Considering Culturally Relevant Parenting Practices in Intervention Development and Adaptation : A Randomized Controlled Trial of the Black Parenting Strengths and Strategies (BPSS) Program

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A Randomized Controlled Trial of the Black Parenting Strengths and Strategies (BPSS) Program

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A randomized prevention pilot trial compared caregivers who participated in the Black Parenting Strengths and Strategies (BPSS) Program with control caregivers. BPSS is a strengths- and culturally based parenting program designed to improve aspects of parenting associated with the early development of conduct problems and the promotion of social and cultural competence. Parenting variables included monitoring, positive parenting, harsh discipline, and the use of proactive racial socialization. Child variables included conduct problems and social competence. Relative to control caregivers, intervention caregivers used significantly more racial socialization strategies, positive parenting practices, and less harsh discipline. Also, despite caregivers' multiple risk factors, high rates of attendance and satisfaction were achieved. Results of this pilot support the feasibility, acceptability, and potential efficacy of a culturally relevant intervention program.

The prevalence of aggression problems in preschool and early school-age children is approximately 10% and may be as high as 25% for low-income children (Rimm-Kaufman, Pianta, & Cox, 2000; Webster-Stratton & Reid, 2004). Problem behaviors can place young children at considerable risk for the development of serious future problems including crime, substance abuse, and academic failure (Flory, Milich, Lynam, Leukefeld, & Clayton,

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2003; Galaif, Hser, Grella, & Joshi, 2001). As a result, the number of prevention programs targeting the promotion of emotional, social, and behavioral development in young children has increased and is one strategy for decreasing the risk of serious childhood conduct and mental health problems (Greenberg, Domitrovich, & Bumbarger, 1999; U.S. Department of Health and Human Services, 1999, 2001b).

Preventing the development of significant conduct problems and later antisocial and risky behavior among youth is generally recognized as a national public health priority (American Academy of Child and Adolescent Psychiatry, 2005; U.S. Department of Health and Human Services, 2001b); however, risk factors unique to visible racial or ethnic group youth (e.g., Hispanic, African American) have received limited attention. Many social risk factors such as unemployment, high population density, poverty, and drug abuse that are associated with poor child outcomes are overrepresented among Blacks/African Americans. In addition, the impact of sociocultural and sociopolitical factors such as racism, discrimination, and prejudice on families and the parenting of children warrant consideration when attempting to understand and service African American youth and families. For example, racism has been found to contribute to compromised behavioral and psychological functioning (Simons, Murry, McLoyd, Lin, Cutrona, & Conger, 2002) and substance use (F. X. Gibbons, Gerrard, & Lane, 2003). Culturally based parenting practices (i.e., proactive racial socialization to racial and cultural norms, values, and bicultural competence) have been found to strengthen identity in youth in such a way as to be protectors against the development of conduct problems and later antisocial and high-risk behavior (Brody et al., 2004; Hill, Soriano, Chen, & LaFromboise, 1994). Therefore, it is plausible that such factors should be considered in the development of new preventive interventions targeting African American families as well as in the adaptation of existing parent- and family-based empirically valid approaches and prevention programs.

The Role of Parenting in the Development of Problem Behavior

The position shared by different theoretical models (e.g., problem behavior theory, social learning theory, and sociological accounts of delinquency) is that disruptions in parenting practices (e.g., inconsistency in disciplining, high hostility and criticalness, unclear rules and commands, poor parental involvement and/or supervision) increase a child's risk for developing problem behavior (Gottfredson, 2001). The most comprehensive formulation of disruptions in parent–child interaction has been the coercive model described by Patterson and his colleagues (Patterson, 1982; Patterson, Reid, & Dishion, 1992). In this process, a child's problem behavior occurs in the

context of an escalating cycle of coercive parent–child interactions in the home. Such early studies demonstrate the significant link between parenting practices and the development of problem behavior and serve as the basis for the development and testing of a new generation of prevention interventions, namely, parent- and family-based programs.

Parenting, Parent Training Models, and Contextual Considerations

The general consensus is that parenting programs aimed at modifying parenting practices and promoting child social skills and behavior regulation are particularly efficacious in both preventing and treating problem behavior in children (Gottfredson, 2001; Kumpfer & Alvarado, 2003; Webster-Stratton & Taylor, 2001). However, studies have also shown that the developers of such programs need to improve efforts to promote the interest, participation, and satisfaction of low-income families and visible racial or ethnic group families (Roosa, Dumka, Gonzales, & Knight, 2002). This is particularly the case given that African American families are often difficult to recruit and retain (Kumpfer, Alvarado, Smith, & Bellamy, 2002), and for low-income single mothers, parenting can be an especially stressful experience. Low-income single mothers are reported to be more likely to drop out of services, more likely to relapse or fail to make significant improvements following services, and less likely to maintain effects over time (Wahler & Barnes, 1988). As a result, there have been efforts to develop contextually focused parent- and family-based intervention models that target the multiple environments (e.g., adverse effects of poverty and its accompanying stressors) in which low-income children and their families operate (e.g., Webster-Stratton, 1998a, 1998b). Although such efforts emphasize the importance of the social context and the needs of low-income parents and children, parent-training models tend to overlook specific cultural factors.

