

11-1-2008

# Parenting Latino Toddlers and Preschoolers: Clinical and Nonclinical Samples

Marie E. Perez

*Marquette University*, maria.perezoberbruner@marquette.edu

Robert A. Fox

*Marquette University*, robert.fox@marquette.edu

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Marie E. Perez

*Department of Counseling and Educational Psychology  
College of Education  
Marquette University  
Milwaukee, WI*

Robert A. Fox

*Department of Counseling and Educational Psychology  
College of Education  
Marquette University  
Milwaukee, WI*

*Parenting practices contribute significantly to the social-emotional development of young children. There is limited literature that addresses the role of culture in parenting, particularly among Latino families who have very young children with significant behavior problems. The current study compared the parenting practices of 30 low-income Latino mothers whose young children had been referred for mental health services for their behavior problems with a similar group of 30 mothers of children without behavior problems. Results showed that mothers in the clinical sample nurtured their children less often and used more frequent verbal and corporal punishment as discipline than the nonclinical sample. The clinical sample also had a significantly higher incidence of mental health problems in their families. Results also showed the significant toll that raising young children with challenging behaviors takes on their mothers. The implications of these findings for the early identification of these children are discussed.*

Parents and other caregivers play a significant role in the socialization of young children (Collins, Maccoby, Steinberg, Heatherington, & Bornstein, 2000). Different parenting styles and practices (Darling & Steinberg, 1993) have been consistently shown to be associated with differing socialization outcomes for children (Baumrind, 1991), with an authoritative style associated with the most positive long-term outcomes for children and adolescents (Steinberg, Elmen, & Mounts, 1989). There are multiple determinants that contribute to development of different parenting styles and practices, including the unique characteristics of the child and the parent and the social context in which they live (Belsky, 1984). For example, temperament (O'Connor, Deater-Deckard, Fulker, Rutter, & Plomin, 1998) and health status (Carey, Nicholson, & Fox, 2002) are two of many possible child characteristics that influence reciprocal parental responses. Regarding the impact of parent characteristics and social factors on parental behavior, Fox, Platz, and Bentley (1995) reported less favorable parenting practices among mothers who were younger, single, from lower socioeconomic and educational levels, and who had more than one young child living at home.

One important social factor in parenting young children that has not received significant attention in the literature is culture (Bornstein, 1991), particularly among Latino families with very young children (Vega, 1990). Santiago-Rivera, Arredondo, and Gallardo-Cooper (2002) reported that Latino children are expected to acquire *respeto*, or respect for authority, including extended family members who are often involved in child rearing and child care. Values such as solidarity, *familismo*—close identification and attachment to the nuclear and extended family—and friendship are strongly desired features in Latino families (Santiago-Rivera et al., 2002). What has emerged from studies of parenting in the Latino culture is an inconsistent picture, with some researchers describing parents as warm, nurturing, egalitarian, and family oriented (Keefe, 1984) while others describe them as authoritarian, overcontrolling, and strict (Falicov, 1998; Garcia-Preto, 1998). In a study comparing the child-rearing values of low-income Puerto Rican and Caucasian parents of preschool children, Gonzalez-Ramos, Zayas, and Cohen (1998) reported values of loyalty, respect, and obedience among the former and autonomy, assertiveness, and independence among the latter.

