CONJOINT BEHAVIORAL CONSULTATION WITH PARENTS AND TEACHERS OF HISPANIC CHILDREN: A STUDY OF ACCEPTABILITY, INTEGRITY, AND EFFECTIVENESS

By

MARGUERITA LYNN CAGLE

Bachelor of Science
Oklahoma State University
Stillwater, OK
1971

Master of Science
Oklahoma State University
Stillwater, OK
1975

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Thesis Approved:

Thesis Advisor

Dean of the Graduate College

PREFACE

The conceptual basis for Conjoint Behavioral Consultation (CBC) suggests potential for positive outcomes when used with parents and teachers of Hispanic children. Thus, the purpose of this study was to investigate the appropriateness of CBC in promoting the success of preschool Hispanic students when addressing behavior concerns. Data were analyzed with respect to acceptability and implementation integrity of both the CBC process as well as treatments, and effectiveness of treatments. Post-consultation interviews with consultees and consultants also provided information relevant to perspectives on future use of CBC by participants.

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TABLE OF CONTENTS

Chapter		Page
I.	INTRODUCTION	1
	Background	1
	Statement of the Problem	8
	Purpose of the Study	9
II.	REVIEW OF LITERATURE	10
	Chapter Overview	10
	Terms Denoting Diversity	11
	Hispanic Population in the United States	13
	2000 Census	13
	Hispanic Students	14
	Selected Elements of Hispanic Culture	17
	Family as an Element of Hispanic Culture	17
	Communication as an Element of Hispanic Culture	19
	Religion as an Element of Hispanic Culture	20
	Multicultural Counseling	20
	Guiding Models and Principles of Multicultural Counseling	20
	Practices Specific to Hispanic Individuals	26
	Multicultural Issues When Working with Children	28
	Roles of School Professionals	28
	Family Involvement	29
	Consultation for Children	34
	History of Consultation Models	34
	Caplans' Mental Health Consultation Model	35
	Behavioral Consultation Model	35
	Conjoint Behavioral Consultation	38
	Evaluation of Consultation	45
	Cultural Issues in Consultation for Children	48
	Preschool Children	52
	Preschool Social Skills	52
	Project Head Start	55
	Founding of Project Head Start	56
	Multicultural Character of Head Start	58
	Statement of the Problem	62
	Purpose of Study and Hypotheses	63

Chapter Page

III. METHODOLOGY 67

Research Methodology 67
Participants 67
Clients 68
Consultees 68
Consultants 69
Interpreters 70
Case #1 (K) 71
Case #2 (B) 72
Case #3 (F) 72
Case #4 (A) 73
Instruments 74
Social Skills rating System – Parent Form (SSRS-P) and Teacher Form (SSRS-T) 74
Behavior Assessment System for Children – Parent Rating Scales (BASC-PRS) and Teacher Rating Scales (BASC-TRS) and Structured Developmental History (BASC-SDH) 75
Consultation Preference Survey 76
Goal Attainment Scaling (GAS) 76
Parent/Teacher Data Collection Forms 76
Treatment Integrity Form (TIF) 77
Treatment Evaluation Questionnaire – Parent Teacher Forms (TEQ-P, TEQ-T) 77
Parent/Teacher Consultation Services Questionnaire (PCSQ and TCSQ . . 77
Consultee/Consultant Post Consultation Interviews 78
Procedure 78
Screening 79
Baseline Phase 80
Treatment Phase 80
Evaluation Phase 81
Experimental Design 81
Treatment Acceptability 82
Treatment Integrity 83
Treatment Effectiveness 84
Future Perspectives 84

IV. RESULTS 86

Findings Relevant to Substantive Questions 86
Question #1 86
Treatment Content Acceptability 86
Treatment Process Acceptability 87

Chapter Page

Question #2 89
Integrity of CBC Model 89
Integrity of Treatment Implementation 90
Question #3 92
Question #4 98
Post-consultation Parent Interviews 98
Post-consultation Teacher Interviews 101
Post-consultation Consultant Interviews 103

V. DISCUSSON OF RESULTS, IMPLICATIONS, LIMITATIONS, AND FUTURE RESEARCH 110

Discussion of Results 110
Context of Current Study 110
Context of Multicultural Consultation Literature 113
Implications 126
Limitations of the Study 130
Future Research 131

REFERENCES 133

APPENDIXES 150

APPENDIX A – CONSULTATION PREFERENCE SURVEY 150

APPENDIX B – GOAL ATTAINMENT SCALING 154

APPENDIX C – DATA COLLECTION FORM 156

APPENDIX D – TREATMENT INTEGRITY FORM 159

APPENDIX E – TREATMENT EVALUATION QUESTIONNAIRE – PARENT AND TEACHER FORM 161

APPENDIX F – PARENT/TEACHER CONSULTATION SERVICES QUESTIONNAIRE 164

APPENDIX G – PERCEPTIONS OF CBC INTERVIEWS – CONSULTANT, PARENT, TEACHER 173

APPENDIX H – PARENTAL CONSENT FOR SCREENING PARTICIPATION 176

Chapter Page

APPENDIX I – INFORMED PARENT CONSENT FOR PROJECT PARTICIPATION 178

APPENDIX J – TEACHER CONSENT FORM 186

APPENDIX K – CONJOINT PROBLEM IDENTIFICATION INTERVIEWS (CPII). 188

APPENDIX L – CONJOINT PROBLEM ANALYSIS INTERVIEW (CPAI) 194

APPENDIX M – CONJOINT TREATMENT EVALUATION INTERVIEW (CTEI) 197

APPENDIX N – CONJOINT BEHAVIORAL CONSULTATION OBJECTIVES CHECKLIST 200

APPENDIX O – INSTITUTIONAL REVIEW BOARD APPROVAL 204

LIST OF TABLES

Table Page

1. Child Participant Demographics 69

2. Case Descriptions 71

3. Measures Schedule 79

4. Parent and Teacher Responses to Treatment Effectiveness Questionnaires 87

5. Parent and Teacher Responses to Consultation Services Questionnaires 88

6. Parent Consultation Preference Scale 89

7. Parent and teacher SSRS Standard Scores Comparisons 97

8. Structural Fit of CBC with Parents and Teachers of Hispanic Preschool Children . 124

LIST OF FIGURES

Figure Page

1. Parent Treatment Integrity 91

2. Teacher treatment Integrity 91

3. Parent GAS Ratings 93

4. Teacher GAS Ratings 94

5. Comparison of Parent Acceptability, Integrity, and Effectiveness 95

6. Comparison of Teacher Acceptability, Integrity, and Effectiveness. 95

7. Comparisons of Combined Parent and Teacher Acceptability, Integrity, and Effectiveness 96

CHAPTER I

Introduction

Background

National statistics for the school year 1997-1998 (National Center for Education Statistics, 1998) report that whereas 33% of the students were minority, that percentage increases to 66% in the 100 largest school districts. Furthermore, eight of ten of the largest school districts have over 75% minority student membership. For the most part, the composition of these "new" students is of Hispanic origin with English being a second language to them and, in many instances, not spoken at all in their homes. Students of diverse cultural and language backgrounds are at risk for development of academic and behavior difficulties in the nation's public schools. It has long been acknowledged that a larger number of students from ethnic or racial minority backgrounds are placed in special education than is predicted by their proportion of general elementary and secondary school population membership (MacMillian, Gresham, & Siperstein, 1993). Dropout rates among minority students further demonstrate the public schools' difficulties in meeting the educational needs of our nation's children (National Center for Education Statistics, 1998).

Perhaps nowhere are these dilemmas more poignantly evident than with the Hispanic children and youth in our public schools. As members of a minority culture, Hispanic children have difficulties added to their normative age-related educational and developmental tasks (Baruth & Manning, 2000). They are faced with the added stresses of negotiating two different cultures (Huang & Gibbs, 1992), or three when the student culture is included (Romo & Falbo, 1996). Language problems, value clashes, and a sense of alienation from the basic infrastructure of the school are among the daily issues faced by Hispanic students (Huang & Gibbs). For those students from lower income families, the struggle for survival further impacts their school experience and expectation (Vega, Hough, & Romero, 1983).

The over representation of Hispanic children and youth among the special education and dropout statistics supports the need for programs and services to assist this student population in being successful learners in our public schools. Although nondiscriminatory assessment is mandated under federal law pertaining to special education, the overrepresentation of Mexican Americans in some states has been as high as 300% in the special education programs under the learning disabilities classification (Cummins, 1986). Those who are not identified as special education students seem to fare little better. Twenty-five percent of Hispanic eighth graders have repeated one grade, and over 15% have been retained two or more times during their educational careers (Gersten & Woodward, 1994).

Furthermore, Hispanic students appear to terminate their education before high school graduation in numbers higher than other racial or ethnic school populations. Recent figures show the dropout rate for Hispanic students is 25.3% (National Center for

Education Statistics, 1998). This is translated into Hispanic students being approximately 3 1/2 times more likely to leave school before completing high school than their White European American peers (7.6%), and almost twice as likely as African American students (13.4%). Such statistics are in contrast to high parental expectations found by Romo and Falbo (1996) indicating all families in their study wanted their children to get high school diplomas, and Retish and Kavanaugh (1992) reporting most Hispanic parents want their children to complete college. The reasons for this disparity between parent aspirations and dropout rates of Hispanic students are unclear. Rumberger (1987) grouped the main factors influencing students to drop out of school into five major categories: demographic, family-related, peer, school-related, and individual. Hess and D'Amato (1996) charged that because the demographic variables are not amenable to change, do not offer direction for intervention, and tend to levy blame on the child and his or her family, it is critical future focus for change be directed toward the attitudes and behaviors of school systems, as well as students and their families. They further identified in their study that the elementary-age siblings of Mexican American students who did not complete high school were likely to have more absences and lower expectations of completing high school than those students who persisted in their schooling. This suggests that focus should not be limited to only individual and family variables. Rather, Romo and Falbo indicate that the school holds primary accountability for educating students, and Hess and D'Amato conclude, attention must be given to the "educational and societal systems which contribute to a child's alienation from school" (p. 366), and that such attention should be given early in a child's educational career. Early intervention is further underscored by the findings of Chavkin (1989) and Espinosa

(1997) suggesting Hispanic children enter school at-risk for difficulties in regard to both academic as well as behavioral/social domains.

Parental involvement in their child's education has been linked to numerous practical indicators of school success, including increases in student achievement and attendance, decreases in dropout rate, positive parent-child communication, improvement of student attitudes and behavior, and more parent-community support of school (Chavkin, 1989; Educational Resources Information Center, 1996; Henderson, 1987; Keith & Lichtman, 1994). Furthermore, Chavkin and Williams (1985) reported that more than 95% of both educators and minority parents strongly support parent involvement in education. However, other studies (Lynch & Stein, 1987; Sontag & Schadht, 1994) have found differences in parent participation among Hispanic, Native American, African American, and White European American families. Thus, as suggested by Leon, Ortiz, Sena, & Medina (1996), there appears to be a need for acknowledgement of cultural, linguistic, and socioeconomic factors when considering parental involvement in decision making affecting the educational experiences of their children. To do otherwise would only exacerbate the mismatch between traditional White European American expectations and communication styles and those of the culturally different family, and seriously limit any potential for successful family-school interaction outcomes. The structure of parental involvement is also an important consideration. Research suggests that children derive far-reaching benefits when home and school interact collaboratively (Carlson, Hickman, & Horton, 1992; Mullis, 1998; Power & Bartholomew, 1985; West & Idol, 1993), with the concept of collaboration conveying the voluntary and egalitarian

nature of the interpersonal relationship occurring during the interactive process (Friend & Cook, 1996).

Such collaborative characteristics are basic to Caplan's mental health consultation model (1970), which originally defined consultation as occurring between professionals and pertaining only to work-related concerns. Since then, however, application of the consultation process has been advanced by others (Brown, Pryzwansky, & Schulte, 1998; Heller, 1985; Lippitt & Lippitt, 1986; Sheridan, 1993) to include interaction between a consultant and a wide variety of individuals and systems, for example families, students, and social groups, and broadening the scope of what is considered work-related. Furthermore, Conoley, Conoley, Ivey, and Scheel (1991) found that when consultants matched their consulting strategies to the values of their consultees, the likelihood of success increased. The promise of collaboration and consultation methods for addressing issues in children's education, in general, and parent-school interaction, in particular, have been highlighted by a number of authors (e.g., Alpert & Yammer, 1983; Bergan, 1977; Bergan & Kratochwill, 1990; Christenson & Cleary, 1990; Christenson & Conoley, 1992; Comer, 1984; Comer & Haynes, 1991: Conoley, 1987; Galloway & Sheridan, 1994; Gresham & Noell, 1993; Rosenfield & Gravois, 1995). Behavioral consultation has typically been the model of choice when working with children based upon the aforementioned literature.

Conjoint Behavioral Consultation (Sheridan & Kratochwill, 1992) as a consultation model was developed with a basis in behavioral consultation (Bergan, 1977), yet incorporating important concepts of both systems (Minuchin, 1974) and ecological

(Bronfenbrenner, 1997) theories. Sheridan and Kratochwill define Conjoint Behavioral Consultation (CBC) as:

> a systematic, indirect form of service delivery, in which parents and teachers are joined to work together to address the academic, social, or behavioral needs of an individual for whom both parties bear some responsibility. It is designed to engage parents and teachers in a collaborative problem-solving process with the assistance of a consultant, wherein the interconnections between home and school systems are considered crucially important. (p. 122)

Research has demonstrated the effectiveness of CBC in addressing a variety of problem behaviors presented by children including social withdrawal (Sheridan, Kratochwill, & Elliott, 1990), academic underachievement (Galloway & Sheridan, 1994), irrational fears (Sheridan & Colton, 1994), and cooperative play difficulties of boys diagnosed with ADHD (Colton, Sheridan, Jenson, & Malm, 1995). Other research has suggested that CBC promotes increased parent verbalization during problem-identification interviews (Sheridan, 1994). Though the above studies were with a small number of participants, a larger scale study conducted by Sheridan, Eagle, Cowan, and Mickelson (2001) also showed favorable results with regard to efficacy, acceptability, and satisfaction. Furthermore, both professionals (Sheridan & Steck, 1995) and parents (Freer & Watson, 1999) have rated CBC as more acceptable than other modes of service delivery. Limitations of these studies, however, suggest that there remains a need for additional investigation incorporating parents from diverse populations and teachers who have actually participated in the CBC process.

The use of CBC when addressing the needs of children from Hispanic families appears to be promising. With collaboration as a central element in each stage of the CBC model, the cooperative problem solving approach valued by the Hispanic culture (Brown, 1997) is honored. The emphasis placed on the extended family by those of Hispanic origin (Zapata, 1995) is also readily incorporated within the inclusive nature of CBC, which draws information from multiple informants and settings so as to improve the likelihood of treatment generalization. Additionally, the CBC aspect of consultation occurring with both family and school personnel at the same time aligns with the preference expressed by Hispanic consultees for face-to-face communication that allows for development of an increased personal relationship (Espinosa, 1997; Sue & Sue, 1999). Furthermore, by bringing all parties together, both physically and as participants in the CBC process, the concept of cultural embeddedness proposed by Szapocznik and Kurtiness (1993) is acknowledged. Though Chavkin and Williams (1985) found minority parents desired a more active, decision-maker role in their children's education, the strong Catholic religious beliefs of many Hispanics cause them to have difficulty being assertive, and they may even resign their difficulties to fate (Yamamoto & Acosta, 1982). Since CBC is based on behavioral therapy principles, it employs the active, concrete problem solving orientation expected by Hispanic Americans (Cases & Vasquez, 1996; Juarez, 1985). Finally, the identification and support of consultee strengths is inherent in the philosophy and practice of Conjoint Behavioral Consultation so as to develop a natural treatment plan (Sheridan, Kratochwill, & Bergan, 1996). The strong family and child-oriented values of the Hispanic family (Sue & Sue, 1999) provide rich resources from which to draw in this regard.

Statement of the Problem

Because children of Hispanic heritage are at increased risk for school difficulties, failure, and dropout, more effective ways of addressing the needs of Hispanic students are needed that take into consideration the unique cultural characteristics and language diversity that they bring to public schools. Multicultural counseling has laid both theoretical and empirical groundwork as to qualitative aspects such interventions might incorporate. For example, preference and greater likelihood of subsequent success in interaction has been associated with the inclusion of the following attributes during parent-school meetings: family members and values are acknowledged and incorporated (Brown, 1997; Chavkin, 1989; Espinosa, 1997); written and oral communications are provided using both Spanish and English and in a face-to-face manner (Espinosa); the responsibility to initiate interaction is assumed by the school (Sue & Sue, 1999); and specific ways in which he or she can be an active participant in a cooperative home-school relationship are provided to the parent (Chavkin & Williams, 1985). Competencies for the counselor or consultant have also been set forth which include acknowledgement of not only the beliefs and values inherent within the diverse culture as represented by the child and his or her family, but personal awareness of the professional's own assumptions, values, and biases (Sue, Arredondo, & McDavis, 1992), as well. Furthermore, research in the fields of education and educational psychology suggest that early intervention is beneficial to reducing risk of development of serious academic and behavior problems. However, there has not been implementation and assessment of an intervention during the early years of children's educational careers that

systematically takes into consideration the unique cultural and language characteristics of the Hispanic family when attempting to resolve their children's difficulties within the public school setting.

Purpose of the Study

The conceptual bases for CBC suggest potential for positive outcomes when used with teachers and parents of Hispanic children. Thus, the purpose of this study was to investigate the appropriateness of Conjoint Behavioral Consultation (CBC) in promoting the success of preschool Hispanic students when addressing behavior concerns. Answers to the following substantive questions are integral to such a purpose.

1. Is CBC acceptable to parents and teachers of Hispanic children in changing identified behaviors of Hispanic children?
2. What is the level of treatment integrity by parents and teachers of Hispanic children resulting from the CBC process?
3. Is CBC, incorporating the parents and teachers of Hispanic children, effective in changing identified behaviors of Hispanic children?
4. Do the parents and teachers of Hispanic children who served as consultees in this study and the consultants consider CBC a viable behavior change model they will use in the future to address concerning behaviors of their children/students with Hispanic heritage?

CHAPTER II

Review of the Literature

Chapter Overview

This review of relevant literature will begin by presenting and defining conceptual terms used to describe diversity. Next, in order to appreciate the importance of research addressing the needs of students with Hispanic heritage, their families, and teachers, a review of the status of Hispanic people in the United States will be presented. This will include current census statistics pertaining to the U. S. Hispanic population, Hispanic student representation in public schools, and the unique elements of diversity key to understanding and working with this population. Next, the contributions of multicultural counseling will be discussed, as it provides a general basis from which to move then to more specific issues relevant to working with children from diverse cultures. Consultation will then be addressed flowing from a general history to more specific focus on its use with children and practices within a multicultural context in public schools. Finally, in deference to the specifics of this proposed study, attention will be given preschool children's behavior and Project Head Start.

Terms Denoting Diversity

Key terms used when describing groups of people include race, culture, and ethnicity, and it is not uncommon for them to be used interchangeably. Race, however, is a biological concept that differentiates people according to physical traits. The use of race to explain the behavior of individuals, or groups, can be misleading and even prejudicial. The concepts of culture and ethnicity offer a greater range of descriptors with which to describe individuals and groups.

Culture has been defined in various ways including varied patterns of living, traditions, and attitudes possessed by individuals (Mosley-Howard, 1995), as well as social norms, roles, values, and beliefs (Betancourt & Lopez, 1993; Brislin, 1990). Frisby (1992) identified six connotative meanings associated with the concept of culture: (1) the "characteristic patterns of living, customs, traditions, values, and attitudes that are associated with broad differences in intercontinental habituation or a society's sophistication" (p. 533); (2) the unique contributions of the members of a given ethnic/racial group or ancestral homeland; (3) behaviors, attitudes, and beliefs that serve to advance interest in and promote identification with one's race regardless of differing levels of education, social class status, or area of residence; (4) the values, beliefs, and customs that are inherent in the environments in which a person receives information about society; (5) adherence to particular styles of dress, religious worship, culinary practices; and (6) outer appearances. Therefore, culture is multileveled and influenced by numerous factors (Mosley-Howard) and should not be considered, as Hanson (1992) wrote, "rigidly prescribed ..., but rather a framework through which actions are filtered

or checked as individuals go about daily life" (p.3). The degree to which an individual identifies with a particular culture varies considerably along a continuum (Frisby; Hanson, 1992). In keeping with the designation put forth by Sue and Sue (1999), Hispanic will be used to acknowledge common background of Spanish language and customs of people living in the U. S. with ancestry from Mexico, Puerto Rico, Cuba, El Salvador, the Dominican Republic, and other Latin American countries. Thus, the term Hispanic will be used as a cultural descriptor.

The concept of ethnicity is narrower than that of culture (Flanigan & Miranda, 1995). According to Banks and Banks (1993), an ethnic group is "a microcultural group or collectivity that shares a common history and culture, common values, behaviors, and other characteristics that cause members of the group to have shared identity" (p. 357). For example, though persons from Puerto Rico and Mexico may share many aspects of the Hispanic culture, they may also express certain behaviors or preferences that are unique to their distinct place of origin.

Other terms or concepts useful when describing groups of people include minority, socioeconomic status (SES), and acculturation. Minority refers to a smaller group, when compared to the majority group, in society that is disadvantaged and discriminated against by the majority group (Flanigan & Miranda, 1995). Atkinson, Morten, and Sue (1993) identified minority with non-Caucasians while the majority group is comprised of Caucasians in the United States. Socioeconomic status can be a source of the above-mentioned disadvantage and includes variables ranging from income, educational attainment, occupational aspirations, and lifestyles, to selection of friends, activities, and social roles. Huang and Gibbs (1992) indicate the level of socioeconomic

status to be directly related to the range of opportunities, choices, and challenges available to persons. Acculturation refers to the response of individuals from one culture who become involved in another more dominant culture. Though there exists a variety of acculturation scales, Sue and Sue (1999) warn of the danger of stereotyping that may result from dependence on such measures. According to Flanigan and Miranda, the degree to which an individual acculturates influences his/her attitudes, values, and beliefs. Based upon the integral factors of socioeconomic status and participation in cultural activities, it is evident why Ogbu (1978) reported that persons, or groups, of lower socioeconomic status tend to also be least acculturated into the majority culture.

Hispanic Population in the United States

2000 Census

There has been little doubt for many years that the demographics of the United States population are changing to reflect increased diversity. The majority of these diverse persons are members of visible racial/ethnic groups (Atkinson, Morten, & Sue 1998) with different and varied cultural characteristics. In recognition of this trend and the potential for significant impact to government decision-making, the 2000 Census included 15 options from which to select, in addition to allowing the respondent to select more than one, when indicating the race(s) the respondent considered him/herself to be. Additionally, since the federal government considers race and Hispanic origin to be two separate and distinct concepts (U. S. Census Bureau, 2001 May), there was a separate

question pertaining to whether the respondent was of "Spanish/Hispanic/Latino" origin. The U. S. government considers that Hispanics may be of any race and use the terms "Hispanic" and "Latino" interchangeably in reports (U. S. Census Bureau, 2001 March). Of the 281.4 million people reported to be living in the United States by Census 2000, 35.3 million, or 13%, were Latino (U. S. Census Bureau, 2001 March). This represents an increase of 57.9% from the 1990 Census results for the Hispanic population as compared to a 13.2% increase for the total U.S. population (U. S. Census Bureau, 2001 May). Mexicans increased by 52.9% to 3.4 million, Puerto Ricans increased by 24.9% to 20.6 million, and Cubans increased by 18.9% to 1.2 million (U. S. Census Bureau, 2001 May). According to Sue and Sue (1999), the notable demographic change is primarily a result of two major factors: (a) immigration rates and (b) differential birth rates. It is the latter factor that is most notably impacting the public schools.

Hispanic Students

National statistics for the school year 1997-1998 (National Center for Education Statistics, 1998) report that whereas 33% of the students, nationally, were minority, that percentage increases to 66% in the 100 largest school districts. Furthermore, eight of ten of the largest school districts have over 75% minority student membership. For the most part, the composition of these new students is of Hispanic origin with English being a second language to them and, in many instances, not spoken at all in their homes. As members of a minority culture, Hispanic children have difficulties added to their normative age-related educational and developmental tasks (Baruth & Manning, 2000).

The added stresses of negotiating two different cultures can result in language problems, value clashes, and a sense of alienation from the basic infrastructure of the school (Huang & Gibbs, 1992). Low income compounds their struggle (Vega, Hough, & Romero, 1983).

There is sharp over-representation of Hispanic children and youth among those in special education programs. Cummins (1986) found that Mexican American students were identified as eligible for special education under the learning disabilities classification as much as three times more often than their white peers in some states. Grade retention of Hispanic students has also been found to be a relatively common practice. Gersten and Woodward (1994) reported that 25% of the Hispanic eighth graders in their study had repeated one grade, and over 15% had been retained two or more times. A 1996 study by Hess and D'Amato revealed that out of the 80 elementary Hispanic students in their study addressing high school completion, 26% had experienced retention, whereas the average yearly rate of retention for the elementary schools in the district where the students attended was less than 1%.

The number of Hispanic students who do not complete their education is also high. National Center for Education Statistics (1998) shows the dropout rate for Hispanic students is 25.3%. This is compared to rates of 7.6% and 13.4% for white and African American students, respectively. The reasons for such high dropout rates among Hispanic students is unclear. In a review of literature pertaining to dropouts, Rumberger (1987) identified five major factors influencing the decisions of Hispanic students: demographic, family-related, peer, school-related, and individual. Among demographic variables are socioeconomic status, language spoken in the home, and acculturation. Parenting styles, parental attitudes toward school, and sibling school completion were included in the

family-related factor. Having meaningful friendships with peers in school was found to have a positive correlation with high school completion regardless of ethnicity. School-related factors included attendance, poor classroom performance, failing grades, and retention. Issues of self-esteem, educational attitudes and expectations are among those Rumberger included within the individual factor. Hess and D'Amato (1996) compared elementary age Hispanic siblings of older students who had dropped out of school to siblings of students who had completed school or were still attending high school on variables of completion expectancy, academic self-competence, school attitude, absences, and retention. Absences and high school completion expectancy were the only two factors found to significantly differentiate the two groups, with the authors concluding that system interventions to promote regular school attendance and expectations of high school graduation are needed at the elementary-age school level. System changes were also called for by Romo and Falbo (1996) resulting from their study of Mexican American youths and factors that affect their likelihood for high school graduation. Changes identified included (1) clarifying scholastic standards, (2) preventing school failure, (3) creating clear pathways to good outcomes, (4) making schools accessible, (5) putting the learning of students first, (6) making participation in schoolwork rewarding, and (7) emphasizing hard work. In levying accountability for the educating of students with the schools, the authors indicated cultural differences between homes and schools do not represent inevitable educational barriers unless school policies make them so.

Poor educational outcomes for Hispanic students have been misinterpreted as resulting from limited value placed on education by the Hispanic culture, in general, and families that do not encourage their children toward high achievement in school.

However, such assumptions are in direct contrast to the 1996 report by Romo and Falbo that all the parents involved in their study reported expectations of high school graduation for their children. Additionally, Retish and Kavanaugh (1992) found Hispanic parents included in their study did have high aspirations for their children, with the majority desiring college graduation for their children. Though such researchers (Hess & D'Amato, 1996; Romo & Falbo, 1996) concluded that attention should go beyond individual and family variables to those of educational and societal systems when looking for explanations, the key elements of Hispanic culture for which such educational and societal systems must account should be reviewed.

Selected Elements of Hispanic Culture

Family as an Element of Hispanic Culture

Characteristics of family can vary significantly from culture to culture in terms of role of the family system, the modes of interaction with children including correction of their behavior, and the male-female relationships (Mosley-Howard, 1995). Review of such dimensions can be enlightening as to the functioning of persons within that particular culture. According to Flanigan and Miranda (1995), success of interventions with children and their families is dependent upon the fit of such interventions within the cultural context of family characteristics. To disregard these unique characteristics may be interpreted as disrespectful and compromise the effectiveness of service delivery. Family tradition is an important aspect of life for Hispanic people (Sue & Sue, 1999).

Elements basic to this perspective include respect and loyalty towards the family as a unit, with cooperation rather than competition stressed among its members. Though fading among the urban population as a result of the increasing independent activity of Hispanic women relevant to work and school (Sue & Sue), the roles of males and females in the family have been strongly delineated in the traditional Hispanic family (Avila & Avila, 1995). Whereas the father is the primary authority figure, the feminine role is to be submissive to the male, restrained, and self-sacrificing for her family (Avila & Avila). Along with males, the elderly and parents occupy positions of particular authority within the family (Sue & Sue), while women are respected for their moral and spiritual superiority as well as being long suffering (Garcia-Preto, 1996). Although children are a welcomed source of pride, they are expected to be obedient. As children get older, boys are afforded greater freedom of behavior while girls are more restricted (Sue & Sue). Children are expected to contribute financially to the family when possible (Sue & Sue). With family unity taking priority, the individual may be impacted negatively by family decisions. Avila and Avila (1995) found that such practices sometimes resulted in school attendance problems for Hispanic children. Also, because a child may be more adept at adjusting to new social demands than the parents, they may assume the role of emissary for parents in certain social contexts. This can disrupt the hierarchical nature of the Hispanic family and result in tension and disharmony (Huang & Gibbs, 1992). Extended family, including grandparents, as well as distant aunts, uncles, and cousins, is commonly relied upon for support by the often very young married couple and parents. Godparents, in particular, are held in high regard with their participation closely associated with the moral, religious, and spiritual upbringing of the child (Sue & Sue).

Communication as an Element of Hispanic Culture

Spoken language is probably the most obvious element of diversity relevant to communication with persons of Hispanic origin. Sue and Sue (1999) report that the bilingual background of many groups, including Latino/Hispanic Americans, may lead to much misunderstanding. Limited English skills may force an individual to use simple, disconnected words when attempting to describe complex experiences and emotions. This can result in their feeling inferior as well as fostering false interpretations and presuppositions of their being uncooperative, uncaring, and/or intellectually deficit (Sue & Sue). The most advantageous scenario when working with limited English speaking Hispanic persons is for the professional to speak Spanish. However, this is not commonly possible. The use of an interpreter has been suggested as an option in such cases, but it has been suggested (Cooper & Costas, 1994; Sue & Sue, 1999) that interpreters may, in fact, compound difficulties by distorting messages and/or responses, misconstruing the goals of the interaction, and becoming personally involved with the client. In an attempt to minimize such contamination, Cooper and Costas (1994) have suggested that the professional review with the interpreter ahead of time goals for the interaction, expectations of the interpreter's involvement, and areas to be discussed, as well as include an indigenous worker who is knowledgeable about the community.

Communication style is another aspect of cultural, or ethnic, orientation. The Hispanic culture is considered a high-context culture (Flanigan & Miranda, 1995). They, along with Asian American, Native American, and African American persons derive meaning in communication through shared experience, history, and implicit messages

rather than the explicit aural language and content characteristic of Euro-Americans. Personal contact such as face-to-face communication has been found to be more successful with Hispanic Americans, while written communication is not as useful even when written in Spanish (Espinosa, 1998). However, as is the case with Native Americans, prolonged eye contact with persons of the Hispanic culture is considered disrespectful (Flanigan & Miranda).

