

2015

Comparing Preferences in Parent Training Between Low-Income and Middle-upper Income Ethnic Minority Caregivers

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Comparing Preferences in Parent Training Between
Low-Income and Middle-upper Income Ethnic Minority Caregivers

Ernesto R. Barnabas, Jr.

Lehigh University

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2015

Certificate of Approval

Approved and recommended for acceptance as a dissertation in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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Abstract

This study investigated the most and least preferred components of parent training programs among ethnic minority families from middle-upper income backgrounds. Preferences were evaluated using a Q-sort method (McKeown & Thomas, 1988). Participants were primary caregivers from urban areas who self-identified as ethnic minorities and middle-class or above. Participant preferences were measured to assess the potential cultural relevance of PT program components among families from middle-upper income and ethnic minority cultures. In addition, this investigation was a follow-up to a previous study by the same author using the same measure to investigate the preferred components of parent training programs among ethnic minority families from low-income backgrounds. Preference data from low-income ethnic minority families collected during the previous study were compared with preference data from middle-upper-income ethnic minority families collected during this investigation. These data were examined to compare the potential influences of income on PT preferences between income groups. Results indicated that the ethnic minority groups often generalized in the current literature may be far more heterogeneous than expected, with implications discussed for future research and practice.

Chapter 1: Statement of the Problem

Exploring SES and Preferences in Behavioral Parent Training

Although recent research indicates 7% to 25% of children in the general population meet the diagnostic criteria for behavior disorders, the prevalence of severe behavioral difficulties is disproportionately overrepresented among children from low-income and ethnic minority families (American Psychiatric Association, 2013; Forness, Freeman, Paparella, Kauffman, & Walker, 2012; Kazdin, 2005; Wichstrøm, Belsky, Jozefiak, Sourander, & Berg-Nielsen, 2014). Several sources corroborate a prevalence rate of 35% for this vulnerable group of children, with remarkably high rates among very young children (McWayne & Bulotsky-Shearer, 2013; Skiba, Poloni-Staudinger, Gallani, Simmons, & Feggins-Azziz, 2006; Webster-Stratton, Reid, & Hammond, 2004). According to Gross, Sambrook, and Fogg (1999), as well as Wiley and colleagues (Wiley, Brigham, Kauffmann & Bogan, 2013), disproportionate ethnic minority representation has been a challenge in the field for decades, with approximately 26% of two-year-old children and 34% of four-year-old children in low-income and ethnic minority urban environments having behavior needs significant enough to increase the likelihood of developing clinical symptoms meeting DSM diagnostic criteria for attention deficit-hyperactivity disorder, oppositional defiant disorder, and conduct disorder by nine years-of-age.

Research also indicates the majority of low-income and ethnic minority families disproportionately lack access to sufficient resources necessary to obtain adequate or culturally appropriate social-emotional health services (Fantuzzo, Weiss, & Coolahan, 1998; Gresl, Fox, & Fleischmann, 2014; Roberts, Mazzucheli, Taylor, & Reid, 2003). On average, African American families earn an annual wage of \$15,000 less than European Americans, are twice as likely to be unemployed, and are nearly three times more likely to be living below the poverty line (Gradin,

2012). Similarly, Hispanic Americans are three times as likely to be living in poverty, are half as likely to earn an equal salary, and are two times as likely to work within a service occupation when compared to their European American counterparts (Macartney, Bishaw, & Fontenot, 2013).

Hence, barriers to treatment and access to healthcare appear to be disproportionately overrepresented among low-income families and ethnic minority groups. The impact of these economic and sociocultural disadvantages is manifested in minimal participation in family-based interventions among overworked, underpaid parents who are limited by scarce resources and high stress levels (Brown, Marshall, Bower, Woodham & Waheed, 2014; Jones & Flores, 2009; Lau, Lin, & Flores, 2012; Snowden, Masland, Libby, Wallace, & Fawley, 2008). Parental stress related to sociocultural disadvantage decreases responsiveness to therapeutic intervention for caregivers and children alike, challenging school psychologists to deliver culturally relevant and appropriate family services (Kazdin, 2005a; 2005b). These challenges warrant further investigation involving effective, efficient, and culturally relevant interventions for low-income and ethnic minority families. However, despite the need to address the challenges in providing evidence-based parenting interventions among low-income and ethnic minority families as described in the literature, there is a paucity of research investigating the differential influences of SES and ethnic minority status on parent training outcomes.

Parent Training: Accounting for SES and Ethnicity

Given the positive prevention and intervention outcomes in the existing body of parent training literature, the multiple developmental and behavioral benefits of parent training (PT) are widely accepted (Ingoldsby, 2010). For the current study, the principal investigator reviewed literature involving over 110 PT investigations since 1985 with concurrent findings to confirm

the efficacy of PT in decreasing defiance and aggressive behaviors among children and families either with or at-risk for developing disruptive behavior disorders (Reyno & McGrath, 2006). Among these studies, nearly 40% ($n = 39$) of the literature reviewed involved middle-upper income ethnic majority families alone. Hence, more investigations appear to be needed among both low-income families and ethnic minority families, given the distinctively decreased levels of PT involvement within the literature involving these sociodemographic groups (Eiraldi & Diaz, 2010).

Approximately 20% ($n = 24$) of PT investigations reviewed by the principal investigator specifically targeted the influence of SES on PT outcomes, regardless of ethnicity. In general, these studies have concluded that contextual barriers to intervention (i.e., lack of transportation, difficulties obtaining child care, and overall resources required) are closely tied to lack of adequate intervention involvement (Brown et al., 2014; Lakes et al, 2009). Similarly, nearly 15% ($n = 16$) of PT studies reviewed specifically investigated the relationships between culture, ethnicity, and family-based interventions, regardless of SES. Another 16% ($n = 18$) investigated the combined influences of SES and culture in various proportions. These studies generally concluded that there may be a wide margin between caregivers' culturally specific beliefs and the beliefs expressed by components of existing parenting programs in the literature, which are mostly derived from middle-upper income ethnic majority participants (Jones et al., 2010).

The current PT literature remains primarily divided between investigations isolating the influence of either SES or ethnicity. However, there is a paucity of literature investigating the confounding relationship between SES and ethnic minority status on PT preferences. Only 10% ($n = 10$) of PT investigations reviewed focused on the difficulties of discerning between the influences of SES and ethnicity on poor PT fidelity, participation, attendance, and related

outcomes. Of these, less than 2% ($n = 2$) of PT investigations reviewed specifically examined the previous conclusions that SES-related stress may also be related to stressors involving ethnic minority status. And, less than 1% ($n = 1$) of PT investigations reviewed the influence of SES and ethnic minority status on PT components among families earning enough to qualify as middle-upper income. Hence, the current literature is bereft of PT studies involving middle-upper income ethnic minority families, cultural influence on PT preferences, and comparisons across SES levels while holding ethnicity constant. These investigations are needed to determine: (1) the influence of culture on PT preferences regardless of SES, and (2) the research and clinical benefits of discerning the interrelated influences of SES and ethnicity on caregiver preferences for PT components.

A key element affecting all ethnic and socioeconomic parenting research to date has been the limited participation of ethnically and socioeconomically diverse parents (Lavigne et al., 2010). Even when considering the unique parenting perspectives of middle-upper income ethnic minority families, results remain inconclusive as to whether culturally relevant interventions should involve adaptations specific to needs based on income or ethnicity in order to increase participant recruitment, retention, and fidelity in PT research and clinical work (Eiraldi & Diaz, 2010). In accordance with the lack of combined ethnically and socioeconomically diverse research samples, parenting beliefs and behaviors have been judged based on knowledge developed relative to middle-upper income ethnic majority parents. When diverse parenting concepts have been labeled using terms like harsh parenting, psychological control, strict discipline, and ethnic-racial socialization (ERS), the origin of such labels has been influenced by generalizations stemming from a literature composed primarily of middle-upper income

European American participants (Brown et al., 2014; Ho, McCabe, Yeh, & Lau, 2010; J. Ho, Yeh, McCabe, & Hough, 2007; Yeh, Forness, Ho, McCabe, & Hough, 2004).

Before the relationship between SES, income, ethnicity, and parenting can be teased apart, the field of parenting intervention as a whole must begin to collect more grassroots quantitative and qualitative data from increasingly diverse populations. Rather than making conclusions based on nomothetic but ethnically limited data, parenting researchers must first make grassroots efforts to collect information regarding the idiographic parenting attitudes, beliefs, and behaviors of unique ethnic groups across a variety of specific socioeconomic contexts neglected in the literature (i.e., middle-upper income ethnic minority families). With a more diverse body of data involving the ideographic perspective of groups that have been historically neglected in the psychological literature, researchers can begin to gain new insight involving the SES-ethnicity dynamic and related parenting beliefs.

PT: Middle-upper Income, Ethnic Majority Families

One promising treatment method for providing evidenced-based supports for low-income and ethnic minority children with challenging behavior has been PT. Although the use of PT has increased among both low-income and ethnic minority caregivers, the majority of PT research demonstrating effective amelioration of Disruptive Behavior Disorder (DBD) symptoms has involved middle-upper income ethnic majority parents (Kazdin, 1997, 2005a, 2005b, 2014). Evidence-based PT from this specific demographic group has often been categorized as either behavioral PT (BPT) or parent management training (PMT). BPT has a strong history of effectiveness in reducing clinical severity among children with disruptive behavior disorders by replacing parent coercion and harsh punishment skills with a combination of social rewards, token economies, mild punishment procedures, and natural consequences (Anastopoulos,

DuPaul, & Barkley, 1991; Antshel & Barkley, 2008; Barkley, 1986; Barkley, 1987; Barkley, 2000; Barkley, 2002). Similar to BPT, PMT has a history of effectiveness using more individualized techniques to develop changes in parent-child interaction patterns (Kazdin, 1997, 2005a, 2014; Kazdin, Esveldt-Dawson, French, & Unis, 1987; Sanders, 1999; Webster-Stratton, 2001, 2004).

Parent training in general (PT) has been established as an intervention using social learning theory and applied behavior analysis to improve the health of children with or at-risk for developing disruptive behavior disorders through fostering parent strengths and changing parent behavior (Alberto & Troutman, 2003; Bandura, 1962; Golding, 2000). PT interventions over the past 20 years have been associated with many positive outcomes including increases in parent nurturance, parent-child praise, and problem-solving skill development as well as decreases in parent stress, harsh discipline, and disruptive child behavior. Because PT prepares parents to teach and maintain behavior across natural settings and learn to respond to challenging behaviors appropriately, it has been identified as an evidence-based practice for effectively reducing child challenging behaviors and preventing at-risk children from developing clinically significant behaviors altogether (Kazdin, 1997, 2005a, 2005b, 2014; Webster-Stratton, 2001).

Among the middle-upper income ethnic majority group more commonly involved in the existing evidence-based PT literature, intervention components involving strategies to increase desired behaviors (e.g., social rewards, token economies, alpha commands, and verbally attending to appropriate behavior) are frequently used and endorsed (Calvert & McMahon, 1987; Graf, Grumm, Heim, & Fingerle, 2014; Hill & Bush, 2001; Hill & Craft, 2003; Hill, Bush, & Roosa, 2003; Hill, Murry, & Anderson, 2005; Hill, 2006). Middle-upper income ethnic majority caregivers throughout the PT literature have described these strategies as easy to understand,

easy to implement, and more useful than other punitive-oriented strategies. In contrast, mild punishment strategies designed to decrease excessive behaviors such as time out and planned ignoring have generally been described as less effective and more difficult to implement (Dawson-McClure et al., 2014, Hoff-Ginsberg & Tardif, 1995). Some researchers have speculated that this apparent bias toward incentive rather than punishment based strategies may arise from preferences toward intervention components that involve egalitarian rather than hierarchical parent-child relationships and emphasize developing children's independence from authority over obedience and conformity (Garcia & Garcia, 2014; Hill & Bush, 2001; Hill & Craft, 2003; Hill et al., 2003; Hill, Murry, & Anderson, 2005; Hill, 2006; Horvat, Weininger, & Lareau, 2003).

PT: Low-Income Families

Despite the supportive evidence for PT among middle-upper income families, several investigations have indicated limited benefits for low-income and ethnic minority families. (Kazdin et al., 1987; Garbacz, Brown, Spee, Polo & Budd, 2014; Lakes, Vargas, Riggs, Schmidt, & Baird, 2011; McGoey, Eckert, & DuPaul, 2002; Orrel-Valente, Pinderhughes, Valente, & Laird, 1999; Sanders, 1999; Vesely, Ewaida, & Anderson, 2014). In all income and ethnic groups, child characteristics such as age, severity of challenging behaviors, history of challenging behaviors, and method of the PT intervention itself have appeared to affect family attendance and overall intervention success (Huey Jr., Tilley, Jones, & Smith, 2014; Maughan, Christiansen, Jenson, Olympia, & Clark, 2005; Reyno & McGrath, 2006). However, specific family characteristics such as socioeconomic disadvantage, single-parenthood, young maternal age, high parent stress, and low social support have been associated with reduced PT short-term and long-term outcomes (Kazdin, 1997, 2011). Two family characteristics in particular, low SES

and maternal psychopathology, have been identified as the most influential variables affecting desired behavioral changes between PT and control groups (Baker, Arnold, & Meagher, 2011; Webster-Stratton & Hammond, 1990; Webster-Stratton et al., 1997).

Within the limited PT literature explicitly involving low-income families, caregivers have commonly expressed favoritism toward more controlling intervention components involving increased level of harsh punishment, strict monitoring, and firm discipline (Baldwin, Baldwin, & Cole, 1990; Brody et al., 2001; Ceballo & Hurd, 2008; Gonzales, Cauce, Friedman, & Mason, 1996; Gresl et al., 2014; Sampson & Groves, 1989). Moreover, low-income families have consistently exhibited less maternal warmth in parent-child interaction relative to their higher income counterparts (Klebanov, Brooks-Gunn, & Duncan, 1994; Pinderhughes, Nix, Foster, & Jones, 2001; Sheely-Moore & Ceballos, 2011). When comparing differences in intervention responses between middle-upper income versus low-income families, many researchers have concluded that parenting beliefs and behaviors are more associated with income and socioeconomic status than they are with ethnic or cultural factors (Maughan et al., 2005; Reyno & McGrath, 2006; West-Olatunji, Sanders, Mehta, & Behar-Horenstein, 2010).

PT: Ethnic minority families

Relative to middle-upper income, low-income, and ethnic majority families, there has been a dearth of PT research involving primarily ethnic minority families (Huey Jr. et al., 2014; Kazdin, 2005; Lau, 2006). Of the limited research available, ethnic minority status has appeared to be related to parenting beliefs and behaviors by families' relatively decreased access to family health services, including samples in which SES was controlled (Garland, Landsverk, & Lau, 2003; United States Department of Health and Human Services, 2008). Along the same lines, when ethnic minority families have had access to and the ability to utilize family health services

involving PT, caregivers have been likely to end treatment prematurely. Although SES and other contextual community factors undoubtedly played a role in the repeated attrition and limited participation of ethnic minority parents in PT, culture appeared to influence ongoing patterns of interactions between included members that closely affects families' parenting beliefs and behaviors (Hill, 2006). Indeed, parenting for minority families has involved culturally- and ethnically- specific PT adaptations and responsiveness to the influences of SES, social stratification, and institutional discrimination (Garcia-Coll, Meyer, & Brillon, 1995).

Similarly, other theories posit that culture has affected parenting via customs for discipline, childcare, and child development in the home (Harkness et al., 2010; Super & Harkness, 1997). Remaining theories contend that regardless of SES, culture has affected all ethnic minority families through the interaction of beliefs that support and oppose the perspectives of the ethnic majority, ethnic minority families in general, and families within specific ethnic minority sub-groups (Allen & Boykin, 1992). Although it has not been made theoretically clear exactly how ethnic status and culture affect parenting, it has been widely accepted in the scientific community that ethnic minority status closely influences parenting beliefs and behaviors (Baumrind, 1972; Brody & Flor, 1998; Brody et al., 2001; Dornbusch, Ritter, Leiderman, Roberts, & Fraleigh, M. J. (1987); Garcia-Coll et al., 1995; Hill & Bush, 2001; Hill, Murry, & Anderson, 2005; Lareau, 1987; Lareau, 2007; Lareau & Weininger, 2008).

PT: Preferences Among Low-Income Ethnic Minority Caregivers

Among families of ethnic minority and low-income status, researchers have experienced difficulty differentiating between the influence of culture and SES. Although some researchers have even described ethnic minority status as a euphemism for low-SES, most acknowledge the difficulty in evaluating the separate influences of income versus ethnic minority status on

parenting intervention beliefs and behaviors (Graf et al., 2014; Sue, Zane, Hall, & Berger, 2009). The primary reason for this difficulty has most often appeared to be the disproportionate overrepresentation of ethnic minority families living in poverty. Disproportionate overrepresentation has led to some rich information on ethnic minority families from low-income backgrounds, but at the same time prevented researchers from learning more about ethnic minority families earning middle-upper incomes. Disproportionate overrepresentation of ethnic minority families in poverty has also led to overgeneralizations regarding health and pathology behaviors that may be specific to the interaction of both statuses rather than specific to all cases of one or the other.

When considering parenting beliefs and behaviors, a number of studies involving ethnic minority families from low-income backgrounds have concluded that income and SES (including education, employment, and other social resources) are more influential than ethnicity (Rodgers, 2004). Wright and colleagues (Wright, Stroud, & Keenan, 1993) examined the parenting beliefs and behaviors of a sample involving a wide variety of different income, socioeconomic, and ethnic statuses. Based on these diverse data, Wright and his associates concluded that low-income and low-SES significantly predicted parent problems with understanding and carrying out PT strategies regardless of families' mainstream, minority, or ethno-centric status. Similar to Wright's conclusions, Davis-Kean (2005) worked with a sample of low-income and ethnic minority caregivers in PT and concluded that parents' income and education levels were more influential than their ethnic status in terms of parent-child interaction and home-based involvement in early childhood. Indeed, maternal warmth and quality of the parent-child relationship were affected more by income and education levels than ethnicity. When parents of any ethnicity were provided with the resources for intellectual and social-emotional activation,

then the effects of financial strain on parenting intervention involvement were decreased, regardless of caregivers' ethnicity. Similarly, Ceballo and colleagues (Ceballo & Hurd, 2008) found that within an economically diverse sample of African-American parents, income levels negatively predicted parents' attitudes toward parental warmth, behavioral control (e.g., social and materials rewards) , psychological control (e.g., guilt, shame, and blame), and strict supervision and monitoring.

Among families sharing both low-income and ethnic minority status, several studies favored the influence of cultural beliefs on parenting over socioeconomic stressors. Hill and colleagues (Hill & Craft, 2003) partnered with low-income Mexican American, Non-Hispanic White, and Mexican Immigrant families from contextually similar neighborhoods in order to specifically isolate the relationship between cultural beliefs and parenting. In this study, parents of Mexican Immigrant background reported more harsh parenting behaviors and beliefs than Non-Hispanic White caregivers. As the most isolated independent variable between the parent groups, ethnic background was believed to have had the greatest effect on parenting. Furthermore the level of acculturation, a measure of assimilation and conservation of core cultural values such as parenting among different ethnic groups, differentiated among Mexican-American caregivers. In contrast to the Mexican Immigrant and Mexican American parents with low acculturation, Mexican-American caregivers with high levels of acculturation reported less harsh parent-child interactions.

Based on qualitative follow-up data collection, it appeared that harsh interactions were perceived as caring and protective among low-income Mexican American families with low acculturation (Hill & Craft, 2003). While adhering to cultural parenting beliefs developed child strengths in low-income Mexican-American families, the same "harsh" parent-child interactions

were associated with conduct problems for low-SES European American families. Moreover, economically disadvantaged Mexican-American families who were less acculturated to the US demonstrated high levels of maternal warmth and decreased levels of family-stress and parental psychopathology. The balance of these parenting behaviors were similar to those observed among middle-upper income European American families with low levels of controlling discipline. Hence, regardless of SES and community contextual factors, caregivers appeared to favor different parenting strategies on the sole basis of their cultural perceptions for appropriate parent-child interactions.

Similarly, Ceballo and colleagues (2008), along with several other researchers (Hill, 2006; Le et al., 2008; McPherson, Lewis, Lynn, Haskett, & Behrend, 2009), favored the influence of culture over SES on parenting beliefs and behaviors. These researchers collectively studied the potential importance of culturally-based parenting practices that have appeared maladaptive by ethnic majority families while seeming adaptive among various ethnic minority caregivers. For example, the restrictive and controlling disciplinary approaches aligned with the development of DBD (Disruptive Behavior Disorders) in European American families have often been perceived as protective and adaptive amongst Asian American, Latino, and African-American parents (Baldwin et al., 1990; Dornbusch et al., 1987; Lamborn, Dornbusch, & Steinberg, 1996; Whaley, 2000).

Overall, SES and income levels appeared to influence parenting differently within and across ethnic groups in accordance with perceived family stress. Hence, the exact relationships among these factors, ethnicity, culture, and parenting attitudes has remained poorly understood. Parenting beliefs that vary by ethnic group have repeatedly been described as “culturally-defined

coping mechanisms” for various contextual stressors involving the dynamic between ethnicity and socioeconomic factors (Garcia-Coll et al., 1995, p. 1904).

For example, many socioeconomic factors have historically been associated with a variety of different family stressors often overrepresented within ethnic minority groups, including maternal depression and child conduct problems (Brody & Flor, 1998; Conger, Ge, Elder, Lorenz, & Simons, 1994; Dennis, Parke, Coltrane, Blacher, & Borthwick-Duffy, 2003; McLoyd & Wilson, 1994; McLoyd, 1994; McLoyd, Jayaratne, Ceballo, & Borquez, 1994; Parke et al., 2004). Other data have supported the notion that the inconsistency of between-group differences among ethnic minorities implied greater cultural influence over parenting than socioeconomic factors (Ceballo & Hurd, 2008). In some of these studies, African-American parents demonstrated more warmth toward their children than Latino and European American caregivers, while in other studies the reverse was true. Researchers have described these cultural differences as reflecting specific patterns of ethnically-specific parent acculturation, identity, spirituality, religiosity, warmth, control, monitoring, and communication style factors (Hill, 2006).

PT: Preferences Among Middle-upper Income Ethnic Minority Caregivers

In order to more specifically understand the influence of ethnic minority status on parenting attitudes, some researchers have begun investigations with ethnic minority families earning middle-upper level incomes. This research has offered a unique comparison between caregivers of the same ethnicity while evaluating the independent influences of SES and community contextual factors. A growing number of studies involving this unique group have begun to assemble in order to better understand the dynamic relationship between SES and ethnic minority status.

Hughes and colleagues (Hughes, Bachman, Ruble, & Fuligni, 2006) contended that ethnic minority parents from middle-upper income backgrounds offered a unique perspective on the interplay between parenting attitudes, beliefs, and behaviors dependent on the interaction between SES and ethnicity. SES and income factors have been recorded to closely affect parenting attitudes, beliefs, and behaviors regardless of ethnic status (Hill, 2006). The exact nature of the relationships between SES and these parenting variables, however, has remained debatable. SES and income factors have affected all families' access to material resources closely tied to parenting, including social supports, knowledge of child development, and teaching family values deemed age- and culturally appropriate (DeGarmo & Forgatch, 1999; DeGarmo, Forgatch, & Martinez, 1999; Duncan, Brooks-Gunn, & Klebanov, 1994; Duncan & Magnuson, 2002; Hoff-Ginsberg & Tardif, 1995; Magnuson & Duncan, 2002). According to these and other researchers, middle-upper income ethnic minority parents have often reported parenting according to principles of a concept known as ethnic-racial socialization or ERS (Stevenson et al., 2001; Stevenson, 2003).

According to ERS researchers, middle-upper income African-American caregivers have espoused a distinctive set of values involving the proactive development of culturally-based protective factors for their children through building self-esteem, better understanding the influence of barriers to education and treatment, and increasing awareness of stratification based on the social-economic-ethno-political-historical context of African Americans in United States history. More specifically, ERS consists of: (1) Cultural Socialization, composed of various parenting attitudes beliefs and behaviors to develop knowledge of ethnic customs and pride, (2) Preparation for Bias, including various parenting attitudes, beliefs, and behaviors to teach coping skills for the experience of racial discrimination, and (3) Promotion of Mistrust, which teaches

consciousness of discrimination without a focus on coping skills. In contrast to middle-upper income African American parents, Stevenson and his colleagues have described middle-upper income Non-Hispanic White families as communicating very different messages about race, including Egalitarianism (emphasizing individual qualities over racial group membership qualities) and Silence About Race (avoiding race in discussion because attitudes, beliefs and behaviors are already a part of the mainstream and therefore difficult to compare) (Stevenson, 2003; Stevenson, Davis, & Abdul-Kabir, 2001).

Although ERS parenting tendencies have been observed to vary by ethnic group, they have also been demonstrated to vary according to educational and occupational levels. That is, middle-upper income ethnic minority parents in the literature have been more likely to engage in ERS parenting involving Cultural Socialization, Preparation for Bias, and Promotion of Mistrust, than their low-income counterparts. (Hughes & Chen, 1997, 1999). ERS parenting practices across ethnic minority and majority groups have also tended to vary according to child gender, with middle-upper income ethnic minority males learning more Preparation for Bias and Cultural Mistrust while females learn more about Cultural Socialization. Among ethnic majority families in general, minimal research has investigated PT programs developed according to ERS research findings.