A few studies specifically addressed Latino parenting practices with children younger than 5 years of age. Solis-Camara and Fox (1995) compared the parenting practices and developmental expectations of parents from Mexico and the United States matched on educational levels and found no differences between groups on the use of corporal or verbal punishment as a form of discipline, nurturing, or developmental expectations. Solis-Camara and Fox (1996) studied parenting practices among a sample of 221 Mexican mothers and found that younger, unmarried, lower income, and less educated mothers were less nurturing and used stricter forms of discipline than older, married, higher income, and more educated mothers, which was consistent with findings from a large, representative sample of 1,140 mothers in the United States (Fox et al., 1995). In another study (Fox & Solis-Camara, 1997), Mexican and U.S. fathers from lower and higher socioeconomic levels were compared. The results showed that when socioeconomic levels were controlled, there were no differences between the two groups of fathers on their use of discipline and nurturing practices or their developmental expectations. However, lower income fathers from Mexico and the United States both used more corporal and verbal punishment and less nurturing than their higher income counterparts. In one of the few studies that controlled marital status, acculturation, and socioeconomic status (SES) of 38 Hispanic mothers living in the United States with 38 Caucasian mothers, Cardona, Nicholson, and Fox (2000) reported a higher use of verbal and corporal punishment, lower nurturing scores, and similar developmental expectations for the Hispanic mothers compared to Caucasian mothers.

Studies on parenting across cultures have demonstrated, particularly for the Latino culture, that it is important to consider the diverse subcultures represented in this group (Mexican, Puerto Rican, Cubans, Central and South Americans, and Dominicans), the parents' socioeconomic and educational levels, the level of their acculturation in the United States (Taylor, Hurley, & Riley, 1986), and the adequacy of the instruments used to assess their parenting practices (Vega, 1990). While a clear consensus regarding the parenting practices of Latino mothers with very young children has not emerged, the majority of the evidence suggests that there may be more similarities than differences in raising young children across cultures, once important

variables such as parent educational and socioeconomic levels are controlled.

In addition to culture, an important child characteristic for predicting parenting practices is the level of management difficulty young children present to the parent in terms of behavior problems. Behavior problems in very young children are common. As early as 1975, Richman, Stevenson, and Graham identified difficulties with eating, sleeping, toileting, temper, fears, peer interactions, and high activity levels as typical in this younger population. An ongoing issue has been to determine when these developmentally normal behaviors increase sufficiently in frequency or severity to be considered more serious behavior problems that require professional attention (Keenan & Wakschlag, 2000). In her often-cited literature review, Campbell (1995) reported that between 10% and 15% of young children have mild to moderate behavior problems. These early behavior problems may persist well into the child's formal school years (Campbell, 1997), increase in severity (Hofstra, Van Der Ende, & Verhulst, 2002), and adversely affect the children's relationships with caregivers (Greene & Doyle, 1999), development of social skills (Mendez, Fantuzzo, & Cicchetti, 2002), and communication ability (Sigafos, 2000). Young children's behavior problems also have been associated with higher levels of parental stress (Eyberg, Boggs, & Rodriguez, 1992) and are likely to produce less than favorable parenting practices. As evidence, Brenner and Fox (1998) found that parental use of verbal and corporal punishment discipline practices uniquely predicted problem behaviors in young children above and beyond parent characteristics (i.e., marital status, SES, age, and education level). Parents confronted with the reality of raising a difficult young child may seek professional help that could result in their children receiving a psychiatric diagnosis such as oppositional defiant disorder or conduct disorder (American Psychiatric Association [APA], 2000).

The principal aim of the present study was to examine parenting practices in a sample of Latino mothers who were experiencing behavior problems with their young children that were sufficiently severe that they sought help from a mental health clinic. This sample was compared to another group of Latino mothers who were not experiencing significant behavior problems with their young children but were similar to the other sample of mothers in terms of their age, education, level of acculturation, and SES. The primary question

addressed by this study was "Do Latino mothers of young clinic-referred children differ significantly from mothers of non-clinic-referred children in their developmental expectations and nurturing and disciplinary parenting practices?"

