



Developing a Latinx-Adapted Primary Care Parenting Program Through Expert Consensus: A Delphi Study

David M. Haralson¹ · Andrew S. Brimhall² · Jennifer L. Hodgson² · Eboni Baugh² · Sharon Knight² · Julian Crespo²

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Abstract

The purpose of this study is to establish consensus among a group of experts on the most effective ways to develop and implement a primary care parenting program for Latinx parents. Using a Delphi methodology, researchers sought consensus among Latinx, first-generation parents, Latinx researchers, and primary care experts by soliciting the suggestions of 23 women and five men from 10 different Latinx countries. Consensus was established across six out of seven themes. Themes where consensus was met included facilitator knowledge; program participants; program characteristics; program timing, length, and duration; program topics; and program educational methods. These results indicate that several programmatic changes need to be made to better adapt primary care parenting programs to the needs, values, and preferences of Latinx parents. Suggestions for programmatic changes are given at the end of this article.

Keywords Culture · Hispanic · Latino · Parenting education · Parenting program

Latinx Americans are part of the largest ethnic group in America, accounting for approximately 17% of the U.S. population (Pew Research Center 2015). Latinx American is a term used to identify any Latino, Latina, or Hispanic person who is currently living in the United States who immigrated, or whose descendants immigrated, from Central or South America or the Caribbean (U.S. Census Bureau 2017). Over the last 30 years, researchers have identified differences in healthcare access, outcomes, and satisfaction

based on race and ethnicity (Vega et al. 2009). For example, research has demonstrated that Latinx Americans have lower rates of health insurance (Centers for Disease Control and Prevention [CDC] 2017), lower rates of satisfaction and access to preventative care (CDC 2017), and higher levels of social isolation than their White, non-Latinx counterparts (Aldama et al. 2012; Anzaldúa 1999). One factor that may contribute to these disparities is the lack of health-promoting programs that are culturally attuned to the populations to which they serve (Potowski and Rothman 2011). One type of health-promoting program that has grown in popularity over the last decade are primary care parenting programs (PCPP) (Shah et al. 2016).

PCPPs are any parenting service with a written curriculum that has been adapted or developed for use in a primary care medical clinic (Haralson et al. 2020). Primary care medical clinics are clinics where patients receive continuous and comprehensive care by a team of trained professionals, with the hope of being a patient's first entry into the healthcare system (American Academy of Family Physicians [AAFP] 2017). Today, primary care agencies serve as the hub for most basic healthcare services, including services for both individual and family health (Substance Abuse and Mental Health Service Administration [SAMHSA] 2017). Primary care health clinics are also the location where most Americans, including Latinx Americans, prefer to have their

✉ David M. Haralson
david.haralson@pfeiffer.edu

Andrew S. Brimhall
brimhalla@ecu.edu

Jennifer L. Hodgson
hodgsonj@ecu.edu

Eboni Baugh
baughe@ecu.edu

Sharon Knight
knights@ecu.edu

Julian Crespo
crespoj15@students.ecu.edu

¹ Pfeiffer University, 600 Airport Blvd Suite 600, Morrisville, NC 27560, USA

² East Carolina University, Greenville, NC, USA

physical and mental healthcare needs met (Herman et al. 2016; Kessler and Stafford 2008).

One of the challenges, however, of implementing a parenting program within a primary care setting is adapting or developing a program that meets the cultural needs of those who are served. A recent review of eight of the most popular PCPPs indicated that more work is needed to better adapt PCPPs to meet the needs of Latinx parents and their children (Haralson et al. 2020). The purpose of this manuscript is to begin the process of developing a culturally attuned PCPP by asking primary care, research, and first-generation Latinx parent experts about their recommendations for building such a program. Following these results, recommendations for developing a culturally attuned parenting program within a primary care setting are given.

Literature Review

The American Academy of Pediatrics [AAP] (2012), the leading medical organization for children's health, recommends that medical providers discuss parenting issues with their patients, whether that means addressing the issues in-house (i.e., at the clinic itself) or referring out to a specialist in the community. For those pediatric clinics that are able to provide parenting services in-house, PCPPs can be effective in minimizing both individual and family-related health problems. Previous systemic reviews (e.g., Cates et al. 2016; Shah et al. 2016) have indicated that PCPPs can help reduce parental stress and depression; reduce harsh discipline; increase parental monitoring and responsiveness; improve literacy, numeracy, vocabulary, and school readiness; improve shared parent–child reading quality; and improve sibling and parent–child relationship quality.

