Chapter Five

Cultural Competence

Cultural Competence Assessment in Systems of Care: A Concept Mapping Alternative

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Introduction

At a time when the populace of this country increasingly reflect a very diverse world, human service organizations strive to develop culturally competent services, programs, and employees. Census data indicate that the growing population of children and adolescents in this country is extremely diverse. It is estimated that by the year 2005, 40% of the population of children and adolescents in this country will be of color ("Embracing the Dynamics of Difference," 1997). Historically, mental health services have not effectively addressed the needs of children of color and their families (Hernandez & Isaacs, 1998; Knitzer, 1982). However, by including cultural competence as a key philosophical value, systems of care for children with serious emotional disturbance and their families are bringing this value to the forefront of service delivery systems (Stroul & Friedman, 1986).

A framework for developing effective, culturally competent services for emotionally disturbed minority children was provided by Cross, Bazron, Dennis and Issacs (1989). With few methods available for measuring the development of cultural assessment in systems of care, monitoring this process is a challenging yet critical component of evaluation. For example, the Cultural Competence Self-Assessment Questionnaire (CCSAQ; Mason, 1995), offers a scaling tool for organizations to assess the competence of their direct service workers and administrative staff with people of color on five sub-scales. Another instrument, the System of Care Practice Review (SOCPR; Hernandez, Gomez & Worthington, 2001), offers a case study approach for assessing culturally competent practice within organizational and familial cultural contexts along four sub-domains. While these methods provide valuable options, the CCSAQ does not gather input from family members and focuses primarily on people of color; and the lengthy data gathering process of the SOCPR limits its use by communities.

This study was developed to allow participants in the local system of care to offer views of cultural competence from their individual perspectives and determine which aspects of cultural competence are most critical for them. The assessment process used in this study was guided by systems of care values and offers a mixed-method approach for assessing cultural competence from multiple perspectives in a relatively short period of time. Preliminary findings from this study suggest that the methodology used offers a unique alternative for systems of care to define, assess, and track cultural competence within an individual community's context.

A specialized team was assembled for the specific purpose of conducting a cultural competence assessment of the systems of care efforts in Texas. These preliminary results focus on an assessment conducted in a Center for Mental Health Services (CMHS), Substance Abuse Mental Health Services Administration (SAMHSA) grant site. The core team consists of a research associate, a family evaluator, and two contracted facilitators. This culturally diverse team, reflecting the various cultures of Texas communities, and a committee of representatives from systems of care communities in Texas, participated in planning the assessment. The purpose of the evaluation was twofold: (1) to provide communities with a baseline assessment and process for monitoring their development of cultural competence, and (2) to provide individual communities with information necessary for developing technical assistance and training plans to address issues related to cultural competence.

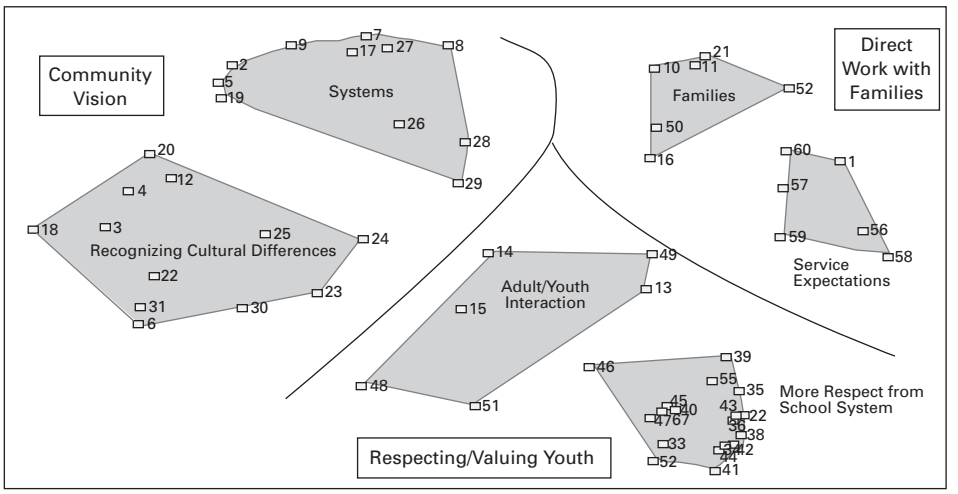
Method

Sample. The sample for this study included caregivers, youth, staff of various levels (direct service, administration, board members), and providers. Responses from 19 people are included in these preliminary data, with 11 participants represented in the sorting and rating results.

Methodology. The methodology chosen for the study was Concept Mapping as developed by Concept Systems, Inc. (Trochim, 1989). This methodology uses a participatory approach to conduct a mixed-method evaluation. An additional strength of the methodology is its ability to use the information gathered from participants to create clear and concise graphic pictures and numerical results, providing immediate feedback to the community. The Concept Systems software uses multivariate statistical techniques, including multidimensional scaling and hierarchical cluster analysis, to provide pictorial representations of relationships and relevance of the data generated. The graphic maps depict how participants' ideas group together and how they place value on these conceptual groups. Comparisons can be made between two groups, producing a correlation coefficient indicating the strength of that relationship. Maps were produced for the community indicating how participants view the relationships among the data elements and which elements indicate the most substantive significance.

Data Collection and Analysis. A total of 60 qualitative statements were gathered from participants through groups and one-on-one discussions describing the participants' individual ideas of a culturally competent system of care. In subsequent meetings, participants sorted the data elements into piles in a way that made sense to them and labeled each pile. Participants then placed value on the data by rating each element on three criteria: (a) importance of the element, (b) frequency of demonstration of the element, and (c) inclusion of the element in policy. These data were used to generate the relational concept maps and comparisons between groups. After analysis by the evaluation team, an interpretation session was held with participants to discuss the results and determine the number of clusters and cluster label assignments.

Figure 1
Point Cluster Map



Preliminary Results

Concept Mapping offered a helpful method for conceptualizing cultural competence in the local system of care community. Concrete examples of cultural competence were generated along with numerical comparisons of participant group priorities. Figure 1 illustrates the 6-cluster map solution chosen by participants to depict the data gathered. Points on the map represent each of the examples generated. The distance between the points indicates their relationship to one another. Points placed closer together are more similar in conceptual meaning. The farther away the points are from each other, the less similar they are in meaning. The names of each of the clusters provide a brief indication of the area of cultural competence described by the clustered qualitative statements. For example, the cluster "Families" describes the focus of qualitative statements 10, 11, 16, 21, 50, and 52. The clusters were categorized into three distinct groupings: (a) community vision, (b) direct work with families, and (c) respecting/valuing youth. Statements assigned to each of the clusters offer concrete examples of what a culturally competent system of care would look like as described by participants.

Ratings of participants indicate very high levels of importance (4.55-4.81 on a 1-5 Likert-type scale) and lower levels of frequency of demonstration (2.33-3.24 on a 1-5 scale) of the examples in the clusters. On importance, statements in the Families and Service Expectations clusters were rated the highest, and statements in the Systems cluster were rated the lowest. On frequency of demonstration ratings Service Expectations and Adult/Youth Interaction were rated the highest, and Systems and Recognizing Cultural Differences were rated the lowest.

A moderate correlation was found between patterns of importance and frequency of demonstration (r = .66), indicating a modest baseline for tracking progress. There were, however, differences between some of the participant groupings in how they rated importance and demonstration of the examples. For example, the People of Color and White/European groups were not in agreement on the ranking of cluster importance (r = .01), but these groups strongly correlated in rankings of demonstration (r = .89). The Family and Staff groups demonstrated moderate agreement on importance (r = .60) and on demonstration (r = .62).

Finally, participants rated how often the examples of cultural competence are included in agencies' written policies. There were no group comparisons on the policy ratings since the results are based on input from only nine participants. A total of 41% of all the ratings indicated no participant knowledge of policies related to the examples. Overall, statement ratings indicated fairly low averages of inclusion in policies. Service Expectations and Families clusters were rated as most often included in policies, and Recognizing Cultural Differences and More Respect from School System were rated as least often included in policies.

These preliminary results offer early indications that the method of assessment used will help establish a baseline for tracking cultural competence development over time. Additionally, the statements generated by participants offer concrete information for developing technical assistance and training plans around issues of cultural competence. The authors expect that data currently being collected from additional participants will strengthen the reliability of the results and will further define differences between participant groups.