## **Method**

### *Participants*

The participants were 60 Latino toddlers and preschoolers from a large urban community. Eligibility criteria included: (a) children were 2 to 4 years, 11 months of age, (b) parents were not well acculturated into American society, and (c) families were of low SES. The Bidimensional Acculturation Scale for Hispanics (BAS; Marin & Gamba, 1996) was used to assess the parents' acculturation levels. The eligibility criteria for this study were a Hispanic domain score above 2.5 and a non-Hispanic domain score below 2.5. SES scores were computed using Hollingshead's (1975) weighted ratings for parent education and occupation, with a possible range of scores between 8 and 66. For this study, SES eligibility scores were between 8 and 30, indicating lower SES. The sample included two groups of children: clinical and nonclinical. Children in the clinical sample had been referred by their parents for behavior and emotional problems to an outpatient mental health clinic that was housed within a large, community-based health center. In addition, these children exceeded established cutoff scores (intensity scale  $\geq 131$ ; problem scale  $\geq 15$ ) for significant behavior problems on a screening measure, the Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999). The nonclinical sample was drawn from two local Head Start programs; children in the nonclinical group did not meet either of the cutoff scores on the ECBI. Children who were diagnosed with pervasive developmental disorders, mental retardation, significant physical handicaps (e.g., cerebral palsy), or had serious medical concerns were not included in the study. Participants were solicited until both sample sizes reached 30. A summary of the eligibility scores for both samples is shown in Table 1.

### *Instruments*

*Demographic questionnaire.* Participants were asked the following information: parent age, marital status, ethnicity, years of

formal education, present occupation, length of time living in the United States, preferred language, income, number of children, age and gender of the focus child for this study, previous psychological services for the child, and history of mental health issues in the family.

*The BAS.* To control for acculturation, parents were selected on the basis of their level of acculturation. Each parent completed the BAS (Marin & Gamba, 1996) that included Language Use, Linguistic Proficiency, and Electronic Media subscales. Based on their responses to these subscales, parents received a Hispanic and a non-Hispanic domain score with a possible range of scores from 1 to 4 for each cultural domain. A score of 2.5 was used as a cutoff score to designate low or high level of identification with each cultural domain. The eligibility criteria for this study were a Hispanic domain score above 2.5 and a non-Hispanic domain score below 2.5. The validity coefficients for the three language-related subscales combined are .90 for the Hispanic domain and .96 for the non-Hispanic domain (Marin & Gamba, 1996).

*Hollingshead's Index of Social Status.* To compute each family's SES based on Hollingshead's (1975) index, education was defined as the number of years of formal schooling and was scored on a 7-point scale (e.g., less than seventh grade = 1; high school graduate = 4; graduate professional training = 7). Each participant's occupation was rated on a 9-point scale (e.g., higher executives, proprietors of large businesses, and major professionals = 9; small business owners, skilled manual workers, craftsmen = 4; farm laborers and service workers = 1; participants who were dependent upon welfare with no regular occupation also received a score of 1). An estimate of SES for each family was derived by multiplying the scale value for occupation by a weight of 5 and the scale value for education by a weight of 3. Education and occupation scores for married households were summed and divided by 2 if both were working outside the home. The computed scores on the Hollingshead could range between 8 and 66. Since the current study aimed at identifying families from lower SES, only those scoring between 8 and 30 were included in the study.

*The ECBI.* The ECBI (Eyberg & Pincus, 1999) is a 36-item instrument that measures common behavior problems in children between the ages of 2 and 16. Parents rated the frequency of each behavior problem on a 7-point scale that resulted in an Intensity score ranging from 36 to 252. Parents also indicated if each behavior was a

current problem with either a yes or no, which resulted in a Problem score ranging from 0 to 36. Test-retest reliability for the ECBI is .86 for the Intensity scale and .88 for the Problem scale. The internal consistency for both scales is .98. Eyberg and Ross (1978) reported that the ECBI was able to differentiate children referred for behavior problems from children referred for other reasons. For the present sample, coefficient alphas were .96 for the Intensity scale and .92 for the Problem Behavior scale.

