

# FOCAL POINT

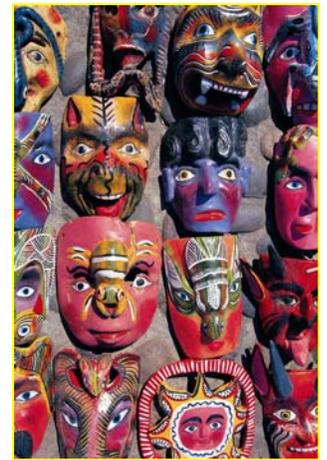
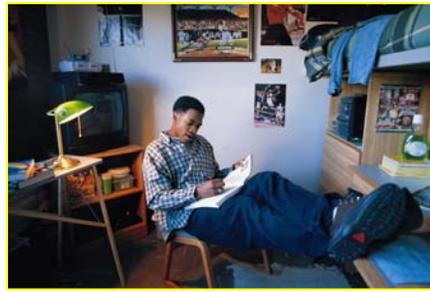
*A National Bulletin on Family Support and Children's Mental Health*



## **Cultural Competence, Strengths, and Outcomes**



Summer, 2003



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*We invite our audience to submit letters and comments: Janet Walker, Editor, [walkerj@rri.pdx.edu](mailto:walkerj@rri.pdx.edu)*

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## A Challenge to Professionals: Developing Cultural Reciprocity with Culturally Diverse Families

Saroja, who comes from India, speaks fluent English and has a post-graduate degree in English Literature. She keeps her maiden name, wears jeans and t-shirts on most occasions, and her hair short. Over the course of her ten years in the U.S., she has become well-acclimated to the nuances of interpersonal communication styles of mainstream America. "For example, now I'm quite used to setting up times to meet my friends, both Indian and American, before I visit them," she states "I miss people dropping in without notice, like they do in India, but, quite honestly, if they did, I'd find it hard to be a gracious hostess! I've learned the meanings of sports idioms like 'that's par for the course' and 'the bases are loaded' even though I know nothing about golf or baseball, and have become familiar with many American expressions and can repartee with the best of them. I've even come to understand that when they ask, 'How are you doing?' they don't want you to give them a list of your ailments!" Yet, Saroja, whose 14-year-old daughter with developmental disabilities receives special education services, admits that when it comes to communicating with the school about her daughter, "It's a whole different ballgame!"

What is it about home-school communication that makes otherwise articulate and self-confident parents feel inadequate? Research indicates that many middle-class, Caucasian or mainstream American parents experience feelings of inadequacy and loss of control when dealing with schools in the process of ensuring an appropriate education for their child with special needs (Turnbull, & Turnbull, 2001). However, there are additional factors or characteristics that specifically affect families from culturally diverse or minority backgrounds, that makes home-school communication "a whole different ballgame." This paper identifies some of these factors and describes strategies toward facilitating culturally reciprocal interactions. These strategies are informed by the notion that awareness of cultural identity occurs at three levels: overt, covert, and subtle (Kalyanpur, 1998). The overt level is an awareness of obvious aspects of cultural difference, such as outward



appearance. The covert level is an awareness of aspects of cultural difference that are not immediately identifiable, such as communication styles or religion. The subtle level is an awareness of aspects of cultural difference that are imbedded, even taken for granted, such as our values and belief systems. By developing our cultural awareness to incorporate

all three levels, we can develop culturally reciprocal interactions with the families we serve. In this paper, each level of awareness of cultural identity is illustrated through the stories of culturally diverse families. All names are pseudonyms.

### Responding to Externalities

Externalities such as outward appearance, including color of skin, dress and even accent, often generate an initial negative response. As one African-American mother explained, "It's like you start off at a disadvantage and you have to prove yourself. They just automatically assume that just because you're black and you don't speak nice, like them, that you're less than them." A Pakistani mother described her experience: "I always make it a point to wear western clothes, like a skirt or formal pants, when I attend IEP meetings now. At my first meeting, I wanted to be formally dressed, so I wore my native dress, a shalwar-kameez. But when I entered the room, something in the looks I received from the principal and others who hadn't met me before made me realize I had made a mistake. I felt that I put myself at a disadvantage at the outset by looking different. The principal asked me if I spoke English and was rather condescending in her approach. Since then, I've tried to look 'American' (at meetings), and although we've changed two school systems, and met many new faces, I have never again been asked if I could speak English." Malka, who comes from Israel, said, laughing, "I always send Ben (her American husband) to meet the teachers in the beginning of school. Otherwise, if they met me first, with my accent, (the reaction) would be altogether different." This initial negative stereotype response to a difference in dress or speech makes participation harder for culturally diverse parents. Professionals who see

difference as deficit force parents into a position where they must establish their credibility as competent adults first before they can be perceived as partners in the decision-making process.

Reactions to externalities are instinctive, as they are based on deep-seated stereotypes about certain groups of people, can be positive or negative, and are fairly ubiquitous. Indeed, we are compelled in our everyday interactions to make snap judgments about the people we meet. Should I hire this young woman with shaven head, tattoos and numerous body piercing as a baby-sitter? Can I trust this non-white cashier to give me back the correct change? Or we might think: I can trust this man walking down the street in a business suit to give me the right directions to where I want to go. The challenge to professionals is recognizing these triggers, such as a different appearance from ours, and becoming aware that they generate such a response, particularly if the reaction is negative. This is an overt level of cultural awareness. A service provider who wears a long-sleeved blouse and long skirt at an IEP meeting on the assumption that she is responding to the religious sensibilities of a Muslim family is demonstrating a positive, overt level of cultural awareness (Kalyanpur & Harry, 1999).

### **Providing Cultural Capital**

Bowers (1984) has referred to “cultural capital” as the knowledge and skills with which we negotiate our way in society as competent adults. Acquiring cultural capital about the special education system, for instance, empowers parents to become effective partners in the educational decision-making process for their child. Knowing how school systems work is easier for parents who have been through the system themselves as children and perhaps observed how their own parents negotiated their way through it. This knowledge is harder to come by for parents who have not experienced the American public school system themselves, or may have had negative experiences while doing so.

Saroja recalls how difficult it was for her to acquire the cultural capital needed to help her negotiate her daughter’s schooling needs. “I still remember the time my older daughter came home and told me she needed to take some things to school that week for ‘show-and-tell’, and I had absolutely no idea what she meant by ‘show-and-tell!’” she said. “I noticed that the other Indian parents in our social circle were constantly asking parents with older children all the questions they had about school. Everybody was helping everybody figure out the system. But there weren’t any other children with disabilities in our group, so there was no one else to ask about special education. And special education is just so

much more complicated! At first, it was comforting to have them (the special education professionals) making the decisions, but I didn’t even have an idea what they were talking about, what they meant when they used these terms. I felt stupid saying, ‘Stop, I don’t know what you’re talking about,’ and nobody took the time to explain. Ten years later, I still feel sometimes that I’m groping in the dark.”

Often, the acquisition of cultural capital is difficult for culturally diverse parents because they are more comfortable using informal sources of information, through personalized connections and conversational language, whereas within the bureaucratized structure of the special education system, information is transmitted formally, that is, written and/or using technical language (Kalyanpur & Harry, 1999). For instance, while the professionals believed they were keeping Saroja well-informed at IEP meetings by making sure she heard their professional opinions and received all the documents, Saroja would have preferred if she could have built a personalized relationship with one person, with whom she would have felt safer admitting she didn’t understand.

When professionals recognize that not all families will access information through formal approaches, they allow the possible use of alternative, informal approaches and enhance parental empowerment. This is cultural awareness at the covert level. During her son’s first year in school, Rajni, who comes from India, found that the telephone conversations she had with the speech-language therapist once a month were more useful to her than the written notes from the special education teacher once a week. Talking directly to the therapist allowed her to get clarification, ask questions, and build a relationship. At the end of the year meeting, she asked the special education teacher if she would be willing to call her rather than send home a note. The special education teacher readily agreed to her request and was later surprised to find how actively involved Rajni was in her son’s education. Changing her communication style changed her attitude toward the parent and, in turn, enabled the parent’s further acquisition of cultural capital. We believe that it is the professional’s responsibility to help parents acquire cultural capital. Professionals are more familiar with schools systems and how they work, having been trained to work in them and/or having actually worked in them. Parents have not had these experiences. If we respond by saying, “But they can find out by asking,” we are overlooking the fact that, in new situations, people often don’t know what questions to ask, or even what they need to find out. For instance, the first time my son was diagnosed with an ear infection, the pediatrician gave me all the information she thought was relevant. She asked me if I had any questions and I said

no; as a new mother, I didn't know what to ask. When he developed severe abdominal cramps and I thought to read the literature that accompanied his antibiotic medication, I realized I should have asked about possible side effects. The next time, I did. It would be impossible for professionals to anticipate every contingency and provide parents with all the answers. However, if professionals are aware of this responsibility and make a conscious effort to help parents acquire cultural capital, especially those new to the process, they can provide information that parents may not think to ask about. As parents acquire more experience, they will be able to ask more informed questions.

