuals to self-identify as either Latino or Hispanic (2010). In addition, the U.S. Census Bureau distinctly defines Latino or Hispanic as an ethnic group and not a racial group (2010). Therefore, those who identify as Latino and Hispanic must also identify as one of six federally-recognized racial groups: white, black or African American, Indian/Alaskan Native, Hawaiian/Pacific Islander, or Some Other Race. On a different note, others have opted for the use of a more gender-neutral term such as Latinx or Latin@ instead of Latino or Latina (de Onis, 2017). For the purposes of this study, Latino is defined as anyone living in the United State who is originally from Central, South America, or the Caribbean, regardless of what language(s) they speak. Latino was selected over the terms Latinx and Latin@ because the word Latino can be used in reference to all Latino individuals, regardless of their sex or gender identity (Gonzalez & Morrison, 2016).

Latino Culture

It is important to note that Latinos vary considerably in their cultural beliefs and practices, depending on numerous factors such as where they live within the United States and their country of origin (Savoy, 2016). Just as with any other race or ethnicity, those of Latino decent do not abide by the same cultural expectations or abide by it to the same extent (Pew Research Center, 2012). Research has shown, however, that while there are many differences among Latino individuals, there also remains many similarities (Marin & Marin, 1991). For example, research generally categorize Latinos as a collective group of people (Arevalo, So, & McNaughton-Cassill, 2016). This means that they place heavy emphasis on interdependence and loyalty toward members of their immediate and extended family system. Within the Latino culture literature, this phenomenon has been termed *familismo (*Smith-Morris, Morales-Campos, Alvarez, & Turner, 2013).

Latino families are also similar in many other ways. Research has shown that Latino families show a high degree of warmth and affection toward their family members. These similarities are exemplified by their use of physical touch and nombres cariñoso (caring names) among friends and family. This attribute has been termed *personalismo* in the literature (Barker, Cook, & Borrego, 2010). Additionally, Latino families show a high degree of respect and deference toward parents, grandparents, doctors, teachers, and other people in positions of authority. The tendency to avoid conflict has been termed *simpatia* and this deference toward authority figures has been termed *respeto* (Guillermo-Ramos et al., 2009). Latino culture has also, historically, placed on different gender roles between men and women – with men more likely to be the head of the home and the financial "breadwinners" for their family and women more likely to be in charge of homemaking and the raising of children (Dreby, 2006; Torres, Solberg, & Carlstrom, 2002). Finally, Latino families are more likely to encourage a belief in God to their children and to derive peace and healing from spiritual or religious practices (Lubell et al., 2008).

These cultural values are important to understand because they can also greatly influence the ways in which Latino families parent their children. For example, parents may expect their children to show complete obedience, attention, and deference toward authority figures (Barker et al., 2010), or they may teach their children that the needs of others take precedent over their own needs (Mendez-Luck, Applewhite, Lara, & Toyokawa, 2016). For many Latino families, gender roles are also important, with fathers often playing the role of the financial provider, protector, and discipliner, and women as nurturers, moral guides, and homemakers (Torres et al., 2002). These gender roles also influence how they parent their children, with researcher demonstrating that many Latino parents give more autonomy to boys and more warmth and

monitoring shown toward girls (Domenech Rodríguez, Donovick, & Crowley, 2009). For those Latino families who place emphasis on spirituality, they may also rely on prayer and other spiritual practices to heal their children or they may place strong emphasis on the development of "inner characteristics" such as respect and honesty (Guillermo-Ramos et al., 2007). Researchers examining parenting styles found many Latino families adopt what has been called a "protective" parenting style. This style is characterized by parents showing high levels of warmth, high levels of demandingness, and low levels of autonomy-granting toward their children (Domenech Rodríguez et al., 2009).

These sociocultural tendencies are important to understand because they impact Latino families in many facets of their life – from how they parent their children to how they interact with their medical providers. Being aware and sensitive to these cultural beliefs and values is important for providing culturally sensitive-programs designed to minimize the health disparities impacting Latino children (Varela & Hensley-Maloney, 2009). A brief review of these health disparities are included in the following section.

Health Disparities Impacting Latino Children

Research has demonstrated that Latino children suffer from many health disparities when compared to their non-Latino counterparts (Vargas Bustamante, Fang, Rizzo, & Ortega, 2009; Vega, Rodriguez, & Gruskin, 2009). According to the U.S. Census Survey from 2007-2011, approximately 22% of all Latino Americans fell below the federal poverty rates (Macartney & Bishaw, 2013), with approximately 16.2% of all Latinos being without health insurance as of 2015 (Barnett & Vornitsky, 2016). Research has also shown that Latinos are less likely to be satisfied with their healthcare services (Haviland, Morales, Dial, & Pincus, 2005), less likely to receive appropriate preventive care (Vargas Bustamante, Chen, Rodriguez, Rizzo, & Ortega,

2010), and more likely to have poorer healthcare outcomes than white, non-Latinos (Tienda & Mitchell, 2006). In addition to these healthcare disparities, research has also shown that Latino children have high rates of obesity (Center for Disease Control and Prevention, 2017), depression (Céspedes, & Huey, 2008), anxiety (Varela & Hensley-Maloney, 2009), substance use (Partnership for a Drug-Free Kids, 2012), academic problems (Child Trends, 2015), drop-out rates (Krogstad, 2016), suicidal thoughts and attempts (Zaya & Pilat, 2008), teenage pregnancy (Rocca, Doherty, Padian, Hubbard, & Minnis, 2010), and risky sexual behaviors (Deardorff, Tschann, Flores, & Ozer, 2010). The theory of acculturation can be used as framework for understanding these health disparities, particularly when it relates to health status differences between generations.

The Theory of Acculturation

These disparities are due, in part, because the United States has failed to enact policies and programs that embrace multiculturalism (Potowski & Rothman, 2011). Multicultural programs are programs that are adapted to the needs and preferences of their patients - most particularly, minority groups (Berry, 2005). Acculturation expert, John Berry, has discovered that minority groups that migrate to other counties tend to endorse one of four different strategies when adapting to their new country: (a) integration, (b) assimilation, (c) separation, or (d) marginalization. He also discovered that the selection of these strategies is highly dependent on the acculturation strategies endorsed by the majority culture. Those within the majority culture who embrace what he calls "multiculturalism," encourage an acculturation strategy of integration by the minority group. Integration occurs when those from the minority group (a) adapt to the cultural values and practice of their new country, and (b) maintain cultural values and practices from their country of origin. In 2006, Berry and his colleagues discovered that those immigrants

who endorsed an integration strategy had the lowest levels of depression, anxiety, psychosomatic symptoms, academic problems, conduct problems, and discrimination when compared to all other strategies (Berry, Phinney, Sam, & Vedder, 2006). According to the theory of acculturation, helping Latino families endorse an integrated strategy of acculturation would result in the best health outcomes for Latino children.

Theoretical Application to Latino Families

According to Berry's theory of acculturation, majority groups should do all that is possible for developing policies and programs that are multicultural. Multicultural policies and programs are policies and programs that advocate for (a) the maintenance of heritage cultures and identities and (b) full and equitable participation of all cultural groups in society (Berry & Sam, 2013). Berry and Sam suggested that multiculturalism must go beyond the notion of diversity, or the living of people from different cultural backgrounds within the same region. They suggested that it must include regular interaction between those from each cultural group. Applying the theory of acculturation to primary care parenting programs means that programs should, with the exception of abusive practices, encourage the maintenance of parenting values, beliefs, preferences, and styles from their country of origin. It also means that parenting programs should be developed by the voice of those whom the parenting program affects and that it should be inclusive of all parents, regardless of their values, beliefs, and styles. Barker and colleges argue that it is not enough that parenting programs are being adapted to the preferred *language* of Latino families - they must also be adapted to the preferred *beliefs, values,* and *practices* of Latino families (2010). Only by making more multicultural programs, parenting programs included. can researchers hope to minimize the health disparities impacting Latino children and their family members.

The Purpose and Design of Study

The aim of this study, therefore, was to survey Latino parenting experts, primary care parenting experts, and first-generation Latino parenting experts with the purpose of coming to a consensus on what topics should be included in a primary care parenting program and which formats for delivery are the most effective, efficient, and culturally sensitive. In order to accomplish this goal, a Delphi methodology was used (Dalkey, 1969). This methodology was designed to bring together the voices of experts who have a shared interest in a particular topic, with the end goal of coming to a working consensus between all participants. This consensus process was accomplished through the use of questionnaires, which were administered over a course of a specific timeframe. Each successive questionnaire was adapted based on the participants' responses on the previous questionnaire (Hasson, Keeney, McKenna, 2000). The end goal of this current Delphi study was to generate a list of suggestions, opinions, and best practices that experts can agree upon for delivering a culturally-relevant primary care parenting program to first-generation Latino parents and their children.

The second chapter of this study includes an in-depth review of the research literature on Latino-adapted parenting programs and primary care parenting programs. This chapter shows that primary care parenting programs have, overall, been found successful in improving parent-child relationships, reducing parental stress and depression, and helping children reach important development milestones such as reading and counting (Berkule et al., 2014; Boyle et al., 2010; Cates et al., 2016; Kendrick et al., 2008). This chapter also demonstrates, however, that few primary care programs have been adapted to the needs of Latino children. At the end of this chapter, recommendations are given for ways to better serve first-generation Latino parents in primary care settings.

The third chapter includes a description of the methodologies used for this study. This chapter reviews the purposes of a Delphi study and explains the recruitment process, the study procedures, and the data analyses that were applied. Researchers recruited participants until 30 people who either identified as: (a) a first-generation Latino parent, (b) a Latino culture researcher, or (c) a primary care healthcare provider who works regularly with Latino families were identified. Finally, this chapter also addresses ethical considerations when completing a Delphi study and what steps the researchers took to minimize ethical concerns.

Chapter four is dedicated to the first of two publishable manuscripts for this study. The purpose of this first manuscript was to examine pre-existing primary care parenting programs along a number of programmatic factors including length, format, costs, and Latino cultural adaptations. The results of this manuscript demonstrated that most primary care parenting programs had few cultural adaptations outside of Spanish translation. This manuscript showed that significantly more research is needed to better adapt primary care parenting programs to the cultural needs of Latino families. Finally, recommendations for future primary care parenting programs are given.

Chapter five contains the second publishable manuscript based on the findings from this dissertation study. For this manuscript, the authors explain the literature review, the methods, the results, and the discussion sections of a Delphi study that was completed by 28 Latino culture, parenting, and primary care experts. The results demonstrated that primary care parenting facilitators should be knowledgeable in familismo, the extent of diversity among Latino families, and the role of acculturation and its effects on Latino families. These findings also demonstrate which parenting topics are the most important, which educational methods are

the most effective, and other preferred characteristics of a primary care parenting program that is adapted to the needs and preferences of first-generation Latino parents.

Lastly, chapter six will be presented. The purpose of this chapter is to review the results from Chapter 5 and to discuss implications for clinical practice, research, policy, and medical family therapy. Clinically, the researchers recommended that primary care agencies create an environment where: (a) language proficiency is the norm, (b) family-oriented care is standard, patient interactions are both (c) professional and (d) personal, (d) gender roles are openly discussed, and (e)immigration history, and (f) trauma are thoroughly assessed. Research implications include the need for more operational, clinical, and financial research and policy implications include greater attention to family-oriented and culturally-relevant healthcare policies. The results of this study demonstrate that systematically and biopsychosocially-trained therapists, such as medical family therapists, are ideal candidates for leading culturally-relevant parenting programs in a primary care environment.

CHAPTER 2: REVIEW OF THE LITERATURE

Since 1970, over 40 million immigrants from Latin American have come into the United States. Today, Latino is the largest ethnic group within the United States, representing approximately 17% of the United States population as a whole and approximately 25% of all children (Pew Research Center, 2015). Acculturation expert, John Berry, suggests that when immigrants come into a new country they adopt one of four basic in strategies in response to being within a new culture: (a) assimilate (b) integrate, (c) separate, or (d) marginalize (2005). His theory of acculturation also postulates that those from the majority implement one of four basic strategies in response to being in contact with the minority culture: (a) melting pot, (b) multiculturalism, (c) segregation, and (d) exclusion (2005). Follow-up studies have indicated that those within the majority should do all that is possible to develop programs that are multicultural – programs that advocate for (a) the maintenance of heritage cultures and identities and (b) full and equitable participation of all cultural groups (Berry & Sam, 2013). Programs that are multicultural encourage those from the minority group to adopt an integrative strategy of acculturation – a strategy where minority groups (a) adapt to the cultural values and practice of their new country and (b) maintain cultural values and practices from their country of origin (Berry & Sam, 2013).

Although strides have been taken for making primary care agencies multicultural (Callahan & Gandara, 2014; Hseish, 2016), a recent review of primary care parenting programs revealed that most parenting programs do little to adapt their programs beyond Spanish translation (Haralson, Hodgson, & Brimhall, 2018). In response to the lack of cultural adaptations made for parenting programs, several authors have challenged parenting program developers to more fully consider the language, the values, and the needs of Latino parents –

including more attention to spirituality (Santiago & Wadsworth, 2011), familismo (Calzada, 2010), personalismo (Chang & Liou, 2009), and gender roles (Rafaelli & Ontai, 2004). In addition, other researchers have recommended that more attention be paid to the acculturation stress (Barker et al., 2010), the generation gaps between parent and child (Marsiglia et al., 2009), the immigration trauma (Nathenson-Mejia & Escamilla, 2010), the legal issues related to immigration (Martinez & Eddy, 2005), and the economic disparities (Pew Research Center, 2012) that impact many Latino families. The purposes, therefore, of this chapter is to review the existent literature on primary care parenting programs and cultural adaptations that have been made for these programs. Following this review, the theory of acculturation and how it applies to primary care parenting adaptation will be described in greater detail. Finally, recommendations for future studies on primary care parenting programs will be given and the purposes of this current study will be outlined.

Primary Care Parenting Programs

Although relatively sparse, parenting programs designed for implementation in primary care do exist. Parenting programs include set manualized procedures designed to enhance parenting behaviors (Child Welfare Information Gateway, 2013). It is important to distinguish it from parenting services which is a general term used to describe all programs, interventions, or resources designed to assist parents. Research has shown that parenting programs conducted within a primary care setting come in a variety of formats and that they are implemented at different levels of behavioral health integration (McDaniel, Doherty, & Hepworth, 2014). For example, some programs may have a behavioral health provider who is always on-call for parenting consultation, while others may expect their behavioral health provider to follow-up at a later time via a telephone call. For programs directly implemented at the primary care site, they

generally target parents of children six and under and are usually integrated into routine well child visits (Shah, Kennedy, Clark, Bauer, & Schwartz, 2016; Svetaz, Garcia-Huidobro, & Allen, 2014). Primary care parenting programs are generally brief in nature (i.e., a 15-minute psychoeducational session) and administered as part of an on-going parenting program (Boyle et al., 2010). In addition, some of these programs may take place while parents wait for the provider while others are implemented directly after the medical provider has seen the patient (Shah, DeFrino Kim, & Atkins, 2017). These programs may also include in-home visits, telephone information lines, video recordings of parent-child interactions, parenting groups, and one-on-one services as needed (Cates et al., 2016; Minkovitz et al., 2003; Scholer, Hudnut-Beumler, Mukherjee, & Dietrich, 2015; Weisleder et al., 2016). Research has also demonstrated that these primary care parenting programs differ widely in purpose.

Purpose of primary care parenting programs. The purposes and intended outcomes of these programs are varied (Haralson et al., 2017). Some have been designed to help children reach important developmental milestones such as literacy, numeracy, and cognitive stimulation while others have been designed to improve parent-child relationships, reduce parental stress, or increase knowledge around appropriate parenting practices (Berkule et al., 2014; Cates et al., 2016; Kendrick, Barlow, Hampshire, Stewart-Brown, & Polnay, 2008). Some parenting programs teach more general parenting skills while others are designed specifically to aid parents in coping with, preventing, or treating certain health condition such as autism spectrum disorders (Tellegen & Sanders, 2014), post-partum depression (Cook et al. 2012), or childhood obesity (Gerards et al., 2012). Research on the effectiveness of primary care parenting programs have shown mostly positive results.

Effectiveness of primary care programs. Most primary care parenting programs have been found successful in preventing, managing, and improving healthcare outcomes, particularly for children under six years of age (Cates, Weisleder, & Mendelsohn, 2016). For programs offered to young children, primary care parenting programs reduced symptoms of parental stress and depression, harsh discipline, and the prevalence of childhood disruptive behavior; as well as improved parental responsiveness, cognitive stimulation, and monitoring (Berkule et al., 2014; Boyle et al., 2010; Cates et al., 2016; Kendrick et al., 2008). In addition, these programs helped children be better prepared for school, have better literacy and numeracy, improved vocabulary, and reduced exposure to media (i.e., television). Relationally, these programs improved family functioning, shared reading quality, and parent-child relationships satisfaction (Berkule et al., 2014; Cates et al., 2016; Kendrick et al., 2008). However, two studies measuring the effectiveness of the Primary Care Triple P program found no significant difference between their program and treatment as usual in preventing psychosocial problems or improving parent-child interaction (Schappin et al., 2014; Spijker, Jansen, & Reijneveld, 2013). While parenting interventions have been shown to be effective, overall, in primary care more research is clearly needed on how to make these programs more effective. One way that may improve the effectiveness is to develop programs that are adapted to the cultural values and preferences of those whom they serve.

Parenting Programs for Latino Families

According to several reviews on Latino parenting and culture, parenting programs that are adapted to the language, values, and culture of Latino parents, have better parent-child outcomes than programs that do not adapt their programs (Barker et al., 2010; Domenech Rodriquez, Baumann, & Schwartz, 2011). Those programs that are adapted to the values, needs,

and preferences of Latino parents are considered culturally relevant –demonstrating clear and intentional cultural adaptations (Aronson & Laughter, 2016). Adaptation, in general, refers to changes within a parenting program's curriculum, while tailoring signifies a more individual adaptation that is designed to meet the needs of a particular group of people or to ameliorate a specific problem (Collado, MacPherson, Risco, & Lejuez, 2013). For example, while a program may be adapted to the meet the cultural value of familismo, it may be tailored to providing a parenting program for substance use cessation or designed to lower a patient's body mass index. In recent years, many programs have been developed which have been adapted to the linguistic needs of Latino parents (i.e., direct translation into Spanish), including Healthy Steps, Incredible Years, Play Nicely, Reach out and Read, Safe Environment for Every Kid, Video Interactive Project, Helping our Toddlers, Developing our Children's Skills, Triple-P Parenting Program, Becoming a Love and Logic Parent, Child-Parent Relationship Therapy, The Magic Years, the Nurturing Parenting Program, Criando a Nuestros Ninos hacia el Exito, Avance Parent Child Education Program, Community University Initiative for the Development of Attention and Readiness, and the Early ON School Readiness Project (Agazzi et al., 2010; Ceballos & Bratton, 2010; Cudaback et al., 1994; Devall, 2004; Dumas et al., 2011; Johnson & Walker, 1991; Lakes et al., 2009; Lakes et al., 2011; Montanez et al., 2010; Winter et al., 2007). Although these programs have adapted their programs to the linguistic needs of many Latino patients, research indicates that cultural adaptation are still lacking (Vesely, et al., 2014).

Cultural Adaptations for Parenting Programs

A recent systematic review (Vesely, et al., 2014) and conceptual paper (Haralson, Hodgson, & Brimhall, 2018) have demonstrated that significantly more attention is needed in adapting parenting programs to the cultural values and preferences of Latino parents. In 2013,

Vesely and colleagues compared 13 parenting programs where 50% or more of the participants identified as Latino or Hispanic. Of the thirteen programs reviewed in this systematic review, only seven of the programs offered cultural adaptations beyond translation, including flexible start and end times, emphasis on familismo and personalismo, bringing and sharing food among participants, and making personalized phone calls. Considering that more than half of the participants in these studies identified as Latino, the authors recommend that more needs to be done to further adapt these programs to the needs of their participants. The authors gave the following recommendations when developing a parenting program for Latino families: (a) staff who provide parenting service must be culturally competent, (b) staff must recognize that cultural competence is a process that takes place over time, (c) local community leaders and stakeholders must be connected to ensure cultural competence among staff members, (d) diverse voices, including Latinos, should be heard throughout all phases including development, implementation, and evaluation, (e) programs must go beyond Spanish translation, and (f) staff must be provided with on-going training and mentoring (Vesely et al., 2014).

More recently, Haralson and colleagues conducted a conceptual paper which compared primary care parenting programs that were translated into Spanish (2018). Their purpose was to discover if and how primary care parenting programs are adapting their programs to the values, needs, and preferences of Latino families. They rated each of these primary care parenting programs as either have none, few, some, or many cultural adaptations. Of the eight programs reviewed, one had no adaptations, four had few adaptations, two had some adaptations, and one had many adaptations. The adaptations that they discovered included offering parenting groups, having pictures of Latino parents on websites or brochures, consultations with community and Latino culture experts, research that asked Latino parents about their level of satisfaction with

their program, and Spanish language options on their websites. Although these programs implemented some adaptations, none of the programs described how their actual parenting curriculum was adapted or how Latino parents preferred to receive parenting services within a primary care setting. The authors recommended an increase in: (a) community-based participatory research, (b) financial research that examines cost-effective approaches to parenting programs, and (c) programs that incorporate commonly held Latino values such as familismo, personalismo, simpatia, respeto, time flexibility, gender roles, and spirituality (Haralson et al., 2018).

Primary Care Parenting Programs for Latino Families

While several primary care parenting programs have been translated into Spanish (Berkovits et al., 2010; Billings, 2009; Dubowitz et al., 2009; Mendlesohn et al., 2007; Minkovitz et al., 2003; Perrin et al., 2015; Scholer et al., 2009), little is known on how primary care parenting programs are being adapted to meet the needs and values of Latino families. One program, Reach Out and Read (Byington et al., 2008), which is routinely implemented within primary care, encourages parents to read to their child, while providing books in either English or Spanish. Although they have a long, established relationship working with Latino parents in primary care, their program does not address parenting issues beyond shared reading time between parent and child.

Another parenting program, Play Nicely, which is routinely offered within primary care settings, is available in both English and Spanish, with no cultural adaptations outside of language translation (Smith et al., 2017). However, in a survey administered to 41 people who identified as Latino, nearly 100% of the participants found that the intervention addressed their family's needs, respected their family's values, were presented in a way the family could

understand, and were sensitive to their family's belief system (Smith et al., 2017). Despite these positive results, this intervention was, on average, only seven minutes long and addressed one specific problem - how to intervene when siblings fight with one another.