Hence, it would be natural for parenting programs involving middle-upper income African American families to include a variety of key ERS components. However, the existing body of scattered ERS research has yet to be integrated into any type of PT components or modules. Although Hill (2006) wrote that the SES-ethnicity dynamic affects parenting through experiences and beliefs related to education levels (Hughes & Chen, 1997, 1999; Hughes & Johnson, 2001; Hughes, 2003; Hughes et al., 2006; Hughes, et al., 2006; Kohn & Schooler,

1978; Umaña-Taylor & Fine, 2004), no modules to help middle-upper income ethnic minority parents communicate the importance of education have been developed. Other ERS investigations have concluded that middle-upper income, ethnic minority parents working in ethnic majority environments perceived significantly higher levels of discrimination when compared with parents working in primarily ethnic minority settings (Portes, Kyle, & Eaton, 1992; Williams & Harris-Reid, 1999; Williams, 1999). Again, despite the apparent opportunities for more in-depth investigation, no PT modules for teaching middle-upper income, ethnic minority children to respond appropriately to discrimination have been examined in the literature.

The SES-Ethnicity Confound & Ethnically Limited Research

One possible explanation for low levels of PT participation among ethnic minority families has been a mismatch between the components of PT programs and their delivery to low-income and ethnic minority families. Empirically-supported PT models in the general population initially have focused on child problems, parent data collection skills, and positive reinforcement (Kazdin, 2005) as well as parent-child play and planned ignoring (Webster-Stratton, 2001; Webster-Stratton et al., 2004). In contrast, the limited literature on successful parenting programs for urban, ethnic minority families has emphasized an initial focus on community strength building and inclusion of culturally relevant components (Fantuzzo et al., 1998; Stevenson et al., 2001). At this time, however, it remains unclear in the literature whether ethnic minority status or SES has had a greater influence on PT outcomes. While some studies have suggested that the culturally relevant beliefs of ethnic minority parents affect treatment acceptability and participation (Coard, Wallace, Stevenson, & Brotman, 2004; Stevenson et al. 2001), other studies indicated that SES was more influential (Dumas, 1984a, 1984b, 1984c; Dumas & Albin, 1986;

Dumas, 1986; Dumas, Nissley-Tsiopinis, & Moreland, 2007; Dumas, Moreland, Gitter, Pearl, & Nordstrom, 2008; Nix, Bierman, & McMahon, 2009; Reyno & McGrath 2006).

Researchers have currently only begun to investigate methods for helping ethnic minority families maintain the treatment adherence and attendance necessary for clinically significant outcomes (Kazdin, 1997, 2005). Prinz and Miller (1994) attempted to address the unique family outcome factors of low-income and ethnic minority families participating in PT by encouraging caregivers to become more involved in treatment. Families attending PT sessions that specifically addressed parent stress, occupational anxiety, health needs, and feelings about being involved in treatment were found to have significantly lower drop-out rates in comparison to a families receiving typical PT services. However, statistical power was measured a low 0.15 and the findings between session content and drop out should be interpreted cautiously. Similarly, Nock and Kazdin (2005) argued that low attendance and treatment adherence occurred when PT treatment demands exceeded adult participant motivation, which was indirectly affected by barriers such as lack of transportation, beliefs that treatment was irrelevant, or poor relationships with the PT therapist/facilitator.

Currently, a dearth of research exists investigating the acceptability of PT components among low-income and ethnic minority caregivers. One recent study by Barnabas and Manz (in preparation) used a partnership-based approach to investigate the preferred components of PT programs among low-income and African American and Hispanic families. Preferences were evaluated using a quantitative Q-sort method (McKeown & Thomas, 1988). Participants consisted of low-income and ethnic minority primary caregivers from urban settings, whose preferences were measured to assess the potential cultural relevance of PT program components.

The resulting parent factors included Active-Responsive-type (Coolahan, McWayne, Fantuzzo, & Grim, 2002), No-Nonsense-type (McWayne, Owsianik, Green, & Fantuzzo, 2008), and Passive-Permissive type preferences (Barnabas & Manz, in preparation). Active-Responsive-type caregivers strongly preferred behavioral PT components while not preferring components in which they felt efficacious (e.g., knowledge of child development and addressing community barriers). No-Nonsense-type caregivers strongly preferred parent-child relationship components while not preferring active ignoring or refraining from harsh punishment. Finally, Passive-Permissive-type caregivers strongly preferred to learn about parenting and child development while not preferring consequences or limit setting. Although this study identified these parenting preference profiles and preferences, it was not designed to clarify whether these results were more specific to SES or ethnic minority status. Hence, there has been a need for further investigations to determine if the PT component preferences from Barnabas and Manz are likely to generalize across income levels (i.e., low-income versus middle-upper income) for ethnic minority families.

In sum, the existing literature has demonstrated a profound and immediate need to evaluate the influences of parent SES on PT program development, interventions, and outcomes among minority families of shared ethnicity. The design of PT interventions that are engaging and culturally relevant for specific socioeconomic and/or ethnic populations has been a difficult, yet vital necessity for school psychologists and other education professionals involved with children with or at-risk for developing disruptive behavior disorders. Failure to recognize the salience of socioeconomic, cultural, and political influences in the lives of participating families has ultimately led to a mistrust of research and limited the use of any findings originating from investigations in both low-income and ethnic minority communities (Fantuzzo et al., 2003).

Purpose and Research Questions

PT programs have historically been composed of several different components including using reward-based strategies to consistently reinforce desired behaviors, education in child development, and various response strategies for inappropriate behaviors. According to Kazdin (2005), Webster-Stratton (2001), and other prominent PT researchers, the components of common parent education programs may have a history of being less preferred by ethnic minority caregivers from a variety of SES strata. However, the discernment of unique contributions of ethnicity and SES to parents' preferred PT components has not been adequately undertaken. In order to validly evaluate the preferences for PT intervention components among low-income and middle-upper income ethnic minority families, a Q-method approach was used in this investigation.

The purpose of this study was three-fold: 1) to identify parenting profiles based on the structure of their PT component preferences as evidenced through the Q-sort, 2) to identify salient (highly or least preferred) PT components for middle-upper income parents, and 3) to compare the Q-sort results of PT preferences for this sample of middle-upper income parents to a prior Q-sort study of low-income parents conducted by Barnabas and Manz (in preparation). Using a Q-sort method approach to compare variability within and between groups of parents who differ in SES, this study addressed five specific research questions. First, "What specific caregiver preference ranking profiles for PT components will emerge from Q-sorting middle-upper income ethnic minority families?" That is, identifying the specific caregiver preference profiles for PT components among middle-upper income ethnic minority families derived from the Q-sort. Based on the only existing research in ethnic minority PT preference profiles, (Barnabas & Manz, in preparation), it was hypothesized that there would be three profiles: 1)

preferences for mostly proactive PT components (e.g., authoritative style valuing praise, rewards, use of effective commands), 2) preferences for mostly reactive components (e.g. authoritarian style valuing response-cost strategies and extinction procedures), and 3) preferences for a more equally balanced between proactive and reactive PT components.

Following identification of a PT preference structure for middle-upper income parents, salient PT components for this sample were examined. The second research question, “What specific PT components are ranked as most preferred by middle-upper income ethnic minority families?” sought to identify specific PT components that were ranked as most preferred by primary caregivers from middle-upper income ethnic minority families. Regarding research question two, the investigator hypothesized that the middle-upper income ethnic minority families would strongly prefer the same authoritative-style components as low-income Active-Responsive parenting profiles in a previous Q-sort investigation (Barnabas & Manz, in preparation). This hypothesis was based on the self-described resourcefulness of the Active-Responsive profile parents in the previous study as well as the prevalence of the authoritative style in the existing literature involving middle-upper income caregivers. More specifically, the investigator hypothesized middle-upper income ethnic minority families would strongly prefer components that included specific behavioral PT strategies such as delivering social and material rewards, responding effectively to a child’s tantrum behaviors, and effective use of time out procedures.

In contrast, research question three, “What specific PT components are ranked as least preferred by primary caregivers from middle-upper income ethnic minority families?” sought to identify specific PT components that were ranked as least preferred by middle-upper income ethnic minority families. Regarding research question three, the investigator hypothesized that

the middle-upper income ethnic minority families would also share strong non-preferences similar to the low-income Active-Responsive parenting profiles in a previous Q-sort investigation (Barnabas & Manz, in preparation). More specifically, the investigator hypothesized middle-upper income ethnic minority families would strongly not prefer components involving resources which they perceived themselves already possessing (e.g., knowledge in child development, access to adequate social support networks, ability to overcome parenting stressors or barriers and so forth).

The final purpose of this investigation was to compare salient PT components between the middle-upper income sample recruited and Q-sort findings from a previously conducted study with low-income parents (Barnabas & Manz, in preparation). The fourth research question, “To what extent are specific PT component rankings shared across low-income and middle-upper income ethnic minority caregivers?,” sought to determine the extent to which specific PT component rankings were shared across low-income and middle-upper income ethnic minority caregivers, each as a collective group (single synthetic profile). The fifth research question, “To what extent are PT component rankings shared between specific caregiver preference ranking profiles for PT components across low- and middle-upper income ethnic minority families?,” sought to examine the extent to which PT component rankings were shared between the three hypothesized middle-upper income ethnic minority family profiles in this investigation as compared with the three low-income ethnic minority family profiles from the previous investigation. It was hypothesized that middle-upper income ethnic minority caregivers would collectively rank specific behavioral PT components as strongly preferred (highest four rankings) and preferred (highest twelve rankings). At the same time, PT components developed in response to barriers among low-income ethnic minority families (e.g., developing positive

social networks with other parents) would be collectively ranked as strongly non-preferred (lowest four rankings) and non-preferred (lowest 12 rankings).

Chapter 2: Literature Review

The purpose of this study was to explore differences in preference for PT components between low-income and middle-upper income ethnic minority families. An in-depth analysis of these components in the literature included overall PT concepts, approaches utilizing these concepts in applied settings (i.e., proactive and reactive approaches), PT modalities (i.e., tiered levels of implementation differentiated by intensity and/or presentation of curricular material), group- or individually-based curricula, and model of delivery (e.g., expert-based, collaboration-based, or partnership-based).

General Description of PT Program Components and Characteristics

Over the past two decades, PT has become increasingly identified as both an intervention and a preventive measure for families with or at-risk for developing conduct disorder and related sequelae (Furlong et al., 2012; Pearl, 2009; Wright et al., 1993). Across a variety of contexts, consultative intervention with caregivers has been demonstrated as an efficient and effective intervention for reducing children's problem behaviors. By focusing on building parental skills and developing therapeutic home environments, PT has been used to re-establish healthy, non-coercive interaction patterns between children and their parents (Baker-Ericzén, Hurlburt, Brookman-Frazee, Jenkins, & Hough, 2010). As a result, PT has not only led to reductions in disruption and aggression among children, but has also aligned with significant changes in decreased parental abuse, harsh interaction, or coercive disciplinary tendencies.

Proactive PT program components. The many positive results of PT have appeared to be linked with a number of key components necessary for cultivating new parent-child interaction patterns (Pearl, 2009). First, nearly all PT programs have included proactive components designed to increase overall levels of children's appropriate behaviors, thereby

increasing positive interactions between the parent and the child. In some programs this component manifested as attending to appropriate behavior, while in other programs it has been described as Attending or the Child's Game (Kaminski, Valle, Filene, & Boyle, 2008). Attending involved parents following the child's behaviors during play, describing their specific actions in an enthusiastic manner, and avoiding any questions or commands. In other programs, this component also involved imitating children's actions, words, and gestures and avoiding critical statements toward the child. Other programs simply described this component as an exercise in building parental skills in differential reinforcement of appropriate behavior. Hence, additional components following attending skills in PT curricula remain based in operant positive reinforcement.

After working on attending skills, parents in PT learned proactive strategies such as delivering behavior specific praise, establishing home- and school-based token economies, encouraging healthy thoughts and emotions, and selecting potential reinforcement options from a dynamic menu of tangible, social, and activity rewards (Lavigne et al., 2010). Closely related to reward components, effective directions or "Alpha command" components helped caregivers learn to deliver requests in a manner that increased the probability their children would comply, receive their desired rewards, and learn to make appropriate behavioral choices within a reasonable amount of time. Effective command components taught caregivers to say their child's name, verbalize the exact behavior involved in the request, and be firm while avoiding questions, vagueness, or insincerity. A number of nonverbal components for effective commands, including modeling, gesturing, changing body posture, and using partial-to-full physical prompts were also taught in order to help parents learn to communicate in a direct and firm manner without being overly aggressive or passive.

Reactive PT program components. Along with PT components to teach pro-social behaviors and develop positive parent-child relationships, the majority of programs also enhanced caregivers' abilities to set limits and follow through by using mild punishment procedures and extinction while avoiding physical punishment (Lavigne et al., 2010; Pearl, 2009; Wright et al., 1993). Although different PT programs included a variety of different strategies, mild punishment and extinction components often involved very similar content. One of the most common mild punishment components in the literature has been time-out from reinforcement, in which parents removed children's access to fun activities or toys for a time period specified according to child developmental status and severity of inappropriate behavior. For example, disruptive tantrum behavior by a two year old during free-play would result in a 2-5 minute time out in a room without any toys or while watching other children play with toys appropriately before re-joining the play session. Alternatively, repeated peer-aggression by a five year old during play with siblings would result in a 5-10 minute time out period. Some programs included practicing specific time out procedures outside of emotionally reactive situations in order to increase fluency and comfort with the process among caregivers and children alike.

Along the same lines, response-cost components were often included in PT programs as another tool to support caregivers' abilities in setting appropriate limits (Lavigne et al., 2010; Pearl, 2009). Similar to time-out, response-cost strategies involved limiting access to preferred tangible, social, and activity rewards. Also like time-out, response cost procedures specified an age and developmentally appropriate time period for the punishment. For example, disruptive tantrum behavior by a two year old during free-play would result in loss of free play or a preferred toy used during free play for the next 1-2 hours. Along the same lines, repeated peer-aggression by a five year old during play with siblings would result in a loss of free-play

privileges for the next 24 hours and/or until additional chores have been completed. In this sense, response-cost was also included as a component of token economies and other reward procedures in that inappropriate or undesirable behaviors result in a loss of points, tokens, play-time, toy use, or any other form of prolonged loss of access to reinforcement. In order to avoid a frustrating and emotionally taxing cycle of endless punishment for highly disruptive children, response-cost was typically included with a specific focus on balancing discipline by limiting punishment procedures only to those times when absolutely necessary and simultaneously emphasizing the frequent and preferred use of reward components.

Like time-out and response-cost, extinction-based components (often described as planned-ignoring) constituted the mildest range of punishment procedures (Van Camp et al., 2008). During planned-ignoring, inappropriate behaviors that were very brief and only distracting or mildly disruptive (e.g., making noises or animal sounds, tapping or drumming on the table, playing with clothing buttons or strings, etc.) did not result in any physical (e.g., touching), verbal (e.g., redirection or reprimands), or gestural (e.g., looking, pointing, or otherwise orienting) responses toward the child. Planned-ignoring components were carefully explained, modeled, and practiced with caregivers because they included several caveats which could become counter-productive or even detrimental to treatment. Implementation of planned-ignoring components was often followed by extinction bursts in which the child would up the ante by becoming increasingly distracting or disruptive until they received attention or whatever other reinforcement may have been fueling the inappropriate behavior. Many caregivers also terminated implementation of planned-ignoring during this extinction burst for a variety of reasons (e.g., feeling like the strategy is not working, feeling like an inadequate parent, concern that the level of distraction or disruption may intensify into dangerous or aggressive behavior),

resulting in a variable-ratio schedule of reinforcement for increasingly intensive inappropriate behaviors (Lucyshyn et al., 2004). PT components involving planned-ignoring were very specific in preparing caregivers to be conscious of and avoid variable-ratio schedules of reinforcement that rewarded behaviors following an unpredictable number of responses, similar to activities like gambling or other games of chance. Without this specific emphasis the more intensive inappropriate behaviors sometimes rapidly increased in frequency and intensity, exacerbating the overall parent-child interaction problems.

PT modalities. Although different PT programs tended to share similar components, program modalities and overall structure have been quite varied (Lundahl, Nimer, & Parsons, 2006; Porzig-Drummond, Stevenson, & Stevenson, 2014). Some programs have involved small parent groups for cost-effectiveness and efficient content delivery, yet others have been based on consultation with individual families. While group and individual programs have been implemented in clinical and/or community settings, many individually-based programs have utilized home-visits for sessions. No matter the location, the content and components of PT programs were often delivered in very different ways. Some programs were based primarily on didactic presentation and education for parents within the timeframe of a limited number of sessions. Other programs emphasized en-vivo practice and content delivery either within a specific number of sessions or until caregivers have appeared to master the understanding and implementation of components. Based on these inherent modalities of content delivery, each PT program had potential to involve material that was more general for all parents or, to some extent, more individualized to the specific needs of participating families. These treatment components and the modalities for delivering them were amalgamated within PT programs empirically supported to effectively and efficiently develop healthier parent-child relationships.

Some of the most effective programs combined different PT modalities throughout the scope and sequence of their sessions in order to more specifically meet client needs. One the most well-known programs, the Incredible Years, included different components for different family needs (Webster Stratton, 2001; Webster-Stratton et al., 2004). For example the BASIC program included all key PT components described above, while the ADVANCE program enhanced caregivers' abilities to problem-solve and emotionally cope with their most significant family stressors. Similarly, Sanders' (Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009) well-known Triple P program provided multi-tiered modalities for PT including: (1) UNIVERSAL (video and literary media materials involving parent-child interaction), (2)SELECTED (UNIVERSAL program combined with brief parent consultations in changing interaction patterns, positive reinforcement strategies, and mild punishment procedures), (3)INDICATED (SELECTED program with additional consultation sessions in addition to selected intervention procedures for children with subclinical emotional and behavioral problems), (4) INDICATED INTENSIVE (INDICATED with additional multiple sessions targeting PT skills in the home, in small groups, and intensive homework assignments) and (5) INDICATED ADVANCED (INTENSIVE along with a variety of parent and family supports individualized to meet specific family's needs that may have been preventing full involvement at other levels of intervention).

A number of additional PT programs based on operant behavior principles such as Helping the non-Compliant Child (Forehand & Kotchick, 2002), Families / Living with Children and Adolescents (Patterson, 2005), Defiant Children (Barkley, 1997), and the Kazdin (2005) Parent Management Training (PMT) method followed the same strategies with individual families or groups of caregivers. Like their counterparts, these programs were also focused on developing healthy parent-child interaction patterns, building parents' repertoire of positive

reinforcement and mild punishment skills, and teaching child prosocial skills. In sum, these and similar programs have been considered cost-effective in light of increases in costs for healthcare and incarceration, both of which have been aligned with the long-term outcomes of untreated anti-social tendencies and related sequelae such as increasingly intensive patterns of non-compliance, rule/law violations, and coercive behaviors (Price, Chamberlain, Landsverk, & Reid, 2009).

PMT may have differed between practitioners, participants, and specific programs, but collectively followed a general set of implementation guidelines and practices (Kazdin 1997, 2005, 2014). Most PMT programs involved providing parents with knowledge and/or skills to develop positive interactions and warmth with their children, avoid power struggles, respond effectively to or prevent challenging behaviors altogether, and learn practical coping and/or self-caring skills (Sanders 1999; Stevenson et al., 2001; Webster-Stratton, 1994, 2001). PMT programs also operated on risk factors for families and communities, including harsh parenting styles, family stress, and parent social networks (Webster-Stratton, 2001). Through proactive and positive parenting strategies for affection and discipline, the PMT intervention process provided families with supports to decrease harsh parent-child interactions and parent stress levels while helping parents identify potential social support networks.

The process of parent behavior change in PMT essentially unfolded through provision of practical and emotional supports for primary caregivers in group treatment sessions involving role-play, in-home coaching, or some combination of the two. Practical supports were primarily composed of essential skills and knowledge necessary to develop positive day-to-day parent-child interactions through attention, delivering specific praise, making high-probability requests, establishing household rules, designing token economies or other reinforcement techniques for

use in the home, and delivering effective verbal warnings (Kazdin, 1997, 2005, 2014; Webster-Stratton, 2001). Emotional supports for parents often included therapist/facilitator rapport, empowerment, coaching through difficult situations, and developing ties in family communities (Dinkmeyer, McKay, & Dinkmeyer, 1997; Stevenson et al., 2001; Webster-Stratton, 1994).

Along with PMT, Behavioral PT (BPT) has been demonstrated to effectively reduce frequency and intensity of parent-child coercive interactions, child oppositional behavior, and parental reinforcement contingencies for child misbehavior (Jones et al., 2014; Schrepferman & Snyder, 2002). These coercive interactions, if left unmitigated, often predicted high levels of delinquency and antisocial behavior later in life, giving strong preventative implications to BPT and related PT interventions. Even under conditions of children with high impulsiveness, low academic achievement, familial histories of criminal behavior, high parental conflict, and communities experiencing high levels of violent crime, BPT has shown small to moderate effect sizes (Welsh & Farrington, 2007a; Welsh & Farrington, 2007b). The mechanisms of BPT and related PT interventions often involved five specific individual parenting skills including: (1) attending to appropriate behavior, (2) token economies and rewards, (3) planned ignoring, (4) effective commands and requests, and (5) effective use of mild punishments procedures such as time out and response-cost (Anastopoulos, Shelton, DuPaul, & Guevremont, 1993; Pisterman et al., 1992). These basic skills were taught through three primary methods of delivery including: (1) explaining the rationale, (2) explaining the rationale with modeling, and (3) modeling alone (Calvert & McMahon, 1987).

Another more individualized evidence-based program, known as Parent-Child Interaction Therapy (PCIT), has focused more on individual parent-child dyads rather than parenting groups (Hakman, Chaffin, Funderburk, & Silovsky, 2009; McNeil et al., 2010). PCIT has been highly

effective in reducing child maltreatment and parental abuse. During the first phase of PCIT, Child Directed Interaction (CDI), parents were taught different modalities of play therapy in order to strengthen parent-child attachment through developmentally appropriate play and joint activities (Eyberg & Robinson, 1982; Eyberg & Robinson, 1983; Eyberg, 1988). During CDI sessions, parent learned the concepts and skills involving following the child's lead and avoiding commands or questions or criticisms in a process described as PRIDE (praise, reflecting, imitating, describing, and using enthusiasm). In this child directed stage, the parent-child relationship was strengthened through praise without added pressure from demands or questions. Only after parents have achieved mastery in the concepts and skills in PRIDE could they progress to the second PCIT phase known as Parent Directed Interactions or PDI. PDI was oriented more toward increasing parent capacities similar to the main principles of BPT, reducing harsh parenting behaviors and increasing positive parental responses to appropriate child behavior within the first three to five treatment sessions following CDI. Along the same lines, levels of child defiance and disruptive behavior typically decreased dramatically a short time. The PDI phase consisted primarily of parents learning to master the components of delivering effective requests and setting limits with a variety of follow-through strategies.

PT settings and contexts. Settings for PT included homes, schools, or clinical laboratories (Kazdin, 1997, 2005, 2014). Programs were often carried out in laboratory, school, and outpatient hospital settings in a group format (Kazdin, 1997, 2005, 2014; Webster-Stratton, 2001). Group format parenting programs that focus on providing parent skills often resulted in improved child outcomes across several environments. Parents with the knowledge and skills to self-manage and provide self-care became empowered to support their children both in the home and across community contexts (Stevenson et al., 2001). Although group sessions proved

beneficial, in-home PT programs resulted in relatively less participant attrition and more family engagement than group-based treatments (Stormshak, Kaminski, & Goodman, 2002).

Providing in-home PT to families on an individual basis has increased in recent literature, but remained relatively rare overall (Fox, Duffy, & Keller, 2006; Kazdin, 2010). Recent research also suggested that the one-to-one modeling and coaching processes characteristic of in-home PT interventions comprised the mediating variables that enhanced the generalization of appropriate child behavior and increased parent acceptability (Fox et al., 2006; Kazdin, 1997, 2005). In-home, school, and clinical PT settings appeared to have similar overall benefits, as each can provide effective practical and emotional parent supports that ultimately decrease child antisocial behaviors (Kratowill, Elliott, Loitz, Sladeczek, & Carlson, 2003; Sanders & Glynn, 1981). In-home programs may also have resulted in more clinically significant changes for families than group-based programming (Maughan et al., 2005).

Despite the potential research benefits of in-home PT, its effects appear to have been mediated by their specific focus on either parent deficits or parent skill lessons. In-home PT interventions that focused predominantly on changing parent deficits often reduced generalization of treatment effects, leading to challenging behaviors across limited environments. Child misbehavior may have decreased at home or with a single parent, but would often continue in other settings or with specific family members. In-home PT also required rich resources including adequate time, training and personnel to visit several families in various locations. Thus, the most widespread PT programs were still delivered in a group format designed to provide supports through knowledge, role-play, and facilitator interaction (Presnall, Webster-Stratton, & Constantino, 2014; Webster-Stratton, 2001; Webster-Stratton et al., 1997, 2004).

PT models. Two common models of PT, expert and collaborative, have been distinguished by distinctly different facilitator-parent(s) relationships (McGilloway et al., 2014; Webster-Stratton, 2001). The expert model has been described as hierarchical and focused on a lack of parent knowledge, parent skill deficits, and a unilateral approach to providing treatment (Fantuzzo & Mohr, 2000; Fantuzzo et al., 2003). The expert facilitators focused on past parental mistakes to assess and change the child behavior by providing predetermined packages of corrective feedback and instruction, general parenting knowledge and skills, and homework assignments. In contrast, the collaborative facilitators were non-hierarchical, recognized the expertise of parents, promoted active participation in forming parent/child goals, created open communication, and recognized parent concerns regarding certain behavior management techniques (e.g., ignoring and extinction). According to Webster-Stratton's definition, collaboration supported rather than blamed parents, respected each parent's contribution and culture during group interaction, allowed parents to evaluate each therapy session, and provided other appropriate avenues for parent participation during treatment (Webster-Stratton, 1994, 2001). Parents also set therapy goals and helped to adjust the agenda for intervention (Webster-Stratton, 1997).

