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Delivering CBT to Rural Latino Children with Anxiety Disorders: A Qualitative Study

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Abstract

Qualitative methods were used to understand community perspectives about ways to deliver cognitive behavior therapy (CBT) to rural Latino youth with anxiety. First, four focus groups were conducted with 28 bilingual Latino mental health providers to examine perceptions of CBT using telephone based, therapist supported bibliotherapy, and bibliotherapy without therapist support. Second, qualitative interviews were conducted with 15 Latino parents from a rural community to better understand attitudes toward CBT, and modes of service delivery. Qualitative findings revealed that parents were mostly positive about psychotherapy, and the core elements of CBT for anxiety. However, both parents and providers emphasized the need for adaptations to address practical and perceived barriers to treatment, such as time, convenience, homework, and literacy. Many parents spoke favorably of a telephone-based approach that could address many of their perceived barriers, while providers were expressed more negative views. Such findings are important for data-driven treatment development efforts.

Keywords

Latino; Rural; Child anxiety; Cognitive behavior therapy; Telemedicine

Introduction

Research on rural Latino youth is lacking and few studies have examined the effectiveness of evidence-based treatments for psychiatric disorders in this population. While prevalence rates of psychiatric disorders are similar across rural and urban populations, Latino youth and rural residents receive fewer mental health services than their Caucasian and urban counterparts (Alegría et al. 2004; Angold et al. 2002; Elgar et al. 2003; Kataoka et al. 2003). In the 2001 National Health Interview Survey, rural residence, low education, and lack of insurance were associated with lack of service use among children with ADHD symptoms (Cuffe et al. 2009). In an epidemiological study that examined both ethnicity and urban–

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rural differences, Latino children in both urban and rural areas were less likely to have a mental health visit than Caucasian children (Howell and McFeeters 2008).

Underutilization of mental health services by Latinos has been associated with a variety of barriers including difficulties with language, logistic factors, beliefs about causes, stigma associated with mental health treatment and the potential influence of social network (Cabassa et al. 2006). Among rural populations, transportation limitations, concerns about confidentiality and difficulty recruiting and retaining mental health providers all conspire to effect a rural resident's ability to access mental health service (Paul et al. 2006; US Congress 1990). In addition, most evidence-based treatments for children are not widely disseminated outside of urban areas (Chorpita 2002; Kazdin 2001), despite somewhat favorable attitudes toward these interventions by rural providers (Paul et al. 2006). In combination, these barriers make it very unlikely that rural Latino children with mental health problems, such as anxiety, will receive the services they need.

The presence of such disparities in the context of increasing cultural diversity has created a critical need to examine the effectiveness of evidence based interventions with underserved youth. Cognitive behavioral therapy (CBT), which usually consists of 12–16 in person sessions, is the gold-standard treatment for children with anxiety disorders. Findings from randomized clinical trials have found mostly comparable outcomes between Latino and Caucasian youth on measures of clinical response, remission, symptom severity and overall functioning (Pina et al. 2003; Pina et al. 2012; Silverman et al. 2008). However novel modes of service delivery are necessary in order to address the needs of rural Latino populations where geographic distances are prohibitive and clinician shortages abound.

Technological advances and telemental health interventions may help to address such disparities. In general, studies have found that more self-directed approaches that are delivered by telephone and/or computer and involve minimal contact with a therapist come with the advantages of increasing access to services, decreasing stigma associated with going to a mental health specialty clinic, and addressing other barriers such as cost, transportation, time, and convenience. Some findings however, suggest that families who receive some therapist contact, even minimal (e.g., by telephone), make greater gains compared to families who do not have any assistance (Lyneham and Rapee 2006). These results suggest that telephone based, therapist supported bibliotherapy for anxious children (Lyneham and Rapee 2006), in which a parent learns CBT skills from workbooks and implements these skills with their child with therapist support by telephone, may be a useful option for groups with limited access to evidence based interventions. However additional research is necessary to further assess the generalizability and acceptability of these self-directed, telephone-based interventions with underserved populations such as rural Latinos.

