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The Experience of Therapists Working with Mexican American Children of Substance Abusing Parents

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Abstract

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MS, Walden University, 2008

BS, Boise State University, 2007

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

The need for culturally competent mental health providers and the Mexican American immigrant population in the United States are growing. This study focused on themes from therapists' narratives that may help to comprehend the intricacy of difficulties facing Mexican American children living with substance-abusing parents. The firsthand knowledge and experiences of the therapists who have worked with this population provided a basic understanding of what to expect and which therapeutic interventions may work best for both the child and their parents. The purpose of this narrative inquiry was to qualitatively identify therapists' lived experiences and understand how they interacted with their Mexican American patients. The theoretical framework was the Multilevel Model (MLM) which incorporated cultural, sociopolitical, historical, and help-seeking behavior understanding of immigrant clients, as well as the impact of pre and post migration experiences. Six distinct themes in the therapeutic process were revealed from telephone interviews completed with five therapists in the Las Vegas, Nevada area. Narrative data analysis, written notes and audio recordings were analyzed for historical, social, and cultural contexts. The results identified competencies that therapists view as important when working with the target population including being culturally competent, using modalities such as cognitive behavioral theory (CBT) or psychoeducation, and being aware of barriers to treatment that can arise from parents and their children. The results of this study has the potential to benefit therapists working with Mexican American children whose caregivers are dealing with substance abuse issues leading to positive social change.

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Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction to the Study

Introduction

Therapists working with Mexican American children of substance-abusing parents face an unusual challenge in that there is little in the current literature that deals specifically with working with the Mexican American population in general, and Mexican American children whose parents are struggling with addiction in particular. For this study, the therapist was any clinical mental health professional. The goal of this study was to reveal through chronicling the therapists' experiences the modalities and techniques that truly work best for these children.

Although some studies exist on best practices for therapists working with Mexican Americans there was limited clinical evidence-based research concerning what works best when working with Mexican American children, especially those with parents who have a SUD (Ahn et al., 2014; Goodman et al., 2015; Pina & Gonzalez, 2014). With the current exploration, I hope to add to the available research on working with Mexican American children who are dealing with the problems inherent in living with parents who are addicted to drugs or alcohol. To do so, it was necessary to examine the issues that exist for all children who are dealing with drug or alcohol-addicted parents but to also focus on specific problems experienced by Mexican American children (see Contractor et al., 2012; Jimenez et al., 2014). More than 8.3 million children under 18 years of age (11.9%) in the United States live with at least one parent who was dependent on or who has significantly abused alcohol or an illicit drug during the past year (Merikangas &

McClair, 2012), and of those 8.3 million children, approximately 10% are of Hispanic origin (Shorey et. al., 2013).

The need for therapists who understand how to treat Mexican American children will only continue to rise as more and more Mexican Americans settle in the United States (Fish et al., 2015). Studies have shown a dramatic continuous change in United States demographics; every year, more and more immigrants arrive from Mexico as well as other Latino countries, meaning that the percentage of Mexican immigrants now accounts for a much larger number of people in the United States than ever before and will continue to rise (citation). Regional studies of Latin immigrant laborers have identified substance abuse prevalence rates as high as 80% for regular binge drinking, 39% for alcohol dependence, and 25% for methamphetamine and/or cocaine use (citation). Clinicians must be able to provide culturally responsive services to the growing diverse needs of immigrants, including support to immigrant families facing substance abuse issues (Bemak et al., 2014). Additionally, research indicates that when comparing Caucasians, African Americans, and Hispanics, males from a Hispanic background are at higher risk than males from these other demographic groups of having drug or alcohol problems, especially alcohol (Sparks et al., 2013). The increase in substance use is often directly related to social environment, struggles with acculturation, and political structure. The studies also show that Mexican American immigrants with substance abuse disorders (SUD's) often have higher rates of intimate partner violence, legal problems, and cirrhosis mortality (see citation). Unfortunately, the study also shows that standard treatments rarely work with addressing the needs of the Mexican American

population; however, there is minimal empirical evidence that looks at what needs are not being met or strategies designed to meet those needs.

This is an important issue for therapists and other mental health workers to be aware of because they will be working with ever-increasing numbers of Mexican American children over the coming years. Understanding that these children may react differently to counseling techniques and how they experience their home lives will be important in learning to treat this group effectively.

Background of the Study

Cultural relativity matters in therapy; it affects the barriers individuals may face, the way they view addiction, their stressors, their support system, and everything unique about the individual (Ahn et al., 2014; Jimenez et al., 2014). Mexican immigrants believed differently about therapy than those who have been born and raised in the United States: they typically struggle to understand the mental health system (Blackson et al., 2014). Euro-American alcohol treatment programs are less effective and do not meet the needs of the Mexican American addict especially Mexican American immigrants (Sparks et al., 2013). Economical and logistical barriers are often to blame as well.

Understanding Mexican American immigrants' substance abuse tendencies in both their home country and in the United States gives therapists a better understanding of how substance abuse might affect the children of Mexican American immigrants once they are in this country (Blackson et al., 2014). Prior research has shown patterns that link immigrants to their home country; therefore, having a cultural understanding is important when working with Mexican American children who have parents with

substance abuse issues. Researchers are starting to see a rise in second and third-generation substance abuse. One of the contributing factors to this generational increase in substance use is parental use of drugs and alcohol (Sparks et al., 2013). Substance abuse does not just affect the abuser; it affects the entire family (Center for Substance Abuse Treatment, 2004). A modality cluster that accounts for both the effects of substance abuse and the differences in family dynamics is the family therapy principles and treatment modalities, which helps to meet the entire family's needs. Therapists using this approach must understand the stages of motivation, cultural considerations combined with substance abuse, and family therapy.

When assessing the needs of Mexican American children whose parents are struggling with SUD's, researchers must look at the cultural barriers they are experiencing to getting the services needed (Contractor et al., 2012). There is a stigma about mental healthcare, especially within Mexican American culture, especially when one or both parents are suffering from a SUD. Studies have shown in the past that the stigma has led to a lack of resources and increased uncertainty about mental health treatment in general; this lack of needed mental health treatment has reduced participation in after school activities, parental involvement, peer support, and overall success for the family unit (see citation). The fact that Mexican American parents and children alike distrust the mental health system and do not participate in them has led to the underrepresentation of Mexican Americans in counseling as well, which in turn leads to programs such as peer mentoring, parent training, or after school programs being cut or never developed in the first place (citation).

In addition to understanding the different types of problems suffered by members of this population, it is necessary to learn to use multicultural sensitivity when working with them and to learn how they might react to counseling compared to other groups (Contractor et al, 2012). Overcoming an initial resistance to counseling is a good first step, followed by becoming knowledgeable about the various cultures these clients emigrate from. Seeing these clients as both individuals and as a unique part of their larger ethnic and cultural group will help these children greatly, as they are both and need to be seen as such.

Problem Statement

As the Mexican American immigrant population continues to grow, so does the need to be culturally responsive, especially to the children of immigrants, who will grow up to be a part of the next American generation (Bemak et al., 2014). Clinicians already know that children who grow up in homes with one or more of their caregivers addicted to drugs or alcohol have a much higher chance of developing risky behaviors, using drugs or alcohol themselves, and having behavior problems, delinquency, and/or developmental problems (Cederborg, 2010; Karlson, 2014; Skinner, et al., 2014). Finally, to understand the vast complexity of problems facing the Mexican American child living with substance-abusing parents, interventions must be responsive to the cultural practices and worldviews of the child and parents for whom these interventions are intended (Blackson et al., 2014; Contreras et al., 2012; Pina & Gonzalez, 2014). Therapists must be trained and prepared to understand and accept different cultural worldviews while acknowledging different attitudes toward child rearing and beliefs about health and

mental illness. To achieve cultural competence, therapists must also be sensitized to their prejudices, biases, and privileges as well as to how historical and sociopolitical factors affect their clients from immigrant populations (Bemak & Chung, 2015).

The service needs of multicultural populations are of national interest, particularly because of documented patterns of health care service inequities and potential negative consequences of these inequities for this population (Guerrero et al, 2013). For an effective clinical intervention to take place within an ethnic minority family system coping with substance abuse, identifying the practices of therapists working with children from these systems can be of clinical relevance (Ahn et al., 2014). Focusing on ethnicity-specific research in the substance abuse field is also clinically significant (Contreras et al., 2012; Flückiger et al, 2013). Scholars also recommend that qualitative research focusing on the experiences and struggles of therapists interacting regularly with ethnic minority children of addicted parents can offer a cultural education to other service providers of similar populations (Ahn et al 2014; McCabe et al., 2013).

Levels of acculturation among first- and second-generation Hispanic immigrants have a strong positive association with substance use (Salas-Wright et al., 2014). Specifically, more acculturated individuals are more likely to experience substance abuse. Reports show the use of alcohol and other substances among English-speaking Mexican Americans to be as much as eight times more prevalent than in their Spanish-speaking counterparts (Center for Substance Abuse Treatment, 2004; Reingle et al., 2014). Given the paucity of scholarly inquiry in ethnic-specific research on therapeutic work and culturally responsive interventions for children of addicted parents, a gap in the literature

existed in studies that specifically focused on an in-depth understanding of therapists' experiences with Mexican American children of substance-abusing parents (Ahn et al, 2014; Fish et al., 2015; Goodman et al, 2015; Pina & Gonzalez, 2014; Sparks et al., 2013).

Purpose of the Study

The purpose of this qualitative, narrative research study was to present themes emerging from the narratives of therapists' experiences with Mexican American children of substance-abusing parents that will show what modalities or techniques will work best with this population (see Ahn et al., 2014; Fish et al., 2015; Pina & Gonzalez, 2014). One of the reasons this question has so much value is because studies have shown that Mexican American children have more problems in all areas than children from Mexico and nonMexican American children and the level of problems greatly increases when one or both parents are substance abusing (see Sparks et al., 2013). Therefore, investigating past occurrences in a therapist's work experience, finding what has worked in this area and what has not, will aid therapists in planning future therapeutic actions (Polkinghorne, 1988). This research has supplied rich information that was used to examine therapists' experiences and to find patterns of success for all mental health providers to use when working with Mexican American children of substance-abusing parents (see Clandinin & Connelly, 1987). This is extremely important because previous research has shown that Mexican Americans, much like Latinos in general, will respond better to a therapist they trust (citation). However, trust is not given by simply being the therapist; it is earned by therapists endeavoring to understand the client, their cultural uniqueness, and how well

the two work together, which is known in Spanish as *simpatía* (Contreras et al., 2012). This study has helped gain the understanding needed for future therapists to be able to achieve the level of simpatia needed to work with Mexican American children. I also explored, from the perspective of the therapists, how these children have adjusted to life in a new country and culture, and whether their ability to adjust is affected by the substance abuse of their parents, as well as how this population differed in how it deals with parents who abuse substances and their willingness to seek help from others.

Research Questions

RQ1: What themes emerged from the narratives of therapists working with Mexican American children of parents with SUD regarding their successes and challenges within their therapeutic relationship with the child?

RQ2: What themes emerged from the narratives of therapists working with Mexican American children regarding their successes and challenges within their therapeutic relationship with the child's parents/custodial guardians?

Theoretical Framework

Research has shown that one of the most integral pieces of working with Mexican American children whose parents are struggling with substance abuse is the need for cultural humility and sensitivity (Jiminez, et al., 2014); this was explored through a theoretical framework that supported how the therapist navigated psychotherapy with cultural sensitivity. The theory framed in this study was the multilevel model of intervention for psychotherapy and social justice (MLM; Bemaket al., 2003). In the MLM model, there are five interrelated levels of intervention for mental health

professionals to use in a culturally sensitive framework: (a) mental health education; (b) cultural empowerment; (c) individual, group, and family; (d) integration of Western and indigenous healing methodologies; and (e) social justice and human rights (Bemak et al., 2003; Bemak & Chung, 2015). The MLM redefined the role of therapists to incorporate advocacy, consultation, human rights, social justice, indigenous healing, social networking, and heightened cultural responsiveness into more traditional culturally competent counseling practices (Chung et al., 2007). Chapter 2 provides more detail on how the MLM integrates an understanding of cultural, sociopolitical, historical, and help-seeking behaviors of immigrant clients, as well as the impact of pre and postmigration experiences. Therapists need to have a deep-rooted understanding of the racial and ethnic identity of their clients and themselves, as well as current knowledge about the contextual political and social response that has an impact on their mental health; this is especially true of clients from immigrant populations (Bemak & Chung, 2015; Chung et al., 2011).