Religion as an Element of Hispanic Culture

The Catholic religion is also a major force in the lives and interactions of Hispanic groups. Its influence is evident in their beliefs regarding the inherent dignity and respect of all persons (Sue & Sue, 1999). Regardless of their lot in life, people are destined, or born into, their life state (Inclan, 1985). The consequence of such fatalism, or inevitability, is that many Hispanics have difficulty behaving assertively (Sue & Sue), because they view problems and events as meant to be and unchangeable (Yamamoto & Acosta, 1982).

Multicultural Counseling

Guiding Models and Principles of Multicultural Counseling

For the most part, multicultural counseling is based on theoretical principles derived from extrapolations of previously developed individual models and clinical

experiences of practitioners. It is defined by Jackson (1995) as "counseling that takes place between or among individuals from different cultural backgrounds" (p. 3). Flanigan and Miranda (1995) report that attention to the effects that cultural differences have on interpersonal relations is a rather recent development. This is perhaps linked to recognition of increasing diversity in this country and the subsequent political impact of intervention strategies involving diverse populations (Katz, 1985). Central to this development is the controversy in the multicultural counseling literature described by Fischer, Jome, Atkinson, Frank, and Frank (1998) involving the etic and emic approaches to counseling and therapy. Proponents of the etic approach believe that if certain general psychological theories and techniques are followed, the needs of all clients, regardless of individual characteristics, will be adequately addressed. Sue and Sue (1990) exemplify the emic approach in advocating the necessity of counseling strategies and techniques tailored to the specifics of a client's culture.

In an attempt to reconcile the etic and emic perspectives dichotomy, Fischer et al. (1998) identified four common factors central to effective multicultural counseling which provided venues through which cultural specifics could be pursued and explored during therapy. The first factor, the therapeutic relationship, refers to the positive and trusting relationship between client and therapist that has been associated with positive, healing outcomes for their interaction. Much attention has been given personal and professional qualities of the therapist in this regard. Shared worldview was identified by Fischer et al. as the second common factor, and is described in terms of the counseling participants sharing an understanding of each other's worlds. It is through this shared understanding that acceptable explanations and interventions can be developed and implemented. The

third factor pertains to client expectations for positive benefit from therapy. A shared worldview resulting in a positive therapeutic relationship is seen to give the client hope for improvement, according to Fischer et al. The authors labeled the fourth factor as ritual or intervention conducted in therapy. In this regard, Fischer et al. emphasized that both counselor and client must believe in the potential of the agreed upon intervention strategy to alleviate the concern, and that this can only be accomplished through appropriate recognition/accomplishment of the preceding three factors.

The development of identity models further supports the precedence of cultural characteristics within the therapeutic process. The Black Identity Model of Cross, Asian American Identity Model of S. Sue and D. W. Sue, Minority Identity Development Model by Atkinson, Morten, and Sue, and Racial/Cultural Identity Development Model of D. W. Sue and D. Sue (as cited in Sue & Sue, 1999), as well as the People of Color and White identity models of Helms (1995) represent differences in racial identity development as well as the oppression experienced by respective groups. A model focusing on the development of ethnic identity in children has also been developed by Bernal et al. (as cited in Casas & Pytluk, 1995). A Latino/Hispanic American identity development model authored by Ruis (1990) identified five stages for this group: causal stage, cognitive state, consequence stage, working through stage, and successful resolution state. The underlying beliefs of the model include (1) belief in a culture-specific explanation of identity; (2) the marginal status of Latinos is highly correlated with maladjustment; (3) negative experiences of forced assimilation are considered destructive to an individual; (4) having pride in one's cultural heritage and ethnic identity

is positively correlated with mental health; (5) pride in one's ethnicity affords the Hispanic greater freedom to choose.

There have been advanced several general models of counseling which are in line with an emic philosophy and take into consideration cultural as well as individual uniqueness. The model put forth by Atkinson, Thompson, and Grant (1993) suggests counselors adopt different roles, based on combinations of points along three dimensions: locus of problem etiology (internal vs. external), client's acculturation level (low vs. high), and goals of helping (remediation vs. prevention). The roles that counselors take based on their judgment of the origin of the problem and status of the client's acculturation include advocate, facilitator of indigenous healing methods, change agent, and psychotherapist. The major construct of this model is purported to be flexibility in roles.

Leong (1996) proposed a model for cross cultural counseling that incorporated three dimensions of individuals: a universal dimension defined as how the individual client is like all others; a group dimension referring to how the individual client is like some others; and an individual dimension referencing the unique qualities of the individual client. Using these three dimensions, Leong developed a framework within which counseling would shift over the course of the relationship.

The concept of worldview provides the foundation around which Trevino (1996) constructed his model. For Trevino, worldview has two levels: an abstract level that includes one's general beliefs and a specific level that represents unique perceptions. A match between the counselor and client's general worldviews provides a greater basis for trust between the two, along with increased likelihood for credibility of interventions.

Discongruency between counselor and client at the specific level gives impetus for change during the counseling process.

Attempts to codify multicultural service delivery have also been made through the publication of a number of competency standards. In 1982, Sue et al. published the Division 17 Cross-Cultural Counseling Competencies. These competencies were further revised in 1992 (Sue, Arredond, & McDavis, 1992) and adopted by the Association for Multicultural Counseling and Development. In the latter work, 31 multicultural counseling competencies were put forth within the three domains of (1) counselor awareness of own assumptions, values, and biases, (2) understanding the worldview of the culturally different client, and (3) developing appropriate intervention strategies and techniques. The following year, the American Psychological Association (1993) published the Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations. The National Association of School Psychologists (1997) addressed issues of service delivery to diverse populations in their Standard for the Provision of School Psychological Services with particular reference to nonbiased assessment.

Theoretical counseling considerations particularly relevant to culturally diverse families have been identified by Ho (1997) and McGoldrick and Giordana (1996). (1) Ethnic minority reality refers to the racism and poverty that dominate the lives of minorities. (2) Conflicting value systems imposed by White Euro-American society upon minority groups have also caused great harm to them. (3) Biculturalism refers to the fact that minorities in the United States inherit two different cultural traditions. (4) Ethnic differences in minority status refers to the life experiences and adjustments that occur as a

result of a group's minority status in the United States, for example, the abuses, resentments, and discrimination experiences resulting from immigration status. (5) Ethnicity and language refers to the common sense of bonding among members of a group that contributes to a sense of belonging. The symbols of the ethnic group are most manifested in the language. (6) Ethnicity and social class refers to aspects of wealth, name, occupation, and status. Gushue and Sciarra (1995) further emphasize a multidimensional approach when working with a bilingual, bicultural family. Their approach encourages counselors to consider both themselves and the families along three intracultural dimensions: differences in language ability; acculturation; and racial/cultural identity. The authors warn that failure to do so can result in viewing the family in ethnocentric or stereotypical terms, promote premature termination by the family, as well as limit the development of effective and appropriate interventions. Szapocznid and Kurtiness (1993) recommend acculturation be the "identified patient" with interventions developed that are congruent with the culturally diverse client's existing belief system.

Empirical research has also identified more singularly specific recommendations relevant to the practice of multicultural counseling. Clients have been found to be less likely to drop out of therapy if they were matched with their therapist on the basis of language and/or ethnicity (Flaskerud, 1986; Sue, Fujino, Hu, Takeuchi, & Zane, 1991). Sue, Ivey, and Pedersen (1996) concluded that clients of color prefer a therapeutic relationship in which the therapist is more active and self-disclosing. In an article by Atkinson and Lowe (1995), the authors reviewed the research of others and assessed the effects of the counselor's cultural responsiveness to the cultural content in counseling sessions. Their conclusions suggested cultural responsiveness of the consultant led to

improved counselor credibility, satisfaction with counseling, depth of self-disclosure, and willingness to return to counseling.

As has been mentioned before, caution must be exercised when applying general multicultural research to specific cultural groups. With this in mind, research findings specific to working with individuals with Hispanic heritage are discussed.

Practices Specific to Hispanic Individuals

The need for culturally responsive counseling by persons of Hispanic heritage appears particularly important in that, besides underutilizing traditional mental health services, they have been found to terminate therapy after only one contact at a rate over 50% (Sue & Sue, 1999). In a study conducted by Atkinson, Casas, and Abreu (1992) with Mexican American clients, findings suggested the reflection of similar attitudes and values by the counselor to be preferred over similarities of ethnicity, personality, education, age, or same sex. Personal, face-to-face contact has been credited with the increased likelihood of positive results (Sontag & Schacht, 1994; Sue & Sue, 1999). Behavior therapy has been identified as particularly suited to working with Hispanic individuals based on research observations of their preferring therapists who employ active, concrete, directed techniques (Casas & Vaszuez, 1996; Juarez, 1985). Furthermore, there has been strong evidence supporting the use of family therapy due to the importance of family and extended family in the Hispanic culture (Sue & Sue, 1999; Szapocanik & Kurtines, 1993).

Szapocanik and Kurtines (1993) have gone further than just the family in their theoretical model development that has been driven by practice and related research pertaining to Hispanic youths. Their contextualist perspective extends the concept of embeddedness of the individual within the context of the family to include the family's embeddedness within the context of culture, and to emphasis that this embeddedness involves more than one culture. They developed the bicultural effectiveness training (BET) approach using structural family therapy concepts as a framework. BET involves two change strategies: (1) focusing both the intergenerational and intercultural differences on the cultural conflict as the identified patient; and (2) creating new cross alliances between family members and cultures through exercises designed to increase the comfort level of parents and youths with both cultures.

In summary, multicultural counseling literature suggests agreement that consideration of cultural diversity and preferences brought to the therapeutic interaction by the participants are important to therapy success. The values and beliefs held by both client and professional impact their perspectives, expectations, and course of action. Various models of service delivery have been offered so as to enhance cultural sensitivity. Competencies have been established by various professional organizations in recognition of the professional's responsibility to accommodate for the needs of the client. With regard to practices involving persons of the Hispanic culture, the involvement of family has been particularly encouraged. More specific preferences include increased personal interaction by therapists who express similar attitudes and values, and who employ direct, concrete techniques. But, in what ways has multicultural counseling, in general, and counseling with Hispanic individuals, more particularly,

impacted the delivery of services to children of diverse cultures? The following section will address this question by moving, again, from general elements to be considered when working with children of cultural diversity, to practices specific to Hispanic children and youth.

Multicultural Issues When Working with Children

In 1999, Sue and Sue indicated that by the year 2000, 45% of the students in the nation's public schools would be racial/ethnic minorities. This presents significant challenges for the public schools these students attend not only in the area of education, but in provision of student support/mental health services, as well. Difficulties are compounded in cases where the students do not speak English, and have prompted observations that schools have been poorly equipped to deal with the large numbers of Spanish-speaking students (Sue & Sue, 1999).

Roles of School Professionals

School psychologists and counselors have a special opportunity to incorporate culturally sensitive and appropriate considerations in their service delivery. The attention of school psychologists to multicultural issues has historically been primarily related to their role in student evaluation and diagnosis. Increasingly, however, school psychologists are expanding this traditional role to include more preventative and therapeutic activities as well as providing both indirect and direct support services to

other school personnel, students, and families. As such, the multicultural counseling literature has been applicable to their service delivery. Kiselica, Changizi, Cureton, and Gridley (1995) identified school counselors as being important agents in the education of school personnel about the value systems and cultural experiences of racial/ethnic minority families, as well as educating racial/ethnic minority parents about the public school system. Baruth and Manning (2000) presented guidelines for middle school counselors who work in multicultural settings. Their rationale for multicultural counseling with early adolescents is based on the premise that this period lends itself to a particular need for effective multicultural counseling since "during early adolescence, boys and girls develop their sense of self-esteem and cultural identities and form opinions of other individuals and cultural groups" (p. 243).

Literature specifically relevant to teachers and cultural diversity has focused on curriculum issues. Multicultural education is not, however, a part of this study.

Family Involvement

From the early years of acknowledging the role of culture in intervention development in the schools, researchers (Brown, 1997; Chavkin, 1989; Espinosa, 1997; Mosley-Howard, 1995) have generally been in agreement that effective multicultural service delivery in the schools must incorporate the families of the children being served. They have also found that culturally diverse parents want to be a part of their children's education (Chavkin & Williams, 1985; Metropolitan Life Survey of the American Teacher, 1987), and in increasingly active roles such as co-learner, advocate, and

decision-maker (Chavkin & Williams). Comer (1986) has suggested involvement by minority parents has been hampered by the lack of clear mechanisms for participation. Furthermore, it is the school's responsibility to initiate contact with the families of their culturally diverse students (Sue & Sue, 1999). After all, in many instances parents do not understand the help they may receive (Brown, 1997). Additionally, as is the case for Hispanic families, it may be contradictory to their beliefs associated with inherent good and the fatalistic nature of the future to seek help (Sue & Sue, 1999).

This has left culturally diverse children especially at risk for social and emotional problems. In a 1992 study, Roberts and Sobhan discovered Mexican American adolescents report more depressive symptoms and conduct disorders than white youth; small-town Mexican American youth have severe and elevated rates of alcohol and drug abuse; and suicidal behaviors are high in Hispanic female adolescents and Puerto Rican males. Hanson (1992) encouraged school psychologists and other services providers in the schools to work toward developing a respect for the values of other cultures, and Mosely-Howard (1995) recommended facilitating rather than negating the diverse cultural influences on youth and their consequent behaviors as a means of more effectively meeting the needs of students.

Espinosa (1997) identified general factors important for educators to understand in their strategies for promoting Hispanic parent participation in schools. Cultural factors influencing parents' child rearing and socialization practices are centered around the Hispanic culture's emphasis on strong family commitment. Aspects of communication style can be the source of culture clash. Hispanics generally emphasize cooperation and tend to be very sensitive to nonverbal indicators of feeling represented by preference for

personalized styles of interaction, a relaxed sense of time, and a preference for informal communication. There is a definite division in duties of the family and school with absolute authority afforded the school and teachers with regard to education, while the parents' job is to nurture. The author included the following descriptors in making recommendations to increase Hispanic parent participation: make it easy; use face-to-face communication; go slow; use non-judgmental communication; put the parents' agenda first in making involvement meaningful; provide written and oral communication in Spanish and English.

In a study comparing parent participation and information needs with regard to early intervention among groups of Hispanic, American Indian, and White parents, Sontag and Schacht (1994) found support for unique strategies to encourage participation of parents from different ethnic groups. Hispanic, along with American Indian, parents reported a greater need to receive information about how to get services, when compared to White parents. They also selected therapists as a source of information much less frequently than did White parents, whereas they were more likely to select hospitals as a place for information. Regarding the kinds of problems parents had getting information; Hispanic parents were much less likely than White and American Indian parents to feel they had been told what could be done for their child. Fewer Hispanic and American Indian parents reported helping make decisions about their child's program, as compared to White parents. Furthermore, when compared to White parents, American Indian and Hispanic parents were significantly less likely to help give information and support to other parents. The authors interpreted the study results as suggesting the families were confident of their own abilities to make decisions, and wanted professionals to provide

information about available services so they could make informed decisions as to what was best for their children and families.

Parental participation and awareness with respect to early intervention programs for preschool children with developmental disabilities were the foci of a descriptive study conducted by De Leon, Ortiz, Sena, and Medina (1996). The Hispanic parents in the study expressed acceptance of and gratitude for the school services provided their children, and only expressed dissatisfaction indirectly. When asked how they would like to be involved, the majority chose school meetings and home meetings. They expressed desire for better networking between school and home. Responses to questioning as to whether the parents understood the child's educational process were inconsistent. Though 61% said they understood, further questioning suggested such might not actually be the case.

Both parents and older siblings in Mexican-descent families have been found to be important resources for learning of young children by Perez-Granados and Callanan (1997). Rather than focus on such information relevant to providing a better match between learning and socialization processes in the schools with those in the homes, the authors contend that the two environments should be seen as complementing one another. Teachers and families should work in collaboration to best provided learning experiences for children.

In a review of literature relevant to childhood socialization in Hispanic families, Zayas and Solari (1994) suggest Hispanic parents differ from parents of other ethnic groups in their child rearing values and the interpersonal behavior they want their children to display at home and school, and that such differences should be considered

when working with Hispanic children and their families. In the resulting article, contrasts were presented between Euro-American values and those of Hispanic parents. A general trend was identified indicating Hispanic parents appear to prefer behaviors in children that encourage family closeness, parental authority, and interpersonal relatedness (Zayas & Solari, 1994). Meaningful engagement of Hispanic parents in programs addressing parenting skills and child behavior should include, according to the authors, initiating discussion of the specific child rearing values and beliefs held by Hispanic parents and making them integral components of the interventions proposed.

Gonzalez-Ramos, Zayas, and Cohen (1998), in a study involving only Puerto Rican mothers, also found that the child-rearing values held most closely diverged considerably from those associated with the Anglo culture. In this study, the mothers ranked highest the values of honesty, respect, responsibility, loyalty to family, affection, and sharing. The authors encourage the clinician's recognition of diverse parental values when evaluating a child's behavior in that presenting behaviors may be misinterpreted as representing potential pathology.

With increasing cultural diversity characterizing the nation's student population, issues of multicultural counseling are gaining prominence in the public schools. As the literature pertinent to this arena suggests, the principles and guidelines of multicultural counseling have guided the delivery of services in schools, in general. Particular attention has been given to incorporating families in efforts to enhance cultural sensitivity. As a result, greater understanding of the factors impacting a culturally diverse student is possible, as well as greater appreciation of the potential for misunderstanding between home and school as a result of differing child rearing philosophies. Findings particularly

relevant to parents of Hispanic culture include their desire for greater specificity as to meaningful ways in which they can be involved in their children's education, greater knowledge as to the means of accessing services, preference for personal informal communication methods, use of both English and Spanish in written communication, and greater acknowledgement of their child rearing values when problem solving. Knowledge is of little use without the means of using it, however. Consultation is one venue that has been frequently used in the context of service delivery to children. In the following section, the history of consultation will be briefly discussed while leading to information particularly relevant to Conjoint Behavioral Consultation and its application within a multicultural context in schools. Accepted methods of research associated with investigations pertaining to consultation will also be presented in this section.

Consultation for Children

History of Consultation Models

Medical model for consultation. The roots of consultation are in medicine, with reports being found as early as the thirteenth century in response to the fields increasing specialization (Brown, Pryzwansky, & Schulte, 1998). The participant interaction characteristic of this clinical model consisted of an expert, or consultant, providing diagnostic and prescriptive treatment assistance to another professional, consultee, who is then left to implement the intervention with the patient, or client. Though also practiced by psychologists in mental health and educational settings, the clinical model declined in

acceptance and practice primarily as a result of three reasons: (1) its emphasis on diagnosis provided little connection to treatment; (2) it emphasized abnormality; and (3) the expert role of consultant was contradictory to the collegial relationship appreciated by many professionals in the mental health field (Brown, Pryzwansky, & Schulte).

Caplan's mental health consultation model. The current mental health consultation model, first published by Gerald Caplan in 1970, was developed following World War II in response to the numbers of Jewish refugee children in need of mental health assistance (Brown, Pryzwansky, & Schulte, 1998). Caplan's model differed from the previous clinical model on the following three aspects: (1) an egalitarian relationship between the consultant and consultee; (2) concept of theme interference which has as its basis mild confrontation of stereotypical ideas held by the consultee; and (3) a taxonomy of four approaches (Brown, Pryzwansky, & Schulte). Additional facets of Caplan's mental health model that are important in its differentiation from other models and which have been questioned include the following: the external locus of the consultant, the idea that the consultee has sole responsibility for implementing the intervention(s), the idea that consultation can only take place when the consultant and consultee are both professionals, and the focus of consultation is a work related problem.

Behavioral consultation model. The popularization of behaviorism with its basic tenant of behavior being a function of environmental antecedents and consequences added new perspective to consultation considerations and those involved when behavior change was the goal (Brown, Pryzwnansky, & Schulte, 1998). Bergan (1977) probably

provided the first most fully developed behavioral consultation model which was later refined by Bergan and Kratochwill (1990). In their work, Bergan and Kratochwill defined consultation as an indirect, problem-solving service involving a collegial relationship between the consultant and consultee in which the consultant acquires and communicates psychological data pertinent to the consultee's problem as well as the psychological principles that will enable the consultee to utilize the data. The authors identified three goals of consultation from this perspective: (1) to change the client's behavior; (2) to alter the consultee's behavior; and (3) to produce changes in the organization that improve communication and problem solving within the organization (Bergan & Kratochwill). The consultant's role in this relationship is to provide psychological information and principles to the consultee (Brown, Pryzwansky, & Schulte). Communication from the consultant is focused on obtaining a description of the background and current information pertaining to the behavioral concern of the consultee. In order to effectively do this, the consultant structures the communication by asking questions framed so as to elicit the necessary information. Thus, the relationship between consultant and consultee can be characterized as one of equal respect, but the format of communication is determined by the consultant. The role of the consultee is to describe the problem in specific terms, decide upon a plan to deal with the problem behavior, implement the plan/intervention, and supervise the client's behavior (Brown, Pryzwansky, & Schulte). According to Bergan and Kratochwill (1990), clients may participate in the consultation process, especially in the selection of interventions, resulting in increased effectiveness. The behavioral consultation of Bergan and Kratochwill incorporates four major steps: problem identification, problem analysis, plan implementation and problem evaluation.

Five verbal processes, structured by the consultant, are incorporated within each step: specification, evaluation, inference, summarization, and validation. The behavioral descriptors of incidence, duration, intensity, and time of occurrence are central to data collection during behavioral consultation, as well as the use of observation.

In 1990, Gutkin and Conoley suggested that in order to bring about meaningful change in the lives of children, the adults who control children's environments are integral to intervention success. For a school-aged child, those influential adults include the parents and teachers. In making a case for the use of consultation services for children, Gutkin and Conoley go on to say, "By providing treatment to children through primary caregivers such as parents and teachers, indirect services provide psychologists with a vehicle for influencing and modifying both the significant adults in children's lives and the children themselves" (p. 209). Several rationales have been offered in promoting consultation services for children (Sheridan, Kratochwill, & Bergan, 1996): (1) consultation directly addresses environmental variables related to the problems and the adults involved in the problem; (2) indirect assessment practice that is commonly observed within settings other than homes (or the place in which misbehavior is occurring) may be ineffective and inefficient; (3) consultation involving the teaching of skills to those who work with the child on a regular basis may have a broader impact on children's behavior; and (4) teachers and parents can generalize the consultation procedure to other children within the classroom or family, respectively.

The behavioral approach has frequently been said to lend itself well to work with children (Alpert & Yammer, 1983; Henning-Stout, 1993; Medway, 1979). Behavioral consultation has been described by Sheridan, Kratochwill, and Bergan (1996) to bestow a

number of unique benefits. First, when consultation services are provided to a consultee, a larger number of clients can potentially receive services as a result of the consultee's empowerment to utilize learned techniques to solve and/or prevent future problems. Second, behavioral consultation is a decision-making, goal-oriented service delivery model that is "based on empirical, data-based research that can be translated into practice" (p. 4). Third, behavioral consultation implies a collegial relationship between the consultant and consultee. This assumption has been questioned (Erchul, 1999; Gutkin, 1999a, 1999b) with regard to the characteristic structural control by the consultant. However, results of research conducted by Erchul et al. (1999) suggest the levels of control by consultants and consultees generally even each other out. Whereas, consultants were scored higher on their attempts to structure the interactions, consultees scored higher on influence during decision-making.

Conjoint Behavioral Consultation. Though parallel behavioral consultation with teachers and parents separately does include the adults who control children's environments, as recommended by Gutkin and Conoley (1990), concerns have been expressed that such a model does not account for all the elements of the environment. Sheridan, Kratochwill, and Bergan (1996) implied such practices to be limiting by not accounting adequately for the ecological influence by the interrelated systems within which the child operates and by which the child is impacted. The inclusion of both parents and school personnel in decision-making for the welfare of a student has long been a cornerstone of the special education arena. Since its inception in 1975 with Public Law 94-142, special education has provided for the involvement of parents, along with

educators, in the development of an appropriate education program for their children with disabilities. One of the major outcomes of P. L. 105-17, or the Individuals with Disabilities Education Act (IDEA) Amendments of 1997, was the enhancement of parental involvement in the identification, evaluation, and/or placement decisions affecting their children. In addition to previous regulations addressing parent notification and due process rights, IDEA 97 included several provisions specifically requiring schools to seek active parental input. Information provided by parents must be considered when determining eligibility for special education services. Along with education personnel, the parent is a member of the team that determines eligibility. Furthermore, parents are members of the child's Individualized Education Plan (IEP) team. Their concerns must be taken into account during the development of the IEP, and they are integral to the team's decision as to educational placement of their child. Additionally, a review of committee reports accompanying the 1997 Amendments revealed an intent for the contents of IEPs to facilitate parental involvement by allowing them to be able to monitor their child's progress via the statements of measurable annual goals and short-term objectives (Jones & Aleman, 1997).

But, what can be done with the concept of parent and teacher consultation outside of the formal stipulations of special education regulations? Parental involvement in their child's education has long been linked to school success (Educational Resources Information Center, 1996). Its positive impact has been evidenced in varied programs addressing the improvement of educational outcomes for children at risk for school failure (Comer, 1984), the enhancement of students' social development (Comer & Haynes, 1991), and improved academic performance (Wang, Gennari, & Waxman,

1985). In describing the most beneficial relationship between home and school, Christensen (1995) sets forth that "best practices are characterized by viewing parents as partners in - not problems for - the success of students" (p. 265). Christensen continues by challenging educators to view parents as allies in sharing goals, information, decision-making, resources, and accountability for students' educational progress.

In 1992, Sheridan and Kratochwill developed the Conjoint Behavioral Consultation (CBC) model defined as "a systematic, indirect form of service delivery, in which parents and teachers are joined to work together to address the academic, social, or behavioral needs of an individual for whom both parties bear some responsibility. It is designed to engage parents and teachers in a collaborative problem-solving process with the assistance of a consultant, wherein the interconnections between home and school systems are considered crucially important" (p. 122). The authors promoted several advantages of CBC. First, by gathering information from multiple individuals who know the child in varied settings, a more comprehensive description of behaviors and related conditions is obtained across settings and over time. Second, by adhering to a structured problem-solving framework simultaneously involving both parents and teachers, data can be collected and interventions implemented more consistently and systematically across settings. Thus, possible behavioral side effects can be more closely monitored, and the generalization of treatment effects is enhanced. Finally, CBC increases "the potential for effective communication, constructive partnerships, and productive relationships between home and school" (p. 122).

Research has demonstrated the effectiveness of CBC in addressing a variety of problem behaviors presented by children, as well as when comparing it to other singular

consultation methods. In 1990, Sheridan, Kratochwill, and Elliott studied the outcomes of CBC and teacher-only consultation when attempting to increase the social initiation behaviors of socially withdrawn children. Teachers and parents worked together with a school psychologist consultant in the CBC condition, with behavioral treatment implemented across home and school settings. Only teachers and a school psychologist worked together in the teacher-only condition, with the same behavior treatment implemented at school only. A multiple-baseline-across-participants design was used to evaluate the effectiveness of the separate consultation conditions. Results showed the social initiations increased in both home and school settings when CBC was used. However, initiations increased only at school when teacher-only consultation was used. Social initiations increased more dramatically using CBC, as well. Furthermore, maintenance of treatment effects was stronger when CBC procedures were utilized, and measures of social validity and treatment integrity were also positive.

CBC used in the context of instructional consultation was demonstrated by Galloway and Sheridan (1994). Six elementary school children identified as often failing to complete math assignments on time and with accuracy as a result of performance deficits were the subjects, or clients, of the two separate case studies. Both treatment conditions involved the use of a standard home-note intervention, but conjoint parent and teacher consultation procedures were utilized as well in the CBC experimental treatment. All children in the home-note and home-note-with CBC conditions demonstrated improvements in math completion and accuracy. The improvements in the home-note-with CBC condition, however, were greater and more stable. Treatment integrity by

parents was higher with the CBC condition, but that of teachers was the same for both conditions. Satisfaction by parents and teachers was more positive for the CBC condition.

A study using CBC by Sheridan and Colton (1994) addressed the bedtime fears at home and stories of nightmares at school of a 6-year-old boy who refused to sleep in his own room. The goal of the fading of environment and positive reinforcement procedure incorporated in treatment was for the child to sleep in his own room on a consistent basis. Observational reports by the mother reflected immediate dramatic improvement upon initiation of the treatment demonstrating the effectiveness of CBC addressing a behavioral problem that does not typically include school involvement.

The use of CBC to improve the cooperative play behavior of three boys of low socioeconomic status and diagnosed with ADHD was the focus of study for Colton, Sheridan, Jenson, and Malm in 1995. A behavioral social skills program was implemented within the context of CBC. Results of the study reflected improved social behaviors of all clients such that they approached the level of comparison peers. Treatment acceptability was rated high by both parent and teacher consultees as well as child clients. Treatment integrity by both consultants and consultees was also measured as high.

A study of the effectiveness of CBC using self-administered manual vs. videotape parent-teacher training was conducted by Loitz (2000). Children exhibiting externalizing or internalizing behavioral problems who attended Head Start Programs were the targets for intervention. Children were randomly assigned to either one of the two treatment groups or a no-treatment control group. Results indicated that both treatment groups demonstrated greater improved behaviors compared to the no-treatment group, with the

manual treatment group showing the greatest number of improvements. Though direct behavioral observations did not indicate clinically relevant improvements in behavior, goal attainment reports by both parents and teachers described students as meeting their behavior goals, in general. Parents and teachers also reported high rates of treatment acceptability with both treatment programs.

In 1994, Sheridan conducted descriptive analysis of teacher statements made in consultation with teachers only with those made during CBC. Contrary to predictions, there was no difference found in the amount of statements made regarding background environment and behavior setting in the CBC transcripts as compared to teacher-only consultation transcripts. Consistent with research predictions was the finding that parents were actively involved in problem-identification interviews. The teacher's verbal contribution to discussions during CBC was less than in consultation wherein the teacher served as sole consultee. Teachers were found to ask proportionately more questions in CBC than in teacher-only consultation. Consultants were found to control more of the discussion in CBC. This was hypothesized as a deliberate and active attempt to structure the discussion.

In a national survey, Sheridan and Steck (1995) investigated the acceptability of CBC by nationally certified school psychologists who served as consultants during the process. Their findings showed CBC was rated more acceptable than any other mode of service delivery equally across academic, behavioral, and social-emotional problem types. Furthermore, ratings of CBC acceptability were most affected by external constraints of time concerns and perceived administrative/organizational support for implementing the procedure.

Freer and Watson (1999) conducted a study of parental acceptability comparing CBC to the more traditional behavioral consultation models involving teacher-only and parent-only approaches. Parents responded to a survey describing differing consultant and consultee involvement characteristic of the three consultation approaches, and did not require that parents had actually participated in prior consultation. The majority of parents expressed preference for the CBC model. Upon citing racial demographics and method of obtaining information as study limitations, the authors called for the need for future investigations incorporating larger numbers of parents from diverse populations and who had actually participated in the CBC process.

At the conclusion of a 4-year investigation, Sheridan, Eagle, Cowan, and Mickelson (2001) published data that did include larger numbers of consultees and consultants who had participated in CBC. Identified clients included 52 students with disabilities or at risk for academic failure. Co-consultees included 53 parents and 56 teachers, along with 30 graduate student consultants. Seventy-seven percent of the student clients were categorized as Caucasian by the authors, while 10% were Hispanic, and the remainder were reported to be African American, Native American, Chinese, or biracial. Subjective ratings by consultees of the efficacy, acceptability, and satisfaction associated with their CBC experiences were positive. Moderate to large effect sizes were found across home and school settings with regard to target behavior improvement, while greatest improvements were associated with older clients with less severe symptoms and younger clients with more severe symptoms. To assess the integrity with which consultants met CBC interview objectives, trained observers coded each interview using checklists previously developed by Sheridan et al. (1996). Though interobserver

agreement was not reported, the authors reported an average of 83% of CBC objectives were met, overall, with 82%, 83%, and 80% of the CPII, CPAI, and CTEI objectives met, respectively. Study limitations cited by the authors included the dependence on self-report outcome and treatment integrity data provided by parents and teachers.

