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Strengthening Positive Parenting in the Context of Intimate Partner Abuse

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Abstract

Intimate partner violence has been associated with long-term negative effects on mothers' mental health status, use of positive parenting practices, and their children's externalizing behavioral difficulties. Especially strong is the association between concurrent experiences of partner violence and maternal parenting. In this case study, we examined the impact of behavioral parent training on parenting and outcomes for a 6-year-old Latino diagnosed with oppositional defiant disorder (ODD). The family was participating in a larger study examining the implementation and cultural adaptations of an evidence-based parent training program, Helping the Noncompliant Child. Mother reported a history of domestic violence and ongoing abusive behavior from her intimate partner but only wanted services focused on addressing child's behavioral difficulties and improving the quality of parent-child interactions. Adaptations included but were not limited to the translation of all intervention materials, extending the number of sessions focused on each parenting strategy, flexibility with regard to the location and time of therapy sessions, negotiating safe times for the family to participate in treatment, and case management. Parent reports of child behavior and parenting stress moved from the clinical range to the normal range from pre- to post-test. Mother also reported increased use of positive parenting practices. These data, along with closing semi-structured interviews, suggest that within the context of ongoing partner abuse, a mother's parenting and her child's behavior can be positively affected by parent training that is adapted and responsive to the context of their family's situation.

Keywords

parenting and intimate partner violence; undocumented Latinas; undocumented women and intimate parent violence

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1 Theoretical and Research Basis for Treatment

This case study examined the impact of behavioral parent training (PT) on the parenting of an undocumented Mexican immigrant mother victim of intimate partner abuse (IPA) and outcomes for her 6-year-old son. For the purposes of this case study, the review of the IPA and the PT literature will be tailored to the particular characteristics of the case.

Prevalence of Intimate Partner Abuse and Risk Factors

IPA is a pernicious societal problem in the United States (US) defined by a pattern of multiple forms of restrictive and abusive behaviors to control and hurt another person that includes physical, sexual and psychological harm, and financial dependence by a current or former romantic partner (Black et al., 2011). IPA is a gendered social problem—85% of victims are women—with prevalence rates of 5.9 out of every 1,000 women. Risk for IPA peaks for women during the prime child bearing years of 25 to 34 with a prevalence rate of 12.1 out of 1,000 (Catalano, 2012). In the US, about one out of every four women is a victim of severe physical violence and 48.4% experience psychological aggression by an intimate partner in their lifetime (Black et al., 2011).

The risk factors identified in the literature highlight that IPA exists within contexts and co-occurs with other negative life events (Capaldi, Knoble, Shortt, & Kim, 2012). Capaldi et al. (2012) conducted a systematic review of IPA risk factors and grouped them into three categories: (a) contextual characteristics, (b) developmental and behavioral characteristics of couples, and (c) relationship risk factors. Contextual risk factors included socioeconomic status, age, gender, race/ethnicity, and acculturation stress. Developmental risk factors included victims' and perpetrators' history of childhood abuse and exposure to IPA in family of origin, associating with deviant peers, substance/drug abuse, and mental health status with conduct problems and antisocial behaviors as robust predictors for perpetrators. Relationship risk factors included relationship status (married, cohabitating, separated), satisfaction with relationship, and degree of discord in the relationship. Most of these risk factors had a positive relationship or association with IPA, whereas marital satisfaction and age are inversely associated with IPA.

Prevalence of IPA in Ethnic/Racial Minority Groups

Membership in some minority groups increases the risk of IPA (Capaldi et al., 2012). Latinos and African Americans, the two largest minority groups in the United States, have higher IPA incidence and reoccurrence rates than White Americans, with African Americans typically experiencing the greatest risk (Black et al., 2011; Caetano, Field, Ramisetty-Mikler, & McGrath, 2005). Caetano et al. (2005) in a longitudinal study found that at baseline and follow up, African Americans were 3.5 times more likely to report IPA and had a severe IPA reoccurrence rate 6 times higher than White Americans, whereas Latinos were 2.5 times more likely to initiate IPA between baseline and follow-up and had a severe IPA reoccurrence rate 4 times higher than White Americans. Conversely, Golden, Perreira, and Durrance (2013) found that Latinas (25.5%) and foreign-born women (35%) experienced higher rates of IPA than White Americans (16.4%) and African American (17.4%) women living with their partners. These differences in physical abuse and coercion were explained

by economic hardship and dependence, traditional gender beliefs, and neighborhood disadvantage.

The limited research on prevalence and risk factors in Latino subgroups indicate IPA is influenced by nativity and country of origin and that rates are higher for Mexican Americans/Mexican immigrants (e.g., Cho, Velez-Ortiz, & Parra-Cardona, 2014). Relatedly, among Latinas, nativity and immigration status highlight the complexity of disclosure and formal help-seeking and point to a hierarchical pattern in which undocumented women are least likely to reach out for help. While non-Latinos are more likely to access shelters and be more informed about community resources for IPA than Latinos (Ingram, 2007), U.S.-born Latinos (14.7%) are more likely to seek formal help than Latino immigrants (6.9%; Ingram, 2007), and Latina immigrants with permanent legal status are more likely than their undocumented counterparts to seek formal help for IPA (Zadnik, Sabina, & Cuevas, 2014). Moreover, for Mexican women having more traditional gender role attitudes and immigrant status is associated with less reporting of abuse (Harris, Firestone, & Vega, 2005). Furthermore, reporting and seeking help can be a double edged sword: opening doors to formal services as well as increasing risk of injury from perpetrator, rejection from family members, and involvement of child protective services. An important factor of reporting IPA unique to undocumented couples is that reporting not only reveals the abuse but potentially “outs” their precarious, marginalized, and covert existence risking deportation, other legal consequences, and family separations across international lines.

