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Buffering Effect of Relational Support in African American Marriages

Aimee Galick
Loma Linda University

LOMA LINDA UNIVERSITY
School of Behavioral Health
in conjunction with the
Faculty of Graduate Studies

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The Buffering Effect of Relational Support in African American Marriages

by

Aimee Galick

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the requirements for the degree
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Each person whose signature appears below certifies that this dissertation in his/her opinion is adequate, in scope and quality, as a dissertation for the degree Doctor of Philosophy.

_____, Chairperson

Brian Distelberg, Associate Professor of Counseling and Family Sciences

_____

Winetta Baker, Assistant Professor of Counseling and Family Sciences

_____

Chalandra Bryant, Professor of Human Development and Family Science, University of Georgia at Athens

_____

Carmen Knudson-Martin, Professor of Counseling and Family Sciences

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ABBREVIATIONS

SERT	Socioemotional Relational Therapy
SEM	Structural equation modeling
APIM	Actor-partner independence model

ABSTRACT OF THE DISSERTATION

The Buffering Effect of Relational Support in African American Marriages

by

Aimee Galick

Doctor of Philosophy, Graduate Program in Marriage and Family Therapy
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Dr. Brian Distelberg, Chairperson

Racial discrimination is a common experience for African Americans in this country. Racial discrimination can have a negative effect on the physical and mental health of marital partners, as well the quality and stability of the relationship. Few studies investigate relational support as an important coping strategy. Bodenmann's (1995) divorce-stress model asserts that positive dyadic coping strategies such as relational support can buffer partners and marriages from the negative consequences of stress. Socio-emotional relational therapy (SERT) provides marital and family therapists with a model of relational support in couple relationships. SERT's definition formed the basis for the conceptualization of relational support in this study. Using Structural Equation Modeling (SEM) and actor-partner interdependence models we tested two theoretical models. In the first model we investigated the buffering effect of relational support between racial discrimination and health. In the second model we tested the buffering effect of relational support between racial discrimination and marital stability. Findings suggest that relational support provides an important buffering effect from racial discrimination in African American marriages for husbands, but not wives. Relational support was associated with marital stability for husbands and wives and for the health of

husbands. This study provides support for the gendered provision of support in marriage which tends to benefit men more than women. The findings provide support for further investigation into relational protective factors. Although wives' racial discrimination was negatively associated with their health, relational support did not buffer this association. Also since women do not seem to benefit from support in the relationship more research is needed to understand the factors that buffer them from the negative effects of racial discrimination on their health.

CHAPTER ONE

INTRODCUTION

The purpose of this study is to examine the role of relational support on the known negative effect of racial discrimination on African American marriages. We hypothesize that relational support will moderate the indirect connection between racial discrimination and negative outcomes. Links between racial discrimination and both health and marital stability will be tested. The study is broken down into two overall aims; first we will examine the direct and indirect links between racial discrimination and marital stability. Secondly we will examine the direct and indirect links between racial discrimination and health of African American couples. According to the stress-divorce model (Bodenmann, 1995) and Socioemotional Relational Therapy (Knudson-Martin & Huenergardt, 2010), relational support between partners should function as a buffer against external stressors such as racial discrimination, but there is some evidence that men and women do not benefit equally from relational support.

Background

"One of the most firmly established and frequently reported patterns in the distribution of health status in the United States is that African Americans (or Blacks) have higher rates of death, disease and disability than whites" (Williams, Yan Yu, Jackson, & Anderson, 1997, p. 336). Additionally, health disparities for African Americans have been getting worse over the past 25 years (Mays, Cochran, & Barnes, 2007). A 2005 report from the Center for Disease Control states that Blacks are more likely to die from 3 of the 10 leading causes of death (HIV, homicide, and septicemia).

For the remaining 7 leading causes of death, mortality and morbidity rates are higher for Blacks than whites (Office of Minority Health, 2005). According to Mays, Cochran and Barnes (2007), a significant factor in this disparity is the continued effects of racial discrimination. While racial discrimination has been linked to psychological stress (Kessler, Mickelson, & Williams, 1999; Williams et al., 1997), Mays et al. (2007) argue that the psychological stress experienced by racial discrimination triggers a stress reaction which has implications for health. Experiencing racial discrimination is thought to increase heart rate and blood pressure, change biochemical stress reactions, and create experiences of extended hyper-vigilance. These biological responses, if experienced frequently and over prolonged periods of time, can produce significant negative health outcomes (Mays et al., 2007).

