The *Madres a Madres* Programme

Nancy G. Guerra, Professor of Psychology and Associate Provost for International Programs, University of Delaware, Newark, DE, USA

The *Madres a Madres* programme was developed specifically to address adaptation of parenting programmes to Latino families.
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Replication of evidence-based positive parenting programmes may not be as successful as the original if their adaptation to new cultural settings is only superficial. This article describes how the *Madres a Madres* ('Mothers to Mothers') home visiting parent-training programme was based on principles of evidence-based programmes, but designed specifically for the unique cultural and contextual needs of recent Latino immigrants to the United States. Early results suggest that the programme is successful in improving parenting skills.

Over the past two decades, there has been an increasing emphasis on building an evidence base of effective programmes to prevent childhood violence perpetration and victimisation. Although various standards of 'evidence' have been used, a commonly accepted gold standard requires a randomised controlled trial and at least one replication study for an intervention to be recommended as effective.

Using this standard, a number of best practices have been documented in specific developmental contexts including schools, peers, families and communities (for examples, see Blueprints for Violence Prevention at the University of Colorado[1]). Across these multiple contexts, family intervention and parenting programmes have emerged as particularly promising targets for intervention. Indeed, early interventions that increase parenting skills can lead to lower levels of harsh punishment and parental violence against children, as well as lower levels of children's aggression towards others (Sweet and Appelbaum, 2004; Eyberg *et al.*, 2008).

However, a key challenge in implementing these programmes in different cultural and community contexts is the extent to which even the 'best' practices are relevant across different settings. A gold standard of two evaluation studies, often with recommendations that implementation follows a strict protocol, does not adequately address potentially important cultural and contextual differences when implementing programmes with different populations.

These differences also may vary within specific population groups. For instance, several parenting programmes to prevent aggression and violence have been adapted and evaluated with Latino children and families. Many of these programmes have been successful with minor adaptations, such a translation into Spanish, incorporation of Latino family values, and use of ethnically matched intervention specialists (for a review, see Leidy *et al.*, 2010). Still, within the Latino population, very few programmes have been adapted specifically for recent immigrant families, and programmes adapted broadly for Latino families have been shown to be less successful for immigrants (Martinez and Eddy, 2005).

Tailored programmes for immigrant Latino families

The *Madres a Madres* programme was developed specifically to address this gap. It was developed as part of a collaboration between the Southern California Academic Center of Excellence on Youth Violence Prevention, funded by the Centers for Disease Control and Prevention (CDC), and a community-based agency, Latino Health Access (LHA), that served recent and predominantly Mexican immigrant Latino families. The CDC was interested in implementing and evaluating evidence-based programmes to prevent violence victimisation and perpetration in high-violence communities. In a similar vein, families served by LHA were plagued by increasing community violence, and also had asked the agency to teach them effective parenting skills.

Because the CDC encouraged use of evidence-based programmes, the collaboration initially selected and implemented a programme with strong empirical support, Families and Schools Together (FAST), that had been translated into Spanish and seemed to be a good cultural match for Latino values. However, the FAST programme yielded minimal and insignificant effects for the recent immigrant sample (Knox *et al.*, 2011).

In follow-up qualitative interviews and focus groups, families stated that they needed more specific information on parenting skills and discussed several unique challenges that were not addressed in the FAST programme. These included differences in levels of acculturation between parents and children, children speaking English and parents only speaking Spanish (leading to a reversal of the power structure), overcrowded housing, unfamiliarity with the US school system, and fear of immigration raids.

Families also had difficulty travelling to the intervention sites and arranging babysitting for other children. The cost to LHA of implementing the programme in multiple community sites also made it impossible to sustain the project without continued external funding (Guerra and Knox, 2008). Because these concerns were not adequately addressed in any of the available evidence-based parenting programmes, the next step was to tailor a programme to the specific needs of this population.

Indeed, we believed that the specific parenting skills that recent immigrant Latino families needed – coupled with the importance of feasible service delivery and implementation methods – required developing new, customised programmes. Rather than taking a 'packaged' programme and implementing it as developed, it was necessary to build on empirically supported principles of effective programmes but to tailor the programme to the unique circumstances of participants. This strategy guided the development of the *Madres a Madres* programme. Specifically, the programme was designed to build on critical components of evidence-based parent-training programmes while also incorporating identified parenting concerns of participants as well as feasibility of implementation for LHA.

We looked to the parenting literature to identify skills that were consistently associated with positive programme outcomes. Based on programme reviews and a recent meta-analysis of 77 parenting programme outcome studies (Kaminski *et al.*, 2008) we identified several, including positive communication strategies, time-out, consistent discipline skills, and regular practice of these skills in intervention sessions. In response to family concerns, we also included information on normative child development and on skills specific to immigrant families as discussed in focus groups with community residents. These skills included how to maintain authority when children speak English and parents speak only Spanish, how to interact with schools and other agencies to leverage community resources and be effective advocates for their children, and how to build social support networks.

