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Reaching Latino families through pediatric primary care: Outcomes of the CANNE parent training program

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Abstract

The lack of culturally adapted parenting programs for Latinos contributes to low engagement in effective parenting programs. *Criando a Nuestros Niños hacio el Éxito* (CANNE), a culturally adapted program, improves family dynamics by decreasing problematic child behavior and helping parents manage stress. CANNE was delivered with 12 Latino parents of children (age 3–7). Increased attendance and participation resulted in less child behavior problems and parenting stress from pre- to post-intervention. A culturally-relevant adaptation of an evidence-based parenting program improved engagement, child behavioral outcomes, and parenting stress. Implications of mental health services in primary care facilities for Latino families are addressed.

Keywords

parenting management training; child maltreatment prevention; cultural adaptations; primary care

Introduction

Successful child development depends on positive parent-child relationships; parenting programs improve familial relationships and thereby minimize parent stress and child behavioral issues (Begle & Dumas, 2011). Programs are essential in disadvantaged communities where glaring health disparities augment familial instability and development of delinquent behavior (Domenech Rodríguez, Rodríguez, & Davis, 2006), further contributing to high-risk behaviors for child maltreatment. Due to the high prevalence of child maltreatment as a significant public health concern, it is critical to address factors often related to child maltreatment, including delinquent behavior and parent stress. Studies have found that better management of both child behavior problems and parent stress are associated with prevention of child maltreatment (Begle, Dumas, & Hanson, 2010).

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The Latino community in particular faces challenges related to language barriers, legal documented status, and cultural incongruence with American parenting norms, rigid work schedules, and limited transportation access (Ku & Matani, 2001; Dumas, Arriaga, Begle, & Longoria, 2010). Despite significant need, Latino-focused parenting programs that address these potential barriers to treatment are scarce. Although culturally modified empirically-supported treatments exist (e.g., GANA Program for Mexican Americans), engaging parents remains an obstacle (McCabe, Yeh, Garland, Lau, & Chavez, 2005) due to lack of culturally competent programs, logistical barriers, or parent attitudes that interventions are not relevant to their family/background (Ray-Sannerud et al., 2012). Parenting management training (PMT) programs that are not culturally adapted fail to recognize health disparities, and therefore do not attract participation, resulting in high attrition rates and lack of effective findings (Castro, Barrera, & Martínez, 2004).

Based on significant need in the Latino community, Parenting Our Children to Excellence (PACE) was selected for cultural adaptation, resulting in the culturally tailored program: *Criando a Nuestros Niños hacio el Éxito,* or CANNE (Dumas et al. 2010). Like PACE, CANNE also focuses on socially disadvantaged populations and specifically targets traditional engagement barriers (i.e., childcare, transportation, and food). Specifically, PACE and CANNE interventions include provision of child care during the program, gas vouchers and bus passes for transportation needs, and inclusion of food (generally dinner) for children and parents. In a study of 610 parents of preschoolers, engagement in PACE significantly improved child and parent outcomes (Begle & Dumas, 2011). PACE is shorter in length (8 weeks) to many other effective parent training programs (e.g., The Incredible Years; Webster-Stratton, Jamila Reid, & Stoolmiller, 2008; Triple P, Sanders, 1999) and can be implemented by paraprofessionals due to detailed training, fidelity monitoring, and supervision (described below), increasing feasibility of parental engagement and community adoption and dissemination.

Adaptation included community consultation and systematic adaptation, which refers to the process of adaptation that includes both translation of the program into Spanish, but also incorporating cultural differences in assumptions and priorities regarding parenting (see Dumas et al., 2010). Research has indicated that adaptations are likely to be ineffective and to not demonstrate considerable differences from the original treatment without including adaptations to both language and differences in assumptions and priorities (Dumas et al., 2010). The systematic adaptation was completed in several steps, including initial input from consultants, input from members of the target population, additional input from consultants, and manual adaptation and adaptation fidelity (detailed discussion in Dumas et al., 2010).

CANNE focuses on improving family dynamics by decreasing problematic child behavior and helping parents manage stress, within a Latino cultural framework. CANNE was implemented in urban elementary schools in the Midwest. Parents actively attended and participated and over program duration, decreased harsh/inconsistent discipline; children improved on social competence and social/communication. Higher attendance led to increased positive parenting practices, and child social competence/communication skills; and decreased harsh/inconsistent discipline, and child aggression/hyperactivity (Dumas, Arriaga, & Begle, 2011).

