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CONTEXTUAL FACTORS AND ATTITUDES TOWARD FAMILY THERAPY AS A HELP-SEEKING OPTION AMONG MIDDLE-CLASS AFRICAN AMERICANS

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By

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ABSTRACT

CONTEXTUAL FACTORS AND ATTITUDES TOWARD FAMILY THERAPY AS A HELP-SEEKING OPTION AMONG MIDDLE-CLASS AFRICAN AMERICANS

By

Monica Mouton Sanders

The purpose of this study is to explore attitudes toward family therapy among middle-class African Americans. An ecologically sensitive approach accounting for the interplay between race, social class, and culture is utilized to understand how contextual factors influence attitudes toward family therapy as a help-seeking option among an underresearched group of African Americans. Contextual factors considered include gender, racial socialization that includes beliefs about religious and extended family involvement, perceived social support and perceived access to mental health services. Help-seeking comfort, that is, how comfortable a person is with seeking help from others in time of stress, is examined as a variable that potentially moderates the relationship between contextual factors and attitudes toward family therapy.

A sample of 135 participants was selected from a southern community within the United States. Both male and female participants were asked to complete a survey within a group setting. Survey items pertained to contextual issues, including gender, perceived social support, racial socialization attitudes regarding spirituality and caregiving from within the extended family context, and perceived access to mental health services and help-seeking comfort. Attitudes toward family therapy include issues of need, stigma, openness to services, and

confidence in the ability of family therapists to address interpersonal distress. Results demonstrate that women tend to exhibit more positive attitudes toward family therapy than men, though, overall, both exhibit positive attitudes toward family therapy. Analyses were used to explore whether or not one's comfort with help-seeking accounts for the relationship between contextual factors and attitudes toward family therapy. However, prerequisite factors, necessary to detect the effect of a moderator variable, were not present. Thus, help-seeking could not be treated as an intervening variable in the present study. Nevertheless, perceived access to mental health resources, gender, and help-seeking comfort were found to predict attitudes toward family therapy in the present study. Implications for future research, policy initiatives and clinical perspectives are discussed.

DEDICATION

I would like to take this opportunity to dedicate this manuscript to those who came before me. Those persons, along with their ancestors, paved the way so that my parents and their children would have hope for something that racial barriers (of that time) would not allow--- a quality education. I write their names as a remembrance of the sacrifice that they made as servants, sharecroppers, washwomen, lumbermen, and common laborers so that a college education could be attainable for my parents and generations to come. I write their names to recognize their knowledge of life that far outweighed their elementary level education.

I write their names as I honor them for their diligence, hardwork, and faith as Christians. They were known for living their faith, not just as persons attending church, but as individuals who worked hard to provide a stable home life so that their children and their children's children might know that through the journey of marriage and family life, unconditional love and support are forever unwavering.

And so, to my grandparents Vera Mouton, Mattie Derouen Mouton, Frank Polk Sr., and Rhea Polk Mitchell, I dedicate this manuscript to you. May you forever know how much you meant to your families during your time here. I hope and pray that you are looking down on us with a smile, satisfied that your seeds of wisdom and sacrifice have allowed many to blossom, now and for years to come.

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Scripture tells us, "In all thy ways acknowledge Him, and He shall direct thy path" (Proverbs 3:6). To that end, I would first like to give honor and praise to God, my Creator. Through Jesus Christ, as lead by the Holy Spirit, I have been filled with such grace that has allowed me to grow in faith that God does exist, hope for a time when God's children will be as one, and love for all humankind. I am so honored that through this graduate experience, God has touched me in a way that allows me to be forever changed and for that I am truly grateful.

Through this conversion, I have found that faith, perseverance, good times, sacrifice, and "the village" are essential to completion of a task of this magnitude---a metaphor for life. Again, for this lesson, I am forever grateful.

To my "village dwellers," there are too many to mention. Nevertheless, know that in my effort to be all inconclusive, I hope that each and everyone of you know how you personally touched my life. Your support and faith in me, a little ole' southern girl from "Lou-si-ana," gave me the strength to complete this process. For that, I am forever grateful.

To Dr. Marsha Carolan, my marriage and family therapy mentor, your support and faith in me carried me through the joys and challenges of completing the marriage and family therapy program. Thank you.

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To my friends, both near and far, thanks for your support, questions of curiosity, and "I'm so proud of you" moments. I am honored to call each and every one of you "friend."

To my extended family, they say it takes a village to raise a child, but oh, how I know that means so much more to me! Through your unconditional love and support you have shown me what true family means, fueling my desire to love and help other marriages and families to thrive. Thank you!

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gift of family and the journey of family life and for that I am forever grateful. Love ya!

Special thanks to Kim, aka "Nannie"—Gab's third parent. Know that we could not have gotten through this year so smoothly without you!

To my parents, Joseph Curley Mouton and Earline Polk Mouton, you believed in me as a little girl and allowed me to feel invincible in my quest to be the very best I am called to be in this life. People ask, "Why a doctoral degree?" and I respond, "Why not?" Thank you for all of your hard work and confidence in my ability to complete this process. I love you.

To Hubert, my husband and best friend, Gabrielle, my first born ("dissertation baby") and others to come (God-willing), thank you for the gift of marriage and family life. I am honored to be witness to your spirit and the divine in you. I will be forever grateful for the life lessons you have taught and continue to teach me. I love you and look forward to each and every moment I am allowed to spend with you.

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CHAPTER 1

Introduction

The purpose of the present study is to identify attitudes toward family therapy among middle-class African Americans. High rates of ethnic mental health disparities, across social class, suggest that a major undertaking is needed in assessing help-seeking patterns among African Americans. While scholars have targeted culturally sensitive research in the area of individual psychopathology, a dearth of research exists in the area of emotional and psychological distress within the family context. Thus there exists a place within mental health research for family therapy clinicians and researchers to begin addressing how African American communities respond to family therapy as a help-seeking option.

The following sections begin with topics relative to a comprehensive discussion of African Americans' responses to family intervention. The sections include: a discussion of attitudes and needs as related to family intervention, consideration of family therapy as an effective intervention, and the consideration of context related factors such as culture, social class and race. Additional factors such as gender, perceived access to mental health services, and help-seeking comfort are considered, as an ecological lens is used to better understand the role that context plays in shaping attitudes and behaviors. Finally, a statement of problem and purpose followed by theoretical frameworks outlining the conceptual lens of the present study is presented.

Background

African Americans have been targeted within the field of family therapy as an ethnic group that benefits from family-based services (e.g., McGolderick, 1996; Bean, Perry, & Bedell, 2002). Postmodern theories have been promoted in an effort to redefine how traditional models are used for treatment within African Americans' cultural context. A legacy of resilience and survival interwoven into a cultural fabric of communal coping has shaped family existence among African Americans. Yet therapists have begun to recognize how sociocultural stressors, such as public policy and employment inequality, social class barriers and a historical context of oppression, have led to intergenerational disconnectedness and the breakdown of the family unit (Boyd-Franklin, 1989).

With a heightened awareness of the potential for "effective" intervention within the family context, family therapy scholars have begun to address the needs of African American families from a culturally sensitive orientation (e.g., Hardy & Ariel, 1999). Accomplishing this task includes: 1) gaining knowledge of the cultural experiences of African American families (Pinderhughes, 1989); and 2) acknowledging the differences that exists between therapists/researchers and these families, and the families and larger society (Searight, 1997; Imber-Black, 1988).

To date, the study of distress within the family context has primarily targeted middle-class Caucasian and lower income African Americans. Limited emphasis has been placed on exploring the cultural experiences of middle-class African Americans (Bean, Perry, & Bedell, 2002;McAdoo,1999; Bagarozzi, 1995). Given

that middle-class households account for at least 30% of the 5 million African Americans currently present in the United States (McKinnon, 2002; US Census, 2002), family therapists are challenged to account for class-related help-seeking attitudes among African Americans. The present study informs this area of study by accounting for both class and culture-related factors among a middle-class sample of African Americans.

Attitudes and Family Intervention

Identifying attitudes toward formal intervention is critical to understanding the cultural experiences that shape help-seeking patterns among middle-class African Americans. In the study of family therapy among African Americans, this becomes an important question as research demonstrates that overall utilization of formal mental health services is low for this population (Gibbs, Snowden, & Huang, 1996; Alvidrez, 1999; Snowden, 2001). In order to better understand the gap between theory that suggests that African Americans benefit from family therapy and utilization trends, family therapy researchers must first take a fundamental step towards assessing the *attitudes toward* family therapy among African Americans. Taking that culturally relevant step means also acknowledging "within group" variations that emerge based on contextual factors such as social class, gender, spirituality, extended family involvement, social support and access to mental health services (Duncan, 2003; Bagley & Carroll, 1998; Stevenson, 1994).

Need and Family Intervention

A lack of clear findings exists when tackling the issue of need for family intervention among African Americans. A historical context of "race-based exclusion from health, educational, social and economic resources translates into socioeconomic disparities" often leading to high rates of depression, anxiety and phobic related mental illness among African Americans (US Surgeon General, 2001). This phenomenon ultimately impacts African Americans both at the individual and familial level; however, empirical evidence is limited (US Surgeon

General, 2001). Reasons for inconclusive evidence has included: mistrust leading to minimal reporting of psychological distress and a lack of culturally sensitive research with large enough data sets of African Americans (US Surgeon General, 2001).

A need for family intervention can be inferred from a national study that looked at the use of police contact as a formal intervention among African Americans (Washington, 1996). It was found that "interpersonal" distress, such spousal/partner and parent-child conflict, was the most prevalent problem reported. Additionally, Neighbors (1985) found that the majority of respondents reported "interpersonal difficulty" as the most common problem encountered compared to economic, physical, emotional, and death related problems. To that end, the need for family intervention capable of addressing interpersonal conflict seems apparent in the study of help-seeking among African Americans (Washington, 1996).

Family Therapy as an Effective Intervention

Embedded in a systems theory perspective, the field of marriage and family therapy recognizes that families function within larger systems which then in turn influence family and individual outcomes (Goldenberg & Goldenberg, 2000). Emphasizing parent-child and spousal communication patterns makes family therapy uniquely different from traditional approaches that solely emphasize individual behavior and mental processes. Different from traditional psychotherapeutic models, the field of marriage and family therapy fosters more

opportunities to explore therapeutic intervention within the family system (Becvar & Becvar, 2000).

Family therapy has the potential to be an effective intervention among African Americans as family harmony and resilience is generally considered to be part of their cultural framework (McGoldrick & Giordano, 1996; Boyd-Franklin, 1989). The field of marriage and family therapy incorporates the assumption that contextual experiences of family life, both harmony and disconnectedness, ultimately shape the development of individuals (Beavers & Hampson, 1990). Cultural traditions that are based on collectivism, that is, the view that interpersonal harmony is central to individual functioning, carry this same familial theme (Kaniasty & Norris, 2000). Thus, the collectivist ideology within African American culture would appear to be particularly conducive to the family therapy context. Yet, while researchers and clinicians promote family therapy as an effective intervention, African Americans have not been "empowered" to inform the field of their attitudes toward family therapy (Boyd-Franklin, 1989). This suggests that a gap exists between theoretical ideologies and the reality of the family therapy context within African American communities. A culturally sensitive approach that accounts for the contextual interplay between *culture*, *social class*, and *race* is needed as to transcend monolithic assumptions about attitudes and functioning among African Americans.

Culture. The ways in which culture manifests among African Americans has to be inferred from general help-seeking literature, as little is written about the role culture plays in influencing attitudes toward family therapy. Traditionally, African

Americans' cultural context suggests a reliance on informal interventive options, such as seeking counsel with a family member or neighbor, in addition to more formal interventive options, such as consulting with a religious figure, physician or psychologist (Snowden, 2001, Broman, 1996). The cultural context of social support and adaptive behavior often involves a range of supports including emotional, social, and financial (Caldwell & Koski, 1997). Regarding support for emotional and psychological distress, formal contacts such as ministers and physicians are often pursued in conjunction with informal sources (Neighbors & Jackson, 1985; Neighbors, Musik, & Williams, 1998). Mental health professionals are considered, but only in cases where there is threat of "severe mental illness," also commonly referred to as a "nervous breakdown" (Neighbors, 1985; Mays, Caldwell, & Jackson, 1996). These issues of multiple sources and problem severity have been found to shape help-seeking patterns among African Americans. Thus, a culturally sensitive paradigm considers family intervention within the context of multiple supports and African Americans' identification of family distress as a significant problem.

Social class. With regard to social class, African Americans are found to be diverse in their access to resources, mobility, and levels of achievement (Frazier, 1957; Billingsley, 1968; McAdoo, 1997). Yet, despite scholarly efforts (e.g., McAdoo, 1978), the majority of empirical study has been done with middle- class European Americans and lower class African Americans with minimal exploration of the experience of middle-class African Americans (Boyd-Franklin, 1989; Bean, Perry, & Bedell, 2002).

In a recent content analysis, Bean, Perry and Bedell (2002) found that a lack of empirical family therapy research has been conducted with middle-class African Americans. This population deserves attention given that socio-contextual factors unique to this group make needs and outcome vary from the above-mentioned groups. Issues of poverty and limited access to resources differentiate the lower income context from this group, while less exposure to blatant experiences of racial discrimination and prejudice make the Caucasian middle-class context varied as well (Bagarozzi, 1995). Issues such as the maintenance of upward mobility across generations, political empowerment within a racially hostile society, and acculturation (e.g., maintaining a sense of both racial and class-related legacies) make the middle-class experience unique (Haynes, 2001). The study of family intervention among African Americans requires empirical exploration counter to monolithic approaches that make no effort to articulate class or other characteristics within racial groups (Hardy, 1995). Therefore, the middle-class, as a sub group within the African American population, is targeted in this study in an effort to contribute to a body of literature that articulates group experiences when accounting for middle-class status.

Race. Finally, when considering race, adaptation has been a central theme in the survival of African American individuals and families functioning within a traditionally hostile socio-cultural environment. One way that African Americans prepare their children for optimal adaptation to such an environment is through the transmission of racial messages that prepare children for racially hostile conditions (Johnson, 2001). Referred to as racial socialization, this means of

racial adaptation has been documented as a central element in the socialization behaviors found within African American families (Boykin & Toms, 1985; Stevenson, 1994). From a multidimensional perspective, Stevenson articulates racial socialization across four key domains—spiritual/religious coping, extended family caring, cultural pride reinforcement, and racial awareness teaching. Spiritual/religious coping and extended family caring are particularly relevant to the adaptive culture of help-seeking, as the church and extended family contexts have been environments through which intervention is often pursued (Stevenson, 1993). These factors have particular relevance as the field of marriage and family therapy is challenged to consider the role of religion/spirituality and extended family in conjunction with class, thus transcending the traditional "myth of sameness" in addressing the diverse needs of African Americans (Hardy, 1995).

Additional Contextual Factors to Consider

Gender. Other factors such as gender can also shape family functioning and adaptive experiences among African Americans (Garcia Coll, Lamberty, Jenkins, McAdoo, Crnic, Wasik , & Garcia, 1996). Middle-class African American men and women, even within their integrated neighborhoods and job settings, experience discrimination as common occurrences (Boyd-Franklin, 1989). However, their socialization experiences often result in differences in coping and help-seeking behaviors. Women are often socialized to believe that self-reliance and autonomy emerge at the expense of relationships and other mechanisms of social support. This was particularly promoted during the 1960s when the single-

mother family structure was promoted as the predominant African American family paradigm that minimized the role of men and their help-seeking options. This paradigm, which is still promoted today, continues to make it difficult for African American men to reach out for help within their communities without being ridiculed or labeled as deficient.

In the area of family intervention, women tend to initiate help-seeking more readily than men (Boyd-Franklin, 1989). Still, it is suggested that men do in fact, value psychological services (Duncan, 2003), though little is known about their attitudes toward family intervention. To that end, there exist the need to expand the understanding of attitudes toward family intervention both for women and men.

Perceived access to mental health services. Potential barriers often impact the dissemination of services to those who can benefit from them. With regard to family intervention, a primary barrier that has been prevalent among racial minority groups is perceived access to mental health services. Given that mental health services are often imposed on African Americans by courts, schools, and social welfare agencies, resistance to self-referral is heightened (Boyd-Franklin, 1987). Furthermore, due to limited analysis of middle-class African Americans, treatment options are often generalized from research with lower income African Americans or middle-class European Americans (Ham, 2003). Additionally, little research has been recently conducted with middle-class African Americans which limits the knowledge of their current attitudes regarding access and utilization of mental health services.

Help-seeking comfort. Finally, people are often reluctant to seek help for distress because either they believe it does not exist or because they are uncomfortable. Comfort with asking for help is often a predictor of whether or not a person receives help (Kaniasty & Norris, 2000). To that end, help-seeking comfort can present as a possible asset or barrier to therapeutic services. Regarding help-seeking among African Americans, Duncan (2003) notes that cultural mistrust and self consciousness are associated with a willingness to pursue formal support services. Given that formal help-seeking has been low among African Americans in general, investigation of "help seeking comfort" warrants a comprehensive assessment of factors accounting for attitudes toward family therapy.

Statement of Problem

Family life has played a central role in the survival of African Americans. Rooted in communal interdependency and family cohesion, the African proverb of "I am because we are" has set the foundation for this survival despite a historical context of racial hardships and barriers (Sudarkasa, 1997). Family, church, and neighborhood communities have preserved African Americans' overall sense of self worth and value (Ellison, 1997; Johnson 1995). Yet, despite the existence of such institutions, African Americans still suffer from high rates of depression, anxiety and familial distress (US Surgeon General, 2001). The collective identity within African American culture suggests that the functioning of the individual is highly dependent upon the functioning of the family, especially within the middle-class context (see McAdoo, 1997). While African American

researchers and clinicians recognize the value of family therapy, utilization is low within most African American communities (Alvidrez, 1999; Diala, Muntaner, Walrath, Nickerson et al, 2000; Whaley, 2001).

Since a gap exists between scholars' promotion of family therapy and knowledge about its perceived value among African Americans, it is imperative that attitudes toward family therapy as a help-seeking option be examined. A study of the middle class-informs the literature of attitudes among this population given that the majority of mental health studies of African Americans tend to focus primarily on lower income or working class populations.

Statement of Purpose

The purpose of this study was to explore middle-class African Americans' attitudes toward family therapy as a formal help-seeking option. Specifically, the aim was to a) identify attitudes toward family therapy among a middle-class sample of African Americans; b) examine whether or not contextual factors account for attitudes toward family therapy among this sample; and c) assess whether or not one's comfort with help-seeking influences the relationship between contextual factors and attitudes toward family therapy. Help-seeking comfort (HSC) was incorporated as an intervening variable as it has been found that comfort is related to help-seeking attitudes and behavioral outcome (Gary, Leashore, Howard & Buckner-Dowell, 1982; Rogler & Malgady, 1989; Kaniasty & Norris, 2000). Furthermore, literature suggests that contextual factors such as extended family caring socialization (Stevenson, 1994), religious/spiritual coping socialization (Stevenson, 1994), perceived social support (Delphin & Rollock,

1995), gender (Leaf & Bruce, 1987), and perceived access to mental health services (Snowden, 2001) have been associated with attitudes and help-seeking behavior. Therefore, these variables were incorporated within this model as contextual factors that potentially impact attitudes toward family therapy.

Theoretical Framework

The guiding theoretical perspective of this study is based on an ecological framework. Informing the framework are two major models: 1) Bronfenbrenner's (1999) ecological paradigm and 2) Garcia-Coll, Lamberty, Jenkins, McAdoo, Crnic, Wasik and Garcia's (1996) integrative model, which incorporates ecological factors relevant to adaptation and functioning of families of color.

The ecological approach allows for consideration of contextual factors as they relate to attitudes toward family therapy. Bronfenbrenner's ecological paradigm (1986) is widely used within family-based and ecological research (Westney, 1993). Recognizing that a person is constantly engaging in multiple contexts, this model has evolved from the awareness of context (Bronfennbrenner, 1986) to the recognition that it is a person's *interaction* with varied contexts that shapes behavioral outcomes (Bronfennbrenner, 1999). Referred to as the *bioecological* or person-process-context model, Bronfenbrenner uses this paradigm to state that person-environment processes vary as a function of the interplay between personal characteristics and contextual factors (Bronfenbrenner, 1999). This is reiterated in Magnusson and Stattin's (1998) presentation of holistic interactionism. Like Bronfenbrenner, they suggest that individual outcomes are dependent upon processes involving the interchange between mental,

behavioral, social and cultural aspects of the environment. While it is impractical to operationalize an exhaustive ecological model, the key to effective context-sensitive research is articulation of the level at which multicontextual complexity is being examined (Magnusson & Stattin,1998).