### Developing Creative Solutions

Some parents from culturally diverse backgrounds might find themselves in difficult situations that arise from the different values that they uphold. The following story illustrates how, in these circumstances, families will often seek creative solutions that are compatible with their own values, regardless of the solutions professionals might offer them.

Rajni came to the U.S. as a young bride and lived with her husband in her parents-in-law's house, on the culturally-based, tacit understanding that they would move out when they were financially able to maintain a separate household. Soon after, her first son, Bittoo, was born. Rajni recalled her mother-in-law's reaction to his disability: "In the beginning, she refused to believe there was any problem with Bittoo. First, she said it was in my mind. Then, she began blaming me. She said if she took him on a pilgrimage in India, he would be fine." On the other hand, Rajni knew that her son needed physical therapy and contacted the local human service agency, which sent an early interventionist and therapist over for an assessment. However, when the professionals arrived, the mother-in-law sent them away. "The therapists got upset and wanted me to speak to her, or they said they would speak to her. But what could I do? She is my mother-in-law!" To avoid creating a further rift within the family, Rajni decided to stop the process of seeking intervention. However, she didn't give up the fight.

While on the face of things, she appeared to have complied with her mother-in-law's wishes, thus maintaining the harmony of the household, over the course of the next year, she was able to convince her husband that they were financially ready to move out on their own. Since the reason for the move was presented to the in-laws in terms of their financial viability – a laudable achievement, and not in terms of Bittoo's needs, Rajni pointed out, "We left their house with a good relationship, and my mother-in-law is still a support to me

## STRATEGIES FOR INCREASING PARTICIPATION IN IEP MEETINGS

**Follow up the letter of notice with a telephone call or e-mail reminder.** This helps parents realize their participation is valued. It also helps to answer some of their questions about the meeting. This is a good time to find out if they would like an interpreter to be present at the meeting.

**Be flexible with meeting times.** Parents may be more likely or willing to attend if the meeting is held outside school hours when they don't have to take time off from work. Holding the meeting in the evenings or even in the child's home increases parent participation, and allows other family members to sit in on the meeting as well.

**Arrange a pre-IEP conference meeting.** It is helpful for parents if you explain ahead of time what they can expect to happen at the IEP meeting, who will attend, how they can contribute.

**Let parents know they can invite other family members or advocates from the community to the meeting, if they wish.** Parents are often intimidated by the fact that they are the only non-professionals representing the student at the meeting, and having another non-professional familiar to them be present can help to ease their discomfort.

**Find out the reasons why they cannot attend and identify a resource to meet this need.** For instance, some schools arrange to have someone look after the preschool siblings in the school while the mother attends the IEP meeting. Other schools arrange to have team members take turns to provide the parents with a ride to and from school. If the parent has difficulty getting to the school, let them know that they can choose to attend via speakerphone.

**Involve the student or older siblings and let them know how important it is for their parent or guardian to attend.** When one school promised the students a pizza party if they persuaded their parent to come to the meeting, a parent admitted that she had not initially planned to go because "it didn't seem to make much difference if she went or not," but changed her mind because she didn't want to let her third-grader down.

**Find out if the time of the scheduled meeting suits them.** Let them know they can ask for the meeting to be rescheduled for another time, if this time does not suit them.

and my husband.” Once established in her own domain, Rajni re-initiated the process of locating and procuring early intervention services. As she put it, “In the larger scheme of things, one year in Bittoo’s life won’t make so much of a difference. It was more important to keep good family relations.”

For the professionals, who were coming from the perspective that timing is crucial in early intervention, Rajni’s decision to stop services was upsetting, as she herself pointed out. But Rajni was not an uncaring, neglectful mother: while she recognized that Bittoo would benefit from the therapy, she also knew she would need to come up with a solution that would not compromise her family’s values and jeopardize her relationship with her mother-in-law. Professionals who understand her need to do so would be demonstrating cultural awareness at the subtle level.

### Implications for Professionals

Banks (1997) has stated that cultural identity is fluid and highly nuanced, so that no two families may share the same values or levels of acculturation. By the same token, although there may be some convergence of professional values due to educational training, no two professionals will share all the same values. Developing culturally reciprocal relationships with families involves an understanding of each family’s uniqueness, and the recognition that the relationship is an outcome of the interaction of all the variables of cultural identities, of both the family and the professional. If, as professionals, we respond to, Saroja’s family based on stereotypic or preconceived notions about what we think we know Indian families do or believe, or without an understanding of what we think and believe, we are doing both her family and ourselves a disservice. For professionals, the first step toward cultural reciprocity is building self-awareness and developing a sense of one’s own cultural identity. Clarifying our personal values by identifying the adages we grew up with, the lessons our parents taught us, and our moral standards as adults is one strategy (Lynch & Hanson, 1998).

Another strategy is by asking the question “why?” when we recommend a service to a family. “Why does three-year-old Kavita need to eat independently?” “Why do I send written notes home to communicate with my students’ parents?” By doing so, we can identify the personal or professional value imbedded in the practice, such as the high value mainstream society places on independence and self-reliance or our professional reliance on the written word for documentation and accountability. This understanding facilitates a dialogue between professional and family where the values of the

## QUICK TIPS FOR PROFESSIONALS

**Ask parents what mode of communication they prefer.** Sometimes parents may have trouble reading hand-written notes, or with reading itself, and are more comfortable talking directly over the phone. Other parents may be fluent readers, but still prefer the immediate feedback loop that a phone call provides. Some parents may want to receive and respond to email messages at their own convenience.

**Encourage parents to visit your classroom.** Let them know they are welcome to come in and observe. Some parents are happy to help around the classroom. Create opportunities for both open and specified times for parents to visit, and let them know of these times in your conversations, phone calls or other communications.

**Let parents know that you recognize that they know their child best and that you want to learn from them.** Brainstorm with parents when trouble-shooting through their child’s specific behavior problem. Ask them what strategies they use with their child at home. Share good news about their child as well.

**Invite parents to share their cultural heritage.** Many parents are happy to be guest speakers and talk about their customs and traditions. Include family elders, like grandparents, in this endeavor too, if possible.

**Make time to engage parents in conversations to get to know them.** At school events, walk up to parents and start a conversation instead of waiting for them to initiate (some may feel intimidated, others may not know if it’s okay to do so). Tell them stories about your life; they will feel encouraged to share stories of their lives.

**Arrange a pre-IEP conference meeting.** It is helpful for parents if you explain ahead of time what they can expect to happen at the IEP meeting, who will attend, how they can contribute.

**Be reflective about your work.** Ask yourself what values you uphold that might be imbedded in your professional practice. Identify what triggers negative reactions with some parents and positive reactions with others.

family, if different, are highlighted. As the family learns the mainstream value and recognizes where the conflict lies, they acquire cultural capital.

In a way, with cultural reciprocity, home-school communication is “a whole different ballgame,” but one that works for, not against, parents. No longer are the schools the experts, setting the rules of the game and establishing the parameters for how communication will occur. No longer are the families the novices on the field, the only players who don’t know what the rules are and can’t find someone to take the time to explain them. In this ballgame, every player is new to the game but is recognized and respected for bringing their area of expertise to the playing field; and every player has the responsibility for helping the other players learn from them even as they learn from the others.

