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Effectiveness of the coping power program in a Mexican-American sample: distinctive cultural considerations

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This study responds to the challenges associated with delivering culturally sensitive and evidence-based treatment (EBT) to at-risk children. Current research supports group interventions based on the Coping Power Program (CPP) curriculum as EBT for improving the frequency of positive behaviors in children and adolescents. However, the effectiveness of the CPP in a Mexican-American sample has not been explored to date. This study investigated the effectiveness of the CPP delivered as a preventative intervention to Mexican-American adolescents in a rural school setting. A major emphasis is put on cultural sensitivity when working with this population. Cultural sensitivity is expressed by minor adaptations of the CPP. The adaptations consisted of modifying treatment content, providing culturally relevant examples, contextualizing content and so forth, while maintaining program value. Our hypothesis was that when using the adapted EBT curriculum on the Mexican-American subsample, both groups would have similar scores and retention rates. As hypothesized, no significant differences were found between the two treatment groups (non-adapted EBT European-American and adapted EBT Mexican-American). Overall, the results suggest that EBT interventions for at-risk Mexican-American youth might require cultural adaptation in order to maximize its effectiveness.

Keywords: cultural competence; evidence-based treatment; Mexican-American; school; rural; mental health

Introduction

By the year 2050, conservative projections are that in the USA 50% of the population will be comprised of ethnic minorities. Currently, estimates are that 17% of the total population in the USA is a minority and, of that 17%, the largest racial and ethnic minority group is Hispanic-American (US Census Bureau, 2010). In fact, Hispanic-American minority groups account for 13% of the overall population (US Census Bureau, 2010). There have been many studies that suggest that Hispanic-American youths, including Mexican-American youths, are more likely to score higher than their European-American counterparts in areas such as depression, anxiety and other mental health issues (Alderete, Vega, Kolody, & Aguilar-Gaxiola, 2000; Roberts, Roberts, & Chen, 1997; Rossello & Bernal, 1996). Acculturation issues found among Mexican-American individuals, such as adapting and conforming to a

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European-American culture, may be one of the predominant issues influencing reports of depression and anxiety (Alderete et al., 2000; Lau et al., 2005). The need for treatment among Mexican-American youths and the lack of available culturally-specific services to address those needs demonstrates some of the unique challenges faced by both Mexican-Americans and by those providing services to this community.

Utilization of mental health services and ethics

In general, there is under-utilization by minority groups when seeking mental health care. In particular, at-risk Mexican-American youths were found to access mental health services up to 10% less often than European-American at-risk youths (Garland et al., 2005). Under-utilization and barriers to treatment have also been found in other minority groups, including Asian-Americans (Leong & Lau, 2001) and African-Americans (Liddle, Jackson-Gilfort, & Marvel, 2006). When looking for ways to increase participation by minority groups in treatment, adapted treatment programs result in a 41% higher retention rate than do non-adapted treatments (Martinez & Eddy, 2005).

The American Psychological Association (APA) code of ethics states that psychologists 'use assessment instruments whose validity and reliability have been established for use with the members of the population tested' (APA, 2002, p. 1071). The challenge then exists to provide culturally sensitive treatment while maintaining reliability and validity. Because there are so few treatment programs standardized with minority groups, the argument for adaptation becomes even more important. In an effort to provide such services, various forms of adaptation have transpired. Adaptation can include, but is not limited to: (1) modifying treatment content and providing culturally relevant examples, (2) contextualizing content to a particular community and (3) taking into consideration ways to increase involvement of minority groups while at the same time maintaining the value of the original program (Castro, Barrera, & Martinez, 2004). There are both adaptations with initial proven success, which continue to be studied, and adaptations that have not succeeded in increasing the effectiveness of EBT programs or maintaining reliability and validity in test outcome measures (Castro et al., 2004; Kumpfer, Alvarado, Smith, & Bellamy, 2002).

