Being raised in a context outside the White American middle-class experience can lead an interventionist to approach parent training (PT) dissemination with some trepidation about the fit of standard practice with the sensibilities of immigrant families. How would my own immigrant Chinese parents have responded to this guidance in childrearing? How would specific PT practices be viewed, and how could they be encouraged in families who may be wary of or wholly unaccustomed to these strategies?

I have previously argued that cultural adaptations should be guided by data that inform the design of specific content or process adaptations (Lau, 2006). This would safeguard against less defensible, improvised drifts away from fidelity that may be inert or even detrimental to treatment outcomes. For example, displacing skills training to include discussion of cultural values decreased the efficacy of the Strengthening Families Program adapted for Asian American and Latino families (Kumpfer, Alvarado, Smith, & Bellamy, 2002). Accordingly, we conducted a series of studies to inform adaptations.

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that would be relevant and responsive to the needs of Chinese Americans. This chapter includes reflections on the research pursuits that proved fruitful and those that did not.

At the outset, our approach to adaptation was top-down, to be driven empirically by research findings in the aggregate rather than by clinical observation. Many clinical scientists have been socialized to mistrust such observations, valuing only data from conventional research methods, which may not shed light on rich clinical phenomena (Miller, 1998). This can be contrasted with a bottom-up approach, where adaptation starts with observations made during implementation. Adopting the former strategy had much to do with our initial readiness to exploit survey research methods, focus groups, and semistructured interviews for gathering information from families and community clinicians. In practice-ready contexts, deployment-focused models of adaptation may be more quickly pursued in a bottom-up approach.

Cultural adaptations were envisioned as falling into two categories: those designed to enhance engagement of ethnic minorities in evidence-based treatments and those meant to contextualize intervention content to ensure the fit with the needs of the target group (Lau, 2006; see also Chapter 2, this volume). A set of Phase 1 studies was designed to inform these two types of adaptations to be worked out in Phase 2 and tested in Phase 3. In hindsight, the utility of much of the data that could be generated by these Phase 1 studies may have been overestimated. In contrast, the lessons learned in the intervention deployment in Phase 3 have been highly instructive. We did not fully appreciate the feedback loop from deployment to adaptation design and the vital importance of practice-based evidence in informing evidence-based practice.

In this chapter, we discuss the path traversed to our revised hypotheses about promising strategies for optimizing PT for immigrant Chinese families. This path had some blind alleys and detours, but thankfully some thoroughfares, too.

**PHASE 1A: DATA COLLECTION EFFORTS FOR ENHANCING ENGAGEMENT**

**Social Validity Survey**

Previous efforts to produce cultural adaptations of PT have been fueled by concerns about the acceptability of PT strategies for ethnocultural groups (e.g., McCabe, Yeh, Garland, Lau, & Chavez, 2005). Since there is wide variation in parenting practices across cultures, there may likewise be wide
variation in receptivity to prescribed changes in parent–child interactions (Kazdin, 1997). Forehand and Kotchick (1996) outlined central cultural values, sociocultural experiences, and common parenting practices among the four major ethnocultural groups that may require reconciliation with PT approaches. Mistrust may arise if PT is seen as promoting conformity to a White American standard unshared by ethnocultural groups. Understanding the acceptability of PT interventions across groups may direct our attention to techniques that require adaptation.

Social validity studies ask potential consumers to rate specific PT techniques along dimensions of acceptability (i.e., is the treatment palatable, feasible, or helpful?). Research on the acceptability of PT across immigrant groups is sparse in general. We collected data on the perceived acceptability of common PT strategies among immigrant Chinese parents, examining cultural correlates of treatment attitudes (Ho, McCabe, Yeh, & Lau, 2011). We presented parents with an externalizing behavior problem vignette and described six PT strategies (praise, differential reinforcement, tangible rewards, effective commands, time out, and response cost). Parents rated statements pertaining to acceptability (e.g., “I would be willing to use this method”), barriers (e.g., “This method would be difficult to do”), and anticipated support for this method from others (e.g., “My spouse would help me with this method”).

We found that parents rated praise, effective commands, and tangible rewards as more acceptable than time out, response cost, and differential attention. These findings were at odds with clinical descriptions of Chinese parents disliking praise and rewards given their cultural belief that children should simply be expected to obey and comply (Ho et al., 1999; Liew-Mak et al., 1984). PT acceptability ratings were positively associated with indices of acculturation, parenting stress, and authoritative parenting, but negatively associated with cultural values concerning the use of shaming as a child socialization practice and a history of child protective services involvement. Our findings supported the concern that less acculturated immigrant parents who endorse traditional values regarding hierarchy and control in the parent–child relationship may be more difficult to engage in PT. Thus, the data confirmed impressions from the clinical literature that there is some cultural distance between PT strategies and values concerning parent-centered control among Chinese parents.

The findings were limited in practical utility in informing how to better engage Chinese parents in the intervention. We could not infer how to adapt teaching “time out and ignore” simply on the basis of lower acceptability ratings. Furthermore, we had to be circumspect about our interpretations given the analogue design of the study. Ultimately, surveys of treatment acceptability among non–treatment-seeking samples may not be a reliable indicator of the
social validity of interventions when offered in treatment settings. Among parents who have received PT, perceptions of the acceptability, relevance, effectiveness, and demandingness of procedures are associated with treatment persistence and outcomes (Kazdin, 2000; Kazdin, Holland, & Crowley, 1997). In contrast, ratings of treatment acceptability among parents not yet in treatment fail to predict the initiation of care across ethnic groups (Bennett, Power, Rostain, & Carr, 1996; Krain, Kendall, & Power, 2005). Reactions to descriptions of PT procedures may not predict engagement when quality care is received within a therapeutic relationship. On the other hand, attitudes toward techniques tend to become more favorable following initiation of PT (Hobbs, Walle, & Caldwell, 1984).