This article examines CANNE in a clinical outreach setting in South Carolina, the state with the fastest growing rate of Latinos (US Census, 2011) and in a more rural location compared to the urban location where Dumas and colleagues (2011) delivered the program. Given that mental and behavioral health disparities are even greater in rural areas due to increased stigma, lack of anonymity, lack of resources, and more logisitical barriers with transportation, the feasibility and relevance of the CANNE program in this rural Latino settlement warranted further examination. Primary care is crucial for low-income Latino families, who rely heavily on providers serving patients of low socioeconomic status who are vulnerable, uninsured, or underinsured (Rodriguez, &Vega, 2009). Using the *Promotora de Salud model* to provide insight into individual, familial, and community factors to adapt CANNE to a primary care setting, we wanted to ensure a contextually relevant program, and not one based on ethnic preconceptions or generalizations (Kumpfer et al., 2002). In this model, *promotoras*, or community health workers, are members of a target population sharing many of the same social, cultural and economic characteristics as potential patients or participants. As trusted members of their community, promotoras are often the bridge between the diverse populations they serve and healthcare delivery and navigation. Promotoras can often serve as a patient advocate, educator, mentor, outreach worker or interpreter. The promotora model is often used in the United States and Latin America to reach Latino/a communities. It is also used in rural communities to improve the health of migrant and seasonal farm workers and their families (Pittman, Sunderland, Broderick, & Barnett, 2015). In addition to a trusted community health worker, or promotora, from within the community, a trustworthy and dependable primary care facility was used for delivery of the program. The healthy and established relationship between the immigrant Latino community and the pediatric primary care clinic is evidenced by the number of Latino children provided health care through this clinic (52% of their patient population is Latino) as well as the number of bilingual staff and health care providers at this clinic (23 out of 25; 92% of employees).

We hypothesized that: (1) Parents would attend CANNE regularly and participate actively in sessions held at their trusted primary care facility, (2) child and parent outcomes (i.e., child coping competence and behavior problems; parent competence and stress) would improve throughout the program, and (3) parents would be satisfied with CANNE as evidenced by reported outcomes on a satisfaction survey.

Methods

Participants

Ten mothers and 2 fathers (“parents”) participated in CANNE. Each parent, with ages ranging from 26 to 42 (M = 33.83, SD = 5.17), represented a distinct family with one target child age of 3 to 7. All described their ethnicity as Latino and Spanish as their primary language. Seventy-five percent were married/in a relationship; 67% had completed grades 1 through 8, 25% grades 9 through 11, and 8% the Central American equivalence of high school. Mean yearly household income was $9,250 ($SD$ = $6,675). Children were a mean age of 5.02 (SD = 1.20); 75% were boys.

Procedures/Intervention Applications

Given that primary care physicians are considered to be the most utilized healthcare resource for a variety of physical, emotional, or behavioral problems in the US (Ray-Sannerud et al., 2012), delivery of CANNE in a primary care clinic was decided. Following Institutional Review Board approval, CANNE was conducted within a primary care pediatric clinic. This clinic is extremely disadvantaged; 52% of the patients are Latino or non-English speaking, and 91% Medicaid-eligible (MUSC Children's Hospital, 2010). All Spanish-speaking parents with children ages 3 to 7 who receive services at the clinic were eligible to participate.

Recruitment included poster advertisements in the clinic and sending registration forms to all eligible parents. Posters summarized the content of each session, that the program was free and that, at each session, parents and children would receive a free meal, free childcare, and a transportation voucher. CANNE used a *Promotora de Salud* model to encourage engagement (Balcazar, Alvarado, Cantu, Pedregon, & Fulwood, 2009). The *promotora* was a full-time staff member at the outreach clinic and a native Spanish speaker, whose role involved increasing parents' motivation, building a parent-researcher alliance, developing trust, and communicating feedback or concerns (Santisteban, Suarez-Morales, Robbins, Szapocznik, 2006; Perez, 2008).