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## References

- Banks, J.A. (1997). *Teaching strategies for ethnic studies* (6th Ed.). Needham Heights, MA: Allyn & Bacon.
- Bowers, C.A. (1984). *The promise of theory: Education and the politics of cultural change*. New York: Longman.
- Kalyanpur, M. (1998). *The challenge of cultural blindness: Implications for family-focused service delivery*. *Journal Of Child And Family Studies*, 7, 317-332.
- Kalyanpur, M. & Harry, B. (1999). *Culture in special education: Building reciprocal family-professional relationships*. Baltimore: Paul H. Brookes.
- Lynch, E.W., & Hanson, M.J. (Eds.). (1998). *Developing cross-cultural competence: A guide to working with children and their families* (2nd Ed.). Baltimore: Paul H. Brookes.
- Turnbull, A.P. & Turnbull, H.R. (2001). *Families, professionals, and exceptionality: Collaborating for empowerment* (4th Ed.). Columbus, OH: Merrill.



## Youth Clinical Outcomes: Does Race/Ethnicity Matter?



Artwork by Julia Chang, age 10

A growing emphasis on cultural competence in children's mental health has increased our awareness of the need to tailor interventions and service delivery approaches to make them appropriate for children, youth, and families from different cultural groups. When we evaluate services and service systems, we are therefore interested in seeing whether or not they demonstrate an acceptable level of cultural competence. One of the ways that this is often done is by examining clinical outcomes in an effort to determine whether children and youth from different races or ethnic groups appear to be benefiting from services. However, there are a number of difficulties and complexities involved in using outcome data in this way. This article explores some of this complexity, and uses data from a study of mental health outcomes to illustrate what standardized outcomes measures can—and can not—tell us about whether services are effective for children from different cultures.

Although the investigation of racial/ethnic differences in mental health outcomes is often impeded by the need for large samples of services users, such examinations may be possible in conjunction with the many quality improvement efforts being put into place to assess youth outcomes in public sector mental health services across the nation. Mental health performance evaluation programs are increasingly encouraged in order to assess the effectiveness of service systems. To this end, service systems have implemented large-scale data collection procedures for evaluating youth outcomes. These evaluations often include county or multi-county community service systems and therefore provide large amounts of data that can be used to analyze youth outcomes comparatively. These systematic efforts are important for identifying factors such as client race/ethnicity that may or may not be associated with improved youth outcomes.

These initiatives are heartening for the field of mental health but they may also be a source of some concern. Pressures for accountability may force the process of program evaluation to progress quickly, and with limited information on the appropriateness of evaluation tools and procedures across services for diverse populations. Standardized outcome assessment protocols are mandated in many public and private mental health systems, and the results of such protocols may be used to influence funding and service delivery decisions. Consequently, it is extremely important to understand factors such as race/ethnicity that may be related to reported change on clinical outcomes.

To set the stage for interpreting differences in youth outcomes by race/ethnicity in mental health services, let us examine two related issues: 1) multiple informant reports and 2) utilization of services.

Research on the first issue, multiple informant reports, has found that clinician, parent, and youth reports on assessments may differ significantly. Each informant's report appears to represent a unique and independent perspective, and low correlations between clinicians, parents, and children/youth are not simply due to differences in situations (Phares, Compas & Howell, 1989; Kazdin, Esveltd-Dawson, Unis & Rancurello, 1993). Different informants may actually be reporting on different types of problems or behaviors. It has been suggested that measuring child psychopathology involves studying both the behavior of children *and* the lens through which adults view child behavior. In other words, it is important to understand the perceptions, attitudes, and beliefs that lead adults to regard some forms of child behavior as problematic or pathological (Weisz, McCarty, Eastman, Chaiyasit & Suwanlert, 1997). How adults view child behavior may be heavily influenced by ethnicity and, more specifically, by culture. Cultures may differ markedly in terms of the specific problems for which

children tend to be referred to mental health specialists (Weisz et al, 1987). Parents of various cultures appear to have different “adult distress threshold” levels (Weisz, 1989). This means that what parents from one culture perceive as problematic behaviors or symptoms requiring professional attention may not be perceived in the same fashion by parents from another culture. It remains unknown, however, whether observed ethnic differences result from actual syndrome experiences or from cultural variability in the expression, manifestation, and reporting of problems (Good & Kleinman, 1985; Gibbs & Huang, 1989). In sum, reports of youth impairment are probably amalgams of actual behavior, perceptions, beliefs, and threshold levels, all of which may be influenced by the reporter’s culture. Therefore, when examining racial/ethnic differences in clinical outcomes, it is advantageous or even critical to consider reports from multiple informants.

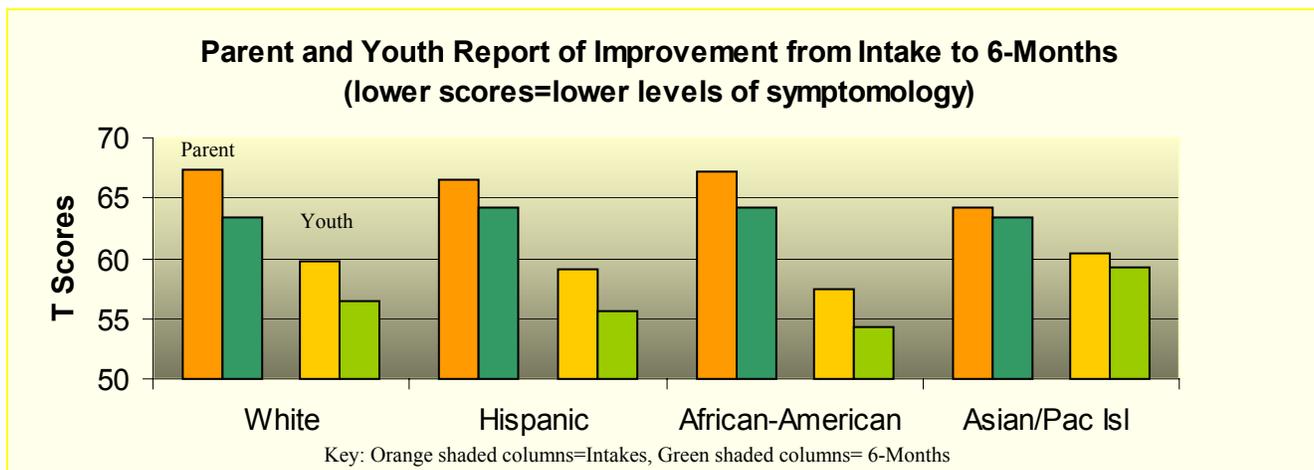
Secondly, race/ethnicity has been found to be a significant factor in utilization of services, even after controlling for level of symptomatology. While inconsistencies in identifying utilization trends-do occur, it appears that Asian American/Pacific Islanders use outpatient and inpatient services at much lower rates than what would be expected based on their population. African-American/Blacks appear to utilize services at a higher rate than expected. Native Americans/Alaska Natives appear to use services equivalent to their population, and there are mixed findings for Latinos/Hispanics (Breux & Ryujin, 1999; Bui & Takeuchi, 1992; McCabe, Yeh, Hough, Landsverk, Hurlburt, Culver & Reynolds, 1999; Pumariaga, Holzer & Nguyen, 1993). These rates are determined by comparing an ethnic group’s representation in a population to the proportion of usage in that population by race/ethnicity. Since the rates are determined by representation in any given population subgroup, utilization rates may vary by

national, regional, or local patterns. Other confounding factors in utilization rates include the effects of education, income, age and level of acculturation, each of which may be associated with race/ethnicity. Racial/ethnic differences in service utilization rates have implications for interpreting service outcomes, as the sample of service-users may not be representative of all children actually in need of care.

### An Examination of Outcome Differences

Now, let us examine the data collected through a mandated evaluation program that used standardized assessments of youth mental health outcomes to evaluate services in a large metropolitan community in California. Of interest are the following questions: Do all race/ethnic youth clients improve after participating in community based mental health outpatient services? Do all ethnic groups fare equally well when compared to each other after treatment? Do different types of informants rate improvements similarly across different racial/ethnic groups?

The study sample included 1,412 youth ranging in age from 3-18 years old who received services in a public mental health outpatient clinic in a California community for at least 6 months within the years of 1997 to 2001. The average age of the youth in service was 11 years. Two thirds of the youth were male (63%) and the racial/ethnic distribution was as follows: 35% Caucasian, 47% Hispanic, 13% African-American, and 5% Asian American/Pacific Islander. (Population distributions are 47% Caucasian, 37% Hispanics, 7% African-American and 10% Asian/PI.) The Asian American/Pacific Islander youth differed descriptively from the other groups, as these youth were half male and half female and were older, with an average age of 14.