Finally, the Aqui Para Ti program hires bilingual and bicultural providers, gives out medical information in both English and Spanish, and provides care to both parents and their children in the same visit (what the researchers call "parallel care") (Svetaz, Garcia-Huidobro, & Allen, 2014). While this program does assess for areas such as family cohesion and communication and provides information on parenting strategies, parenting is only seen as an auxiliary service, with their main parenting component focused heavily on preventing smoking and other forms of substance use among teenagers (Allen et al., 2017). In addition, outside of direct family involvement within the primary care environment, the program does little to explain how it, in other ways, adapts to the cultural values of Latino parents (Svetaz et al., 2014). Using the theory of acculturation as a framework, it is suggested that primary care parenting programs do more to adapt their programs to the values, preferences, and needs of Latino parents. Doing so will encourage more Latino parents to use an integrative strategy of acculturation when parenting their children within the United States.

The Theory of Acculturation

John Berry has studied the process of acculturation for more than 40 years (Berry, 1974). He is interested in understanding the phenomenon that takes place when two or more cultures come in contact with one another. He discovered that minority groups that migrate to other counties tend to endorse one of four different acculturation strategies (Figure 1). The selection of these strategies is dependent on the acculturation strategies endorsed by the majority culture. Those within the majority culture who embrace what he calls "multiculturalism," encourage an

acculturation strategy of integration by the minority group. In 2006, Berry surveyed over 5,300 youth from over 13 different countries (Berry, Phinney, Sam, & Vedder, 2006). He and his colleagues discovered that youth who used an integration strategy had the lowest levels of depression, anxiety, psychosomatic symptoms, academic problems, conduct problems, and discrimination when compared to all other strategies. Integration occurs when those from the minority group: (a) adapt to the cultural values and practice of their new country, and (b) maintain cultural values and practices from their country of origin.

According to this theory, majority groups have a duty to provide policies and programs that embrace multiculturalism advocating for: (a) the maintenance of heritage cultures and identities, and (b) full and equitable participation of all cultural groups in society (Berry & Sam, 2013). Berry and Sam suggested that multiculturalism must include regular interaction between those from each cultural group, not simply living together without routine interaction. Applying the theory of acculturation to primary care parenting programs means that programs should encourage the maintenance of parenting values, beliefs, preferences, and styles from their country of origin within the bounds of non-abusive parenting. It also means that parenting programs should be developed by the voice of those whom the parenting program affects and that it should be inclusive of all parents, regardless of their values, beliefs, and styles.

Conclusion

In sum, effective parenting has consistently been linked to the prevention, improvement, and elimination of health conditions that routinely impact children (Carlson et al., 2014; Froehlich et al., 2012; Guilamo-Ramos et al., 2009; Hoskins 2014; O'Connell et al., 2009; Rosser et al., 2014; Santelli & Beilenson, 1992; Zayas & Pilat, 2008). Parenting interventions have been also shown to prevent, improve, or minimize the impact of many childhood health

conditions such as asthma, obesity, eczema, learning disorders, and teenage pregnancies (Dyches, Smith, Korth, Roper, & Mandleco, 2012; Morawska, Mitchell, Burgess, & Fraser, 2017; Olvera & Power, 2010; Rose, Prince, Flynn, Kershner, & Taylor, 2014). Researchers found primary care facilities can be an effective way of preventing healthcare disparities related to access and outcome, reaching those who are underserved, reducing the stigma associated with mental health, and meeting the cultural needs of ethnic minorities (Brunelle & Porter, 2013; National Association of Community Health Centers, 2017). Unfortunately, primary care parenting programs have often been negligent in meeting the cultural and linguistic needs of Latino parents (Smith, et al., 2017; Svetaz et al., 2014). Using the theory of acculturation as a guide, the researchers give the following recommendations for future primary care parenting programs.

1. Primary care parenting programs should involve the voices of Latino parents when developing their programs. This can be done in numerous ways such as through focus groups, field observations, questionnaires, and participant consensus.
2. Greater attention needs to be paid to the process of acculturation among Latino parents. Particularly for those parents who are the first of their immediate family to live in the United States, the process of individual and family acculturation has a significant impact on the type of parenting a Latino parent will employ and the effectiveness of that strategy.
3. Primary care program should seek the voices of both Latino parents themselves and those who care for Latino parents. This may include Latino parenting researchers, medical providers, outreach workers, primary care support staff (i.e., medical assistance, front desk staff), operational and financial managers, and mental health providers. Delphi

methodologies may be particularly useful in eliciting the voices of participants who live a considerable distance from one another.

4. Primary care parenting programs must see parenting as more than an auxiliary service. All staff members must be trained in Latino culture and evidence-based parenting strategies and policies need to be in place which promote family-centered healthcare services such as parenting programs.

Previous literature indicates that few primary care parenting programs exist that have cultural adaptations. This trend is unfortunate because previous research has shown that culturally-adapted programs can help improve client retention and satisfaction (Domenech Rodríguez, Baumann, & Schwartz, 2011). This dissertation hopes to fill this gap by enlisting experts who can provide recommendations for making culturally-relevant primary care parenting programs for Latino families.

The Purpose of this Study

While systematic reviews have been completed on general Spanish-adapted parenting programs (Vesely et al., 2014), and on primary care parenting programs (Cates et al., 2016; Shah et al., 2016), no known study has investigated how to develop a parenting program that is both adaptive to the primary care environment and grounded in Latino culture. The theory of acculturation suggests that programs developed within primary care must be inclusive of those whom they serve (Berry & Sam, 2013). Because parenting programs are being implemented with greater frequency within primary care environments (Cates et al., 2016), it is imperative that more research is done on how to make these programs multicultural. Multicultural programs are of particular importance to Latino children and their parents, who make up the largest ethnic or racial minority group within the United States (Pew Research Center, 2015) and who continue to

suffer from a plethora of health disparities when compared to their non-Latino counterparts (Vega et al., 2009). The purpose of this dissertation, therefore, is to come to a working consensus on what components a parenting program adapted to first-generation Latino families must have in order to be (a) effectively and efficiently administered in a primary care setting and (b) culturally relevant to the Latino parents whom they serve.

CHAPTER 3: METHODS

Latino children suffer from many health disparities when compared to their non-Latino counterparts (Vega et al., 2009). Latino teenagers, particularly those born within the United States (Alvarez, Jason, Olson, Ferrari, & Davis, 2007), have higher rates of depression, anxiety, substance use, dropping out of high school, risky sexual behavior, suicidal thoughts, and suicidal attempts than white, non-Latino teenagers (Céspedes, & Huey, 2008; Department of Health and Human Services, 2015; Partnership for a Drug-Free Kids, 2012; Krogstad, 2016; Vega, Rodriguez, & Gruskin, 2009; Varela & Hensley-Maloney, 2009). One way that healthcare professionals have attempted to minimize these health disparities is by implementing parenting support programs within primary care (Shah et al., 2016; Svetaz et al., 2014). These programs have been proven successful in improving some parent and child healthcare outcomes, including reduced rates of harsh discipline and improved rates of literacy (Cates et al., 2016; Scholer et al., 2015). However, most of these programs have either been: (a) designed for children under the age of 5 (Shah et al., 2016), or (b) have been developed with little to no cultural adaptations to speak of (Smith et al., 2017).

According to Berry's theory of acculturation (2005), when immigrants come to a new country, they will either: (a) assimilate (b) integrate, (c) separate, or (d) marginalize to the dominant culture of the host country. Integration, as described in the literature review, has been shown to have the best psychological outcomes for minority groups migrating to new countries (Berry et al., 2006). Because integration results in the best outcomes for the minority group, those within the majority group have a responsibility for developing an integrative environment. This can be done by adopting what Berry calls a multicultural strategy – a strategy of adapting the dominant cultural practices to the cultural practices of the minority group and by allowing the

minority group to adapt in the ways that fit them best (Berry, 2011). The purpose of this study, therefore, was to develop a consensus from experts both in Latino parenting and parenting programs within a primary care setting. Given that resources are often limited, developing a consensus from a group of identified experts is important because it can potentially help researchers and curriculum developers save time and energy when developing programs for Latino parents in the future. Through this research, the researchers sought the answers to the following two questions:

(a) What topics need to be addressed when providing a parenting intervention to first-generation Latino parents in primary care?

(b) How can primary care parenting interventions be delivered to first-generation Latino parents in an effective, efficient, and culturally sensitive way?

To answer each of these questions a Delphi methodology was used. The following sections will describe the process and purposes of the Delphi method, as well as the specific ways the researchers recruited, administered questionnaires, analyzed data, and ensured the completion of ethical research for this study. Prior to beginning the study, the study was approved by the University's Institutional Review Board (IRB).

The Delphi Method

The Delphi methodology was first developed in the 1950's by Dalkey and Helmer (1963) as a systematic way of coming to expert consensus on a particular topic. Delphi methods are distinct in the fact that participants do not have to meet face-to-face in order to come to consensus. Experts are recruited from various parts of the world, with the consensus process generally taking place over the Internet, through the use of questionnaires. The Delphi process

for this study followed three basic steps: (a) recruitment, (b) procedures and analysis, and (c) ethical considerations. Each of these steps will be described in the sections that follow.

Recruitment. To obtain group consensus, the researchers recruited experts on Latino parenting. Consistent with Ludwig's recommendations (1993), this study sought the expert opinion among different, yet related experts, including those who the outcomes of this study were intended to help (Anderson & Schneider, 1993). The researchers decided that the coming together of these three distinct, yet overlapping groups of people would give the study the depth of expertise that was desired. In order to recruit these participants, the researchers followed an adapted version of Okoli and Powlowski's recruitment process (2004). This recruitment process included four basic steps: (a) prepare a knowledge resource worksheet (KRNW), (b) populate the KRNW with names, (c) nominate additional experts, and (d) invite participants.

Step 1: Prepare a knowledge resource nomination worksheet (KRNW). The knowledge resource nomination worksheet was designed to increase the chances of recruiting a diverse panel of experts who could comment on different aspects of Latino parenting, primary healthcare settings, and parenting programs for Latino families. Using this worksheet, the researchers designed (a) the inclusion criteria that the participants must meet to be considered an expert, and (b) the strategies that the researchers would use to recruit these experts (Table 1). The researchers decided on the following inclusion criteria: (a) researchers who have published at least five articles on the topics of Latino culture and parenting, (b) primary care healthcare providers who provide a minimum of 10 hours of parenting services each week to Latino families, and (c) first-generation Latino parents who have a child eighteen years or younger living at home (Table 2).

Step 2: Populate the KRNW with names. Because the researchers were interested in recruiting participants from three distinct categories, the researchers used several different methods to recruit each category of experts. The researchers recruited through: (a) an email listserv, (b) a search of the literature, (c) university and journal websites, (d) personal contacts, (e) a local community health center, and (f) direct referrals from other experts. Prior to contacting the potential participants, the researchers obtained university IRB approval. To reduce the probability of attrition, the researchers offered an incentive after each phase and at the end of the final survey phase. After each survey was completed, the researchers gave each participant a code for a complimentary 1-night DVD rental. Among those who completed all three surveys, the researchers randomly selected one to receive a $100 gift card.

For those who were recruited through a local community health center, they were recruited by bilingual medical family therapists employed at the site. These medical family therapists, who routinely provide brief behavioral health interventions (i.e., 15-20 minutes) for first-generation Latino parents, handed a flyer in Spanish to each patient who they believed met at least one of the inclusion criteria. The medical family therapists briefly described the purpose, the requirements, and the incentives for the study and invited each parent to contact the lead investigator, via email if interested in participating.

Step 3: Nominate additional experts. The purpose of this step was to ask those who agreed to participate if they knew of any other people who met the inclusion criteria. If the participants knew of other experts who might be willing to participate, the lead researcher contacted each potential participant either by phone, through email, or in person. If they consented to participate, the researchers added their names to the list of participants. The researchers repeated steps two and three until a minimum of 30 people consented to participate.

For participants who met more than one of the inclusion categories, they were placed into the expert category with the least amount participants until each category had a minimum of 10 participants.

Step 4: Invite participants. For this step, the researchers emailed each participant with a brief description of the study (Appendix C) and a link to the Qualtrics survey. The following sections of the Qualtrics survey were included (in this order): (a) language preference, English or Spanish, (b) informed consent document, (c) demographic survey questionnaire survey, and (d) seven open-ended questions related to Latino parenting and primary care programming.

Procedures and Analysis. The Delphi method is an ideal approach for eliciting the voices of minority group members and the voices of those who regularly work with them (Dalkey & Helmer, 1963). In order to elicit these voices, a three-phase method (Green et al., 1999; Proctor & Hunt, 1994) was used in this study. Each phase, other than the final one, consisted of three basic steps: (a) administer the survey, (b) analyze the data, and (c) develop a survey for the next phase. For the final phase, researchers administered the survey, analyzed the data, and then wrote the final results. Table 3 outlines the Delphi procedures followed in this study.

Phase 1. For the first phase, researchers began with seven open-ended questions in order to elicit a large amount of data from participants without overwhelming them (Green, 2014). Although there is no set amount of open-ended questions that all researchers agree upon, one researcher suggested that at least six questions should be asked (Schmidt, 1997). This process ensured that the researchers elicited sufficient data to develop themes among the participants and that a variety of subjects on the same topic could be explored. After the first questionnaire was completed, the researchers extracted themes from the qualitative data (Brady,

2015; Corbin & Strauss, 2008) and then designed a new questionnaire based on the results. The results of the qualitative analysis process were then integrated into a second questionnaire that was administered in phase two. There were three steps for phase two: (a) survey administration, (b) data analysis, and (c) survey design.

Survey administration. Participants began the Delphi process by indicating whether they wanted their questionnaire to be administered in Spanish or English, indicating which inclusion criteria they identified with (based on certain criteria), and agreement to the online-administered informed consent. Directly after the informed consent was signed, the participants completed a 19-question demographic survey questionnaire and, following Schmidt's (1997) recommendations, answered seven open-ended questions related to the two over-arching research questions that inform this study. The researchers used the translation component of Qualtrics to translate each questionnaire into Spanish. These translations were then verified independently by two bilingual and bicultural experts. The seven open-ended questions in English are presented in Table 4.

Having all questionnaires turned in within a specific timeframe is important in a Delphi study because analysis cannot begin until all questionnaires for that phase are complete. To help participants complete the study in a timely manner, email reminders were sent to each of the participants approximately one week after the initial recruitment email and approximately once a week after that. Once all participants completed the phase one questionnaires, the researchers began the data analysis process for that phase.

Data analysis. To begin the analysis process for phase one, the researchers translated the participants' responses from Spanish into English using two independent translators. Following the translation, the researchers uploaded the responses into Nvivo 11, a program designed to

assist in the process of categorizing qualitative data (Nvivo, 2010). Once the data was placed into Nvivo 11, the researchers read and coded the data, line by line, until final themes and categories began to emerge (Brady, 2015). Themes indicated a broader, more over-arching meaning that was based on the data while a category indicated a single statement that summarizes the essence of several participant responses. For example, a group of responses that centered around the topic of acculturation were collapsed into one single category entitled acculturation and the stress derived from this process, and placed into a larger over-arching theme called Facilitator Knowledge. To minimize bias, the researchers also kept analytical journal – journals which helped the researchers write down their thought processes, their values, and biases as they analyzed the data (Corbin & Strauss 2008). Once each participant analyzed their portion of the data, the researchers discussed the data and any identified categories, as well as emerging themes. During this part of the analysis process, the researchers discussed which themes and/or categories to either (a) keep, (b) abandon, or (c) merge. This process continued until the researchers reached 100% agreement. The seven themes that emerged from the coding process were: (a) Facilitator Knowledge, (b) Program Participants, (c) Program Characteristics, (d) Program Timing, Length, and Duration, (e) Program Location (f) Program Topics, and (g) Program Educational Methods. After the data were categorized, an auditor reviewed the results to ensure they were grounded in the raw data. This was a person who was listed on the study's IRB.

In addition to participants' responses, the researcher conducted a literature review. Using the help of a librarian trained in systematic reviews and literature searches, the researchers located systematic reviews, meta-analysis, or comprehensive literature reviews on Latino parenting programs found within and outside of primary care settings. They used the following

databases in order to accomplish this task: CINAHL, Ovid Medline, PubMed, and PsycInfo and the following keywords: “Latino,” “Latina,” “Hispanic,” “Parenting,” “Parenting Program,” “Parent Education,” “Primary Care,” “Community Health Center,” and “Integrated Care.” The purpose of this literature search was to find articles that could answer the two overarching research questions: (a) What topics need to be addressed when providing a parenting intervention to first-generation Latino parents in primary care? and (b) How can primary care parenting interventions be delivered to first-generation Latino parents in an effective, efficient, and culturally sensitive way? The articles were selected if they could provide specific recommendations for making parenting programs culturally relevant to Latino families and/or relevant to primary care agencies.

Additional cross-references were also used until all possible articles were found. After eliminating articles that did not meet the inclusion criteria, the authors located a total of eight articles. Once all articles were located, the researchers merged the data from the research articles with the data from the expert participants. Once the data from both sources were combined, the researchers then applied Brady’s (2015) thematic analysis process (as explained previously) to analyze: (a) the participants’ responses, (b) the discussion sections of the meta-analysis or systematic reviews, and (c) the manuscript as a whole for the literature review.. The researchers selected the discussion sections of the articles because they provided a succinct review of the findings of each article and because they elicited the suggestions and opinions of the researchers based on the findings for that study.

In the Delphi process, the researchers added questions addressing information derived from the literature to the second questionnaire. This strategy ensured that the participants’ initial responses on the questionnaire used during first phase of the Delphi process were given equal

consideration and not simply used to verify what is in the peer-reviewed literature. Adding categories derived from the literature to the questionnaire administered during the second phase of the Delphi process may have helped spur new ideas that the participants had not thought of or had forgotten.

Creation of a new questionnaire. Once the data from both the literature review and the participants were agreed upon by both researchers, the researchers then eliminated in repetitive responses and/or merged responses that held similar meanings. This was done until complete agreement among the co-researchers was obtained using the same process described in the previous section. Data were then transformed into questions and uploaded into Qualtrics where a four-item level of "importance" response choice in the form of a four-point Likert scale was offered for each statement. Response choices to the questions were: [1] Not Important, [2] Somewhat Important, [3] Very Important, and [4] Essential. This four-point scale was chosen to capture participants' beliefs about each statement's level of importance.

Phase 2. The purpose of the second phase (and all other intermediate phases) is to clarify and rank the participants' responses using Likert scales and statistical analyses (Hasson et al., 2000). This is generally accomplished by developing a list of mutually exclusive responses spoken by the participants, followed by a Likert scale that assesses each participants' level of agreement with that response. This may also include statements that are derived from the research literature. Through the use of descriptive statistics, the researchers then ranked each statement by those with the highest selected statistical parameter (such as mean, median, or mode) that fits the purposes of their study.

Administer the survey. The second Delphi questionnaire was administered to those who participated in Phase one of the study. This questionnaire consisted of a combined list of

participants' responses, separated into the seven working themes, on a four-point Likert scale. The researchers gave participants two weeks to complete the survey. Reminder emails were sent to participants who had not yet responded by the requested deadline. Additionally, the researchers added survey questions that reflected ideas from the related peer-reviewed literature.

Analyze the data. For the data analysis step in phase two, the researchers began by exporting the quantitative data from Qualtrics into a Microsoft Excel spreadsheet. Within Microsoft Excel, the researchers calculated the standard deviation, median, mode, mean, and interquartile ranges for each response.

Creation of a new questionnaire. After the statistical analysis was complete, the researchers developed a third questionnaire. Each statement was listed in rank order by its mode and interquartile range (≥ 1) score. Mode was selected because mean scores are not recommended with ordinal data and median scores are not recommended with scales that have data point (such as a 4-point Likert scale) (Holey, Feeley, Dixon, & Whittaker, 2007). Interquartile range, which measures the median differences between data in the upper 25% of data and data from the lower 25%, was also used to analyze the data. This number helped researchers know the degree of variability between the data and together, with the mode, and provided a robust data analysis process for verifying whether consensus was reached. After each theme, the researchers asked the following question: "Reflecting on each response and their percentages from the list above, to what extent do you agree with these results?" followed by a comment box which stated, "Please comment below if you would like to explain more." At the end of this questionnaire, one final question was asked: "Reflecting on the entire survey, to what extent do you agree with the results as a whole?"

The response choices for the third questionnaire were in the form of a 6-point Likert scale that ranged from strongly agree to strongly disagree. The researchers selected a 6-pont scale to provide participants greater variability in their final answer choices then the previously used 4-point Likert scale. The data derived from the comment boxes were analyzed using Brady's thematic analysis (2015), as described previously.

Phase 3. The purpose of the final phase of the Delphi process was to confirm each participants' level of agreement with the final product (Hsu & Sandford, 2007). Although there is no agreed-upon standard for what equates to consensus, most researchers suggest that anywhere from 50% to 80% of the respondents should agree with the final product (Hasson et al., 2000). If the numbers fall below 50%, the researchers can report the data and discuss why consensus was not possible, or they can provide additional phases until the consensus threshold is met. For this study, 100% of all the participants either somewhat agreed, agreed, or strongly agreed with the final results.

Administer the survey. The final survey, which included a list of participants' statements, ranked in order by their median scores, were accompanied with one final question to assess whether consensus has been obtained. This survey was administered to each participant approximately one week after receiving and analyzing the results of the second questionnaire. The participants were given approximately 10 days to complete the final survey.

Analyze the data. Data elicited from the final survey underwent both qualitative and quantitative analyses. The same qualitative methodology used previously (Brady, 2015) was used again to analyze the qualitative data, and the same descriptive statistics used previously were ran to analyze the quantitative data. The researchers then transferred over the final results to Microsoft Word to be used for the final manuscript write-up.

Final results write-up. The final results accompanied by a discussion section are presented in Chapter 5. In this study, the researchers determined that consensus was established if at least 50% of the participants marked either "Very Important" or "Essential" and if the category had an Interquartile Range of 1.0 or less. The implications of the findings presented in Chapter 5 are discussed in Chapter 6 in conjunction with implications for further research.

Ethical Considerations. There are several ethical concerns to keep in mind when administering a Delphi study. First of all, anonymity between the researcher and the participants is usually not possible during a Delphi study (Goodman, 1987). Typically, researchers have access to each participants' contact information in order to track which experts had responded to questionnaires associated with each phase of the process, to send reminders to participants to complete a survey, and to forward incentives if necessary. Anonymity was ensured, however, between each of the participants' responses, with each participant uninformed about the identity of other participants in the study. Additionally, researchers needed to carefully track the responses of each participant to ensure that participants completed each phase of the study in a timely manner. For these reasons, it was important that researchers had a password-protected database where they could keep track of all confidential data that was being collected.

To ensure confidentiality for this study, all data were stored in two password-protected locations: (a) Qualtrics and (b) ECU Pirate Drive. All emails, phone calls, data transcription, translation, and analysis took place in this same office space or another confidential and secure room in a University campus building. To ensure confidentiality when recruiting at the local community healthcare centers, special precautions needed to take place. First, the researchers ensured that only the potential participants were in the room when discussing the logistics and qualifications of the study, and they only received explanations about (a) the purposes of the

study, (b) the requirements for the study, and (c) incentives associated with the study. Each potential participant was handed a flyer with the researcher's University email address on it; no personal information for this research study was collected during this time. Before recruiting participants at this site, the researchers received written permission from the community healthcare center's Chief Executive Officer to conduct the research study, and they advised the prospective participants' providers that the researchers were taking a few minutes of their patient's wait time to recruit for the study. Second, to ensure that the researchers did not take away clinically useful time from the provider or patient, the researchers collected data only when participants were waiting to see their provider and when no other medical procedure or test was being performed. The researchers also ensured that healthcare providers for potential study participants knew that data collection would be commencing, that the encounters would take no more than five minutes of their patient's time, and that the researchers were talking with their patients only while their patients were waiting to be seen.