The stress-divorce model (Bodenmann, 1995) asserts that external stressors are a threat to optimal couple functioning and ultimately can contribute to marital dissolution. This model is unique because it focuses on chronic external stressors, rather than acute major stressors. The origin of chronic external stressors is often the larger social context in which the couple is embedded (Randall & Bodenmann, 2009). We extend this model to examine the effect not only on relationship stability, but also on the health and well-being of each partner. Positive dyadic coping is viewed as an important buffer against the detrimental effects of stress (Bodenmann, 2005). Relational support may be a particularly important positive dyadic coping strategy in this population considering the heavy emphasis on kinship in African American culture (Staples & Johnson, 1993). The stress-divorce model has not been examined exclusively with the African American population, or in terms of a specific source of social support, such as relational support.

There has been overwhelming evidence that marriage is beneficial to well-being because it creates an environment of support which protects spouses from the negative effects of stress (Coombs, 1991). While the benefits of spousal support are widely documented (Coombs, 1991; Graham, Christian, & Kiecolt-Glaser, 2006), there appears to be a differential effect of spousal support based on gender. Men tend to benefit more from marriage than women (Knudson-Martin, 2003; Robles & Kiecolt-Glaser, 2003).

In this study we will examine how relational support between partners protects African American couples from the negative effects of racial discrimination. Since racial discrimination has been shown to have differential effects on men and women, this study will specifically focus on the gender differences in the connection between racial discrimination and health and marital stability. Men often benefit more from spousal support than women (Kiecolt-Glaser & Newton, 2001). Feminist theorists and therapists attribute this discrepancy to power imbalances which skew the benefits of support in the direction of the more powerful partner which is often the man (Dolan-Del Vecchio, 2008; Knudson-Martin & Mahoney, 2009).

Socioemotional Relational Therapy (SERT) is a model of feminist family therapy which places relational support at the center of therapy (Knudson-Martin & Huenergardt, 2010). SERT is based on the belief that heterosexual intimate relationships are inherently unequal in the provision of relational support. In SERT special attention is paid to how societal constructs such as gender and culture impede partners' ability to engage in mutually supportive ways (Knudson-Martin & Huenergardt, 2010). In this study, relational support and power are intrinsically related and are based in relationship maintenance patterns (Williams, Galick, Knudson-Martin, & Huenergardt, 2012). The

partner who is not attending to the relationship, or his/her partner's experiences and feelings, holds more power in the relationship. The Principle of Least Interest (Waller, 1938) states that the partner who is less emotionally invested in the relationship has more power. Support cannot be mutual under these conditions because only the powerful partner's experience is being attended to and subsequently supported. Over time power imbalances lead to inequalities in the provision of support.

Equality in emotional involvement has been linked to increased marital satisfaction and stability (Sprecher, Schmeeckle, & Felmlee, 2006). The second purpose of this study is to examine how racial discrimination impacts the marital stability of African Americans. Racial discrimination may impact the provision of relational support and marital stability, particularly for men. It has been suggested that the family may be the only environment where some African American men can experience a position of power (Pinderhughes, 2002), and women, sensing this need support men to feel powerful in the home. This dynamic may create an environment where husband's needs for support may take precedence over wives'.

Objectives

The first objective is to examine how racial discrimination impacts the marital stability of African American husband and wives (Figure 1). Racial discrimination is a significant stressor on African American marital well-being (Bryant et al., 2010) and may be a threat to marital stability. In the early years of marriage couples are forming an intimate bond. This is made more difficult by the social, political, and economic environment of oppression, frustration, and tension African American couples experience

(Lawrence-Webb, Littlefield, & Okundaye, 2004). Some studies have found that both African men and women report equality as being an important value to them in relationships (Cowdery et al., 2009; Cutrona, Russell, Burzette, Wesner, & Bryant, 2011), while other authors (Lawrence-Webb et al., 2004; Pinderhughes, 2002) suggest that African American men wish to have more dominant roles in the family to compensate for the powerlessness they experience because of racial discrimination. Lacking in the literature are investigations of relational protective factors for African American marital stability. We are going to test the hypothesis that husband's experiences of racial discrimination will impact the provision of relational support, as well as marital stability. We are also going to examine how relational support affects wives' marital stability within the context of racial discrimination.