Evaluation of Consultation

Gutkin (1993a) addressed research methodologies for consultation services to children with suggestions for the nature of future research. In his writings, he called for greater specification of processes involved in the consultation being conducted beyond merely stating the consultation was implemented. Treatment integrity of consultation process, as well as treatment intervention, is also necessary to accuracy of results interpretations and conclusions. Gutkin also suggested the need for greater inclusion of behavioral observation data as opposed to self-report and attitudinal type data, as well as addressing greater numbers of variables using multiple methods in keeping with the increasing ecological perspective of consultation. Issues of long-term follow-up and research representativeness were also discussed. Gutkin also identified several methodologies considered to be "promising" in addressing such future research goals. Use of small-n methodologies was proposed by Gutkin as a reasonable response to his aforementioned methodological problems. By focusing on only a small number of consultation cases in each study, Gutkin indicated "researchers will find it much easier to define in greater detail the specific consultation processes used during consultation interactions; collect data pertaining to the integrity of the consultation processes that were

employed during consultation; collect data pertaining to the integrity of treatment interventions resulting from consultation; gather direct observational data for consultants, consultees, and clients; assess a much broader (multivariate) range of consultant, consultee, and client data; conduct long-term follow-up of cases after the completion of consultation; and determine whether the consultation processes under investigation are representative of the approaches used naturally in the field by practitioners" (p. 233). Gutkin defines small-n studies as ranging from one to three in the number of individual cases included. In response to the criticism that small-n designs are not robust enough for adequate external validity, Gutkin pointed to the potential resulting from large numbers of replications of small-n studies. On the other hand, problems associated with the need for a baseline period, added to the possible withdrawal or reversal of treatment effects associated with establishing internal validity are identified as drawbacks for the use of small-n designs. The standardization of consultation processes and desirability for more case study methodologies are also discussed with implications for future research.

Gresham and Noell (1993) have criticized the presentation of consultation research outcomes as being "alien, incomprehensible, and irrelevant, speaking little to the practical significance of a particular research finding" (p. 250), and go on to discuss ways in which it can be reported in a manner more relevant and useful to practitioners. The authors discussed three research designs that have typified consultation research: group experimental; single case experimental; and case study. Though Bergan and Kratochwill (1990) have characterized case study designs as being uncontrolled and subjective, Gresham and Noell pointed out such does not have to be the fact. They argued that the use of AB case study designs with replication across subjects provides for internal

validity threats similar to that found in multiple-baseline single case designs. Gresham and Noel further advocated that replicated case studies are more practitioner friendly. Bergan and Kratochwill identified characteristics of a case study methodology that allowed for valid inferences: using objective data; repeated measurement of the dependent variable; manipulation of the independent variable; replication across subjects, monitoring of treatment integrity; maintenance of a formal design structure; and social validation of treatment effects. Gresham and Noell also expressed agreement with Gutkin (1993) in emphasizing the need for an expanded scope of potential dependent variables beyond those associated with problem identification during the consultation process, thus, making research more relevant to practice. Social validation combining quantitative evidence of behavior moving in the direction of average peers along with subjective appraisal of that change and the methods used to affect it is suggested as a viable alternative to more traditional methods for reporting consultation outcomes such as parametric statistics, effect size, and visual analysis of data. Along such lines, the use of a reliable change index and method involving the computing of the percentage of nonoverlapping data points between baseline and treatment phases (Mastropieri & Scruggs, 1985-86) are suggested instead of traditional significance testing to document consultation outcomes. Review of the Treatment Evaluation Inventory (Kazdin, 1980), Parent's Consumer Satisfaction Questionnaire (Forehand & McMahon, 1981), and Consultation Services Questionnaire (Zins, 1984), suggests these instruments align with Gutkin's call for combined social validation procedures, as well. Babcock and Pryzwansky (1983) also offer the Consultation Preference Scale as a pre-post instrument to measure change in attitude toward consultation style as an outcome.

In an article specifically addressing evaluation incorporated into a conjoint behavioral consultation framework, Sladeczek, Elliott, Kratochwill, Roberson-Mjaanes, and Stoiber (2001) presented goal attainment scaling (GAS) as a viable methodology. Among its features making GAS particularly well suited for CBC, Sladeczek et al. pointed out the GAS framework whereby goals, progress, and documentation of intervention outcomes are specified is an extension of the collaborative process by consultation participants inherent within CBC. As such, it provides consensus among consultation participants and there is increased potential for intervention acceptability; Furthermore, GAS provides a common language to discuss goal attainment progress, as well as being nonintrusive, inexpensive, and conducive to personalization. Additionally, since GAS ratings are obtained on a weekly basis, communication, cooperation, and ownership among participants are supported, according to authors. Sladeczek et al. listed GAS limitations including its inappropriateness for establishing causal relationships and, as it is tied to social validity, it is not useful in establishing an absolute functioning level.

Cultural Issues in Consultation for Children

The relevance of cultural issues pertinent to the school-based consultation process is founded primarily in the multicultural counseling and psychotherapy literature base (Ramirez, Lepage, Kratochwill, & Duffy, 1998). In fact, according to Bergan and Kratochwill (1990), distinction between consultation and counseling is not always made in theory or practice. It is generally agreed (Ramirez et. al., 1998; Conoley & Conoley, 1992; Gutkin, 1993b) that effective consultants do not ignore the influences of

ecologically based variables, including culture, on the behavior and educational performances of children. That is not to say that all aspects of the consultation process lend themselves to preferences that have been found among differing cultures. For example, Ramirez et al. (1998) suggested the collaborative, egalitarian relationship between the consultant and consultee may be awkward with respect to Native American, Asian American, and Latino cultures. Consultees from these cultures have a tradition of communication patterns that may make it difficult to initiate the conversation characteristic of the consultation session. However, such consultees may benefit from the consultant's maintaining a collaborative style (Ramirez et al., 1998) and interactive structure that would draw out their cooperative problem-solving skills. Additionally, ineffective treatment may result when cultural variables such as perceptions of normal and abnormal as well as interpersonal interactions are not taken into consideration during the problem identification (Ramirez et al.). Furthermore, the acceptability of a recommendation has been found to be positively correlated with the likelihood of its implementation (Conoley, Conoley, Ivey, & Scheel, 1991; Conoley, Padula, Payton, & Daniels, 1994). Thus, interventions developed with considerations given to the cultural aspects of the consultees and clients increase the probability of their implementation.

An entire volume of School Psychology Review (Ingram & Myers, 2000) has been devoted to multicultural and cross-cultural consultation in the schools. In this miniseries, Ingraham (2000) sets forth the Multicultural School Consultation (MSC) framework consisting of five components designed to support each of the members of the consultation process. The first component consists of MSC competency domains for consultant learning and development. Component two delineates domains for consultee

learning development. The third component lists cultural variations in the consultation role constellation: consultant-consultee similarity; consultant-client similarity; consultee-client similarity; and three-way diversity, or tri-cultural consultation. The fourth component recognizes the contextual and power influences potentially inherent in the consultation relationships and process. Finally, component 5 presents hypothesized methods for supporting consultee and client success. The incorporation of these five components within the consultation structure and process naturally evolves into acknowledgement of multiculturalism defined by individual differences described by Tarver-Behring and Ingraham (1998): each family's uniqueness in terms of ethnic heritage, level of acculturation, socioeconomic status, language practices, belief systems, religious and life-style orientation, number and ability levels of members, and involvement with extended family members.

Also in this School Psychology Review miniseries was an article examining consultant practices in two educationally and linguistically heterogeneous Latino schools (Goldstein & Harris, 2000), and report of a study by Lopez (2000) regarding the use of interpreters during instructional consultation. Upon studying the various records pertaining to intervention development and development of individual education plans in the two schools, Goldstein and Harris found that three themes emerged: role of primary language in education, role of parents in the school, and previous attitudes regarding the nature of disability. In examining how the use of school interpreters influenced the process of instructional consultation, Lopez utilized a case study methodology to examine five instructional consultation cases in which interpreters were used to facilitate the communication between Limited English Proficient students, their parents, consultants,

and consultees (teachers). Results indicated the use of interpreters slowed the pace of consultation and had inconsistent effects relevant to communication clarity among participants and establishing positive rapport and trust in the consultation.

In an article also a part of the miniseries, Sheridan (2000) discussed the structural applicability of Conjoint Behavioral Consultation within the context of multiculturalism and diversity. Multicultural CBC was defined as "a home-school consultation relationship wherein important individual differences are present among two or more participants (i.e., parent, teacher, student, school psychologist-consultant) with respect to association with distinct cultural group(s)" (p. 345). For purposes of this definition, Sheridan included sociodemographics such as race, gender, national origin, class, language, as well as beliefs, attitudes and values of individuals, and norms and customs of schools within the concept of culture. Sheridan discussed the behavioral consultation steps/stages incorporated within the CBC structure in terms of potentials for difficulty when working with consultees from diverse cultures. The "problem" identification stage may semantically present a challenge when working with families that perhaps already feel alienated from the school. In response to such concern, Sheridan (2000) suggested consultants should emphasize the ecological system orientation by describing the behavioral concern in terms of the "mismatch between the child, his/her uniqueness, the primary caregivers in his/her life, and the environments within which they are embedded" (p. 346). Aligned with this statement is the notion that it should not be the biases or values of the majority culture that defines the problem. Likewise, a solution focus should be maintained during the treatment evaluation stage. The same must be said about goals setting in that the sharing of educational and developmental goals between schools and

homes should result in agreed upon goals reflecting respect for the values of both parent and school consultees. Similarly, sensitivity and flexibility with regard to diversity must characterize the problem analysis, plan development, and treatment implementation phases of the consultation process. Precision of data collection characteristic of behavioral data collection and assessment may also be a source of difficulty and/or misunderstanding for those cultures who do not perceive time and privacy issues in the same way as Euro-Americans. Sheridan summarized by calling for additional empirical research in the effective use of behavioral and conjoint behavioral consultation with diverse individuals.

Thus, Conjoint Behavioral Consultation appears promising when addressing the needs of children from Hispanic families. The collaborative relationship between parents and teachers encouraged by the CBC process structure would appear to encourage the sharing of child rearing philosophy and rearing differences that, if gone unacknowledged and resolved, could result in serious misunderstanding. It is noted that the effects of these differences are first experienced by children when they enter school. Yet, the preschool age student is omitted from multicultural consultation literature in this respect.

Preschool Children

Preschool Social Skills

Developing successful social skills has been described as one of the most important accomplishments of childhood (Elliott, Racine, & Bussee, 1995). Gresham and

Elliott (1984) defined social skills as socially acceptable learned behaviors enabling a person to interact with others in ways that elicit positive responses and assist the person in avoiding negative responses. The development of such behaviors is understood to begin soon after birth and is influenced by personal variables as well as environmental variables (Elliott, Racine, & Busse). Personal variables include such individual aspects as physical abilities, language, and communication skills. Environmental variables begin with family, but progress to include such factors as other significant adult interactions, educational opportunities, and peer involvement. Parker and Asher (1987) have associated untreated, ineffective social skills with poor academic performance, as well as social adjustment problems as the child grows older and into adulthood.

Social skills consist of both verbal and nonverbal behaviors. Providing the underlying structure of their Social Skills Rating System, Gresham and Elliott (1990) categorized these behaviors into five major clusters: cooperation, assertion, responsibility, empathy, and self-control. Cooperation consists of behaviors associated with helping, sharing, and compliance. Assertion involves both verbal and nonverbal behaviors involved in the initiation of interaction with others as well as responding to the behaviors of others. The responsibility category includes behaviors that demonstrate one's ability to communicate with adults and show concern about property. Behaviors that reflect concern for the feelings and wellbeing of others are included within the empathy category. Finally, self-control refers to behaviors demonstrated during conflict situations. The demonstration of these behaviors has been studied primarily as they relate to two goals in social interaction of preschool children: social initiation and maintenance of social interaction. In a review of relevant literature, Elliott, Racine, and Busse (1995)

concluded that successful initiation requires "specific nonverbal and verbal communication behaviors that clearly transmit the entering child's desire as well as awareness of contextual accommodations" (p. 1010). Effective social skills that maintain interaction have been studied from a cognitive developmental standpoint associated with a child's increased ability to consider the perspective of others in their own decision-making (Elliott et al.).

Social validity of social skills refers to judgment made as to the significance of behaviors demonstrated in specific situations with reference to predicting important social outcomes for children and youth (Gresham, 1983). Judgments are made by the significant persons who regulate the child's environments with outcomes identified by Gresham (1995) as including peer acceptance, friendships, significant others' judgments of social skill, positive feelings of self-worth, academic achievement, and positive adaptation to school, home, and community. In a 1989 study conducted by Elliott, Barnard, and Gresham, teachers and parents of preschool children were asked to rate the frequency and importance of over 50 different social behaviors. Behaviors associated with compliance, cooperation, and orderliness topped the teachers' list. Behaviors rated high by parents fell into the two categories of basic communication skills and behaviors indicating respect for others. One might say preferences of teachers and parents are generally complementary. The categorization of responses says nothing, however, about the manner in which such behaviors are demonstrated relevant to specific cultural expectations of the family and school systems. As discussed earlier with respect to Hispanic child-rearing practices (Gonzalez-Ramos, Zayas, & Cohen, 1998; Zayas &

Solari, 1994), role socialization goals, and communication styles, agreement of outcome category does not constitute agreement with the means toward those ends.

Furthermore, the need for more definitive information beyond social skill category may be required to better describe a child's behavior if pathology is a concern. The Behavior Assessment System for Children (Reynolds & Kamphaus, 1992) has been found useful in measuring a variety of child behavior problems and adaptive skills. Separate parent and teacher forms are available, with the parent form available in both English and Spanish.

Conflict between home and school expectations becomes most apparent with the entry of children into the public school system, and preschool programs are increasingly being the standard entry level for students. With its history of service to diverse children and families, the Head Start program would seem a logical source for participant recruitment.

Project Head Start

Minority children often enter school developmentally behind children from majority families (Chavkin, 1989). Hispanic children enter school at-risk for difficulties in regard to both academic as well as behavioral/social domains. According to Espinosa (1997), their language development is delayed upon entering kindergarten regardless of whether they are bilingual, speak only English, or speak only Spanish. Thus, early intervention should be a priority. Such philosophy is basic to the Head Start program.

Founding of Project Head Start. Project Head Start was implemented in 1965 as a component of President Lyndon Johnson's War on Poverty. Initially under the auspices of the then newly formed Office of Economic Opportunity, it was central to the Community Action Programs of the time. Over the years, Head Start has been a part of varied government agencies and now resides with the Department of Health and Human Services Administration on Children, Youth and Families.

Head Start began as a summer program, but quickly expanded to provide year-round educational, health, social, and special services for poor preschool children, their parents, families, and communities (Ellsworth & Ames, 1998). Starting with an enrollment of 561,000 during the summer of 1965, it has served a total of 19,397,000 children as of the March 20, 2001 update of the 2001 Head Start Fact Sheet (Head Start Bureau, March 2001). Data for fiscal year 2000 placed enrollment at 857,664 attending programs in 18,200 centers at an average cost of $5,951 per child (Head Start Bureau, March 2001). At 56%, the majority of children are served in the 4 year-old classes, with 33% being 3 year-olds, 6% under three years of age, and 5% five years old and older (Head Start Bureau, March 2001). Latest figures show that the largest percentage of children in Head Start are listed as Black (34.5%), with White children comprising 30.4%, Hispanic children 28.7%, American Indian 3.3%, Asian 2.0%, and Hawaiian/Pacific Islander children being1.0% (Head Start Bureau, March 2001).

The program was founded primarily according to two philosophically and politically based tenants. The first purported the poor were deficient or culturally deprived, with their homes providing minimal opportunities for the development of appropriate physical, cognitive, social, and moral habits. Thus, such deficits were passed

from generation to generation (Kuntz, 1998). Since it was assumed the first five years of life were most crucial to the course of a child's development, early intervention was heralded as one arena in which to attack this generational cycle of poverty. The second tenant was based on the assumption that by keeping control of community institutions within the community, community members would be empowered to improve their own lives.

By 1970, such community control survived in the form of codified parental involvement. Head Start Program Performance Standards (U. S. Department of Health and Human Services, 1992) mandates active parental participation in matters of curriculum, finance, hiring and firing, as well as policy making. Parent participation is recruited for both volunteer as well as paid employee capacities. It is through their involvement that each Head Start is shaped in responding to the unique needs, concerns, and priorities of the respective communities (Kuntz, 1998). Thus in fulfilling this purpose, the enrollment and personnel of each Head Start center should reflect the demographics of the feeder community. However, Hamilton, Hayes, and Doan (1998) found problems associated with language translation needs, transportation, and childcare affect the actual level of parent participation. Hamilton et al. further reported another reason why Head Start parents may not be more active participants is associated with their low self-esteem and feelings of inadequacy. In fact, it was reported many immigrant females suffered with depression as a result of being separated from their extended families and having no social supports in their current living locations (Hamilton et al.)

Eligibility for participation in a Head Start program is determined by income. To be eligible, children must come from low-income families or from families eligible for

public assistance (U.S. Department of Health and Human Services, February 2001). According to the Head Start Act, income eligibility is based on the poverty guidelines updated annually by the federal government (U.S. Department of Health and Human Services Administration on Children, February 2001). The public assistance criterion refers to family participation in the Temporary Assistance for Needy Families program or the Supplemental Security Income program (U.S. Department of Health and Human Services, February 2001).

Multicultural Character of Head Start. All eligible children, however, do not participate in a Head Start program. Some may attend another preschool program or remain home. In a study of Head Start covering the years 1993-1996 and commissioned by the Administration on Children, Youth, and Families (ACYF) (Hamilton et al., 1998), participation demographics were collected and compared, particularly with regard to the multicultural composition of programs. Results indicated Head Start enrolls a higher proportion of minority children than white children (Hamilton et al.). Though the actual percentages varied by region and state, approximately 66% of eligible Native American children were enrolled, while 59% of eligible African-American children, 45% of eligible Hispanic children, and 43% of eligible Asian children were enrolled at the time of the study (Hamilton et al.).

A further finding by Hamilton et al. (1998) was that 20% of eligible children and 17% of those actually participating in Head Start did not speak English in the home. Qualified personnel who also speak the varied languages represented are not always available to individual programs, however. There is little wonder, then, that staff

language was the most often listed problem for programs serving non-English speaking families (Hamilton et al.). Therefore, Head Start is challenged to adequately fulfill its commitment to serve the needs of the diverse ethnic, racial, and linguistic groups represented in its programs in a culturally sensitive manner.

In 1991, the ACYF issued Multicultural Guidelines (U. S. Department of Health and Human Services, 1991). The following ten principles resulted:

1. Every individual is rooted in a culture.
2. The cultural groups represented in the communities and families of each Head Start program are the primary source of culturally relevant programming.
3. Culturally relevant and diverse programming requires learning information about the culture of different groups and discarding stereotypes.
4. Addressing cultural relevance in making curriculum choices is a necessary, developmentally appropriate practice.
5. Every individual has the right to maintain his or her identity while acquiring the skills required to function in our diverse society.
6. Effective programs for children with limited English speaking ability require continued development of the primary language while the acquisition of English is facilitated.
7. Culturally relevant programming requires staff who reflect the community and families served.
8. Multicultural programming for children enables children to develop an awareness of, respect for, and appreciation of individual cultural differences. It is beneficial to all children.

9. Culturally relevant and diverse programming examines and challenges institutional and personal biases.
10. Culturally relevant and diverse programming and practices are incorporated in all components and services.

The above principles can be difficult to implement in the day-to-day activities of Head Start classrooms, however, despite the dedication and willingness to learn found of both Head Start administrators and teachers by Hamilton et al. (1998). One such source of difficulty arises from the very strong developmental theoretical and philosophical foundations of the Head Start educational curricula. In studies involving Hmong and Latino families, Quintero (1998) found the Developmentally Appropriate Practice Guidelines (Bredekamp, 1987) which guide Head Start educational curricula, fail to take into consideration the differences in child-rearing practices of its culturally diverse families. Reyes (1993) further suggests the child-centered, nondirected teaching style associated with developmentally based instruction may be in direct contradiction to the value of parental authority by Latino parents and their subsequent emphasis on respect for teachers and school. Parental expectations of what is to be taught may also be in disagreement with Head Start practices as reported by Quintero who indicated Hmong parents expected greater insistence on children speaking English in the classroom. High/Scope is an early childhood curriculum approach developed through the Perry Preschool Project in Ypsilanti, Michigan (Schweinhart & Weikart, 1993). It and variations of it are used in over 25% of Head Start programs. Active learning involving independent exploration is the basis on which instruction takes place. In a study of the satisfaction of Southeast Asian Head Start parents in two Head Start classrooms, Inoway-

Ronnie (1998) found parents felt High/Scope promoted values and orientations conflicting with their cultural beliefs, and did not teach their children the procedures and practices of traditionally structured schools that would promote success in future educational settings.

In a study conducted by Currie and Thomas (1999) the effects of Head Start were investigated with regard to participating Hispanic children. It was the hypotheses of the study that Head Start may promote greater language and cultural assimilation in addition to providing better quality preschool educational experiences than other preschool or child care arrangements utilized by poor Hispanic families. Comparison of outcomes was conducted for sets of siblings, one of whom attended Head Start and one of whom did not. Outcomes were identified as test scores on the Peabody Picture Vocabulary Test (PPVT), the Peabody Individual Achievement Test in Mathematics (PIAT-MATH), the Peabody Individual Achievement Test in Reading Recognition (PIAT-READING), and examination of grade retention responses. Data from the National Longitudinal Survey Child-Mother (NLSCM) was used with the Hispanic sample consisting of 750 children drawn from 324 families. Results suggested Head Start closes at least one quarter of the gap in test scores between Hispanic children and the average non-Hispanic white child in the NLSCM, as well as two-thirds of the gap in the probability of grade repetition (Currie & Thomas, 1999). Currie and Thomas also found the greatest gains were among the Mexican-origin children, while little benefit was indicated by Puerto Rican children relative to siblings who stayed at home.

Literature suggests that the development of appropriate social skills as children is vital to school success as well as successful interpersonal interaction in later life.

Furthermore, Hispanic children may demonstrate social behaviors putting them at risk for social and academic difficulties as a result of culturally based child-rearing differences. Therefore, intervention at the preschool level would seem appropriate in addressing these differences. Furthermore, it follows that the Head Start program, with its history of parental involvement and multicultural student population, would provide an appropriate population from which to recruit participants for this study.

Statement of the Problem

The number of Hispanic school-age children has been increasing dramatically, with such growth projected to continue in the future. Statistics for academic performance, special education placement, retention, and high school completion depict very limited successes for Hispanic children and youth in the public school system thus far. Therefore, more effective methods of addressing the needs of Hispanic students are needed. Multicultural counseling has laid both theoretical and empirical groundwork as to qualitative aspects such interventions might incorporate. For example, preference and greater likelihood of subsequent success in interaction has been associated with the inclusion of the following attributes during parent-school meetings: acknowledge and incorporate family members and values (Brown, 1997; Chavkin, 1989; Espinosa, 1997); facilitate face-to-face communication and provide written and oral communication in Spanish and English (Espinosa); initiate interaction by the school (Sue & Sue, 1999); and make clear to the parent how he or she can be an active participant (Chavkin & Williams, 1985) in a cooperative home-school relationship (Sue & Sue). Competencies for the

counselor or consultant have also been set forth which include acknowledgement of not only the beliefs and cultures inherent within the diverse culture as represented by the child and his or her family, but personal awareness of the professional's own assumptions, values, and biases (Sue, Arredondo, & McDavis, 1992), as well. The conceptual bases for Conjoint Behavior Consultation suggest potential for positive outcomes when used with parents and teachers of Hispanic children with respect to the acknowledgement and integration of such characteristics and standards. However, not only is there little evidence of empirical investigation as to the merits of CBC when addressing behavioral concerns relevant to Hispanic children, there is an even more notable absence of information pertaining to its use with the parents and teachers of preschool Hispanic children.

Purpose of Study and Hypotheses

The purpose of this study is to investigate the appropriateness of Conjoint Behavioral Consultation in promoting the success of preschool Hispanic children when addressing behavioral concerns. Answers to the following substantive questions are integral to such a purpose, and consideration of the unique characteristics and preferences of the Hispanic culture within the CBC structure results in the hypotheses that follow each question.

1. Are the CBC process and resultant treatments acceptable to parents and teachers of Hispanic children in changing identified behaviors of their children as measured by their responses on the Parent/Teacher Consultation Services Questionnaire, the

Treatment Evaluation Questionnaire - Parent and Teacher Forms, and the parents responses to the pre- post- Consultation Preference Survey instruments?

Hypothesis: It is hypothesized, based upon the following criteria, the parents and teachers of Hispanic preschool children involved in this study will find CBC acceptable. By the physical presence of representatives of both the home and school systems during CBC interaction, the importance of cooperation and Hispanic preference for face-to-face personal communication are affirmed. The participation of parents as co-consultees during decision-making activities of CBC acknowledges the important role family plays in the lives of Hispanic children and the parents' desire for active involvement in their children's education. Data collection from multiple sources, in multiple settings, and using multiple methods takes into account the concept of extended family associated with the Hispanic culture as well as providing a comprehensive base from which to develop treatments. The cooperative problem-solving preference of the Hispanic culture supports the collaborative relationship of parent and teacher consultees in CBC. Since CBC is based on behavioral therapy principles, it employs the active, concrete problem solving orientation expected by many Hispanic persons. Values and beliefs associated with child rearing practices and expectations are central to both parent and teacher responses relevant to problem identification, analysis, and treatment development. The frequent requests for elaboration, specification, and prioritization written into the CBC scripts afford the Hispanic parents opportunity for valid representation of the unique factors characterizing their child's life. Additionally, the wording of the CBC scripts provides a means for Hispanic parents to communicate their concerns and desires in a manner

consistent with their religious beliefs by expressing their viewpoints without appearing confrontational or disrespectful of authority. Though positive in some regards, the rigid structure of the CBC process does not readily afford the time that might be required for the personal, informal interaction found to be valued by people of the Hispanic culture.

2. What is the level of treatment integrity by parents and teachers of Hispanic children resulting from the CBC process, as measured by their self-report during consultation sessions?

   Hypothesis: The preference for more informal and relaxed interaction, coupled with their nurturing perspective of familial role, may pose potential threats to treatment integrity with respect to the Hispanic parents. However, teachers familiar with such empirical Euro-American structure are hypothesized to maintain treatment integrity at a higher level than their Hispanic parent co-consultees.

3. Is CBC, incorporating the parents and teachers of Hispanic children, effective in changing identified behaviors of Hispanic children as measured by behavioral observations, GAS ratings, and pre-post self-report measures using the SSRS-P, SSRS-T, BASC-PRS, and BASC-TRS?

   Hypothesis: Effectiveness of a treatment is highly dependent upon the preceding elements of acceptability and integrity. Considering the strong case made for acceptability with respect to question #1, it is hypothesized results of the instruments used to measure effectiveness will reflect positive outcomes. Furthermore, since monitoring and adjustment are incorporated within the CBC structure, the potential for effectiveness is enhanced. However, objective data collection may be limited as is

not uncommon with behavioral consultation, in general, and consistent with predictions relevant to CBC in multicultural context, in particular.

4. The final question pertains to the practical application of CBC with regard to the ways in which the consultees' and consultants' experiences during the course of this study will affect their future actions. Do participants consider CBC a viable behavior change model they will use in the future to address concerning behaviors of their children/students with Hispanic heritage?

   Hypothesis: The answer to this question is based in the outcomes pertaining to the preceding questions of acceptability, integrity, and effectiveness. Given the hypothesized positive results in these three areas, it would follow that consultees and consultants would be favorable to the future use of CBC when addressing concerning behaviors of students with Hispanic heritage. Moreover, it is suggested the parents of this study will consider the school as a resource when dealing with concerning home behaviors.

CHAPTER III

Methodology

Research Methodology

Participants

This study was an extension of a student initiated research grant project funded by the United States Department of Education Office of Special Education and Rehabilitative Services (OSERS). The initial project included eight children whose parents and teachers participated in Conjoint Behavioral Consultation. Four of the original grant project children and their families were located eight weeks following CBC completion which was approximately two weeks prior to the beginning of the children's kindergarten school year. Future perspectives interviews were conducted with the parent and teacher co-consultees for those four children, and it is the information pertinent to those cases that follows. Basic to the practice of consultation are the three participant roles of client(s), consultee(s), and consultant(s). Additionally, an interpreter was used as necessary in order to facilitate communication among consultation participants.

Clients. The clients were four Hispanic children who met participation criteria, for whom parent and teacher consent for participation was obtained, and who completed the CBC future perspectives interviews. The children included three girls and one boy ranging in ages from 4-years 8-months to 5-years 3-months who attended a four-year-old program at Reed School of the Tulsa Head Start Program. Reed School is within a high Hispanic student catchment area of Tulsa, OK. Two of the girls were identified as demonstrating minimal class participatory behaviors such as would put them at-risk in maximizing educational opportunities, with the mother of one of the girls also expressing concern with regard to her child's crying and nonparticipation with peers in the neighborhood. The mother of a third girl reported the child's crying behavior was a significant family concern. The mother of the boy identified his noncompliance when leaving his grandparents' house as a problem behavior for her. Neither parents nor teachers reported any developmental concerns with regard to any of the four children.

Consultees. The consultees included the parents and teachers of the four Hispanic children. The mothers of all four children participated as consultees during the CBC process. Both mothers and fathers of the four children were originally from Mexico. Two sets of parents had lived in the United States for more than ten years, while the other two families had lived in the United States between two and three years. Spanish was the primary language spoken in all four homes. An interpreter was always used when communicating with the two mothers who had lived in the United States the least amount of time. The other two mothers, however, were able to converse in English, and, in fact, one of the mothers was quite adamant about not needing an interpreter. Parent completion

of high school was reported for one family and another family reported eighth grade completion. The highest parent education levels of the two families having lived in the United States the shortest length of time were sixth and fifth grades. One mother did not work outside the home, while two worked in fast food, and a fourth was in domestic services. Fathers in all four cases were employed as construction or landscape laborers. A demographic summary is provided in Table 1.

Table 1

Child Participant Demographics

Case	Child Gender	Child Age	Hispanic Ancestry	Home Language	# Yrs Family in US	Mean Parent Edu
#1	Female	4-9	Mother & Father	Spanish	14 yrs	8th grd
#2	Female	5-3	Mother & Father	Spanish	2 yrs	5th grd
#3	Female	4-10	Mother and Father	Spanish	10 yrs	12th grd
#4	Male	4-8	Mother & Father	Spanish	3 yrs	6th grd

Three different teachers were consultees, as two of the children were in the same class. All three of the teachers were female, with one being African American and two being of White European American decent.