While these results are encouraging, most studies to-date were conducted with White, Euro-American children and their parents. A recent article which compared primary care parenting programs confirmed the need for more PCPPs that are adapted to the values, beliefs, and preferences of Latinx families (Haralson et al. 2020). In this comparison, the authors compared PCPPs across several domains including their focus, cost, targeted age group, and training requirements. The authors also compared each program across five cultural adaptation strategies: linguistic, peripheral, constituent, sociocultural, and evidential (Kreuter et al. 2003). While each program translated its content into Spanish, at least partially (a linguistic strategy), only four of them used pictures of Latinx families (a peripheral strategy), three consulted with community Latinx experts (a constituent strategy), three consulted with culturally-informed researchers (an evidential strategy), and none of them built in specific sociocultural values into their curriculum (a sociocultural strategy). In addition to these noted strategies, the researchers could

find little evidence of what the developers actually did to make culturally-informed changes to their curriculum based on their consultations with community or research experts.

Results from this comparison are concerning because research has consistently shown that ethnic minorities are less likely to engage in health-promoting programs, to be satisfied, and to complete these programs than their majority counterparts (van Mourik et al. 2017). Two ways that service providers have sought to minimize these disparities are by (a) matching the patient's characteristics (such as their race or ethnicity) with that of their provider (Meghani et al. 2009) or (b) making specific adaptations to the health-promoting program based on the cultural needs of their patients (Bornstein 2012; van Mourik et al. 2017). Because it is not possible to match providers with their patients on every characteristic, nor is it beneficial to match in every situation (Meghani et al. 2009), it is recommended providers learn to be culturally attuned with their patients (Bornstein 2012) and that health-promoting programs adapt their process and content to meet patients' needs, values, and preferences (Barker et al. 2010).

Theory of Acculturation

Research on acculturation outcomes has consistently shown that those who integrate have better psychological outcomes than minority groups who reject the language and culture of their new country (a separation strategy), who reject the language and culture of their country or origin (an assimilation strategy), or those who reject the beliefs, values, and cultural practices from their country of origin and their new country (a marginalization strategy) (Berry et al. 2006; Berry and Sam 2013). Because of the positive outcomes derived from choosing an integrative strategy, it is recommended that those from the majority culture strive to adopt a multicultural strategy of acculturation (Berry et al. 2006). According to the theory, policies that are multicultural (a) advocate for the maintenance of cultural identity among minority groups, (b) encourage full participation by those within the minority group, and (c) promote regular interaction between those from the minority and majority group (Berry and Sam 2013).

Using the theory of acculturation as a guideline for Latinx-directed, multicultural, primary care programs, the design of such programs should: (a) advocate for the maintenance of Latinx language and values, (b) encourage full participation of Latinx parents within their healthcare environment (including language and cultural understanding), and (c) provide opportunities for routine interactions between Latinx families and those of different cultures. It also means that parenting program developers and Latinx patients should collaborate regularly with one another in

order to provide the highest level of care for Latinx parents. Viewed in this way, theory of acculturation (Berry 2005) can guide both developers and patients on best practices for developing culturally attuned primary care parenting programs for Latinx parents.

While researchers have systematically reviewed Spanish-adapted N-PCPPs (Vesely et al. 2014) and non-Spanish-adapted PCPPs (Cates et al. 2016; Shah et al. 2016), they have not yet investigated factors that are important in designing or developing a Latinx parenting program tailored to a primary care environment. Although the theory of acculturation suggests that programs developed within primary care be inclusive of those whom they serve (Berry and Sam 2013), none of the existing programs have been developed using these recommendations. Because parenting programs have been implemented with greater frequency within primary care environments (Cates et al. 2016), researchers are responding to the imperative that more work be conducted on factors germane to the development of multicultural programs.

The purpose of this study, therefore, was to explore factors perceived to be critical in developing first generation Latinx-directed, primary care-based parenting programs. In order to address this aim, the researchers sought to attain an expert consensus about what components a parenting program must include in order for a parenting program to be (a) effectively and efficiently administered in a primary care setting, and (b) culturally appropriate and relevant to the needs of first generation Latinx parents. The researchers used a Delphi process (Dalkey and Helmer, 1963) as a means to address these questions.