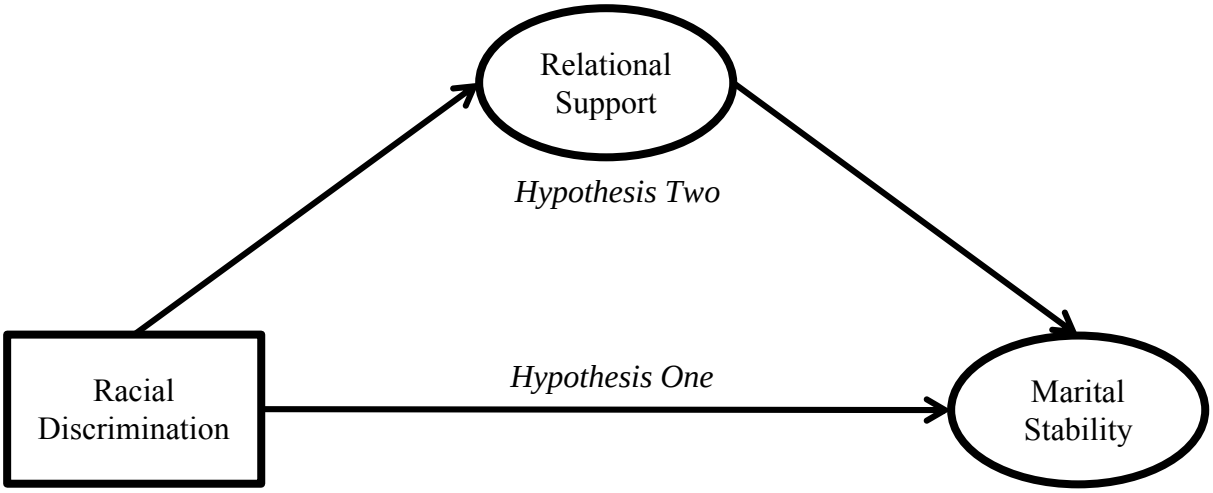

Figure 1. Theoretical Model of the Indirect Effect of Relational Support on Marital Stability.

The second objective of this study is to examine the effect of racial discrimination and relational support on health in the context of African American marriages (Figure 2). We will be using structural equation modeling (SEM) to investigate these relationships since we wish to test the validity of the stress-divorce model (relational support moderates the relationship between racial discrimination and health outcomes). Additionally, since it is known that racial discrimination has differential effects on men and women, this study will also investigate the differential effects of gender within the stress-divorce model. In this regard, the researcher predicts that relational support will be a stronger moderator for husbands since they appear to be more directly affected by racial discrimination and marital support may be one of their only sources of support. We also predict that wives' health will be affected more by relational support than by racial discrimination because they appear to be affected more by their interpersonal context.

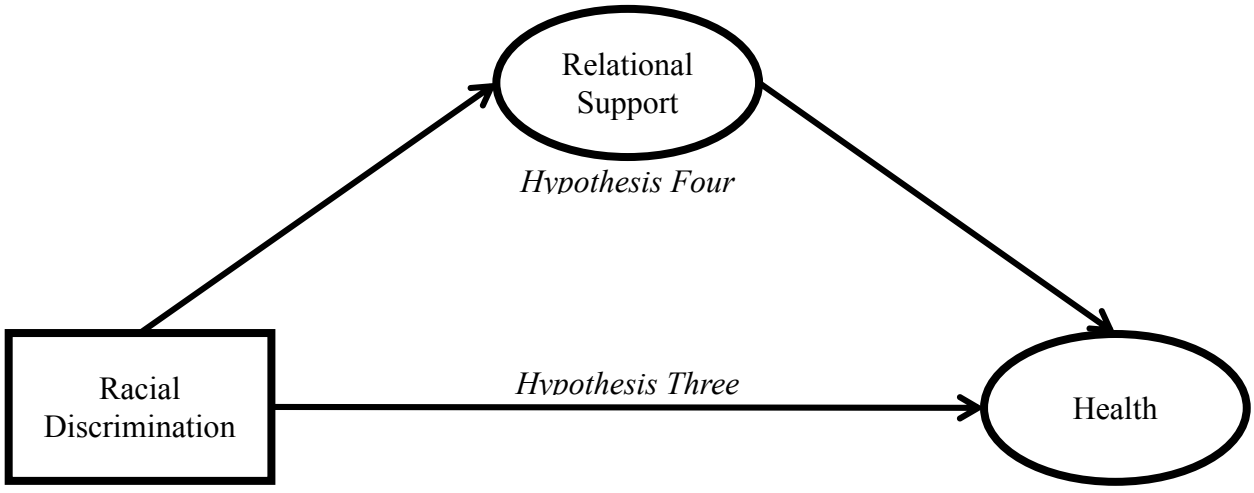

Figure 2. Theoretical Model of the Indirect Effect of Relational Support on Health