Detrimental Two-Generational Effects of Victimization

IPA frequently takes place in the presence of children. According to the National Survey of Children’s Exposure to Violence, 16% are exposed to psychological/emotional aggression and 17% are exposed to physical aggression in their lifetime (Hamby, Finkelhor, Turner, & Ormrod, 2011). Moreover, children exposed to IPA are 3.7 times more likely to develop mental health difficulties than those with no IPA exposure (Martinez-Torteya, Bogat, von Eye, & Levendosky, 2009). Specifically, research indicates that IPA exposure negatively impacts children’s cognitive functioning, socio- emotional and behavioral development, and endorsement of trauma symptoms, with notable gender differences in the presentation of externalizing (e.g., aggressive behaviors) and internalizing (e.g., depression, anxiety, trauma symptoms/post-traumatic stress disorder) behavioral disorders identified across many studies (Evans, Davies, & DiLillo, 2008; Holt, Buckley, & Whelan, 2008; Hungerford, Wait, Fritz, & Clements, 2012), with numerous studies finding boys to be more likely to develop externalizing behavioral problems than girls (Evans et al., 2008).

An interrelated body of research shows IPA exposure is multidimensional, involving witnessing physical, verbal, and psychological aggression; maladaptive conflict resolution; and limited adult regulation of strong emotions (Anderson & Cramer-Benjamin, 1999). Hence, its impact on children is not unidimensional. Children are more likely to be abused themselves, may get less supervision, less warmth, and harsher disciplines (Holt et al., 2008). Moreover, retrospective data suggest that witnessing IPA as a child is significantly associated with IPA in adolescence and adulthood, both for perpetrators and victims (e.g., McKinney, Caetano, Ramisetty-Mikler, & Nelson, 2009). Casanueva Martin, Runyan, Barth,

and Bradley (2008) found that women who were current (25%) or past victims (20%) of IPA had significantly higher rates of childhood abuse experiences than those reporting no experience of IPA, implying an increased vulnerability for future abuse for this population.

The most common conceptual model used to understand the impact of IPA on the parent–child relationship is the spillover hypothesis which “proposes that the negative affect and emotion arising from interparental conflict sets in motion processes that ultimately negatively influence interactions within the parent-child system” (Sturge-Apple, Davies, Cicchetti, & Fittoria, 2014, p. 983). Ample research supports this hypothesis indicating that interparental conflict characterized by aggression, frustration, hostility, and abuse is often not contained within a couple’s intimate relationship and interactions but rather spills over to the parent–child relationship in the form of harsh parenting, lax control, emotional unavailability, and lack of support (Krishnakumar & Buehler, 2000). The spillover impact of IPA on parenting is mediated by its impact on mothers’ negative psychological functioning and satisfaction with her relationship (Levendosky & Graham-Bermann, 2001). Specifically, IPA is associated with negative effect on mothers’ mental health status with depression, post-traumatic stress (Casanueva et al., 2008; Golding, 1999), and anxiety as the most common problems (e.g., Golding, 1999; Lagdon, Armour, & Stringer, 2014). Hence, IPA negatively impacts parenting and child adjustment by compromising the psychological functioning of mothers (Levendosky & Graham-Bermann, 2001), which then disrupts their ability to provide caregiving that is warm, attuned to children’s negative emotions, effective, authoritative, and fosters a positive parent–child relationship (Hungerford et al., 2012). Also, parent behaviors appear to be differentially impacted by IPA. Krishnakumar and Buehler (2000), in a meta-analytic review, found that harsh discipline and parental acceptance were the parental behaviors most affected by interparental hostility. Moreover, recency of IPA has also been found to predict parenting, with better parenting scores on the Home Observation for Measurement of the Environment Short Form obtained by mothers reporting past experiences of abuse than those reporting current experiences of abuse (Casanueva et al., 2008), indicating a strong association between concurrent experiences of IPA and maternal parenting.

Agency and Resilience in the Context of Victimization

The IPA literature underscores its detrimental effects on parenting and maternal and child mental health; however, there is also evidence indicating variability in how children are affected by exposure to IPA (Martinez-Torteya et al., 2009). In contrast to the spillover hypotheses, the compartmentalization hypothesis proposes that in the marital conflict context, some parents control the impact of IPA on parenting by containing their negative feelings and reactions within the confines of their interpartner discord (Sturge-Apple et al., 2014), using specific strategies to keep children physically safe, and specific psychological strategies (e.g., reassuring and supportive parenting, and compartmentalizing) to decrease the negative impact of IPA on their children (Lapierre, 2010). This literature highlights parenting practices and protective factors that appear to differentially ameliorate the impact of IPA on children’s adjustment. Several protective factors that promote the healthy behavioral and emotional development of children exposed to IPA have been identified: positive parenting (e.g., warm, supportive, positive expectations, and low criticism), easy

child temperament (e.g., approachable, adaptable, low reactivity) and high child cognitive ability (Martinez-Torteya et al., 2009), tangible help, social support, and friendship quality (Capaldi et al., 2012). However, the predominant protective factor is a secure attachment to the nonviolent parent or primary caregiver (Holt et al., 2008).

