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Implementation Strategies to Improve the Delivery of Parent-Child Interaction Therapy among Spanish-Speaking Families

A Dissertation submitted in partial satisfaction of the

requirements for the degree Doctor of Philosophy

in Counseling, Clinical, and School Psychology

by

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To my parents, siblings, partner, mentors, friends, and ancestors.

VITA OF BERTA ERIKA LUIS SANCHEZ
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PUBLICATIONS

Barnett, M.L., Bernal, N.A. & Luis Sanchez, B.E. (2020). Direct-to-Consumer marketing for Parent-Child Interaction Therapy: Impact of language and messenger. *Journal of Child and Family Studies, 29*(71). https://doi.org/10.1007/s10826-019-01575-6

Barnett, M. L., Klein, C. C., Gonzalez, J. C., Luis Sanchez, B. E., Green Rosas, Y., & Corcoran, F. (2021). How do lay health workers engage caregivers? A qualitative study to enhance equity in evidence-based parenting programs. *Evidence-Based Practice in Child and Adolescent Mental Health*, *00*(00), 1–15. https://doi.org/10.1080/23794925.2021.1993111

Barnett, M. L., Luis Sanchez, B. E., Green Rosas, Y., & Broder-Fingert, S. (2021). Future directions in lay health worker involvement in children's mental health services in the U.S. *Journal of Clinical Child and Adolescent Psychology*, *00*(00), 1–13. https://doi.org/10.1080/15374416.2021.1969655

Davidson, B. C., Davis, E., Cadenas, H., Barnett, M., Luis Sanchez, B. E., Gonzalez, J. C., & Jent, J. (2021). Universal Teacher-Child Interaction Training in early special

education: A pilot cluster randomized control trial. *Behavior Therapy, 52*(2), 379-393. https://doi.org/10.1016/j.beth.2020.04.014

Flores, I., Consoli, A. J., Gonzalez, J. C., Luis Sanchez, B. E., & Barnett, M. L. (2021). "Todo se hace de corazón:" An examination of role and identity among Latina promotoras de salud. *Journal of Latinx Psychology*. https://doi.org/10.1037/lat0000194

Klein, C. C., Luis Sanchez, B. E., & Barnett, M. L. (2021). Improving the quality of children's mental health care with progress measures: A mixed-methods study of PCIT therapist attitudes. *Administration and Policy in Mental Health and Mental Health Services Research*. https://doi.org/10.1007/s10488-021-01156-0

Klein, C. C., Luis Sanchez, B. E., Gonzalez, J.C., Flores, I., Green Rosas, Y., & Barnett, M. L. (2020). The role of advocacy within community-partnered research with Lay Health Workers in Latinx communities (promotoras de salud). *The Behavior Therapist, 43*(7), 250–253.

Luis Sanchez, B.E., Klein, C., Tremblay, M., Rastogi, M., Corcoran, F., & Barnett, M.L. (2023). Adapting to unprecedented times: Community clinician modifications to Parent-Child Interaction Therapy during COVID-19. *Evidence-Based Practice in Child and Adolescent Mental Health.* https://doi.org/10.1080/23794925.2023.2238741

Luis Sanchez, B. E., Klein, C. C., Corcoran, F., & Barnett, M. L. (2022). A mixed-methods study of clinician adaptations to Parent-Child Interaction Therapy - What about culture? *Evidence-Based Practice in Child and Adolescent Mental Health*, 1–17. https://doi.org/10.1080/23794925.2022.2070883

Luis Sanchez, B. E., Urbina, E., & D'Anna-Hernandez, K. L. (2020). Sociocultural stressors across the perinatal period and postpartum depression in women of Mexican descent. *Cultural Diversity and Ethnic Minority Psychology, 26*(1), 124–133. https://doi.org/10.1037/cdp0000278

BOOK CHAPTERS

Barnett, M. L., Ramos, G., Luis Sanchez, B. E., Green Rosas, Y., & Harms, M. (In Press). PCIT with Latine and Spanish-speaking families. In A. T. Scudder, T. Hembree-Kigin & C. B. McNeil (Eds.) Clinical Handbook of Advancements in Parent-Child Interaction Therapy. Springer.

ABSTRACT

Implementation Strategies to Improve the Delivery of Parent-Child Interaction Therapy among Spanish-Speaking Families

by

Berta Erika Luis Sanchez

Parent-Child Interaction Therapy (PCIT) is an evidence-based practice (EBP) for young children with challenging behaviors. PCIT has been adapted to treat varying clinical presentations and culturally diverse families, including Mexican American families. Although efforts have been made to disseminate PCIT into community settings, which often serve clinically complex, socio-culturally diverse, and marginalized communities, barriers to disseminating adapted models remain. Additionally, when EBPs are implemented in community settings, ad-hoc adaptations to interventions are inevitable to meet the needs of the clientele served. However, past research has found that community clinicians rarely adapt or tailor PCIT to address their clients' cultural backgrounds. These findings indicate that community therapists may benefit from support on how to adapt treatment for ethnically diverse families. Furthermore, Spanish-speaking clinicians may have other unique training and supervision needs when delivering PCIT. The current study used methodology from the field of implementation science to determine adaptations needed for 1) intervention materials, 2) training, and 3) ongoing supervision so that Spanish-speaking therapists are

supported in their delivery of PCIT. Clinicians who endorsed providing PCIT in Spanish or PCIT trainers who endorsed training and/or consulting with Spanish-speaking therapists were recruited to participate. Thirty-one participants completed quantitative measures, and ten also completed semi-structured qualitative interviews. Quantitative results indicated that Spanish-language PCIT was moderately acceptable (M = 3.83, SD = 0.48; 2.40 – 4.90), as was Spanish-language PCIT training and supervision (M = 3.88, SD = 0.79; 1.20 – 5.00). Qualitative analysis expanded on quantitative findings, showing a split between provider experiences. Participants reported that when implementation strategies had been adapted to address the needs of Spanish-speaking families they were extremely satisfied with their training and supervision; clinicians expressing dissatisfaction commonly commented on a lack of support or adaptations to training and supervision hindered their ability to provide PCIT for their Spanish-speaking Latinx families. Providers noted how establishing and facilitating access to ongoing and systematically adapted training and consultation could reinforce their ability to deliver Spanish-language PCIT. Implications for adapting training and supervision to better support Spanish-speaking therapists delivering EBPs are discussed.

Keywords. Parent-Child Interaction Therapy, Adaptations, Spanish, Implementation

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I. Purpose

Parent-Child Interaction Therapy (PCIT) is an evidence-based parenting program that successfully reduces challenging behaviors among youth ages 2-7 years old (Lieneman et al., 2017). PCIT clinicians coach parents in-vivo through a 2-way mirror, working to strengthen the parent-child bond and establish consistent approaches to discipline (Niec, 2018; Kaminski & Claussen, 2017). PCIT consists of two phases. In the first phase, the goal is to support the caregivers' use of positive parenting skills (e.g., labeled praises, reflections, and descriptions of caregiver-approved behaviors) to strengthen the parent-child attachment and build a strong foundation for the second phase, where parents learn to implement consistent and safe disciplinary strategies (i.e., timeout) that do not risk endangering the parent-child bond. Not only has PCIT proven effective in preventing and reducing externalizing and internalizing symptoms (Niec et al., 2016; Chase & Eyberg, 2008) and child maltreatment (Chaffin et al., 2004), but also in lowering caregiver stress (Niec et al., 2016) and depression (Timmer et al., 2011), and in improving parental responsiveness to their children (Niec et al., 2016). The empirically based intervention follows a clear protocol and uses standardized measures to monitor progress and assess clinical outcomes.

Notably, multiple efficacy studies, which test whether interventions yield appropriate results under optimal conditions (i.e., under a rigorous research protocol), have provided support for adapted PCIT protocols to treat diverse clinical presentations (e.g., anxiety-related behavioral challenges) and racially and ethnically diverse families, including

Spanish-speaking Latinx[1] families (Comer et al., 2018; Cotter et al., 2018; Hansen & Shillingsburg, 2016; Matos et al., 2009; Matos et al., 2006; McCabe et al., 2012). Though systematic cultural adaptations to the PCIT protocol for Mexican-American families were shown to be effective (McCabe et al., 2012; McCabe & Yeh, 2009), barriers to disseminating adapted protocols remain to meet the various cultural, clinical, and linguistic needs of families served within community mental health. Instead, most training efforts for PCIT have focused on the standardized protocol. While intervention materials are available in Spanish, these are infrequently used in training, are not refined, and may not be congruent with the complexity and richness of the Spanish language. The richness within. Indeed, within-group heterogeneity amongst Latinx families, including variants of the Spanish language and the diversity of idioms used across Spanish-speaking regions, likely contribute to difficulties in determining a single adapted model that would serve all Spanish-speaking clients. Instead of developing a single adapted version of PCIT in Spanish, individualized tailoring strategies are likely necessary, which requires specific attention to clients' cultural beliefs and values (Bernal et al., 2009).

Undoubtedly, implementation of evidence-based practices (EBPs) in community settings often requires ad hoc adaptations to address clientele needs as well as navigate environmental (e.g., agency) factors (Barnett et al., 2018; Lau et al., 2017; Meza et al., 2019). Previous research suggested that therapists engage in ad hoc or on-the-ground adaptations to make EBPs fit for their clients. For instance, Kim et al. (2020) analyzed the

[1] According to the National Latino/a Psychological Association Ethical Guidelines (2018), Latinx is the preferred gender-neutral term for referring to individuals of Latino origin.

types of adaptions therapists made and the rationale for adaptions during individual sessions across multiple EBPs in community settings. The researchers reported that ad hoc adaptations occurred in 60% of sessions, which were primarily driven by child age and clinical presentation. Similarly, Barnett et al. (2018) reported on a qualitative study including a sample of predominantly Latinx clinicians (61%) delivering various EBPs to predominately Latinx children and families within community mental health. In their study, Barnett et al. (2018) found that clinician adaptations to EBPs primarily responded to child and family characteristics, including clinical presentations and emergent life events, but not culture. Similarly, Luis Sanchez et al. (2022) found that therapists delivering PCIT reported engaging in adaptations to PCIT in response to clinical presentation, but adaptations due to the client's culture were rare. When cultural adaptations were discussed, these were primarily concerned with tailoring the language and presentation of PCIT when explaining concepts to match idioms or phrases that Spanish-speaking parents used (Luis Sanchez et al., 2022). Noteworthily, 30% of clinicians in Luis Sanchez et al.'s (2022) study reported working with ≥50% Latinx caseloads. The American Psychological Association's (APA) Task Force on Re-envisioning the Multicultural Guidelines for the 21st Century published ten guidelines recommending seeking to understand the role that context, identity, and intersectionality play in providing care (APA, 2017). Specifically, the multicultural guidelines call for using culturally adaptive interventions and advocacy and conducting culturally appropriate and informed research to provide high-quality care for ethnically diverse populations (APA, 2017). APA's multicultural guidelines, combined with the above findings on ad hoc adaptations to EBPs such as PCIT, point to the need to improve cultural responsiveness to adequately serve ethnically and linguistically diverse families.

Beyond focusing on the adaptations that therapists make to the EBPs themselves to improve fit, it has been increasingly recognized that implementation strategies (e.g., training, supervision, and consultation) also need to be adapted to appropriately support clinicians delivering interventions in Spanish (Miller et al., 2021; Oquendo-Figueroa et al., 2021). The crucial role that training, supervision, and consultation play in the dissemination and implementation of EBPs such as PCIT is well established (Bearman et al., 2017; Becker et al., 2011; Herschell et al., 2009; Jackson et al., 2017; Nadeem et al., 2013; Powell et al., 2014). The challenges clinicians face when delivering services in Spanish, as well as recommendations to support them, have also been documented (Castano et al., 2007; Oquendo-Figueroa et al., 2009; Valencia et al., 2018; Vendinelli et al., 2021). Yet, specific research on implementation strategies to support clinicians in delivering EBPs in Spanish remains lacking. For example, for bilingual therapists working with Spanish-speaking families, proper ongoing implementation support entails accessibility to adequately translated materials and, ideally, bilingual training, consultation, and supervision.

Studies on implementation outcomes have informed on the implementation strategies that facilitate or can complicate the successful implementation of PCIT (Beveridge et al., 2015). Implementation strategies, such as training, ongoing supervision, and consultation, have all been shown to lead to increased therapist knowledge and attitudes toward PCIT and decreases in child behavioral problems (Funderburk et al., 2015; Herschell et al., 2021; Jackson et al., 2017). Clinicians training to deliver PCIT have also reported on challenges associated with supervision and consultation format, with live feedback and individual supervision being preferred (Christian et al., 2014). However, any ad hoc modifications to implementation strategies specifically to support Spanish-speaking PCIT providers are

virtually unknown. Therefore, to increase equity in providing PCIT and other evidence-based treatments, it is critical to understand the types and nature of implementation strategies that increase therapist capacity and cultural responsiveness in working with Spanish-speaking Latinx families. The current study used methodology from the field of implementation science, the Framework for Reporting Adaptations and Modifications to Evidence-based Implementation Strategies (FRAME-IS; Miller et al., 2021), to answer the following research questions in an effort to inform the development of structured implementation strategies that can be tested to enhance equity in service delivery for Spanish-speaking families.

Research Questions

1. What provider characteristics influence PCIT implementation outcomes for Spanish-language PCIT?
    a. Quantitative methodologies were used to measure PCIT clinicians' and PCIT supervisors' acceptability and satisfaction with Spanish-language training and analyze provider characteristics, which may be associated with acceptability and training satisfaction.
2. What is the content and nature of modifications made to PCIT implementation strategies to support the Spanish delivery of PCIT?