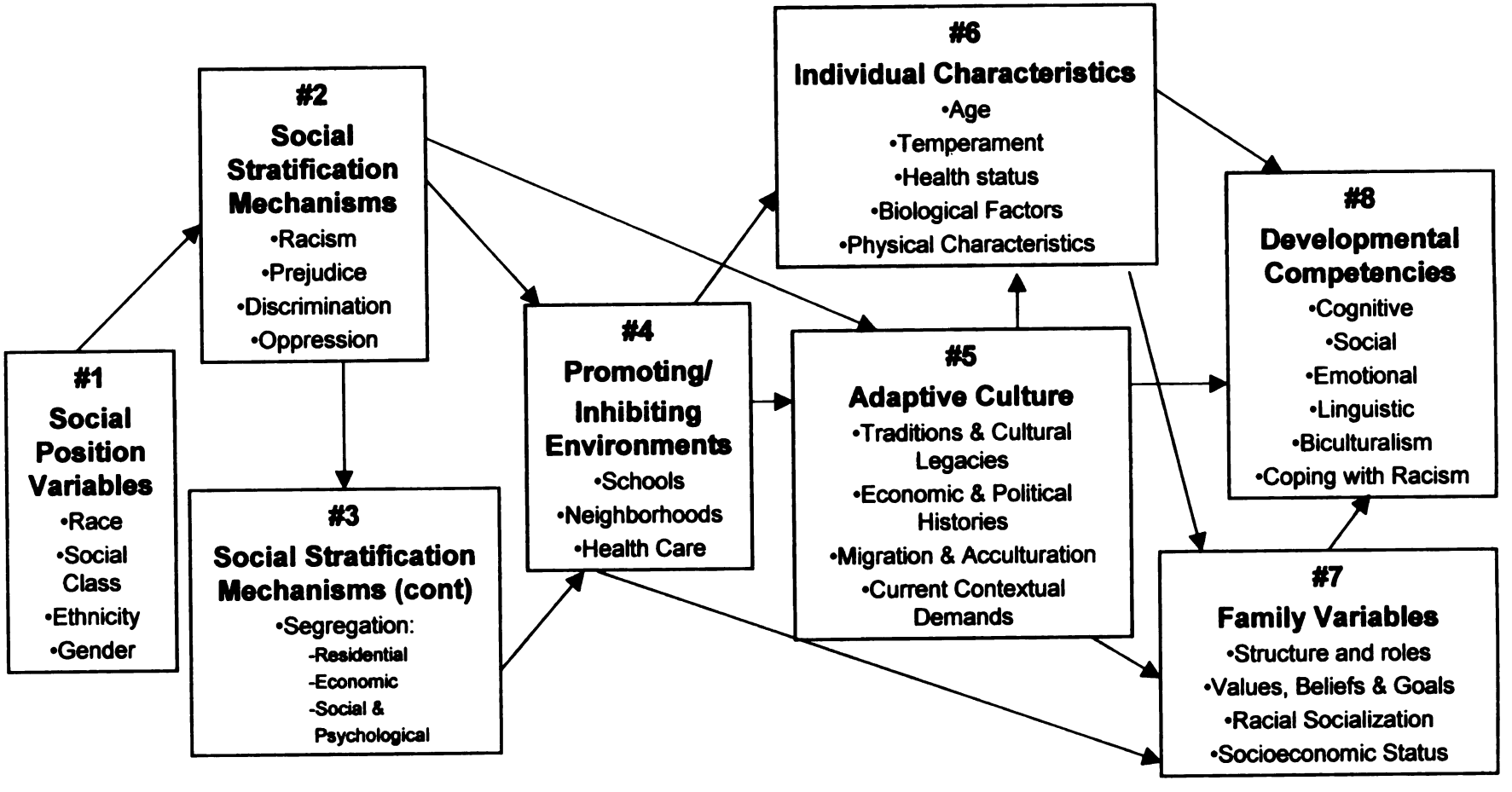
Regarding middle-class African Americans' attitudes toward family therapy, Bronfenbrenner's ecological approach allows for a multivariate model that moves beyond bi-variate relationships. The ecological lens provides a framework through which context-related variables may be incorporated, allowing the researcher to move beyond mere correlational links between demographic and outcome variables. Bronfenbrenner's person-process-context model (1999) serves as the foundation of this study as it articulates how contextual factors may account for or predict attitudes toward family therapy.

Additionally, the theoretical framework of Garcia-Coll, Lamberty, Jenkins, McAdoo, Crnic, Wasik, and Garcia (1996) as the culturally sensitive expansion of Bronfenbrenner's paradigm is utilized for the present study. Conceptualized as ecologically relevant to children and their families, this paradigm integrates social class, race, and cultural factors that are often overlooked within the ecological literature (Garcia-Coll et al, 1996). This multidimensional and comprehensive approach incorporates key context- relevant factors when examining development and functioning among families of color. These factors include "social position" variables such as class, gender, and ethnicity; "social stratification" factors such as a) racism, prejudice, and discrimination and; b) social and psychological means of segregation; "promoting/inhibiting"

environments such as neighborhoods and health care environments; "adaptive culture" factors such as cultural legacies and economic history; "individual characteristics" such as temperament and age; "family factors" such as religious/spiritual coping socialization and extended family caring socialization; and "developmental competencies (outcomes)" such as a person's behavioral or cognitive functioning (Garcia Coll et al., 1996, p. 1896).

Figure 1 is an illustration of Garcia-Coll and colleagues' original conceptualization of culturally relevant contextual areas. Each numbered section represents a factor that is identified as key in the ecological assessment of areas that mediate and/or influence developmental outcomes for children and families of color. Though an exhaustive inclusion of all facets of the Garcia-Coll and colleagues' integrative model would take this study beyond its intended scope, several contexts of this model, together with Bronfenbrenner's overarching paradigm, shapes the conceptual framework through which middle-class African Americans' attitudes toward family therapy are examined.

Figure 1. Garcia Coll and colleagues' integrative ecological model. *



* This is a replication of the integrative model developed by Garcia Coll, Lamberty, Jenkins, McAdoo, Crnic, Wasik, & Garcia (1996). An integrative model for the study of developmental competencies in minority children. Child Development, 67,1891-1914.

Conceptual Framework

Common in person-centered research is the hermeneutic principle. As stated by Habermas (1971), "the aim of the hermeneutic principle is to achieve an intersubjective understanding in spite of cultural differences." This principal as viewed through the ecological lens, acknowledges the experience of a population by allowing the participants to share in the meaning behind their personal attitudes. Thus, this study seeks to acknowledge middle-class African Americans' attitudes toward family therapy. It is believed that this research informs the field of family therapy in three key ways. First, this present study increases the understanding of how middle-class African Americans view formal help-seeking for family distress outside of their traditional help-seeking context. Secondly, taking into consideration factors such as gender and perceived social support contributes to a comprehensive discussion of what contextual elements may account for certain attitudes. Finally, findings empirically inform scholars of attitudes toward family therapy through the lens of a middle-class African America sample which ultimately influences theory, treatment and policy implications regarding this population.

Figure 2 is an illustration of factors relevant to the ecological context of African Americans as adapted from the Garcia-Coll et al. model (1996). Items located in white boxes under each factor heading, represent contextual factors unique to this study. Though the goal was not to revise the integrative model, the intention is to identify those contextual items that represent aspects that Garcia-Coll and colleagues identify as important to an ecological understanding of the

experiences of African American families. For example, gender as a social position factor is primary in shaping the socio-cultural position of individuals in American society (Garcia-Coll et al., 1996). Given the association that has been found between gender and help-seeking attitudes (e.g., Leaf & Bruce, 1987; Gary, Leashore, Howard, Buckner-Dowell, 1982), it is assumed that a relationship will exist between gender and attitudes toward family therapy.

Additionally, perceived access to social support as a social stratification mechanism incorporates a person's perceived access to resources that foster healthy emotional and social well-being (Garcia-Coll et al., 1996). Given that research demonstrates an association between perceived access and attitudes toward mental health service use (e.g., Stefl & Prosperi, 1985), it is assumed that there will be a relationship exists between perceived access and attitudes toward family therapy.

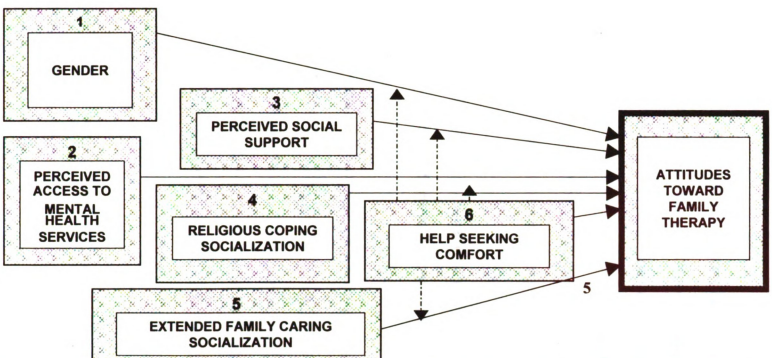
Furthermore, racial socialization domains such as religious/spiritual coping and extended family caring are included as family socialization factors, as they have been found to buffer the effects of distress among African Americans as well as foster heightened self-esteem and identity (Demo & Hughes, 1990). Thus it is hypothesized that as traditional racial coping mechanisms, religious/spiritual coping and extended family caring may be more valued than family therapy as help-seeking options.

Finally, help-seeking comfort (HSC) as an individual characteristic is incorporated as research demonstrates that how comfortable one is with asking for help is associated with utilization and openness to seek both formal and

informal interventive options (Kaniasty & Norris, 2000). Thus it is assumed that a relationship exists between help-seeking comfort and attitudes toward family therapy. In addition to a bi-variate association, help-seeking comfort is treated as a moderator variable, that is, one that influences the relationship between predictor and outcome factors. Thus, as an individual characteristic, it is hypothesized that help-seeking comfort (HSC) moderates the relationship between contextual factors and attitudes toward family therapy. No known empirical study confirms this association, but this theoretical model does suggest that one's level of comfort with help- seeking potentially impacts how individual factors such as gender and perceived social support are associated with attitudes.

Finally, attitudes toward family therapy as a cognitive outcome factor are relevant as attitudes involve cognitive processes that shape beliefs and values about certain phenomena, which can ultimately influence behavioral patterns (Paolucci, Hall, & Axinn, 1977). Attitudes toward family therapy are considered relevant to this component of the model as the present study provides insight into the way in which middle-class African Americans view family therapy.

Figure 2. A conceptual model of contextual factors and attitudes toward family therapy as a help-seeking option among middle-class African Americans.



•This is an adaptation of the integrative model developed by Garcia Coll, C., Lamberty, G., Jenkins, R., McAdoo, H., Crnic, K., Wasik, B., & Garcia, H. (1996). An integrative model for the study of developmental competencies in minority children. Child Development, 67,1891-1914.

Definitions of Key Conceptual Terms

Contextual Factors

Racial socialization domains: extended family caring socialization and religious/spiritual coping socialization: pertains to attitudes regarding the value of race-related messages typically transmitted within the family context. For purposes of this study, these will include attitudes toward messages about the role that extended family plays in child-rearing and social support and the role that spirituality and religious involvement play in helping one to cope with race-related stressors.

Perceived social support: pertains to one's belief about his or her access to social support in the form of emotional, financial or task-completion assistance from either family or friends.

Perceived access to mental health services: pertains to one's belief about his or her access to mental health services through the following means: a) workplace, church, private practice, hospital, or community agency; b)health insurance or other financial means; c)time availability; and d) presence of therapists in one's community. Mental health services involve formal individual or family counseling or psychotherapy.

Intervening or Moderator Factor

Help-seeking comfort: pertains to how comfortable one feels with asking others (either friends or family) for help in dealing with emotional stress, material needs, task completion or decision-making.

Dependent or Outcome Factor

Attitudes toward family therapy: pertains to one's perceived value, that is, how positive are one's views toward considering family therapy as an effective help-seeking option.

Research Questions

With the intention of providing an ecological assessment of family therapy attitudes among a middle-class sub-sample of African Americans, specific research questions include:

1) What are attitudes toward family therapy given the interplay between race (African American), social class (middle-class status) and culture (contextual factors)?
2) Considering context-sensitive factors such as gender, racial socialization attitudes, perceived social support, and perceived access to mental health services, how might such factors influence attitudes toward family therapy?
3) Given that how comfortable one feels with help-seeking may impact attitudes toward family therapy, does help-seeking comfort account for the relationship between contextual factors and attitudes toward family therapy?

Summary

The aim of Chapter 1 was to assess help-seeking needs among African Americans and their families, the role of therapeutic family intervention in addressing family based needs, and the role that contextual factors such as

social class status, culture and race play in shaping help-seeking attitudes and beliefs. Furthermore, given the discussion of ecological theory, examining attitudes toward family therapy from an ecological perspective means incorporating a theoretical paradigm that considers the role that environmental factors play in shaping attitudes. This includes recognizing bi-variate relationships between contextual factors and attitudes as well as potential intervening factors.

In subsequent chapters, the content of the research questions will be specifically addressed from a context-sensitive orientation. Chapter 2 is a presentation of relevant research that suggests the need for an empirically supported understanding of help- seeking needs and attitudes toward family therapy among African Americans. Chapter 3 involves a presentation of the methodology, hypotheses, operational and conceptual definitions of key variables, as well as data collection and analytical procedures relevant to research questions. Chapter 4 provides a summary of the sample's demographic profile, descriptive findings, preliminary analyses, findings relative to research questions and hypotheses, and post hoc findings. Chapter 5 consists of a interpretive discussion of key findings, limitations and implications with regard to future study, policy and clinical relevance to this population.

CHAPTER 2

LITERATURE REVIEW

Issues of access to resources and discrimination often plague families of color (Montalvo & Gutierrez, 1995), while factors such as gender and socioeconomic status add to diverse within group contextual experiences (Hardy, 1995). Therefore, it is appropriate to examine contextual factors as relevant to this discourse on family therapy. The following review of literature explores the help-seeking context as related to therapeutic intervention among African Americans and their families. Themes of informal and formal help-seeking options will be explored as research suggests that both are utilized by African Americans (Snowden, 2001). Family therapy as a formal help-seeking option will be explored, given the strong theoretical assumptions about its effectiveness with African American families. The ecology of African American families that encompasses contextual factors such as gender, racial socialization (e.g., extended family caring domain; religious/spiritual coping domain), perceived social support and perceived access to mental health services will also be explored. Middle-class demographic trends and findings regarding attitudes toward therapy among middle-class African Americans will be presented followed by a conclusive summary of the above-mentioned areas as related to research questions being targeted by the proposed study.

Help-Seeking and Intervention Among African Americans

Mental health was originally defined as an individual's level of "psychological well-being and resilience" and was used prior to the community mental health

movement of the 1950s (Vega & Rumbaut, 1991). This term, mental health, was often used in an attempt to broaden traditional psychiatric terms often used in the in-patient treatment of clinical populations. However, in recent decades, mental health as a description of psychological well-being has been introduced and promoted as more appropriate when addressing the need and level of distress that occurs among non-clinical populations. While mental health often referred to an individual's level of psychological distress, minimum focus has been placed on contextual factors such as race, ethnicity, socioeconomic status or interpersonal experiences (Vega & Rumbaut, 1991).

Given a heightened awareness of psychological distress among African Americans (see Theriot, Segal & Cowsert, 2003; US Surgeon General, 2001; Snowden, 1999), scholars ha begun to broaden the discussion of help-seeking among African Americans by exploring those contextual factors that promote and/or inhibit optimal functioning of individuals and their families. One outcome of this research has been the recognition of informal and formal help-seeking networks as contexts that assist African Americans with coping or confronting mental health issues.

Help-seeking as a process is comprehensive and multidimensional in nature (Leong, Wagner, & Tata, 1995). While social class and culture have been correlated with help-seeking patterns (Leong et al, 1995), little is empirically known about the influence of both social class and culture on African American help-seeking patterns in the family context.

To that end, the following section highlights perspectives in the literature that examine the use of both informal and formal help-seeking options. Additionally, family therapy, as a potential help-seeking option among African Americans is also examined.

Informal Help-Seeking Among African Americans

A common thread in the intervention literature is recognition that African Americans tend to rely either on informal sources of help or informal in conjunction with formal sources for a range of problems (Neighbors & Jackson, 1984; Snowden, 2001). Informal help-seeking (Taylor, Hardison, & Chatters, 1996) has traditionally included a reliance on family and friends (Snowden, 2001). These networks of non-fictive and fictive kin, that is, blood and non-blood relationships, have been more commonly relied on in dealing with daily stressors (Tatum, 1997). Though help is sought for a range of problems including finances and childrearing (Hofferth, 1984), it has been found that help-seeking for emotional and interpersonal problems are also associated with informal networks (Broman, 1996).

Help-seeking among family. Family kinships, both nuclear and extended, have been found to be traditionally fundamental help-seeking networks among African Americans, not only for lower income, but for middle -class as well (McAdoo, 1997). In their analysis of a data set from the National Survey of Black Americans (Jackson, 1991), Taylor, Hardison, and Chatters (1996) found that the majority (83%) of respondents reported that they sought help from their family network. In the family context, McCabe, Clark, and Barnett (1999) found that family kinship

and social support enhanced parental warmness toward children and buffered the relationship between behavioral problems among children and family stressors. Carolan and Allen (1999) found, in their qualitative analysis of middle-class African Americans, that spousal support played a role in coping with the emotional stress associated with racial discrimination. Thus, family networks play an instrumental role among African Americans as they are commonly relied on for a range of distress-related needs.

Help-seeking among friends. In addition to a reliance on family kinships, African Americans often seek help among friends. In fact, an increased number of friendships and close proximity of friends are associated with happiness among older African Americans (Keith, 1997; Ellison, 1990). Clinton and Anderson (1999) found that among upwardly mobile African Americans, those with more close friendships tend to express less social loneliness. Sherman (1997) notes in a multicultural study of friendships, that across the life span, friendship positively influences social development, particularly among African Americans. Godfrey (1997) suggests that among African American women, friendships often modify the effect of conflict that may exist between a woman and her mother. Mattis, Murray, Hatcher, Hearn, Lawhon, Murphy, & Washington (2001) through a study of African American men found that spirituality was a predictor of perceived support in same sex friendships. Thus, friendships as informal networks, seem to play a fundamental social support role in the overall positive well being of both African American men and women.

Formal Help-Seeking Among African Americans

Formal help-seeking, that is, the reliance on church community, physicians or mental health professionals, is prevalent among African Americans, usually in conjunction with informal networks (Neighbors & Jackson, 1984; Snowden, 2001). There exists a reality that in addition to informal networks, African American families do not function with a vacuum and therefore, often must rely on other support contexts (McCubbin, Futrell, Thompson, & Thompson, 1998).

Religious/spiritual involvement. Traditionally, the church community has played a critical role in meeting the spiritual, social, physical and emotional needs of African Americans and their families (Bagley & Carroll, 1998). In the study of Black preaching within African American churches, Pipes (1997) found that the cathartic atmosphere often fostered by Black sermons resulted in an emotional release that countered the daily frustrations of inequality African Americans often encounter. Haight (1998) echoes the reliance of African Americans on the church environment in an ethnographic study of the role Sunday school plays in promoting resilience among African American children. Findings suggest that positive teacher-child interaction emphasizing child-centered scriptural teaching, common in many churches, fosters positive well-being. Furthermore, African American ministers have been found to engage in two critical tasks within African American communities: serving as a primary help-seeking option and; serving as "gatekeepers" in referring church members to mental health professionals (Neighbors, Musick, & Williams, 1998). Furthermore, Musick in a study of private (i.e., Bible reading, prayer) and public (i.e., church attendance) religious

involvement found that both private and public involvement had positive effects on subjective health among older African Americans. Given the role that churches, ministers, and spiritual life have played among African Americans, religious/spiritual coping via these avenues are critical to the psychological well being of individuals and their families.