A large body of research supports focusing on the parent–child relationship “as the therapeutic mechanism for change” (Lieberman, Van Horn, & Ippen, 2005, p. 1241), its critical role in promoting child adjustment, and on changing maladaptive patterns of interactions and behaviors within the parent–child dyad (e.g., Eyberg, Nelson, & Boggs, 2008; Kaminski, Valle, Filene, & Boyle, 2008). PT is the psychosocial treatment of choice to address behavioral difficulties, in particular for young children (Eyberg et al., 2008). PT is also an effective intervention for ethnic-racial minority families (e.g., Chaffin et al., 2004; Matos, Torres, Santiago, Jurado, & Rodríguez, 2006; Reid, Webster-Stratton, & Beauchaine, 2001). Furthermore, the research on PT in the context of IPA—although limited—has found that PT reduces parenting stress, and improves parental self-efficacy and emotional well-being and that for children it increases compliance and reduces internalizing and externalizing behavioral difficulties (Rizo, Macy, Ermentrout, & Johns, 2011). Common across PT programs used with IPA victims is the primary importance given to the parent–child relationship, and the concentrated focus on decreasing child behavioral difficulties and improving child’s functioning by first addressing the parent–child relationship (communication, quality of interactions, time spent together) and then addressing parents’ limit setting and discipline practices.

In summary, mothers have been found to take specific actions to protect their children in the context of IPA (Lapierre, 2010; Sturge-Apple et al., 2014). The parental ability to compartmentalize, buffer, protect, and nurture takes place within the hostile context of IPA and in relation to other variables (e.g., maternal history of childhood abuse, lack of social support, and negative life events; Levendosky et al., 2001), which underscore the limitations of maternal protectiveness and efforts to be “good” mothers (Lapierre, 2010). PT programs are designed to help parents’ alter their children’s environment by changing the environmental contingencies for their behaviors. However, parents’ success altering their children’s environment and environmental contingencies is circumscribed by the context of ongoing IPA. The following sections describe a mother’s agency and resilience in her use of positive parenting strategies while participating in a study, *Padres Latinos Ayudando a sus Niños a Cambiar* (PLANAC; Latino Parents Helping Their Children to Change), examining the implementation and cultural adaptations of an evidence-based PT program, *Helping the Noncompliant Child* (HNC; McMahon & Forehand, 2003) by community mental health providers using it with low-income Latino immigrant families. The study was approved by the institutional review board at the University of Illinois at Chicago; the therapist’s name is not used and client names were changed to protect their confidentiality. This case study combines three streams of data: clinician’s reports and notes, pre- and post-treatment quantitative data, and qualitative data from technical support records and semi-structured interviews conducted at the end of the study.

2 Case Introduction

Azucena, a 34-year-old monolingual Spanish-speaking Mexican immigrant, and her husband, Manuel, lived with their three children: 6-year-old son Gonzalo and his younger siblings, a 4-year-old girl, and a 2-year-old boy. When Gonzalo was 3 years old, he and his family migrated to the United States from a small semi-rural town in Mexico. At the time of their participation in treatment, all were undocumented immigrants—except the youngest child—and only the children had health insurance. Educationally, Azucena obtained a bachelor's degree in public accounting prior to her marriage and Manuel completed elementary school. Azucena reported a household annual income below the poverty line, between \$16,000 and \$20,000.

3 Presenting Complaints

Azucena sought therapy for Gonzalo due to concerns about his noncompliance, tantrums, increasing aggressive behavior toward his younger sister at home, and increasing noncompliance and physical aggression toward peers at school. Azucena and Gonzalo met criteria to participate in the PLANAC program because they were a Latino immigrant family, behavioral difficulties were the primary reason for parental initiation of therapy, and based on parent-completed measures Gonzalo met criteria for Oppositional Defiant Disorder (ODD).

Early in treatment, Azucena disclosed a history of IPA in her marriage. After disclosing the IPA, she expressed concern that Gonzalo's witnessing the physical abuse as a toddler and the ongoing psychological and emotional abuse was associated with his behavioral difficulties. Azucena reported she was unable to discipline her son and to control the chaos at home; she explained feeling hopeless, depressed, guilty, and inadequate as mother. The daily home environment was described as inconsistent, unstructured, and with very few opportunities for positive mother-child interactions. Azucena refused services to directly address her abusive situation, and focused on getting help to address child's noncompliant and aggressive behaviors. She expressed particular interest in developing a more positive relationship and decreasing the negative interactions with Gonzalo.

4 History

Azucena reported being concerned about Gonzalo's noncompliant, aggressive, and demanding behavior since he was a toddler and that as an infant she struggled to soothe and calm him. When he started school for the first time in kindergarten, teachers expressed concern about his behavior, called Azucena repeatedly about his aggressive and noncompliant behavior, and the school counselor referred mother to the therapist's agency. Azucena also reported frequent disagreements with Manuel about how to discipline and consequence Gonzalo, which often resulted in arguing, fighting in front of him, followed by child misbehaving. Azucena described Manuel as overindulgent with Gonzalo, minimizing seriousness of child's behavior, not enforcing consequences, and unwilling to work with her on helping Gonzalo correct his behavior.