*The Parent Behavior Checklist (PBC).* The PBC (Fox, 1994), a 32-item rating scale, was designed to assess behaviors and expectations of parents with children 1 to 5 years of age. The PBC consists of three subscales: Expectations—parents' developmental expectations; Discipline—parental responses to children's challenging behaviors; and Nurturing—parent behaviors that promote a child's psychological growth. Coefficient alphas and test-retest reliabilities, respectively, were Expectations = .97, .98, Discipline = .91, .87, and Nurturing = .82, .81. The coefficient alphas and test-retest reliabilities of the Spanish version of the PBC were Expectations = .95, .96, Discipline = .87, .88, and Nurturing = .83, .91 (Solis-Camara & Fox, 1996). For the present sample, the following coefficient alphas were found: Expectations = .80, Discipline = .81, and Nurturing = .69.

*The Kiddie Schedule for Affective Disorders and Schizophrenia: Present and Lifetime version (K-SADS-PL).* The K-SADS-PL (Kaufman et al., 1997) was completed to determine whether or not a child met one or more psychiatric diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; APA, 2000)*. The K-SADS-PL is a semistructured diagnostic interview designed to evaluate current and past episodes of psychopathology in children. Since the K-SADS-PL was not specifically designed for preschoolers, this study took the developmental appropriateness of the child's behavior into account by adding age-appropriate probes similar to the work of Wakschlag and Keenan (2001).

*Interview questions.* Each parent interview included the following three open-ended questions: "How difficult has raising your child been for you?" "How is raising this child different from what you expected?" and "To what degree have you relied on others (family, friends, and professional services) to help you with parenting?" These three questions were then rated on a 10-point Likert-type scale in order to assess the difficulty of raising the child (1 = *very easy*, 10 = *very*

*difficult*), how different raising the child is from what they expected (1 = *same as expected*, 10 = *very different than expected*), and to what degree they relied on others to help with parenting (1 = *no reliance on others*, 10 = *complete reliance on others*).

*Parent-Child Relationship Scale (PCRS)*. This scale provides a global assessment of the overall quality of the parent and child relationship on a scale of 0 to 100 with five behavioral anchors at 20-point intervals (Fox & Nicholson, 2003) similar in format to the Global Assessment of Functioning Scale used in the *DSM-IV*. The scale rates the appropriateness of parental expectations, parental warmth, the reciprocity of the observed parent-child interactions, and parental use of limit setting.

## **Procedures**

The primary caregiver and focus child were met with in their home by the first author for 2 to 3 hours for data collection. Within an interview format, participants were administered the demographic form, the study's self-report instruments, and the diagnostic measure. In order to ensure that participants understood the items on the study's instruments, each of the measures was administered verbally to each participant in the language of their choosing (English or Spanish). The parent-child interactions also were informally observed to permit the researcher to evaluate the quality of the relationship. The interview concluded with three open-ended questions; the caregiver's responses were tape-recorded for later transcription. All participants were given a \$20 gift certificate after completing all protocol materials. If parents were not receiving sufficient mental health services for their children, referral information was provided, and in some cases, the first author assumed the responsibility for providing mental health services for the child in her role as a psychologist in the community-based health center.

## **Results**

Demographic information on the children and their caregivers is shown in Table 2. A series of *t* tests for continuous variables and chi-square tests for categorical variables were computed to determine if there were significant differences between the clinical group and the nonclinical group. There were no significant differences between groups in number of siblings, maternal age, education, or

socioeconomic status. However, there was a significant difference in monthly income ( $t(58) = 2.78, p = .007$ ), with the nonclinical group reporting higher monthly income than the clinical group. There was also a significant difference between groups on the number of years living in the United States. The clinical sample ( $M = 9.57, SD = 5.63$ ) reported living more years living in the United States than the nonclinical sample ( $M = 6.53, SD = 2.71, t(58) = 2.66, p = .011$ ). No significant differences were found between group assignment and the following categorical variables: child's gender or maternal employment status. However, significant differences were found for marital status ( $\chi^2(1, N = 60) = 4.29, p = .038$ ), with significantly more mothers of the nonclinical children being married (60%) than mothers of the clinical children (33%). There was also a significant difference observed between groups with regards to family history of mental health problems ( $\chi^2(1, N = 60) = 24.31, p < .001$ ), with significantly more mothers in the clinical group reporting a family history of mental health problems (87%) than the nonclinical sample (23%). Reported problems included depression, anxiety, and attention deficit hyperactivity disorder.

