

Examining the Effectiveness of a Culturally Adapted Social-Emotional Intervention for African American Males in an Urban Setting

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The purpose of the present study was to assess the efficacy of a culturally adapted version of the Strong Start intervention program on the social-emotional outcomes of African American male students. Externalizing behavior problems of children, specifically African American males, are of great concern for schools. Punitive discipline policies such as expulsion and suspension have proved to be ineffective and harmful. Consequently, school-based social-emotional learning (SEL) interventions have been proposed to teach children coping skills that can help them increase positive social behaviors and emotional regulation. Sixty-one African American male students enrolled in an urban elementary school participated in this intervention. This study employed a randomized delayed treatment control design. Results indicated positive effects in the areas of self-regulation and self-competence. However the intervention did not have an impact on student's empathy, responsibility, or externalizing behavior. Implications are discussed in terms of developing culturally relevant school-based interventions for African American males.

Keywords: African American males, urban schools, social-emotional learning

The state of African American males and school disciplinary procedures has been a consistent topic in the educational and psychological literature (Howard, 2013; Thomas & Stevenson, 2009). These policies generally result in punitive actions such as suspensions and expulsions, which leads to the loss of valuable classroom instructional time. In fact the suspension rates for African Americans is almost double that of their white peers; which manifests itself in Black boys having a higher out-of-school rate than any of their peers (U.S. Department of Education Office for Civil Rights,

2014). Relatedly, African American males are disproportionately placed in the special education category of emotional and behavioral disturbance (EBD; U.S. Department of Education Office for Civil Rights, 2014). Students placed in EBD demonstrate the least favorable longitudinal outcomes (i.e., grades, graduation rates, and employment rates) of students in any special education category (Bradley, Dolittle, & Bartolotta, 2008; Stevens-Watkins & Graves, 2011; Wagner, Newman, & Cameto, 2004). As a consequence of the state of African American male behavioral outcomes, significant intervention research is necessary to alleviate this issue (Serpell, Hayling, Stevenson, & Kern, 2009). Therefore, the purpose of this study is to address the current gap in preventative school-based interventions tailored to African American male students.

Background

Research indicates that public schools serve as the major providers of mental health services for children (Reinke et al., 2011). In light of

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this, the President's New Freedom Commission Report on Mental Health recommends improving and expanding school mental health programs as a means of improving access for children (New Freedom Commission on Mental Health, 2003). Unfortunately, schools currently lack systematic and coordinated efforts to meet the mental health and behavioral needs of students despite being the main system for children's mental health service delivery (Rones & Hoagwood, 2000; Walker, 2004). Additionally, there is substantial gap in school personnel's knowledge of evidence-based interventions for EBD in schools (Stormont, Reinke, & Herman, 2011). Despite the availability of and policy support for evidence-based interventions, mounting data suggests that a significant proportion of school-based prevention programs are not implemented to a satisfactory level in terms of duration, intensity, frequency of activities, content of programming, method of delivery, and participation among staff and students (Gottfredson & Gottfredson, 2002). For example, an evaluation of drug-use prevention practices in schools demonstrated that more than 80% of school districts implemented some type of drug use prevention program, but only 17% of schools used efficacious methods to deliver the program, and only 14% used efficacious program content (Ennett et al., 2003). Interventions used in schools are typically heavily marketed programs that are compatible with past practices, despite lack of scientific support (Ingraham & Oka, 2006).

Urban Schools and Communities

Urban schools are characteristically diverse in their student populations. Children growing up in urban neighborhoods with concentrated poverty are at increased risk for negative outcomes. African American youth, especially those residing in urban environments, are more likely to suffer from untreated mental health problems than their peers (Kataoka, Zhang, & Wells, 2002). Additionally, African American youth are more likely to experience significant psychosocial stressors and experience mental health difficulties that warrant services (Tolan & Henry, 1996). While this is the case, research has indicated that African Americans youth are less likely to use outpatient services, compared to non-Hispanic Whites. In a study of 1,256