Summary

The inherent nature of cultural competence demands individualization at the family, organizational, and community levels. The Concept Mapping methodology offers a unique way of gathering data from many individuals that can then be analyzed across multiple levels of a community's system of care. Investigators suggest that this study demonstrates a promising method for integrating participatory principles and values of systems of care philosophy in planning, implementation, and reporting design.

References

Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Toward a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed*. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Embracing the dynamics of difference: Cultural competence in children's mental health. (1997, Spring). *Networks.* Alexandria, VA: National Technical Assistance Center for State Mental Health Planning.

Hernandez, M., Gomez, A., & Worthington, J. (2001). *System of care practice review*. Tampa: Department of Child & Family Studies, Louis de la Parte Florida Mental Health Institute, University of South Florida.

Hernandez, M., & Issacs, M. R. (1998). *Promoting cultural competence in children's mental health services*. Baltimore: Brookes.

Knitzer, J. (1982). *Unclaimed children: The failure of public responsibility to children and adolescents in need of mental health services*. Washington, DC: Children's Defense Fund.

Mason, J. (1989). *The cultural competence self-assessment questionnaire.* Portland, OR: The Portland State University Research and Training Center for children and Youth with Serious Emotional Handicaps and their Families.

Stroul, B. A. & Friedman, R. M. (1986). *A System of care for children and youth with severe emotional disturbances. (Revised edition).* Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Trochim, W. M. K. (1989). An introduction to concept mapping for planning and evaluation. *Evaluation and Program Planning, 12*, 1-16.

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American Indian Cultural Identity Insignificant Resiliency Factor in Face of Trauma

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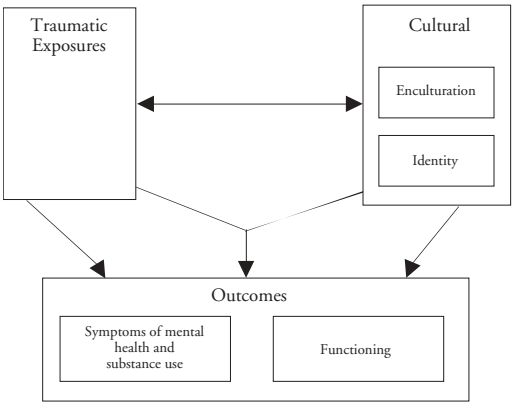
Introduction

Cultural factors such as identity and enculturation in one's culture of origin have been posited to serve as resiliency factors for American Indian youth. As such they may directly reduce symptoms or reduce the effect of traumatic events and other risk factors in producing symptoms related to addictions, mental health and daily functioning. Models such as Aponte & Johnson's (2000) posit that such cultural factors effect symptoms and functioning. The "Indigenist" Stress-Coping Model of Walters and Simoni (2002) posits that cultural factors such as enculturation and "identity attitudes" buffer the results of traumatic life events, abuse and historical trauma. This paper tests the roles of cultural identity and enculturation in directly effecting and moderating the risk factor of exposure to traumatic events on outcomes of mental health, substance use symptoms, and life functioning. The model tested herein is based on both of these models (see Figure 1), and includes both cultural identity as a product and enculturation as a process as resiliency factors that lead directly to better outcomes (less symptoms and less functioning problems) and serve a protective function in the context of the risk factor of exposure to traumatic events.

Figure 1
Cultural Resiliency Model



Methods

Four hundred and one American Indian youth from both an urban setting and a peri-urban reservation were interviewed as a part of the American Indian Multisector Health Investigation (AIM-HI) and a National Institute on Drug Abuse (NIDA) funded project, "Culture in Congruence and Substance and Mental Health Treatment Access." A random sample, based on school records and tribal records of 600 youth (300 from both areas), were given a short screening questionnaire which included the Columbia Impairment Scale (CIS; Bird et al., 1993) and the Youth Self-Report of the Child Behavior Checklist (CBCL; Achenbach, 1991). One hundred and fifty youth from each area were then randomly selected to do a longer (1.5-2 hour) interview to ascertain their mental health and substance use symptoms and daily functioning, their cultural identity and enculturation, and the services they had received. In addition, 50 youth from each area who exceeded clinical cutoffs on the screening interview were selected for the long interview, to enrich the sample with high-need youth.

Symptoms of conduct disorder, substance abuse or dependence (including inhalants, marijuana, or any drug identified by the youth), alcohol abuse and dependence, depression, suicidality, and post traumatic stress were identified by the Diagnostic Interview Schedule (DIS-IV; Robins & Helzer, 1994). All symptoms were summed into a single total symptom count variable. Although the data could have been looked at by diagnosis, symptom clusters may more accurately identify need, since some diagnoses are difficult to meet in adolescence. Summing the symptoms allows for the full variance, from no symptoms to the total co-occurring symptoms most youth experience.

Funding: National Institute for Drug Abuse funded, American Indian Multisector Help Inquiry RO1 DA 13227; Culture in Congruence RO3 DA 14398 (Dissertation funding).

Functioning was measured with the World Health Organization Disability Assessment Schedule II (WHO-DAS II; WHO, 1999). The WHO-DAS II was developed to measure the burden of diseases. It has a 12 item screener, with an additional 24 items answered when a particular screening question is answered positively. Answers indicated from no problem and up 3 points for increasing severity. The DIS-IV PTSD (Robins & Helzer, 1994) section was used to identity the number of traumatic events the youth had lived through. These were summed.

Enculturation was defined as both exposure to and knowledge of tribal community and language based on factor analysis showing that these items loaded on one factor. It included the number of years a youth lived on a reservation, whether the youth still had either relatives or friends on a reservation, whether the youth speaks his traditional language, and whether the youth understands the traditional language. Note that these items are not things the youth would control; that is, they do not reflect voluntary choice.

Factor analysis was also used to create cultural identification. It includes youth pride in being Native American; participation in Native American activities, such as memorials/feasts, sweats, talking circles, spiritual running, healing ceremonies, naming ceremonies, give-a-ways, and religious events; and parent's participation in the American Indian way of life (this item is from the Oetting & Beauvais [1991] Orthogonal Cultural Identity Scale).

Univariate analyses were used to describe the variables. Bivariate relationships between all variables were explored. Both used SAS (SAS Institute, 2000) with weight statements. Multiple regression models were run predicting both symptoms and functioning using STATA (STATA Corporation, 2001) allowing finding robust standard errors, required due to the weighting.

Results

Cultural identity was not significant in explaining any of the variance in either symptoms or functioning. Enculturation was statistically significant in predicting 2% of functioning (see Table 2) and 5% of symptoms (see Table 1). Exposure to traumatic events predicted 5% of functioning, and when enculturation was added, the variance explained only increased by 1%, to 6% (see Table 2). In the model predicting the most outcome variance in symptoms, a combination with traumatic events and an interaction term of enculturation and traumatic events explained 31% of the variance, but the betas for enculturation and the interaction term were not significant. The best model with symptoms as the dependent variable predicted 30% of symptoms, with enculturation thus adding only 3% more to the variance explained by traumatic events alone (27%). This is not enough to be clinically meaningful. Although theories persist in suggesting that enculturation and cultural identity are important factors in either directly reducing the development of poor outcomes or in moderating the effect of risk factors in the development of mental health and substance problems in teens, in neither this case, nor in previous studies, has this been the case.

Discussion

Exposure to traumatic events had a significant effect on youth outcomes of symptoms, and some effect on functioning. Thus the exposure to this risk factor is quite significant for these youth, and presents a clinically significant target for efforts to produce improved outcomes for American Indian teens.

Reasons for the small statistical findings, and lack of clinically significant findings for cultural factors in these analyses, can be grouped into four areas: (a) incorrect theory, (b) lack of conceptual clarity, (c) lack of measurement clarity, and (d) specific characteristics of this sample. However, it should be noted that little research supports the importance of cultural identity as a protective or resiliency factor.