Intimate Partner Abuse

Azucena and Manuel had a brief courtship. After the wedding, the IPA began and she became aware of his heavy drinking. Azucena dreaded the weekends, because after drinking heavily he would return to the house very inebriated and paranoid that she had been unfaithful or had not done things at home how he had instructed. When drunk, Manuel would grab her by the hair, punch, kick, slap, and insult her. Azucena reported he often told her she did not have the capacity to learn new things. She reported attempting to engage him in normal interactions after each IPA incident. He did not allow her to use contraception and she reported feeling surprised and sad when she became pregnant with Gonzalo. The IPA continued throughout the pregnancy. Azucena described increasing feelings of inadequacy, hopelessness, depression and anxiety, and disempowerment. Azucena also reported that as children, she and Manuel witnessed male-on-female IPA and disregard for women in their families of origin. Furthermore, she also described perceiving that part of women's common experience or natural condition is to suffer, be mistreated, and disrespected at the hands of others, primarily men.

The IPA was described as more severe and frequent during the first four years of marriage, with a significant reduction in physical aggression when the family immigrated. Azucena reported that the remaining physical abuse (pushing and shoving) stopped when Gonzalo started therapy: the psychological, emotional, and coercive abuse continued, and Manuel told her not to disclose the nature of their relationship. Once in the US, Manuel restricted her outings, contact with others, and did not allow her to develop friendships. He called her constantly and required that she report to him several times during an outing about her whereabouts and activities. Due to this isolation and restriction, when Azucena and Gonzalo started therapy, she did not know how to use public transportation, the names of the main streets close to her home, or other information that could help her travel to different places. However, the complaints from Gonzalo's school and the therapy referral had forced Manuel to be less restrictive and, fortuitously, created an opportunity for her to become more visible and engaged in the world outside her home.

The interface with Gonzalo's school counselor and therapist was Azucena's family's first introduction to and receipt of mental health services. She described that before immigrating she was not aware that IPA in marriage was atypical for women and seeking help to address it was not something she had witnessed. Azucena described not discussing her experience of IPA with her family and that if her relatives knew about it, they kept silent. She explained perceiving her role as holding the marriage together and as her duty to help her husband change his abusive behavior.

5 Assessment

Azucena completed a packet of questionnaires—administered in Spanish, in interview format, and in her home—to evaluate the impact of the PT intervention on parent and child functioning: changes in parent behavior and stress, and changes in child behaviors. The measures used have good reliability and validity, have been used with poor and ethnic-racial minority families, and are found to be sensitive to treatment effects (Abidin, 1995; Achenbach & Rescorla, 2001; Baydar, Reid, & Webster-Stratton, 2003; Gross et al., 2007).

The Parenting Practices Interview (PPI; Baydar et al., 2003) was used to measure reliance on coercive and negative parenting strategies. The PPI has seven subscales evaluating parent's discipline style: Appropriate Discipline, Harsh and Inconsistent Discipline, Positive Verbal Discipline, Monitoring, Physical Punishment, Praise and Incentives, and Clear Expectations. The Parenting Stress Index–Short Form was used to measure stress in the parent–child system (PSI; Abidin, 1995). The PSI measures child characteristics, parent characteristics, family context, and life stress events using four scales: Parental Distress, Parent–Child Dysfunctional Interaction, Difficult Child, and a Total Score. At baseline, Azucena's PPI scores fell within the clinical range for Harsh and Inconsistent Parenting, Monitoring, Physical Punishment, and use of Clear Expectations. Her PSI scores fell within the clinical range for Total Stress and the Difficult Child subscale measuring parents' perception of the severity of child's behavioral difficulties. Her PSI Parental Distress and Parent–Child Dysfunctional Interaction subscale scores were in the upper end of the normal range.

Two complimentary parent-completed measures of child functioning, the Eyberg Child Behavior Inventory (ECBI) and Child Behavior Checklist–Revised (CBCL-R), were used to screen and evaluate Gonzalo's progress. The ECBI measures child conduct problem behaviors for children between the ages of 2 and 16 with two scales: the Problem Scale (PS) and the Intensity Scale (IS; Eyberg & Pincus, 1999). The PS provides a score of the total number of child problem behaviors reported; the IS provides a score indicating the frequency of these behaviors. The CBCL-R is composed of two broadband scales measuring children's internalizing and externalizing problems (Achenbach & Rescorla, 2001). Gonzalo's CBCL baseline scores placed him in the clinical range for the Total Problem score, Externalizing Problems, and the Aggressive Behavior subscale. His ECBI baseline scores also placed him within the clinical range for intensity/severity of behaviors and for parent's perception of these behaviors being a problem.

6 Case Conceptualization

IPA negatively impacted the parent–child bond. Gonzalo was conceived against Azucena's will and she was saddened by the news of his approaching birth. Azucena described mothering Gonzalo as challenging and not feeling successful at soothing and calming him as an infant, struggling to redirect and effectively address his noncompliant and aggressive behaviors as a toddler, and these difficulties increasing when he started school. Azucena also described marital disagreement about how to address Gonzalo's behavioral difficulties, with Manuel minimizing Gonzalo's difficulties and being unwilling to consistently address his behavior. Azucena described increasing feelings of inadequacy, hopelessness, disempowerment, depression, and anxiety related to her difficulties parenting Gonzalo, the ongoing IPA, and worry that her son's behavioral difficulties were associated with witnessing this abuse. However, Azucena declined services to directly address the IPA and individual mental health services for herself due to the social and travel restrictions placed on her by her husband, and her undocumented and uninsured status.