Consultants. Three advanced graduate students in the School Psychology Program at Oklahoma State University served as consultants in this study. One graduate student was the consultant for two of the four cases. All three consultants had completed training in Conjoint Behavioral Consultation (CBC) using the model developed by Sheridan, Kratochwill, and Bergan (1996), as well as multicultural counseling coursework within the context of their Ph.D. program. Each consultant was provided a notebook containing

a schedule of consultation phases and activities, scripts to be used for each of the four CBC stages (Problem Identification, Problem Analysis, Treatment Implementation, and Treatment Evaluation), as well as all of the instruments to be used during the study. Consultants met weekly with the faculty and student project directors to review progress and discuss challenges.

Interpreters. In keeping with the community and parent involvement that is basic to Head Start programs, the building director requested that a Hispanic parent serve as interpreter. A female Hispanic parent was identified by the building director and provided interpretation services when consultee and consultant schedules permitted. Otherwise, one of the Hispanic Head Start teaching assistants assisted with interpretation when it was needed.

Table 2 provides a summary of participant factors pertaining to each of the four cases. A brief summary of target behavior(s) and subsequent interventions follows.

Table 2

Case Descriptions

Case	Parent Consultee	Interpreter	Teacher Gender/ Ethnicity	Consultant Gender/ Ethnicity	Target Behavior
#1	Mother	No	F*/White Euro American	F*/White Euro American	Participation
#2	Mother	Yes	F*/White Euro American**	M*/White Euro American***	Participation
#3	Mother	No	F*/White Euro American**	M*/White Euro American***	Crying
#4	Mother	Yes	F*/African American	M*/White Euro American	Compliance

Note. * F = Female, M = Male. ** Denotes same teacher. *** Denotes same consultant.

Case #1 (K). K's mother reported concerns regarding her daughter's limited expression of self-pride and enthusiasm in her daily activities. Her teacher indicated she would like to see K participate more in discussion and exhibit happier expression and behavior. During the course of CBC, the hypothesis that K may not be getting adequate rest because she did not go to sleep until her mother came home from work was discussed, in that her tiredness may have been contributing to the identified behavioral concerns regarding participation. An intervention was developed incorporating a more

specific bedtime routine at home in conjunction with reinforcement (special sticker) and verbal praise provided at school when K reported on her bedtime progress.

Case #2 (B). Both the mother and teacher reported concerns regarding B's limited responsiveness to verbal communication. B's mother also indicated it was not uncommon for her to cry before going to school. Three main hypotheses were generated as to possible contributors to B's behavior: 1) hearing problems, 2) her poor English, and 3) school is stressful to her because of the new language and culture, so she tends to shut down. Behavioral observations by mother and teacher indicated B communicated with friends and her parents in Spanish, and there did not appear to be problems hearing in that context. The intervention plan in the home developed by B's mother and teacher was to increase her association with English by having her watch Disney or other English cartoons and talking to her parents about them in English. The intervention plan at school was 1) provide increased individualized attention specifically focusing on improving her English, and 2) give her simple tasks and praise her for following through.

Case #3 (F). F's mother expressed concern and personal distress regarding her daughter's frequent crying, particularly associated with preparing to go to school. The teacher reported no crying behavior, but did indicate F was sometimes bossy when interacting with peers. During the course of CBC, participants generated the hypothesis that F's crying and her mother's prodding in the mornings represented a power struggle. The less frequent bossy behavior at school was viewed similarly. Interventions included the mother calmly stating expectation at home and assisting F to self-monitor by charting

the target behavior of not crying before school, with a weekly reward tied to her progress. At school, the teacher increased attention to F in redirecting her when she interacted with peers in a bossy manner.

Case #4 (A). The identified problem behavior in this case was A's noncompliance/tantruming when leaving his grandparents' home on Sundays. Both of his parents worked on Saturdays so he spent Friday evening until Sunday afternoon with his grandparents. A's teacher reported he did not demonstrate such behaviors at school and described A as a "model student". Agreed upon interventions included A's teacher regularly reminding all children at school to comply with parental requests without engaging in tantrum behavior, and A's mother establishing a more structured routine of picking him up incorporating the active support and participation of the grandparents. The routine involved establishing a routine time for the exchange whereby the grandparents would have A ready and waiting for the parents' arrival, and A would immediately get in the car without further interaction between parents and grandparents. A reinforcer (stop at the video store) was offered upon compliant behavior during the transition. Eventual conceptualization of this case focused on perceived authority in that A's mother described herself as having limited disciplinary control in the family, with A's father being the primary disciplinarian. Furthermore, she reported that since the grandparents were paternal grandparents, she was concerned she might offend them and subsequently was hesitant to discuss the matter with A's father.

Instruments

A series of measures was taken repeatedly throughout this study. All written material provided parents was available in Spanish and/or translated by an interpreter.

Social Skills Rating System - Parent Form (SSRS-P) and Teacher Form (SSRS-T). The SSRS-P and SSRS-T (Gresham & Elliott, 1990) are norm-referenced rating scales. The Preschool version utilized in this study is intended for use with children aged 3 - 5 years. The SSRS forms have two main scales: social skills and problem behaviors. Three subscales are incorporated into the 40-item SSRS-T social skills scale: cooperation, assertion, and self-control. The parent form is comprised of 49 items and incorporates four social skills subscales: cooperation, assertion, self-control, and responsibility. Problem behaviors are divided into those of internalizing and externalizing. Both scales measure how often a particular social behavior occurs (never, sometimes, or very often) and how important the parent or teacher views the behavior. Mean coefficient alpha reliability estimates for the SSRS-T subscales range from the high .80s to 90s, with SSRS-P coefficients in the .70s (Gresham & Elliott, 1990). Studies reported by Gresham and Elliott (1990) reveal questionable, but adequate, criterion-related validity for participation screening. Technical information for the SSRS (Gresham & Elliott, 1990) describes racial/ethnicity demographics for the norm samples as being consistent with the 1988 U. S. population.

Behavior Assessment System for Children - Parent Rating Scales (BASC-PRS) and Teacher Rating Scales (BASC-TRS) and Structured Developmental History (BASC-SDH). The BASC-PRS and BASC-TRS (Reynolds & Kamphaus, 1992) are normed referenced ratings scales. The Spanish edition of the PRS was used by the two non-English speaking parents. Both the BASC-PRS and BASC-TRS are designed to assess emotional difficulties, adaptive behavior, personality constructs, and behavioral problems in children and adolescents aged 4 to 18 years of age. The preschool level for children aged 4 to 5 years was used. BASC-PRS results are computed for eleven separate subscales on the preschool form, as well as two broad problem behavioral dimensions (e.g., externalizing vs. internalizing problems) and one adaptive behavioral dimension. Both BASC-PRS and BASC-TRS compute a single summary score referred to as the Behavioral Symptoms Index. The general-population norm sample for the preschool level of the BASC-PRS consisted of 13% Hispanic children. However, the samples were weighted so distributions of race/ethnicity would match the 1988 U. S. population figures resulting in 11% Hispanic representation (Reynolds & Kamphaus, 1992). Internal-consistency reliabilities of the BASC-PRS composite scores are in the middle .80s to low .90s, with individual scale reliabilities ranging from .69 on the Atypicality scale to .86 on the Social Skills scale. Coefficient alpha reliabilities of the BASC-TRS scales range from .78 on the Adaptability and Withdrawal scales to .90 on the Aggression scale, with composite reliabilities in the low to mid .90s. The BASC-SDH (Reynolds & Kamphaus, 1992) was used by consultants when interviewing parents to obtain demographic information as well as comprehensive understanding of the child's development.

Consultation Preference Survey. The Consultation Preference Survey (Appendix A) consists of four questions: one for each of the four phases of behavior consultation, i.e., problem identification, problem analysis, treatment implementation, and treatment evaluation. Following each question, the parent selected the statement that best fit with her preference for involvement. The statements were guided by four consultation models including expert, teacher only, parent only, and conjoint. The same series of four questions was asked relevant to problems of both academic and behavioral nature.

Goal Attainment Scaling (GAS). GAS (Appendix B) is a method for quantifying the progress made on a specific target behavior in order to facilitate monitoring the treatment program (Kiresuk, Smith, & Cardillo, 1994). Parents and teachers were asked to identify a specific goal during the Conjoint Problem Analysis Interviews and rated the child's progress on a weekly basis during both baseline and intervention weeks. A 5-point scale was used ranging from "-2", defined as the desired target behavior observed less than 20% of the time, to "+2", defined as the desired target behavior observed 80% or more of the time, and "0" reflecting the desired target behavior observed approximately 50% of the time.

Parent/Teacher Data Collection Forms. Parents and teachers were asked to collect data pertaining to the child's target behavior(s) each week during baseline and treatment phases employing data collection forms (Appendix C).

Treatment Integrity Form (TIF). The TIF (Appendix D) was used as a measure of consultee compliance in implementing the agreed upon intervention activities. Based on verbal reports by consultees, consultants recorded weekly how consistently consultees carried out agreed upon interventions. Percentage ratings were used for recording, with 0% indicating no attempt toward executing interventions, to 100%, or full compliance with intervention activities.

Treatment Evaluation Questionnaire - Parent and Teacher Forms (TEQ-P, TEQ-T). These rating forms (Appendix E) consist of 20 items, each. Items reflect acceptability, appropriateness, and effectiveness of an intervention strategy using a 6-point scale (1="strongly disagree" to 6="strongly agree"). This scale was adapted from the Treatment Evaluation Inventory (TEI; Kazdin, 1980). Kazdin developed the original TEI to assess the reported effectiveness of the treatment by the teacher and the parent, with items chosen through factor analysis process.

Parent/Teacher Consultation Services Questionnaire (PCSQ and TCSQ). The PCSQ and TCSQ (Appendix F) were developed to assess parent and teacher levels of satisfaction with the consultation process. Specific questions reflecting attitudes toward behavioral consultation, consultant, and treatment are addressed on a 7-point Likert scale. P/TCSQ items were adapted from the Parent's Consumer Satisfaction Questionnaire (Forehand & McMahom, 1981) and Consultation Services Questionnaire (Zins, 1984).

Consultee/Consultant Post Consultation Interviews. The student project director interviewed consultants using the Perspectives of CBC (Appendix G) interview format approximately one week after consultation completion. Consultants were asked to share their impressions of CBC in accommodating for unique issues pertaining to consultation involving parents and teachers of Hispanic preschool children, including both challenges and successes. Two weeks prior to the beginning of the fall school term, or approximately eight weeks following consultation participation, interviews were conducted with the parent and teacher co-consultees of the four original grant project children who could be located. Interview items were developed in an attempt to ascertain parent consultee perspectives pertaining to the manner in which the CBC model addressed the "emic" qualities of behavioral consultation as well as how, or if, their experiences will change their future school involvement in problem solving related to their children. Similarly, items for the teacher consultees addressed their perceived impact of CBC in their future interactions with parents of Hispanic children.

Procedure

The above instruments were completed within the sequence of screening, baseline, treatment, and evaluation phases of the research (Table 3).

Table 3

Measures Schedule

	Study Phase			
Instrument	Screening	Baseline	Treatment	Eval
SSRS-P/SSRS-T	X			X
BASC-PRS/BASC-TRS		X		X
Consultation Preference Survey		X		X
GAS		X	X	X
P/T Data Collection; P/T TIF		X	X	
P/T TEQ; P/T CSQ				X
Consultee/Consultant Post Interviews				X

Screening. For the larger grant research project, of which this study was an extension, parents and teachers of Hispanic children from the Reed Head Start program were recruited for participation using a variety of methods including flyers, teacher contact, and project presentation at a monthly school meeting for Hispanic parents. Recruitment focused on children whose parents or teachers had concerns regarding their exhibiting or developing problem behaviors. The initial recruitment language included focus on "problem behaviors", and was later modified to emphasize a school success orientation so as to be more sensitive to cultural perceptions and child developmental characteristics. Upon obtaining parental consent for child screening (Appendix H), parents and teachers completed respective SSRS forms for the prospective client child. If parent and/or teacher SSRS ratings indicated difficulties in social skills or problem behavior ($\pm$ 1/2 SD), more detailed information pertaining to the goals, timelines, and

participant expectations were provided parents and teachers, while soliciting their consent for project participation (Appendixes I and J). As stipulated in the OSERS grant, this procedure was successively conducted case by case until ten children met eligibility criteria and for whom informed consent for participation from their parents and teachers was obtained. Ten children were identified for participation in the original grant project, but eight completed the Conjoint Behavioral Consultation phases. The mother of two identified children withdrew them following screening explaining that their father had rescinded his approval for participation. She reported he was concerned their participation would in some way "label" the children and result in future discrimination.

Baseline Phase. Upon parent and teacher consent for participation, each parent completed the BASC-SDH with the consultant. An interpreter was used as needed. At the first conjoint meeting, the parent and teacher completed the BASC-PRS and TRS rating forms. The consultant and parent/teacher consultees completed the CBC Problem Identification Interview (CPII) (Appendix K). At the end of the CPII, each parent and teacher was asked to collect baseline data.

TreatmentPhase. Following collection of baseline data, a second conjoint meeting including the parent and teacher consultees, consultant, and interpreter, as warranted, was held. Data were reviewed and the CBC Problem Analysis Interview (CPAI) (Appendix L) was completed so as to clarify goals, target behaviors, and intervention strategies. It is noted, and discussed at greater length in Chapter Five, that the use of objective data collection methods was minimal by both parent and teacher consultees. At the end of the

CPAI, consultants obtained baseline GAS ratings with the parent and teacher so as to determine level of target behavior goal achievement during treatment and upon consultation completion.

The treatment phase lasted four weeks. Each week during the treatment phase, the parents and teachers reported GAS ratings, and consultants completed TIFs measuring the parent's and teacher's treatment implementation integrity.

Evaluation Phase. Following four weeks of treatment/intervention, the consultant conducted the CBC Treatment Evaluation Interview (CTEI) (Appendix M). The parent and teacher GAS ratings were recorded, BASC-PRS and TRS forms and SSRS parent and teacher forms were completed, parents and teachers completed the Treatment Evaluation and Consultation Services Questionnaires, and parents completed the post Consultation Preference Surveys. Final treatment integrity percentages were recorded for both parents and teachers, as well. Consultants were interviewed using the Perceptions of CBC interview format one week after consultation completion. Two weeks prior to the beginning of the following school year, which was approximately eight weeks post consultation completion, the parents and teachers of the four located children were interviewed using the respective Perceptions of CBC interview formats.

Experimental Design

A single-subject replicated time series AB design was used in applying the structured Conjoint Behavior Consultation (CBC) model. This included the baseline

phase (A) and treatment phase (B). Though it is recognized such an A-B design is subject to validity limitations, it is acknowledged that the desired effects of consultation cannot be completely withdrawn. The independent variable in this study was the CBC process between the consultees and consultant, which was defined as the treatment used during the treatment implementation phase of CBC. The dependent variables were the children's behavioral outcomes (i.e., parent/teacher rating scales and parent/teacher GAS ratings). Evaluation of CBC with the targeted population of parents and teachers of Hispanic children occurred through the consideration of treatment acceptability, treatment integrity, and treatment effectiveness. Additionally, parent and teacher consultees were interviewed approximately eight weeks post consultation completion as to how their participation in the study changed their perceptions of future home - school involvement. Consultants were interviewed with respect to challenges experienced relative to this specific client and consultee population. Suggestions for future consultation practices involving parents and teachers of Hispanic children were also requested of consultees and consultants.

Treatment Acceptability

Treatment acceptability addressed both content and process. Treatment content acceptability referred to the parents' and teachers' perceptions of whether the specific intervention strategies implemented to change a child's behavior were acceptable. The acceptability of the treatment content was assessed during the treatment evaluation phase of the study using the Treatment Evaluation Questionnaire - Parent and Teacher Forms.

Treatment process acceptability referred to parents' and teachers' perceptions of whether CBC was acceptable for changing behaviors such as those involved in the study. It, too, was assessed during the treatment evaluation phase using the Parent/Teacher Consultation Services Questionnaire and pre- and post- scores on the Consultation Preference Survey completed by the parents. Descriptive statistics were used in reporting the results of these instruments. Treatment acceptability was compared to treatment effectiveness data.

Treatment Integrity

Treatment integrity refers to the accuracy with which the specified treatment was implemented. Treatment integrity was assessed on the process and content of the study. To ensure the integrity of the behavioral consultation model was maintained across all phases of this study, the three CBC interviews, CPII, CPAI, and CTEI, were tape-recorded for each case. Using the checklists of essential objectives for each interview (Appendix N) developed by Sheridan, Kratochwill, and Bergan (1996), two observers rated the CPII, CPAI, and CTEI interviews for each of the four cases resulting in a total of twelve interview ratings. This method has been used in other studies (Sheridan et al., 2001) addressing the integrity with which the CBC protocol has been followed by consultants, with the ratings yielding percentages of objectives met for each interview as well as collectively across interviews. Observers were Ph.D. graduate students who had been trained in CBC during their graduate coursework and demonstrated mastery criteria during video and audio taped practice.

The second area of treatment integrity involved the evaluation of the parents' and teachers' implementation of the interventions agreed upon during consultation. Using the Treatment Integrity Form, consultants recorded the percentage of consultee intervention implementation according to verbal self-reports by parents and teachers. Levels of intervention implementation integrity were compared to treatment effectiveness data.

Treatment Effectiveness

Goal Attainment Scale (GAS) ratings were obtained from both parent and teacher consultees during the baseline and treatment phases of consultation. These GAS ratings are graphically presented as well as the percentage of non-overlapping data points computed (Mestropieri & Scruggs, 1985-86). Analyses for treatment effectiveness also involved the parent and teacher pre- and post- SSRS measures using a reliable change index (RCI; Hawley, 1995) technique. Consultants encouraged consultees to use objective data gathering methods to record target behaviors, and various means of recording were developed during consultation sessions. However, consultees demonstrated very limited follow through in this regard; an observation that is addressed in Chapter V.

Future Perspectives

Post-study interviews with parent and teacher consultees as well as consultants addressed the questions of acceptability, integrity, and effectiveness. Additionally,

respondents were encouraged to share unique benefits and challenges associated with their CBC experiences, suggestions for future use of the model, and the impact of their participation on their future school involvement. Information is presented in narrative format.

CHAPTER IV

Results

Findings Relevant to Substantive Questions

Presentation of results will follow a format dictated by the study's four substantive questions considering acceptability, integrity, effectiveness, and future practice.

Question #1: Is CBC acceptable to parents and teachers of Hispanic children in changing identified behaviors of Hispanic children?

Treatment acceptability addressed content pertaining to the actual intervention developed during consultation, and process defined by the structured format of CBC.

Treatment Content Acceptability. Parents and teachers of the four preschool Hispanic children found the interventions developed during CBC acceptable. Based on a 6-point scale, scores on the four case TEQ parent forms ranged from a 4, or "slightly agree", to a 6, "strongly agree", reflecting general parent satisfaction with the treatment interventions developed and implemented during CBC, with the overall mean Parent TEQ = 5.08. TEQ teacher form scores ranged from a 2, or "disagree", to a 6, "strongly

agree", and an overall mean Teacher TEQ = 5.23. Though still suggestive of overall satisfaction, the teacher ratings reflected a greater range of satisfaction with the treatment interventions developed and implemented during CBC. Only one 2 rating, or "disagree", was reported by a teacher, and that was in reference to Case #3, item #5 (The child's behavior problem was severe enough to warrant use of this intervention). The teacher qualified the score by saying the crying behavior had not been a significant problem at school, but the mother was concerned with the behavior at home. With that item exception, the teacher rated all items with 5s, or "agree".

Table 4

Parent and Teacher Responses to Treatment Effectiveness Questionnaires

Case	Mean	SD	Case	Mean	SD
Case #1			Case #3		
Parent	4.30	.47	Parent	5.15	.67
Teacher	5.90	.45	Teacher	4.85	.67
Case #2			Case #4		
Parent	4.85	.75	Parent	6.00	.00
Teacher	4.65	.59	Teacher	5.50	.51

Treatment Process Acceptability. Parents and teachers found the CBC process acceptable for changing behaviors such as those involved in the study according to their responses to the Consultation Services Questionnaire items (Table 5). Responses were recorded using a 7-point Likert scale. With the exception of items #8, #9 and #10, which were reversed scored, a rating of "1" reflected the most negative attitude and "7" reflected

the most positive attitude. Mean scores for parent responses on the CSQ indicated positive attitudes toward use of the CBC process with the overall mean score for Parent CSQ = 6.18. The minimum Parent CSQ rating was a 5, indicating greater than neutral positive perceptions regarding CBC across parent participants. Teacher ratings were also between 5 and 7 with the overall mean score for Teacher CSQ = 6.10.

Table 5

Parent and Teacher Responses to Consultation Services Questionnaires

Case	Mean	SD	Case	Mean	SD
Case #1			Case #3		
Parent	6.27	.79	Parent	6.00	.47
Teacher	6.80	.42	Teacher	6.20	.42
Case #2			Case #4		
Parent	6.09	.30	Parent	6.36	.50
Teacher	5.70	.48	Teacher	5.70	.82

Parent responses on the Consultation Preference Scale before and after their participation in the CBC study (Table 6) revealed that the parents in Cases #1 and #4 increased their preferences for problem solving incorporating a conjoint approach involving both parent, teacher, and a consultant. This preference change was reported for both academic as well as behavior problems. The parent for Case #3 reported a decline in preference for conjoint consultation relative to solving problems of an academic nature. Explanation was not offered in this regard since the target behavior for Case #3 was behavioral in nature (crying). There was no evidence of preference change associated with Case #2, with that parent endorsing maximum support of a conjoint consultation

model both before and after study participation across both academic and behavior problems. With the exception of Case #3 post-CBC participation scores, it is noted parents tended to respond similarly across both academic and behavior type problems. Furthermore, their responses reflected preferences for working together with a consultant and teacher which is consistent with structure of the CBC model.

Table 6

Parent Consultation Preference Scale

Case	Pre- CBC Participation		Post- CBC Participation	
	Academic Total/Mean	Behavior Total/Mean	Academic Total/Mean	Behavior Total/Mean
#1	13/3.25	13/3.25	16/4	16/4
#2	16/4	16/4	16/4	16/4
#3	16/4	16/4	12/3	16/4
#4	14/3.5	14/3.5	16/4	16/4

Question #2: What is the level of treatment integrity by parents and teachers of Hispanic children resulting from the CBC process?

Treatment integrity refers to progression of each case according to CBC model format and assessment of how well parents and teachers implemented interventions.

Integrity of CBC Model. Using a checklist of essential interview objectives (Sheridan et al., 1996), the CPII, CPAI, and CTEI audio taped interviews from each of the four cases were reviewed by one of two observers to assess the integrity with which

the CBC structured interview scripts (Sheridan et al.) had been followed. The two observers were trained in CBC and had met mastery criteria during their training program using video and audio taped practice. Both observers rated one randomly selected interview for each of the four cases resulting in 92% overall interobserver agreement. Across observers and all twelve interviews, an average of 83% of the CBC interview objectives were met. Averages of met objectives on CPII, CPAI, and CTEI interviews were 82%, 80%, and 87%, respectively. Individual interview percentages ranged from 61% to 94%. Objectives included in the interviews were not always addressed in the sequential order formatted in the interview script. This was particularly evident with regard to the CPII interviews reviewed where consultants attempted to follow the sequential order of objectives, but teacher consultees tended to offer treatment intervention suggestions prematurely. Furthermore, review of the tapes revealed considerable extraneous conversation within the context of the interviews. Nevertheless, results suggest generalization of training objectives and application of the CBC format in field-based casework with parents and teachers of preschool children with Hispanic heritage consistent with that reported in studies of CBC use with populations other than primary Hispanic heritage (Sheridan et al., 2001).

Integrity of Treatment Implementation. According to verbal self-reports, parents and teachers were able to implement the interventions developed during CBC sessions. Parent treatment integrity was reported to be consistently at the 100% level for Cases #1, #2, and #3, whereas it declined over the 4-week intervention period for Case #4. It should be remembered that the mother consultee for Case #4 described herself in terms

suggesting that she did not enjoy an authoritative/disciplinarian role in the family and did not experience the intervention support reported by other parent consultees.

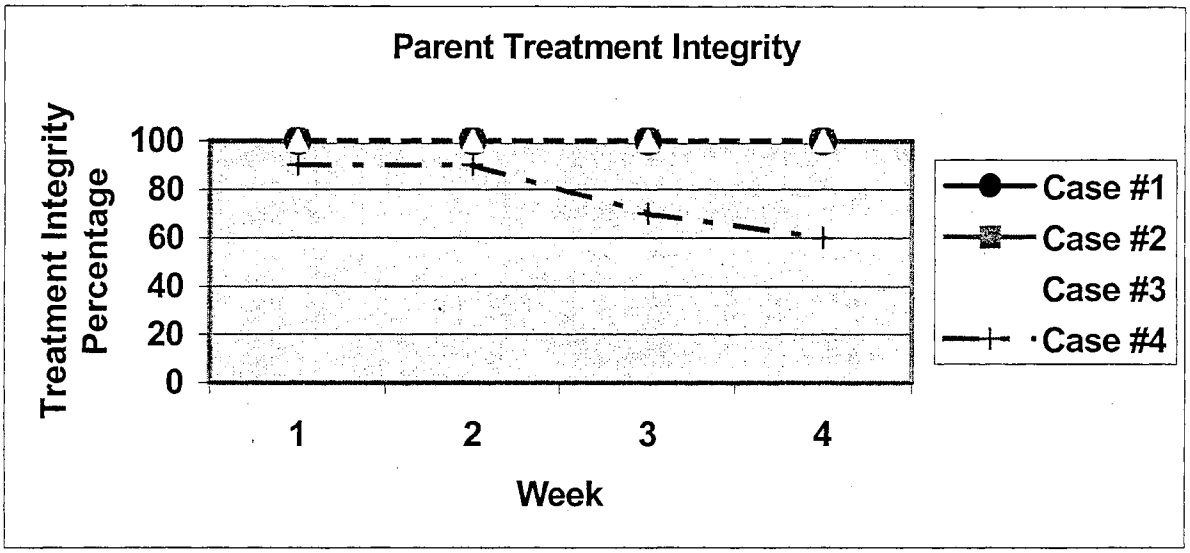

Figure 1. Parent treatment integrity.

Teacher treatment integrity for Cases #2, #3, and #4 was 100% across the four-week intervention period, whereas that for Case #1 declined somewhat.

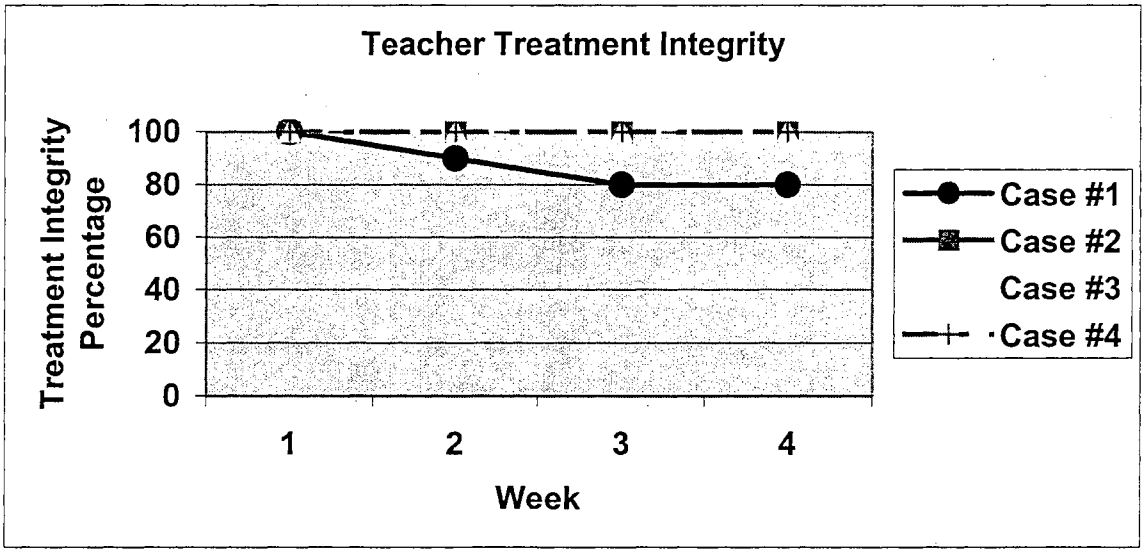

Figure 2. Teacher treatment integrity.

Question #3: Is CBC, incorporating the parents and teachers of Hispanic children, effective in changing identified behaviors of Hispanic children?

Parent GAS profiles depict overall trend of improvement of target behaviors for all four children. Children in Cases #1, #2, and #3 were eventually successful in demonstrating the desired behaviors 80% to 100% of the time. The child's compliance behavior in Case #4 improved to approximately 50% of the time. Progress varied for each of the four cases. Whereas immediate and continued improvement of behavior was recorded for Case #1 with 100% of non-overlapping data points recorded comparing intervention phase Parent GAS scores to the baseline GAS score, behavior improvement for Case #4 was not recorded until the second week of intervention resulting in 75% non-overlapping data points. Response of Case #2 to intervention could be considered somewhat typical for behavior management trials in that the problem behavior worsened before improving. The Parent GAS ratings for Case #2 reflect only one, or 25%, non-overlapping data points even though the parent reported the child successfully demonstrated the desired participation behavior 80% to 100% of the time by the end of the intervention phase. Case #3 implemented an intervention that had been mentioned during the CPII when example strategies had been given by the consultant as a part of the CBC process explanation discussed with the parent. This resulted in improved behavior prior to the first GAS rating. The parent liked the intervention, so it was continued for reinforcement and maintenance of the new behavior, but such tends to skew study results in reflecting a 0% of non-overlapping data points.

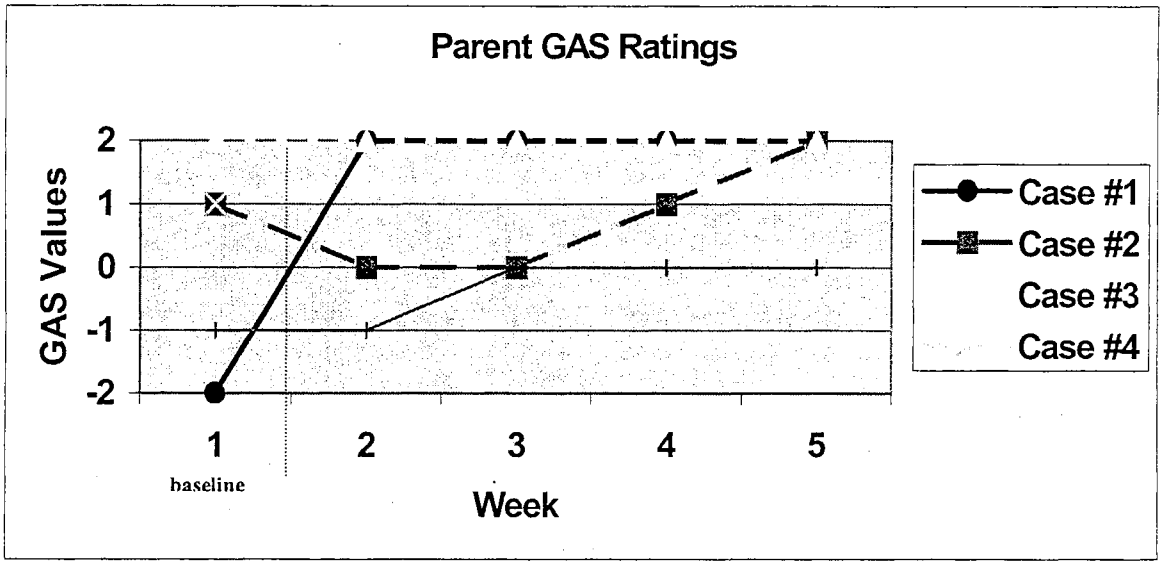

Figure 3. Parent GAS ratings.