Informed by the FRAME-IS, qualitative semi-structured interviews were developed to:

    a. Inquire about ad-hoc adaptations and modifications made to systematic training and ongoing supervision and consultation in response to linguistic needs encountered in the Spanish delivery of PCIT.

b. Inquire about additional adaptations/modifications that could enhance Spanish PCIT implementation outcomes.

II. Background

A. Spanish Service Access and Utilization

Improving mental health services for families speaking a language other than English (e.g., Spanish), is critical for several reasons. Firstly, 13.2% of the U.S. population (roughly 41 million) speaks Spanish (exclusively or in addition to English) at home (American Community Survey, 2020), making Spanish the second most spoken non-English language in the U.S. and making it the second country with the most Spanish speakers after Mexico (Thompson, 2021; Pew Research Center, 2022). Secondly, immigrant, Spanish-speaking individuals are more likely to encounter a greater number of barriers to accessing and utilizing mental health care, despite mental health service need (Bridges et al., 2012; Triplett, 2015). For instance, in a sample of adult immigrants, 39% met diagnostic criteria for at least one mental health disorder, and 31% identified the lack of services in Spanish as a primary barrier to accessing services (Bridges et al., 2012). When Spanish-speaking individuals do access services, the interventions are less likely to be evidence-based (U.S. Department of Health and Human Services, 2001).

For practices to be considered evidence-based, they must have undergone a multi-phase empirical process, from intervention development to efficacy trials (i.e., randomized controlled trials) to effectiveness studies, which evaluate outcomes under conditions that approximate community settings as compared to previously established effective interventions (Horvitz-Lennon, 2020). Some concerns with EBPs include the research-to-practice gap, given the length of time required to establish an evidence base, and the fact that evidence tends to be more aligned with homogenous groups, which may not resemble clients served in community settings (Beahm & Cook, 2021; Horvitz-Lennon, 2020).

Therefore, some have advocated for the use of practice-based evidence, which establishes evidence-based through the exchange of knowledge based on history, experience, and comparisons in collaboration with key stakeholders, for example, community members and providers (Barkham & Margison, 2007; Beahm & Cook, 2021; McDonald and Viehbeck, 2007). Nevertheless, EBPs are acceptable and effective for minoritized youth, including Latinx youth; hence, their implementation has been highly encouraged (Pina, Polo, & Huey, 2019). An approach that combines evidence-based practice and practice-based evidence is to study how community clinicians adapt EBPs to make them fit for the diverse communities they serve (Kim et al., 2020; Yu et al., 2022).

While the majority of mental health care providers remain primarily White and English-speaking (Lin et al., 2020; Salsberg, et al., 2020; The Justice Collective, 2021), they serve a significant percentage of Spanish-speaking clients (Luis Sanchez et al., 2022). This highlights the need to diversify the provision of mental health care across the board (Mokrue, 2022; NLPA, 2017). More specifically, there needs to be a significant increase in the number of providers of evidence-based mental health services, such as PCIT, to increase reach and acceptability among Spanish-speaking communities (Mokrue, 2022; The Justice Collective, 2021)While efforts to improve the recruitment of bilingual providers increase, providing quality training and support for current providers is crucial to ensuring they continue meeting the needs of the Spanish-speaking Latinx community.

B. Parent-Child Interaction Therapy (PCIT)

One EBP that has been widely implemented in community settings, including with Spanish-speaking families, is PCIT (Lyon & Budd, 2010; Pearl et al., 2012; Scudder et al., 2017; Timmer et al., 2016; Woodfield et al., 2022). PCIT has an extensive evidence base

(Brabson et al., 2019; Thomas et al., 2017; Valero-Aguayo et al., 2021; Ward et al., 2016) and employs the following empirically-supported strategies: 1) emphasizing the parent-child relationship, 2) using standardized assessments to inform treatment, and 3) using in vivo feedback (i.e., coaching) to help parents develop parenting skills. Treatment is provided in two phases: Child Directed Interaction (CDI) and Parent-Directed Interaction (PDI) (Herschell et al., 2002; Lieneman et al., 2017). During the CDI phase, parents learn the PRIDE skills, which include providing labeled (specific) praises for, reflecting, imitating, and describing appropriate child behaviors, and enjoying the parent-child interaction. Parents are also taught to selectively attend to appropriate child behaviors and ignore minor attention-seeking behaviors. PCIT therapists provide coaching in vivo to increase parents' skill acquisition and to help parents apply the skills correctly. During the second phase, PDI, parents continue using these positive parenting skills in addition to learning and being coached to successfully implement discipline strategies (i.e., an effective and developmentally appropriate time-out sequence) as a consequence of child misbehavior and non-compliance. Successful progress through PCIT is based on parental proficient use of skills and decreased child disruptive problems; the PCIT protocol incorporates weekly administration of standardized assessments (e.g., parent report of child behaviors and behavior observations of parent-child interactions) to inform treatment and monitor progress.

C. Cultural Adaptations to PCIT

Culturally adapted PCIT models have been developed and tested to fit the diverse cultural backgrounds of families (Baumann et al., 2015), including Mexican-American families (McCabe et al., 2012; McCabe et al., 2005; McCabe & Yeh, 2009). Particularly,

Guindos a Niños Activos (GANA) is a culturally adapted form of PCIT that showed efficacy in reducing child externalizing symptoms for Mexican American families and was even more effective than standard PCIT in reducing child internalizing symptoms (McCabe et al., 2012; McCabe et al., 2005; McCabe & Yeh, 2009). GANA aimed to increase the cultural fit of PCIT by re-framing the intervention to reduce stigma and shame, focusing more time on building rapport, including pictures and materials relevant to Latinx and Hispanic culture and demographics, and increasing clinician cultural responsiveness through additional cultural training. Adaptations incorporated in the GANA protocol were intended to augment the delivery of PCIT for Mexican American families while maintaining core components of the intervention.

Cultural adaptations of EBPs, such as the GANA program, have been informed by theoretical frameworks highlighting systematic adaptation processes, which delineate when and how to adapt and who should be involved in adaptation decisions (Baumann et al., 2015; Bernal et al., 1995; Domenech Rodríguez & Wielding, 2004; Lau, 2006). These models largely promote an augmentation approach to cultural adaptations. That is, they recommend adding components to treatment to make it more culturally relevant, for example, using relevant idioms or metaphors to frame interventions, addressing known risk factors for disorders in the target community, or lengthening the treatment to provide more opportunities to acquire skills that may be culturally unfamiliar (Bernal et al., 2009; Chu & Leino, 2017; Lau, 2006). Several meta-analyses reveal that culturally adapted interventions demonstrate moderate to large effect sizes on clinical outcomes (Benish et al., 2011; Cabral & Smith, 2011; Hall et al., 2016; Smith & Cabral, 2011; van Mourik et al., 2017). However, when adapted protocols are compared to original protocols, effect sizes are small or non-

existent (Hall et al., 2016; Stirman et al., 2017). Lastly, creating adapted models to fit the characteristics of individual cultural groups would be impractical, given the diversity both between and within cultures and the changing nature of cultural norms, and has the potential to lead to stereotyping families based on cultural affiliation rather than addressing aspects of the intervention relevant to individual families (Cabassa & Baumann, 2013; Stirman et al., 2017). Such an outcome would be inconsistent with ethical guidelines for improving services for Latinx communities (NLPA, 2018). Because community-based clinicians typically have culturally diverse caseloads with complex clinical presentations (Park et al., 2018), it is also possible that they are already employing ad hoc adaptations to address their client's unique needs.

D. Adaptations and Implementation within Community Implementation

Learning from therapists' practice-based expertise in delivering EBPs could further inform implementation and dissemination efforts (Chambers & Norton, 2016; Green, 2008). Consistent with an implementation science framework, adaptations to EBPs occur naturally when transported into the community (Barnett et al., 2018; Lau et al., 2017; Meza et al., 2019). Community clinicians may adapt interventions to meet clients' needs or to improve client engagement (Gibbs et al., 2016; Ramos et al., 2021; Stirman et al., 2013). These adaptations are often driven by concerns regarding the relatively low number of racially and ethnically diverse populations represented in clinical trials of EBPs (Miranda et al., 2005). Furthermore, clients in community settings tend to be more clinically complex due to greater co-morbidity rates and greater exposure to trauma and poverty (Merikangas et al., 2010; Southam-Gerow et al., 2012). Additionally, community-based providers may share demographic traits, such as cultural, racial, or linguistic backgrounds, with clients, enabling

them to adapt treatment by, for example, communicating in a client's native language or integrating culturally familiar values and metaphors into treatment (Ramos et al. 2021). Nonetheless, it should not be the therapist's sole responsibility to ensure the fit of EBPs such as PCIT for diverse families. Valencia-Garcia and Montoya (2018) called for attending to additional burdens placed on Spanish-speaking trainees when expected to be competent in providing services in Spanish given their bilingual or native-Spanish speaker status. Therefore, understanding how to adapt training and supervision to best support Spanish-speaking therapists delivering EBPs for their Spanish-speaking clients is crucial to continue increasing access to culturally sensitive interventions.

Frameworks for studying EBP adaptations have been developed and are useful in investigating the process, nature, and outcomes of clinician-driven adaptations for Spanish-speaking Latinx families. Stirman et al. (2019) developed the Framework for Reporting Adaptations and Modifications-Expanded (FRAME), which helps implementation researchers examine adaptations and modifications of EBPs in a multifaceted and comprehensive manner. In their framework, Stirman et al. (2019) recommend focusing on both the process of adaptation and the reasons for adapting. In order to understand adaptation process, they suggest investigating when and how changes were made, whether changes were planned or unplanned, who determined changes needed to occur, the content/nature of changes, and whether changes remained fidelity consistent. Similarly, Lau et al. (2017) reported findings from a system-wide reform of children's community mental health services to understand how therapists adapt multiple EBPs; their findings indicated that community therapists engage in two types of adaptations: 1) Augmenting adaptations, which entail making additions to EBPs (e.g., tailoring presentation of strategies, integrating

supplemental content, and lengthening the treatment or slowing the pacing); 2) Reducing/Reordering adaptations, which entail disengagement from some elements or structure of the original practice (e.g., omitting components, reordering components, or shortening the treatment or quickening the pacing). In a study of community implementation of multiple EBPs with a predominately Latinx client population, Lau et al. (2017) found that Latinx therapists appeared to make more extensive Augmenting adaptations than non-Latinx, White therapists. Barnett et al. (2018) expanded on these findings with qualitative interviews and found that clinicians reported engaging primarily in augmenting adaptations that tailored the language, terminology, and presentation to frame interventions, lengthened or extended the pacing of interventions, and integrated supplemental content into interventions. It has been suggested that community clinicians may adapt EBPs to meet the needs of their culturally diverse clients (Lyon et al., 2014). However, more research is needed to determine whether community clinicians receive adequate training and supervision to continue serving their ethnically diverse and Spanish-speaking clients to ensure equity in the provision of care.

E. Service Delivery of PCIT

While limited, research pertaining to the Spanish delivery of PCIT has indicated the experiences of Spanish-speaking Latinx families in this EBP are unique (Heymann et al., 2022; Ramos et al., 2018). Particularly, skills acquisition, a key feature determining family progress and readiness in PCIT, may be equally impacted by family and therapist characteristics. Past research has found Spanish-speaking Latinx parents to use more controlling behaviors (e.g., giving commands), which PCIT aims to decrease throughout treatment (Ramos et al. 2018). Additionally, therapist coaching styles have also been found

to differ depending on the language of delivery in PCIT, which could impact parent outcomes in treatment (Green-Rosas et al., 2022; Heymann et al. 2022). Lastly, while not extensively, therapists delivering PCIT to Spanish-speaking families in community settings have been reported to adapt the intervention; for example, Luis Sanchez et al. (2022) found that therapists reported tailoring the language used to explain PCIT concepts, such as labeled praises (a positive parenting skill to praise specific, positive, parent-approved child behaviors such as being respectful) to match idioms or phrases that Spanish-speaking parents used. Evidently, meeting the linguistic needs of Spanish-speaking Latinx families in PCIT is essential to ensure successful treatment completion. This further highlights the need for tailored implementation strategies to support the effectiveness and sustainability of parent training interventions such as PCIT delivered in Spanish to achieve equity in children's mental health provision.

F. Implementation Strategies in EBPs

Implementation strategies are defined as methods and techniques to augment the adoption, implementation, and sustainability of EBPs (Proctor et al., 2013). From an implementation science approach, the goal is to understand the process (i.e., the how) underlying implementation strategies (Powell et al., 2014; Proctor et al., 2012). That is, what types of implementation strategies are effective, and what adaptations are needed to increase efficacy. Past research has documented the nature of implementation strategies and the varying types of implementation strategies. Regarding the nature and content of implementation strategies, it has been highlighted that training, supervision, and ongoing consultation as implementation strategies play a crucial role in EBP implementation and sustainment (Barnett et al., 2021; Novins et al., 2013). For example, Bearman et al. (2013)

reported on the efficacy of supervision that involves modeling and role-playing of strategies to increase therapists' ability to use strategies in subsequent sessions in implementing CBT for anxiety, CBT for depression, and a behavioral parent training program for conduct disorder. Additionally, agency and supervision support have been directly linked with therapists' positive attitudes toward EBPs (Jensen-Doss et al., 2009) and improved child behavior problems (Funderburk et al., 2015). Barnett et al. (2021) reported on findings from a large-scale PCIT implementation suggesting that clinician participation in additional training and having a within-agency trainer influenced PCIT sustainment.