Medical and mental health agency sectors. In addition to informal and religious networks, medical and mental health sectors are thought of as help - seeking options among African Americans. In an early study of formal services utilized, Neighbors (1985) found using a National Survey of Black Americans sample, that the majority of participants utilized hospitals and physicians as a first line of help for high levels of distress. More recently, it is suggested that African Americans still rely heavily on use of hospitals and private physicians for emotional distress (Snowden, 2001). One explanation is that while patients often present with physical symptoms such as panic attacks or high blood pressure, these are often identified as somatic signs of distress associated with anxiety or phobia related stressors (Snowden, 1999). In addition, the mental health sector in the form of community agencies and private practices has been targeted within the help seeking literature. However, though low utilization can be found across social class, underutilization exists particularly among middle-class African Americans though they tend to have greater access to private insurance compared to their lower income counterparts (US Surgeon General, 1999). One explanation may be that given the level of authority that ministers and physicians have within African American community, utilization trends are higher within

medical and church contexts (Gibbs, Snowden, & Huang, 1996). Furthermore, psychologists and psychiatrists who may often represent a non-African American orientation toward mental health, fuel feelings of distrust that may contribute to the lack of success of these sectors as help-seeking options among African Americans (Thompson, Sanders, Akbar, & Bazile, 2002). Still, scholars suggest that African Americans, across social class, benefit and utilize formal means of intervention for mental health. In fact, recent studies (e.g., Theriot, Segal, & Cowsert, 2003; Bean, Benjamin & Bedell, 2002) call attention to alternative mental health sectors such as self-help agencies and family therapy intervention in an effort to broaden the discussion of options yet to be promoted within African American help-seeking literature.

The Paradox of Informal and Formal Help- Seeking Options

When considering the meso-context of help-seeking, that is, the link between informal systems (e.g., family and friendships) and formal systems (e.g., churches, hospitals, private/public agencies), a potential paradox exists. Rogler, Malgady, and Rodriguez (1989) expound on this through their presentation of Alternative Resource Theory. The underlying premise of this perspective is the following paradox: that the informal system is viewed as both a "help-giving system" and as a "source of distress" (Rogler et al., 1989).

Goldenberg and Goldenberg (2000) further state that for people of color, the family context can be viewed as counter to the context of therapeutic intervention, which tends to view the family as the source of dysfunction. On the other hand, Rogler and colleagues add that help-seeking behaviors for

individuals are typically seen "in the context of interpersonal relations and networks, all in juxtaposition with the mental health agency system" (p. 49). Thus the following question is posed: Can informal resources (i.e., family system) coexist with formal services (i.e., family therapy)? This question is relevant to African Americans as an empirical debate is present regarding the congruency and incongruency in help-seeking among informal social networks and formal services (see Diala, Muntaner, Walrath, Nickerson, LaVeist, & Leaf, 2001; Leaf, Bruce, Tischler, & Holz, 1987; Neighbors, 1984; Snowden, 1998).

Family Therapy as a Formal Help-Seeking Option

A need for family intervention. One of the most widely used studies addressing help-seeking behavior and intervention among African Americans has been the National Survey of Black Americans (NSBA)(Neighbors & Jackson, 1996). Given the comprehensive nature of this study, it represents the first in recent decades to articulate multiple sociocultural experiences among a non-clinical sample of African Americans.

Neighbor's (1985) assessment of problem severity and type was related to the utilization of formal intervention among 1322 respondents from the NSBA. Problem severity was defined as "the point of a nervous breakdown" and "the problem at some level of distress below the nervous breakdown point." (Neighbors, 1985, p. 158). Findings suggest that the majority of respondents reported a high level of problem severity (at or above the point of a nervous breakdown). Also, 41% of respondents stated that "interpersonal difficulty" was the problem type that burdened them most, followed by economic (22%) and

physical (12%) problems. Several points can be made about these findings. First, it is interesting to note that the majority of respondents stated that "interpersonal difficulty" was the most common problem experienced. Secondly, although several professionals were listed that included physicians, clergy and psychotherapists, there was no inclusion of family therapists as mental health professionals. To that end, findings from this national study suggest that there is a need for discussion that explores the role of family therapy as a help-seeking option given that family therapy originates from an interpersonal paradigm.

Family therapy and African Americans. In addition to traditional help seeking networks, the context of family therapy has been articulated as an effective intervention that addresses the role that family functioning plays in promoting and/or inhibiting emotional and mental distress among individuals (Hines & Boyd-Franklin, 1996). Scholars and clinicians through case study analyses (e.g., Laszloffy & Hardy, 2000), inform the field of family therapy as they suggest African American families benefit from family therapy, especially therapy that stems from a culturally sensitive orientation.

A prevailing issue in the study of family therapy with any family of color is the awareness of culture as context (Ariel, 1999). Carter (1995) refers to culture as the "transmission of knowledge, skills, attitudes, behaviors, and language from one generation to the next..." (p. 12). Via this definition, Carter suggests that culture is the process of transmitting behaviors that help give meaning to one's experience. To be sensitive to culture means being sensitive to behaviors and values that give meaning to an experience within a given context.

Family therapy literatures of recent decades have begun to promote an awareness of the cultural context, particularly within African American communities. Boyd-Franklin (1995) leads this trend as she identifies several themes universal to the cultural context of African American families. Some of these themes include: the bond of the extended family, a strong religious orientation and cultural diversity. Kinship networks, both non-fictive (blood) and fictive (non-blood), are regarded as proximal systems that foster adaptation and coping among individuals and families. Religion and spirituality play a central role as noted by Carolan and Allen (1999), who found that among African American couples, spirituality and religious devotion are associated with high levels of intimacy. Cultural diversity pertains to the awareness that there is variation in family structure, gender roles, social class status, and family based adaptation and distress (Hardy & Laszloffy, 1992). Hardy (1989) explored the cultural context by challenging family therapists to move beyond homogeneous ways of describing family functioning and adaptability by illuminating the presence of cultural diversity. Through his "theoretical myth of sameness (TMOS)" paradigm, Hardy notes that there is a prevalence of "neglect of context" particularly in many theoretical frameworks of the field. He argues that a "contemporary view of TMOS" recognizes the primary role that context assessment has in understanding the diverse experiences and needs of African American families.

A conclusion based on the above findings and theoretical perspectives is four-fold. First, empirical findings suggest that both informal and formal options are utilized among African Americans although the use may be paradoxically

intertwined. Secondly, the majority of findings across studies suggest that formal services are, in fact, perceived as help-seeking options among African Americans. Third, the lack of reference to family therapy, yet the presence of interpersonal difficulty as a significant problem-type offers an opportunity for family therapy to be explored as a formal help-seeking option among African Americans. Fourth, family therapy as a formal intervention must take into account the variations within the cultural context of African American family life. There exists "universal" themes of strong kinship networks and religious/spiritual coping which have been linked to optimal functioning of African American's and their families. Thus a valid examination of family therapy as a help-seeking option considers the interplay of culture, social class and race in assessing culturally sensitive treatment options among African Americans.

Contextual Correlates of Attitudes Toward Formal Help Seeking Among African Americans

Informal and formals contexts are generally considered as help-giving systems that encompass a range of contextual factors that influence outcome (Jackson, 1991). However, minimal emphasis is placed on factors as correlated with attitudes toward such help-giving systems among the middle-class (Mannino & Shore, 1984). This view is particularly prevalent in the treatment of African American families (Hardy, 1989). The following section informs this discourse, as contextual factors typically associated with attitudes toward formal help-seeking among African Americans are presented.

Gender

Gender as a contextual factor is pertinent as men and women experience values and ways of being according to gender role experiences (Boyd-Franklin & Franklin, 1998; Vecchio, 1998). Attitudes toward help-seeking are often shaped by such gendered experiences. In a recent study of help-seeking among African American male college students, Duncan (2003) found that students tend to exhibit positive attitudes toward seeking psychological help. In an early study of help-seeking among African American men, Gary, Leashore, Howard, and Buckner-Dowell (1982), found that men would be willing to seek help from both informal and formal help sources. Forty-four percent stated that they believed that friends, family or their wife would be a source of assistance when facing an emotional problem. Forty-two percent stated they would be willing to use a hospital, physician, psychiatrist or community mental health center, while 14% stated that they would rely on self.

With regard to women, in the area of family intervention, it has been found that African American women tend to initiate help-seeking more readily than African American men (Boyd-Franklin, 1989). However, Mays, Caldwell, & Jackson (1996) suggest that for emotional problems, women tend to pursue help-seeking options within community mental health centers in addition to other informal sources instead of private practice offices.

Traditionally, while men and women have been open to multiple help-seeking options, both formal and informal, theoretical explanations account for variation in issues that may affect gendered experiences within the family context. Boyd-

Franklin and Franklin (1998) note that racism and paradoxical expectations result in gendered experiences that often place women and men in a conflictual relational position. While it is promoted that men are to assert themselves as providers for their families, this assertiveness is often interpreted as aggression and is therefore, discouraged in society or the workplace. Furthermore, partners may label men as "inadequate" when they do not convey a level of assertiveness in the home (Boyd-Franklin & Franklin, 1998). Women on the other hand, receive messages suggesting that their independence is paramount, yet they are socialized from a young age to desire the interdependency of a male-female relationship (Dickson, 1993). These mixed messages poses several concerns. On the one hand, mixed messages about independence and assertiveness potentially foster an environment of role-conflict oppose to role-complementarity within the couple or family system. Secondly, this socialization process may result in the absence of help-seeking in the couples or family context, which may lead to isolation and minimal coping skills that result in higher levels of dysfunction or "interpersonal distress" as was noted in earlier NSBA studies (Neighbors, 1985; Broman, 1996).

In summary, given the finding that gender is predictive of formal help-seeking outcome (Leaf & Bruce, 1987; Washington, 1996), the promotion of family therapy treatment as a help-giving system must account for gendered experiences. This perspective is relevant to the present study as family therapy has the potential to challenge African American couples and families to create

healthy relational paradigms that are based on present needs oppose to habit or obsolete intergenerational traditions.

Racial Socialization

Racial socialization as a family process is the way in which African Americans receive race-related messages that can be protective and proactive in nature (Hughes & Chen, 1997; Stevenson, Reed, & Bodison, 1996; Demo & Hughes, 1990). Socialization that occurs among African American girls and boys highly effects attitudes about roles and behaviors they are to exhibit as adults (Dickson, 1993). In a study of racial coping skills among middle class parents and their children, Johnson (1994) found that parents who exhibited proactive racial coping methods had children who had a diverse range of coping methods. Though much of the racial socialization literature has pertained to children, attitudes toward racial socialization and racial group identification among adults have been targeted (e.g., Parham & Williams, 1993; Demo & Hughes, 1990). In a study of racial socialization experiences among adults, Sanders Thompson (1994) found that the majority of participants stated that they had encountered some discussion of race either with their parents (79%) and/or other family members (85%). Furthermore, in addition to race-related messages, the interpersonal dynamics with family and friends within this socialization context also is found to impact adult attitudes and identity development (Demo & Hughes, 1990).

Racial socialization: religious/spiritual coping and extended family caring. Regarding help-seeking and racial socialization, several points exist. First, both adults and children tend to encounter socialization within the nuclear or extended

family context. Stevenson (1994) suggests that the multidimensional nature of racial socialization encompasses multiple domains which include proactive and/or protective ways of dealing with one's minority status and racial group orientation within a traditionally hostile societal context. Second, given that help seeking behaviors such as coping and enhancing of self worth often occur within the socialization context of the family, family therapists must be cognizant of attitudes regarding racial socialization if culturally sensitive intervention is to occur (Stevenson, 1994). Thirdly, Stevenson (1995) identifies positive attitudes toward religious coping and extended family caring as strong indicators of racial socialization among adults and adolescents, which are consistent with universal themes of religious coping and extended family involvement as help-seeking behaviors. Emphasis is placed on these two factors given that help-seeking literature suggests that spirituality/religion and extended family ties are associated with attitudes and utilization of formal therapeutic services (see Diala et al, 2001; McRae, Carey, & Anderson-Scott, 1998; Neighbors, Musick & Williams, 1998). This is reiterated by Boyd-Franklin's (1989) presentation of extended family network and religious involvement as factors that are key contributors of optimal functioning among African Americans.

Given the positive association between these factors and positive psychological well being, it is thus important to explore whether or not African Americans who value religious/spiritual coping socialization and extended family caring socialization would consider family therapy as an help seeking option given the presence of these race-based alternative coping mechanisms.

Perceived Social Support

In addition to racial socialization, perceived social support has also been found to play an intricate role in the adaptation and functioning of African Americans. As a contextual factor, social support pertains to the supportive behavior received from significant relationships (Myers, 1996). Two elements of social support have gained wide attention in the social support literature: *received* social support and *perceived* social support. Received social support pertains to "naturally occurring behaviors that are being provided", while perceived social support pertains to the "belief that such helping behaviors would be provided if needed" (Norris & Kaniasty, 1996). Emphasis is placed on perceived social support as there is evidence that one's perception of support is directly related to emotional and psychological well being (Walls, 1992). In a study of suicide risk and perceived social support among African Americans, Palmer (2001) found that higher perceived social support significantly correlated with lower suicide risk. Looking at correlates of life satisfaction, Vauhn-Sharp (2001) found that perceived social support was positively associated with higher life satisfaction among African Americans. These findings suggest that perceptions of social networks of family and friends impact coping outcome. In assessing the family therapy context, this is relevant to a comprehensive understanding of help-giving systems as the presence or lack of access to support networks may impact attitudes toward formal supports for families experiencing serious personal or interpersonal problems.

Perceived Access to Mental Health Services

As a contextual factor, perceived access to mental healthcare has been a major healthcare disparity issue, particularly for African Americans (Wells, Klap, Koike, & Sherbourne, 2001). In a study of older African Americans, it was found that lack of access to mental healthcare is attributed to insufficient resources, lack of outreach services, lack of transportation, and lack of publicity/information about services that do exist (Biegal, Farkas, & Song, 1997). While this study targeted an older population, a theme of limited access to mental health services (e.g.., publicity, outreach services) has been generalized across age and social class (Snowden, 2001).

Kliman (1998) identifies assumptions that illuminate the role that social class plays. One key theme is that "class position governs access to resources" (p. 53). While managed care and private insurance coverage would seem to increase access to mental health services among the middle- class, low rates of utilization exists highest among this group. In fact, higher rates of utilization occur among their lower income counterparts who tend to rely more on community centers and public welfare agencies (Snowden, 1998). Thus, while access to private mental health services may exist among middle-class African Americans, low utilization rates raise question about non-income related factors that may influence help-seeking within the mental health service sector.

This section raises a contextual question for the field of family therapy. That is, given that the social context of middle-class African Americans, what factors account for utilization rates or overall openness to family intervention? To begin

this discourse, knowledge about attitudes toward family therapy is critical if the field of family therapy desires to succeed in authentic and context sensitive outreach.

Help-Seeking Comfort as a Potential Intervening Factor

The comfort that an individual feels in seeking assistance from another is associated with help-seeking behaviors (Hobfoll & Lerman, 1989). Kaniasty and Norris (2000) note that "the most direct predictor of whether or not an individual receives help is that person's *willingness* to receive help" (p. 546). In a recent study of help-seeking comfort for an emergency crisis across three ethnic groups (i.e., Latina/o, African Americans, Caucasians), African Americans demonstrated the highest level of help-seeking comfort. It was also found that help-seeking comfort is a strong predictor of help-seeking behavior (Kaniasty & Norris, 2000). Furthermore, Halgin, Weaver, Edell, and Spencer (1987) found that help-seeking comfort is associated with positive help-seeking attitudes. Thus, it can be concluded that help-seeking comfort is potentially associated with help-seeking outcome among African Americans.

Ecological literature suggests that an assessment of relationships between variables that considers the role of intervening variables, offers a more context-sensitive examination of phenomenon. Help-seeking comfort allows for the consideration of a personal attribute that may intervene in the relationship between contextual factors and attitudes. Given that help-seeking attitudes play a role in the accessibility of effective intervention of personal or interpersonal distress (Gellis, Huh, Lee, Kim, 2003; Yeh, 2002), it is imperative to explore

people's level of comfort with this process as related to their value of family intervention.

Given the discussion of ecology and implications for family therapy among African Americans, several points are relative to the present study. In an effort to widen the focus of effective intervention among African American families, the field of family therapy must take into account multiple ecological factors. Issues of family socialization, social class, gender, perceived social support and access to mental health services must be examined as they shape a family's ability to adapt, cope, and restructure to a level of homeostasis that leads to optimal functioning of individuals in the context of their daily culture. Also, if family therapy as a formal option is to be considered in the empirically valid study of help-seeking among African Americans, then a research orientation that is "systemic and context oriented" is needed, as person-centered ecological research considers the context in which behavior and outcome emerge (Spencer, 1999). Including a context-sensitive variable such as help-seeking comfort, meets this challenge, as it allows for a multivariate approach that goes beyond the bi-variate relationship between predictor and outcome variables.

Attitudes Toward Formal Therapeutic Intervention Among African Americans

Beliefs about a phenomenon often influence reactions to that phenomenon (Paolucci, Hall, & Axinn, 1977). Based on this premise, beliefs regarding a particular intervention will influence the willingness to embrace that intervention as a help-seeking option. Given that beliefs often translate into behavior to be

carried out (Paolucci et al., 1977), understanding attitudes toward family therapy can assist scholars and clinicians in understanding the gap between the promotion and utilization of family therapy a help-seeking option.

With regard to attitudes toward help-seeking within the family context, much has to be inferred from the help-seeking literature. While two known studies (Richards, 1993; Duncan, 2003) explore attitudes toward therapy among middle-class African Americans, little is known about attitudes toward *family* therapy among a non-clinical population of African Americans.

As literature suggests, there are no known current epidemiological studies of family therapy among African Americans (Bean, Perry, & Bedell, 2002). Apart from single clinical case studies, empirical research regarding African American attitudes toward family therapy is non-existent. Thus, to inform the present study, a trend of research on African Americans' general attitudes toward mental health intervention is presented. Also, one known study exploring attitudes towards of psychotherapy among middle-class African Americans are presented in an effort to infer from findings, the benefits of exploring attitudes among African Americans from a particular context (e.g., social class).

Research Trends

Shared beliefs and behaviors combine to shape attitudes toward mental health services among cultural groups (Dana, 1998). These experiences influence the acceptability and credibility of such help-giving systems (Dana, 1998). Non-institutionalized African Americans traditionally have not had access to formalized mental health services (Vega & Rumbaut, 1991). Thus, a reliance

on help seeking-options (e.g., family, religion/spirituality) within their cultural framework has taken precedence.

Openness to mental health services. Despite limited access, low rates of self-referrals, and early termination rates (Barbarin, 1996), it is suggested that African Americans do value mental health services (Leaf, Bruce, Tischler, & Holzer, 1984). In a recent analysis of a national probability sample, findings suggest that African Americans, both from a clinical and non-clinical context, have positive attitudes toward seeking mental health services (Diala, Muntaner, Walrath, Nickerson, LaVeist, and Leaf, 2001). As efforts are made to address low utilization rates, these findings suggests that other contextual issues may be influencing the incongruency between attitudes and utilization outcomes.

Cultural influences and attitudes toward mental health services. It has been postulated that the cultural experiences of African Americans influence their attitudes about mental health services. Delphin and Rolluck (1995) found that ethnic identity and alienation experiences among African American college students affect attitudes and knowledge of mental health services. For example, those students who had a Pro-black/Anti-white ethnic identity orientation were less likely to value such services. Consequently, those who had experienced campus alienation and minimal access to mental health resources were also less likely to value services. Another finding was that knowledge and attitudes predict mental help-seeking (Delphin & Rolluck, 1995). The theme of cultural relativity is echoed in Thompson, Akbar, and Bazile's (2002) study of attitudes toward psychotherapy among African Americans. In their qualitative study involving 201

participants, key barriers to mental help-seeking included: cultural stigma of mental illness, mistrust, expense, culturally insensitive service delivery and cultural misunderstanding (on the part of both potential clients and practitioners). Findings further suggested that cultural sensitivity and outreach on the part of mental health professionals are factors important in combating a cultural context of low utilization (Thompson et al., 2002). Thus, facets of the cultural context of help-seeking among African Americans may ultimately impact African Americans' attitudes and utilization of services.