PT Program Limitations Involving Primarily Middle-upper Income Ethnic Majority Families

Evaluation data of the most common PT programs, particularly those based primarily on operant behavior principles, has indicated that they can effectively mitigate several of the problems aligned with the long-term outcomes of untreated anti-social tendencies and related sequelae (Graf et al., 2014; Price et al., 2009). For example, PT programs have effectively reduced increasingly intensive patterns of non-compliance, rule/law violations, and coercive

behaviors while also effectively reducing costs in behavioral healthcare and incarceration related to problems with antisocial and aggressive behaviors (Sherman et al., 1998). Collectively, these programs have demonstrated greater effectiveness and less probability of relapse for treating child antisocial behaviors in less time than pharmacotherapy alone, psychoanalytic treatment, family therapy, individual child counseling, and other programs involving several months or even years of treatment (Graziano, 1983; Graziano & Diament, 1992). Moreover, these positive changes in behavior and child caseness have been maintained for over one year post-intervention and delivered in a variety of clinical settings with effective outcomes in a relatively short amount of time with high levels of caregiver acceptability and satisfaction (Costin & Chambers, 2007; Costin et al., 2004).

When combined with contingencies for school-based behavior, PT has also proven more effective than cognitive-based intervention alone in creating positive prevention effects across multiple contexts and for children with multiple psychiatric diagnoses (Pelham Jr., Wheeler, & Chronis, 1998). In some cases, PT has proven more effective than psychopharmacologic interventions and is almost universally rated higher on acceptability (Johnston, Hommersen, & Seipp, 2008). Further investigation of PT has tied its preventative properties with overall decreases in parenting stress and increase in parenting self-efficacy following intervention. Finally, the effects of PT have shown some promise for facilitating change among even the most high-risk parents (Smagner & Sullivan, 2005).

However, despite the collection of supportive evidence for PT in the scientific literature, several investigations have indicated there are limited benefits for families who do not identify as middle-upper income and ethnic majority status (Kazdin et al., 1987; Kazdin, 2005, 2007, 2014; McGoey et al., 2002; Orrel-Valente et al., 1999; Sanders, 1999). Distinct child characteristics

such as age, severity of challenging behaviors, history of challenging behaviors, and method of the PT intervention itself may have affected family attendance and overall intervention success (Maughan et al., 2005; Reyno & McGrath, 2006). Family characteristics such as socioeconomic disadvantage, single-parenthood, young maternal age, high parent stress, and low social support have been associated with reduced PT short-term and long-term outcomes (Kazdin, 1997). Three distinct family characteristics have also been identified as the most influential variables affecting desired behavioral changes between PT and control groups, including: (1) low socioeconomic status, (2) ethnic minority status, and (3) stressors significantly impairing parent mental health.

One hypothesis for differential outcomes related to socioeconomic, ethnic minority, and mental health status has been disparate access to more individualized, in-home PT program services (Lau, 2006). More precisely, parents experiencing stressors related to low SES, ethnic minority status, and/or mental health needs may have been less likely to participate in in-home PT. Meta-analyses of group and in-home individual coaching revealed that in-home PT programs carried an overall effect size of .67 in between-subjects designs and .68 in single subject-designs (Reyno & McGrath, 2006; Serketich & Dumas, 1996). Analyses for group PT treatment effect sizes were 0.16 and 0.27, respectively. In terms of clinical significance, as indicated by effect size (Cohen, 1977; Cohen, 1992a; Cohen, 1992b; Cohen, 2003), in-home PT appeared to be more advantageous than group PT sessions. However, low-income families, ethnic minority families, and families experiencing significant mental health needs were less likely to access in-home PT services.

Collectively, the components and characteristics of the PT programs involved in the effectiveness literature have been delivered to a variety of different SES and ethnic minority groups. At the same time, these programs were developed and evaluated almost exclusively by

primarily middle-upper income ethnic majority scientists using primarily middle-upper ethnic majority research participants (Lau, 2006). Furthermore, those evaluation results have been difficult to replicate outside of primarily middle-upper income ethnic majority populations (Kazdin et al., 1987; Kazdin, 2005, 2014; McGoey et al., 2002; Orrel-Valente et al., 1999; Sanders, 1999). The source(s) of these differential outcomes have remained indeterminate in the current research literature. In order to better understand the potential origin(s) of income- and ethnicity-specific limitations to PT programs, further scientific inquiry is needed specifically addressing PT program experiences among families who identify themselves as low-income, ethnic minority, low-income ethnic minority, and/or middle-upper income ethnic minority status.

PT Program Limitations Involving Primarily Low-Income Families

Many of the limitations to PT have been strongly related to SES and associated stressors (Kazdin & Whitley, 2003; Leijten, Raaijmakers, de Castro, & Matthys, 2013). The primary limitations on the benefits of PT were noted for situations in which the parents were experiencing stress and competing influences that inhibited their ability to attend and respond to parenting tasks in a timely and appropriate manner (Mabe, Turner, & Josephson, 2001; Mabe, 2003). For nearly thirty years, PT research has indicated that SES stressors present several barriers to treatment such as parent affective state, cognitive variables, marital variables, parent task variables, and limited social support. As a result, low-income families have been identified as experiencing reduced participant engagement, adherence, and maintenance of program effects in PT (Bailey & Sori, 2005; Bailey et al., 2010; Bailey, 1998; Bailey, 1998; Barker, Cook, & Borrego, 2010; Sanders, 1984; Sanders & Christensen, 1985). The influence of SES on PT outcomes has been so great that some researchers have suggested that the related stressors for many families characterized by severe adverse social and material conditions may render them

unable to benefit from intervention regardless of the extent to which they participate in treatment (Dumas & Albin, 1986; Dumas, 1986). Mothers experiencing low-SES related stressors have consistently reported more harsh parenting behaviors toward their children, along with greater levels of indiscriminate aversion responses among children when compared to controls, as discriminate analysis models reliably predicted treatment failure for low-SES, high-stress caregivers (Dumas, 1984a; Dumas, 1984b; Dumas, 1984c; Dumas et al., 2007; Dumas, et al., 2008). Overall, researchers indicated that despite scores of studies documenting positive outcomes for PT programs, there have been many undesirable treatment outcomes related to contextual life stressors that impaired the PT treatment process (Assemany & McIntosh, 2002; Assemany, 2003).

In order to address these limitations, several strategies have been attempted to better assess the relationship between intrafamilial, extrafamilial, and training variables within each parent's ecological environment and to develop individually tailored intervention components. For example, many programs have changed content delivery to increase parent engagement among low-income single-mother families involved in PT (Chacko et al., 2008; Chacko et al., 2009). In addition to single-parenthood, low-SES families experienced stressors associated with increased maternal negative verbalizations and cognitions, increased harsh responses to neutral child behaviors, decreased maternal praise, and lower maternal intellectual functioning, each of which strongly predicted low engagement and low maintenance of effects (Fernandez & Eyberg, 2009; Werba, Eyberg, Boggs, & Algina, 2006). Along the same lines, these stressors were strongly related to lower levels of parent social supports and higher levels of maternal daily stress and depressive symptoms (Harwood & Eyberg, 2006; Harwood, 2007).

Recent research in PT among ethnic minority caregivers has suggested a strong but unclear ethno-cultural influence on parenting (Bernal, & Domenech Rodríguez, 2012; Le et al., 2008; McLoyd, 1994; McLoyd & Smith, 2002). Moreover, one of the primary reasons for the unclear ethno-cultural influence on parenting has been the use of middle-upper income ethnic majority families as the standard for comparison in the existing body of PT research. Although this group has been most available for recruitment, engagement, and participation research in the past, recent changes in the demographic makeup of the United States populations most at-risk for developing emotional behavior disorders have suggested the need for more socioeconomically and ethno-culturally targeted comparison groups (Kazdin, 1997; 2005; U.S. Census Bureau 2002).

Regardless of ethnicity, when socioeconomic and ethno-cultural success factors (e.g., earning more than a living wage, healthy cultural identity development) were compounded, caregivers were more likely to support parenting beliefs linked with substantial family involvement, adequate supervision, consistent discipline, and parental warmth (Brody et al., 2001; Brody et al., 2003; Coulton, Korbin, Su, & Chow, 1995; Duncan et al., 1994; Duncan & Magnuson, 2002; Garbarino, Crouter, & Sherman, 1977; Garbarino & Crouter, 1978; Graf et al., 2014; Klebanov et al., 1994; O'Neil, Parke, & McDowell, 2001; Simons & Johnson, 1996; Simons, Johnson, Beaman, & Conger, et al, 1996). In contrast, in situations where risk factors for socioeconomic and financial difficulties accumulated, the compounded effects seemed to result in increased disciplinary harshness and inconsistency (Hoff-Ginsberg & Tardiff, 1995; Pinderhughes et al., 2000). In these more disadvantaged contexts, caregivers of many ethnicities have demonstrated increased support for more controlling parenting strategies such as strict

monitoring of child whereabouts and firm consequences for rule violations (Baldwin et al., 1990; Brody et al., 2001; Sampson & Groves, 1989).

Several researchers have attempted to address the limitation related to low-SES stressors using a variety of methods. For example, (Lees & Ronan, 2008) used a parent engagement strategy involving economical strategies and incentives to enhance attendance rates and engagement among low SES caregivers, resulting in 100% participant program completion, high levels of maternal engagement, increased overall family functioning and parenting self-efficacy, improved child behavior, and reduced symptoms of parent depression and acute stress. Other incentive-based programs have increased the effectiveness of PT in socially disadvantaged community contexts, increasing participation and overall parent behavior change by involving a larger part of the targeted population (Heinrichs, 2006; Heinrichs, Hahlweg, & Bertram, 2006; Heinrichs, Hahlweg, & Kuschel, 2006; Heinrichs, Krüger, & Guse, 2006).

Alternatively, Kazdin and his colleagues examined the role of parental cognitive problem-solving skills to increase engagement among low-SES parents with higher levels of psychopathology and lower levels of quality of life, resulting in decreased perceived barriers to treatment among parents (Kazdin & Wassell, 2000a; Kazdin & Wassell, 2000b; Kazdin, 2000a; Kazdin, 2000b). Other researchers have used engagement strategies including increased school involvement in PT (Ouellette & Wilkerson, 2008) and intervention matching based on parent MMPI personality profiles (Firestone & Witt, 1982). Hence, several researchers have approached parent barriers related to low-SES such as single- parent status and maternal depression (MacKenzie, Fite, & Bates, 2004), by including intervention components targeting parental cognitions (i.e., maternal locus of control and self-esteem) and parenting-specific factors such as maternal parenting efficacy and intensity of parenting stressors (Gerdes et al., 2007). In addition

to the detrimental effects of parental stressors on parent-training engagement, other research has demonstrated that low-SES parents with a clinical psychological diagnosis have greater attrition (Peters, Calam, & Harrington, 2005). Overall, the literature suggested that PT has been less successful for low-SES families because (1) the same stress factors that explained the relation between economic hardship and children's externalizing behaviors were also related to unsuccessful PT outcomes; and (2) PT interventions were less acceptable to poor parents, and therefore less likely to be adopted (Eamon & Venkataraman, 2003).

PT Program Limitations Involving Primarily Ethnic Minority Families

Caregivers' culturally-based beliefs about parenting can closely influence their participation in PT interventions. In addition to stressors related to SES, many PT limitations have been strongly related to ethno-cultural stressors (Kazdin & Whitley, 2003; Kazdin, 2003b). In addition to influencing differences in parenting beliefs, ethnicity and other culturally related factors appeared to differentiate parents' perspectives and interpretations of caregiver-child interactions (Le et al., 2008; Mason et al., 2004). For example, parenting practices often labeled as over-controlling, restrictive, and harsh among ethnic majority families have been interpreted as adaptive and protective among African-American families (Stevenson et al., 2001). Further complicating matters, research results have suggested that community resources, social capital, and other systemic factors related to ethno-cultural variables influenced parenting and child development in a variety of ways (Brody et al., 2001; Brody et al., 2003; Hill & Craft, 2003; Hill, Bush, & Roosa, 2003; Leventhal & Brooks-Gunn, 2000; McLoyd & Wilson, 1994; McLoyd & Smith, 2002; Prinz et al., 2009; Roosa, Morgan-Lopez, Cree, & Specter, 2002). Furthermore, these ethno-cultural variables affected parenting attitudes and beliefs differently according to caregivers' educational levels and occupational opportunities (Hoff-Ginsberg & Tardif, 1995).

One possible explanation for low engagement in PT among specific ethnic and cultural populations has been a mismatch between the components of PT programs and their delivery to low-income and ethnic minority families. For example, empirically-supported PT models in the general population initially focused on child problems, parent data collection skills, and positive reinforcement (Kazdin, 2005) as well as parent-child play and planned ignoring (Webster-Stratton, 2001; Webster-Stratton et al., 2004). In contrast, the limited literature on successful parenting programs for urban, ethnic minority families emphasized an initial focus on community strength building and inclusion of culturally relevant components (Fantuzzo et al., 1998; Stevenson et al., 2001). For example, Martinez and Eddy (2005) found a culturally adapted PT intervention for Mexican-Americans to be feasible, effective, socially valid, and related to increased parenting skills and parent-child encouragement as well as decreased child aggression, externalizing behaviors, and likelihood of drug use. Although some research has suggested that evidence-based care is likely to generalize to both African American and Latino populations, (Miranda et al., 2005), there has been a need for further outcome research involving more diverse populations and trajectories of treatment outcomes (McCart, Priester, Davies, & Azen, 2006).

PT Program Limitations Involving Low-Income Ethnic Minority Families

Based on cultural differences and increased likelihood of socioeconomic stressors, non-participant families from low-income and ethnic minority cultures have historically emphasized a general set of unique priorities for PT intervention programs (Coard et al., 2004; Fagan & Stevenson, 2002; Fantuzzo et al., 1998; Nock & Kazdin, 2005; Orrel-Valente et al., 1999). Research with low-income ethnic minority families involved in more effective parenting intervention has suggested that effective programs are: (a) partnership-based, (b) focused on relationships, (c) consider ecological fit, (d) address the specific community needs of low-

income parents and families, (e) include culturally relevant components, and (f) encourage active parent participation. In general, effective PT programs for low-income ethnic minority families have emphasized mutual trust and respect in every step of the research process, addressed the everyday impact of multiple environmental stressors affecting parenting, acknowledged and actively involved resilient parents and other community members in the intervention, and validated the cultural distinction of population-specific parenting practices.

Despite the potential benefits of PT for specific low-income and ethnic minority populations, researchers have only recently begun to investigate methods for helping these families maintain the treatment adherence and attendance necessary for clinically significant outcomes (Kazdin, 1997, 2005). Prinz and Miller (1994) attempted to address the unique family outcome factors of low-income and ethnic minority families participating in PT by encouraging caregivers to become more involved in treatment. Families attending PT sessions that specifically addressed parent stress, occupational anxiety, health needs, and feelings about being involved in treatment were found to have significantly lower drop-out rates in comparison to a families receiving typical PT services. However, statistical power was measured a low 0.15 and at best the findings between session content and drop out could be interpreted with caution. Similarly, Nock and Kazdin (2005) argued that low attendance and treatment adherence occurred when PT treatment demands exceeded adult participant motivation, which was indirectly affected by barriers such as lack of transportation, belief that treatment content was irrelevant, or a poor relationship with the PT therapist/facilitator.

Although Prinz and Miller (1994) did not achieve clinically significant change, their findings suggested that including caregiver contributions in the development of intervention procedures would increase adult involvement and motivation for low-income and ethnic minority

families participating in PT. Building upon the work of Prinz and Miller, Nock and Kazdin (2005) increased family participation in PT by involving families in co-planning the specific order, emphasis, and management of treatment modules over time while systematically reviewing the necessity for attendance and adherence. Participating parents attended an average of 1.2 more PT sessions and increased adherence by 0.2 points when compared with control parents, resulting in statistically significant differences between groups. However, as seen in Prinz and Miller's work (1994), small effect size (0.20) rendered these results clinically non-significant. Several aforementioned factors outside of the facilitator-parent-child relationship (transportation needs, perceived treatment relevance, poor PT therapist/facilitator relationship, etc.) influenced the clinical significance of PT results. PT researchers must begin to address these outside factors and their relationships to treatment before truly significant benefits result for low-income and ethnic minority PT families.

In a further attempt to include low-income and ethnic minority caregivers in PT, Webster-Stratton's (2001) The Incredible Years Program has been adapted to several different languages including treatment sessions in Spanish and Vietnamese. Adaptations to the current lesson have also occurred as facilitators used feedback from individual parents to reflect more culturally pertinent practices. Facilitators that were told PT practices may be inapplicable were trained to brainstorm more appropriate and familiar alternatives. Transportation, meals, child care, flexible hours, and safe locations were also considered to involve low-income and ethnic minority families as much as possible. Despite these laudable efforts, however, early investigations of The Incredible Years curriculum recruited samples consisting of no more than one-third ethnic minority families; a level too low to represent the number of low-income

African American and Hispanic American families currently residing in urban areas of the United States (U.S. Census Bureau, 2003, 2004).

Similarly, by applying The Incredible Years curriculum within Head Start centers, Webster-Stratton, Reid, and Hammond (2001) were able to recruit 67% ethnic minority participants, but the available sample was too small to evaluate by ethnic background.

In sum, the existing literature base demonstrates a profound and immediate need to evaluate the influences of participant culture on PT program development, interventions, and outcomes.

Development of PT interventions that are engaging and culturally relevant for low-income and ethnic minority families will be a difficult, yet vital necessity for school psychologists and other education professionals involved with at-risk children.

PT Program Limitations Involving Primarily Middle-upper Income Ethnic Minority Families

Ethnic-racial socialization. Cultural minority parents carry the additional responsibility of Ethnic-racial socialization, or ERS: preparing their children with cultural pride and other practices to create a buffer for the inevitable experiences of unresolved racial pain, fear, anger, and helplessness they will face within the majority culture (Coard et al., 2004). Racism affects parenting practices among cultural minority families, particularly African Americans, through an emotionally and linguistically distinct process. In order to develop child competencies and coping skills in preparation for the realities of potential oppression under the majority culture, ethnic minority caregivers engage in a process identified in the psychological literature as ERS. ERS, studied almost exclusively among middle-upper income African-American caregivers, is composed of a series of values parents use to proactively develop their children's protective factors through building self-esteem, better understanding the influence of social barriers and

stratification based on the current ethno-political-social-economical-historical context of the United States.

For example, ethnic minority parents may feel it is their responsibility to prepare their children by providing strategies to address implicit and explicit oppressive biases: “Some people may not like you because of the color of your skin, but don’t give up,” and “When teachers and police officers are ignorant of our culture . . . you must be smarter than they are by not inciting their basest fears” (Stevenson et al., 2001, p. 47, 173). Hence, because of the influence of racism and racist perceptions in our society, distinct differences in parenting needs exist between cultural minority and cultural majority parents. These differences are believed to be particularly salient in the misinterpretation of the behavior and misbehavior of cultural minority children (Blanchett, Mumford, & Beachum, 2005; Skiba et al., 2006). Cultural differences between minority and majority families clearly exist and necessitate diverse parenting needs and priorities.

ERS is conceptually organized according to the meanings and goals of specific parenting practices. Cultural socialization is one specific practice involving joint activities to educate children about their individual and group heritage, history, and other forms of tradition conveyed in a manner to cultivate pride and positive identity. For example, cultural socialization might include parents and children developing and completing a project (e.g., book, creative writing work, art work, or presentation) involving the civil rights movement, or successful ethnic minority entrepreneurs. Preparation for Bias, another ERS concept, emphasizes parents’ protective desire to prepare their children for coping with the experiences of discrimination in a healthy way. For example, ethnic minority parents may tell their children to be prepared for differential treatment from police or other authority figures, as well as different strategies to

avoid escalating hostility or other negative emotions in these situations (Hughes & Chen, 1999; Hughes et al., 2006; Hughes et al., 2006).

Another ERS concept, Promotion of Mistrust, involves parents telling their children to be aware of any indications of mistrust or danger involving interactions with persons from any different racial, ethnic, and cultural backgrounds with which they have previously experienced oppression or discrimination (Hughes & Chen, 1997; Hughes & Johnson, 2001). Unlike Preparation for Bias, however, Promotion of Mistrust practices do not include any coping strategies for experiencing negative interracial interactions. Another important ERS concept, Egalitarianism, emphasizes the importance of individual traits over group tendencies, paying particular attention to those traits that appear to be most valued within the ethnic majority culture (Boykin, 1984; Boykin & Toms, 1985; Spencer, 1983). Egalitarianism also generated the ERS concept of Silence About Race, in which parents socialize children to avoid any discussion or mention of race and related issues in the presence of the ethnic majority in order to avoid a loss of social value. For example, ethnic minority parents may socialize their children to be more competitive and emphasize their individual traits for a job interview in the ethnic majority mainstream while avoiding their cooperative qualities and topics of ethnic and/or cultural diversity.

While ERS concepts are well-described and agreed-upon in the literature, there are few in-depth explanations of ethnic minority parents' actual attitudes and beliefs toward them. One reason for this paucity of mutual understanding is that ERS can be influenced by a number of important factors. Interestingly, the most influential factors in the literature appear to be family income and SES. Parenting attitudes and beliefs regarding ERS differ according to their income, occupation, and education. While ethnic minority parents from low-income and education strata

may be more at-risk for a variety of health and mental health difficulties, their middle-upper counterparts report a higher perception of prejudice and discrimination in their everyday experiences (Portes & Stepick, 1985; Portes et al., 1992; Williams & Harris-Reid, 1999; Williams, 1999). Along the same lines, income seems to closely affect ethnic minority parents' support for or against ERS practices (Hughes & Chen, 1997). When compared with low-income ethnic minority parents, middle-upper income ethnic minority parents report significantly higher rates of support and enactment of all ERS concepts. Similarly, ethnic minority parents in professional and managerial jobs report greater support for Cultural Socialization and Preparation for Bias than ethnic minority parents working primarily in clerical, bench-work, or machining services. The same is true for ethnic minority parents with higher income and education levels (Caughy, O'Campo, Randolph, & Nickerson, 2002).

In addition to income and SES, ERS can also be influenced by parents' previous discrimination experiences and racial identities, children's developmental levels, and even child gender. It appears that middle-upper income ethnic minority parents are more likely to try and prepare their children for discriminatory experiences (Preparation for Bias and Promotion of Mistrust), especially those that parents themselves have used to try and navigate successfully through ethnically limited educational, occupational, income, and community environments (Hughes & Chen, 1997; Hughes, 2003; Kohn & Schooler, 1978; Umaña-Taylor & Fine, 2004). Moreover, among middle-upper income ethnic minority parents, high levels of perceived discrimination and support for ERS are associated with greater experiences of institutional-level discrimination. In other words, middle-upper income ethnic minority parents had greater exposure to environments with social-political-historical limits on ethnic and cultural diversity,

resulting in support for developing more cautions, warnings, and potential coping strategies for helping their children function in similar contexts.

Support for these ERS practices were even more prominent among middle-upper income ethnic minority parents who strongly identified with their racial group. ERS parenting preferences also varied according to children's cognitive and physical development (Hughes & Chen, 1997; Hughes & Johnson, 2001; Umaña-Taylor & Fine, 2004). Among children below eight years of age, middle-upper income ethnic minority parents are likely to engage in limited Cultural Socialization and Egalitarian ERS practices. As children mature, they are more likely to be exposed to other ERS concepts like Preparation for Bias and Promotion of Mistrust, particularly during adolescence and among boys (Fischer & Shaw, 1999; Sampson & Laub, 1993; Sampson & Laub, 1994; Stevenson Jr., Cameron, Herrero-Taylor, & Davis, 2002; Stevenson, Herrero-Taylor, Cameron, & Davis, 2002). Girls, on the other hand, are likely to continue receiving increasingly more complex conceptualizations of Cultural Socialization (Bowman & Howard, 1985; Thomas & Speight, 1999).

The SES-Ethnicity Confound: The Combined Challenges of SES and Ethnicity in PT

Research also indicates the majority of low-income and ethnic minority families do not possess sufficient resources to obtain adequate or culturally appropriate social-emotional health services such as community-based PT programs (Fantuzzo et al., 1998; Roberts et al., 2003). On average, African American families earn an annual wage of \$15,000 less than European Americans, are twice as likely to be unemployed, and are nearly three times more likely to be living below the poverty line (U.S. Census Bureau, 2003, 2004). Similarly, Hispanic Americans were three times as likely to be living in poverty, are half as likely to earn an equal salary, and

are two times as likely to work within a service occupation when compared to their European American counterparts.

While more controlling and compensatory strategies have often had increased acceptability among parents struggling with socioeconomic disadvantages, they have also been reported as more popular among economically diverse African-American, Mexican-American, and other ethnic minority groups (Brooks-Gunn & Duncan, 1997; Darity Jr., 2003; Darity et al., 2006; Darity Jr. & Nicholson, 2005; Wilson & Neckerman, 1987; Wilson, 2010a; Wilson, 2010b). Thus, although it has been important to differentiate between parent attitudes and beliefs that affected ethno-cultural and socioeconomic factors, the existing body of parenting research has contained a seemingly endless array of confounds involving the dynamic relationships between ethnicity, culture, neighborhood characteristics, perception of discrimination experiences, and overall resilience. The direct and indirect relationships between these factors, combined with the limited comparisons within a literature saturated with middle-upper income ethnic majority examples, may have collectively compromised the ability to make conclusions regarding the acceptability of parenting attitudes and beliefs among ethnic minority caregivers (Hill et al., 2005).