Sociodemographic, child, and parent measures were collected at pre- and post-intervention, which were translated during the original adaptation process (Dumas et al., 2010). Measures were verbally administered in Spanish in a group format to ensure that parental reading level did not contribute to inaccurate responses. Parents provided informed consent prior to data collection and received $15 for the pre- and $20 for the post-assessment. A standardized procedure was used to track data collection. Specifically, the following procedures were utilized as necessary by the promotora: (1) up to five attempts were made to contact the parent by phone, leaving a scripted message if needed each time to ask the parent to contact the CANNE office; (2) alternate contact person(s), provided by the parent at program enrollment, were contacted to request the parent's new contact information and to ask the parent to call the office; (3) a letter was mailed to the parent's most recent address on file; (4) the promotora assisted the CANNE research staff member in reaching the parent; and (5) a trained interviewer went to the parent's last known address to schedule or conduct an interview in person. Parents were contacted the day prior to each group meeting by the promotora, to remind them of the date and time and discuss barriers to attendance (e.g., work schedule, childcare).

CANNE Session Content

CANNE was delivered over eight, 2-hour sessions conducted once per week at the primary care clinic. The eight sessions or modules covered the following topics: (1) Introduction to the program and bringing out the best in our children; (2) Setting clear limits for our children; (3) Helping our children behave well at home and beyond; (4) Making sure our children get enough sleep; (5) Encouraging our children's early thinking skills; (6) Developing our children's self-esteem; (7) Helping our children do well at school; and (8)

Anticipating challenges and seeking support. A more detailed description of the sessions or modules is included in Table 2.

Program Fidelity

Identical to procedures implemented in the PACE study (Begle & Dumas, 2011), each CANNE parenting group was conducted by a trained leader and assistant. Prior to leaving a group, each leader completed a 2-day, 8-hour training in implementation of CANNE. Training, supervision, and fidelity assessments focused on program *content* and *process*. Content training pertained to the topics to be covered in each session, and to their rationale, presentation, and supporting materials (videotapes, posters, handouts). Process training focused on effective communication skills. It emphasized the importance of involving parents in all aspects of each session and provided specific instruction on how to encourage and channel parental discussion, avoid criticism and unsolicited advice giving, provide frequent positive feedback, and deal with resistance. Training was conducted in small groups and consisted of didactic presentations, vignettes, modeling, role-playing, discussions, and practice sessions. In the course of training, staff competence was evaluated using formal quizzes and live observations. In addition, throughout the study, group leaders received weekly supervision that included feedback from weekly fidelity assessments.

Group leader fidelity was assessed with procedures identical to in the PACE protocol, described in Dumas et al. (2001). Leaders wore a lapel microphone attached to a small portable recorder to audiotape all sessions. Trained coders working under the supervision of an expert coder listened to these tapes weekly and coded them for fidelity to program content and process with the help of checklists developed for that purpose. Results from these assessments were sent to the group leaders' supervisor on a weekly basis for ongoing feedback and provided overall estimates of adherence to protocol.

Measures

Engagement.

Attendance: Whether the parent attended each session or not was summed to form an overall attendance score (0 to 8). A parent was considered "present" if they attended at least ¾ of the session (1 hour, 30 minutes). *Quality of Participation:* After each session, the group leader rated each parent's quality of participation by answering one question "Overall, how well did the parent participate during the session?" Answers ranged from "(1) Did not participate or obstructed group functioning and activities" to "(5) Participated enthusiastically. Was obviously interested and attentive to other group participants." Quality of participation scores were then averaged within each participant across the sessions attended, which was calculated by summing the participation scores across all sessions attended by the particular participant and dividing by that number.

Sociodemographic characteristics.—Sociodemographic information included parent gender, age, ethnicity, marital status, education, family income, and child gender and age.

Parent and child outcomes.