Methods

The Delphi method is a systematic way of coming to expert consensus on a particular topic (Dalkey and Helmer 1963). Delphi methods are used when participants live in various parts of the world, with a consensus process taking place through questionnaires via phone, by mail, in person, or via the Internet. These questionnaires are generally administered in two to four distinct phases, with each phase issuing a

different questionnaire based on responses from the previous phase (Hasson et al. 2000). The Delphi method used for this study included a three-phase process (Schneider et al. 2016). Permission was obtained from a University Institutional Review Board (IRB) prior to conducting this work (Table 1).

Phase One

Researchers recruited participants via purposive and snowball sampling until a minimum of 30 experts (a minimum of 10 experts from each inclusion criterion) completed the first questionnaire. Thirty participants were selected for two reasons: to keep attrition rates low and to ensure a diversity of opinion. Ultimately, this diversity would promote a meaningful consensus that adheres to the guidelines given by experts in Delphi methodologies (Hasson et al. 2000). Specifically, participants were recruited through research journals, university websites, personal contacts and referrals, flyers at a community health center, local tiendas (markets), and healthcare association email listservs. To be included in the study, experts had to self-identify as either (a) Latinx research experts, (b) primary care experts, or (c) first-generation Latinx parent experts (see Table 2 for complete definitions). Informed consent, given in both English and Spanish, was obtained through an online document prior to completing the first survey. Once participants agreed to participate in the study (10 from each inclusion criteria), a demographic survey, and a questionnaire with seven open-ended questions were given. Translation of all materials into both English and Spanish was accomplished by (a) using the Qualtrics (2018) translation program and (b) verifying all translations by two bilingual researchers who independently evaluated the Qualtrics (2018) translation. Because the study included two groups of participants, those who spoke English as their primary language and those whose primary language was Spanish, translations from Spanish to English, and English to Spanish, took place at each phase throughout the entire Delphi process.

After the data were translated, the researchers then analyzed the results. Using Brady (2015) thematic analysis, two researchers reviewed the data within a qualitative data software (QSR International Pty Ltd 2018), line by line,

Table 1 Expert inclusion criteria

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- (1) Latinx Research Expert: Published at least 5 peer-reviewed research articles or conceptual papers on the topic of Latinx parenting needs, practices, values, or preferences
 - (2) Primary Care Expert: Primary care healthcare provider who provides healthcare to Latinx children and who teaches, counsels with, or provides parenting interventions at least 10 h per week with Latinx families. A primary care healthcare provider includes anyone in a health-related field who provides direct healthcare services (e.g., physician's assistant, nurse practitioner, nurses, marriage and family therapist, clinical social worker, etc.). This does not include support staff (medical assistant, front desk staff, case workers)
 - (3) First-Generation Latinx Parent Expert: Latinx parent who has at least one child under the age of 18 years, who currently lives with them. They are the first of their immediate family to live in the United States permanently
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Table 2 Demographics from Survey #2 (n = 28)

	Country of Origin (n = 16)		
Gender			
Male	5 (18%)	Mexico	7
Female	23 (82%)	Peru	2
		Puerto Rico	2
Age (years)		Colombia	2
18–24	2 (7%)	Honduras	1
25–34	4 (14%)	Nicaragua	1
35–44	14 (50%)	Venezuela	1
45–54	6 (21%)	Cuba	1
55–64	2 (7%)	Brazil	1
		El Salvador	1
Inclusion criteria	Survey #1	Survey #2	Survey #3
Researcher only	5	4	3
Primary care only	11	11	11
Latinx only	11	9	8
Primary care, Latinx	2	0	0
Researcher, Latinx	2	2	2
Researcher, primary care	0	0	0
Researcher, primary care, Latinx	3	2	2
Total	34	28	26

Additional demographics, such as SES and education levels, are available upon request. Please contact David Haralson at david.haralson@pfeiffer.edu for additional results

until themes emerged. The seven themes were (a) facilitator knowledge, (b) program participants, (c) program characteristics, (d) program timing, length, and duration, (e) program location (f) program topics, and (g) program educational methods. Throughout the analysis process, the researchers also kept analytical journals in order to note their thought processes while categorizing the data (Strauss and Corbin 2008). Since qualitative researchers are often considered the research instrument (Strauss and Corbin 2008) these journals helped provide an audit trail for future coding and helped become a reference point for when the researchers discussed their independent analyses. Following this process helps increase the credibility and trustworthiness of the findings (Brady 2015).