Parent Training and Racial, Ethnic, and Cultural Relevance

It has been argued that because parent-training models have traditionally been designed for European American, middle-class parents and families, their utility for many visible racial or ethnic groups and low-income families remains questionable (Alvy, 1987). Specifically, these programs have not been formulated to address the specific needs, problems, and concerns of African Americans, and they do not take into account the historical, present, and future conditions of this group. It is further argued that programs targeting families must be both culturally sensitive and culturally relevant to be optimally effective (Carter, 1996; Lynch & Hanson, 1998; Tillman & Shirley, 2002). That is, culturally relevant factors should be considered at every stage

of the intervention development process including program conceptualization, study design, implementation, analysis, interpretation, and dissemination (Coard, Wallace, Stevenson, & Miller Brotman, 2004; Dumas, Rollock, Prinz, Hops, & Blechman, 1999; Roosa et al., 2002). Similarly, Chang and Sakai (in press) stressed the importance of placing value on cultural strengths in intervention development and contended that all intervention programs should be assessed on their commitment to cultural diversity and the ability to articulate and demonstrate it in both their materials and their staff training. Such a commitment recognizes parents' diverse backgrounds and the need to value their beliefs, traditions, perspectives, and unique resources. It also acknowledges that there are differing, but equally valid, approaches to child rearing. Although there has been some recognition of this need, the focus has primarily been on efforts to address language, the racial makeup of staff, and illustrations and visuals used in parenting and family programming. More recently, advocates of culturally relevant interventions have stressed the importance of moving beyond surface modifications and toward addressing deeper issues of cultural traditions and significantly differing perspectives of parenting and child rearing (Brody et al., 2004; Coard et al., 2004). However, there remains a need for greater consideration of culturally specific competencies, resources, and strategies that exist in families to inform program development and strengthen relevancy to the families being targeted.

Parenting and African American Families

In the literature on parenting in the context of African American families, there is emerging research on specific parenting strategies that are likely to be important in the design of parenting programs targeting African American families. Research suggests that African American parents are faced with distinct parenting challenges. That is, African Americans in this country disproportionately face difficult sociopolitical realities and obstacles (e.g., poverty, unemployment, incarceration, and crowded urban environments) that have been linked to the manifestation of racism in America (Franklin, Boyd-Franklin, & Draper, 2002; Stevenson, Davis, & Abdul-Kabir, 2001; Ward, 2000). African American parents and families serve to insulate and lessen the negative and often deleterious consequences that accompany racial group status (i.e., prepare their children to navigate and negotiate the terrain of racism). Although great diversity exists within the African American community, one commonality is that African Americans must make psychological sense out of the dominant culture's historically disparaging view of them and negotiate racial barriers in an environment where marginalization exists. It has been argued that as a group, African

Americans, regardless of class, are forced to grapple with the significance of race in defining themselves as well as deciding what it means to be Black within their own life experiences (Murry, 2000; Schaefer, 2004). For African American parents, this has meant raising children to thrive in an environment that has been historically hostile, prejudiced, and discriminatory (McAdoo, 1998). Researchers have suggested that these factors provide critical insight into the psychosocial functioning of African American families and African American parenting practices (Boykin & Toms, 1985; Murray, Stokes, & Peacock, 1999; Stevenson, 1994a, 1994b; Stokes, 2005; Thornton, 1997).

Racial socialization is defined as the process by which messages are transmitted or communicated inter- and intragenerationally regarding the significance and meaning of race and ethnicity (Coard & Sellers, 2005). Furthermore, racial socialization involves teaching children values and norms associated with race and ethnicity and problem-solving skills that enable children to be flexible in their approach to race-related situations, without losing a core sense of self. These communications are considered an important determinant of children's race-related attitudes and beliefs and their sense of efficacy in negotiating race-related barriers and experiences (Caughy, O'Campo, Randolph, & Nickerson, 2002; Coard et al., 2004; Hughes, 2003; Smith, Atkins, & Connell, 2003; Stevenson et al., 2001). Studies have provided evidence of the relationship between perceived and actual parent racial socialization practices and positive child outcomes including a well-developed racial identity (Demo & Hughes, 1990; Stevenson, 1995), socioemotional functioning (Swanson, Spencer, & Dell'Angelo, 2002), higher academic functioning (Sanders, 1997), better behavioral competence (Caughy et al., 2002), heightened self-esteem (Constantine & Blackmon, 2002), involved mother–child interactions (Frabutt, Walker, & MacKinnon-Lewis, 2002), decreased depression and anger (Stevenson, Reed, Bodison, & Bishop, 1995), racial coping and cultural competence (Johnson, 2001), and prosocial bonding to other socialization agents (e.g., school, community). Racial socialization has been deemed important because it (a) influences children's beliefs about the way the world works, (b) informs children's beliefs and attitudes regarding the self, (c) helps shape children's repertoires of strategies and skills for coping with and navigating racism, and (d) impacts the nature of the children's inter- and intraracial relationships and interactions (Coard & Sellers, 2005).