A treatment plan was developed to address Azucena's primary reason for seeking mental health services: Gonzalo's behavioral difficulties at home and at school. PT with an emphasis on reducing harsh parenting, developing and strengthening the parent–child bond

while also providing Azucena with effective behavioral management strategies was combined with the provision of instrumental and emotional support as recommended in the IPA literature (Jouriles et al., 2009; Jouriles et al., 2001). Because PT uses a triadic service model—where therapist trains parent to deliver the intervention—it prioritizes strengthening the parent–child relationship by empowering the parent with responsive, effective, and adaptive strategies to understand and address her child’s behavior. Reflecting Sokoloff and Dupont’s (2005) recommendation to “simultaneously acknowledge the existence of victimization and agency among all battered women” (p. 55), Azucena’s decision to not directly address her victimization was respected. She was supported as an agent of change in her relationship with Gonzalo, parenting practices, and in addressing his behavioral difficulties. Moreover, because Azucena also struggled managing the behaviors of her two other children, the treatment plan also included supporting her in generalizing her use of the parenting strategies with all of her children.

The Helping the Noncompliant Child (HNC) Program

The HNC is a relationship-based behavioral PT intervention designed to help parents address their children’s (ages 3-8) noncompliant and oppositional behaviors (McMahon & Forehand, 2003). There is extensive research demonstrating the effectiveness of the components of the HNC and of the long-term effects of the program (McMahon & Forehand, 2003). Notably, the core components of the HNC have been used in research testing the successful use of child management strategies by mothers who are victims of IPA (Jouriles et al., 2009; Jouriles et al., 2001). Relatedly, Parent-Child Interaction Therapy (PCIT), which has several features in common with the HNC (e.g., relationship-based, a two-stage approach, behavioral performance criteria for parents, and structured homework play sessions), has also been found to be successful with children exposed to IPA (McMahon & Forehand, 2003; Pearl, 2008; Timmer, Ware, Urquiza, & Zebell, 2010). The key component differentiating the HNC from other PT programs is its emphasis on the child being present during all sessions and learning about the parenting strategies their parent is learning and practicing (McMahon & Forehand, 2003). See Table 1 for a brief description of the HNC strategies. The goals of HNC are to help parents (a) improve their parenting skills, (b) disrupt the coercive interactions they experience with their children, and (c) decrease noncompliant and oppositional behaviors while increasing prosocial behaviors in their children. The program is conducted with individual families or parent(s)–child dyads and the participation of both in all sessions. According to the manual, the program takes an average of ten 75 to 90 min, consecutive weekly sessions.

The HNC focuses primarily on six consecutive and cumulative parenting strategies that increase the occurrence of appropriate child behavior divided across two phases: attending, social rewards, ignoring, clear instructions, consequences (e.g., time out), and standing rules. During Phase 1, Differential Attention, the focus of the work is on the mother–child relationship by decreasing problematic child behaviors via the strategic use of parental attention to increase positive alternative child behaviors. The strategies in Phase 1 are introduced within the context of a child-directed play situation—the Child’s Game (CG)—in which parents practice using the strategies with their child during sessions and daily at home. Parents are encouraged and supported in generalizing their use of these strategies

throughout the day in their daily interactions to reinforce their child's engagement in positive alternative behaviors. Phase 2, Compliance Training, builds on the progress made during Phase 1, and focuses on further reducing problematic child behaviors by using effective behavioral management strategies. In both phases, parents are taught the strategies in-vivo via the extensive use of modeling, role-play, homework, and handouts. In addition, it includes a performance criteria—parent's use of a strategy is observed and evaluated—to help establish parents' proficiency in each skill.

Cultural Adaptations to Treatment

An ecological validity approach informed the delivery of services (Bernal, Bonilla, & Bellido, 1995; Domenech Rodríguez & Bernal, 2012; Maríñez-Lora & Atkins, 2012) to assure congruence between the needs and goals of treatment as defined by the client and the services delivered. Clinician's notes, bi-weekly technical support records, and parent and therapist semi-structured interviews conducted at the end of the study suggest that the intervention content was perceived as culturally relevant, applicable, understandable, and motivating by both (Castro, Barrera, & Steiker, 2010). Hence, adaptations to the HNC content were not made and not recommended. However, several adaptations were made to engage, support, protect, and respond to Azucena and Gonzalo during their participation in treatment. Specifically, adaptations addressed language, client–therapist culture and gender matching, parents' goals for treatment and the cultural and social context in which these emerged, and the methods used to deliver the intervention. To address the language needs of Azucena's family, all intervention materials were translated (Maríñez-Lora, Boustani, del Busto, & Leone, 2016) and services were delivered in Spanish. Azucena's service provider was a Mexican immigrant woman which appeared to help in her engagement in treatment. To address the social and cultural contexts of ongoing IPA and undocumented status, treatment was inherently flexible, meaningful and relevant to the clients, and tailored to the level of support that Azucena required to experience success in using the PT strategies within her precarious contexts (Smith, Domenech Rodríguez, & Bernal, 2011). For example, the number of sessions focused on each parenting strategy was extended to allow for setbacks, additional practice, and planning. To be able to continue to engage Azucena and Gonzalo in treatment and reduce Manuel's discomfort with their participation in therapy, therapy sessions were moved from agency-based to home-based. Sessions were flexibly scheduled during “safe times,” times of the day in which Manuel was not home and he would be comfortable with someone visiting his wife.