The current study begins to examine issues of feasibility of novel modes of service delivery (i.e., telephone based, therapist supported bibliotherapy, and self-directed bibliotherapy), with rural Latino children who have anxiety disorders. Qualitative methods are used to gather community feedback regarding the feasibility of these modes of delivery and to identify potential areas of poor fit. In particular, we query issues relevant to the acceptability of such interventions, comprehension of treatment related materials, and barriers that may

deter optimal engagement. Using both focus groups and qualitative interviews, we gather input from Latino mental health providers and rural Latino parents to provide data regarding the potential need for modifications to existing telephone based, CBT bibliotherapy interventions for children with anxiety disorders in a rural and predominantly Latino community.

Methods

Findings from two qualitative studies are presented. In the first study, 28 bilingual Latino mental health providers from a rural Latino community as well as a large metropolitan area in Southern California participated in four focus groups. In the second study, qualitative interviews were conducted with 15 parents from a rural Latino community in Southern California. Both studies were approved by the IRBs at the respective institutions.

Study 1: Focus Groups with Mental Health Providers

Mental health providers were recruited from community mental health agencies in both a rural and a metropolitan area. Providers were also recruited through a regional Latino professional group. The decision to recruit providers from both the rural and metropolitan areas was made in order to obtain a sample of bilingual providers with diverse strengths including working with rural Latino and low-income populations as well as expertise in using evidence-based approaches such as CBT. Providers were eligible to participate it they were bilingual and had experience working with Latinos in mental health settings. Providers received a $50 honorarium for participation in a focus group that lasted approximately 2 h. Two focus groups were held in the rural community and two were held in the metropolitan community.

In total, there were 28 participants who participated in one of four focus groups. The two focus groups in the urban community consisted of 5 and 7 providers, respectively and in the rural community, each focus group consisted of 8 providers. Providers also completed a basic demographic questionnaire to gather data on therapy theoretical orientation, years of training, and experience with Latino populations. All providers self-identified as Latino and were fluent in written and spoken Spanish. Many participants in each focus group participated in both English and Spanish. Seventy percent of participants reported that they had experience with CBT on a demographic questionnaire. Providers included paraprofessional educators (promotoras; 11 %), masters level therapists (37 %), psychologists (19 %), and psychiatrists (22 %). The majority of the providers were female (78 %).

Focus Groups—In total, four focus groups were conducted. Three members of the research team were present at each focus group; the group was co-facilitated by two-researchers who had both treatment and qualitative research experience. Each focus group began with a brief presentation of CBT for child anxiety, and modes of service delivery (e.g., telephone based, therapist supported bibliotherapy, and more self-directed approached) to improve access for rural populations. We used a semi-structured interview guide and providers were asked to comment on their perceptions of these modes of service delivery and possible ways to tailor the intervention to meet the needs of rural Spanish-speaking

families. Providers were also asked to comment on possible adaptations including engagement strategies and media adjuncts (audiobook, DVD) and to discuss cultural factors that could affect recruitment, adherence and retention. After each focus group, the research team debriefed. This process allowed for preliminary generation of theories, new concepts, modification of interview questions and preliminary generation of theories and follow-up questions for subsequent group. Focus groups were audiotaped and transcribed verbatim by trained research staff. Each audio recording was transcribed by a bilingual research assistant. A second bilingual research assistant listened to each of the four audio recordings while reading the transcript to check for accuracy.

Study 2: Qualitative Interviews with Parents

Parent participants were recruited in primary care clinic waiting rooms. A bilingual research team member, who was also a member of the local community, rotated through three rural primary care clinics to provide flyers, describe the study, screen and consent interested parents. Parents were eligible to participate if they had a child between ages 8–13, and endorsed a clinical level of anxiety for their child on a well-established child anxiety screen. Parents received a $30 gift certificate for participation in a qualitative interview that lasted approximately 45–60 min.

The sample included a total of 15 parent participants. The majority of participants were mothers (n = 14), and one participant was a father. The mean age was 34.76 years. All parents self-identified as Latino and 66 % identified English as their primary language. The median reported income for participating parents was $15,000. With regard to education level, 20 % had less than a high school education, 20 % were high school graduates, 20 % had attended some college, 18 % were college graduates and 22 % of participants did not respond to this item.

Measures—The following measures were used to screen parents as eligible and to characterize our sample.

Demographic Questionnaire: A questionnaire which included items querying parent's gender, age, education, ethnicity, income, employment and other related demographic items was administered in self-report format.