Theory supporting the effects of culture on youth symptoms and functioning has not explicated the mechanisms of action, the "dosage" needed, nor the possible negative effects of cultural factors. Measures vary from research to research, differing based on the concept of identity used by the investigators and

Table 1
Regression Analyses on Dependent Variable Total Symptoms

		Enculturation/Symptoms Models			*Cultural Identity/Symptoms Models*		
	A Traumatic Events only – Direct Effect	*B Enculturation only – Direct Effect*	*C Enculturation and Traumatic Events*	*D Enculturation – Interactive Effect with Traumas*	*E Cultural Identity only – Direct Effect*	*F Cultural Identity and Traumatic Events*	*G Cultural Identity – Interactive Effect with Traumatic Events*
Enculturation		*b* = .58*** *se* = .12	*b* = .47*** *se* = .11	*b* = .25 *se* = .14			
Cultural Identity					*b* = .26 *se* = .14	*b* = .00 *se* = .13	*b* = .07 *se* = .17
Traumas	*b* = 4.87*** *se* = .45		*b* = 4.65*** *se* = .44	*b* = 3.40*** *se* = .79		*b* = 4.87*** *se* = .45	*b* = 5.30*** *se* = .94
Interaction term				*b* = -.11 *se* = .05			*b* = -.03 *se* = .07
F Value	118.09*** *df* = 1,387	22.19*** *df* = 1,400	72.46*** *df* = 2,386	52.81*** *df* = 3,385	3.04 *df* = 1,400	58.89*** *df* = 2,386	42.55*** *df* = 3,385
R^2	0.27	0.05	0.30	0.31	0.00	0.27	0.27

***$p < .001$, **$p < .01$, *$p < .05$

Table 2
Regression Analyses on Dependent Variable Functioning

		Enculturation/Functioning Models			*Cultural Identity/Functioning Models*		
	A Traumatic Events only – Direct Effect	*B Enculturation only – Direct Effect*	*C Enculturation and Traumatic Events*	*D Enculturation – Interactive Effect with Traumas*	*E Cultural Identity only – Direct Effect*	*F Traumatic Events and Cultural Identity*	*G Cultural Identity – Interactive Effect with Traumatic Events*
Enculturation		*b* = .34** *se* = .11	*b* = .32** *se* = .11	*b* = .14 *se* = .16			
Cultural Identity					*b* = .04 *se* = .12	*b* = -.02 *se* = .12	*b* = -.09 *se* = .17
Traumas	*b* = 1.95*** *se* = .57		*b* = 1.81** *se* = .58	*b* = .79 *se* = .72		*b* = 1.97*** *se* = .59	*b* = 1.56 *se* = 1.04
Interaction term				*b* = .09 *se* = .07			*b* = -.03 *se* = .07
F Value	11.14*** *df* = 1,384	9.14** *df* = 1,396	9.34*** *df* = 2,383	6.64*** *df* = 3,382	.10 *df* = 1,396	5.56** *df* = 2,383	3.69* *df* = 3,382
R^2	0.05	0.02	0.06	0.07	0.00	0.05	0.05

***$p < .001$, **$p < .01$, *$p < .05$

authors. This sample may have had a lower cultural identity and enculturation than youth on a more isolated reservation. In addition, the cross sectional nature of this research may have limited findings.

However, Native American communities are concerned about their youth, and are willing to work to produce better futures for them. This research shows that prevention efforts targeting the health of families, schools and the community as a whole may reduce symptoms and functioning problems for youth more effectively than attempting to increase adolescent's links to their culture. This does not mean that such cultural efforts are unimportant, but it does mean that at these levels they are not effective in reducing symptoms in the highly traumatic environments of these youth.

References

Achenbach, T. M. (1991). *Manual for the Youth Self-Report and 1991 profile*. Burlington: Department of Psychiatry, University of Vermont.

Aponte, J. F. & Johnson, L. R. (2000). The impact of culture on the intervention and treatment of ethnic populations. In J. F. Aponte & J. Wohl (Eds.), *Psychological intervention and cultural diversity (2nd ed.)*. Needham Heights, MA: Allyn & Bacon.

Bird, H. R., Shaffer, D., Fisher, P., Gould, M. S. Staghezza, B., Chen, J. Y., & Hoven, C. (1993). The Columbia Impairment Scale (CIS): Pilot findings on a measure of global impairment for children and adolescents. *International Journal of Methods and Psychiatric Research, 3*, 167-176.

Oetting, E. & Beauvais, F. (1991). Orthogonal cultural identification theory: The cultural identification of minority adolescents. *International Journal of Addictions, 25*(5A&6A), 655-685.

Robins, L. & Helzer, J. E. (1994). The half-life of a structured interview: The NIMH Diagnostic Interview Schedule (DIS). *International Journal of Methods in Psychiatric Research Special Issue: A ten-year retrospective on the NIMH Epidemiologic Catchment Area (ECA) Program 4*(2), 95-102.

SAS Institute Inc. (2000). *SAS procedures guide*, (Version 8). Cary, NC: SAS Institute Inc.

STATA Corporation. (2001). *STATA Reference Manuals*, (Version 7). College Station, TX: Author.

Walters, K. L. & Simoni, J. M. (2002). Reconceptualizing Native women's health: An "indigenist" stress-coping model. *American Journal of Public Health, 92*(4), 520-524.

World Health Organization. (1999). *WHO disability assessment schedule II: Interviewer training manual (Version 3.1a: Phase 2 field trials).* Geneva, Switzerland: World Health Organization.

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Symposium Overview

The American Indian Multisector Help Inquiry (AIMHI)

Chair
Arlene Rubin Stiffman

Authors
Arlene Rubin Stiffman et al.
Catherine Woodstock Striley et al.
Gordon Limb et al.

Symposium Introduction

The papers from this symposium are all based on data from AIM-HI (American Indian Multisector Help Inquiry), a NIDA-funded study of service use and drug-use information on two American Indian populations, one urban and one reservation. The samples are unique in that both are from a Southwestern state, and this state provides stable, state-financed mental health services. A total of 401 youth were interviewed in person in 2001. Two hundred youth were from the reservation population, and 200 were from the urban population. These youth will later be followed yearly to obtain ongoing information about service needs and pathways of use.

Results reported in this group of papers address: (1) service utilization patterns; (2) the relationship between functioning and service utilization; (3) the impact of out-of-home placement on drug/alcohol use and service utilization; and (4) issues related to balancing research integrity with sensitivity to the human and cultural needs of participants for this population.

American Indian Teens: Southwestern Urban and Reservation Youths' Need for Services and Who They Turn to for Help

Arlene Rubin Stiffman, Eddie F. Brown, Catherine Woodstock Striley, Gordon E. Limb, & Emily Ostmann

Introduction

American Indian youth suffer from many problems that require services. American Indian youth have higher rates of substance use (Gfellner & Hundleby, 1995), antisocial behavior, pathological gambling, panic disorder (Novins, Harman, Mitchell, & Manson, 1996), depression (Dick, Manson, & Beals, 1993), and suicide (Manson, Beals, Dick & Duclos, 1989) than other ethnic groups. In addition, the gap for American Indian youth between service need and use is larger than the known large gap for the general population (Costello et al., 1995; Swinomish Tribal Mental Health Project, 1991). This paper details the service configurations reported for both the ruban and reservation study groups.

Method

Measures of service use came from the Service Assessment for Children and Adolescents (SACA; Stiffman et al., 2000). Data were collected on lifetime and past year use of informal, inpatient, outpatient, and school service settings. Questions were refined to include culturally relevant services, such as informal help and traditional American Indian healing practices.

Results

Seventy-nine percent of the youth had some mental health or addiction problems, and 25% percent of youth with a problem did not have any identified helper.

Youth who did receive help used a variety of service configurations or combinations of helpers. The three most common service configurations were: (a) only informal adult friends and peers (n = 54), (b) all helpers except traditional (n = 47), and (c) informal adult friends and specialist or nonspecialist professionals (n = 24). Reservation youth were twice as likely as urban youth to use "only informal

adult and specialist or nonspecialist professionals" (10% and 4.6%, respectively; $\chi^2 = 3.5$, $p = .05$). In contrast, twice as many urban youth than reservation youth used "all helpers except specialist or nonspecialist professional" (4.6% and 2.5%, respectively; $\chi^2 = 6$, $p = .01$).