The data was analyzed for differences on change in clinical outcomes after six months of community mental health outpatient services. Standardized clinical measures were completed by multiple informants: clinician, parent, and youth. Measures assessed levels of youth impairment and symptomatology. Clinicians reported on youth functioning by completing the Child and Adolescent Functional Assessment Scale (CAFAS, Hodges & Wong, 1996). Parents reported on youth symptomatology by completing the Child Behavior Checklist (CBCL, Achenbach, 1991) and youth (aged 11 or older) reported on their own symptoms by completing the Youth Self Report (YSR; Achenbach, 1991, a companion measure to the CBCL).

*Do ethnic minority youth clients improve after participating in community based mental health outpatient services?* To address this first question, the data collected at intake into services was compared to the data collected at six months after services for each race/ethnic group. The data revealed that youth from the four race/ethnic groups entered services with similar levels of symptoms and impairments. There were no statistically significant differences between the groups across informants, but there was a trend for clinicians to report Hispanic youth as less impaired and parents of Asian/Pacific Islander youth to report less severe levels of symptoms compared to youth of the other groups. Only three of the four race/ethnic groups reported significant levels of improvements from all three informants (clinician, parent and youth) after six months of mental health services. Asian American/Pacific Islander youth and parents did not report improvements, whereas the clinicians treating these youth did report improvements.

*Do all ethnic groups fare equally well after treatment?* To address this question, regression analyses (controlling for age, gender, and impairment level) were used to compare the improvements across the four races/ethnic groups. These analyses revealed answers to the third question as well: Do different types of informants rate improvements similarly across different racial/ethnic groups? According to our results, clinicians report that Asian American/Pacific Islander youth improve the most, significantly more than youth of other races/ethnic groups. This appears to contradict the finding that parents of these youth report no improvement after services. Parents of White youth report their children as making significantly larger improvements than other youth. Clinicians report Hispanic youth as less impaired yet improving similarly to other groups. Lastly, a main effect for informant was evident revealing that youth, overall, report less symptomatology than parents and clinicians.

The results indicate both a race/ethnicity effect and an informant effect; however our analyses cannot answer many questions raised by the data. It remains unclear if the differences in reported outcomes by clinicians, parents and youth are more related to: 1) measurement error of outcomes assessment, 2) different cultural interpretations or expectations of symptoms severity, or 3) true behavioral disparities. What is clear is that administrators, researchers, and clinicians alike should be cautious of making service delivery decisions based on aggregated information across race/ethnicities and/or from a single perspective. It is also clear that we need to learn more about how race/ethnicity and culture are related to outcome measurement and to outcome differences. Research on measurement error is needed to tease out the possible influencing factors such as language, beliefs, and customs that can produce different understandings of questions used to assess client outcomes. Research on acculturation, values, treatment expectations, and change mechanisms is needed to further define the different cultural interpretations of symptom severity and improvement. Finally, research is needed that further defines the family, therapist, and situational characteristics that are associated with treatment progress and positive outcomes between and across various race/ethnic groups.

Like other studies on similar topics, our evaluation study has several limitations that further complicate interpretation of the results. First, the race/ethnic groupings were "panethnic," meaning that all members identifying from a large class of people, such as Asians, were classified together without measurement of acculturation level or cultural beliefs. Second, the parents and youth reported on youth symptomatology, whereas, the clinicians reported on youth functional impairment. Although symptomatology and functional impairment are related and diagnoses include problematic levels of both, the results of the data may be affected by the measurement equivalence issues. Last, information regarding treatment process is unavailable. It is unknown if a certain race/ethnic group received treatment elements that differed from those received by another. What is known is that youth from all subgroups participated in community outpatient clinics (typically in their home neighborhoods) and that services were provided in their language of choice by clinicians trained in cultural competence issues (and often of similar race/ethnicity as clients).

In sum, our study provides an illustration of how much we have yet to learn about why race/ethnicity is associated with varying rates of service utilization and with differences in outcomes on standardized measures.

To better understand this issue, we will need to develop a more sophisticated understanding of how particular beliefs, behaviors, and values come into play as people access and receive services and as they evaluate symptomology and outcomes. With this sort of knowledge we can achieve improvements in the quality of mental health care for all youth.

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## References

- Achenbach, T.M. (1991a). *Manual for the Child Behavior Checklist/4-18 and 1991 Profile*. Burlington: University of Vermont Department of Psychiatry.
- Achenbach, T. M. (1991b). *Manual for the Youth Self-Report Form and 1991 Profile*. Burlington: University of Vermont Department of Psychiatry.
- Breaux, C. & Ryujin, D. (1999). Use of mental health services by ethnically diverse groups within the United States. *The Clinical Psychologist*, 52, 4-15.
- Bui, K. & Takeuchi, d. T. (1992). Ethnic minority adolescents and the use of community mental health care services. *American Journal of Community Psychology*, 20, 403-417.
- Gibbs, J. T., & Huang, L. N. (1989). *Children of color: Psychological interventions with minority youth*. San Francisco: Josey-Bass.
- Good, B., and Kleinman, A. (1985). Culture and depression. In A. Kleinman and B. Good (Eds.), *Culture and depression* (pp. 491-505). London: Tavistock Press.
- Hodges, K., Wong, M. M., (1996). Psychometric characteristics of a multidimensional measure to assess impairment: The Child and Adolescent Functional Assessment Scale. *Journal of Child & Family Studies*, 4, 445-467.
- Kazdin, A. E., Esveldt-Dawson, K., Unis, A. S., & Rancurello, M. D. (1993). Child and parent evaluations of depression and aggression in psychiatric inpatient children. *Journal of Abnormal Child Psychology*, 11, 401-413.
- McCabe, K., Yeh, M., Hough, Richard L., Landsverk, J., Hurlburt, M. S., Culver, S. W., & Reynolds, B., (1999). Racial/ethnic representation across five public sectors of care for youth. *Journal of Emotional & Behavioral Disorders*, 7, 72-82.
- Phares, V., Compas, B. E., & Howell, D. C. (1989). Perspectives on child behavior problems: Comparison of children's self-reports with parent and teacher reports. *Psychological Assessment*, 1(1), 68-71.
- Pumariega, A. J., Holzer, C. A., & Nguyen, H. (1993). Utilization of mental health services in a tri-ethnic sample of adolescents. In C. Liberton, K. Kutash, & R. Friedman (Eds.), *The eighth annual research conference proceedings, a system of care for children's mental health: Expanding the research base* (pp359-364). Tampa: University of South Florida.
- Weisz, J. R. (1989). Culture and the development of child psychopathology: Lessons from Thailand. In D. Chicchetti (Ed.), *The emergence of discipline: Rochester symposium on developmental psychopathology, Vol. 1* (pp. 89-117). Hillsdale, NJ: Erlbaum.
- Weisz, J. R., McCarty, C. A., Eastman, K. L., Somsong, S., and Chaiyasit, W., (1998). Developmental psychopathology and culture: Ten lessons from Thailand. In S. S. Luthar, J. Burack, D. Cicchetti, and J. R. Weisz (Eds.), *Developmental psychopathology: Perspectives on adjustment, risk, and disorder*. Cambridge: Cambridge University Press.
- Weisz, J. R., Sunwanlert, S., Chaiyasit, W., & Walter, B.R. (1987). Over- and undercontrolled referral problems among children and adolescents from Thailand and the United States: The wat and wai of cultural differences. *Journal of Consulting and Clinical Psychology*, 55, 719-726.