Our data did not provide guidance on how to tailor PT to be more engaging for the Chinese American families who are most likely to be skeptical—those who are less acculturated and who have had involvement with child protective services. Thus, the data were interesting but not instrumental in the adoption process—the first blind alley. In hindsight, by relying on survey methods, we missed an opportunity to engage in open-ended discussions with Chinese American parents about what they liked, what they would engage in, and why. Qualitative data may have been instrumental in learning how pre-treatment attitudes could be affected through effective engagement processes during PT. Toward this end, we did enter into conversations with therapists working with Chinese immigrant families in community settings.

Focus Groups With Community Clinicians

We conducted three focus groups with 24 bicultural, bilingual Asian American (70.8% Chinese American) psychologists, social workers, and marriage and family counselors with experience treating immigrant parents and their children in community clinics. None of the therapists reported training in a specific evidence-based PT intervention, although most were providing individual or group parent counseling. We began each group with an orientation to the basic skills taught in a typical evidence-based PT program. We introduced and showed videotapes to illustrate child-directed play, praise, tangible rewards, differential reinforcement, and response cost. We then facilitated discussion about the cultural relevance and acceptability of each strategy and likely barriers to engagement or effectiveness when delivered to Chinese immigrants. Presented next are clinician impressions about the cultural relevance of PT practices that emerged using steps outlined in Krueger’s (1994) practical framework analysis approach. Raw transcript data were indexed and charted from transcribed text into tables, and criteria for theme extraction were based on frequency, extensiveness, and specificity following Krueger and Casey (2000).
Play

In many PT programs, child-directed play is introduced first as a means toward strengthening the parent–child relationship in families where child compliance and positive parenting are in low supply. The effective application of positive discipline is thought to be accomplished best when the child is invested in a responsive relationship with the parent. This type of play requires the parent to increase attention to the child’s prosocial behavior, follow the child’s lead (rather than directing the play), and use descriptive commenting and praise. Focus group clinicians’ comments about play skills fell into three related categories of concern: (a) lack of familiarity, (b) credibility of the goal, and (c) need for experiential learning.

Several therapists remarked on the incongruence between the concept of child-directed play and the nature of parent–child interactions in East Asian cultures. One therapist explained, “Play generally isn’t something that Asian parents and their kids do, it’s not hierarchical. . . . There’s a proper position of the parent and the child so that following the child doesn’t fit.” This commentary is consistent with the common description of Confucian family structure, in which parental authority and child obedience organize interactions. Another therapist elaborated, “Culturally, this kind of play is almost nonexistent. It’s not seen as something that’s beneficial. The Chinese culture is more achievement oriented. So everything has to have educational value.” In PT, parents may be asked to refrain from play that places academic demands on children (e.g., counting or adding objects). A third therapist anticipated parent objections:

They will say, “Well when I was a kid no one played with me. I just had to do my work. Therefore, I expect my child to work.” So, I think just in terms of cultural factors, the idea of play is foreign and maybe not acceptable.

Yet many clinicians saw play as integral to the success of repairing parent–child relations that have gone awry in clinic-referred families where child behavior problems and ineffective discipline have taken root. Many emphasized the importance of experiential learning in place of didactic instruction on playing: “They need to experience it, they just have to try it and feel it. . . . We played two sessions and they were so loud, they used to be really quiet. I was surprised . . . it’s better than just talking about it.”

Another therapist was more circumspect about engaging his clients in learning the skills involved in child-directed play. He anticipated reluctance and a steep learning curve:

Asian parents would say “I don’t have the time” and also that they probably would tell the kid what to do instead of follow the child’s lead. I think it would take us maybe 5 months to get the concept into their mind and to get them to carry it out.

ADAPTING PARENT TRAINING FOR CHINESE IMMIGRANTS
Although therapists reported or anticipated problems in teaching child-directed play, there was optimism among the clinicians who had incorporated play into their work with Chinese immigrant families. These therapists tended to adopt an enactment strategy to engage parents in developing this skill. There was a shared impression that immigrant parents who did not initially see the value of play would be compelled to change their interactions with their child once they engaged in this self-reinforcing activity. Thus, behavior change may precede changes in attitudes or values. Although some therapists indicated that it would be important to address parents’ misgivings about play (e.g., children would have less respect for parents), at least one therapist felt that too much time focused on cultural barriers would by itself be unproductive.

Praise

Focus group participants described cultural beliefs about motivations that contraindicate praise: “They believe the more you praise them, the more you’ll spoil them,” and “Everyone says they won’t try hard if you praise them.” This is consistent with research indicating that East Asians tend to hold a self-improving orientation in which criticism of performance motivates task persistence, whereas White Americans hold a self-enhancing orientation to maintain self-esteem (Heine et al., 2001):

Praising—that’s not in the formula. They don’t praise for what is an expectation—to do well in school, to do your chores. . . . And if you’re doing a good job you should know it. When you are not doing it right, that’s when they start telling you. And they bring it up over and over. The parent has to remind you about the bad thing that you did wrong rather than discipline you for that behavior and move on.