Half of the youth met criteria for one or more diagnoses and almost one quarter met criteria for two or more. The more criteria a youth met, the more likely he or she was to use service configurations with informal adults, professionals, or specialists (see Table 1). In contrast, the pattern for peer help differed, as youth with only one diagnosis were more likely than youth with either no or two or more diagnoses to have a peer helper (63%, vs. 41% for no diagnosis, and 50% for two or more). There were no significant differences for youth using traditional healers.

Table 1
Use of Helper Type by Diagnostic Category (*N* = 345)

Helper Type	*No Diagnosis*	*One Diagnosis*	*Two or more Diagnoses*
Informal Adult	44%	61%	64%
Non-Specialist Professional	15%	29%	42%
Specialist Professional	3%	14%	23%
Peer Helper	41%	63%	50%

Youth reaching diagnostic criteria for drug dependence or abuse (27%), conduct disorder (24%), depression (20%) or alcohol dependence or abuse (13%) were three times more likely than those who did not meet the criteria to use service configurations with a specialist. Youth with alcohol dependence or abuse were more likely than youth without those disorders to use only the configurations with specialists or nonspecialists, not the other configurations. Uniquely, youth with depression were more likely than youth without depression to use configurations with peers or with traditional healers (65% vs. 45% for peers and 15% vs. 8% for traditional healers).

Regardless of the specific disorder, youth used the following providers in ascending order: traditional, specialist, nonspecialist, peer, and informal adult. There appeared to be no major differences between rates of use of traditional healers or specialists, and rates of use of nonspecialist professionals and peers. Not surprisingly, youth who used traditional healers and informal adults scored significantly higher on ethnic identity (ethnic identity scores of 16 vs. 8 for traditional healers, and 10 vs. 8 for informal adults).

Discussion

Use of service configurations with specialist providers for the American Indian youth was lower (less than 12%) than the known low rates for other ethnic groups (Burns, et al., 1995; Costello, et al., 1995; Stiffman, Dore, Cheng, & Chen, 1995). However, this lack of services was potentially offset by use of an extensive range of informal adults, nonspecialist professionals, peers, and traditional healers. Researchers must recognize the importance of the role of informal adult and peer helpers, and adjust their research questions to include these key elements of the natural service system. If informal helpers, nonspecialist providers, and traditional healers are providing the bulk of services, it is incumbent to provide them with the requisite support and skills so they can function effectively in this helper role.

American Indian Teen's Functioning Predicts Teen Desire for Talking About, and Receiving Services

Catherine Woodstock Striley, Arlene Stiffman, Emily Ostmann, & Eddie F. Brown

Introduction

Services researchers often measure symptomatology rather than functionality to predict both recognition of need for services and service receipt. This aspect of the AIM-HI explores the utility of measures of functioning through examination of three hypotheses: 1) that functioning predicts youth desire for services even though they haven't received any; 2) that functioning predicts youth talking to an adult about their problems; and 3) that functioning predicts actual service receipt.

Method

Questions designed to measure functionality came from the World Health Organization Disability Assessment II (WHO-DAS II; World Health Organization 2000), a promising instrument for measuring adolescent functioning in research and practice, capturing a great deal of variation with predictive validity. This instrument is a 12-item screener that includes an additional 24 items that are asked when a screening question is answered positively. The WHO-DAS II contains six domains: (a) understanding and communication, (b) getting around, (c) self-care, (d) getting along with people, (e) life activities (e.g., work and chores), and (f) participation in society. Functioning (weighted) is set as greater than or equal to 2, that is, there must have been one area of moderate difficulty on the screener, or 2 of mild to have a functioning difficulty, or the two questions in each area were both scored as mild difficulty.

Results

A little more than half (52%) of the sample of 401 youth had at least one moderate or two mild functioning difficulties due to physical, emotional or behavioral problems. Twenty three percent had problems with understanding and communicating. Functioning in the community was a problem for 21% of the youth. Nineteen percent had problems getting around. Eleven percent had functioning problems related to home responsibilities, and seven percent had problems with work, for a total of 18% having problems in the life domain. Getting along with others was effected in 18% of the youth. Self care, a physical functioning problem, was a problem for 2% of the youth.

Youth who received no services were more likely to desire services if they had functioning problems ($\chi^2 = 5.05$, $df = 1$, $p < .05$; see Table 1). Youth with functioning problems were significantly more likely to talk to and receive help from a parent, friend, elder, or Native leader about their problems ($\chi^2 = 4.59$, $df = 1$, $p < .05$; see Table 2). Youth with functioning problems also were more likely to receive services as predicted ($\chi^2 = 16.44$, $df = 1$, $p > .0001$; Table 3).

Table 1
Functioning by Youth Desire for Help If Not Helped (*n* = 216)

	No functioning problem	*Functioning problem*
No youth desire	94 (88)*	91 (97)
Youth desire	9 (15)	22 (16)

$\chi^2 = 5.05$, $df = 1$, $p < .05$ (*expected cell frequencies)

Table 2
Functioning by Talking about Problem to Family/Friend/Tribal Leader/Elder

	No functioning problem	*Functioning problem*
No talking	82 (71)	74 (84)
Talking about problem	102 (112)	143 (133)

$\chi^2 = 4.59$, $df = 1$, $p < .05$

Table 3
Functioning by Service Receipt

	No functioning problem	*Functioning problem*
No service receipt	34 (21)	12 (25)
Service receipt	150 (163)	205 (192)

$\chi^2 = 16.44$, $df = 1$, $p < .0001$

Discussion

Results suggest that youth functioning is relevant to youth feeling a need for help, to youth reaching out for that help by talking to significant adults, and to youth receipt of services. Reduced functioning also seems to trigger adults to provide services for teens. However, functioning is seldom measured formally by practitioners, and is not always measured by services researchers when looking at recognition of need for services and access to services. Adults may pay more attention to the youth's reduced functioning, and functioning measures may thus be helpful in predicting and increasing youth access to services.

The Impact of Out-Of-Home Placement on American Indian Teens' Drug Use and Service Utilization

Gordon Limb, Eddie F. Brown, Arlene Stiffman, Catherine Woodstock Striley, & Emily L. Ostmann

Introduction

This paper examines the relationship of out-of-home placement of American Indian teens to drug and alcohol use and service utilization. Surveys conducted in the mid-1970s found that 25% to 35% of all American Indian children had been separated from their families (Byler, 1977). Historically, high rates of problems on American Indian reservations have been linked to the devastating effects of large numbers of American Indian children being separated from their families (Plantz, Hubbell, Barrett, & Dobrec, 1989). Prior studies of American Indian teens report a substantial decrease in drug use and suicidal activity for those who utilize formal and informal helpers (Centers for Disease Control, 1998).

Method

Measures of alcohol and drug abuse or dependence, depression, conduct disorder, and posttraumatic stress came from the National Institute of Mental Health's Diagnostic Interview Schedule (DIS-IV; American Psychiatric Association, 1994; Robins & Helzer, 1994).

Results

Fourteen percent of the youth ($n = 57$) had experienced prior placement in out-of-home care. Specifically, 19 (33.3%) reported being placed in a foster/kinship home, 12 (21.0%) in a group home, 13 (22.8%) in a shelter or residential institution, and 13 (22.8%) in an other placement setting. When comparing youth with and without lifetime placement in out-of-home care, youth in out-of-home care were 1.5 times more likely than youth not in out-of-home care to have drug problems (57.9% and 38.2% respectively, $\chi^2 = 7.8$, $p = .006$) and were 1.7 times more likely than youth not in out-of-home care to have alcohol problems (36.8% and 22.4% respectively, $\chi^2 = 5.5$, $p = .03$).

American Indian teens placed in out-of-home care were 1.8 times more likely than those not in out-of-home care to access professionals (73.7% and 40.2% respectively, $\chi^2 = 22.1$, $p < .001$) and were 1.7 times more likely to use traditional healers/helpers (24.6% and 14.1% respectively, $\chi^2 = 4.1$, $p = .05$). More importantly, American Indian teens placed in out-of-home care were 1.3 times more likely to solicit help from family members than teens who were not in out-of-home care (83.9% and 65.5% respectively, $\chi^2 = 7.5$, $p = .005$). Even after being separated from their parents, a higher proportion of American Indian teens placed in out-of-home care still went to their parents for help. Of youth reporting that they went to their parents for help, 56.1% were in out-of-home care, and 48.4% were not. American Indians placed in out-of-home care were also significantly more likely than American Indians not placed in out-of-home care to go to grandparents (1.8 times more likely, 43.6% and 24.6% respectively, $\chi^2 = 8.6$, $p = .005$) and other relatives (1.5 times more likely, 64.9% and 44.6% respectively, $\chi^2 = 8.1$, $p = .006$) for the help they need.