## Implementing Culturally Competent Research Practices: Identifying Strengths of African-American Communities, Families, and Children

*Mrs. Miller, a 69 year old African-American grandmother, has been parenting her deceased daughter's five children for the past 10 years, beginning when they were 7, 5, 4, 3, and 2 years old. Since Mrs. Miller was very active in her church, she solicited the church's help when her granddaughters moved into her home, enrolling the girls in several youth activities sponsored by the church. She also informed staff at each school that her granddaughters attended that she wanted to be involved in their education. She attended most of their parent-teacher conferences. Mrs. Miller often sat down with her grandchildren and talked about the family rules in the house. She stated that they had to attend school and they had to do well. She reminded them that they were sisters, and they had to be responsible for each other. They were also told that they had to make something out of their lives. Mrs. Miller never finished high school, but she had worked hard to keep her now-deceased daughter and her only son in school. Mr. and Mrs. Miller valued education as a way to get out of the bad environment in which they lived, and she has now instilled that same value in her grandchildren. Mr. Miller lived long enough to see his children graduate from college. Mrs. Miller proudly stated that all of her girls (daughter and granddaughters) were excellent students. They made A's and B's, and they never missed any days from school. They were all very well mannered and liked by everybody. Even though the Millers lived in an area where drugs and other bad things happened daily, none of those negative influences had touched her girls; they were all good girls, and the granddaughters all wanted to go to college.*

In the course of our research, we asked Mrs. Miller to describe her major strengths, but she stated that she did not have any. Mrs. Miller is a very strong and



determined woman, with a deep commitment to the survival of her family—even to the point of sacrificing her own fragile health and other resources. How many other African-American families are just as purposeful in their commitment to the survival of their families? What are the internal strengths and resources that they possess, and that facilitate and enhance individual and family achievements?

Mrs. Miller and others like her are the inspiration for our research on strengths in African-American families and communities. We believe that a better understanding of such strengths will ultimately lead to higher levels of cultural competence and greater effectiveness in the services and systems utilized by African-Americans. During our work, we have encountered many families like the Millers, and we have collaborated with parents, relatives, community leaders, seniors, and adolescents alike. Our challenge has been to conduct our research in ways that both generate new knowledge and contribute to the empowerment of the community and its members.

This article focuses on the methods and results of two research projects aimed at identifying strengths in African-American families and communities. The first study identified strengths-based behaviors that exist in African-American families and communities (Briscoe & McClain, 2000), while the second study involves the development of a strength-based assessment tool (Joseph, Briscoe, Smith, Sengova, & McClain, 2001). Our goal in the article is to demonstrate our efforts to build and maintain a philosophical congruence between the method, content, and goals of the study. Thus, before turning to a discussion of the research process and results, we describe the philosophy that guided our work and helped us to be

sure that our research was implemented in a way that revealed and enhanced the strengths of all who collaborated in it. The guiding philosophy underlying our work is one that combines strengths-based and cultural competence perspectives.

### **Guiding philosophy**

#### *African-American strengths.*

Many early, traditional researchers of African-American families perceived these families as being highly dysfunctional, disorganized, disadvantaged, and unstable. Our research team consciously chose to recognize that African-American families come from a long line of strong African ancestors who have overcome tremendous obstacles, including slavery, discrimination, and segregation. Surviving in the face of such obstacles has created sources of strength and resilience within African-American families and communities. Hill's enumeration of these strengths (1972; 1997) includes strong kinship bonds, strong work orientation, adaptability of family roles, high educational achievement, and a strong religious orientation. Our research is guided by the fundamental belief that the strengths of African-American families and communities should be recognized and sustained by those who seek to understand, provide, and improve services available to African-Americans.

#### *Culturally competent research practices.*

Researchers, practitioners, policy makers, and neighborhood residents for decades have actively advocated for guidelines, principles, and values to promote and sustain culturally competent research practices. It has been the concern of Cross, Bazron, Dennis, and Isaacs (1989) that research is usually conducted "without the consent, consultation, or participation of the subject population and the resulting information has not found its way back into the community" (p.11). Jackson (1988) called for "developing multidisciplinary research approaches and cooperation among university and social service professionals" (p. 19). The goal of culturally competent research—or culturally competent intervention—is to always preserve and enhance the interests, dignity, and integrities of children, families, and the diverse cultural communities in which they live.

We believe that a culturally competent approach to research within African-American communities is grounded in an awareness of the historical, cultural, socioeconomic and political circumstances and

experiences that have had significant impacts on African-American people's physical, mental, and psychological well-being and survival. Researchers adopting a cultural competence perspective must also investigate their own beliefs, knowledge, and information about the community being studied. Our team explored its own level of cultural awareness and cultural sensitivity, and took inventory of the cross cultural skills that we have developed over time in working with children and their families who live in ethnically diverse communities.

Combining strengths and cultural competence perspectives, and building on our own experiences as African-American people and scholars, we founded our work on the proposition that African-American families are able to provide rich information about their strengths, and about the everyday, positive, lived experiences that sustain African-American life and survival in America. Through this research, we hope to increase understanding of these strengths, and ultimately, to find ways to tap into them as a direct source of energy and strength for individual, family, and community betterment.

### **Research studies**

#### *Study 1: African-American Family Support Coalition (AAFSC)*

This first research effort undertaken by our team began in 1997 as the African-American Family Support Coalition (AAFSC; Briscoe & McClain, 2000), a consumer-driven project designed 1) to plan, coordinate, and implement an analysis to identify strengths and family supports that exist in African-American families and communities, and 2) develop community capacity to use this information

We designed a research protocol based on our vision of strengths-based, culturally competent work in African-American communities, and including elements from action research and grounded theory approaches. Action research approaches involve the theme of "learning by actions" (O'Brien, 1998), and pursue action and outcomes concurrently. The research team generated active dialogue that stimulated family members to recognize, articulate, and build on their strengths. Grounded theory methods involve "discovery work" and theory development, where data are grounded in the realities of the everyday lived experiences of the targeted study group (Strauss and Corbin, 1998). Our approach is also consistent with the system of care philosophy described by Stroul and Friedman (1986), which prescribes that service approaches within the system

should be family centered, community based, culturally competent, and strengths based.

The research protocol for the AAFSC prescribed the active participation of community/neighborhood residents in identifying how their own ongoing activities contribute to the development of children and families in their own communities. Members of community organizations actively assisted with developing research questions, collaborated in identifying indicators of success, and worked actively with our research staff. As neighborhood residents participated at different levels of the process, levels of trust, confidence, and optimism grew. This inclusive process strengthened our entrance, as researchers, into the community and validated our interest and intention to involve and respect the contributions of the communities and their members. Being involved throughout the process enhanced community members' awareness of our commitment to the idea that they were major stakeholders, and that their involvement was primary to the success of the research process. Community members wanted to be involved in the process of finding out about their community and wanted to be a part of the process of seeking solutions that built on their strengths. Because of the level of collaboration required, the research process took longer to implement than we had planned, but we were committed to designing and implementing the project to reflect neighborhood goals and strategies. Additional time was required for data collection in natural neighborhood environments. However, as a result of these activities, community members learned how to participate in the research process and became co-participants in solving their own issues.

The AAFSC created a community-wide team of stakeholders that planned and conducted a comprehensive analysis of family and community resources and strengths, based on:

1. An in-depth census analysis to help identify demographic factors.
2. An examination of local data, (articles, reports, surveys, newspaper articles) provided by African-American organizations and individuals, governmental agencies and universities.
3. A review of the research literature.
4. Asset mapping.
5. Summit meetings where providers, residents, and other professionals identified perceptions, strengths, and resources within four target communities.
6. Focus groups were conducted with successful children, parents of successful children, seniors, at-

large residents, educators and service providers in the target neighborhoods.

Most information on data findings was provided in a timely fashion during neighborhood meetings with residents as deemed appropriate by the community. These reports, both formal and informal, were shared with residents immediately after the research project was completed. This was an agreement established in advance so that the communities could use this information (which they owned) with the expectation that the information will help inform their respective communities and family organizations as they planned various activities and services. Traditional studies have tended not to be community friendly or have not appreciated the importance of community ownership of the data.

The neighborhood-university partnership was a mutually beneficial relationship. Together the partners developed the vision and mission for the project, critically analyzed the neighborhood issues, and developed and designed evaluation interventions aimed at achieving the agreed upon goals. The research team strove to be culturally competent, respectful, open-minded, and non-judgmental of the community members. Consequently, community members felt validated as true members of the team. This built mutual trust and enhanced the research process. The university partners provided technical assistance in program development and training for neighborhood members.



The major findings of this analysis are identified as the seven global strengths that exist in African-American families and communities, and are shown in Table 1:

**Table 1 Global Findings**

<b>Global Strengths of African-American Families</b>	
<b>Global Findings</b>	
<b>1. Neighborhood Solutions</b>	Community members have a desire to solve their own community problems (from the heart of the people)
<b>2. Power of the Church</b>	The church has the ability to influence and promote community economic development through the spiritual strength of the family
<b>3. Family Networks</b>	Strong ties exist within families and extended family networks
<b>4. Education Valued</b>	Families value education
<b>5. Neighborhood Pride</b>	Residents have pride in and cohesiveness within their neighborhoods
<b>6. Neighborhood Organizations</b>	Strength and power reside in tradition African-American support systems and neighborhood groups
<b>7. Youth Achievement</b>	Many youths have a strong desire to achieve

Currently, four committees in the community participate in building upon the identified African-American strengths. These are the committees for: Strengthening the Coalition, Promoting Strength-based Practices, Implementation, and Community Support.