Examples of the types of implementation strategies include single-component and multi-faceted implementation strategies. The former typically entails dissemination efforts to spread the reach of intervention or services to other settings, while multi-faceted implementation strategies are characterized by multiple, often step-wise components, including training, supervision, ongoing consultation, and feedback (Edmunds et al., 2013; Powell et al., 2014). Multifaceted implementation strategies can also be described as packaged strategies, as they are often developed and utilized to aid the implementation of a specific EBP, such as PCIT.

G. PCIT Implementation Strategies

To date, the three most frequently used training models to implement PCIT and their outcomes have been summarized (Herschell et al., 2021). Firstly, cascading training models (a.k.a. train-the-trainer models) seek to train eligible, experienced clinicians within an agency to be able to train future cohorts within the agency. Secondly, learning collaborative models tend to have a team-based approach involving multiple organizations with staff involved at varying levels within organizations and utilize several delivery formats (e.g.,

virtual and in-person training). Thirdly, distance education models allow trainees to learn interventions independently by accessing all training materials, including video reviews. Across the board, these training models have been associated with improved implementation outcomes to varying degrees, including increasing clinician capacity for EBPs, knowledge and attitudes towards EBPs, and client outcomes (Christian et al., 2014; Funderburk et al., 2015; Herschell et al., 2021; Proctor et al., 2011). As effective as these training models have been, research on whether such models are equally effective in implementing PCIT in Spanish and whether modifications need to be made to support bilingual Spanish-speaking trainees remains lacking.

H. Implementation Strategies for Spanish-Speaking Providers

Past research incorporating the perspectives of English-Spanish bilingual providers delineated the need for special attention to be given to linguistic competence and responsiveness in early childhood interventions (Sattler et al., 2022). Interviews with parent coaches trained to deliver an evidence-based home-visitation intervention suggested that while the bicultural identities of parent coaches strengthened their capacity to deliver the intervention, limitations in the accessibility of translated materials and accessibility to bilingual supervisors were noted and often led to parent coaches having to spend more time preparing and translating for each session (Sattler et al., 2022). Additionally, specialized training and supervision may be needed to ensure proper translation of often formal and academic language to accessible terms in Spanish. This would be consistent with calls to conceptualize and address language competency as an essential aspect of cultural responsiveness in mental health care provision (Valencia-Garcia & Montoya, 2018) and the acknowledgment that therapists' bilingual abilities do not automatically equate cultural

responsiveness (Castaño et al., 2007; Estrada et al., 2018).

I. EBP Adaptation Frameworks for Spanish Service Delivery

Most research has focused on measuring the adaptations therapists make to EBPs (Lau et al., 2017); recently, emphasis was placed on the importance of understanding adaptations needed for implementation strategies (e.g., training, supervision) to support clinicians (Miller et al., 2021). The FRAME-IS was developed to provide a framework for identifying and investigating modifications made to implementation strategies to ensure the intended implementation outcomes are successfully achieved. This adaptation implementation framework allows for documenting modifications to implementation strategies through four core and three supplementary modules (Miller et al., 2021). Core modules are related to identifying the EBP being implemented, what is being modified (e.g., training content), the nature or type of modification (e.g., tailoring), and the goal of such modifications (e.g., linguistic responsiveness). Supplemental modules relate to when modifications occur, whether modifications are planned, who is involved in the modification-making process, and the reach of modifications (e.g., individual, group of clients). Informed by the FRAME-IS, the proposed study sought to investigate the content of identified PCIT implementation strategies – training and ongoing supervision and consultation – as well as the nature or type of modifications to these implementation strategies, including currently lacking modifications, and the goal of said modifications.

III. Methods

A. Design

This mixed-methods study investigated implementation strategies that support bilingual therapists in successfully delivering PCIT for Spanish-speaking Latinx families. Specifically, a mixed-methods design allowed the use of a quantitative approach to evaluate the effect of implementation strategies (i.e., training, supervision, consultation) on two implementation outcomes, acceptability and feasibility of PCIT for Spanish-speaking Latinx families among clinicians training/trained to deliver PCIT and PCIT trainers/supervisors; while the qualitative approach allowed to triangulate on the quantitative findings and expanded on the content and nature of modifications needed to make implementation strategies acceptable (Palinkas et al., 2011). The FRAME-IS provided a framework for documenting modifications to implementation strategies. Mixed-methods designs have been suggested as an appropriate approach to augment EBP implementation by integrating the perspective of consumers of EBPs, including practitioners (e.g., community therapists; Proctor et al., 2009).

Additionally, the current study was framed within a post-positivistic approach, following logical, empirical, cause-and-effect, and deterministic (based on a priori theories). From this perspective, inquiry is viewed as a series of logically related steps, multiple realities are believed to exist, and multiple levels of data analysis (qualitative and quantitative methods) are utilized for rigor throughout the research process (e.g., data collection, analysis, and reporting; Creswell & Poth, 2018). This is all consistent with the aims of qualitative research for implementation science. Specifically, the current study sought to elicit perspectives from providers (PCIT trainees and supervisors), who are key stakeholders in the implementation

of EBPs. The use of more than one source of data (i.e., interview transcripts and survey results) was used to triangulate findings; in other words, answering the same research questions via mixed methods (The Qualitative Research in Implementation Science Group; QUALRIS, 2019).

B. Participants

Participants included therapists who endorsed providing PCIT in Spanish or PCIT trainers who endorsed training and/or consulting with Spanish-speaking clinicians. For the purposes of the current study, PCIT clinician refers to providers trained to deliver the intervention regardless of their professional status (e.g., graduate student, master's-level clinician, psychologist, etc.) PCIT Trainers/supervisors refer to providers who reported acquiring PCIT trainer status (e.g., Within-Agency Trainer) and were in charge of training and supervising clinicians learning to deliver PCIT. Thirty-one participants completed qualitative measures and 10 also completed semi-structured interviews. Therapists in the full sample were predominantly female (96.8%) and Latinx/Hispanic (96.8%), PCIT-certified (67.7%), and had a Master's degree (80.6%). Table 1 displays a detailed breakdown of the demographic and professional characteristics of participants in the full and interview samples.

C. Procedure

Recruitment for this study occurred within an academic-community partnership with the PCIT Spanish Coalition, a grassroots organization consisting of Spanish-speaking PCIT therapists and trainers. Participants were recruited via the PCIT International and UC Davis PCIT Training listservs. Using strategies that have led to successful data collection with

community therapists (Lau & Brookman-Frazee, 2016), outreach was conducted via recruitment emails sent to the listservs. Emails provided a description of the study (e.g., participation in a semi-structured interview concerning training needs for providing PCIT in Spanish). Interested therapists accessed a Qualtrics link to determine eligibility, and those eligible were asked to review an information sheet. Participants were then asked to complete a brief questionnaire to obtain information on their personal and professional characteristics. Fifty-seven clinicians began answering the survey; however, only clinicians responding to implementation strategy outcome measures (i.e., PCIT acceptability and satisfaction) were included in the final sample of thirty-one. Upon completing the survey, therapists were asked if they were interested in completing a 60-minute semi-structured interview. Participants received $10 gift certificates for completing the survey and $40 gift certificates for completing the semi-structured interview. Participants were allowed to complete the interview in English or Spanish via Zoom video conferencing. Throughout the qualitative data collection phase, the research team discussed interview content and emerging themes during weekly meetings. Meeting discussions were annotated and transcribed, serving as an archive of recurrent content and emerging patterns. All study procedures were deemed exempt by the University of California Santa Barbara Institutional Review Board.

D. Measures

Demographics and clinician characteristics. The Therapist Background Questionnaire (Brookman-Frazee et al., 2012) was administered to collect information on participants' personal and professional characteristics. Demographic characteristics included age, gender, and race/ethnicity. Professional background characteristics included licensure status, mental health discipline, and highest degree obtained (i.e., Bachelor's, Master's, Doctorate).

Workload characteristics included number of hours in direct service per week and the number of clients in caseload. Additional questions inquired about PCIT certification status (e.g., in training, certified, certified as a trainer), years of experience with PCIT (as therapists or supervisors), number of PCIT clients, and estimates of total PCIT clients seen (e.g., 0-2, 2-6, 6-20, 20+).

PCIT Implementation Outcomes. The Clinician Use of and Satisfaction with PCIT (CUSP) was a measure developed to examine therapists' experiences with PCIT training, acceptability, and training satisfaction (See Appendix B). The CUSP is composed of 18 open-ended questions assessing specific domains regarding the PCIT model as well as 20 Likert scale items assessing therapist satisfaction with PCIT training and acceptability of the PCIT model. Responses range from 1=Strongly Disagree to 5=Strongly Agree. Responses are averaged, and higher scores indicate greater satisfaction with training and acceptability of the PCIT model (Christian et al., 2014; Niec et al., 2018). The 20-item survey has yielded good internal consistency, $\alpha = 0.80$ (Niec et al., 2018). The CUSP yielded good internal consistency ($\alpha = 0.86$) with the current sample.

Semi-structured interview. Two versions of a semi-structured interview were developed and informed by the FRAME-IS (Miller et al., 2021). For PCIT clinicians, the interview guide asked about how their training and ongoing supervision prepared them to deliver PCIT to Spanish-speaking Latinx families. Open-ended questions also inquired about modifications needed for training and supervision to enhance their capacity to provide PCIT in Spanish. Questions included: *What was your experience like with access to and availability of PCIT training materials in Spanish? What was missing in your training to deliver PCIT in Spanish?* For PCIT trainers/ supervisors, the interview guide also inquired

about modifications made to training and supervision that had been used or could be used to support trainees in their PCIT Spanish delivery endeavors. Questions included: *What has been your experience supervising therapists delivering PCIT in Spanish? How do you go about supporting therapists to problem-solve challenges arising in their delivery of PCIT?* The semi-structured interviews are included in Appendix C.

Spanish Translation Process. Survey and interview questions were translated into Spanish in the current study to allow participants to complete the survey and interview in their preferred language (English or Spanish). Two bilingual/bicultural graduate students with native Spanish language proficiency and PCIT training engaged in translation. First, the CUSP questionnaire was translated by this author. Then, another graduate student reviewed the translation. Translators met with the research team to discuss translation discrepancies and ensure appropriate cultural fit. The semi-structured interviews were initially developed and refined in English. A similar process was followed to complete the translation of interview questions. Although available to all, no participant opted to complete the survey or interview in Spanish.

D. Data Analytic Plan

Mixed-Methods Design. This study employed a QUAN + QUAL approach with simultaneous data collection and equal weight for quantitative and qualitative analyses. (Palinkas et al., 2011). Quantitative data was collected to obtain information regarding therapists' demographics, professional characteristics, their acceptability of PCIT for Spanish-speaking Latinx families, and satisfaction with Spanish-language PCIT implementation strategies. Qualitative interviews were conducted to gain a deeper understanding of past and future modifications to training and ongoing supervision and

consultation necessary to enhance the Spanish delivery of PCIT.

Quantitative Data Analysis. Descriptive statistics were obtained to observe the samples' demographic composition and professional characteristics. Given that therapist characteristics such as age, case load, and discipline have been associated with implementation outcomes (Barnett et al., 2021; Jackson et al., 2017), multiple regression analyses were conducted to determine any relationships between clinician demographics and professional characteristics on PCIT training satisfaction and acceptability in the current study. Quantitative analyses were conducted with SPSS v29.

Qualitative Data Analysis. Qualitative data was analyzed using a thematic analysis approach, a commonly used approach in psychotherapy research (Braun & Clarke, 2006) and implementation research (National Institute of Health, 2019). Thematic analysis seeks to highlight shared meaning and contrasts (Clarke & Braun, 2018). The six steps outlined by Braun and Clarke (2006) were followed. First, the research team familiarized themselves with the qualitative data by transcribing and auditing all interviews and noting down initial ideas about codes and themes. Interviews were entered into NVivo v13, a software that aids the coding, organization, and retrieval of codes. In the second step, initial codes were generated informed by the FRAME-IS (Miller et al., 2021) as thematic analysis allows for theory-driven coding if the research questions are based on previous theory. An iterative process was utilized where the preliminary codebook was first applied to a sample text to ensure all relevant themes were captured, emergent codes were added, a priori codes were revised, and coding discrepancies were discussed and resolved following consensus meetings by the research team. A final codebook, with definitions of each code, was developed collaboratively by the entire research team. In the third step, the research team

searched for themes by analyzing the co-occurrence of codes related to the nature of the modifications (e.g., tailoring, adding elements) and the goal of the modification (e.g., increase acceptability, increase health equity). Next, themes were finalized and refined through consultation and collaboration among all research team members. This led to the final step of thematic analysis, which involved naming and writing up the themes. Table 2 provides a list of all codes used and their corresponding definitions.

When conducting qualitative analyses, it is essential to recognize how the researcher's lived experiences can influence qualitative data collection and analysis (Creswell & Poth, 2018). As such, the research team actively engaged in self-reflection of how their lived experiences shaped their interpretation of the qualitative data as they familiarized themselves with clinician responses. The research team comprised two doctoral candidates, a doctoral-level clinical psychologist, and an undergraduate research assistant. Both doctoral candidates, who translated measures, conducted semi-structured interviews, and oversaw the transcription, auditing, and coding of interviews, had native written and spoken Spanish proficiency. Both doctoral candidates and clinical psychologist had experience providing PCIT intervention and training in English and Spanish. The undergraduate research assistant was involved in transcribing, auditing, and coding of interviews and was knowledgeable of the PCIT model. The current study's lead researcher identifies as a Mexican immigrant, bilingual doctoral candidate who has provided PCIT services in community settings in English and Spanish and has been involved in the translation of PCIT materials for dissemination in Spanish-speaking countries.