As a result, some clinicians reported difficulties trying to teach praise as a culturally unfamiliar practice:

Praise comes from a very Western stance of nurturing as a parent, and for an Asian parent it can be very foreign. Their role as parent is not about nurturing emotional development . . . So it’s really it’s very difficult to engage in.

Praise was also thought to misalign the desired hierarchy in the Chinese parent–child relationship: “I think that [parents] have their status threatened. They feel that respect is commanded . . . if they praise their kid too much, the kid will think they are better than them.”

A number of seasoned clinicians offered suggestions for countering these concerns to engage parents in using praise. Again, therapists discussed
therapy process and experiential learning. They described the parallel process of praising their parent clients:

I just sit back and say "How do you feel about how I praise you?" And most of them have very positive feedback, "Oh teacher, I really feel a little bit more confident." "What do you think your child would feel if you try doing that? Do you think your child would have overblown self-esteem because of too much praising?"

Another therapist remarked on the importance of using acceptable translations of the concept, which can drive treatment attitudes:

In Chinese, praise is sort of like sugar-coating something. I change the word to encouragement, to reflect how it's good to reinforce their behaviors. So I don't use the word "praise" (biao yan kan). Instead, I say "li kan" (encouraging).

Other therapists stressed the importance of psychoeducation about the special family context of the immigrant parent raising a child in a new culture:

I go back to the need for bicultural parenting and their understanding that they are not raising a child that will be socially appropriate in China, but a child that is going to be socially appropriate in America, and that requires different skills.

This therapist captured the notion that therapy can be a vehicle for adaptation of immigrants into the host "American" culture (Bernal & Domenech Rodríguez, 2009). Such adaptation can be promoted in a supportive, affirming manner without requiring a loss or condemnation of the person's culture of origin, and even with a celebration of that culture. In contrast, behavior change can be promoted through PT in a culture-disconfirming manner, communicating that traditional parenting practices are inferior or deficient. Introducing the goal of bicultural competence is one avenue toward engaging parents in a culture-affirming manner.

Therapists illustrated the bicultural context of children in immigrant families by highlighting how children must bridge across both home and school cultures. Since school adjustment is a major concern of Chinese American parents, they may be encouraged to try praise to align with American school culture. One therapist shared her approach:

I say, "All of this worked back in China, and it was great. It worked on you, you turned out fine. But here your children have a lot of different influences. They're getting different cultural feedback from teachers and friends and other people. So, you're not necessarily doing things wrong, but it's different here because of what your kids are experiencing."
Likewise, another therapist attempted to build empathy for the bicultural child: "When the kid enters school, the teachers always praise them. And now they come home and they expect you to say something. And when you don’t do it and always criticize, how does he feel?"

Moreover, Chinese parents’ lack of personal experience being praised presents difficulties even when they are willing to try. “They just can’t say it out loud. It’s like they don’t know how to say it in words. I try to have them practice in class, you know, it’s really hard for them.” Another therapist observed that learning to use praise is a long and slow process for immigrant parents:

It’s not one session you talk about praise, and then they will learn how to praise. They need to learn how to see the positive side of the kid. Usually it’s towards almost the end of the treatment they will start getting just a little more positive.

So even when Chinese immigrant parents can be convinced that praise is a helpful strategy, they may need additional support in learning it.

Tangible Rewards

In all three focus groups, there was consensus about Chinese American parents’ attitudes toward tangible rewards for increasing desired behaviors in children. Chinese American parents reportedly felt that concrete reinforcers were acceptable, but they had difficulty implementing the systems effectively: “They were open to trying it out. But they had issues following through with it.” Several therapists reported problems with execution: “They just don’t do it . . . So each time I go to the home visit I reintroduce the whole strategy all over.” Another stated,

You tell them how to do it. We give them the sticker sheet and all that, and walk them through it, step by step. They always miss something. And then they give up so easily. They say, “Oh it doesn’t work.”

Other therapists reported that their clients don’t adhere to the plan:

Once they get home, the rewards start to change. They don’t give the kid the rewards according to what was put on the paper. Because they feel the kid is now getting the advantage. They start changing it at home, it starts to drift into something else. They demand more for the rewards.

The therapists did not locate these difficulties as uniquely cultural; they instead emphasized the importance of best practices in setting up and monitoring tangible reward systems with Chinese American families. In establishing the system,
Chinese parents will say, "Do well. Be good." I say that's not concrete enough. When they say "be good" that means a lot of things. So, we practice in the class. I say, "Okay, tell me what do you mean by 'be good'?

The therapists cited the importance of close monitoring and accountability:

Consistency has really been difficult for most parents. So I have them bring in their behavior charts every session to make sure that they've been consistent. And then I also ask the children, "Has your mom been giving you the stickers when you did this or that this week?" Sometimes they'll say as they come in, "My mom didn't give me stickers this week and I did all the dishes!" So that really helps to point it out because if you're not consistent then they don't need to be consistent.

These comments suggest that clinicians may not necessarily encounter a cultural impasse regarding the appropriateness of rewards; rather, sometimes the challenges concerned getting the parents to adhere to a consistent reinforcement schedule. It may be productive to proceed under the assumption that parents have genuine difficulty implementing a novel strategy and to address possible "resistance" when parents explicitly raise concerns or objections.