Child Anxiety Symptoms: Child anxiety symptoms were assessed by utilizing the Screen for Anxiety and Related Disorders (SCARED) (Birmaher et al. 1997, 1999), a child and parent-report screening tool to assess anxiety in youth. The SCARED has a short and long form. The shorter version, used as a screening questionnaire, consists of five items that load highest on each of the factors in a discriminant function analysis of the longer version (Birmaher et al. 1999). It has a classification rate of 78 % when discriminating "anxiety" from "no anxiety". The SCARED has been frequently used in community samples and psychometric properties are established for both the parent and child versions (Birmaher et al. 1997, 1999). Research supports the use of the SCARED with ethnically diverse US youth (Skriner and Chu 2014). In this study, parents completed the SCARED in either English or Spanish and were eligible to participate if the total score for their child's anxiety was above

the suggested cutoff indicating clinical anxiety. The Spanish version was translated and back-translated by mental health experts for the purposes of this study.

Parent Qualitative Interviews: Individual qualitative interviews were conducted with parents who expressed concerns about their children being anxious, nervous, fearful, or worried, and who endorsed that their child had significant anxiety symptoms as measured by the SCARED. Individual interviews were chosen over focus groups to ensure that parents could be as comfortable as possible discussing their child's anxiety problems, and their perceptions of the program materials. Interviews were conducted in English (n = 12) or Spanish (n = 3), depending on the parent's preference.

Interviews followed a semi-structured interview script comprised of open-ended questions. Interviewers prompted for more information by using neutral prompts ("tell me more", "how so?") and utilizing active listening skills (restating parent words as a question, summarizing information) to elicit complete answers. Initially, parents were asked to comment on their perceptions of their child's fears or worries, perceptions of anxiety and strategies to manage anxiety, as well as attitudes toward varying types of treatment and modes of service delivery for child anxiety. Second, interviewers oriented parents to example worksheets of the CBT skills in either English or Spanish (e.g. thought challenges and exposure), and inquired about parent perceptions of language and readability of worksheets as well as the actual CBT skills. Next, parents were asked about their thoughts and willingness to learn these skills using self-help materials (i.e., bibliotherapy) and to guide their children through the program with and without therapist support by telephone. Parents were also asked how much time they felt they could spend with program materials as well as on the phone with a therapist. Lastly, parents were asked for their thoughts on using media adjuncts, such as audiotape versions of workbook materials and video examples of using the core CBT skills.

Most interviews were audiotaped (n = 11), however some parents (n = 4) stated they did not feel comfortable with audio-taping, and were still allowed to participate in the interview. After a set of 4–5 interviews had occurred, the research team debriefed. This process allowed for preliminary generation of theories, identification of new concepts, and modification of interview questions for subsequent parent interviews. Audio taped interviews were transcribed verbatim by one research assistant, and a second research assistant listened to the audio recordings while reading the transcript to check for accuracy. For interviews that were not audio recorded, detailed notes were taken by the interviewer during the interview, and content was included in the coding process.

Data Analysis for Focus Groups and Qualitative Interviews

Coding of focus groups and parent interviews was done by trained research staff using methodology outlined by Willms et al. (1992) rooted in a grounded theory approach (Glaser and Strauss 1967). Initially, all personal identifying information was removed to maintain confidentiality and anonymity, and thereafter, the transcripts were reviewed by the lead author and a bilingual post-doctoral fellow to establish a general understanding of interview content. For the focus groups, the same procedure was followed.

Next, the data was coded using open coding where one investigator went through the transcript line by line and coded the participant responses. Thereafter a second researcher open coded the transcript to ensure concurrence. Segments of transcripts ranging from a phrase to several paragraphs were assigned codes based on a priori (i.e., interview and focus group guide) or emergent themes. In some instances, the same text segment was assigned more than one code. Disagreements in assignment or description of codes were resolved through discussion amongst the research team. QSR International's NVivo 8 qualitative data analysis software (2008) was used to facilitate coding and analysis.

Coding occurred within and across transcripts. Data was coded to determine individual codes and categorization of codes, to monitor concept saturation, and to facilitate theme generation. Concept saturation was determined by a review of the data and ongoing discussion within the research team. For the parent interviews, the research team realized early on that ideas and concepts were being repeated, and that little new information was emerging after the 10th interview, however as proposed, we continued to conduct interviews until we had a sample of 15 parents, in order to ensure theme saturation. We used this same process of review and data analysis to determine saturation for the focus groups.