Discussion

Even in circumstances resulting in out-of-home placement of American Indian children and youth, family ties were not broken. In fact, when seeking help, the kinship or family network was actually utilized to a significantly greater degree than for those not placed in out-of-home care.

Research Solutions for Cultural and Human Subjects Issues Concerning American Indian Youth

Arlene Rubin Stiffman, Eddie F. Brown, Catherine Woodstock Striley, Gordon E. Limb, & Emily Ostmann

Introduction

Researchers have a basic dilemma in handling the competing pressures between research and the ethical needs of human subjects. For example, research must: (a) obtain the same responses each time from each person, (b) avoid influencing the responses, (c) avoid interfering with natural changes over time, and (d) maintain promises of confidentiality. How can one handle these issues without either impacting research integrity or violating ethical concerns? This question is especially poignant for research among American Indians, as they have a history of having been "cheated" by unscrupulous business and research arrangements.

Methods

Initial project planning for AIM-HI interviews was made with the guidance of a research implementation team composed of tribal elders, American Indian human service workers, council members, parents, and representative youth. Extensive plans were incorporated in the research to reassure the community that the youth would not be stressed, and that any questions that the community thought engendered stress would be brought to the attention of the appropriate authorities.

Two methods were implemented. First, sensitive questions were flagged in the computerized interview. At the end of the interview, if any flagged questions had been answered positively, a procedure was initiated through additional follow up questions for referral of the youth to services, an abuse/neglect hotline report, or an emergency suicidal intervention service. The researchers arranged, in both the urban and the reservation areas, individualized service providers on 24-hour call. Second, sections that the council members thought might be upsetting were prefaced with the statement that "some people may wish not to answer these." The youth were also shown the questions so they could decide whether they wanted to skip the section or answer it themselves without an interviewer.

Results

Despite being given the choice to "skip out" of seven different sections of the interview, most youth did not skip any sections (90%), while 4% skipped one, 1% skipped two, and 1% skipped three or more.

Almost 90% of the youth were flagged as having problems. Over one-third had a flag triggered for abuse or neglect, one-third had a flag triggered for suicidality, and the other flags were triggered for environmental issues. This rate was 2-3 times higher than in the authors' other research projects, but consonant with the known high needs of the American Indian community.

Reports of abuse presented a significant problem, especially because the communities are close knit and small. Of those youth who triggered a flag for abuse, approximately one quarter were already involved with protective services, 5% agreed to an immediate call with the interviewer to protective services. When asked to clarify the bullying incident, 20% described an incident that was clearly not abuse (e.g., bullying or being picked on in a playground). For 40% of respondents, the last occurrence of abuse was over a year ago, with half of those having been ten or more years ago. Over 10% said they already received help and were now in a new family situation (i.e., the abuser had left home, or was incarcerated).

A third of the youth reported feelings of suicidality, with 30% having thought about it and over 15% having attempted suicide. For actively suicidal feelings, the interviewer stayed with the youth until a parent or provider was present. Only 18% of the youth with a suicidality flag were currently suicidal. Almost all agreed to call a crisis line, call a parent, or call a doctor. Of the youth who were not actively or currently suicidal, 22% refused any help.

For both abuse and suicidality, incident reports documented the flags and the youth's responses. The interviewer's supervisor was informed immediately. In the reservation area, these incident reports were turned over to Human Services. At the specific request of the agency and of the tribal council, human services were to screen those reports and provide services.

Discussion

The pressure within the American Indian community to provide services, and the concern about the sensitivity of the questions asked, required creative balancing of human subjects and ethical issues with the research concerns. The positive response of so many youth to questions that required services strained the project. Despite these difficulties, the researchers and the American Indian community were satisfied that the interview did bring many youth who were in need of services to the attention of providers.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders. (4th revised ed.)*. Washington, DC: Author.

Burns, B. J., Costello, E. J., Angold, A., Tweed, D., Stangl, D., Farmer, E. M. Z., & Erkanli, A. (1995). Children's mental health service use across service sectors. *Health Affairs 14*(3), 147-159.

Byler, W. (1977). Removing children: The destruction of American Indian families. *Civil Rights Digest, 9*(4), 19-27.

Centers for Disease Control. (1998). Youth risk behavior surveillance: United States, 1997. *Morbidity and Mortality Weekly Report 47*(3), 1-89.

Costello E. J., Angold A., Burns, B. J., Farmer, E. M. Z., Stangl, D. K., Erkanli, A. & Messer, S. C. (1995). Great Smoky Mountains study: 1. Use of service for mental health care. *NIMH Mental Health Services Research Conference*.

Dick, R. W., Manson, S. M., & Beals, J. (1993). Alcohol use among male and female Native American adolescents: Patterns and correlates of student drinking in a boarding school. *Journal of the Study of Alcohol 54*(2), 172-177.

Gfellner, B. M., & Hundelby, J. D. (1995). Patterns of drug use among Native and white adolescents: 1990-1993. *Canadian Journal of Public Health 86*(2), 95-97.

Plantz, M., Hubbell, R., Barrett, B., & Dobrec, A. (1989). Indian child welfare: A status report. *Children Today, 18*(1), 24-29.

Manson, S. M., Beals, J., Dick, R. W., & Duclos, C. (1989). Risk factor for suicide among Indian adolescents at a boarding school. *Public Health Report 104*(6), 609-614.

Novins, D. K., Harman, C. P., Mitchell, C. M., & Manson, S. M. (1996). Factors associated with the receipt of alcohol treatment services among American Indian adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*(1), 110-117.

Robins, L. N., & Helzer, J. E. (1994). The half-life of a structured interview: The NIMH Diagnostic Interview Schedule (DIS). [Special Issue: A ten-year retrospective on the NIMH Epidemiologic Catchment Area (ECA) Program]. *International Journal of Method in Psychiatric Research, 4*(2), 95-102.

Stiffman, A. R., Horwitz, S. M., Hoagwood, K., Compton, W., Cottler, L., Narrow, W., & Weisz, J. (2000). Adult and child reports of mental health services in the Service Assessment for Children and Adolescents (SACA). *Journal of the American Academy of Child and Adolescent Psychiatry, 39*(8), 1-8.

Stiffman, A. R., Doré, P., Cheng, L., & Chen, Y. (1995). Adolescent mental health problems and health clinic treatment. Paper presented at *The 8th Annual Research Conference, A System of Care for Children's Mental Health: Expanding the Research Base.* Tampa, FL.

Swinomish Tribal Mental Health Project. (1991). *A gathering of wisdoms, Tribal mental health: A cultural perspective*. Mt. Vernon, Washington: Veda Vanguard.

World Health Organization (2000). *World Health Organization Disability Assessment II Training Manual: A Guide to Administration*. Geneva: Author.

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Symposium Overview

Strengths of African-American Families: Identifying and Building on African-American Family Strengths

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Discussant
Robert Hill

Presenters
Gwen McClain
W. James Favorite
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Introduction

The purpose of the African-American Family Supports Coalition (AAFSC) analysis was to identify strengths of African-American families in order to help improve the services or systems of care that are most utilized by them. The analysis focused on providing data that would help to better understand and assess the community-based family support systems designed to meet the needs of children and families in African-American communities. This analysis provides findings that can be useful in developing a culturally-sensitive instrument for service delivery (see "Developing a strengths based instrument for African-American children and families," this volume). This paper will describe the integrated approach used to identify African-American family strengths and community supports in the Tampa Bay area. It will highlight the university/community and neighborhood partnerships involved in this initiative, along with the strength-based, action research and grounded theory approaches used as the overall research methodologies in this project.

Many early studies characterized African-American families as being highly unstable, disorganized, deprived, and disadvantaged. This deficit model leads to a service system that fails to address strengths in African-American children and their families. Although a theoretical framework that recognizes strengths of African-American families is being constructed, there remains a lack of definitive research in this area.