Differential Reinforcement (Ignoring Misbehavior)

Therapists discussed common cultural barriers to Chinese American parents' acceptance of the differential reinforcement of other behavior, in which bothersome behaviors (e.g., protesting) are ignored and attention is restored when appropriate behavior (e.g., compliance) begins. Ignoring annoying misbehavior and tantrums is difficult for parents across groups. Common concerns were raised: "They have a really hard time because 'the neighbors will complain, we live in an apartment, it's so embarrassing.'" In addition, our informants located Chinese parents' concerns in cultural ideals about the appropriate role of parents. "They are very cultured to reprimand and criticize and yell and direct . . . When you talk about ignoring the kid, they think you are giving the child more power." A central concern about ignoring misbehavior centered on threats to face:

Ignoring is very hard for Chinese parents because usually they will do whatever it takes to stop the misbehavior, especially in public, because they think it's really shameful. To just stand by and wait for the behavior to stop is unacceptable. . . . They cannot tolerate what they see as doing nothing.

The impulse to do something to quell misbehavior feels urgent—not only for correcting the child but also because of those who may be watching and judging the parent.
One therapist described an instance of how she used therapeutic process to leverage these concerns about shame and embarrassment to motivate parents:

One kid would tantrum from my clinic all the way home. He would cry and scream and the mom would be so embarrassed. At the next session she would say “You asked me to ignore his tantrum, but as we walked people were looking at us and I feel so embarrassed.” And that’s when I took the opportunity to validate her feeling, provide support, and help her understand that, yes, at the time you may feel embarrassed, but I ask her, “So, do you want him to change? Do you want him to continue to tantrum every time he wants something? If you set your firm limits ‘No, you’re not gonna get it’ and ignore him, he may tantrum one time, two times, but then likely his behavior will change. But, if he doesn’t change, that means a lot more embarrassment in the future.”

While some therapists reported avoiding the concept of ignoring misbehavior because of cultural concerns, others reported that Chinese parents often arrive at the clinic at a critical teachable moment when their level of distress is high. One therapist explained,

They have to yell a lot, they feel like they’re so exhausted, so stressed because they have to keep doing that. So I try to motivate them, “Okay, try something new. You don’t have to keep doing that.” I try to convince them, “You’ll use less energy later because it works.” So I think when they are so desperate and so exhausted, they’ll come to a point that they’ll try something different.

One therapist described how she explains to distressed parents that ignoring can be a form of self-care, telling them, “Ignoring is a good place to take a break.”

Time Out

As in our discussion of ignoring, many practical concerns were raised about implementing time out in close living quarters with neighbors all around, and harried days where it is hard to take the time for time out. “They will not do time out. It’s too inconvenient. It’s just easier to yell or spank right away and then it’s done. Time out takes too much time and effort, and it’s hard to do.” In addition, specific cultural barriers to time out were detailed:

I think that Western culture emphasizes that the reason for time out is that the child will be able to calm down and think over what’s going on. Time out is sort of a social deprivation. But, at the same time, the Chinese do not think of it that way. I think the Chinese culture focuses on more immediate correction. Right back to the reprimand; not “You’re on your own to think about it” But “I’ll tell you what to think.”

142 ANNA S. LAU
In this view, parental control and hierarchy trump using time out as a way to help children cultivate self-regulation. Some therapists described Chinese parents’ more punitive orientation as a barrier to effective use of time out:

It is important to educate the parents about what you really want to accomplish through time out, to encourage it to be practiced right, instead of them using time out as a punishment. . . . They say, “You kneel down there on the floor in front of the altar.” Sometimes they put uncooked rice on the floor, so it is borderline abuse. So really they don’t understand what time out is trying to accomplish.

These examples suggest that some Chinese parents may be inclined to use punitive responses to misbehavior and require a very clear explanation of the rationale of negative reinforcement.

Other therapists described Chinese immigrant families who felt that time out was too aversive and threatening to the parent–child relationship:

They think it’s too cruel to leave your kids somewhere all locked up by themselves and a lot of times the parents cry, too. They have a hard time with their kids not liking them if they put them in time out. So, I try not to do time out because they’ll say “Oh sure, I’ll use it,” but then they won’t follow through.

Another therapist reported, “Some Chinese parents see this as worse than hitting because it is social deprivation.” From these examples, it is difficult to predict responses to an intervention strategy in a given cultural group because of the large intragroup variability. The same range of responses to time out was reported by McCabe et al. (2005) in their work with Mexican American parents, with some viewing time out as too aversive to children and some viewing it as not punitive enough. These observations highlight the challenge of ensuring that an intervention is flexible enough to accommodate variability within any particular cultural group.

Response Cost

Therapists reported that Chinese parents are generally very open to using loss of privileges as a consequence for child misbehavior. They reported few cultural barriers to acceptability, but many shared examples of common barriers to teaching effective use of response cost. For example, Chinese American parents with a more punitive orientation required extra guidance in using realistic and enforceable consequences, “so I also have to teach them is that you don’t give them consequences until you cool down. Don’t tell him you’re grounded for the whole week if you’re not ready to follow through with it that whole week.” Therapists described the need to teach and reteach this strategy a number of times.

ADAPTING PARENT TRAINING FOR CHINESE IMMIGRANTS 143
They need constant reminding. Just because this week they did it beautifully, the next week you still have to remind them, reinforce them for their own behavior as parents. And their own commitment to change, you constantly have to reinforce that too. Because otherwise, even though they did it once last week, they may say “Well, I don’t need to do that. Forget it, that’s hard.”

Thus, the challenge in teaching response cost was not as much about overcoming misgivings as about providing sufficiently sustained training and reinforcement of an acceptable technique that requires practice and reinforcement.