Another ethical concern of a Delphi study, as is common in most other qualitative studies, is researcher bias and its potential influence on the study's outcomes (Noble & Smith, 2015). To mitigate this potential ethical concern, it is recommended that researchers undergo typical qualitative steps that ensure results are as unbiased as possible. To mitigate research bias for this study, the researchers engaged in reflexivity (Palaganas, Sanchez, Molintas, & Caricativo, 2017)), analytical journaling (Brady, 2015),member-checking (Birt, Scott, Cavers, Campbell, & Walter, 2016), and bracketing (Tufford & Newman, 2012). Although the process of reflexivity and bracketing took place throughout the analysis process (Palaganas, Sanchez, Molintas, & Caricativo, 2017), it began by having the researchers write down their values and beliefs regarding Latino/Hispanic culture and parenting, parenting programs, parenting in

general, and primary care settings. From there, the researchers kept analytical journals in order to continue the reflexivity and bracketing process throughout the entirety of the analytical process. During the journaling process, the researchers made special efforts to journal about: (a) why they selected the answers they did, (d) judgements concluded about the responses, and (c) thoughts of either disagreement or agreement with the participants' statements (Corbin & Strauss 2008). Additionally, the Delphi process itself ensures a form of member-checking by asking each participant to comment on the statements that are being provided during each phase of the survey process. Finally, an internal auditor reviewed the data and the coding to ensure that the codes were based in the participants' responses. The researchers took these steps to help minimize the influence of research bias in the analysis of the data.

Conclusion

One way to include parents more effectively in the healthcare decision-making of their children is to involve them in a parenting program that can be implemented in primary care. A group that are experiencing health disparities within the United States is Latino children and their parents. They suffer from many physical and emotional health disparities when compared to their non-Latino counterparts. Implementing a parenting program, specifically designed to meet the needs of first-generation Latino parents, could help reduce these health disparities. The purpose of this current study, therefore, was to ask Latino parenting and primary care experts, along with the Latino parents themselves, about what topics should be taught in a primary care parenting program for first-generation Latino parents and how they could develop a culturally-relevant parenting program in a primary care setting. Using the Delphi Method, the researchers aimed to gain insight into culturally appropriate content and best strategies for implementing a culturally-sensitive parenting program for first generation Latinos within a primary care setting.

Table 1. Knowledge Resource Nomination Worksheet – Inclusion Criteria

(1) **Latino Research Expert:** Someone who has published at least 5 research articles or conceptual papers on the topic of Latino parenting needs, practices, values, or preferences.

(2) **Primary Care Expert:** A primary care healthcare provider to Latino children who teaches, counsels with, or provides parenting interventions at least 10 hours per week with Latino families. A primary care healthcare provider includes anyone in a health-related field who provides direct healthcare services. This does not include support staff.

(3) **First-generation Latino Parenting Expert:** A Latino parent who has at least one child under the age of 18 years, who currently lives with them. They are the first of their immediate family to live in the United States permanently.

(5) Must be able to read and write in either Spanish or English.

(6) Must have access to the Internet and a working email address.

Table 2. Knowledge Resource Nomination Worksheet – Recruitment Strategies

Latino Research Experts:

(1) *Literature Searches:* Using a trained librarian as a guide, the researchers searched the words "Latino," "Latina," "Hispanic," "primary care," "community health center," "parenting education," "parenting program," and/or "parenting intervention" into CINAHL, Ovid, PsycINFO, and PubMed.

(2) *Listserv Emails:* Recruitment emails were sent out through the following organizations

(3) *Professional Websites*: Researchers were recruited either through University, research agency, or research journal websites.

(4) *Referrals:* Participants were asked if they knew of others who were interested in participating via the snowball sampling method.

(5) *Personal Contacts:* Latino research experts who were known by the research team were invited to participate.

Primary Care Experts:

(1) *Listserv Emails:* Recruitment emails were sent out to healthcare organizations

(2) *Community Health Center:* Providers and patients at a local community health center were asked to participate.

(3) *Personal Contacts:* Primary care experts who were known by the research team were invited to participate.

First-generation Latino Parenting Experts:

(1) *Listserv Emails:* A recruitment email was sent out through healthcare organizations.

(2) *Community Health Center:* Patients at a local community health center were invited to participate.

(3) *Community Outreach:* Flyers at local stores, restaurants, churches, and schools where there are a high population of Latino families were dropped off.

(4) *Personal Contacts:* First-generation Latino parenting experts who were known by the research team were invited to participate.

Table 3. Delphi Procedures

Phase 1
Step 1 – Administer a questionnaire with open-ended questions.
Step 2 – Analyze the questionnaire using qualitative methods.
Step 3 – Develop a new questionnaire based on the qualitative methods.
Phase 2
Step 1 – Administer a questionnaire using Likert or other multiple-choice questions.
Step 2 - Analyze the questionnaire using descriptive statistics and qualitative methods.
Step 3 – Develop a new questionnaire based on the results of the statistics.
Phase 3 (The final phase)
Step 1 – Administer the final questionnaire, inquiring about each participant's level of agreement with the final results.
Step 2 – Analyze the results of the final questionnaire using descriptive statistics. Calculate percent needed to reach consensus.
Step 3 – Write up the study results.

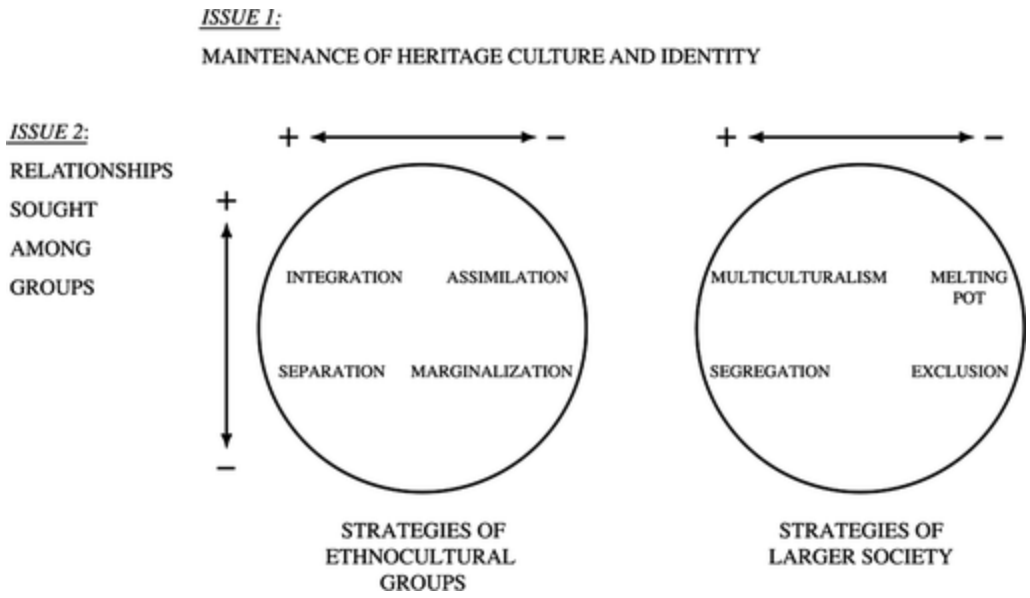
Table 4. Seven Open-Ended Questions for Phase 1

1. What do you believe are the major challenges that first-generation Latino parents face while parenting within the United States? Please describe this in as much detail as possible.
2. If you were to create a parenting program for first-generation Latino children within a primary care medical setting, are there any topics that you would make sure to address? If so, what would those topics be? Please describe this in as much detail as possible.
3. Drawing on your personal and professional experiences with primary care medical settings, what do you believe is the best way to deliver parenting interventions to first-generation Latino parents within primary care? Please describe this in as much detail as possible.
4. If you were to create a parenting program for first-generation Latino parents within a primary care medical setting, when would be the best time to deliver such a program? (i.e., in the waiting room, before or after the doctor's visit). Please explain why you would deliver the program in that way. Please describe this in as much detail as possible.
5. If you were to create a parenting program for first-generation Latino parents within a primary care medical setting, how long would you recommend that each parenting session last (e.g., 5 minutes, 15 minutes, 30 minutes, an hour)? Please explain why you would deliver the program in that way. Please describe this in as much detail as possible.
6. If you were to create a parenting program for first-generation Latino parents within a primary care medical setting, would your program be time-limited (i.e., 6 sessions

long), would it be on-going (no beginning or end), or would you use some other format? Please explain why you would deliver the program in that way. Please describe this in as much detail as possible.

7. If you were to create a parenting program for first-generation Latino parents within a primary care medical setting, how would you ensure that your program was culturally appropriate to the needs, values, and preferences of Latino parents in the United States? Please describe this in as much detail as possible.

Figure 1. Acculturation Strategies*



*Berry et al., 2006

CHAPTER 4: A COMPARISON OF PRIMARY CARE PARENTING PROGRAMS FOR LATINO FAMILIES

Since 1970, over forty-four million Latino families have immigrated to the United States (Pew Research Center, 2015a). Today, nearly one in four children under the age of eighteen identifies as Latino, with approximately 90% of all Latino children living in the United States born within its borders (Child Trends, 2014a). Latino children living within the United States suffer many health disparities when compared to their non-Latino peers including higher rates of depression, anxiety, substance use, conduct disorders, teenage pregnancies, suicidal thoughts, and suicide attempts (American Psychiatric Association, 2017; Becker et al., 2014). However, it is well known that parents can be a powerful source for minimizing health disparities and preventing, improving, and treating health conditions affecting children (Shah, Sobtka, Chen, & Msall, 2015) and that improved health for the child can result in improved health for the entire family system (Luciano et al., 2012).

Parenting experts have lamented, however, that there are not enough culturally-relevant parenting programs for Latino parents (Barker, Cook, & Borrego, 2010, Domenech Rodriguez, Donocik, & Crowley, 2009; Svetaz, Garcia-Huidobro, & Allen, 2014; Vesely, Ewaida, & Anderson, 2014). Out of those programs that have been developed, many were adapted from previously designed parenting programs or adapted through Spanish translation only (Vesely et al., 2014). Ensuring that parenting programs are sensitive to the cultural values, needs, and preferences of those who attend is important because research has shown that cultural and linguistic mismatches between the practitioner and the patient, the stigma of seeking mental health services, and limited socioeconomic resources keep many ethnic minorities from engaging with and finishing parenting programs (Dumas, Moreland, Gitter, Pearl, & Nordstrom, 2008).

Eliminating these barriers is key for improving the accessibility and effectiveness of parenting programs for Latino families.

One model of care that has proven successful in eliminating socioeconomic and stigma-related barriers to mental health care is the Patient Centered Primary Care Collaborative model (PCPCC). According to the PCPCC healthcare model, primary care services should be integrated and comprehensive and should include provisions for behavioral healthcare services (PCPCC, 2018). This model attempts to eliminate socioeconomic and stigma-related barriers by integrating medical, dental, behavioral health and other services into one location, minimizing the chances of others knowing *why* a patient has come to see their healthcare provider. This model of care is also in-line with medical and behavioral health researchers who found that most people, Latino families included (Herman, Ingram, Rimas, Carvajal, & Cunningham, 2016), prefer to see their primary care provider for mental health issues (Kessler & Stafford, 2008).

One barrier to treatment, however, that remains unexplored is how well-adapted primary care parenting programs are to the needs, values, and preferences of Latino parents and their families. While a meta-analysis and a systematic review have previously been completed on primary care parenting programs for young children (Cates et al., 2016; Shah, Kennedy, Clark, Bauer, & Schwartz, 2016), no systematic reviews or meta-analyses have been conducted on Latino-adapted or designed primary care parenting programs (Smith, Hadnut-Beumier, & Scholer, 2017; Svetaz et al., 2014). Using the theory of acculturation as a guide, this article will review primary care-based parenting programs to better understand if and how they are culturally relevant to Latino parents. Recommendations will be provided for primary care settings interested in adapting or developing culturally-relevant primary care parenting programs for their Latino patients.

Primary Care Parenting Programs

Although community-based parenting classes have been around for many years (Gordon, 1970), their implementation into primary care settings is relatively new (Sege et al., 1997). With the recent national push toward family-centered, comprehensive primary care services, providing parenting programs within primary care is becoming more feasible (U.S. Department of Health and Human Services, 2008).

Parenting programs within primary care have been delivered in a variety of formats. In general, they have been studied as either a discrete intervention (i.e., brief psychoeducation session) or as part of a manualized parenting program administered to parents of children under the age of five during well-child visits (Cates et al., 2016; Shah et al., 2016). Some programs are assessment and referral based (Paradis, Sandler, Manly, & Valentine, 2013) while others are part of a more comprehensive parenting strategy; delivered in diverse formats (face-to-face, video, telephone, and written material) and locations (the doctor's office, the waiting room, the community room, or the patient's home) (Cates et al., 2016; Shah et al., 2016).

The foci of primary care parenting programs are also varied. Some have been designed to help children reach important developmental milestones such as literacy, numeracy, and cognitive stimulation (e.g., through reading and playing) (Mendelsohn et al., 2007), while others have been designed to improve parent-child relationships through reduced parental stress (Berkule et al., 2014), increased parental knowledge (Kendrick, Barlow, Hampshire, Stewart-Brown, & Polnay, 2008), or improved parent-child relationships (Berkovits, O'Brien, Carter, & Eyberg, 2010). A few primary care parenting programs have been designed to prevent or mitigate specific health problems such as attention deficit hyperactivity disorder (ADHD) (McMenamy, Sheldrick, & Perrin, 2011), substance abuse (Allen et al., 2017), or obesity

(O'Connor, Hilmers, Watson, Baranowski, & Giardino, 2013). These programs range from brief interventions (such as a brief family session) to entire clinics dedicated to addressing one particular health problem (i.e., obesity clinics).

The Need for More Multicultural Parenting Programs

The theory of acculturation, developed by John Berry (2005), posits that programs and policies that are multicultural yield the best long-term outcomes for both majority and minority groups. In a study in 2006 by Berry and colleagues, they discovered that participants followed one of the following four distinct strategies when adapting to a new culture: (a) integration, (b) assimilation, (c) separation, or (d) marginalization. They discovered that those who used an integration strategy had the lowest levels of depression, anxiety, psychosomatic symptoms, academic problems, conduct problems, and discrimination compared to the other strategies. Integration occurred when immigrants attempted to maintain cultural aspects from their country of origin, as well as adopted certain cultural practices from their host country (Berry et al., 2006). In addition, integration was more likely to occur when the dominant group employed a multicultural strategy – a general desire for diversity, equity, and inclusion across all cultural groups (Berry & Sam, 2013). On this crux, Berry along with many other cross-cultural researchers, advocate for more multicultural programs, policies, and procedures (Arends-Tóth & van de Vijver, 2003; Berry & Sam, 2013).

Relating to parenting programs specifically, many parenting and cross-cultural experts also advocated for more multicultural parenting programs (Barker et al., 2010, Domenech Rodriguez et al., 2009; Svetaz et al., 2014; Vesely et al., 2014). They suggested that more research and attention needs to be paid on both the process (Vesely et al., 2014) and content of parenting classes (Barker et al., 2010). For example, Vesely and colleagues (2014) found in their

systematic review on Latino-adapted parenting interventions that many parenting programs adapted to Latino-preferred processes by: (a) allowing flexibility to the start and end times of parenting programs, (b) providing group parenting sessions over individual parenting courses, (c) allowing time to socialize before beginning class, (d) making personalized phone calls during the week, and (e) encouraging members of the parenting classes to bring food to share.

In addition to adapting parenting program processes to Latino values, other researchers recommended that the content of parenting programs need to be adapted as well. In Barker and colleagues' review of Latino culture (2010), they suggested that parenting program materials should be translated into Spanish and verified by a Latino culture expert and that programs should place emphasis on principles of respeto (respect), familismo (family connection), personalismo (friendliness), acculturation stress, machismo (masculine gender roles), and marianismo (feminine gender roles) (Barker et al., 2010; Guillermo-Ramos et al., 2007). In addition to recommendations (Barker et al., 2010), researchers identified that religion and spirituality are also important components of parenting for many Latino families (Salkas, Magaña, Marques, & Mirza, 2016).

Because over 34% of all Latinos have immigrated to the United States from another country (Pew Research Center, 2015a), it is also important that researchers understand the struggle that many Latino parents go through when deciding which parenting culture they want to adopt (American Psychological Association, 2012; Berry, 2005). This decision-making process is difficult because their children may also be torn between two or more different cultures, causing distress for both parent and child. Researchers also highlighted that Latino parents and children reported experiencing higher rates of discrimination, racism, violence, and substance abuse than their white, non-Latino counterparts, particularly if they have immigrated

to the United States from another country (American Psychological Association, 2012). If parenting programs are going to be effective, it is imperative that they address the role of trauma and its influence on parenting.

Comparison of Parenting Programs Adapted to Primary Care

Primary care settings, the place where most Latinos prefer to have their mental and physical health care needs met (Herman et al., 2016), are an ideal setting for addressing parenting issues and developing culturally-relevant programs. However, little is known on how primary care parenting programs are being adapted or developed for Latino parents (Smith et al., 2017; Svetaz et al., 2014). According to Berry's theory of acculturation (2005), to develop a multicultural parenting program, primary care parenting programs should go beyond Spanish translation by adding specific educational methods, delivery formats, and content areas that Latino families prefer. However, to date, no one has reviewed the available primary parenting programs to see which ones have been adopted to meet the needs of Latino families.

The following comparison project was completed to highlight which primary care parenting programs have been translated in part or full for Spanish-speaking patients, and which, if any, were designed by and for Latino families. Because most Latinos within the United States identify Spanish as their dominant language (Pew Research, 2015b), programs offered in Spanish and/or designed to honor Latino culture were the focus of this project. For the purposes of this project, we defined Latino as anyone originally from Central America, South America, or from the Caribbean, whose dominant language is Spanish (Varela & Hensley-Maloney, 2009). However, in order to showcase what has been designed or adopted for Latino families specifically, a broader review of existing primary care parenting programs, regardless of language or cultural considerations, was initiated. To be included in the comparison, parenting

programs must have included the following: (a) a published program name, (b) a step-by-step, manualized treatment protocol, (c) be designed/adapted for use in a primary care setting, and (d) have parenting as its central focus and not as an auxiliary service (i.e., a program whose primary purpose is to provide education on diet). Because the focus of the comparison table (Table 5) was to review general parenting programs, studies were excluded if their primary focus was on treating a diagnosable health condition such as obesity (O'Connor et al., 2013).

The process for identifying primary care parenting programs was as follows. First, the authors looked for systematic reviews on primary care parenting programs using relevant academic search engines (PubMed, MEDLINE, CINAHL, PsycINFO; limiting the search to "systematic review") and a systematic review database (Cochrane Library). Two critical systematic reviews were identified (Shah et al., 2016; Cates et al., 2016). Second, the words "parenting class," "parenting program," "parenting education," "primary care," "community health," "Latino (a)," and "Hispanic" were searched using the academic search engines listed previously. Once a parenting program was identified, each published article's literature review and reference sections were carefully examined for additional parenting programs along with cross references from each lead author. After reading the program description sections in each article, the parenting program study was either kept or eliminated from the comparison project based on the aforementioned inclusion/exclusion criteria.

Once all the parenting programs that met the inclusion criteria were identified, additional programmatic information was obtained by either: (a) contacting the program developers or lead authors, (b) searching the program's official website, or (c) searching for additional articles written on that specific parenting program. Once the criteria for the comparison chart was established (Table 5), each author reviewed the comparison matrix line by line to ensure

accuracy of data. The information was then organized into columns according to the following categories: (a) references (b) focus, (c) age of child, (d) delivery, (e) sequence, (f) duration, (g) training length, (h) estimated start-up costs, (i) number of cultural adaptations, and (j) adaptations. Each will be operationalized below.

References

References refers to articles that were used to provide programmatic information for the creation of the comparison matrix. Although not specified in the matrix, data derived from each programs' website was also used.

Focus

Programs were classified into one of four distinct foci – *Basic infant care, school readiness, discipline,* and *referral*. *Basic infant care* refers to any program designed to help parents who are adapting to having an infant at home – this includes basic education around sleeping routines, social support, breastfeeding, playing, and reaching developmental milestones. *School readiness* are those programs designed to help children prepare to enter formal education, typically between the ages 3 and 5 years old. These programs generally place emphasis on reading, counting, cognitive stimulation, attention, and social skills, among other areas important to this age range. *Discipline* refers to those programs whose primary purpose is to instruct and guide parents on how to respond to difficult behaviors such as tantrums, sibling rivalry, or disobedience. *Referral* refers to programs where its primary purpose is to assess for developmental, behavioral, mood disorders, or other concerns; provide a brief intervention; and then refer out to other programs or services.

Age of Child

This category refers to the chronological age of the child for which the program reportedly was designed to target.

Composition

This category refers to the family composition that the intervention was designed to benefit. In other words, can the intervention be used with parents only or is it necessary to have children involved in the intervention? Programs that do not require the presence of the child to administer the intervention, are called *Individual.* Although the intervention may include the use of role-plays or other interactive activities, the intervention does not require the child to be present. Programs that require the presence of both the parent and child to be administered, are called *Family* interventions.

Sequence

This category refers to whether or not the program takes place during routine well-child checks (WCC). Although most programs can be used in conjunction with well-child checks, only programs designed specifically for use during well-child checks were marked as WCC. Programs that were used as needed were labeled PRN (A medical term meaning "As needed").

Duration

Duration refers to the recommended length of the program. Some programs' duration varies based on severity of the problem, the needs of the parents, the type of therapy format, or the age of the child.

Training Length

Training length refers to the length of time that it takes to qualify to teach or offer the parenting class.

Estimated Start-Up Costs

For the purposes of this study, only the costs of training, material, and curriculum were calculated for each program. Once these start-up costs were calculated, programs were assigned a value using $ through $$$$$ depending on its overall start-up costs (i.e., ranging from $0 to more than $10,000). Several of the programs noted that their programs were billable through health insurance, meaning that some or all of their expenses could be recouped.

Number of Cultural Adaptations

Number of cultural adaptations refers to the number of intentional adaptations that each program underwent to incorporate Latino culture. These cultural adaptations could include a Spanish-translated website, pictures of Latino families, personalized phone calls as part of the curriculum, cultural consultation during development, time flexibility, time set apart for open discussion, or group/family formats. Programs were rated as either possessing none, few, some, or many. Because all of the programs listed in this comparison matrix were, at a minimum, translated into Spanish, the word *none* refers to programs with no cultural adaptations outside of Spanish translation. Programs were rated as *few* if they had one to two cultural adaptations, rated as *some* if they had three to four cultural adaptations, and rated as *many* if they had five or more cultural adaptations.