Attitudes toward therapy among middle-class African Americans. Racism in the form of institutional glass ceilings and cultural indifference, often lead to feelings of isolation and heightened levels of distress among middle-class families. Thus, it is imperative that assessment and treatment of African Americans and their families taken into account social class (Hardy & Laszloffy, 1992).

There is no readily known empirical study of family therapy that considers the middle class social context. However, Richards (1993) explores underutilization of mental health intervention among this social class, emphasizing areas of cultural mistrust, reluctance to self-disclose and alternative coping strategies. In a study of middle-class African Americans and their European American counterparts, Richards found that middle-class African Americans and European Americans both seem willing to seek therapy. This finding is in despite of the fact that African Americans reported higher cultural mistrust than European Americans. Furthermore, African Americans reported a greater reliance on

extended family, friends, and the religious community than their European American counterparts. Other findings suggest that middle-class African Americans are no more likely to use passive coping mechanisms and are no different in the level of disclosure to therapists compared to European Americans in the sample. Similarly, with regard to gender, it was found that women, regardless of race, prefer a same sex therapist more so than men. Finally, a reliance on family coupled with gender accounted for willingness to seek therapy for both racial groups.

Several conclusions are made from this study. For instance, though the sample size (i.e., 59 African Americans; 48 European Americans) may have affected the statistical validity of the predictability of several factors, credibility exists in that among this middle-class sample, for African Americans, the use of informal networks co-exists with an openness to seek therapy. Also, the effort to explore attitudes within an under researched social class population introduces opportunity for further comparative studies to be done that examine context related variables within this sociocultural milieu. Moreover, given that gender and social support account for willingness to seek therapy, it can be concluded that these factors are pertinent to a context-sensitive study of help-seeking among a middle-class sample of African Americans. Finally, the non-deficit based orientation of comparing African Americans and European Americans promotes an asset-based paradigm for studying mental health attitudes that can be generalized to various areas of mental health including the family therapy context.

A Demographic Profile of Middle-Class African Americans

Considering the cultural context of African Americans, this study proposes that social class as a determinant of social position can influence access to resources and attitudes that ultimately impact service utilization. The following section presents current trends of middle-class African Americans, an underrepresented population within current help-seeking literature. Characteristics of "middle-class" status and demographic trends are presented.

What Constitutes the African American Middle Class?

There is no clear consensus on how middle-class is defined (Pattillo-McCoy, 1999). In fact, the US Census does not officially designate what constitutes middle-class (US Census Bureau, 2000). Yet throughout history, indexes based on access to land and homeownership, occupation, educational attainment, household income and self-affiliation have been consistent in efforts to clarify ranks of economic and social categories (Frazier, 1957; US Census Bureau, 2000; Haynes, 2001). With regard to African Americans, sociological discourse on the middle-class status did not fully blossom until the 1950s, with designations based on characteristics such as skin color and educational access. Likewise, plantation and family affiliation as well as ex-slave versus free Black status fostered social ranking during the time of slavery and the post slavery reconstruction periods (Billingsley, 1968). With the attainment of land, education and geographical mobility during the World War I and II, and the Civil Rights eras, a trend of social and economic differentiation continued to expand within African American communities. Despite the establishment of communities of free

Blacks in the North during the late 1800s and early 1900s, it was the free communities of the South that achieved the greatest class structural divide (Frazier, 1957). Though many African Americans migrated to the North during the industrialization period, a "New South" migration is taking place. Of the total increase in the population of African Americans, 58% has occurred within the South, with a growing middle and upper class on the rise, according to recent Census data (Frey, 2001). To that end, despite an inconsistent declaration of what constitutes middle-class, a discussion of characteristics associated with middle-class status is necessary in an effort to identify this social context as related to unique social needs and attitudes pertinent to this population of African Americans.

Income. Despite the unofficial description of middle-class status, there is still much discussion about the categorizing of households and individuals within this class designation. Recent census data suggests that households earning at or above the $50,000 income range are well into what is categorized as the "middle-class" income bracket. Findings suggest that 3 out of 10 (30% of African American family households) have an income of $50,000 or above, which constitutes a middle-class or higher status (Frey, 2003). Robinson (1997), a Harvard statistics researcher, studied the African American middle-class trends between the 1970s through 1994. His findings support research that implies that the "Black middle- class" has varied income-based designations. Robinson noted that in 1994, analysis trends and self-ratings placed middle-class African American households between $15,000 and $49,999. Yet, he suggested that it is

more accurate to identify the income range as $25,000 and $49,999 given that the 1994 poverty line for a family of four was set at $15,141(Robinson, 1997). More recently, dividing household income into ten categorical ranges, the 2002 Census data showed that among African American households, at least 29%, fell into the 7th and 8th categories which included the $25,000-49,000 income range. Fifteen percent fell into the 9th categorical range of $50,000-74,999, which constituted upper middle-class and lower upper-class categories. A 10th category, ranging $75,000 and over, constituted the upper-class range. Thus, taking into account data from Robinson's research and the 2002 Census, there is a substantial number of African American households that fall within the seemingly middle-class economic bracket, despite the decline of middle-class status since the 1970s (McAdoo, 1997; Robinson, 1994).

Home ownership and residential lifestyle. Middle-class migration has been and still is intended for the inquiring of improved housing, low crime community living, increased access to competent school systems and an improved lifestyle now affordable with higher income (Pattillo-McCoy, 1999). In a recent study of Nepperhan-Runyon Heights, one of the first intergenerational middle-class suburbs of metropolitan New York, Haynes (2001) assesses the lifestyle and residential aspirations of this predominately African American community. Emerging from a working-class population of Southern migrants and West Indian immigrants, the aim of this community was an opportunity for quality living and economic stability. A qualitative and statistical analysis of historical and census records suggest that occupational security leading to ownership of private

property, interconnectedness and intermarriage of generations of upwardly mobile residents, along with political opposition to regress to impoverished standards of living, were hallmark to this community (Haynes, 2001). Though the study of Nepperhan-Runyon Heights is a case study of the middle-class progression of one community, the theme of home ownership and quality residential occupation are central to the discourse of the hope of upward mobility among African Americans.

Educational background. Educational attainment is yet another characteristic commonly associated with middle-class status. Since the time of slavery, where literacy was forbidden, to current agendas promoting quality education, there has always existed an association between access to education and upward mobility. In a recent study involving sociocultural characteristics of the middle class, educational level was as a determinant of middle-class status (see Alba, Logan, & Stults, 2000). In an analysis of Census 2002, Frey (2003) identifies, "knowledge workers," those middle-class African Americans characterized as having both "middle-class" incomes and a college education. He notes that in the top 15 metropolitan areas with African American college graduates (e.g., San Jose, CA; Atlanta, GA), African American middle class populations have both a college education and at least a middle-class income. Though scholars suggest that middle-class status has declined and stabilized since the 1970s and 1980s, a steady rise in college attainment among African Americans (e.g., 8.3% in 1980, to 11.4% in 1990, to 14.3% in 2000) (Frey, 2003), suggests a progressive increase in educational attainment among African Americans.

Occupation. Job position has also been commonly associated with middle-class status. Current trends suggest that numbers of African Americans in middle-class job positions have increased (Smith and Horton; 1997). In their analysis of such middle-class trends, Smith and Horton found that only 385,586 African Americans had obtained what constituted middle class positions (e.g., business owners, managers, officials) by the 1960s. However, that number grew to well over 1 million by the 1980s with an increase to 7 million by 1995 (Smith & Horton, 1997). Recent census data shows that service occupations, managerial, and professional positions are among the highest ranking positions among African Americans (US Census Bureau, 2002). However, these positions, which have traditionally been affiliated with upward mobility, are not always positively correlated with movement to higher social class levels (Pattillo-McCoy, 1998). This outcome is often due to job and salary increase discrimination, low patronage of many black owned businesses and a societal devaluing of traditional positions (e.g., teaching) thus altering the role that occupation plays in upward mobility trends for African Americans. This reality gives a context-sensitive picture of the disproportionate relationship between occupation and middle-class status.

Summary

Chapter 2 provides an overview of key theoretical frameworks and research findings with regard to help-seeking patterns and behaviors among African Americans. Emphasis was placed on looking at contextual factors critical to this study, that is, gender, perceived social support and access to mental health

services as well as family socialization attitudes that all are found to be associated with help-seeking among African Americans. Finally, middle-class as a complex and multidimensional construct was presented. Chapter 3 provides specific methodological procedures that were used to operationalize research questions pertinent to this study.

CHAPTER 3

METHODOLOGY

The aim of the present study is to add empirical evidence of the attitudes towards family therapy among middle class African Americans to the family therapy literature. Specific objectives of this study is to:

1. identify how likely will a sample of middle-class African Americans view family therapy as an intervention option within their help-seeking context;
2. explore the influence of contextual factors such as gender, racial socialization domains such as religious/spiritual coping and extended family caring, perceived social support, and perceived access to mental health services on attitudes toward family therapy;
3. examine whether or not one's *comfort* with help-seeking, influences the relationship between contextual factors and attitudes toward family therapy;
4. increase empirically based knowledge of attitudes toward family therapy among African Americans from a specific social class and contextually sensitive perspective;
5. better understand help-seeking behavior among middle-class African Americans to promote effective intervention and family health policy initiatives that take into account this sociocultural context.

Instrumentation

The following section is a description of each instrument that was used to operationalize variables of interest in the present study. Information includes a description of the variable being operationalized, the name of the instrument, the author and purpose of the instrument, sample questions, administration and standardization procedures, number of scale items in the original instrument, subscale information and reliability information. Finally, demographic information pertinent to the present study is identified.

Racial Socialization

The parent version of the Scale of Racial Socialization for African Americans (SORS-P) was utilized in the present study. This measurement tool examines to what extent do adults value messages about religious/spiritual coping as effective coping and self-empowerment mechanisms that are transmitted from African American parents to their children. In 1993, Howard Stevenson, beginning with a 35-item pilot study, devised the original complete scale. The purpose of this scale was to assess African Americans' level of acceptance of race-related messages reflecting protective (e.g., extended family caring) and proactive (e.g., racial pride) elements of their cultural framework (Stevenson, 1993; Stevenson, 1996).

The 35-item self-administered scale initially included items that were scored on a 4-point Likert style scale ranging from strongly disagree (1) to strongly agree (4). Based on themes common in the racial socialization literature (see Demo & Hughes, 1990; Boykin & Toms, 1985), content areas of the original scale include

race-related messages pertaining to education, extended family involvement, spirituality, racism and society, African American heritage and pride (Stevenson, 1996). Reliability analyses resulted in the adding of 10 items to improve representation of specified domains. Also, the preliminary 4-point Likert style scale was changed to a 5-point scale to allow for greater response variability (Stevenson, 1996).

Stevenson (1994) administered a final 45-item, 5-point Likert-style scale version to 200 African American adolescents who were participating in a summer job program. Based on Stevenson's factor analysis, four factors from a five-factor model were determined to be most significant. The four factors that emerged were *spiritual/religious coping* (α=.74); *extended family caring* (α=.70); *cultural pride reinforcement* (α =.63); and *racism awareness teaching* (α =.60)(Stevenson, 1996). Though *life achievement struggling* was a fifth factor, it was omitted from the model due to low internal consistency.

While emphasis was placed on administering the total scale to adolescents (e.g., SORS-A), the original compiling of items came from racial socialization themes also found to be present among African American adults (see Marshall, 1995; Parham & Williams, 1993; Sanders Thompson, 1994). Thus, construct validity have been found to remain consistent among adults. Nevertheless, continued analyses are currently underway with the parent version of this scale (SORS-P), which was administered to adults (H. Stevenson, personal communication, January 27, 2004).

Religious/spiritual coping socialization. In the present study, spiritual/religious coping socialization (SRCS) as a subscale is used since many African Americans report experiencing a family environment that promotes prayer, faith in God, and church attendance as effective ways of coping with distress and hostile social conditions (McRae, Carey, & Anderson-Scott, 1998). This subscale has moderately high reliability

(α =.74) and includes items such as "It is important for families to go to church or mosque where spiritual growth can happen" and "A belief in God can help a person deal with tough life struggles."

Extended family caring socialization. Extended family caring socialization (EFCS), a subscale, pertains to those messages that convey the importance of extended family involvement in child rearing and management of family life (Stevenson, 1996). With one of the higher reliability scores (α =.70), this subscale was used in the proposed study as research confirms that many African American families often rely on extended family involvement and social support in the effective rearing of children (Stevenson, Reed, & Bodison, 1996). Thus, EFCS is used to identify attitudes pertaining to this domain of socialization that includes statements such as "Relatives can help Black parents raise their children" and "Children who have good times with their relatives become better people."

Perceived Social Support

The Perceived Social Support Scale (PSSS) is utilized for the present study in order to assess to what level do individuals rely on family, friends or a significant

other for support for emotional, problem solving and decision-making needs (Blumethal, Burg, Barefoot, Williams, Haney, & Zimet, 1987). This 24-item instrument has a 5-point Likert scale ranging from strongly disagree (1) to strongly agree (5). In addition to tallying a total score, 3 subscale scores may be obtained which include receiving support from family, friends, or a significant other. Examples of questions include "There is a special person who is around when I am in need" and "I get the emotional help and support I need from my family."

Initially standardized from a sample of 275 students at Duke University, the PSSS has a fairly high level of internal reliability for the total scale (α=.88) as well as for the subscales (e.g., family α =.87; friends α =.85; significant other α =.91) (Blumethal et al., 1987). Test-retest reliability for the total and subscales (ranged from α=.85-.72) confirmed maintenance of internal reliability.

Perceived Access to Mental Health Services

In an effort to identify people's perceived access to mental health services, four descriptive items were developed for the present study. Specifically, items were operationalized where participants provided a "yes" or "no" response to questions such as: "I have mental services available to me or my family through a workplace, church, school, private practice office, hospital, or community agency" and "I could afford mental health services either through health insurance or some other financial means."

Attitudes Toward Family Therapy

The Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS) (Fischer & Turner, 1970) was adapted for the present study. The adaptation involved replacing such statements as "Although there are clinics for people with mental health troubles, I would not have much faith in them" with "Although there are therapeutic offices for couples and families with relationship troubles, I would not have much faith in them."

The ATSPPH Scale was devised in collaboration with clinical psychologists. These trained professionals had been experience in multiple mental health settings, which included state/federal hospitals, clinics, schools, and private practices devised the original attitude items. Construct validity was established as the original items were randomly ordered and subjected to judgment by a panel of qualified psychologists and psychiatrists (Fischer & Turner, 1970).

Several waves of testing were conducted with administration to different groups of college students (total n=815). Upon final standardization procedures, 29 remaining items were considered as the final version with a 4-point Likert scale varying from probable disagreement (0) to probable agreement (3). An alpha of .83 suggests fairly high internal reliability.

In an effort to account for greater variability in scores, the adaptation, the Attitudes Toward Family Therapy Scale expands the likert scale from 4 to 5 points. This allows for greater consistency with other instruments given that that the 5-point scale is a more commonly used rating scale (Kent, 2001).

Help-Seeking Comfort

Hobfoll and Lerman (1989) devised a 10-item measure to quantify participants' comfort with seeking help for various needs from family and friends. Examples include, "How comfortable do you feel requesting material aid from friends if you are in need of such aid?" and "How difficult is it for you to request emotional support from family if you have problems or are undergoing a crisis?"

There were three waves of administration of the help-seeking comfort items. Phase 1 involved an administration to 101 females who were accompanying children with medical needs. A Cronbach alpha of .81 suggests fairly high internal reliability for this phase. Phase 2 involved a follow up administration that occurred 11 months to 1 year after Phase 1 completion. To confirm objectivity of self-assessments with the social support scales, Phase 2 involved an administration to females (n=101) and their spouses (n=78). Mean scores between Phase 1 (29.88) and Phase 2 (28.65) suggests that scores remained reliable for the female participants despite about a one-year lapse between Phase 1 and Phase 2. Correlation analyses yielded decent agreement between female and spousal scores (r=.58) which also adds to the validity of the comfort seeking items (Hobfoll & Lerman, 1989).

Demographic Form

In order to gain a comprehensive assessment of a majority middle-class sample, the demographic form requested that participants provide their age, gender, highest degree earned, occupation, income level, home ownership status, self-rating of social class, marital status, parental status, religious

affiliation, and age. Screening of participants for middle-class status was based on an assessment of the demographic questions in addition the following criteria: the completion of at least a bachelor's level college degree or a dual earner family income. The selection of these factors was based on recent census analyses and studies of social class among African Americans that suggest that a college education and dual earner household income level tend to account for upward mobility with regard to a middle-class social category (Frey, 2003; Pattillo-McCoy, 1999).

To be as concise as possible with regard to the class category of participants, Hollingshead's Factor Index of Social Status (1975) was utilized. This multidimensional index incorporates one's educational level with a range of "less than 7th grade [1]" to "graduate professional training [7]"; occupational level ranging from a score of 1 (e.g., "service workers") to a score of 9 (e.g., "higher executive"). For a total score calculation, occupation is typically given a factor weight of 5, while education is given a factor weight of 3 (Hollingshead, 1975). Thus, a person scoring of 8 for occupation and 7 for education yields a total score of 61 (8x5=40; 7x3=21; 40+21=61). However, updated use of this scale switches factor weights (e.g., education=5; occupation=3) among African Americans as educational level, more so than occupation, has been found to carry more factorial weight when detecting social status within this population (McAdoo, 1978).

Conceptual and Operational Definitions

The following section encompasses the following components: a) a presentation of variables of interest and instruments that are utilized to operationalize these variables; b) a description of research questions and hypotheses; c) the research design format; e) a description of participants, procedures, analyses and a chapter summary.

Table 1 is an illustration of variables and the methods used to operationalize them.

Table 1. *Conceptual and operational definitions of independent, dependent, and potential moderator variables.*

CONCEPTUAL DEFINITION	OPERATIONAL DEFINITION
Independent Variables	
1. **Gender**	1. Designation of "male" or "female" on the demographic form
2. **Spiritual/religious coping socialization** (value of religion /spirituality within the family, as an effective racial coping mechanism)	2. Score obtained from the 7 item-Religious Coping subscale of the Scale of Racial Socialization for African Americans (Stevenson, 1993a) Sample questions: • It is important for families to go to a church/mosque for spiritual growth. • A belief in God can help a person cope through life struggles.
3. **Extended family caring socialization** (value of extended family involvementin child-rearing as an effective racial coping mechanism)	3. Score obtained from the 11 item-Extended Family Caring subscale of the Scale of Racial Socialization for African Americans (Stevenson, 1993a) Sample questions: • Relatives can help African American parents raise their children. • Children who spend a lot of good time with their relatives become better citizens.
4. **Perceived social support** (how one views the level of support obtained from a significant other, family, or friends)	4. A total score obtained from the 12 item Perceived Social Support Scale (Blumenthal, Burg, Barefoot, Williams, Haney, & Zimet, 1987). Sample questions: • There is a special person who is around when I am in need. • I get the emotional help and support I need from my family.
5. **Perceived access to mental health services** (whether or not an individual has access to mental health services based on locale, finances, time availability and the presence of a therapist in the	5. Designation of "no" (0) or "yes" (1) on the demographic form (4 items) Sample questions: • I have access to mental health services for a family member or myself through my workplace,

community)	church, a private office, hospital, or community agency. • I could afford mental health services either through health insurance or some other financial means.
Dependent Variable	
6. **Attitudes toward family therapy** (values that people hold toward the use of family therapy as a help-seeking option)	6. A total score obtained from the 29-item Attitudes Toward Seeking Professional Psychological Help Scale (Fischer & Turner, 1970)(adapted for present study) DOMAINS: 1) need for family therapy 2) stigma associated with family therapy 3) openness to family therapy 4) confidence in the success of family therapy "Adapted" sample questions: • Although there are therapeutic offices for couples and families with relationship troubles, I would not have much faith in them. • People with serious couples or family disturbances would probably feel most secure in a good therapeutic office setting.
Potential Moderator Variable	
7. **Help seeking comfort** (identifies level of comfort with asking friends or family for help with emotional stress, material needs, task completion or decision-making)	7. A total score obtained from the 10-item Help Seeking Comfort Scale (Hobfoll and Lorman, 1989) Sample questions: • How difficult is it for you to request emotional support from friends if you have problems or are undergoing a crisis? • How difficult is it for you to request advice or information from family when you need it?