Once themes were developed and illustrative responses were placed into each theme, the researchers came together to discuss which themes and categories they chose. When discussing the rationale of why each researcher selected the themes and categories they did, together the researchers made one of three choices: (a) abandon the category or theme altogether, (b) merge the category or theme into one, or (c) keep both themes or categories. For example, the categories that were previous entitled (a) the process of acculturation and (b) stress from the merging of two cultures were

categorized into one category: (c) acculturation (the degree to which families accept or reject the cultural practices of those from another culture) and the stress derived from this process. The researchers also eliminated themes and/or categories that were either repetitive or unrelated to the two overarching research questions and provided clarification of meaning where necessary. At first, the themes and categories were nearly identical approximately 50% of the time. Over the course of four separate meetings (both in person and via technology), they came up seven themes and 89 categories that both researchers could agree upon.

In addition to the themes and categories derived from the participants' responses, with the help of a trained librarian, a thorough literature review was also conducted until eight literature reviews, meta-analyses, and/or systematic reviews that made specific recommendations for making parenting programs culturally relevant to Latinx families and/or relevant to primary care agencies were located. Once all relevant manuscripts were located, the researchers placed the discussion sections from these articles alongside the participants' responses, as if the articles were representing eight additional participants. Once the discussion sections and the participants' responses were combined, the researchers used thematic analysis (Brady 2015) (as explained above) to analyze the combined data. Once participants' responses and data derived from the literature reviews were sorted into themes and categories, the researchers began developing questions for the second survey.

Phase Two

The first step of phase two was to design a survey questionnaire based on the qualitative findings associated with the first survey, with additional survey categories derived from the peer-reviewed literature. The second phase survey, which is form of member-checking (Birt et al. 2016), consisted of a list of categories followed by Likert-style response choices measuring the level of importance for developing a primary care parenting program. The response choices were: "Not Important," "Somewhat Important," "Very Important," and "Essential." The survey was also constructed so that participants were able to enter additional data through free text qualitative comments in a box located after each survey section.

The second step of phase two was to analyze the qualitative and quantitative data. Qualitative data were analyzed first by translating study participants' data into English and then analyzing the data elicited from free text responses. The quantitative data were transferred into Microsoft Excel, where the standard deviation, median, mode, mean, and interquartile ranges were calculated for each category. Each statement was then listed in rank order by its mode ("50%"

or higher marked either “Very Important” or “Essential”) and interquartile range (\geq one) score.

Phase Three

The first step of the third phase was to develop a questionnaire based off of the data from the phase two survey. The researchers included the categories in the third survey if (a) 50% or more of the participants who completed the phase two survey marked either “Very Important” or “Essential” for that category and (b) that category had an interquartile range score \geq one. Although there is no established consensus on what consensus looks like in a Delphi study, researchers generally recommend between 50 and 80% agreement and an interquartile range of 1.0 or less (Hasson et al. 2000; Latif et al. 2017). Each category that met the inclusion criteria for the third survey was then presented to the participants in a list, with those categories with the highest total percentage listed first. Categorical statements were nested under one of seven themes that captured their intent. The final themes, as derived from both the literature search and the participants’ responses were (a) facilitator knowledge, (b) program participants, (c) program characteristics, (d) program timing, length, and duration, (e) program location, (f) program topics, and (g) program educational methods. Following each thematic section, researchers asked participants to reflect on the extent to which they agreed with those results. The answer choices on the 6-point Likert-scale were: “Strongly Disagree,” “Disagree,” “Somewhat Disagree,” “Somewhat Agree,” “Agree,” and “Strongly Agree.”

The second step of phase three inquired about each participants’ level of agreement with the final results. The answer choices for this 6-point Likert-scale ranged from “Strongly Agree” to “Strongly Disagree”, with a comment box after each question. The results of the Delphi study are presented in the sections that follow.

Results

Results indicated that consensus was established for 42 out of the original 89 categories. Although not necessary to establish consensus, the results are strengthened by the fact that 100% of those who participated in survey three agreed with the results as a whole (8% selected “Somewhat Agree”, 52% selected “Agree”, and 40% selected “Strongly Agree”).