Integration of Quantitative and Qualitative Findings. The functions of this QUAN+QUAL mixed-method design were (1) Convergence – triangulating both sets of

results to answer the same question and determine if both generate similar conclusions, (2) Complementarity –with qualitative narratives providing depth of understanding (e.g., what therapists found helpful or lacking in their training) and quantitative findings to provide breadth of understanding (e.g., the degree to which therapists were satisfied with PCIT training), and (3) Expansion – using qualitative results to further explain therapist training experiences reported in the quantitative findings (Palinkas et al., 2011).

IV. Results

Quantitative results indicated that Spanish-language PCIT was moderately acceptable (M = 3.83, SD = 0.48; 2.40 – 4.90), as was PCIT training and supervision (M = 3.88, SD = 0.79; 1.20 – 5.00). Clinician characteristics were not associated with the Acceptability or Satisfaction of PCIT for Spanish-speaking Latinx families. Table 3.

Despite quantitative findings showing moderate PCIT acceptability and satisfaction among Spanish-speaking PCIT providers, qualitative analysis expanded on quantitative findings showing a split between provider experiences based on the nature of the adaptations made to the implementation strategies to focus on the needs of Spanish-speaking families and clinicians. This split in acceptability reflected the overarching theme, **satisfaction with training, and supervision related to the amount of specific support related to delivering PCIT in Spanish.**

Participants who had received **specific support for Spanish delivery reported being extremely satisfied with their training and supervision**. One clinician stated, *"She [trainer] had a lot of resources for the actual handouts or things that we needed to use to change it to Spanish. So, that made it easier because, as someone who's usually worked in places where I'm one of the few or the only one who speaks the language, it's been very much on my shoulders to kind of figure out. So, thankfully she had a lot of that. So, that was helpful. And she could also not just understand the language but understand the culture as well. So, when we had supervision, she understood what my challenges were. So, I think she's been very helpful in that aspect."* Another clinician shared, *"It was quite interesting because I felt more comfortable having sessions in Spanish for the first, I want to say, six months to a year. Almost all my families were Spanish speaking because I felt more*

comfortable being able to discuss the skills. I just became very comfortable with the Spanish protocol. Spanish is my first language. But English, I speak it more fluently I would say because I was raised here.

Conversely, clinicians expressed **dissatisfaction with PCIT training when the lack of support hindered their ability to provide the intervention in Spanish**. For example, one clinician stated, *"I did PCIT in Spanish, but my supervisor didn't speak Spanish, so I never got any feedback. I don't know if I did it well. I'm assuming I did based on the training I got before. But like there was no extra help with the language and what other phrases I can use. So sometimes I catch myself like I'm just saying the same phrase over and over again because I'm just used to saying that phrase. And sometimes, I struggle with my Spanish. 'Cause even though I see a large portion of the families here who speak Spanish, like I'm constantly switching between English and Spanish. And there are just some words that I'm like yeah, no, I'm definitely struggling to say these words in Spanish. So, I think if I had more supervision in Spanish, I think it would help build my vocabulary."* Another clinician commented on the added burden and stress that the lack of materials and support in Spanish often created and shared, *"I think if you work in other places where you're the only Spanish-speaking therapist right, what happens is that you sort of get stuck in this translator position – where you're the one, you as the therapist not only are you doing the therapy with your clients, but you also have to do the work of translation of documents and things to better serve your families. And we do it right because that's part of you know. The great and not so great part of being an empathetic person and caring about your clients is that you know you're going to do what you can to help them. But like at the same time, we're not*

professional translators. Maybe we are translating it based on how we're interpreting those documents."

Regardless of how satisfied with an acceptable providers found Spanish-language PCIT to be, they generally noted how **establishing and facilitating access to systematic, ongoing training and consultation could reinforce their ability to deliver Spanish-language PCIT**. Specifically, clinicians noted the need to have more practice with Spanish-language PCIT to further their training. One clinician stated, *"… I think just having videos too, that would be helpful too. I don't know if there is a general website that has the Spanish videos. I haven't checked, so yeah because it can get a little, there can be like grey areas, where they are like oh well they never mentioned that in my training and it was in English. So I think that would be helpful."* Another clinician shared, *"I think training in Spanish makes sense to me. It might be a little more challenging, or I guess just take more brainpower. But I mean, we want to provide this service in that language. I don't know, it just makes sense to me, I think."*

PCIT providers also highlighted the need for a centralized set of resources for Spanish-speaking clinicians to further their training and provide a booster. One clinician shared, *"I think for year one, they do a great job at providing that support for Spanish-speaking therapists. But I would say continuing to provide resources in Spanish. I think that's where I do struggle. There are families that are bilingual, and I can send them handouts in English. But I do feel like there are certain handouts that I have to do my own research because [there] isn't enough resources in Spanish for these families. We need more handouts translated in Spanish."* Another clinician noted, *"Ongoing support, continual support in the Spanish, like I mentioned with the Spanish resources. Coding and*

coaching, I think that's very supportive as well. Being able to problem solve as a team, as a PCIT community, not just as English speaking, but also as first Spanish-speaking therapists, so that they have that support moving forward and being able to problem solve when things come up. And I know there's a listserv, which is helpful. I think maybe having one that's geared for Spanish-speaking, that would be nice as well. I'm not sure if there is one."

Clinician qualitative responses also shed light on the type and nature of adaptations made to PCIT implementation strategies. **PCIT providers noted how trainers adapted the intervention, primarily by tailoring and adding their training and consultation to increase the acceptability of Spanish-language PCIT**. Few providers commented on tailoring occurring during the initial training phase of PCIT. For example, a trainer stated, *"We talk a lot about family values and hierarchy. Because we have a lot of families, a lot of younger couples that live with their parents. So, we have to talk about hierarchies, and we have to talk about who is really doing the parenting, and how roles shift. Because here, in session, you have the child and his mother. But once they get home, the mother's mother takes over, in a lot of ways. So, we talk a lot about involving the grandparents, whenever possible. We talk about a lot of respect for the roles different family members play. Seeing the father as the head of the family unit, and in many cases, reaching out directly to invite the father to participate, or to just come hear what PCIT is about, and address any questions or concerns they may have. We talk a lot about, I'm from Mexico, so we use a lot of sayings. So, bring them into your teaching, into your therapy, using sayings. It's going to help a family understand what you're trying to accomplish."* Another trainer noted the usefulness of providing more practice with PCIT terminology in Spanish during supervision and shared, *"we started doing our Spanish consultation calls or groups or meetings or*

whatever exclusively in Spanish. Like we started doing that in the past year. Just to practice it and everybody was very open and wanting to do that." Lastly, a PCIT trainee noted, *"my supervisor is familiar with Hispanic culture and the Spanish language, although she's not fluent. So, it's almost like she helps me more in the PCIT skills, while I help her tweak it to the culture and the language 'cause I understand that more, if that makes sense."*

PCIT clinicians and trainers also reported adaptations involving adding components to PCIT training and consultation to be more culturally responsive to Spanish-speaking Latinx families. As one trainer shared, *"We started using a cultural formulation interview as part of our intake. And we sort of adapted it to just kind of our the information like we need to know for our purposes and for our brand and for our program. And so we talk about and tell families straight away things that they can expect in treatment from the get-go so they can decide… we ask questions about values and culture and if they feel like there's certain things about their culture or their identity that are impacting them now or that help or make things more challenging you know. Like one question, like kind of secondary question I'll ask about them is do you think that you're affected by like discrimination or people like mistreating you or whatever.* Other clinicians spoke about adding adaptations that occurred during supervision and consultation. One trainer shared, "*…we created in our program we created like a group like a little consultation group. And so we meet like once a month and so we talk about coding, which is always you know [challenging], I feel like in every language but especially in Spanish, because like the Spanish people, so we kind of started creating some of our own answers to some of these questions of the families that we see down here, which are unique I think. I think any place where you're seeing Spanish-speaking families like everybody's unique. They come from*

different countries, and even just like the area, perhaps there are different speeches and stuff that are kinda more for that specific area…" Although PCIT acceptability or satisfaction was not related to providers' years of experience with PCIT, and some ad-hoc cultural/linguistic adaptations were made, **clinicians and trainers commented on the need to further improve cultural responsiveness in Spanish-language PCIT training and supervision/consultation.** For example, one trainer shared, *"I think in training and supervision, we can get really focused on just meeting competencies. Because like I get an agency that wants clinicians to have been trained in PCIT, so you do everything to work with them. So you know, those things [cultural factors] might come, but at times might also not be top priority you know. Even though they are important to working with families, and I think that it is important component of the training. Because if those cultural aspects and pieces are missed, I think it can also, a clinician can lose a family, just because they're not tapping into those cultural considerations that are gonna be a game changer and retaining families in services."* Another clinician stated, *"I guess just more cultural awareness, overall. I think my supervisor is familiar with some of the patterns we might see with our Spanish-speaking families, in terms of like maybe a higher need for some more case management type of help. But I don't think that she's necessarily culturally sensitive, I guess. I don't know how to put it. I think there's a recognition of some patterns, but I don't know if there is like an understanding, I guess."*

PCIT clinicians and trainers highlighted the type and nature of modifications still needed in PCIT, specifically changes to the packaging or materials. Generally, providers commented on the need for PCIT training and supervision/consultation to be delivered in Spanish. For example, one clinician stated, *"Probably a training in Spanish. And for me,*

practicing live. That's really important…" Another A trainer also noted, *"I think that what has been not always available it's just more, on videos to show certain aspects of the treatment… Let's say a video. We say things, clinicians that are learning PCIT as a model, they want more examples in the language that they are gonna be providing services, so that they can see how it plays out. And I think that Spanish speaking video have, there isn't a lot. So you can find more in English but not in Spanish.*

V. Discussion

PCIT has been found to effectively treat difficult-to-manage child behaviors for Spanish-speaking Latinx families (Matos et al., 2009; Matos et al., 2006; McCabe et al., 2012). Yet, barriers to training and supporting Spanish-speaking therapists limit equity in access. Guided by Miller and colleagues' (2021) FRAME-IS, the current mixed-methods study explored PCIT providers' experiences and needs related to adapting intervention materials, training, and supervision to deliver PCIT in Spanish. Quantitative findings suggested that participants also reported moderate satisfaction with training and supervision to deliver PCIT in Spanish, which is consistent with previous studies assessing clinician perspectives on PCIT training and implementation in English (Christian et al., 2014; Niec et al., 2018). However, qualitative results expanded on quantitative findings, revealing a dichotomy between participants reporting to be extremely satisfied with their training and supervision and those who noted that the lack of training resources hindered their ability to deliver quality PCIT services for Spanish-speaking Latinx families. While attempts have been made to adapt implementation strategies to increase the cultural responsiveness of PCIT for Spanish-speaking Latinx families, there continues to exist room for improvement. In addition, the current study's findings highlight that while EBPs with robust evidence, such as PCIT, are acceptable among Spanish-speaking providers, further work is needed. The finding that providers find Spanish-language PCIT moderately acceptable is excellent news and consistent with previous findings regarding positive clinician attitudes towards EBPs for Latinx populations (Ramos et al., 2021). As English-language PCIT has well-established training guidelines and requirements (PCIT International, 2024), it already has a foundational structure that can be systematically modified to provide proper training for

bilingual trainees. Guided by the FRAME-IS regarding modifications made to the nature (e.g., content) and consistent with participant qualitative responses in the current study, PCIT intervention materials and training and supervision guidelines should be tailored to retain fidelity to the core components of the intervention. Simultaneously, PCIT implementation strategies should strive to promote cultural responsiveness and address linguistic differences consistent with APA's multicultural guidelines to improve the delivery of high-quality care for ethnically diverse families, including Spanish-speaking Latinx families (APA, 2017). For example, training guidelines may incorporate prompts and examples for clinicians to employ cultural humility – a lifelong process of self-evaluation and critique, promotion of interpersonal sensitivity and openness, addressing power imbalances, and appreciation for the richness and diversity within and between cultures and individuals to avoid stereotyping (Stubbee, 2020). Future research may test the efficacy of such an adapted culturally responsive training protocol.

The FRAME-IS also provides guidelines on evaluating the nature and goal of modifications to implementation strategies such as training and supervision. Generally, participants in the current study commented on the need to tailor PCIT delivery as well as adding components (i.e., Spanish consultation groups), hence necessitating increased access to resources and materials to continue meeting the needs of their Spanish-speaking Latinx families; that is, to increase the clinical effectiveness (i.e., clinical outcomes) for Spanish-speaking families. Some efforts have already been made to translate PCIT intervention materials for Spanish-speaking families. For example, UC Davis has developed translated client-facing materials (e.g., handouts) for providers to use. Though PCIT International had some materials translated into Spanish, qualitative findings from the current study suggested

that these materials were not acceptable. Fortunately, PCIT International has recently announced an initiative to formally translate its intervention protocol to make it available to providers.