The Coping Power Program (CPP)

The CPP is a school-based anger-coping program originally developed for at-risk youths to help prevent future substance abuse (Lochman & Wells, 2002). It was later enhanced to include a parent component to further aid in the attempt to prevent substance abuse issues among emerging adolescents (Lochman & Wells, 2004). Substance abuse issues are still relatively low with children in elementary school; however, as they transition into middle school, school stressors and peer pressure increasingly make this age group an ideal target (Peterson, Hamilton, & Russell, 2009). Therefore, providing children with coping skills and better self-awareness at an earlier age might prepare them to deal with stressors and reduce the likelihood of engaging in high-risk behaviors (Lochman & Wells, 2004). Moreover, current literature suggests that the CPP is an effective treatment for peer relationship problems in children and adolescents (Peterson et al., 2009).

Poder Resolver – implementation of adapted EBT

In preparing to implement this program within local elementary schools, it became evident that rural areas had higher migrant populations and/or communities with a higher population of Mexican-Americans. Addressing the need of Mexican-American children who were identified as appropriate for participation in the program became a priority. Questions about how to better involve the students, as well as how to engage with many of the parents who were monolingual Spanish-speakers, were subsequently answered with solutions that fit the program. The first adaptation was to translate the brochure developed for the program and all parental consent and information forms from English into Spanish. It was hoped that having materials in the parents' native language would increase understanding of the program and reduce potential concerns. Additionally, providing a Spanish-speaking contact increased the likelihood of direct communication with parents to answer questions and/or concerns about their children's involvement.

During group settings, a considerable amount of contextualization transpired throughout the program. References to Mexican/Mexican-American cultural events such as *Quinceañera* (the Latin equivalent of a young girl's sweet sixteen party), Latin music, sports, family customs and the use of the Spanish language to enhance understanding or emphasize meaning were regularly used. The presenter's fluency in Spanish was a significant factor as it allowed the students to express themselves in both Spanish and English. In addition, and perhaps an unintended but apparent adaptation, it helped keep the students engaged in group activities and was a deterrent to them believing that they could talk among themselves in Spanish on non-group topics without the presenter's awareness.

Overall, the objective of the CPP was to provide a group treatment program in a public school for at-risk youths who otherwise may not have services available to them. The purpose of implementing Poder Resolver, the adapted version of the CPP, was to explore the effectiveness of the program for at-risk Mexican-American adolescents. The current study examines improvement and retention rates for two groups: a Mexican-American at-risk group and a European-American group. In order to test our hypotheses we compared at-risk Mexican-American youths' scores to their European-American peers. Equal gains in improvement and equal retention rates would support the hypothesis that adaptation, when correctly done, improves treatment outcomes for at-risk Mexican-American youth.

Methods

Participants

Participants were 6th graders (mean age = 11.59, SD = 0.39) enrolled in a public school in rural Oregon. There were 70 total participants in the program; 14 (six male) in the Poder Resolver (PR) group all of Mexican-American descent and 56 (35 male) in the Coping Power Program (CPP) European-American group. School faculty were asked to identify 6th grade students who were considered at-risk due to behavioral and academic problems. At-risk behavioral concerns were defined as the presence of disruptive social behavior, aggression, atypicality, sexual inappropriate behavior, history of substance abuse and hyperactivity. Literature shows that disruptive behaviors have been implicated as a primary cause of academic underachievement, as

well as problems with truancy and school dropout (Jurecska, Hamilton, & Peterson, in revision).

Instruments and materials

Permission to conduct the study was obtained through the George Fox University Human Subjects Research Committee for use of this de-identified data and APA ethical guidelines were followed.

Behavior Assessment System for Children (2nd ed.) Teacher Rating Scales (BASC-2 TRS)

Once the students had been identified by faculty, a teacher with knowledge of and history with each child completed the BASC-2 TRS. The BASC-2 TRS is an assessment tool for evaluation of adaptive and problem behaviors and takes approximately 10–20 minutes to complete (Reynolds & Kamphaus, 2004). Teachers completed pre- and post-program BASC-2 TRS for both groups.