Child coping competence: The 26-item *Coping Competence Scale – Revised* (*CCS_R*; Moreland & Dumas, 2007) used a 5-point Likert scale, from (1) Very good to (5) Very poor. The scale has high internal consistency (Cronbach α = .91 in Moreland & Dumas, 2007, and .87 in this study). *Child behavior problems:* The 36-item, Intensity subscale of the *Eyberg Child Behavior Inventory – 2* (*ECBI;* Boggs, Eyberg, & Reynolds, 1990) measures frequency-of-occurrence of disruptive behaviors from (1) never to (7) always. The scale is internally consistent with Latino children (Gross et al., 2007; in this study, α = .92). *Parent competence:* The 16-item *Parental Sense of Competence Scale* (*PSOC;* Johnston & Mash, 1989) evaluates parent fulfillment on a 6-point scale from (1) Strongly agree to (6) Strongly disagree, and has been used successfully with Latino parents of young children (Haack, Gerdes, Schneider, & Hurtado, 2011; in this study, α = .93). *Parenting stress:* Parent level of stress was measured with the 36-item *Parenting Stress Index/Short Form (PSI/SF;* Abidin, 1997), on a Likert scale from (1) Strongly agree to (5) Strongly disagree. The total score has been used successfully with Latino children (Mendelsohn et al., 2007; in this study, Cronbach α = .92).

Parent opinion and satisfaction.—Parents were asked about their opinions and satisfaction of the program halfway through the intervention (i.e. during session 4) and at completion of the CANNE intervention (i.e., after session 8), on a 6-item, 5-point Likert scale from (1) Strongly disagree to (5) Strongly agree; parents who were absent were reached by telephone. Parents rated their satisfaction using one question ("How satisfied are you with what you have learned in this program") on a 5-point Likert scale from (1) Very dissatisfied to (5) Very satisfied.

Results

Analyses examined whether parents attended CANNE regularly and participated actively (hypothesis 1). Of the 12 parents, 100% attended at least 1 session and 50% of the parents attended at least 75% of the total sessions ($M = 4.92$, $SD = 2.54$; see Table 1). Quality of participation was high, as 92% of parents received average ratings of 3 or more out of 5, 50% of 4 or more out of 5 ($M = 3.96$, $SD = 0.72$). Attendance and quality of participation were significantly correlated ($r = .67$, $p < .05$). Twelve parents completed the *Parent Survey* at pre- and 11 at post-intervention (92% retention rate). Parents who completed both interviews were compared to parents who did not; all t-tests were non-significant.

To test hypothesis 2 that child and parent outcomes would improve following CANNE, paired sample t-tests compared overall mean changes in pre- and post-intervention values. Results indicated significant differences in child behavior problems and parenting stress (see Table 1), with parents reporting significantly less behavior problems and parenting stress from pre- to post-intervention. Although significant change was not found in other variables, mean values indicate improvement in child and parent outcomes (see Table 1).

Results on parent opinions indicated that parents held very high opinions of the program and rated that they were very satisfied in the program during sessions 4 and 8 (see Table 1).

Discussion

Reducing parental stress and successfully managing child behavior problems are effective tools for the prevention of child maltreatment (e.g., child physical abuse). The prevention of child maltreatment is a continual public health concern since child physical abuse has been associated with acute and long-term consequences including aggression, attention problems, conduct disorder, depression, PTSD, delinquency, substance use, academic problems, and violent criminal behavior (Kilpatrick et al., 2003).

Importantly, rates of child maltreatment differ across racial/ethnic groups, as findings indicate that Latino and African American youth (16.4% and 14.9%) are more likely to report injurious spanking and physically abusive punishment by a caregiver compared to their Caucasian peers (11%) (Hawkins et al., 2011). Although prevalence of child maltreatment tends to be higher among racial/ethnic minority youth, these families are often underserved in terms of health-related prevention and intervention efforts (Cunningham et al., 2000). In addition to racial/ethnic differences, rural communities have a greater number of people living below the poverty line (15% in rural vs. 13% in urban/suburban areas; Spotlight on Poverty, 2010). Research suggests that poverty may present greater obstacles for families living in rural areas, compared to urban settings (DeLeon, Wakefield, & Hagglund, 2003). Specifically, rural areas lack community resources such as access to public transportation, which, in turn, creates longer commutes to work and less access to community agencies (e.g., childcare, health facilities). Therefore, positive parent-child interactions are essential to the development of socially and emotionally competent children and are a major protective factor in reducing risk for child maltreatment (Begle, Dumas, & Hanson, 2010; Eisenberg, Fabes, & Spinrad, 2006).