A key goal for modifying implementation strategies and potentially enhancing intervention effectiveness and acceptability is related to increased cultural responsiveness (Miller et al., 2021), consistent with APA's multicultural guidelines (APA, 2017). Although limited, the qualitative findings in the current study showcased attempts to include how to respond to Spanish-speaking Latinx families' cultural aspects in PCIT training and supervision/consultation. Clinician reports regarding embedding discussions regarding family structure and dynamics (e.g., multigenerational families) and the need for exposure to more examples and practice with PCIT terminology in Spanish seemed consistent with cultural modifications in the GANA program (McCabe et al., 2005). For example, GANA prompted providers to enhance caregiver engagement in treatment at the initial contact. The goals were to clarify treatment expectations, increase caregiver help-seeking, describe GANA, assess who the child's caregivers were to attempt to engage all involved (e.g., grandparents, fathers), assess for existing attitudes toward treatment, and problem-solve logistical barriers to treatment access and engagement. Another modification in GANA entailed translating PCIT materials into Spanish and making handouts less verbose (McCabe et al., 2005). Such an adaptation is consistent with the current study's findings regarding the need for adequately translated PCIT training materials and accessible training resources, including videos with examples of PCIT skills featuring the diverse terminology that describes a skill (e.g., labeled praises). Supplemental materials, such as the behavioral coding system (i.e., the dyadic coding system training manual and accompanying quizzes),

must also be translated to continue supporting Spanish-speaking clinicians. Given the diversity and richness of the Spanish language, Spanish-speaking providers may need opportunities to observe other bilingual providers or train alongside a seasoned bilingual PCIT co-therapist, which can be advertised on mainstream PCIT websites. Finally, the GANA program also followed a tailoring approach, an initial assessment of caregivers' culturally derived concepts (e.g., parenting beliefs), prompting specific recommendations relevant to each family. This would be consistent with the PCIT clinicians' wishes in the current study, which were to have more flexibility and prompts to know when and how to embed cultural responsiveness. Notably, participants in the current study did not reference GANA.

Research highlighting best practices to support bilingual counseling trainees has included the provision of supervision and training in Spanish (Cardona, Zamora, & Reyes, 2005; Consoli and Flores, 2020; Diaz-LePage et al., 2023; Perry & Sias, 2018; Roller et al., 2023). While this would be ideal, the limited number of Spanish-speaking providers in the mental health field arena greatly limits this option. Nevertheless, other alternative recommendations for supporting the professional development of bilingual mental health clinicians have been suggested and include creating consultation calls, providing formalized coursework (e.g., workbooks, in vivo practice), and building connections with community agencies that can provide mentorship for trainees (Valencia-Garcia & Montoya, 2018). Such recommendations are consistent with the current study's findings, which show that PCIT clinicians and trainers agreed that having formal avenues to access support would be helpful. Furthermore, a potential future direction may involve leveraging the use of training models already used in PCIT. More specifically, PCIT dissemination commonly follows a train-the-

trainer model; recent findings suggested that PCIT clinicians reported greater satisfaction, knowledge, and competence in delivering the intervention when training and receiving supervision from advanced PCIT trainers (trainers certified to provide community training and consultation) compared to receiving supervision from within agency trainers (Brabson et al., 2021). A great next step to advance Spanish-language PCIT provision may be to identify advanced bilingual trainers or increase efforts to encourage (and facilitate certification processes) experienced bilingual trainers to acquire advanced trainer status that can provide ongoing consultation and supervision for clinicians. As stated by multiple participants in the current study, having a Spanish-speaking trainer and supervisor greatly enhanced PCIT clinicians' ability to deliver the intervention in Spanish and likely led to greater acceptability.

Developing and increasing accessibility to formally and professionally translated PCIT training materials may greatly diminish the burden and workload often placed on bilingual providers. Previous research has highlighted significant challenges and demanding workloads (e.g., case management, translation responsibilities) frequently encountered by Spanish-speaking providers in community agencies where they are often one of few, if not the only, Spanish-speaking providers (Alvarado et al., 2019; Ramos et al., 2021). Additionally, findings suggested that close to 70% of Spanish-speaking mental health providers reported finding it difficult to translate therapeutic terminology into Spanish and wanting formal training in therapeutic terminology in Spanish (Estrada, Brown, & Molly, 2018). This is consistent with the finding in the current study, as several participants commented on how the added responsibility to translate materials in efforts to offer Spanish-language PCIT for families often relies on the provider’s informal language proficiency and

expertise and seldom receives feedback. This is especially concerning given recent trends suggesting that while the number of Spanish-speaking individuals increases in the United States, the percentage of agencies providing Spanish-language services has decreased (Pro et al., 2022).

The qualitative finding that clinicians would like more training and support to improve the cultural responsiveness of PCIT was not surprising, given the existing literature on PCIT and cultural adaptations. In fact, Luis Sanchez et al. (2021) reported that community-based PCIT clinicians engaged in minimal to moderate adaptations to the intervention, suggesting that clinicians were likely to retain good fidelity to the treatment model and that the intervention was adequately flexible for a range of client clinical and cultural presentations. However, researchers also noted that minimal clinician-reported adaptations were made due to the client's culture, which was consistent with previous findings on culturally relevant adaptations in other EBPs (Barnett et al., 2018). Luis Sanchez et al.'s (2021) findings that clinicians primarily tailored the language and presentation of PCIT for their Spanish-speaking clients were consistent with clinicians' reports in the current study, noting the need and helpfulness of having more opportunities to practice how to deliver and explain PCIT concepts, such as labeled praises (a positive parenting skill to praise specific, positive, parent-approved child behaviors such as being respectful). Existent literature on the effect of being able to use their mother tongue (such as Spanish) vs. English among bilingual providers suggests numerous therapeutic benefits, including enhanced accessibility to emotional expression, recollection of experiences, therapeutic alliance, trust in the therapeutic process, and improved communication and understanding (Pérez-Rojas et al., 2019; Rolland et al., 2021; Roller et al., 2023). Therefore, the need to support Spanish-

speaking provider's exposure to examples, language, and terminology, is well supported and may greatly influence PCIT outcomes for Latinx Spanish-speaking families.

A. Strengths and Limitations

The mixed-method approach utilized in the current study allowed to obtain both breadth and depth of information to understand clinician acceptability and satisfaction with Spanish-language PCIT training, supervision, and consultation. To the authors' knowledge, this was the first study to specifically inquiry regarding implementation supports used and/and or needed for Spanish-speaking providers and added to the literature on culturally responsive considerations in EBPs such as PCIT to advance knowledge and efforts to continue increasing access to quality mental health services for traditionally underserved populations.

These findings should be considered within the limitations of the study. While the size of the sub-sample completing semi-structured interviews was adequate as it has been suggested that saturation, the point at which no new insights are obtained, is reached between 9 and 17 interviews (Hennink & Kaiser, 2022) and comparable to other studies (Luis Sanchez et al., 2021), the full sample completing surveys was small with an N of 31. Recruiting clinicians through PCIT listservs allowed us to reach a large number of clinicians, but the number of Spanish-speaking clinicians subscribed to the listservs may have been limited. Although the PCIT Spanish Coalition listserv is believed to have approximately 200 members within and outside the U.S., it had been inactive for approximately one year at the time of recruitment. Additionally, the study sample included providers in the U.S. only; future studies may expand to investigate the acceptability and satisfaction with PCIT training and supervision in Spanish-speaking countries.

VI. Conclusions

The findings in the current study highlighted the differing, dichotomized experiences with training from therapists providing PCIT in Spanish in community settings. Informed by the FRAME-IS, when training was adapted to include opportunities to practice using PCIT terminology in Spanish in training or ongoing supervision, the acceptability of training increased. Based on therapist reports, their competence in delivering PCIT in Spanish also increased with this training, which in turn could impact the quality of care for Spanish-speaking families. These results inform the need to develop systemic training, supervision, and consultation supports to ensure therapists providing PCIT to Spanish-speaking Latinx families receive and have access to training and implementation resources to ensure the delivery of effective, high-quality interventions. This is crucial in an effort to promote mental health equity for Latinx families with potentially clinically complex presentations in settings with possibly increased exposure to trauma, poverty, and systemic disadvantages

References

Alvarado, M., Lerma, E., Cavazos Vela, J., & Wright, A. (2019). Experiences of Spanish speaking counseling students: Implications for the profession. *Journal of Counselor Preparation and Supervision*, *12*(4), 1.

American Community Survey. (2020). https://data.census.gov/cedsci/

American Psychological Association. (2017). Multicultural guidelines: An ecological approach to context, identity, and intersectionality. Retrieved from: http://www.apa.org/about/policy/multicultural-guidelines.pdf

Barkham, M., & Margison, F. (2007). Practice-based evidence as a complement to evidence-based practice: From dichotomy to chiasmus. In C. Freeman & M. Power (Eds.) *Handbook of evidence-based psychotherapies: A guide for research and practice* (pp. 443-476). John Wiley & Sons Ltd.

Barnett, M., Brookman-Frazee, L., Yu, S. H., Lind, T., Lui, J., Timmer, S., Boys, D., Urquiza, A., Innes-Gomberg, D., Quick-Abdullah, D., & Lau, A. S. (2021). Train-to-Sustain: Predictors of Sustainment in a Large-Scale Implementation of Parent-Child Interaction Therapy. *Evidence-Based Practice in Child and Adolescent Mental Health*, *6*(2), 262–276. https://doi.org/10.1080/23794925.2020.1855613

Barnett, M. L., Brookman-Frazee, L., Gonzalez, J. C., Zhan, C., Rodriguez, A., Stadnick, N. A., & Lau, A. S. (2018). Qualitative reports of how and when therapists adapt children's Evidence-Based Practices during community implementation. *Journal of Clinical Child and Adolescent Psychology*, *00*(00), 1–12. https://doi.org/10.1080/15374416.2018.1485107

Baumann, A. A., Powell, B. J., Kohl, P. L., Tabak, R. G., Penalba, V., Proctor, E. K.,

Domenech-Rodriguez, M. M., & Cabassa, L. J. (2015). Cultural adaptation and implementation of evidence-based parent-training: A systematic review and critique of guiding evidence. *Children and Youth Services Review, 53*, 113–120. https://doi.org/10.1016/j.childyouth.2015.03.025

Beahm, L.A. and Cook, B.G. (2021). Merging practice-based evidence and evidence-based practices to close the research-to-practice gap. In B. G. Cook, M. Tankersley, & T. J. Landrum (Eds.) *The next big thing in learning and behavioral disabilities*: A*dvances in learning and behavioral disabilities*, *Vol. 31* (pp. 47-60). Emerald Publishing Limited. https://doi.org/10.1108/S0735-004X20210000031004

Bearman, S. K., Weisz, J. R., Chorpita, B. F., Hoagwood, K., Ward, A., Ugueto, A. M., & Bernstein, A. (2013). More practice, less preach? The role of supervision processes and therapist characteristics in EBP implementation. *Administration and Policy in Mental Health and Mental Health Services Research*, *40*(6), 518–529. https://doi.org/10.1007/s10488-013-0485-5

Benish, S. G., Quintana, S., & Wampold, B. E. (2011). Culturally adapted psychotherapy and the legitimacy of myth: A direct-comparison meta-analysis. *Journal of Counseling Psychology*, *58*(3), 279–289. https://doi.org/10.1037/a0023626

Beveridge, R. M., Fowles, T. R., Masse, J. J., McGoron, L., Smith, M. A., Parrish, B. P., Circo, G., & Widdoes, N. (2015). State-wide dissemination and implementation of parent-child interaction therapy (PCIT): Application of theory. *Children and Youth Services Review*, *48*, 38–48. https://doi.org/10.1016/j.childyouth.2014.11.013

Brabson, L. A., Herschell, A. D., Snider, M. D., Jackson, C. B., Schaffner, K. F., Scudder, A. T., ... & Mrozowski, S. J. (2021). Understanding the effectiveness of the

cascading model to implement Parent-Child Interaction Therapy. *The Journal of Behavioral Health Services & Research*, *48*, 427-445

Brabson, L. A., Jackson, C. B., Liebsack, B. K., & Herschell, A. D. (2019). PCIT: Summary of 40 years of research. In *Handbook of Parent-Child Interaction Therapy for Children on the Autism Spectrum* (pp. 251–275). Springer International Publishing. https://doi.org/10.1007/978-3-030-03213-5_14

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Bridges, A. J., Andrews, A. R., & Deen, T. L. (2012). Mental health needs and service utilization by Hispanic immigrants residing in mid-southern United States. *Journal of Transcultural Nursing*, *23*(4), 359–368. https://doi.org/10.1177/1043659612451259

Brookman-Frazee, L. I., Drahota, A., & Stadnick, N. (2012). Training community mental health therapists to deliver a package of evidence-based practice strategies for school-age children with autism spectrum disorders: A pilot study. *Journal of Autism and Developmental Disorders*, *42*(8), 1651–1661. https://doi.org/10.1007/s10803-011-1406-7

Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology*, *58*(4), 537–554. https://doi.org/10.1037/a0025266

Cardona, J., Zamora, J. A., & Reyes, N. A. (2005). The process of integrating language, context, and meaning: The voices of bilingual and bicultural therapists.

Castaño, M. T., Biever, J. L., González, C. G., & Anderson, K. B. (2007). Challenges of Providing Mental Health Services in Spanish. *Professional Psychology: Research and Practice, 38*(6), 667–673. https://doi.org/10.1037/0735-7028.38.6.667

Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Brestan, E. V, Balachova, T., Jackson, S., Lensgraf, J., Bonner, B. L., & al., et. (2004). Parent-child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology*, *72*(3), 500–510. https://doi.org/10.1037/0022-006X.72.3.500

Chambers, D. A., & Norton, W. E. (2016). The Adaptome: Advancing the science of intervention adaptation. *American Journal of Preventive Medicine*, *51*(4), S124–S131. https://doi.org/10.1016/j.amepre.2016.05.011

Christian, A. S., Niec, L. N., Acevedo-Polakovich, I. D., & Kassab, V. A. (2014). Dissemination of an evidence-based parenting program: Clinician perspectives on training and implementation. *Children and Youth Services Review*, *43*, 8–17. https://doi.org/10.1016/j.childyouth.2014.04.005

Clarke, V., & Braun, V. (2018). Using thematic analysis in counselling and psychotherapy research: A critical reflection. *Counselling and Psychotherapy Research*, *18*(2), 107–110. https://doi.org/10.1002/capr.12165

Creswell, J. W., & Poth, C. N. (2016). *Qualitative inquiry and research design: Choosing among five approaches*. Sage publications.