Nature of the Study

The nature of this study was qualitative. Qualitative research seeks to provide an in-depth and interpreted understanding of the social world of research participants by learning about their social and material circumstances, their experiences, their cultural perspectives, and their histories (Patton, 2002). Consistent with the purpose of this study, this narrative inquiry research study provided an in-depth understanding of at least four different therapists' experiences with Mexican American children of substance-abusing parents. It addressed the questions of "So what?" and "Who cares?" as Clandinin (2013) dictated this was the only way to truly justify narrative stories. Although narrative inquiry

research is used for various purposes, it was used predominantly to explore and authenticate an individual's life conditions (Clandinin, 2014; Clandinin & Connelly, 2000). In this study, I explored and authenticated the experiences of therapists who directly worked with Mexican American children of substance-abusing parents.

When using research questions that are ethnic-specific, the most effective method was to use is narrative inquiry (citation). Even though there are other forms of qualitative research, using the narrative method allowed the qualitative research to work closely with participants and establish trusting relationships (Clandinin, 2013; Connelly & Clandinin, 1990). The narrative inquiry study design afforded the research better support than other methods would have for those participants who may felt discomfort when divulging information about their critical life experiences working with children of Mexican American children and their parents (see Wimberly, 2011). This type of research also helped to create a place where therapists had a voice to express themselves freely about culturally sensitive therapeutic experiences that they felt were clinically significant when they were working with Mexican American children (Clandinin & Connelly, 2000). To complete this research topic the narrative inquiry methodology was used to collect data appropriately. This method of inquiry generated narratives and provided a framework for (a) understanding past occurrences in a person's life, and (b) planning future actions (see Polkinghorne, 1988). A critical event approach was used to document crucial events in the participants' narratives, thus addressing the study's purpose and research questions (see Webster & Mertova, 2007). I collected data from five therapists working with Mexican American children of substance abusing parents in an outpatient clinic setting.

The narratives from the therapists' field texts served as raw data for me to analyze (see Clandinin & Connelly, 1987).

Unlike other forms of qualitative research such as phenomenology or the case study method, a narrative inquiry was the most effective method for answering the research questions in this ethnic-specific research (Clandinin, 2013). This investigation required me to be able to hear the stories of the therapist and see the stories come to life from the view of the therapist. Only the narrative inquiry approach allowed me to understand the stories the way the therapist understood them; in this way the research process became personal. The qualitative approach was viable for this research study because it provided me not only the opportunity to work closely with participants and the ability to establish trusting relationships, but also enabled better support for those participants that might have feelings of possible discomfort that came from disclosing critical life experiences from working with children of Mexican American children and their parents (see Wimberly, 2011).

Definition of Terms

Children: Individuals under the age of 18 requiring the supervision and care of a guardian, caregiver, or parent (Contractor et al, 2002; Karlsson, 2014; McCabe et al., 2013).

Culture: A unique perspective that is learned in groups through members' commonalities (Chung & Bemak, 2002; Hser et al., 2014).

Immigrants: Individuals born in one country who are residing in a different country, either legally or illegally (Ahn et al., 2014; Bemak & Chung, 2014; Chung et al., 2008).

Intervention: Any method used to improve the lives of the clients who work with the participant of the study, including assessment, counseling (Bemak & Chung, 2011; Chung et al., 2011), educational programs, after-school programs, or help with everyday living needs Mexican American: Mexican born individuals living and residing in America (Jimenez et al., 2014; McCabe et al., 2013).

Substance abuse: The use of legal or illegal illicit substances or alcohol to the extent that it interferes with the ability to live normally and productively (Fluckiger et al, 2013; Guerrero et al., 2013; Hser, et al., 2014).

Substance use disorder (SUD): Used interchangeably with a person struggling with a substance abuse problem (Contractor et al, 2012).

Assumptions

In narrative inquiry research, the research was set within the framework of sociocultural theory (Moen, 2006). The real challenge was for me as I had to be able to examine and understand the data. I had to be able to interpret the data supplied in the narratives and understand any human actions and the social and cultural context. In this case, the data collected was from interviews with the therapists regarding their experiences with the phenomena being researched. I worked directly one-on-one with the participants and built mutual trust and encouraged the participants to share their experiences openly, honestly, and freely (see Creswell, 2003). It was assumed that the

participating therapists were culturally competent to work with the groups they are assigned to work with and that the participants' clients were representative of the Mexican American or Hispanic country from which they originate. Since I interviewed only the therapist it was important there that was an assumption that the therapists and clients worked together in a spirit of honesty and trust (see Wang & Geale, 2015) and that therapists respected their clients' confidentiality and privacy at all times, without there is a barrier that prevents progress (see Bemak et al., 2014).

Delimitations

There is no straightforward answer to what the sample size should have been for a narrative inquiry or even a qualitative study in general (Vasileiou et al., 2018). However, Moen (2006) stated that an understanding of a story can begin with as little as one participant. I chose to use a small sample size for numerous reasons. One of the most basic reasons was the available sample size of therapists who work with Mexican American children of drug-abusing parents is by nature small. An even smaller sample size was used partially for financial reasons and partly because of time constraints but also because smaller sample sizes have several benefits for qualitative studies (see Vasileious, et al., 2018). When doing a qualitative study with a narrative inquiry method a small sample size allows the researcher to be able to support the intricacy of each participants' story. However, with such a small sample size, generalization of the study was difficult, and even the reliability of the study might be called into question.

Limitations

One of the biggest limitations in this study was the limited amount of literature, particularly 2009 and newer. Because of this, several articles older than 2009 were used to gain background knowledge and an understanding of this subject. Whenever possible articles and literature from 2009 and newer were used. Another limitation found came with the subjects of the study themselves. Trust on the part of the Mexican American is limited when it comes to mental health; immigrants' feelings of acceptance have often been tainted by racism, intolerance to their differences, and xenophobia, which is an irrational, baseless fear towards people of another country (Bemak et al., 2014; Shorey et al., 2013). Fear is another limitation and barrier for many immigrants especially Mexican American immigrants. It is estimated that at least 25% of all Mexican immigrants are in the United States without proper documentation (Chung et al., 2008). Studies have shown that as much as 50% of all Mexican immigrants have a significant language barrier and struggled to meet the acculturation expectations placed on them (Chung et al. 2008 & Contreras et al., 2012). When referring to therapeutic limitations specifically, this is where a bias might be found because there are fewer therapists that are truly culturally competent than Mexican American clients are seeking out mental health services, especially with addiction and family components. Another not-so-obvious therapeutic limitation and barrier that studies have found is the Mexican American family system. Even though the Mexican American family system tends to be incredibly supportive it can also create codependence and strengthen an individual's substance abuse, which can significantly increase the need for highly culturally competent therapists (Contreras et al.,

2012). Because of these limitations, the sample group of therapists available for this study was limited.

Significance of the Study

Given the disparities in substance use treatment response among Mexican Americans, it was important to identify factors that may contribute to treatment outcomes. To promote social change for this under researched population, it was critical to determine factors that provide researchers and program providers the information necessary to design and implement treatments that best address these influences and improve treatment outcomes (Fish et al., 2015). Such a study can inform both clinical psychology educators and therapists in the substance abuse and family therapy field on developing protocols for culturally competent therapists and raising awareness of Mexican American culture and values (Substance Abuse and Mental Health Services Administration, 2004). Additionally, the dissemination of knowledge from this study may be able to guide therapists on how to establish meaningful communication with Mexican American recovering addicts and their children regarding how to rebuild healthy family dynamics (Sparks et al., 2013). There needs to be cultural competency in the substance abuse treatment field to help Mexican American families heal and grow beyond addiction to recovery. Finally, researching culturally based narratives for this at-risk population of children can also inform public policymakers on how to provide culturally appropriate substance abuse prevention and family support resources within Mexican American and other Latin-American communities (Ager, 2013).

Summary

Given the limited amount of research concerning therapists working with Mexican American children of substance abusing parents, this study fills a crucial gap in the literature. Although several studies exist on best practices for therapists working with Mexican American families, there is limited clinically significant research concerning how therapists work with Mexican American children of substance abusing parents (see Ahn et al., 2014; Goodman et al., 2015; Pina & Gonzalez, 2014). I hope to add to the available research on working with Mexican American's and other Mexican American children dealing with the problems inherent with living with a parent who is addicted to drugs or alcohol. To do so, it is necessary to recognize the issues that all children may face who are dealing with a substance abusing parent, we then compared that to the problems experienced by Mexican American children to make note of all of the issues that might be involved with this specific population (see Contractor et al., 2012; Jimenez et al., 2014). It is hoped that this study added to existing research in best methods and practices for working with Mexican American children of substance abusing parents.

Chapter 2: Literature Review

Introduction

The purpose of this study was to focus on the experiences of therapists working with Mexican American children whose parents are struggling with addiction. The subsequent literature review covered current research, articles, and peer-reviewed journals on different aspects of this topic. Both the analysis and review began with looking at Mexican American culture and its views on therapy (see Jimenez et al., 2014). I did this by taking a deeper look at Mexican American immigrants' culture, traumas, and struggles, and in general the overall motivating forces for them and their families (see Ager, 2013; Ahn, et al., 2014; Clandinin & Connelly, 2000; Contreras et al., 2012). Research also revealed that there is a great need to educate therapists before they going into the field on cultural understanding, social justice, and how to work with a diverse population (see Bemak & Chung, 2011, 2012; Bemak et al., 2011, 2012; Goodman et al., 2015). This literature review then looked at addiction and substance abuse in general (Customer Satisfaction n.d.) as well as the case for cultural awareness within drug treatment programs (Guerrerro et al., 2013). Research has shown that as part of the larger Latino immigrant population, Mexican American immigrants are struggling with a significant substance abuse problem. However, there are many more barriers to quality treatment for this population than are found in the general White American population (Blackson et al., 2014; Guerrero et al., 2013; Salas-Wright, et al., 2014). When looking at addiction it is important to observe the effects within the entire family unit, especially on the children (Adelson, 2010; Blackson et al., 2014; Fish et al., 2015; Hser et al., 2013). I

looked at the best forms of treatment not just for the addict but for the entire family, which included the children (see Contreras et al., 2012; Pina & Gonzales, 2014;). Finally, I looked specifically at the treatment methods for the Mexican American child whose parent is struggling with an addiction as both a treatment and prevention plan (see Pina & Gonzalez, 2014; Reingle et al., 2014).

Literature Search Strategy

Different search engines and journals were used in the selection of research papers. Search engines like Google Scholar, PsychInfo, and PsycArticle have been used. The articles also were taken from different peer-reviewed psychology journals such as the *Journal of Substance Abuse Treatment, International Journal for the Advancement of Counseling,* and *Global Journal of Community Psychology Practice.* Search terms used were *experiences of clinicians working with Mexican American children, Experiences of clinicians working with children with addicted parents,* and *clinicians who work with Mexican American children*. Approximately 100 articles were located, of which 39 were ultimately included in the literature review.

Theoretical Framework

The purpose of this study was to focus on the experiences of therapists working with Mexican American children whose parents are struggling with addiction with the hope of finding what themes work best for those children. The study was focusing on parents who are immigrants of Mexico and their children who were born in the United States and are not immigrants themselves but rather first-generation Mexican Americans. According to the literature by Jimenez et al. (2014), one of the most important

considerations in working with Mexican American children is the need for cultural humility and sensitivity as a theoretical framework. Literature showed that immigrants do not understand the U.S. mental health system; therefore, to be successful at therapy with those children we must become culturally aware and sensitive to their needs (see Ahn et al., 2014). The Latino population, which includes Mexican Americans, is described as a population that is increasing faster than the ability to keep up with their mental health needs (Jimenez et al., 2014). The literature in this study validates the need for cultural sensitivity, given that the United States is predicted to see an increase in Latino immigration of up to 30% by the year 2050. Jimenez et al. (2014) further discussed the pervasiveness of substance abuse among this group and the need for culturally sensitive therapists.