*Study 2: Identifying Strengths in African-American Families (ISAAF)*

The second project, Identifying Strengths in African-American Families (Joseph, Briscoe, Smith, Sengova, & McClain, 2001) focused on designing a strengths-based assessment tool for African-American children and families. As in the first study, this study was built on a philosophy combining strengths and cultural competence perspectives. The research framework was also informed by grounded theory and action research approaches.

Focus groups were convened as a vehicle for engaging residents and service providers in conversations about the activities and assets that contributed to raising successful children and youth in the community. Twenty-five focus groups (five at each site) were conducted in Baltimore, Detroit, Plant City (FL), San Diego, and Savannah (GA). Focus groups included successful youth (age 11-17), parents of successful youth, senior citizens, at-large residents, and service providers. Focus group dialogue was transcribed and analyzed, and meetings were subsequently held at each site to report on findings to the families and communities.

A summary of the major findings from this research is provided in Table 2. Fifteen cross-site family strengths were culled from extensive analyses of the focus groups. The family strengths numbered 1 through 10 on Table 2 were identified consistently across all five sites; four sites reported 11 and 12, while 13, 14, and 15 were reported in at least three sites. Table 2 also lists the 13 child strengths. All of the five sites consistently identified the first four child strengths, while four sites identified 6 and 7. The rest, 8 through 13, were identified in at least one of the five sites. Next steps in the project include developing an instrument to measure these strengths and testing the instrument for reliability and validity.

**Table 2 Cross-Site Summary of Family and Children’s Strengths**

<b>Major Cross-Site Findings</b>	
<b>Family Strengths</b>	<b>Child Strengths</b>
1. Emphasis on Education/High Expectations	1. Positive Self Image/High Esteem
2. Parental Support, Supervision and Guidance	2. Focused/Motivated and Hardworking
3. Extended Family Support	3. Determined/Resilient
4. Effective/Positive Role Models	4. Leadership/serve as role models
5. Spirituality	5. Respectful/Obedient
6. Family Cohesiveness/Family Structure	6. Responsible
7. Open Communication and Trust	7. Talented /Competent/Possess certain skill
8. Teaching Values to Children by Action and Example e.g. honesty	8. Helpful/Altruistic
9. Discipline	9. Independent
10. Unconditional Love	10. Ability to make good judgment and choices
11. Family Activities/Broader Exposure For Children	11. Confident/Self efficacy
12. Family Security/Consistency	12. Honest and Trustworthy
13. Strong Work Ethic	13. Culturally Aware
14. Strong Survival Skills	
15. Cultural Awareness and Identity	

Identified by all sites and previous study

Identified in four of the five target sites.

Identified in three or less of the target sites.

**Conclusion**

These two studies provided a strong foundation for identifying and supporting the development of a strengths-based approach with African-American children, families and communities. The studies also provide an example of research conducted using what we have termed an applied strengths-based framework. Our expectation is that using such a framework will help African-American families, along with their service providers, to identify and utilize family and community strengths to support and nurture successful African-American children. The applied strengths-based framework involves a neighborhood-based methodological approach for identifying strengths and university researchers collaborating with community members to achieve favorable outcomes.

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## References

- Briscoe, R. V., McClain, G. (2000). *African-American family support analysis: Strengths of African-American families*. Tampa: Children's Board of Hillsborough County.
- Cross, T., Bazron, B., Dennis, C., & Isaacs, M. (1989). *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed (Vol. 1)*. Washington, DC: CASSP Technical Assistance Center Georgetown University Child Development Center.
- Hill, R. (1972). *The strengths of Black families*. New York: Emerson Hall.
- Hill R. (1997). *The strengths of Black families: Twenty-five years later*. Washington, DC: R&B Publishers.
- Jackson, J. (1988). Michigan research conference on mental health services for Black Americans executive summary. In A.O. Harrison, J.S. Jackson, C. Mundy, N. Bliedan (Eds.), *A search for understanding: Michigan research conference on mental health services for Black Americans* (pp. 12-20). Detroit, MI: Community Foundation for Southern Michigan.
- Joseph, R., Briscoe, R., Smith, A., Sengova, J., & McClain, G. (2001) *Strengths of African-American families: A cross-site analysis of families in Baltimore, Detroit, Plant City, San Diego and Savannah*. Tampa, FL: Department of Child and Family Studies, Florida Mental Health Institute, University of South Florida.
- O'Brien, R. (1998). *An overview of the methodological approach of action research*. Toronto: University of Toronto.
- Strauss, A., & Corbin, J. M. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage Publications.
- Stroul, B. A., & Friedman, R. M. (1986). *A system of care for severely emotionally disturbed children and youth*. Washington, DC: Child and Adolescent Service System Program (CASSP) Technical Assistance Center, Georgetown University.



## Assessing Behavioral and Emotional Strengths in Black Children: A Measure Designed by and for Blacks

Professionals who work with black children continue to voice concern regarding the sparseness of the research and theoretical literature on black children's functioning, particularly their behavioral and emotional adjustment. Despite our knowledge that strengths are an important foundation upon which intervention and prevention can be scaffolded, research and theory on black children's strengths are extremely limited. Assessing children's strengths for research and intervention requires reliable, valid measures; however, few such measures exist, and those specifically designed for and standardized on black children are noticeably absent. This article describes the development of the Behavior Assessment for Children of African Heritage (BACAH), a strengths-based instrument designed by and for blacks.

### *Historical Background*

Understanding black children's behavioral and emotional strengths requires an appreciation of how blacks' history and contemporary social ecology shape their functioning. Prior to their forced migration to the Americas, black children and families were members of African cultures in which family and community were tightly bound together, and in which there was a strong emphasis on the survival and well being of the entire community. These cultures tended to imbue a strong sense of duty, and to value achievement, wisdom, respect (especially for one's elders and peers), justice, and spirituality (Staples, 1999). This cultural foundation was assailed during the period of slavery and continues to be battered in contemporary society. Yet the central beliefs and values have endured, providing a source of strength that has sustained people of African descent through a difficult history and into the present.



### *Context of Strengths of Today's African-American Children*

Existing literature on black children focuses primarily on deviance in high-risk contexts such as extreme poverty. Comparing black children's behavior and functioning to that of white children, researchers often employ psychosocial models that cast black children's difference as deficiency. These deficit models ignore the behavioral and emotional strengths black children have developed, and they also ignore the ways in which environmental and socio-demographic factors can mediate and/or moderate black children's functioning. For example, black children's performance on cognitive psychological measures decreases if they perceive that testers stereotype them. Differences in functioning can also be seen as alternative competencies, which, while adaptive in the black community, may inhibit functioning in the majority culture. In one study, for example, black children, their parents, and professionals who work with them reported resistance toward mainstream social systems/institutions and fearlessness in expressing opinions as strengths. In contrast, compliance, valued by white culture, was absent from their reports (Lambert, Markle, & Francois-Bellas, 2001).

### *Problems with Measurement*

Most measures of children's behavior and functioning are developed to assess children from any ethnicity or culture, so as to permit cross-group comparisons and the widest research application. Measurement developers often include representative samples of youth from diverse socioethnic backgrounds when establishing norms for their measures; however, the representation of black and other minority youth in such samples is usually insufficient to allow for a full exploration of how these measures function within these different populations. Thus, the content of measures tends to reflect a theoretical and empirical literature base

developed primarily by white scholars for white middle-class children, and the measure may not capture the relevant facets of behavior or functioning among children of different cultural groups. This sort of difficulty around issues of *content validity* makes indiscriminate use of measures across diverse populations problematic (Haynes, Nelson, & Blaine, 1999).