youth aged 6–18 years who received services in a large, publicly funded system of care (i.e., juvenile justice, special education, alcohol and drug abuse, mental health service sectors, and child welfare) African American youth were the least likely to utilize mental health services. Specifically, 64% of African Americans received services in comparison to 79% of non-Hispanic White children and 70% of Latino youth (Garland et al., 2005). Previous studies of African American youth's underutilization of community-based mental health services have identified economic barriers and preference to explain this phenomenon. In particular, African American families were more likely to get help from their families, friends, and religious institutions (Harrison, McKay, & Bannon, 2004; Lindsey, Joe, & Nebbitt, 2010). Therefore, delivering mental health services via schools could address barriers that prevent children from receiving services in their communities (New Freedom Commission on Mental Health, 2003). Given these obvious needs in low-income urban communities, the development and implementation of social-emotional learning (SEL) interventions is vital.

Social-Emotional Learning

It is essential for schools to promote students' SEL. As such, the field of education has made significant developments in school-based interventions such as SEL programs (Merrell, 2010). A recently published meta-analysis by Durlak et al. (2011) included 213 studies involving universal SEL interventions for children in preschool through 12th grade. Consistently, study outcomes suggested statistically significant increases in social-emotional skills, socially appropriate behavior, positive attitudes, and academic performance. Additionally, significant decreases were found in conduct problems and emotional distress.

While this may be the case, many available SEL and behavioral programs do not successfully address life situations that are experienced by urban African American children. For instance, in Farahmand, Grant, Polo, Duffy, and Dubois' (2011) meta-analysis that compared school-based mental health interventions conducted with low-income urban youth with school-based interventions implemented with the broader population of adolescents, a major-

ity of interventions with low-income urban youth were not as effective. Specifically, 55% of the interventions conducted with low-income urban youth were classified as ineffective relative to 28% for those conducted with the broader population (Farahmand et al., 2011).

Unfortunately, African American students who live in urban contexts tend to endure major contextual stressors more often than students from suburban and rural areas (Graves, Proctor, & Aston, 2014). Urban schools are generally associated with high rates of poverty, limited resources, high population density, and lower academic achievement (U.S. Department of Education, National Center for Education Statistics, 2011). These issues often lead to negative social outcomes. Consequently, culturally adapting current existing SEL programs may help students identify, grasp, maintain and generalize the curriculum material in a more efficient manner (Beier & Ackerman, 2005).

Strong Start Social-Emotional Curricula

The Strong Kids social-emotional intervention is part of a family of intervention programs: Strong Start, Strong Kids, and Strong Teens. Lesson objectives aim to enhance children's emotion knowledge and management skills by explicitly teaching students to identify a range of body cues, facial cues, and situational cues that will aid in labeling their own emotions and emotions of others. Additional lessons focus on practicing strategies for effectively handling uncomfortable emotions such as anger and anxiety, making and keeping friends, and solving problems with friends.

This family of interventions has been documented to be effective in increasing social competence, decreasing teacher-reported problem behavior, and increasing self-reported coping skills (see Caldarella et al., 2009; Gueldner & Merrell, 2011; Harlacher & Merrell, 2010; Kramer et al., 2010). The Strong Start program is a 12-lesson, skill-based SEL program that was developed with the idea that resiliency skills can be learned and taught in school (Merrell, Carrizales, Feuerborn, Gueldner, & Tran, 2007). In addition to the proven efficacy of the curriculum, the fact that Strong Start was developed by the late Kenneth Merrell, a school psychologist specifically for school settings,

added to our belief that this curriculum could be utilized for our intervention needs.

Need for Present Study

Research has documented the effectiveness of the Strong Start intervention; however, none of these studies have been conducted with predominately African American populations in urban settings (see Caldarella et al., 2009; Gueldner & Merrell, 2011; Harlacher & Merrell, 2010; Kramer et al., 2010). In addition, the majority of Strong Start studies were not randomized samples, which limits the generalizability of this research. Consequently, if SEL curriculums such as Strong Start are to be considered efficacious for all populations, they should be empirically evaluated. Moving forward, it is important for SEL programs to consider if the role of culture is a factor in the program's overall effectiveness and outcomes. According to the developers of the Strong Start program, making careful, appropriate, cultural adaptations to SEL is not just about complying to ethical guidelines; it is about increasing the chances of helping at-risk and underserved students (Merrell & Gueldner, 2012). As such this is the first study that has examined the Strong Start curriculum with an African American male population in a high-risk urban context. Hence, we sought to answer the following questions:

1. Does implementation of Strong Start result in to an increase in knowledge of social and emotional skills in urban African American students?
2. Does Strong Start increase the social-emotional assets in urban African American students?
3. Does implementing Strong Start decrease externalizing behavior in urban African American students?