Results

Main Themes from Focus Groups and Qualitative Interviews

Views of Counseling, Cognitive Behavior Therapy, and Telephone-Based, Therapist-Supported Bibliotherapy

Psychotherapy/Counseling: Parents Prefer it to Medication: Many parents (69 %) expressed a favorable attitude towards psychotherapy/counseling to treat their child's anxiety and reported that therapy could help their child's anxiety. As one parent stated, "I think counseling is probably a really good first alternative and hopefully that would suffice… (medication) would be a last resort." Two parents expressed mixed feelings due to negative experiences with counseling in the past where the parents reported that they were not involved enough in the process. Interestingly, when parents were asked the best ways to help children with anxiety, most mentioned that allowing children to express their feelings and "talking to them" is most helpful (60 %). Other parents mentioned distraction (20 %) and prayer (13 %) as possible strategies to help their child.

Some parents (47 %) expressed negative feelings about treatment with medication. Parents expressed that medication would be a "last resort" in many cases, and would prefer counseling for anxiety. "I think we have a problem with just medicating kids. I think an attempt should be made to try to give parents the tools and educate them on the way we can help our children. Other parents focused on the negative side effects that they believed to be associated with medication. Drugs are man-made and have negative side effects on body." Another parent stated, "No medication. They will depend on meds, drinking pills, which is not healthy for them; then they will freak out if they don't have pills." In some cases (30 %), parents had concerns about the side effects of medication but expressed a wiliness to try medication if the anxiety was severe; "I'm reluctant to put my son on meds. Only if it is at the point where he can't function daily, then I would consider it." Only one parent expressed

a positive opinion of medication stating “Mí opinión, que sé un niño tiene mucho miedo y necesita medicina, yo pienso que sí, es necesario. Como todo la medicina” (“In my opinion, if I know a child has a lot of anxiety and needs medication, I think it is necessary. Like with all medicine”).

Interestingly, mental health providers emphasized the many challenges of conducting therapy with Latinos and were much more positive about medication than parents. Providers noted that parents often do not want to talk to a therapist because of fears of being blamed, and some felt that parents would be more receptive to the idea of medication than therapy. Some noted concerns about counseling stating that parents often want “*quick results”* and feel disappointed if they are not provided medication. Another provider offered that parents may agree to therapy but will not engage in treatment; “We go to our doctors and have a hard time contradicting what the doctor tells us… We have a hard time saying no. We just say ‘oh yeah’ and then leave and never come back.”

Cognitive Behavior Therapy Skills Make Sense, but Homework is Difficult: Parents were presented a description of specific cognitive behavior therapy skills (e.g., exposure, cognitive restructuring) by the interviewer and reviewed corresponding worksheets. Most parents (73 %) responded positively to the use of thought challenges to address anxious thoughts, as exemplified by one parent who stated, “I think that’s pretty good actually. Makes them think of the pros and cons to help them figure out things on their own.” “It dissects the problem. See another perspective and think outside the box. It will help them to find out it’s not such a big issue after all.” Some parents (27 %) expressed mixed feelings or reservations. One parent agreed with using thought challenges, however stated that it would be best if they were done with a counselor or therapist rather than the parent. Another parent expressed her skepticism about thought challenges and stated, “She will still come up with worries…It would be hard.” Similarly, most parents (87 %) responded well to the idea of using exposure with children, and positively endorsed the strategy of using gradual steps to help children confront their fears as well as the corresponding use of rewards to reinforce these behaviors. One parent stated, “It would help really good-little steps. Can’t just push them in right away, they are afraid. It makes sense. The kids will understand it.” Another parent stated, “It is good step by step so it isn’t a dramatic change if they have fear.”

In contrast to parents’ reactions to CBT, only three mental health providers (11 %) expressed full support for using this approach with Latinos. One provider who supported the use of CBT commented, “Twenty years ago, even ten years ago people would have said, ‘you can’t do CBT with Latinos.’ Now we are passed that…” However, many providers (29 %) expressed concern that CBT approaches often rely too heavily on homework, stating, “homework is just painful.” One provider noted, “they’ve done problem solving therapy in Hispanic populations… and the big issue is they don’t do homework.” Other providers discussed issues of treatment compliance including completion of homework exercises and practical barriers that deter attendance and overall engagement. Providers emphasized the need to be proactive about problem solving barriers and destigmatizing mental illness, and treatment.