Although a number of evidence-based parenting- and family-based programs exist that address parenting practices and their role in fostering child social and behavioral competence, very few consider culturally based parenting practices. We contend that providing African American families with both contextually and culturally relevant parent and family skill-building resources may enhance the effectiveness of their parenting

efforts and provide a measure of added protection against the development of problem behavior and poor mental health outcomes in children. With the exception of a few programs, such as the Strong African American Families Program (Brody et al., 2004) and the Effective Black Parenting Program (Alvy, 1987), parent-training models have overlooked the role of parental racial socialization practices. It is plausible that combining culturally specific content and delivery strategies designed to foster parental racial socialization strategies with an established, empirically supported parent-training program designed for the prevention of problem behavior in young children might influence the overall effectiveness of the program when targeting African American families. Doing so requires systematic development, culturally relevant translation, and rigorous evaluation.

Summary of the Study

We present a randomized, controlled trial pilot investigation of an innovative intervention designed to improve the aspects of parenting associated with the early development of conduct problems in children. The primary goal of the pilot was to develop and test the feasibility of a strengths- and culturally based program designed for low-income African American parents of young children. Because of the dearth of trials targeting this population and the lack of evidence-based programs that are culturally relevant, it was necessary to establish the feasibility of recruiting low-income African American parents with young children who were at risk yet free of clinically significant behavior problems. Furthermore, the study was designed to establish the acceptability and adequacy in retaining participants and the potential efficacy of the intervention.

We hypothesized that following the prevention program, parents and caregivers who participated in the culturally enhanced program would display significantly better parenting practices (i.e., positive parenting, monitoring, and racial socialization) than parents assigned to the control condition. No prediction was made regarding children's short-term behavioral response to the program (immediately postintervention) because their behavioral status at the beginning of the intervention was not expected to be highly problematic. However, it was believed that group differences on child behavior would be detectable if control participants developed problems over the course of the intervention period at a greater rate than children in the intervention condition. The expectation was that intervention children whose parents showed improvements in parenting practices would be significantly less likely than control children to develop conduct problems. Finally, it was important to establish whether in addition to standard determinations of program success (i.e., improved parent and/or child outcomes), the Black Parenting Strengths

and Strategies (BPSS) Program influenced program engagement (e.g., attendance, participation, satisfaction), which is known to be challenging when administering parent-training programs to low-income and/or African American families. Consumer satisfaction and perceptions of services were considered important levels of evaluation, and if positively affected, important results would have been obtained.

METHOD

Participants

Thirty-eight primary caregivers of children ages 5 and 6, who self-identified as African American and resided in urban communities in the North and Southeast, were recruited from the community and schools through a number of community- and school-sponsored events: school fairs, open houses, after-school programs, and parents' resource nights. For the purposes of this study, *African American* was defined using the following criterion: a maternal and paternal familial history reported to be U.S. born and solely of Black African ancestry for at least three generations (grandparent, parent, and child). Caregivers who reported primary identification as bi- or multiracial, bi- or multiethnic, and/or bi- or multicultural and children who had a diagnosed mental disorder (including oppositional defiant disorders or conduct disorders or a major medical or neurological disorder) were excluded from this initial study. Thirty-two of 38 interested primary caregivers were deemed eligible by phone and/or in-person screening. After enrollment, 2 caregivers (1 per condition) ceased participation due to out-of-state relocation. These 2 families were subsequently omitted from analyses. The final sample consisted of 30 families (30 caregivers and 30 target children). Of the 30 caregivers, 16 were single mothers, and 15 were unemployed and received public assistance. Twenty-five caregivers were the target children's biological or adopted mothers, and 5 caregivers were the target children's grandmothers. The mean age for the final sample of caregivers was 36.4 years. The target child sample consisted of 18 boys (60%) and 12 (40%) girls, with a mean age of 5 years 3 months ($SD = 0.49$).

Procedure

Informational presentations on the BPSS intervention were made to local community agencies (e.g., Boys and Girls Club, YMCA) and school administrators. Economic factors (e.g., low-income, poor) and environmental factors (e.g., inner-city residence, neighborhood violence and crime)

were used to identify families and children who were possibly at risk. Risk burdens associated with historical disenfranchisement (racism, discrimination) were also assumed. The challenges of recruiting an African American–only sample were addressed during the pilot. For example, schools serving predominately African American children were approached, and procedures for excluding families from other racial or ethnic groups who attended the same schools were developed (e.g., provided interested non–African American parents with information on alternative parenting programs, resources, and services). Recruitment and marketing of the intervention emphasized its strengths- and culturally based philosophy: It was "developed with African American parents in mind." An African American–only staff was used, and pictures of program staff members along with brief biographical narratives appeared on all distributed written recruitment materials.