As discussed in Chapter 1, the theoretical framework for this study was the MLM designed by Bemak and Chung (2003). The reason this model was chosen is that it has worked well in other cases where clients were having to adjust to a new cultural environment while trying to navigate the need for mental health services (see Bemak et al., 2003). In this study, cultural identity and its characteristics were significant to the outcome. Bemak and Chung (2014) found that refugees and immigrants have shown distinct characteristics that are directly related to their country of origin and to the communities they subsequently resettled in. The MLM is an appropriate model for working with immigrants and their families because it offers a culturally sensitive framework for applying affective, cognitive, and behavioral interventions. Bemak et al. (2003) has stated that the cultural differences between the therapist and the client must be

recognized and incorporated into the actual therapy itself, in all forms of therapy to include family, individual, community, and group. This is important because Mexican Americans, much like their larger cohort of Latino-Americans, have a lower rate of using addiction treatment services as well as a lower success rate when they do use treatment programs. To have the best result possible we need to be as culturally sensitive and aware as possible (Fish et al., 2015). Mexican American immigrants are subject to many types of acculturation and their children who are born here are even more susceptible to high levels of acculturation, which can cause significant family conflict, especially when dealing with addiction and mental health issues (Sparks et al., 2013).

This is where the MLM's five levels of intervention became an important framework (Bemak et al., 2003; Bemak & Chung, 2015). The MLM uses an intervention approach that has been seen as a complex blend of western methods with a holistic backbone, which together can meet the unique needs of immigrants (Bemak, Chung, & Bornemann, 1996). This is done by identifying the client's cultural belief system, including the integration of mainstream mental health services, adding psychosocial adaptations, adjustments, and acculturation, and addressing the implications of resettlement policies for mental health.

Conceptual Framework

I hoped to make an original contribution to the MLM by documenting therapists' experiences working with Mexican American children of parents diagnosed with SUD. Bemak and Chung (2012) stated that more research is needed to document the integration of a wide range of culturally appropriate intervention techniques and strategies for

therapists to navigate potential cultural barriers (Ahn et al., 2014). By seeking out the experiences of the therapists who worked with this client base there was an opportunity to learn about the ways that these families explored family dynamics issues and we were able to see how they were able to better support their children with help from their therapist's culturally sensitive approaches (see Ahn & Miller, 2010).

Literature Review

Understanding of Immigrants as Clients

To work with immigrants or the children of immigrants it was important to define who an immigrant was (Bemak & Chung, 2014). The term or word "immigrant" usually refers to those who have voluntarily left their country to move to another country, usually in hopes of finding a better life (citation). Therapists need to keep in mind that just because the decision to move was their own does not mean it was an easy one, and often immigrants have had some kind of premigration trauma before leaving (citation). In this study, this trauma would have been experienced by the parents of our Mexican American children who are being treated and seen by the therapist.

As of 2014, there were at least 214 million immigrants globally, and of those in it is estimated as many as 64 million immigrants reside within United States. borders (Bemak & Chung, 2014; Guerrero et al., 2013).). This number is three times higher than the country with the second highest number of immigrants. This suggests that the likelihood of a therapist having an immigrant as a client is much higher in the United States than in any other country. For this reason, therapists need a deep rooted understanding of the racial and ethnic identity of the immigrant client and themselves, as

well as current knowledge about the contextual political and social responses to immigrants that might have an impact on their mental health (Bemak & Chung, 2015; Chung et al., 2011).

It might be hard to understand the challenges associated with being an immigrant, but as a therapist, it must be part of the job. Immigrants not only have the previously mentioned premigration trauma, but they also may experience new trauma once in the United States, and it often comes from the stereotypes, myths, and xenophobia of the communities they have moved to (Chung et al., 2011). The level of trauma or lack thereof is often a direct result of public reactions to them as a group and the smaller community's willingness to accept or not accept them. However, it is important to note that the media often influences both larger public views and smaller community views and actions (citation). When the media talks about immigrants or immigration they are often referring to "undocumented" immigrants (citation). Historically, the media has propagated myths and stereotypes that the immigrant population hurts the United States economy by taking American jobs, misusing resources and services, and making life harder for United States citizens (citation). These myths, biases, and stereotypes create fear, intolerance, and ultimately xenophobia. Therapists working with immigrants and children of immigrants must understand the trauma that those clients may or may not have endured if they do not they are at a higher risk of not understanding the misunderstandings and prejudices that their clients may have encountered.

Teaching Clinicians Cultural Sensitivity

While therapist preparation programs claim to offer training in multiculturalism, diversity, and social equity, some studies indicate that there is sometimes almost no preparation, or very little preparation, in these areas (see Bemak & Chung, 2012; Goodman et al., 2015). Diversity and multiculturalism are not taught in depth in most undergraduate or even graduate programs (Goodman et al., 2015). Therapists and specialists have to figure out how best to function with individuals from different backgrounds, particularly as the social face of the United States continues to evolve (Chung et al., 2011).

MLM theorists redefined the role of clinicians to incorporate advocacy, consultation, human rights, social justice, indigenous healing, social networking, and heightened cultural responsiveness into more traditional culturally competent counseling practices (Chung, Bemak, & Talleyrand, 2007). These things are especially important when working with the children of immigrant populations. The MLM merges social justice, psychotherapy, and counseling into new ways to be culturally sensitive. The MLM can aid therapists and student learners in gaining a better understanding of the racial and ethnic identity of the immigrant client. The end goal of being trained in using these kinds of modalities is to expand one's knowledge and skills to work with various cultures (citation). In cases where students are professionally trained at the undergraduate and graduate levels in working with minority populations, their expertise in working with these clients has been shown to improve dramatically (Ahn et al., 2014; Chung et al., 2007; Chung et al., 2011). According to Chung et al. (2007), the teacher or mentor has an

important role for the student who will someday be a therapist working with clients from other cultures. These three themes emerged as being important in the mentor/student relationship: trust/comfort/honesty, respect, and a strong teacher/student/guide relationship. This dynamic between teacher and student guides the student to developing the same roles when they are a therapist working with their clients, the students learn as a therapist to work better together with their clients, to trust each other more, and to encourage full disclosure by the client to the clinician.

A training manual known as treatment improvement plan (TIP), written by CSAT(n.d.) was released in an attempt to help clinicians learn how to improve themselves and their treatment approaches in specific areas, such as substance abuse. This training manual addresses how substance abuse affects the entire family and how substance abuse treatment providers can use principles from family therapy to change the interactions among family members (CSAT, n.d.). TIP provides fundamental data about family treatment for substance abuse treatment experts, and essential data about substance abuse treatment for family specialists. The TIP shows the models, procedures, and standards of family treatment with unique consideration given to the phases of inspiration in addition to treatment and recuperation. Likewise, the dialog concentrates on clinical basic leadership and preparation, supervision, social contemplation, unique populaces, financing, and research. CSAT recognizes that distinctive societies and conviction frameworks exist, and each requires an alternate sort of treatment plan. Family treatment can be characterized as an accumulation of restorative methodologies that offer faith in the adequacy of family-level appraisal and intercession (CSAT, n.d.). An

adjustment in any piece of the framework may affect changes in other parts of the framework. Substance abuse treatment has two principal purposes: (a) to use the family's qualities and assets to help discover or create approaches to living without substance abuse, and (b) to diminish the negative effect of substance abuse on both the recognized patient and their family (CSAT, n. d.).

The Necessity of Cultural Understanding in Drug Treatment Programs

Latinos are among the fastest-growing population in the United States with their numbers exceeding 64 million (Guerrero et al., 2013). Of that population, almost 64 percent are Mexican. Latinos are also in need of substance abuse treatment at a higher rate than almost any other ethnic group. There are some difficulties with availability issues when dealing with minority populations. The therapists who are available at various treatment facilities need to learn about the special needs of clients from different minority groups that they may be working with and that include the needs of their children. In certain cases, clients from a minority group have received inadequate care in treatment facilities because they are being compared to clients that are not from their minority group. All populations require a level of sensitivity and care; however, minority groups require unique care, which not all clinicians are sufficiently trained to provide. If therapists do not receive appropriate education and a lack of cultural sensitivity continues, Mexican American parents and their children who are seeking treatment for substance abuse issues will not get the quality healthcare they need to recover.

To achieve cultural competence in the area of substance abuse counseling, therapists, psychologists, counselors, and clinicians must first be sensitized to their

prejudices, biases, and privileges as well as to how historical and sociopolitical factors affect their clients from minority populations (Bemak & Chung, 2004). According to the MLM model, there are five levels of intervention for mental health professionals to use in a culturally sensitive framework. These include mental health education, cultural empowerment, integration of western healing methodologies, social justice, and individual, group, and family counseling. Therapists are required to develop a clear understanding of the racial identity of Mexican American clients as well as current knowledge about the political and social response to Mexican American immigrants that may have an impact on their mental health. The MLM model promotes the most effective ways to work with these populations (Bemak et al., 2014.)

It has been determined that very soon, one in three children living in the United States will be either first or second-generation immigrants (Bemak et al., 2014). America has a larger immigrant population than other nations, and consequently, specialists and advocates must be prepared and ready to work with foreigners in their practices (Bemak et al., 2014). To work effectively with immigrants, clinicians must not only be aware of their prejudices and assumptions regarding people of other cultures and ethnic groups but also understand the reality of what life is like for many immigrants (Bemak et al., 2014). Abandoning one's nation for another one is seldom accomplished without injury and endeavoring to acclimatize into one's new home country is quite often an extremely difficult task. Furthermore, most immigrants are significantly more inclined to experience destitution, dialect challenges, trouble understanding the "rules" in their new nation, and

hesitancy to search out for what they need because of a general sense of distrust of experts (Bemak et al., 2014).

All these considerations make treating clients from immigrant populations with substance abuse issues difficult but treating their children is even more extremely problematic—from persuading them to seek help in the first place throughout the entire process. Treating immigrant populations is much more difficult than treating patients who are native to this country (Bemak et al., 2014). Additionally, a therapist who plans to work with immigrant populations ought to search out specific training that will prepare them to work with this altogether different set of clients (Ahn, et al.,2014; Bemak & Chung, 2012; Fluckiger et al., 2013; Guerrero et al., 2013; Jimenez et al., 2014).

Despite the enormous toll that mental health and drug and alcohol addictions take upon the well-being of Mexican American children and families, disparities in access to and the adequacy of quality treatment exist for this group. They are more likely to receive inferior services as compared to non-Latino Whites (Jimenez et al., 2014). Clinicians working with Mexican American children must not only be interested in treating the child; they should also be engaged with achieving or displaying social equity for the child and their family—working with the child and their family as they would wish to be dealt with (Bemak & Chung, 2012). Earning the trust of a child is one thing but earning the trust of someone with a different cultural background, whose parents are foreigners to our customs and cultures, is huge. A large part of getting Mexican American children of Mexican parents to engage in and get the most out of treatment, and to earn their trust, the therapists must know why clients are hesitant. Part of their therapy and approach is to

work to alleviate those obstructions (Bemak and Chung, 2012). Social boundaries are continually going to be an issue when working with a settler populace, and it is the duty of the specialist, not the client, to attempt to eliminate these hindrances (Bemak & Chung, 2012).

The Effects of Parental Drug Abuse on Children

One particular study showed that drugs used by mothers while pregnant or nursing affect their children early in life (Hser et al., 2014). According to this study, children of mothers who received drug treatment were examined between the ages of 6 and 17. They found 22 percent of the children who had been exposed to drugs showed behavioral problems. Many studies have shown the amount of damage that maternal alcohol and drug use can cause to children, and the ongoing use of drugs in mothers of young children can cause damage to families and children (Hser et al., 2014). However, it is not just mothers who cause an increased risk to their children when they abuse substances. The children of substance abusing parents demonstrate an alarming increase in the risk of addiction themselves (Merikangas & McClair, 2012). Studies have found that the genetic factors involved in addiction play a much greater role in its etiology than even negative environmental factors.

Some parenting characteristics such as harsh parenting, inconsistencies, and low parental warmth level have been shown to cause problematic behavior in children of all ages. These traits are associated with alcohol and drug abuse (McCabe et al., 2013). This connection has been tested using European subjects. However, recently some Latino parents who self-reported both using drugs and/or alcohol and having parenting

characteristics that are affected by this abuse had children with significantly more severe behavior problems than parents who did not admit to drug or alcohol use. This study (McCabe et al., 2013) suggests that no matter the age of the children in question, parental drug use can lead to severe consequences.