Given challenges Latino families face in managing child behavioral problems and reducing parental stress, CANNE, an 8 week culturally adapted parent management training (PMT) program targeting Latino families, was implemented as health promotion and child maltreatment prevention in a primary care pediatric clinic in the heart of the Latino community. With the use of a *promotora*, families were recruited through a well-known, trusted community clinic rather than an office-based or school-based setting. Results showed that parents reported fewer child behavioral problems and reduction in parent-related stress following engagement in CANNE, two very salient factors related to child maltreatment. Furthermore, the use of a culturally tailored program in a well-trusted setting led to high levels of engagement (attendance and participation). Contrary to other studies that find engagement and attendance of Latino families in mental health services an obstacle (McCabe, Yeh, Garland, Lau, & Chavez, 2005), results of this community based study demonstrate that Latino parents are willing to attend and able to benefit from a short-term PMT program when logistical barriers are proactively addressed (e.g., food/daycare provided, reminder phone calls) and attitudinal barriers are assuaged through existing trust (e.g., use of promotora, location of trusted pediatric care clinic).

The implementation of a Latino focused mental health prevention services in a primary health care setting also proved successful. Given that underutilization of mental health services by ethnic minority families have been attributed to limited access to health-related

resources, as well as potential mistrust of the health care system for historical/ immigration reasons (Cunningham et al., 2000), the use of the promotora model may have addressed attitudinal barriers to treatment participation. The recency of arrival of immigrants in this quickly growing population may actually account for more trust of medical professionals and related medical facilities than other underserved populations that have longer histories with the health care system in this country. In contrast to typical English-speaking participants of PACE, other community based strategies such as school based mental health services may potentially hold less accountability and engagement of recently immigrated Latino families since "school culture" in many Central American countries consists of respecting the teacher's authority by not interrupting with school matters and remaining independent from educators. This change in school culture is actually a topic of discussion in CANNE to help clarify parents' misunderstandings associated with the U.S. school system and encourage parents to forge a better partnership with their child's school (Dumas et al. 2010). Group format was important in this CANNE module as parents shared information about Spanish speaking administrators at surrounding schools that could facilitate communication with newly enrolled parents. Furthermore, while a desired byproduct of PMT is reduced parental stress, the advertisement of CANNE as an intervention to help *children* that is delivered in a *youth-focused* facility is also more consistent with Latino/a values of *marianismo*, a traditional Latina gender role that is associated with mothers' self-sacrifice in order to meet the needs of her children and spouse. In the Latino community, there seems to be more buy-in and acceptance of CANNE as a program to help one's children instead of one's own parenting skills. Framing a mother's own self-care as an essential step in prioritizing a child's needs proved to be a successful strategy in addressing attitudinal barriers to participation. Cultural sensitivity is crucial so that interventions can be tailored to maximize benefits to specific targeted populations.

While positive changes in child behavior and perceived parental stress were noted, analyses did not show changes in child coping competence or parental competence. A recent study (Cappa, Begle, Conger, Dumas, & Conger, 2010) demonstrated that child behavior influences child coping competence; suggesting that child behavior problems in this study may have indeed improved, but because improvements in child emotional regulation and adaptive behavior are of higher cultural value (Julian et al., 1994), changes in actual behavior may have been more salient to Latino parents and consistent with the traditional value of *respeto* (and related obedience) than child coping competence. Similarly, lack of changes in parental competence could be an artifact of greater social desirability among Latinos, given congruence of impression management with culture-specific *simpatía*, or need for behaviors that promote smooth, pleasant interpersonal relations (Marín & Marín, 1991). While parental stress does not hold as much value judgment, social desirability could have inflated ratings of parental competence at pre-intervention.

Conclusions

Although results are promising, limitations must be considered and results need to be replicated in larger, more representative samples. Given the significant influx of Mexican families in this region, the extent to which families were representative of US Latino families is unknown. The fact that several of these changes occurred before and after the