AAFSC Community Context and Background

The AAFSC was established in 1997 to plan, coordinate and implement a project to collect information that could be used by human service providers—and to initiate a plan of action to increase community capacity to more effectively empower families in African-American neighborhoods in Hillsborough County. Key individuals in the community formed the initiative as a way to begin discussing the need for an analysis of African-American family support systems and a coordinated service delivery system. The group was comprised of individuals representing a broad spectrum of the community, and included many other individuals and organizations within the community that the group had identified as potential coalition members. These coalition members work in partnership with the University of South Florida, Hillsborough Community College, and Beulah Institutional Baptist Church, to promote of African-American family strengths.

The 1997/1998 AAFSC Analyses

Through the proposed analysis, The AAFSC membership outlined three goals that it sought to accomplish: (a) to create, from existing services, a community-wide coordinated team of stakeholders with the expertise, willingness and the ability to make positive changes in their communities through the service delivery process; (b) to create strategic action plans that would promote resiliency in African-American families, and; (c) to create awareness and provide educational opportunities through earnest and honest discussions that address a culturally sensitive service delivery system.

The analysis was conducted in two phases. Phase I involved strategic community planning that included a series of neighborhood meetings where volunteers and partners were recruited; information gathering and sharing were the intended outcomes of these meetings. The primary focus of Phase I was to assemble a diverse, representative group of community stakeholders who would assist in a more in-depth system analysis and determine the target and scope of the initiative activities. The details of the analysis plan were contingent upon the outcome of the discussions and planning meetings with

this larger group of stakeholders. In Phase II of the analysis, data were gathered from multiple sources. Data were then analyzed and disseminated though summit meetings, reports, and presentations.

AAFSC Project Framework

The overall AAFSC project involved several theoretical frameworks, philosophies and principals. For example, the project adopted a university and community partnership approach by which university researchers use the most fundamental components of action research theory to implement the project. This strategy helped to build relationships with communities. The AAFSC also used a multi-faceted research approach based on the fundamental belief that families and individual members within various family structures possess certain strengths, and that communities also have resources and strengths. The project adopted several theoretical frameworks, including: (a) Hill's findings (1972, 1997, 1998); (b) a grounded theory approach (Glaser & Strauss, 1967; Strauss, 1990); (c) action research (Dick, 1997; Lewin, 1946; O'Brien, 1998; (d) systems of care (Stroul & Friedman 1996); and (d) community development (Anderson, Kubisch, & Connell, 1998). The framework that finally emerged was based on some of the elements and principles related to the strength-based models (Hill, 1972, 1997), action research and grounded theory. The framework also reflects the experiences, expertise and values of the research team. Other features of the AAFSC include its own unique philosophy about how the study was to be implemented. This study was centered on Stroul and Friedman's system-of-care principles that are community-based, family-centered, culturally sensitive, and strengths-based.

Methodology and Findings

The overall methodology used in this study included a number of research methods that are briefly discussed in this section.

Local Literature. Information from a local literature review, along with national, state and local data, were analyzed. Local data from newspaper articles, as well as a number of studies and reports, formed the basis of this review.

Documented Research. Research literature on the strengths that exist within African-American families and their communities were also synthesized. More than 100 articles were reviewed; a majority supported the traditional deficit-deficiency model describing African-American families.

Census Analysis. A census analysis of the was also undertaken to identify demographic factors including family type, education, home ownership, and employment for four Tampa Bay area neighborhoods. Twenty-four maps and eleven tables containing current local demographic information on families and households were examined. Assets were found in the areas of family roles, kinship bonds, work orientation and the corresponding areas of income, school enrollment, academic achievement, education and employment.

Community Summits. Community summit meetings were held with providers, residents and other professionals to gather additional information on perceptions, strengths and resources within the target communities. Community participants also reflected on various strategies that they found helpful when working collaboratively with university researchers. They shared their experiences and assisted with funding plans and implementation of services using strength-based neighborhood oriented approaches. Fifty-five participants attended these summits; some residents were identified for leadership roles (i.e., taking positive community action), and were asked what government and other agencies could do to assist them.

Focus Groups. Focus groups were held with successful children, parents of successful children, seniors, at-large residents, educators and service providers in two of the target neighborhoods. Characteristics for *successful children* were determined by community members, and included: an academic grade point average of at least 2.7; clearly identified goals and aspirations; appropriate dress; a demonstrated sense of self; creativity; and the ability to maintain positive relationships with family

members, adults, and peers. As shown in Table 1, this group arrived at nine family strengths.

Table 1
Family Strengths

1. Spirituality and a strong church foundation
2. Discipline within the family structure
3. Immediate and extended family support
4. Positive role models
5. Open communication between parent (adult) and minor child
6. Parental Support
7. Quality time with children
8. Emphasis on education
9. Unconditional love

Global Findings

The major findings of this analysis are referred to as *global strengths of African-American families* (Briscoe & McClain 2000). The global findings constitute a synthesis of each analysis and their methodologies. Overall, the project participants identified seven core strengths that exist in African-American families and communities (see Table 2).

Recommendations and Lessons Learned

Throughout the project there were lessons learned that were important to improving the process and to ultimately achieving project outcomes or goals. Lessons Learned are categorized in three areas: (a) managing the collaborative process, (b) engaging community residents as equals in a collaborative initiative, and (c) implementing research strategies with and within communities. In order to address the recommendations that came out of this project, a comprehensive partnership approach was used to promote Strengths-Based Solutions (S-B-S) for local problems. The aim of the S-B-S is to increase the awareness of available services and resources within the community, develop formal linkages and partnerships, and to implement strategies using strength-based neighborhood oriented approaches.

Table 2
Community Strengths

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

Five committees are charged with the mission of building on the African-American strengths identified by the AAFSC. These committees operate in the following areas: (a) strengthening the coalition; (b) promoting strength-based practices; (c) implementation or, and community support for, building strengths; (d) resource development; and (e) accountability and quality improvements.

Discussion

Robert B. Hill

The work by the USF research team and its community partners have many important implications for similar efforts throughout this country. First, it suggests that in order to revitalize low-income communities, it is imperative that initiatives build on their assets and capabilities. Second, such interventions will only succeed when grassroots groups are made genuine partners in all phases of decision-making and implementation. Third, the AAFSC has meticulously worked to develop a culturally-sensitive strategy to identify the strengths of African-American families and communities.

An instrument to measure African-American strengths will be based upon the findings of the AAFSC study. The instrument will be one of the few assessment tools in this nation to be developed and validated based on periodic feedback from community residents. The following symposium overview, "Developing a strengths-based instrument for African-American children and families" (this volume) discusses this pioneering tool. When completed, this instrument will make a major contribution toward enhancing the resilience of families and empowering communities of color.

References

Briscoe, R. V., & McClain, G. (2000). *African-American family support analysis: Strengths of African-American families*. Tampa, FL: Children's Board of Hillsborough County.

Dick, B. (1997). *Action learning and action research*. Retrieved from: www.scu.edu.au/schools/gcm/ar/arp/actlearn.html

Glasser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine.

Hill, R. (1972). *The strengths of Black families*: New York, NY: Emerson Hall Press.

Hill, R. (1997). *The strengths of Black families: Twenty-five years later*. Washington, DC: R & B Publishers.

Hill, R. (1998). Enhancing the resilience of African-American families. In L. A. See (Ed.), *Human behavior in the social environment from an African-American perspective*. New York: Hawwin Press.

Lewin, K. (1946). Action research and minority problems. *Journal of Social Issues, 2*(4), 34-46.

O'Brien, R. (1998). *An overview of the methodological approach of action research*. University of Toronto. Retrieved from: www.web.net/~robrien/papers/arfinal.html

Strauss, A.. (1990). *Basics of qualitative research: Ground theory procedures and techniques*. Newbury Park, CA: Sage.

Stroul, B., & Friedman, R. (1996). *A system of care for children and youth with severe emotional disturbances (revised edition)*. Washington, DC: Georgetown University Child Development Center, CASSP, Technical Assistance Center.