Utilizing a Contemporary Family System Approach in Drug Treatment Therapy

The Contemporary Family system approach to drug treatment suggests that the behavior of drug users in a family affects the dynamics of the whole family, especially the children (Adelson, 2010). According to Adelson, the behavior of drug users has the potential to hurt an entire family and change the entire family structure. It is a common observation that in a family where one or more individuals are drug-addicted, the rest of the family are more likely to alter their behavior and adjust to the goals of the addicted individual. This puts a hurdle in the way of other family members fulfilling their needs. Moreover, family rituals, values, and traditions emerge within a family and change the way nonaddicted family members interact with each other and the people around them. This breakdown of family rituals makes it tough for the children of addicted parents to ask for assistance from others to improve their situation (Karlsson, 2014). The specialists and clinicians who work with such children often face a difficult time in separating the truth of a child's situation from the fantasy that has been created in the child's mind. This approach can enable all the family members to recognize how they are being affected by the behavior of drug abuse and take help for their problems (Karlsson, 2014).

Another area in which family examination is helpful especially when working with children is in the area of family conflict. It has shown that the amount of conflict

within a family can predict the level of substance abuse in the individual and its reduction can lead to better treatment results (Fish et al., 2015).

Treatment Methods for Children of Drug-Abusing Parents

It is generally acknowledged in the psychological and psychiatric community that the best form of treatment is, in fact, prevention. Pina and Gonzales (2014) stress the importance of working to prevent problems in children with drug-addicted parents before they start. By expanding programs for such youngsters in schools and other group settings, it is anticipated that kids in this circumstance can learn approaches to either help themselves or contact others for the assistance they require before they are past the point of no return (Pina & Gonzalez, 2014). Since dependents of substance abusing parents are at a considerably higher danger of abusing substances themselves, (Sparks et al., 2013) programs such as medication management, mindfulness courses and 12-stage plans, and AlaTeen have been created to help keep the offspring of substance-dependent guardians from mishandling substances themselves (Sparks et al., 2013). One of the reasons treatments for Mexican Americans children with parents who are using or abusing substances is so important is because these children are more vulnerable to developing substance abuse or mental health issues themselves (Reingle et al., 2014).

The children of Latino immigrants are and have been often recommended for mental health treatment because of the stress of their lives as immigrants. However, according to research, Latino immigrants, including those from Mexico, tend to have a negative opinion about American mental health or substance abuse treatment (Ahn et al., 2014). They often do not comprehend the need for emotional well-being or therapy;

thinking that it is too difficult, confusing, and hard to explore (Reingle et al., 2014). Generally, these immigrants are of lower socioeconomic status and live in more chaotic households, and this can lead to disruptive behavior that draws the negative attention of teachers or other adults outside of the family unit. Mexican (Ahn et al., 2014; Fluckiger et al., 2013).

According to Contreras and his colleagues (2012), the ideal counseling or therapeutic treatment for Mexican American children would be provided by Mexican American therapists or clinicians. The advantages of this kind of treatment are straightforward: a large number of the issues related to conventional treatment settings would be eliminated and the specialists would have a better understanding of the culture. There are not enough such therapists and clinicians, however. Maybe if there were ways to encourage more Mexican Americans into the helping fields it would fill a gap in our mental and substance abuse needs (Contreras et al., 2012; Clandinin & Connelly, 2000; Ager, 2013). Unfortunately, a solution of this magnitude, if possible, at all, would take years to put into effect, though the recent development of bilingual, bicultural recovery houses for recovering adolescents is a start in meeting the needs of our ever-growing multiethnic population.

Using drug-addicted parents to help their children avoid becoming addicts themselves can be very difficult (Shorey et al., 2013) however if the parents are completely in recovery the bond, they share with their children may be an effective tool in preventing future substance abuse in their children.

Given the lack of research focused on working with Mexican American children of substance abusing parents, this study does fill a crucial gap in the literature. Although studies have existed on practices for clinicians working with Mexican Americans in general and on working with children living with substance abusing parents, there is limited clinical significance-based research concerning how clinicians work with Mexican American children with substance abusing parents (Ahn et al, 2014; Pina & Gonzalez, 2014; Goodman et al., 2015). The researcher for the current study hoped to add to the available research on working with Mexican American children dealing with the problems inherent with living with a parent or caregiver who is addicted to drugs or alcohol. To do so, it was necessary to combine the issues of all children who are dealing with drug-addicted parents with the particular problems experienced by Mexican American children to make note of all of the issues involved with this specific population (Contractor et al., 2012; Jimenez et al., 2014). It is hoped that this study has added to existing research on best methods for working with Mexican American children of substance abusing parents.

Chapter 3: Research Method

Examining how therapists have worked with Mexican American children of substance abusing parents required that I get a good understanding of the past experiences of therapists who had worked with this population. By conducting a qualitative study with a narrative inquiry research study, I was able to see what past therapists have done, what has worked, and what has not (see Polkinghorne, 1988). This research study provided information that was used to examine and find patterns of success (see Clandinin & Connelly, 1987) directly from the therapists working with Mexican American children of substance-abusing parents. Furthermore, the data from this study is invaluable to future therapists who might have clients from this population when they are creating future treatment goals and plans for these children.

Research Design and Rationale

Though there are different research designs, a qualitative approach was chosen as the best option for this study because the qualitative research design best allowed me to gain the fullness of the participants' experiences, and in-depth interviews with therapists were able to uncover their unique experiences working with this population (Mexican American children of substance-abusing parents; see Stangor, 2011). The qualitative approach allowed me the opportunity to work closely with participants while establishing a trusting relationship with them. The approach also allowed for better support for those participants in the off chance that revealed feelings of discomfort regarding disclosing sensitive and critical experiences (Wimberly, 2011).

Several approaches could have been used to conducting qualitative research, all with long-standing traditions. Creswell (2003) had established five types of strategies that he felt were best suited for the qualitative approach. These included narrative inquiry, ethnography case studies, grounded theory, and phenomenological research. For this research study, the narrative inquiry was selected as the most suitable choice for gathering information. Choosing an approach that truly supported the in-depth questioning of therapists' past experiences was important to the quality of the research and understanding of the data analyses. When asking a therapist to look at specific cases involving Mexican American children whose parents are struggling with a substance abuse problem, the narrative inquiry approach allowed me to develop a rich and thorough understanding of the unique and complex experiences that they had while working with these specific clients (see Clandinin & Connelly, 2000; Stangor, 2017; Webster & Mertova, 2007).

The narrative inquiry approach was specifically intended to investigate the human side of experiences and the interpretation of an experience through the telling of a story about those experiences (Clandinin, 2014; Webster & Mertova, 2007). The narrative inquiry approach aligned with the purpose of this study. This approach provided a strong pathway to gain in-depth insight into the therapists' different experiences while working with various traumas and situations Mexican American children who had substance-abusing parents experienced and what did and did not help them.

According to the existing literature and research, the narrative approach is effective when it comes to understanding the experiences of people who are drug-

addicted and those of their families (Moen, 2006). Similarly, the narrative inquiry technique was effective in helping me recognize, describe, and address traumatic experiences as well. There are three fields of the narrative technique: the material realm, the organic realm, and the realm of meaning (Polkinghorne, 1988). The use of technology during the narrative inquiry approach has many benefits. Audiotaping, videotaping, and related means can be used alongside questionnaires to explain the client's experience more effectively (Szeto, 2014; Webster & Mertova 2007). For this research study digital audio recording was used to capture the interview as well as handwritten notes.

Role of the Researcher

The role of the researcher is not only to identify and interview participants but to also look at the data and find a clear and concise understanding of the stories (Creswell, 2003; Wong & Geale, 2015). As the researcher, I have minimal experience working with addiction; therefore, my personal biases on this topic were minimal. I do not have any previous relationships or history with any of the participants, which also reduced the "backyard" effect. The backyard effect is when the researcher has some history with participants that can lead to compromises in the researcher's ability to be objective and unbiased (citation). Random therapists were chosen that were known to treat Mexican American children. LinkedIn was a used source to help identify these therapists. Once therapists voluntarily showed interest in participating in the study they were asked if they worked with or had previously treated Mexican American children whose parents are substance abusers. Before the start of the study, all participants were sent an informed consent form and were required to have signed and returned the form before the interview

with the researcher, which stated that they were willing to be in the study and that they had the freedom to withdraw at any time.

Methodology

Population

This research was designed to focus on a very specific population: Therapists who have previously worked with Mexican American children whose parents or caregivers are dealing with a substance abuse problem, whether it has been formally diagnosed or not. The study population was therapists who had worked with this specific client base.

Sampling Strategy

Because this was a qualitative study there was no expectation for random sampling; instead, convenience sampling and purposeful sampling were used as the sampling strategy for this particular research study (see Creswell, 2003; Patton, 2002). This took place by contacting local therapists through LinkedIn and asking for volunteers who had worked with this population to take part in this study. The criterion for this research was very narrow: therapists willing to volunteer for this study must have worked with children whose parents are immigrants from Mexico and are dealing with substance abuse. The participants were chosen very carefully to ensure that the therapists participating in this study were able to provide the kind of information being sought after by this study. However, due to the rarity, it also must be one of convenience. A well-formulated research design was incorporated so that if more than one of the sampling strategies had been presented that it could have been used if it was possible (see Creswell, 2003), however only one strategy was used.

Criteria for Selection

Therapists were chosen based on a few specific criteria. The first criterion was that the therapist must have treated or be currently treating Mexican American children whose parents have a substance abuse problem; preferably the therapists chosen would have worked with multiple children from this population to draw experiences from. Secondly, the therapists chosen had to have a high level of cultural competence since they have been working with Mexican American families; it was not required that they speak Spanish, only that they were culturally competent. For this study, the area of discipline that the therapists must have been from was from the following: clinical social work, clinical practicing counseling, marriage and family therapy, or as a psychologist as either a licensed or intern practitioner.

Sample Size

This research study used a multistage sampling process because the first thing did was the sample of local therapists in the area. From the cluster of agencies, organizations, and individual therapists who work directly with the Mexican American population a smaller more specific sample group was found (see Creswell, 2003), all of which had worked with several Mexican American children that had at least one parent or caregiver with a substance abuse problem. The sample size is typically based on three main elements: the resources available, the research questions, and the data collection (citation). Based on those criteria, I decided I would collect data from at least four different therapists who work with Mexican American children of substance abusing parents in an outpatient setting, but it was found that the sample size that fit the criteria

was made up of five therapists. The sample size was limited by the constraints of time, the number of clinicians working in the research field, and the funds available.

Each potential therapist was contacted by the researcher once identified as a possible match through their LinkedIn response. A request for permission to conduct an interview was presented to the therapist as defined in the narrative inquiry tradition. When it was found that the therapist met the criterion and had agreed to be interviewed, they were then asked to sign an informed consent form. The therapist was informed about the duration and the location of the meeting, since we have been involved in a coronavirus shut down it was suggested that a phone interview be done, and they were informed that the interview would also be recorded via a digital audio recording for accuracy purposes.

The narratives from the interviews were considered as raw data retrieved for research (see Clandinin & Connelly, 2000). For each interview, I collected all data in the form of stories by allowing the therapist to talk freely and making handwritten notes about what the therapists were saying. The therapists were all thanked and debriefed at the end of the interview. They were asked if they want a copy of the dissertation when it is complete, all of the participants said yes.

Procedure for Recruitment

TI attempted to find agencies or independent therapists throughout the Las Vegas Valley area who have primarily worked with Mexican American families as well as people dealing with substance abuse. There were no agencies in Las Vegas that had enough therapists in their agency that worked with Mexican American children to partner

with actual agencies. Because of this, participation requests were sent out via LinkedIn to individual therapists that fit these very narrow criteria. I then contacted the interested therapists directly and invited them to participate. An interview was then scheduled with the therapist. This process was repeated until five independent therapists were found who were willing to participate.

Instrumentation

As part of the challenging data collection process, I asked participants to tell their stories (see Creswell, 2003) during an unstructured phone interview. Even though originally it was planned that phone interviews could be done, the hope was for face-to-face interviews. However, due to Covid19 phone interviews became the only data collection method as face-to-face interviews were no longer a viable choice. I asked the participants questions about the themes that the therapists had seen emerging from their experiences in working with Mexican American children of parents with SUDs. The unstructured interview questions (Appendix A) were aimed to find barriers and themes that naturally emerged during the experiences the therapist had working with Mexican American children of parents with substance abuse disorders.