Method

Setting

This intervention took place in a predominately African American (98.8%) kindergarten to fifth-grade school. The school was located in an urban city in the Mid-Atlantic region of the United States. Ninety-eight percent of the stu-

dents at this school were eligible for free or reduced lunch and 59% of the population is male. According to school district assessment data, 65% of the students are not proficient in reading and 46.6% are not proficient in math. In addition, this district has a history of overrepresenting African American males as EBD.

Sample and Participant Selection

Once Institutional Review Board permission was obtained, an overview of the study was presented to the school's principal and counselor; during which time the school leadership agreed to allow the researchers to proceed with the study. Students were recommended for intervention by their teachers because they were as at risk for being referred to the student assistance team for emotional support due to their problematic behaviors. Given the fact that this school had a history of overrepresentation of males in special education, the school leadership sought to implement preventive measures before referrals were made. After the teachers provided the specific student names to the school counselor, the researchers then provided the school counselor with informed-consent forms to distribute to parents. All students were required to return their parental consent forms before they were allowed to participate in the intervention. Students from nine different classrooms participated in the study. Teachers completed pre- and postintervention assessment for each participant. Preintervention assessments were completed within 5 days of beginning the intervention began and postintervention instruments were completed within 5 days of the interventions conclusion. Teachers received a small indication of gratitude for filling out the forms (e.g., classroom supplies, university logo pens, university logo pencils).

Sixty-one students participated in the Strong Start intervention. Participants were randomly assigned to the Strong Start intervention or the delayed treatment control group (see Figure 1 for randomization procedures). There were 19 kindergarten, 22 first-grade, and 20 second-grade students who participated in the study. The average age of the participants was 7.2 ($SD = .81$) years of age. Each group was comprised of an average of five students. All of the children who participated in the intervention were African American males and eligible for

free or reduced lunch. Analysis of demographic information revealed no significant difference in age or socioeconomic status (e.g., free and reduced lunch status) between participants assigned to the two groups.

Each group was led by a combination of two doctoral students in school psychology or the first author who is a school psychology professor and a doctoral student. The Strong Start lessons were implemented over a course of 14 weeks. One intervention was taught per week. Implementation took place in a smaller room, with everyone sitting at the same table. The Strong Start intervention was conducted over the course of 1 academic year. The first author met with the school guidance counselor in November of the school year to discuss the potential implementation of the intervention. Initial assessments were conducted in January with the intervention beginning in February. Lessons were not implemented during the school district's and the university's spring break.

Modifications

According to the developers of Strong Start, to facilitate and encourage students to participate, lessons should reflect the interests and abilities of students in the group. However, the underlying theory and critical components were left intact. The Strong Start developers based their framework on the American Psychological Association's Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations. The Strong Start curriculum was designed based on the five pathways to well-being developed by Cowen (1994). Specifically, the following concepts were incorporated: (a) forming early attachments, (b) acquiring age-appropriate competencies, (c) having exposure to settings that favor wellness outcomes, (d) having the empowering sense of being in control of one's fate, and (e) coping effectively with stress.

Furthermore, we followed the developer's recommendations and made modifications to the program consistent with the following: (a) get to know your students (e.g., understand common experiences, problem situations, and challenging life circumstances confronted by students), (b) get to know your students community (i.e., ask teachers/community members about students specific issues), (c) deliver the