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Symposium Overview

Developing a Strengths-Based Instrument for African-American Children and Families

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Discussant
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Presenters
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Introduction

Identifying Strengths in African-American Families (ISAAF) is a two-year study designed to develop an instrument for measuring strengths in African-American families. ISAAF was aimed at validating or nullifying findings from two previous studies by the African-American Family Supports Coalition (AAFSC), conducted in 1997 and 1998 (see "Strengths of African-American families: Identifying and building on African-American families' strengths," this volume). The findings of the AAFSC comprised several key factors crucial to determining the successful well being of African-American children and families and to help families and providers assess individual and family strengths. The purpose of this paper is to briefly describe the major family and child strength findings obtained from ISAAF's year 2000 focus groups, and the strengths-based instrument development process in year 2001.

Methodology

ISAAF's basic research framework was embedded in a *grounded theory* and *action research* strategy. The former stresses *discovery work* and theory development, where data are grounded in the realities of the lived experiences of the targeted study group (Strauss & Corbin, 1998). The latter strategy involves the themes of "learning by actions" (O'Brien, 1998), and of concurrently pursuing action and research outcomes.

Focus groups

Focus groups comprised the primary data collection tool to engage community residents and service providers in conversations about their opinions and insights on family and child strengths, strategies and methods they use to raise healthy, successful children and youth. Twenty-five focus groups were conducted in Baltimore, Detroit, San Diego, Savannah, and Plant City, Florida. There were five discussants in each group and groups consisted of successful youth ages 11-17, parents of successful youth, senior citizens, at-large community residents, and service providers. Characteristics for *successful youth* were determined by community members, and included academic achievement and social goals (e.g., a demonstrated sense of self; creativity; the ability to maintain positive relationships with family members, adults, and peers; appropriate dress; and goals and aspirations). Focus group transcripts were then analyzed and summit meetings were held at the five sites to report on research findings and to provide feedback to families.

Demographic Profile

One hundred eighty-eight participants took part in the focus groups. Table 1 provides a breakdown of participants across the five groups.

The youth were between 11 and 17 years old (except for one 18 year old), and adults were from 19 to 85 years old. The majority of participants were female.

Table 1
Participants by Group

Site	*Youth*	*Parents*	*Seniors*	*At-Large*	*Service Providers*	*Total*
Baltimore	6	4	4	7	7	28
Detroit	7	5	10	8	9	39
Plant City	8	9	10	8	6	41
San Diego	8	6	11	10	9	44
Savannah	5	7	7	7	10	36
Total	34 (18%)	31 (17%)	42 (22%)	40 (21%)	41 (22%)	188

Fifty-eight (40%) of our families were married, 44 (30%) were single, 10% were divorced, and 20% were widowed. Most were also long time residents of their respective communities and were reportedly caring, in total, for 162 children.

Of 113 adult participants, 66 (58%) were employed and 47 (42%) were unemployed. Information available on home ownership for 146 participants showed that 67 (45%) rented, and 78 (53%) owned their own homes. One respondent had other living arrangements. Earned income data available for 140 of the participants indicated that 47% made less than %20,000 per year, 24% made between $20-$35,000 per year, and 29% made more than $35,000 per year.

Results

On Strengths

An increasing number of studies have focused primarily on Black family strengths rather than weaknesses or deficits. Scholars theorize that African-American families utilize methods of coping and patterns of engaging with the social environment that have proven to be instrumental in helping them combat the oppressive forces and conditions of American society (Billingsley, 1968; Hill, 1972, 1997; Nobles 1974, etc.). ISAAF and the earlier AAFSC studies (Briscoe & McClain, 2000; Joseph, Briscoe, Smith, Sengova, & McClain., 2001) suggest that family structures and relationships as well as extended kinship care provide fundamental strengths and viable resources in African-American families. Fifteen family and 13 child strengths were obtained from ISAAF's 2000 focus group findings.

Family Strengths

Table 2 represents the 15 cross-site Family Strengths obtained from reviews and analyses of the focus group transcripts and compares their distribution among the five sites. The strengths numbered 1 through 10 were identified consistently across all five sites; 11 and 12 were reported by four sites, while 13 was reported in three sites. Strength number 14 was reported in two sites, and 15 was reported in one site.

Many of the 15 identified Family Strengths are complemented by other research findings. For instance, Extended Family Support and Effective/Positive Role Models (3 and 4) reportedly exemplified through relatives, friends, churches and other community-based agencies, were identified consistently; they are also supported by previous research (Hill, 1972, 1987; Hurd, Moore, & Rogers, 1995; Martin & Martin, 1978, 1985; Smith, 1994, 1998; Staples & Boulin-Johnson, 1993; Rapp, 1998). Some researchers also suggest that the care giving and helping tradition continues on within many African-American families where many children of color are not reared by one or two parents, but by a caregiving system of related and non-related kin (Hill, 1972; 1997, Martin & Martin, 1978, 1985; Stack, 1974).

Child Strengths

With regard to Table 3, all of the five sites consistently identified the first four Child Strengths, while four sites identified strengths 5, 6 and 7. The rest, strengths 8 through 13, were identified in as many as three, and in at least one, of the five sites.

Instrument Development

ISAAF's instrument development process involved the following steps adapted from Crocker and Algina (1986):

1. Identifying the purpose of the instrument,
2. Identifying behaviors and defining domains,
3. Constructing initial pool of items,
4. Reviewing and revising items,

Table 2
Cross-Site Summary of Family Strengths

Number	Strengths	Previous Study	Baltimore	Detroit	Plant City	San Diego	Savannah
1.	Emphasis on Education/High Expectations	Yes	Yes	Yes	Yes	Yes	Yes
2.	Parental Support, Supervision and Guidance	Yes	Yes	Yes	Yes	Yes	Yes
3.	Extended Family Support	Yes	Yes	Yes	Yes	Yes	Yes
4.	Effective/Positive Role Models	Yes	Yes	Yes	Yes	Yes	Yes
5.	Spirituality	Yes	Yes	Yes	Yes	Yes	Yes
6.	Family Cohesiveness/Family Structure	Yes	Yes	Yes	Yes	Yes	Yes
7.	Open Communication and Trust	Yes	Yes	Yes	Yes	Yes	Yes
8.	Discipline	Yes	Yes	Yes	Yes	Yes	Yes
9.	Teaching Values to Children by Action and Example e.g. honesty	Yes	Yes	Yes	Yes	Yes	Yes
10.	Unconditional Love	Yes	Yes	Yes	Yes	Yes	Yes
11.	Family Activities/Broader Exposure For Children	Yes	Yes	Yes	No	Yes	Yes
12.	Family Security/Consistency	No	Yes	No	Yes	Yes	Yes
13.	Strong work ethic	No	Yes	No	Yes	No	Yes
14.	Strong survival skills	No	Yes	No	Yes	No	No
15.	Cultural Awareness and Identity	No	No	No	No	Yes	No

[1] Though the study also obtained findings on a set of more global African-American 'Community' strengths, such as strong community-based organizations and support networks, these assets are not discussed in the present analysis

Table 3
Cross-Site Summary of Children's Strengths

Number	Strengths	Baltimore	Detroit	Plant City	San Diego	Savannah
1.	Positive Self Image/High Esteem	Yes	Yes	Yes	Yes	Yes
2.	Focused/Motivated and Hardworking	Yes	Yes	Yes	Yes	Yes
3.	Determined/Resilient	Yes	Yes	Yes	Yes	Yes
4.	Leadership/serve as role models	Yes	Yes	Yes	Yes	Yes
5.	Respectful/Obedient	Yes	No	Yes	Yes	Yes
6.	Responsible	No	Yes	Yes	Yes	Yes
7.	Talented/Competent/Possess certain skill	Yes	Yes	Yes	Yes	No
8.	Helpful/Altruistic	No	Yes	No	Yes	Yes
9.	Independent	Yes	No	Yes	Yes	No
10.	Ability to make good judgment and choices	Yes	Yes	No	No	Yes
11.	Confident/Self efficacy	No	Yes	Yes	No	No
12.	Honest and Trustworthy	No	No	No	Yes	Yes
13.	Culturally Aware	No	No	No	No	Yes

5. Pilot testing the instrument,
6. Field testing the items,
7. Determining statistical properties on item scores,
8. Designing and conducting reliability and validity studies, and
9. Developing guidelines for instrument administration.

In addition to reviewing the literature on instrument development and African-American strengths, researchers successfully completed steps 1 through 5 above. Step 2, identifying behaviors and defining domains, and step 5, pilot testing, were particularly crucial to the instrument development process.