Collective, T. J. (2021). *Pathway to a more equitable and inclusive PCIT International*.

Comer, J. S., del Busto, C., Dick, A. S., Furr, J. M., & Puliafico, A. C. (2018). Adapting PCIT to Treat Anxiety in Young Children: The PCIT CALM Program. In L. N. Niec

(Ed.), *Handbook of Parent-Child Interaction Therapy: Innovations and Applications for Research and Practice* (pp. 129–147). Springer International Publishing. https://doi.org/10.1007/978-3-319-97698-3_9

Cotter, A., Todd, M., & Brestan-Knight, E. (2018). Parent-Child Interaction Therapy for Children with Selective Mutism (PCIT-SM). In L. N. Niec (Ed.), *Handbook of Parent-Child Interaction Therapy: Innovations and Applications for Research and Practice* (pp. 113–128). Springer International Publishing. https://doi.org/10.1007/978-3-319-97698-3_8

Diaz-LePage, A., Lauer, M., Santa-Sosa, E., Abdul-Chani, M., Garcia, A., Hoet, A., ... & Marchante-Hoffman, A. (2023). En sus propias palabras (in their own words): Reflections of Spanish–English bilingual psychologists and trainees in the United States. *Training and Education in Professional Psychology*.

Edmunds, J. M., Beidas, R. S., & Kendall, P. C. (2013). Dissemination and implementation of evidence-based practices: Training and consultation as implementation strategies. *Clinical Psychology: Science and Practice*, *20*(2), 152–165. https://doi.org/10.1111/cpsp.12031

Estrada, O., Brown, J. L. C., & Molloy, L. (2018). Bilingual Therapists' Confidence Using Clinical Spanish Language Terminology. *Journal of Teaching in Social Work, 38*(3), 324–341. https://doi.org/10.1080/08841233.2018.1468384

Funderburk, B., Chaffin, M., Bard, E., Shanley, J., Bard, D., & Berliner, L. (2015). Comparing client outcomes for two evidence-based treatment consultation Strategies. *Journal of Clinical Child and Adolescent Psychology, 44*(5), 730–741. https://doi.org/10.1080/15374416.2014.910790

Green, L. W. (2008). Making research relevant: If it is an evidence-based practice, where's the practice-based evidence? *Family Practice*, *25*((suppl 1)), i20–i24. https://doi.org/10.1093/fampra/cmn055

Hall, G. C. N., Ibaraki, A. Y., Huang, E. R., Marti, C. N., & Stice, E. (2016). A meta-analysis of cultural adaptations of psychological interventions. *Behavior Therapy*, *47*(6), 993–1014. https://doi.org/10.1016/j.beth.2016.09.005

Hansen, B., & Shillingsburg, M. A. (2016). Using a modified Parent-Child Interaction Therapy to increase vocalizations in children with autism. *Child and Family Behavior Therapy*, *38*(4), 318–330. https://doi.org/10.1080/07317107.2016.1238692

Hennink, M., & Kaiser, B. N. (2022). Sample sizes for saturation in qualitative research: A systematic review of empirical tests. *Social Science & Medicine*, *292*, 114523.

Herschell, A. D., Calzada, E. J., Eyberg, S. M., & McNeil, C. B. (2002). Parent-Child Interaction Therapy: New directions in research. *Cognitive and Behavioral Practice*, *9*(1), 9–16. https://doi.org/10.1016/S1077-7229(02)80034-7

Herschell, A. D., Kolko, D. J., Scudder, A. T., Taber-Thomas, S. M., Schaffner, K. F., Hart, J. A., Mrozowski, S. J., Hiegel, S. A., Iyengar, S., Metzger, A., & Jackson, C. B. (2021). A statewide randomized controlled trial to compare three models for implementing Parent Child Interaction Therapy. *Journal of Clinical Child and Adolescent Psychology*, *00*(00), 1–17. https://doi.org/10.1080/15374416.2021.2001745

Heymann, P., Heflin, B. H., & Bagner, D. M. (2022). Effect of therapist coaching statements on parenting skills in a brief parenting intervention for infants. *Behavior Modification*, *46*(4), 691–705. https://doi.org/10.1177/0145445520988140

Horvitz-Lennon, M. (2020). Evidence-based practices or practice-based evidence: What is the Future? In: H. Goldman, R. Frank, & J. Morrissey (Eds.), *The palgrave handbook of American mental health policy* (pp. 603-638). Palgrave Macmillan, Cham. https://doi.org/10.1007/978-3-030-11908-9_21

Jackson, C. B., Herschell, A. D., Schaffne, K. F., Turiano, N. A., & McNeil, C. B. (2017). Training community-based clinicians in parent-child interaction therapy: The interaction between expert consultation and caseload. *Professional Psychology: Research and Practice, 48*(6), 481–489. https://doi.org/10.1037/pro0000149

Jensen-Doss, A., Hawley, K. M., Lopez, M., & Osterberg, L. D. (2009). Using Evidence-Based Treatments: The Experiences of Youth Providers Working Under a Mandate. *Professional Psychology: Research and Practice, 40*(4), 417–424. https://doi.org/10.1037/a0014690

Kim, J. J., Brookman-Frazee, L., Barnett, M. L., Tran, M., Kuckertz, M., Yu, S., & Lau, A. S. (2020). How community therapists describe adapting evidence-based practices in sessions for youth: Augmenting to improve fit and reach. *Journal of Community Psychology*, *48*(4), 1238–1257. https://doi.org/10.1002/jcop.22333

Lau, A., Barnett, M., Stadnick, N., Saifan, D., Regan, J., Wiltsey Stirman, S., Roesch, S., & Brookman-Frazee, L. (2017). Therapist report of adaptations to delivery of evidence-based practices within a system-driven reform of publicly-funded childrens mental health services. *Journal of Consulting and Clinical Psychology*, *85*(7), 664–675. https://doi.org/10.1037/ccp0000215

Lieneman, C. C., Brabson, L. A., Highlander, A., Wallace, N. M., & McNeil, C. B. (2017). Parent–Child Interaction Therapy: Current perspectives. *Psychology Research and*

Behavior Management, *10*, 239–256. https://doi.org/10.2147/PRBM.S91200

Luis Sanchez, B. E., Klein, C. C., Corcoran, F., & Barnett, M. L. (2022). A Mixed-Methods Study of Clinician Adaptations to Parent-Child Interaction Therapy - What about Culture? *Evidence-Based Practice in Child and Adolescent Mental Health*, 1–17. https://doi.org/10.1080/23794925.2022.2070883

Lyon, A. R., & Budd, K. S. (2010). A community mental health implementation of Parent-Child Interaction Therapy (PCIT). *Journal of Child and Family Studies*, *19*(5), 654–668. https://doi.org/10.1007/s10826-010-9353-z

Lyon, A. R., Lau, A. S., McCauley, E., Stoep, A. Vander, & Chorpita, B. F. (2014). A case for modular design: Implications for implementing evidence-based interventions with culturally diverse youth. *Professional Psychology: Research and Practice*, *45*(1), 57–66. https://doi.org/10.1037/a0035301

Matos, M., Bauermeister, J. J., & Bernal, G. (2009). Parent-Child Interaction Therapy for Puerto Rican preschool children with ADHD and behavior problems: A pilot efficacy study. In *Family Process* (Vol. 48, Issue 2, pp. 232–252). FPI, Inc. www.FamilyProcess.org

Matos, M., Torres, R., Santiago, R., Jurado, M., & Rodríguez, I. (2006). Adaptation of Parent-Child Interaction Therapy for Puerto Rican families: A preliminary study. *Family Process*, *45*(2), 205–222. https://doi.org/10.1111/j.1545-5300.2006.00091.x

McCabe, K. M., Yeh, M., Garland, A. F., Lau, A. S., & Chavez, G. (2005). The GANA program: A tailoring approach to adapting parent child interaction therapy for Mexican Americans. *Education and Treatment of Children*, *28*(2), 111–129. https://doi.org/10.13016/eman-s23m

McCabe, K., & Yeh, M. (2009). Parent-child interaction therapy for Mexican Americans: A randomized clinical trial. *Journal of Clinical Child and Adolescent Psychology*, *38*(5), 753–759. https://doi.org/10.1080/15374410903103544

McCabe, K., Yeh, M., Lau, A., & Argote, C. B. (2012). Parent-Child Interaction Therapy for Mexican Americans: Results of a pilot randomized clinical trial at follow-up. *Behavior Therapy*, *43*(3), 606–618. https://doi.org/10.1016/j.beth.2011.11.001

McDonald & Viehbeck (2007). From evidence-based practice making to practice-based evidence making: Creating communities of (Research) and Practice. *Health Promotion Practice*, *8* (2), 140-144. doi: 10.1177/1524839906298494

Merikangas, K. R., He, J. P., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., Benjet, C., Georgiades, K., & Swendsen, J. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: Results from the national comorbidity survey replication-adolescent supplement (NCS-A). *Journal of the American Academy of Child and Adolescent Psychiatry*, *49*(10), 980–989. https://doi.org/10.1016/j.jaac.2010.05.017

Meza, R. D., Jungbluth, N., Sedlar, G., Martin, P., Berliner, L., Wiltsey-Stirman, S., & Dorsey, S. (2019). Clinician-reported modification to a CBT approach in children's mental health. *Journal of Emotional and Behavioral Disorders*, *00*(0), 1–10. https://doi.org/10.1177/1063426619828369

Miller, C. J., Barnett, M. L., Baumann, A. A., Gutner, C. A., & Wiltsey-Stirman, S. (2021). The FRAME-IS: a framework for documenting modifications to implementation strategies in healthcare. *Implementation Science*, *16*(1), 1–13. https://doi.org/10.1186/s13012-021-01105-3

Mokrue, K. 2022. K. Limited english proficiency population: A call to action. The Behavior

Therapist, 45(2), 58-63.

National Latina/o Psychological Association. (2018). *Ethical Guidelines National Latina/o Psychological Association*. Retrieved from https://www.nlpa.ws/assets/docs/ethical%20guidelines%20nlpa_adopted%20jan%201st.pdf.

Niec, L. N., Abrahamse, M. E., Egan, R., Coelman, F. J. G., & Heiner, W. D. (2018). Global dissemination of parent-child interaction therapy: The perspectives of Dutch trainees. *Children and Youth Services Review*, *94*(January), 485–492. https://doi.org/10.1016/j.childyouth.2018.08.019

Novins, D. K., Green, A. E., Legha, R. K., & Aarons, G. A. (2013). Dissemination and implementation of evidence-based practices for child and adolescent mental health: A systematic review. *Journal of the American Academy of Child and Adolescent Psychiatry*, *52*(10). https://doi.org/10.1016/J.JAAC.2013.07.012

Oquendo-Figueroa, Y., Johnson-Esparza, Y., & Muther, J. P. (2021). Considerations and strategies for enhancing the supervision and training of foreign-born Spanish-speaking supervisees. *Journal of Contemporary Psychotherapy*, *51*(3), 211–218. https://doi.org/10.1007/s10879-021-09495-7

Palinkas, L. A., Aarons, G. A., Horwitz, S., Chamberlain, P., Hurlburt, M., & Landsverk, J. (2011). Mixed method designs in implementation research. *Administration and Policy in Mental Health and Mental Health Services Research*, *38*(1), 44–53. https://doi.org/10.1007/s10488-010-0314-z

Park, A. L., Tsai, K. H., Guan, K., & Chorpita, B. F. (2018). Unintended consequences of evidence-based treatment policy reform: Is implementation the goal or the strategy for

higher quality care? *Administration and Policy in Mental Health and Mental Health Services Research*, *45*(4), 649–660. https://doi.org/10.1007/s10488-018-0853-2

Passel, J. S., Lopez, M. H., & Cohn, D. (2022, February 2). *U.S. Hispanic population continues its geographic spread in the 2010s.* Pew Research Center. https://www.pewresearch.org/fact-tank/2022/02/03/u-s-hispanic-population-continued-its-geographic-spread-in-the-2010s/

Pearl, E., Thieken, L., Olafson, E., Boat, B., Connelly, L., Barnes, J., & Putnam, F. (2012). Effectiveness of community dissemination of parent-child interaction therapy. *Psychological Trauma: Theory, Research, Practice, and Policy*, *4*(2), 204–213. https://doi.org/10.1037/a0022948

Pérez-Rojas, A. E., Brown, R., Cervantes, A., Valente, T., & Pereira, S. R. (2019). " Alguien abrió la puerta:" The phenomenology of bilingual Latinx clients' use of Spanish and English in psychotherapy. *Psychotherapy*, *56*(2), 241.

Perry, V. M., & Sias, S. M. (2018). Ethical concerns when supervising Spanish-English bilingual counselors: Suggestions for practice. *Journal of Counselor Preparation and Supervision*, *11*(1), 10.