*Cultural validity* is closely related to content validity, and is an assessment of how well a measure covers culturally relevant content, and whether such content reflects idiomatic expressions of the groups for which they were designed. Measures with cultural validity have items that are appropriately phrased in the “voice” of specific groups, and respondents’ interpretation of the items reflects the meanings intended by the developers of the measure. Language and content for most measures of children’s functioning emerges from the literature reviews or expert opinion. However, such literature is often unsophisticated in its appreciation of black culture, and “experts” are likely to be white, middle-class, and/or unfamiliar with black culture and the idioms of its expression. Discrepancies between intended test item meanings and respondents’ understanding may lead to misinterpretation of measurement items, measurement errors, and inappropriate diagnostic and treatment decisions (see Knight & Hill, 1998).

*The Voice of Black Children and Adults Who Live or Work with Them*

Addressing the need for culturally relevant strength and problem assessment procedures, we relied on the expertise of black children and the adults who closely interact with them. Using face-to-face contact and interactive television linkage, we conducted 20 focus group sessions with black parents, children, clinicians, and teachers, as well as with a few white professionals working directly with black children. Participants who had administered or completed psychological tests pointed out that such measures seemed to omit behavioral and emotional strengths, especially those that are deemed most important by many black children and families, such as spirituality, cooperation, respect for others, and sense of humor. Parents and children noted that they were sometimes unsure of the meaning of the items on the measures they completed and had little confidence that



their responses matched the test authors’ intent.

Although our research focuses on strengths, participants also described problems not identified in widely-used measures of children’s behavior such as: being vulgar or disrespectful, wearing revealing clothing, being verbally assaultive, attributing too many problems to racism, and having no outlook or belief regarding a personal future. Participants noted that the rating scales of most measures only scored the presence

and magnitude of competence and problems. They suggested that instruments should measure the *effects* of the strengths on the child, since, in certain contexts, strengths can produce negative effects for the child. For example, in some school environments peers ridicule students with excellent academic skills. Participants therefore noted the need for ratings regarding whether children’s strengths might produce some negative effects, as this information could be critical for intervention planning.

*The Behavioral Assessment for Children of African Heritage*

The Behavior Assessment for Children of African Heritage (BACAH) consists of four forms. These forms are (a) a parent-report form for parents to report on children ages 4 to 18, (b) a teacher-report form for teachers to report on school-aged (i.e., ages 5 to 18) children, (c) an adolescent self-report form for children ages 11 to 18, and (d) an interview schedule for ages 6 to 10. Written at a sixth grade reading level, the first three forms are designed for self-administration but can also be administered in an interview. As described above, the BACAH forms were designed with considerable input from the black community. In addition to seeking input from the focus groups, we also asked 30 black children, their parents, and their teachers to complete the measure and to provide feedback on difficulties with the measure. Another group of 30 black children, parents, teachers and other professionals rated the clarity of instructions on the forms, and rated individual items according to their relevance for black children. We modified the forms according to the input we received from these respondents.

### *Challenges in Developing the Measure*

The development of the BACAH presented a number of challenges beyond those normally associated with this sort of process. One of the main challenges was finding financial support for our work, as funding agencies were reluctant to support our efforts. For example, one program officer from a federal funding agency told us that designing measures for a particular ethnic group is troubling, as other groups might wish the same. Moreover, one would be unable to compare functioning across groups. A president of a foundation asked us "Where are the white children?" This officer also noted that unless we included children from the majority culture in our samples, we would be unable to obtain sufficient resources to complete the project especially if he was heading the funding agency. We viewed these comments as myopic and uninformed. Nevertheless, we were able to proceed, using creative means of funding the project. We used our own financial resources, and obtained funding within our respective universities and from external collaborators.

The other central challenge involved building trust within the black community. With good reason, many blacks are suspicious of researchers, and many are aware of past abuses inflicted on research subjects. Although we are both black researchers, we are associated with the "establishment" (i.e., a university), as some potential research participants mentioned. Others protested that we planned to use their children as guinea pigs, but because the measures' content emerged from considerable input from the black community, we usually responded by pointing out that "The guinea pigs designed these measures." Some informants and community leaders asked why we are looking at children who have no problems. We have noted special interest in showcasing children who are functioning well as too often we focus on the negative in our children.

In order to build trust, we worked to establish relationships with trusted black community leaders in the Midwest and Northeast. People within the black community know that these individuals will do everything possible to protect the community and its members from exploitation. Equally important is that in all phases of our research program, we paid participants for the time they invested with us. Our strategies appear successful as we continue to attract participants.

### *Project status*

Currently, we are using an approach based on Item Response Theory to test the psychometric properties of the BACAH forms. We have shortened the forms, making them a quarter of their original length. We hope to publish the BACAH strengths measure in late 2003 or early 2004.

Across parent, teacher and self reports, we have identified the following three dimensions of strengths: Emotional Connection and Social Adroitness (e.g., feels safe, gets along with older children), Emotional Control and Ecological Adjustment (e.g., deals appropriately with his/her emotions, avoids doing things to make others look bad), and Aesthetic and Cultural Appreciation (e.g., interested in own history and culture, appreciates art and music). An additional dimension we labeled Resilience (e.g. mediates conflicts, problem solving skills, knows own limits) emerged from teacher reports. Preliminary analyses of the data revealed that troubled children are rated lower on all these dimensions.

### *Scaffolding Intervention with BACAH findings*

Because the BACAH forms are written in the voice of black children, their families, and professionals who work with them, informants find it culturally sensitive. Comments from children and parents who complete the measure include "This test was worth my time," and "Finally there is something out there for blacks." Children wrote extensively regarding some questions. That children invest time to complete the BACAH in its lengthy experimental form and write extensively about its items is especially promising. We are optimistic that the BACAH will provide professionals with accurate and useful information for intervention planning and for intervention outcome evaluations. For example, most focus group members reported that children who have an outlook for the future are well adjusted. Some focus group members noted that a lack of such outlook might be indicative of typical suicidal behavior or placing oneself self in situations (e.g., gang activity) which can be life threatening, since the child feels that "He/she has nothing to lose."

Professionals can administer BACAH strength items with a rating scale for the presence and magnitude of strengths, but the rating scale for strength effects might be particularly important. For example, one child who has multiple strengths might view them positively while another child might see having the same strengths as a liability (e.g., demonstrating good academic achievement can result in being accused of acting "too white"). The

professional working with the first child might bolster such strengths, use them as a foundation for the eradication of liabilities, and assist the child in developing strengths in other domains. For the second child, the professional's first task might be to investigate factors contributing to the child's views (e.g., peers, the educational environment). With a better understanding of these factors, the professional can focus on building interventions that are more sensitive to the child's social ecology.

#### *Summary and Conclusion*

Little documentation on black children's strengths exists, yet a better understanding of such strengths is critical. Strengths in the black community reflect African culture, a history of enslavement, and the social realities of contemporary society. Measures of strengths developed for other populations are unlikely to capture this heritage and the adaptations that blacks have made to survive and thrive in America. We have developed the BACAH in an effort to provide a strengths-based instrument that can be used as the basis for culturally sensitive and effective intervention with black children. Additionally, we believe that the BACAH will be useful in research settings, for learning more about how and why strengths buffer black children and contribute to positive outcomes.

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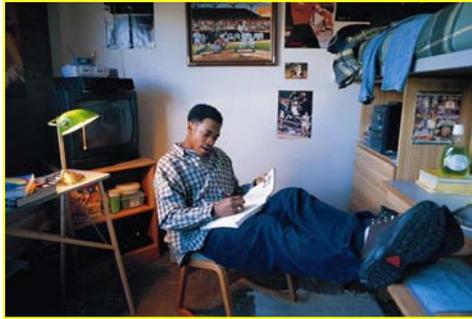
#### **References**

- Embretson, S. E., & Reise, S. P. (2000). *Item response theory for psychologists*. Mahwah, NJ: Lawrence Erlbaum.
- Haynes, S. N., Nelson, K., & Blaine, D. (1999). Psychometric issues in assessment research. In P. C. Kendall, J. N. Butcher, & G. N. Holmbeck (Eds.), *Research methods in clinical psychology* (pp. 125-154). New York: John Wiley & Sons.
- Knight, G. P., Hill, N. (1998). Measurement equivalence in research involving minority adolescents. In V. C. McLoyd & L. Steinberg (Eds.), *Studying minority adolescents: Conceptual, methodological, and theoretical issues* (pp. 183-210). Mahwah, NJ: Lawrence Erlbaum.
- Lambert, M. C., Markle, F., & Francois-Bellas, V. (2001). Psychopathology and assessment in African American children and families: A historical, ecological, and strength-based perspective. In A. Neal-Barnette, J. Contreras, & K. A. Kerns (Eds.), *Forging links: A clinical developmental understanding of African American Children*. (pp. 1-22). Westport, CT: Greenwood Publishing Group.
- Staples. (1999). *The Black family: Essays and studies*. (6th ed.). Albany, NY: Wadsworth.