Handwritten notes and a transcript from an audio recording were generated from the interviews and served as data for the researcher. All transcriptions were page numbered as part of the coding system (Webster & Mertova, 2007). The discussion during the interviews created a setting that stimulated the therapists to talk about their experiences in working with Mexican American children of substance abusing parents. The therapists were asked to describe their various experiences working with this

population as it differs from other populations. Narrative inquiry (NI) as a research methodology (Clandinin, 2013) was used to gain powerful insight by having the participant tell their stories as a response to the questions and prompts, which was a vital link between the human experience and transferring of that information to someone else (Webster & Mertova, 2007).

The interview was conducted in four phases and never took more than 1 hour to complete. The table below shows the four stages and rules that were observed while doing the interview (Camila, 2014).

Table 1

Phases and Rules when Conducting a Narrative Interview

Phases	Rules
Preparation	• Explore the field • Researcher interest questions formulation • Open ended questions
Initiation	• Formulate the initial topic for narration. • Questions are to be avoided.
Main narration	• nonverbal encouragements are allowed to continue the narration • Why-questions, arguing on contradictions, opinion, and attitude questions were allowed
Questioning phase	• What happened then questions' type were allowed
Small talk	• Why questions were allowed

Note. Collection, 1996; Camila, 2014

These phases were arranged in an order to help facilitate the gathering of quality information thoroughly and systematically. The phases range from the preparation phase, through the initiation, the main narration, the questioning period, and into the small talk.

In the first step, the researcher explored the field by getting more information in the area of study; this allows identifying questions to be answered.

Sufficiency of Data Collection Instrument.

Reliability and validity in quantitative narrative inquiry refer to the stability and consistency of the data collection instrument (Polkinghorne, 1988; Webster & Mertova, 2007). These two things were achieved through the trustworthiness of the participant, the notes, transcriptions, and the researcher's ability to accurately represent the data in the research. The reliability of a narrative inquiry is based on the accessibility to the data and the accuracy of the data once integrated into the research.

Data Analysis Plan

All data collected by the researcher was organized for analysis with multiple components (Croswell, 2003). The narrative analysis consisted of deploying means for making sense of the data obtained during the interview while simultaneously gaining a deeper understanding of the subject of the narrative inquiry. In narrative data analysis, written notes and audio recordings were analyzed by looking at the historical, social, and cultural context from many different points of view. They were dismantled to show hierarchies and meanings and consistent reflection. Even though there were many different ways to analyze qualitative narrative inquiry data there was a generic process that guided most of the data analysis, this can be found in the graph below.

Table 2

Analysis Process

Step 1	Organize and prepare the data for analysis. This was a process of visually scanning material, transcribing all interviews, typing up field notes, and arranging data into different categories.
Step 2	Reading through all the data. This was done to gain an overall general understanding of the data and its meaning. What are the general ideas? Is it credible, does it make sense, what are the overall themes, etc?
Step 3	Coding, this a process of organizing materials and data into chunks or categories. This involved labeling, topic dividing, and getting a general sense of the language of the data.
Step 4	Using the coding process to develop an overall theme of the participants, categories, settings, etc. descriptiveness, ethnographies, and narrative projects are broken down into a few main themes. The researcher started interconnecting themes, creating complex connections.
Step 5	Representation of themes and descriptions. This often includes a chronology, detailed discussions, visuals, figures, or charts. This was the advanced ethnography and descriptions of each participant.
Step 6	The final step of data analysis was the interpretive understanding of the whole picture. What lessons were learned, what themes became clear, this was often the researchers own interpretation. Comparison to literature confirms theories or unravels new questions or theories.

Qualitative narrative inquiry is more than just regurgitating stories; as a researcher, I did more than listening to stories, recording them with analyzing them (Webster & Mertova, 2007). Coding is an important part of the qualitative process; for this reason, I took time to review all the data, transcripts, and notes to get a good understanding of the whole picture before I started the coding process (Creswell, 2003). There were essentially eight steps that have been commonly used in coding during the qualitative process. 1- get a good understanding of the data as a whole 2-take one piece of

information at a time, review it and make a short note of what the underlying meaning of that piece of data is 3- make a list of topic found within your data 4- create a coding system based on the topics 5- create categories based on the topic descriptions 6- create abbreviations for the categories and alphabetize the codes 7- categories 8-recode if necessary. This is the most commonly used process for breaking down, organizing, and coding qualitative data. By doing this, researchers can truly see a collaborative story that speaks to the readers as well as the next set of researchers.

Trustworthiness

Trustworthiness in qualitative research means something quite different than it does in quantitative research (Creswell, 2003). This research is qualitative, which means that in this research trustworthiness must equate with accuracy, it must be legitimate, and it must refer more specifically to the field notes, audio and transcriptions, and how closely the research was able to accurately incorporate the raw data (Polkinghorne, 1988; Stangor, 2007). For this research, I kept accurate field notes, use digital audio recordings, and kept transcripts to refer back to for accuracy. This process is called verisimilitude, which simply means that the research yields results that reflect a level of trust and/or reality (Creswell, 2003; Webster & Metova, 2007).

Credibility

Since I did a narrative inquiry qualitative study; terms such as credibility are notably important, for one reason criteria's such as validity are not a used as a goal. Validity asks for things not achieved in storytelling or narrative inquiry style study. Therefore, creditability is even more imperative to this study. The raw data in this

research is used to increase credibility and honesty (Webster & Mertova, 2007). In this research, my quest was to gain the stories, experiences, and opinions of the therapists who composed my study sample. It is said that our mind remembers the most important details of an experience, and credibility was gained by the evaluation of the stories told by the participants.

Transferability

Transferability is an implied thought that an accurate impression of information would allow another person in a similar setting to be able to draw from the information given, compare the similarities, and use needed parts of the information (Webster & Mertova, 2007). This study has a great deal of transferability because it can easily be replicated in a similar setting and similar results would be gained.

Dependability

The dependability of the data in narrative research is usually referring to the reliability of data; can you be sure that what the participant is saying is accurate (Webster & Mertova, 2007). There should be a process of verifying that the person chosen to be a participant has the qualifications to have their stories used for the research. Dependability is truly about the trustworthiness of notes and transcripts, it sustains the rational viewpoint of reliability (Huttunen & Kakkori, 2020; Polkinghorne, 1988; Webster & Mertova, 2007).

Confirmability

The personal confidence level of a researcher is defined as confirmability. Confirmability usually is achieved by doing one of two things: an audit trail or reflexivity

(Huttunen & Kakkori, 2020). The audit trail is a commonly used option as it only requires the researcher to make note of the processes that they used in collecting data, how they analyzed and interpreted the data. Often researchers will also have a list of notes that were thoughts, interesting or important details, themes that arise they may have information about the coding, explanations, or rationale about notes coding or merges made. The other major technique used in qualitative research is reflexivity; this is most commonly used with phenomenological research. Reflexivity starts with the use of a journal or notes that the researcher can reflect on at a later time. This technique requires that the researcher do a lot more introspection of one's background, self, and biases.

Ethical Procedures

In all types of research studies, the researcher has an ethical responsibility to protect the participants. They must protect the dignity, privacy, and welfare of the participant (Creswell, 2003; Wang & Geale, 2015) even if the participant does not know they need protection. In working with therapists who work with children, it is important that I used a wide range of tools to protect the participants (Webster & Mertova, 2007). Ethical issues are of prime importance throughout the inquiry because of the relational aspects of narrative historical interaction. It is the role of the researcher to inform all participants about the rules, activities, location, and duration of the survey and the researcher must let all participants know that this is completely voluntary. Researchers should always make sure no harm will come to the potential participants, their sites, or even to the field itself. Not only must researchers such as myself think about ethics before they begin the research process, but ethical concerns should be calculated throughout the

entire research process (Clandinin, 2013) which, was something that I did regularly. One of the most important ethical procedures that a researcher should always implement is to prevent putting any participant at risk in any way (Creswell, 2003). All research must be approved by the IRB before any actual research occurring. I obtained permission to conduct this research through Walden's IRB and I was given an IRB Approval # 03-06-20-0063458. before doing anything regarding this research. Not only should the researcher gain the consent of the participant but also any authority entities that may be over the participant also known as the gatekeepers such as site supervisors should provide permission as well (Creswell, 2003). In this research, all therapists were independent therapists meaning they had no identifiable gatekeepers.

The researcher's integrity and ethics in recording and relaying the data is another critical ethical issue (Stangor, 2007). Honesty was a must when performing this research as it should be with all research, this includes the actual conducting of interviews, collecting of data, giving of proper credit of ideas or thoughts, and reporting of the data collected. As a researcher, I understand that I cannot lie, mislead, or even bend the truth to have the data or anything else say something other than exactly what the participant was intending to say. However, researchers are human, and they make honest unintentional errors; for this reason, all researchers must double-check their work, which is what I did.

Summary

The study design is a core part of conducting research. In this chapter, a narrative inquiry is described as the research design that was used while exploring the experience

of a therapist working with Mexican American children of substance-abusing parents. This narrative inquiry was conducted in three phases: 1) the preliminary phase in which participants and colleagues were identified and invited to participate in the interview; 2) the primary phase in which data was gathered via an unstructured narrative interview; and 3) the analysis phase, in which the data was analyzed. The last step led to the creation of categories for this study. This is seen in the next chapter, where the interpreted data will be discussed based on the primary purpose of the study: uncovering modalities or methods that worked best for therapists who work with Mexican American children of substance abusing parents.

Chapter 4: Results

Introduction

The purpose of this qualitative, narrative research study was to uncover themes that emerged from the narratives of therapists' experiences working with Mexican American children of substance abusing parents. The goal was to find what modalities therapists have found work best with these children (see Ahn et al., 2014; Fish et al., 2015; Moen, 2006; Pina & Gonzalez, 2014) using the combined narratives of the five different therapists that have worked with this population successfully. I collected data that, when later indexed and coded, was able to tell its own story (see Camila, et al., 2014; Polkinghorne, 1988). Historically, people of all professions and all walks of life have used storytelling to pass on knowledge (Moen, 2006). Narrative inquiry is the truest form of storytelling. This method has been particularly effective when dealing with trauma, stress, or even major catastrophes (Wimberly, 2011). Narrative inquiry is truly about being able to bring meaning to the stories that are being told and retold; it is about bringing meaning to the stories of the individuals being researched. The narrative inquiry chosen for this research will bring to life and amplify the participants' themes and common experiences (Moen, 2006; Wang & Gaele, 2015). Since this was a narrative inquiry study, the questions were open-ended to allow the participants to speak freely about the subject. The following were the two research questions I aimed to answer.

RQ1: What themes emerge from the narratives of therapists working with Mexican American children of parents with SUD regarding their successes and challenges within their therapeutic relationship with the child?

RQ2: What themes emerge from the narratives of therapists working with Mexican American children regarding their successes and challenges within their therapeutic relationship with the child's parents/custodial guardians?

All participants voluntarily participated in the study of their own free will and with no compensation or reimbursement given. I approached each interested participant about taking part in the research through LinkedIn, a professional networking site. Those individuals who responded that they were interested in participating in the LinkedIn post were contacted and then given the informed consent form before participating in the research. Chapter 4 will provide details in broken down into sections that will cover an overview of the entire study as well as an introduction, demographics, data collection, data analysis, evidence of trust, results, and a final summary.

Setting

The qualitative study results were based on interviews of five different therapists from across the Las Vegas Valley. As a result of the current pandemic and the quarantine requirements from COVID19, face-to-face interviews were not able to be conducted. Therefore, all five interviews were conducted as phone assessments. I initiated all interviews via cellphone from my home office. The calls were placed on speakerphone and digitally recorded by a second electronic device, which the participants knew and agreed to before the interview.

Demographics

Five therapists were chosen as qualified participants to be part of this study. Participants in this study were all therapists who have worked with several Mexican

American children who all had at least one parent or caregiver that was using or abusing drugs or alcohol. All five therapists were women: three were of Hispanic ethnicity, one was Caucasian, and one was African American. All five therapists lived and worked in the greater Las Vegas area. Even though this is a very narrow field of participants, the goal was to find therapists who had successfully worked with several children with at least one parent or caregiver struggling with addiction to either drugs or alcohol. All therapists had significant experience working with this population. The minimum number of clients by any of the participants was at least nine. One therapist was English speaking only, one understood Spanish but could not speak Spanish, the other three were bilingual.