Research Questions and Hypotheses

The following section is a presentation of two key research questions established for the proposed study. Each question includes theoretical themes as related to variables of interest, followed by selected hypotheses. For clarity purposes, all independent variables are referred to as contextual factors. Help seeking comfort (HSC) is presented as a variable that potentially moderates the relationship between contextual factors and attitudes toward family therapy.

Research Question #1:

What are attitudes toward family therapy given the interplay between race (African American), social class (middle-class status) and culture (contextual factors)?

As research suggests, utilization of mental health services are low. Yet, studies have been found to show that for serious emotional distress, African Americans do consider mental health treatment as an help-seeking option. Articulating this for the middle-class is complex, given that there is minimal empirical data found on their attitudes toward therapeutic intervention (Bagarozzi, 1995). Nevertheless, Richards (1992) found that although middle-class African Americans exhibited greater cultural mistrust, they are no different in their willingness to seek therapeutic intervention when compared to their Caucasian counterparts. Thus, it is was hypothesized that:

Hypothesis 1: Middle-class African Americans will have moderate to very positive attitudes toward family therapy.

Research Question #2:

Considering context-sensitive factors such as gender, racial socialization domains such as religious/spiritual coping and extended family caring, perceived social support, and perceived access to mental health services, how might such factors influence attitudes toward family therapy?

Gender differences and similarities often shape help-seeking attitudes and beliefs. While this is a universal theme, it has also been found among African Americans (Plowden & Miller, 2000; Snowden, 2001). Gendered socialization can often hinder or foster healthy attitudes toward formal intervention. Moreover, variation exists in men and women's help-seeking attitudes and beliefs with regard to family based intervention(Pearlmutter, 1996). Thus, the following is hypothesized:

Hypothesis 2: Women tend to exhibit more favorable attitudes toward family therapy than men.

Racial socialization factors such as religious/spiritual coping (RSCS) and extended family caring (EFCS), are associated with culturally sensitive childrearing within families and self-competency among African American adults (Stevenson, 1996; Demo & Hughes, 1990). As coping mechanisms, these processes provide experiences that buffer the impact of personal and societal stressors on families, thus potentially minimizing an interest in outside or formal intervention. Thus it is hypothesized that attitudes toward family therapy intervention are negatively associated with heightened religious/spiritual coping

and extended family caring socialization. This is specifically outlined in the following hypotheses:

Hypothesis 3: As positive RSCS attitudes increase, there is a decrease in positive attitudes toward family therapy.

Hypothesis 4: As positive EFCS attitudes increase, there is a decrease in positive attitudes toward family therapy.

Perceived social support (PSS) pertains to whether or not individuals believe that they can rely on family and friends for help (Ulbrich & Warheit, 1989). Though African Americans traditionally perceived that they can rely on family and friends for social support, help-seeking within this network lessens with the presence of emotional distress. Furthermore, reliance on family decreases when there is interpersonal distress (Taylor et al., 1996). Thus, African Americans may be more open to family therapy when they perceive that social support is low. Therefore, the following is hypothesized:

Hypothesis 5: As PSS decreases, there is an increase in positive attitudes toward family therapy.

Access to mental health services has increased in recent decades with the advent of community mental health agencies and managed healthcare programs. Whether or not individuals perceive that they can access such services can influence beliefs and utilization trends (Thompson, Akbar, & Bazile, 2002). With greater access to educational and financial resources, middle-class African Americans are more likely to have access to mental health services compared to

their lower income counterparts (Neighbors, 1990). Given the association between utilization attitudes and accessibility (Stefl & Prosperi, 1985), the following is hypothesized:

Hypothesis 6: Those who have perceived access to mental health services have more positive attitudes toward family therapy.

Research Question #3:

Given that how comfortable one feels with help-seeking may impact attitudes toward family therapy, does help-seeking comfort account for the relationship between contextual factors and attitudes toward family therapy?

Leaf and Bruce (1987) suggest that intervening variables may account for the relationship between various factors and help-seeking attitudes. How comfortable one is with asking for help is associated with help-seeking attitudes and behaviors (Kaniasty & Norris, 2000). Diala and colleagues (2001) found that, among African Americans, those who felt "very" or "somewhat" comfortable talking with a mental health professional also had positive attitudes towards mental health services. Thus, help-seeking comfort (HSC) may exist as a moderating factor, that is, one that may help to explain the relationship between contextual factors and attitudes toward family therapy. It should be noted that when incorporating a moderator variable, several points should be made. First, in a design model involving a moderator variable, it is assumed that significant relationships must exist between independent and dependent variables. Secondly, a significant relationship

should exist between the moderator and the dependent variables. Additionally, a moderator variable is treated as a categorical variable for statistical clarity, thus it is typically established as a high/low variable (Baron & Kenny, 1986). For example, it may be assumed that someone with access to mental health services and high help-seeking comfort may have more positive attitudes toward family therapy than someone with the same access to mental health services but who reports low help-seeking comfort. Therefore, the following is hypothesized:

Hypothesis 7: Women with high HSC have more positive attitudes toward family therapy compared to women with low HSC.

Hypothesis 8: Men with high HSC have more positive attitudes toward family therapy compared to men with low HSC.

Hypothesis 9: When there is high HSC, there is a change in the relationship between contextual factors and attitudes toward family therapy.

Research Design

This study was carried out in a quasi-natural setting and is cross sectional in nature. A convenience sample of African American male and female participants was identified, majority of whom are of a middle-class social status. This inferential survey design utilized multivariate analyses.

Targeted Participants

The 2002 Census Bureau of the United States suggests that there has been steady economic progress since 1990 in two geographical regions- the Midwest

and the South. Despite the mobility decline of the 1970s through the 90s, recent analyses suggest that there are suburban and metropolitan areas of the South that are gradually advancing in access to college education, and professional or managerial jobs (e.g., Lewis Mumford Center, 2002). In fact, Frey's (1999) recent analysis of the 1990s population growth suggests that 58% of the African American growth occurred in the South. He also found that "New Blacks" of the South have a middle-class status- 19% college graduate, and 30% professionals and managers in the workplace. To that end, a non-random convenience sample of a middle-class population from a southern community within United States was selected for the present study. This researcher, given her status as native to this area of the country, contacted local educators, ministers, social organizations, and churches in order to generate a list of names of potential participants. The researcher through a snowball sampling process (Babbie, 1998), then identified participants based on middle-class screening and inquired about their knowledge of other potential participants.

A minimum of 120 participants was selected based on a power analysis completed for this study (see the following "Procedure" section). Oversampling occurred to account for incompletion or missing items. Adults 21 years and older were targeted. In an effort to establish an equal distribution of males and females, a recruiting of males through spousal contacts and local men's social organizations occurred. As previously stated, there was an attempt to control for middle-class status as participants were screened for home ownership, college completion, occupational history, and/or income level as these have been status

symbols that are typically used when identifying middle-class category distinctions (e.g., Alba, Logan, & Stults, 2000; Pattillo-McCoy, 1999). Self-rating of middle-class status was also obtained as this criteria has been included in efforts to comprehensively assess this status affiliation (see McAdoo, 1997) among the present sample.

Procedure

Power analysis, the process through which statistical calculations are conducted as to identify an appropriate sample size, is a critical step in current social science research trends. In the social science field, a statistical calculation for sample size, commonly referred to as the "effect size" (i.e., d= some value) ranges from small (d=.10 to .25), medium (d=.25 to .50 range), and large (d= greater than .50) (Cohen, 1988). Identifying the effect size (d) informs the researcher of the sample size needed in order to detect significant variations between variables and units of analysis (Cohen, 1992). Furthermore, power of significance is an additional calculation that informs the researcher of the probability of rejecting a hypothesis that states that an insignificant relationship occurs between variables. For the present study, an effect size (d=.70) was determined. Analyses revealed that this effect size yielded a power of .91 in order to detect a significant relationship between the moderator variable (help-seeking comfort) and the dependent variable (attitudes toward family therapy). For the main effect, that is, a detection of significant relationships between independent (contextual) and dependent (attitudes) variables, the effect size of .70 yielded a power of .79. A power analysis accounting for these effect sizes

and power of significance suggests that a minimum sample size of 120 participants be used in order to obtain statistically significant detections of the main effects of independent (contextual factors) and moderator (help-seeking comfort) variables on the dependent variable (attitudes toward family therapy).

Confidentiality

In accordance with the Michigan State University Committee on Research Involving Human Subjects (UCHRIHS), the following precautions were taken as to minimize any potential risks to participants and researcher biases:

1) The consent form included the following:
    a. A brief description of the study;
    b. A option to voluntarily withdraw from the study at any time;
    c. A notice in the consent form stating that names and individual demographic information will not be analyzed. Rather, analyses of grouped data will take place;
    d. A statement suggesting that questions may be directed to the doctoral committee co-chairs, researcher, and/or Dr. Peter Vasilenko, Chair of UCHRIS;
    e. A statement suggesting that minimal psychological risks are present, particularly given that names will not be identified in the final analysis of the group data set;
    f. A statement informing the participants of anticipated time (30-50 minutes) and offer of refreshments, information to take home regarding family therapy services, a $7 gift card to a local

restaurant and an opportunity to have one's name drawn for a $100 raffle.

2) Participants were asked to personally detach consent forms from survey packets to be placed in a separate envelope upon completion of the survey.
3) Research assistants were informed of UCHRIS guidelines and asked to double check survey completion by participants only with consent forms detached from survey.
4) Data was coded and entered by the Michigan State University Institute for Public Policy and Social Research as to minimize researcher bias.

Data Collection Procedure

This researcher and assistants contacted individuals who had been identified as potential participants. The purpose of this initial phone contact was to introduce the participants to the study and to inquire about interest and availability. During this initial phone contact, the researcher or assistant a) explained the initial intent of the study; b) requested that the participant verbally commit to at least one of the several scheduled group administration times; and d) requested that the individual refer the researcher or assistant to two or more individuals that may be interested in the study.

A group format was utilized for the present study. This consisted of administering surveys to groups of individuals in a local library as donated by a local elementary school principal. Survey administration involved providing participants with survey materials and pencils. An initial presentation by this

researcher took place and involved a general explanation of the study and the procedure of survey completion. Participants were asked to read and sign the consent forms. They were then asked to detach the consent form from the survey packet. A research assistant placed all forms in a designated envelope. Participants were allowed up to two hours to complete the survey. Refreshments were provided during this time. Participants were also provided with educational materials regarding family therapy as a profession after survey completion. A raffle slip was attached to the initial consent form and consent forms were gathered. The raffle for $100 was announced after the final group administration took place and the winner was notified via phone call and mailed a money order.

Analyses

Several procedures were used to examine the relationship between contextual factors and attitudes toward family therapy. Descriptive statistics were calculated in order to determine the demographic profile of this sample. This included a frequency distribution and central tendency findings for each of the independent variables (contextual factors), and the dependent variable (attitudes toward family therapy). Correlational analyses were conducted as to identify how significant the relationship is between the independent variables and dependent variable. T-tests were conducted as post-hoc analyses in order to test for significant within-group differences.

Additionally, multiple regression analyses were conducted to determine which model (independent variable accounting for the dependent variable) is the best fit when other independent variables are controlled for. This included a hierarchical

regression analysis in order to identify which contextual variables are more likely to account for or predict attitudes toward family therapy in comparison to others.

Finally, a moderator variable (help-seeking comfort)(HSC) was analyzed as the intervening variable possibly affecting the strength or direction of the relationship between contextual factors and attitudes toward family therapy.

Summary

Chapter 3 is an outlined presentation of key objectives, operational and conceptual definitions of factors most relevant to this study. Research questions and hypotheses were presented along with procedures that involved efforts to maintain confidentiality and objective data collection. Intentions for statistically analyses were also presented with the consideration of specialized analyses when considering the role that a moderator may play within a bi-variate (independent variable-dependent variable) model.

The following chapters include findings as related to research questions and hypotheses. Specifically, Chapter 4 is a presentation of the demographic profile of the identified sample and statistical findings. Chapter 5 is an interpretative discussion of key findings, followed by limitations and implications as related to policy and clinical relevance to this population.

CHAPTER 4

RESULTS

The present study examined attitudes toward family therapy (ATFT) among a sample of middle-class African Americans from a southern community within the United States. Findings suggest that participants exhibit positive attitudes toward family therapy as a help-seeking option. Also, it was found that participants perceive that they have informal social supports (e.g., family, friends) (PSS), while still believing that family therapy can be an effective formal intervention.

It was also found that participants value religious/spiritual coping socialization (RSCS) and extended family caring socialization (EFCS) while still valuing family therapy as an effective family support option. Additionally, participants reported a belief that they have access to mental health services in their community (ACCESS). Such belief also seems to predict positive attitudes toward family therapy.

Furthermore, participants reported a moderately high level of comfort with seeking help (HSC) in time of need. Results also suggest that this comfort level predicts attitudes toward family therapy.

Finally, it was found that both women and men exhibit positive attitudes toward family therapy, though women tend to exhibit more positive attitudes compared to men. Also, as with access to mental health services and one's help-seeking comfort, gender was found to predict attitudes toward family therapy.

This chapter is a presentation of the above-mentioned findings after data coding and statistical analyses were conducted with this sample. The chapter is

divided into the following sections: a) demographic profile of the participants, b) descriptive findings as related to attitudes toward family therapy (ATFT), c) descriptive findings as related to contextual factors, d) findings illustrating preliminary correlations between attitudes toward family therapy and contextual factors, e) preliminary analyses as related to identifying those factors accounting for attitudes toward family therapy, f) research questions and hypotheses findings, and g) post hoc findings.

A Demographic Profile of the Participants

A sample size of 135 participants was included in the final analysis. This number of participants was appropriate given that the power analysis for the present study suggested a minimum of 120 participants. A total of 146 participants initially completed the series of measures compiled for the present study. However, missing values existed for various sections of the survey. In an effort to increase the likelihood that survey items accurately represented variable constructs, a listwise deletion procedure was conducted. This procedure allowed the researcher to set the sample size at a number that reflects only those participants who answered items for all variables (Vogt, 1999).

As presented in Table 2, the sample consisted of 81 women (60%) and 54 men (40%). Majority of participants were over 40 years of age with a mean age of forty-eight. Most participants (66.6%) had obtained an undergraduate college degree or graduate degree. The remaining participants had acquired either a high school diploma/equivalent or partial college/specialized training. Only two participants reported obtaining less than a high school diploma.

Table 2

Demographic Profile of African American Sample: Gender, Age, Level of Education (N= 135)

	n	(%)	M	SD
Gender			.60	.492
Female (1)	81	(60)		
Male (0)	54	(40)		
Age			48	13.49
Under 40 (1)	37	(27.4)		
Over 40 (2)	95	(70.4)		
No response	3	(2.2)		
Level of education			5.85	1.10
Graduate degree (7)	44	(31.9)		
Undergraduate degree (6)	48	(34.7)		
High school diploma or equivalent (5)	21	(18.1)		
Partial college/specialized training (4)	18	(13.9)		
Partial high school (3)	1	(.7)		
Junior high school (2)	1	(.7)		
Less than seventh grade (1)	0	0		
No response	2	(1.5)		

Table 3 reveals that most of the participants are married while others fall into other categories (i.e., widowed, never married, divorced, or separated). Furthermore, results indicate that most participants are parents with the remaining group falling into the non-parent or sole-parent categories.

Table 3

Demographic Profile of African American Sample: Relationship and Parental Status (N=135)

	n	(%)	M	SD
Relationship status			4	1.23
Never married:				
No present relationship (1)	7	(4.8)		
In a relationship (< 3 yrs.) (2)	8	(5.5)		
Long-term relationship (3)	6	(4.1)		
Married (4)	106	(72.6)		
Separated (5)	4	(2.7)		
Divorced (6)	5	(3.4)		
Widowed (7)	10	(6.8)		
Cohabitating	0	0		
Parental status			1.89	.419
Non-parent (1)	19	(14.1)		
Parent (or guardian) (2)	105	(77.8)		
Sole parent (full custody) (3)	5	(3.7) (4.4)		
No response	6			

Given that home ownership and income level are often associated with middle-class status within the literature, information regarding these areas was obtained. Table 4 illustrates that the majority of participants own their own home with 71% earning an annual household income between $35,000 and over $75,000. Given that this range exists in income, Hollingshead index findings are most relevant to this sample, given that occupation and educational level have been found to be better determinants of a middle-class status among African Americans than solely basing status on income.

Table 4

Demographic Profile of African American Sample: Home Ownership and Income (N=135)

	n	(%)	M	SD
Home Ownership			1.51	1.34
Yes (1)	116	(86)		
No (0)	17	(13)		
No response	2	(1.5)		
Income			4	1.19
75,000 and over (5)	30	(22.2)		
50,000 to 74,999 (4)	38	(28.1)		
35,000 to 49,999 (3)	28	(20.7)		
20,000 to 34,999 (2)	26	(19.3)		
Below 20,000 (1)	6	(4.4)		
No response	7	(5.2)		

Occupational categories of this sample are also presented. Initially, approximately 80 occupational categories were identified given that participants were given the option of specifying their particular occupation. These occupational categories were narrowed down to 18 key occupational categories based on how the 80 categories grouped together. Table 5 illustrates these 18 categories where participants reported either current occupation or retired status with a listing of his or her prior occupation.

Table 5

Occupational Categories for African American Sample (N=135)

Occupation	n	(%)
No mention	7	(5.2)
Teacher/Educator	63	(46.6)
Bus Driver	2	(1.5)
Law Enforcement	2	(1.5)
Skilled Laborer	8	(5.9)
Sales/Customer Services	4	(3.0)
Clerical/Secretarial	10	(7.4)
Attorney/Judge	2	(1.5)
Social Worker	3	(2.2)
House Keeper/Maid	1	(0.7)
Custodian	4	(3.0)
Accountant	1	(0.7)
Nurse	1	(0.7)
Managerial	7	(5.2)
Computer Programmer	2	(1.5)
Retired Misc.[a]	5	(3.7)
Misc.[b]	13	(9.6)

[a]refers to those retired persons who did not designate from which occupation they are retired.

[b]refers to those occupations that have been categorized as "other" which pertains to occupational categories that did not fall into the major categories listed.

In an effort to identify how people perceived their social class status, a self-rating of social class was obtained. Table 6 suggests that the majority of participants rated themselves as middle-class. However, individual perceptions of social status often vary due to socialization experiences, along with the inconsistency within literature regarding what defines middle class (Pattillo-McCoy, 1999). Thus, the Hollingshead's Factor Index of Social Status (1975) formula, which takes into account educational level and occupation in identifying one's social category, was utilized. This was in an attempt to comprehensively assess the middle-class status of this sample. Table 6 suggests that based on the Hollingshead assessments of those participants reporting occupation and educational level, most participants are at the lower middle-class range or above. Of those reporting both educational and income levels, only one person fell below the middle-class level.

Table 6

Demographic Profile of African American Sample: Self-rating of Social Class and Hollingshead Social Status Ranking (N=135)

	n	(%)	M	SD
Self-rating of social class			2.24	.599
Upper class (1)	7	(5.2)		
Middle class (2)	87	(64.4)		
Working class (3)	30	(22.2)		
Lower income (4)	4	(3.0)		
No response	7	(5.2)		
Hollingshead social strata categories[a]		---[b]	48.29	9.75
Upper class range (66-55)	42			
Upper middle class range (54-40)	50			
Middle class range (39-30)	17			
Lower middle class range (29-20)	6			
Lower class range (19-8)	1			
No response	19			

[a] For a total score calculation, occupation is given a factor weight of 3, while education is given a factor weight of 5 thus, a person scoring 8 for occupation and 7 for education would yield a total score of 59 (8x3=24; 7x5=35; 24+35= 59).

[b] Given that social class items were based on educational and occupational categories, no percent values were obtained for the Hollingshead ranges. Only frequencies are reported.

Finally, religious affiliation was reported for this sample. Results from Table 7 suggest that the majority of participants are either Protestant (54%) or Catholic (42.2%). A small percent (3.7%) of participants identified themselves has having no religion or some other unidentified religious affiliation.