BASC-2 Self-Report of Personality (BASC-2 SRP)

Each participant completed the BASC-2 SRP, an assessment tool for evaluation, differential diagnosis and treatment planning (Reynolds & Kamphaus, 2004). This assessment takes approximately 10–30 minutes to complete and is designed for use with children and adolescents. The scales identified for the purposes of this study were taken from three different measures utilized in both the BASC-2 TRP and BASC-2 SRP; these measures are identified as Clinical, Adaptive and Composite measures. In the Clinical measures, higher scale scores represent negative characteristics. In the Adaptive measures, higher scores represent positive adjustment and lower scores indicate possible problem areas. In the Composite measures, with the exception of the Adaptive Skills scale in the TRP and the Personal Adjustment scale in the SRP, higher scores represent negative characteristics and/or problem areas.

Specific scales were chosen for inclusion in this study based on theoretical criteria that they were measures most informative as to teacher and student report of both interpersonal skills and outward behavior. The scales used from the BASC-2 TRP Clinical Measure were: Aggression, Anxiety, Conduct Problems, Learning Problems and Withdrawal; scales used from the Adaptive Measure were: Adaptability, Functional Communication, Social Skills and Study Skills; and scales used from the Composite Measure were: Adaptive Skills, Behavioral Symptoms Index, Externalizing Problems, Internalizing Problems and School Problems. The scales used from the BASC-2 SRP Clinical Measure were: Anxiety, Attention Problems, Attitude to School, Attitude to Teacher, Locus of Control, Sense of Inadequacy and Social Stress; scales used from the Adaptive Measures were: Interpersonal Relations, Self-Esteem, and Self-Reliance; and scales used from the Composite Measure were: School Problems, Internalizing Problems, Personal Adjustment and Emotional Symptoms Index.

Regarding psychometric properties, the authors of the BASC-2 SRP reported an internal consistency reliability composite of .90 (.84–.96) with consistencies of individual scales at .82 and .97 (.91–.97). The BASC-2 TRS has a mean internal consistency scale of .88 (.81–.95). Test-retest reliability for the SRP is .82 (.74–.84)

with scales at .75 (.61–.90); the TRS has a composite of .89 (.81–.92) and scales at .81 (.64–.90) (Reynolds & Kamphaus, 2004).

Group curriculum

The CPP, an EBT developed by John Lochman and Karen Wells (2002), was originally targeted for youths with substance and/or anger control problems. The original program has been adapted to a number of needs and the program used in this study was an abbreviated version lasting on average six to seven months. There were 24 different components to be administered as an in-school program. Due to time constraints of the school or the researcher, some of the components have been combined, shortening the total length of the program implementation. The total number of meetings completed by the Mexican-American group was 20, which is also the average number of completed meetings for European-American students. Accounting for school winter holidays, the total program lasted six months. The CPP has been reported to be successful in improving both maladaptive and pro-social behaviors (Lochman, & Wells, 2004).

Procedure

BASC-2 pre-test

After the first week's introduction to the program, participants were asked to take a pre-test BASC-2 SRP.

Group curriculum

The weekly meetings consisted of group participation dealing with both written and verbal exercises to better understand emotions and behaviors of both the self and others. Group discussions included how one's ability to understand and cope with different emotions and behaviors impacts not only the individual but his/her peers. Additionally, at various times throughout the program, the researchers asked to obtain teacher and parental feedback on progress of different student-identified goals, such as turning in homework, paying better attention in class, better peer relations and so forth.

BASC-2 post-test

Upon completion of the CPP, the students were asked to complete a post-program BASC-2 SRP and the same teachers who originally completed the pre-program BASC-2 were asked to complete a post-program BASC-2 TRS for each participant.