A wide array of research has suggested that racial and economic disparities affect parenting practices across socioeconomic, political, and cultural contexts, potentially influencing the structure of PT among low-income and ethnic minority families (Fagan & Stevenson, 2002; Kazdin, 1997, 2005). In groundbreaking work to more closely investigate the influence of culture over SES, Hill (2006) examined parenting attitudes and beliefs among several diverse participants sharing a wide variety of social and community assets. By looking at different ethnic groups who share similar neighborhood and community characteristics, Hill was able to control

for many socioeconomic factors and compare parenting differences based almost solely on ethnicity.

Interestingly, Hill (2006) found that many parenting attitudes and beliefs were shared across ethnic groups regardless of socioeconomic characteristics. Both African American and Non-Hispanic White parents shared positive attitudes and beliefs toward parenting strategies based on social and tangible rewards and had difficulties with mild punishment strategies like planned ignoring and time out. Similarly, child outcomes involved with these strategies were similar across ethnic groups, with the distinct exception of differentially adaptive child outcomes involving hostile control strategies utilized by African American caregivers. Taking the rare approach of looking at variations within ethnic groups across a wide variety of socioeconomic characteristics, Hill also examined differences in parenting despite shared culture and ethnicity. Results indicated that parent and family stress were defining factors in parenting attitudes and beliefs, regardless of ethnic, cultural, or socioeconomic factors (Horvat et al., 2003; Knitzer & Cohen, 2007; Lareau, 2006; Lareau, 2007).

For example, attitudes favoring harsh control and rejection were high among both middle-upper income ethnic majority as well as low-income and ethnic minority caregivers with high levels of stress. Hence, parenting attitudes and beliefs may have been shared by low-income ethnic minority and middle-upper income ethnic majority families as long as their stress levels were similar (Hill & Bush, 2001; Hill & Craft, 2003; Hill, Bush, & Roosa, 2003; Hill, Murry, & Anderson, 2005; Hill, 2006). In some cases, stress appeared to moderate the effects of cultural and socioeconomic factors on parenting, with high stress levels accompanying approving attitudes and beliefs towards harsh parenting strategies. These attitudes and beliefs did not manifest in the absence of high stress. With the effects of stress manifesting across

socioeconomic and cultural groups, the influence of these factors on parenting attitudes and beliefs remained difficult to determine. Although high stress was associated with harsh parenting for low-income ethnic minority and middle-upper income ethnic majority caregivers, the opposite was true for middle-upper income ethnic minority parents (Hill & Bush, 2001; Hill & Craft, 2003; Hill, Bush, & Roosa, 2003; Hill, Murry, & Anderson, 2005; Hill, 2006). In high stress contexts, middle-upper income African American families reported less approval of harsh parenting and demonstrated lower levels of parent-child rejection. In comparison to the low-income ethnic minority and middle-upper income ethnic majority caregivers in the study, stress appeared to have a differential effect among middle-upper income ethnic minority parents along lines that were both socioeconomic (opposite effects for low-income families sharing ethnic minority status) and cultural (opposite effects for ethnic majority parents sharing income-level status).

In sum, many parenting attitudes and beliefs have been shared across ethnic groups with similar income and socio-economic features. Middle-upper income parents from a variety of ethnic groups have shared the same preferences. Income and socioeconomic factors appeared to account for differences in parenting between ethnic groups. Regardless of ethnicity, low-income caregivers appeared to have similar parenting attitudes that differed distinctly from middle-upper income caregivers' beliefs. When parent and family stress were introduced at high levels, stress moderated the relationships between income and ethno-cultural factors on parenting attitudes, aligning low-income ethnic minority parents with middle-upper income ethnic majority caregivers. More specifically, stress decreased parental tolerance for disruptive behavior and overall psychological functioning while increasing the likelihood of harsh, inconsistent, and abusive discipline (McPherson et al., 2009). However, when stress has been considered in the

context of middle-upper income ethnic minority parents, these families' parenting beliefs have aligned socioeconomically with ethnic majority parents and ethno-culturally with low-income parents. Hence, middle-upper income ethnic minority caregivers have appeared to require further, more intensive study as a distinct group that can offer a novel perspective on the simultaneous influences of income-based, ethno-cultural, and stress-related factors on parenting beliefs.

Only a very limited number of studies in the literature have examined the relationship between income level and parenting preferences within ethnic minority groups, as the majority of investigations have been focused on ethnic minority caregivers living in poverty. While researchers have agreed that families living in poverty are more likely to endorse harsh discipline, authoritarian family hierarchies, and psychological control involving order, obedience, conformity, these characteristics also appear to be shared across low-income African-American, Latino, and Asian-American ethnic groups (Hill, Murry, & Anderson, 2005; Hill, 2006; Hoff-Ginsberg & Tardif, 1995; Pinderhughes et al., 2001). Hence, ethno-cultural similarities has appeared to be an unlikely cause for these shared parenting endorsements, suggesting SES must have been the determining factor. However, low-income minority groups of different ethnicities have reported experiencing the same types of discrimination and prejudice involving the mainstream majority culture (Boykin, 1984; Boykin & Toms, 1985; Garcia-Coll et al., 1995; Hill, Murry, & Anderson, 2005). Portes (Portes & Stepick, 1985) described this phenomenon as the Cultural Adaptation Hypothesis, in which a variety of ethnic minority families experiencing similar perceptions of racial and economic oppression endorse the same controlling parenting practices.

Hence, a number of significant limitations in the literature remained to be addressed: (1) ethnicity and SES have too often confounded in parenting literature, (2) the existing data has consisted primarily of comparisons between low-income ethnic minority and middle-upper income ethnic majority families, making it nearly impossible to accurately determine whether observed parenting differences were due primarily to ethnic background or income / SES, (3) even when existing studies statistically controlled for SES, results and conclusions were difficult to generalize because of few low-income ethnic majority and middle-upper income ethnic minority participants, and (4) any observed differences in parenting factors among economically and ethnically diverse caregivers may have also be due to environmental characteristics specific to income and ethnicity, such as community resources, creating even further confounds.

Lavigne (2009) investigated the influence of demographic predictors and barriers to treatment on caregiver satisfaction and participation in PT, concluding that only low-SES and ethnic minority status were significantly associated with poor treatment completion. While middle- and upper SES statuses predicted treatment success, low-SES and ethnic majority statuses predicted some likelihood of treatment failure. Overall, low-SES ethnic minority status predicted the greatest likelihood of treatment failure. Barriers to treatment including parental stress, obstacles to treatment, and treatment demands were strongly related to social class and minority status, decreased consumer satisfaction, and treatment attendance. Hence, while both low-SES and ethnicity clearly influence PT outcomes, the different effects of each of these demographic factors on PT outcomes and acceptability remains to be seen.

Addressing the SES-Ethnicity Confound

A collective group of cultural researchers have developed a number of inter-related theories involving the potential influences of ethnicity on both SES and parenting attitudes and

beliefs. Together, the Integrative theory (Garcia-Coll et al., 1995), the Developmental Niche Theory (Super & Harkness, 1997), and the Triple Quandary theory (Allen & Boykin, 1992) have distinctively explained a number of parenting factors influenced by ethnicity across various levels of SES. According to Integrative theory, the influences of culture and ethnicity on parenting vary according to differences in adaptive behavior across SES levels. In other words, the influence of SES on parenting differs according to cultural perspectives. In terms of adaptiveness or appropriateness, the same parenting situation may be perceived very differently between low-income minority, middle-upper income minority, low-income majority, and middle-upper income majority parents. Although parenting situations would be influenced primarily by SES, the perspective on that influences would vary greatly according to parent culture and ethnicity; ethnic majority families would be more inclined to view the influence of SES from more distal and surface-level cultural influences (e.g., ceremonies, rituals, blatant and explicit discrimination) while ethnic minority families would have a more proximal view (e.g., marginalization, institutional discrimination, systemic ethnic stratification).

Similar to Integrative theory (Garcia-Coll et al., 1996), the Developmental Niche Theory (Super & Harkness, 1996) posited that ethnicity and culture were constantly influencing children's development across proximal and distal levels. Defined as an inter-systemic interaction, the developmental niche involved the systems of the home environment, ethno-centric parenting beliefs within that environment, and ethno-centric family customs within that environment. In the home system, the child's development was influenced by the people in the home (e.g., nuclear family, extended family, communal kinships, and so forth) and their patterns of interaction with the child (e.g., sole caregiver role, blood-related caregiver role, or shared caregiver role). Among blood-related and other caregivers alike, ethno-centric emphases of

parenting (e.g., emphasis on rewards, emphasis on correction, or emphasis on supervision) shared a strong influence on child development. These emphases detailed caregivers' most prominent attitudes and beliefs about more and less important parenting practices as well as expectations about children's developmental needs (appropriate level of independence, timing of developmental milestones, and so forth). The third system involved in the developmental niche interaction was composed of those childcare customs that were common across ethnic groups, often considered ubiquitous enough to be expected and understood as universal child developmental traits. Examples of these included older siblings or community members caring for younger children and progression from simple to more advanced and complex tasks (e.g., learning to crawl before learning to walk or run).

In addition to the Integrative (Garcia-Coll et al., 1996) and Developmental Niche (Super & Harkness, 1996) theories, the Triple Quandary theory (Allen & Boykin, 1992) sought to further explain the interrelationship between SES and ethnicity as applied to parenting attitudes and beliefs. As the name implies, the Triple Quandary theory proposed that three distinct cultural worlds or perspectives simultaneously co-influenced ethnic minority parenting across levels of SES. The mainstream perspective included those attitudes, beliefs, and values that were associated with the majority culture. At the same time, the minority perspective added a variety of oppression/discrimination-related coping strategies and defense mechanisms utilized to reduce stress related to negative impacts of social, historical, political, and financial marginalization of ethnic minority groups. The third perspective, known as the ethno-cultural experience, involved both positive and negative aspects of specific ethnic status (e.g., Asian American, African American, Mexican Immigrant, and so forth). Hence, the Triple Quandary theory posited that ethnic minority parents' attitudes and beliefs affected their perception of the influence of SES on

parenting through three simultaneous perspectives that varied according to caregivers' cultural contexts.

Considered collectively, the three theories of ethno-cultural influence on parenting contended that parenting goals, attitudes, beliefs, and expectations were more influenced by culture than SES (Allen & Boykin 1992; Garcia-Coll et al., 1995; Garcia-Coll et al., 1996; Super & Harkness, 1996). For example, regardless of SES, African American parents frequently valued interdependence, collective goals, and struggle against adversity or oppression, yet these values were manifested differently according to SES levels (Hill et al., 2005). Furthermore, these values as a whole were often labeled “no-nonsense” parenting attitudes (Brody & Flor, 1998; Hill & Craft, 2003; Hill, Bush, & Roosa, 2003; Hill, Murry, & Anderson, 2005) combining authoritative affection with authoritarian correction (Stevenson et al., 2001). Like African American parents, Non-Hispanic White parents also had a set of values that were frequently endorsed, including individualism, individual achievement, and competition (Horvat et al., 2003; Lareau, 2000; Lareau, 2006). As a group, these values tended to align more with authoritarian parenting characteristics involving correction in the form of reasoning and discussion. Interestingly, despite the differences in parenting perspectives between these groups, both sets of parenting attitudes, beliefs, and behaviors appeared to be associated with positive and adaptive outcomes such as increased levels of academic achievement, physical health, and overall mental health (Hill & Bush, 2001).

In an effort to investigate potential effects of low-SES and ethnic minority status on PT acceptability, Barnabas and Manz (in preparation) used a partnership-based research process to identify fundamental components of PT interventions preferred by low-income, ethnic minority families. Parents from primarily low-income and ethnic minority communities completed a Q-

sort measure, an instrument designed to identify “person-type factors,” (McKeown & Thomas, 1988) within a target sample. The research questions of this study concerned the most-preferred (question one) and least-preferred (question two) components of PT among primary caregivers from low-income and ethnic minority cultures.

Although initial hypotheses involved a single set of most-preferred and least-preferred components among all low-income and ethnic minority participants in the sample, their study led to the identification of three separate sets of preferences distinct to three separate person-type factors or “profiles” of parenting preferences: the Active-Responsive profile, No-Nonsense profile and Passive-Permissive profile. Contrary to research indicating that parents would identify self-care and developing ethnic or racial pride among low-income and ethnic minority caregivers as more acceptable, the results of this study indicated distinct within-group differences for parents’ preferences for PT intervention components. Along the same lines, their results suggested the need for family-based researchers and practitioners serving low-income and ethnic minority populations to assess the composition of their participant and/or client groups prior to designing and implementing parenting interventions (Brody & Flor, 1999; Coolahan et al., 2002).

Low-SES and ethnic minority parenting preference profiles. Families representing the Active-Responsive profile parenting preference factor represented an amalgamation of qualities to promote healthy, pro-social child behavior. Active-Responsive profile preferences were strongly associated with PT components to set appropriate limits, build children’s verbal problem solving and compliance behaviors, and discourage physical aggression. Active-Responsive profiles also shared strong non-preference for PT components explaining child development details or elaborating on the relationship between culture and parenting style.

Qualitative interview data from parents with Active-Responsive profile preferences indicate that their responses were based on efficacy in developing child autonomy and maintaining caring parent-child interaction. Among low-income and ethnic minority parents, similar findings are rarely reported in the scientific literature (Coolahan et al., 2002; Kazdin 1997, 2005).

Caregivers in the No-Nonsense profile parenting preference factor combined harsh discipline with components described by previous researchers as culturally valid and protective (Brody & Flor, 1999; Stevenson et al., 2001). No-Nonsense profile caregiver preferences involved strengthening parent-child attachment, school readiness, appropriate limit setting, and building children's self-esteem. Strong non-preferences within the No-Nonsense profile included components involving avoidance of physical punishment and ignoring inappropriate behavior. Hence, these parents' preferences simultaneously emphasized both affection and traditionally harsh parenting behaviors. On one hand, these parents strongly preferred programs to help build their child's self-esteem, acknowledge appropriate behavior, set appropriate limits, and encourage school readiness. On the other hand, these same parents expressed strong disinterest in PT components related to increased affection, including attending to appropriate behavior and avoiding physical or harsh punishment.

Participants in the Passive-Permissive profile parenting preference factor combined eagerness to learn about child behavior and improve parenting efficacy with a lack of opportunities for high levels of involvement in their children's lives. These parents expressed strong preferences for learning about their children's behavior at home, increasing their confidence, and avoiding physical discipline, with strong non-preference for learning effective reward- or consequence-based discipline procedures.

Implications of Parenting Preference Profiles for Low-Income Ethnic Minority Caregivers

By gaining a better understanding of parents' preferences for intervention components, parenting researchers and clinicians may be able to fit the delivery of PT intervention curricula to the subjective and specific needs of their clients. Using this information at the beginning of intervention, providers could quickly determine the degree of fit between their intervention and the specific needs unique to their target parent population. In this way, Q-sort data could be used to provide researchers and practitioners with the means to individually tailor family-based prevention and intervention efforts to the interests and needs of the families they serve, potentially increasing parent engagement, treatment fidelity, and efficient resource allocation.

Parents in the Active-Responsive profile preference factor may have found existing PT programs a "good fit" for their families because their preferences would be aligned with content of most behaviorally-based PT curricula in the literature. However, the qualitative interview data suggest that these parents may also have considered themselves well-informed about many topics included in common PT curricula. For example, the quantitative Q-sort data indicated that Active-Responsive profile caregivers had strong non-preferences for learning about child development. At the same time, qualitative interview data indicated that Active-Responsive caregivers had this strong non-preference because they already considered themselves familiar with child development.

Active-Responsive caregivers preferred PT components likely to be included in evidence-based programs resulting in beneficial parent-child interactions linked to decreases in child anti-social behavior and the prevention of later delinquency, drug abuse, high-risk sexual behavior, and other adolescent health risks (Patterson, Reid, & DiShion, 1992; Reid, Patterson, & Snyder, 2002). Similar to Baumrind's authoritative parenting style involving responsiveness, parent-child affection, and verbal problem solving or limit setting (1972, 1991), parents in the Active-

Responsive preference factor conveyed strong implications for intentionally developing strength and resoluteness among low-income and ethnic minority caregivers.

Along the same lines, parents in the No-Nonsense profile preference factor may have potentially benefited from intervention modifications initially focused on improving parent-child relationships with delayed use of extinction and mild punishment procedures, as they may have been more responsive to parenting interventions with an initial focus on controlling parenting methods (e.g., low levels of physical and verbal affection, frequent commands, and frequent statements to direct or control child behavior). Their preferences resembled those associated with Active-Restrictive (Coolahan et al., 2002) and Either-Or parenting styles among low-income and ethnic minority caregivers (Stevenson et al., 2001), expressing the need to use either affectionate or harsh parenting behaviors relative to their children's appropriate or inappropriate behaviors. Interestingly, Either-Or parents felt that physical discipline and tough love were motivated by protective tendencies (i.e., helping children understand from an early age that they would have few second chances for inappropriate behavior in high risk communities). Traditionally, African-American families have more often been associated with authoritarian style parenting featuring high levels of controlling behavior and low levels of nurturance behavior (Reid et al, 2002). While this type of parent-child interaction has been predictive of pathological and anti-social outcomes among majority children (Patterson et al., 1993; Reid et al., 2002), these preferences may have been perceived as protective and nurturing within low-income and ethnic minority families. Hence, low-income and ethnic minority caregivers in the No-Nonsense parenting preference factor may have been expressing these same protective tendencies.

Finally, caregivers in the Passive-Permissive profile parenting preference factor may have needed counseling or other social and community supports before they could even begin to

engage meaningfully in any form of PT intervention. The literature indicated that these parents' Passive-Permissive preferences (e.g., preferences to avoid limit-setting) may have been exacerbated by life stressors affecting access to their basic needs like food, shelter, and personal safety (Clark, 2005; Kazdin 1997, 2005). This pattern resembled a similar pattern described in the literature as indifferent-uninvolved parents, characterized by avoidance and escape from childrearing demands, making them inconsistent and unavailable (Maccoby, 1983). Overall, it appeared that caregivers in the Passive-Permissive parenting preference factor may have been more likely to be involved in parenting interventions that initially provide links with community social service assets than specific parenting strategies.

Implications for Future Research

Future research should focus on further development of the Q-sort assessment and linking that assessment to PT interventions. One unaddressed area has been extending the qualitative Q-sort interview to focus on the preferences of middle- and upper-income ethnic minority families rather than low-income families alone. In order to more specifically understand the influence of ethnic minority status on parenting attitudes, more investigations with ethnic minority families earning middle-level incomes and above are needed. This research would offer a unique comparison between caregivers with shared ethnicities while evaluating the independent influences of more SES- and community-related factors. A growing number of studies involving this unique group have begun to assemble in order to better understand the dynamic relationship between SES and ethnic minority status. Middle-upper income ethnic minority parents have offered a unique perspective on the exact nature of the relationships between SES-based and culturally-based parenting variables, as ethnicity could be held constant across income groups.

Using ethnically similar groups to compare parenting preferences across income levels, researchers would be able to better understand the role that SES plays in caregiver preferences for parenting program content, independent of ethnic minority status. That is, if parenting preferences and parent-factor-profiles were the same among ethnic minority caregivers regardless of SES, then PT interventions would need to be adapted to the specific and subjective needs of ethnic minority culture. For example, Matos (Matos, Torres, Santiago, Jurado, & Rodríguez, 2006; Matos, Bauermeister, & Bernal, 2009) successfully adapted PCIT content to better fit the needs of Puerto Rican families with young children exhibiting significant behavior problems by incorporating cultural elements and modifications into the treatment protocol. McCabe (McCabe, et al., 2005) adapted PCIT to be more culturally appropriate for Mexican American families by combining information from research involving Mexican American families and qualitative data from focus groups and interviews with Mexican American families and clinicians. However, if parenting preferences and parent-factor types are different across SES levels regardless of ethnicity, then PT interventions may need to be adapted to the specific and subjective needs of low-SES culture. Currently, there have been almost no PT studies comparing caregiver preferences for treatment components across SES levels while holding ethnicity constant. With a more diverse body of data involving the ideographic perspective of groups that have been historically neglected in the psychological literature, researchers can begin to gain new insight involving the SES-ethnicity dynamic and related parenting beliefs. These investigations have been needed in order to better understand the interrelated influences of SES and ethnicity on caregiver preferences for PT components as well as the role of ethnicity alone.

Chapter 3: Method

Participants

Middle-upper income participants were recruited as self-identified primary caregivers of young children, regardless of their kin relationship. Geographic locations for recruitment included urban and suburban South Florida (primarily middle-upper income Hispanic), suburban and rural Central Pennsylvania, and urban Southeast Pennsylvania (primarily middle-upper income African American). Criteria for inclusion in this investigation included: (1) families of young children between the ages of two and four years, (2) caregivers who spoke English, (3) families self-identified as ethnic minorities, and (4) families living at or above the income levels calculated utilizing tool developed by the National Center for Children in Poverty (NCCP, 2014). These tools were designed to measure family resources considering not only income, but also living expenditures necessary to support basic living costs (e.g., annual childcare costs). As described in Table 1, the middle-upper income parent sample was matched with the existing data from the low-income parent sample on four factors in order to enable comparison: ethnic identity (88% African American, 12% Hispanic/Latino across groups), child age ($M = 3.2$ years, $SD = 0.8$ years, age range: 2-4 years), caregiver language (100% English across groups), and caregiver gender (83% female, 17% male across groups). Consistent with recommendations for the Q-sort methodology applied in this study (Brown, 1980a, 1980b; McKeown & Thomas, 1988; Schlinger, 1969; Woosley, Hyman, & Graunke, 2004), 40 participants were included in the middle-upper income sample (M age = 35.7 years, $SD = 5.8$, age range: 23-44 years). Chi-square tests were carried out in order to identify any significant differences between the expected frequencies and the observed frequencies in key demographic categories across income groups. Both caregiver employment status and education level were identified. More specifically, a chi

square test of independence was performed to examine the relation between caregiver income and employment status. The relation between these variables was significant, $X^2(1, N = 40) = 18.46, p <.01$. Middle-upper income caregivers were more likely to be employed part-time or full time while low-income caregivers were more likely to be unemployed. A chi square test of independence was performed to examine the relation between caregiver income and education level. The relation between these variables was significant, $X^2(1, N = 40) = 6.37, p <.01$. Middle-upper income caregivers were more likely to have completed a high school degree or beyond while low-income caregivers were less likely to have completed high school.

Recruitment Procedures

Families with young children meeting the aforementioned inclusion criteria were recruited for participation in this investigation through family-based organizations serving middle-upper income ethnic minority children including university childcare centers, charter schools, and Jack and Jill of America, Incorporated. First, family organization staff members were notified of the opportunity for parents to participate in the investigation. Family-based organization administrators and staff arranged for interested parents to contact the investigator for specific information regarding the study. The investigator then provided a brief script of information regarding the aims of the investigation, the risks and benefits involved, and the required inclusion criteria. Interested and eligible participants made arrangements for data collection appointments to complete the Q-sort in their child's school/daycare, in their home, or in a preferred location identified in their community (e.g., a local library or café). Compensation for parents' time and efforts was provided, including refreshments and a monetary incentive. Because adequate translation services were unavailable, the only excluded caregivers were non-English speaking.

Q-Methodology

Q-sort purpose. Q-methodology allows researchers to understand the meaningfulness of the experiences and general attitudes of a specific, subjective target group toward a given topic (Brown, 1980a, 1980b; McKeown & Thomas, 1988; Schlinger, 1969; Woosleyn et al., 2004). The Q-sort is used to determine the experiences and attitudes that characterize a distinct set of individuals rather than an aggregate assessment of an overall picture of the general population akin to survey research. In this investigation, the specific target group was the subjective experiences of middle-upper income ethnic minority caregivers of young children.

The Q-sort method can be specifically used to categorize participant experiences and attitudes based on similarities between precise statement responses (McKeown & Thomas, 1988). The statements include the unique details and components of an overall theme related to the investigative research question. The “nuts and bolts” of the overall theme, including every major and minor characteristic feature, are known as the *concourse*. In the current study, the target population included middle- and upper-income primary caregivers and the overall theme was related to parenting program practices derived from a variety of programs described in the literature. Hence, the *concourse* was comprised of the details and theory behind various forms programs of evidence-based behavioral PT (Kazdin, 1997, 2005, 2007, 2014).

Q-sort methodology is not subject to power analysis, as adequate sample size is instead determined by the characteristic traits held by members of a specific target group (Brown, 1980a, 1980b). Sample size is also determined by the relationship between participant demographics and the overall topic as well as availability of access. In this study, Q-methodology principles limited the principal investigator to an income- and ethnicity-specific sample with subjective

parenting preference characteristics believed to differ from the general population, determining a final sample size of 40.

Q-sort procedures and item selection. When considering the research questions and related hypotheses, it is important to note that the Q-sort is not a measure of parenting style. Instead, the PT Q-sort is a measure of parents' preferences for the components of PT intervention services. Because the Q-sort is a measure of parenting preferences rather than actual parenting behavior, all parent preference factors will be described using the term "profile" (e.g., authoritative-profile, authoritarian-profile, and permissive-profile). The Q-sort began with a series of statements describing components of evidence-based PT programs derived from the concourse of PT literature and shuffled in random order. This study included 36 item statements co-developed through the caregiver pilot along with an investigation of PT literature including parent self-care, social support, response to specific child behaviors, and ethnic emphases (McKeown & Thomas, 1988). Derivation from the concourse of PT literature included the principal investigator reviewing literature involving over 110 PT investigations between 1985 and 2008. Essential elements of PT demonstrated to be effective in the literature were identified and included in the concourse to the extent that as any essential elements of PT would be included while avoiding repetition and over-saturation of the Q-sort content. These essential components in the PT literature were written as the brief, 6th grade reading level statements that comprised the concourse of the Q-sort used in this investigation.