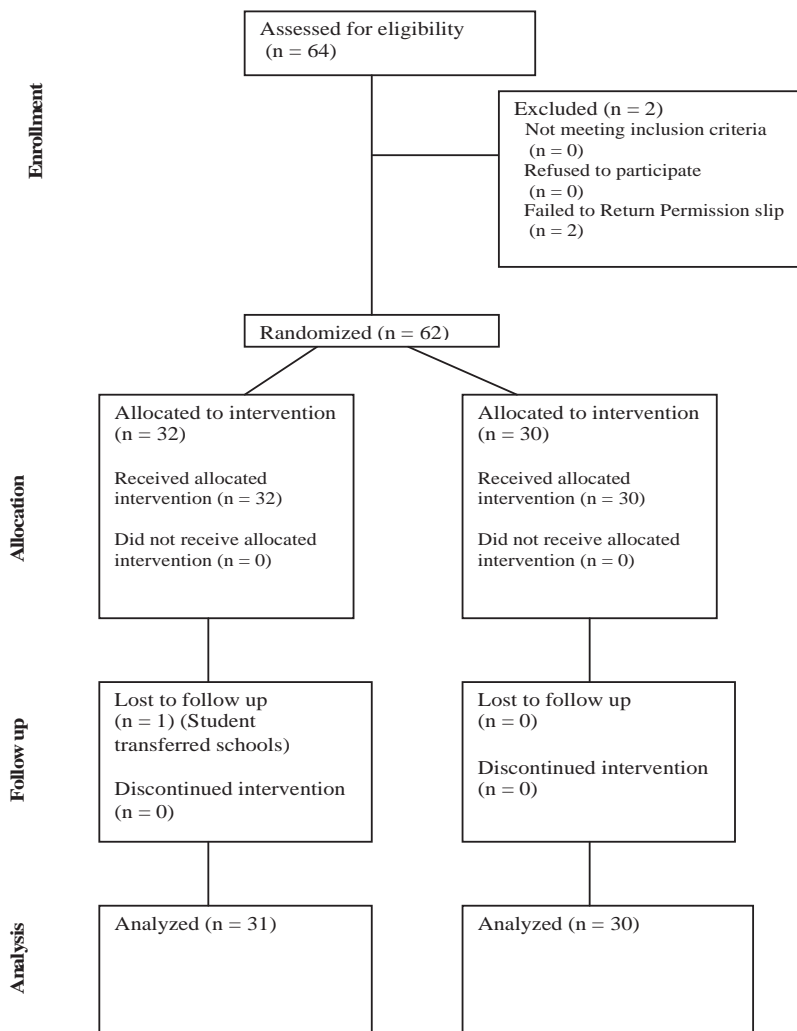


Figure 1. Consolidated standards of reporting trials (CONSORT) flowchart showing Strong Start participant accountability.

curriculum in a manner that children understand (e.g., modify the language of each lesson so that students can easily understand the key ideas), (d) encourage tolerance of others viewpoints, (e) become aware of variations within cultures (i.e., continually examine the accuracy of your assumptions about beliefs and behaviors), and (f) seek feedback (e.g., consult with teachers and the principal about the relevance and accuracy of adaption efforts). These modifications were made in accordance to Strong Starts developers and others who have modified versions of this curriculum for diverse populations (Castro-Olivo, 2014; Merrell & Gueldner, 2012).

Literature modifications were designed to enhance the curriculums relevance for the African American sample (see Table 1 for the complete list of literature modifications). In this instance, the modifications made to the Strong Start curriculums were with the language, content examples and scripts, and book recommendations. Accordingly, issues were discussed that were related to the urban community. In particular literature modifications were made to utilize storybooks that have central characters that were African American, while still maintaining the overall theme of each lesson. To accomplish this, the

Table 1
Cultural Adaptations

Lesson	Potential suggested book	Cultural adaption
1. About strong start	<i>My Many Colored Days</i> by Dr. Seuss	<i>Everett Anderson Good Bye</i> by Lucille Clifton
2. Basic feelings 1	<i>The Feelings Book</i> by Todd Parr	<i>C is for Curious: An ABC of Feelings</i> by Hubbard, Woodleigh
3. Basic feelings 2	<i>Jamaica and the Substitute Teacher</i> by Juanita Havill	<i>Feelings</i> by Joanne Murphy
4. I'm angry	<i>Mean Soup</i> by Betsy Everitt	<i>Harriet, You'll Drive Me Wild!</i> by Mem Fox
5. I'm happy	<i>A Bad Bad Day</i> by Kirsten Hall	<i>What I Like About Me!</i> by Allia Zobel Nolan
6. I'm worried	<i>Arthur's Baby</i> by Marc Brown	<i>Peter's Chair</i> by Ezra Keats
7. Basic feelings	<i>The Kissing Hand</i> by Audrey Penn	<i>Danitra Brown, Class Clown</i> by Nikki Grimes
8. What does a good friend do?	<i>Will I Have a Friend?</i> by Miram Cohen	<i>My Best Friend</i> by Pat Hutchins
9. The stop, count, in, out strategy	<i>The Giving Tree</i> by Shel Silverstein	<i>Stop Drop and Chill</i> by Derrick Barnes
10. Finishing up	<i>I Can't Wait</i> by Elizabeth Crary	<i>Even if I Did Something Awful</i> by Barbara Hazen