Adaptations

This category specifies in what ways the program was adapted or developed to meet the needs of Latino parents. *Group Option* refers to programs that offer group parenting formats. *Latino Pictures* refers to programs that have Latino pictures on their written material or videos. *Video Translation* refers to programs that translated their videos into Spanish and *Cross-Cultural Research* refers to programs that have included aspects of Latino culture in their research.

Community Consult refers to programs that have consulted Latino community members during development and *Expert Consult* means they have consulted cultural experts when adapting or developing their programs. *Spanish Website* refers to programs who have an option of viewing most or all of their website in Spanish. And finally, *Not Applicable* refers to programs with no known cultural adaptation to their program (outside of Spanish translation).

Results and Discussion

The results from this comparison matrix demonstrate that primary care parenting programs vary greatly in purpose, implementation format, and level of cultural adaptation. Consistent with previous research (Cates et al., 2016; Shah et al., 2016), most parenting programs have been designed for children five years old or younger. Only one parenting program that met the inclusion criteria was tailored to children between the ages of eight and sixteen years old. None of the programs were developed for parents of children 17 years old or older. This lack of attention to the needs of Latino teenagers is concerning because previous researchers found that Latino teenagers and young adults have higher rates of substance use, risky sexual behavior, and mental health challenges than their non-Latino teenage and young adult peers (American Psychiatric Association, 2017; Becker et al., 2014; U.S. Census Bureau, 2015). Parenting programs in primary care could aid Latino parents in discussing these challenging but critical adolescent and young adult topics, by developing a culturally safe place to talk and learn about these topics (Svetaz et al., 2014).

Secondly, these programs varied in how they were adapted for primary care settings. Two of the programs are family-based while six of the programs could be delivered without a child present. Because the value of familismo is important to Latino families, delivery methods that involve both the parent and child may be ideal. In addition, only two of the programs

provided optional group modalities as part of their primary care curriculum. Previous researchers reported that, for Latina women, group formats may be preferable to individual sessions, as this enabled participants to socialize with other women in similar situations (Nadeem, Lange, and Miranda, 2008). Group formats may also be preferable to individual formats because group formats present one way of honoring the collectivistic nature of Latino culture. These formats are particularly important as women are significantly more likely than men to attend parenting sessions (Panter-Bricker et al., 2014) and primary care visits with their children (Garfield & Isacco, 2006). The material for each program compared also varies with some using more printed material (Spijkers, Jansen, & Reijneveld, 2013) to others using more technology-based delivery protocols (Monroe Carell Jr. Children's Hospital, 2017). The prevalence of technology-based parenting programs is significant because previous researchers reported that Latino patients were significantly more likely to experience illiteracy than white, Non-Hispanic patients and therefore, may prefer more visual educational methods (such as video demonstrations) (U.S. Department of Education, 2003).

While the training length for each program was similar (2-3 days), the cost of each program varied widely. The least expensive programs were those not seeking continuing education credit. The SEEK program, for example, had no start-up costs, with all modules, handouts, and screening tools available free online. On the more expensive side, two of the programs cost over $10,000 in estimated start-up fees. The costs of these programs depended greatly on the intensity of the program, with wrap-around, comprehensive services being more expensive than those that are one-time interventions. Steep initial and on-going costs may be a significant barrier for primary care settings, particularly for those serving low-income families (e.g., Federally Qualified Healthcare Centers and Public Health Departments). Because

approximately 21% of Latino families are below the U.S. poverty rate, parenting programs that are expensive may prevent some agencies from being able to provide affordable parenting services (U.S. Census Bureau, 2016). However, it is important to note that several of the larger, more expensive programs have shown that the benefits out-weigh the long-term costs of not implementing their program and that certain parenting services can be reimbursable through health insurance (Foster, Prinz, Sanders, & Shapiro; 2008; The Women's and Children's Health Policy Center, 2003).

Although each of the programs listed in this comparison matrix have been translated into Spanish, this comparison shows that much more work is needed to make parenting programs more multicultural so that effectiveness can be measured appropriately. Four programs had a few cultural adaptations, two programs had some cultural adaptations, and one had many cultural adaptations. For one program, no cultural adaptations were found in the literature. Although a few of the programs cited Latino cultural values in their research (Smith et al., 2017; Zuckerman, 2009), none of the programs mentioned how their program reflected familismo, personalismo, machismo/marianismo, spirituality, or acculturation in their curriculum or delivery methods.

Perhaps the lack of cultural adaptation can be attributed to the fact that many of the programs analyzed in this comparison were considered by developers as a "universal" or "general" parenting program, teaching parenting principles that cut across cultural lines (Shah et al., 2016). This focus on developing general parenting programs is concerning, however, because researchers uncovered that (a) programs that adapt to cultural variables have higher use and retention rates (Dumas et al., 2008) and (b) multicultural programs and policies have been shown to increase tolerance, safety, and justice among minority groups (Arends-Tóth & van de Vijver, 2003). Based on the information presented in the comparison matrix and suggestions

from other cultural experts (Barker et al., 2010, Domenech Rodriguez et al., 2009; Svetaz et al., 2014; Vesely et al., 2014), recommendations are provided below for furthering the research, development, and implementation of parenting programs for Latino families in primary care settings.

Recommendations and Conclusion

Integrating behavioral health services (such as a parenting class) into primary care settings is no small feat (Peeks & the National Integration Academy Council, 2013). Program developers who wish to adapt their programs into primary care must create a realistic plan for financial and cultural sustainability, as well as on-going research to prove effectiveness (Hodgson, Lamson, Mendenhall, & Crane, 2014). Developers must find primary care champions (e.g., PCPs, nurses, behavioral health providers) who have interest in multiculturalism, and a desire to address the parenting issues present among families seeking care in their practices. Several parenting programs and community-based researchers advocate for finding a "champion" who can spearhead their project (Katigbak, Foley, Robert, & Hutchinson, 2016; Reach Out and Read, 2014). As demonstrated in this comparison, topics such as program focus, length, delivery method, sequence, age of child, and duration warrant consideration. In addition, developers must find ways to pay for both start-up and on-going costs. Program-related expenses can be addressed through health insurance reimbursement, funded grants, fee-for-service, donations, or other ethical mechanisms for covering the cost of a parenting program. Without a strong plan for both cultural and financial sustainability, multicultural programs cannot hope to survive within a reimbursement driven field like healthcare (Rivers & Glover, 2008).

One particular minority group focused on in this paper are Latino families. As indicated in this paper, many existing programs were written for majority group families and adapted linguistically to the Latino population (e.g., translating existing information into Spanish). While linguistic adaptation is a step toward cultural adaptation, it is not sufficient. More effort needs to be paid to designing culturally appropriate programs that are tailored to the population and adapting existing parenting programs to align with Latino beliefs, values, and customs. These adaptation efforts can be accomplished by using both top-down and bottom-up approaches (Beasley et al., 2014). Top-down approaches include the adaptation of parenting programs based on previous research that has been completed with the population. In regard to Latino culture, more parenting programs can strive to incorporate values such as familismo, personalismo, time flexibility, and spirituality into their curriculum

These programs should also be designed in a way that is tailored to the population, from the bottom-up, by consulting with agency stakeholders (such as administrators, medical providers, and behavioral health specialists), community leaders (such as civic and religious leaders), and family members (such as Latino fathers, mothers, and children). This can be done through focus groups, interviews, observations, ethnographic research, questionnaires, and a number of other strategies where the primary audience for the intervention is engaged in the process. One way that primary care clinics can begin or extend their journey toward multiculturalism, like with Latino families, is by implementing agency clinic-wide self-evaluations, as illustrated in Table 6. A self-evaluation can be used to identify areas of strength, improvement, and facilitate group discussion toward a strategic plan for greater cultural adaptation. Program evaluation efforts must also be key component to any future parenting program tailored to Latino parents.

Another way that primary care health centers can better involve the community in the design, implementation, and evaluation of their programs is through community-based participatory research (CBPR). CBPR is an active research approach designed to bring together the voices of healthcare providers, researchers, and local community members for the purposes of solving community-wide problems (Berge, Mendenhall, & Doherty, 2009). Although this type of research is relatively new, the outcomes of this type of research are promising (Salimi et al., 2012). For example, CBPR research used with parenting programs have been shown to reduce substance use among Latino youth (Allen et al., 2013), extend parenting programs to fathers (Lee, Hoffman, & Harris, 2016), and develop culturally-relevant parenting programs for American Indians (Kulis, Ayers, & Baker, 2015). Future primary care parenting programs must ensure that program evaluation is a consistent part of the program design and implementation phases.

Finally, more research is needed comparing start-up and on-going costs of various primary care parenting programs. The programmatic costs that are described in this article serve as starting points for future research in this area. One strategy for assessing program expenses is a comparison of short and long-term cost-effectiveness of primary care parenting programs and by evaluating if and how these programs help to reduce the costs of population health problems (e.g., substance use, obesity, etc.). When analyzing the cost-effectiveness of these parenting programs, it is also important to understand which programs are reimbursable through health insurance and which are not. Although this type of financial research would be useful for all primary care agencies, it may prove even more beneficial to health centers that are more limited on resources, such as federally-qualified health centers.

In conclusion, parenting programs and services within primary care offer an ideal setting for addressing the parenting needs of Latino families. However, more community-based research is needed in order to design and adapt parenting programs that are culturally relevant to the beliefs, values, and preferences of Latino families. By using the comparison matrix (Table 5) and discussion points (Table 6), the information in this article can serve as a guide for healthcare providers who wish to design or develop new or existing parenting programs that are tailored or adapted to the cultural needs of their Latino patients. By developing more multicultural primary care parenting programs, primary care agencies will be closer to closing the health disparity gap that affects millions of Latino children living in the United States

Table 5
Spanish-Translated Primary Care Parenting Programs

Program Name	References	Focus	Age of Child	Composition	Sequence	Duration	Training Length	Estimated Start-Up Costs	# of Cultural Adaptations	Adaptations
Healthy Steps*	Minkovitz et al., 2005 Minkovitz et al., 2007	Basic Infant Care School Readiness Discipline Referral	3 and Under	Individual	WCC	9-15 Sessions Monthly groups	2-3 Days^ 6 calls to specialists	$$$$$	Few	Group Option
Incredible Years Well-Baby	Perrin et al., 2015	Basic Infant Care	9 Months and Under	Individual	WCC	7 sessions	2-3 Days	$$	Few	Latino Pictures
Play Nicely*	Scholer et al., 2009 Smith et al., 2017	Discipline	1-5 Years	Individual	PRN	1 session	No Training Required	$	Some	Community Consult Latino Pictures Video Translation Cross-Culture Research
Primary Care – PCIT	Berkovits et al., 2010 Borrego et al., 2006	Discipline	2-7 years old	Family	PRN	4 Sessions	3 Days^	$$$$	Few	Group Option
Primary Care Triple P*	Spijkers et al., 2013	Discipline	16 and Under	Individual	PRN	4 Sessions	3 ½ Days	$$$	Some	Community.Consult. Expert Consult Spanish Website Latino Pictures
Reach Out and Read	Billings, 2009 Byington et al., 2008 Zuckerman, 2009	School Readiness	6 months – 5 years	Individual	WCC	10 Sessions	1.5 hour online training	$$	Many	Cross-Culture Research Community Consult Expert Consult Spanish Website Latino pictures
Safe Environment for Every Kid (SEEK)	Dubowitz et al., 2009 Dubowitz, 2014	Referral	0-5 years	Individual	PRN	1 session	2-3 hour^ online training	$	None	Not Applicable
Video Interaction Project*	Mendlesohn et al., 2005 Mendelsohn et al., 2007	Basic Infant Care School Readiness Discipline	1 month – 5 Years	Family	WCC	9-14 Sessions	3 Days	$$$$$	Few	Spanish Website

Note: * = Programs where contact was made through email, face-to-face, or phone conversations PRN = As needed, WCC = Well Child Check Estimated Start Up Costs (training + material): $ = 0-$99, $$ = 100-$999, $$$ = 1,000-2,999, $$$$ = $3,000 - $9,999, $$$$$ = $10,000 or higher ^ = Recommends or requires that a licensed mental health professional deliver the program

Table 6
Self-Evaluation for Developing Multicultural Programs within Primary Care

- What services does my practice have that assess and/or address the unique needs of our Latino parents and minor patients developmentally and culturally?

- What policies exist within our practice that encourage multiculturalism? Where is more attention needed (e.g., translated materials, artwork, hiring of bilingual and bicultural providers)?

- How well do we react and respond to patient requests that may be rooted in their culture (e.g., requests for more flexible appointment times, translator, more joining time before initiating care)?

- Does our practice value engaging family members in patient care? How may we improve in this area (e.g., welcome family into the exam room, ask family members what they are concerned about regarding the patient and family's health and well-being, extend parenting support programs and programs)?

- How well are we meeting the cultural values of our Latino patients (e.g., respeto, familismo, personalismo, and marianismo)?

- What can we do to track how well we are successfully meeting the needs of our Latino patients? Where is improvement needed in this area?

- How are we evaluating the programs and services we offer our Latino patients?

CHAPTER 5: DEVELOPING A LATINO-ADAPTED PRIMARY CARE PARENTING PROGRAM THROUGH EXPERT CONSENSUS: A DELPHI STUDY

The Pew Research Center found Latinos are the fastest growing ethnic group within the United States, accounting for approximately 17% of the U.S. population (Pew Research Center, 2015). According to the U.S. Census Bureau, "Hispanic or Latino refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race." (2010). Latino children make up approximately 25% of all U.S. children (Child Trends, 2014a). In response to the growing population of Latin Americans and immigrants from other countries, healthcare services that are delivered in languages other than English have dramatically increased (Hseish, 2016). Although more and more healthcare agencies are hiring bilingual staff and providing cultural competency training than years prior (Callahan & Gandara, 2014), research indicates that Latino families continue have lower rates of health insurance (Center for Disease Control & Prevention, 2017), lower rates of satisfaction and access to preventative care (Center for Disease Control and Prevention, 2017), and higher levels of social isolation than their non-Latino community members (Aldama, Sandoval, & García, 2012; Anzaldúa, 1999).

One reason that these health disparities may exist today is because the United States has failed to adopt policies and programs that promote multiculturalism (Potowski & Rothman, 2011). In particular, not enough programs are being adapted to both the preferred *language* of Latino families, as well as their preferred *beliefs*, *values*, and *practices* (Barker, Cook, & Borrego, 2010). One healthcare setting, however, that has found success in developing multicultural programs and policies for Latino families and their children is primary care (Baig et al., 2014; Chavez-Korell et al., 2012; National Association of Community Health Centers, 2017,

Trinh et al., 2011). The American Academy of Family Physicians describes a primary care practice as a place where patients can have continuous and comprehensive care by a team of trained professionals. They insist that this should be a patient's first entry into the healthcare system (American Academy of Family Physicians, 2017). These environments have been shown to eliminate barriers to treatment (such as time and transportation) to those with fewer resources (National Association of Community Health Centers, 2013), extend services in multiple languages (Yoon, Grumbach, & Bindman, 2004), and adapt some of their interventions to the cultural needs of their patients (Mathieson, Mihaere, Collings, Dowell, & Stanley, 2012). Although adaptations have been made, recent studies on primary care and cultural adaptations demonstrate that much more adaptation is needed (Haralson, Hodgson, & Brimhall, 2018; Vesely, Ewaida, & Anderson, 2014). Primary care has also become a prime location for the integration of various types of mental health and family-oriented services (Peeks, 2008), such as parenting programs.

Although relatively new in its inception, preliminary results have shown that primary care parenting programs can be a powerful way of improving health outcomes for Latino children (Zuckerman, 2009). However, parenting programs have been slow to adapt to the linguistic needs and cultural values of Latino parents and their children (Barker et al., 2010; Vesely et al., 2014). There is also little to no research on how to adapt a culturally-relevant parenting program to the logistical needs of a primary care environment (Smith, Hadnut-Beumier, & Scholer, 2017; Svetaz Garcia-Huidobro, & Allen, 2014). This lack of due diligence leaves primary care practitioners guessing on what interventions to use, what topics to address, and what formats, delivery methods, or material will yield the best results for Latino parents (Perreira Chapman, & Stein, 2006).

Latino Health Disparities

Although Latino families have many cultural commonalities despite originating from many different countries (Marin & Marin, 1991), they also vary considerably in their cultural beliefs and practices. These differences are based on many factors such as their religious beliefs, immigration status/experience, how long they have lived in the United States, where they live within the United States, their socioeconomic status, and the country from which they originated (Santisteban, Mena, & Abalo, 2012; Savoy, 2016). While Latino populations may different from one another, researchers demonstrated that they also have many things in common. For example, when compared to non-Latino families, Latino families placed a greater emphasis on interdependence and loyalty toward members of their immediate and extended family systems (Arevalo, So, & McNaughton-Cassill, 2016). They also demonstrated a high degree of warmth and affection toward their family members and a high degree of respect and deference toward authority figures (i.e., parents, grandparents, doctors, teachers) (Guillermo-Ramos et al., 2009). Finally, Latino families tend to adhere to more traditional gender roles, with men being more likely to be heads of the home and the financial providers and women more likely to be in charge of homemaking and raising children (Dreby, 2006; Torres, Solberg, & Carlstrom, 2002).

Latino families also differ from non-Latino families in many other ways. Compared to non-Latino families, Latino families suffer from many healthcare (i.e., access to health insurance, satisfaction) and health status (i.e., higher rates of certain medical conditions) disparities. For example, Latino families were observed to be more likely to fall below the federal poverty line (Macartney & Bishaw, 2013), be uninsured (Barnett & Vornitsky, 2016), be dissatisfied with their healthcare services (Haviland, Morales, Dial, & Pincus, 2005), and less likely to receive appropriate preventive care than their non-Latino counterparts (Vargas

Bustamante, Chen, Rodriguez, Rizzo, & Ortega, 2010). Researchers have observed that Latino children had poorer healthcare outcomes than non-Latino children (Vega, Rodriguez, & Gruskin, 2009). As a whole, Latin Americans have been shown to have higher rates of infant mortality, obesity, substance use (Center for Disease Control and Prevention, 2017), asthma (Akinbami et al., 2012), depression (Céspedes, & Huey, 2008), anxiety (Varela & Hensley-Maloney, 2009), suicidal thoughts and attempts (Department of Health and Human Services, 2015), and risky sexual behavior (Deardorff, Tschann, Flores, & Ozer, 2010). In addition to these health disparities, researchers found Latino children experience several educational disparities including lower rates of school readiness for kindergarten (Child Trends, 2015) and higher rates of dropping out of high school (Krogstad, 2016). Although some of these childhood health disparities have improved within the last 40 years (Vega et al., 2009) more needs to be done to improve access to treatment, to improve patient satisfaction, and to improve healthcare outcomes for Latino children.

Primary Care Parenting Programs

One method for reducing both healthcare and health status disparities that has been shown effective, is to provide parenting support services within a primary setting (Cates, Weisleder, & Mendelsohn, 2016; Vesely et al., 2014). A primary care practice can be described as a medical clinic where patients receive continuous and comprehensive care by a team of trained professionals (AAFP, 2017). In the past, these clinics were mostly used to care for a patient's physical needs only. Now, primary care agencies serve as the hub for most basic healthcare services, including services for psychological and family health (Substance Abuse and Mental Health Service Administration, 2017). Additionally, researchers reported that primary care is where most Latino individuals prefer to have their physical and mental healthcare needs

met (Herman, Ingram, Rimas, Carvajal, & Cunningham, 2016; Kessler & Stafford, 2008). While there have been two recent systematic reviews documenting the integration of parenting services into primary care settings (Cates et al., 2016; Shah, Kennedy, Clark, Bauer, & Schwartz, 2016), these studies have not specifically focused on designing and developing programs and services that are culturally sensitive to the Latino population.

Previous studies indicated that primary care parenting programs improved parent well-being by reducing parental stress and depression and improved parenting skills by reducing harsh discipline and increasing parental monitoring and responsiveness (Berkule et al., 2014). They help children achieve numerous developmental outcomes such as improved literacy, numeracy, vocabulary, and school readiness (Cates et al., 2016). Also, they help improve family functioning, shared reading quality, sibling relationship quality, and parent-child relationship satisfaction (Kendrick et al., 2008). While these results are encouraging, most of these studies were conducted with populations that reflected the dominant culture.

A recent article which compared primary care parenting programs confirmed the need for more primary care parenting programs that are adapted to the values, beliefs, and preferences of Latino families (Haralson et al., 2018). In this review, the researchers examined the cultural adaptations of eight Spanish-translated primary care parenting programs. Of the eight programs reviewed, one had no adaptations to Latino culture, four had few adaptations, two had some adaptations, and one had many adaptations. Although this review demonstrated that a few parenting programs have made Latino-directed cultural adaptations (i.e., Latino pictures, a Spanish-translated website, and group programming), none of the programs described whether their actual parenting curriculum was adapted or if culturally-preferred adjustments were implemented for a primary care setting. The findings of the study echoed the sentiment of

several Latino parenting researchers who have advocated for more culturally-relevant parenting programs for Latino parents (Barker et al., 2010; Calzada, Huang, Anicama, Fernandez, & Brotman, 2012; Vesely et al., 2014). One way researchers can develop more culturally-relevant parenting programs is by grounding their programs in theories that are designed to deal with cultural issues. One theory, for example, that can be used as a framework for developing better parenting programs for Latino parents is the theory of acculturation (Berry, 2005).

Theory of Acculturation

The theory of acculturation is based on the work of John Berry, who has studied the process of acculturation for over 40 years (Berry, 1974; Berry & Sam, 2013). According to Berry, acculturation is the strategy that minority and majority groups take when confronted with cross-cultural contact (2005). Through his research he discovered that minority group members who immigrate to new countries tend to adopt one of four basic strategies in response to their new cultural contact: They either (a) assimilate, (b) integrate, (c) separate, or (d) marginalize to the new culture. He also discovered that individual selection of these strategies was highly dependent on the acculturation strategies endorsed by the majority group (Berry & Sam, 2013). When those in the majority group chose a multiculturalism strategy, they increased the likelihood that those in the minority group would choose an integrative acculturation strategy. An integrative strategy occurred when those from the minority group (a) adopted cultural practices and values of the majority culture while simultaneously (b) maintaining cultural values and practices from their country of origin (Berry, 2005). His research on acculturation outcomes has consistently indicated that those who integrate have better psychological outcomes than minority groups who completely reject the language and culture of their new country, who completely reject the language and culture of their country or origin, or those who reject the beliefs, values,

and cultural practices from their country of origin and that of their new country (Berry, Phinney, Sam, & Vedder, 2006; Berry & Sam, 2013).