The decision to include 36 statements was based on Q-sort methodology literature and principles indicating an ideal number of statements ranging between 20 and 75; enough to create stability and statistical reliability without mentally overwhelming respondents (Brown, 1980a, 1980b; Schlinger, 1969). Furthermore, items were divided into three general domains across PT

programs: behavior management, relationship building, and culturally focused. While behavior management items were focused on the mechanics of PT, relationship items included details related to the parent-child interaction process, and cultural items explored preferences for specific ethnic foci in PT content. In order to minimize the effects of memory, stress, and distraction during the Q-sort, fewer statements and a minimal number of items were chosen to adequately represent the PT concourse. Moreover, the readability of all items was developed to be at or below a sixth grade level in order to maximize potential readability and ease of use. Wording and terminology were reviewed with the pilot sample for clarity, with no reported changes or adaptations needed to clarify details or fit their preferences. A complete list of these statements is included in Appendix A (Kazdin, 1997, 2005, 2014; Stevenson et al., 2001; Wagner, Spiker, & Linn, 2002; Webster-Stratton, 2001).

Using a model similar to Rimm-Kauffman et al. (2006), a pilot sample of 10 participants was recruited to modify, adapt, and co-construct 36 relevant Q-sort statements. The initial pilot sample consisted of 10 middle- and upper-income ethnic minority caregivers identified by their family organization staff or peers as leaders. These 10 individuals were then contacted and determined to be eligible. The pilot sample completed the Q-sort according to standard procedures, then shared their opinions of the Q-sort format, wording, and delivery with the investigator in order to develop a final Q-sort scale with content validity established through the co-construction process. After reviewing all of the sample statements for relevance, pilot caregivers also completed a brief readability interview and questionnaire (see Appendix B) to identify those items containing confusing or unclear wording. No statements were commonly identified as confusing or unclear among members of the pilot group. Hence, because no changes were made to the initial Parenting Q-sort measure or the procedures for completing it among the

pilot sample, the Q-sort data collected from the 10 participants in the pilot sample were included in the overall data collected from the middle-income group.

The majority of Q-sort sessions were administered by investigator to small groups of two to five primary caregivers. Specific procedural guidelines for these Q-sort sessions are described in Table 2. Caregivers that were interested in completing the Q-sort but did not prefer the group administration format were given the option to schedule individual in-home Q-sort sessions with the investigator. Each Q-sort session began with the principal investigator providing concourse statements to caregivers, then reading each concourse statement aloud. All concourse statements were re-read to participants upon request to facilitate ease of the Q-sort process.

A forced choice Q-sort format was used in this study, requiring participants to place a limited number of statements under each distribution marker (McKeown & Thomas, 1988). Use of forced choice in Q methodology was required to access the nuances of participant beliefs that determined their priorities between concourse statements and thereby capture a true representation of their preferences that would otherwise be difficult to obtain using Likert-type scales or similar measures involving less time and more choice. The forced choice format required three initial Q-sort anchors that indicated which PT characteristics individual caregivers found to be most preferred, least preferred, or neutral/uncertain. All items were judged in response to an initial statement known as the condition of instruction (McKeown & Thomas, 1988). In this study, the condition of instruction was: “In my opinion, the best parenting program for my family would help me learn good ways to. . .” The term “best program” was operationally defined for caregivers as “a program that would best fit your family and parenting style.” Participants then sorted the statements in each of the three categories using a second set of distribution markers ranging between -2 and +2. A visual representation of the distribution

markers is included in Appendix C. Based on their responses to the initial three anchors, caregivers then used five anchors to systematically rank statements from the right (preferred: +1 or +2), then the left (non-preferred: -1 or -2), and finally to the middle (neutral: 0) until all items had been placed. When participants finished placing all of the items, they completed brief individual interviews regarding their reasons for selecting their most and least preferred items (see Appendix D). Duration of administering the Q-sort and interview ranged from approximately 20-75 minutes, with an approximate average time of 30 minutes. The investigator then recorded each of the participants' final Q-sort scores.

Q-sort data analytic plan. Using a Q-method approach to compare variability within and between groups of parents with similar preference profiles, this study addressed five specific research questions: (1) What specific caregiver preference ranking profiles for PT components will emerge from Q-sorting middle-upper income ethnic minority families?, (2) What specific PT components are ranked as most preferred by primary caregivers from middle-upper income ethnic minority families?, (3) What specific PT components are ranked as least preferred by middle-upper income ethnic minority families?, (4) To what extent are specific PT component rankings shared across low-income and middle-upper income ethnic minority caregivers as a collective group?, and (5) To what extent are PT component rankings shared between specific caregiver preference ranking profiles for *PT components* across low- and middle-upper income ethnic minority families?

Analyzing Q-sort data required a distinctive principal components analysis in which person-type factor profiles are identified and interpreted as described in Figure 1. While typical R-technique factor analyses are used to explore, confirm, or otherwise determine construct-type factor profiles within specific models or measures such as surveys or personality inventories

(Kazdin, 2003a), the Q-technique factor analysis in this investigation involved initial correlation analyses among participants and variables/items arranged along the y and x axes, respectively, followed by the identification or confirmation of specific constructs within the measure based on significant loadings. Factors meeting the criteria for significant loadings were then examined and interpreted according to theoretical research hypotheses as well as evidence in related scientific literature.

Q-technique factor analysis resembles R-technique in several ways, with two important and distinct differences. First, the Q-technique has been used to determine person-type factor profiles from shared participant responses rather than examining constructs based on within-measure item groupings (Brown, 1978, Brown, 1986). Second, the social and political contexts of Q-sort data are weighted more heavily than statistical significance alone. Thus, although a particular factor may not reach an eigenvalue greater than 1.0 or contain several statistically significant loadings, it may still be included in the research model. If the factor profile is defined according to qualitative data or relevant empirical literature related to the social/political context of a specific respondent group (e.g., middle- and upper-income ethnic minority parents with post-secondary education living in urban settings), then it may be recognized despite an eigenvalue below 1.0, few significant loadings, and/or accounting for a relatively small amount of unique variance.

As described in Figure 1, Q-sort data were first analyzed using principal components factor analysis to determine parenting preference factors using SPSS and PQ Method (2002) software. Varimax orthogonal rotation determined the final loadings used to interpret factor analysis data. As described by Watts and Stenner (2005), varimax rotation was selected as the preferred option in Q method due to its inherent simplicity and reliability in revealing the range

of perspectives represented by the target participant group. As Brown (1980b) and McKeown and Thomas (1988) describe, in Q-method varimax rotation is the most conventional of the factor extraction and rotation methods in order to achieve simple structure that maximizes the purity of saturation among as many Q sorts as possible on the initially extracted factors. The simple structure and enhancement to the orthogonality of the data (maximizing variance between factors while minimizing the amount of data variance related to mixed and null cases), varimax rotation was selected in order to increase confidence that the emerged factor types would be more likely to bear direct correspondence to actual q sorts or traits, leading to high loadings on the primary factor, with near-zero loadings on the other.

At the same time, it is important to note that in Q method, although varimax and other factor rotations could be examined in terms of geometry and statistical criteria, these are generally viewed simply as the necessary mechanism for Q-technique. That is, rotation does not change the consistency in the perspectives embedded in the sample of individual Q sorts or the relationships between those Q sorts; it simply shifts the perspective from which they are observed. The mechanism is akin to small clusters of artists (e.g., impressionists, realists, and post-modernists) looking at a large painting from different positions around an art museum showroom. Each group of artists (person-centered factors) retains their own distinct interpretation of the painting's subjective meaning regardless of where they are standing in the showroom and the subsequent angle at which the painting is viewed (rotation). Hence, varimax rotation is most often preferred in Q-method investigations in order to ensure that each group of artists can be distinguished from one another as reliably and simply as possible in order to continue the data analysis process with confidence in the distinctiveness of the factors that emerged. In this investigation, the purpose of rotation was to give the researcher the most useful

focus for providing insight into the research questions. Hence, varimax rotation was selected as useful to identify the most prominent clusters of agreement among the Q-sort sample.

Following varimax rotation, specific criteria for identifying valid parenting preference factor profiles included: a) factors with eigenvalues greater than or equal to 1.0, b) factors including four or more significant loadings greater than or equal to an absolute value of 0.43, and c) factors containing strongly preferred and non-preferred items describing a qualitatively similar social/political context (Carr, 1992). The factor loading criterion of 0.43 for the 36 items Q-sort were identified according to Stephenson's (1977) formula: $2.58 * (1/\sqrt{[\text{Number of items}]})$.

In sum, the PQ Method software (2002) and parent-based focus group were utilized to combine quantitative and qualitative data assembled from the factor array, z-score rankings, and interview data were cumulatively examined to determine final parenting preference factor profiles (see Figure 1). As seen in Figure 1, obtaining results in the Q-sort involved a series of data analyses beginning with principal components factor analysis (Brown, 1978; Brown, 1986). In the initial correlation matrix of the principal components factor analysis, person-type factor profiles were identified according to acceptable eigenvalues and significant factor loadings. Next, a factor array was used to compare identified factor loadings for viable parenting preference constructs according to unique item response patterns. Similarities and differences among strongly preferred (scored +2) and strongly non-preferred (scored -2) items were examined between each factor profile as an initial step toward further defining each parent type. After examining the factor array, anchor scores ranging from -2 to +2 were converted to normally distributed z-scores among the defined parenting preference factor profiles to more precisely examine: a) the degree of difference between strongly preferred items within each parenting preference factor, b) the degree of difference between strongly non-preferred items

within each parent type, and c) the extent to which each parenting preference factor differs among strongly preferred and strongly non-preferred items (Carr, 1992; Stephenson, 1953).

Parenting preference factor profiles were further defined by: a) items with high z-scores unique to specific factors (i.e., unique items), b) items with z-scores which differ significantly from one another (i.e., difference items), and c) items which were most likely to be shared among all factors (i.e., consensus items). Finally, the factor loadings, factor array, and z-score quantitative data were further interpreted to examine the social and political meaning provided by the qualitative context of post Q-sort interview data. The results of these analyses were then cumulatively used to eliminate factor profiles that could not be interpreted according to the combined quantitative and social/political qualitative data. The resulting overall z-score rankings and parenting preference factor profile z-score rankings were compared with the rankings of the low-income sample from the original study for similarities and differences between low-income and middle-upper income ethnic minority caregivers.

It is worth noting that the importance of the social/political context was essential in interpreting the Q-sort data because the importance of a factor profile was not only determined by statistical criteria, but also accounted for the social and political setting to which the factor profile was organically connected (Stephenson, 1977). Hence, upon completing the quantitative data analyses, the investigator coordinated a focus group session to review quantitative data analyses with the parents and receive their feedback for qualitative interpretation. The focus group was held during a 1-time session at an eatery local to the majority of the middle-income participants in urban and suburban southeast Pennsylvania. Caregivers willing and able to participate self-selected to attend the focus group. During the focus group, the investigator presented families with verbatim qualitative responses from highly ranked distinguishing

statements for each profile that emerged from the Q-sort. From these responses, parents assisted the investigator in interpreting further insight into the ways of thinking behind the rankings of each profile as well as developing labels for each profile that were identified as acceptable and not offensive.

Research question 1. The Q-sort was analyzed using SPSS and PQ Method Software to perform a principal components factor analysis of participant responses with varimax rotation to determine factor scores (Brown, 1980a, 1980b; McKeown & Thomas, 1988; Schlinger, 1969; Woosley et al., 2004). Factor scores were used to measure similarities in preference or indifference toward specific PT components. This study included all factors with eigenvalues above 1.0. Based on post-Q-sort interviews, potential factors with eigenvalues approximate to but below 1.0 that appeared to load on existing factors were included. Factor weights for each statement were summed and converted to z scores, then utilized to rank factor scores among all participants as well as those participants representing specific preference ranking profiles.

Research questions 2 and 3. The PT component ranking data resulting from the analyses involved in Research Questions 2 and 3 were used to construct a weighted factor array (see Table 3) in order to extract profiles of middle-upper income ethnic minority caregivers based on similarities in their preference rankings of PT components (i.e., the factors resulting from the Q-technique factor analysis). These profiles comprised the data to address Research Questions 2 and 3, determining the PT component preference rankings among the sample of primary caregivers from middle-upper income ethnic minority families. The highest PT component rankings among all middle-upper income ethnic minority participants comprised the data to address Research Question 2, while the lowest rankings comprised the data to address Research Question 3.

Research questions 4 and 5. The PT component preference ranking profile data from middle-upper income ethnic minority caregivers in Research Question 1 were compared with PT component preference ranking profile data from low-income and ethnic minority caregivers. Analyses for this comparison included kappa, the percentage of agreement in PT component rankings between low-income ethnic minority caregivers (Barnabas & Manz, in preparation; Kazdin, 2003b), as compared with middle-upper income ethnic minority caregivers, regardless of caregivers' preference ranking profiles (Research Question 4). Finally, the same analyses used for Research Question 4 were used to compare the percentage of agreement and disagreement in PT component rankings between specific caregiver ranking profiles from low-income and ethnic minority families as compared with the specific caregiver ranking profiles from middle-upper income ethnic minority families (Research Question 5).

Chapter 4: Results

Specific PT Preference Profiles Among Middle-upper Income Ethnic Minority Families

(Research Question 1)

In order to identify the specific factor structures of the PT preference profiles, a principal components analysis (PCA) was conducted. Overall the PCA analysis indicated that up to a four-factor model could meet specific criteria for inclusion, but for the final model a three-factor solution was selected to represent three distinct parent education preference profiles. In this three-factor solution, the quantitative inclusion criteria were met with an eigenvalue of 3.20 and 11 significant loadings. Components were deemed meaningful given their alignment with the social/political context of interview responses and current parent education research reviewing preferences for parenting lessons. More specifically, the three components represented parents learning to cope with feelings of high stress and low self-efficacy. Along the same lines, young children's social emotional health was also influenced by parental disciplinary practices described as simultaneously firm but nurturing, as well as parenting practices incorporating cultural values and beliefs (Butler, 2012; Caughy et al., 2002; Coard et al., 2004; Hill, 1997, 2001, 2006; Kotchick & Forehand, 2002; Slaughter-Defoe, 2005; Suizzo, Robinson, & Pahlke, 2007).

The selected three-component solution was also examined relative to models with one, two, and four-factor solutions. In the one-factor solution, the single component presented with an eigenvalue of 9.370 and 16 significant loadings. Moreover, the qualitative criteria for inclusion were met within the participant interview responses and PT literature reviewing preferences for parenting lessons involving the promotion of children's social-emotional health via incorporating cultural values into parenting practices (Butler, 2012; Caughy et al., 2002;

Coard et al., 2004; Hill, 1997, 2001, 2006; Kotchick & Forehand, 2002; Slaughter-Defoe, 2005; Suizzo et al., 2007). The one factor solution was rejected because further variance could be accounted for by other multi-factor models when compared to the remaining potential solutions. The two factor solution met the same quantitative inclusion criterion, with an eigenvalue of 4.21 and 20 significant loadings. In addition to incorporating cultural values into parenting practices, the two-factor solution interview responses also met the qualitative inclusion criteria, sharing social/political lines of reasoning with current PT literature investigating preferences for parenting lessons involving the promotion of children's social-emotional health via a combination of firm but nurturing discipline practices.

Although the two-factor solution met the quantitative inclusion criteria, further variance could be accounted for by other three- and four-factor models. Although the four-factor solution met the quantitative inclusion criteria with an eigenvalue of 2.7 and 5 significant loadings, no qualitatively similar social/political statements were identified beyond those identified in the one, two, or three factor solutions. Therefore, because the four-factor solution met the quantitative inclusion criteria but not the qualitative social-political-meaningfulness criteria, the four-factor solution was rejected. In sum, three PT preference profile factors emerged from the principal components factor analysis and were examined further according to caregiver ranking in factor arrays, normally distributed z-scores, inter-item comparisons, and the social / political context of both interview data and PT literature (Baumrind, 1972; Brody & Douglas, 1998; Patterson & Forgatch, 2005; Roche et al., 2007).

The final three-factor PT preference profile accounted for 42 % of the total variance explained. Factor 1 PT preference profile accounted for 17 % of the explained variance and was strongly associated with 13 participants (participants 1, 2, 4, 5, 10, 18, 20, 21, 22, 24, 27, 34, and

3). Factor 2 PT preference profile accounted for 11% of the explained variance and was associated with 10 participants (6, 7, 9, 11, 14, 15, 25, 28, 32, and 40). Factor 3 PT preference profile accounted for 14 % of the explained variance and was closely associated with 11 caregivers (8, 12, 16, 19, 23, 26, 31, 36, 37, 38, and 39). Six caregivers (3, 13, 17, 29, 30, and 33) did not load significantly on their preferences for any meaningful pattern of PT components included in the Q-sort.

Specific PT Components Ranked as Most Preferred (Research Question 2) and Least Preferred (Research Question 3) Among Middle-upper Income Ethnic Minority Families

Examining the factor array and corresponding z-scores to differentiate PT preference profile factors. As described in Figure 1, the PT preference profile factors identified in PCA were compared according to shared preferences among the Q-sort items using a factor array grid and corresponding z-score rankings. Table 4 presents the factor array grid resulting from the PCA. Those items determined most unique to each factor (distinguishing items) were identified according to the significant differentiation in the standard error of differences between item z-scores for each of the three parenting preference factors as described by Stephenson (1977) and Brown (1980). Although the z-score data presented identical rankings to the factor array, normally distributed scores for each item were used to allow for a more precise analysis of the degree to which PT preference profile factors were relatively similar or different. Table 5 presents the z-score data and relative rankings of strongly preferred and non-preferred items shared with the factor array.

Middle-upper income parenting preference factor 1: Coping-centered. As indicated in Tables 4 (factor array data) and 5 (z-score data), the pattern of distinguishing items and brief interview responses involved in Middle-Upper Income Factor 1 led the researcher and a small

focus group of parents to agree to the label “Coping-Centered.” Distinguishing preference statements items for Coping-Centered parents included items 24, 13, 23, 6, and 32. Brief interview responses for preferred distinguishing items indicated that Coping-Centered parents appeared most concerned about managing daily stress related to parenting and employment as well as responding to their children in a healthy and nurturing way.

Distinguishing non-preference statements for Coping-Centered parents included items 15, 19, 28, 9, and 21. Brief interview responses for non-preferred distinguishing items indicated that Coping-Centered parents appeared to have confidence in their existing abilities to communicate with educators and family members about their child’s behavior. Moreover, Coping-Centered parents expressed that they could already balance physical and non-physical discipline strategies appropriately according the intensity level of the child’s disciplinary infraction. Finally, Coping-Centered parents expressed the belief that their culture did not closely affect their parenting style.

Middle-upper income parenting preference factor 2: Child-centered. As indicated in Tables 4 (factor array data) and 5 (z-score data), the pattern of distinguishing items and brief interview responses involved in Middle-Upper Income Factor 2 led the researcher and a small focus group of parents to agree to the label “Child-Centered.” Distinguishing preference statements for Child-Centered parents included items 9, 25, 10, and 14. Brief interview responses for preferred distinguishing items indicated that Child-Centered parents appeared to prioritize nurturance and attachment parenting. More specifically, Child-Centered parent responses focused on a maintaining a loving and positive parent-child relationship by avoiding physical discipline or other harsh strategies while emphasizing praise and activity/social rewards to build children’s self-esteem and spend more quality time together (Dixon, Graber, & Brooks-Gunn, 2008; Winter, Morawska, & Sanders, 2012).

Distinguishing non-preference items for Child-Centered parents included items 22, 21, 34, 33, and 30. Brief interview responses for Child-Centered distinguishing items appeared to indicate the belief that medication and medical care should be considered a low-value option or “last resort” for addressing children’s social-emotional challenges. In addition, Child-Centered parents appeared to emphasize the lack of importance for cultural influences on parenting and the parent-child relationship.

Middle-upper income parenting preference factor 3: Culture-centered. As indicated in Tables 4 (factor array data) and 5 (z-score data), the pattern of distinguishing items and brief interview responses involved in Middle-Upper Income Factor 3 led the researcher and a small focus group of parents to agree to the label “Culture-Centered.” Distinguishing preference statements for Culture-Centered parents included items 33, 35, 12, 21, and item 34. Brief interview responses for preferred distinguishing items indicated that Culture-Centered parents appeared to place a high value on helping to teach their children positive associations with culturally-relevant behaviors, perceptions, values, and attitudes in order to maintain high self-esteem despite negative social messages or stereotypes (Bluestone & Tamis-LeMonda, 1999; Carpenter & Mendez, 2013; Dean, Marsh, & Landry, 2013; Querido, Warner, & Eyberg, 2002). For example, several parents mentioned their children being the only children of color in their community and wanting to protect them from feelings of isolation and/or negative self-image.

Distinguishing non-factors for Culture-Centered parents included item 10 (appropriate use of praise and social rewards) as well as item 9 (avoiding physical discipline) and item 17 (setting appropriate limits and not giving in to inappropriate behavior). Brief interview responses for preferred distinguishing items indicated that Culture-Centered parents appeared to believe that they already had the ability to set appropriate limits and did not need any further help in that

area. Interview responses also indicated that the use of praise and social rewards was regarded as bribing children or providing them with a sense of entitlement or dependency that would hinder rather than help them later in life. Finally, Culture-Centered parents expressed that there was a distinct difference between appropriate physical discipline (e.g., spanking) and inappropriate physical abuse (e.g., injuring a child or hitting/striking a child excessively).

For Middle-Upper Income and Low-Income samples, a comparison of the degree of agreement for all PT Components (Research Question 4) and PT component rankings shared between preference profiles (Research Question 5)

Collective PT components rankings for middle-upper income caregivers. In order to gain an overall, macro-level perspective on middle-upper income parents as a whole, their collective z-score rankings were examined as a single, synthetic profile. As indicated in Table 6, collective z-score rankings for middle-upper income ethnic minority caregivers indicated that strongly preferred PT components included helping their children understand ideas about prejudice and cultural biases ($z = 1.64$), discussing healthy responses to prejudice ($z = 1.59$), helping to increase children's self-esteem ($z = 1.45$), and helping children to develop pride in their culture ($z = 1.20$). Preferred PT components also included preferences to learn more about stages of child development ($z = 1.18$), helping children learn the value of maintaining their culture over time ($z = 1.09$), managing daily parenting stress ($z = 1.08$), and increasing awareness of caregiver strengths and weaknesses ($z = 1.07$). Strongly non-preferred PT components included learning more about alternatives to physical discipline ($z = -1.84$), knowledge of extinction / planned ignoring procedures ($z = -1.62$), increasing access to community social services ($z = -1.50$), and developing ongoing strategies to communicate child behavior in the home while the caregiver is at work ($z = -1.44$). Other non-preferred PT

components included addressing community barriers to effective parenting ($z = -1.38$), increasing access to and utilization of medicine and medical services ($z = -1.29$), improving family-based social support networks ($z = -0.01$), and fostering more affectionate/nurturing parent-child interactions ($z = -0.08$).

Collective PT component rankings for low-income caregivers. Low-income caregiver results for this study were utilized from a dataset in a previous investigation (Barnabas & Manz, in preparation). Results from the low-income parenting preference profile investigation identified three low-income factors: Active-Responsive, No-Nonsense, and Passive-Permissive. Active-Responsive caregivers were uniquely defined by their strong preferences for PT components that encouraged verbal problem solving and compliance behaviors (items 5, 8, 9, and 17) while discouraging physically aggressive child behaviors (items 19, 22, 31, and 32). No-Nonsense caregivers were uniquely defined by their strong preferences for PT components involving strengthening parent-child attachment, school readiness, appropriate limit setting, and building children's self-esteem (items 10, 17, 25, and 26) while not preferring the avoidance of physical punishment and ignoring inappropriate behavior (items 9, 19, 22, and 30). Finally, Passive-Permissive caregivers were uniquely identified according to their strong preferences for PT components teaching caregivers to increase their parental monitoring and parenting efficacy (items 9, 25, 27, and 31). Please refer to the addendum at the end of this document for more precise information regarding low-income PT preference profiles.

As indicated in Table 5, collective z-score rankings for low-income ethnic minority caregivers indicated that strongly preferred PT components included helping children communicate their needs using words instead of aggression ($z = 2.17$), setting appropriate disciplinary limits and boundaries ($z = 1.67$), effective use of praise and social rewards ($z = 1.51$),

and learning more about alternatives to physical parental discipline ($z = 1.47$). Preferred PT components also included preferences to learn more about using time out procedures effectively ($z = 1.02$), increasing children's independence ($z = 0.92$), increasing compliance with adult directions ($z = 0.89$), and managing daily parental stress ($z = 0.86$). Strongly non-preferred PT components included learning more about understanding how culture and parenting are related ($z = -1.77$), increasing family-based social supports ($z = -1.59$), increasing access to and utilization of medicine and medical services ($z = -1.48$), and knowledge of extinction / planned ignoring procedures ($z = -1.25$). Other non-preferred PT components included developing ongoing strategies to communicate child behavior in the home while the caregiver is at work ($z = -1.18$), increased knowledge of child development ($z = -1.04$), increasing parenting self-efficacy ($z = -0.99$), and helping children learn the value of maintaining their culture over time ($z = -0.90$).