researchers utilized the university's curriculum center with the aid of the university's librarian. The curriculum center is a collection of pre-K–12 educational resources designed to support schools and programs on campus working with children including the School of Education, Music Education, School Counseling and School Psychology programs, Speech and Language Pathology, English as Second Language, and children's and young adult literature courses. Included in the center's collection are materials by leading professional development and educational organizations and children's literature publishers.

Finally, Strong Start has primarily been utilized as a classroom wide intervention. However, in this instance the authors implemented it within a Tier II scope (small group, pullout intervention for those students at-risk). We utilized this as a Tier II intervention because the skills taught in the intervention avail themselves well to the skills that were in demand by the teachers. According to the teachers in our study, the children demonstrated social skills deficits, and this manualized treatment has been documented to be an effective intervention for social skills in the published literature. Additionally, when we reviewed the existing literature on Tier II behavior interventions, there were aspects of

the published literature that did not benefit our specific setting. In particular, in Bruhn, Lane, and Hirsch's (2014) review of Tier II interventions, 15 of the 18 studies used were Check, Connect, and Expect; Check In Check Out; or the Behavior Education Program, which share the common component of students meeting with an adult mentor at the beginning of the day to set behavioral goals and end of the day to receive feedback about those goals. It was not possible for us to use this format, as we did not have the structure in place to provide student's access to a mentor to have the students check in with. As such, we thought a small group format was best suited for our specific site. Thus, it was also adapted in this regard.

Dependent Variables

This study included three dependent variables: (a) social-emotional knowledge, (b) social-emotional assets, and (c) externalizing behaviors. Social-emotional knowledge skills were assessed by the Strong Start Content Knowledge Assessment (SSCK). Social-emotional assets were measured with the Social-Emotional Assets and Resiliency Scales (SEARS). Externalizing behavior was measured with the Behavioral Assessment System for Children, Second Edition (BASC-2). So-

cial validity data was gathered from the students and teachers in a questionnaire format.

Social-Emotional Knowledge

The SSCK, a tool that assesses emotion identification, emotion recognition in others, and basic social problem-solving strategies taught within the Strong Start curriculum. The SSCK is a paper-and-pencil task that takes approximately 10 min to administer and complete. There are a total of 18 items and students received 1 point for each correct response. Students responded by circling or marking the picture or word that best answers the question or scenario provided. Test items included statements such as "Circle the face that shows disgust." Students were assessed on their content knowledge pre- and postintervention.

Social-Emotional Assets and Resilience

The SEARS is a strength-based, cross-informant social-emotional assessment system aimed at assessing positive social-emotional attributes of children and adolescents, including social-emotional knowledge, peer acceptance and relationships, resilience in the face of difficulties, coping skills, problem-solving abilities, empathy, global self-concept, and other positive traits (Merrell, Cohn, & Tom, 2011). The scales range in length from 35 to 41 items, and approximately take approximately 15 min to complete, using a categorical 4-point scale. Three rating forms comprise the system: a student self-report, a teacher report, and a parent report. The Cronbach's alpha for the SEARS was .95. In this instance teachers of the students completed a SEARS pre- and postintervention.

Externalizing Problems

To measure externalizing problems, the BASC-2 was administered. The BASC-2 is one of the most commonly used rating scales by psychologists to assess behavior in a wide variety of domains. The study used the Externalizing Behavior Composite as a measure of problem behavior. This composite measures attention, aggression, and conduct problems. Internal consistency for the teacher rating

scales of the BASC-2 were .93. Teachers completed this scale pre- and posttest.