Demographics

Out of the 34 participants who responded to survey one, 28 responded to survey two, and 26 responded to survey three. Participants were recruited in order to: (a) obtain the minimum of 10 experts from each criterion and (b) to

overcompensate for possible attrition. Over the course of three surveys, the attrition rate was 23.5%. Demographic data for survey two are described in Table 2 because consensus was considered established after the second survey. Participants came from nine different regions of the United States, with the majority from the South Atlantic (32%). Among all participants, 36% did not have any children, 57% were married, and 57% identified as Latinx. Just over half of the participants had acquired a doctorate or medical degree (53.5%), with the majority having an annual family income between \$75,000 and \$149,999 (57%). When asked about approximate number of hours they have had in formal parenting training, 32% had over 100 h, 18% had 30–99 h, and 28.5% had 29 or fewer hours. Some of the participants had acquired so many hours of training that they were unsure of the total number of hours they spent in parenting training (21%). Although 36% of the participants did not have children and 43% did not identify as Latinx, each was an expert in primary health care, research on Latinx culture, or was a Latinx parent themselves. This diversity of expertise, along with the diversity of country representation, was necessary for establishing a broad level of consensus. Future Delphi studies can help establish consensus among experts in the same field and participants from the same country of origin.

Results from Each Category

The results from the facilitator knowledge section fell into three basic subthemes: (a) acculturation and trauma, (b) Latinx values, and (c) extent of Latinx diversity. Of the 13 categories that the participants could agree upon, three of the categories were related to the process of acculturation, acculturation stress, or trauma; seven were related to generally accepted Latinx values; and three were related to Latinx diversity. The results also indicated that certain members of a family unit are more important to invite to a primary care parenting class than others. The only two people that the majority of participants felt should be invited to participate in a primary care parenting class were a child’s mother and father. The relevancy of other family forms (such as single parents or same-sex couples) or gender identities (such as transgender or non-binary) were not mentioned by the participants. Participants indicated that there are certain programmatic characteristics that are important to have when delivering a primary care parenting program. They agreed that primary care parenting programs for first-generation Latinx parents should: (a) be delivered by someone who is fluent in the preferred language of the participants, (b) provide free childcare, (c) use qualitative research, and (d) use quantitative research. Although the categories of qualitative and quantitative research could be subsumed under one broad category such as “research driven,” participants in

phase one specifically mentioned preferences for one type of research or the other.

When asked about program timing, length, and duration, the participants agreed upon seven out of 18 categories. The participants agreed that the program must be: (a) flexible to the participants' needs, (b) implemented at every well-child visit, (c) take place in the evening, (d) take place on weekends, (e) completed in conjunction with family medical visits, (f) be 15 to 30 min in length, and (g) have a set topic at each session or visit. Although 64% of the participants indicated that having a parenting class within a parenting facilitator's room and 61% within a group or community room was either very important or essential, the interquartile range was over one for both of these categories. This meant that the participants could not come to agreement on any of the categories related to location. The participants agreed that 10 out of 17 topics were important to include in a primary care program for first-generation Latinx families. Topics that participants agreed upon fell into three basic subthemes: (a) physical health, (b) psychological health, and (c) social health. Of the 10 agreed-upon categories, five were related to social health, two were related to psychological health, and three were related to physical health. The participants also agreed that certain educational methods were preferable to others. They agreed that primary care parenting classes for first-generation Latinx parents should (a) be face-to-face (as opposed to technology-based), (b) conversational or discussion-based, (c) provide research-based information plus interactive activities, (d) use of role-plays or other interactive activities, and (e) use play therapy. Agreement was not achieved on the use of technology-based interventions (e.g., on the Internet, tablet, or TV), psychoeducational methods, the use of educational brochures or workbooks, or the use of cognitive behavioral therapy.

Overall Agreement of Survey Results

Although not used to establish consensus, the final survey was used as a form of member-checking (Birt et al. 2016) to ensure that the results from the second survey were trustworthy. After presenting findings to participants (as described in the previous section), said participants were asked about the extent of agreement with the themes as a whole. Results from this third survey indicated that all of the participants ($n = 26$) agreed (8% "Somewhat Agree"; "52% "Agree"; 40% "Strongly Agree").

Discussion

Research looking at ethnic differences in health has indicated that Latinx children have higher rates of many health-care conditions when compared to their White, non-Latinx

counterparts (CDC 2017) and that primary care agencies can be effective locations for minimizing some of these disparities (Shah et al. 2016). However, previous research (Haralson et al. 2020) found primary care parenting programs are failing to provide culturally attuned parenting programs to Latinx parents. The purpose of this study was to respond to this failing by providing primary care providers with practical guidelines for developing or adapting parenting programs to the needs, beliefs, and values of first-generation Latinx parents.