Data Collection

I arranged one pilot or mock interview, which was done in person (before the quarantine brought on by the COVID19 pandemic). By doing a pilot study or a practice interview, I was able to practice my interview structure and redefine my approach by practicing how to best ask questions (see Creswell, 2003) and learning what open-ended questions led to the highest level of responses and which questions where most clearly understood.

The original design of this study included four therapists, with the hopes of finding more if possible. I was able to find five therapists and one pilot, all of which increased the validity and power of the study (see Stangor, 2011). As previously mentioned, all interviews were done as phone interviews due to the unusual circumstance of the pandemic Covid-19. I digitally recorded all five interviews for accuracy and reliability.

Coding was done by randomly creating file numbers, writing them on the top of blank papers, then arbitrarily selecting from the coded papers to write notes during the interview process. to be used to take notes (all names started with WD for Walden Dissertation) followed by three numbers, none of the numbers were in chronological order with no rhyme or reason. All five interviews were reviewed for common themes that emerged. These themes were categories such as the patient's diagnosis, language, barriers, modalities, important keys to therapy, trauma, and things to avoid. There were no apparent discrepancies in the cases, themes or patients found.

Data Analysis

The study was a qualitative study that used narrative inquiry as a method to find themes that emerged from the experiences of therapists working with Mexican American children with substance abusing parents. Coding was done inductively without the use of coding software. In the first step, all the interview transcripts were read and listened to before coding began to increase familiarity with the data. Next, each interview transcript was read in greater detail. In doing so, I generated a list of general topics of items discussed. During this stage, participants' responses were grouped or clustered under several topics, with all responses relevant to the study included in the initial coding. Themes or categories were then identified based on the identified topics. After further refinement of the themes through reviewing and cross-checking themes from each interview, the themes were assigned names and meanings. These seven themes emerged:

1. Modalities- Modalities that the therapist most commonly used with Mexican American children with substance abusing parents.

2. Diagnosis's –Diagnoses that were most commonly given to therapists' patients.
3. Barriers -These are both the barriers the therapist experienced with the children as well as the parents.
4. Important issues – The issues deemed as the most important by therapists when working with Mexican American children with substance abusing parents.
5. Language concerns – Refers to concerns about language barriers and if it mattered if a therapist spoke Spanish or not.
6. Referral source- How did the therapist get the clients referred to them?

Evidence of Trustworthiness

Creditability

The raw data is the credibility of this research study (Webster & Mertova, 2007). The raw data for this research were the notes created when conducting the interviews with the therapists; it was the statements of the therapists and their stories condensed into themes. The original goal was to find the stories, experiences, and opinions that come directly from the therapists, which was obtained by interviewing each therapist carefully. The hope was to listen to the stories not just as individual interviews but hear the stories as one story.

Transferability

This study offers a great deal of transferability. Transferability refers to whether the same themes or results would appear if a study were duplicated (Patton, 2002;

Webster & Mertova, 2007). Even though this study used five random therapists that gained their clients from various sources similar themes about the treatment of Mexican American children of substance abusing parents emerged. Even if the participants of this study had some variation in the details of the themes I believe that the same themes would appear if the study was duplicated.

Dependability

Dependability concerns the trustworthiness of notes and transcripts (Polkinghorne, 1988; Webster & Mertova, 2007). Therefore, accurate notes were made to increase the study's dependability. Additionally, the interviews were recorded and listened to multiple times for the accuracy of notes.

Conformability

The term conformability has to do with the data having autonomy and objectivity (citation). For this study, conformability was addressed by reviewing the notes and the recorded interviews, ensuring a good understanding of the statements by the therapists. A narrative inquiry requires the researcher to have a dual role with the participant, both a technical and professional role ensuring accuracy and authenticity, and a role of intimacy where the participant trusts the researcher and is willing to disclose their most sacred stories and moments (Wong & Gaele, 2015). Consistency was maintained within the data by being mindful, detailed, and accurate during the data collection process.

Results

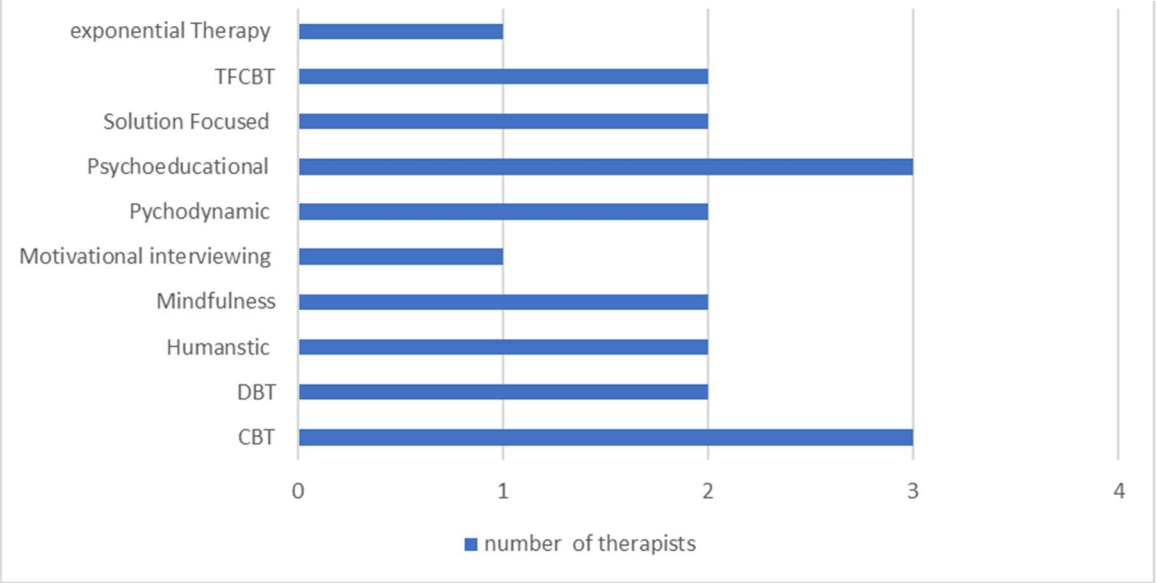
This section of the study will present the results of the research organized by theme.

Modalities

Modalities refer to treatment approaches used by therapists during sessions (citation). The five therapists interviewed shared a total of 10 different modalities that they felt worked best for treating Mexican American children with substance abusing parents. In all five cases, the therapist used a blend of two or more modalities when working with the children. Figure 1 below displays all the modalities mentioned and the number of therapists that reported using each modality.

Figure 1

Modalities Used to Treat Mexican American Children with Substance Abusing Parents



Even though there were several modalities used, the two most used modalities were psychoeducation and cognitive behavioral therapy (CBT), with three therapists reporting they used one or both of these modalities. Psychoeducation involves providing patients and their families with education on how to cope with their condition and empower them to lead fruitful lives by providing self-regulation strategies (Bäuml et al.,

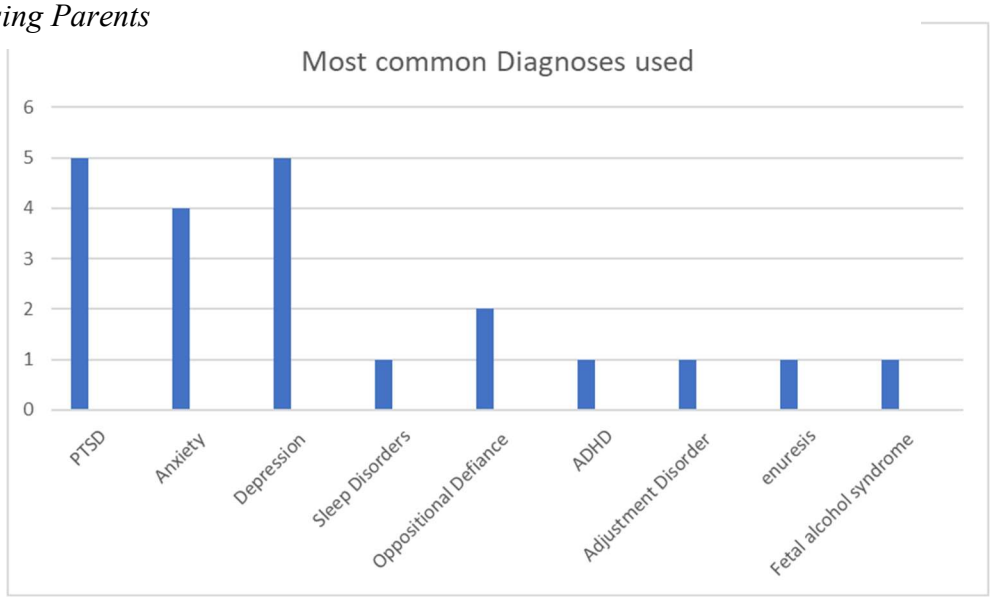
2006). Previous research has demonstrated that psychoeducation for children with parents with psychiatric disorders is effective (see Küçük et al., 2020). CBT focuses on teaching children skills needed to overcome a specific problem by emphasizing how thoughts, emotions, and behaviors are all connected (Higa-McMillan et al., 2015). Often, children and therapists create goals for therapy together with input from parents (Higa-McMillan et al., 2015). Exponential therapy and motivational interviewing were the least commonly used modalities, with only one therapist using each.

Diagnosis

The study found that the children of Mexican American parents with substance abuse disorder end up in therapy with a variety of diagnoses. the most common diagnoses were trauma and pression, with anxiety disorders being a close second. A total of nine main diagnoses were identified, as shown in Figure 2.

Figure 2

Most Common Diagnoses of Mexican American Children with Substance Abusing Parents



When therapists working with immigrants are not culturally competent, they have a higher rate of misdiagnosing the clients (Bemak & Chung 2014). Some behaviors, such as talking to recently deceased family members, may be typical in someone's culture but may be misunderstood by a non-culturally competent therapist. Getting an accurate diagnosis is only one of the reasons having a strong knowledge of cultural competence is important. Having a good diagnosis is also an essential part of therapy because we know that children of substance abusing parents have an increase in behavioral and clinical issues even years after the parents have stopped using (Hser et al., 2014).

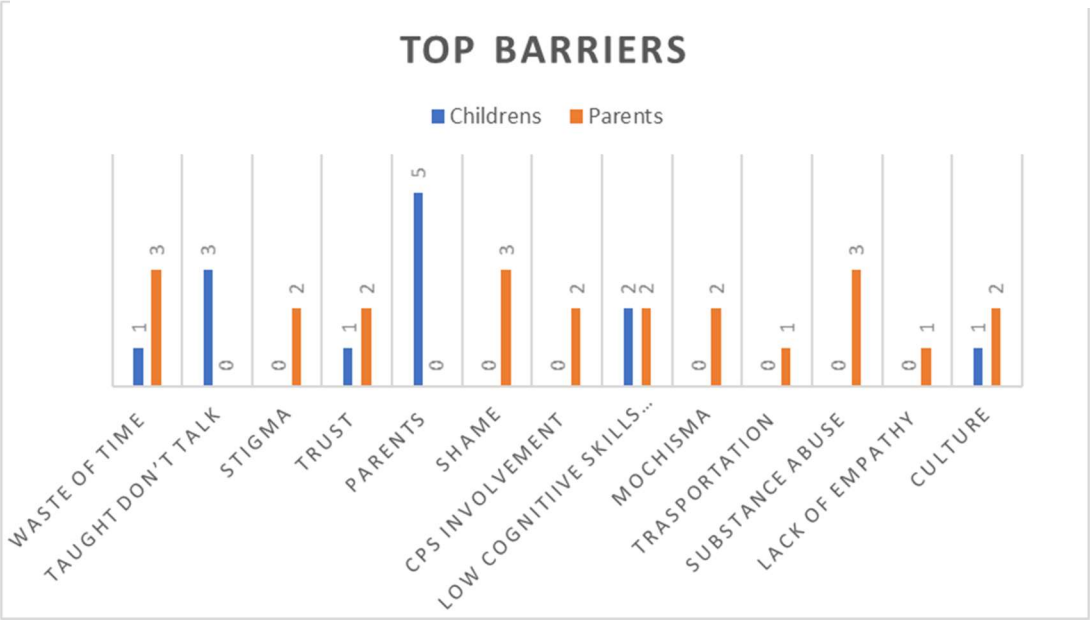
Barriers

Barriers are factors that interfere with the therapist's success in any kind of therapy (Bemak & Chung, 2014). Since the clients in this study were children, therapists encountered barriers relating to both parents and their children. Knowing how they were referred to therapy may help understand some of the barriers. These children might be going to therapy for various reasons; it may be by choice or they may be being required to go for due to law enforcement, school, or child protective services.