The subscale scores for the ECBI and PBC are shown in Table 3. A MANOVA was computed with group assignment (clinical or nonclinical) as the independent variable and the Problem Behavior and Intensity sub-scale scores on the ECBI as dependent variables. As expected, a significant effect was found between mothers of clinical and nonclinical children on the ECBI ( $\lambda = .14, F(1, 58) = 178.46, p < .001$ ). Follow-up univariate ANOVA revealed significant differences on the Problem Behavior scores ( $F(1, 58) = 203.53, p < .001$ ) and the Intensity scores ( $F(1, 58) = 317.22, p < .001$ ), with the mothers of the clinical sample reporting more frequent and intense behavior problems in their children than mothers in the non-clinical sample. A second MANOVA was computed with the Expectations, Discipline, and Nurturing scores on the PBC as dependent variables. A significant effect was found between mothers of clinical and nonclinical children on the PBC ( $\lambda = .78, F(1, 58) = 5.28, p = .003$ ). Follow-up ANOVAs revealed significant differences on the Discipline ( $F(1, 58) = 11.25, p = .001$ ) and the Nurturing scores ( $F(1, 58) = 10.64, p = .002$ ), with mothers of the clinical sample reporting more frequent use of corporal and verbal punishment and less frequent use of nurturing strategies

with their children than mothers in the nonclinical group. No differences were found between groups on the Expectations subscale.

Several significant relationships were found among the subscale scores on the study's two measures. The PBC's Discipline and Nurturing scores were negatively correlated ( $r = -.60, p < .01$ ); parents who reported using frequent corporal and verbal punishment as discipline also report using less frequent nurturing practices with their young children. The discipline scores were positively related to the ECBI's Problem and Intensity scores ( $r = .43, p < .01$  and  $r = .42, p < .01$ , respectively); parents who reported using frequent corporal and verbal punishment also reported more frequent conduct problems in their children. Nurturing scores were inversely related to the Problem and Intensity scores ( $r = -.40, p < .01$  and  $r = -.45, p < .01$ , respectively); parents who reported a lower frequency of using of nurturing behaviors also reported more frequent and intense problems in their young children. Finally, the Intensity and Problem scores were highly related ( $r = .90, p < .01$ ); parents who reported more intense behaviors also considered these to be more problematic.

The total number of children in the clinical sample who met criteria for one or more *DSM-IV* diagnoses was 20. Of these, 3 were diagnosed with oppositional defiant disorder (ODD), 6 with conduct disorder (CD), 3 with ODD and attention deficit hyperactivity disorder (ADHD), and 8 with CD and ADHD. None of the children in the nonclinical group met criteria for any psychiatric diagnosis.

Parent responses to each of the three interview questions, "How difficult has raising your child been for you?" "How is raising this child different from what you expected?" and "To what degree have you relied on others (family, friends, professional services) to help you with parenting?" were tape-recorded and transcribed. The transcripts were imported into NVivo7 (Richards, 2006), a software program designed to assist in the analysis of qualitative data. A reviewer trained on the NVivo7 software assisted the first author in utilizing the software to organize and manage the data to allow for a systematic review of the content. Transcripts from the clinical sample were reviewed first. Both reviewers simultaneously read each mother's responses and "coded" the data in an inductive process. This involved labeling key concepts with unique codes, or "nodes," that described the concepts under review. Review of the clinical sample interviews produced a total of 21 nodes. The nonclinical sample interview data

were reviewed using the same process. Content analysis revealed that 17 of the 21 initial nodes identified in the clinical sample also fit with the concepts identified in the nonclinical sample. The transcripts and nodes were then provided to a third independent reviewer who had experience with consensual qualitative research. This reviewer evaluated the transcripts and organized the content into the nodes that were provided. After an independent review of the nodes by the second reviewer, the first author met with the two reviewers for further evaluation and consensus of themes. Seven of the initial 21 nodes were discarded because they were only present in 10% or less of the total sample and could not be merged with other identified nodes. For example, the node "financial difficulties" occurred in only two cases and did not fit in with the other identified nodes. The reviewers then looked for commonalities among the 14 remaining nodes and through an iterative process developed six broad themes. The most frequently identified themes and supporting statements from clinical and nonclinical mothers are shown in Table 4.