Research Question # 1: What Topics Need to be Addressed When Providing a Parenting Intervention to First-Generation Latinx Parents in Primary Care?

While experts in this study recommended parenting program topics consistent with previous literature (Child Welfare Information Gateway 2019), they also contributed a few unique ones that may be particularly beneficial to first-generation Latinx parents. First, the participants agreed that primary care parenting facilitators should discuss signs of mental health distress, substance use, and sexual behavior in their children. Although unique to the world of primary care parenting programs (National Research Council 2009), the suggestion to screen for and educate about substance use, mental health issues, and risky sexual behavior within primary care is consistent with recommendations by several major healthcare entities including the American Academy of Pediatrics (Cheung et al. 2018) and SAMHSA (2017). Although these topics would be beneficial to all patients who come to see their doctor, they may be particularly important to Latinx children who historically have had higher rates of substance use, depression, anxiety, and risky sexual behavior than their White, non-Latinx counterparts (Céspedes and Huey 2008; Krogstad 2016; Partnership for Drug-Free Kids 2012; Varela and Hensley-Maloney 2009).

Second, consistent with prior findings, this study confirms the need for more parenting programs to consider the role that acculturation plays for Latinx families. According to Berry (2005), acculturation can be defined as a process that takes place when two or more cultures come into contact with one another. The results from this study coincide with Berry's theory which emphasizes the need for more multicultural parenting programs. Barker et al. (2010) suggested that parenting facilitators can be in tune with the process of acculturation by using acculturation scales such as the Acculturation Rating Scale for Mexican Americans-II (Gutierrez et al. 2009), by assessing for English language proficiency, and the level(s) of stress that is related to opposing cultural values within the family system (Lorenzo-Blanco et al. 2016).

Third, the results of this study also demonstrate the importance of assessing for trauma when working with

Latinx families. A plethora of studies indicate that Latinx families experience trauma at higher rates than their White, non-Latinx counterparts (Fortuna et al. 2008; Holman et al. 2001; Rojas-Flores et al. 2017) and that trauma impacts the way they care for their children (Levendosky and Graham-Bermann 2001). Despite these studies, very few, if any, parenting programs exist that address trauma as a central component (Foli et al. 2018). Because trauma can dampen a parent's emergency response system (Bremner 2006) and weaken a parent's ability to be attuned to the mental state of their child (Suardi et al. 2017), parents who have experienced trauma are more likely to be physically and psychologically unavailable or neglectful to their children (Schechter et al. 2007).

Although many researchers recommend assessing for trauma, some scholars (Suardi et al. 2017) gave specific instructions on what exactly needs to be assessed. They suggest that health care providers assess (a) for current safety in the home, (b) the ways parents describe their child's personality (Is it negative, harsh, or totalizing?), (c) how the parent interacts with their child in the waiting room and other areas of the clinic, and (d) the way in which the parent's attachment style was formed in childhood. This same type of assessment may be useful when working with Latinx parents; however, more research is needed to better understand the most culturally appropriate ways to assess trauma within Latinx families, especially if wanting to honor cultural values such as "respeto."

Research Question # 2: How can Parenting Interventions that are Delivered to First-Generation Latinx Parents Within a Primary Care Setting be Effective, Efficient, and Culturally Sensitive?

This study highlighted the need for several systematic changes that could make primary care parenting programs more efficient. For example, this study highlighted the essential involvement of parents in the health of their children. Involving parents may mean making a more concerted effort to engage fathers, who have historically been less likely to take their children to see primary care providers than mothers (Panter-Bricker et al. 2014). Using the suggestions given in this study, primary care agencies might increase father engagement by offering programs after 6 pm or on the weekends. Previous research on father involvement in parenting programs recommend persistence in father involvement, explicitness in inviting fathers to participate, offering in-home visits, developing a program specifically to fathers (e.g., the parenting program entitled *Dads on Board*), or providing the parenting class at a medical location (Brown et al. 2012; Maxwell et al. 2012).