Pina, A. A., Polo, A. J., & Huey, S. J. (2019). Evidence-based psychosocial interventions for ethnic minority youth: The 10-year update. *Journal of Clinical Child & Adolescent Psychology*, *48*(2), 179-202. https://doi.org/10.1080/15374416.2019.1567350

Powell, B. J., Proctor, E. K., & Glass, J. E. (2014). A systematic review of strategies for implementing empirically supported mental health interventions. *Research on Social Work Practice*, *24*(2), 192–212. https://doi.org/10.1177/1049731513505778

Pro, G., Brown, C., Rojo, M., Patel, J., Flax, C., & Haynes, T. (2022). Downward national

trends in mental health treatment offered in Spanish: State differences by proportion of Hispanic residents. *Psychiatric Services*, *73*(11), 1232-1238.

Proctor, E. K., Powell, B. J., Baumann, A. A., Hamilton, A. M., & Santens, R. L. (2012). Writing implementation research grant proposals: Ten key ingredients. *Implementation Science*, *7*(1), 1–13. https://doi.org/10.1186/1748-5908-7-96

Proctor, E. K., Powell, B. J., & McMillen, J. C. (2013). Implementation strategies: Recommendations for specifying and reporting. *Implementation Science*, *8*(139), 1–11. https://doi.org/10.1186/1748-5908-8-139

Proctor, L. J., Van Dusen Randazzo, K., Litrownik, A. J., Newton, R. R., Davis, I. P., & Villodas, M. (2011). Factors associated with caregiver stability in permanent placements: A classification tree approach. *Child Abuse and Neglect*, *35*(6), 425–436. https://doi.org/10.1016/j.chiabu.2011.02.002

Ramos, G., Blizzard, A. M., Barroso, N. E., & Bagner, D. M. (2018). Parent training and skill acquisition and utilization among Spanish- and English-speaking Latino families. *Journal of Child and Family Studies*, *27*(1), 268–279. https://doi.org/10.1007/s10826-017-0881-7

Ramos, G., Brookman-frazee, L., Kodish, T., Rodriguez, A., Lau, A. S. (2020). Providers' experiences with evidence-based practices : The role of therapist tace/ethnicity. *Cultural Diversity and Ethnic Minority Psychology*. https://doi.org/10.1037/cdp0000357

Rolland, L., Costa, B., & Dewaele, J. M. (2021). Negotiating the language (s) for psychotherapy talk: A mixed methods study from the perspective of multilingual clients. *Counselling and Psychotherapy Research*, *21*(1), 107-117.

Roller, K. M., Snow, W., Grapa, J., Hernandez, M., Consoli, A., Pineda, B., & Vargas, E. A. (2023). Estimating the impact of limited English language proficiency on mental health services for Spanish speakers in the United States. *Journal of the National Hispanic Medical Association*, *1*(2), 10-17.

Rosas, Y. G., McCabe, K. M., Zerr, A., Yeh, M., Gese, K., & Barnett, M. L. (2022). Examining English-and Spanish-Speaking Therapist Behaviors in Parent–Child Interaction Therapy. *International Journal of Environmental Research and Public Health*, *19*(8). https://doi.org/10.3390/ijerph19084474

Sattler, P. L., Paceley, M., Byers, K., Mulkey, Z., & Mendenhall, A. (2022). Lost in Translation: Bilingual Parent Coaches' Experiences Implementing an Un-adapted Early Childhood Intervention with Non-English Speakers. *Global Implementation Research and Applications*, *2*(1), 12–21. https://doi.org/10.1007/S43477-022-00037-4

Scudder, A. T., Taber-Thomas, S. M., Schaffner, K., Pemberton, J. R., Hunter, L., & Herschell, A. D. (2017). A mixed-methods study of system-level sustainability of evidence-based practices in 12 large-scale implementation initiatives. *Health Research Policy and Systems*, *15*(102). https://doi.org/10.1186/s12961-017-0230-8

Smith, T. B., & Cabral, R. R. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology*. http://scholarsarchive.byu.edu/facpub

Southam-Gerow, M. A., Rodríguez, A., Chorpita, B. F., & Daleiden, E. L. (2012). Dissemination and implementation of evidence based treatments for youth: Challenges and recommendations. *Professional Psychology: Research and Practice*,

43(5), 527–534. https://doi.org/10.1037/a0029101

Stirman, S. W., Gamarra, J. M., Bartlett, B. A., Calloway, A., & Gutner, C. A. (2017). Empirical examinations of modifications and adaptations to evidence-based psychotherapies: Methodologies, impact, and future directions. *Clinical Psychology: Science and Practice*, *24*(4), 396–420. https://doi.org/10.1111/cpsp.12218

Stubbe, D. E. (2020). Practicing cultural competence and cultural humility in the care of diverse patients. *Focus*, *18*(1), 49-51.

Thomas, R., Abell, B., Webb, H. J., Avdagic, E., & Zimmer-Gembeck, M. J. (2017). Parent-Child Interaction Therapy: A meta-analysis. In *PEDIATRICS* (Vol. 140, Issue 3). www.aappublications.org/news

Thompson, S. (2021, May 27). *The U.S. has the second-largest population of Spanish speajers - How to equip your brand to serve them.* Forbes. https://www.forbes.com/sites/soniathompson/2021/05/27/the-us-has-the-second-largest-population-of-spanish-speakers-how-to-equip-your-brand-to-serve-them/?sh=2d48b9b4793a

Timmer, S. G., Urquiza, A. J., Boys, D. K., Forte, L. A., Quick-Abdullah, D., Chan, S., & Gould, W. (2016). Filling potholes on the implementation highway: Evaluating the implementation of Parent-Child Interaction Therapy in Los Angeles County. *Child Abuse and Neglect*, *53*, 40–50. https://doi.org/10.1016/j.chiabu.2015.11.011

Triplett, N. S. (2015). Addressing the gaps in mental health care for Spanish-speaking individuals in Durham, N.C.: A needs sssessment and compilation of relevant empirical literature. *Yale Review of Undergraduate Research in Psychology*, 60–70. https://cpb-us-

w2.wpmucdn.com/campuspress.yale.edu/dist/a/1215/files/2016/05/Triplett-19i5fze.pdf

Valencia-Garcia, D., & Montoya, H. (2018). Lost in translation: Training issues for bilingual students in health service psychology. *Training and Education in Professional Psychology*, *12*(3), 142–148. https://doi.org/10.1037/tep0000199

Valero-Aguayo, L., Rodríguez-Bocanegra, M., Ferro-García, R., & Ascanio-Velasco, L. (2021). Meta-analysis of the efficacy and effectiveness of Parent-Child Interaction Therapy (PCIT) for child behaviour problems. *Psicothema*, *33*(4), 544–555. https://doi.org/10.7334/psicothema2021.70

van Mourik, K., Crone, M. R., de Wolff, M. S., & Reis, R. (2017). Parent training programs for ethnic minorities: A meta-analysis of adaptations and effect. *Prevention Science*, *18*(1), 95–105. https://doi.org/10.1007/s11121-016-0733-5

Ward, M. A., Theule, J., & Cheung, K. (2016). Parent–Child Interaction Therapy for child disruptive behaviour disorders: A meta-analysis. *Child and Youth Care Forum*, *45*(5), 675–690. https://doi.org/10.1007/s10566-016-9350-5

Woodfield, M. J., Merry, S., & Hetrick, S. E. (2022). Clinician adoption of Parent–Child Interaction Therapy: A systematic review of implementation interventions. *Implementation Research and Practice*, *3*, 1–14. https://doi.org/10.1177/26334895221082330

Yu, S. H., Brookman-Frazee, L., Kim, J. J., Barnett, M. L., Wright, B., & Lau, A. S. (2022). Therapist adaptations to evidence-based practices and associations with implementation outcomes in child therapy sessions. *Journal of Consulting and Clinical psychology*, *90*(1), 39. doi: 10.1037/ccp0000667

Appendix A

Table 1

Demographic and Professional Characteristics of Survey and Interview Sample

	Survey Sample	Interview Sample
Demographics		
Age, *M (SD;* range)	37.94 (7.44; 25-57)	36.80 (8.63; 25-57)
N (%) Female	31(96.80%)	10 (100%)
Ethnicity	*n* (%)	
Non-Hispanic White	1 (3.20%)	1 (10%)
Latinx/Hispanic	30 (96.80%)	9 (90%)
Race	*n* (%)	
White	19 (61.30%)	7 (70%)
American Indian/Alaska Native	1 (3.20%)	0
Multiracial/ Not Listed	9 (35.50%) (2 missing)	2 (20%) (1 missing)
Professional Characteristics		
Professional Discipline	*n* (%)	
Clinical Psychology	6 (19.40%)	2 (20%)
Social Work	7 (22.60%)	2 (20%)
Counseling	10 (32.30%)	4 (40%)
Marriage Family Therapy	8 (25.80%)	2 (20%)
Highest Degree Obtained	*n* (%)	
Master's degree	25 (80.60%)	7 (70%)
Doctoral degree	6 (19.40%)	3 (30%)
N (%) who are licensed clinicians	23 (74.20%)	8 (80%)
Years as therapist *M (SD;* range)	9.90 (7.34; 0-31)	9.80 (8.98; 1-31)
PCIT Experience		
Years Trained in PCIT *M (SD;* range)	6.69 (5.03; 0.8-20)	5.35 (3.43; 1-13)
Designation/Role	*n* (%)	
Trainee	2 (6.50%)	0
Staff	25 (80.60%)	10 (100%)
Independent Contractor	4 (12.90%)	0
Training Body	*n* (%)	
UC Davis	11 (35.50%)	3 (30%)
PCIT International	11 (35.50%)	5 (50%)
Other	8 (25.80%) (1 missing)	1 (10%) (1 missing)
N (%) PCIT Certified Therapist	21 (67.70%) (1 missing)	7 (70%) (1 missing)
N (%) PCIT Certified Trainer	11 (35.50% (1 missing)	4 (40%) (1 missing)
PCIT Trainer Level	*n* (%)	
Withing-Agency	9 (81.81%)	3 (75%)
Regional	2 (18.18%	1 (25%)
Current Caseload Characteristics		
PCIT caseload *M (SD;* range)	5.19 (4.72; 0-16)	7.70 (5.85; 0-16)

Spanish-speaking PCIT caseload *M* *(SD;* range)	2.03 (2.64; 0-12)	2.60 (3.60; 0-12)
PCIT Acceptability	3.83 (0.48; 2.40-4.90)	3.87 (0.60; 3.10-4.90)
PCIT Satisfaction	3.88 (0.79; 1.20-5)	3.97 (0.74; 2.90-4.90)

Note. PCIT = Parent-Child Interaction Therapy.

Table 2

Codebook of Adaptations to Implementation Strategies

Codes	Definitions
Process Codes	
Removing/skipping	Removing or skipping elements of training, supervision, or consultation in PCIT.
Shortening/condensing	Reducing the pacing/timing of training, supervision, or consultation.
Reordering	Changing the order of intervention modules or segments.
Lengthening/extending	Extending the pacing/timing of training, supervision, or consultation.
Integrating/adding	Adding another treatment into PCIT training, supervision, or consultation
Tailoring/tweaking/refining	A change to the training, supervision, or consultation that leaves all of the major intervention principles and techniques intact (e.g., modifying language, creating somewhat different versions of handouts or homework assignments, cultural adaptations).
Changes in packaging or materials	Alterations in the materials used: for example, changing the toys used.
Substituting	Substituting one element of PCIT for another.
Spreading	Breaking up session content over multiple sessions.
Loosening structure	Departing from the intervention ("drift") followed by a return to protocol within the encounter; drift from protocol without returning; adding extra sessions (e.g., check-in with parents only, collateral sessions) that replace or delay PCIT.
Reasons for Adapting	
Race/ethnicity	References to race or ethnicity.
Acceptability	References to the acceptability, appropriateness, and feasibility of PCIT for Spanish-speaking families.

Satisfaction	References to satisfaction with PCIT training and supervision (e.g., didactics, materials, translation, etc.)
Engagement	References to increasing engagement.
First/spoken language	Clinician references to clients' first or spoken language.
Cultural or religious norms	Clinician references to clients' cultural or religious norms.

Note. This codebook was informed by the FRAME-IS Model (Miller et al., 2021).

Table 3.

Results of multiple regression analyses of the influence of participant characteristics on PCIT Acceptability and Satisfaction

	PCIT Acceptability			PCIT Satisfaction		
Effects	*B*	*t*	*p*	*B*	*t*	*p*
Years as therapist	0.009	0.03	.977	-0.35	-1.23	.234
Total caseload	-0.04	-0.20	.841	0.01	0.07	.949
PCIT Caseload	0.16	0.67	.512	0.24	1.12	.275
Years PCIT trained	0.29	0.91	.371	0.57	1.94	.066
Hispanic Ethnicity (Yes vs No)	0.08	0.33	.742	0.26	1.22	.235

Note. PCIT = Parent-Child Interaction Therapy.

Appendix B

Clinician Use and Satisfaction with Parent-Child Interaction Therapy (PCIT)

(1) When were you trained in PCIT _____ *(month & year)* and what agency did you work for _____ *(agency)*. Have you changed agencies since your PCIT training?

1 [ ] No

(1A) Has your job within your agency changed (e.g., has the population you serve changed? Has the type of services provided changed?)

1 [ ] No

2 [ ] Yes

(1AA) Could you describe the changes to your job since your PCIT training?

_____

2 [ ] Yes

(1B) How many times have you changed agencies since your training?___

(1C) What type of agency do you work for now?