To reduce stigmatisation commonly related to mental health care for Latinos and to increase the limited access and utilisation of services by immigrant populations, the programme was implemented in families' homes by lay community health workers (*promotoras*). Home visiting services have a long history of successful implementation in low-income and marginalised populations, and have been particularly effective in preventing child maltreatment and other health problems during infancy and early childhood (Sweet and Appelbaum, 2004). This approach is particularly useful for families who are unable to access regular transport or safe passage to clinic or agency-based services. Using lay community workers also facilitates cultural relevance and 'fit' to client needs, because the health workers are themselves parents from the same communities.

Promotoras were identified as coaches rather than experts. They were encouraged to spend time building rapport with mothers and connecting them with others. Overall, this method of service delivery is a cost-effective strategy for increasing engagement in under-served communities, to provide culturally sensitive intervention services, and to disseminate evidence-based practices (Perez and Martinez, 2008; Rotheram-Borus *et al.*, 2012).

The *Madres a Madres* programme

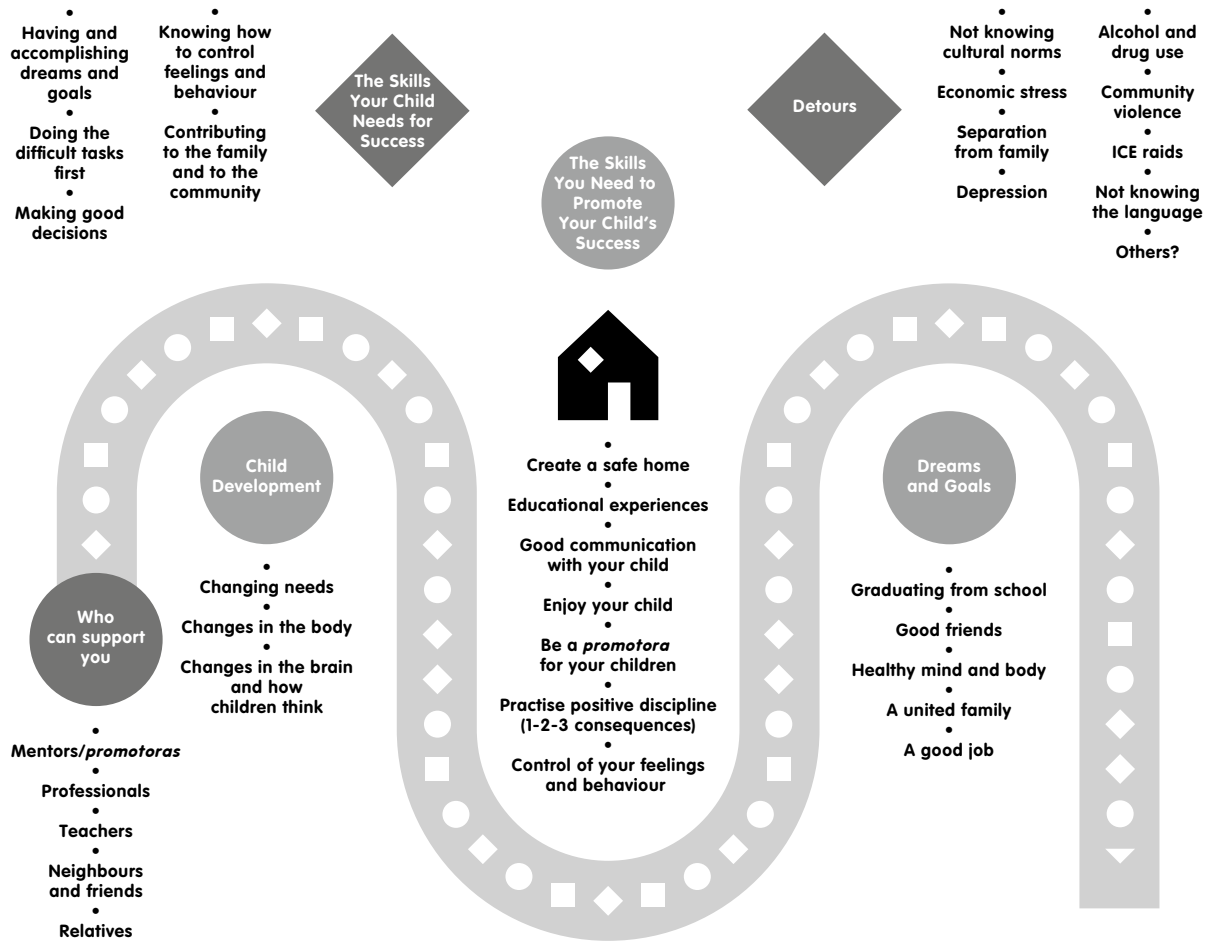
Because *Madres a Madres* was designed to be preventive in nature and feasible to implement under resource constraints, it was intentionally brief and was delivered in the home setting by lay community workers or *promotoras*. Although fathers and other family members or caregivers were invited to participate, only mothers enrolled in the initial pilot phase. Four 2-hour sessions were delivered over the course of 4 weeks. Instruction focused on specific core content areas:

1 normative child development and related social competencies
2 positive parent–child interaction techniques
3 positive behavioural management strategies
4 service navigation to support access to community resources.