Table 7

Demographic Profile of African American Sample: Home Ownership and Income (N=135)

	n	(%)
Religious Affiliation		
Catholic	57	(42.2)
Protestant		
Baptist	39	(28.9)
Methodist	8	(5.9)
Church of Christ	3	(2.2)
Congregationalist	2	(1.5)
Nondenominational	13	(9.6)
Full Gospel	6	(4.4)
Other misc. Christian	2	(1.5)
Muslim	0	0
Jewish	0	0
No religion	3	(2.2)
Other	2	(1.5)

Attitudes Toward Family Therapy

Attitudes toward family therapy were obtained via the use of an adaptation of the Attitudes Toward Seeking Professional Psychological Help Scale (Fischer & Turner, 1970). The adaptation, the Attitudes Toward Family Therapy (ATFT) Scale was utilized for the purpose of this study (see appendix A). The ATFT scale, a 5-point likert scale, measures attitudes toward family therapy and is divided into adapted subscales that assess attitudes regarding need for family therapy, stigma associated with family therapy, openness to seeing a family therapist, and confidence in the ability of a family therapist to effectively address couple or family related problems.

Table 8 presents descriptive values for the ATFT Scale as well as its subscales. The Cronbach alpha coefficient suggests that high reliability (a=.89) was achieved in the ability of this scale to accurately measure attitudes toward family therapy. Additionally, alpha ranges (a=.79-.60) for the Need, Openness, Confidence, and Stigma subscales also suggest high to moderate reliability. Findings suggest that participants' score range is moderate to high suggesting moderate to very positive attitudes toward family therapy. This is confirmed given that the average score (M=104.23) fell closer to the maximum possible score.

In addition to total score findings, Table 8 also presents results from the four subscales of the ATFT Scale. Though standard deviation coefficients suggest less variability of items (due to smaller item number), mean scores suggest that participants' scores are moderate to high when assessing how scores fall in

relation to the possible score range. This suggests that participants, overall, believe that there is a need for family therapy; believe that stigma would not prevent them from pursuing or encouraging another to pursue family therapy; exhibit openness to family therapy as a therapeutic option; and are confident that family therapists can effectively address problems/concerns as related to their couple or family relationships. Though emphasis is placed on the total score findings for purposes of this study, these subscale findings are presented in order to identify how scores fall for specific attitude-related constructs (i.e., need, stigma, etc.).

Table 8

Descriptive Values for Attitudes Toward Family Therapy (ATFT) Scores (N=135)

	M	(SD)	min.	max.	Cronbach Alpha
ATFT Scale	104.23	(14.36)	64	142	.89
Possible Score Range (PSR)			29	145	
ATFT Subscales					
NEED	27.07	(5.01)	12	40	.74
(PSR)			8	40	
STIGMA	17.51	(2.09)	10	22	.60
(PSR)			5	25	
OPENNESS	23.99	(4.81)	13	34	.71
(PSR)			7	35	
CONFIDENCE	32.56	(5.19)	20	45	.79
(PSR)			9	45	

Contextual Factors

Perceived Social Support

The Perceived Social Support (PSS) Scale is utilized to assess to what level do individuals rely on family, friends, or a significant other for support as related to emotional, problem-solving, and decision-making needs. Based on Table 9, this 5-point likert scale exhibits a Cronbach alpha coefficient that suggests high reliability in this scale's detection of a person's perceived level of social support. A mean score close to the possible maximum score suggests that participants perceive that they have a high level of social support among friends, family, and a significant other.

Extended Family Caring Socialization (EFCS)

Extended family caring socialization (EFCS) pertains to what extent does a person value messages conveying that extended family play an important role in child-rearing among African Americans. This is measured via the use of the extended family caring socialization subscale of the SORS (Scale of Racial Socialization for African Americans). Based on a 5-point scale, high scores (closest to 55) suggest that one highly values such attitudes regarding the involvement of extended family. Table 9 illustrates a fairly high cronbach alpha which suggests that this subscale accurately measures extended family caring socialization. The mean fell closest to the maximum possible score, and suggests that participants highly value the belief that extended family involvement in child-rearing is an important coping mechanism among African Americans.

Religious/Spiritual Coping Socialization (RSCS)

Religious or spiritual coping socialization pertains to what extent does a person value religious/spiritual coping as an effective help-seeking option. This construct is operationalized via the use of the religious/spiritual coping subscale of the SORS scale. According to Table 9, though a moderate cronbach alpha exists, results of the mean suggest that participants scored closer to the maximum possible score. This suggests that overall, participants value religious/spiritual coping as an effective help-seeking option among African Americans.

Table 9

Descriptive Values for Perceived Social Support (PSS), Extended Family Caring Socialization (EFCS) and Religious/Spiritual Coping Socialization (RSCS) Scores (N=135)

	M	(SD)	min.	max.	Cronbach Alpha
PSS Scale	53.10	(6.90)	27	60	.86
Possible Score Range (PSR)			12	60	
EFCS Scale	45.72	(5.41)	30	55	.70
Possible Score Range (PSR)			11	55	
RSCS Scale	35.69	(3.24)	27	40	.65
Possible Score Range (PSR)			8	40	

Perceived Access to Mental Health Services (ACCESS)

Given that the researcher could not identify a scale measuring a person's perception about his or her access to mental health services, 4 items were developed for the present study. Items pertained to access with regard to a person's belief that he or she has access through locale and financial means as well as time and therapist location. Level of access was identified by scoring a 1 (for access) or a 0 (for no access) on each of the four items. Table 10 shows a low Cronbach alpha (a=.42) for the ACCESS construct. Nevertheless, descriptive results reveal that the majority of participants (64.4%) perceive that they have access to mental health services given that they scored a 1 on each of the 4 items. As suggested in literature, this heightened perception of access seems to be reflective of the social class category of the given sample.

Help-Seeking Comfort (HSC)

Help-seeking comfort pertains to how comfortable a person is with seeking help for emotional, crisis-related, information, material, and financial needs. A 10-item measure (Hobfoll & Lerman, 1989) was utilized and is based on a 5-point likert scale. Table 10 presents findings suggesting that a very high Cronbach alpha (a=.92) exists for this construct. Mean values suggest that participants have a moderate to high level of help-seeking comfort with much variability in score ranges as identified by the standard deviation value.

Table 10

Descriptive Values for Perceived Access to Mental Health Services (ACCESS) and Help-Seeking Comfort (HSC) Scores (N=135)

	M	(SD)	min.	max.	Cronbach Alpha
ACCESS Scale	3.50	(.791)	0	4	.42
Possible Score Range (PSR)			1	4	
HSC Scale	37.60	(9.51)	12	50	.92
Possible Score Range (PSR)			10	50	

Gender

It is important to note that gender is considered as a contextual factor in the present study. Descriptive information presented earlier in this chapter, suggests that more women are present in the study compared to men. T-test findings suggest that women and men do not vary in reported perceived access to mental health services (t=.04, p=.97); perceived social support (t=.1.43, p=.154); help-seeking comfort (t=.61, p=.54); extended family caring socialization (t=-1.35, p=.18); and religious/spiritual coping socialization (t=-.92, p=.36). However, t-test findings (t=4.19, p<.01) reveal that there is a statistically significant difference between men and women with regard to how their scores varied on attitude toward family therapy items. It was found that women have an average score (M=108.21) approximately 10 points higher than men (M=98.25). Still, given that the minimum possible score is 29 and the maximum possible score is 145, both men and women exhibit moderate to very positive attitudes toward family therapy. Thus, these findings call into question the idea that men are not open to engaging in therapy while supporting literature that states that women have a greater propensity to seek therapy compared to their male counterparts.

Contextual Correlates of Attitudes Toward Family Therapy

Table 11 is an illustration of bi-variate correlations among attitudes toward family therapy and contextual factors. Results indicate that significant associations exist between attitudes toward family therapy (ATFT) and contextual factors. Specifically, the correlation (r=.27) suggest that ATFT is significantly associated with perceived social support (PSS)(p<.01) which indicates that

individuals with perceived higher levels of social support, are also more likely to have positive attitudes toward family therapy.

The significant correlation (r=.19) between ATFT and extended family caring socialization (EFCS)($p<.05$) suggests that as there is an increase in the value of that extended family caring as an effective coping mechanism within African American families, there is an increase in positive attitudes toward family therapy. Also, the significant correlation (r=.18) between ATFT and religious/spiritual coping socialization (RSCS) ($p<.05$) suggests that as there is an increase in one's value of religious beliefs or spirituality as effective coping mechanisms, there is an increase in positive attitudes toward family therapy.

The significant correlation (r=.33) between ATFT and perceived access to mental health services (ACCESS) ($p<.01$) suggests that as the belief that one has access to mental health services increases, there is an increase in positive attitudes toward family therapy. Furthermore, a significant correlation (r=.34) between ATFT and gender ($p<.01$) suggests that women tend to have more positive attitudes toward family therapy than men. Finally, a significant correlation (r=.27) between ATFT and help-seeking comfort (HSC)($p<.01$) suggests that as there is an increase in one's comfort with asking for help, there is also an increase in positive attitudes toward family therapy.

Thus it can be concluded that those with highly perceived social support, perceived access to mental health services, extended family caring socialization, and religious/spiritual coping socialization tend to exhibit more positive attitudes toward family therapy, with women exhibiting slightly higher attitudes than men.

However, it is important to note that in addition to significant associations existing between ATFT and contextual factors, significant associations were also found among contextual factors as illustrated in Table 11.

Specifically, correlational coefficients suggest that there is a significant association between EFCS and RSCS ($r=.50$, $p<.01$), as well as, PSS and HSC ($r=.65$, $p<.01$). Furthermore, HSC seems highly associated with all contextual factors except ACCESS and GENDER. Given that contextual factors are more highly correlated with each other (i.e., $r=.65$, .50) than with attitudes toward family therapy, the significant associations that exist among these factors (known as multicollinearity) may be accounting for the positive association between these contextual factors and attitudes toward family therapy.

Table 11

Bi-variate Correlations Between Attitudes Toward Family Therapy and Contextual Factors (N=135)

Variable	1	2	3	4	5	6	7
Attitudes Toward Family Therapy (ATFT) (**1**)	---	.27**	.19*	.18*	.33**	.34**	.26**
Perceived Social Support (PSS) (**2**)		---	.26**	.36**	.15*	.12	.65**
Extended Family Caregiving Socialization (EFCS) (**3**)			---	.50**	.29**	-.12	.34**
Religious/Spiritual Coping Socialization (RSCS) (**4**)				---	.32**	-.08	.43**
Perceived Access to Mental Health Services (ACCESS) (**5**)					---	.00	.17*
Gender (GENDER) (**6**)						---	.05
Help-Seeking Comfort (HSC) (**7**)							---

** p< .01

* p< .05

What Accounts for Attitudes Toward Family Therapy?

While research questions and hypotheses will later address how specific contextual factors may account for attitudes toward family therapy, this section will present preliminary analyses necessary to establish a model that incorporates those contextual factors (independent variables) that explain the variance in attitudes toward family therapy.

Multiple regression is often a statistical procedure used to test how two or more independent variables predict or account for a dependent variable (Schroeder, Sjoquist, and Stephan, 1986). While correlation analyses look at positive or negative associations between variables, multiple regression takes these associations one step further by examining how multiple variables, independent of one another, might be accounting for the dependent variable. More specifically, with hierarchical regression, the researcher theoretically predicts how variables account for a dependent variable and enter those variables into that model. The aim is to answer the following two questions: Is there a significant increase or decrease in the dependent variable when there is a one unit change in a given independent variable when controlling for other independent variables? How much of the dependent variable is explained by a given independent variable when controlling for other independent variables? These questions are best answered via the use of the regression line. This line is set on a multi dimensional plane with Y (dependent variable) and X (independent variable) axes. By identifying the way in which data points cluster around the

regression line, the researcher will be informed of how much X may be accounting for Y for a given sample.

In the present study, the following questions were raised: Is there a significant increase or decrease in the attitudes toward family therapy score when there is a unit change in contextual factor scores? How much of the attitude score is explained by a given contextual factor when controlling for other contextual factors? To answer these questions, a standard regression equation model is used:

$$Y = a + b_1(X_1) + \ldots b_n(X_n) + e,$$

where Y= the dependent variable (attitudes toward family therapy); a= the point at which the regression line intersects the Y axis; b= the slope measuring the intersection of Y and X; X= a given independent variable; and e= error, which is the amount of unexplained variance not accounted for in the model. Referring back to the six independent variables (PSS=perceived social support; EFCS= extended family caring socialization; RSCS= religious/spiritual coping socialization; ACCESS= perceived access to mental health services; HSC= help-seeking comfort; and GENDER) and the dependent variable (ATFT= attitudes toward family therapy), the following unrestricted (UR) equation model was established:

$$ATFT=a+b_1(PSS)+b_2(EFCS)+b_3(RSCS)+b_4(ACCESS)+b_5(GENDER)+b_6(HSC)+e$$

To identify how the above-mentioned variables potentially account for attitudes toward family therapy, statistical analyses were conducted using this

model. Table 12 provides a summary of coefficients pertinent to identifying the level of significance of the model with all independent variables included.

Based on this model, a R^2 of .27 means that 27% of the variance in attitudes toward family therapy (ATFT) seems to be explained by this model. However, only two (3.39, 4.32) out of six values are significant which suggests that only two (ACCESS, GENDER) out of six contextual factors significantly account for ATFT in this model. Therefore, this model may be weak in the ability of all contextual factors to explain attitudes toward family therapy.

Given the level of insignificant findings for this UR model, the issue of multicollinearity must be taken into account. As noted in Table 11, the result of these significant interrcorrelations among contextual factors may be accounting for some of the variance in attitudes toward family therapy, thus potentially influencing the lack of significance of this UR model. Though the issue of multicollinearity could potentially invalidate findings, which suggest that significant correlations exist between contextual factors and attitudes toward family therapy, procedures exist that allow the researcher to address this issue as to prevent the nullification of the theoretical model. The following section addresses this concern.

To address the issue of multicollinearity, a statistical calculation was conducted that identifies the variance inflation factor (VIF). This factor consists of a configuration that accounts for the amount of variance in a given independent variable that is potentially being explained by other independent variables (Crown, 1998). Furthermore, the VIF suppresses any effect that interrelationships

among independent variables may have on the ability of these variables to account for the dependent variable (McDaniel, 2001). For the UR model, VIF calculations revealed that high multicollinearity no longer exists once PSS, EFCS, and RSCS were deleted from the model. The revised model that remained is the following:

$$ATFT= a+ b_1(ACCESS)+b_2(GENDER)+b_3(HSC)+e$$

To determine the significance of this model, a regression analysis was conducted for this restricted (RE) model. Table 12 is a summary of contextual factors and their regression coefficients.

Based on the RE model, ACCESS, GENDER, and HSC factors are statistically significant as noted by the significant values for all three variables. Thus the following can be concluded: 1) For a unit increase in ACCESS scores, there is a 5.39 unit increase in ATFT scores when controlling for GENDER and HSC; 2) Women score 9.63 units higher than men on the ATFT scale when controlling for ACCESS and HSC; 3) As HSC scores increase, there is a .29 unit increase in ATFT scores when controlling for GENDER and ACCESS.

However, the following question is raised: Given that PSS, EFCS, and RSCS were initially thought to theoretically account for attitudes toward family therapy, how will omitting them affect the overall level of significance of the RE model in its ability to explain attitudes toward family therapy? One criteria involves measuring how the model accounts for the sum of squared error (SSE), that is, the model's ability to minimize the effect that unexplained error may have in explaining the variance in attitudes toward family therapy. An F test calculation

(McDaniel, 2001) was conducted in order to measure SSE and compare differences between the UR and RE models. This allowed for a gauging of whether or not deleting variables from the original model would affect its theoretical relevance:

$$F= [(SSR_{RE}-SSR_{UR})/df_{RE}-df_{UR})]/[SSR_{UR})/(n-k-1)]$$

Referring to Table 12, coefficients were plugged into the formula to calculate F:

$$F= [(20383.4015-20055.647)/6-3)]/[(20055.647)/(135-6-1)]$$

$$F= .69727$$

To test for the statistical significance of this coefficient, a critical value equal to 2.68 was determined ($p<.05$). An F score below this critical value would confirm that there is no significant difference between the UR and RE models with regards to how much variance in attitudes toward family therapy is being significantly explained. Thus an F score of .69727 suggests that there is no difference between the models and therefore, omitting PSS, EFCS, and RSCS variables does not alter the statistical validity of the model.

Table 12

Predictors of Attitudes Toward Family Therapy: Summary of Coefficients for Unrestricted (UR) and Restricted (RE) Regression Models (N=135)

Unrestricted Model (UR)

Variable	B	SE B	t
PSS	.18	.21	.9
EFCS	.24	.24	1.03
RSCS	-.03	.42	-.07
ACCESS	4.96	.14	3.39**
GENDER	9.73	2.25	4.32
HSC	.17	.16	1.09

R^2=.27
SSE Residual = 20055.647
(F [6, 128] = 8.06, p<.01)

Restricted Model (RE)

Variable	B	SE B	t
ACCESS	5.39	1.38	3.9**
GENDER	9.63	2.19	4.49**
HSC	.29	.11	2.56**

R^2=.27
SSE Residual = 20383.4015
(F [3,131] =15.53, p<.01)

Summary of Findings

In an effort to clearly articulate findings as related to proposed hypotheses, the following section is divided based on specific research questions. Hypotheses relevant to a given research question is located immediately following that research question followed by findings that either support or refute that hypothesis.

Research question #1

What are attitudes toward family therapy given the interplay between race (African American), social class (middle-class status), and culture (contextual factors)?

Hypothesis 1: Middle-class African Americans will have moderate to very positive attitudes toward family therapy.

Findings (referring back to Table 8, p. 89) reveal that with an average score of 106 with a possible minimum/maximum score range of 29 to 145, it is concluded that for this sample of middle-class African Americans, there are moderate to very positive attitudes toward family therapy as an effective help-seeking option. Furthermore, subscale findings suggest that participants tend to believe that there is a need for family therapy, that stigma should not prevent one from pursuing family therapy, that he/she would be open to participating in or referring one to family therapy, and that family therapists are competent in their ability to address couple and/or family related problems.

Research question #2

Considering context-sensitive factors such as gender, perceived social support (PSS), extended family caring socialization (EFCS), religious/spiritual coping socialization (RSCS), and perceived access to mental health services (ACCESS), how might such factors account for attitudes toward family therapy (ATFT)?

Hypothesis 2: Women tend to exhibit more positive attitudes toward family therapy than men.

Though correlational results confirm this hypothesis, the RE model more accurately supports this hypothesis given that the issue of intercorrelation among independent variables is being addressed in this model. Referring to Table 12 (p.104) the restricted (RE) regression model suggests that women tend to score 9.63 units higher on the ATFT scale which means that they tend to exhibit more positive attitudes toward family therapy compared to men when controlling for the effects of ACCESS and HSC factors. This is also supported by previously discussed t-tests that suggest that there is a mean score difference between men and women for the attitudes toward family therapy total score.

Hypothesis 3: As positive RSCS attitudes increase, there is a decrease in positive attitudes toward family therapy.

Referring to Table 11(p.98) correlational findings suggest that RSCS is positively correlated with attitudes toward family therapy. This refutes this hypothesis that suggests that a negative relationship exists between RSCS and ATFT. However, multicollinearity suggests that the relationship between RSCS

and other factors may be accounting for this correlation. Furthermore, the beta coefficient for the unrestricted (UR) regression model (see Table 12) suggests that as RSCS increases, there is a decrease in positive attitudes toward family therapy. However, this finding is statistically insignificant and thus RSCS is removed from the model as illustrated in the RE model. Therefore, it cannot be concluded that RSCS significantly accounts for attitudes toward family therapy with this particular sample.

Hypothesis 4: As positive EFCS attitudes increase, there is a decrease in positive attitudes toward family therapy.

As with RSCS, Table 11 suggests that EFCS is positively associated with attitudes toward family therapy, which does not support this hypothesis. However, considering that a high correlation between EFCS and other contextual factors, and EFCS' insignificance in the UR regression model, it cannot be concluded that EFCS significantly accounts for attitudes toward family therapy with this particular sample when controlling for ACCESS and gender variables.

Hypothesis 5: As PSS decreases, there is an increase in positive attitudes toward family therapy.

Table 11 illustrates that PSS is significantly associated with attitudes toward family therapy, however through a positive association. Thus, hypothesis 5 is not supported. Rather, preliminary findings suggest that as PSS increases, so does positive attitudes toward family therapy. However, given that this variable is insignificant in the UR model and thus was removed in the RE model, it cannot

be concluded that PSS significantly accounts for attitudes toward family therapy for this particular sample.