Comparing PT component preferences across income levels. When collectively compared across income levels, ethnic minority parents reported a variety of different PT preference rankings. Middle-upper income ethnic minority parents strongly preferred PT components focused on cultural relevance and self-esteem while low-income parents reported strong preferences for behavioral components to set limits, avoid aggression, and provide social rewards like praise. At the preferred level, middle-upper income ethnic minority parents ranked components involving caregiver strengths and weaknesses as well increased knowledge in both stress management and stages of child development. In contrast, low-income ethnic minority parents reported preferences for components including effective use of time out procedures and increasing child compliance with adult directions. Managing parenting stress was the only common preference across income levels. Regarding strong non-preferences, middle-upper income ethnic minority caregivers expressed disinterest in learning alternatives to physical

discipline, planned ignoring, and monitoring children's behavior in the community. At the same time, low-income ethnic minority parents shared strong non-preferences for culturally-specific content and planned ignoring procedures as well as social and medical supports. Other low-income non-preferences included planned ignoring procedures and increased access to family and medical supports as the most closely related non-preferences shared across income groups.

PT Component Rankings Shared Between Specific Caregiver Preference Ranking Profiles Across Low-And Middle-upper Income Ethnic Minority Families

Agreement in parenting preferences across income groups. As described in Table 7 (Agreement in Parenting Preferences Across Income Groups), the most highly agreed upon preferred content areas across middle-upper income group (Culture-Centered, Coping-Centered, and Child-Centered) and low-income group (Active-Responsive and No-Nonsense) parenting profiles included familiarity with stages of child development, promoting developmentally appropriate child independence, effectively utilizing praise and social recognition, promoting child self-esteem, and helping children follow adult directions. Middle-upper income families expressed strong preferences for learning about stages of child development. Brief interview data demonstrated that Culture-Centered profile parents expressed strong preferences focused primarily on the potential efficacy of child development content to help them improve their parenting skills. More specifically, their preference was reportedly founded in the belief that the content would allow them to more effectively assess and intervene upon atypical development patterns in their children. For example, in response to item #31 in the post Q-sort interview, Culture-Centered profile parents reported "I want to be able to catch any underdevelopment or irregularities in my child ahead of time," and "it's important to know how to differentiate typical from atypical development so as a parent I can understand and catch anything (atypical) going on

with my child early.” Similarly, low-income families comprising the Active-Responsive parenting profile expressed strong preferences for the content, but emphasized the effects of stages in their children’s development on the parent-child relationship. According to brief interview data, their preference appeared to be based particularly on a desire for learning methods to increase social-emotional responsiveness by fitting their affection and communication to their child’s developmental level. For example, in response to item #31 in the post Q-sort interview, Active-Responsive profile parents reported “the mother and child have to connect at the (developmentally appropriate) level for the child so he can understand and learn from her.” When compared together, both income groups shared substantial quantitative agreement in their preferences to learn more about child development ($\kappa = 0.96$), but were qualitatively distinguished by the Culture-Centered profile focus on assessment of atypicality as compared to the parent-child relationship. Hence, while both groups shared similar ethnic identities and quantitative preference rankings, each parenting preference profile differed in their income level and their distinct qualitative rationales for supporting their preferences.

Middle-upper income families also expressed strong preferences for learning about promoting child independence. Coping-Centered profile parents emphasized both the importance of children’s autonomy and the need to prepare their children for the future. Brief interview data suggested they shared the belief that helping children become independent early in life would make them more resilient and better equipped to face future challenges. More specifically, the most common future challenges to children’s success included influences from negative peers or stereotypes. For example, in response to item #7 in the post Q-sort interview, Coping-Centered profile parents reported “I want my kids to not conform to the norm of the people around them,” and “to grow up believing more in themselves than in what others think about them in order to be

more focused and successful,” Low-income families reported similar foci, also emphasizing the importance of independence on preparing children for the future. Brief interview data from No-Nonsense profile parents included a desire to increase their children’s self-regulation in a way that would prepare them for school and other authority institutions that might not give children a second chance after making a mistake (e.g., getting suspended by school authorities or being arrested by law enforcement authorities). For example, in response to item #7 in the post Q-sort interview, No-Nonsense profile parents reported a desire to “help (their) child understand from an early age that they wouldn’t always get a second chance in school or in life if they are always in trouble with the other kids who ‘act a fool’ in class or out on the street.” When compared together, both income groups shared substantial quantitative agreement in their preferences and rationales for learning more about promoting developmentally appropriate child independence ($\kappa = 0.95$). At the same time, the two preference profiles were qualitatively distinguished by the Coping-Centered profile focus on resilience in the face of future challenges as compared to the No-Nonsense profile focus on adherence to authority (Lareau, 2011). Hence, while both groups shared similar ethnic identities and emphases on developing children’s independence and preparing them for the future, each parenting preference profile differed in their income levels and their distinct rationales for supporting their preferences.

In addition, middle-upper income families reported strong preferences for learning more about utilizing praise and other PT strategies utilizing social recognition strategies to consistently reinforce desired child behaviors over time. Child-Centered profile parents emphasized the importance of praise on enhancing the parent-child relationship and preparing children for the future. Brief interview data indicated a collective desire to facilitate children’s positive self-image and subsequent resistance to negative stereotypes in the future by providing frequent,

positive praise during parent-child interactions. For example, in response to item #14 in the post Q-sort interview, Child-Centered profile parents reported “We need to learn to recognize the (children’s) positives which helps (us) to act on the positives also and not look to the negatives of the child all the time” and “(giving praise) helps children learn to show love because that is what (parents) are teaching them.” Low-income families emphasized the importance of the parent-child relationship on developing children’s independence and preparing them for the future. Brief interview data from Active-Responsive and No-Nonsense profile parents demonstrated a desire to help their children learn to encourage themselves and others in order to promote lifelong habits of positive attitudes and activities. For example, in response to item #14 in the post Q-sort interview, Active-Responsive and No-Nonsense profile parents reported that parent encouragement “helps build (children’s) strength and be able to keep going even if they have a problem,” and “(children) learn to believe in themselves and know they can figure it out if they get stuck in school or have a problem with their friends.”

Furthermore, middle-upper income families expressed strong preferences for PT components promoting child self-esteem. When compared together, Child-Centered middle-upper income groups and both Active-Responsive ($\kappa = 0.85$) and No-Nonsense ($\kappa = 0.82$) low-income groups shared substantial quantitative agreement in their preferences and rationales for learning more about praise and social recognition strategies to consistently reinforce desired child behaviors over time, facilitating children’s short-term strengths and resilience, and resistance to long-term negative influences. At the same time, the income groups were qualitatively distinguished by the Child-Centered profile focus on future independence as compared to the Active-Responsive and No-Nonsense foci on future positive attitude and activities. Hence, while both groups shared similar ethnic identities and quantitative rankings

emphasizing the parent-child relationship and preparing children for the future, the parenting profiles differed in their income levels and their distinct qualitative rationales for supporting their preferences.

Coping-Centered profile parents focused on enhancing children's independence. Brief interview data demonstrated their belief that high self-esteem would help children learn to avoid negative stereotypes and create their own self-images rather than relying upon the opinions of others. For example, in response to item #26 in the post Q-sort interview, Coping-Centered profile parents reported that they, "want (their) child to be ready for teasing in middle school and later on in high school because their self-image starts at a young age and plays a big part in them being successful in life by not following the group or the norm and feeling ok with making decisions for themselves and not relying on the opinions of others." Low-income families also reported strong preferences for PT components promoting child self-esteem, emphasizing their desire to prepare their children for the future. Active-Responsive profile parents provided brief interview data focused on enhancing children's self-esteem in order to increase their strength and resoluteness, thereby preparing them for future challenges in life. For example, in response to item #26 in the post Q-sort interview, Active-Responsive profile parents reported "My child's self-esteem is part of what makes them strong so they can make something of themselves when they grow up and not matter where they come from." When compared together, both Coping-Centered and Active-Responsive parenting preference profile groups shared substantial quantitative agreement in reported preferences for learning about PT content involving development of children's self-esteem ($\kappa = 0.84$). At the same time, the two preference profiles were qualitatively distinguished by the Coping-Centered profile focus on self-reliance as compared to the Active-Responsive profile focus on resilience. While Coping-Centered profile

parents focused on their children's independent ability to develop a positive, strength-based self-image, Active-Responsive parents focused on preparing their children for the future. Hence, while both groups shared similar ethnic identities and quantitative ranking emphases, they also differed in their income levels and their distinct qualitative rationales for supporting their preferences.

Finally, middle-upper income caregivers also expressed strong preferences for learning to effectively help children follow adult directions, with Coping-Centered profile parents focused on preparing their children for the future. When compared together, both Coping-Centered and No-Nonsense preference profile groups reported quantitatively similar emphases on preparing their children for the future, with learning to follow directions recognized as an essential skill learning for learning respect for authority and safety by avoiding the potential risks that come from disrespecting authority (suspensions, arrests, police abuse). ($\kappa = 0.84$). At the same time, the two preference profiles were qualitatively distinguished by their different foci. Hence, while both groups shared similar ethnic identities and quantitatively ranked emphases on preparing their children for the future, they also differed in their income levels and their distinct qualitative rationales for supporting their preferences.

Brief interview data indicated that they collectively believed following directions would help their children at school and at work later in life. Following directions was also recognized as a mechanism for relieving daily parenting stress. For example, in response to item #8 in the post Q-sort interview, Coping-Centered profile parents reported that "children need firm and calm guidance to help them listen the first time, with no backtalk; it helps prevent everyone from getting frustrated because when they don't listen they learn to feed off of that and it can develop into problems and challenges that affect not just the child, but all of us in the family and in the

community.” Low-income families also reported a focus on following directions as a means to enhance the parent child relationship and prepare their children for the future. No-Nonsense profile parents shared brief interview data stating that following directions made the parent-child relationship more positive, thereby teaching children life-long lessons involving the benefits of compliance with rules from adult authorities. For example, in response to item #8 in the post Q-sort interview, No-Nonsense profile parents reported “My children need to be told all the time what to expect and what rules to follow so they learn to not get punished or get in trouble and they know not to push parents’ buttons or test limits.”

Agreement in parenting non-preferences across income groups. As described in Table 8 (Agreement in Parenting Non-Preferences Across Income Groups), the most highly agreed upon content areas for non-preferred learning across the parenting profiles between both middle-upper income group (Culture-Centered, Child-Centered) and low-income group (No-Nonsense, Active Responsive, and Passive-Permissive) included planned ignoring, integrating culturally relevant material, effective time-out procedures, and learning alternatives to physical discipline. Among the middle-income group, Culture-Centered profile parents shared brief interview data concerning perceived content ineffectiveness and current parenting-efficacy regarding planned ignoring. Several parents reported that they saw no benefit to ignoring inappropriate behaviors. More specifically, they described all forms of inappropriate behaviors as indicators of underlying problems that, if not addressed immediately, would be likely to develop into more severe and complex problems as children grow older. Moreover, many middle-upper income parents reported their belief that ignoring inappropriate behavior was a missed opportunity for teaching, and instead advocating for immediate verbal correction. As one parent stated in response to item #30, “Ignoring is choosing to pretend that the child is good all

the time; that the little child already knows right from wrong, and never engages in any inappropriate behavior.” Low-income families also expressed strong non-preferences of the content. No-nonsense profile parents provided brief interview data describing planned ignoring procedures as ineffective relative to their current parenting practices, particularly in preparing children for the future. Their reports involved the belief that ignoring their children’s undesired behaviors was “setting them up for failure;” that ignoring inappropriate behavior did nothing to prepare children for school or the workplace later in life. Low-income parents who shared non-preferences for planned ignoring instead advocated for immediately responding to inappropriate behavior by combining physical discipline with and verbal correction. When compared together, both income groups reported similar emphases on the ineffectiveness of planned ignoring, the effectiveness of their current parenting strategy alternatives, and the need to prepare their children for the future by setting appropriate limits. Both middle-upper and low-income parents shared advocacy for the necessity of immediate correction and the long-term risks associated with allowing inappropriate behaviors to be ignored ($\kappa = 0.99$). Hence, while both groups shared similar ethnic identities and quantitatively similar emphases on the ineffectiveness of planned ignoring, they differed in their income levels and their distinct qualitative rationales for supporting their non-preferences. More specifically, middle-upper income Culture-Centered profile parents’ non-preferences for learning about planned ignoring were based upon their perception that it was not effective simply because it resulted in a missed teaching opportunity. In contrast, low-income No-Nonsense profile parents’ non-preferences were based upon their perception that planned ignoring was not effective because children needed an immediate and intense response to correct in inappropriate behavior.

Middle-upper income parents also shared substantial agreement in their non-preferences for PT content integrating culturally relevant material. Child-Centered profile parents reported a focus on concerns emphasizing child independence. Brief interview data demonstrated an apparent focus on their children's identities as individuals being both separate from and more important than their identities as members of an ethnic minority cultural group. For example, in response to item #21 in the post Q-sort interview, Child-Centered profile parents reported "culture is important but it does not identify who my child is as a person or who I am as a parent." Low-income families also shared strong non-preferences for the same content. Active-Responsive profile caregivers provided brief interview responses describing integrated cultural content as important for their children. At the same time, they expressed a non-preference for learning about it in a PT context, citing their families and faith-based agencies as the preferred resources for integrating their culture into their caregiver roles. For example, in response to item #21 in the post Q-sort interview, Active-Responsive profile parents reported "Culture can come from kids being around family or at church; it shouldn't come from any classes for kids or parents." When compared together, both income groups reported quantitatively similar levels of agreement for non-preferred content involving integrating cultural content into PT ($\kappa = 0.931$) as well as qualitatively dissimilar rationales for their non-preferences. Hence, while both groups shared similar ethnic identities and quantitative agreement in non-preferences for integrating cultural content, they differed in their areas of emphasis and qualitatively distinct rationales for supporting those non-preferences.

Along the same lines, middle-upper income parents also shared substantial agreement in their non-preferences for learning effective time-out procedures. Child-Centered profile parents reported a focus on the ineffectiveness of the intervention as well as concerns emphasizing child

independence. Brief interview data responses from these parents described time-out was an unsustainable and unreliable disciplinary practice due to the time and energy required, especially as children continued into more advanced stages of physical and mental development. Moreover, time-out was perceived as detrimental to the development of the self-regulation and self-reliance skills necessary to foster independence. Instead, time-out was associated with children described as over-dependent on adults in their environment. For example, in response to item #4 in the post Q-sort interview, Child-Centered profile parents reported “Time out does nothing to teach children how they need to learn to control themselves; I don’t like it, my kids don’t like it, and they don’t learn anything from it so it doesn't work.” Low- income families shared substantial agreements in non-preferences with middle-upper income families. Passive-Permissive profile parents related their non-preferences for learning time-out procedures to high levels of implementation difficulty combined with low levels of intervention effectiveness. As a collective, brief interview responses from these parents described their lack of confidence in time-out and other limit-setting techniques because children with inappropriate behavior were naturally challenging and difficult to manage. Additionally, they identified time-out procedures as a stressor that was more likely to lead to increases in adult frustration and/or physical discipline than to decreases in children’s social, emotional, and behavioral challenges. For example, in response to item #4 in the post Q-sort interview, Passive-Permissive profile parents reported “it doesn’t help to chase (children) around while they keep trying to leave time out or cry and scream.” When compared together, both income groups reported similar emphases on the ineffectiveness of time out procedures ($\kappa = 0.93$). While middle-upper income parents cited threats to developing independence as a primary reason for non-preferences, low-income parents described their rationale as a desire to avoid the increased stress and decreased frustration

tolerance involved in time-out procedures. Hence, while both income groups shared similar ethnic identities and quantitative non-preferences, the qualitative social-political rationales supporting their non-preferences were distinctly different.

Finally, middle-upper income parents shared substantial agreement in non-preferences for learning alternatives to physical discipline. Culture-Centered profile parents emphasized their current level of parenting self-efficacy as their rationale for non-preference. More specifically, brief interview responses from these parents focused on their current knowledge and skills in the area; they already possessed an array of alternatives to physical discipline strategies. Among those most often used, parents cited verbal reprimands/explanations and removing privileges (e.g., access to preferred items or activities). For example, in response to item #9 in the post Q-sort interview, Culture-Centered profile parents reported “(avoiding physical discipline) is not a skill we need to work on in our home; it’s easy for us to parent our child with alternative strategies; like talking or taking away favorite toys instead of hitting; just verbal discipline is enough.” Similar to their middle-upper income counterparts, low-income families described their non-preferences in terms of confidence in their current repertoire of effective parenting strategies. Active-Responsive profile parents reported that their non-preferences also stemmed from emphases on maintaining a healthy parent-child relationship and the overall ineffectiveness of physical discipline strategies. These parents reported confidence in their abilities to use more effective means of discipline with less risk to the parent-child relationship, including strategies for providing or restricting praise and other social rewards. For example, in response to item #9 in the post Q-sort interview, Active-Responsive profile parents reported “We have to talk children through their problems so they learn from us how to talk and not learn to hit when things don’t go their way; when they get into (a problem) with other kids then they learn to come

to us or another grown person they know and look for help instead of hitting to fix whatever they are going through at that time.” When compared together, both income groups reported similar emphases on their existing abilities to discipline their children without having to resort to physical discipline, thus having non-preferences to learn more content in an area with which they were already familiar ($\kappa = 0.93$). Hence, while both income groups shared similar ethnic identities and quantitative agreement in non-preferences, the qualitative social-political rationales for supporting their non-preferences were substantially different.

Chapter 5: Discussion

Given the results of the Q-sort, the research hypotheses were collectively rejected. Regarding research question one, the Q-sort yielded Coping-Centered, Child-Centered, and Culture-Centered parenting preference profiles rather than the proactive authoritative, reactive authoritarian, and balanced profiles that were hypothesized based on previous research with low-income parents (Barnabas & Manz, in preparation). Coping-Centered parents prioritized PT component involving managing daily stress related to parenting as well as maintaining nurturing parent-child interactions. These parents expressed confidence in their existing abilities to communicate with educators and family members, balance physical and non-physical discipline strategies, and minimal cultural influences on parenting. Although the Coping-Centered profile did not match any of the hypothesized profiles, their unique combination of shared preferences and non-preferences most closely resembled the balanced hypothesized profile (e.g., a combination of preferences for both proactive authoritative components as well as reactive authoritarian components). While Coping-Centered profile parents reported regularly engaging in reactive parenting practices such as physical discipline (Borre & Kliewer, 2014), they also reported a desire to develop and utilize more proactive strategies through PT. Nevertheless, Coping-Centered profile parents mostly reported engaging in harsh discipline in reaction to experiencing parenting stress and frustration, not because of any expressed belief that PT sessions should involve a balance of both proactive and reactive strategies.

Child-Centered parents prioritized nurturance and attachment parenting, focusing on maintaining a loving and positive parent-child relationship by avoiding physical discipline and emphasizing praise or activity/social rewards to build children's self-esteem and parent-child bonding. Child-Centered profile parents were also distinguished by their disbelief in medication, and cultural influences on parenting (Graves Jr, & Serpell, 2013; Morgan, Hillemeier, Farkas, &

Maczuga, 2014; Zuckerman, Mattox, Sinche, Blaschke, & Bethell, 2014). Although Child-Centered profile preferences and non-preferences did not exactly match any of the hypothesized profiles, their responses did approximate the proactive authoritative hypothesized profile (e.g., authoritative style valuing praise, rewards, use of effective commands). While Child-Centered profile parents reported a desire to expand upon their existing foundation of social reinforcement and semi-egalitarian approaches to discipline, they also reported non-preferences for proactive child and family resources such as social support networks.

Culture-Centered profile parents valued teaching their children positive associations with culturally-relevant materials and maintaining high self-esteem despite negative social stereotypes (Baumann et al., 2015; Garner, Mahatmya, Brown, & Vesely, 2014). Other distinguishing characteristics for Culture-Centered profile parents included the belief that praise and social rewards were forms of bribery that encouraged children's sense of entitlement and dependency as well as advocating for the appropriate use of physical discipline (e.g., spanking). Although the Culture-Centered profile preferences and non-preferences did not match any of the hypothesized profiles, their responses closely approximated the reactive authoritarian hypothesized profile (e.g., authoritarian style valuing response-cost strategies and extinction procedures). While they did express a non-preferences for learning proactive parenting strategies (e.g., attending to appropriate child behaviors), they also communicated a desire for more proactive PT content to help them increase child independence. Most notable among Culture-Centered profile parents was their rejection of PT content focused on decreasing physical discipline, thereby supporting several examples of past research suggesting that traditional African-American parenting tend to be more authoritarian (Cain & Combs-Orme, 2005, Christie-Mizell, Pryor, & Grossman, 2008; MacKenzie, Nicklas, Waldfogel, & Brooks-Gunn, 2012).

Regarding research questions two and three, middle-upper income families' highest and lowest component preference rankings were unique in that no preferences were shared with low-income Active-Responsive profile caregivers, despite the Active-Responsive similarities to the hypothesized authoritative profile. (i.e., preferences for delivering social and material rewards, responding effectively to a child's tantrum behaviors, effective use of time out, and other specific behavioral components of PT). That is, none of the middle-upper income preference profiles shared the same sets of strongly-preferred and strongly non-preferred components as the low-income preference profile most similar to the hypothesized middle-upper income Authoritative profile. Hence, rejection of the hypotheses for the first three research questions was further supported.

Regarding research question four, middle-upper income families demonstrated a collective preference for PT components involving cultural relevance and the integration of cultural material into the content (i.e., Help my child understand may be viewed because of their culture, Discuss prejudice with my child and how to help him or her deal with it, Help my child have pride in his or her culture, Help my child increase his or her self-esteem; Baumann et al., 2015; Garner, Mahatmya, Brown, & Vesely, 2014). In comparison, middle-upper income families' collectively ranked preferences did not favor any components involving specific behavioral techniques (e.g., planned ignoring, praise and social reinforcement, time out from reinforcement; Ortiz & Del Vecchio, 2013). The lowest collectively ranked middle-upper income preferences not only included barriers to effective parenting components (increasing access to family social services and communicating child behaviors when under the supervision of other caregivers in the home), but also included planned ignoring and avoiding physical discipline. Two PT components, planned ignoring and communicating child behaviors when

under the supervision of other caregivers in the home, were shared amongst the lowest collective rankings of both low and middle-upper income respondents. Interestingly, avoiding physical discipline was one PT component highly ranked among low-income caregivers, but ranked amongst the lowest collective preferences for middle-upper income caregivers (Greene & Garner, 2012).

Regarding research question five, none of the hypothesized parenting profiles were yielded by the Q-sort. Hence, the hypothesized middle-upper income profiles (1) strong preferences for limit setting with strong non-preferences for active ignoring, 2) strong preferences for social and material rewards with strong non-preferences for using harsh punishment, and 3) strong preferences for active ignoring with strong non-preferences for limit-setting techniques) could not be confirmed. Instead, agreement between income groups specific to each profile appeared to depend upon the content of certain PT components that involved heterogeneous rather than homogeneous themes and related preferences or non-preferences across income groups as described below (LeCuyer, Christensen, Kreher, Kearney, & Kitzman, 2015). That is, shared component rankings between income groups appeared to depend on a variety of within-profile responses to qualitative themes amongst preferred and non-preferred PT components.

One Size Does Not Fit All: Heterogeneous Trends

Overall, the collective results of the study indicated an important lesson regarding research and conclusions involving specific population groups or sub-groups: one size does not fit all. For decades researchers have operated development and data analysis processes according to the statistical axiom that variability is always greater within groups than between groups. Yet research efforts to focus on the needs of a specific population or sub-group (e.g., at-risk students,

gifted students, families receiving free and reduced lunch) may also promote notions of homogeneity among target groups while neglecting important aspects of heterogeneity. These heterogeneous characteristics may better inform current and future efforts in applied research among specific target groups, and therefore should be emphasized rather than neglected or ignored in research.

Middle-upper income ethnic minority families in the current body of research literature appear to have been approached through a homogeneous perspective. Relative to middle-upper income majority populations, ethnic minority families that do not identify or qualify as low-income are rarely included as a specific target population in current research (Harris-McKoy, Brantley, Fincham, & Beach, 2014). Hence, nearly all information we have regarding middle-income ethnic minority families is based on either middle-income majority families (perspectives based on the notion that income has more influence on parenting outcomes than race and ethnicity) or low-income ethnic minority families (perspectives based on the notion that race and ethnicity have more influence on parenting than income). However, parenting beliefs and styles are distributed differently among ethnic minority families with differing developmental trajectories (Brody & Flor, 1998; Jabaghourian, Sorkhabi, Quach, & Strage, 2014; Mayo & Siraj, 2014).

Furthermore, as a burgeoning body of research is developing to meet the increasingly diverse needs of the U.S., a sociocultural discontinuity has emerged between the social and cultural capital of middle-upper income ethnic minority parents and their majority counterparts (Iruka, Dotterer, & Pungello, 2014). That is, culturally-specific parenting beliefs and behaviors have been demonstrated to mediate the relationship between socioeconomic status and social-behavioral-academic outcomes. Moreover, the social and cultural capital related to parenting

beliefs and behaviors outside of the ethnic majority have been conceptualized in terms of deficits rather than as contextually responsive or adaptive (Baker & Rimm-Kaufman, 2014; Garcia-Coll, et al., 1996). These results add to the growing literature demonstrating the necessity for researchers and practitioners to actively investigate the unique parenting and family needs of middle-upper income ethnic minorities and related sub-groups served by the fields of psychology and education.