Because of the positive outcomes derived from choosing an integrative acculturation strategy, Berry recommends that those from the majority culture strive to adopt or create a multicultural strategy of acculturation (Berry et al., 2006). According to him, policies that are multicultural (a) advocate for the maintenance of cultural identity among minority groups, (b) encourage full participation by those within the minority group, and (c) promote regular interaction between those from the minority and majority group (Berry & Sam, 2013). Using the theory of acculturation as a guideline for Latino-directed, multicultural, primary care programs, the design of such programs should: (a) advocate for the maintenance of Latino language and values, (b) encourage full participation of Latino parents within their healthcare environment (including language and cultural understanding), and (c) provide opportunities for routine interactions between Latinos and those of different cultures. It also means that parenting program developers should advocate for the voices of Latino parents when designing parenting programs, and that they should encourage the integration of both Latino and non-Latino values when teaching about parenting (in as much as those cultural practices do not include child maltreatment). Viewed in this way, Berry's theory of acculturation (2005) can guide the development of culturally-relevant parenting programs for Latino parents within primary care settings.

Purpose of this Study

While a systematic literature review has been completed on general Spanish-adapted parenting programs (Vesely et al., 2014), and researchers conducted two systematic literature reviews on primary care parenting programs (Cates et al., 2016; Shah et al., 2016), researchers

have not yet investigated factors that were important in designing or developing a Latino parenting program tailored or adapted to the primary care environment. The theory of acculturation suggests that programs developed within primary care be inclusive of those whom they serve (Berry & Sam, 2013). Because parenting programs have been implemented with greater frequency within primary care environments (Cates et al., 2016), the researchers responded to the imperative that more research be conducted on factors germane to the development of multicultural programs. The purpose of this study, therefore, was to explore factors perceived to be critical in developing first generation Latino-directed, primary care-based parenting programs. In order to address this aim, the researchers sought to attain an expert consensus about the components a parenting program that must be included in order for the parenting program to be (a) effectively and efficiently administered in a primary care setting, and (b) culturally appropriate and relevant to the needs of first generation Latino parents. The researchers used a Delphi process (Dalkey, 1969) as a means of addressing the research question.

Methods

The Delphi method was first developed in the 1950's by Dalkey and Helmer (1969) as a systematic way of coming to expert consensus on a particular topic. Delphi methods are distinct in the fact that participants do not have to meet face-to-face in order to come to consensus. Rather, the experts are often recruited from various parts of the world, with the consensus process taking place either over the phone, by mail, in person, or via the Internet through the use of questionnaires. These questionnaires are generally administered in two to four distinct phases, with each phase issuing a different questionnaire based on the responses from the previous phase (Hasson, Keeney, & McKenna, 2000). The Delphi method used for this study included a three-phase process (Schneider et al., 2016).

Phase 1 Survey Questionnaire

The first step in phase 1 was recruitment. The researchers recruited until a minimum of 30 experts completed the first questionnaire. The experts for this study self-identified as either (a) Latino research experts, (b) primary care experts, or (c) first-generation Latino parent experts (see Table 7 for definitions). The researchers recruited primary care healthcare providers and Latino researchers via research journals, university websites, healthcare association email listservs, personal contacts, and referrals. They recruited first-generation Latino parents through flyers at a community health center, local tiendas (markets), healthcare association email listserv, and personal contacts. These experts were contacted either through email, telephone, or face-to-face contact.

The second step of phase one was to administer an informed consent, a demographic survey, and a questionnaire with seven open-ended questions (e.g., What do you believe are the major challenges that first-generation Latino parents face while parenting within the United States?). This was accomplished by emailing each of the potential participants. Because the researchers were interested in recruiting participants whose preferred language was either English or Spanish, translation of all material was required. This was accomplished by (a) using Qualtrics' translation program and (b) verifying all translations by two bi-lingual researchers who independently evaluated the Qualtrics translation. The researchers then discussed their findings until complete agreement was achieved. Recruitment continued until a minimum of 10 people from each expert group finished the first survey.

The third and final step of phase one was to analyze the results. The analysis process began by translating each participant's responses into English (as described in the previous paragraph) and by uploading all data into NVivo, a qualitative data analysis program (Nvivo,

2012). Using Brady's thematic analysis (2015), two researchers reviewed the data, line by line, until themes emerged. Theme refers to an over-arching categorization of the data and category refers to the conglomeration of the participant's responses into a singular statement which captures the essence of their responses. Once themes were developed, the researchers placed each of the participants' responses into an over-arching theme. These seven themes were (a) Facilitator Knowledge, (b) Program Participants, (c) Program Characteristics, (d) Program Timing, Length, and Duration, (e) Program Location (f) Program Topics, and (g) Program Educational Methods. Throughout the analysis process, the researchers also kept analytical journals. These journals helped the researchers to note their thought processes when categorizing the data (Corbin & Strauss 2008). Once themes were developed and responses were placed into each theme, the researchers came together to discuss which themes they chose, which lines of data they placed in each theme, and their thought processes as described in their analytical journals. Together, the researchers then eliminated themes and/or data that was either repetitive and/or unrelated to the two overarching research questions.

Next, the researchers merged all data into categories that represented the essence of the participants' responses. For example, when the researchers asked the participants about which topics should be included in a primary care parenting program, a few of the participants reported that discussing the differences been Latino culture and American culture and the stress derived from choosing which cultural practices to adhere to would be an important topic. These responses were then merged into one category that said: "Acculturation (the degree to which families accept or reject the cultural practices of those from another culture) and the stress derived from this process" and placed into an overarching theme entitled "Program Topics." At first, the researchers agreed on approximately 50% of the themes and categories. When

discussing the rationale of why each researcher selected certain themes and categories, they decided on one of three choices: (a) abandon the category or theme altogether, (b) merge the category or theme into one, or (c) keep both themes and categories. After four meetings (both in person and via technology), the researchers came to 100% agreement with the final themes and categories.

During this phase, a thorough literature review was also conducted. With the help of a trained librarian from a local University, the researchers located eight literature reviews, meta-analyses, and/or systematic reviews. The goal of this search was to find all known literature reviews, systematic reviews, or meta-analysis regarding Latino program/policy adaptation, Latino parenting, and primary care parenting programs that could effectively answer the two guiding research questions:

(a) What topics need to be addressed when providing a parenting intervention to first-generation Latino parents in primary care?

(b) How can primary care parenting interventions be delivered to first-generation Latino parents in an effective, efficient, and culturally sensitive way?

Once all relevant literature reviews, systematic reviews, and meta-analyses were located, the researchers used Brady's (2015) thematic analysis process (as explained previously) to analyze either the discussion or literature reviews sections of each article. For those studies that were either systematic reviews or meta-analyses, the researchers selected the discussion sections because they provided a succinct review of the results and included researchers' recommendations and implications for that study. For those studies that were literature reviews, the researchers placed the entire manuscript into Nvivo for analysis (Nvivo, 2012).

Phase 2 Survey Questionnaire

The first step of phase 2 was to design a survey questionnaire based on the qualitative findings associated with the first survey, with additional survey categories derived from the peer-reviewed literature. Once all data derived from the first Delphi survey the research literature were analyzed, the researchers used the data to design the second Delphi survey. The second phase survey consisted of a list of categories followed by Likert-style response choices measuring the level of importance for developing a primary care parenting program. For example, one of the questions from the second survey was: "How important is it that the program's facilitator is knowledgeable about the following topics?" The response choices were: "Not Important," "Somewhat Important," "Very Important," and "Essential." The survey was also constructed so that participants were able to enter additional data through free text qualitative comments in a box located after each survey section.

The third and final step of phase 2 was to analyze the qualitative and quantitative data. Qualitative data were analyzed first by translating study participants' data into English and then analyzing the data elicited from free text responses. The quantitative data were transferred into Microsoft Excel, where the standard deviation, median, mode, mean, and interquartile ranges were calculated for each category. Each statement was then listed in rank order by its mode (50% or higher marked either Very Important or Essential) and interquartile range (≥ 1) score.

Phase 3 Survey Questionnaire

The first step of the third phase was to develop a questionnaire based off of the data from the phase two survey. The researchers included the categories in the third survey if (a) 50% or more of the participants who completed the phase two survey marked either "Very Important" or "Essential" for that category and (b) that category had an interquartile range score ≥ 1. Each

category that met the inclusion criteria for the third survey was then presented to the participants in a list, with those categories with the highest total percentage listed first. Categorical statements were nested under one of seven themes that captured their intent. The final themes were (a) Facilitator Knowledge, (b) Program Participants, (c) Program Characteristics, (d) Program Timing, Length, and Duration, (e) Program Location (f) Program Topics, and (g) Program Educational Methods. Following each thematic section, researchers asked participants to reflect on the extent to which they agreed with those results?" The answer choices on the 6-point Likert scale were: Strongly Disagree, Disagree, Somewhat Disagree, Somewhat Agree, Agree, and Strong Agree.

The second step of phase 3 inquired about each participants' level of agreement with the final results. At the end of the third survey, the researchers asked the participants to reflect on the entire survey as a whole. The answer choices for this 6-point Likert scales ranged from strongly agree to strongly disagree, with a comment box after each question. The final step for phase 3 was to report the results and write up the final manuscript. The results of the Delphi study are presented in the sections that follow.

Results

The purpose of this study was to come to consensus on (a) What topics need to be addressed when providing a parenting intervention to first-generation Latino parents in primary care and (b) ways that primary care parenting interventions can be delivered to first-generation Latino parents that are effective, efficient, and culturally sensitive. Consensus was considered established if (a) 50% or more of the participants chose "Very Important" or" Essential" for an category and if (b) that category had an interquartile range of 1 or less. The results indicated that consensus was established for 42 out of the original 89 categories. Although not necessary to

establish consensus, the results are strengthened by the fact that 100% of those who participated in survey #3 agreed with the results as a whole (8% selected Somewhat Agree, 52% selected Agree, and 40% selected Strongly Agree). After completing the analysis, the researchers organized the results into seven main sections based on the themes of this study. The seven themes are: (a) Facilitator Knowledge, (b) Program Participants, (c) Program Characteristics, (d) Program Timing, Length, and Duration, (e) Program Location (f) Program Topics, and (g) Program Educational Methods. In order to provide an overview of each section and develop an overarching description of what categories should be included in a Latino-based primary care parenting program, the results from each theme along with the demographic data will be described in the sections that follow.

Demographics

Understanding the participants' demographic data helps readers understand important characteristics about those who participated in the study. Thirty-four participants responded to survey #1, 28 responded to survey #2, and 26 responded to survey to #3. Over the course of three surveys, the attrition rate was 23.5%. The demographic data for survey #2 are described below because consensus was considered established after the second survey. Of the 28 participants who finished survey #2, 82% were female (23) and 18% male (5) and 50% were between the ages of 35 and 44 years old. Participants came from over nine different regions of the United States, with the majority from the South Atlantic (32%). Thirty-six percent of the participants did not have any children, 57% were married, and 57% identified as first-generation Latino. Of the 16 people who identified as first-generation Latino, nine of them did not identify with any other inclusion category. Additionally, of those 16 first-generation Latino parents, 10 different Latin American countries were represented: Mexico (7), Peru (2), Puerto Rico (2),

Colombia (2), Honduras (1), Nicaragua (1), Venezuela (1), Cuba (1), Brazil (1), and El Salvador (1). Just over half of the participants in this study had acquired a doctorate or medical degree (53.5%), with the majority having an annual family income between $75,000 and $149,999 (57%). When asked about approximate number of hours they have had in formal parenting training, 32% had over 100 hours, 18% had 30-99 hours, and 28.5% had 29 or fewer hours. For some of the participants, they had acquired so many hours of training that they were unsure of the total number of hours they spent in parenting training (21%) (Table 8).

Facilitator Knowledge

The results of this study indicated that proper facilitator preparation for teaching a parenting class to Latino parents was important (Please see Table 9 for more information on the results). The results from this section fell into three basic subthemes: (a) acculturation and trauma, (b) Latino values, and (c) extent of Latino diversity. Of the 13 categories that the participants could agree upon, three of the categories were related to the process of acculturation, acculturation stress, or trauma (e.g., "acculturation and the stress derived from this process"), while seven out of the 13 categories were related to generally-accepted Latino values (respect, gender roles, time flexibility, personalismo, familismo, the role of extended family, and consejo (advice) to children). The remaining three categories were related to Latino diversity: "Extent of diversity among Latino families," "participants' country of origin," and "other characteristics of the participants."

Program Participants

The results of this study also indicated that certain members of a family unit are more important to invite to a primary care parenting class than others. While participants agreed that facilitators should understand the role that extended family and fictive kin play on Latino

parenting (see the results from the previous section), the only two people that the majority of participants felt should be invited to participate in a primary care parenting class were a child's mother and father. The participants could not come to agreement on whether or not family members outside of the parents should be included in the parenting program (i.e., the child who the parents are concerned about, siblings, grandparents, etc.)

Program Characteristics

Participants indicated that there are certain programmatic characteristics that are important to have when delivering a primary care parenting program. They agreed that primary care parenting programs for first-generation Latino parents should: (a) be delivered by someone who is fluent in the preferred language of the participants, (b) provide free child care, (c) use qualitative research, and (d) use quantitative research.

Program Timing, Length, and Duration

Another aspect of primary care parenting programs that was important to understand was related to the time, length, and duration of a primary care parenting program for first-generation Latino parents. For this section, the participants agreed upon 7 out of 18 categories. The participants agreed that the program must be: (a) flexible to the participants needs (b) implemented at every well-child visit, (c) take place in the evening or (d) take place on weekends, (e) completed in conjunction with family medical visits, (f) be 15 to 30 minutes in length, and (g) have a set topic at each session or visit.

Program Location

The researchers presented six locations within a primary care environment to the participants for this section. Although 64% of the participants indicated that having a parenting class within a parenting facilitator's room and 61% within a group or community room was

either very important or essential, the interquartile range was over 1 for both of these categories. This meant that the participants could not come to agreement on any of the categories related to location.

Program Topics

The participants agreed that 10 out of 17 topics were important to include in a primary care program for first-generation Latino families. Topics that participants agreed upon fell into three basic subthemes: (a) physical health, (b) psychological health, and (c) social health (Engel, 1877;1980). Of the 10 agreed-upon categories, five were related to social health: Healthy ways of communicating, setting limits on child behavior, ways to form a secure attachment between parent and child, building parental social support, and acculturation differences between parent and child. Two of the categories were related to psychological health: Signs of mental health distress or substance use of children and emotion regulation to avoid conflict; and three were related to physical health: Nutrition and/or physical activity education and sex education. Please see Table 9 below for a list of all programmatic topics that were recommended for inclusion.

Program Educational Methods

The participants also agreed that certain educational methods were preferable to others. They agreed that primary care parenting classes for first-generation Latino parents should (a) be face-to-face (as opposed to technology-based), (b) conversational or discussion-based, (c) provide research-based information plus interactive activities, (d) use of role-plays or other interactive activities, and (e) use play therapy. Although the participants marked that research-based information and interactive activities were important, they also marked that role plays and other interactive activities were important. The researchers are unsure if marking role plays and other activities meant that the participants were opposed to educational information or if it

simply meant they thought either choices was important. The participants could not come to agreement on the use of technology-based interventions (i.e., on the Internet, tablet, or TV), psychoeducational methods, the use of educational brochures or workbooks, or the use of cognitive behavioral therapy.

Overall Agreement of Survey Results

Although not used to establish consensus, the final survey (out of 3) was used as a form of "member-checking" (Birt, Scott, Cavers, Campbell, & Walter, 2016) to ensure that the results from survey two were well-represented. After presenting the results to the participants (as described in the previous section), the participants were asked about their extent of agreement with the themes as a whole (approximately 2-11 categories were presented per theme). The results of this third survey indicated that 100% of the participants marked either Somewhat Agree, Agree, or Strongly Agree on 5 out of the 6 themes (for Program Characteristics 96% were in agreement). At the end of survey #3, the participants were asked about their level of agreement with the results as a whole. Out of the 26 people who responded to the third survey, 100% of the participants agreed with the results of this study as a whole (8% marked Somewhat Agree, 52% marked Agree, and 40% marked Strongly Agree).

Discussion

Research looking at ethnic differences in health has indicated that Latino children have higher rates of many healthcare conditions when compared to their white, non-Latino counterparts (Center for Disease Control & Prevention, 2017) and that primary care agencies can be effective locations for minimizing some of these disparities (Shah et al., 2015). In addition, Latino families prefer to have their mental health care needs taken care of by their primary care provider (Herman, et al., 2016). Implementing parenting classes within the context of primary

care has been shown to improve childhood health outcomes on a number of biological, psychological, and social health indicators (Cate et al., 2016). However, previous research reviewed by Haralson and colleagues (2018) found primary care parenting programs are failing to provide culturally-relevant parenting programs to Latino parents. The purpose of this study was to fill this research gap by providing primary care parenting with practical guidelines for developing or adapting parenting programs to the needs, beliefs, and values of first-generation Latino parents. Using the research questions as a guideline, the following sections will discuss how this current study contributes to the research literature on parenting, primary care, and Latino culture. Following this discussion, practical guidelines for improving existent primary care parenting programs or developing new programs will be given. The first research question that will be discussed is: What topics need to be addressed when providing a parenting intervention to first-generation Latino parents in primary care?

Culturally-Relevant Parenting Topics

While experts in this study recommended parenting program topics consistent with previous literature (Child Welfare Information Gateway, 2013), they also contributed a few unique ones that may be particularly beneficial to first-generation Latino parents. First, the participants agreed that primary care parenting facilitators should discuss signs of mental health distress, substance use, and sexual behavior in their children. Although unique to the world of primary care parenting programs (National Research Council, 2009), the suggestion to screen for and educate about substance use, mental health issues, and risky sexual behavior within primary care is consistent with recommendations by several major healthcare entities including the American Academy of Pediatrics (Cheung, Zuckerbrot, Jensen, Laraque, & Stein, 2018) and the Substance Abuse and Mental Health Services Administration (SAMHSA, 2017). Although these

topics would be beneficial to all patients who come to see their doctor, these topics may be particularly important to Latino children who historically have had higher rates of substance use, depression, anxiety, and risky sexual behavior (Céspedes, & Huey, 2008; Krogstad, 2016; Partnership for a Drug-Free Kids, 2012; U.S. Department of Health and Human Services, 2009, 2015; Varela & Hensley-Maloney, 2009).

Second, consistent with prior findings, this study also confirms the need for more parenting programs to consider the role that acculturation plays for Latino families. According to Berry (2005), acculturation can be defined as the process that takes place when two or more cultures come in contact with one another. The results from this study coincide with Berry's theory which emphasizes the need for more multicultural parenting programs. Barker and colleagues (2010) suggested that parenting facilitators can be in tune with the process of acculturation by using acculturation scales such as the Acculturation Rating Scale for Mexican Americans-II (Gutierrez, Franco, Gilmore Powell, Peterson, & Reid, 2009), by assessing for English language proficiency and by assessing the level of stress that is related to opposing cultural values within the family system (Lorenzo-Blanco et al., 2016).

Third, the results of this study also demonstrate the importance of assessing for trauma when working with Latino families. While there is a plethora of studies that indicate that Latino families experience trauma at higher rates than their non-Latino counterparts (Fortuna, Porche, & Alegria, 2008; Holman, 2001; Rojas-Flores, Clements, Koo, & London, 2017) and that trauma impacts the way they care for their children (Levendosky & Graham-Bermann, 2001); interestingly, little to no parenting programs exist that address trauma as a central component (Foli, Woodcox, Kersey, Zhang, & Wilkinson, 2018). Because trauma can dampen a parent's emergency response system (Bremner, 2006), and weaken a parent's ability to be attuned to the

mental state of their child (Suardi, Rothenberg, Serpa, & Schechter, 2017), parents who have experienced trauma are more likely to be physically and psychologically unavailable or neglectful to their children (Schechter, 2007). In assessing for trauma, one researcher suggests that healthcare professionals assess: (a) for current safety in the home, (b) the ways parents describe their child's personality (Is it negative, harsh, or totalizing?), (c) how the parent interacts with their child in the waiting room and other areas of the clinic, and (d) the way in which the parent's attachment style was formed in childhood (Suardi et al., 2017). This same type of assessment may be useful when working with Latino parents as they discuss the parenting challenges they are experiencing.

While understanding the best parenting topics for Latino parents is important, primary care parenting programs cannot exist if experts do not address the systemic barriers that hinder the implementation of primary care parenting programs (Grazier, Smiley, & Bondalapati, 2016). This next section will address programmatic changes that are needed to enhance the efficiency and effectiveness of culturally-relevant parenting program within primary care. It will seek to answer the second research question guiding this study: How can parenting interventions that are delivered to first-generation Latino parents within a primary care setting be effective, efficient, and culturally sensitive?

Efficiency in Primary Care Parenting Programs

This study highlighted the need for several systematic changes that could make primary care parenting programs more efficient. For example, this study highlighted the essential involvement of mothers and fathers in the health of their children. Involving mothers and fathers may mean making a more concerted effort to engage fathers, who have, historically, been less likely to take their children to see their primary care provider than mothers (Panter-Bricker et al.,

2014). Using the suggestions given in this study, primary care agencies may be able to better reach fathers by offering programs after 6pm or on the weekend.

Third, the participants in this study have indicated that implementing parenting programs within well-child visits, between 15 to 30 minutes in length, is the preferred way of administering a primary care parenting program for Latino parents. Research has shown that well-child visits are generally well-attended by parents within the United States (Child Trends, 2014b) and that most primary care parenting programs are already being administered within these visits (Haralson, et al., 2018). If a parenting program is implemented during well-child visits, this would also give parents the opportunity to regularly evaluate their parenting skills and the relationship they have with their child by a trained professional. Although relatively new in their inception, several studies have shown that behavioral health services, such as parenting, have aided in reducing healthcare costs and improving numerous health-related outcomes (Melek et al., 2017).

One way that primary care parenting programs could be implemented within the scope of a well-child visit is by routinely providing parenting education *before* the parent comes to see their medical provider. Implementing the program before every well-child visit, before the patient sees their provider, ensures that patients will be seen by the parenting facilitator and it normalizes the importance of caring for one's emotional and relational health. While efficiency is important in healthcare, this study was also interested in finding ways to improve the effectiveness of primary care parenting programs.

Effectiveness in Primary Care Parenting Programs

Effectiveness has been defined as providing healthcare services that are validated by research to people who could benefit from the service (The Institute of Medicine, 2001). The

results of this study suggested that primary care parenting programs need to regularly use both qualitative and quantitative research and that research-based parenting techniques (such as play therapy) should be used. In addition, these results suggested that parenting programs for first-generation Latino parents should be: (a) face-to-face, (b) discussion-oriented, (c) grounded in prior research, (d) and interactive. These results coincide with previous research that found first-generation Latino individuals are more likely to have technological challenges than white, non-Latino individuals and that they prefer face-to-face interactions over technological interactions (Machado-Casas, Sánchez, & Ek, 2014, Child Trends, 2016). Filial play therapy, an interactive, research-based therapy model designed to improve parent-child attachment may be useful for Latino parents in primary care settings (Garza & Watts, 2010). However, this model is centered on having both the parent and child together in the same room, and the results of this study are inconclusive on whether or not children should be a part of parenting programs for Latino families (although the participants did agree on the importance of family medical visits). Another avenue that may be beneficial to Latino parents is to have parenting classes within a group setting (Nadeem, Lange, & Miranda, 2008). Group settings would allow Latino parents to have time to socialize, share food and ideas, and improve their social support in the community. Improving social support is vital for Latino families because they are more likely to live in rural environments, with fewer means of transportation, than white, non-Latino individuals (Mora et al., 2014). The final aspect of the second research question centered around developing a parenting program that is culturally-relevant.