Teacher GAS ratings reflect improvement in the target behaviors of Cases #1 and #2. The participation target behaviors in these two cases were specifically amenable to teacher observation, whereas, the target behaviors for Cases #3 and #4 were primarily identified as home concerns by parents. Cases #2, #3, and #4 were able to demonstrate desired behaviors 80% to 100% of the time by the end of the intervention phase. The participation behavior of the child in Case #1 improved immediately upon intervention implementation resulting in 100% of non-overlapping data points when intervention phase Teacher GAS ratings were compared to the baseline GAS rating. However, Case #1 participation behavior improvement appeared to plateau at 60 to 80 percent. The participation behavior of the child in Case #2 also improved immediately resulting in demonstration of the desired behavior between 80% and 100% of the time by the end of the 4-week intervention and 100% non-overlapping data points. Again, it is noted that Case #3 implemented an example intervention mentioned during the CPII, and the crying problem behavior identified by the mother had not been a concern in the classroom. Nor

was the behavior targeted in Case #4 specifically observed in the classroom (e.g., compliance with leaving the grandparents' home on the weekends). The teachers in these cases based their GAS ratings on related observed behaviors of the children in the classroom, crying and compliance, respectively, resulting in profiles reflecting consistent maximum demonstration of desired behaviors and 0% overlapping data points.

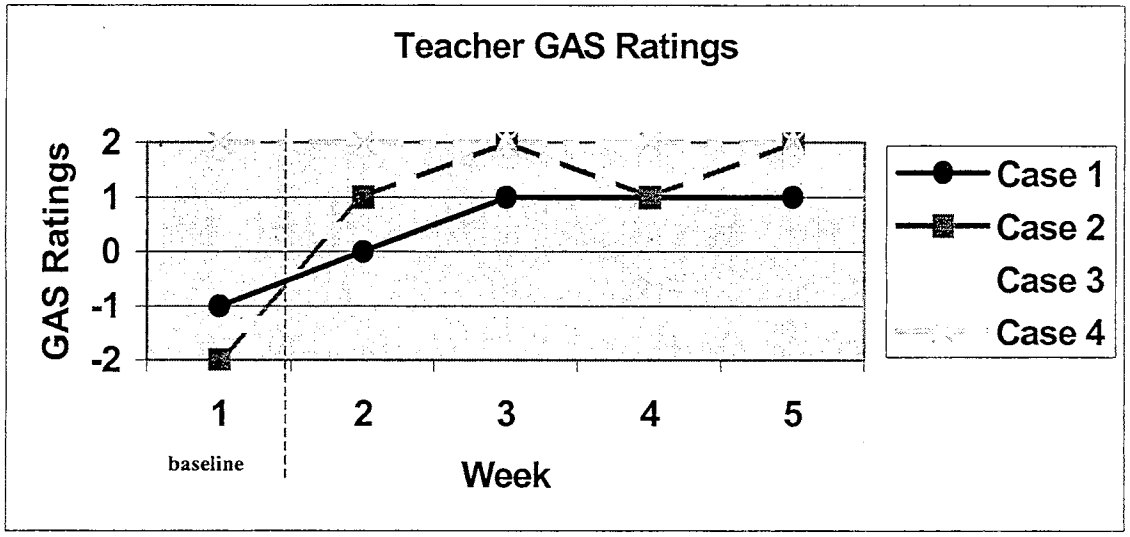

Figure 4. Teacher GAS ratings.

Acceptability, integrity, and effectiveness data were compared for each case by converting scores to rank orders and plotting the rank orders for each case on a graph. Figure 5 and Figure 6 depict the relationships between such data for parents and teachers, respectively. Figure 7 shows these relationships for parent and teachers, combined. Combined data was obtained by summing parent and teacher scores on each of the four variables (i.e., GAS effectiveness scores, treatment integrity scores, acceptability of treatment, and acceptability of CBC process) and dividing by two for each of the four cases. Case scores were then rank ordered from 1, meaning the highest score, to 4, meaning the lowest score for each variable. Visual inspection of the resulting graphs tend

to suggest a slight positive trend between teacher integrity of treatment implementation and teacher judgement of treatment effectiveness per GAS scores. No apparent relationships are suggested by other teacher, parent, or combined comparisons.

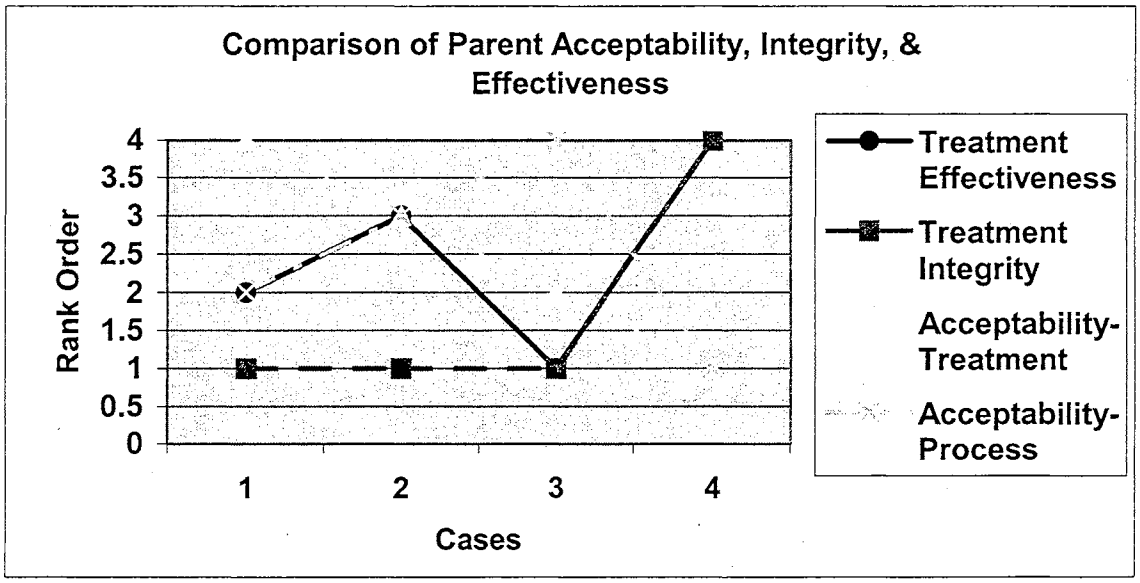

Figure 5. Comparison of parent acceptability, integrity, and effectiveness.

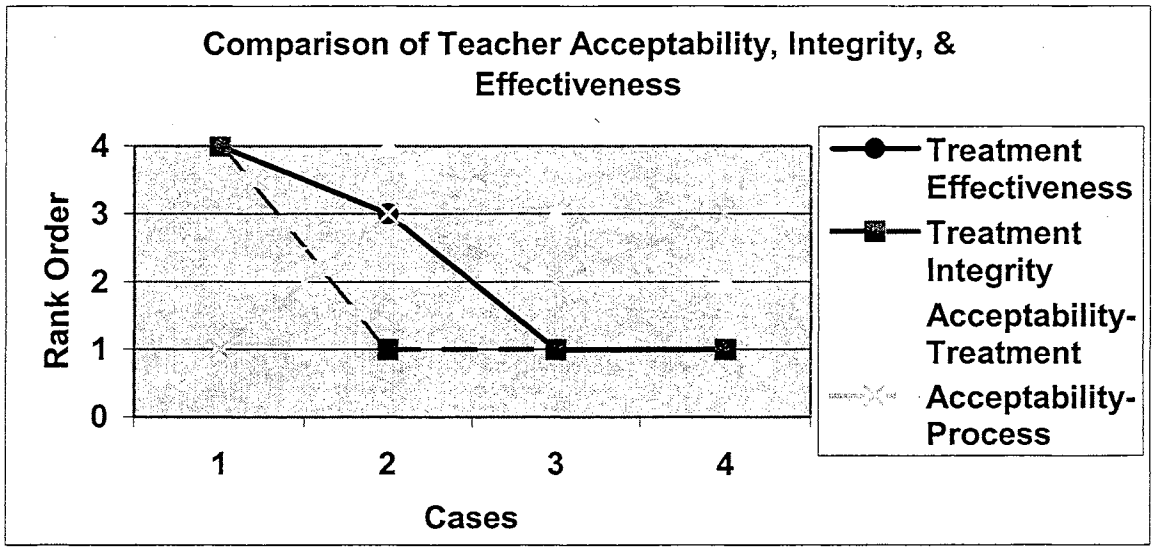

Figure 6. Comparison of teacher acceptability, integrity, and effectiveness.

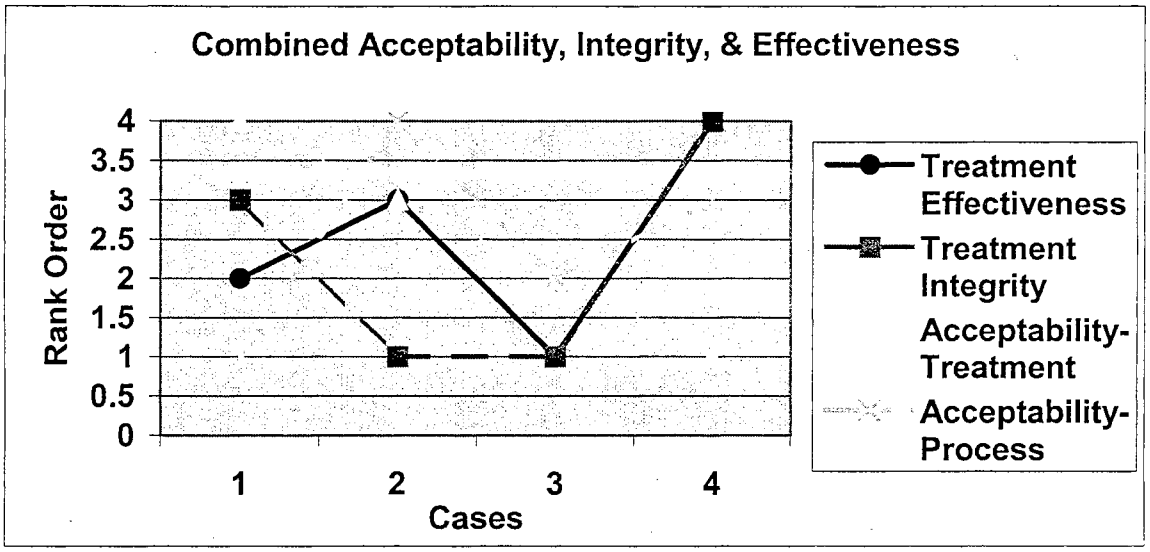

Figure 7. Comparisons of combined parent and teacher acceptability, integrity, and effectiveness.

Pre- and post-SSRS standard scores for the Social Skills and Problem Behaviors scales were compared using the reliable change index (RCI) developed by Jacobson and Truax (1991). RCI scores greater than 1.96 deem change large enough to be reliable. Results suggested significant positive changes in behaviors for children in three of the four cases (Table 7). Teacher's ratings of problem behaviors for Cases #2 and #3 reflected significant improvement. Both the parent and teacher for Case #4 reported significant positive change in the child's social skills. It is noted that both pre- and post- parent ratings for Case #1 are suspect in that the parent marked all items with a "1" score.

Though pre- and post- BASC scores were also to be compared with respect to treatment effectiveness, review of Case #1 parent response pattern and follow-up elaboration with the other three parents called question to the validity of results. The parent for Case #1 marked all items as "Sometimes" occurring. Furthermore, when parents for Cases #2, #3, and #4 were asked to elaborate on reported behaviors, it was not uncommon for them to contradict their BASC ratings. Though subjectively it could not

be said that the four Hispanic parents were deliberately biased in their BASC responses, verbal descriptions of behaviors frequently differed when given the opportunity for clarification. It is suggested the more negative phrasing and greater number of BASC items may have influenced this when compared to SSRS items.

Table 7

Parent and Teacher SSRS Standard Score Comparisons

Case	Social Skills			Problem Behaviors		
	Pre	Post	RCI*	Pre	Post	RCI*
#1						
Parent	81	82	+.08	119	119	0
Teacher	85	94	+.80	107	107	0
#2						
Parent	86	75	-.86	110	102	+1.89
Teacher	84	82	-.17	130	111	+4.48**
#3						
Parent	106	99	-.55	128	128	0
Teacher	116	112	-.35	107	89	+4.25**
#4						
Parent	62	122	+4.71**	97	85	+1.59
Teacher	84	102	+2.83**	92	96	-.94

Note: *$RCI = x_2 - x_1 / S_{diff}$. Since greater Problem Behavior standard scores reflect increased severity of problem behaviors, the RCI formula would result in a negative score when behavior had improved. Thus, RCI scores reflect the absolute value of change with + and - added to indicate improvement or decline in severity of problem behaviors.

**($p < .05$)

Question #4: Do participants consider CBC a viable behavior change model that they will use in the future to address concerning behaviors of their children/students with Hispanic heritage?

Perspectives of parent and teacher consultees, and consultants are addressed separately.

Post-consultation Parent Interviews. Using the Perceptions of CBC (Parent) interview format, parent consultees for Cases #1, #2, #3, and #4 were interviewed two weeks prior to their children beginning kindergarten which was approximately eight weeks following the CBC completion. The interviews were conducted in family homes for Cases #1, #2, and #3, with the parent in Case #4 choosing to have the interview at a local fast-food restaurant. With the exception of Case #2, interviews were with the mothers who participated as consultees. Both the father and mother were present during the Case #2 interview, with the father taking the primary speaking responsibility. Although it was noted that he frequently consulted his wife as to a response and his responses reflected ample knowledge of the CBC experience, he actually was not a primary consultee participant during the CBC sessions. An interpreter was present and participated during Case #2 and #4 interviews.

Three of the four parents reported that what they gained most from participation in their CBC experience was the increased number of intervention ideas, or suggestions, afforded them by working with their children's teacher and a consultant. They indicated that they continued to use some of the suggestions by generalizing them to other

behaviors they desired their children to change, as well as to other children in the family. Case #1 mother described her child's increase in both classroom and home interaction as her primary gain. All four parents indicated that their opinion of asking school personnel for assistance when dealing with their children had changed, and they felt more comfortable about doing so. Case #3 mother explained that her mother-in-law had warned her the "school" should not and could not help with home concerns, and since this was her first child she had not had the opportunity to experience anything different. She continued by saying "now I know they can, so I will ask". Similar endorsements were made by the parents in Cases #1, #2, and #4. All parent participants reported that as a result of their positive CBC experiences, they were more favorable about the prospect of working with school personnel in regard to their children's welfare, and were more likely to seek assistance from and participate in the school their children attend during kindergarten. One mother, Case #1, qualified her positive response by saying she liked the interaction between herself and the consultant, and future involvement depended greatly on the quality of the interpersonal relationships between herself and the school personnel. She emphasized her desire for personal attention which included feeling she was listened to and respected for her ability to contribute to the success of her child in school. Furthermore, all four parent participants stated they would recommend CBC participation to other Hispanic parents who had concerns about their children's academic and/or behavioral functioning in school.

Parents did not consider language difference as affecting their participation in the consultation sessions and activities. The two non-English speaking parents reported they were accustomed to working with interpreters. Though the mother in Case #1 denied

language difference as a concern relevant to her CBC experience, she did remark that she thought "her English" bothered the teacher and felt the teacher tended to dismiss her because of it. She went on to relate other experiences when she perceived she and her children had been slighted because her English had limited her ability to advocate for her children. This mother had refused the services of an interpreter when the offer was made at the initial meeting.

With the exception of Case #1 mother, the parents indicated they had felt a part of the CBC decision making because they perceived the consultant and teacher had made efforts to listen to their ideas and offered feedback. Although the mother in Case #1 said she appreciated the consultant's efforts, she would have liked more attention from her child's teacher. Cases #3 and #4 mothers reported they liked meeting together with the teacher and consultant at the same time because it provided a better opportunity to compare behaviors in the home vs. school settings. This, then, allowed the teachers to better use their influences with the children at school in reinforcing intervention strategies at home. Consultants were primarily appreciated as sources of intervention strategies and suggestions according to all four Case parent reports.

Scheduling consultation sessions around work schedules was indicated by parents as the most problematic aspect of their CBC experiences. The father in Case #2 suggested evening sessions would have been more convenient for him. Case #1 mother also stated she believed the teacher could have participated more. Data gathering was not listed as a difficulty by any of the Case parents. In fact, the mother in Case #3 reported she had suggested the behavior recording technique she used to another parent who had expressed a desire to change a child's behavior.

Post-consultation Teacher Interviews. The three teachers who served as consultees in the four cases were also interviewed within the same time frame as parents. All three identified being able to work with the parents as well as the children as what they liked best about CBC. The gains mentioned by teachers were across home and school target behavior settings. The teacher for Case #2 described the child's behavior as a "complete turnaround" once the parent was brought into the process. She reported that prior to her involvement in this study, she had not actually considered lack of classroom participation as particularly problematic for Hispanic children at the Head Start level, and still would not present it to parents in that light. Rather, she now acknowledges such behavior in a more positive reframe by emphasizing the behaviors associated with later school success, such as asking and answering questions as well as using developing English skills during circle sharing time. It should be noted the parents in Case #2 were non-English speaking, and only with their active involvement within the CBC context was it learned they really valued their daughter learning English and wanted her to be able to use it more effectively both at school and home. This teacher's only regret was CBC had not been implemented earlier in the school year so the child could have benefited more from her increased classroom participation. Case #4 targeted compliance behavior at home, and the teacher in this case reported she would have never known this child could have a compliance problem at all if she had not had the opportunity to participate in this study. Her classroom experience with the 4-year-old boy was that he was very cooperative. She went on to explain that her experience with Hispanic mothers had been that they tended to be rather quiet and reticent, but within the structured format of CBC, Case #4 mother was able to express her ideas and concerns. Furthermore, this

teacher remarked that in her opinion, the successful collaboration of school and home in addressing a home concern had enhanced the likelihood of this mother's future school involvement.

Teachers reported scheduling as the most problematic aspect of this study, citing just the inclusion of additional persons in the problem solving process increased the difficulty of establishing a mutually agreeable appointment time. The teacher for Case #1 sited absences of her teaching assistant as a hindrance to her CBC session participation in that she could not leave her class unattended. The teacher for Cases #2 and #3 also identified the unexpected absences of Case children as presenting a difficulty in that parents did not, and could not be expected to, come to CBC session appointments if their children were sick. Thus, consultants might come prepared for a session only to discover it had to be rescheduled due to parents not coming. It was noted that the parents never notified personnel they would not be keeping the scheduled appointment, and it was frequently difficult to contact them since they may have gone on to work and left the sick child with a family member or friend. On a couple of occasions, appointments were not kept because children had medical or dental appointments, or parents had to attend meetings regarding other children in the family. Again, there was not prior notification of such conflicts. Also related to the issue of session scheduling problems was the fact that the consultants were not on site. The teachers of Cases #1, #2, and #3, in particular, expressed that by having the consultants on-site, there could have been greater flexibility in meeting both parent and teacher time demands. The two teachers for Cases #2, #3, and #4 indicated language difference had not presented any difficulty, particularly since use of an interpreter was not unusual in their Head Start program. The teacher for Cases #2

and #3 reported she considered the interpreter used with her non-English speaking family, Case #2, had been particularly effective because she already had a relationship with the family. This teacher identified the presence of good interpersonal relationships as especially important to Hispanic families in promoting positive and effective communication.

Teachers reported they perceived the parents as active participants during the CBC sessions with regard to presenting descriptions of their children and families, and were eager to implement intervention suggestions offered by teachers and consultants. Contributions by consultants reportedly included keeping the process on track by providing structure and focus with regard to principles of behavior consultation, as well as offering alternative perspectives and additional intervention options. In expressing her desire for consultants being on-site, the teacher for Cases #2 and #3 remarked that she appreciated the skills of the consultants and would have "used them more" in addressing the needs of all her students if consultants had been available on-site.

Post-consultation Consultant Interviews. The four consultants for all eight cases of the original grant project were interviewed approximately one week following CBC completion using the Perceptions of CBC (Consultant) interview format. All consultants found the structure of the CBC model helpful and the written interview formats of each stage beneficial to investigating target behaviors and setting events. They also remarked that it helped in drawing parents into problem-solving participation. Consultants did qualify their remarks by indicating each modified the written questions somewhat in order to facilitate communication particularly for the parent consultee participants.

Frequently, questions needed to be asked in different ways so as to obtain needed information. Furthermore, three of the four consultants reported that, in their opinions and in deference to the superimposed time constraints of the study, greater time should be allotted to building rapport between consultant and consultees before the problem solving consultation process begins with Hispanic families.

Consultants agreed the overarching challenge of implementing the CBC model with the Hispanic families of this study centered on the families' expectations with regard to their parent role in the process. One consultant described the CBC process as tedious for parent participants, in that they did not understand the value of adhering to the four CBC stages. Another consultant described parents as expecting answers which would suggest process more consistent with the expert model of consultation. Thus, parents may have not fully understood, or appreciated, their role in the CBC process.

More specific challenges reported by consultants included data gathering and scheduling appointments. The systematic objective methods employed in data gathering characteristic of behavior consultation were difficult to implement with the teachers and Hispanic parents of this study which resulted in greater reliance on self-report measures (i.e., GAS, TIF). Only one parent followed through with the specific data-recording task developed and agreed upon during the consultation sessions, and that was done inconsistently. Reflecting on their experiences in this regard, consultants suggested reasons for difficulty might have been that such technical activity seemed foreign to the cultural expectations of nurturing mothers and was not within their repertoires. One consultant indicated he had not felt comfortable in pressing for objective, pencil-and-paper, data recording because the chasm between such expectations and parent

understanding was so great that to do so would have possibly jeopardized the rapport between parent consultee and himself. In contrast, however, consultants reported remarkable accuracy and detail of verbal descriptions of behaviors and treatment interventions. In this vein, although one father did attend the initial consultation session and spoke for the parent couple, the mothers of the Hispanic children typically participated as consultees and had the responsibility to explain the interventions to the fathers at home. This was particularly problematic in the two cases where the mother worked in the evenings during the time children were at home most and when interventions were to be implemented. Though more consistent than that of parents, data gathering by teachers could also be described as inconsistent. In the case of teachers, however, reasons for limited follow through included time constraints, personnel absences, and general unfamiliarity with implementation of such objective practices. One consultant reported he believed teachers and parents were accepting and compliant when implementing interventions, but were just unfamiliar with the concept of providing objective evidence of behavior.

Consultation sessions were most frequently scheduled at the beginning of the school day since the Hispanic parents characteristically brought their children to school, and mothers often stayed in classrooms for sometime after school activities began so as to observe and interact with other Hispanic mothers. However, scheduling and keeping consultation appointments were somewhat problematic and affected every consultation case at one time or another during this study. Change in parent work schedules and commitments to other children in the family or extended family members were the most frequent causes of missed appointments. Participant children being sick or taken out of

school early on the consultation appointment day also resulted in consultee parents not coming to the school as scheduled. As mentioned before, there was no prior notification of parents not coming to scheduled session appointments, with explanation given only when the consultant was able to make next contact with parents. The consultant being from out of the local telephone calling area possibly contributed to this tendency of parents not to notify of conflicts. Coordination with interpreters, along with consultants experiencing last minute delays and/or interruptions also contributed to some missed appointments. Furthermore, the absence of classroom teacher assistants sometimes required meetings to be delayed until someone could be found to supervise the students while the teacher participated in consultation sessions or the sessions were conducted in the classroom while students engaged in learning center activities or watched a video. Consultants reported parents did not express concern with regard to schedule inconsistencies, and teachers indicated such behavior by Hispanic parents was in keeping with their school related scheduling experiences.

Consultants were unanimous in their concerns as to whether the parent responses on the behavior rating scales and study participation evaluation rating scales accurately reflected opinions of the parents. Consultants indicated parents may have underreported severity of problem target behaviors due to what they perceived as the Hispanic parents being more relaxed in their child rearing practices and accepting with regard to behavioral expectations of children at this preschool age. Additionally, one consultant reported that the Hispanic parent consultees seemed particularly sensitive to the possibility that their children would be perceived as "bad", as well as suspicion called to their caretaker abilities as mothers. As for the Hispanic parents' responses to Consultation

Preference, Treatment Evaluation, and Consultation Services questionnaires, consultants reported results may have been more a reflection of the parents' appreciation for assistance rather than evaluation of their CBC experiences. Consultants indicated their perspectives in this regard were influenced by the pervasive "agreeableness" of the parents throughout direct CBC exchanges.

The descriptions by consultants of their experiences with interpreters varied. The inclusion of an interpreter, of course, added one more person around whose other commitments CBC sessions had to be scheduled. In all but one instance, consultants reported that interpreters, in cases requiring their use, enhanced the rapport building between consultants and parent consultees. The interpreter in that instance was not the parent or teaching assistant from the Reed Head Start, but rather a doctor who seemed to promote a personal agenda. His services were terminated following additional discussion and clarification as to his role as interpreter. In addition to enhanced rapport, one consultant described his experience with interpreters as positive because he believed the interpreters were able to provide valuable insight and perspective of parents and Hispanic culture that afforded the opportunity for more effective communication among participants. Consultants reported attention sometimes strayed from the standard CBC protocol as a result of parents engaging interpreters in personal conversations, but also indicated this seemed generally expected since, in cases where interpreters were not required, parents characteristically engaged in more personal, informal conversation style, as well. As for the impact of the more general issue pertaining to language diversity, one consultant reported she believed the non-English speaking parents were

less willing to provide relevant environmental setting information, tended to be more accommodating, and were less likely to ask questions.

Consultants responded affirmatively when asked if they would use CBC again when working with parents and teachers of Hispanic children. Within the context of the standard CBC model, they did, however, suggest several areas warranting particular attention that would seem beneficial to working with teachers and parents of Hispanic children, based on their experiences during the course of this study. First, more time should be allocated to informal communication prior to initiation of the consultation process. Additionally, prior to beginning CBC, it should be assured parents understand the progressive stage-model of CBC and the significance of those stages to behavior change success, as well as their role as collaborative consultee and the subsequent behavioral expectations associated with that role. One consultant suggested that time spent separately with teacher and parent prior to consultation sessions would have been helpful with regard to enhancing both rapport as well as consultant credibility with teachers and parents. Furthermore, it was suggested that, although CBC model stages should guide the course of consultation, the scripted format attempted with regard to this study may be too goal directed, and a more flexible format allowing for greater dialogue would be advantageous when working with the Hispanic consultee population. Developing methods of data collection that are more culturally relevant was also suggested. Consultants identified the fact that they were not on-site as contributing to problems carrying out CBC in these cases. By being employed on a full time basis in the Reed School, consultants would have had more opportunity to interact with parents and children in an ongoing relationship and, thus, develop the greater personal and family

oriented relationships seemingly appreciated by parents. On-site consultants could have also been greater and more immediate resources to teachers in their implementation of interventions and communication of concerns to parents.

CHAPTER V

Discussion of Results, Implications, Limitations, and Future Research

Discussion of Results

Context of Current Study

The parents and teachers of Hispanic preschool children who served as consultees in this study found the use of Conjoint Behavioral Consultation acceptable according to their responses on the Treatment Effectiveness and Consultation Services questionnaires. They reported satisfaction with both the interventions developed during consultation as well as the defining CBC collaborative process whereby the interventions were developed. These results are consistent with the acceptability hypothesis that was based on literature from multicultural counseling which suggests persons of Hispanic heritage appreciate cooperative problem solving that is focused and concrete in orientation. Nevertheless, consultant observations and findings with regard to integrity suggest such conclusions should be qualified. The scripted structure of the CBC stages was initially considered advantageous in not only accomplishing behavioral objectives, but also in encouraging greater input from Hispanic parents and teachers. However, consultants reported strict adherence to the scripts was neither possible nor practical. In fact, review

of interview tapes suggested a decrease in the number of CBC objectives met when the consultant was more rigid in following the interview script. Though issues of diverse language among CBC participants may have in part caused such deviations from the standard protocol, the very social nature of the Hispanic parents was also a major contributor, according to consultants. The limited follow through by teachers and especially parents with regard to systematic objective data collection is another factor that may be seen as calling question to acceptability of all CBC components. Limitations with regard to data collection tend to be a common concern with behavior consultation, however, and consultants agreed greater time might have been helpful in educating parents as to task expectations of their roles as consultees. Furthermore, the perceived accommodating nature of the Hispanic parents has been suggested to have positively skewed acceptability results. If true, this might be a reflection of the deference to authority attributed by multicultural counseling literature to persons of Hispanic culture.

Answers to the question addressing integrity are somewhat contradictory. As noted above, consultants were unable to adhere strictly to the scripted format of the four CBC stages. However, the four stages of identification, analysis, intervention, and evaluation were carried out in each of the four cases. Furthermore, the 83% average of CBC objectives met is consistent with that reported by Sheridan et al. (2001) for parent participants not of primary Hispanic heritage. Certainly in considering the integrity of treatment implementation had to be based on narrative self-report provided by consultees rather than the objective data recording of traditional behavioral consultation, integrity measurement results could be questioned. However, consultants reported amazing detail in the parents' descriptions providing support for the consultants' subjective ratings.

Surprisingly, the hypothesis that teachers would exercise higher levels of treatment implementation integrity did not prove true. In fact, they were generally consistent with those of parents. Consultants listed possible reasons for such performance as including limited time and personnel absences. However, as mentioned above, data collection is a common limitation associated with behavior consultation.

With regard to treatment effectiveness, all four children demonstrated improved behaviors at completion of the CBC intervention stage according to parent and teacher GAS ratings. This is particularly noteworthy in light of the fact that interventions were implemented for only four weeks. Though comparisons of pre- and post-SSRS scores do not reflect the consistent positive treatment impact suggested by GAS ratings, there were no significant negative effects on social skills or problems behaviors. Furthermore, significant improvements were indicated by at least one consultee for three of the four cases. Consultants questioned parent responses to the SSRS and BASC with respect to reliability and subsequent validity, with the BASC scores ultimately being disregarded. Greater acceptance of children's behavior, desire for positive regard, and limited experience with such standardized rating forms by the Hispanic parents were offered as explanations for what appeared to be patterned response tendencies and the consultants' concerns. No significant relationships emerged when acceptability, integrity, and effectiveness data were compared for each case. This is not necessarily unexpected, however, in light of the small-n associated with such single case designs.

The parents, teachers, and consultants involved in the four cases highlighted in this study reported that they looked favorably on future participation in CBC as a means of addressing behavioral problems of their children/students. Furthermore, parents of the

Hispanic preschool children indicated their experiences during the course of the study made it more likely they would seek assistance from their children's kindergarten school if they had concerns with regard to home behaviors. Consultants agreed the CBC model did inherently afford the opportunity for collaborative consultee participation that held potential in addressing issues of possible cultural diversity when working with teachers and parents of Hispanic children. However, they suggested modifications with regard to initial consultee orientation and role expectations, as well as flexibility in the scripted structure, would be beneficial in promoting even greater and more effective participation by Hispanic parents.

Context of Multicultural Consultation Literature

It is important to consider the information resulting from this study within the context of previously existing knowledge. Using the emic and etic philosophical multicultural counseling constructs appears an appropriate context in which to do this. The factors identified by Espinosa (1997) as being important for promoting Hispanic parent involvement in their children's schools, and the recommendations made by Romo and Falbo (1996) to increase the likelihood of high school graduation by Hispanic students provide templates to address the emic fit of these results. As to etic characteristics, the components of the CBC model provide the structure within which results are discussed.