Figure 3 displays the barriers associated with parents and children that were identified by therapists in the interviews.

Figure 3

Barriers Associated with Parents (Orange) and Children (Blue)



As seen in the figure, there are many more barriers associated with parents than with children. Shame, current substance abuse, and not believing in therapy by thinking it was a waste of time were the three biggest barriers associated with parents. Often parents do not want to face that they are part of the problem; they just want their children "fixed," or they are overwhelmingly concerned about what the child might be saying in therapy.

The children's biggest barrier in therapy was their parents, as noted by four out of five therapists. This is significant because it reveals that the biggest barrier children face during therapy is entirely out of their control. Barriers to children's therapy stemming from their parents might be due to a lack of parental follow-through, missed appointments, parent-inflicted trauma, and parental interference with treatment. Three of

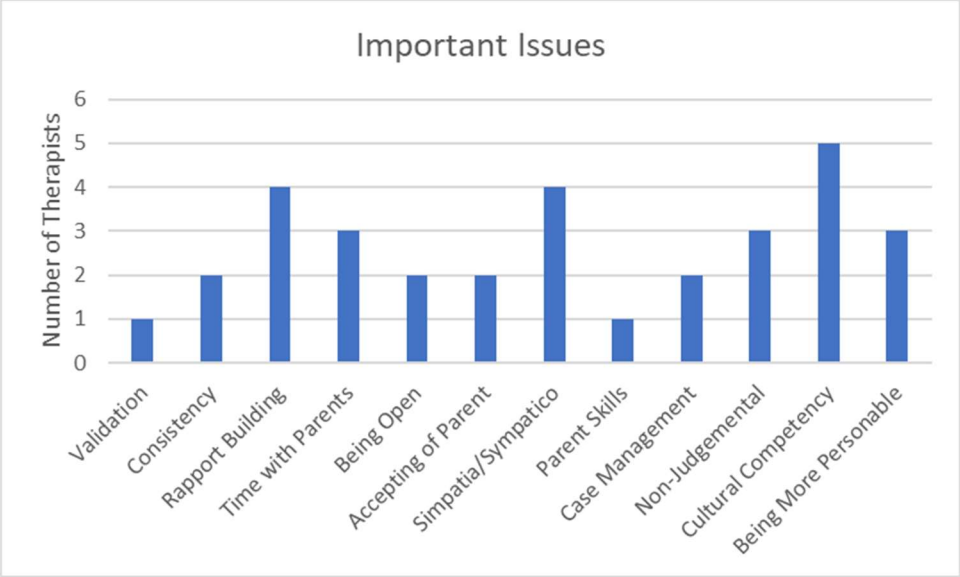
the five therapists identified children's unwillingness to talk as being a barrier to therapy. This can be caused by several things, both internal and external. Additionally, several barriers were identified as being associated with both parents and children, including trust, viewing therapy as a waste of time, low cognitive skills, and culture.

Important Aspects in Therapy

In therapy, therapists often keep in mind basic clinical rules that they try to follow. However, with Mexican American children of parents with SUD, the important aspects to keep in mind might be what makes the difference between successfully creating a therapeutic relationship and not connecting with the child. Understanding cultural nuances are thus very important. Table 4.4 illustrates the important issues identified by therapists to keep in mind when working with the children of Mexican American substance abusing parents.

Figure 4

Important Issues for Therapists Working with Mexican American Children of Substance Abusing Parents



Five out of five participants stated that having a high level of cultural competence is one of the most important things to keep in mind when working with this population. The American Counseling Association (ACA) and the American Psychological Association (APA) have stated that cultural competence is vital in therapy (Bemak & Chung, 2011). Some schools have worked hard to start making cultural competence and social justice an obligatory facet of their programs. Often, however, cultural competency is only covered in one or two classes (Bemak & Chung, 2011; Goodman, 2015), making it hard to know how to be truly culturally competent.

Of course, cultural competency is not the only thing to keep in mind when working with Mexican American children of substance abusing parents. Simpatia, or sympatico, was a term that four of the five therapists stated was one of the most important things to remember in therapy. This term, especially in Latin cultures, is

described as a pleasing and pleasant mix of empathy and sympathy within a social relationship (Contreras, et al, 2012; Chung, et al., 2002). Empathy is a Greek-based word meaning to have an understanding of another person by attempting to enter their world (Chung, 2008). Simpatia is culturally important during therapy, so important they have their very own word for it. Chung (2002) states that in western therapy, empathy has primarily been a concept that has been found in same culture therapy. All too often, minimal attention has been given to cross-cultural empathy within the therapeutic relationship. Empathy or sympatico should be a core concept when a therapist is involved in cross-cultural therapy (Chung, et al., 2002).

Aside from empathy and simpatico, four out of five therapists agreed that rapport building and making an authentic connection with the parents and having family involvement were important parts of therapy. A family-based approach must be used when treating clients experiencing substance abuse (Adelson, 2010; Center for Substance Abuse Treatment, 2004), which again, means building rapport with the client and family. Including the family in therapy has the potential to strengthen the family bonds as a whole (Ager, 2013). Participants stated that without family buy-in, they can sabotage the therapy, which is another important reason to include the family and build rapport.

Language

For any immigrant, language barriers are one of the most difficult barriers to overcome; it is not just a barrier in therapy but job seeking, resource acquisition, and social interaction. Language can be one of the most significant barriers in therapy (Bemak & Chung, 2014). All five therapists stated that language was a huge factor in the

success and ease of therapy with these children and their families. The ability (or inability) to communicate with children and their parents in their native language affected the therapist's ability to connect to the children and gain the trust of both parents and children.

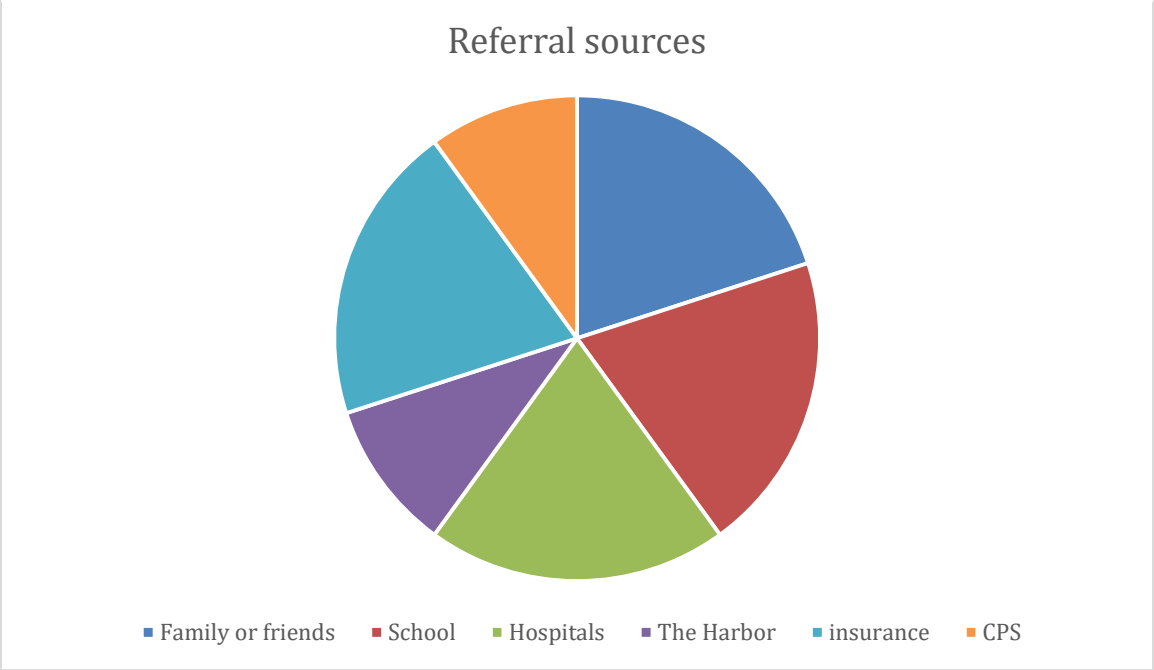
Referral Source

Knowing the referral source is an important theme because the difference between voluntary therapy and mandated therapy can affect treatment outcomes (Ahn, 2014). Mandated therapy is where there may be more violence, abuse, and trauma (Ahn, 2014). The participants all agreed they had a mix of both mandated versus nonmandated clients. Some are referred by the schools, some by mobile crisis or hospitals, as well as the mandated referrals sources such as the Department of Justice, child protective services, and the department of family services. The most common referral sources were family friends (2), schools (2), hospitals (2), and insurance (2). See table 4.5 for a full list of what referral sources were mentioned during these interviews.

Table 4.5: Referral Sources

Figure 5

Referral Sources



Summary

This chapter summarizes the results founded through a narrative inquiry study that was based on the individual interviews of 5 therapists who have successfully worked with Mexican American children of substance abusing parents. All the therapists participated in a phone assessment of their own free will.

Using the narrative inquiry qualitative approach allowed me to use open-ended questions, which allowed the therapists the freedom to tell their stories in their own words. This allowed the participants to feel free to talk about different subjects and areas within their past therapeutic relationships with clients that fit the research criteria. After listening to the stories, and rereading interview notes, common themes began to emerge.

An unforeseen theme that emerged was the revealed trauma that all participants found in their experiences with this population. The trauma varied between neglect, sexual abuse, physical abuse, emotional neglect, and abuse and verbal abuse.

Chapter 5 will report in more detail all the conclusions that were found from the analysis of the data presented in this chapter. This study will fill a gap in literature while also providing a basis for social change and future research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to find the themes that emerge from the experiences of therapists who work with Mexican American children with parents who have SUD. The study was a qualitative narrative inquiry. Narrative inquiry is a method in which the goal is to capture "the whole story," as Webster and Mertova (2007) stated. Other types of methods may seek specific points, thoughts, or goals, but only the narrative inquiry examines everything that the storyteller is telling (Camila et al., 2014; Webster & Mertova, 2007). The narrative inquiry intends to stimulate and encourage the participants to tell the most details within their story. My goal in this study was to identify themes that emerge from the narratives of therapists working with Mexican American children of parents with SUD regarding their successes and challenges within their therapeutic relationship with the child. These themes emerge from the participants regarding their successes and challenges within their therapeutic relationship with the child's parents/custodial guardians.

All phone interviews were recorded and reviewed several times to identify themes that emerged. After listening to the interviews, coding them, and relistening to them, six major themes became clear. The following is the list of themes that emerged:

1. Modalities.
2. Diagnoses of the children.
3. Barriers.
4. Important issues with the child or the parent.

5. Language concerns.

6. Referral source.

The first theme was the modalities that the therapist used most frequently with this population. Specifically, five of the therapists used more than one modality. There was a total of 10 modalities identified, but psychoeducation and CBT were the most common modalities used. However, several of the modalities, such as mindfulness, motivational interviewing, trauma-focused CBT, client-centered, psychodynamic, experiential, and dialectal behavioral therapy, were all a close second with two of the five therapists using them. However, it is important to remember that all five therapists stated that they use more than modality during therapy, many on a case-by-case scenario.

The second theme discovered was what diagnoses they most often gave to those clients. As previously stated in Chapter 4, the most common diagnoses were posttraumatic stress disorder (PTSD) and depression; five of five therapists stated that trauma and depression were the common issues they found in Mexican American children of parents with substance abuse disorder. However, anxiety was a close second, with four in five participants asserting that they often see this diagnosis. Chung (2008) stated that immigrants and their families, in general, are at a higher risk for depression, anxiety, PTSD, and substance abuse, as well as lower social-economic living, which increases the first diagnoses of depression, anxiety, and PTSD. However, there were other diagnoses noted including oppositional defiance, sleep disorders, enuresis, attentional deficit hyperactive disorder (ADHD), adjustment disorders, and fetal alcohol syndrome.

The third major theme that arose was regarding barriers; this can be barriers with the parents or barriers regarding the child. The number one barrier with the children is their parents. Resistance to talking about things during therapy was a close second. The most common barrier relative to parents is a shame; shame also creates other behaviors such as being upset by the child's honesty or being overly concerned about what the child is saying. With an increase in shame comes a resistance to therapy, all of which comes out in trying to treat the child. Trust and a fear of the stigma are both a close second in barriers with both the parents and the children. Language concerns were also an identified barrier. All five therapists agreed that being bilingual is especially beneficial; some of the children do not speak much Spanish, and many of the parents do not speak much, if any, English. The need to be able to communicate with both the children and the parents is critical and can become a barrier to therapy if a trustworthy translator is not available.