Hypothesis 6. Those who have perceived access to mental health services (ACCESS) have more positive attitudes toward family therapy.

Table 11 findings suggest that as ACCESS scores increase, so do positive attitudes toward family therapy. This is confirmed in both the UR and RE regression models (see Table 12), independent of the effects that other contextual factors are having on attitudes toward family therapy. Thus, it can be concluded that participants' perceived access to mental health services accounts for attitudes toward family therapy. This is supported by the RE model that suggests that as there is an increase in ACCESS scores, there is a 5.39 unit increase in ATFT scores when controlling for gender and help-seeking comfort.

Research question #3

Given that how comfortable one feels with help-seeking may impact attitudes toward family therapy, does help-seeking comfort, as a contextual factor, account for the relationship between other contextual factors and attitudes toward family therapy?

Hypothesis 7: Women with high HSC (help-seeking comfort) have more positive attitudes toward family therapy compared to women with low HSC.

T-tests were used to determine whether or not a difference in mean scores exists for attitudes toward family therapy when comparing those women with high help-seeking comfort to those with low help-seeking comfort. Findings suggest that women with high help-seeking comfort ($\underline{M}$= 111.22) tend to score, on

average, approximately 6 points higher than women with low help-seeking comfort (M= 105.16) on the ATFT Scale. Furthermore, a t-test reveals that this conclusion is significant (t=-2.09, p<.05). Therefore, a difference does exist suggesting that women with high help-seeking comfort tend to exhibit more positive attitudes toward family therapy than those with low help-seeking comfort.

Hypothesis 8: Men with high HSC have more positive attitudes toward family therapy compared to men with low HSC.

Similar to that of women, t-tests were conducted in order to measure whether or not there are mean score differences among men with high help-seeking comfort compared to those with low help-seeking comfort with regard to attitudes toward family therapy. Findings reveal that men with high help-seeking comfort have a mean score (M=102.32) that is approximately 8 points higher than the mean score for men with low help-seeking comfort (M=94.18) on the ATFT Scale. Thus, it can be stated that according to this mean difference, men with high help-seeking comfort tend to exhibit more positive attitudes toward family therapy compared to men with low help-seeking comfort. This was confirmed by a t-test (t=-2.26, p<.05) suggesting that the mean difference is statistically significant.

Hypothesis 9: When there is high HSC, there is a change in the relationship between contextual factors and attitudes toward family therapy.

It was found that with the total sample (N=135), there is approximately a 6 point mean score difference among those with high help-seeking comfort (M=107.20) compared to those with low help-seeking comfort (M=101.12) on the

ATFT Scale. This is confirmed by a t-test (t=-2.90, p<.01) suggesting that this difference in mean scores is significant. Moreover, as noted in Table 11 (p.98) high intercorrelating exists between HSC and other contextual factors suggesting that there is possibly an interaction or pathway between HSC and these variables that is not being accounted for in the theoretical model of this present study. Initially, Hypothesis 9 aimed to treat help-seeking comfort as a potential moderator variable set at a high and low level. However, in order to treat an independent variable as a moderator variable, key assumptions must be true: 1) the potential moderator variable must be independent of other independent variables; and 2) must be significantly correlated with the dependent variable (Baron and Kenny, 1986). In the case of help-seeking comfort, it is significantly correlated with attitudes toward family therapy (r=. 264, p<.01) and significantly accounts for attitudes toward family therapy within the RE regression model (B=.29, p<.01)when controlling for gender and access to mental health services. However, help-seeking comfort is also highly correlated with several independent variables thus the first key assumption is not supported. To that end, pre-requisites needed to test help-seeking as a moderator variable were not met. Nevertheless, help-seeking comfort remains significant with regard to those with high help-seeking comfort reporting more positive attitudes toward family therapy compared to those with low help seeking comfort. Also, the ability for help-seeking comfort to account for attitudes in the RE model suggest that it is an important variable to re-examine as an explanatory model accounting for attitudes toward family therapy emerges.

Post Hoc Findings

Findings suggest that three (HSC, ACCESS, GENDER) out of six contextual factors account for 27% of the variance in attitudes toward therapy within this sample. However, given that the sample slants toward upper middle-class teachers who are married, the following question is proposed: Are those participants who are not of the above-mentioned demographic profile scoring differently on the ATFT scale? To answer this question, a series of post hoc tests were run included t-tests that revealed whether or not there are mean group differences for the following groups with regard to how they are scoring on the ATFT items: teachers versus nonteachers and married versus nonmarried. Results revealed that for marital status ($t=-.896$, $p=.37$), there is no difference between married and non-married individuals in how they score on the ATFT scale. However, regarding teacher status ($t=2.83$, $p<.01$), there is a statistically significant difference in mean ATFT scores. Nevertheless, when addressing specific hypotheses, group differences were not found to impact the overall statistical validity of the RE model for this particular sample.

Summary

The overall purpose of this chapter was to present findings based on descriptive and statistical analyses. With regards to attitudes toward family therapy, participants exhibit moderate to very positive attitudes toward family therapy. Moreover, participants tend to perceive that they have social support. Additionally, extended family involvement with childrearing and religious/spiritual coping as racial coping mechanisms are valued socialization themes among

participants. Also, participants believe that they do have access to mental health services and are comfortable with asking for help with various needs.

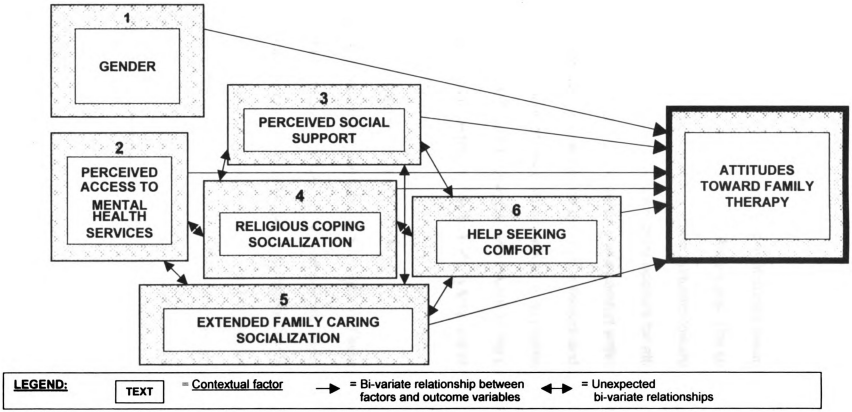
With regards to specific hypotheses, it was confirmed that women exhibit more positive attitudes than men. It was hypothesized that as there is an increase in perceived social support, a value extended family caring socialization and religious/spiritual coping socialization, there would be a decrease in positive attitudes toward family therapy. Contrary to what was expected, participants with moderate to high levels of perceived social support, extended family caring socialization and religious/spiritual coping socialization exhibited positive attitudes toward family therapy, though these associations were later found to be insignificant in the regression model. It was found that participants perceived that they have access to mental health services and that this, along with gender and help-seeking comfort, significantly predict positive attitudes toward family therapy.

Finally, it was expected that help-seeking comfort accounts for attitudes toward family therapy and potentially accounts for the relationship between other contextual factors (i.e., PSS, GENDER) and attitudes toward family therapy. It was found that help-seeking comfort significantly predicts attitudes toward family therapy when controlling for gender and access to mental health services. However, prerequisites needed to determine help-seeking comfort as a moderating variable were not met. Nevertheless, it can be concluded that both men and women with high help-seeking comfort levels tend to have more positive attitudes toward family therapy compared to men and women with lower

help-seeking comfort levels. The findings also confirm that interrelationships exist among contextual factors as noted in Figure 3. Though an analysis of such relationships is beyond the scope of this study, future analyses will address how these findings inform the comprehensive study of contextual factors and confounding issues yet to be addressed.

The following chapter incorporates a discussion of the above-mentioned findings, limitations and recommendations for future study.

Figure 3. A revised conceptual model of contextual factors and attitudes toward family therapy as a help-seeking option among middle-class African Americans.



* This is an adaptation of the integrative model developed by Garcia Coll, C., Lamberty, G., Jenkins, R., McAdoo, H., Crnic, K., Wasik, B., & Garcia, H. (1996). An integrative model for the study of developmental competencies in minority children. Child Development, 67,1891-1914.

CHAPTER 5

CONCLUSION

The purpose of this present study was to explore attitudes toward family therapy among a sample of middle-class African Americans. The study was specifically aimed at determining the nature of their attitudes toward family therapy; examined whether or not contextual factors account for attitudes toward family therapy among this sample; and whether one's comfort with help-seeking accounted for the relationship between other contextual factors and attitudes toward family therapy. The focus of this chapter will be to: a) present an interpretive discussion of key findings; b) explore limitations of the present study; and c) provide implications with regard to future study, policy and clinical relevance with this population.

Discussion of Key Findings

Middle-class African Americans and Attitudes Toward Family Therapy

Findings from the present study reveal that among a sample of middle-class African Americans, moderate to very positive attitudes toward family therapy exist. Participants believe that there is a need for family therapy. Specifically, the majority of participants: 1) believe that time and expense should not deter one from valuing family therapy, 2) believe that sometimes emotional difficulties within couples or families only work out with formal intervention, and 3) convey a willingness to pursue family therapy if family or couple-related problems exist. Participants also believe that stigma should not deter one from pursuing family therapy. For example, majority of participants stated that they would not feel

uneasy if others knew that they were attending family therapy. Also, the majority of participants stated that they do not believe that people who participate in family therapy should feel shameful for pursuing such services. Participants report openness to family therapy as demonstrated by disagreeing with the following statement: "I resent a person—professionally trained...who wants to know about my personal family difficulties"; and agreeing with the following statement: "I would willingly confide intimate matters to an appropriate person if I thought it might help me, my partner, or my family."

Moreover, participants displayed an overall sense of confidence in family therapists' ability to effectively assist with couple or family related issues as majority of participants stated that they would recommend family therapy to a friend who may ask for advice about a relational problem. Participants also stated that they would be first inclined to get professional attention if they were overwhelmed with a couples or family related problem. Finally, participants reported feeling confident that family therapy would provide relief for family or couple-related crises.

African Americans have not been "empowered" to inform the field of family therapy about their attitudes with regard to whether or not family therapy is a viable help-seeking option (Boyd-Franklin, 1989). Research suggests that African Americans, do, in fact, value mental health services (Leaf et al., 1984; Diala et al., 2001). Richards (1993) supports these assumptions as her research findings suggest that middle-class African Americans value psychotherapy as an effective

help-seeking option. However, no known study has specifically explored attitudes toward *family* therapy among a middle-class sample of African Americans.

The present study informs this area of research as this sample of middle-class African Americans reports, overall, positive attitudes toward family therapy as an effective help-seeking option. This includes the belief that there exists a need for family therapy; that stigma about pursuing therapy should not prevent the pursuit of such intervention; that openness to family therapy exists; and that there is confidence in the ability for a family therapist to effectively address family or couple-related problems. Thus, despite reports of underutilization of mental health services among this population of African Americans (US Surgeon General, 1999), this study supports the assumption that middle-class African Americans exhibit positive attitudes toward therapeutic intervention.

Contextual Factors and Attitudes Toward Family Therapy

Gender. Prior discussion of gender suggests that women tend to initiate family therapy more often than men (Boyd-Franklin, 1989). Thus, the assumption may be that women tend to value or regard family therapy more positively than men. This assumption is supported in the current study as women exhibited more positive attitudes toward family therapy. Nevertheless, when mean scores were considered, overall, it was found that despite the difference between men and women, both exhibit moderate to positive attitudes toward family therapy. To that end, while it has been concluded within the field of family therapy that African American women tend to initiate therapy more often than men, significant findings from this study suggest that men from a middle-class sample are at least

demonstrating an interest in family therapy and recognize benefits of family therapy as a help-seeking option.

Religious/spiritual coping socialization. Religious or spiritual coping has often been considered an effective coping option among African Americans (Carey & Anderson-Scott, 1998; Neighbors et al., 1998). Also, Stevenson (1994) suggests that an understanding of racial socialization such as the process utilizing religious or spiritual coping within the familial context can assist family therapists in effectively working with African Americans. The current study supports the belief that religious or spiritual coping socialization is a valued coping mechanism among this sample of African Americans. Findings suggest that there is a positive association between attitudes toward family therapy and religious/spiritual coping socialization. This offers an opportunity for future research to further explore this association, particularly given the role that religious/spiritual coping has as a fundamental component of African American reslience.

Extended family caring socialization. Similar to religious/spiritual coping socialization, extended family caring socialization is viewed as a coping mechanism. The belief is that messages conveying the importance of extended family involvement are highly embraced among African Americans and that extended family involvement is often viewed as a help-seeking option in conjunction with formal mental health options (Neighbors & Jackson, 1984; Snowden, 2001). For the present study, it was proposed that extended family involvement may buffer one from the effects of race-related distress, resulting in

little need or interest in formal intervention. Conversely, results from the present study affirm findings by Neighbors & Jackson as well as Snowden as participants not only value extended family caring as a coping option, but they also value family therapy. The positive association found between attitudes regarding extended family involvement and attitudes toward family therapy confirmed this outcome. On the other hand, further analyses suggest that extended family caring socialization does not predict specific attitudes toward family therapy. Still, the association that exists between the two offers an opportunity for future research to examine this relationship and the paradoxical argument suggesting that the family is often seen both as the source of coping and source of distress (Rogler et al., 1989).

Perceived social support. It has been suggested that one's perception that s(he) has access to social support is clearly related to emotional and psychological well-being (Walls, 1992). In the present study, it was hypothesized that a strong social support network might result in less interest in family therapy as a formal help-seeking option, assuming that there would be no need for such intervention. Findings reveal that participants not only perceive that they have a strong social support network, but that this is positively associated with attitudes toward family therapy. This supports NSBA findings (Snowden, 2001), suggesting that informal support networks are valued in juxtaposition with formal intervention. While the ability for perceived social support to predict attitudes toward family therapy was insignificant, the association between these two factors provides opportunity for future research to explore the role that social

supports in conjunction with formal support services increase help-seeking options among African Americans and their families.

Perceived access to mental health services. It is stated that social-class tends to position one in society in a way that allows greater access to a variety of resources (Kliman, 1998). Thus it would be assumed that given the role of managed healthcare and private insurance options, middle-class African Americans have greater access to family therapy options compared to their lower-income counterparts. However, utilization is found to be higher among lower-income African Americans who often rely on community centers and public welfare agencies (Snowden, 1998). A primary step in tackling the question of utilization among middle-class African Americans is to explore their beliefs about therapy and access to mental health options. In the present study, it was hypothesized that participants who perceived that they have access to mental health services would also value family therapy assuming that a perception of access would be positively associated with openness to services. Findings supported this hypothesis as it was revealed that participants not only perceive that they have access to mental health services, but that this perception significantly predicts positive attitudes toward family therapy. This informs both the mental health and family therapy field as results suggest that among a sample of middle-class African Americans, there is a belief that mental health service options exist and that family therapy as one help-seeking option is valued. This provides an opportunity for future research to further examine how this conclusion may relate to utilization trends.

Help-seeking comfort. In this study, help-seeking is viewed as a contextual factor that potentially moderates or predicts the association between other contextual factors and attitudes toward family therapy. This is due to the belief that a person's "willingness" to receive help often predicts whether or not a person receives help (Kaniasty & Norris, 2000). Furthermore, it has been stated that help-seeking attitudes play a pivotal role in obtaining appropriate intervention for personal or interpersonal distress (e.g., Gellis, Huh, Lee, Kim, 2003; Yeh, 2002). In the present study it was hypothesized that help-seeking comfort would moderate the relationship between contextual factors and attitudes toward family therapy. Nevertheless, prerequisites for exploring such association were not met. Instead, it was found that help-seeking is highly correlated with other contextual factors compared to attitudes toward family therapy. For example, help-seeking is so highly correlated with perceived social support that it is theorized that participants may have perceived *comfort* with help-seeking and *having others available* in times of help-seeking as interchangeable. Though further analyses suggest that help-seeking comfort significantly predicts attitudes toward family therapy, given its level of association with other contextual factors, it could not be set up as a moderator factor in the proposed model. Still, was found that those with high help-seeking comfort tended to exhibit more positive attitudes toward family therapy than those with low help-seeking comfort. Future research that examines the relation of help-seeking comfort to other contextual factors (e.g., gender) can provide clarity as to whether or not help-seeking comfort is a predictor of contextual factors associated with attitudes toward family therapy or

a variable that accounts for the relationship between other contextual factors and attitudes toward family therapy.

Overall, the present study successfully incorporated the theoretical paradigms of Bronfenbrenner and Garcia-Coll and colleagues. Emphasizing that multiple contextual factors are associated with and account for attitudes toward family therapy allows the researcher to gain comprehensive insight into those environmental experiences that can shape attitudinal outcome. Furthermore, maintaining cultural sensitivity that takes into consideration the experience of culture and class also transcends monolithic conclusions about African American attitudes and behavior.

Limitations

This study is successful in contributing knowledge to the literature regarding attitudes toward family therapy among a sample of middle-class African Americans. However, limitations exist. For instance, a non-random sample of middle-class African Americans from a southern community presents limitations in the ability for the present study to exhibit reliable external validity. A demographic profile consisting of a large number of middle-class African American females, who are married Christian parents, though representative of this region, may be less representative of middle-class communities around the country.

Secondly, while this study contributes knowledge about attitudes toward family therapy, little continues to be known about actual behavioral outcome. A paradox exists in that literature signifying that middle-class African Americans

tend not to primarily utilize mental health services for personal distress. Yet, this study along with earlier studies, suggests that they do value mental health services as a help-seeking option. Thus, there lies a continued gap in understanding the link between attitudes and behavioral outcome.

Thirdly, due to limited statistical findings, help-seeking comfort could not be incorporated in the design model as a moderator variable, as was hypothesized through the theoretical model. While it is assumed that one's comfort with help-seeking would affect associations between attitudes toward therapy and gender, perceived social support, extended family caring, religious/spiritual coping, or perceived access to mental health services, findings suggest that there must first be clarity as to how help-seeking comfort relates to or predicts these contextual factors.

Fourth, a non-random and limited sample size may be contributing to the multicollinearity issues and lack of significance in the ability of several variables to significantly predict attitudes toward family therapy. Thus, future study calls for a larger sample size and attempts to expand to a national random sample if findings are to be appropriately generalized to a larger population of middle-class African Americans.

Finally, primary focus has been on the relationship between contextual factors and attitudes toward family therapy, thus limiting the exploration of interrelationship among contextual factors. Though such analyses would take one beyond the scope of this present study, post dissertation analyses of the compiled dataset will explore relationships among contextual factors and how

they are associated with help-seeking comfort and attitudes toward family therapy. Additionally, it is important to acknowledge that other factors such as age and family structure are variables that would add to an understanding of generational influences and family structure in shaping attitudes. While these factors add to the multi-variate complexity of this research, they are not included here. Future examination of the dataset from the present study will target these areas in an effort to expand knowledge of multiple contextual factors that are associated and potentially predictive of attitudes toward family therapy.

Implications

Policy

With regard to policy, several implications exist based on findings from the present study. For example, results from this study suggest that there is interest in family intervention among middle-class African Americans. Yet, local and state-funded community outreach services are often utilized by lower-income families. Such services often address poverty related issues such as stable housing, income and adequate food as these factors often take precedent with this population. On the other hand, middle-class European Americans may have community-based wellness programs that fall short of addressing issues of discrimination and historical oppression that often plague families of color, regardless of social class affiliation. Thus, local and statewide programs are obligated to consider the needs of middle-class African Americans as issues (e.g., glass ceiling barriers, acculturation strain) unique to this social class make

their needs varied from their lower-income and European middle-class counterparts.

Additionally, legislative promotion of partnerships between community mental health programs and local social organizations, churches, and school systems can begin addressing the gap that exists between attitudes and utilization as middle-class African Americans are often found in leadership positions within these social systems, but yet are often plagued with a threat of stigma when it comes to attending to their own mental health and family-related needs.