Results

BASC-2

At the beginning of the implementation of the CPP, a pre-test BASC-2 TRP was completed by teachers on all students ($n = 70$). After completion of the program, only the intervention (Mexican-American) group of students completed post-test BASCs.

The first step in data analysis was to look for any pre-existing differences between groups in order to ensure that the groups were somewhat comparable. One-way

ANOVAs were performed for gender, group membership (European American or Mexican American) and teacher. No teacher rating differences were found. Similarly, no gender differences were found except for the Interpersonal Relations scale found on the BASC-2 SRP. On this scale, males scored more than 11 points higher than females (M males = 53.83, M females = 42.67, $p = .019$).

Teacher report scales

Several scales were chosen for analysis from the BASC Teacher Report. Of these, five were chosen from the Clinical measures, four were chosen from the Adaptive measures and five were chosen from the Composite measure. A Repeated Measures ANOVA was conducted on the pre-test/post-test data. Out of the 14 scales, only the Withdrawal scale resulted in a statistically significant difference, indicating that the CP group scored higher than the PR (M difference between CP group and PR = 7.08, $p = .006$).

Within group (Poder Resolver) pre/post test analysis

Twenty-eight scales from the BASC-2 SRP and BASC-2 TRP were chosen for analysis: 14 from the SRP and 14 from the TRP. Of the 28 total scales, there were only 9 total significant changes between the pre-test and post-test; 5 found on the SRP scales (see Table 1) and 4 found on the TRP scales (see Table 2), each representing a worsening of reported problem behavior.

Discussion

The original goal of this study was to determine whether adapting the CPP for Mexican-American youths resulted in improved treatment outcomes. Research shows that adolescent Mexican-American youths have lower retention rates and lower outcome scores on EBT programs (Martinez & Eddy, 2005). These programs have

Table 1. SRP-Poder Resolver, pre- post-test scores with significant differences.

Scale	T ₁ M (SD)	T ₂ M (SD)	Δ
Anxiety	51.62 (9.777)	53.15 (11.320)	- 1.538
Attention problems	52.69 (8.769)	50.23 (9.960)	2.462
Attention to school	44.67 (4.755)	46.17(6.408)	- 1.500
Attention to teacher	52.46 (8.151)	54.69 (11.056)	- 2.231
Emotional symptoms index*	52.15 (10.367)	55.08 (11.842)	- 2.923
Internalizing problems	52.92 (11.383)	54.38 (13.023)	- 1.462
Interpersonal relations	48.46 (8.482)	48.00 (11.277)	.462
Locus of control	53.23 (10.084)	54.15 (11.327)	- .923
Personal adjustment*	48.62 (8.109)	43.92 (11.191)	4.692
School problems	48.17 (4.469)	51.50 (7.598)	- 3.333
Self-esteem*	51.08 (10.364)	46.15 (10.455)	4.923
Self-reliance*	46.00 (7.594)	41.85 (9.415)	4.154
Sense of inadequacy	56.15 (11.824)	53.46 (9.475)	2.692
Social stress*	48.92 (9.962)	52.31 (9.214)	- 3.385

Note: * $p < .05$, indicates that change from T₁ to T₂ is statistically significant.

Table 2. Mean scores on teacher report pre- and post-test BASC, by treatment group.