Written materials describing the study were distributed to interested caregivers along with a telephone number to call for additional information. Caregivers preferring to sign up on-site were asked to provide contact information for later follow-up. Project staff members followed a detailed script for the initial telephone contact and for the consent visit: They were "interested in talking with African American parents about raising young African American children." Parents were provided with basic information about the study over the telephone. Later, during the face-to-face visit in the family's home, parents or caregivers were provided with more detailed information about the rationale for the study, including the focus on African American families, intervention, random assignment, the wait-list control condition, length and extent of study involvement, confidentiality, mandates of reporting child abuse or neglect, and other human participants issues. Caregivers willing to participate consented to their own and their children's participation and were scheduled for a subsequent home visit to complete baseline assessments. Before data collection, assessment staff received 8 hours of training in administering the child and caregiver protocols. Caregivers and their children were administered measures via an interview format in separate rooms and were later joined to participate in a parent–child observation. Two hours were allotted for the administering of measures. Instrumentation procedures were developed and refined in an earlier measurement pilot conducted with African American community members who were representative of the population from which the sample was drawn.

After completion of the baseline assessment (Time 1), families were randomized to the BPSS prevention program ($n = 16$) or to a wait-list control condition ($n = 16$). The BPSS curriculum was administered over the course of 12 weeks (12 two-hour sessions provided once a week). Two leaders conducted the 2-hour groups (6 to 8 parents per group) in accordance with the collaborative approach proposed by Webster-Stratton (1998a). Following

the intervention, the families completed a postintervention assessment (Time 2). Families assigned to the wait-list control condition were offered the intervention on completion of the postassessment. Two cohorts (each consisting of a treatment condition and a control condition) participated in the study from fall 2003 through spring 2005. Parents in both conditions received $30 for each assessment session. Meals and child care were provided during parent group sessions. All study procedures were approved by the Institutional Review Board.

Intervention Implementation and Fidelity

BPSS (Coard, 2003) incorporates culturally specific content and delivery strategies concerning racial socialization into an empirically supported standard program while maintaining all the key elements of that standard program. Furthermore, the intervention needs to be feasible and acceptable to low-income, African American families. BPSS is a culturally based adaptation of the Parenting the Strong-Willed Child (PSWC) program (Forehand & Long, 2002), recognized internationally for its general effectiveness for both prevention and treatment (Forehand & Long, 2002; McMahon & Forehand, 2003). PSWC is designed to improve parent–child relationships as well as increase positive child behaviors and involves the teaching of skills that assist parents in the management and prevention of noncompliance and other problematic behavior. PSWC teaches parents skills considered to be universally applicable to manage and prevent noncompliance and other problem behaviors. PSWC was selected as the base program for both its established reputation as a model program and its flexible approach, making cultural adaptations possible (McMahon & Forehand, 2003). Although the effectiveness of PSWC has been established and it has been used with ethnically diverse populations, it does not consider the deeper cultural adaptations (specific values, traditions, conditions) that may promote optimal effectiveness. Although BPSS, like PSWC, teaches evidence-based skills that assist parents in dealing with and preventing noncompliance and other problematic behaviors (i.e., attending, rewarding and ignoring, giving effective directions, and how to use time-out appropriately with the goal of preventing behavior problems), what distinguishes BPSS is that it does so in the context of the sociocultural and sociopolitical realities that exist and draws on the strengths, unique parental strategies, and processes inherent to African American families (e.g., racial socialization). In addition to the standard parenting skill topics, session topics focused on improving parents' understanding of social and emotional development in Black children, how to increase their children's confidence in school environments, developing positive self-image in Black children, promoting positive and developmentally appropriate parent–child

discussions about racial issues, and enhancing children's problem-solving skills. The BPSS parenting program assists African American parents in fostering cultural, social, and emotional health in their children in preparation for their overall success by strengthening parenting skills, improving parental involvement, empowering parents to be advocates and access resources and support, and ultimately guiding parents in preparing their children for success. The following content- and delivery-related adaptations were based in part on an initial qualitative pilot study (see Coard et al., 2004).

Content adaptations. Additional parenting issues were included that reflected cultural nuances, behaviors, and perceptions that African American parents could relate to. A portion of the parenting group session was devoted to the review and discussion of these specific challenges, for example, how to discuss and problem solve with one's child about isolating or potentially volatile interactions that the child may experience with peers (e.g., social exclusion because their skin is "ugly" or "dirty"), how to promote academic achievement despite perceived barriers and social distance in schools (e.g., how to advocate for one's child on issues of curriculum bias or low expectations from teachers and others), and how to deal with events that are common to group members (e.g., overt and subtle incidences of racism, prejudice, and discrimination). Also included was a greater focus on helping parents to reflect on their individual and group experiences as African American women and men, independent of their parental role; to gain knowledge of the developmental progression of racial awareness and racial identity in children; to learn strategies for discussing race-related content in a developmentally appropriate manner; and to access culturally affirming resources in their communities for their children and themselves.