In the current investigation, a homogenous perspective on family income or family race and ethnicity would have neglected the idiosyncratic needs expressed by each parenting profile and their preferences and non-preferences regarding PT content that current research identifies as essential for effective parent and child outcomes. As seen in the collective response (research question 4), utilizing a homogeneous perspective to collectively approach all middle-upper-income African-American parents in the study would have yielded results indicating a desire for PT components involving racial socialization and preparation for bias as well as developing cultural pride. The same approach among all low-income African-American parents in the study would have yielded results indicating a desire for PT components involving learning to avoid physical discipline and set limits using a combination of social reinforcement, time out from reinforcement, and other strategies often considered as traditionally behavioral approaches. Yet the idiosyncratic preferences expressed by each of the parenting profiles within both income groups demonstrated that a collective, homogenous perspective alone would have masked important within-group subtleties.

To date, so few studies have included middle-upper income African-American and ethnic minority participants that researchers in education, psychology, and human development do not yet know what PT components may be most meaningful (McNeil et al., 2010). Collective

preferences for middle-upper income African American parents in this investigation indicated a strong preference for culturally-related content (i.e., Help my child understand may be viewed because of their culture, Discuss prejudice with my child and how to help him or her deal with it, Help my child have pride in his or her culture, Help my child increase his or her self-esteem), indicating a possible need to include such content in PT programs in order make them more meaningful for middle-upper income African American parents. A possible explanation for these preferences may be a family process identified in the literature as racial socialization or Ethnic-racial socialization (ERS). In recent decades, ERS content has been recognized in peer-reviewed literature, describing a distinctive parenting issue among African-American families involving a process by which the family shapes children's attitudes about race over time and demonstrates how children fit into the racial context of their family in society (Hughes & Chen, 1999; Hughes, Rodriguez, Smith, Johnson, Stevenson, & Spicer, 2006; Julian, McKenry, & McKelvey, 1994; Mandara & Murray, 2001; Rotheram & Phinney, 1987).

More specifically, ERS has been identified as parent-child interactions that intentionally and unintentionally provide information about the nature of race status with specific components including group identity (pride in cultural and ethnic heritage, history, and traditional customs), preparation for bias (being aware of prejudicial and discriminatory actions/attitudes), promoting mistrust (increased wariness when interacting with individuals from different racial or ethnic groups) and egalitarianism (appreciating people from all different groups). More recently, Hughes and colleagues (2006) have redefined these processes as Cultural Socialization to include a variety of parent-child interactions and joint activities that operate together to communicate messages about the racial context in which the child is growing up. This was particularly true for the majority of middle-upper income African-American parents with higher levels of education

reportedly engaging in more frequent ERS activities than low-income parents of the same racial and ethnic background.

Although many cultural socialization practices have been regarded as occurring during adolescence, African-American parents, such as those in the current investigation, have been observed to engage in related processes with children in the 2-4 year old range (Hughes et al., 2006). More specifically, Cultural Socialization acts involving race awareness (parents teaching children about people have different skin tones) and group identity (parents teaching children to self-identify their family and/or group identity as African-American) are typically the most common among parents of young children. Mostly involving group identity and egalitarianism, African-American parents of young children like those involved in the current investigation have utilized cultural socialization as a protective factor to help prepare children against the negative effects of perceived racial discrimination (Harris-Britt, Valrie, Kurtz-Costes, & Rowley, 2007). Hughes and colleagues confirmed that parents' cultural socialization processes directly affect children's coping behaviors later in life, including decreases in internalizing and externalizing problems, confirming the potential for promoting resilience and building active-coping skills.

Contrary to the generalized emphasis on cultural socialization content among middle-upper income African-American parents in the current literature, the Q-sort results in this investigation indicated that only Culture-Centered profile parents would be likely to find cultural socialization content meaningful. Meanwhile, the Coping-Centered and Child-Centered middle-upper income caregivers actually expressed strong non-preferences for culturally-specific content (instilling cultural value in young children through parenting, improved understanding of the relationship between culture and parenting, increasing children's awareness of cultural differences and appropriate social responses). Hence, increased heterogeneous approaches hold

the potential to better inform PT researchers of methods to address current challenges to meaningful PT intervention programming by differentiating between strongly preferred and strongly non-preferred content within the same ethnic group. The heterogeneous differences in PT preferences related to cultural socialization exemplify the extent to which those challenges are related to factors involving family income and education, family race and ethnicity, and the idiosyncratic subtleties of specific subgroups that exist within intervention target populations (Tamis-LeMonda, Briggs, McClowry, & Snow, 2009).

The middle-upper income profiles derived from the Q-sort further the notion of heterogeneity beyond cultural socialization issues within groups of ethnic minority parents. Although several parenting goals or preferences appear universal across income and ethnic groups, the specific means to accomplishing those goals can vary according to participants' social and cultural contexts (Bornstein & Bradley, 2014). In this investigation, the three parenting preference profiles that emerged from the middle-upper income Q-sort reflect the heterogeneity of ethnic minority parents and caregivers, particularly those who self-identify as African-American. Middle-upper income African-American parents in each profile expressed concerns according to their unique beliefs and the social-cultural contexts that influenced those beliefs. Coping-Centered profile parents indicated that their social and cultural contexts were linked with parenting needs such as managing daily parenting stress while feeling more confident in their parenting and minimizing frustrations that might impair their relationships with their children. Child-Centered profile parents communicated that the most meaningful parenting needs from their perspectives were learning alternatives to physical discipline and improving parent-child interaction patterns in order to better maintain loving and positive parent-child relationships. Culture-Centered profile parents expressed that their social and cultural contexts

necessitated parenting beliefs that placed a high value on helping to teach their children positive associations with culturally relevant behaviors, perceptions, values, and attitudes in order to maintain high self-esteem despite negative social messages or stereotypes. For example, several parents mentioned that as their children were the only ones of color in their community, they wanted to protect them from feelings of isolation and/or negative self-image. Hence, these within-income ethnic minority profiles highlighted the importance of considering heterogeneity in population subgroups, particularly within ethnic minority populations, when developing parent and family-based interventions.

Although the heterogeneity within the middle-upper income ethnic minority parents was emphasized by their highest ranked preferences, important evidence of heterogeneity also emerged from their lowest, least meaningful content rankings. As a whole, middle-upper income ethnic minority parents ranked PT content involving communication and supervision of children's behavior in the home, connecting with family social services, using planned ignoring strategies, and avoiding physical discipline as lowest and least meaningful according to their collective social and cultural context. However, when making the same comparison across the middle-upper income profiles instead of a collective middle-income group, the heterogeneity of middle-upper income ethnic minority parents was made evident. The only strongly not preferred ranking shared within middle-upper income ethnic minority profiles was content involving avoidance of physical discipline for both Coping-Centered and Culture-Centered profiles. In terms of social and cultural contexts influencing parenting beliefs, Coping-Centered profile parents stated that they already knew how to avoid physical discipline and would not find any related PT content to be meaningful for them. At the same time, Culture-Centered profiles parents communicated that they endorsed physical discipline so long as it was not abusive,

leading them to find any related PT content less meaningful as well. In stark contrast, Child-Centered profile parents ranked PT content strategies to avoid physical discipline as strongly preferred and stated that they would find it meaningful to find ways to discipline their child without risking the quality of the parent-child relationship.

When comparing responses across income groups, learning to avoid physical discipline was the only strongly preferred ranking collectively shared between lower- and middle-upper income families. Similar to the middle-upper income Coping-Centered profiles, low-income Active-Responsive profiles indicated that they already knew how to avoid physical discipline. In the same manner as the middle-upper income Culture-Centered profiles, the low-income No-Nonsense profiles communicated that physical discipline is sometimes a necessary and effective tool for parents to teach their children. Finally, along the same lines as middle-income Child-Centered profiles, low-income Passive-Permissive profiles ranked learning to avoid physical discipline as one of the most meaningful and preferred content areas due to their desire to eliminate its use from their limited parenting repertoire. Each of these examples stands contrary to a body of research stating that as a group, African-American and other ethnic minority caregivers homogeneously find physical discipline and corporal punishment to be an adaptive and necessary commonplace parenting strategy (Adkison-Bradley, Terpstra, & Dormitorio, 2014; Bradley, 1998; Westbrook, Harden, Holmes, Meisch, & Vick, 2013).

At the same time, learning alternatives to physical discipline was a shared strong non-preference for both middle-income Culture-Centered and low-income Active-Responsive profiles. Neither profile expressed need to learn more about avoiding physical discipline as Culture-Centered caregivers reported knowing how and when to limit the use of corporal punishment within their repertoire of discipline strategies and Active-Responsive caregivers

reported having adequate alternative strategies. Both self-perceptions, either knowing when and how to use physical disincline (Culture-Centered) or not having to resort to physical discipline at all (Active-Responsive), would make it difficult for maltreatment prevention/intervention researchers to provide PT services with parents who believe they do not need such content.

Multiple examples in current research support the Culture-Centered profile assertions that a majority of African-American caregivers agreed that strict, rigid, and authoritarian discipline practices as adaptive methods by supportive parents to prepare their children to function well in a biased society. (Cain & Combs-Orme, 2005, Christie-Mizell, Pryor, & Grossman, 2008; MacKenzie, Nicklas, Waldfogel, & Brooks-Gunn, 2012). Overall, acceptance of physical discipline as viable strategy has appeared to be associated with a combination of both ethnic identity and daily stress in which African-American parents may be more likely to utilize corporal punishment as a tool in their cultural capital toolbox to more quickly terminate challenging behavior while experiencing brief or extended time periods of daily hassle stress (Ibanez, Borrego Pemberton, & Terao, 2006; Lee, 2009; Lansford, Deater-Deckard, Dodge, Bates, & Pettit, 2004; McLoyd, Kaplan, Hardaway, & Wood, 2007). Taylor and colleagues (2011) explored these possibilities through in-depth qualitative interviews with African-American parents, ascertaining that physical discipline was perceived as effective and necessary in situations when a child was being unsafe or disrespectful in order to prepare them for coping with future challenges and responsibilities in an expression of love (not harm). Given these results, the importance of understanding the heterogeneity of parenting beliefs, as well as the social and cultural contexts underlying those beliefs, prior to the development and implementation of EBP family-based interventions cannot be overstated.

One Size Does Fit Some: Homogeneous Trends

Despite the numerous examples of heterogeneity within ethnic and income groups in this investigation, agreement in preferences and non-preferences also highlighted a number of broad and narrow homogenous patterns within the sample. Agreement in preferences between income groups revealed a cluster of homogeneous highly ranked content. High levels of agreement in non-preferences made further homogenous patterns apparent as well. Fewer homogenous preferences than non-preferences were demonstrated within income groups, but nevertheless suggested insight into PT content with the potential for universally meaningful content among parents across income groups and within ethnic minority populations.

The most homogeneous agreement in PT content rankings resulted from comparisons involving preferences among profiles across income groups. Middle-income Culture-Centered and low-income Active-Responsive profiles shared high levels of agreement in their preferences for PT content to increase parent's knowledge of children's development. Although Culture-Centered profiles were focused on assessing atypical development and Active-Response profiles focused on a developmentally responsive parent-child relationship, both profiles shared a desire to learn more about and use developmental PT content to better their children's current and future lives in a way that they found to be meaningful. These results suggest that PT content involving child development knowledge may be widely applicable for ethnic minority parents regardless of income, albeit for different reasons. Middle-upper income ethnic minority parents may favor such content in order to equip themselves with knowledge necessary to catch and address any developmental delays before the child could be considered at-risk (Harry & Klingner, 2014). On the other hand, low-income ethnic minority parents may find the related potential to improve parent-child interaction to be more meaningful. Recent research has indicated that African-American mothers commonly associate parent knowledge of child

development with more sensitive and nurturing parent-child interactions (Huang, O'Brien, Caughy, Genevro, & Miller, 2005; Zand, Pierce, Thomson, Baig, Teodorescu, & Nibras et al., 2014). More specifically, knowledge of child development appeared to facilitate the parents' behavior toward their child during dyadic interactions as well as child's ability to learn from joint activities. Hence, it appears that including knowledge of child development components in future PT programs for ethnic minority families with young children may involve a variety of parent and child benefits.

In a further example of limited homogeneity in this investigation, middle-income Coping-Centered and low-income No-Nonsense profiles shared high levels of agreement in their preferences for PT content both to help parents increase children's independence and to increase compliance with adult directions. Despite their income differences, parents from each profile emphasized the importance of children becoming more independent while complying with authority in order to prepare them for the future by avoiding conformity with negative stereotypes or peers that may lead to dangerous consequences (e.g., being hurt due to following peer's negative actions or resisting authorities such as schools or police). While Coping-Centered profiles appeared to be seeking stress relief in PT content designed to support increased child independence and compliance, the No-Nonsense profiles appeared to be seeking means to better prepare their children for the future via fostering positive behaviors from an early age. Zand and colleagues (2014) demonstrated that increasing child compliance and developmentally appropriate independence at pre-school ages facilitated child social-emotional competence as well as child resilience and flexibility to health challenges experienced in the home and community. Moreover, related research suggested that parenting skills focused on increasing compliance and independence appeared to directly reduce disruptive and other problematic

behaviors in young children (Perrin et al., 2014). Thus, inclusion of these more homogeneous PT components in future PT programs may be more likely to result in meaningful parent engagement as well as desired child outcomes.

Middle-income Coping-Centered profiles also shared high preference rankings with low-income Active-Responsive profiles in their emphases to learn more ways parents can bolster children's self-esteem. Both profiles described self-esteem as a necessary foundation for developing children's independence and helping them define who they are for themselves rather than being defined by others. Across income groups, these ethnic minority parents seemed to share a homogeneous desire to protect their children from conformity to negative influences and negative stereotypes in the future by building their children's self-image and confidence. In their interviews with and observations of African-American mothers, Dyer and colleagues (2014) found that parenting oriented toward child self-esteem was associated with increased academic and social school readiness in preschool age children. Hilliard's (2002) review of African-American parent-child interaction included similar findings that children's later self-esteem and avoidance of internalizing negative stereotypes were directly dependent on parent behaviors toward and interactions with young children. Furthermore, Bean and colleagues (2003) found that African-American mother's efforts to support their children's self-esteem predicted later academic outcomes at the middle school level, validating some of the beliefs described in this investigation linking self-esteem with future success. Hence, recent research supports the mothers' notions that PT content oriented toward increasing children's self-esteem would likely meet their need for preparing their children for future success.

Finally, the most overlapping area of agreement in preferences for PT content was between middle-income Child-Centered profiles and both low-income Active-Responsive and

No-Nonsense profiles regarding their desire to improve in providing praise and social recognition for their children. Their shared priorities for improving praise and social recognition appeared to be rooted in mutual desires to help children stay focused on positive solutions to potential challenges later in life as well as their self-efficacy in addressing such challenges without dependence on others. Despite research indicating more authoritarian and harsh parenting devoid of praise among African-American caregivers (Cain & Combs-Orme, 2005; Christie-Mizell et al., 2008; Lee, 2009, MacKenzie et al., 2012), a number of African-American parents in both income groups this investigation expressed a desire for PT content to improve upon their self-perceived robust skills in delivering praise and social rewards. One possible explanation for this phenomenon could be the link between praise and future independence or successful avoidance of negative stigma or stereotypes expressed by the parents in the qualitative interviews override any reservations about utilizing praise. Likewise, Ortiz and Del Vecchio (2013) assert that the majority of PT content, including praise and social rewards skills, are already flexible enough to meet the needs of a variety of ethnic groups in a culturally competent manner. For example, Tucker and Herman's (2002) Model Program for African American parents utilized a focus on themes involving community-based partnership and self-empowerment to facilitate engagement in parenting groups rather than adding multiple African-American-specific components to existing PT content.

In addition to agreement in preferred PT content, agreement in rankings for non-preferred content also yielded a number of interesting homogenous patterns across income group profiles. Middle-income Culture-Centered and low-income No-Nonsense profiles shared strong non-preferences for PT content involving extinction procedures and planned ignoring. Both profiles emphasized their perceived ineffectiveness of these strategies both in the moment and in leaving

their children under-prepared for situations where troublesome behaviors may have immediate consequences in the future. Similarly, Middle-income Child-Centered and low-income Passive-Permissive profiles also shared homogeneous non-preferences across income groups for PT content involving effective time out procedures. Perceptions of overall ineffectiveness and implementation difficulty were shared across profiles despite their differences in income and education. Although one explanation for these rankings may be that PT content involving planned ignoring and time-out procedures is less meaningful overall for select African-American parents across income groups, recent research indicates that ethnic minority caregivers find these types of PT content more meaningful only after experiencing some first-hand success implementing the procedures correctly, particularly with in-person coaching (Morawska, Sanders, Goadby, Headley, Hodge, L., & McAuliffe, et al., 2011; Prinz & Dumas, 2004). Because the current investigation only dealt with parent beliefs regarding related PT content, no such first-hand experience was available for caregivers.

Beyond between-group agreement, agreement in preferences and non-preferences within income groups highlighted a number of other notable homogeneity patterns as well. Interestingly, the majority of homogeneous rankings emerged from parent profile non-preferences. Profiles in both middle-upper and low-income groups shared strong non-preferences for PT content involving the use of medicine and medical services involving children's social-emotional health and involving strategies and resources for overcoming community barriers to parenting. Unique to middle-income profiles, agreement was also shared in non-preferences for behavioral communication and recognition systems (e.g., token economies related to monitoring children's behavior in the community or under the supervision of a babysitter). The only shared agreement in preferences was among the low-income group,

with profiles sharing a high ranking for PT content to improve parent skills in providing praise and social recognition.

One of the strongest agreements in non-preferred PT content involved the use of medicine and medical services to address children's social-emotional health. Strong non-preferences were shared among Culture-Centered and Coping-Centered middle-upper income profiles as well as Active-Responsive and No-Nonsense profiles low-income profiles. Within the middle-upper income profiles, homogeneous patterns emerged involving perceived ineffectiveness, perceived detriment to the parent-child relationship, perceived impairment to children's independence, and mistrust of the medical care system involving the use of medicines in children. On the other hand, both low-income profiles described a perception of already being familiar with medical care for and the use of medicines with children, making any related PT content unnecessary and irrelevant.

When prompted to describe their familiarity in more detail, these parents shared their certainty about the same concerns expressed by their middle-upper income counterparts. One of the most plausible explanations for these findings may be that overall level of mistrust between the medical community and African-American or other ethnic minority parents in the sociopolitical context of the United States. Rajakumar and colleagues (2009) found that African American parents mistrusted medical service providers significantly more than European American caregivers, particularly among middle-upper income and highly educated African-Americans, perpetuating barriers to involvement in PT programs with content including medicine and medical services involving children's social-emotional health. Even among African-American caregivers whose children are experiencing chronic health challenges, relatively higher reports of stigma, mistrust, concerns about psychotropic medication (e.g.,

addiction risk), and non-adherence with medical regimens are significantly higher relative to European-American parents (Bailey & Owens, 2005; Butz, Lipkin, Anixt, Weiner, & Chernoff, 2006; Davison & Ford, 2001; Mychailyszyn, Myers, & Riley, 2007; Olaniyan, DosReis, Garriett, Mychailyszyn, Anixt, & Rowe, et al., 2007).

PT content involving strategies and supports to overcome community barriers to parenting was homogeneously perceived as ineffective due to parents' beliefs in their efficacy to overcome barriers on their own as well as a desire to develop children's independence and resilience. All three middle-upper income profiles shared the importance of teaching their children that negative community influences should be focused on as challenges overcome by the strength and quality of the parent-child relationship. The same was true for the Active-Responsive and No-Nonsense low-income profiles. Regarding behavior communication and recognition systems, Coping-Centered and Culture-Centered profiles shared a homogenous non-preference for related PT content. Both profiles expressed similar ideas involving perceived ineffectiveness of the content due to negative experiences with babysitters and childcare providers involving other adults providing poor supervision and/or examples of inappropriate behavior. Finally, agreement in a single shared preference indicated a slight homogeneous trend involving low-income Active-Responsive and No-Nonsense profiles' shared preference for PT content involving the use of praise and social rewards. Both profiles expressed a desire to learn more about praising their children and how to use it in a way that would build their children's resilience through self-efficacy and the ability to persevere through challenging circumstances. Across income groups and PT preference profiles, these findings amounted to a collective desire for PT content focused on building child and family resilience.

Ungar (2015, p.43) defines resilience as “a shared set of personality, cognitive, behavioral and sociopolitical protective factors for populations exposed to individual and collective adversity,” including variation in homogeneous and heterogeneous factors between cultures. Relationship building (praise and social rewards, high-quality parent-child relationship) and experiences of power and control (independently overcoming community barriers) are two culturally variant protective factors cited by Ungar that appear to fit the current PT investigation, with parent interaction playing a direct role in building at-risk children’s resilience (Bloir, 1997). Moreover, the effects of the resilience-building preferences expressed in this investigation appear to be bolstered when combined with ERS or cultural socialization practices such as those endorsed by the Culture-Centered profiles (Coard, Foy-Watson, Zimmer, & Wallace, 2007). Once they have been established in a family, these resilience factors even appear to be transmittable from generation to generation through positive and nurturing parenting interactions (Schofield, Conger, & Neppl, 2014).

Furthermore, when applied from community and public health perspectives, the relationship-building and independence over community barriers resilience factors may have the potential to fortify entire communities of families against mental health risks over multiple generations (Khanlou & Wray, 2014). For example, in their district-level ParentCorps intervention with African-American families parenting young children, Brotman and colleagues (2011) found significant improvement in parenting skills as well as reductions in child problem behaviors for components involving praise and social rewards as well as improving the quality of the parent-child relationship. Similarly, a 5-year Strengthening Families comprehensive parenting intervention involving resilience factors in parent-child interaction for at-risk families demonstrated residual improvement over time in family functioning domains such as parenting

efficacy, parent positivity, family communication, and family organization (Kumpfer, Whiteside, Greene, and Allen, 2010). Given the homogeneous preferences for praise/social rewards along with the near-ubiquitous non-preferences recognizing African-American families' potential for resilience in the face of barriers to parenting in this investigation, future PT services aligned with this content have the potential for both short and long-term PT engagement and effects.

Limitations & Future Research

A number of notable limitations were involved in this investigation. Primarily, the specific idiosyncrasies of Q-methodology involve inherent limitations such as small sample size and absence of the use of Cohen's (1977, 1992a, 1992b) power analysis. At the same time, the nature of Q-methodology inherently involves exploring the specific idiosyncrasies of a targeted population that is often challenging to reach and/or address using more typical aggregate data collection methods (e.g., middle-upper income ethnic minority parents of children 2-4 years old who are both willing and able to partake in face-to-face extended data collection sessions with unfamiliar research investigators). Hence, although the sample size limits external validity and overall generalizability, Q-methodology is designed to find key populations-specific information that may often be lost in aggregate analyses, such as the heterogeneous characteristics found among African-American parents regardless of income levels in this investigation (Block, 2008).

Another limitation involved the six caregivers who did not load significantly on their preferences for any meaningful pattern of PT components included in the Q-sort. Although they were included in the overall comparison of agreement between collective groups (Research Question 4), they were not identified in any of the specific parent profiles identified (Research Question 1). Hence, these six caregivers may help explain some of the unanticipated results involved in this investigation. For example, middle-upper income groups collectively ranked

culturally-related PT components as strongly preferred, but only one profile (Culturally-Centered) emerged as distinctively demonstrating preference for these components above and beyond that which could be accounted for by chance or error. These parents may also have constituted a group that was unique in some unanticipated aspect of SES or ethnicity. For example, these caregivers may have been raised in a low-income family and then transitioned into middle-upper income family through education and employment in adulthood. Alternatively, they may have been among the only caregivers who had ethnically divergent families of origin but self-identified as African American or Hispanic while involved this study. Measures of caregiver racial identity development status (pre-encounter, encounter, immersion/emersion, internalization) may also have provided further insight into subjective differences (Tatum, 1992, 2003). In the future, limitations like these could be better evaluated if more information were collected regarding caregiver family of origin, follow-up or in-depth interviews specifically with caregivers who did not fall into distinct profiles, or other methods to further assess unique characteristics among those caregivers.

Along the same lines, geographic limitations of the sample introduced inherent variability that was likely to have affected the preference rankings and profiles derived in this investigation. Within income groups, middle-income caregivers may have differed substantially in their perspectives on parenting strategies in accordance with differences in local geographic norms. For example, the majority of middle-upper income Hispanic/Latino parents in this investigation anecdotally reported first or second generation immigrant status from a variety of South and Central American countries, while the remaining middle-upper income caregivers did not report immigrant status. Levels of acculturation alone could have accounted for differences in parenting preferences in such an example (Rusch, Frazier, & Atkins, 2015). Similarly, middle-

upper income African-American families in primarily rural geographical areas of central Pennsylvania would likely differ in some parenting perspectives from ethnically similar parents raising children in the urban locations of southeast Pennsylvania (Miller & Votruba-Drzal, 2013).

Along the same lines, the majority of the sample in both the low-income and middle-income samples was African-American, with only 12 % of each income group self-identifying as Hispanic/Latino. While it was necessary to match the numbers of African-American and Hispanic/Latino parents across income groups, the tradeoff was a loss of insight into the degree of similarities and differences in differences in parenting between ethnic groups. For example, Hispanic parents in both income groups may have been more likely to have differing perceptions of cultural, behavioral, and other PT components based on their current levels of acculturation (Rusch, Frazier, & Atkins, 2015). At the same time, recent research has highlighted evidence that Hispanic mothers may be likely to find the use of praise and social rewards acceptable while rejecting planned ignoring and the avoidance of physical discipline (Calzada, Basil, & Fernandez, 2013).