The three interview questions also were rated by each mother on a 10point, Likert-type scale in order to assess the level difficulty of raising the child (1 = *very easy*, 10 = *very difficult*), how different raising the child is from what they expected (1 = *same as expected*, 10 = *very different than expected*), and to what degree they rely on others to help with parenting (1 = *no reliance on others*, 10 = *complete reliance on others*). On each of the three interview questions, *t* tests were computed to compare the clinical and nonclinical samples. There was a significant difference in how the mothers assessed the level of difficulty in raising their child ( $t(58) = 9.86, p < .001$ ), with the clinical group reporting greater difficulty in raising their child ( $M = 7.83, SD = 1.76$ ) than the nonclinical group ( $M = 3.13, SD = 1.93$ ). There also was a significant difference between groups on how different raising the child is from what they expected ( $t(58) = 3.74, p < .001$ ), with the clinical group reporting a greater magnitude of difference in raising their child as compared to what they expected ( $M = 7.47, SD = 2.30$ ) than the non-clinical group ( $M = 4.63, SD = 3.45$ ). A significant difference was also observed in the degree to which the groups rely on others to help with parenting ( $t(58) = 2.64, p = .011$ ), with the clinical group reporting greater reliance on others to help with parenting ( $M = 4.23, SD = 2.99$ ) than the nonclinical group ( $M = 2.60, SD = 1.59$ ).

Finally, the quality of the parent-child relationship was assessed using a parent-child relationship scale that was completed after a thorough review of the evaluation data and observations made during the home visit. A *t* test for independent samples was computed to compare the two samples on the parent-child relationship. A statistically significant difference was found between the two groups ( $t(58) = 5.66, p < .001$ ), with lower ratings found for the clinical group ( $M = 54.83, SD = 15.78$ ) than the nonclinical group ( $M = 74.50, SD = 10.61$ ).

## **Discussion**

The purpose of this study was to examine the parenting practices in families with very young Latino children who had been referred for mental health services due to significant behavior problems. All mothers were considered nonacculturated and from lower educational and socioeconomic levels. The results indicated that mothers of children identified as having clinically significant behavior problems reported using verbal and corporal punishment with greater frequency than mothers of children without these problems. These findings are consistent with previous research (Brenner & Fox, 1998; Burbach, Fox, & Nicholson, 2004) that found a strong association between behavior problems and the frequent use of verbal and corporal punishment. Other researchers also have found that authoritarian, hostile, or punitive parenting styles are associated with childhood behavior difficulties (Rubin & Burgess, 2002). A related finding of the current study was that mothers of children identified as having clinically significant behavior problems reported lower frequencies of nurturing behaviors than mothers in the nonclinical group. Goldstein, Harvey, and Friedman-Weieneth (2006) also found less warmth, more lax parenting, and more negative affect among parents of children who were hyperactive and oppositional.

These findings support the reciprocal nature of the parent-child relationship (Maccoby, 1992). Young children's challenging behaviors often demand attention from a parent. The form that this attention takes is often negative, which in turn may exacerbate the very behavior problems that the parent was trying to stop. Moreover, as a result of this negative parent-child interaction cycle repeating over time, the parent may not be as likely to respond to the child's prosocial behaviors when they do occur with positive, nurturing

practices. This latter conclusion was partially supported by the inverse relationship found between the maternal use of verbal and corporal punishment and nurturing behaviors.