Results and Implications for Adaptation

Many by-products emerged from the conduct of these focus groups. First, mutual interest in PT was kindled, and good things came of it. None of our participants had previously been trained in an evidence-based PT intervention, but the majority had been providing treatment informed by social learning principles. Among some participants, attendance at the group catalyzed interest in receiving training, and facilitating these conversations led to community–university partnerships that were instrumental in building capacity for implementation. Three of the focus group participants ultimately became involved in the later phases of our research as clinicians, administrators, and consultants.

Second, it was instructive to hear from clinicians in practice, to adopt a learning role, and to receive feedback that not only described problems but also provided solutions. Table 7.1 summarizes some observations about specific cultural barriers to engagement in PT among Chinese parents, as well as the specific strategies for addressing these barriers.

PHASE 2A: A ROAD MAP FOR ENGAGEMENT

Gathering perspectives on PT from parents and clinicians working with this population yielded interesting areas of convergence and divergence in terms of implications for cultural adaptation. For example, discussions with therapists who had varying levels of success implementing PT indicated that Chinese immigrant parents do not use praise and thus may be likely to reject instruction in this skill. Yet, parent survey data suggested high absolute levels of acceptability of this strategy. One possible interpretation is that parents who are most likely to have misgivings about praise are the ones who have typically ended up in treatment contexts for PT (e.g., less acculturated parents mandated to treatment). Immigrant Chinese parents may want to use praise but have not had the experiences that let them learn how. It may be unfair to attribute failure
### TABLE 7.1
Summary of Therapist Feedback

<table>
<thead>
<tr>
<th>Technique</th>
<th>Barriers</th>
<th>Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Praise</td>
<td>Beliefs about praise reducing effort, humility&lt;br&gt;Praise is foreign hence difficult</td>
<td>Experiential learning&lt;br&gt;Praise in the therapeutic relationship&lt;br&gt;Behavior change precedes attitude change</td>
</tr>
<tr>
<td>Child-directed play</td>
<td>Challenges parent-child hierarchy&lt;br&gt;No experience, play does not come naturally</td>
<td>Psychoeducation on bicultural parenting&lt;br&gt;Ample modeling and supported rehearsal</td>
</tr>
<tr>
<td>Differential reinforcement</td>
<td>Ignoring misbehavior threatens face&lt;br&gt;Prefer punishment</td>
<td>Behavior problems at clinic entry represent a teachable moment&lt;br&gt;Framing as instrumental for reducing future “shameful” behavior&lt;br&gt;Ignore/time out in the context of self-care&lt;br&gt;Make purpose clear</td>
</tr>
<tr>
<td>Time-out</td>
<td>Seen as inconvenient, difficult&lt;br&gt;Prefer punishment, ad hoc punitive measures added&lt;br&gt;Separation seen as cruel by some</td>
<td>Hold parents accountable for consistency&lt;br&gt;Thorough teaching of concepts, emphasize feasibility and sustainability&lt;br&gt;Monitor use throughout treatment</td>
</tr>
<tr>
<td>Response cost</td>
<td>Generally acceptable&lt;br&gt;Difficult to set enforceable consequences when angry</td>
<td></td>
</tr>
<tr>
<td>Tangible rewards</td>
<td>Generally acceptable&lt;br&gt;Difficult to follow through, parents withholds agreed-upon rewards</td>
<td></td>
</tr>
</tbody>
</table>

to praise as culturally rooted resistance when real skills deficits need to be addressed through additional supportive instruction. One must also consider that the focus group clinicians had varying levels of experience and did not have training in an evidence-based protocol. Their frustration was apparent at times, and their statements suggested that they may not have been supported with sufficient training and supervision in PT.

Taking together the data from parents and clinicians suggested distinctive directions for PT adaptation. First, cultural barriers to engagement are likely to be significant, especially for parents with low levels of acculturation who are not voluntarily seeking PT. Some barriers may be located within culturally rooted misgivings about prescribed PT strategies, whereas other barriers may be attributed to immigrant parents’ difficulties in initiating foreign practices. As such, culturally competent PT must flexibly address parental concerns about cultural incongruence of techniques through effective therapeutic process. This
is accomplished in a culturally affirming manner driven by respectful listening and discussion to reveal points of concern that motivate change toward shared and valued goals. However, motivational enhancements to address cultural concerns may not be sufficient without highly supportive instruction in novel techniques. Modeling, enactment, rehearsal, and monitoring of parental use of PT techniques is essential precisely because of potential cultural misgivings and the strangeness of the techniques. Thus, engagement must involve (a) anticipating but not assuming cultural misgivings about PT, (b) building in therapeutic process elements to reveal points of cultural concern and to responsively motivate change toward valued goals, and (c) supporting progress in behavior change.

As an optimal starting point, we selected a PT model with evidence of engagement and efficacy for immigrant parents. The Incredible Years (IY) program utilizes videotape modeling and group discussion to teach effective parenting skills in a collaborative rather than didactic manner (Webster-Stratton, 2011). Given the potential for low acceptability of some fundamental PT strategies, such as praise and ignore, the intervention builds in methods to address attitudinal barriers to engagement. As each technique is introduced, the group collectively generates a list of benefits and barriers. Thus, the leader actively elicits and explores cultural barriers to using the technique but also motivates uptake by drawing parallels between the benefits of the technique and parents’ stated goals. In each session, videos of parent–child interactions are viewed, and the group leader facilitates a discussion in which the parents construct the key principles underlying effective parenting. Treatment manuals orient leaders toward common attitudinal barriers to each skill (e.g., concerns that praise will “spoil” children) and provide guidance on using group process to address these concerns. Group processes leverage experiential learning, such as praising and rewarding parents in session as they are instructed to do with their children. In addition, IY emphasizes enactment and rehearsal, with role-plays, homework assignments, and close monitoring and feedback on parent performance.