The fourth theme that emerged was regarding important things to remember. When therapists work with Mexican American children, many things are important for them to remember; however, when the child has a parent with a substance abusing problem, there are even more things that the therapists should keep in mind to create the greatest amount of success as possible. The participants had several things that they believed were important to keep in mind, but only one thing they all agreed on, and that was to be culturally competent. The runner-up to the need for cultural competency was four important things therapists should keep in mind: (a), sympatico, (b), rapport building, (c) working with the parents, and (d) family participation.

The fifth theme that emerged regarded factors that should be avoided in the therapy experience. Though there was no one thing that everyone agreed on, not shaming the parents or the children was the most common theme, followed by not challenging beliefs and not being overly blunt. The participants identified these elements as important because they can affect the trust and building blocks of the therapeutic relationship.

The sixth and final theme was about the referral source. Understanding where referrals come from is important to therapy; the difference between the parents asking for help versus the school or law enforcement can make a big difference in the parents' willingness to participate. Though there was not one major referral source that stuck out, seven common sources were identified. The schools, hospitals, insurance referrals, and friends or family were identified by two of the five therapists with The Harbor, a juvenile assessment center, child protective services (CPS), and the courts also being identified as referral sources.

Interpretation of Findings

The results of this study revealed that much like using MLM, the participants found that using two or more modalities gives the therapist a wider range of tools to work with the client (Chung et al., 2008). Though none of the therapists used the term MLM (Ahn et al., 2014; Chun Et al., 2011), by identifying what themes emerged that worked with their clients, they did identify similar themes to the five levels of MLM. Level 1 of MLM is mental health education (citation); all the therapists were Master's degree educated mental health therapists. Level 2 of the MLM is using individual, family, and group interventions. Three of the five participants stated that family involvement was

critical to success. Level 3 of the MLM relates to cultural empowerment (Ahn et al., 2014; Chung et al., 2008; Chung et al., 2011). All five of the participants stated that being culturally competent was especially important to their success. Level 4 of the MLM was the integration of Western and traditional practices (citation). Participants did not directly state that the integration of Western and traditional methods was crucial to therapeutic success, but when looking at the findings as a whole it is clear that including traditional elements was important to building a comfortable therapeutic relationship. For example, four of the five therapists stated that developing sympatico with their clients and their parents was very important. Additionally, four of the five therapists interviewed identified rapport building as important to therapy, while all five stated the cultural competency was important. All these factors are interrelated and suggest that achieving a balance between including traditional therapeutic elements and traditional concepts such as sympatico would help facilitate a better relationship with children and their parents. Level 5 of the MLM relates to social justice and human rights; this involves making sure families receive equal treatment and community resources (citation). This was not something directly stated, but the greater story of the narrative inquiry implies that this was the goal. Even though I cannot say the participants used MLM, the narrative inquiry of their story would suggest that they meet the MLM method's criteria.

This study's results show consistency with some of the literature in the field regarding working with Mexican Americans in general. One of the main findings of this study was that the stigma with which Mexican American families view mental healthcare can be a barrier to successful treatment. This finding is corroborated by other studies

conducted by Ahn et al. (2014) and (Reingle, et al. (2014), who also observed that these families tend to have a negative opinion about mental healthcare treatment. Literature has shown that a superlative therapeutic approach for Mexican American children would be by someone that understands both cultures, preferable by being a Mexican American therapist (Contreras, et al., 2012). Because that is not always an option, literature has suggested being culturally competent can help enhance the therapeutic relationship (Bemak & Chang, 2004; Bemak et al., 2014). Literature has also shown that the children of substance abusing parents, regardless of culture or ethnicity, have a considerably higher likelihood of abusing substances themselves (see Sparks et al., 2013). Furthermore, there are a limited number of clinically based studies concerning how clinicians approach the treatment of Mexican American children of parents with SUD (Ahn et al, 2014; Goodman et al., 2015; Pina & Gonzalez, 2014). The results from this study added to this growing body of literature by identifying competencies that therapists view as important when working with this population. Such factors included being culturally competent, using modalities such as CBT or psychoeducation, and being aware of barriers to treatment that can arise from parents and their children.

Limitations of the Study

Transferability is the degree that something can be replicated (Patton, 2002; Webster & Mertova, 2007). The five participants of this study showed variations in the details of their experiences; when coded and combined, they showed common themes, but depending on the therapist's individual experiences, there may not always be the same themes that emerge. Even though therapists who work with Mexican American

children with a parent or caregiver who is a substance abuser have similar experiences, common experiences are never guaranteed.

As previously mentioned in Chapter 1, one of the biggest limitations found in this study was the limited amount of literature, particularly literature within the last 7 years. Thus, several articles and literature used in this study were older. Another thing that increased the use of older articles used in this study was the length of time it took this study to get through the approval process. Articles that may have fallen into the 7 to the 9-year range when this study was first coming together are now consisted of being older, but this literature was still used without updated material.

Another not so apparent therapeutic limitation and barrier that studies have found are those stemming from the Mexican American family system. Even though it was not a direct connection to this study, the subsequent correlation is worth noting. The fear that these families have is a major barrier that we have a hard time quantifying; they fear due to being undocumented, fear due to language barriers, and fear and shame of their substance abuse (Bemak, et al., 2014; Chung et al., 2013; Shorey et al., 2013). These fears may affect how well these families participate in and accept therapy, which has an indirect effect on this study by indirectly affecting how they reacted when in therapy with our participants (Chung, et al. 2008; Contreras et al., 2012). It is believed that these limitations mean that there are limited clients, meaning there are limited therapists as well.

Another limitation of this study was the sample size. Larger sample size can sometimes give the study an increase in power; however, large sample sizes are not

always possible. These requirements and specifications for participants were tightly defined. Additionally, while qualitative methods enable the exploration of a particular phenomenon or shared experience in greater depth, they produce results that are not easily generalizable to other populations due to their specificity and small sample size (Creswell, 2003). As a result, the findings from this study cannot be applied to other populations.

Recommendations

The results of this study revealed competencies that therapists feel are crucial to uphold when working with Mexican American children of substance abusing parents. Interviews with therapists demonstrated that factors such as cultural competency, sympatico, the use of modalities like psychoeducation, and barriers relating to the development of trust play important roles in the treatment outcomes of Mexican American children with substance abusing parents. Based on the results and limitations of this study, a few recommendations for future research can be made:

1. First, future studies should consider using a quantitative or mixed-methods approach to the topic of what treatments work best for Mexican American children. One advantage of using quantitative methods is that they are well-suited for application on a large sample population and therefore produce more generalizable results. Because there is a dearth of literature on best practices for therapists working with Mexican American children with substance abusing parents (Ahn, et al., 2014; Pina & Gonzalez, 2014; Goodman et al., 2015), results that are more generalizable would have a

wider-reaching impact because they would be applicable in more contexts. A quantitative study could also measure the correlation between certain factors identified as important in this study, such as cultural competence, and treatment outcomes in Mexican American children. Such an approach would provide more specific information on what therapeutic elements drive successful treatment outcomes in this population.

2. This study did not differentiate between the different types of substance abuse that parents could be experiencing. It may be that the children of alcoholic parents experience different traumas and treatment outcomes than the children of parents addicted to opioids or other drugs. Future research could consider further refining the sample population or utilize quantitative methods to compare treatment outcomes across different sample populations.
3. A cross-cultural study could be performed to determine if and how Mexican American children of substance abusing parents respond to treatment differently from children of other backgrounds.
4. Future research could focus on only one of the themes that were discovered through this study (e.g. modalities, barriers to treatment, language) to provide a more holistic and nuanced view of how a particular factor affects treatment.

Implications

The Implication for Social Change

As previously mentioned, the implication for social change is first seen for new therapists wanting or needing to work with Mexican American children who have at least one or more caregivers that are struggling with substance abuse. the implications for change also go beyond this narrow population. Therapists working with Mexican American children, in general, can use this study to gain knowledge about what things the study participants found were important to gaining parents' buy-in or the children's trust. Families of immigrant parents have fears that are categorically essential regardless of the specifics (Bemak & Chung, 2014). The world, not just the United States, is experiencing an increase in global immigration, especially among Hispanics (Chung et al., 2011). Implications for social change include learning how to work with cultures outside of our own and learning how to put our own biases aside to see a world through someone else's lens, both of which form a massive piece of social change (Chung et al., 2002).

Implications for Practice

The results from this study can help therapists and clinical psychology educators develop protocols for the development of more culturally sensitive treatments and more culturally competent mental health workers (Substance Abuse and Mental Health Services Administration, 2004). As demonstrated in this study, a high level of cultural competency and sensitivity is important to the success of treatment. The findings from this study will also help guide therapists on how to establish meaningful communication with Mexican American recovering addicts and their children to assist with the

development of healthy family dynamics (Sparks, Tisch & Gardener, 2013). Finally, researching culturally based narratives for this at-risk population of children can also inform public policymakers on how to provide culturally appropriate substance abuse prevention and family support resources within Mexican American and other Latin-American communities (Ager, 2013).

Conclusion

This narrative inquiry study fills a gap in the literature regarding therapist's experience when working with Mexican American children of substance abusing parents. The study sought to identify themes that emerged from the narratives of therapists working with Mexican American children of parents with SUD regarding successes and challenges within their therapeutic relationships with both children and their parents. Six main themes were uncovered relating to modalities for treatment, diagnoses given to children, barriers to treatment, important issues specific to working with Mexican Americans, language concerns, and the referral source. Key findings included that cultural competency and the development of feelings of sympatico were important to establishing a successful therapeutic relationship with both children and their parents. Common barriers to treatment included a lack of trust, feelings of shame, and stigma. Parents themselves can also present a barrier to treatment. The results of this study have important implications for therapists working with Mexican Americans and other minority populations, as they emphasize that cultural sensitivity and breaking down language barriers are important to treatment outcomes. The findings from this study can

also be used to train therapists and other mental workers how to be more culturally competent, particularly when dealing with children from minority backgrounds.

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Appendix A: Interview Guide

Theme	Theorical framework	Interview question
What themes emerge from the narratives of therapists' experiences in working with Mexican American children of parents with SUD's?	Multilevel Model of Intervention (MLM)	1. Why did the children of Mexican American parents with SUD's start coming to see you? Probes: how long have you been seeing this population? 2. What are some of the biggest issues or concerns that these children are experiencing? Probes: how do they feel about those concerns? 3. How do you gain their trust? Probes: how do you know when you have gained their trust? 4. Describe the process of working with these children? 5. Describe how cultural awareness and sensitively has made a difference and why it is so important to progress.
What themes emerge from the narratives of therapists working with Mexican American children of parents with SUD regarding their strengths and challenges within their therapeutic relationship with the child?	Multilevel Model of Intervention (MLM)	1. What are some of the strengths and challenges of working with Mexican American children of parents with SUD's? Probes:

a. what are some of the goals of the children?
b. What barriers have you found?
c. What was most helpful in the process of working with the children?
d. What worked best with the aggression in the children.

2. How is the relationship of the children with their parents before and after treatment?

Probes:

a. when do you start seeing a change?
b. When did the parents or children start seeing the change?
c. Describe any major experiences that can show how therapy changed their relations with their parents

3. How is cultural sensitivity and awareness important to the children?

Probe:

a. how would you have worked with these children if they had a different cultural background?

		b. How does the cultural awareness need compare to need of the parent?
What themes emerge from the narratives of therapists working with Mexican American children regarding their strengths and challenges within their therapeutic relationship with the child's parents/custodial guardians?	Multilevel Model of Intervention (MLM)	1. What are some of the strengths and challenges of working with the SUD parents of Mexican American children? Probes: a. what are some of the goals of the parents? b. What barriers have you found from the parents? c. What was most helpful in the process in dealing with the parents? 2. What were some of your experiences like working with the SUD parents of the children? Probes: a. Describe some of the parental resistance you have found? b. What worked best with parental resistance? 3. How is cultural sensitivity and

	awareness important to the Parent? Probe: a. has the parents needs culturally effected the children in a positive or negative way? b. Can you describe any situations or experiences that were culturally driven that were significant?