Interview data of mothers in clinical and nonclinical samples revealed both similarities and differences with respect to how their children affect them and how they feel about parenting. The mothers of the clinical group reported feeling tired as a result of constantly dealing with their children's behaviors and also having to make modifications in their lives; for example, "I can't even go out in public with how he behaves." The mothers of the nonclinical children attributed their tiredness to the normal demands associated with raising a young child. There also was variability in responses among mothers of the clinical group with respect to maternal expectations. Several of these mothers made comparisons of their child with other children their age and seemed to wonder why their child was not as well behaved. Other mothers of clinical children expected difficult behaviors because it was already evident in the family history. Mothers of nonclinical children reported few problem behaviors in their child and did not expect to have to deal with more than what was developmentally normal for children this age. Mothers of the clinical group reported the absence of a father figure with greater frequency and were more likely to shoulder the burden of raising their child by themselves. These mothers also indicated that they were not coping well with the challenges of parenting. Mothers of the nonclinical children described a greater reliance on their spouses for help with the child rearing and more effective coping strategies.

Perhaps one of the most striking results of the current study was the significance of the reported family history of mental illness in the clinical group. Of the 30 mothers in the clinical sample, 87% reported that they or another immediate or extended family member suffered from disorders such as depression, anxiety, post-traumatic stress disorder, ADHD, or psychotic disorders. This finding has been reported in numerous studies that have found associations between child behavior problems and problems reported in their families. For example, Cunningham and Boyle (2002) found that mothers of children at risk for ADHD reported higher scores on personal depression measures than mothers of a non-ADHD comparison group. Another study of preschoolers conducted by Lancaster, Prior, and Adler (1989) found an association between externalizing behavior problems

and maternal psychological factors such as anxiety and insomnia, somatic symptoms, social dysfunction, and depression.

Raising young children is a complex process that is influenced by several factors including culture and the level of management difficulties that children may present due to behavior problems. However, despite the number of potentially contributing factors, the present study identified a family history of mental illness as a major difference between the clinical and nonclinical samples. More research is needed to explore how this family characteristic may contribute to a young child's predisposition to develop behavior problems as well as how it may influence their caregiver's parenting practices, which in turn may exacerbate these challenging behaviors in early childhood. Clearly, early identification of challenging behaviors in young children is a necessary first step to identify families in need of assistance. Empirically validated treatment programs are available to interrupt an undesirable developmental pathway and promote a healthier social-emotional development for these young children (Solis-Camara, Fox, & Nicholson, 2000).

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## Appendix

**Table 1: Eligibility Scores for the Clinical and Nonclinical Samples**

Variable	Clinical Sample			Nonclinical Sample		
	M	SD	Range	M	SD	Range
Child's age (months)	43.93	8.38	24-58	44.33	10.06	24-59
Hollingshead (SES)	13.77	5.95	8-30	13.40	5.15	8-26
Acculturation						
Hispanic Domain	3.83	0.26	3.1-4.0	3.89	0.25	2.8-4.0
Non-Hispanic Domain	1.43	0.45	1.0-2.3	1.36	0.38	1.0-2.3
Eyberg						
Problem scores	22.83	4.47	15-31	7.13	4.05	0-14
Intensity scores	170.07	20.32	133-221	78.90	19.32	42-122

Note: SES = socioeconomic status

**Table 2: Descriptive Characteristics of Children and Mothers in the Clinical and Nonclinical Samples**

Variable	Clinical Sample (n = 30)					Nonclinical Sample (n = 30)				
	M	SD	Range	n	%	M	SD	Range	n	%
Child's gender										
Females				16	53				15	50
Males				14	47				15	50
Siblings	1.6	1.3	0-5			1.4	1.2	0-4		
Mother's age	28.1	7.4	18-46			28.0	5.0	20-38		
Mother's education	8.83	2.8	1-14			8.5	3.4	3-15		
Monthly income	1,144	302	600-1,800			1,409	426	840-2,400		
SES	13.8	6.0	8-30			13.4	5.2	8-26		
Marital status										
Not married				20	67				12	40
Mother's ethnicity										
Mexican				20	67				29	97
Puerto Rican				9	30				1	3
Central American				1	3				0	0
Mother's employment										
Homemaker				20	67				19	63
Employed				10	33				11	37
Family history of mental health problems										
Yes				26	87				7	23
No				4	13				23	77

Note: SES = socioeconomic status.