In these ways, the IY model has built-in strategies for enhancing engagement of culturally diverse parents in ways that were described as necessary by our focus group participants. Our material preparation, training, and ongoing supervision emphasized methods to capitalize on the manualized therapeutic processes outlined in the IY program to enhance engagement. In our translated manuals, we highlighted common misgivings about each technique that were listed (e.g., praise will lead to poorer effort) and the relevant discussion points to address each concern. In supervision, we role-played culturally responsive strategies for engaging Chinese parents (e.g., how to initiate and support role-plays), discussed culturally sensitive communication styles (e.g., how to address reticent or mistrustful Chinese parents), and shared ways of explaining concepts...
that included reference to cultural idioms (e.g., li kan instead of biao yan kan) and references (e.g., in discussing communication we present the Chinese character for “listen,” which includes radicals for “heart” and “ear”).

PHASE IB: DATA COLLECTION FOR CONTEXTUALIZING TREATMENT CONTENT

The second thrust of the adaptation was premised on the identification of culturally relevant risk factors for ineffective discipline in immigrant Chinese families. If the target problem emerges within a distinctive sociocultural context, adaptations should address culturally specific risk processes (Lau, 2006). PT has often been augmented to address ancillary stressors (e.g., marital conflict) that interfere with the uptake of effective parenting skills (Miller & Prinz, 1990). We conducted a survey to examine correlates of punitive discipline among Chinese immigrant parents to identify instrumental treatment goals to target in an augmented PT program for high-risk families (Lau, 2010).

For immigrant families, stress associated with immigration, acculturation, and minority status may interfere with effective parenting. Parents may be subject to acculturative stress stemming from discrimination, communication barriers, discomfort with new cultural norms, lack of social support, or downward social mobility (Liebkind, 1996; Williams & Berry, 1991). These strains may erode effective parenting when coping resources are overwhelmed. Within the immigrant family system, adjustment difficulties can arise as children acculturate more rapidly than their parents, resulting in estrangement (Portes & Rumbaut, 2001). These acculturation gaps have been associated with increased conflict, low cohesion, and parental aggression in Asian American families (Farver, Narang, & Bhadha, 2002; Lee, Choe, Kim, & Ngo, 2000; Park, 2001; Ying, Lee, Tsai, Lee, & Tsang, 2001). Another potential source of stress concerns academic performance. In Chinese families, schooling is considered the primary responsibility of parents, and a child’s success in school indicates parenting competence (Chao & Tseng, 2002). Chinese immigrants often migrate to invest in their children’s schooling, sacrificing the security of extended family, community, and homeland (Fuligni & Yoshikawa, 2004). A child’s poor performance in school may be risky given both the cultural traditions valuing achievement and the lofty investment of immigration made for educational opportunity.

In our survey of Chinese immigrant families, we examined cultural values related to parental control, contextual stressors related to acculturation, parent-child acculturation conflicts, and problems in children’s schooling as predictors of physical discipline (Lau, 2010). Our findings indicated that children’s problems in school were directly associated with increased risk
of physical discipline. Parental acculturative stress contributed to risk indirectly through increased child school problems and acculturation conflicts. In addition, parent–child acculturation conflicts were related to risk of physical discipline when parents held traditional values about firm parental control. Immigrant Chinese parents who strongly valued hierarchy and control may respond more punitively to an acculturated child’s bid for autonomy.

PHASE 2B: AUGMENTING PARENT TRAINING TO REDUCE RISK

This survey provided the data to guide the design of an augmented IY protocol to reduce ineffective discipline among immigrant Chinese. We augmented the IY Basic Parenting program by including three supplemental modules to target the strains we found to be most proximal to use of physical discipline in immigrant Chinese families. Content and materials for these sessions were extracted from IY Advanced program and the IY School-Aged program for Supporting Your Child’s Education. The resultant protocol included 14 sessions, nine of which covered the basic skills of goal setting, child-directed play, praise, tangible rewards, effective commands, ignoring misbehavior, time out, and logical consequences. The augmented content covered the skill domains introduced to address the identified risk factors.

First, cognitive restructuring was introduced to help parents to control upsetting thoughts about children’s bids for autonomy and school-related problems that concerned the use of punitive discipline. Cognitive restructuring activities were focused specifically on maladaptive cognitions triggered by child misbehavior or school-related problems. Parents were taught to identify their upsetting thoughts about child noncompliance that lead to ineffective parenting. Common examples are blaming attributions that lead to overly punitive discipline or helpless thoughts that lead to inconsistent discipline. Parents were taught to replace upsetting thoughts with nonblaming, self-efficacious thoughts that mobilized effective behavior management strategies. For example, when a child leaves a mess and does not comply with a request to tidy up, parents are taught to identify their blaming thoughts (“He is lazy and spoiled, he shows me no respect”) or helpless (“No matter what I do, he never listens”) and replace them with calming and empowering thoughts (“He’s still young, it’s my job to help him follow directions”).

Second, training in psychoeducation and communication skills was added to help reframe and resolve recurrent conflicts in immigrant families. This content was introduced to support bicultural parenting skills in immigrant families. Training focused on active listening and communication skills to be used in structured, routine family meetings. Parents were taught problem-solving steps to elicit the child’s perspective on the problem, communicate
their own concerns effectively, collaborate in generating a variety of solutions, evaluate the options, make a plan, and monitor the results. This technique may run counter to cultural expectations for parental authority and is introduced as an important adaptation for the bicultural family. We emphasized that parents guide and evaluate the appropriateness of solutions generated, and thus parental authority is not incompatible with open discussion and problem solving.