Delivery adaptations. Delivery strategies included the use of African American language expression, common language, and the African American–perspective use of *we*; an emphasis on African American values about collective responsibility, cooperation, and interdependence; the use of African proverbs, sayings and affirmations, poems, quotes, symbols, and pledges; the use of prayer, role-playing, storytelling, extended family participation, and humor; and use of a setting and motif representative of the population. Taking a collaborative approach to working with parents, the program was all for greater sensitivity to individual cultural differences and personal values. Furthermore, it allowed for each family's individual needs and goals and each child's strengths and weaknesses. By providing the intervention in a group format, the program was not only more cost-effective but addressed an important risk factor for child conduct problems—lack of social support. The parent groups provided a model for accessing and strengthening informal support networks.

Throughout the adaptation process, it was essential that the key elements of the standard parenting program were maintained and not diluted by the addition of new content or omission of existing content. Ongoing consultation from PSWC program developers was provided throughout the adaptation process to ensure fidelity to the standard program. For example, an aspect of the standard program that could not be altered was the order in which the specific parenting skills were taught. Therefore, these key elements remained unchanged. The companion parenting issues were shifted and altered (e.g., give more culturally relevant examples when teaching the standard skills). The BPSS intervention was fully manualized following a prestudy (open pilot) of the program with nine families conducted to refine the intervention.

Selection and training of parent group leaders. Two interventionists were trained by the first author to lead parent groups. Training included learning the program manual and an intensive 2-day training (16 hours) of didactics divided into two parts: (a) training in parent–child relationships and the application of cognitive–behavioral strategies to improve parenting and training in developing a collaborative therapeutic relationship and (b) training in developmental and parenting issues specific to African American children. Of particular relevance for BPSS group leaders were specific cultural competency guidelines stated by the American Psychological Association (2003). The first author co-led an earlier open pilot group (with no comparison group) to obtain preliminary feasibility data and for training purposes. Subsequent randomized, controlled trial groups were observed weekly by the first author at on-site meetings and videotaped sessions. All group leaders were African American women. In addition to the first author (a PhD faculty member), one parent group leader was a 1st-year doctoral student in psychology and the other was a master's-level social worker (recent master's in social work and nonlicensed). Credibility was established early on with study participants across conditions through regular interactions in the community and staff involvement in community activities prior to and for the duration of the study.

Intervention integrity and supervision. Close monitoring and supervision, standardized materials, and comprehensive training assured the integrity of the BPSS program. The intervention manual for the treatment condition specified the content of each session, questions to be explored, recommended role-plays, weekly activities and stories, and homework assignments. Intervention integrity was measured to assure that the BPSS intervention was implemented as outlined in the intervention manual.

Measures of integrity for the cultural components were developed based on measures of integrity for the standard parent program.

Attrition and attendance. Given that the BPSS program was being piloted on a population determined to be at risk but not necessarily presenting with problems (i.e., community sample), it was anticipated that parents who were not seeking help for current problems would be more unlikely to be motivated to attend sessions, even after expressing initial interest in the prevention program. In addition, retention of control families was viewed as a major challenge (despite their wait-list status and the offer for future participation in the program). To protect the integrity of the study (i.e., maximize cooperation and minimize dropouts), we instituted a number of procedures designed specifically to maintain parent participation. Parents or caregivers were paid for assessments ($30); first assessments (initial contact appointment) were conducted in the families' homes; cards were sent to families for holidays, birthdays, or simply to say hello; families were periodically called to check in; and a presence was maintained in their schools and neighborhoods, which assisted in establishing credibility and trust and fostering collaborative relationships.

Measures

The Family Demographics Interview is a structured interview that was conducted with the parent at baseline to assess family demographics. This includes child age, gender, caregiver age, ethnicity, employment history (time in current job, type of job, time on public assistance, time since last job, if unemployed), marital status, and education information for the primary caretaker, biological mother (if different), primary caretaker's spouse or partner, and biological father (if different).

The Parenting Practices Interview (PPI) is a 72-item questionnaire adapted from the Oregon Social Learning Center's Discipline Questionnaire and revised for young children ages 3 to 8 (Webster-Stratton, 1998b). It can be administered as an interview or a self-report questionnaire completed by the child's primary caregiver. It takes approximately 15 minutes to complete. The questionnaire is composed of seven subscales—Harsh Discipline (14 items), Harsh for Age (9 items), Inconsistent Discipline (6 items), Appropriate Discipline (16 items), Positive Parenting (15 items), Clear Expectations (3 items), and Monitoring (9 items)—rated on a 7-point scale ranging from 1 (*never*) to 7 (*always*). Three of these subscales, Monitoring, Positive Parenting, and Harsh Discipline, were of interest to this study. Cronbach's alphas for the subscales were .64, .72, and .75, respectively.

The Parent Experiences of Racial Socialization (PERS) Scales (Stevenson, 1994b) is a 40-item measure that assesses the frequency with

which parents communicate messages to their children regarding racial or cultural pride, racial struggle, racial survival, and spiritual and religious coping. Items are phrased as statements, and responses are indicated as "never," "a few times," or "lots of times." There are four factors: Racism Struggles Socialization, Cultural Survival Socialization, Pride Development Socialization, and Spiritual Coping Socialization (Cronbach's alphas were .73, .76, .88, and .81, respectively). The PERS total score (PERS-T) was used for this study, and it had an alpha of .90.