Telephone-Based, Therapist Supported Bibliotherapy (TTB): TTB Might Work: The use of telephone based, therapist supported bibliotherapy received both favorable and unfavorable reactions from providers and parents. Many parents expressed positive reactions (53 %) to TTB and cited the following reasons for supporting this approach: (1) the inclusion of parents in the intervention; (2) a skills based focus; (3) greater comfort completing treatment in their own home, and; (4) the opportunity to learn the skills and complete the activities on their own time. One parent shared, “That sounds good because at least you don’t have to take the time to get out of work and go somewhere and make a particular stop somewhere else, because you can do it out of your home”, referring to ease of participating when balancing competing demands. Some parents (20 %) expressed concerns about the TTB approach because of worries about child compliance, the need to be able to read the workbooks, and a general lack of familiarity with such a telephone, bibliotherapy approach. One parent stated “Pues, te diré que es algo raro” (“Well, I’ll tell you that is somewhat weird”), expressing skepticism over the new mode of treatment delivery. Some parents expressed mixed feelings due to the lack of face-to-face contact (27 %), and potential difficulty with weekly telephone contacts to support the bibliotherapy (20 %).

Many providers (57 %) recommended the need for some type of face–face support, such as a community health worker or a parent support group to be used in conjunction with the telephone based, therapist supported sessions. A few providers (11%) indicated that TTB could be difficult with this population due to access to telephone service, frequent moves, and financial barriers regarding cell phone minutes. “A lot of parents don’t have money. They don’t pay the telephone and the telephone is disconnected for like a month. That’s very common.” Another provider stated, “My experience has been depending on the level of acculturation if parents who are new to the country, they don’t like phone calls… People that have been more acculturated, have been growing up here. they love the phone.” Other providers expressed support (14 %) due to the potential of TTB to address barriers, such as convenience in a community where agricultural work and long hours are prevalent, travel to therapy sessions, and stigma related to going to a mental health clinic. For example, one provider stated, “Getting to treatment is another stressor… In a rural area where they might have to travel 30–40 minutes to get to a clinic and back home and it takes 3 hours every day, this is a really nice way for them to get the help that they need.” Some also shared their experience with telephone-based interventions: “I actually deliver my interventions over the phone and I found there’s more privacy. They don’t feel judged … It was surprising for me that I was able to connect with the participants even over the phone.”

Uncertainty About “Self-Help Materials/Bibliotherapy” Without Therapist Support: The idea of completely self-directed, parent-implemented bibliotherapy without any therapist support by telephone, was also presented to parents and providers. Some parents reacted positively (30 %) to the self-help model, stating, “that would be fine. We like to read. We like to look up information and implement it.” Many parents expressed uncertainty or were decidedly against the self-help alone model (50 %). One parent stated, “It’s good because you’re doing it on your own and that’s actually … the best way you know, because I mean people are learning on their own. But then there will be people that might not understand something, and it’s kind of frustrating.” Another parent stated, “It

would be hard for me because I would be second guessing myself and ‘how do I do this intervention?’ ‘Am I doing it right?” As another example, one parent stated, “I don’t think it would work…. I wouldn’t just want a workbook… I wouldn’t want to do that. I did that before and it was overwhelming.”

Mental health providers also expressed mostly unfavorable views about the completely self-directed model. One provider voiced concern by stating “It’s so hard when nobody is telling you… you can buy a self-help book. It’s just hard.” Additionally providers stated that if families are given materials to read, “they don’t read it.”

Barriers to Telephone-Based, Therapist-Supported Bibliotherapy (TTB)

Language and Literacy as Barriers: Many mental health providers (46 %) were concerned about literacy and education level, as well as the simplicity of therapy materials as potential barriers to the successful completion of the therapist supported bibliotherapy, or self-directed bibliotherapy intervention. Providers also emphasized the need to consider the different language abilities and literacy levels of parents and children. These providers suggested materials written at the 3rd grade level, without the use of clinical jargon. Many providers voiced support for potential media adjuncts including an audiobook of the treatment workbooks in both English and Spanish as well as a DVD with vignettes of children working on the core activities and CBT skills; “I like the DVDs [audio books and DVD] because a lot of people I work with are illiterate. a lot of people. They’re struggling families with low socioeconomics. I work with MediCal families. I would say 90 % can’t read in any language.” Overall, mental health providers (40 %) were supportive of adjunctive audio and video supplements, and those who had concerns suggested that they would be in favor of media adjuncts, if they were high quality, brief, and in English and Spanish.