Second, the participants in this study have indicated that implementing parenting programs within well-child visits,

between 15 and 30 min in length, is the preferred way of administering a primary care parenting program for Latinx parents. Research has shown that well-child visits are generally well-attended by parents in the United States (Child Trends 2014) and that most primary care parenting programs are already being administered within these visits (Haralson et al. 2020). If a parenting program is implemented during well-child visits, this would also give parents the opportunity to regularly evaluate their parenting skills and the relationship they have with their child by a trained professional. Although relatively new in their inception, several studies have shown that behavioral health services, such as parenting, have aided in reducing healthcare costs and improving numerous health-related outcomes (Melek et al. 2018).

Effectiveness has been defined as providing healthcare services that are validated by research to people who could benefit from the service (Institute of Medicine 2001). The results of this study suggested that primary care parenting programs need to regularly use both qualitative and quantitative research and that research-based parenting techniques (e.g., play therapy) should be used. In addition, these results suggested that parenting programs for first-generation Latinx parents should be: (a) face-to-face, (b) discussion-oriented, (c) grounded in prior research, (d) and interactive. These results coincide with previous research that found first-generation Latinx individuals are more likely to have technological challenges than white, non-Latinx individuals and that they prefer face-to-face interactions over technological interactions (Machado-Casas et al. 2014; Child Trends 2016). Filial play therapy (Guerney 1964), an interactive, research-based therapy model designed to improve parent-child attachment may be useful for Latinx parents in primary care settings (Garza and Watts 2010). However, this model is centered on having both the parent and child together in the same room, and the results of this study are inconclusive on whether or not children should be a part of parenting programs for Latinx families (although the participants did agree on the importance of family medical visits) (Table 3).

Culturally Attuned Primary Care

Results for this study can be used for (a) improving extant parenting programs and (b) creating new parenting programs by making them more culturally relevant to first-generation Latinx parents. This is important because previous researchers indicated that participants in culturally adapted parenting programs have higher levels of effectiveness, satisfaction, and retention (Domenech Rodríguez et al. 2011; Reese and Vera 2007; Parra Cardona et al. 2012). Barker et al. (2010) suggested six values that should be considered when implementing a parenting

Table 3 Level of importance among categories in survey #2

Category	Very important (%)	Essential (%)	Combined total (%)
Question 1: How important is it that the program's facilitator is knowledgeable about the following topics?			
Familismo	32	64	96
The degree to which the child or parent feels "caught" between two different cultures (the culture from their country of origin and the United States)	50	46	96
Extent of diversity among Latinx families	46	46	92
Acculturation (the degree to which families accept or reject the cultural practices of those from another culture) and the stress derived from this process	53	39	92
Question 2: How important is it that the following people attend your program?			
The mother	18	82	100
The father	25	71	96
Question 3: How important is it that the program has the following characteristics?			
Delivered by someone who is fluent in the preferred language of the participants	14	82	96
Provides free child care	46	46	92
Question 4: How important is it that the program is delivered in the following ways?			
Flexible to participants' needs	32	61	93
Question 5: How important is it that the program is delivered at the following places? ***No responses on this question met the Mode and Interquartile requirements for inclusion			
Question 6: How important is it that your program facilitator teaches the following topics to their patients?			
Health ways of communicating	43	54	97
Setting limits on child behaviors	29	64	93
Question 7: How important is it that your program is delivered using the following formats or methods?			
Face-to-face	21	79	100
Conversational or discussion-based	46	46	92

Only criteria that were marked as either Very Important or Essential by 90% or more of the participants were displayed in this table. Please contact David Haralson at david.haralson@pfeiffer.edu for additional results

program for Latinx families: (a) language proficiency, (b) familismo, (c) respeto, (d) personalismo, (e) marianismo and machismo, and (f) acculturation. Just like the findings from this study, they emphasized that it is important for parenting facilitators to understand the extent of diversity that exist among Latinx parents and to not assume that all Latinx parents share these same values. While this study identified how community-based parenting programs can adapt their services to align better with the values of Latinx parents, they do not describe how these values can be instilled within a primary care setting. It is recommended that primary care agencies follow the suggestions given in Table 4 in order to apply these values, along with previously stated recommendations, to primary care settings.

These recommendations will aid primary care agencies in becoming a more inclusive environment for first-generation Latinx families. They encourage healthcare providers to assess for important yet often over-looked aspects of care such as family relationships, acculturation stress, and trauma. While this study has many strengths there are also

some important limitations that should be considered to help guide future research in this area.