1 [ ] Community Mental Health

2 [ ] Hospital

3 [ ] Private Practice

4 [ ] HMO (e.g., Kaiser-Permanente)

5 [ ] Non-Profit Agency

6 [ ] Other _____

(2) Do you currently treat families with children aged 2 to 6 years with disruptive behavior problems (e.g., aggression, noncompliance, and defiance)?

1 [ ] No

2 [ ] Yes

(2A) About how many families with children aged 2-6 with disruptive behaviors do you currently see per week?____

(2B) Do you use PCIT with any families that have children aged 2 to 6 with disruptive behavior problems?

1 [ ] No

(2AA) What techniques or orientations do you use with families that have children aged 2 to 6 with disruptive behavioral difficulties?

_____

2 [ ] Yes

(2BB) About how many PCIT clients you currently see per week? ____

(3) Approximately how long ago did you see your last PCIT client? _____

(4) You participated in the initial PCIT training in _____ *(month & year).* Since you completed your five-day initial PCIT training, have you done any of the following?

1 Met regularly with other PCIT therapists to talk about cases (other than consultation calls)?

1 [ ] No
2 [ ] Yes

2. Attended a PCIT Conference?
1 [ ] No
2 [ ] Yes
(4A) How many? _____

3 Participated in a PCIT advanced continuation training (i.e., the one-day training run by Larissa Niec)
1 [ ] No
2 [ ] Yes

4 Read recent PCIT studies/literature?
1 [ ] No
2 [ ] Yes
(4B) Which of the following:
1 [ ] Articles
2 [ ] Blog
3 [ ] Other _____

5 Read or submitted comments on the PCIT listserve?
1 [ ] No
2 [ ] Yes

6 Have you done any other training activities related to PCIT?
1 [ ] No
2 [ ] Yes
(4C) Please describe _____

7 None
1 [ ] No
2 [ ] Yes

Now you will be asked about your experiences as a therapist implementing PCIT. We are interested in hearing your honest opinions. After reading each of the following statements, please indicate whether you strongly disagree, disagree, are neutral, agree, or strongly agree with the statement.

Overall, I find PCIT…	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
(5A) Easy and straightforward to deliver.					
(5B) Helps keep families in treatment.					
(5C) Decreases child disruptive and oppositional behaviors.					
(5D) Families who complete PCIT are less					

likely to need additional mental health services.					
(5E) Increases family drop-out from treatment.*					
(5F) Increases warm and secure interactions between parents and children.					
(5G) Increases child disruptive and oppositional behaviors.*					
(5H) Decreases parental stress.					
(5I) Enjoyable to implement.					
(5J) Complicated and difficult to implement.*					

*Reverse coded

Now you will be asked about your experiences with specific aspects of Parent-Child Interaction Therapy.

Co-Therapy

(7) In your agency currently, how many PCIT therapists are on one case at a time?

1 [ ] 1
2 [ ] 2

(8) How do you feel about the co-therapy model of PCIT?

_____

Barriers to Implementing PCIT

(9) Have you experienced any difficulties or barriers to implementing PCIT with families?

1 [ ] No
2 [ ] Yes

(9A) In which of the following areas have you experienced barriers? (Check all that apply)

1 [ ] Support (e.g., lacking from supervisor or other therapists)
2 [ ] Population served (e.g., no kids with behavior problems in the appropriate age range; families resistant to the therapy)
3 [ ] Personal (e.g., comfort with PCIT)
4 [ ] Availability of continued training/supervision
5 [ ] Availability of necessary sound equipment/rooms/toys

(9B) Could you describe the barrier(s) you mentioned?

_____
__

Q What are you currently doing? What's currently working for you?

Elements of PCIT

Assessments

Typically in PCIT there are a number of assessments that are part of the treatment. We are interested in what you are current doing. What is working for you.

(10A) What measures (if any) are you currently using before treatment starts?

(10B) What measures (if any) are you using weekly?

(10C) What measures (if any) are you using at the end of treatment?

Didactic

In PCIT, didactic, or teaching, sessions allow parents to learn about the skills they will be developing during each phase of treatment (i.e., Child-Directed Interaction and Parent Directed Interaction).

(11) How has your experience been with the didactic sessions?

Coaching

In PCIT, coaching is used to teach parents skills, shape parent behavior, and model skills for parents.

(12) How has your experience been with coaching?

Mastery Criteria

In PCIT, parents must demonstrate mastery of the child-led skills (e.g., 10 labeled praises, 10 behavior descriptions, and 10 reflections) before moving on to the next phase of treatment.

(13) How do you feel about mastery criteria?

Length of Treatment

(14) How do you feel about the length of PCIT treatment?

Termination

(15) How do you decide your PCIT case is ready for termination?

Supervision

(16A) How do you feel about the supervision and consultation you received/are receiving?

(16B) What do you feel was/is the most helpful about the supervision and consultation?

(16C) What would you have liked or would like to be different about your training?

(16D) Would you change the length of PCIT consultation? How?

Training Experiences
When you attended the five days of PCIT training, you participated in lectures and discussion, watched videos, and practiced skills with children and other therapists.

After reading each of the following statements, please indicate whether you strongly disagree, disagree, are neutral, agree, or strongly agree.

	Strongly Disagree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
(17A) I found PCIT training materials to be clear and thorough.					
(17B) Periodic assessments of my knowledge and skill level as a PCIT therapist are beneficial to my training.					
(17C) I learned a number of useful techniques during my training that help me to more effectively administer PCIT to families.					
(17D) I feel that I have received enough training to enable me to implement PCIT effectively.					
(17E) I feel that my PCIT training experience so far has been worthwhile, and I would recommend it to my colleagues.					
(17F) I believe that PCIT is an appropriate treatment for families with young children with behavior problems.					
(17G) I feel committed to the behavior principles on which PCIT is based.					
(17H) I feel comfortable implementing PCIT as a treatment for children's conduct problems.					
(17I) I use/plan to use PCIT regularly with families of					

children with conduct problems.					
(17J) I feel confident in my current ability to administer PCIT.					

Other

(18) Is there anything about which I did not ask that you would like to share (e.g., what has gone especially well

_____

Thank you so much for your time.

Appendix C

PCIT Clinician Interview Guide

Hello. Thank you for taking the time to be interviewed. My name is _____ and I will be conducting the interview today. I am a graduate candidate at UCSB in the Department of counseling, clinical, and school psychology. I am part of a research team interested in learning about your training as a PCIT clinician. I will ask you some questions about your training in PCIT and experiences receiving ongoing supervision for delivering PCIT to Spanish-speaking families. There are no wrong or right answers.

First, I am going to ask you about your work in PCIT

1. Tell me about your background providing PCIT
2. What have been your experiences providing PCIT in Spanish?

Thank you for sharing about your background in PCIT. Now, I am going to ask you some more questions about your training to provide PCIT to Spanish-speaking families.

3. In what language did you receive PCIT training?
    a. *Training provided in Spanish or English?*
    b. *Opportunities to watch video clips in Spanish?*

4. Where there any **changes, adaptations, or modifications made** to your training for Spanish delivery of PCIT? What were they?
    a. *Tailoring/tweaking/refining?*
    b. *Changes in materials?*
    c. *Adding or removing elements?*
    d. *Shortening or extending?*
    e. *Integrating other strategies?*

5. What was your experience with access to and availability of PCIT training materials (e.g., translated manual, coding manual, Spanish videos for practice, etc.)
    a. Were materials in Spanish available/provided at your agency?
        i. *Treatment Protocol*
        ii. *DPICS Coding book*
        iii. *DPICS Coding quizzes / practice sheets*

6. Why where changes made? **What was the goal?**
    a. *Increase effectiveness?*
    b. *Increase acceptability / appropriateness / feasibility?*
    c. *Improve sustainability?*
    d. *Increase health equity / decrease disparities in delivery?*
    e. *Increase reach?*

7. What was missing in your training to deliver PCIT in Spanish?

   a. *What would have been helpful in your ability to deliver the intervention in Spanish?*
   b. *Did you have to translate materials on your own?*
   c. *Translations (process, particular words/phrases difficult to translate)?*

8. What have been your experiences with training to coach PCIT in Spanish?
   a. *Challenges?*
      i. *Translating/using certain PCIT concepts (e.g., timeout, praise)*
   b. *Differences in idioms?*
   c. *What helped make it work?*
      i. *What supports helped you deliver PCIT in Spanish?*

9. Have you seen any differences in how English speaking versus Spanish speaking families respond to coaching?

10. Did you get other forms of support in your training?
    a. *PCIT Spanish coalition*
    b. *Listserves*

Thank you for sharing these experiences. Now, I want to ask you specifically about your experience with ongoing supervision or consultation in your delivery of PCIT in Spanish.

11. Tell me about what ongoing supervision has been like?
    a. *Frequency*
    b. *Specific strategies offered?*
    c. *Is supervision done in English or Spanish?*

12. What **changes, adaptations, modifications** have been made to supervision or consultation to increase your ability to deliver PCIT in Spanish?
    a. *Tailoring/tweaking/refining?*
    b. *Changes in materials?*
    c. *Adding or removing elements?*
    d. *Shortening or extending?*
    e. *Integrating other strategies?*

13. Why where changes made? **What was the goal?**
    a. *Increase effectiveness?*
    b. *Increase acceptability / appropriateness / feasibility?*
    c. *Improve sustainability?*
    d. *Increase health equity / decrease disparities in delivery?*
    e. *Increase reach?*

14. What have been your experiences with supervision/consultation to support your coaching in Spanish?
    a. *Challenges?*
       i. *Translating/using certain PCIT concepts (e.g., timeout, praise)*

    b. *Differences in idioms?*
    c. *What helped make it work?*
        i. *What other supports helped your coaching in Spanish?*

15. What has been missing in supervision or consultation?

16. What would you like to see in future supervision or consultation to support the delivery of PCIT in Spanish?

PCIT Trainer/Supervisor/Consultant Interview Guide

Hello. Thank you for taking the time to be interviewed. My name is _____ and I will be conducting the interview today. I am a graduate candidate at UCSB in the Department of counseling, clinical, and school psychology. I am part of a research team interested in learning about your training as a PCIT clinician. I will ask you some questions about your training in PCIT and experiences receiving ongoing supervision for delivering PCIT to Spanish-speaking families. There are no wrong or right answers.

First, I am going to ask you about your work in PCIT

1. Tell me about your background providing PCIT Training/Supervision/Consultation
2. What have been your experiences providing PCIT Training/Supervision/Consultation in Spanish?

Thank you for sharing about your background in PCIT. Now, I am going to ask you some more questions about the PCIT training you provide, including for Spanish-language PCIT.

3. In what language do you provide training?
    b. *Training provided in Spanish or English?*
    c. *Show video clips in Spanish?*
4. Where there any **changes, adaptations, or modifications made** to the training your provide for Spanish delivery of PCIT? What were they?
    a. *Tailoring/tweaking/refining?*
    b. *Changes in materials?*
    c. *Adding or removing elements?*
    d. *Shortening or extending?*
    e. *Integrating other strategies?*

5. What was your experience with access to and availability of PCIT training materials (e.g., translated manual, coding manual, Spanish videos for practice, etc.)
    f. Were materials in Spanish available/provided at your agency?
        i. *Treatment Protocol*
        ii. *DPICS Coding book*
        iii. *DPICS Coding quizzes / practice sheets*

6. Why where changes made? **What was the goal?**
    a. *Increase effectiveness?*
    b. *Increase acceptability / appropriateness / feasibility?*
    c. *Improve sustainability?*
    d. *Increase health equity / decrease disparities in delivery?*
    e. *Increase reach?*

7. What may be missing in current training to deliver PCIT in Spanish?
    d. *What would have been helpful in your ability to train others to deliver the intervention in Spanish?*

    e. *Did you have to translate materials on your own?*
    f. *Translations (process, particular words/phrases difficult to translate)?*

8. What have been your experiences with training to coach PCIT in Spanish?
    a. *Challenges?*
        i. *Translating/using certain PCIT concepts (e.g., timeout, praise)*
    b. *Differences in idioms?*
    c. *What helped make it work?*
        i. *What supports helped you train other to coach PCIT in Spanish?*

9. Have you seen any differences in how English speaking versus Spanish speaking families respond to coaching?

10. Did you include other forms of support in your training?
    a. *PCIT Spanish coalition*
    b. *Listservs*

Thank you for sharing these experiences. Now, I want to ask you specifically about your experience providing ongoing supervision or consultation for PCIT in Spanish.

11. Tell me about what ongoing supervision/consultation has been like?
    a. *Frequency*
    b. *Specific strategies offered?*
    c. *Is supervision done in English or Spanish?*

12. What **changes, adaptations, modifications** have been made to supervision or consultation to increase your therapist ability to deliver PCIT in Spanish?
    a. *Tailoring/tweaking/refining?*
    b. *Changes in materials?*
    c. *Adding or removing elements?*
    d. *Shortening or extending?*
    e. *Integrating other strategies?*

13. Why where changes made? **What was the goal?**
    a. *Increase effectiveness?*
    b. *Increase acceptability / appropriateness / feasibility?*
    c. *Improve sustainability?*
    d. *Increase health equity / decrease disparities in delivery?*
    e. *Increase reach?*

14. What have been your experiences with supervision/consultation to support therapists' ability to coach in Spanish?
    a. *Challenges?*
        i. *Translating/using certain PCIT concepts (e.g., timeout, praise)*
    b. *Differences in idioms?*
    c. *What helped make it work?*

    i. *What other supports have you included to help therapists coaching in Spanish?*

15. What may be currently missing in supervision or consultation for PCIT in Spanish?

16. What would you like to see in future supervision or consultation to support the delivery of PCIT in Spanish?