Similar reactions toward media adjuncts were noted by parents, but for different reasons than those given by the providers. Overall parents responded favorably to the idea of audiobook adjuncts (87 %), with the majority explaining that it would address barriers such as time, “I think that would be very helpful. I don’t have time to sit down and read a book”, as well as “It would be better because I could probably put it on and go about my business washing dishes and just listening to it”, and “That would be perfect cause I have a 45 minutes drive to work and I’m always listening…to the radio.” Only one parent expressed disapproval of an audiobook due to preferring to read. Similarly, parents responded overwhelmingly favorably (87 %) to the idea of a DVD adjunct with video exemplars of the skills, responding, “I could play it back and see how you do it.”

Time and Availability as Barriers: Both providers and parents expressed concerns about parents having enough time to engage in a telephone based, therapist supported bibliotherapy approach, given the many demands and stressors that families face on a daily basis. Parents (40 %) underscored the need for therapist flexibility due to work schedules and various life demands. One parent stated, “it would be beneficial to be able to contact the therapist as needed similar to a hotline rather than scheduled contacts.” Another parent expressed the struggle many parents face when it comes to allocating special time to one child; “everybody wants my attention and you know, it’s like I can’t split myself into three.”

Many mental health providers (29 %) echoed parent's concern regarding the parent's ability to spend time on the telephone with a therapist as well as reading and implementing program materials. One provider stated "when are they supposed to have that time set aside, not only that telephone conversation, but when are they going to have time? Most people aren't going to have just one kid." Providers suggested that therapists should work around parent availability and also be flexible with telephone contacts, such as being available in the evening when parents get home from work as well as on the weekends: "[Parents] are so busy that you're going to have to create an environment that works for them." Providers also stated that media adjuncts would assist with parents receiving the treatment material in the context of busy schedules and multiple stressors.

Cultural Fit

Some parents (27 %) voiced concerns about the lack of inperson contact when discussing their perceptions of a telephone based, bibliotherapy model. One parent stated, "I would wanna sit down with the provider and you know, teach me how to do this… I just like to have that face to face contact." Some parents (27 %) suggested the idea of parent groups, where parents could meet with a promotor/a or community educator to discuss program skills, problem-solve as a group and provide social support to one another. Mental health providers (25 %) also expressed concern about TTB due to cultural values such as *personalismo*, the emphasis on warm and friendly interpersonal relationships within Latino culture. As one provider stated, "Latinos need to see somebody face-to-face to trust." Providers suggested having the initial session in person, sending a photo of the therapist, using promotoras, parent groups, or using videoconferencing, although there was some disagreement amongst providers on how parents would react to new technology such as videoconferencing.

Discussion

Qualitative findings from both the parent and provider studies provide important feedback regarding treatment acceptability, comprehension of skills, barriers to treatment participation, and overall program fit for novel modes of treatment delivery such as telephone based, parent-implemented, CBT programs, that are being transported to underserved communities. Consistent with existing cultural adaptation frameworks (Castro et al. 2010; Lau 2006), qualitative findings can be useful in guiding modifications that are data-driven, selective and targeted, with an underlying aim to preserve the existing validity of the intervention.

In the current study, qualitative findings suggest that rural Latino parents are mostly positive about counseling/psychotherapy interventions and mostly negative about the use of medications as a first-line approach to treat anxiety symptoms in their children. Such findings are consistent with past studies suggesting that parents are more accepting of psychosocial interventions compared to medication and that Latinos and ethnic minorities are less accepting of medications than their non-Latino white counterparts (Chavira et al. 2003; Pescosolido et al. 2007).

The majority of parents expressed a willingness to try the telephone-based, therapist-assisted, mode of treatment delivery (i.e., TTB). While parents discussed the cultural value of "personalismo" and expressed a preference for treatment to include some in-person support, such as a community health worker (promotora) or parent support group, many also noted that the TTB approach would address some of their concerns about time, convenience, transportation, stigma, and childcare. Further, when presented with greater details about the TTB intervention as well as the actual treatment materials (e.g., worksheets explaining exposure, thought challenges), parents reported that they understood the CBT skills and would be agreeable to implementing these strategies with their children. However many parents were concerned about having enough time to participate in a therapy intervention as well as complete "therapy homework." Completely self-directed, parent-implemented, bibliotherapy approaches, without any therapist support, were perceived unfavorably and with skepticism.