To prevent lack of childcare from becoming a barrier to receiving services, Azucena was encouraged to prepare all her children for participation in treatment by making sure all of them were fed and used the bathroom before sessions. Special toys and activities were dedicated for siblings to use only during sessions while therapist worked with Azucena and Gonzalo. This situation created the need to support mother in generalizing her use of the strategies she was learning to all her children earlier than recommended by the HNC manual. Additional support and information about resources were also provided to Azucena to inform her of other services and supports in her community she might find helpful. These adaptations are described in more detail in the following sections.

7 Course of Treatment and Assessment of Progress

The delivery of the HNC took approximately five times longer than estimated in the HNC manual. Azucena and Gonzalo participated in 50 sessions—averaging 88 min per session—over twelve-and-half months; approximately 78% of session time focused on parenting strategies and the remaining 22% focused on addressing other issues and concerns. The first 28 sessions were delivered at the agency, the rest took place in the home. Sessions started with a check-in on Gonzalo's behaviors and Azucena's progress using the strategies learned and practiced during the prior session and throughout her daily interactions with Gonzalo, problem-solving with her around consistent practice of strategies, and a check-in focused on her overall emotional status, needs, safety concerns, and marital problems. Throughout the course of treatment, Manuel required Azucena to keep her cell phone on during sessions, and called a couple of times during each session to confirm her whereabouts and activities.

Azucena reported no prior PT experience. However, she quickly conceptually understood the strategies included in the HNC. She struggled with their consistent implementation. Prior to starting Phase 1, two strategies from Phase 2—standing rules and time out—were used to address excessive disruptive child behavior during sessions that were potentially dangerous (e.g., throwing objects), as recommended by the HNC manual. Gonzalo responded quickly and positively to the behavioral management strategies and the focus of treatment returned to Phase 1 strategies. Overall, Gonzalo responded very well to the HNC parenting strategies, in particular to the Phase 1 strategies which facilitated obtaining positive attention and time with his mother. Azucena reported improvements in Gonzalo's behavior at home early in the intervention.

Gonzalo also demonstrated increasing compliance during sessions. With each additional strategy, Gonzalo's behavior improved and Azucena reported that the quality of her interactions with him was more positive, that Gonzalo thrived with the positive attention, that she felt they were emotionally closer, and that the frequency and severity of his noncompliant and aggressive behavior had decreased substantially. However, the maintenance of his improved behavior depended on Azucena's ability to consistently use and generalize the strategies outside the session context to situations at home and outside the home. The marital conflict, emotional and psychological abuse, and the social isolation imposed on Azucena by Manuel negatively influenced her consistency, self-confidence, and expressed anxiety and sadness. The therapist described her approach with Azucena as purposefully gentler, at a slower pace, and more nurturing than with some of her other clients:

She is very frail, a low self-esteem. She apologizes for everything. I always notice great enthusiasm for the work. I am always aware of being careful not to make her feel incompetent. Because her husband makes her feel incompetent all day long ... With her self-esteem low, she forgets. She needs lots of support as a mother and as a woman. I focus on her empowerment within the limitations of her context. She does not want to go to a shelter. She wants to stay in her house with her kids.

Each strategy was practiced and reviewed several times—even after Azucena had met the performance criteria—to problem solve around when, where, and how to use the strategies at

home. Particularly during the first 6 months of treatment—when marital conflicts were described as more frequent than during the last 6 months—Azucena was very inconsistent, used the strategies for 1 to 2 weeks, and then would return to prior patterns of addressing Gonzalo's behaviors. Nine months into treatment, Azucena met the performance criteria for all HNC strategies. However, she was still inconsistently using the strategies outside of sessions with Gonzalo and his siblings. Hence, sessions focused primarily on supporting Azucena's consistent use of the strategies for the last 3 months of treatment. Specifically, the focus was on helping her generalize her use of the strategies with all of her children. Therapist observed several behavioral setbacks for Gonzalo in situations where his sister's infractions were not addressed (e.g., mother ignored and did not consequence her for tearing-up Gonzalo's art work) or the consequences given were considerably milder than what he would receive (reprimand vs. time out for hitting). Therefore, part of the work focused on helping mother empathize with Gonzalo's frustration with the differential treatment he experienced and to support her in addressing her daughter's noncompliant and aggressive behaviors. Phase 1 strategies and Azucena generalizing the HNC strategies across settings and children were prioritized. The first 26 sessions focused on Phase 1 strategies, 16 were focused on Phase 2 strategies, and the last eight focused on reviewing all the strategies to improve their consistent use across settings and children. Following is a brief description of treatment with each HNC phase.

HNC Phase 1: Differential Attention

The introduction of the HNC with the first strategy of Phase 1, Attending, revealed that Azucena was uncomfortable with play, had no prior history of playing with Gonzalo, and in her own family of origin no memory of adults engaging in active child-led play. Hence, engaging in the CG, the context in which in the HNC the parent first learns and practices positive parenting strategies, was initially difficult. Phase 1 strategies were postponed until she was more comfortable with play. Modeling, role-playing, and coaching were used to help Azucena become more comfortable playing with her son. This preliminary work included supporting her to demonstrate interest, curiosity, and enthusiasm toward Gonzalo's activities, and to understand play as important to children's development, and as a vehicle to understand his perspective, and strengthen their parent-child bond (Ginsburg, 2007).