Espinosa (1997) identified three cultural considerations educators should keep in mind when attempting to engage Hispanic parents in school participation: (1) role of

family, (2) communication style preferences, and (3) expectations of family and school. As to the first consideration regarding role of family in the Hispanic culture, observations related to this study support the claim of strong family commitment. Audio recordings and consultant descriptions of parent participation during consultation sessions reflected parents' genuine concerns for the welfare of their children both at home and school. These concerns were typically expressed in ways that highlighted the interactive and interdependent relationships of family members, and gave a positive impression of the family. The increased interest in study participation demonstrated by parents following the reframing of behavior focus to reflect greater success orientation is considered a specific example of Espinosa's (1997) family commitment factor. The prominent presence of gender role differences in the families involved in this study is suggested to be an extension of strong family commitment. The differentiation of male and female roles and authority levels was evident in all four cases. It was clear through observation and verbal acknowledgement that the female, or mother's role, was that of caretaker of the children, yet her position of limited control/power in the family made it difficult for her to make decisions regarding the children. Such contradictions were particularly noted with regard to Cases #1, #2, and #4 of this study, and the early termination of two potential cases in the grant project. In Case #1, the mother worked during the evening leaving the father to care for the children. The original intervention plan of a parent reading to the daughter as part of a bedtime routine had to be amended to having an older brother read to her or for her to look at a book. The father did not consider reading or looking at a book with his children among his caretaker duties. During the course of the consultation, the mother in this case eventually quit her evening job because she was

unable to maintain the household and attend to the needs of her four children. When the mother in Case #2 learned the consultant would be a male, special arrangements were made to allow the father to attend the first consultation session so as to approve her future participation. It was noted he did the talking for the family at that time, and when the post interview was conducted in their home, he was the primary spokesperson even though he had attended only the first session during the consultation. Differential power was most obvious among the four cases of this study with regard to Case #4. Though the mother was an active participant during intervention development, she expressed concerns as to her ability to influence the paternal grandparents and was hesitant to discuss the matter with her husband. Her reports reflected contradictions in that she was charged with the responsibility of caring for her son, but deprived of the authority to effect changes as she thought appropriate. With respect to the larger grant project, two cases from the same family terminated participation just after screening as a result of the father's objections. Even though personal contact was never made so as to obtain clarifying information about the project, his objection to the family's participation superseded and subsequently nullified the interests of the mother.

Aspects of communication style that, according to Espinosa (1997), are particularly important to successful interaction with Hispanic parents include cooperation and nonverbal indicators of feeling represented. The value placed on cooperation associated with the Hispanic culture suggests a natural fit with the collaborative philosophy underlying Conjoint Behavioral Consultation. At least that would appear the case on the surface, and, in fact, the presence and participation of the parent/mother consultees throughout the consultation would support such an interpretation. However,

the cooperation within the context of collaborative consultation is based on egalitarian relationship among participants. Based on reports by consultants and observations made with regard to the parents' completion of rating scales, it is suggested that the participation of the mothers may more appropriately be attributed to agreeableness rather than collaborative cooperation. It is unclear whether this is related to gender role expectations as discussed within the context of family commitment, deference to teacher/school personnel authority when in the educational environment, or history of disfranchisement. Nevertheless, as a result of the positive outcomes of their participation, outcomes verified by teacher observations and reports, it is suggested that the mothers/parents involved in this study have gained greater perspective of the school as a resource. Furthermore, with additional school experiences encouraging collaborative interactions, they will be increasingly able to effect the egalitarian expectations of their consultee role. Reports by consultees and consultants were rife with examples of the three considerations included within the concept of nonverbal indicators of feeling represented: relaxed sense of time, personalized styles of interaction, and preference for informal communication. Missed sessions occurred at some time during each of the four cases. The standard operating procedure at this Head Start seemed to be to "grab" parents when they were available rather than strictly adhering to timed appointments. This practice made it difficult to determine whether the nature of the parents' attendance and punctuality was the result of culture influence or learned behavior. It was noted, however, that scheduling at a specific time in the morning usually resulted in the meeting convening whenever the parent brought her child to school. Parents typically did not notify teachers or consultants prior to their being unable to keep previously scheduled

appointments. Rather, explanations at following sessions most often included work schedule changes, illness, or needs of other family members that required attention, and they were stated in a matter-of-fact manner if offered at all. Most often parents seemed equally as unaffected by tardiness or absences of consultants and teachers, as well. However, one mother did report she did not think the teacher liked her, and this conclusion was based on her perception that the teacher did not spend enough time with her. Parents presented as unhurried and socially gracious during sessions. The personable nature of these Hispanic parents was a prominent theme running throughout interactions. They regularly inquired about the consultants' personal lives and families, and seemed to expect social conversation intermixed with the "official business" of the consultation sessions. Elaboration including stories about other children and/or family members as well as related behaviors of the client children was also common. Such was the case even when an interpreter was used, with parents engaging the interpreter in social conversation, as well. Consequently, consultation sessions were generally lengthy and strict following of the CBC scripts was not possible. Fortunately, however, the objectives of the consultation sessions could be achieved without strictly following the script sequence, thus affording all participants the opportunity to personalize their communication of information. In reflecting on the difficulties associated with parental compliance to requests for systematic objective recording of behavioral data, it is suggested such practices are stark contradictions to their informal and personalized communication style. The questionable responding patterns by parents to the BASC and SSRS may also, at least in part, be interpreted in light of this preferred communication

factor, as well as the unfamiliarity of such rating scales to these parents of young children.

According to Espinosa (1997) and others (Chavkin & Williams, 1985; Romo & Falbo, 1996), Hispanic parents are eager to participate in their children's education by virtue of the nurturing role they ascribe to family. However, they tend to defer authority for educating their children to teachers and related school personnel. This factor was exemplified in the parents' hesitancy and difficulty at embracing their egalitarian role with consultants and as co-consultees with teachers when developing and implementing interventions during the CBC process. It may also have been related to the limited participant recruitment numbers. Those Hispanic parents who did participate were willing to bridge that division, and reported satisfaction with the experience and future use of school resources for home-related concerns.

Of the seven recommendations specific to Romo and Falbo's 1996 research addressing factors contributing to increased high school graduation of Mexican American youths, four are supported by principles of CBC and its use in this preschool study. Two recommendations made by Romo and Falbo were to clarify scholastic standards and create clear pathways to good outcomes. By providing a collaborative forum where both teacher and parent consulttees are present and driven by the systematic and sequential processes of behavior analysis, the CBC model affords greater structured opportunities for reciprocal inquiry, explanation, and understanding of academic and behavioral expectations. Making schools accessible to parents was a third recommendation by Romo and Falbo. The egalitarian relationship of consultees participating in CBC encourages respectful and meaningful communication with parents, thus encouraging their

participation. Furthermore, the collaborative problem solving of CBC enhances the probability of subsequent educational decisions affecting children and their families reflecting cooperation and compromise by home and school rather than unilateral decisions imposed by the school as an impersonal entity. Therefore, the chances of intervention implementation and success are increased along with a fourth recommendation by Romo and Falbo, preventing school failure.

Elements of CBC lending themselves to etic interpretation with regard to its fit with parents and teachers of Hispanic children are identified as including the collaborative philosophy, consultation phases, scripted structure, participants, and data gathering. A collaborative relationship among the consultant and consultees is central to the CBC model. Though the parent consultees of this study were very willing to participate in the problem solving activities of the CBC sessions, they were not perceived to have the egalitarian participation expectations embraced by CBC. They were willing to answer questions and provide descriptive information, as well as agree to implement interventions, and, thus, were cooperative, but they typically deferred communication control to the consultant and/or teacher consultee. This is consistent with suggested cultural separation of responsibilities whereby education is considered the sole responsibility of schools, while the role of the family is that of nurturing children. The CBC session scripts as well as environment based behavioral principles encouraged greater and more assertive parent participation, which was not rejected. However, the subordinate level of the mother's authority to that of the father when making decisions potentially affecting the whole family was also a factor affecting the participant

relationship expectations. The influence of the father was ever present despite his physical absence in consultation sessions.

The four phases of CBC, problem identification, problem analysis, treatment/intervention implementation, and treatment evaluation, are inherent within its behavioral basis. The high context communication style and interests in the personal lives of consultants and teacher consultees expressed by the Hispanic parents from Mexico who participated in this study suggest that an introductory phase be added to the sequence. Not only would this allow for increased development of interpersonal relationships, but would also afford the opportunity for specific explanation of the consultation format and expectations, therefore, better preparing consultees for participation. Separate introductory, or preparatory, sessions for parent consultees and teacher consultees might even be beneficial in this regard. The scripted structure of the CBC model is considered to have afforded specific opportunities for consultee input in attending to environmental factors affecting the children's behaviors. As this relates to the communication style expressed by the parents, however, greater emphasis must be placed on achievement of phase objectives rather than script sequence, and, therefore, calling for patience and flexibility coupled with thoroughness in achieving the CBC objectives. Also, consistent with potential difficulties suggested by Sheridan (2000) in applying CBC multiculturally, semantics associated with participant recruitment and "problem" identification presented challenges in relationship to communication among participants, and required cultural adaptation to reflect greater success orientation.

The participants of CBC in this study included preschool children clients, parent and teacher consultees, consultants, and interpreters. By incorporating information from

both home and school environments, a more comprehensive assessment of each child was obtained including both cultural as well as individual differences. Interventions developed based on such assessment have increased likelihood of positive outcomes within those unique environments, and, therefore, promoting success for the children involved. In keeping with their responsibility for the welfare of the family's children, mothers were the primary parent consultees in each of the four consultation cases of this study. They expressed sincere interest and commitment in their participation, but their decision-making abilities were compromised by their positions within the family authority structure, as a whole. As discussed elsewhere, the dominance of the father was a constant factor impacting study participation as well as intervention implementation. Teacher consultees seemed more comfortable with the collaborative expectations of CBC likely as the result of their professional training and experiences. Not only were they able to identify behaviors concerning to them as educators, they supported parent observations and concerns by recognizing similar classroom behaviors. Furthermore, the teacher consultees carried out interventions within the classroom setting, as well as reinforced interventions of the home. The consultant role in CBC is also collaborative. Nevertheless, results of this study suggest consultants should be prepared to take more responsibility for educating consultees, particularly the Hispanic parent consultees, and guiding the process. In preparation for their participation, it is suggested that familiarity with the multicultural literature would be beneficial so as to be better prepared for potential culturally related aspects of interactions. Additionally, on-site presence of consultants was strongly recommended by both consultant and teacher consultee participants, as providing greater flexibility in meeting the needs of both teacher and parent consultees.

The role of interpreter during communication exchanges with parents of this study was considerably less rigid than that traditionally ascribed. Again, the communication style expressed by the Hispanic parents from Mexico involved in these cases required that, when present, interpreters were active consultation participants. They provided valuable interpretation of not only words, but nonverbal communication, as well, and served as liaison connections to the family environments of the Hispanic children clients. As such potentially influential participants, they should be instructed in the philosophy and principles of CBC as part of their preparatory training.

Consistent with other behavior consultation cases and identified by Sheridan (2000) as a source of difficulty when implementing CBC with clients and consultees of cultures different from White European American, reliable data gathering was problematic during the course of this study. This was evident with regard to parent completion of the SSRS and BASC rating scales and with respect to both parent and teacher behavior data recording. Though teachers were more accustomed to such practices, time constraints were reported as limiting their responsiveness. Several factors are considered relevant with regard to parent responses. First, it is unlikely the parents had previous experiences with such practices, especially considering the children in participant families were young and at early grade levels. Another factor specific to the rating scales in general, and the BASC in particular, the questions tended to focus on maladaptive behaviors which is contradictory to the respectful beliefs associated with persons of Hispanic culture in multicultural literature. Additionally, language differences, despite the use of interpreters and Spanish translations of written material, may have contributed to the limited responses of parents. Finally, the high context communication

style of parent participants that relies on descriptive language and complex nonverbal language is not amenable to the reductionism of data recording and objective behavior ratings/classifications. Thus, greater attention and creativity in developing culturally meaningful data gathering methods is needed. Additionally, the use of permanent products naturally resulting from intervention/treatment is perhaps a viable consideration in this regard. Though the Hispanic parents were specific in identifying target behaviors, they tended to present behaviors within an interdependent context of family interactions. As the process guides during CBC, consultants should be aware of such challenges with regard to funneling focus so as to develop effective interventions. A summary of how the above five CBC elements are impacted in its application to parents and teachers of the Hispanic preschool children in this study is presented in Table 8.

Table 8

Structural Fit of CBC with Parents and Teachers of Hispanic Preschool Children

CBC Element	Observation	Impact to CBC Process
Collaborative Philosophy	▪ Parent consultees cooperative but did not have egalitarian participation expectations ▪ Greater egalitarian participation by teachers ▪ Mother's family authority subordinate to father's	▪ Education of consultees in CBC prior to engaging in consultation sessions ▪ Increase attempts to have father physically present at sessions ▪ Increase consultant awareness of gender role impact on decision making and CBC process
Consultation Phases	▪ Parent desire for personal relationship ▪ Semantic difficulties	▪ Individual introductory phase/sessions with parents and teachers ▪ Emphasis on success orientation
Scripted Structure	▪ Parents' high context communication style	▪ Thoroughness, patience, and flexibility in achieving objectives

Table 8 (continued)

CBC Element	Observation	Impact to CBC Process
Participants	▪ Home and school representation afforded more comprehensive assessment ▪ Mothers were parent consultees ▪ Teachers able to identify classroom concerns and support parent concerns ▪ Limited parent egalitarian expectations ▪ Interpreters were active consultation participants and liaisons to family environments	▪ Increased intervention relevance ▪ Increase attempts to have father physically present at sessions ▪ Increase consultant awareness of gender role impact on decision making and CBC process ▪ Encourage family and school partnership relationship ▪ Increased consultant responsibilities for consultee education and guiding CBC process ▪ Less rigid interpreter role ▪ Educate interpreter in CBC philosophy and principles
Data Gathering	▪ Very limited follow-up by parents and teachers, but rich verbal descriptions ▪ Patterned responses by parents on rating scales	▪ Permanent products naturally resulting from interventions ▪ Culturally meaningful data gathering methods ▪ Verbally administer rating scales

Implications

Though this study suggests modifications during implementation of the CBC model with this population may be beneficial, it is, nevertheless, the collaborative philosophy underpinning this structured behavior change model affording the researcher or practitioner the opportunity to accommodate for the unique cultural and individual qualities of the participants. The following recommendations are made based on results and experiences gained during this research study, and are considered applicable to Conjoint Behavioral Consultation as well as to interaction with parents of Hispanic children, in general, when addressing issues pertaining to their children.

It is imperative that a success orientation is emphasized with parents of Hispanic children when identifying target behaviors and developing interventions. Ignoring this will seriously limit research participation, as demonstrated in this study, and foster suspicion and mistrust in practice. The parents of this study expressed attentive eagerness when judgmental behavior labeling was avoided in favor of discussing their children in terms of promoting greater success associated with learning and school participation, as well as individual and family happiness. Another recommendation seeming particularly relevant to working with parents of Hispanic children, whether in terms of research or practice, is that greater time should be allotted for rapport building between parents and other CBC participants. Such time is essential to learning and exercising sensitivity with respect to home resources of time, space, caregivers, and language. Consistent with conclusions resulting from multicultural therapy experiences, the parent participants in this study welcomed a greater personal knowledge of the consultants, and even readily

inquired as to the consultants' families. Their conversations also characteristically incorporated the whole family into discussions pertaining to the preschool child. Furthermore, though the mother typically assumed the caregiver role and participated as the consultee during the CBC sessions, the father's influence in the family was an ever-present element to be considered. Thus, whenever possible, the father should be included in consultation sessions. Though CBC is a very structured, even scripted, behavior consultation model, there is within each step the flexibility to take time to build a more personal rapport, and the step structure actually promotes greater investigation of setting events that would include unique family characteristics.

Probably the greatest challenge to the use of CBC experienced during the course of this study was associated with data collection. The collection of observable and measurable data from which to identify target behaviors, develop interventions, and evaluate the success of those interventions is an integral component of the CBC process, as with all behavior consultation models. Daily collection and recording of data was an unfamiliar activity for the parents of this study, as is often the case for consultees in behavior consultation. Again, parents expressed a preference for more personal interaction by their very explicit verbal accounts of intervention trials and subjective descriptions of outcomes. Thus, creativity in developing culturally meaningful, non-intrusive data collection techniques would be beneficial to the consultant using CBC with parents of the Hispanic population.

The role of an interpreter is to enhance communication and understanding among consultant and consultees. In the course of their training, it is usually emphasized that interpreters should only translate/interpret exactly what is said by the consultation

participants while avoiding any personal involvement. Subsequently, it follows that interpreters are typically preferred who do not have a prior personal relationship with those for whom they are interpreting. However, experiences associated with this study tend to contradict such standard practices and suggest benefits from less clear boundaries between interpreter and consultation participants. The Hispanic parents' preference for greater personal interaction extended to the interpreter, as well. The presence of another person who could not only speak their language, but also had greater knowledge of their unique cultural, as well as personal, attributes and limitations, appeared to put parents at ease and enhanced openness in discussion. Certainly this places an added dimension to interpreter training and responsibility in suggesting greater attention must be given to tempering personal relationships with objective interpretation.

The results and experiences associated with this study lead to two additional recommendations with regard to the implementation of Conjoint Behavioral Consultation, or other programs, with teachers and parents of preschool Hispanic children. Ideally, consultants should be on-site so as to afford greater flexibility in meeting the time demands of both teachers and parents. Finally, enlisting the cooperation of existing parent organizations lends credibility and provides access to a greater audience in disseminating information about proposed programs.

In conclusion, contributions of this study include (1) support for use of CBC with teachers and parents of Hispanic children as reflected by their positive effectiveness, integrity, and acceptability ratings, as well as predicted future use, (2) increased knowledge and understanding of strategies promoting positive relationships between Hispanic families and schools by demonstrating active participation of family members

affords the opportunity to incorporate the unique Hispanic cultural and language characteristics necessary for intervention success, (3) enhanced knowledge pertaining to alternative service delivery models addressing multicultural needs of school children, and (4) extended repertoire of problem prevention and early intervention strategies available to educators. In consideration of the multicultural literature, CBC offers an "etic" structure within which the "emic" differences of consultees can be acknowledged and investigated when problem solving. Application of these findings can have contradictory political implications, however. Superficial implementation of CBC procedures under the guise of exercising cultural competence could further denigrate cultural differences when targeting Hispanic children's compliance and using White European American expectations as evaluation standards. In contrast, by bringing parents and teachers together at the same time in CBC, idiosyncrasies of not only the cultures involved, but of individual clients, their families, school, and classrooms, can be incorporated in an ecologically sensitive manner when addressing the needs of the children. Furthermore, though abuses are ever possible, study results suggest CBC encourages positive expectations of future school involvement by Hispanic parent participants, and these parents are empowered with effective problem-solving tools that can reduce potential for suppression of their cultural differences. Such empowerment promotes the pride in cultural heritage and ethnic identity Ruis (1990) correlates with mental health according to his Latino/Hispanic American identity development model.

Limitations of the Study

In addition to the limitations included above within the context of elaboration on results, there are a number of others that must be acknowledged. Certainly, the specific characteristics of this study's participants must be considered with respect to external validity. Though such is a legitimate concern associated with all research, inferences from small-n case studies must be offered with particular caution as being representative of a larger population. Therefore, the results from this study are only representative of the four Hispanic families from Mexico, three preschool teachers from Reed Head Start in Tulsa, Oklahoma, and three consultants who were participants. Greater generalizations cannot be appropriately made to parents of the greater Hispanic culture and their children without additional small-n studies. Similarly, studies encompassing more grade levels and across varied geographic locations are necessary for generalization of results beyond the preschool level in this southwest city. Also, as with other studies whose participants are volunteers, the four families may have had a propensity to collaborate with their children's school greater than that of Hispanic families who did not volunteer. Thus, a bias toward successful participation and satisfaction would have been present from the start. This factor was not controlled, though consultation style preference was measured for the four participant families.

Limitations relevant to internal validity are associated with the AB design despite the actual variation of CBC initiation across participants. The inclusion of a control group or comparison group(s) using other consultation models is a consideration for future research. Prominent reliance on self-report measures in this study is another source for

cautious interpretations. This is particularly so in light of the social desirability factor suspected of the Hispanic parents and the absence of systematic data collection with regard to treatment integrity. However, it is pointed out that parent and teacher responses were generally in agreement, and self-report integrity measures are not uncommon within consultation research (Sheridan et al., 2001).

Future Research

The results as well as limitations associated with this study provide bases from which future research may be launched. Certainly, additional small-n replications would provide additional information relevant to the generalizability of these findings and inferences to similar Hispanic and school populations. Meta-analysis of such studies may then address variables including varied Hispanic culture origin, acculturation, socioeconomic factors, target behaviors, grade level, and classroom/curriculum design.

CBC is but one model for school consultation. Future studies that compare and contrast CBC with other consultation and problem-solving models, such as teacher-only, parent-only, and expert, when addressing the needs of Hispanic children would benefit the ongoing efforts to improve service delivery to this growing population of students. Furthermore, investigations using CBC with other diverse populations in public schools, for example, Muslim, Native American, African American, and Asian, would be appropriate. A child's school success is a consideration over time. Therefore, a longitudinal study involving a CBC experimental group and control group would be useful in providing data as to the differences in parent involvement and behavioral impact

as children progress through school. The incorporation of this study into subsequent research is viable in addressing culturally competent and effective service delivery in the nation's public schools so all children may experience success.

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Appendix A

Consultation Preference Survey

If your child was having **academic/learning** difficulties at school, which statement under each of the following would you prefer when correcting the difficulty? Please identify the statements that best reflect your preferences by circling a, b, c, or d.

1. Circle the statement describing what you would prefer when identifying the difficulty.

    a. I would like for a consultant who has special training in working with children to identify the specific difficulty.
    b. I would like for a consultant to work with my child's teacher to identify the specific difficulty.
    c. I would like for the consultant to work with me to identify the specific difficulty.
    d. I would like for the consultant to work with my child's teacher and me to identify the specific difficulty.

2. Circle the statement describing what you would prefer when developing a plan for correcting the difficulty.

    a. I would like for a consultant who has special training in working with children to develop the plan.
    b. I would like for a consultant to work with my child's teacher to develop the plan.
    c. I would like for the consultant to work with me to develop the plan.
    d. I would like for the consultant to work with my child's teacher and me to develop the plan.

3. Circle the statement describing how you would prefer implementation of the plan.

    a. I would like for a consultant who has special training in working with children to implement the plan.
    b. I would like for a consultant to work with my child's teacher to implement the plan.
    c. I would like for the consultant to work with me to implement the plan.
    d. I would like for the consultant to work with my child's teacher and me to implement the plan.

4. Circle the statement describing what you would prefer to have happen following implementation of the plan.

    a. I would prefer that the consultant not have additional meetings.
    b. I would prefer that the consultant only have additional meetings with my child's teacher.
    c. I would prefer that the consultant only have additional meetings with me.
    d. I would prefer that the consultant have additional meetings together with my child's teacher and me.

If your child was having **behavior** difficulties at school, which statement under each of the following would you prefer when correcting the difficulty? Please identify the statements that best reflect your preferences by circling a, b, c, or d.

1. Circle the statement describing what you would prefer when identifying the difficulty.

a. I would like for a consultant who has special training in working with children to identify the specific difficulty.
b. I would like for a consultant to work with my child's teacher to identify the specific difficulty.
c. I would like for the consultant to work with me to identify the specific difficulty.
d. I would like for the consultant to work with my child's teacher and me to identify the specific difficulty.

2. Circle the statement describing what you would prefer when developing a plan for correcting the difficulty.

a. I would like for a consultant who has special training in working with children to develop the plan.
b. I would like for a consultant to work with my child's teacher to develop the plan.
c. I would like for the consultant to work with me to develop the plan.
d. I would like for the consultant to work with my child's teacher and me to develop the plan.

3. Circle the statement describing how you would prefer implementation of the plan.

a. I would like for a consultant who has special training in working with children to implement the plan.
b. I would like for a consultant to work with my child's teacher to implement the plan.
c. I would like for the consultant to work with me to implement the plan.
d. I would like for the consultant to work with my child's teacher and me to implement the plan.

4. Circle the statement describing what you would prefer to have happen following implementation of the plan.

a. I would prefer that the consultant not have additional meetings.
b. I would prefer that the consultant only have additional meetings with my child's teacher.
c. I would prefer that the consultant only have additional meetings with me.
d. I would prefer that the consultant have additional meetings together with my child's teacher and me.

Preferencia de consulta escame

¿Si su niño el **académico** estaba teniendo aprender dificultades en la escuela cuál declaración cada uno lo siguiente de tú cuándo preferiría corregir la dificultad? Por favor identifique las declaraciones que mejor reflecte sus preferencias al circundar el alfabeto o d.

1. Circunde la declaración describa qué preferiría cuándo identifique la dificultad.

   e. Yo gustaría por el consultor que tiene especial que entrenar dentro trabajando para identificar la dificultad específica con los niños.
   f. Me gustaría el consultor que trabajar con el profesor de mi niño identificaré la dificultad específica.
   g. Me gustaría el consultor trabajar para identificar la dificultad específica con me.
   h. Me gustaría el consultor que trabajar con el profesor de mi niño me identificaré la dificultad específica.

2. Circunde la declaración describa preferiría revelador que plan corrija cuál dificultad.

   e. Yo gustaría por el consultor que tiene especial que entrenar dentro trabajando para desarrollar el plan con los niños.
   f. Me gustaría el consultor que trabajar con el profesor de mi niño desarrollaré el plan.
   g. Me gustaría el consultor trabajar para desarrollar el plan con me.
   h. Me gustaría el consultor que trabajar con el profesor de mi niño me desarrollaré el plan.

3. Circunde cómo preferiría la implementación del plan la declaración describía.

   e. Yo gustaría por el consultor que tiene especial que entrenar dentro trabajando para implementar el plan con los niños.
   f. Me gustaría el consultor que trabajar con el profesor de mi niño implementaré el plan.
   g. Me gustaría el consultor trabajar para implementar el plan con me.
   h. Me gustaría el consultor que trabajar con el profesor de mi niño me implementaré el plan.

4. Circunde la declaración describa qué preferiría tener suceder siga la implementación del plan.

   e. Preferiría que el consultor no tenga las reuniones adicionales.
   f. Preferiría solamente que el consultor tenga las reuniones adicionales con el profesor de mi niño.
   g. Preferiría solamente que el consultor tenga las reuniones adicionales con me.
   h. Preferiría que el consultor tenga las reuniones adicionales con el profesor de mi niño y me.

¿Su niño estaba teniendo **dificultades de comportamientos** en la escuela cuál declaración cada uno lo siguiente de tú cuándo preferiría corregir la dificultad? Por favor identifique las declaraciones que mejor reflecte sus preferencias al circundar el alfabeto o d.

1. Circunde la declaración describa qué preferiría cuándo identifique la dificultad.

   e. Yo gustaría por el consultor que tiene especial que entrenar dentro trabajando para identificar la dificultad específica con los niños.
   f. Me gustaría el consultor que trabajar con el profesor de mi niño identificaré la dificultad específica.
   g. Me gustaría el consultor trabajar para identificar la dificultad específica con me.
   h. Me gustaría el consultor que trabajar con el profesor de mi niño me identificaré la dificultad específica.

2. Circunde la declaración describa preferiría revelador que plan corrija cuál dificultad.

   e. Yo gustaría por el consultor que tiene especial que entrenar dentro trabajando para desarrollar el plan con los niños.
   f. Me gustaría el consultor que trabajar con el profesor de mi niño desarrollaré el plan.
   g. Me gustaría el consultor trabajar para desarrollar el plan con me.
   h. Me gustaría el consultor que trabajar con el profesor de mi niño me desarrollaré el plan.

3. Circunde cómo preferiría la implementación del plan la declaración describía.

   e. Yo gustaría por el consultor que tiene especial que entrenar dentro trabajando para implementar el plan con los niños.
   f. Me gustaría el consultor que trabajar con el profesor de mi niño implementaré el plan.
   g. Me gustaría el consultor trabajar para implementar el plan con me.
   h. Me gustaría el consultor que trabajar con el profesor de mi niño me implementaré el plan.

4. Circunde la declaración describa qué preferiría tener suceder siga la implementación del plan.

   e. Preferiría que el consultor no tenga las reuniones adicionales.
   f. Preferiría solamente que el consultor tenga las reuniones adicionales con el profesor de mi niño.
   g. Preferiría solamente que el consultor tenga las reuniones adicionales con me.
   h. Preferiría que el consultor tenga las reuniones adicionales con el profesor de mi niño y me.

Appendix B

Goal Attainment Scaling

GOAL ATTAINMENT SCALING - PARENT FORM

Goal attainment scaling (GAS) provides a method for quantifying parents' and teachers' reports of treatment progress with regard to a target behavior and problem situation. The consultant will be responsible for working with parents to provide an overview of the goal attainment scale during the latter portion of the initial visit.

The basic elements of a goal attainment scale are a five point scale ranging from a +2 to a -2 and descriptions of the target behavior and problem situation that correspond to the following conditions: Best possible behavior (+2) to Worst possible behavior (-2). The example below provides the framework for which parents should rate treatment progress.

Example:

+2 The child is compliant with parental requests 80 to 100 % of the time
+1 Child is compliant 60 to 80% of the time
0 Child is compliant about 50% of the time
-1 Child is compliant about 20 to 40% of the time
-2 Child is compliant with parental requests less than 20% of the time

Individualized Scale:

+2 _____

+1 _____

0 _____

-1 _____

-2 _____

By using the numerical ratings for each of the five descriptive categories of behavioral functioning, parents should be able to provide a weekly report of treatment progress. These data accompany other more direct indicators of progress (e.g., direct observations).

GAS Progress Report

Put an X in the box that best represents your rating for each of the following weeks.

2								
1								
0								
-1								
-2								
Week	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**

GOAL ATTAINMENT SCALING - TEACHER FORM

Goal attainment scaling (GAS) provides a method for quantifying parents' and teachers' reports of treatment progress with regard to a target behavior and problem situation. The consultant will be responsible for working with teachers to provide an overview of the goal attainment scale during the latter portion of the initial visit.

The basic elements of a goal attainment scale are a five point scale ranging from a +2 to a -2 and descriptions of the target behavior and problem situation that correspond to the following conditions: Best possible behavior (+2) to Worst possible behavior (-2). The example below provides the framework for which teachers should rate treatment progress.

Example:

+2 The child is compliant with parental requests 80 to 100 % of the time
+1 Child is compliant 60 to 80% of the time
0 Child is compliant about 50% of the time
-1 Child is compliant about 20 to 40% of the time
-2 Child is compliant with parental requests less than 20% of the time

Individualized Scale:

+2 _____

+1 _____

0 _____

-1 _____

-2 _____

By using the numerical ratings for each of the five descriptive categories of behavioral functioning, teachers should be able to provide a weekly report of treatment progress. These data accompany other more direct indicators of progress (e.g., direct observations).

GAS Progress Report

Put an X in the box that best represents your rating for each of the following weeks.