Furthermore, within Hispanic/Latino communities, parent beliefs in proactive and positive strategies or more harsh strategies can vary by language and exposure to differing psychosocial and socioeconomic risks (Martin, Fisher, & Kim, 2012). Between African-American and Hispanic/Latino ethnic groups, Ethnic-racial socialization (ERS) has been recorded as manifesting quite differently: while African-American families focused on ERS endorsed parenting beliefs aligned with the Culture-Centered profile parents in this investigation, Hispanic/Latino variations of ERS have appeared to differ according to native language competency and related levels of acculturation (Calzada, Huang, Anicama, Fernandez, &

Brotman, 2012; Priest, Walton, White, Kowal, Baker, & Paradies, 2014). In sum, although the overall Hispanic/Latino population only comprised 12% of the sample, these caregivers represented a heterogeneous variety of viewpoints and perspectives that would have provided vital insight into preferred PT components if the sample population had been more ethnically diverse.

Other related limitations involve potential experimenter bias as the Q-sorts and interviews were completed, as well as participant reaction/fatigue to the data collection process and social desirability or other response characteristics (Block, 2008). Reactivity to the forced choice methods and unfamiliarity with the Q-sort may also have led to challenges involving accuracy of participant reports. The settings for data collection were not uniform as some parents could only meet in the home, while others preferred to meet in libraries, childcare centers, eateries, or other community venues. The parenting Q-sort designed specifically for this investigation had also not established validity or standardization at an aggregate level. A strict protocol for Q-sort data collection, including a warm-up practice sort and standardized response during interview questioning, was designed and applied in order to minimize potential threats to validity in these areas. Moreover, the forced-choice time-intensive nature of the Q-sort minimizes social desirability effects and other response characteristics.

Given these limitations, future research should involve comparisons of similar populations using statistical methods designed to assess or identify person-level profiles combined with interview data analysis. Carpenter and Mendez (2013) used a within-group research design and person-centered cluster analysis to identify multidimensional profiles of parenting styles and parenting practices among low-income African American mothers. Their results yielded a variety of adaptive and resilient parenting profiles, each closely related to child problem

behaviors. Repeating similar methods with aggregate samples of middle-upper income African American or other ethnic minority parents would be an appropriate step to follow-up and verify details regarding the prevalence of heterogeneous profiles within ethnic minority consumers or potential consumers of PT services. Along the same lines, exploring heterogeneous profiles within income groups in the future could provide further bases for designing PT content to meet the differentiated needs within a given group targeted for PT services.

Furthermore, future investigations would benefit from recording caregivers' previous experiences with or exposure to PT prior to completing the Q-sort. Caregiver experience with different PT components, or lack thereof, may have been a factor affecting overall rankings within and between profiles. For example, parents who had experience with components such as planned ignoring and time-out may rank them higher than parents without experience who are responding to perceived impressions rather than firsthand experience with implementing difficult parenting strategies with guidance and coaching.

Conclusions

The current investigation began with an inquiry into the fit between PT intervention content and specific, subjective preferences within either SES or ethnic groups. Rather than identifying a content fit within an ethnic or SES group as a whole, the research hypotheses were collectively rejected as preliminary findings instead indicated that the ethnic minority groups often generalized in the current literature may be far more heterogeneous than expected. Since Forehand and Kotchick's (1996) call to more thoroughly investigate the fit between European-American derived PT content and the needs identified by ethnic minority parents, researchers have approached and written about specific ethnic groups as though they were homogeneous. Based on the statistical axiom that variability is always greater within groups than between

groups, this notion that PT content can be fit or adapted to the needs of a specific ethnic or SES group involves an inherent fallacy. Each ethnic and SES group is not homogeneous. One size does not fit all. Instead, prevention and intervention target groups are made up of a number of heterogeneously unique subgroups, making it virtually impossible to develop and apply a single model of PT content that will be meaningful and engaging.

In their recent review of PT content effects among ethnic minority groups, Ortiz and Del Vecchio (2013) assert that PT interventions over the past 15 years have appeared to be equally effective across a variety of populations, when able to be received by present and engaged families, regardless of ethnicity. These equal effects appeared to have manifested regardless of the inclusion of culturally-adapted content modified to fit a specific cultural context of targeted stakeholders. Based on their findings, Ortiz and Del Vecchio recommended that researchers break from a sole focus on ethnicity as a moderating factor affecting the contextual fit of PT interventions. Additionally, the authors recommended any foci on ethnic difference in PT interventions involve actual findings of more in-depth or complex models of ethnicity, such as the heterogeneous profiles depicted in the current investigation, in order to better explain any cultural differences observed.

As demonstrated in the current investigation, middle income Child-Centered and low-income Active-Responsive parents reported significant agreement in their non-preferences for PT components involving culturally relevant adaptations. While Child-Centered profiles cited culture as less important than individual identity and Active-Responsive profiles described family and faith as superior in influence, both profiles shared an emphasis on the minimal relevance of culture in parenting and PT content. This sentiment is aligned with Ortiz and Del Vecchio's (2013) overall recommendation to utilize well-established PT interventions with

enough flexibility to work effectively with participant differences. More specifically, the authors recommended enough flexibility to allow parents to choose their own goals according to their cultural needs and childrearing practices.

Hence, tools and methods like the Parenting Q-sort in this investigation could be used to identify the specific needs of any populations receiving PT intervention services and differentiate delivery of the content to specifically fit families' needs. Lyon and colleagues (2014) examined the utility of a modular design to facilitate the flexible delivery of established psychological interventions for ethnically diverse participants. Using a tool like the Parenting Q-sort, future PT researchers could identify specific parenting preference profiles in the subjective populations they serve and use that information to differentiate PT instruction and deliver the most meaningful modules first to best meet the needs of the parents they serve as early as possible in intervention delivery. In close relation, Mytton and colleagues (2014) completed a review of qualitative studies investigating barriers and facilitators to parents' engagement PT interventions. Their conclusions identified differences in researcher versus participant opinions regarding the most meaningful components of PT interventions, emphasizing the need for PT program developers and deliverers to actively investigate the views of their target participant audience.

Tools and methods such as those involved in the Parenting Q-sort utilized in this investigation would provide an effective means to specifically identify the subjective needs of a given PT target group and deliver the most meaningful content to them first. Until PT researchers engage in efforts to closely assess the in-depth and subjective parenting needs perceived by their heterogeneous participants, the field is likely to continue experiencing low engagement in what would otherwise be an effective intervention model in PT. With the PT intervention proven track record for ameliorating individual, family, and community challenges

involving children's externalizing behaviors and parent-child dysfunction, delivering content to families in a way that they find subjectively meaningful must be made a priority in applied research. If PT researchers actively work to investigate the heterogeneous nature of the ethnically and economically specific groups we serve through tools and methods like the Parenting Q-sort in this investigation, more aggregate cluster analyses such as those utilized by Carpenter and Mendez (2013), or similar pre-intervention needs assessments, then perhaps an established model for engaging a variety of diverse parents with subjectively meaningful content can be developed.

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Table 1

Demographic Data for Middle and Low Income Caregivers

	Middle Income (<i>N</i> = 40)		Low Income (<i>N</i> = 40)	
Matching Demographic Data				
Caregiver Ethnicity	African American	88%	African American	88%
	Hispanic / Latino	12%	Hispanic / Latino	12%
Child Age	<i>M</i>	3.2 years	<i>M</i>	3.6 years
	<i>SD</i>	0.8 years	<i>SD</i>	0.7 years
	Range	2-4 years	Range	2-4 years
Caregiver Language	100% English		100% English	
Caregiver Gender	Male	17%	Male	17%
	Female	83%	Female	83%
Other Demographic Data				
Caregiver Age	<i>M</i>	35.71 years	<i>M</i>	31.27 years
	<i>SD</i>	5.84 years	<i>SD</i>	9.46 years
	Range	23-44 years	Range	21-59 years
Caregiver Income	Less than 10K	0%	Less than 10K	46%
	10-15K	0%	10-15K	13%
	15-20K	0%	15-20K	20%
	20-25K	0%	20-25K	9%
	25-30K	0%	25-30K	12%
	30-40K	31%	30-40K	0%
	40-50K	8%	40-50K	0%

	50-60K	6%	50-60K	0%
	60-70K	5%	60-70K	0%
	70-80K	6%	70-80K	0%
	80-90K	5%	80-90K	0%
	90-100K	31%	90-100K	0%
	More than 100K	8%	More than 100K	0%
Caregiver Education*	Less than high school	0%	Less than high school	20%
	Some high school	0%	Some high school	17%
	High school / GED	20%	High school / GED	30%
	Some college	2%	Some college	30%
	2 year college degree	17%	2 year college degree	3%
	4 year college degree	27%	4 year college degree	0%
	Advanced degree	49%	Advanced degree	0%
Caregiver	Not employed	24%	Not employed	53%
Employment**	Part time	12%	Part time	20%
	Full time	64%	Full time	27%

* $X^2 = 18.46$, $p < .01$

** $X^2 = 6.37$, $p < .01$

Table 2

Specific Q-sort Procedures

Sequence of Steps	Specific Procedures
1	Caregiver(s) are asked to read through the items and become familiar with them, then sort them into three piles: those with which the subject agrees on the right, those to which the subject disagrees on the left, and those which the subject finds either neutral, ambivalent, or uncertain in the middle.
2	Statement cards are spread out under distribution markers while maintaining the left to center to right relationships.
3	Caregivers select the items that are most agreeable under the highest distribution marker on the right (e.g., +2).
4	Caregivers select the items that are most disagreeable under the highest distribution marker on the left (e.g., -2).
5	Caregiver returns to the right and selects items to fit in the next highest distribution marker (e.g., +4), but is free to switch items with those under other distribution markers.
6	Caregiver returns to the left and selects items to fit the next highest distribution marker on the left (e.g., -4), and is again free to switch desired items.
7	Items are placed under the middle distribution marker (0) after all the positions to the left and right have been filled. Once the caregiver decides all items are placed correctly, the Q-sort is complete.

Table 3

Example Factor Array

Statement	Factor Scores	
	A	B
1. Teach parents to develop relationships with other community members	+2	+2
2. Teach discipline ideas that include rewards for children such as fun activities or toys	-2	+2
3. Teach parents how and when to give attention to their children	-1	-2
4. Teach parents effective ways to use time out	+1	0
5. Teach parents to help their children solve problems using words instead of physical violence	+2	+2
6. Teach parents how to deal with daily stressful events	+1	-1
7. Teach parents ways to help their children become independent (being ok playing by themselves, not crying when their mom leaves the room)	+2	-2

Table 4

Q-sort Factor Loading Data

Loadings	Factors		
	Coping-Centered	Child-Centered	Culture-Centered
1	.56*	.08	-.39
2	.66*	.39	.19
3	.27	.19	-.18
4	.73*	-.27	.11
5	.48*	.14	.17
6	.33	.44*	.24
7	.29	.43*	.14
8	.06	-.03	.55*
9	.43	.48*	.19
10	.78*	-.10	.30
11	.21	.49*	.27
12	.07	.18	.58*
13	.02	.15	.30
14	-.03	.43*	-.10
15	.26	-.57*	.28
16	-.14	-.23	.52*
17	.17	.32	.04
18	.60*	.11	-.04

19	.46	-.19	.64*
20	.73*	.19	.14
21	.65*	.00	.08
22	.56*	.42	-.12
23	.45	-.16	.54*
24	.64*	.20	.18
25	-.18	.36*	.22
26	.21	.14	.61*
27	.61*	.07	.60
28	-.20	.64*	.09
29	.16	.39	.39
30	-.18	.11	.22
31	.23	-.28	.51*
32	.36	.64*	-.09
33	.28	.24	-.01
34	.48*	-.05	.39
35	.59*	.42	.12
36	.20	.13	.82*
37	-.05	.39	.49*
38	-.04	.02	.52*
39	.16	.72*	-.04
40	.39	.11	.71*

*indicates a significant loading

Table 5

PT Preference Factor Z-Score Rankings

PT Component (item number)	PT Preference Factor	
	Coping-Centered Z-score (-2.0 to 2.0)	Ranking
Problem solve when I get frustrated or upset (24)	1.88	Strongly Preferred 1
Solve specific problems with my child (13)	1.69	Strongly Preferred 2
Help my child increase self-esteem (26)	1.50	Strongly Preferred 3
Know my own strengths and weaknesses (23)	1.42	Strongly Preferred 4
Choose and use medicine with my child (22)	-1.76	Strongly Non-Preferred 1
Get in touch with teachers and other people in my child's school (15)	-1.69	Strongly Preferred 2
Get in touch with family social services (20)	-1.57	Strongly Preferred 3
Ignore my child's bad behavior (30)	-1.42	Strongly Preferred 4

	Child-Centered Z-score (-2.0 to 2.0)	Ranking
Show warmth and care toward my child (16)	1.87	Strongly Preferred 1
Stay away from hitting, spanking, or slapping my child (9)	1.79	Strongly Preferred 2
Help my child prepare for school (25)	1.34	Strongly Preferred 3
Praise my child when he or she is doing the right thing (10)	1.31	Strongly Preferred 4
Choose and use medicine with my child (22)	-2.00	Strongly Non-Preferred 1
Address community barriers (19)	-1.40	Strongly Non-Preferred 2
Help my child keep our culture alive (21)	-1.35	Strongly Non-Preferred 3
Understand how culture affects my parenting (34)	-1.21	Strongly Non-Preferred 4

	Culture-Centered Z-score (-2.0 to 2.0)	Ranking
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Help my child understand how he/she may be viewed because of culture (33)	2.00	Strongly Preferred 1
Discuss prejudice with my child and how to help (35)	1.73	Strongly Preferred 2
Help my child have pride in his or her culture (12)	1.67	Strongly Preferred 3
Learn about child development (31)	1.36	Strongly Preferred 4
Choose and use medicine with my child (22)	-2.00	Strongly Non-Preferred 1
Address community barriers (19)	-1.40	Strongly Non-Preferred 2
Help my child keep our culture alive (21)	-1.35	Strongly Non-Preferred 3
Understand how culture affects my parenting (34)	-1.21	Strongly Non-Preferred 4

Table 6

Collective PT Component Rankings for Middle-Upper and Low Income Groups

PT Component (item number)	Income Group	
	Middle-Upper Income Z-Score (-2.0 to 2.0)	Ranking
Help my child understand how he/she may be viewed because of culture (33)	1.64	Strongly Preferred 1
Discuss prejudice with my child and how to help (35)	1.59	Strongly Preferred 2
Help my child increase self- esteem (26)	1.45	Strongly Preferred 3
Help my child have pride in his or her culture (12)	1.20	Strongly Preferred 4
Stay away from hitting, spanking, or slapping my child (9)	-1.84	Strongly Non- Preferred 1
Ignore my child's bad behavior (30)	-1.62	Strongly Non- Preferred 2
Get in touch with family social services (20)	-1.50	Strongly Non- Preferred 3
Know if my child is	-1.44	Strongly Non-

	Low-Income Z-Score (-2.0 to 2.0)	Preferred 4 Ranking
behaving at home (27)		
Help my child solve problems with words instead of hitting (5)	2.17	Strongly Preferred 1
Set limits and not “give in” when my child has bad behavior (17)	1.67	Strongly Preferred 2
Praise my child when he or she is doing the right thing (10)	1.51	Strongly Preferred 3
Stay away from hitting, spanking, or slapping my child (9)	1.47	Strongly Preferred 4
Understand how my culture affects my parenting style (34)	-1.77	Strongly Non- Preferred 1
Have better relationships with extended family (18)	-1.59	Strongly Non- Preferred 2
Choose and use medicine with my child (22)	-1.48	Strongly Non- Preferred 3
Ignore my child’s bad	-1.25	Strongly Non-

Table 7

Agreement in Parenting Preferences Across Income Groups

Parenting Preferences	Middle-Income Preference Profiles	Low-Income Preference Profiles	<i>Kappa</i> Agreement
Learn About Stages in My Child's Development	Culture-Centered	Active-Responsive	$\kappa = .96$
Help My Child Develop Independence	Coping-Centered	No-Nonsense	$\kappa = .95$
Use Praise and Social Rewards	Child-Centered	Active-Responsive	$\kappa = .85$
	Child-Centered	No-Nonsense	$\kappa = .82$
Increase Child's Self-Esteem	Coping-Centered	Active-Responsive	$\kappa = .84$
Help My Child Follow Directions	Coping-Centered	No-Nonsense	$\kappa = .84$

Table 8

Agreement in Parenting Non-Preferences Across Income Groups

Parenting Preferences	Middle-Income Preference	Low-Income Preference	<i>Kappa</i>
	Profiles	Profiles	Agreement
Planned Ignoring	Culture-Centered	No-Nonsense	$\kappa = .99$
Culturally Relevant Materials	Child-Centered	Active-Responsive	$\kappa = .93$
Effective Time-Out Procedures	Child-Centered	Passive-Permissive	$\kappa = .93$
Alternatives to Physical Discipline	Culture-Centered	Active-Responsive	$\kappa = .93$

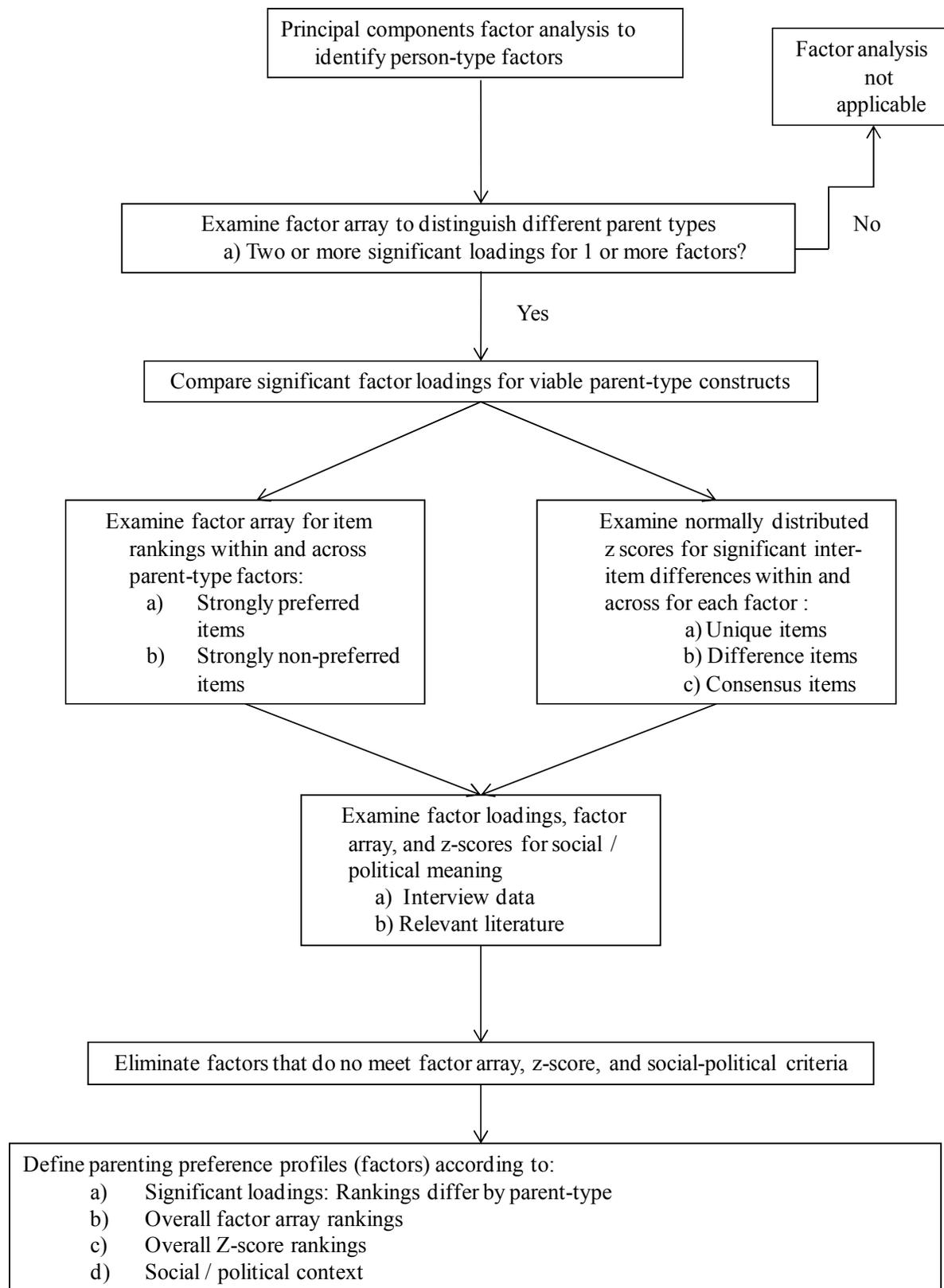


Figure 1: Q-sort Data Analysis Procedures

Appendix A

PT Q-sort Items

1. Meet other families with young children
2. Guide my child's behavior using rewards like fun activities or toys
3. Give attention to my child and good times to do it
4. Use time out with my child
5. Help my child solve problems with words instead of hitting
6. Deal with daily stress
7. Help my child be independent (being ok playing by himself or herself, not crying when I leave the room)
8. Help my child when they don't listen (following directions the first time, no talking back)
9. Stay away from hitting, spanking, or slapping my child
10. Praise my child when he or she is doing the right thing
11. Understand why my child sometimes has bad behavior
12. Help my child have pride in his or her culture
13. Solve specific problems with my child (getting ready for bed, waking up in the morning, stealing, lying)
14. Recognize my child's positive and good behavior
15. Get in touch with teachers and other people in my child's school
16. Show warmth and care toward my child
17. Set limits and not "give in" when my child has bad behavior
18. Have better relationships with extended family (aunts, uncles, cousins, and so forth)

19. Address community barriers (crime, not many jobs) that prevent me from reaching my goals
20. Teach me good ways to get in touch with family social services like medical care and food banks
21. Help my child keep our culture alive
22. Choose and use medicine with my child
23. Know my own strengths and weaknesses as a caregiver
24. Problem-solve when I get frustrated or upset with my children
25. Help my child prepare for school
26. Help my child increase his or her self-esteem
27. Know if my child is behaving at home
28. Know if my child is behaving in my community
29. Know if my child is behaving in school
30. Ignore my child's bad behavior
31. Learn about important stages in my child's development
32. Feel more confident in my parenting style and feel better about how I parent my children
33. Help my child understand how others in society may view him or her because of their culture
34. Understand how my culture affects my parenting style
35. Discuss prejudice with my child and how to help him or her deal with it.
36. Help my child learn about religion and spiritual health

Appendix B

Q-SORT PARENT COMMENT SHEET

1. Were any cards hard to sort or understand? Please list the statements and tell why.

a. Card number: _____

Why was it hard to sort or understand? _____

How would you change the card? _____

b. Card number: _____

Why was it hard to sort or understand? _____

How would you change the card? _____

c. Card number: _____

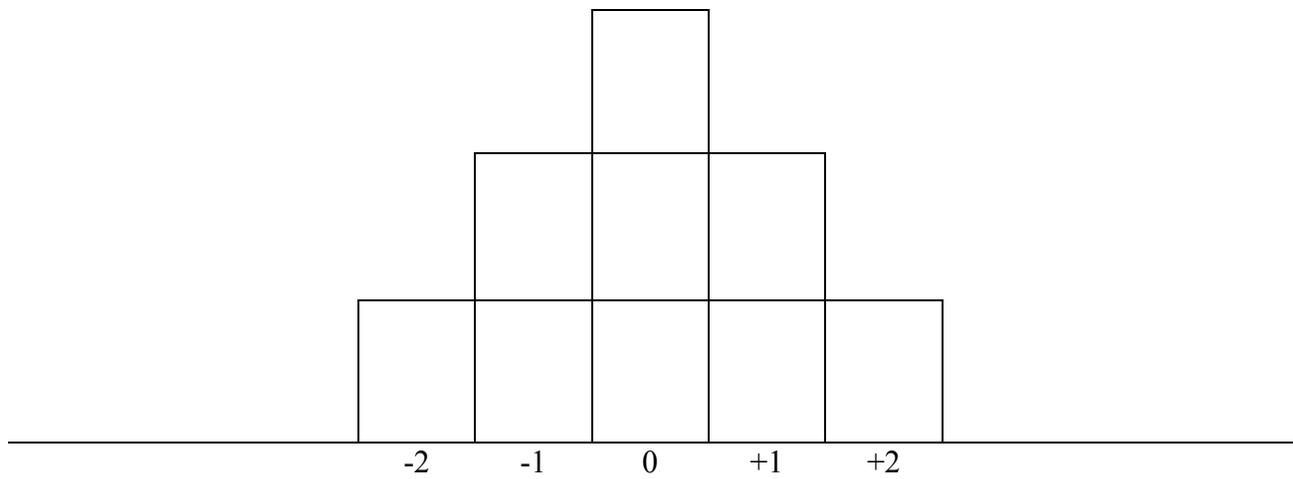
Why was it hard to sort or understand? _____

How would you change the card? _____

**We welcome any other comments you have about the Q-sort (please write them below).
Thank you for your help!**

Appendix C

Q-sort Distribution Marker Visual Model



-2 = Strongly Non-preferred **-1 = Non-preferred** **0 = Neutral** **1 = Preferred** **+2 = Strongly Preferred**

Appendix D

Post Q-sort Interview Questions

1. I see you chose items (___, ___, ___, and ___ items placed in Strongly Preferred) as Strongly Preferred. Can you tell me more about what made you decide to place item ___ in Strongly Preferred? (Continue for each item)
2. I see you chose items (___, ___, ___, and ___ items placed in Strongly Non-Preferred) as Strongly Non-Preferred. Can you tell me more about what made you decide to place item ___ in Strongly Non-Preferred? (Continue for each item)

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- Family-Based Interventions
- Conjoint Problem-Solving Consultation
- Low-Income and Ethnic Minority Families
- Bilingual (English-Spanish) Families