Attending, rewarding, and ignoring.—Once Azucena became comfortable with playing and with the CG, Azucena was able to successfully use the Phase 1 strategies and meet the HNC's performance criteria. In the context of the CG, Azucena was able to attend and slowly learned to refrain from asking questions, give commands, or use the CG as an opportunity to teach Gonzalo. Azucena increased her use of physical, unlabeled or nondescriptive verbal rewards (e.g., good job!), and labeled verbal rewards (Good job putting your trucks away!) which were very well received by Gonzalo and his siblings. Ignoring behaviors that were minor and not dangerous (e.g., tantrums, whining, interrupting) was perceived as a better alternative to yelling, arguing, or reinforcing behaviors she did not like by giving in.

HNC Phase 2: Compliance Training

Clear instruction, sequence, time out, and standing rules.—The transition to Phase 2 was postponed until Azucena was more consistent in her use of the positive parenting strategies included in Phase 1. Azucena reported learning how to give clear instructions that were very helpful in improving her communication skills overall and in helping her give clear and specific commands that include tasks that Gonzalo was able to successfully complete. She also found the clear instruction sequence as a helpful framework; time out was also seen as a welcome alternative to yelling, using words that she later regretted, and getting upset with her son. The HNC uses a chair (duration range: 3-5 min) and two warnings—restatement of parental clear instruction and consequence for not complying—before implementing time out. Two adaptations were made during Phase 2: Gonzalo stood for his time out—he refused to sit—and treatment focused on helping mother generalize Phase 2 strategies to all of her children from the beginning.

Agency and Resilience

Azucena demonstrated agency and resilience in her consistent participation in therapy (50 sessions in 12 months) with Gonzalo and in her ability to learn and use the HNC strategies effectively. Her resilience was further evidenced by her return to the consistent use of the HNC strategies after a setback. Azucena and Gonzalo's raw scores post-test and observations during sessions supported her reports that she was using more positive parenting practices, and that child's behavior had notably improved. Azucena's scores on the PPI moved from the clinical to the normal range for Harsh and Inconsistent Parenting (5.0 → 2.80), Physical Punishment (3.20 → 2.0), and for reported use of Clear Expectations (2.33 → 4.67). Her PSI scores also moved from the clinical to the normal range for Total Stress (94 → 54) and the Difficult Child subscale (39 → 20). Her PSI Parental Distress (30 → 18) and Parent–Child Dysfunctional interaction (25 → 16) scores which were in the upper end of the normal range at baseline also improved. Like his mother, Gonzalo demonstrated agency and resilience. Gonzalo responded well and increasingly engaged in behaviors that pleased Azucena the more consistently she used the HNC strategies, and at post-test did not meet diagnostic criteria for ODD. Gonzalo's CBCL scores moved from the clinical range to the normal range for Total Problems (48 → 7), Externalizing Problems (23 → 3), and the Aggressive Behavior subscale (19 → 2). His ECBI scores also moved from the clinical to the normal range for intensity/severity of behaviors (143 → 64) and for parent's perception of these behaviors being a problem (19 → 8).

Azucena's experience of PT was very positive. She experienced learning and using the HNC strategies as empowering. She reported that being able to have more control over her children's behaviors helped her feel more confident as a mother and as a person. Azucena also reported that due to being able to create a less chaotic and more controlled environment with her children, she was able to feel rested, more energized, and less depressed. Below is a quote in her own words.

It has helped me a great deal because like I told you before I ... I have a clear idea of what, of what is, of what is alright, what they can do, what they can't do. Because before in the middle of screaming and reprimanding all the things between

all the kids, like one gets lost. Now one has things very clear. Oh, this is alright. Oh, that should not be done and that's it.

8 Complicating Factors

The ongoing IPA complicated and challenged the delivery of treatment to the mother–child dyad, the pace, and progress of treatment. Azucena was a victim of psychological and emotional abuse and coercive control to varying degrees throughout treatment and she was not always successful in sheltering her children from witnessing this abuse. Manuel restricted her activities, interrupted therapy during sessions to confirm Azucena's whereabouts and her activities, felt threatened by Azucena's progress with Gonzalo and the other children, sabotaged her efforts to implement the HNC strategies when he was home, and was uncomfortable with Azucena's increasing interactions with the world outside their home. Several measures were taken in response. During sessions, Azucena's mobile phone was left on and she answered her husband's calls. The therapist also answered his calls during session when he requested to talk to her. Sessions were moved to the home to appease his concerns and to be able to continue working with Azucena and Gonzalo. Manuel was invited to participate and learn about the HNC strategies but he only attended a couple of times.

Overtime, the HNC strategies gave Azucena the tools and structure to more effectively compartmentalize and control the impact of the IPA on her parenting. However, her success at altering her children's environment and environmental contingencies was narrowed by her abusive marital context. There were intermittent spillover episodes in the form of inconsistent use, in particular, of the positive parenting strategies of the HNC. Furthermore, she was more effective at using the strategies and compartmentalizing when alone at home with the children than when her husband was home. Given the context of ongoing IPA, the latter part of the clinical work focused on helping Azucena with the complicated task of controlling the spillover and compartmentalizing by helping her become more self-aware of how and when her interactions with Manuel affected her later interactions with her children. Worth noting is that Azucena expressed pride in her progress, the changes in her parenting, her mothering, and her increasing ability to create a more positive and predictable home environment even when this was more the case when her husband was not home.