Policy makers, both at the government and university level, have the opportunity to provide incentives for researchers to establish partnerships with participants of a given community by encouraging open-ended feedback as well as providing materials that educate research participants on family-therapy services available locally and at the national level. An example of successful outcome of such a partnership is present with this current study. For instance, while data collection involved survey completion, it was conducted in a group format with the researcher remaining open to questions and comments related to participants' feedback regarding administered surveys. Upon completion of the survey, participants were given a brochure educating them about the field of marriage and family therapy and services available to them in their area. This researcher observed on several occasions, an appreciation for this information as directly stated by participants. Furthermore, it was later discovered that a local therapist inquired about the work of this study, after hearing about it through word of mouth and exhibited an interest in findings given his outreach to middle-class

African Americans and their families. Thus, there is great potential for collaboration and partnerships to exist between researchers and communities and agencies.

Finally, The question of interest in family therapy among middle-class African Americans is particularly pertinent to the field of family therapy as legislative efforts are underway to have family therapists designated as reimbursable health care professionals across the United States (AAMFT Government Affairs Staff, April 2003). This study confirms interest in family therapy and its relevance to emotional and mental well-being of individuals. Furthermore, results provide evidence of the value of family therapy and its important role within the healthcare context.

Clinical Focus

In addition to policy implications, findings are also relevant to the work of clinicians. First, findings inform the field of family therapy, perhaps for the first time, of overall attitudes toward family therapy among a sample of middle-class African Americans, an often neglected group in family therapy literature (Bagarozzi, 1995). Results confirm that for this group of African Americans, culture and class can coexist and complement each other in the treatment process. For instance, African American cultural history has involved a reliance on family, friends, and church communities for coping with life stressors. On the other hand the middle-class experience in America tends to incorporate a psychotherapeutic approach to mental health and family wellness. To that end, to be effective, intervention among middle-class African Americans must take into

account both culture-related and class-related legacies. This present study suggests that African Americans exhibit a culture of coping through family and community support, as well as and interest in a middle-class value of formal clinical support.

This study also informs family therapy theory. For example, the Solution Focused approach says that the goal of therapy is to discover what works (what leads to optimal functioning) in a family and to do more of that behavior or interaction. Findings for this study confirms that extended family caring and religious/spiritual coping are help-seeking mechanisms that work. Thus an exploration of how these factors may contribute to successful treatment outcomes is relative to a culturally sensitive approach to working with this group of African Americans.

Finally, the Cognitive-Behavior approach, which pertains to matching one's cognitive image of functioning with successful behavioral outcome can also benefit from results of this study. For example, participants from this sample of African Americans believe that family therapy is a needed and valued help-seeking option. Yet, it has been suggested that a utilization gap exists between such beliefs and utilization trends. Bridging the gap between beliefs and behavior must be targeted, both by clinicians and researchers. Future qualitative assessment of how clients move from belief to behavior is the next step in examining the ways in which cognitive processes can match behavioral outcome in the attempt to increase optimal functioning among this population of African Americans.

APPENDICES:

APPENDIX A:

1) Informed Consent Form

2) Sample Survey

INFORMED CONSENT FORM

Title of Research Study: Contextual Factors and Attitudes Toward Family Therapy as a Help-Seeking Option Among Middle-Class African Americans

- You have been invited to participate in this study that will explore attitudes about family life, social support, and professional intervention among African American families. Family therapy as a professional intervention will refer to counseling or other forms of therapy that may include a couple, parent and child or entire family.

- You will be asked to complete a survey that will include a range of questions addressing social support, spiritual/religious and extended family values you have encountered or teach your children, your perception about access to mental health services in your community and your attitudes about the use of family therapy within African American communities.

- The survey will be administered in a group setting. This means that general instructions will be given in a group format. You will then have time to complete the survey at your table, as the questions will be self-explanatory.

- Your participation is completely voluntary and you are free to withdraw from the study without any penalty.

- All information will be kept confidential. Your answers will be coded in such a way that only group data will be analyzed. You will be assigned a participant # as to maintain confidentiality of your name. Consent forms will be placed in a secure file, separate from survey packets.

- If you have questions about the study, please contact Deborah Johnson, Ph.D., Principal Investigator (517-432-9115)(email: john1442@msu.edu). In case you have questions or concerns about your rights as a research participant, please feel free to contact Peter Vasilenko, III, Ph.D., Michigan State University's Chair of University Committee on Research Involving Human Subjects (phone: 517-355-2180)(email: uchris@msu.edu) (address: 202 Olds Hall, East Lansing, MI 48824).

- We foresee no physical or psychological risks to you during the administration of this survey. However, you are always able to ask about your participation and survey procedures at any time.

- It is anticipated that your completion of this survey will take between 35-50 minutes. Upon completion of the survey you are asked to tear off your consent form and place it in the designated envelope. You will be provided with tokens of gratitude that will include: 1) refreshments; 2) A gift ($7) certificate to a local restaurant; and 3) An option to participate in a $100 raffle.

- Once you hand in your completed survey, you will be provided with literature regarding the profession of family therapy in America.

Sign and Date (to confirm that you have read this consent form):

_____

PLEASE REFER TO THE NEXT PAGE TO GIVE YOUR CONSENT TO PARTICIPATE IN THIS STUDY.

Participant #_____

Participant # _____

AFRICAN AMERICAN

ATTITUDES SURVEY

We would like to find out: 1) what your experiences are in areas that deal with family life and friendships and; 2) what are your attitudes about African American families and professional intervention.

This survey should take between 35-50 minutes to complete. If there are questions regarding the clarity of survey items, please see Monica Sanders.

Remember that all responses will remain anonymous, as final scores will be tallied for group analysis only.

Thank you,
Monica Mouton Sanders, MA, LLMFT

SECTION A: We are interested in how you feel about the following statements. Please read <u>each</u> statement carefully. Indicate how you feel about each statement.

<u>Circle</u> the **1** if you Strongly Disagree
the **2** if you Mildly Disagree
the **3** if you are Neutral
the **4** if you Mildly Agree
the **5** if you Strongly Agree

	Strongly Disagree	**Mildly Disagree**	**Neutral**	**Mildly Agree**	**Strongly Agree**
1. There is a special person who is around when I am in need.	1	2	3	4	5
2. There is a special person with whom I can share joys and sorrows.	1	2	3	4	5
3. My family really tries to help me.	1	2	3	4	5
4. I get the emotional help and support I need from my family.	1	2	3	4	5
5. I have a special person who is a real source of comfort to me.	1	2	3	4	5
6. My friends really try to help me.	1	2	3	4	5
7. I can count on my friends when things go wrong.	1	2	3	4	5
8. I can talk about my problems with my family.	1	2	3	4	5
9. I have friends with whom I can share my joys and sorrows.	1	2	3	4	5
10. There is a special person in my life who cares about my feelings.	1	2	3	4	5
11. My family is willing to help me make decisions.	1	2	3	4	5
12. I can talk about my problems with my friends.	1	2	3	4	5

PLEASE CONTINUE

SECTION B: The next section is about how comfortable you are seeking aid from someone else. Please read <u>each</u> statement carefully. Indicate how comfortable you are with each scenario.

PLEASE NOTE: The following images have a distorted manner due to the need to alter their appearance for publication purposes.

13. How comfortable do you feel requesting material aid (money, furniture, etc.) from friends if you are in need of such aid?	*Very Uncomfortable* 1	*Somewhat Uncomfortable* 2	*Neutral* 3	*Somewhat Comfortable* 4	*Very Comfortable* 5
14. How difficult is it for you to request emotional support from friends if you have problems or are undergoing a crisis?	Very Difficult 1	Somewhat Difficult 2	Neutral 3	Somewhat <u>Not</u> Difficult 4	Not Difficult At All 5
15. How comfortable do you feel requesting friends just to be with you during a crisis or when you have a problem?	*Very Uncomfortable* 1	*Somewhat Uncomfortable* 2	*Neutral* 3	*Somewhat Comfortable* 4	*Very Comfortable* 5
16. How difficult is it for you to request advice or information from friends when you need it?	Very Difficult 1	Somewhat Difficult 2	Neutral 3	Somewhat <u>Not</u> Difficult 4	Not Difficult At All 5
17. How comfortable do you feel requesting help from friends in order to get something done (taking care of children, ride to work, shopping, etc.) when you are undergoing a crisis?	*Very Uncomfortable* 1	*Somewhat Uncomfortable* 2	*Neutral* 3	*Somewhat Comfortable* 4	*Very Comfortable* 5
18. How comfortable do you feel requesting material aid (money, furniture, etc.) from family if you are in need of such aid?	*Very Uncomfortable* 1	*Somewhat Uncomfortable* 2	*Neutral* 3	*Somewhat Comfortable* 4	*Very Comfortable* 5
19. How difficult is it for you to request emotional support from family if you have problems or are undergoing a crisis?	Very Difficult 1	Somewhat Difficult 2	Neutral 3	Somewhat <u>Not</u> Difficult 4	Not Difficult At All 5

20. How comfortable do you feel requesting family just to be with you during a crisis or when you have a problem?	*Very Uncomfortable* 1	*Somewhat Uncomfortable* 2	*Neutral* 3	*Somewhat Comfortable* 4	*Very Comfortable* 5
21. How difficult is it for you to request advice or information from family when you need it?	Very Difficult 1	Somewhat Difficult 2	Neutral 3	Somewhat Not Difficult 4	Not Difficult At All 5
22. How comfortable do you feel requesting help from family in order to get something done (taking care of children, ride to work, shopping, etc.) when you are undergoing a crisis?	*Very Uncomfortable* 1	*Somewhat Uncomfortable* 2	*Neutral* 3	*Somewhat Comfortable* 4	*Very Comfortable* 5

PLEASE CONTINUE

SECTION C. Please indicate your agreement with the following statements about African American family life. Please circle a number depending on whether or not you: 1= Strongly Disagree; 2= Disagree; 3=Don't Know; 4= Agree; 5= Strongly Agree

	Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree
23. Grandparents are important in helping parents make decisions.	1	2	3	4	5
24. It is important for families to go to a church or mosque for spiritual growth.	1	2	3	4	5
25. Relatives can help African American parents raise their children.	1	2	3	4	5
26. Religion is an important part of a person's life.	1	2	3	4	5
27. Racism and discrimination are the most difficult problems a Black child has to face.	1	2	3	4	5
28. My friends really try to help me.	1	2	3	4	5
29. Having large families can help African American families survive life struggles.	1	2	3	4	5
30. Parenting children includes teaching them to be proud to be Black.	1	2	3	4	5
31. Children should be taught that all races are equal.	1	2	3	4	5
32. Children who spend a lot of good time with their relatives become better citizens.	1	2	3	4	5
33. A belief in God can help a person cope through life struggles.	1	2	3	4	5
34. Spending quality time with relatives is important for parents as it is for children.	1	2	3	4	5

	Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree
35. Depending on religion and God can help you make good life decisions.	1	2	3	4	5
36. Families who talk about religion or God help their children to grow.	1	2	3	4	5
37. Getting a good education is still the best way for a Black child to survive racism.	1	2	3	4	5
38. "Don't forget where you came from, because you may want to go back someday."	1	2	3	4	5
39. Spiritual battles that people fight are more important than the physical battles.	1	2	3	4	5
40. "Train a child in the way he or she should go, and he or she will not depart from it."	1	2	3	4	5
41. "Black children should know at an early age that God can protect them from racial hatred."	1	2	3	4	5

PLEASE CONTINUE

SECTION D.
Instructions: Below are a number of statements pertaining to couples and family issues. Read each statement carefully and indicate whether you highly disagree (1), disagree (2), are neutral (3), agree (4), or highly agree (5). Please express your frank opinion in rating the statements. There are no "wrong" answers, and the only right ones are whatever you honestly feel or believe.

PLEASE SELECT ONE OF THE FOLLOWING:

1=Highly Disagree
2=Disagree
3=Neutral
4=Agree
5=Highly Agree

	Highly Disagree	Disagree	Neutral	Agree	Highly Agree
42. Although there are clinical offices for family or couples with relationship troubles, I would not have much faith in them.	1	2	3	4	5
43. If a good friend asked my advice about a relational problem, I might recommend that s/he see a family or couples therapist.	1	2	3	4	5
44. I would feel uneasy going to a family or couples therapist because of what some people would think.	1	2	3	4	5
45. A person with a strong character can get over relational problems by him/herself, and would have little need for a family or couples therapist.	1	2	3	4	5
46. There are times when I have felt completely lost and would have welcomed professional advice for a family or couples problem.	1	2	3	4	5
47. Considering the time and expense involved in family or couples therapy, it would have doubtful value for a person like me.	1	2	3	4	5
48. I would willingly confide intimate matters to an appropriate person if I thought it might help me, my partner or my family.	1	2	3	4	5

	Highly Disagree	Disagree	Neutral	Agree	Highly Agree
49. I would rather live with certain family or couples conflict than go through the ordeal of getting formal help.	1	2	3	4	5
50. Emotional difficulties tied to family or couples problems, like many things, tend to work out by themselves.	1	2	3	4	5
51. There are certain problems which should not be discussed outside of one's immediate family.	1	2	3	4	5
52. People with serious family or couples disturbances would probably feel most secure in a good therapeutic office setting.	1	2	3	4	5
53. If I believed I was mentally/ emotionally overwhelmed as the result of a family or couples problem, my first inclination would be to get professional attention.	1	2	3	4	5
54. Keeping one's mind on a job is a good solution for avoiding family or couples-related worries and concerns.	1	2	3	4	5
55. People who have been treated for family or couples problems have a blot (stigma) on their life.	1	2	3	4	5
56. I would rather be advised by a close friend than by a couples or family therapist, even for an emotional problem.	1	2	3	4	5
57. People with couples or family problems are not likely to solve them alone; they are likely to solve them with professional help.	1	2	3	4	5
58. I resent a person—professionally trained or not—who wants to know about my personal family difficulties.	1	2	3	4	5
59. I would want to get professional attention (help) for my family if I was worried or upset about couples or family-related problems for a long period of time.	1	2	3	4	5

	Highly Disagree	Disagree	Neutral	Agree	Highly Agree
60. The idea of talking about problems with a couples or family therapist strikes me as a poor way to get rid of relationship conflicts.	1	2	3	4	5
61. People treated for couples or family problems carry with them a burden of shame.	1	2	3	4	5
62. There are experiences in my family life I would not discuss with anyone.	1	2	3	4	5
63. It is probably best not to know "everything" about oneself or family.	1	2	3	4	5
64. If I were experiencing a serious couples or family crisis at this point in my life, I would be confident that I could find relief in couples or family therapy.	1	2	3	4	5
65. There is something admirable in the attitude of a couple or family who is willing to cope with their conflicts and fears without resorting to professional help.	1	2	3	4	5
66. At some future time I might want to have couples or family therapy.	1	2	3	4	5
67. Couples or families should work out their own problems; getting family counseling would be the last resort.	1	2	3	4	5
68. Had I, my partner, or my family received treatment in a clinical office setting, I would not feel that it ought to be "covered up."	1	2	3	4	5
69. If I thought I, my partner, or my family needed professional help for couples or family problems, I would get it no matter who knew about it.	1	2	3	4	5
70. It is difficult to talk about personal affairs with professionals such as doctors, teachers, and clergymen.	1	2	3	4	5

PLEASE CONTINUE

SECTION E: This section deals with questions about family stress and illness. Please read each question carefully and circle the number that best represents your agreement or disagreement with each statement.

	1 Highly Disagree	2 Disagree	3 Not Sure	4 Agree	5 Highly Agree
71. If a person caring for a spouse or parent diagnosed with a memory-loss illness (ex. Alzheimer's, dementia, "going senile") were experiencing family distress, I would encourage that person to contact a family therapist.	1	2	3	4	5
72. If I were diagnosed with a memory-loss illness and knew that my family might experience a great deal of distress, I would be open to seeing a family therapist.	1	2	3	4	5
73. The emotional distress that a family experiences when a family member hasa memory-loss illness is a personal matter that should not be discussed outside of the home.	1	2	3	4	5

74. Please rate the following based on what you believe to be the most important problem that African American communities are currently facing:
(1=most important problem, 2=2nd most important, 3=3rd most important, 4=4th most important, 5=least important)

a. Marital or Couples relationship problems ____
b. Parent-child conflict ____
c. Conflict with family of origin (the family that a person grows up in) ____
d. Conflict between siblings ____
e. Other _____ (please fill in the blank) ____

75. I have mental health services available to me or my family through a workplace, church, school, private practice office, hospital, or community agency. **Yes or No**

76. I could afford mental health services either through health insurance or some other financial means. **Yes or No**

77. I could make time to commit to attending therapy sessions either weekly or monthly. **Yes or No**

78. I believe that there are therapists/counselors in my community that could meet the needs of people in my community. **Yes or No**

ONE MORE PAGE TO GO.....

SECTION F: DEMOGRAPHIC INFORMATION-------Please circle the statement that describes your background:

75. Age:
    1. Under 40
    2. Over 40

76. Year of Birth: _____

77. Gender
    1. Female
    2. Male

78. Highest Level of Education Completed:
    1. Less than seventh grade
    2. Junior high school (9th grade)
    3. Partial high school (10 or 11th grade)
    4. Partial college (at least one year) or specialized training
    5. High school graduate or equivalent
    6. Undergraduate college or university degree (e.g., BS, BA)
    7. Graduate professional degree (MA, MS, PhD, MD, EdD, etc.)

79. Self-rating of social class:
    1. Upper class
    2. Middle class
    3. Working class
    4. Lower income

80. Relationship status:
    1. Never married (please select #1, 2, or 3)
        1. no present relationship
        2. in a relationship (less than 3 years)
        3. long-term relationship (3 or more years)
    2. Married
    3. Separated
    4. Divorced
    5. Widowed
    6. Cohabitating (living with someone)

81. Parental (or guardian) status:
    1. Non-parent (non-guardian)
    2. Parent (guardian)
    3. Sole parent (Have full custody or child[ren] are with me most of the time)

82. Income range (annual household)
    1. Below $20,000
    2. $20,000 to 34, 999
    3. $35, 000 to 49, 999
    4. $50, 000 to 74,999
    5. $75, 000 and over

83. Do you own your own home? Yes or No

84. Religious affiliation:
    1. Catholic Christian
    2. Protestant Christian (Please circle one of the following:)
        1. Baptist
        2. Lutheran
        3. Methodist
        4. Episcopalian
        5. Other Protestant _____
    3. Muslim
    4. Jewish
    5. No religion
    6. Other _____

85. What is your occupation (if retired, prior to retirement)? _____

AGAIN, THANK YOU.

APPENDIX B

Copyright Materials

January 28, 2004

Monica Mouton Sanders, MA, LLMFT
Doctoral Candidate
Department of Family and Child Ecology
Marriage and Family Therapy Specialization
Michigan State University
3128 Trapper Cove Trail, 2A
Lansing, MI 48910

VIA EMAIL TO: moutonmo@msu.edu January 28, 2004

FEE: NONE

RE: Blumenthal, Burg, Barefoot, Williams, Haney, and Zimet, "Social Support, Type A Behavior, and Coronary Artery Disease"
Psychosomatic Medicine 1987;49:331-340 The Perceived Social Support Scale

USE: Dissertation is to explore what contextual factors predict attitudes toward family therapy among middle class African Americans.

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Requestor accepts: Monica Mouton Sanders Date: 1/28/04

Monica Mouton Sanders

From: "Monica Mouton Sanders" <moutonmo@msu.edu>
To: <moutonmo@msu.edu>
Sent: Tuesday, January 27, 2004 11:00 AM
Subject: Fw: Permission to reproduce scale items

----- Original Message -----

From: Stevan E. Hobfoll

To: Monica Mouton Sanders

Sent: Sunday, February 01, 2004 9:26 AM

Subject: Re: Permission to reproduce scale items

Dear Monica,

By this email, I give you permission to use the scale. There was more recent work on this by Krys Kaniasty who is at Univ. of Indiana, Pennsylvania. He updated and adapted the scale.

Best of luck.

Stevan Hobfoll

----- Original Message -----

From: Howard Stevenson

To: Monica Mouton Sanders

Sent: Tuesday, January 27, 2004 5:55 AM

Subject: Re: Approval of instrument use (SORS-P)

You have my approval and i look forward to seeing your findings. I wish you the best in your work. My only suggestion is that when you only use one or two of the factors or some of the items, you may lose aspects of multidimensionality in the racial socialization construct that help to explain differences in other variables. Because we haven't done much factor work with the measure, this is hard to determine. But I wish you the best. peace. Howard STevenson, Ph.D.
University of Pennsylvania
School, Community, and Child Clinical Psychology Program
3700 Walnut Street
Philadelphia, PA 19104-6216

Graduate School of Education

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