Scale	CP			PR			Control		
	Pre	Post	Dif	Pre	Post	Dif	Pre	Post	Dif
Adaptability	45.0	43.8	-1.2	45.9	45.5	-0.4	46.7	47.1	+0.4
Adaptive skills	44.7	43.9	-0.8	44.9	43.7	-1.2	45.9	46.6	+0.7
Aggression**	49.0	56.0	+7.0	49.3	54.5	+5.2	49.3	53.3	+4.0
Anxiety	51.4	48.5	-2.9	49.2	50.9	+1.7	47.3	48.5	+1.2
Behavioral symptoms index	53.2	56.7	+3.5	53.7	56.8	+3.1	50.2	51.8	+1.6
Conduct problems**	50.5	55.5	+5.0	50.9	55.1	+4.2	50.0	53.7	+3.7
External problems**	50.6	55.9	+5.3	50.8	55.0	+4.2	49.6	52.1	+2.5
Functional communication	47.4	47.3	-0.1	45.5	42.8	-2.7	47.4	48.1	+0.7
Internal problems	50.1	54.7	+4.6	49.5	52.2	+2.7	46.5	48.1	+1.6
Learning problems	53.0	52.6	-0.4	51.1	55.4	+4.3	53.5	51.4	-2.1
School problems	55.5	54.4	-1.1	54.0	56.5	+2.5	54.6	53.1	-2.5
Social skills	47.6	49.5	+1.9	45.4	46.5	+1.1	49.1	51.3	+2.2
Study skills*	42.2	36.8	-5.4	44.1	42.4	-1.7	42.7	41.4	-1.3
Withdrawal	57.1	59.1	+2.0 ^a	55.3	54.9	-0.4	50.1	51.9	+1.8 ^a

Notes: * $p < .05$, ** $p < .01$; indicates that change from T₁ to T₂ is statistically significant; ^a indicates groups are statistically different from one another at the .05 level; CP = Coping Power; PR = Poder Resolver.

traditionally been normed on a predominantly European-American and culturally American population. Our hypothesis was that when using the adapted EBT curriculum on the Mexican-American subsample, both groups would have similar scores and retention rates, equivalent results were found between both adapted and non-adapted SRP scores. This hypothesis appears to have been supported in the study.

It is important when interpreting the results of this study that the Poder Resolver group was an identified group of participants considered as at-risk. Although some of the scales reflect a worsening of scores, of more importance is the fact that most of the scales measured did not get worse. Already identified as at-risk, these participants would likely continue downward in areas measured in both the TRP and SRP scales if an intervention program were not implemented. The fact that most scores did not worsen perhaps shows that the expected downward trajectory was interrupted by the program and that by not getting worse is to be considered a success.

This result appears to be common in most initial studies that have been culturally adapted. Follow up with these students would likely support other findings that continued adapted treatment would, indeed, produce greater positive outcomes over time. In fact, in the one-year follow up with the Poder Resolver group, the authors' observation and participant responses seem to support this theory. Participant self-report in response to the questions asked seemed to show greater participant awareness and understanding of their feelings, as well as improved relationships with others. Additionally, many of the comments about what they remembered and liked about the group were specific to attempts made at making the group program and experience more familiar and applicable to the Mexican-American participants.

It should be noted that retention of the adapted-EBT PR group participants was 100%. Although group participation was voluntary, it is recognized that at school their participation may have been perceived as mandatory. However, the students did give up their lunch hour once a week to participate and no complaint about being in group or losing lunch time was heard from any participant. In fact, at the one-year follow up, many of the students expressed disappointment that there would not be

another group. Retention and participant satisfaction have been shown to be at least as important as measurable outcomes at assessment termination for long-term positive change. This was certainly accomplished in the adaptation experience (Martinez & Eddy, 2005).

In reviewing the Poder Resolver within group pre-/post-test results, an interesting trend appeared to develop. Although nearly all change scores were not statistically significant, there were a number of scores that were, indeed, significant and they all represented worsening of reported problems. It is interesting that the SRP scores leaned much more towards a worsening in emotional and intrapersonal problems, whereas the TRP scores seem to lean more towards observable and outward behavior problems. The argument could be made that often things do, or at least appear to, get worse before they get better. It is proposed that, as participant awareness and understanding of his/her own emotions, interpersonal challenges with peers and teachers and the at-risk factors that each may have identified with, an increase in self-awareness was created that may have been difficult to deal with initially. This is not necessarily unfortunate in the long run. In fact, other studies, including other studies of adaptation outcomes, discuss struggling and working through changes that lead to long-term gains (Martinez & Forgatch, 2001). Martinez and Eddy (2005) cite previous work in which, initially, though negative intervention effects were detected at the termination assessment, over the next two-and-a-half years, strong improving linear trajectories were found (Martinez & Forgatch, 2001).