The Behavioral Assessment System for Children–Parent (BASC-P; Reynolds & Kamphaus, 1992, 2002) is a multidimensional assessment of children's emotional, behavioral, and social functioning. The scale contains 131 items rated on a 4-point scale ranging from *never* to *almost always* and requires approximately a third-grade reading level for completion. The measure includes ten subscales and yields four composite scores: Externalizing Problems (Hyperactivity, Aggression, and Conduct Problems), Internalizing Problems (Anxiety, Depression, and Somatization), School Problems (Attention and Learning Problems), and Adaptive Skills (Social Skills and Leadership). The measure has strong internal consistency (PRS alphas are in the .70s and .80s; composites are in the high .80s to low .90s) and convergent criterion, and discriminant validity (Lett & Kamphaus, 1997; Reynolds & Kamphaus, 1992, 2002). For this study, the Conduct Problems subscale was of interest. The subscale includes 10 items, and the Cronbach's alpha was .88.

The Social Skills Rating Scale-Parent (SSRS-P; Gresham & Elliot, 1990) is a standardized scale where parents assess social functioning. The SSRS-P contains 38 items. Parents rate (0, 1, or 2) their children on frequency and importance dimensions for the social skills components. There are four subscales: Cooperation, Assertiveness, Responsibility, and Self-Control. Test–retest reliabilities and internal consistencies for the subscales and total score have been reported (Gresham & Elliot, 1990). Gresham and Elliott (1990) reported studies documenting concurrent and construct validity of the SSRS-P. For the current study, the Responsibility (28 items), Cooperation (28 items), and Self-Control (28 items) subscales were of interest. Cronbach's alphas for these subscales were .74, .75, and .83, respectively.

Attrition and attendance report. The attrition rate (dropouts) and attendance were considered the best indices of the efficacy of procedures. Multiple procedures were used for handling these issues (e.g., reward system, dinner, reminder phone calls, and child care) to facilitate attendance and decrease attrition. Program attendance (i.e., the number of group sessions attended) was recorded for families in the intervention.

Program satisfaction questionnaire. To provide further information on program acceptability, parents in the intervention program completed satisfaction questionnaires on both a weekly (session-by-session) basis and as part of postassessment. The Parent Satisfaction Questionnaire (adapted from Long & Forehand, 2002) was completed weekly. After each group session, parents were asked to rate the session. Satisfaction with session content, group discussions, and group leaders was rated using a 4-point Likert-type scale ranging from 1 (*not helpful*) to 4 (*very helpful*). At the postassessment, parents completed the Parent Satisfaction II instrument (adapted from Webster-Stratton, 1989). Parents answered questions that rated the overall program (e.g., "How confident are you that you will be able to manage future behavior problems in the home using what you learned from this program?" "How prepared are you in raising a confident Black child in a racially conscious society using what you learned from this program?" "How comfortable are you in managing difficult feelings that your child may have about his race/ethnicity in a way he/she can understand?").

Plan of Analyses

Baseline score equivalence on key demographic characteristics, risk factors, and parenting and child outcomes were evaluated using Fisher's exact tests for categorical variables or *t* tests for continuous variables. Descriptive statistics are reported for attendance and satisfaction with the intervention. Retention rates across conditions were evaluated by Fisher's exact tests. Intervention effects on parenting were evaluated with repeated measures analyses of variance with condition (experimental vs. control) as the between-participants factor, time as the within-participant factor, and the measure of parenting as the dependent variable. Random regression analyses were also employed to allow for the inclusion of children and parents with missing data. In addition to accommodating participants with incomplete data, random regression models allow for the modeling of person-specific effects and serial correlation within participants, factors that play a role in the longitudinal response process (R. D. Gibbons et al., 1993). We used η^2 as a measure of effect size appropriate for analyses of Group × Time interactions (Henson, 2006). According to Cohen (1988), the following conventions apply to η^2: small effect ≥ .0099, medium effect ≥ .0588, large effect ≥ .1379. In this pilot study, assuming no attrition, we had less than 60% power to detect large Group × Time interactions and only 26% power to detect medium effects, two-tailed. Therefore, although significance tests were conducted for completeness, results were interpreted based on observed effect sizes.

TABLE 1: Means and Standard Deviations of Parenting Practices and Parent-Rated Child Behavior for Control and Intervention

	Control Group				*Intervention Group*						
	Baseline		*Post*		*Baseline*		*Post*		*Group × Time ANOVA*		
	M	SD	M	SD	M	SD	M	SD	df	F[a]	*Partial* η^2
PPI											
Monitoring	3.78	0.70	3.33	0.75	3.44	0.88	3.90	0.95	1,26	2.23	.001
Positive Parenting	0.76	0.79	0.41	0.45	0.73	0.43	1.01	0.81	1,26	4.88*	.139
Harsh Discipline	3.00	0.70	3.50	0.66	2.80	0.78	2.60	0.57	1,26	4.99*	.166
PERS											
Total Score	16	3.00	14	2.60	17.1	4.50	23.1	6.20	1,26	5.16*	.133
BASC-P											
Conduct Problems	51.17	10.9	55.08	9.10	54.94	10.1	51.31	12.6	1,26	4.25*	.141
SSRS-P											
Responsibility	99.3	11.7	97	13	100.6	13	118.4	13.2	1,26	5.00*	.140
Cooperation	89.2	16.0	88.6	17.3	91.15	15.9	90.24	16.6	1,26	4.40*	.046
Self-Control	95.1	4.20	95	14	97	12.2	96	11.9	1,26	1.26	.003

a. The *F* statistic represents the comparison on the mean differences (baseline–post) between the control and intervention groups.
*$p < .05$.