Culturally-relevant Primary Care

The results of this study can be used for (a) improving existent parenting programs, or (b) developing new parenting programs by making them more culturally-relevant to first-generation

Latino parents. These adaptations are important because previous researchers indicated that participants in culturally-adapted parenting programs have higher levels of effectiveness, satisfaction, and retention (Domenech Rodríguez et al., 2011; Reese & Vera, 2007; Smith, Domenech Rodríguez, & Bernal, 2010). Barker and colleagues in 2010 suggested five values that should be considered when implementing a parenting program for Latino families: (a) language proficiency, (b) familismo, (c) respeto, (d) personalismo, (e) marianismo and machismo, and (f) acculturation. Just like the findings from this study, they also emphasized that it is important for parenting facilitators to understand the extent of diversity that exist among Latino parents and to not assume that all Latino parents share these same values. While this study identified how community-based parenting programs can adapt their programs to align better with the values of Latino parents, they do not describe how these values can be instilled within a primary care setting. Applying these values, along with previously stated recommendations, to primary care settings, it is recommended that primary care agencies do the following:

(a) *Create an environment where Spanish is the norm (Language proficiency).* This can be accomplished by providing access to bilingual healthcare providers, auxiliary staff, and professional interpreters and by providing material, signs, and websites that are in both Spanish and English.

(b) *Establish policies that encourage family-oriented care (familismo).* This can be accomplished by scheduling family medical visits at times when they can best attend together and making a special effort to build relationships with members of the family who are unable to attend medical visits but play a parenting role.

(c) *Establish a cultural of professionalism (respeto).* This can be accomplished by establishing a policy for professional attire, mannerisms, and language. All healthcare personnel should be polite and cordial in all their interactions with patients and other staff members.

(d) *Get to know Latino families outside of their medical concerns (personalismo).* This can be accomplished by making it a point to remember personal information about patients (such as their birthday) and by asking about personal information (such as their family, their hobbies, or their expertise). This also requires providers to chart and then review any relevant cultural and family-based information before each visit.

(e) *Make it a point to discuss gender roles and expectations (marianismo and machismo).* This can be accomplished by asking about the roles that each family member plays in the caring of children. Who spends the most time with the child(ren) in the home? Who participates in disciplining the child(ren)?

(f) *Thoroughly assess each patient's immigration history (acculturation).* This can be accomplished by asking all patients how long they have lived in the United States, benefits and challenges of their relocation, and family, friends, customs they miss from where they lived previously.

(g) *Thoroughly assess for trauma and record it in the electronic medical record (trauma-informed).* Because trauma can take many forms, providers should compassionately assess for prior traumatic experiences and how they are impacted today. The adverse childhood experience (ACE; Felitti et al., 1998) questionnaire is an excellent tool that can be used for helping identify past traumas.

These recommendations, based in the study's findings, will aid primary care agencies in becoming a more inclusive environment for first-generation Latino families. They encourage healthcare provides to assess for important yet often over-looked aspects of care such as family relationships, acculturation stress, and trauma. While these recommendations exemplify the many strengths this study has to offer, this study has several limitations that should be mentioned to help guide future research in this area.

Strengths, Limitations, and Future Studies

Although several studies have demonstrated the effectiveness of delivering parenting support programs within a primary care setting, none have examined how to make these programs adaptable to first-generation Latino parents (Cate et al, 2016). This study is the first of its kind to engage with Latino culture, parenting, and primary care experts on how to best adapt or develop a parenting program for first-generation Latino families. By asking distinct, yet-overlapping experts for their opinions on this topic, the researchers were able to gather rich data and achieve consensus from multiple vantage points. The rigorousness and thoroughness of the recruitment process, the data analysis, the member-checking between each phase, and the questionnaire development process add to the reliability and validity of these results. This study also surveyed Latino individuals from 10 different Latin American countries, giving it a broader cultural richness. Finally, this study is unique among Delphi studies because the researchers underwent a thorough literature review to uncover previously established data. This literature search gave the data a thoroughness that is not common in Delphi studies. While this study had several strengths, it also had a few limitations that are worthy of mentioning.

First, because the survey was translated back and forth between English and Spanish several times throughout the process and because the translation did not account for dialectic

differences within the Spanish language, it is possible that some of the data was lost during translation (Squires, 2009). Second, although researchers independently coded every section of the research literature for inclusion in the survey, the method had each independently code a portion of the participants' responses and cross check for agreement instead of independently coding all responses and reconciling differences in word choices/phrases (the interrater agreement process is described in more detail in the methodology section). Because a Delphi study requires researchers to code the responses in a timely manner (to reduce attrition), future studies could make independent coding of all sections possible by (a) limiting the number of open-ended questions in the phase one survey, (b) keeping the focus on one research question instead of two or more, and (c) securing funding for paid researchers versus volunteers. Finally, because some of the participants did not complete all three surveys, the researchers were unable to assess their opinions beyond the first or second survey. Future studies could minimize attrition by building personal relationships with potential participants before recruitment and by assessing levels of interest in completing all three surveys before administering the first survey. Despite these limitations, the outcomes of this study can also be used as a catalyst for future studies regarding parenting program development and multiculturalism.

The results offer practical guidelines for future research regarding program evaluation and multicultural parenting program development. First, because the researchers were unable to reach those without Internet connection or computer know-how, future studies should ask the same types of questions from this study via paper and pencil methods – that way the voice of those with fewer resources can be heard. Second, future studies could clarify the meanings of some of the words from this study – words like "healthy communication" and "limit setting" – that way greater consensus can be reached about the specific details of a future parenting

program. Third, a pilot study which tests the usefulness of some of the suggestions from this study could be meaningful. In particular, measuring the effectiveness of a trauma or acculturation-focused program could demonstrate whether a program of this sort is beneficial to the first-generation Latino community. Finally, the information derived from this study can be used in future community-based participatory research studies where researchers work directly with community leaders, members, and stakeholders in crafting a primary care parenting program that is adapted to the needs of first-generation Latino parents living in their area.

Conclusion

Previous research has shown that Latino children suffer from health conditions at higher rates than their non-Latino counterparts (Center for Disease Control & Prevention, 2017) and that parenting support programs can help minimize these negative outcomes (Shah et al, 2016). This study was unique because it sought to minimize these disparities by bringing together the voices of three distinct, yet overlapping experts in order to understand better ways of adapting/developing a primary care parenting program for first-generation Latino parents. The results indicated that there are several programmatic changes that need to take place if primary care parenting programs want to become more culturally in-tune with the values, needs, and preferences of first-generation Latino parents. This study will likely be used as a catalyst for future research around this topic.

Table 7. Expert Inclusion Criteria

(1) Latino Research Expert: Published at least 5 peer-reviewed research articles or conceptual papers on the topic of Latino parenting needs, practices, values, or preferences.
(2) Primary Care Expert: Primary care healthcare provider who provides healthcare to Latino children and who teaches, counsels with, or provides parenting interventions at least 10 hours per week with Latino families. A primary care healthcare provider includes anyone in a health-related field who provides direct healthcare services (e.g., physician's assistant, nurse practitioner, nurses, marriage and family therapist, clinical social worker, etc.). This does not include support staff (medical assistant, front desk staff, case workers).
(3) First-Generation Latino Parent Expert. Latino parent who has at least one child under the age of 18 years, who currently lives with them. They are the first of their immediate family to live in the United States permanently.

Table 8. Demographics from Survey #2 (n=28)

Gender		**Country of Origin (n=16)**	
Male	5 (18%)	Mexico	7
Female	23 (82%)	Peru	2
		Puerto Rico	2
Age (Years)		Colombia	2
18-24	2 (7%)	Honduras	1
25-34	4 (14%)	Nicaragua	1
35-44	14 (50%)	Venezuela	1
45-54	6 (21%)	Cuba	1
55-64	2 (7%)	Brazil	1
		El Salvador	1
Region		**Income**	
South Atlantic	9 (32%)	Less than $25,000	2 (7%)
Pacific	5 (18%)	$25,000-$34,999	1 (3.5%)
Mountain	5 (18%)	$35,000-$49,999	3 (11%)
West South Central	3 (11%)	$50,000-$74,999	3 (11%)
West North Central	2 (7%)	$75,000-$99,999	7 (25%)
East North Central	1 (3.5%)	$100,000-$149,999	9 (32%)
East South Central	1 (3.5%)	$150,000-$199,999	0 (0%)
Middle Atlantic	1 (3.5%)	$200,000 or more	3 (11%)
New England	1 (3.5%)		
Relationship Status		**Formal Education**	
Married	16 (57%)	8th Grade or Less	1 (3.5%)
Single	10 (36%)	High School	1 (3.5%)
Divorced	1 (3.5%)	Some College Credit	2 (7%)
Lifetime Partner	1 (3.5%)	Bachelor's Degree	4 (14%)
		Master's Degree	5 (18%)
		Doctorate Degree	14 (50%)
		Medial Degree	1(3.5%)
Number of Participant's Children		**Hours of Parenting Training**	
0	10 (35.5%)	0-29 Hours	8 (28.5%)
1-2	11 (39%)	30-99 Hours	5 (18%)
3-4	6 (21%)	100 or More	9 (32%)
5 or more	1 (3.5%)	Unknown	6 (21%)

Race / Ethnicity			
White / Non-Latino	11 (39%)	American Indian or Alaskan Native / Latino	1 (3.5%)
Other / Latino	5 (18%)		
White / Latino	4 (14%)	White, American Indian from Central America / Latino	1 (3.5%)
Hispano / Latino	2 (7%)		
Mestizo / Latino	1 (3.5%)		
I object to this question / Latino	1 (3.5%)	Black or African American / Non-Latino	1 (3.5%)
White, Mexican / Latino	1 (3.5%)		

Inclusion Criteria	*Survey #1*	*Survey #2*	*Survey #3*
Researcher Only	5	4	3
Primary Care Only	11	11	11
1st Gen. Latino Only	11	9	8
Primary Care, 1st Gen. Latino	2	0	0
Researcher, 1st Gen. Latino	2	2	2
Researcher, Primary Care	0	0	0
Researcher, Primary Care, 1st Gen. Latino	3	2	2
Total	34	28	26

Table 9. Level of Importance among Categories in Survey #2

Question 1*: How important is it that the program's facilitator is knowledgeable about the following topics?*

Category	Very Important	Essential	Combined Total
Familismo	32%	64%	96%
The degree to which the child or parent feels "caught" between two different cultures (the culture from their country of origin and the United States)	50%	46%	96%
Extent of diversity among Latino families	46%	46%	92%
Acculturation (the degree to which families accept or reject the cultural practices of those from another culture) and the stress derived from this process	53%	39%	92%
The amount of trauma experienced by the family	32%	57%	89%
Consejos to children (Value of giving advice to their children)	36%	50%	86%
The role of extended family members or fictive kin (friends that are treated like family) in Latino families	46%	39%	85%
Personalismo (personal, friendly, warm)	25%	57%	82%
Time Flexibility (flexible with start and end times)	39%	43%	82%
Understanding that culture is an ever-changing process	43%	39%	82%
Other characteristics of the participants (i.e., age, gender, income, work schedules, transportation, etc.	50%	32%	82%
Machismo/Marianismo (masculine/feminine gender roles)	29%	50%	79%
Respect (obeying authority figures)	43%	36%	79%
Participants' country of origin	39%	39%	78%

Question 2: *How important is it that the following people attend your program?*

Category	Very Important	Essential	Combined Total
The mother	18%	82%	100%
The father	25%	71%	96%

Question 3: *How important is it that the program has the following characteristics?*

Category	Very Important	Essential	Combined Total
Delivered by someone who is fluent in the preferred language of the participants	14%	82%	96%
Provides free child care	46%	46%	92%
Uses qualitative research as part of the program (i.e., research about understanding the experiences of the participants)	46%	18%	64%
Uses qualitative research as part of the program (i.e., research about understanding the experiences of the participants)	43%	18%	61%

Question 4: *How important is it that the program is delivered in the following ways?*

Category	Very Important	Essential	Combined Total
Flexible to participants' needs	32%	61%	93%
At every well-child visit (routine visits with their doctor)	50%	11%	61%
In the evenings (6pm or later)	46%	14%	60%
On the weekends	46%	14%	60%
In a family setting (i.e., family medical visit)	43%	14%	57%
15-30 minutes in length	50%	7%	57%

Set topics at each session/visit	29%	21%	50%

Question 5: *How important is it that the program is delivered at the following places?*

***No responses on this question met the Mode and Interquartile requirements for inclusion

Question 6: *How important is it that your program facilitator teaches the following topics to their patients?*

Category	Very Important	Essential	Combined Total
Health ways of communicating	43%	54%	97%
Setting limits on child behaviors	29%	64%	93%
Ways to form a secure attachment between parent and child	32%	57%	89%
Signs of mental health distress or substance use of children	32%	57%	89%
Acculturation differences between parent and children	46%	43%	89%
Basic information on child development	25%	61%	86%
Building parental social support	36%	50%	86%
Emotion regulation to avoid conflict	46%	39%	85%
Nutrition and/or physical activity education	36%	43%	79%
Sex education	50%	25%	75%

Question 7: *How important is it that your program is delivered using the following formats or methods?*

Category	Very Important	Essential	Combined Total
Face-to-face	21%	79%	100%
Conversational or discussion-based	46%	46%	92%
Providing research-based information plus interactive activities	36%	50%	86%
Using role-play or other interactive activities	43%	39%	82%
Using play therapy	36%	21%	57%

CHAPTER 6: IMPLICATIONS FOR DEVELOPING A PRIMARY PARENTING PROGRAM FOR FIRST-GENERATION LATINO PARENTS

Latino children living in the United States suffer from health disparities at a higher rate than their non-Latino counterparts (Center for Disease Control & Prevention, 2017). One service that has been shown to improve health disparities affecting children is parenting programming that is implemented within a primary care medical office (Shah, Kennedy, Clark, Bauer, & Schwartz, 2016). Research has shown that integrating behavioral health services, like parenting support programs, within a primary care medical office helps to eliminate many barriers to services such as transportation difficulties, insufficient finances, and mental health stigma (PCPCC, 2018) and that it is the place where Latino families prefer to have their mental healthcare needs met (Herman, Ingram, Rimas, Carvajal, & Cunningham, 2016). The results from the first manuscript (See Chapter 4) have demonstrated, however, that most primary care parenting programs do not make sufficient cultural adaptations to meet the needs of Latino parents and their children. These cultural adaptations may be the missing link for improving retention and satisfaction rates among Latino parents who attend parenting programs (Ayón, Williams, Marsiglia, Ayers, & Kiehne, 2015).

The Delphi study (Chapter 5) helped to clarify how primary care parenting programs can be adapted to better account for the cultural needs, values, and preferences of first-generation Latino parents. Findings pointed to the need for greater focus on: (a) acculturation and the stress derived from this process, (b) trauma and how it impacts the family system, and (c) core Latino value such familismo, respeto, personalismo, marchismo/marianismo, and time flexibility. In addition, this study emphasized the need for parenting programs to be: (a) face-to-face (as opposed to technology-based), (b) relatively brief (15-30 minutes), (c) implemented within the

context of well-child visits, (d) grounded in previous research findings, and (e) flexible to the participants' needs. The purpose of this final chapter is to review the findings from both the first and second manuscript and then discuss the implications for clinical practice, research, policy, and medical family therapy. To accomplish this goal, the implications will be housed under four over-arching recommendations. These recommendations are based on the most significant findings from both manuscripts and are as follows:

(a) Parenting programs need to be more sensitive to the process of acculturation and the stress that it puts on families.

(b) Parenting programs need to move beyond Spanish translation by providing specific adaptations based on the cultural values of the Latino families whom they serve.

(c) Parenting program facilitators and other primary care personnel need to be properly trained in trauma-informed care.

(d) Parenting programs need to include *all* stakeholders (including parents) in order to design a program that better meets participants' needs.

Recommendation # 1: Parenting programs need to be more sensitive to the process of acculturation and the stress that it puts on families.

Parenting facilitators who serve first-generation Latino parents should focus their energies on improved understanding of the acculturation process. According to John Berry (2005), acculturation is the process of negotiation that takes place when two or more people from different cultures come in contact with one another. The negotiation process occurs as individuals decide the extent to which they will accept the beliefs, values, and practices of their new culture and the extent to which they will maintain the cultural beliefs, values, and practices from their home country. It can be seen at both an individual and at a larger systemic level (i.e.,

national and organizational policies that promote or deny certain cultural practices) and can take place over the span of many years (Berry & Sam, 2013). In general, immigrants adopt one of four basic acculturation strategies when adapting to U.S. culture: (a) assimilation, (b) integration, (c) separation, or (d) marginalization (Berry, 2005).

Acculturation stress occurs as immigrants decide which new cultural practices they will adopt and which ones they will abandon, based on the acculturation strategy they decide to implement (Berry, Phinney, Sam, & Vedder, 2006). For Latino individuals who integrate, they are deciding to adopt cultural values from the United States and maintaining cultural values from their native country. For those who assimilate, they are choosing to adopt cultural values from the United States and abandoning values from their native country. For those who separate, they are rejecting the cultural values of the United States and holding onto the cultural values of their native country. For those who marginalize, they reject the cultural values of the United States and abandon the values from their native country.

Parenting facilitators who work with first-generation Latino parents *must* know the process of acculturation and the strategies individuals take as they navigate the many adjustments that take place as immigrants adjust to a new country. They must know that acculturation is a continual process that each person manages differently, and that conflict can occur when parents and child select different acculturation strategies or adapt at different rates (Telzer, 2011). For example, this study, along with previous research agrees that the cultural values of familismo and respeto are important to many Latino parents (Guillermo-Ramos et al., 2009; Smith-Morris, Morales-Campos, Alvarez, & Turner, 2013). Parents who have not adopted the dominant U.S. value of individualism might expect their children to sacrifice their own needs for the benefit of the family's and to obey their parents' requests without question. Children who

have adopted the value of individualism may reject a parent's request to sacrifice for the family and to acquiesce to their parents' requests. Because these differences in acculturation strategies by the child and parent may create tension and misunderstandings between parent and child, facilitators who are not aware of this process may inadvertently recommend a parenting strategy that might reinforce this pattern instead of improving it.

Recommendation # 2: Programs need specific adaptations based on cultural values

Primary care parenting facilitators who serve first-generation Latino patients need to make sure their adaptations go beyond Spanish translation. According to integrated care expert, C.J. Peek (2008), primary care agencies should attend to three interrelated "worlds" of healthcare when developing new programs: (a) operational world (b) clinical world, and (c) financial world, as well as a fourth one termed "training." According to Peek, each of these worlds is concerned with answering one of three basic questions: What should we do? (clinical), How do we do it and support it? (operational), and What is the return on investment and cost? (financial) (Peek, 2013). Training is critical as well because systems cannot assume cultural competence. People may identify as being from the same ethnicity but perhaps a different country of origin. Healthcare systems would benefit from knowing their communities and training their employees to understand the rich cultures they serve.

To improve clinical outcomes, primary care clinics must begin by providing routine training on Latino culture and language to all relevant staff members. These trainings should, at a minimum, include the following topics: (a) the extent of diversity among Latino families, (b) general Latino values (i.e., respeto, familismo, etc.), (c) the process of acculturation, and (d) how trauma impacts family systems. Because culture is an ever-changing process (Calzada, 2010) and because on-going training is more effective than one-time trainings, Latino cultural training

must be an on-going process. This could be accomplished by having quarterly staff trainings that are focused on the topics described above and routine supervision that includes discussions about cultural competency, humility, and sensitivity.

To improve operational outcomes, primary care parenting programs must begin by soliciting the support of administration (i.e., operations manager), healthcare providers, (i.e., behavioral health and medical providers), support staff (medical assistants and front desk staff) and community members. One way of obtaining this support is by forming a committee of individuals (from each of the categories mentioned above) who are dedicated to improving the health of Latino families. One of the purposes of this committee could be to: (a) understand Latino patients' medical and relational needs, (b) address the workflow needs of the clinic when implementing parenting programming, (c) design and implement operations so clinical protocols to improve Latino health run efficiently, and (d) build templates in the electronic health record (EHR) so parenting program outcomes may be tracked successfully.

In addition to the operational changes mentioned above, the results of the Delphi study indicate the need for several other operational changes. The results from the Delphi study indicate that primary care parenting programs should: (a) be implemented, at a minimum, during routine well-child visits, (b) provide discussion-based parenting programs that are both interactive and grounded in research, (c) be available in the evenings or on the weekends, (d) take place within a family setting whenever possible, (e) provide child care, and/or (f) be approximately 15 to 30 minutes in length. These suggestions can be accomplished by implementing a protocol that every child who comes to see their doctor for a well-child check arrives with their parent 15 to 30 minutes early. During this time, the parenting interventionist will greet the parent and take the parent and their child back to a designated location to extend

parenting programming. Based on the results of this study, this session could be discussion-based, psychoeducational, interactive, or therapeutic (i.e., play therapy). Topics could include healthy communication, limit setting for child behavior, parent-child attachment, or many others (See the results from the Delphi study for additional topics). Although beneficial, these important operational changes cannot be sustained without financial sustainability.

To improve the financial outcomes, primary care parenting programs must ensure that the program is financially sustainable (Peeks & the National Integration Academy Council, 2013). The results from the first manuscript indicated that the cost of primary care parenting programs varies widely, with some programs being free online and others costing more than $10,000 just to get started (Haralson, Hodgson, & Brimhall., 2018). When asked about the costs in the Delphi study, the participants could not come to agreement on whether or not parenting programs should be free, but they did agree that free child care should be provided. Based on the findings from chapters four and five, to accommodate the cultural components and preferences of a Latino-relevant parenting program, the following expenses may need to be considered: (a) the initial costs of training the staff on Latino culture, acculturation, and trauma, (b) the on-going cost of continual education, (c) the cost of hiring a parenting facilitator to administer these programs, (d) the cost of developing and/or adapting the parenting curriculum, (e) the cost or providing child care, and the (f) the cost of providing on-going research.