2								
1								
0								
-1								
-2								
Week	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**

Appendix C

Data Collection Form

Parent Data Collection **Week of:** _____

Child's Name: _____ **Parent's Name:** _____

Target Behavior: _____

Instructions: Please record the occurrence of the target behavior, what happened before the behavior, what happened during the behavior, and what happened after the behavior.

Day	Behavior Occurrence	Before Behavior	During Behavior	After Behavior
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

La Colección de Datos de padre **La semana de:** _____

El Nombre del niño: _____ **El Nombre del padre:** _____

La Conducta del blanco: _____

_____

Las instrucciones: registra por favor la ocurrencia de la conducta del blanco, lo que aconteció antes la conducta, lo que aconteció durante la conducta, y lo que acontecieron después la conducta.

El día	La Ocurrencia de la conducta	Antes de la Conducta	Durante la Conducta	Después de la Conducta
El lunes				
El martes				
El miércoles				
El jueves				
El viernes				
El sábado				
El domingo				

Teacher Data Collection Week of: _____

Child's Name: _____ Teacher's Name: _____

Target Behavior(s): _____

Instructions: Please record the occurrence of the target behavior, what happened before the behavior, what happened during the behavior, and what happened after the behavior.

Day	Behavior	Before Behavior	During Behavior	After Behavior
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				

Appendix D

Treatment Integrity Form

Treatment Integrity Form (Home)

Consultants: Describe the activities that you have asked your consultee to engage in over the course of the past week. Record your perceptions of how well the consultee met your expectations in the form of a percentage, with 0% indicating no attempt toward completing what was requested to 100% or full completion of what was expected.

Definition of Consultee Responsibilities	**0 to 100% Integrity**
[e.g., consultee established consistent bedtime routine	80% (4 out of 5 days)]
1.	_____
2.	_____
3.	_____
4.	_____
5.	_____

Treatment Integrity Form (School)

Consultants: Describe the activities that you have asked your consultee to engage in over the course of the past week. Record your perceptions of how well the consultee met your expectations in the form of a percentage, with 0% indicating no attempt toward completing what was requested to 100% or full completion of what was expected.

Definition of Consultee Responsibilities	**0 to 100% Integrity**
[e.g., consultee established consistent bedtime routine	80% (4 out of 5 days)]
1.	_____
2.	_____
3.	_____
4.	_____
5.	_____

Appendix E

Treatment Evaluation Questionnaire – Parent and Teacher Form

Treatment Evaluation Questionnaire – Parent

You have just completed an intervention program. Please evaluate the intervention by circling the number which best describes your agreement or disagreement with each statement. Please answer each question.

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1. This was an acceptable intervention for my child's problem behavior.	1	2	3	4	5	6
2. Most parents would find this intervention appropriate for behavior problems in addition to the one described	1	2	3	4	5	6
3. The intervention was effective in changing my child's problem behavior.	1	2	3	4	5	6
4. I would suggest the use of this intervention to other parents.	1	2	3	4	5	6
5. My child's behavior problem was severe enough to warrant use of this intervention.	1	2	3	4	5	6
6. Most parents would find this intervention suitable for the behavior problem described.	1	2	3	4	5	6
7. The intervention did not result in negative side-effects for my child.	1	2	3	4	5	6
8. The intervention would be appropriate for a variety of children.	1	2	3	4	5	6
9. The intervention was a fair way to handle my child's problem behavior.	1	2	3	4	5	6
10. I liked the procedure used in the intervention.	1	2	3	4	5	6
11. The intervention was a good way to handle my child's behavior problem.	1	2	3	4	5	6
12. Overall, the intervention was beneficial for my child.	1	2	3	4	5	6
13. The intervention quickly improved my child's behavior.	1	2	3	4	5	6
14. The intervention produced a lasting improvement in my child's behavior.	1	2	3	4	5	6
15. The intervention improved my child's behavior to the point that it would not noticeably deviate from other children's behavior.	1	2	3	4	5	6
16. Soon after using the intervention, I noticed a positive change in my child's problem behavior.	1	2	3	4	5	6
17. Using the intervention not only improved my child's behavior in the home, but also in other settings (e.g., other homes).	1	2	3	4	5	6
18. When comparing my child with a well-behaved peer before and after use of the intervention, my child's and peer's behavior was more alike after using the interventions.	1	2	3	4	5	6
19. The intervention produced enough improvement in my child's behavior so the behavior no longer was a problem.	1	2	3	4	5	6
20. Other behaviors related to the problem behavior also were improved by the intervention.	1	2	3	4	5	6

Treatment Evaluation Questionnaire – Teacher

You have just completed an intervention program. Please evaluate the intervention by circling the number which best describes your agreement or disagreement with each statement. Please answer each question.

		Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1.	This was an acceptable intervention for the child's problem behavior.	1	2	3	4	5	6
2.	Most teachers would find this intervention appropriate for behavior problems in addition to the one described	1	2	3	4	5	6
3.	The intervention was effective in changing the child's problem behavior.	1	2	3	4	5	6
4.	I would suggest the use of this intervention to other teachers.	1	2	3	4	5	6
5.	The child's behavior problem was severe enough to warrant use of this intervention.	1	2	3	4	5	6
6.	Most teachers would find this intervention suitable for the behavior problem described.	1	2	3	4	5	6
7.	The intervention did not result in negative side-effects for the child.	1	2	3	4	5	6
8.	The intervention would be appropriate for a variety of children.	1	2	3	4	5	6
9.	The intervention was a fair way to handle the child's problem behavior.	1	2	3	4	5	6
10.	I liked the procedure used in the Intervention.	1	2	3	4	5	6
11.	The intervention was a good way to handle the child's behavior problem.	1	2	3	4	5	6
12.	Overall, the intervention was beneficial for the child.	1	2	3	4	5	6
13.	The intervention quickly improved the child's behavior.	1	2	3	4	5	6
14.	The intervention produced a lasting improvement in the child's behavior.	1	2	3	4	5	6
15.	The intervention improved the child's behavior to the point that it would not noticeably deviate from other children's behavior.	1	2	3	4	5	6
16.	Soon after using the intervention, I noticed a positive change in the child's problem behavior.	1	2	3	4	5	6
17.	Using the intervention not only improved the child's behavior in the classroom, but also in other settings.	1	2	3	4	5	6
18.	When comparing the child with a well-behaved peer before and after use of the intervention, the child's and peer's behavior was more alike after using the interventions.	1	2	3	4	5	6
19.	The intervention produced enough improvement in the child's behavior so the behavior no longer was a problem.	1	2	3	4	5	6
20.	Other behaviors related to the problem behavior also were improved by the intervention.	1	2	3	4	5	6

El cuestionario de evaluación del tratamiento - Parent

Usted habría completado sólo una intervención programe. Por favor evalúe la intervención circunde el número que el mejor describa su acuerdo o el desacuerdo cada declaración. Por favor conteste cada pregunta.

	Diferenciese fuertemente	Diferenciar	Levemente diferenciese	Levemente acuerde	Acuerde	Acuerde fuertemente
1. La dificultad de mi niño este fue un plan aceptable	1	2	3	4	5	6
2. Los la más muchos parents encontrarían este plan apropiado dificultades además de la uno describí.	1	2	3	4	5	6
3. El plan estuvo dentro de eficaz el cambiante el comportamiento de mi niño.	1	2	3	4	5	6
4. Sugeriría el uso de este plan a los otros parents.	1	2	3	4	5	6
5. La dificultad de mi niño fue mala bastante utilice este plan.	1	2	3	4	5	6
6. Los la más muchos parents encontrarían este plan adecuado para la dificultad describí.	1	2	3	4	5	6
7. El plan no resultó en la negativa los efectos para mi niño.	1	2	3	4	5	6
8. La variedad de los niños el plan sería apropiado.	1	2	3	4	5	6
9. El plan fue un caminar justo manejar la dificultad de mi niño.	1	2	3	4	5	6
10. Me gustó en la intervención que el procedimiento utilizó.	1	2	3	4	5	6
11. El plan fue un caminar bueno manejar la dificultad de mi niño.	1	2	3	4	5	6
12. Global mi niño el plan fue provechoso.	1	2	3	4	5	6
13. El plan mejoró el comportamiento de mi niño rápidamente.	1	2	3	4	5	6
14. El plan produjo un mejoramiento durando en el comportamiento de.	1	2	3	4	5	6
15. El plan mejoró el comportamiento de mi niño al punto que no sería diferente otro notablemente el comportamiento de los niños.	1	2	3	4	5	6
16. Me fijé en utilizar el plan, el comportamiento de mi niño, una modificación positiva.	1	2	3	4	5	6
17. No sólo utilizar el plan mejorar mi niño estaba comportamiento dentro el hogar pero también otro settings como la escuela.	1	2	3	4	5	6
18. Cuándo comparar a mi niño con otro niño antes de y uso de plan el mi niño y el niño fue más semejante utilizar el plan otro comportamiento.	1	2	3	4	5	6
19. El plan produjo en por eso bastante mejoramiento el comportamiento de mi niño el comportamiento fue más una dificultad.	1	2	3	4	5	6
20. Los otros comportamientos se relacionados con la dificultad por el plan además fueron mejorados.	1	2	3	4	5	6

Appendix F

Parent/Teacher Consultation Services Questionnaire

PARENT CONSULTATION SERVICES QUESTIONNAIRE

Thank you for your participation in this consultation project. Your cooperation has been greatly appreciated. The following questionnaire is part of an evaluation of the project. The information obtained will help us evaluate the project; therefore, it is important that you respond as honestly as possible.

Please circle the response that best expresses your feelings.

1. The major problem that originally prompted me to seek treatment for my child is presently

   - considerably worse
   - worse
   - slightly worse
   - the same
   - slightly improved
   - improved
   - greatly improved

2. My child's problems that have been treated during my participation in the project are now

   - considerably worse
   - worse
   - slightly worse
   - the same
   - slightly improved
   - improved
   - greatly improved

3. My child's problems that have not been treated during my participation are

   - considerably worse
   - worse
   - slightly worse
   - the same
   - slightly improved
   - improved
   - greatly improved

4. My feelings now about my child's progress are that I am

   - very dissatisfied
   - dissatisfied
   - slightly dissatisfied
   - neutral
   - slightly satisfied
   - satisfied
   - very satisfied

5. To what degree has the treatment program helped with other general personal or family concerns not directly related to your child?

   - hindered much more than helped
   - hindered
   - hindered slightly
   - neither helped nor hindered
   - helped slightly
   - helped
   - helped very much

6. At this time, I believe that the treatment will continue to have a positive outcome.

   - strongly disagree
   - disagree
   - somewhat disagree
   - neutral
   - somewhat agree
   - agree
   - strongly agree

7. I feel the approach to treating my child's behavior problems by using this type of conjoint behavioral consultation is

   - very inappropriate
   - inappropriate
   - slightly inappropriate
   - neutral
   - slightly appropriate
   - appropriate
   - very appropriate

8. Would you recommend conjoint behavioral consultation to a friend or a relative?

- strongly recommended
- recommended
- slightly recommended
- neutral
- slightly not recommended
- not recommended
- strongly not recommended

9. How confident are you in managing your child's current behavior problems in the home on your own?

- very confident
- confident
- slightly confident
- neutral
- somewhat unconfident
- unconfident
- very unconfident

10. How confident are you in your ability to manage future behavior problems of your child in the home using what you learned from this project?

- very confident
- confident
- slightly confident
- neutral
- somewhat unconfident
- unconfident
- very unconfident

11. My overall feeling about the treatment program for my child and family is

- very negative
- negative
- slightly negative
- neutral
- slightly positive
- positive
- very positive

Parent Benefits

For each of the following statements, circle the number which most accurately reflects the benefits you have received as a result of working with the consultant.

0 = Don't Know or Not Applicable	4 = Neutral
1 = Strongly Disagree	5 = Agree
2 = Somewhat Disagree	6 = Somewhat Agree
3 = Disagree	7 = Strongly Agree

1. I am able to see the problem situation in greater depth.

   0 1 2 3 4 5 6 7

2. I am able to see other ways of dealing with a problem that I hadn't thought of before.

   0 1 2 3 4 5 6 7

3. I find myself trying out some of my own ideas.

   0 1 2 3 4 5 6 7

4. I feel encouraged to make my own decisions regarding the management of my child's problems.

   0 1 2 3 4 5 6 7

5. I am able to interact more effectively with my child.

   0 1 2 3 4 5 6 7

6. Did you implement any of the strategies you learned during consultation?

   _____No _____Yes (Specify which ones: _____

   _____

   (a) If yes, how successful were they?

   Unsuccessful 1 2 3 4 5 6 7 Successful

   (b) If no, why not? _____

   _____

7. How confident are you in your ability to solve similar problems of your child's in the future?

   Not at all 1 2 3 4 5 6 7 Very Confident

PARENT LA CONSULTA REPARE EL CUESTIONARIO

Gracias para su participación en esta consulta proyecte. Su cooperación grandemente ha sido apreciada. El cuestionario lo siguiente es la parte de evaluación del proyecto. La información consiguió nos ayudaré a a evaluar el proyecto así pues es importante usted respondía el posible honestamente.

Por favor circunde la respuesta que exprese sus sensaciones bien.

1. La dificultad mayor que me indujo originalmente buscar ayuda para mi niño es presentemente

   - Considerablemente peor
   - Malmente
   - Levemente peor
   - La lo mismo
   - Levemente mejoré
   - Mejore
   - Grandemente mejoré

2. Las dificultades que de han sido treated durante mi participación en el proyecto mi niño son ahora

   - Considerablemente peor
   - Malmente
   - Levemente peor
   - La lo mismo
   - Levemente mejoré
   - Mejore
   - Grandemente mejoré

3. Mi niño s Las dificultades que no han sido treated durante mi participación son

   - Considerablemente peor
   - Malmente
   - Levemente peor
   - La lo mismo
   - Levemente mejoré
   - Mejore
   - Grandemente mejoré

4. Mis sensaciones ahora sobre mi niño el progreso son eso yo soy

   - Muy disatisfacer
   - Disatisfaga
   - Levemente disatisfice
   - Neutral
   - Levemente satisfecho
   - Satisfaga
   - Muy satisfecho

5. ¿A qué grado el tratamiento programas ha ayudado o la familia otra, general y personal interesa no directamente relacioné con a su niño?

   - Yo dificulté mucho más que ayudé
   - Dificulte
   - Levemente dificulté
   - Ninguno ayudó ni dificulté
   - Levemente ayudé
   - Ayude
   - Mucho ayudé

6. Creo en este momento que el tratamiento continuara teniendo un desenlace positivo.

   - Diferencíese fuertemente
   - Diferenciar
   - Algo diferencíese
   - Neutral
   - Algo acuerde
   - Acuerde
   - Acuerde fuertemente

7. Siento el acercamiento al treating mi niño s Es al las dificultades están utilizando este tipo de conjoint behavioral consulta

   - Muy inapropiado
   - Inapropiado
   - Levemente inapropiado
   - Neutral
   - Levemente apropiado
   - Apropíese
   - Muy apropiado

8. ¿Usted recomendaría conjoint behavioral la consulta un amigo o un familiar?

- Fuertemente recomendé	- Neutral	- Levemente indicado
- Recomiende		- No recomiende
- Levemente indicado recomendé		- Fuertemente no

9. Cómo confiado esté ustedes director el comportamiento actual de su niño ¿Dificultades el hogar por su cuenta?

- Muy confiado	- Neutral	- Algo unconfident
- Confiar		- Unconfident
- Levemente confiado		- Muy unconfident

10. ¿Cómo confiado usted está en su habilidad para conseguir las dificultades de comportamientos futuro de su niño en el hogar qué utilizaba usted aprendió de este proyecto?

- Muy confiado	- Neutral	- Algo unconfident
- Confiar		- Unconfident
- Levemente confiado		- Muyunconfident

11. Sentir que mi global programa a mi niño y a la familia el tratamiento es

- Muy negativo	- Neutral	- Levemente positivo
- Negativa		- Positivo
- Levemente negativo		- Muy positivo

El Parent Beneficia

Cada uno de las declaraciones lo siguiente reflecta circundo el número porque con precisión los beneficios usted ha recibido trabajando con el consultor.

0= No haga Sepa o no Aplicable	4= Neutral
1= Diferencíese fuertemente	5= Acuerda
2= se algo Diferencia	6= algo Acuerda
3= se Diferencia	7= Acuerda fuertemente

1. Puedo ver la situación del problema en la más gran profundidad.

   0 1 2 3 4 5 6 7

2. Puedo ver los otros caminar repartíamos con un problema yo hadn t pensé de.

   0 1 2 3 4 5 6 7

3. Encuentro probando algunas de las ideas mi propio.

   0 1 2 3 4 5 6 7

4. Sienta animé a mi propio la decisión haga el gerencia de mi niño dificultades.

   0 1 2 3 4 5 6 7

5. Yo mi niño puedo interact vigentemente.

   0 1 2 3 4 5 6 7

6. ¿Usted implementó cualquiera de las estrategias que usted aprendió durante la consulta?

   ____Ninguno ____Sí, (Especifique cuáles un: _____

   _____

   a. ¿Cómo sí, exitoso estuvimos ellos?

      Fracasado 1 2 3 4 5 6 7 Exitoso

   b. ¿Si no por qué no? _____

      _____

7. ¿Cómo confiado usted está en su habilidad para solucionar las dificultades similares de su niño fue en el futuro?

   No con todo 1 2 3 4 5 6 7 muy Confiado

TEACHER CONSULTATION SERVICES QUESTIONNAIRE

Thank you for your participation in this consultation project. Your cooperation has been greatly appreciated. The following questionnaire is part of an evaluation of the project. The information obtained will help us evaluate the project; therefore, it is important that you respond as honestly as possible.

Please circle the response that best expresses your feelings.

1. The major problem that originally prompted me to refer the child is presently

   - considerably worse
   - worse
   - slightly worse
   - the same
   - slightly improved
   - improved
   - greatly improved

2. The child's problems that have been treated during my participation in the project are now

   - considerably worse
   - worse
   - slightly worse
   - the same
   - slightly improved
   - improved
   - greatly improved

3. The child's problems that have not been treated during my participation are

   - considerably worse
   - worse
   - slightly worse
   - the same
   - slightly improved
   - improved
   - greatly improved

4. My feelings now about the child's progress are that I am

   - very dissatisfied
   - dissatisfied
   - slightly dissatisfied
   - neutral
   - slightly satisfied
   - satisfied
   - very satisfied

5. To what degree has the treatment program helped with other general classroom concerns not directly related to the child?

   - hindered much more than helped
   - hindered
   - hindered slightly
   - neither helped nor hindered
   - helped slightly
   - helped
   - helped very much

6. I feel the approach to treating the child's behavior problems in the school by using this type of program is

   - very inappropriate
   - inappropriate
   - slightly inappropriate
   - neutral
   - slightly appropriate
   - appropriate
   - very appropriate

7. Would you recommend conjoint behavioral consultation to a colleague?

   - strongly recommended
   - recommended
   - slightly recommended
   - neutral
   - slightly not recommended
   - not recommended
   - strongly not recommended

8. How confident are you in managing current behavior problems in the classroom on your own?

- very confident
- confident
- slightly confident
- neutral
- somewhat unconfident
- unconfident
- very unconfident

9. How confident are you in your ability to manage future behavior problems in the classroom using what you learned from this project?

- very confident
- confident
- slightly confident
- neutral
- somewhat unconfident
- unconfident
- very unconfident

10. My overall feeling about the treatment program for the child is

- very negative
- negative
- slightly negative
- neutral
- slightly positive
- positive
- very positive

TEACHER BENEFITS

For each of the following statements, circle the number which most accurately reflects the benefits you have received as a result of working with the consultant.

---

0 = Don't Know or Not Applicable	4 = Neutral
1 = Strongly Disagree	5 = Agree
2 = Somewhat Disagree	6 = Somewhat Agree
3 = Disagree	7 = Strongly Agree

---

1. I am able to see complexities of the problem situation in greater depth and breadth.

   0 1 2 3 4 5 6 7

2. I am able to see alternative ways of dealing with a problem that I hadn't thought of before.

   0 1 2 3 4 5 6 7

3. I find myself trying out some of my own ideas.

   0 1 2 3 4 5 6 7

4. I feel encouraged to make my own decisions regarding the management of the child's problems.

   0 1 2 3 4 5 6 7

5. I am able to interact more effectively with the child.

   0 1 2 3 4 5 6 7

6. Did you implement any of the strategies you learned during consultation?

   _____No _____Yes (Specify which ones: _____

   _____

   (a) If yes, how successful were they?

   Unsuccessful 1 2 3 4 5 6 7 Successful

   (b) If no, why not? _____

   _____

7. How confident are you in your ability to solve similar problems in the future?

   Not at all 1 2 3 4 5 6 7 Very Confident

Appendix G

Perceptions of CBC Interviews – Consultant, Parent, Teacher

Perceptions of CBC (Consultant)

1. Describe how you followed the CBC process for the
   a. CPII
   b. CPAI
   c. CTEI
2. What did you find most challenging about using CBC with this population of parents and teachers?
   a. data gathering
   b. scheduling appointments
   c. language diversity
   d. tape recorders
   e. other
3. What advantage(s) do you consider CBC to provide when working with this population of parents and teachers?
4. What would you change about the CBC process if you were to do this again?
5. How did you experience language diversity during interactions associated with your CBC consultation cases?
6. Describe you experiences using an interpreter during the CBC consultation sessions?
7. Did you find the written material helpful? If so, in what way(s)?
8. How would you change the written material if you were to do this consultation again?
9. Overall, what did you find most challenging about this consultation experience?
10. Overall, what do you consider most successful about this consultation experience?
11. Will you use CBC again? If so, what changes would you make?
12. If you were to do consultation again with parents and teachers of Hispanic children, what would be helpful or would you do differently?

Perceptions of CBC (Parent)

1. What did you gain from participating in the consultation?
2. How did this experience change your opinion about getting help regarding _(child's name)_ from school?
3. How do you think this consultation experience will affect your participation in _(child's name)_'s school next year?
4. What did you like most about the consultation meetings and activities?
5. What did you like least about the consultation meetings and activities?
6. How would you change the consultation meetings and activities?
7. How did language differences affect your participation in the consultation meetings and activities?
8. How did you feel during the consultation meetings when _(child's name)_ was being discussed and decisions were made?
9. How did you contribute to the discussion and decision making during the consultation meetings?
10. How did _(child's name)_'s teacher contribute to the discussion and decision making during the consultation meetings?
11. How did the consultant contribute to the discussion and decision making during the consultation meetings?
12. What would be helpful for you and _(child's name)_ to benefit more from your interactions with _(child's name)_'s teachers in the future.
13. If we were to do this with other parents, how could we make it better or easier for parents?
14. What other comments would you like to make?

Perceptions of CBC (Teacher)

1. What did you gain from participating in the consultation?
2. What did you learn during this consultation experience about working with the parents of Hispanic children?
3. What will you do differently next year when interacting with parents of Hispanic children in order to promote increased school success for their children?
4. What did you like most about the consultation meetings and activities?
5. What did you like least about the consultation meetings and activities?
6. How would you change the consultation meetings and activities?
7. How did language differences affect your participation in the consultation meetings and activities?
8. How did you feel during the consultation meetings when _(child's name)_ was being discussed and decisions were made?
9. How did you contribute to the discussion and decision making during the consultation meetings?
10. How did _(child's name)_'s parent(s) contribute to the discussion and decision making during the consultation meetings?
11. How did the consultant contribute to the discussion and decision making during the consultation meetings?
12. What would be helpful to increase the effectiveness of your interactions with Hispanic families in the future?
13. If we were to do this again, how could we make it better or easier for parents and teachers?
14. What other comments would you like to make?

Appendix H

Parental Consent for Screening Participation

We are interested in helping parents and teachers of young children with Hispanic heritage who demonstrate challenging behaviors such as aggression, noncompliance, withdrawal, limited social skills, or temper tantrums. Parents and teachers may benefit from our consultation program aimed at improving their ability to work together in understanding, altering, and evaluating behavior change methods with their children and students.

This project is being conducted by Lynn Cagle, a doctoral graduate student in the School Psychology Program at Oklahoma State University. Dr. Judy Oehler-Stinnett, a licensed school psychologist and associate professor at Oklahoma State University, will supervise Ms. Cagle. The research has received university approval. Your participation is voluntary and you and your child may withdraw from the project at any time. Your decision will not impact you in any way.

At this time, we are interested in identifying children who may benefit from this project. To do this, we are asking you to take 15 minutes to complete the parent version of the Social Skills Rating System. By signing below, you are agreeing to complete the Social Skills Rating System which will determine if your child can participate in the consultation program, and you will receive a $5.00 credit that can be used towards the purchase of educational materials. All of the information that you give will remain confidential. If you sign below, your child's teacher will also complete the teacher version of the Social Skills Rating System.

If your child qualifies for this project, an advanced graduate student in school psychology will serve as a consultant to you and your child's teacher. This project will last for 8 weeks. During this time, the consultant will hold three meetings with you and your child's teacher. Also, they, or another observer, will observe your child's behavior in your home and at school. In summary, the consultant will meet with you and your child's teacher to discuss specific difficulties your child is having at school and/or home, suggest ways to help improve your child's behavior, and study the effects of such suggestions.

If your child does not qualify for the project, Ms. Cagle will inform you of alternative resources available within the community if you have behavior concerns about your child.

"I, _____, agree to participate in this research project. As the parent or guardian, I also agree for my child to participate in this project. My rights and responsibilities have been explained to me in words that I can understand.

If I have questions, I may contact Lynn Cagle at 918-272-8812 or through my child's teacher. I may also contact Sharon Bacher, IRB Executive Secretary, 203 Whitehurst, Oklahoma State University, Stillwater, OK 74078; telephone number: (405) 744-6501.

I have read and/or had read to me and fully understand this consent form. I sign this form freely and voluntarily. A copy has been given to me."

Child's Name: _____ **Birthday:** _____

Parent's Signature: _____ **Date:** _____

Parent's Signature: _____ **Date:** _____

El CONSENTIMIENTO de PARENTAL PARA la SELECCION la PARTICIPACION

Estamos interesado en padres de porción y maestros de niños jóvenes con la herencia de Hispanic que demuestra las conductas desafiantes tal como agresión, el incumplimiento, la retirada, las habilidades, o tantrums de genio sociales limitadas. Los padres y los maestros pueden beneficiar de nuestro programa de la consulta apuntó a mejorar su habilidad al trabajo junto en la comprensión, en alterning, y en los métodos del cambio de la conducta que evalúan con su chidlren y estudiantes.

Este proyecto es conducido por Lynn Cagle, un estudiante de granduate de doctoral en el Programa de la Psicología de Escuela en la Universidad del Estado de Oklahoma. Dr. Judy Oehler Stinnett, un psicólogo licenciado de escuela y profesor asociado en la Universidad del Estado de Oklahoma, supervisarán la Sra. Cagle. La investigación ha recibido la aprobación de la universidad. Su participación es voluntaria y usted y su niño pueden retirar del proyecto en cualquier vez. Su decisión no lo impresionará en ninguna manera.

En este tiempo, nosotros estamos interesado a identificar a niños que pueden beneficiar de este proyecto. A hace esto, nosotros lo preguntamos a lleva 15 minutos a completa la versión de padre del Sistema Social de la Calificación de Habilidades. Firmando abajo, usted concuerda a completa el Sistema Social de la Calificación de Habilidades que determinará si su niño toma parte en el programa de la consulta, y usted recibirá un crédito de $5.00 que se puede usar hacia la compra de materias educativas. Toda la información que usted da permanecerá confidencial. Si usted firma abajo, su maestro de niño completará también la versión de maestro del Sistema Social de la Calificación de Habilidades.

Si su niño califica para este proyecto, un estudiante graduado avanzado en la psicología de escuela servirá como un especialista a usted y a su maestro de niño. Este proyecto durará por 8 semanas. Durante este tiempo, el especialista tendrá tres reuniones con usted y con su maestro de niño. También, ellos u otro observador, observará su conducta de niño en su hogar y en escuela. En el resumen, el especialista reunirá con usted y con su maestro de niño a discute dificultades específicas que su niño tiene en escuela y/o hogar, sugieren las maneras a la ayuda mejora su conducta de niño, y estudia los efectos de tales sugerencias.

Si su niño no califica para el proyecto, la Sra. Cagle lo informará de recursos alternativos disponibles dentro de la comunidad si usted tiene la conducta concierne acerca de su niño.

"Yo, _____, concuerda a toma parte en este proyecto de investigación. Cuando el padre o el guardián, yo concuerdo también para mi niño a toma parte en este proyecto. Mis derechos y responsabilidades han sido explicados a mí en palabras que puedo entender.

Si tengo las preguntas, yo puedo avisar Lynn Cagle en 918-272-8812 o por mi maestro de niño. Puedo avisar también Sharon Bacher, IRB Secretario Ejecutivo, 203 Whitehurst, la Universidad del Estado de Oklahoma, Stillwater, OK 74078; el número de teléfono: (405) 744-6501.

He leído y/o había leído a mí y entiendo completamente esta forma del consentimiento. Firmo esta forma libremente y voluntariamente. Una copia ha sido dada a mí."

El Nombre del niño: _____ los Cumpleaños: _____

Firma de Padre: _____ la Fecha: _____

Firma de Padre: _____ la Fecha: _____

Appendix I

Informed Parent Consent for Project Participation

Lynn Cagle, a doctoral graduate student in the School Psychology program at Oklahoma State University, is studying the use of behavior consultation with parents and teachers of Hispanic children. This is being done as part of a project entitled "Implementing conjoint behavioral consultation with Hispanic parents: A study of effectiveness, integrity, and acceptability" and is being used in Ms. Cagle's dissertation research. Dr. Judy Oehler-Stinnett, a licensed school psychologist and associate professor at Oklahoma State University, will supervise Ms. Cagle. The research has received university approval. You were suggested as a potential participant for this project due to previous responses by you and/or your child's teacher on the Social Skills Rating System. Here are some answers to questions parents often ask about this research study? By initialing your name after each section, you are indicating that you understand what was stated. Please ask that information be explained in a different way if you do not understand what is stated. Also, if you have any more questions, please ask them.

What is the purpose of this study?

Conjoint Behavioral Consultation is a method of dealing with behavior problems that includes both parents and teachers working together in a cooperative way to improve a child's behavior. The purpose of this study is to answer three questions related to the use of Conjoint Behavioral Consultation by the parents and teachers of Hispanic children. (1) How effective is Conjoint Behavioral Consultation at improving a child's behavior? (2) How easy is to carry out the behavior interventions agreed on by parents and teachers during the Conjoint Behavioral Consultation meetings? (3) How acceptable is it to the parents and teachers of Hispanic children? The answers to these questions will provide information to help determine better ways of addressing the unique cultural characteristics and needs of children with Hispanic heritage while encouraging positive interaction between their families and teachers.

I understand the purpose of this study. (Parent Initials) _____

What will I have to do to participate in this project?

First, you will be asked to complete the Behavior Assessment System for Children -Parent Rating Scale and Structured Developmental History that will take about 60 minutes. These questionnaires will provide more complete information about your child and his/her behavior. Three interview meetings including you, your child's teacher, and the consultant will be held. A Spanish interpreter will be available at all meetings. The first meeting will be held during the first week of the project, the second meeting will be during the second or third week, and the third meeting will be at the end of the eighth week. The meetings will last between 30 and 60 minutes, and will be audio taped for accuracy. You will also be asked to allow the consultant, or other observer, to come into your home and observe your child's behavior during the 8-week project. In addition to these meetings, you may request that your consultant visit at other times to help you practice your newly learned problem-solving skills.