Social Validity

After the conclusion of the Strong Start intervention, teachers and students were asked to complete a social validity questionnaire. The questionnaire addressed the social significance, social importance, and social appropriateness of the intervention. The teacher survey included statements that required the individuals to respond using a 5-point Likert scale from 1 (*strongly disagree*) to 5 (*strongly agree*). Students answered three questions that included statements, "I liked Strong Start," "I learned a lot during Strong Start," and "My favorite part about Strong Start was ____." For the first two questions, students circled a picture indicated yes, no, or kind of. For the third question, students wrote in a word or drew a picture.

Although teachers were not the primary interventionists, as part of our National Institutes of Health (NIH) prescribed treatment fidelity, each week we discussed our session topics with teachers. Consequently, we interviewed teachers within 2 weeks postintervention to ascertain their views of the social validity of the intervention.

Program Implementation and Fidelity

When interventions are replicated in community settings, they tend to be implemented with lower quality and are less effective than in the controlled conditions in which they were developed (Durlak & DuPre, 2008; Rohrbach, Ringwalt, Ennett, & Vincus, 2006). As a result, the Treatment Fidelity Workgroup of the NIH Behavior Change Consortium published recommendations to encourage more consistent incorporation of treatment implementation strategies into behavioral intervention research. The workgroup was formed and charged with advancing the definition, methodology, and measurement of treatment fidelity and to increase the relevance of treatment fidelity for health behavior change studies (Bellg et al., 2004). Consequently, the NIH Treatment Fidelity Workgroup's recommendations for behavioral intervention research were used for this study (Bellg et al., 2004). Table 2 documents how this study addressed the five NIH recommendations in this project.

Table 2
Intervention Fidelity

Activity	Description
1. Study design	Implementers were required to obtain training in the Strong Kids intervention directly from the primary investigator and they were provided opportunity to practice the necessary skill sets needed for the intervention. Two interventionists per group were used to guarantee intervener availability and minimize impact of turnover, vacations, and illness.
2. Provider training	The project utilized standardized treatment protocols/training manuals included with Strong Kids. Primary investigator and the graduate students completed roleplaying examples of the intervention. Individualized supervision and monitoring was provided by the primary investigator to the doctoral students. Trainings and weekly supervision meetings were conducted by the primary researcher.
3. Treatment delivery	Primary investigator and doctoral students monitored each other's interaction styles and attributes for appropriateness. After each intervention session, the implementers debriefed to discuss if the session goals were met, challenges faced during the session, and how to plan for the next intervention session.
4. Treatment receipt	Investigators used active questioning and behavioral observation to assess student comprehension. Student attendance was taken at each session to ensure students are getting a full complement of the intervention sessions and if specific sessions need to be repeated.
5. Enactment of Skills	Discussions were held every week with teachers to indicate the topic of each lesson and to debrief regarding any issues that arose during the session. Interviews were conducted with study participants and their teachers 4 weeks postintervention.

Additionally, multiple fidelity procedures were instituted. First, all interventionists were required to read the Strong Start manual to become familiar with steps of the intervention. Second, interventionists received three days of group-based training followed by applied practice among members of the group. Additionally, interventionists monitored treatment fidelity throughout program implementation for the Strong Kids intervention. Fidelity was assessed by the first author for approximately 20% of all sessions and sessions were selected randomly. Fidelity was assessed for topic discussed and lesson completion. Treatment fidelity was 100% during the selected sessions. Additionally, approximately 92% of students participated all sessions.

Data Analysis Plan

Outcome measures were analyzed to determine treatment effects using repeated-measures analysis of variance on pretest and posttest scores of students. Given the fact that the SPSS statistical program utilizes partial eta squared (η_p^2) as a measure of effect size, we converted this to eta squared (η^2) because it can be converted to Cohen's *d*. Consequently, effect size

(*ES*) estimates were computed using Cohen's recommended method of analysis and interpretation to evaluate the practical meaning. Cohen's suggested interpretation guidelines are that *ES* estimates of less than .20 are not meaningful, *ES* estimates of .20 to .49 are meaningful and small, *ES* estimates of .50 to .79 are meaningful and of medium size, and *ES* estimates of .80 and higher are larger.