Though few, there were a number of significant variations found in the different sets of analysis which warrant discussion. In controlling for gender as a factor in this study, there was only one significant difference between males and females. This difference was found in the Interpersonal Relations scale found in the BASC-2 SRP. This finding is interesting because, of all the scales measured, Interpersonal Relations seems to be the only one that measures interpersonal, peer-specific relationships and the joy experienced from those relationships. It could be argued that all other scales measure either intrapersonal problems or issues that have to do with others that are not of one's interpersonal peer group. It is possible that this significant difference reflects the nature of 11–12-year-old male peer relationships, which are more focused on friendships and less on emotionally-based relationships than their same-age female peers. The assumption is that female peer relationships at this age are becoming more emotionally based and that, coupled with the social stresses and physical changes a young female may be going through at this time, the young adolescent female's perception of enjoyment derived from peer relationships is much lower (Rose & Rudolph, 2006).

The only significant difference found in the BASC-2 TRS was on the Withdrawal scale. Elevated scores on the Withdrawal scale indicate students with symptoms of depression, abuse and neglect – factors that are strong indicators for at-risk behaviors. Higher scoring individuals also are seen as possibly avoidant and uninterested in participating in social situations. Perhaps the finding was simply significant by chance, however, it is still very interesting that on every other scale there was no significant difference in scores between treatment and control groups.

Limitations

The most significant limitation in this study was the lack of BASC-2 SRP post-test European American group data. Researchers were unable to secure permission for

the BASC-2 SRP testing on this group as it was deemed too time consuming for such a large number of students. The lack of control group scores for the Self-Report does not allow for comparison of students in the two groups. Without this, within group SRP scores are left to a certain level of speculation as to control group SRP score outcomes; instead, the study was left to rely on TRP scores to determine possible conclusions.

Other limitations include: (1) the small number of participants in the Poder Resolver group and (2) all of the participants were of the same age. Though the results are statistically sound, a larger number of participants across a broader number of schools, at-risk students from varied cultural backgrounds and wider age differences would have allowed greater external validity. Though the results may not have been significantly different, a larger number and variety of participants would certainly have added value to the research.

Future research

Whether providing adaptation techniques in intervention programs or individual treatment plans, or with at-risk or non at-risk individuals, there are a number of considerations for future research concerning adaptation. Research continues to stress the growing diversity of our country and the need to provide meaningful mental health care to its people. More sophisticated studies with the ability to provide not only immediate and short-term, but also long-term intervention programs, along with the appropriate follow up measures, will be necessary.

Notes on contributors

Susan O'Donnell received her PhD in Child Psychology from the Institute of Child Development, University of Minnesota – Twin Cities (<http://www1.umn.edu/systemwide/indexsys.shtml>). Current projects include an observational study examining the role of mothers and fathers in the development of motivation in children. She has taught as adjunct faculty at Bethel College in Arden Hills, MN, and at the University of Minnesota. Primary research interests include the unique contributions of fathers to their children's development and, particularly, the development of learned helplessness in young children. Other research interests include the development of autonomy in young adults and the effect of religiosity on adolescent participation in at-risk behaviors.

Diomaris E. Jurecska received a Master's degree in Clinical Psychology in 2009 and is a fourth year doctoral student in Clinical Psychology at George Fox University in Newberg, Oregon. Her research areas include health psychology, cross-cultural Neuropsychology and forensic psychology. She currently teaches as adjunct at the undergraduate department of psychology at George Fox University.

Robert Dyer received his doctoral degree in clinical psychology from George Fox University in 2009. Research interests: psychological interventions and research with Mexican-American population. Dr. Dyer is a licensed psychologist in the state of Oregon.

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