These expenses, however, pale in comparison to the potential cost-savings and benefits of a Latino-adapted primary care parenting program. Using the community-based program, Triple-P parenting (Escobar Doran, Jacobs, & Dewa, 2011; Foster, Prinz, Sanders, & Shapiro, 2008; Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009), as an example, preliminary research suggests that their program has helped: (a) reduce the prevalence of child-based related hospital

visits, (b) reduce the number of out-of-home placement, (c) reduce the number of confirmed child abuse cases, and (d) reduce the prevalence of conduct disorders. They report that Triple-P parenting would pay for itself if conduct disorders were reduced by 5% to 6% and that it could save the state upward of $10.2 million dollars if conduct disorders were reduced by 25%. Although these long-term benefits are encouraging, understanding how parenting programs are sustainable in the short-term is important. In general, primary care parenting programs can be funding in three ways (a) grants, (b) billing through insurance, or (c) fee for service. Although parenting programs are, indeed, billable through medical insurance, their programs cannot be claimed unless they are administered by a licensed mental health professional (Jones, Allen, & Barnes, 2016). More research is needed on the best ways to financially sustain parenting programs that are administered within a primary care environment.

Recommendation #3: Facilitators need to be properly trained in trauma-informed care.

Research has shown that first-generation Latino parents are more likely to have experienced trauma than their non-Latino counterparts (Fortuna, Porche, & Alegria, 2008). For many Latino immigrants, they come to the United States to escape the violence and poverty of their home country (Potochnick & Perreira, 2010). In route to the United States, many Latino individuals have also been subjected to additional traumas such as starvation, violence, imprisonment, and parent-child separation (Fortuna et al., 2008). Within the United States, Latino families are also more likely to experience racism and discrimination than white, non-Latino families (Pew Research Center, 2016). Research has shown that these traumatic events may have a severe impact on parenting skills (Schechter, 2007). Trauma can inhibit a parent's ability to be physical and psychologically available to their child, inhibiting their ability to attune to their child's emotional cues (Schechter, 2007). Additionally, those parents who have been

exposed to trauma are also more likely to be dissatisfied with parenting, be neglectful of their children, use physical punishment, and be involved in child protective services (Banyard, Williams, & Seigel, 2003). When asked about trauma, participants from the Delphi study in chapter five agreed that understanding the impact of trauma on the family system is crucial for parenting facilitators to understand.

Over the last 10 years, research in trauma has accelerated (Alisic, Jongmans, van Wesel, & Kleber, 2011), with more trainings on trauma than ever before. Along with the cultural training mentioned earlier, primary care parenting facilitators who work with first-generation Latino families should receive regular, on-going training on trauma. Using Engel's biopsychosocial model as a guide (1977; 1980), parenting facilitators should be trained on the biopsychosocial effects of trauma and how it disrupts family systems and parent-child relationships. Prominent researchers in the field of trauma has suggested, when assessing for trauma, that healthcare providers (a) assess for current safety in the home, (b) notice the ways parents describe their child's personality (Is it negative, harsh, or totalizing?), (c) notice how the parent interacts with their child in the waiting room and other areas of the clinic (Are they yelling? Impatient?), and (d) the way in which the parent's attachment style was formed in childhood (Suardi, Rothenberg, Serpa, & Schechter, 2017). These subtle clues may prompt healthcare workers to assess for trauma more frequently.

In addition to these suggestions, trauma-informed work cannot be complete without mentioning the importance of utilizing the Adverse Child Experience (ACE) question on a regular basis with patients (Felitti et al., 1998). This questionnaire assesses for 10 prominent forms of childhood trauma: (a) emotional abuse, (b) physical abuse, (c) sexual abuse, (d) emotional neglect, (e) physical neglect, (f) divorce, (g) intimate partner violence, (h) familial

substance use, (i) mental illness, or (j) familial imprisonment. Because adverse childhood experiences have linked to over 40 different health conditions, it is, therefore, recommended that every adult patient in a primary care clinic should have their ACE scores documented in the EHR. This questionnaire, along with the suggestions described previously, will help parenting facilitators to better understand the extent to which Latino families have experienced trauma and the impact it has on their family system.

Recommendation #4: Parenting programs need to include *all* stakeholders.

Consistent with the results of both manuscripts, all stakeholders need to be included when developing a primary care parenting program for Latino families. The Delphi study was unique in that three different, yet interrelated expert groups, were involved in the results. The researchers with expertise in Latino culture were able to draw upon the knowledge they had gained by studying the target population. The primary care experts had regular, direct contact working with Latino families within primary care settings. They had hands-on expertise delivering parenting programming/interventions within a primary care environment. The first-generation Latino parents had direct experience raising children within the United States and understood first-hand the challenges and benefits of raising a child within two different cultures. Together, these experts were able to provide rich data, from multiple perspectives, on the best ways to provide primary-care parenting support to first-generation Latino parents.

Within the last 20 years, community-based participatory research (CBPR) has dramatically increased. Researchers have realized that one-size-fits-all programs do not work (Viswanathan, 2004) – that those offered culturally-adapted programs have been shown to have higher rates of effectiveness, retention, and satisfaction (Domenech Rodríguez et al., 2011; Reese & Vera, 2007; Smith, Domenech Rodríguez, & Bernal, 2010). While the purpose of CBPR vary,

their overall purpose is to elicit the voices of community members by making them active participants in the research process (Minkler & Wallerstein, 2010). Program developers who wish to develop a parenting program for Latino parents should do so with the help of community members (Amendola, 2013) and they should engage in long-term evaluation to continually measure its effectiveness (Webster-Stratton, Rinaldi, & Jamila, 2011). Although useful, the results of this study should not be taken unilaterally to all primary care agencies who serve first-generation Latino parents. For example, this study did not take into account the various Spanish dialects that exist throughout Latin America or the languages of those Latino individuals who speak a language other than English or Spanish (i.e., Portuguese). The results of this study can act as a basic framework for building future parenting programs, but adaptations need to be made according to the individual needs of the community being served.

While eliciting the voices of Latino parents is essential in building future primary care parenting programs, their involvement alone is not enough. Researchers should engage as many people who have power over the operational aspects of running a primary care parenting program. For example, front desk staff should be knowledgeable about how to connect the patients with the parenting facilitators, on how to bill for parenting programs, and how to schedule subsequent parenting classes. Medical assistants and nursing staff should be knowledgeable about how to explain the purposes of the parenting program and connect the patients with the parenting facilitator. Medical providers need to have a strong investment in parenting support and must go out of their way to make parenting facilitators are included in their patients' medical visits.

Administration and healthcare staff need to be sold on the benefits of parenting program and should do all that is necessary to make primary care parenting programs a priority in their

clinics. Researchers should collaborate with administration prior to implementing any new programming, extending program evaluation designs that will help elucidate the merits of the work and identify opportunities to strengthen its reach and value. Behavioral health staff need to be well-versed in the parenting program curriculum and should know how to either offer the program themselves or train others to offer the program. Administrators and personnel, along with the patients' themselves, play a vital role in the success of any future parenting programs that are offered in primary care settings. One profession that may be a particularly good fit for leading the cause of primary care parenting programs for Latino families is medical family therapy.

Medical Family Therapy Implications

In 2010, Lisa Tyndall and her colleagues conducted a Delphi study which aimed to bring clarity to the definition and necessary competencies of medical family therapists (MedFT). After coming to consensus from a panel of experts, they agreed that medical family therapy is a field that extends…

> "an approach to healthcare sources from a BPSS (biopyschosocial-spiritual) perspective and marriage and family therapy, but also informed by systems theory. The practice of MedFT spans a variety of clinical settings with a strong focus on the relationships of the patient and the collaboration between and among the healthcare providers and the patient. MedFT's are endorsers of patient and family agency and facilitators of health workplace dynamics." (2010, p. 68-69)

Since the onset of McDaniel, Hepworth, and Doherty's seminal work on MedFT's back in 1992, the field of MedFT has grown exponentially, with Masters and Ph.D. level training programs and certificates now offered at over 17 Universities throughout the United States

(Hodgson, Lamson, Mendenhall, & Crane, 2014). This study re-emphasized the critical need for medical family therapists in several important ways. First, there is a need for more relationally-trained therapists within medical settings to help address expand patient care to be more family-centered. Second, this study re-emphasized the need for full MedFT integration within primary care settings (McDaniel, Doherty, & Hepworth, 2014), prepared to meet the healthcare needs of Latino families. Third, this study emphasized the need for increased attunement to cultural differences and acculturation, a value of the Medical Family Therapy field (Mendenhall, Lamson, Hodgson, & Baird, 2018). Each of these contributions will be described in the paragraphs that follow with suggestions for improvement in research, clinical services, training opportunities, and policies.

First, this study re-emphasized the need for more relationally-trained therapists within medical settings. Prior research has indicated that systemically-trained therapists who work within medical settings may be more cost-effective than therapists from other mental health disciplines (Crane & Christenson, 2012). One reason for this difference is that because MedFT's are trained to work with entire family systems, thus eliminating the costs associated with seeing each family member individually. Out of the nine topics for parenting topics that the participants could agree upon, five were related to social health. In addition, the participants agreed that facilitators should be knowledgeable in (a) understanding the cultural value of familismo, (b) the role of extended family, and (c) the importance of obeying authority figures. Although these results point to the need for systemically-trained therapists to administer parenting programs for Latino families, more research is needed to see how Latino parents respond to relationally versus individually trained behavioral health providers within primary care settings. This could be done by comparing the satisfaction, the retention, and the effectiveness of parenting programs

administered within primary care settings from behavioral health providers with and without relational training.

Second, the results of this study re-emphasize the need for fully-integrated behavioral health providers (McDaniel et al., 2014). Full-integration is accomplished when behavioral health providers and medical providers share the same electronic medical records, share the same facilities, regularly interact face to face, and regularly collaborate with one another (McDaniel et al., 2014). The results of this study suggest that Latino patients prefer face-to-face meetings with their healthcare team, that they prefer conversational and discussion-based approaches to parent education, and that they would prefer to have parenting programs administered during well child visits. Therefore, MedFT's need to be fully integrated into primary care settings whenever possible. To administer parenting programs within well-child visits requires MedFTs to be on-site, routinely collaborating with the front desk staff and medical providers, and available to provide face-to-face care to patients who are scheduled for well-child visits. Policies that could facilitates these changes include permitting re-imbursement for family-centered care, permitting insurance reimbursement for medical family therapy services that are on parity with licensed psychologists and social workers, and policies that emphasis family medical visits (AAMFT, 2018).

Third, this study emphasizes the need for medical family therapists to be well-trained in cultural competencies regarding Latino culture. Specifically, medical family therapists should be aware of common cultural values such as gender roles, familismo, respeto, and personalismo, and should be knowledge in the theory of acculturation and how it related to Latino immgrants living in the United States. In addition, this research is in line with previous research on family therapy and Latino families. In 2013, researchers who reviewed the research literature on family

therapy practices for Latino families recommended that marriage and family therapists (a) are aware of the within-group differences between Latino populations, (b) that they make a "deeper" cultural assessment, including gender socialization, (c) that they assess for conflicts related to immigration and family life cycle stages, and that they (d) use cultural genograms and discuss ways of effectively negotiating cultural differences between family members (Hernandez & Curiel, 2012). Policies that could facilitate these changes include curriculum changes to medical family therapy programs. These changes could include a greater emphasis on commonly-held Latino values, the extent of diversity among Latino families, the process and stress related to acculturation, and the impact of trauma on the family system.

Conclusion

The chapters outlined in this dissertation indicate a need for increased attention to adapting primary care parenting programs to the values, beliefs, and preferences of first-generation Latino parents. Several clinical, research, policy, and medical family therapy recommendations were drafted in this chapter that could, if implemented, improve the healthcare outcomes for Latino children and their parents. If developers are going to design a parenting program for Latino parents within a primary care environment, several steps must be taken. First, parenting programs should be more sensitive to the process of acculturation and the stress that it puts on families. Second, parenting programs need to move beyond Spanish translation by providing specific adaptations based on the cultural values of the Latino families whom they serve. Third, parenting program facilitators and other primary care personnel need to be properly trained in trauma-informed care. Finally, parenting programs need to include *all* stakeholders (including parents) in order to make a program that better meets the needs of participants. In addition to these recommendations, more adaptations need to be considered among those

marriage and family therapy programs who are interested in increasing their level of culturally competency in Latino culture. These recommendations, if heeded, will equip medical family therapists, primary care healthcare providers, Latino parents, and others who care for Latino families with the tools they need to diminish the health disparities that impact so many Latino children and their parents.

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APPENDIX A: IRB APPROVAL

Notification of Initial Approval: Expedited

From: Social/Behavioral IRB
To: David Haralson
CC:
Jennifer Hodgson
David Haralson
Date: 2/9/2018
Re: UMCIRB 17-002563
Latino-Adapted Primary Care Parenting Program

I am pleased to inform you that your Expedited Application was approved. Approval of the study and any consent form(s) is for the period of 2/9/2018 to 2/8/2019. The research study is eligible for review under expedited category #7. The Chairperson (or designee) deemed this study no more than minimal risk.

Changes to this approved research may not be initiated without UMCIRB review except when necessary to eliminate an apparent immediate hazard to the participant. All unanticipated problems involving risks to participants and others must be promptly reported to the UMCIRB. The investigator must submit a continuing review/closure application to the UMCIRB prior to the date of study expiration. The Investigator must adhere to all reporting requirements for this study.

Approved consent documents with the IRB approval date stamped on the document should be used to consent participants (consent documents with the IRB approval date stamp are found under the Documents tab in the study workspace).

The approval includes the following items:

Name	Description
Dissertation Protocol	Study Protocol or Grant Application
Email Listserv – English	Recruitment Documents/Scripts
Email Listserv – Spanish	Recruitment Documents/Scripts
Face-to-Face Script – English	Recruitment Documents/Scripts
Face-to-Face Script – Spanish	Recruitment Documents/Scripts
Informed Consent – English	Consent Forms
Informed Consent – Spanish	Consent Forms
Personal Email Script – English	Recruitment Documents/Scripts
Personal Email Script – Spanish	Recruitment Documents/Scripts
Qualtrics Demographic Survey – English	Data Collection Sheet
Qualtrics Demographic Survey – English	Surveys and Questionnaires
Qualtrics Demographic Survey – Spanish	Data Collection Sheet
Qualtrics Demographic Survey – Spanish	Surveys and Questionnaires
Qualtrics Survey #1 – English	Surveys and Questionnaires
Qualtrics Survey #1 – Spanish	Surveys and Questionnaires
Qualtrics Surveys #2 & 3	Surveys and Questionnaires
Qualtrics Surveys #2 & 3 – Spanish	Surveys and Questionnaires
Recruitment Flyer – English	Recruitment Documents/Scripts
Recruitment Flyer – Spanish	Recruitment Documents/Scripts
Reminder Email – English	Recruitment Documents/Scripts
Reminder Email – Spanish	Recruitment Documents/Scripts

Social Media Script – English	Recruitment Documents/Scripts
Social Media Script – Spanish	Recruitment Documents/Scripts

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

Study.PI Name:
Study.Co-Investigators:

APPENDIX B: INFORMED CONSENT

Principal Investigator: David M. Haralson, M.S.

Faculty Investigator: Jennifer Hodgson, Ph.D., LMFT

Institution, Department or Division: East Carolina University, Human Development & Family Sciences

Address: 610 E 10th St. Greenville, NC 27858

Telephone #: 252-328-1349

Study Coordinator: David M. Haralson, M.S.

Email Address: haralsond15@students.ecu.edu

Telephone #: 970-616-0662

Researchers at East Carolina University (ECU) study problems in society, health problems, environmental problems, behavior problems and the human condition. Our goal is to try to find ways to improve the lives of you and others. To do this, we need the help of volunteers who are willing to take part in research.

Why is this research being done?

This research is being done to learn how to better serve our Latino parents. To do this, we will be asking various Latino experts about their opinions on how to create a parenting program for Latino families at their doctor's office.

Why am I being invited to take part in this research?

You will be one of about 30-60 people to participate in this study. You are being invited to take part in this research because you meet at least one of the following criteria:

- You are a primary care healthcare provider to Latino children and you teach, counsel with, or provide parenting interventions at least 10 hours per week with Latino families. A primary care

healthcare provider includes anyone in a health-related field who provides direct healthcare services. This does not include support staff.

- You are a Latino parent who has at least one child under the age of 18 years, who currently lives with you. You are the first of your immediate family to live in the United States permanently.

- You have published at least 5 research articles or conceptual papers on the topic of Latino parenting needs, practices, values, or preferences.

Are there reasons I should not take part in this research?

You should not participate in this study if you do not meet the criteria above, if you do not have a working email address, or regular access to the Internet.

What other choices do I have if I do not take part in this research?

You always have a choice whether or not to participate. You can stop participating in this study at any time without any negative consequence.

Where is the research going to take place and how long will it last?

You can participate in this study anywhere you have access to the Internet. The total amount of time you will be asked to volunteer for this study is approximately 90 minutes over the next 3 weeks to 2 months.

You are being asked to do the following:

- Complete a survey about yourself.

- Complete 3 surveys over the space of 3 weeks to 2 months. For survey one, you will be asked to answer 7 short-answer questions.

- For survey two, you will be asked to answer a series of multiple choice questions (Strongly Disagree to Strongly Agree).

- For survey three, you will be asked to review the answers for survey 2 and then will be asked to answer one final question: To what degree do you agree with the final results of this study? There will also be a space for you to write more if you would like.

What possible harms or discomforts might I experience if I take part in the research?

We believe that you will not experience any more harm than what you would experience in everyday life.

What are the possible benefits I may experience from taking part in this research?

We do not know if you will get any benefits by taking part in this study. This research might help us learn more about how to better serve our Latino parents and their children in a primary care setting. There may be no personal benefit from your participation, but the information gained by doing this research may help others in the future.

Will I be paid for taking part in this research?

While we can never truly compensate you for your time, as a token of our appreciation we would like to send you a free DVD code to Redbox. Within 24 hours after completing each survey (a total of 3 surveys), you will be emailed a code for the free Red Box DVD. If you complete all three surveys for this study, your email address will be entered into a drawing with the possibility of winning a $100 gift card. About 1 week after all participants have completed all three surveys, the winner of the drawing will be emailed the $100 gift card.

What will it cost me to take part in this research?

It will not cost you any money to be part of the research.

Who will know that I took part in this research and learn personal information about me?

To do this research, ECU and the people and organizations listed below may know that you took part in this research and may see information about you that is normally kept private. With your permission, these people may use your private information to do this research:

- Any agency that regulates human research. This includes the Department of Health and Human Services (DHHS), the North Carolina Department of Health, and the Office for Human Research Protections.
- The University & Medical Center Institutional Review Board (UMCIRB) and its staff, who are responsible for overseeing your welfare during this research, and other ECU staff who oversee this research. The following people may also have access to your personal information:
- David Haralson, Primary Investigator
- Jennifer Hodgson, Faculty Investigator
- Andy Brimhall, Sub-Investigator
- Sharon Knight, Sub-Investigator
- Eboni Baugh, Sub-Investigator
- Melissa Aguilar, Sub-Investigator
- Florence Lewis, Sub-Investigator
- Julian Crespo, Sub-Investigator

How will you keep the information you collect about me secure? How long will you keep it?

We will make sure your information is kept private. In order to do this, we will store your information in three locations: (a) Qualtrics (survey website), (b) ECU Pirate Drive and (c) a flashdrive. Each of these locations will be protected by a password. When not in use, the flashdrive will be locked in a cabinet located in the Medical Family Therapy Research Facility (The Redditt House) at East Carolina University. The research data will be stored for a minimum of 3 years after the completion of this study. The information you provide may be used for publications, presentations, or future research studies. However, to protect your identity, all identifying information will either be removed or changed.

What if I decide I do not want to continue in this research?

If you decide you no longer want to be in this research after it has already started, you may stop at any time. You will not be penalized or criticized for stopping. You will not lose any benefits that you should normally receive.

Who should I contact if I have questions?

The people conducting this study will be available to answer any questions concerning this research,

now or in the future. You may contact the Principal Investigator at haralsond15@students.ecu.edu or 970-616-0662, and he will contact you within 24 hours.

If you have questions about your rights as someone taking part in research, you may call the Office for Human Research Integrity (OHRI) at phone number 252-744-2914 (days, 8:00 am-5:00 pm). If you would like to report a complaint or concern about this research study, you may call the Director of the OHRI, at 252-744-1971

I have decided I want to take part in this research. What should I do now?

By clicking yes below, you agree to the following:

- I have read and understand all of the above information.
- I agree to participate in this study.
- I have had an opportunity to ask questions about things in this research I did not understand and have received satisfactory answers.
- I know that I can stop taking part in this study at any time.
- I know that an emailed copy of this informed consent will be sent to me within 24 hours after agreeing.
- By clicking agree on this informed consent form, I am not giving up any of my rights.

Do you agree to participate in this study?

○ Yes

○ No

APPENDIX C: DEMOGRAPHICS SURVEY

Demographic Information Form *Please provide a response for each of the following questions:*

Name:

_____

Email Address (This email will only be used for the purposes of this study and will not be linked to any of your responses for this study. It will only be used to send your links to surveys, to ask for the recruitment of other participants, to send you reminder emails, and to provide you with any of the incentives for this study):

_____

Which of the following three categories do you identify with? (Check as many as apply)

☐ I am a primary care healthcare provider who provides healthcare to Latino children and who teaches, counsels with, or provides parenting interventions at least 10 hours per week with Latino families. A primary care healthcare provider includes anyone in a health-related field who provides direct healthcare services (e.g., physician's assistant, nurse practitioner, nurses, marriage and family therapist, clinical social worker, etc.). This does not include support staff (medical assistant, front desk staff, case workers).

☐ I am a Latino parent who has at least one child under the age of 18 years, who currently lives with them. I am the first of my immediate family to live in the United States permanently.

☐ I have published at least 5 peer-reviewed research articles or conceptual papers on the topic of Latino parenting needs, practices, values, or preferences.

How old are you?

- ○ 18-24 years old
- ○ 25-34 years old
- ○ 35-44 years old
- ○ 45-54 years old
- ○ 55-64 years old
- ○ 65-74 years old
- ○ 75 years or older

What is your gender?

_____

Where do you live?

- ○ New England - Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
- ○ Middle Atlantic - New Jersey, New York, Pennsylvania
- ○ East North Central - Illinois, Indiana, Michigan, Ohio, Wisconsin
- ○ West North Central - Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota
- ○ South Atlantic - Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia
- ○ East South Central - Alabama, Kentucky, Mississippi, Tennessee
- ○ West South Central - Arkansas, Louisiana, Oklahoma, Texas
- ○ Mountain - Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming
- ○ Pacific - Alaska, California, Hawaii, Oregon, Washington
- ○ Other: _____

What is your relationship status?

- ○ Single
- ○ Married
- ○ Never Married, or in domestic relationship
- ○ Divorced
- ○ Separated
- ○ Widowed
- ○ Other _____

How many children are you the parent, caregiver, or legal guardian to currently?

_____

_____

_____

_____

_____

If you are the parent, caregiver, or legal guardian of a child, please list the ages of each child under your care below:

- ○ Age of Child 1 _____
- ○ Age of Child 2 _____
- ○ Age of Child 3 _____
- ○ Age of Child 4 _____
- ○ Age of Child 5 _____
- ○ Age of Child 6 _____
- ○ Ages of additional children _____

What is your annual income (or combined annual income if you have a spouse)?