RESULTS

Baseline Equivalence of Intervention and Control Groups

Before conducting the outcome analyses, family sociodemographic characteristics—household per capita income, caregiver's education, caregiver's age, and number of children in the household—and the study variables were examined for equivalence across prevention and control conditions. There were no significant differences between conditions for any measures of children's or parents' demographic characteristics, including parenting practices and child behavior. See Table 1 for baseline scores on parent and child outcomes.

Satisfaction

Parents expressed high levels of satisfaction with the program content and delivery of material, with nearly all sessions rated as very helpful, on average. All parents (100%) said they would recommend the program to a friend. No level of dissatisfaction was reported, and satisfaction ratings obtained at the completion of the program were high as well. A number of parents who completed the intervention program provided unsolicited feedback on their children's progress. For example, one mother sent a thank you card to the project office not only stating that she now engages in regular chit-chats (family meetings) with her three young girls (ages 6-9) but reporting that

> [child's name] is doing better in school because I've been teaching her how to talk to folks without acting out. I am so glad I came to your program because I can tell the difference in myself and my kids notice it too. I carry my red parent binder [program manual] everywhere.

Indicators of satisfaction were also observed during the graduation ceremony for caregivers when they gave videotaped testimonials on what they liked most about the program. Responses included, "I learned a lot about how to raise a confident Black child," "The program taught me how to be a better parent," and "I enjoyed the information because it helped me interact better with my child and handle difficult situations."

Retention Rates Across Conditions

Twenty-eight families participated in postintervention assessments (retention rate of 88%). The overall attendance in groups was excellent. Of the families who attended the first group session, the average attendance across 12 sessions was 85%, with 100% of the families attending half (6 sessions)

or more group sessions. All 15 families (100%) in the intervention condition were retained for the postintervention assessment (Time 2). Thirteen of 15 control families (87%) were reassessed at postintervention. We examined baseline characteristics of those children who were retained at follow-up versus those who were not. There were no significant differences found.

Intervention Effects on Parents and Children

As shown in Table 1, there were significant Group × Time interaction effects for six of the eight scales. Figure 1 shows these interactions visually. Bars above the 0 axis are the amounts that scales increased over time, and the bars below the same axis are the amounts that scales decreased over time. Treatment families showed increases in positive parenting (0.73 to 1.01) and reduction in harsh discipline over time (2.80 to 2.60), whereas control families showed increases in harsh discipline (3.00 to 3.50) and reductions in positive parenting (0.76 to 0.41). The significant Group × Time interaction for parents' experiences of racial socialization (total) was as expected. The treatment parents' scores increased over time (17.1 to 23.1), whereas the control group parents' scores decreased (16 to 14). Parent-reported child externalizing behavior changed in both groups but in opposite directions. Children in the treatment group showed decreases over time (54.94 to 51.31), whereas those in the control group showed increases over time (51.17 to 55.08). Finally, there were significant Group × Time interaction effects for child responsibility and cooperation. Treatment families showed an increase in responsibility (100.6 to 118.4) and a slight reduction in cooperation (91.15 to 90.24), whereas control families showed reduction in both responsibility (99.3 to 97) and cooperation (89.2 to 88.6). All the effect sizes for Positive Parenting, Harsh Discipline, PERS-T, Conduct Problems, Responsibility, and Cooperation (η^2 = .139, .166, .133, .141, .140, and .046, respectively) are considered large, with the exception of Cooperation, which is considered a small effect (Cohen, 1988). When analyses were repeated using random regression models, the results were equivalent.

DISCUSSION

African American children living in low-income, urban communities are disproportionately at risk for the development of serious behavioral problems. In part due to the general environmental risks associated with living in low-income, urban communities, these children bear additional risk burdens associated with minority status (racism, discrimination) and parenting practices