**Table 3: Descriptive Summary Statistics for the Scores on Eyberg Child Behavior Inventory (ECBI) and the Parent Behavior Checklist (PBC) by Group**

Dependent Variable	Clinical Sample			Nonclinical Sample		
	<i>M</i>	<i>SD</i>	Range	<i>M</i>	<i>SD</i>	Range
ECBI Intensity	170.07	20.32	133-221	78.90	19.32	42-122
ECBI Problem	22.83	4.47	15-31	7.13	4.05	0-14
PBC Expectations	40.30	6.20	23-48	38.60	6.37	20-46
PBC Discipline	17.73	5.27	10-31	13.97	3.17	10-21
PBC Nurturing	26.03	5.46	17-35	30.53	5.22	21-40

**Table 4: Most Frequently Endorsed Themes and Supporting Statements of Clinical Nonclinical Mothers**

Interview Theme	Number of Respondents	Supporting Statements
<i>Mothers in clinical sample</i>		
Perceptions about child's behaviors	29	Why does he hurt others without thinking twice? She can't sit still. Even when we're in the car, she gets out of her car seat and jumps around. There isn't a day that goes by that she isn't having a tantrum, screaming and crying.
Effects of child behavior on mother	29	I am just too tired to care, too tired to give consequences. I can't even go out in public with how he behaves. If I knew it was going to be this way, I would not have agreed to have another baby.
Expectations about raising the child	28	I have two older children and I never had these problems with them. I knew she was going to be difficult. It runs in my family and her father's family.
Reliance on others for assistance with child	28	I thought he would be a calmer child but he is not. When she is at Head Start, I consider that a big help. I wish I had someone to help me. They are all in Mexico. Well, I live with my mother. Without her I don't know what I would do.
Father's role in parenting	17	I thought her father would stay and be a father to her and help out. I don't get child support. My husband works second shift, sometimes third. He sleeps all day and everything falls on me. Only rarely does my husband help me, like when it becomes unbearable.
Mother's attributes about her role as parent	18	What kind of mother am I if I say she is so difficult? Since I stay at home, it is my job to raise her and her brother. I am the mother. It's all on me. So unfair but that's the way it is.

**Table 4 (continued)**

Interview Theme	Number of Respondents	Supporting Statements
<i>Mothers in nonclinical sample</i> Perceptions about child's behavior	17	He is the easiest little boy around. Not hard at all! I know I am fortunate compared to a lot of people I know. Not too hard. She has her moods but she's a good girl. She is not bad that often.
Effects of child behavior on mother	18	Lots of work, very tiring but I love being a mother. He's a good boy but he tires me out. She scares me sometimes because she is starting to want to climb up on high places.
Expectations about raising the child	20	It hasn't been too bad. Lots of work but I knew that going in. I think it's pretty normal for her age: the whining, sometimes not listening to me, but it's not something in the extreme. His tantrums are normal for his age. I trust those will pass.
Reliance on others for assistance with child	22	My sister-in-law helps out with talking her to school but that's about it. I work and so does my husband. We rely on each other and also on family. We raise him ourselves. Who can help us? The family is in Mexico and we are all he has.
Father's role in parenting	18	Her father helps me. He entertains her. I have a husband that fell from heaven. He is so good as a father and helps me at every given opportunity, even on top of his work schedule. My husband helps me, not with diapers but with feeding and their bedtime. He helps me fold their clothes.
Mother's attributes about her role as parent	19	It's my responsibility to raise him so I take it on, you know. I do it. I have learned to get results my way.