Third, to prevent punitive responses to school problems, strategies were introduced for increasing positive parental involvement in children’s schooling. Although Chinese American parents are deeply invested in their children’s achievement and provide significant instrumental support in the form of resources (e.g., study materials, computers, tutors) or relief from other obligations (e.g., household chores), they are less likely to monitor homework, assist with school problems, or guide study habits than are White American parents (Asakawa, 2001). First, parents were encouraged to show interest in their child's learning to further build the parent–child relationship. Next, they were taught strategies for structuring a homework routine, with attention to limiting screen time. Parents were instructed on how to support study skills and coach persistence in the face of academic difficulties. Finally, parents were taught how to communicate effectively with teachers to proactively address challenges their children encounter in school.

PHASE 3: DEPLOYMENT-FOCUSED RESEARCH—THE TEST DRIVE

We conducted a waiting-list controlled pilot trial to evaluate the feasibility and effects of the augmented IY program (Lau, Fung, Ho, Liu, & Gudino, 2011). Fifty-two Cantonese or Mandarin-speaking Chinese immigrant parents were referred to treatment for concerns about ineffective parental discipline or child behavior problems. Referral sources included schools, community mental health clinics, and child protective services. Participants were assigned to groups of six to nine parents on the basis of their area of residence and preferred language (Cantonese or Mandarin). Six groups were randomized to receive either immediate (n = 31) or delayed (n = 21) treatment. At baseline, 40.8% of children had elevated internalizing problems, 38.8% had elevated externalizing problems, and 48.1% had either elevated internalizing or externalizing problems. Intent-to-treat analyses indicated a significant group by time interaction in predicting positive involvement ($\eta^2 = .17, p < .01$) and negative discipline ($\eta^2 = .12, p < .05$) on the Alabama Parenting Questionnaire (Shelton, Frick, & Wootton, 1996) and total behavior problems ($\eta^2 = .17, p < .01$) on the Child Behavior Checklist (Achenbach & Rescorla, 2001). Engagement was high, with 79.1% of parents attending at least 10 out of 14 sessions.
Trained observers viewed 36% of sessions and completed the IY Parent Group Leader Process Rating to rate elements of collaborative teaching, enactment support, and group process skills. The data suggested that the group leaders adhered well to manualized therapy process with mean ratings of 4.31 to 4.79 out of 5 across the therapy process elements. As another measure of fidelity, therapists completed detailed session checklists to ensure that the requisite intervention content was delivered. On average, 79.6% of videotaped vignettes were shown and discussed, 74.5% of assigned role-plays were completed, and 82.0% of homework guidance and monitoring items were completed. These data suggested that therapy process was responsive and adherent, but problems with fidelity arose with insufficient time to deliver the interventions in the time allotted. This provided some indirect evidence that PT with immigrant parents might require adaptations in pacing and length of the intervention.

The therapists in our pilot trial duly noted their concerns about pacing and dosage of the adapted intervention. Following the completion of the groups, we convened a meeting of the six master’s level Chinese American therapists involved in the pilot trial to gather their impressions of the implementation. Three group leaders were staff clinicians at our community partner agency. Three additional group leaders were doctoral students in clinical psychology who colead groups with agency staff. Group leaders were asked what contributed to success of the program, what barriers to implementation were perceived, and what led to improved outcomes for this population. First, they shared their impressions about the therapy content that was most valuable for the immigrant Chinese families served. Group leaders nominated the sessions covering child-directed play, praise, ignoring misbehavior, and controlling upsetting thoughts as the intervention components that were critical to improving outcomes for the families they treated. They noted that “these are brand new skills for our families.” For example, one leader remarked, “Culturally we are produced to be didactic. Everything, play, or whatever, has to have an educational purpose behind it.” This made child-directed play particularly novel and difficult to learn.

Praise was not a new concept to Chinese parents, but the techniques were difficult to implement. One leader noted, “Parents know in theory that praise is helpful, but when they actually praised, the words, the statements that they used, were not necessarily praise. It was always weighted with criticism.” Group leaders remarked that these lessons required ample rehearsal for making and sustaining gains. One leader described parents’ backsliding:

We found out towards the end of the group the parents forgot all the beginning basic skills, like praising, spending time, those skills. Forgot! Initially, when we introduced to them they were able to do it right, with homework. And then, towards the end, it was all gone.

150 ANNA S. LAU
Compounding the problem, the group leaders noted that the basic skills are prerequisite for later lessons (e.g., family problem-solving) where immigrant parents "are still trying to get hold of the foundational skills, so they are not yet ready for the more advanced skills."

Second, group leaders commented on the therapeutic process elements that led to change. They reported that the intervention seemed effective to the extent that parents were supported in practicing new strategies in role-play and home activities. For example, leaders felt it was necessary to make home assignments as customized as possible. "We came up with specifically what they should do for their homework, not just a general assignment." This specificity in home assignments made the application of the strategy as concrete as possible and engaged each parent in a clear social contract for the week. Group leaders believed that many of the basic skills were difficult for traditional Chinese parents to carry out and remarked that "monolingual first-generation parents need more guidance, more support and hands-on practice." Unfortunately, they also felt it was difficult to provide enough facilitated practice in the course of treatment. In one group leader's words, "It seems like we do not have sufficient time to kind of walk them through the practice enough on those particular skills to be reinforced because we have to move on to the next topic." Despite her belief that rehearsal was a key mechanism of change, another group leader admitted with honesty, "If we are pressed for time and setting priorities—get through the curriculum or the role-play practice—the role-play is often left off."