9 Access and Barriers to Care

In addition to Manuel's discomfort with Azucena's and Gonzalo's participation in therapy, and the lack of childcare, there were several other barriers to care. Due to their undocumented status, Azucena and Manuel did not have health insurance. Their legal status resulted in marginalization and isolation, and fear of others outside their immediate family and of public institutions which was further exacerbated by the presence of IPA. Poverty contributed to very tangible barriers to care and to Azucena's willingness to address the IPA directly and leave her husband. For example, money for transportation was limited, and was managed and dispensed by Manuel. He did not allow her to work and she had no income of her own to allow her to cover her transportation costs and her own household if she decided to leave him.

10 Follow-Up

Azucena requested additional support generalizing her use of the HNC strategies with all her children, in particular with her daughter, after officially completing the intervention. Sessions were reduced to monthly for the first 6 months after program completion. Hence, Azucena and Gonzalo received support on the use of the HNC strategies for approximately 18 months. At the time of closing the case, Azucena reported feeling more in control of her situation, her life; she added that at a personal level she had become more assertive and had learned to not be afraid to seek help, of calling the police, and pressing charges against her husband. Azucena was encouraged to maintain the option of returning to therapy if needed.

11 Treatment Implications of the Case

The case study of Azucena and Gonzalo demonstrates that within the context of ongoing partner abuse, a mother's parenting and her child's behavior can be positively affected by PT that is adapted and responsive to the context of their family's situation. The safety of Azucena and her children were prioritized by scheduling sessions at "safe times" and locations approved by her husband. Moreover, information about hotlines, programs, and emergency shelters for IPA victims were provided to Azucena to use if she became concerned for her own or her children's safety; she was also informed of the limitations of confidentiality in the event of suspicion of child abuse or neglect.

Although Azucena as an undocumented immigrant woman victim of IPA carried an "adversity package" composed of a history of cumulative and multiple stressors (Rossman, 2000), the experience of victimization did not cancel out agency (Sokoloff & Dupont, 2005). The ecological validity approach with its focus on assuring congruence between the needs and goals of treatment—as defined by the client—and the services delivered was critical to supporting Azucena to perceive herself and act as an agent of change in her children's behaviors. The adaptations made—ranging from the very obvious language adaptation of materials to identifying safe times for therapy, flexibility with place and time of session, and responsive pacing of intervention delivery—helped to tailor treatment to make it meaningful and relevant to Azucena and her children.

12 Recommendations to Clinicians and Students

PT is the first line of treatment recommended to address serious behavioral difficulties in young children (e.g., Eyberg et al., 2008). PT programs used with IPA victims prioritize the parent-child relationship and focus on changing children's experience of their social environment by changing the environmental contingencies for their behaviors, specifically those focused on improving the parent-child relationship. Moreover, because PT is delivered using a triadic service delivery model, the bulk of the work focuses on understanding, preparing, and supporting parents to create changes at home to improve their parenting and their child's behaviors. Parents play a primordial role in changing a child's home environment. This elemental parental role does not change in the context of IPA, rather change is further burdened by the other life events and risk factors often co-occurring with IPA (e.g., poverty, substance/drug abuse, history of childhood abuse and/or exposure, race/

ethnicity). Hence, using an ecological validity approach focused on the fit between client defined needs and goals and treatment is critical to the work with children and their families, particularly for families who are experiencing multiple stressors and risk factors.

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Table 1.

Helping the Noncompliant Child Program.*

Helping the Noncompliant Child strategies (HNC)				
Strategy			Description	
Phase 1			Differential attention	
Parent’s attention motivating child to engage in desired behaviors	Child’s Game	Child present in all sessions	Special play situation in which parent follows child’s lead practices, positive parent practices learned in Phase 1	
	Attending		CG guidelines: Parent does not ask questions, give commands, or try to teach during the CG (10-15 min daily at home)	
	Rewards		During the CG, ongoing verbal comments describing child’s appropriate play behavior similar to a sports caster describing a game play-by-play	
	Ignoring		Focus is on social rewards: Physical, unlabeled, or nondescriptive praise comments, and labeled praise comments	
			Guidelines: Social rewards should be specific, given immediately, used consistently, and acknowledge small improvements in more challenging behaviors	
			The active ignoring of attention-seeking behaviors (e.g., whining, nagging, tantrums, and interrupting) identified ahead of time	
			Guidelines: While ignoring, parent should refrain from having eye, verbal, or physical contact with child	
Phase 2			Compliance training	
Clear communication and consequences increasing child compliance	Clear and unclear instructions	Child present in all sessions	Differentiating between unclear and clear instructions, and practicing revising unclear instructions and how to give clear instructions	
	Clear instruction sequence		Guidelines: Instructions are given one at a time, stated in words child can understand, and that describe what the child can do (i.e., “Do pick up your toys and put them in the red bin” instead of “Don’t make a mess”)	
	Standing rules		Framework that illustrates when to reinforce child with positive attention (attending and rewards), how frequently to repeat a clear instruction, and when to follow-through with a consequence (i.e., time out or loss of privileges). The teaching of time out to parents is the last component of the sequence	
			Rules that apply to all children in the family, are always in effect, and that address specific prohibited behaviors (e.g., hitting)	

Note. CG = Child's Game.

* McMahon & Forehand, 2003.