intervention suggests that CANNE may be efficacious but alternative explanations (e.g., child maturation) cannot be ruled out. Subsequent research should replicate the efficacy of CANNE in larger samples and determine its efficacy and engagement relative to other PMTs. Future analyses should be adequately powered to analyze whether engagement and quality of participation in CANNE sessions serve as mediators or mechanisms of action for improved child and parent outcomes. Recent literature (Thomas & Zimmer-Gembeck, 2012) has also suggested that PMTs help prevent child maltreatment, since child behavior problems are an associated factor. Given that the Latino population is already at high risk of child maltreatment, strategies for dissemination of effective preventions and engagement of families in programs such as CANNE merits further attention. Providers working in well-established and trusted community settings should welcome collaboration with health promotion organizations and prevention task forces to help broaden the available resources to underserved populations, like Latino immigrants. While mental health care disparities suggest that Latino families underutilize mental health care, the cultural values of *familismo* and *respeto* are very important to Latinos, thus culturally adapted programs that highlight these values and incorporate them into program framework might be more acceptable for Latinos and lead to better engagement when presented through a promotora model as prevention and/or family strengthening exercises. Furthermore, delivery of such culturally adapted practices in the primary care facility can lead to more adoption and participation of these traditionally under-utilized services.

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Table 1.

Descriptive Statistics and Mean Differences

Attendance		
Attended 1 session	8%	N = 1 parent
Attended 2 sessions	17%	N = 2 parents
Attended 3 sessions	8%	N = 1 parent
Attended 4 sessions	17%	N = 2 parents
Attended 5 sessions	0%	N = 0 parents
Attended 6 sessions	8%	N = 1 parent
Attended 7 sessions	25%	N = 3 parents
Attended 8 sessions	17%	N = 2 parents

Parent and Child Outcomes						
	Time 1		Time 2			
	M	*SD*	*M*	*SD*	*t*	*p*
Child Coping Competence	6.08	0.99	6.78	0.91	−1.36	.21
Child Behavior Problems	3.08	0.76	1.90	1.15	−3.41	.04
Parent Competence	2.41	0.87	2.70	1.27	.00	1.00
Parenting Stress	4.79	0.81	4.10	0.84	−3.97	.01

Parent Opinion and Satisfaction				
	Week 4		Week 8	
	M	*SD*	*M*	*SD*
Parent Opinion	4.57	0.25	4.91	0.13
Parent Satisfaction	4.50	0.76	4.50	1.07

Table 2.

Purpose and Description of CANNE Modules

Session or Module	Purpose	Description
1. Introduction to the Program and Bringing Out the Best in Our Children	Introduces parents to the program; explores the importance of praise, rewards, and positive activities in parenting, and helps parents recognize and focus on their children's strengths to build them further.	Module discusses various forms of praise and rewards, differences between praise and criticism and rewards and bribery, and activities that encourage positive parent-child interactions to bring out the best in children.
2. Setting Clear Limits for Our Children	Explores ways to encourage positive child behavior, and to reduce child misbehavior and parental stress.	Module concentrates on setting clear limits and rules at home, on giving effective commands, and on using natural and logical consequences to teach children to be responsible for their actions.
3. Helping Our Children Behave Well at Home and Beyond	Explores nonaggressive means of teaching children to obey requests.	Module focuses on ignoring unacceptable behaviors and on establishing effective timeouts by explaining the procedure and addressing difficult situations.
4. Making Sure Our Children Get Enough Sleep	Helps children go to bed without fussing to get a good night's sleep.	Module concentrates on establishing a regular bedtime routine for families in which putting a child to bed is a challenge.
5. Encouraging Our Children's Early Thinking Skills	Explores the importance of reading and playing with young children to encourage early thinking skills that are critical to school success; and to encourage family routines and traditions that help children feel safe and in control.	Module discusses practical reading and play activities that parents can do daily with their children, as ways of giving them positive attention that will help them to think and to behave well. Module also discusses family routines and traditions more generally.
6. Developing Our Children's Self-Esteem	Helps participants devise practical ways to build their children's self-esteem every day, through play, positive feedback, and shared positive routines, and thereby integrates much of the material covered up to this point.	Module stresses the importance of appreciating and respecting children's individual needs and preferences as a means of developing their self-esteem.
7. Helping Our Children Do Well at School	Explores ways in which parents can help their children do well at school, from getting ready on time in the morning to developing a positive relationship with teachers.	Module returns to the importance of working actively to help children do well in all settings – at home, at school, and in the community.
8. Anticipating Challenges and Seeking Support	Helps participants recognize the importance of parenting as a life-long task that requires the ability to manage different sources of stress.	Module helps participants learn to reduce/control their stress by obtaining nurturing support from other adults within and beyond the family, using relaxation techniques, and controlling negative self-talk.