During the study, you will be asked to complete several ratings of your child's behavior. In addition, you will be asked to observe and record your child's behavior every day. Your consultant, or other observer, will also complete brief observations (15 minutes) of your child's behavior in your home (3 times during the first two weeks and once each week for the remaining 6 weeks). In total, the procedures involved in the study typically take between 15 to 20 hours over an 8-week period. This time is necessary so the consultant can get to know you and your child.

I understand what I must do to participate in this study. (Parent Initials) _____

How long will this research study last?

Your participation in this study will last a total of 8 weeks.

I understand that I will be a part of this research study for 8 weeks. (Parent Initials) _____

Are there any benefits to me for participating in this study?

You will receive a $10.00 credit toward the purchase of educational materials from an educational materials catalog provided by the consultant at the last consultation meeting when you complete the study. Other benefits that have been reported by parents who participated in behavioral consultation include the following: (1) learning a new way of solving problems; (2) experiencing fewer problems between parent and child; (3) receiving individual attention and ideas that meet my special needs; and (4) understanding my child's needs better.

I understand that I will receive a $10.00 credit toward the purchase of educational materials and other possible benefits by my participation and completion of the study. (Parent Initials) _____

What are the possible risks or discomforts of the study?

We do not anticipate any risks or discomforts to you or your child resulting from your participation in this study.

I understand that no risks or discomforts for me or my child are expected because of our participation in this study. (Parent Initials) _____

How is my child's teacher involved in this project?

Your child's teacher will complete additional behavior ratings that will provide your consultant with a more complete picture of your child and his/her behavior in the school and classroom, and will participate with you and the consultant in the three interview meetings. The consultant, or another observer, will also observe your child's behavior in the classroom (3 times during the first two weeks and once each week for the

remaining 6 weeks). The teacher may also request that the consultant visit the classroom at other times to help practice their newly learned problem-solving skills.

I understand how my child's teacher will be participate in this project. (Parent Initials) _____

What will happen at the end of the study?

At the end of the study, you will be provided a written summary of the work you and your child's teacher have completed. With your permission at that time, your child's teacher will also receive a copy of this report.

Research results reported without individually identifiable information will be provided to the agency funding this research in compliance with grant requirements, the Head Start Program, made available for public review as agreed in the funding agency grant, as well as maintained by principal and student investigators.

I understand that I will receive a written summary of what happened during my participation in this study. I also understand that others will receive a summary of the project results, but that it will not contain my name or my child's name unless I give my permission. (Parent Initials) _____

Who will see my responses on these questionnaires?

Only the consultant and director of this project will see your actual responses on the questionnaires. The project director will keep all completed questionnaires in a locked file. Reports of study results will include no information that is identifiable to you or your child without you first approving it. All completed questionnaires and other raw data will be destroyed at the completion of the project.

I understand that only my consultant and the project director will be allowed to see my responses on the questionnaires and that they will be destroyed at the end of the project. Reports of study results will not personally identify me or my child unless I first give my consent. (Parent Initials) _____

What other treatments exist for parents who have concerns about their children's behavior?

In addition to services provided through the Tulsa Head Start, other community services exist in the Tulsa area. You may wish to speak to your child's doctor about the concerns you are having. In addition, your consultant can give you the titles of a number of books that have been written for parents who are concerned about their children's behavior.

I understand that information about other services will be provided to me if I request it. (Parent Initials) _____

What if I wish to withdraw or not participate in the study?

You may withdraw from this project at anytime or choose not to participate. The $10 credit towards the purchase of educational materials will be awarded only if you complete the 8-week project. Otherwise, your decision will not impact you in any way.

I understand that I can stop participating in this program at anytime or choose to not participate without fear of any problems. *(Parent Initials)* _____

"I, _____, agree to participate in this research project. As the parent or guardian, I also agree for my child to participate in this project. My rights and responsibilities have been explained to me in words that I can understand.

If I have questions, I may contact Lynn Cagle at 918-272-8812 or through my child's teacher. I may also contact Sharon Bacher, IRB Executive Secretary, 203 Whitehurst, Oklahoma State University, Stillwater, OK 74078; telephone number: (405) 744-6501.

I have read and/or had read to me and fully understand this consent form. I sign this form freely and voluntarily. A copy has been given to me."

Child's Name: _____ Birthday: _____

Signature of Parent: _____ Date: _____

Signature of Parent: _____ Date: _____

El CONSENTIMIENTO INFORMADO del PADRE PARA la PARTICIPACION de PROYECTO

Lynn Cagle, un doctoral estudiante graduado en el programa de la Psicología de Escuela en la Universidad del Estado de Oklahoma, estudia el uso de la consulta de la conducta con padres y maestros de niños de Hispanic. Esto se hace como parte de un proyecto permitido "la consulta de behavioral de conjoint que Aplica con padres de Hispanic: UN estudio de la eficacia, de la integridad, y de la aceptabilidad" y es usado en la Sra. investigación de disertación de Cagle. Dr. Judy Oehler Stinnett, un psicólogo licenciado de escuela y profesor asociado en la Universidad del Estado de Oklahoma, supervisarán la Sra. Cagle. La investigación ha recibido la aprobación de la universidad. Usted fue sugerido como un participante potencial para este proyecto debido a respuestas previas por usted y/o por su maestro de niño en el Sistema Social de la Calificación de Habilidades. Aquí están algunos contestan a padres de preguntas a menudo pregunta por este estudio de investigación. Por initialing su nombre después que cada sección, usted indica que usted entiende lo que se expresó. Pida por favor que esa información sea explicada en una manera diferente si usted no entiende lo que se expresa. También, si usted tiene pregunta más, por favor los pregunta.

¿Qué es el propósito de este estudio?

La Consulta de la Conducta de Conjoint es un método de tratar con los problemas de la conducta que incluye tanto los padres como los maestros que trabajan junto en una manera cooperativa a mejora una conducta de niño. El propósito de este estudio deberá contestar tres preguntas relacionadas al uso de la Consulta de Conjoint Behavioral por los padres y maestros de niños de Hispanic. ¿(1) la Consulta cuán efectiva de Conjoint Behavioral en mejora una conducta de niño? ¿(2) cuán fácil es a se lleva a cabo las intervenciones de la conducta convinieron en por padres y maestros durante las reuniones de la Consulta de Conjoint Behavioral? ¿(3) cuán aceptable es a los padres y maestros de niños de Hispanic? Las respuestas a estas preguntas proporcionarán información a la ayuda determina mejores maneras de dirigir las características y las necesidades culturales extraordinarias de niños con la herencia de Hispanic mientras la interacción positiva alentadora entre sus familias y maestros.

Entiendo el propósito de este estudio. (Iniciales de padre) _____

¿Qué tomo parte en yo este proyecto?

Primero, usted será preguntado a completa el Sistema de la Evaluación de la Conducta para Niños - la Escala de la Calificación de Padre e Historia Estructurada de Developmental que tomarán acerca de 60 minutos. Estos cuestionarios proporcionarán información más completa acerca de su niño y su conducta. Tres reuniones de la entrevista inclusive usted, su maestro de niño, y el especialista serán tenidos. Un intérprete español estará disponible en todas reuniones. La primera reunión se tendrá durante la primera semana del proyecto, el segundo que reúne estará durante el segundo o tercera semana, y el tercero que reúne estará a fines de la octava semana. Las reuniones durarán entre 30 y 60 minutos, y serán la audiofrecuencia grabada para la certeza. Usted será preguntado también a permite al especialista, u otro observador, a viene en su hogar

y observa su conducta de niño durante el proyecto de 8 semanas. Además de estas reuniones, usted puede solicitar que su visita de especialista en otros tiempo a lo ayuda a practicar sus habilidades resolviendo del problema nuevamente aprendidas.

Durante el estudio, usted será preguntado a completa varias calificaciones de su conducta de niño. Además, usted será preguntado a observa y registra su todos los días de la conducta de niño. Su especialista, u otro observador, completará también las observaciones breves (15 minutos) de su conducta de niño en su vez de (3 de hogar durante las primeras dos semanas y una vez cada semana para las restantes 6 semanas). En el suma, los procedimientos involucrados en el estudio toman típicamente entre 15 a 20 horas sobre un período de 8 semanas. Este tiempo es necesario tan el especialista puede llegar a lo sabe y su niño.

Entiendo lo que debo hacer a toma parte en este estudio. (Iniciales de padre) _____

¿Cuán largo esto investigará el estudio dura?

Su participación en este estudio durará un suma de 8 semanas.

Entiendo que seré una parte de este estudio de investigación por 8 semanas. (Iniciales de padre) _____

¿Hay cualquiera beneficia a mí para tomar parte en este estudio?

Usted recibirá un crédito de $10.00 hacia la compra de materias educativas de una materias educativas cataloga proporcionado por el especialista en la última consulta que reúne cuando usted completa el estudio. Otros beneficios que han sido informados por padres que tomó parte en la consulta de behavioral incluye el aprendizaje de de lo siguiente: (1) una manera nueva de resolver los problemas; (2) experimentar menos problemas entre padre y niño; (3) la atención y las ideas individuales recipientes que reúnen mis necesidades especiales; y (4) la comprensión de mis necesidades de niño mejor.

Entiendo que recibiré un crédito de $10.00 hacia la compra de materias educativas y otros beneficios posibles por mi participación y la terminación de este estudio. (Iniciales de padre) _____

¿Qué es los riesgos o las molestias posibles del estudio?

Nosotros no anticipamos cualquiera se arriesga o molesta a usted o a su niño que resulta de su participación en este estudio.

Entiendo que ningún riskks ni las molestias para mí ni mi niño son esperados a causa de nuestra participación en este estudio. (Iniciales de padre) _____

¿Cómo mi maestro de niño está involucrado en este proyecto?

Su maestro del niño completará las calificaciones adicionales de la conducta que proporcionarán a su especialista con un más completa el retrato de su niño y su conducta en la escuela y el aula, y participará con usted y con el especialista en las tres reuniones de entrevista. El especialista, u otro observador, observará también su conducta de niño en la vez de (3 de aula durante las primeras dos semanas y una vez cada semana para las restantes 6 semanas). El maestro puede solicitar también que el especialista visita el aula en otros tiempo a la práctica de la ayuda su ha aprendido nuevamente las habilidades resolviendo del problema.

Entiendo cómo que mi maestro de niño toma parte en este proyecto. (Iniciales de padre) _____

¿Qué acontecerá a fines del estudio?

A fines del estudio, usted será proporcionado un resumen escrito del trabajo usted y su maestro de niño han completado. Con su permiso en aquel momento, su maestro de niño recibirá también una copia de este informe.

Investigación resulta informado sin información individualmente identificable será proporcionado a la agencia que financia esta investigación de acuerdo con requisitos de beca, el Programa de la ventaja, hecho disponible para la revisión pública como concordado en la beca de la agencia que financia, así como también mantenido por investigadores de director y estudiante.

Entiendo que recibiré un resumen escrito de lo que aconteció durante mi participación en este estudio. Entiendo también que los otros recibirán un resumen de los resultados de proyecto, pero que no contendrá mi nombre ni mi nombre de niño a menos que daré mi permiso. (Iniciales de padre) _____

¿Quién verá mis respuestas en estos cuestionarios?

Todas sus respuestas serán confidenciales. Todas materias del estudio se mantendrán en un archivo cerrado. Ninguna información que es identificable a usted ni su niño será liberado a nadie sin usted primero aprobarlo. Todos datos crudos se destruirán en la terminación del proyecto.

Entiendo que nadie será permitido a ve mis respuestas en estos cuestionarios a menos que dé mi permiso específico, y que ellos serán destruidos a fines del proyecto. (Iniciales de padre) _____

¿Qué otros tratamientos existen para padres que tienen concierne acerca de su conducta de niños?

Además de servicios proporcionados por la ventaja de Tulsa, otros servicios de la comunidad existen en el área de Tulsa. Usted puede desear a dirige la palabra a su doctor

de niño acerca del lo concierne tiene. Además, su especialista le puede dar los títulos de varios libros que se han escrito para padres que se preocupa por su conducta de niños.

Entiendo que esa información acerca de otros servicios será proporcionada a mí si yo lo solicito.
(Iniciales de padre) _____

¿Qué si deseo a retira o no toma parte en el estudio?

Usted puede retirar de este proyecto en en cualquier momento o escoger no a participa. El crédito de $10.00 hacia la compra de materias educativas se concederá sólo si usted completa el proyecto de 8 semanas. De otro modo, su decisión no lo impresionará en ninguna manera.

Entiendo que puedo parar tomando parte en este programa en en cualquier momento o escoge a no participa sin el temor de ningún problema.
(Iniciales de padre) _____

"Yo, _____, concuerda a toma parte en este proyecto de investigación. Cuando el padre o el guardián, yo concuerdo también para mi niño a toma parte en este proyecto. Mis derechos y responsabilidades han sido explicados a mí en palabras que puedo entender.

Si tengo las preguntas, yo puedo avisar Lynn Cagle en 918-272-8812 o por mi maestro de niño. Puedo avisar también Sharon Bacher, IRB Secretario Ejecutivo, 203 Whitehurst, la Universidad del Estado de Oklahoma, Stillwater, OK 74078; el número de teléfono: (405) 744-6501.

He leído y/o había leído a mí y entiendo completamente esta forma del consentimiento. Firmo esta forma libremente y voluntariamente. Una copia ha sido dada a mí."

El Nombre del niño: _____ los Cumpleaños: _____

Firma de Padre: _____ la Fecha: _____

Firma de Padre: _____ la Fecha: _____

Appendix J

Teacher Consent Form

We are interested in helping parents and teachers of young children with Hispanic heritage who demonstrate challenging behaviors such as aggression, noncompliance, withdrawal, limited social skills, or temper tantrums. Teachers and parents may benefit from our consultation program that is aimed at improving their ability to work together in understanding, altering, and evaluating behavior change methods with their students/children.

Lynn Cagle, a doctoral graduate student in the School Psychology Program at Oklahoma State University, is conducting this university approved research project. Dr. Judy Oehler-Stinnett, a licensed school psychologist and associate professor at Oklahoma State University, will supervise Ms. Cagle. Your participation is voluntary and you may withdraw from the project at any time, without penalty or loss of benefit.

By agreeing to participate, you will first be asked to identify students with Hispanic heritage about whom you have concerns regarding behaviors associated with cooperation, assertion, self-control, responsibility, aggression, hyperactivity, and/or withdrawal. You will, then, contact their parents and ask them to meet with Ms. Cagle and yourself to discuss a way to address your concerns. An interpreter will also be present at all meetings with the parent. At this first meeting, the project will be explained to the parents and they will be asked to consent to the screening of their child for possible participation in the project. Upon consent by parents, you will then be asked to take approximately 15 minutes to complete the teacher version of the Social Skills Rating System. The first ten students who qualify according to the results of the teacher and/or parent Social Skills Rating System will be included in the study. For each qualifying student that you referred, you will, then, complete the Behavior Assessment for Children - Teacher Rating Scale (BASC-TRS) which will require approximately 20 minutes.

During the next 8 weeks, an advanced graduate student in school psychology will serve as a consultant by guiding you and the child's parent(s) through the process of Conjoint Behavioral Consultation. The consultant, accompanied by an interpreter, will conduct three interviews with you and the child's parent(s) during that period of time. In addition, they, or another observer, will observe the child's behavior within your classroom. In summary, the consultant will meet with you and the child's parent(s) to discuss specific difficulties the child is having at school and/or home, suggest ways to help improve the child's behavior, and evaluate the effects of such suggestions and consultation process. Throughout the 8 weeks, you will also be asked to record data pertaining to the child's behavior. At the end of the 8-week period, you will be asked to complete a series of questionnaires pertaining to your opinion of the effectiveness and acceptability of the behavior management process in which you participated.

For each consultation case in which you participate, you will be allocated a $20.00 credit to be used towards the purchase of educational materials. Additionally, you may learn

skills to help you in addressing behavioral concerns you may have about students and identify ways in which to promote increased home-school interaction including families of Hispanic heritage.

All of your responses will be confidential. All raw data will be destroyed at the completion of the project. At the end of the study and with parental permission, you will be provided a written summary of the work you and your student's parent(s) have completed. Research results reported without individually identifiable information will be provided to the Head Start Program, made available for public review in journal publication and conference presentations authored by the investigators, as well as maintained by principal and student investigators.

You may withdraw from this project at anytime or choose not to participate. Your decision will not impact you in any way.

"I, _____, agree to participate in this research project. My rights and responsibilities have been explained to me in words that I can understand.

If questions arise, I may contact Lynn Cagle at (918) 272-8812. I may also contact Sharon Bacher, IRB Executive Secretary, 203 Whitehurst, Oklahoma State University, Stillwater, OK 74078; telephone number: (405) 744-6501.

I have read and fully understand the consent form. I sign this form freely and voluntarily. A copy has been given to me."

Teacher's Signature: _____ Date: _____

Appendix K

Conjoint Problem Identification Interview (CPII)

Child's Name: _____ Age: _____ Date: _____

Parent's Name: _____

Teacher's Name: _____ Grade: _____

School: _____ Consultant: _____

Goals of the CPII:

- Establish a working relationship between parents and teacher and between the consultant and consultees.
- Define the problem(s) in behavioral terms.
- Provide a tentative identification of behavior in terms of antecedent, situation, and consequent conditions across settings.
- Provide a tentative strength of the behavior across settings (e.g., how often or severe).
- Discuss and reach agreement on a goal for behavior change across settings.
- Establish a procedure for collecting baseline data across settings in terms of sampling plan, what is to be recorded, who is to record the data, and how the behavior is to be recorded.

The consultant should question and/or comment on all of the following:

OPENING SALUTATION

GENERAL STATEMENT TO OPEN CONSULTATION

What seems to be the problem? What is it that you are concerned about?

Home:

School:

BEHAVIOR SPECIFICATION

a. Tell me what you mean by... Give me some specific examples of what you mean by... What does the child do?

Home:

School:

b. What are some more examples?
Home:

School:

c. We've discussed several behaviors, such as ... Which of these is most problematic across settings? ***Prioritize one or two behaviors to target across settings.***
Home:

School:

TARGET BEHAVIOR DEFINITION

Let's define exactly what we mean by ... What would be a good definition of ...?

Summarize Target Behavior in Precise, Observable Terms

HISTORY OF PROBLEM

Approximately when did this specific problem begin? How long has this been a problem?

BEHAVIOR SETTING

a. Where does the child display this target behavior? Give me some examples of where this occurs.
Home:

School:

b. What are some more examples of where this specific behavior occurs?
Home:

School:

c. Which of the settings at school is most problematic? Which of the settings at home is most problematic? ***Establish one setting priority at home and one at school.***
Home:

School:

CONDITIONAL/FUNCTIONAL ANALYSIS

Antecedent Conditions and Setting Events

a. What typically happens at home/school before the behavior occurs?
Home:

School:

b. What is a typical morning like before your child goes to school?
Home:

c. What events occur earlier in the day (in other settings or times of the day) that might affect the child's behavior?
Home:

School:

Consequent Conditions

a. What typically happens at home/school after the behavior occurs?
Home:

School:

b. How are school-related behavior problems handled at home?

Environmental/Sequential Conditions

a. What else is typically happening at home/school when the behavior occurs?
Home:

School:

b. What time of day or day of week is the behavior most/least likely to occur?
Home:

School:

c. What activities are most/least likely to produce the behavior?
Home:

School:

d. With whom are the behaviors most/least likely to occur?
Home:

School:

e. How many other people are in the setting when the behavior is most likely to occur?
Home:

School:

f. What are some other particular situations that might "set off" the behavior?
Home:

School:

g. What other events (e.g., medications, medical complications, routines) may affect the behavior?
Home:

School:

BEHAVIOR STRENGTH ACROSS SETTINGS

a. How often does this behavior occur at home/at school? How long does it last?
Home:

School:

Summarize/Validate the Specific Behavior and Its Strength

GOAL OF CONSULTATION

a. What would be an acceptable level of this behavior at home/at school? What would the child have to do to get along OK? **Is there general agreement of our goal across home and school?**

Home:

School:

EXISTING PROCEDURES

a. What are some programs or procedures that are currently operating in the classroom? How are problems currently dealt with when they occur at home/at school?

Home:

School:

CHILD'S STRENGTHS/ASSETS

a. What are some of the things that the child is good at? What are some of the child's strengths?

POSSIBLE REINFORCERS

What are some things (events, activities, etc.) that the child finds reinforcing? What are some things the child likes to do?

Home:

School:

Summarize/Validate Behavior, Strength, Goal, etc.

RATIONALE FOR DATA COLLECTION

It would be very helpful to watch the behavior for a week or so and monitor its occurrence. This will help us key in on some important facts that we may have missed, and also help us document the progress that is made towards our goal.

CROSS-SETTING DATA COLLECTION PROCEDURES

a. What would be a simple way for you to keep track of the behavior at home/at school?

Home:

School:

Summarize/Validate Data Collection Procedures

DATE TO BEGIN DATA COLLECTION

a. When can you begin to collect data at home/at school?

Home:

School:

NEXT APPOINTMENT

a. When can we all get together again to discuss the data and determine where to go from here?

CLOSING SALUTATION

Appendix L

Conjoint Problem Analysis Interview (CPAI)

Child's Name: _____ Age: _____ Date: _____

Parent's Name: _____

Teacher's Name: _____ Grade: _____

School: _____ Consultant: _____

The goals of the CPAI are to:

- Evaluate and obtain agreement on the sufficiency and adequacy of baseline data across settings.
- Conduct a functional analysis of the behavior across settings (i.e., discuss antecedent, consequent, and sequential conditions).
- Identify setting events (events that are functionally related, but temporally or contextually distal to the target behavior), ecological conditions, and other cross-setting variables that may impact the target behavior.

The consultant should question and/or comment on the following:

OPENING SALUTATION

GENERAL STATEMENT REGARDING DATA AND PROBLEM

a. Were you able to keep a record of the behavior?

Home:

School:

BEHAVIOR STRENGTH ACROSS SETTING

a. According to the data, it looks like the behavior occurred ____ at home/at school.
Record data here.

Home:

School:

ANTECEDENT CONDITIONS

a. What did you notice before the problem occurred at home/at school? What things may have led up to its occurrence? What happened before school on these days? ***Refer to baseline data!***

Home:

School:

CONSEQUENT CONDITIONS

a. What typically happened after the occurrence of the behavior at home/at school? What types of things did you notice afterward that may have maintained its occurrence? What happened after school on these days? ***Refer to baseline data!***

Home:

School:

SEQUENTIAL CONDITIONS

a. What else was happening in the classroom/playground/home when the behavior occurred? What time of day or day of week seemed most problematic at home/at school? What patterns did you notice in the child's behavior at home/at school?

Home:

School:

Summarize/Validate Behavior/Strength/Conditions

BEHAVIOR INTERPRETATION

a. Why do you think the child does this? It sounds like the behavior might also be related to …

Home:

School:

CROSS-SETTING PLAN DEVELOPMENT

a. It seems that we need to try something different. What can be done at both home and school to reach our goal? ***A written plan for teacher and parents may be helpful.***

Home:

School:

Summarize/Validate Plan Across Settings

DATA RECORDING PROCEDURES

a. It would be very helpful if we could continue to collect data on the child's behavior. Can we continue the same recording procedure as before?

Home:

School:

NEXT APPOINTMENT

a. When can we all get together again to discuss the data and determine where to go from here?

CLOSING SALUTATION

Appendix M

Conjoint Treatment Evaluation Interview (CTEI)

Child's Name: _____ Age: _____ Date: _____

Parent's Name: _____

Teacher's Name: _____ Grade: _____

School: _____ Consultant: _____

The goals of the CTEI are to:

- Determine whether the goals of consultation have been attained across settings.
- Evaluate the effectiveness of the treatment plan across settings.
- Discuss strategies and tactics regarding the continuation, modification, or termination of the treatment plan.
- Schedule additional interviews if necessary, or terminate consultation.

The consultant should question and/or comment on all of the following:

OPENING SALUTATION

GENERAL PROCEDURES AND OUTCOME

a. How did things go with the plan? ***Record treatment data here.***

Home:

School:

GOAL ATTAINMENT ACROSS SETTINGS

a. Has the goal been met at home/at school?

Home:

School:

If goals have not been attained, discuss:

PLAN MODIFICATIONS

a. How can we modify the procedures so that the plan is more effective at home and school?

Home:

School:

NEXT APPOINTMENT

a. When can we meet again to discuss the effectiveness of our new or modified plan?

If goals <u>have</u> been attained, discuss:

PLAN EFFECTIVENESS ACROSS SETTINGS

a. Do you think that the behavioral program was responsible for the child's change in behavior?

Home:

School:

EXTERNAL VALIDITY OF PLAN

a. Do you think this plan would work with another child with similar difficulties?

Home:

School:

POST-IMPLEMENTATION PLANNING

a. Should we leave the plan in effect for a while longer?

Home:

School:

PROCEDURES FOR GENERALIZATION/MAINTENANCE

a. How can we encourage the child to display these behavior changes in other settings or with other behaviors? What procedures should we use to make sure that the behavior change continues over time?

Home:

School:

FOLLOW-UP ASSESSMENT PROCEDURES

a. How can we monitor the child's progress to ensure that these positive changes continue?

Home:

School:

NEED FOR FUTURE INTERVIEWS

a. Would you like to meet again to check the child's progress?

Home:

School:

TERMINATION OF CONSULTATION (if appropriate)

CLOSING SALUTATION

Appendix N

Conjoint Behavioral Consultation Objectives Checklist

CBC Stage	Consultant			
Conjoint Problem Identification Interview (CPII)	1	2	3	4
1. Opening Salutation				
2. General Statement to Open Consultation				
3. Behavior Specification				
4. Target Behavior Definition				
5. History of Problem				
6. Conditional/Functional Analysis				
a. Antecedent Conditions and Setting Events				
b. Consequent Conditions				
c. Environmental/Sequential Conditions				
7. Behavior Strength Across Settings				
8. Goal of Consultation				
9. Existing Procedures				
10. Child's Strengths/Assets				
11. Possible Reinforcers				
12. Rationale for Data Collection				
13. Cross-Setting Data Collections Procedures				
14. Date to Begin Data Collection				
15. Next Appointment				
16. Closing Salutation				
Conjoint Problem Analysis Interview (CPAI)				
1. Opening Salutation				
2. General Statement Regarding Data and Problem				
3. Behavior Strength Across Settings				
4. Antecedent Conditions				
5. Consequent Conditions				
6. Sequential Conditions				
7. Behavior Interpretation				
8. Cross-Setting Plan Development				
9. Data Recording Procedures				
10. Next Appointment				
11. Closing Salutation				
Conjoint Treatment Evaluation Interview (CTEI)				
1. Opening Salutation				
2. General Procedures				
3. Goal Attainment Across Settings				
4. Plan Modifications				
5. Plan Effectiveness Across Settings				
6. External Validity of Plan				
7. Postimplementation Planning				

8. Procedures for Generalization/Maintenance				
9. Follow-up Assessment Procedures				
10. Need for Future Interviews/Next Appointment				
11. Termination of Consultation				
12. Closing Salutation				
Total				
Percentage				

Conjoint Behavioral Consultation Objectives

Conjoint Problem Identification Interview (CPII)

1. Opening Salutation
2. General Statement to Open Consultation
3. Behavior Specification
4. Target Behavior Definition
5. History of Problem
6. Conditional/Functional Analysis
    a. Antecedent Conditions and Setting Events
    b. Consequent Conditions
    c. Environmental/Sequential Conditions
7. Behavior Strength Across Settings
8. Goal of Consultation
9. Existing Procedures
10. Child's Strengths/Assets
11. Possible Reinforcers
12. Rationale for Data Collection
13. Cross-Setting Data Collection Procedures
14. Date to Begin Data Collection
15. Next Appointment
16. Closing Salutation

Conjoint Problem Analysis Interview (CPAI)

1. Opening Salutation

2. General Statement Regarding Data and Problem
3. Behavior Strength Across Settings
4. Antecedent Conditions
5. Consequent Conditions
6. Sequential Conditions
7. Behavior Interpretation
8. Cross-Setting Plan Development
9. Data Recording Procedures
10. Next Appointment
11. Closing Salutation

Conjoint Treatment Evaluation Interview (CTEI)

1. Opening Salutation
2. General Procedures
3. Goal Attainment Across Settings
4. Plan Modifications
5. Plan Effectiveness Across Settings
6. External Validity of Plan
7. Postimplementation Planning
8. Procedures for Generalization/Maintenance
9. Follow-up Assessment Procedures
10. Need for Future Interviews/Next Appointment
11. Termination of Consultation
12. Closing Salutation

Appendix O

Institutional Review Board Approval

Oklahoma State University
Institutional Review Board

Protocol Expires: 10/18/01

Date : Thursday, October 19, 2000 IRB Application No ED0134

Proposal Title: IMPLEMENTING CONJOINT BEHAVIORAL CONSULTATION WITH HISPANIC PARENT: A STUDY OF EFFECTIVENESS, INTEGRITY, AND ACCEPTABILITY

Principal Investigator(s) :

Lynn Cagle
422 Willard
Stillwater, OK 74078

Judy Oehler-Stinnett
425 Willard
Stillwater, OK 74078

Reviewed and Processed as: Expedited (Spec Pop)

Approval Status Recommended by Reviewer(s) : Approved

Please provide for the IRB a copy of the consent form written in Spanish prior to the beginning of the research activities.

Signature : Carol Olson

Carol Olson, Director of University Research Compliance

Thursday, October 19, 2000
Date

Approvals are valid for one calendar year, after which time a request for continuation must be submitted. Any modifications to the research project approved by the IRB must be submitted for approval with the advisor's signature. The IRB office MUST be notified in writing when a project is complete. Approved projects are subject to monitoring by the IRB. Expedited and exempt projects may be reviewed by the full Institutional Review Board.

VITA 2

Marguerita Lynn Cagle

Candidate for the Degree of

Doctor of Philosophy

Dissertation: CONJOINT BEHAVIORAL CONSULTATION WITH PARENTS AND TEACHERS OF HISPANIC CHILDREN: A STUDY OF ACCEPTABILITY, INTEGRITY, AND EFFECTIVENESS

Major Field: Educational Psychology

Biographical:

Education: Graduated from Hugo High School, Hugo, Oklahoma in May 1968; received Bachelor of Science degree in Sociology from Oklahoma State University, Stillwater, Oklahoma in January 1972; received Master of Science in Sociology from Oklahoma State University, Stillwater, Oklahoma in July 1975; completed psychometrist certification requirements from The University of Tulsa, Tulsa, Oklahoma in July 1981. Completed the requirements for the Doctor of Philosophy degree with a major in Educational Psychology with School Psychology option at Oklahoma State University in August 2002.

Experience: Employed nine years as psychometrist/prescriptive teacher by Oklahoma State Department of Education; seven and one-half years as Director of Assessment by Claremore Public Schools, Claremore, Oklahoma; employed by Oklahoma State University College of Education as a graduate teaching assistant and graduate research assistant, August 1998 to May 2001; psychology internship with the Kansas Psychology Training Consortium at the Bert Nash Community Mental Health Center in Lawrence, Kansas, August 2001 to present.

Licensure/Certification: Standard Oklahoma Teaching Certificate, School Psychologist and Psychometrist/Educational Diagnostician; Kansas Temporary Masters Level Psychologist License

Professional Memberships: American Psychological Association and Division 16 (School Psychology); National Association of School Psychologists; Oklahoma School Psychological Association