- ○ Less than $25,000
- ○ $25,000 to $34,999
- ○ $35,000 to $49,999
- ○ $50,000 to $74,999
- ○ $75,000 to $99,999
- ○ $100,000 to $149,999
- ○ $200,000 or more

Which of the following race(s) best represents you? (Select as many as apply)

- [ ] Black or African American
- [ ] White
- [ ] Asian
- [ ] American Indian or Alaska Native
- [ ] Native Hawaiian or Pacific Islander
- [ ] Other: _____

Are you Hispanic or Latino in your ethnic origin?

- ○ Yes
- ○ No

Which of the following Latin American countries or territories are you or your family originally from? (Check as many as apply)

- ☐ Argentina
- ☐ Bolivia
- ☐ Chile
- ☐ Colombia
- ☐ Costa Rica
- ☐ Cuba
- ☐ Dominican Republic
- ☐ Ecuador
- ☐ El Salvador
- ☐ Guatemala
- ☐ Honduras
- ☐ Mexico
- ☐ Nicaragua
- ☐ Panama

- [ ] Paraguay
- [ ] Peru
- [ ] Puerto Rico
- [ ] Uruguay
- [ ] Venezuela
- [ ] Other _____

What is the highest degree or level of school you have completed? (if you're currently in school, please indicate the highest degree you have received)

- ○ No schooling completed
- ○ Nursery/pre-school to 8th grade
- ○ Some high school, no diploma
- ○ High school graduate, diploma or the equivalent (for example: GED)
- ○ Some college credit, no degree
- ○ Trade/technical/vocational training
- ○ Associate degree
- ○ Bachelor's Degree
- ○ Master's Degree
- ○ Professional Degree (e.g., JD, MD)
- ○ Doctorate Degree

What type of formal training have received on topics such as child development, adolescent development, or parenting (example: parenting class in the community, college class, webinar, conference)?

_____

_____

_____

_____

_____

About how many total hours of formal training on topics such as child development, adolescent development, or parenting have you ever received?

_____

What is your current employment status?

- ○ Employed full time (40 or more hours per week)
- ○ Employed part time (up to 39 hours per week)
- ○ Unemployed and currently looking for work
- ○ Unemployed and not currently looking for work
- ○ Student
- ○ Retired
- ○ Homemaker
- ○ Self-employed
- ○ Unable to work

If you are employed, what is your current job title?

_____

Please list any professional licenses or credentials that you currently hold (Example: Registered Nurse, Licensed Plumber, Licensed Massage Therapist, Etc.).

_____

_____

_____

_____

_____

APPENDIX D: SURVEY #1

Definitions:

First-generation means anyone who is the first of their immediate family to live in the United States permanently.

Latino refers to anyone originally from Central America, South America, or the Caribbean whose preferred language is Spanish.

Primary care refers to a place where one's basic healthcare needs are met by a medical doctor or another healthcare professional. This is generally the first place you go to when seeking basic medical care.

What do you believe are the major challenges that first-generation Latino parents face while parenting within the United States? Please describe this in as much detail as possible.

_____

_____

_____

_____

_____

If you were to create a parenting program for first-generation Latino children within a primary care medical setting, are there any topics that you would make sure to address? If so, what would those topics be? Please describe this in as much detail as possible.

_____

_____

_____

_____

_____

Drawing on your personal and professional experiences with primary care medical settings, what do you believe is the best way to deliver parenting interventions to first-generation Latino parents within primary care? Please describe this in as much detail as possible.

_____

_____

_____

_____

_____

If you were to create a parenting program for first-generation Latino parents within a primary care medical setting, when would be the best time to deliver such a program? (i.e., in the waiting room, before or after the doctor's visit). Please explain why you would deliver the program in that way. Please describe this in as much detail as possible.

_____

_____

_____

_____

_____

If you were to create a parenting program for first-generation Latino parents within a primary care medical setting, how long would you recommend that each parenting session last (e.g., 5 minutes, 15 minutes, 30 minutes, an hour)? Please explain why you would deliver the program in that way. Please describe this in as much detail as possible.

_____

_____

_____

_____

_____

If you were to create a parenting program for first-generation Latino parents within a primary care medical setting, would your program be time-limited (i.e., 6 sessions long), would it be on-going (no beginning or end), or would you use some other format? Please explain why you would deliver the program in that way. Please describe this in as much detail as possible.

_____

_____

_____

_____

_____

If you were to create a parenting program for first-generation Latino parents within a primary care medical setting, how would you ensure that your program was culturally appropriate to the needs, values, and preferences of Latino parents in the United States? Please describe this in as much detail as possible

_____

_____

_____

_____

_____

APPENDIX E: SURVEY #2

Thank you for taking the time to complete research survey #2 out of 3 on parenting support for Latino families. Your expertise on Latino culture is critical to the success of this parenting and primary care project. The questions selected for this survey are based on your responses from survey #1, along with statements taken from previous research on primary care, parenting, and Latino culture. The purpose of this survey is to:

1) Come to a consensus on what is important for the development of a culturally-sensitive parenting program for first-generation Latino parents.

2) Come to a consensus on the best ways for delivering a culturally-sensitive program to first-generation Latino parents within a primary care setting.

Within 24 hours, after completing this survey, you will be rewarded with a free RedBox DVD. Please keep the following definitions in mind when answering the questions below:

First-generation means anyone who is the first of their immediate family to live in the United States permanently. ***Latino*** refers to anyone originally from Central America, South America, or the Caribbean. ***Primary care*** refers to a place where one's basic healthcare needs are met by a medical doctor or another healthcare professional. This is generally the first place you go when seeking basic medical care.

Please enter the same email address you used for survey #1: (This email will only be used for the purposes of this study and will not be linked to any of your responses for this study. It will only be used to send you links to surveys, to ask for the recruitment of other participants, to send you reminder emails, and to provide you with any of the incentives for this study):

_____

Question 1 out of 7: Imagine that you have created a parenting program for first-generation Latino parents that will be implemented in a primary care clinic. You have decided that this program will be implemented when patients come to see their healthcare provider.

How important is it that the program's facilitator is knowledgeable about the following topics?

	Not Important	Somewhat Important	Very Important	Essential
Respect (obeying authority figures)	○	○	○	○
Familismo (family loyalty and connection)	○	○	○	○
Simpatia (shyness, easy-going)	○	○	○	○
Personalismo (personal, friendly, warm)	○	○	○	○
Machismo/Marianismo (masculine/feminine gender roles)	○	○	○	○
Time Flexibility (flexible with start and end times)	○	○	○	○
Consejos to children (Value of giving advice to their children)	○	○	○	○
Spirituality/religiosity (how religious or spiritual they are)	○	○	○	○
Extent of diversity among Latino families	○	○	○	○
Participants' country of origin	○	○	○	○
Participants' generation status (1st,	○	○	○	○

2nd, or 3rd generation to live in the United States, etc.)				
Participants' immigration status (citizen, working visa, no documentation, etc.)	○	○	○	○
The role of extended family members or fictive kin (friends that are treated like family) in Latino families	○	○	○	○
Understanding that culture is an ever-changing process	○	○	○	○
Acculturation (the degree to which families accept or reject the cultural practices of those from another culture) and the stress derived from this process	○	○	○	○
The degree to which the child or parent feels "caught" between two different cultures (the culture from their country of origin and the United States)	○	○	○	○
The amount of trauma experienced by the family	○	○	○	○
Other characteristics of the participants (i.e., age, gender, income, work schedules, transportation, etc.)	○	○	○	○

Please comment below if there are answer choices that need clarification or if you felt like there was something missing from this list.

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Question 2 out of 7: Imagine that you have created a parenting program for first-generation Latino parents that will be implemented in a primary care clinic. You have decided that this program will be implemented when patients come to see their healthcare provider.

How important is it that the following people attend your program?

	Not Important	Somewhat Important	Very Important	Essential
The child or children who the parent is concerned about	○	○	○	○
Siblings of the child or children who the parent is concerned about	○	○	○	○
The mother	○	○	○	○
The father	○	○	○	○
Grandparents	○	○	○	○
Uncles, aunts, or cousins	○	○	○	○
Others who are considered part of the family	○	○	○	○

Question 3 out of 7: Imagine that you have created a parenting program for first-generation Latino parents that will be implemented in a primary care clinic. You have decided that this program will be implemented when patients come to see their healthcare provider.

How important is it that the program has the following characteristics?

	Not Important	Important	Very Important	Essential
Is free of charge	○	○	○	○
Provides free child care	○	○	○	○
Provides food for participants	○	○	○	○
Provides incentives for those who attend or complete the parenting program (i.e., gift cards, discounts, etc.)	○	○	○	○
Delivered by someone who is fluent in the preferred language of the participants	○	○	○	○
Delivered by someone who is from the same country as the participants	○	○	○	○
Delivered by someone who identifies as Latino	○	○	○	○
Delivered by a community member (volunteer)	○	○	○	○
Delivered by a paraprofessional (promotoras, community health worker, health coaches, etc.)	○	○	○	○
Uses qualitative research as part of the program (i.e., research about understanding the experiences of the participants)	○	○	○	○

Uses quantitative research as part of the program (i.e., using pre- and post-tests to measure program effectiveness)	○	○	○	○

Please comment below if there are answer choices that need clarification or if you felt like there was something missing from this list.

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Question 4 out of 7: Imagine that you have created a parenting program for first-generation Latino parents that will be implemented in a primary care clinic. You have decided that this program will be

implemented when patients come to see their healthcare provider.

	Not Important	Somewhat Important	Very Important	Essential
At every healthcare visit	○	○	○	○
At every well-child visit (routine visits with their doctor)	○	○	○	○
Only with families who have a clear need for parenting services	○	○	○	○
Before the patient sees their doctor	○	○	○	○
After the patient sees their doctor	○	○	○	○
Together with the patient's doctor	○	○	○	○
In a group setting (i.e., group medical visit)	○	○	○	○
In a family setting (i.e., family medical visit)	○	○	○	○
In the evenings (6pm or later)	○	○	○	○
On the weekends	○	○	○	○
Set topics at each session/visit	○	○	○	○
Flexible to participants' needs	○	○	○	○
5-15 minutes in length	○	○	○	○
15-30 minutes in length	○	○	○	○
30 minutes or more in length	○	○	○	○
Program length: 1-4 sessions	○	○	○	○

Program length: 5-6 sessions	○	○	○	○
Program length: 7 or more sessions	○	○	○	○

How important is it that the program is delivered in the following ways?

Question 5 out of 7: Imagine that you have created a parenting program for first-generation Latino parents that will be implemented in a primary care clinic. You have decided that this program will be implemented when patients come to see their healthcare provider.

How important is it that the program is delivered at the following places?

	Not Important	Somewhat Important	Very Important	Essential
In the waiting room	○	○	○	○
In the vitals room (where a medical assistant checks the patient's height and weight before leading the patient to an exam room)	○	○	○	○
In the exam room	○	○	○	○
In a parenting facilitator's office	○	○	○	○
In a group or community room located within the primary care clinic	○	○	○	○

Please comment below if there are answer choices that need clarification or if you felt like there was something missing from this list.

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Question 6 out of 7: Imagine that you have created a parenting program for first-generation Latino parents that will be implemented in a primary care clinic. You have decided that this program will be implemented when patients come to see their healthcare provider.

How important is it that your program facilitator teaches the following topics to their patients?

	Not Important	Somewhat Important	Very Important	Essential
Healthy use of technology	○	○	○	○
Basic information on child development	○	○	○	○
Setting limits on child behaviors	○	○	○	○
The effects of corporal punishment (i.e., spanking)	○	○	○	○
Ways to form a secure attachment between parent and child	○	○	○	○
Health ways of communicating	○	○	○	○
Emotion regulation to avoid conflict	○	○	○	○
Signs of mental health distress or substance use of children	○	○	○	○
Building parental social support	○	○	○	○
Acculturation differences between parent and children	○	○	○	○
Parental rights and child abuse laws in the United States	○	○	○	○
Positive vs. negative reinforcement	○	○	○	○
Education of healthcare and educational systems in the United States	○	○	○	○

Nutrition and/or physical acitivity education	○	○	○	○
Sex education	○	○	○	○
Basic infant care (such immunizations, dental care, car seat safety, feeding, etc.)	○	○	○	○
Culturally appropriate consequences for child misbehavior	○	○	○	○

Please comment below if there are answer choices that need clarification or if you felt like there was something missing from this list.

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Question 7 out of 7: Imagine that you have created a parenting program for first-generation Latino parents that will be implemented in a primary care clinic. You have decided that this program will be implemented when patients come to see their healthcare provider.

How important is it that your program is delivered using the following formats or methods?

	Not Important	Somewhat Important	Very Important	Essential
Face-to-face	○	○	○	○
Educational brochures	○	○	○	○
On a TV	○	○	○	○
On a tablet	○	○	○	○
Over the phone	○	○	○	○
Through educational modules taken online	○	○	○	○
Using a workbook	○	○	○	○
Using play therapy	○	○	○	○
Using cognitive-behavioral therapy or other research-based therapy models	○	○	○	○
Using role-play or other interactive activities	○	○	○	○
Conversational or discussion-based	○	○	○	○
Providing research-based information	○	○	○	○
Providing research-based information plus interactive activities	○	○	○	○

Please comment below if there are answer choices that need clarification or if you felt like there was something missing from this list.

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APPENDIX F: SURVEY #3

Thank you for taking the time to complete this third and final survey on Latino parenting support! The purpose of this final survey is for you to review the results from survey #2 and see how much you agree with the results. In order to do this, you will be asked to do three things:

1) Read through each statement.

2) See if you agree with the order that the statements are listed in. They are ordered from most important to least based on how all participants rated them in survey #2. (**Note:** * means that the statement is equal in importance with the statement right above it.)

3) Rate your overall agreement with all of the results shown on this survey.

To begin, please enter the same email address you used for survey #1: (This email will only be used for the purposes of this study and will not be linked to any of your responses for this study. Your email will allow us to provide you with incentives earned for your time and participation with this study):

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1. Please review the order of the following statements. They are listed in order from the most important to the least important, based on all participants' scores from survey #2. **Note: *** means that statement is equal in importance with the statement right above it. The statements below are based on the following question from survey #2:

Imagine that you have created a parenting program for first-generation Latino parents that will be implemented in a primary care clinic. You have decided that this program will be implemented when

patients come to see their healthcare provider. How important is it that the program's facilitator is knowledgeable about the following topics?

1. Familismo (family loyalty and connection)

2. The amount of trauma experienced by the family

3. The degree to which the child or parent feels "caught" between two different cultures (the culture from their country of origin and the United States)

4. Personalismo (personal, friendly, warm)

***** Extent of diversity among Latino families

5. Acculturation (the degree to which families accept or reject the cultural practices of those from another culture) and the stress derived from this process

6. Consejos to children (Value of giving advice to their children)

7. The role of extended family members or fictive kin (friends that are treated like family) in Latino families

*****Time Flexibility (flexible with start and end times)

8. Understanding that culture is an ever-changing process

9. Machismo/Marianismo (masculine/feminine gender roles)

10. Other characteristics of the participants (i.e., age, gender, income, work schedules, transportation, etc.)

11. Respect (obeying authority figures)

12. Participants' country of origin

13. Participants' generation status (1st, 2nd, or 3rd generation to live in the United States, etc.) 14. Spirituality/religiosity (how religious or spiritual they are) *Simpatia (shyness, easy-going) 15.Participants' immigration status (citizen, working visa, no documentation, etc.)

Question #1: Reflecting on each statement from the list above, and the order that they have been ranked, to what extent do you agree with these results?

- ○ Strongly Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ Somewhat Agree
- ○ Agree
- ○ Strongly Agree

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2. Please review the order of the following statements. They are ordered from most important to least based on how all participants rated them in survey #2. (**Note:** * means that the statement is equal in importance with the statement right above it.)

Imagine that you have created a parenting program for first-generation Latino parents that will be implemented in a primary care clinic when patients come to see their healthcare provider. How important is it that the following people attend your program?

1. The child(ren)'s mother
2. The child(ren)'s father
3. The child or children who the parent is concerned about
4. Grandparents
5. Siblings of the child or children who the parent is concerned about
6. Others who are considered part of the family
7. Uncles, aunts, or cousins

Question #2: Reflecting on each statement from the list above, and the order that they have been ranked, to what extent do you agree with these results?

- ○ Strongly Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ Somewhat Agree
- ○ Agree
- ○ Strongly Agree

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3. Please review the order of the following statements. They are ordered from most important to least based on how all participants rated them in survey #2. (**Note:** * means that the statement is equal in importance with the statement right above it). The statements below are based on the following question from survey #2:

Imagine that you have created a parenting program for first-generation Latino parents that will be implemented in a primary care clinic. You have decided that this program will be implemented when patients come to see their healthcare provider. The statements below are in response to the question: How important is it that the program has the following characteristics?

1. Delivered by someone who is fluent in the preferred language of the participants

2. Provides free child care

3. Is free of charge

4. Uses qualitative research as part of the program (i.e., research about understanding the experiences of the participants)

*****Uses quantitative research as part of the program (i.e., using pre- and post-tests to measure program effectiveness)

5. Provides food for participants

*****Delivered by someone who identifies as Latino 6. Delivered by a paraprofessional (promotoras, community health worker, health coaches, etc.)

*Provides incentives for those who attend or complete the parenting program (i.e., gift cards, discounts, etc.)

7. Delivered by a community member (volunteer)

8. Delivered by someone who is from the same country as the participants

Question #3: Reflecting on each statement from the list above, and the order that they have been ranked, to what extent do you agree with these results?

- ○ Strongly Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ Somewhat Agree
- ○ Agree
- ○ Strongly Agree

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4. Please review the order of the following statements. They are listed in order from the most important to the least important, based on your average scores from survey #2. The * means that statement is equal in importance with the statement right above it. The statements below are based on the following question from survey #2:

Imagine that you have created a parenting program for first-generation Latino parents that will be implemented in a primary care clinic. You have decided that this program will be implemented when patients come to see their healthcare provider. How important is it that the program is delivered in the following ways?

1. Flexible to participants' needs

2. Set topics at each session/visit

3. At every well-child visit (routine visits with their doctor)

4. In a family setting (i.e., family medical visit)

*In the evenings (6pm or later)

5. On the weekends

*****15-30 minutes in length

6. Program length: 5-6 sessions

7. Program length: 1-4 sessions

8. At every healthcare visit

9. 5-15 minutes in length

*****30 minutes or more in length

10. Together with the patient's doctor

11. Only with families who have a clear need for parenting services

12. Before the patient sees their doctor

13. After the patient sees their doctor

*****In a group setting (i.e., group medical visit)

14. Program length: 7 or more sessions

Question #4: Reflecting on each statement from the list above, and the order that they have been ranked, to what extent do you agree with these results?

- ○ Strongly Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ Somewhat Agree
- ○ Agree
- ○ Strongly Agree

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5. Please review the order of the following statements. They are ordered from most important to least based on how all participants rated them in survey #2. (**Note:** * means that the statement is equal in importance with the statement right above it.)

Imagine that you have created a parenting program for first-generation Latino parents that will be implemented in a primary care clinic. You have decided that this program will be implemented when patients come to see their healthcare provider. How important is it that the program is delivered at the following places?

1. In a group or community room located within the primary care clinic 2. In a parenting facilitator's office 3. In the exam room 4. In the vitals room (where a medical assistant checks the patient's height and weight before leading the patient to an exam room) 5. In the waiting room

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Question #5: Reflecting on each statement from the list above, and the order that they have been ranked, to what extent do you agree with these results?

- ○ Strongly Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ Somewhat Agree
- ○ Agree
- ○ Strongly Agree

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6. Please review the order of the following statements. They are ordered from most important to least based on how all participants rated them in survey #2. (**Note:** * means that the statement is equal in importance with the statement right above it.)

Imagine that you have created a parenting program for first-generation Latino parents that will be implemented in a primary care clinic. You have decided that this program will be implemented when patients come to see their healthcare provider. How important is it that your program facilitator teaches the following topics to their patients?

1. Setting limits on child behaviors

2. Health ways of communicating

3. Basic information on child development

*****Ways to form a secure attachment between parent and child

*****Signs of mental health distress or substance use of children

4. Building parental social support

5. Acculturation differences between parent and children

*****Basic infant care (such immunizations, dental care, car seat safety, feeding, etc.)

6. Emotion regulation to avoid conflict

*****Parental rights and child abuse laws in the United States

7. Nutrition and/or physical activity education

*****Culturally appropriate consequences for child misbehavior

8. The effects of corporal punishment (i.e., spanking)

9. Education of healthcare and educational systems in the United States

10. Sex education

11. Positive vs. negative reinforcement

12. Healthy use of technology

Question #6: Reflecting on each statement from the list above, and the order that they have been ranked, to what extent do you agree with these results?

- ○ Strongly Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ Somewhat Agree
- ○ Agree
- ○ Strongly Agree

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7. Please review the order of the following statements. They are ordered from most important to least based on how all participants rated them in survey #2. (**Note:** * means that the statement is equal in importance with the statement right above it.)

Imagine that you have created a parenting program for first-generation Latino parents that will be implemented in a primary care clinic. You have decided that this program will be implemented when patients come to see their healthcare provider. How important is it that your program is delivered using the following formats or methods?

1. Face-to-face

2. Conversational or discussion-based

3. Providing research-based information plus interactive activities

4. Using role-play or other interactive activities

5. Providing research-based information

6. Using cognitive-behavioral therapy or other research-based therapy models

7. Using play therapy

8. Educational brochures

9. Using a workbook

10. On a tablet

11. Over the phone

12.On a TV

13. Through educational modules taken online

Question #7: Reflecting on each statement from the list above, and the order that they have been ranked, to what extent do you agree with these results?

- ○ Strongly Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ Somewhat Agree
- ○ Agree
- ○ Strongly Agree

In addition to these results, the researchers also analyzed each participant's typed comments from survey #2. We came up with 7 themes based on those comments. Please mark below the extent to which you agree with following statements.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Facilitators must be flexible to the needs of the their participants.	○	○	○	○	○
A strong relationship between the facilitator and participant are essential.	○	○	○	○	○
Who to invite to the parenting program is highly dependent on the family structure and the needs of the family.	○	○	○	○	○
Some of the questions from survey #2 would have best be answered with "depends"	○	○	○	○	○
Regardless the facilitator's cultural background or knowledge of Latino culture, it is important that they are culturally humble.	○	○	○	○	○
Not all Latino individuals adhere to the same cultural expectations or to those expectations to the same extent.	○	○	○	○	○

The following topics would also be important to discuss in a parenting class for Latino families: Giving children structured choices, providing logical consequences, and the negative effects of psychological control.	○	○	○	○	○

Final Question: Reflecting on the entire survey, to what extent do you agree with the results as a whole?

- ○ Strongly Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ Somewhat Agree
- ○ Agree
- ○ Strongly Agree

Please comment below if you would like to explain more.

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