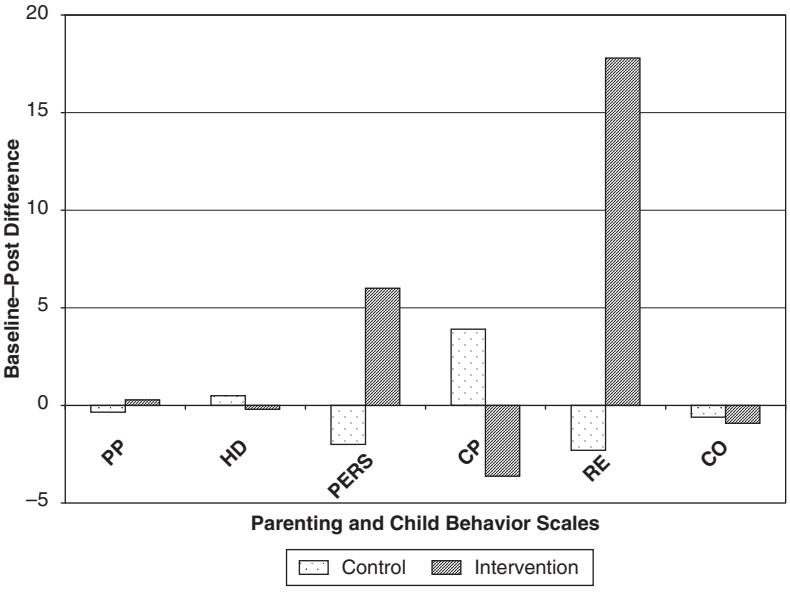

FIGURE 1. Significant Group × Time Interactions
NOTE: PP = Positive Parenting; HD = Harsh Discipline; PERS = Parent Experiences of Racial Socialization Scales total score; CP = Conduct Problems; RE = Responsibility; CO = Cooperation.

that may be compromised due to the regular occurrence of multiple stressors. There is evidence from randomized trials that preventive interventions can be effective in promoting socioemotional development and preventing problem behavior in African American children from low-income backgrounds (e.g., Webster-Stratton, 1998a, 1998b). However, there is also evidence that visible racial and ethnic groups, particularly African Americans, are often difficult to recruit and retain, especially if the program is not culturally appropriate (Kumpfer et al., 2002). For instance, generic universal parenting programs attract only about 20% to 25% of families if they are asked to participate in research (Coie et al., 1991) and as low as 10% for ethnic families in particular (Biglan & Metzler, 1999). As a result, researchers believe that culturally modified programs are essential for the success of prevention (Kumpfer & Alvarado, 1995; Turner, 2000).

This pilot indicates that a culturally adapted intervention (BPSS) is successful in improving aspects of parenting associated with the early development of conduct problems and the promotion of social and cultural competence.

The pilot provides overall support for the feasibility, acceptability, and potential efficacy of the BPSS intervention program, as well as for the acceptability of the randomization procedures in the targeted population. At the same time, it points to the success of a wait-list control condition for retaining families at risk in research studies. These results are consistent with the extant literature highlighting the potential benefit of tailored services in both the amelioration of risk and the fostering of resilience in Black/African American families (Kumpfer et al., 2002; U.S. Department of Health and Human Services, 2001a).

Limitations of the Study

Despite the favorable results of the study, several limitations of this pilot should be noted. The parenting practices measures were parent-report measures and did not include a blind observational measure of parenting practices. Such information would have been useful to consider alongside self-report data and in interpreting the breadth of the impact of the intervention. Second, although we assessed parental satisfaction, we did not assess all the additional procedures, such as regular telephone contact, mailings, provision of referrals, general resources, and additional supports (e.g., accompanying a parent to a parent–teacher conference) that were assumed necessary to keep families engaged. Without including such items as part of the postassessment, we cannot make specific conclusions about their true impact (i.e., which content, delivery, and additional procedural aspects of the program were most influential in keeping parents engaged). Similarly, measures of social support and community readiness would have been useful in the interpretation of findings. Finally, we did not assess parental psychopathology as part of the pre- and postevaluation. Doing so would have provided additional descriptive data on the sample and an opportunity to explore parental psychopathology as a possible moderator.

Future Research

In addition to a planned follow-up to this study, future BPSS studies include an evaluation of BPSS and PSWC via a full-scale randomized, controlled study; development and testing of BPSS–Child (an augmentation of the BPSS curriculum that includes both child and parent–child interaction curricula); development and testing of supplemental BPSS special topic modules (e.g., substance and/or alcohol use prevention) offered to participants following their participation in the base program; and a large-scale evaluation of BPSS. The continued systematic study of BPSS will provide a valuable tool for developmental and family researchers who wish to incorporate culturally relevant interventions into their work with children and parents, thereby advancing basic and applied science.

CONCLUSION

When applying evidence-based parenting programs to Black/African American parents in community settings, it is likely that consideration of cultural issues will facilitate success. However, although many may agree that cultural adaptations such as those proposed in this article (i.e., content and delivery) may be necessary to engage Blacks/African Americans to promote interest, participation, and satisfaction with the intervention (Coard et al., 2004; Roosa et al., 2002), we recognize that little guidance is available regarding the necessary steps involved in tailoring existing programs. We contend that the process and procedures used in the development and testing of BPSS could serve as a model for joining racial, ethnic, and cultural factors with evidence-based prevention models. Equally important to the goal of providing more culturally and contextually appropriate resources to Black/African American children and families and improving overall effectiveness of new and existing program models is that such interventions and integration methods and strategies be based on research and be subjected to rigorous empirical evaluation (Izard et al., 2001).

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