Families had specifically requested information on normative child development – what to expect from their children at different ages, what behaviour was normal and what types of behaviour were cause for concern. To respond to this request, the programme taught basic concepts related to children's cognitive, physical and emotional milestones. Parent–child interaction techniques built on Parent–Child Interaction Therapy (PCIT) (McNeil and Hembree-Kigin, 2010). Mothers were taught to increase positive interactions with their child during a time-limited interaction period called '15 Magic Minutes' through the use of skills such as following the child's lead, reflective listening, and focused praise. During this period mothers spent time engaged in specialised activities and communication with their child. Skills and activities were adapted to fit the child's developmental level, including playing games with younger children (age 6–7) and making a meal for or just talking with older children (age 10–11).

During the sessions, *promotoras* taught or reviewed these skills, coached mothers, and then assigned the mothers homework to engage in the 15 Magic Minutes several times per week. Positive behaviour management strategies emphasised teaching mothers to ignore minor misbehaviour, to discuss rules with the child, and to implement a system of consequences including time-out

Figure 1 The Path of Hope



Source: Southern California Academic Center of Excellence on Youth Violence Prevention/Latino Health Access collaboration

and a contingency management system (Forgatch and Patterson, 2010). To encourage utilisation of community resources and child advocacy, *promotoras* provided mothers with relevant information about community resources (for example housing or food programmes, after school care). Mothers in the programme also were invited to take part in monthly meetings called *cafecitas* ('little cafés') or *quermes* (small charity fairs), designed to bring mothers from the same neighbourhood together to provide opportunities for social connection, support, and mobilisation around the needs of families in the community.

Visual materials, video segments, interactive role-plays, and worksheets were used as instructional aids. Materials were designed specifically for use with Spanish-speaking parents or guardians with low levels of literacy and integrated familiar, community-relevant content. Programme sessions were organised around The Path of Hope (*El Camino de Esperanza*), a visual discussion tool that oriented caregivers to the four intervention components shown in Figure 1. In the pilot phase, the mothers also developed a Personal Parenting Record (PPR) as their own strategic plan for child behaviour management goals. *Promotoras* and mothers developed

the PPR during the first session, and used it throughout the intervention to monitor goals and problem-solve any issues that arose.

Results and conclusions

Although *Madres a Madres* is a brief intervention, mothers who participated in our pilot study reported improvements in parenting skills and family functioning that were statistically significant compared to a matched control group. Mothers' improvement in parenting skills suggests that behavioural parent-training techniques are applicable to recent immigrant Latino parents as long as the issues addressed and the format for implementation are a good cultural fit. Results also suggest that relatively complex behavioural strategies can be taught successfully by lay community health workers. Further, although the skills taught did not directly address family functioning, mothers reported improvements in family support, organisation and cohesion.

We had been interested in whether this programme would also yield improvements in children's adjustment. Although we did not find significant differences in children's aggression, children of parents who participated in the intervention demonstrated statistically significant reductions in depression and internalising behaviours compared to children in the control group (Williamson *et al.*, in press). This finding is interesting because our sample was not drawn from clinically referred young people, nor was the programme specifically designed to address depression in children. It may be that the effects on parenting skills and family functioning created a more positive home environment that spilled over into children's emotional adjustment.

Still, it is important to bear in mind that this programme was implemented with a specific sample of immigrant Latino families from Mexico living in Southern California during the mid- to late 2000s. The culture of immigrant Latino families is not homogeneous and contextual and historical circumstances may differ widely across Latino individuals and immigrant groups. As such, this study is limited in its generalisability to Latino immigrants from different countries, as well as to immigrants in general. What it does point out, however, is that adapting programmes for different cultural groups and in different contexts requires more than surface-level modifications (such as translation into Spanish) of existing programmes. A more nuanced approach utilises principles of evidence-based practices that can be mapped on to specific needs, priorities and challenges in local cultures and settings.

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Note

1 The Blueprints can be accessed via the website of the Center for the Study and Prevention of Violence, at the University of Colorado, Boulder, USA: http://www.colorado.edu/cspv/effectiveprograms.html