Thus, our findings suggested that PT that attends responsively to cultural barriers to engagement can indeed yield strong treatment effects in improving parenting and child behavior problems in high-risk immigrant Chinese families. However, our implementation experience also indicated that slowing the pacing of skill lessons and increasing the dosage of behavioral rehearsal might be an important adaptation in achieving meaningful and enduring changes in parenting in immigrant families.

This need for additional learning support was suggested in previous trials of PT with Chinese communities. Ho et al. (1999) encountered difficulty in teaching Hong Kong parents to praise their children and had to bolster their instruction with the use of feedback on videotaped behavior samples as well as live coaching. Ho et al. (1999) reported that some parents refused to praise, but those who tried initially used praise in a "mechanistic and unemotional manner," limiting its effectiveness. Likewise, Crisante and Ng (2003) reported that Chinese Australian parents required substantial practice of the unfamiliar behaviors of both giving and receiving praise in role-plays so that they better understood the intention to evoke positive affect. PT with Chinese parents is successful to the extent that rehearsal is buttressed. The fact that child-directed play, praise, ignoring misbehavior, and time out are
cultiually distal has dual implications. First, we need to bridge attitudinal barriers that limit motivation. Second, we need to ensure ample opportunity to enact, rehearse, and become facile in using unfamiliar practices.

LESSONS AND TESTS TO COME

Over the course of this work, our thoughts about the likely best strategies for adapting parent training for immigrant Chinese families have evolved. A prevailing concern has been identifying ways to ensure parental engagement in the face of common cultural misgivings about specific PT techniques. Initially, the plan was to include specific manualized directives for framing each strategy in a culturally congruent manner to promote acceptability. This approach revealed itself to be overly prescriptive, lacking the flexibility to address the heterogeneity in parent attitudes toward PT skills among Chinese families (e.g., time out viewed as alternately cruel or not punitive enough). Instead, our data suggested that the cultivation of the therapeutic relationship and dynamic group process is integral to promoting engagement. A working alliance may be achieved most effectively by assuming a hypothesis testing approach informed by cultural knowledge rather than by making assumptions about treatment attitudes based on membership in a given ethnocultural group (Lopez, 1997). Eliciting an exchange of diverse viewpoints on PT strategies can serve to motivate their uptake when their benefits can be aligned with parents' own goals. This process is marshaled in collaborative approaches to PT that build in close attention to attitudinal barriers. Cultural competence has evolved from "the making of assumptions about individuals on the basis of their background to the implementation of the principles of patient-centered care, including exploration, empathy, and responsiveness to patients' needs, values, and preferences" (Betancourt, 2004, p. 953). Cultural adaptations of evidence-based treatments may provide a handy road map to leverage these therapeutic process elements within a given intervention model.

The second guiding principle governing our adaptation was to ensure that therapeutic content attends to culturally relevant stressors that may undermine behavior change in PT. Augmentation was intended to contextualize the intervention with components to address the distinctive context of parenting in immigrant Chinese families. Presuming that contextual stress can interfere with the uptake of positive parenting practices, augmentations were designed to lower known correlates of ineffective discipline among Chinese immigrant families, school-related problems, and familial acculturative stress. For example, after we introduce the skill of ignoring misbehavior, we introduce the augmented session on controlling upsetting thoughts.
We anticipated that Chinese parents would encounter difficulty in ignoring behaviors that were construed as disrespectful, and this would provide a good juncture for cognitive restructuring. Thus, parents were asked to describe the thoughts that interfered with their ability to ignore misbehaviors (e.g., child refuses to eat the dinner prepared equals “What an ungrateful and selfish son!”) and are able to help the parent construct a calming replacement thought (e.g., “Kids are so picky at this age, but I can’t give in”). This calming skill can make way for parents to use basic strategies such as differential reinforcement, praise, and appropriate consequences.

The last of the three avenues for adapting PT emerged from our implementation as well as clinician focus groups and involves optimizing enactment of core PT strategies when cultural factors (e.g., learning history, experience, attitudes) make it difficult for immigrant parents to become facile with the skills. This involves providing treatment with sufficient intensity for immigrant parents to ensure adequate orientation, enactment, rehearsal, consolidation, and generalization of PT skills. The often-cited concerns about cultural differences in parenting practices and values across groups can certainly affect attitudes toward PT strategies, but they may also make mastery of these new behaviors more challenging.

The conclusions from our pilot work reflect the broader tension in the debate over the balance between adaptation and fidelity. At this point, we are not able to conclude whether our treatment effects were enhanced by the inclusion of culturally tailored content to reduce contextual stress in immigrant Chinese families. Nor have we determined whether increasing the standard dose of enactment and rehearsal of core PT skills will enhance treatment effects. Our next step is to investigate whether these two alternative approaches to cultural adaptation (cultural augmentation vs. intensification of treatment dose) yield improvements in outcomes among immigrant families. Posing this question will help us understand the extent to which it is advantageous to do more of the same (increasing the dose of high fidelity PT) or to tailor skills training for salient group-specific presenting problems (contextualizing content).

REFERENCES


154   ANNA S. LAU


**ADAPTING PARENT TRAINING FOR CHINESE IMMIGRANTS**