Mental health providers expressed more negative views about psychotherapy with Latinos in general and telephone based, therapist supported bibliotherapy specifically, citing the numerous challenges that emerge when conducting therapy with Latinos, particularly low income Latinos. With regard to participating in psychotherapy in general, providers noted concerns such as parents' "fears of being blamed" for their child's problems as well as parents wanting "quick results". Therapy interfering behaviors including poor attendance at sessions and homework compliance were also mentioned. Providers also expressed unfavorable views about interventions that were time intensive and dependent on homework assignments. Regarding the telephone based, parent-implemented, mode of delivery, some providers stated that it would be difficult for families to practice the skills independently, and that in the Latino culture face to face appointments are necessary.

Discrepancies between patient and provider perspectives have been found in previous studies and warrant additional attention. For example, in studies of computer based and self-directed approaches for depression, providers' attitudes were more negative than the attitudes of patients themselves (Montero-Marin et al. 2013; Whitfield and Williams 2004). Such attitudes are important and warrant additional attention. It is conceivable that such attitudes may deter the implementation of evidence-based practices in the community and potentially have a negative impact on service uptake and engagement related outcomes such as patient self-efficacy, treatment expectancies and adherence.

Additionally parent perceptions of therapy and therapy related activities (e.g., homework), as "burdensome" represent important barriers to the effective use of CBT interventions in low-income populations. Previous research has found that parental motivation and expectations about treatment directly influence therapy outcomes (Kendall and Sugarman 1997). For example, Kazdin and Wassell (2000) found that barriers (including practical stressors, perceptions about the demandingness and relevance of treatment, and the therapist-parent relationship) shared an inverse relationship with therapeutic change. Given such research, it is critical that efforts are made to address such perceptions (i.e., barriers) prior to and throughout the intervention in order to maximize engagement and optimize outcomes. An additional component of engagement, warranting further attention, is the need for increased

therapist and protocol flexibility, to accommodate families faced with multiple stressors and competing demands.

A final issue that emerged in the provider focus groups was the feasibility of an intervention that emphasized written materials (e.g. workbooks) with participants who had low levels of education and limited literacy skills. At present, many of the materials that accompany existing CBT interventions are written at an 8th grade reading level or above (Williams and Garland 2002). In order to make our interventions as accessible as possible, particularly to underserved groups, efforts are necessary to further simplify existing manuals to a 5th grade reading level or lower, as recommended by Federal Plain Action Language Network (PLAIN) guidelines and various health literacy experts (Plain Action Language Network 2011). In the current study, parents were enthusiastic about media based adjuncts, explaining that these tools could be a useful alternative to reading therapy materials and a way to accommodate their busy lifestyles. Technology and media based adjuncts, such as computer assisted interventions, smartphone apps, text messaging, audio recordings of therapy materials (e.g., “books on tape/CD”), and video exemplars (on DVD or another medium) of core program skills, may facilitate learning but additional research is necessary in this regard. Currently, studies examining various adaptations are underway and have the potential to make interventions more accessible to those with limited literacy skills and to address barriers related to time and convenience.

This study was focused on the opinions of specific groups of individuals, Latino parents and Latino mental health providers, from a specific geographic region, and therefore findings cannot be generalized to other groups throughout the United States. Further, we recruited parents from primary care settings who expressed concern about their child’s anxiety symptoms. This group of individuals is likely a select group that differs from parents who do not recognize or disclose such symptoms in their child. Similarly, a purposive sampling approach was used to select Latino mental health providers (CBT experiences with Spanish speakers, etc.), and as such they have experiences that may not be characteristic of Latino mental health providers broadly.

Conclusions

This project is one of the first gather the opinions of rural community members (i.e., Latino parents and mental health providers) regarding novel modes of service delivery to improve access to existing evidence based treatments, such as cognitive behavior therapy, for children with anxiety disorders. Examining the effectiveness of approaches that rely on more minimal therapist contact, such as telephone based, therapist supported bibliotherapy, is critical in geographic regions where clinician shortages and lack of CBT training abound. Future adaptations of existing evidence based interventions for rural Latino youth, may benefit from considering findings that have emerged from this and other qualitative studies that include community perspectives.

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