Results

Social-Emotional Knowledge

From pretest to posttest, the students' scores increased on the Strong Start Content Knowledge assessment. Between pre- and posttest, students demonstrated an increase in their social-emotional knowledge. Specifically the group average was 68% correct on the pretest and 84% on the posttest.

Social-Emotional Assets

The analysis indicated that students' self-regulation and self-competency improved over the course of the intervention. As listed in Table 3, the teacher rated changes in students' self-

Table 3
Descriptive Statistics of Dependent Measures Between Conditions

Questionnaire	Pretest <i>M (SD)</i>	Posttest <i>M (SD)</i>	<i>F</i> value (<i>df</i>)	<i>p</i> Value	Effect size	
					η^2	<i>d</i>
Self-regulation			9.25 (1)	.00	.19	.99 ^b
Intervention	30.7 (6.9)	41.6 (7.0)				
Control	30.8 (4.9)	33.2 (4.2)				
Self-competence			194 (1)	.03	.33	1.38 ^b
Intervention	30.5 (5.8)	40.5 (6.2)				
Control	30.6 (4.1)	31.9 (4.5)				
Empathy			.09 (1)	.08	.05	.47 ^a
Intervention	46.6 (4.3)	49.7 (4.2)				
Control	47.3 (5.2)	48.9 (4.9)				
Responsibility			.91 (1)	.35	.002	.10 ^a
Intervention	30.1 (6.2)	31.9 (8.1)				
Control	32.4 (8.3)	34.5 (10.8)				
Externalizing behavior			2.75 (1)	.10	.03	.36 ^a
Intervention	59.7 (11.0)	55.9 (9.0)				
Control	62.1 (10.2)	60.4 (8.7)				

^a Small effect size. ^b Large effect size.

regulation, $F(1, 59) = 37.8$, $p < .001$, and self-competency, $F(1, 59) = 194.7$, $p < .001$, were also practically meaningful. This resulted in large effects for self-regulation (ES , $\eta^2 = .19$; $d = .99$) and self-competency (ES , $\eta^2 = .33$; $d = 1.38$) based on Cohen's criteria. In this instance, empathy, $F(1, 59) = 3.2$, $p = .080$ (ES , $\eta^2 = .05$; $d = .43$), and responsibility, $F(1, 59) = .182$, $p = .671$ (ES , $\eta^2 = .002$; $d = .10$), were not found to be statistically significant or practically meaningful.

Externalizing Problems

In this instance, there were not any statistically significant decreases in teacher rated externalizing problems, $F(1, 59) = 2.75$, $p = .10$. To understand the practical significance of the teacher ratings, effect sizes were calculated. As indicated in Table 3, the change in student's aggression as measured by effect sizes was not practically meaningful (ES , $\eta^2 = .03$; $d = .36$).

Social Validity

To address social validity of the intervention, social validity questionnaires were administered to students at the end of the Strong Start intervention. Students responded with positive feedback. Endorsing items such as, "I feel [name] learned important skills from Strong Start" and "I feel [name] uses the skills learned from

Strong Start." All endorsed the item, "I would recommend Strong Start to others." The students themselves also responded positively in regards to the intervention, stating that they liked it and felt that they have learned a lot from it.

The postintervention teacher interview, teachers indicated that they thought the curriculum was relevant to an extent. In particular the teachers thought "the curriculum should have more of an urban focus because we are a high needs urban area." Additionally, all of the teachers thought the intervention should have a greater focus on specific issues related to African American males. In particular, one teacher commented, "I liked the goals of the intervention; however, there needed to be more of a cultural focus on Black boys. The developers of these interventions have good intentions, however they ignore race." Another teacher commented, "The skills that you went over are extremely necessary so it's critical that they have a grasp of this information; however, a majority of our boys are so traumatized with the gun violence and drugs in the community they definitely need something stronger." Finally, all of the teachers thought more time should have been spent on resilience. In particular, "A majority of our boys are raised by their moms and their fathers are in not involved or in jail so we need more focused interventions for them." In

sum, although teachers thought the implementation of the curriculum was a good step, they felt an intervention with a specific focus on African Americans male issues would have been more relevant.