## Cultural Competence in Services to Children and Families

What does *cultural competence* mean in the context of providing services and supports for children with severe emotional disturbances and their families? This article reports on some specific steps that are being taken in New Hampshire to increase the level of cultural competence in a system of care.



The beliefs, behavior, and values that are central to a family's culture may be influenced by race, ethnicity, language, class, religion/spirituality, parenting orientation, self-esteem and empowerment, education/professional background, economic circumstances, geographic location, and other sources. In New Hampshire's system of care, called the Community Alliance Reform Effort (CARE-NH), we have defined culturally competent services as those that honor a family's beliefs and ways while also effectively addressing the needs the family has prioritized. As we think about the cultural competence of services, a variety of issues come into play, including: Yankee pride, rural barriers to service, urban areas hosting huge ethnic and linguistic diversity, Franco American culture, and a population base (including professionals working in the system) inexperienced in cultural diversity.

The core strategy for building cultural competence within CARE-NH is to build family and youth voices into the structures of decision making at every level of our system. At the level of service planning and decision making, each client that is part of our grant services has a paid family partner, supervised by NAMI NH, who works closely with that family and plays an advocacy role in meetings with agency workers. We make ongoing efforts to act in ways that demonstrate our commitment to truly listening to families. We have found it important to ask family members who should be present when decisions are being made. Sometimes this has brought a grandmother into the process who could have been overlooked. Families are encouraged to identify and invite their traditional community "natural" supports. This has yielded pastors and godparents being asked to join community and family action planning meetings regarding a child.

Family members and youth also participate in decision-making processes at the inter-organizational level. CARE-NH is made up of three regional *collaboratives* that include the local agencies providing services for youth and families. Each collaborative has a monthly meeting

attended by agency representatives and family members. Each collaborative deliberately seeks and retains parents as part of decision making on the Executive Committee, the Capacity Development Committee, and the Regional Collaborative Committee. Several strategies support family participation on the committees. One support is a modest meeting stipend we pay family members. Additionally, family members attending meetings receive reimbursement for their transportation and childcare costs. Family members are provided with orientation that provides information about the players and processes involved in the meetings. We have also developed a youth council to advise each collaborative. Members of the youth advisory council receive a modest meeting stipend. Finally, each layer of decision making above the collaborative level (e.g. State Team, Coordinating Committee) also includes family members, who receive a stipend for each meeting.

One current project for this fiscal year is to begin recruiting families from racial, ethnic, and linguistic minority populations to serve as mentors for families entering the system of care. Our goal in this is to help dispel some of the natural, experience-based wariness that many minority families feel towards "the system." Additionally, we hope to recruit some of these same families into decision-making positions so that their perspectives can help us build a more responsive system of care. The faces and voices of American Indians, African Descendants, Asians, Arab-Americans, Latinos and others are important in the social fabric of New Hampshire, although many providers have shallow experience in working with individuals and families from these cultural backgrounds.

A big piece of our work in New Hampshire has been to alert family partners and agency staff to some of the distinctive aspects of generational poverty. If helping professionals unwittingly devalue children or their families because of long-term parental resource limitations, what sort of partnership in care will result? For example, one parent in our Littleton Collaborative discussed quite candidly how she had been ignored and discounted by helping professionals and educators, due to her lack of middle class status and educational attainment. In reality, she had become an expert by necessity in the issues and behaviors experienced by her dually-diagnosed child. The school provided the child's teachers with training on one of the diagnosis areas. The mother informed the school, quite politely, that staff needed a few more pieces to see the whole picture of her child's behavior. She was disregarded, and consequently teachers were left without a basic understanding of the strategies needed for effectively maintaining and educating her child. This situation resulted in several painful months for both the child and teachers. This same mother discussed her surprise at the financial resources available to foster families in contrast to those available to biological parents caring for a disabled child. When a family of limited economic resources is asked to prioritize needs, restoring electrical service may be a higher and more immediate priority than focusing on complex emotional and behavioral issues. Allowing the family to set priorities challenges service providers and the system to respond differently. The mandate of cultural competence is to create discursive space for the discussion of these sorts of issues, and to create equitable policies in the system of care so that these kinds of class-based errors are not repeated.

Cultural competence is not merely a list of nuts and bolts such as:

- Respect the primary role of mothers in emotional and health issues for Franco-American families,
- Ask about including godparents on community teams for Puerto Rican families,
- Interact with children with severe emotional disturbances with consistency and calmness,
- Approach low-income families without assuming that middle class values or skills are within easy reach, or
- Teach alternatives to corporal punishment as ways for Sudanese fathers to obtain cooperation from children.

Cultural competence is gaining knowledge about cultures AND engaging in a comprehensive process that includes: listening to client and families, understanding practices and priorities of the involved organizations, overturning institutionalized disadvantages to certain groups of people, and working for justice.

In conclusion, we foster cultural competence when we:

- Recognize the broad dimensions of culture;
- Respect families as the primary source for identifying needs and defining service priorities;
- Foster the development of family-driven, community-based teams to assist with care;
- Increase the sensitivity of providers to avoid behaviors that may alienate rather than engage family members;
- Build family members and family partners into the decision-making structure of the system of care;
- Create discursive space about the policies, protocols, and practices within the system of care so that ineffective or inequitable systems may be adjusted;
- Build the cultures of the community into the decision-making structure and the pool of providers for the system of care;
- Commit to structural and policy changes that support family voice and cultural diversity at all levels;
- Provide appropriate culture-specific and diagnostic-specific information to helping professionals; and
- Seek long-term successful outcomes for each child in our care.

## A Personal Story

Crystal is mother to Jacy, a six-year-old diagnosed with bipolar disorder, higher functioning autism, and ADHD. Crystal went on TANF two years ago because the school called her every day at her job to come deal with her child. Crystal and Jacy receive CARE—NH services. In an interview, Crystal spoke candidly about her experience.

*It is still hard to get people to listen. They all come with their own agendas, opinions, ways of doing things. I was at a meeting the other day and this guy commented on how low education levels indicate that parents do not know how to care for their child and are the cause of their poverty. But just because some people do not have a pedigree education does not mean that their experience isn't valuable. I have an excellent background in human services now because of Jacy. I am going for a degree in it and I'm going to be the best case worker my clients ever have because of my training with my son.*

*I was lucky because Jacy was diagnosed at age five and a half and I got help early. The school kept insisting that the problem was merely behavior, and the doctor insisted it was just a phase. The doctor treated me as a scatterbrained first-time mother. I can see how parents start to doubt themselves, really, when the professionals in the system constantly contradict you and work against you. It makes you feel like you are going crazy, and that the whole world is out of control.*

*If professionals would listen to and give training and supports to natural parents that are available to foster families, there wouldn't be so many kids in foster care. They can't just complain that a natural parent isn't doing something right. They should be asking me what I need and finding supports, helping me cope.*

*I have been a member of the CARE—NH collaborative in Littleton for two years. It has taken me the whole time to understand the language--many agency workers articulate things so strangely. It can be very intimidating to voice what I think to professional people, especially if they have a role through counseling or at the school. After every meeting I call my family partner, to talk about what I don't understand or what makes me feel angry.*

*There are plenty of times when I have had to struggle with the school. There were times when the school wanted to send him to residential. I said 'No way.' I made it stick because of the confidence I gained from CARE—NH. I didn't stay on welfare for two years and work as hard as I could to train my family, baby sitters, outreach workers, respite care givers, and teachers, only to have them give up and send him away. Jacy is training us all. And slowly the system is learning how to work well with him. He is not the last child the school will face with the sorts of behavioral challenges he brings. The school's attitude was that this kid is trouble, let's send him away. That hopefully is changing. He has a good aide now, who doesn't walk on eggshells around him, but at times I still have to remind him that Jacy's behaviors are part of his disorder. Everyone is learning a lot from him. Now they hardly need to page me."*