Identifying Behaviors and Defining Domains

In order to identify the behaviors and define the domains, an iterative test specification process was used to elucidate the substantive content of the fifteen Family Strength domains. This iterative test specification involved describing behaviors, activities and values using the nuances and terminology articulated by focus group participants. This was an extremely important step because it ensured that the terminology, language and cultural ethnic nuances of the African-American families were captured from the data.

Pilot Test and Data Analysis

We pilot tested the items at the end of 2001. The purpose of the pilot test was to assess the consistency of the two-domain instrument, ensure that the targeted population could understand and relate to the items, and to test the process of administering the instrument. The pilot instrument comprised three sections: Values and Beliefs; Activities and Behaviors; and Qualities and Conditions (see Tables 4, 5, and 6 below). Adhering to the original goal of creating a family-centered and user-friendly instrument, the pilot test instrument was designed to be very clear and easy to read. To help ensure this, Likert scales (i.e. strongly agree, agree, disagree, strongly disagree) were also used for most of the items.

Table 4
A Summary of the Two-Domain Instrument Used for the Pilot Test

Domains/Sub-scales	*# of Items*	*Scale Type*	*Scales Measures*
Spirituality			
Values	15	4 Point Likert	Agreement
Qualities	6	4 Point Likert	Agreement
Behavior	9	4 Point Likert	Agreement
My church services	22	Dichotomous	Yes/no
Other churches services	22	Dichotomous	Yes/no
Spiritual Involvement	11	4 Point Likert	Frequency
Spiritual Participation	23	4 Point Likert	Frequency
Education			
Value	29	4 Point Likert	Agreement
Qualities	4	4 Point Likert	Agreement
Behavior	24	4 Point Likert	Agreement

Table 5
Selected Results from Reliability Analysis for Two Scales, 10 Subscales and a Global Score on Pilot Study of Assessment Instrument with Two Domains *N*=26

Scales/Subscales	*N*	*Mean*	*SD*	*Number of Items*	*Alpha*
Spirituality	12	221.50	18.06	98	.8987
Spiritual Values & Beliefs	25	55.96	3.92	15	.8538
Spiritual Qualities & Conditions	22	20.09	6.85	6	.7449
Spiritual Behaviors	21	32.10	3.03	9	.7391
My Church's Supports and Services	22	33.45	4.96	22	.8882
Other Church's Supports and Services	23	34.87	7.26	22	.9561
Involvement in Activities at Churches	24	32.54	5.92	10	.9684
Participation in Spiritual Activities	19	25.47	10.73	22	.8719
Education/High Expectation	17	198.35	18.83	57	.9552
Education/High expectation values & beliefs	21	104.24	8.35	29	.8996
Education/High expectation Qualities & Conditions	23	12.17	2.33	4	.7123
Education/High expectation Behaviors	19	82.37	8.77	24	.9095
Pilot Global Score	09	428.44	32.29	154	.9536

Table 6
Selected Results from Reliability Analysis for 6 Subscales From Sum of Newly Created Variables on Knowledge and Availability of Specific Church Services *N* = 26

Subscales	*N*	*Mean*	*SD*	*Number of Items*	*Alpha*
Knowledge of My Church's Supports and Services	22	41.86	6.19	23	.9541
Knowledge of Other Churches' Supports and Services	23	37.91	7.31	22	.9646
Total knowledge of Churches' Supports and Services	20	79.50	12.02	45	.9684
Availability of Own Church's Supports and Services	22	32.55	4.96	22	.8882
Availability of Other Churches' Supports and Services	23	31.13	7.26	22	.9561
Total Availability of Churches' Supports and Services	20	63.90	10.40	44	.9429

The pilot sample was obtained through an outreach and screening process similar to that used in the recruitment of the focus groups. Twenty-six African-American caregivers who were raising or had previously raised children were selected. They ranged in age from 19 to 74 years, with a mean average age of 45 years.

Data analyses of the pilot test included the sample's socio-demographic data from the screening forms and the psychometric qualities of the instrument. Statistical analysis of the instrument was based on participants' responses to the pilot test items and a descriptive analysis was performed on all variables. Data were re-coded, making positive responses the higher values to aid in interpreting findings. Cross tabs and an independent means *t*-test were performed on all scales using successful/non successful status to get some indication as to how the two groupings scored differently. No significant differences were revealed between any scale or sub-scale scores.

Pilot Test Results and Findings

Initial data analysis indicated that overall, the items used to measure the two pilot domains of Spirituality and Education were fairly consistently matched and showed promising internal consistency on all scales. As indicated in Table 5, these items generally had alpha scores of .70 and above. ISAAF researchers consider this estimate promising and a move in the right direction because it shows that the items in each of the two domains share much in common.

Discussion

ISAAF findings on African-American strengths obtained through these focus groups provided a strong foundation for the development of a strengths-based instrument. When fully developed, this instrument is expected to help African-American families, as well as their service providers, to identify family strengths. Furthermore, it is expected that, with the support of their service providers, families can use these strengths to help support and nurture successful African-American children.

In order to revitalize low-income communities, it is imperative that initiatives build on their assets and capabilities. Yet such initiatives will only succeed when grassroots groups are made genuine partners in all phases of decision-making and implementation. ISAAF researchers have been committed to the scientific rigor involved in developing a culturally-sensitive instrument to identify the strengths of African-American families and communities; this is one of the few assessment tools in this nation to be developed and validated based on periodic feedback from community residents.

In summary, the implications and expectations of the value of this strengths-based instrument remain very positive. Further studies are needed however, to help validate and expand on some of the ISAAF strengths not previously identified; and more research on children's strengths is needed to support/nullify some of the child strengths identified in this study. Researchers will pilot test the complete instrument with all fifteen strengths domains in 2002, and field-testing, reliability and validity testing are scheduled to occur in 2003 and 2004.

References

Billingsley, A. (1968). *Black families in white America*. Englewood Cliffs, N.J.: Prentice Hall.

Bonecutter, J., & J.P Gleeson. (1999). *Achieving permanency for children in kinship foster care: A training manual*. University Chicago Press.

Briscoe, R. V., & McClain, G., (2000). *African-American family support analysis: Strengths of African-American families.* Tampa, FL: Children's Board of Hillsborough County.

Hill R. (1997). *The strength of Black Families: Twenty five years later*. Washington, DC: R & B Publishers.

Hill, R. (1972). *The strengths of Black families*: New York, NY: Emerson Hall Press.

Hurd, E. P., Moore, C., & Rogers, R. (1995). Quiet success: parenting strengths among African-Americans. *The Journal of Contemporary Human Services. 76*(7), 434-443.

Joseph, R., Briscoe, J. R., Smith, A., Sengova, J., & McClain, G. (2001). *Strengths of African-American families: A cross-site analysis of families in Baltimore, Detroit, Plant City, San Diego and Savannah*. Tampa, FL: Department of Child and Family Studies, Louis de la Parte Florida Mental Health Institute, University of South Florida.

Martin, E. P., & Martin, J. M. (1978). *The Black extended family*. Chicago: University of Chicago Press.

Martin, J. M., & Martin, E. P. (1985). *The helping tradition in the Black family and community.* Silver Spring, MD: National Association of Social Workers.

Nobles, W. (1974). African Root and American Fruit. *Journal of Social and Behavioral Sciences*, *16*: 52-64.

O'Brien, R. (1998). *An overview of the methodological approach of action research*. University of Toronto. Retrieved from: www.web.net/~robrien/papers/arfinal.html

Rapp, C. A. (1998). *The strengths model; Care management with people from severe and persistent mental illness*. New York: Oxford University Press.

Smith, A. (1994, Summer). African American grandmothers' war against the crack cocaine epidemic, *Arete*, 19. University of South Carolina Press.

Smith, A. (1998). Sisterhood among African-American mothers of daughters addicted to crack cocaine. In Kim M. Vaz (Ed.). *Black women in America*. Thousand Oaks, CA: Sage.

Stack, C. (1974). *All our kin*. New York: Harper & Row.

Staples, R., & Boulin-Johnson, L. (1993). *Black families at the crossroads: Challenges and prospects*. San Francisco: Jossey-Buss.

Strauss, A., & Corbin, J. M. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage.

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