Discussion

Given the need to establish efficacy of the frequently utilized Strong Start curricula, this study is the first to examine its efficacy in an urban African American male sample. Although the negative outcomes of African American males are frequently written about in the education and psychology literature, very little preventive research has been conducted to change their negative trajectories (Serpell et al., 2009). Therefore, there is a strong rationale for preventive interventions such as Strong Start to be implemented with diverse cultures.

The significant and practically meaningful gains in students' self-regulation and self-competency were promising and offer assurance to school practitioners that short-term manualized treatments can be utilized effectively in urban high risk populations. These results are also supportive of the notion that skills that contribute to aspects of resilience can be taught over a short period of time. This is also noteworthy in light of the results from Farahmand et al. (2011). Our results add a potential efficacious intervention to the research base. Given the documented ineffectiveness of interventions designed for urban low-income schools, continued intervention development and evaluation within these types of schools is vital.

Although our results did indicate an improvement in self-regulation and self-competence, other aspects such as empathy, responsibility, and externalizing problems did not demonstrate statistical or practical improvement. Contrary to our results, several research papers have documented the success of Strong Start on other aspects (e.g., empathy, responsibility) of social-emotional development (Caldarella, Christensen, Kramer, & Kronmiller, 2009; Kramer, Caldarella, Christensen, & Shatzer, 2010). Given that this is one of the first studies that has utilized Strong Start with an urban African American population, further studies are necessary to understand why this population did not respond in the same manner. Specifically, there

is a need to understand if the lack of gains in areas other than self-regulation and self-competence is an issue directly associated with our urban African American male sample or the Strong Start curriculum.

Additionally, the Strong Start/Strong Kids/Strong Teens programs were designed as a SEL intervention; however, we decided to include a measure of externalizing behaviors in our project because it was one of the first to be conducted with an urban African American population. Given the high need for programs that address externalizing and trauma based programming with this population, we felt an examination of Strong Start in this area was warranted. Our findings are similar to other applications of the Strong Start/Strong Kids/Strong Teens family of interventions. In particular, Merrell, Juskelis, Tran, and Buchanan (2008) found gains in social-emotional knowledge, but no meaningful change in externalizing problem symptomology. Similarly, Caldarella et al. (2009) documented decreases in internalizing problems, with no decrease in externalizing behaviors. However, it must be noted that the BASC-2 was not specifically designed to be a progress monitoring tool. Future research should attempt to utilize more change sensitive measures and direct observations to document changes in aggression.

Although case studies have associated successful SEL curricula implementation with reductions in school discipline for non-White students, there is emerging evidence that disproportionate discipline outcomes persist in schools implementing positive behavior interventions in schools (Kaufman et al., 2010; Vincent & Tobin, 2011). Consequently, the results of this intervention are consistent with best practices designed to improve social-emotional outcomes in early childhood.

Related to the teachers' comments that the intervention was worthwhile but needed a more concentrated emphasis on the student's diverse experiences, a more culture specific focus is warranted. Consequently, more participatory culture-specific research should be undertaken to determine stakeholder's views of essential components of interventions. This type of stakeholder input has led to the development of efficacious interventions in various domains (Hitchcock et al., 2005; Nastasi et al., 1998; Varjas et al., 2006). Utilizing teachers as one of

the primary focuses of intervention development is ideal given that their recommendations are pivotal when making referrals to school psychologists and school-based intervention teams. This would allow researchers to concentrate on specific issues that need to be addressed without utilizing resources on manualized curriculum lessons that may not be focal areas of need.

Despite the increase in research about evidence-based treatments in social and medical sciences, these interventions have not been well translated to diverse populations (Whaley & Davis, 2007). In particular, intervention studies of children with behavioral and social-emotional adjustment issues often include relatively large samples of African Americans, but results are rarely disaggregated by race or ethnicity (Reddy et al., 2009; Serpell et al., 2009). Given the persistent overrepresentation of African Americans in the EBD special education category, intervention projects that focus specifically on targeted groups who are at risk for negative outcomes (e.g., African American males) should be a focus of public policy. While several studies have documented the negative outcomes associated with being an African American male in the public school system, the number of interventions designed to alleviate this issues has not followed suit. Thus, continued and concentrated intervention research with African American males with a cultural specific focus should be undertaken in schools.

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