Strengths, Limitations, and Future Studies

Although several studies have demonstrated the effectiveness of delivering parenting support programs within primary care, none have examined how to make these programs adaptable to first-generation Latinx parents (Cates et al. 2016; Haralson et al. 2020). This study is the first of its kind to engage with Latinx culture, parenting, and primary care experts on how to best adapt or develop a parenting program for first-generation Latinx families. By asking distinct, yet-overlapping experts for their opinions on this topic, the researchers were able to gather rich data and achieve consensus from multiple vantage points. The rigorousness and thoroughness of the recruitment process, the data analysis, the member-checking in phases two and three each, and the questionnaire development process add to the reliability and validity of these results. This study also surveyed Latinx

Table 4 Sociocultural recommendations for Latinx families within primary care medical settings

- a. Create an environment where Spanish is the norm (language proficiency). This can be accomplished by providing access to bilingual healthcare providers, auxiliary staff, and professional interpreters and by providing material, signs, and websites that are in both Spanish and English
- b. Establish policies that encourage family-oriented care (familismo). This can be accomplished by scheduling family medical visits at times when they can best attend together and making a special effort to build relationships with members of the family who are unable to attend medical visits but play a parenting role
- c. Establish a cultural of professionalism (respecto). This can be accomplished by establishing a policy for professional attire, mannerisms, and language. Healthcare personnel should be polite and cordial in all their interactions with patients and other staff members
- d. Get to know Latinx families outside of their medical concerns (personalismo). This can be accomplished by making it a point to remember personal information about patients (such as their birthday) and by asking about personal information (such as their family, their hobbies, or their expertise). This also requires providers to chart and then review any relevant cultural and family-based information before each visit
- e. Make it a point to discuss gender roles and expectations (marianismo and machismo). This can be accomplished by asking about the roles that each family member plays in the caring of children. Who spends the most time with the child(ren) in the home? Who participates in disciplining the child(ren)?
- f. Thoroughly assess each patient's immigration history (acculturation). This can be accomplished by asking all patients how long they have lived in the United States, benefits and challenges of their relocation, and family, friends, customs they miss from where they lived previously
- g. Thoroughly assess for trauma and record it in the electronic medical record (trauma-informed). Because trauma can take many forms, providers should compassionately assess for prior traumatic experiences and how patients are impacted today. The adverse childhood experience (ACE; Felitti et al. 1998) questionnaire is an excellent tool that can be used for helping identify past traumas

These suggestions are based on the recommendations from Barker et al. (2010) and the findings of this current study

individuals from 10 different Latin American countries, giving the results a broader level of consensus. A broad level of consensus provides steppingstones for future Delphi studies interested in surveying participants from the same country of origin.

Because the survey was translated back and forth between English and Spanish several times and because the translation did not account for dialectic differences within the Spanish language, it is possible that some of the data were lost during translation (Squires 2009). Second, although researchers independently coded every section of the research literature for inclusion in the survey, the method had each researcher independently code a portion of the participants' responses and cross check for agreement instead of independently coding all responses and reconciling differences in word choices/phrases (the interrater agreement process is described in more detail in "Methods" section). This method was selected, in place of each researcher coding all sections, to reduce the time between each phase, reducing the likelihood of attrition.

Results offer practical guidelines for future research regarding program evaluation and multicultural parenting program development. First, because the researchers were unable to reach those without an Internet connection or computer know-how, future studies should ask the same types of questions from this study via paper and pencil methods—that way the voice of those with fewer resources can be heard. Second, future studies could clarify the meanings of some of the words from this study—words like "healthy communication" and "limit setting"—that way greater consensus can be reached about the specific details of a future parenting program. Finally, a pilot study which tests the

usefulness of some of the suggestions from this study could be meaningful. In particular, measuring the effectiveness of a trauma or acculturation-focused program could demonstrate if a program of this sort is beneficial to the first-generation Latinx community.

Conclusion

Previous research has shown that Latinx children suffer from negative health conditions at higher rates than their White, non-Latinx counterparts (CDC 2017) and that parenting support programs can help minimize these negative outcomes (Shah et al. 2016). This study was unique because it sought to minimize these disparities by bringing together the voices of three distinct yet overlapping experts in order to understand better ways of adapting/developing a primary care parenting program for first-generation Latinx parents. Results showed that there are several programmatic changes that need to take place if primary care parenting programs want to become more culturally in-tune with the values, needs, and preferences of first-generation Latinx parents. This study will likely be used as a catalyst for future research around this topic.

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Compliance with ethical standards

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