Rationale

African Americans suffer disproportionately from physical and mental illness in the United States (Office of Minority Health, 2005). A review of more than 130 empirical studies determined that married women and men are generally; happier, less stressed, live longer and have better physical and emotional health (Coombs, 1991; Kiecolt-Glaser & Newton, 2001). Equality in relationships has been linked to increases in marital stability and satisfaction (Sprecher et al., 2006). Although it is clear that marriage has a positive benefit in general, less is known about African American marriages in regards to the specific protective mechanisms (Hill, 2006). Presumably African American marriages share a great deal in common with white marriages (Sassler, 2010), but when examining African American marriages it is important to understand the unique socio-historical context in which marriage has evolved (Curran, Utley, & Muraco, 2010; Weber, 2003). Hatchett et al. (1995) have demonstrated that there are many differences between African Americans and whites in terms of the factors that contribute to marital stability. African Americans experience unique stressors such as racial discrimination and this can put strain on their relationships (Pinderhughes, 2002) and their health (Harrell, Hall, & Taliaferro, 2003). The experience of racism has also been linked to negative health outcomes (Armstead, Lawler, Gorden, & Cross, 1989).

Adaptive coping responses are thought to influence psychological and physiological stress responses reducing the negative impact of racism on health over time (Clark, Anderson, Clark, & Williams, 1999). Social support is one adaptive coping strategy thought to buffer against the negative effects of stressful events (Bodenmann, 1995). While social support is known to be a helpful buffer against the negative effects

of stress, research has failed to differentiate the social support received within marriage from the social support received in other relationships. Relational support within marriage is a nuanced process constructed and affected by many macro and micro level issues. One such issue is gender constructions, or the way we are socialized to be men and women, which contribute to inherent inequalities between marital partners (Knudson-Martin, 1995). Equality appears to be valued and important to African American couples (Hunter & Sellers, 1998), but so is being traditionally masculine and feminine (Haynes, 2000). Emphasis on maintaining traditional gender roles is likely a response to racial discrimination and pressure to conform to the dominant culture (Hill, 2005). However, adhering to traditional ideas about masculinity and femininity can contribute to inequalities in the giving and receiving of support. The findings of this study will provide important clarification of how racial discrimination negatively impacts African American marriages. If we find that relational support is an important buffer for health and marital stability, it is important that family therapists know how to help African American couples mutually support one another in spite of racial discrimination.

Socio-emotional relational therapy (SERT) was built on the premise that having a mutually supportive relationship could protect each member of the couple from external stressors (Knudson-Martin & Huenergardt, 2010). In reality, achieving equality in intimate relationships is a difficult task (Knudson-Martin, 2013). In SERT the therapist attempts to understand the couple subsystem within their unique socio-cultural context. SERT therapists socio-culturally attune to contexts such as gender and culture to understand the factors that get in the way of couples, particularly men, acting in mutually supportive ways (Knudson-Martin & Huenergardt, 2010). The emphasis on the

intersection of gender *and* culture makes this a relevant theory for working with African American couples. The findings of this study will provide evidence that relational support can protect the health of members of the couple from external stressors and this should be an important goal of couples therapy with African Americans. The findings will also increase therapist's understanding of how relational support affects marital stability. The provision of support in African American marriages will be illuminated, thus providing insight into the socio-cultural issues to focus on when working with African American couples.

CHAPTER TWO

CONCEPTUAL FRAMEWORK

Theoretical frameworks must take into consideration the unique circumstances, styles, and structures of African American families (Allen, 1978). Many of the contradictions that frequent the literature on African American families are the result of a lack of an explicit theoretical framework (Allen, 1978). For this study, it is important to ground our exploration in a framework that takes into consideration not only the micro level processes within marriage, but also the macro level influences due to culture and context. The stress-divorce model postulates that external stressors can negatively impact partners and the marital relationship (Bodenmann, 1995). Socio-emotional relational therapy (SERT) provides us with a contextual lens through which we can study these connections from a critical perspective as well as define relational support.

Bodenmann's Stress-divorce Model

Bodenmann (1995) outlined a model that has been used extensively in the study of stress, dyadic coping, and marital outcomes. The model attempts to explain the process behind why dyadic stress can have a negative impact on couples' ability to adapt and function. Dyadic stress is defined as, "a specific stressful encounter that affects both partners, either directly or indirectly and triggers coping efforts of both partners" (Bodenmann, 2005, p. 33). Stress negatively impacts marital quality and functioning by impacting couple processes such as self-disclosure, communication patterns, and time spent together (Randall & Bodenmann, 2009). Stress also directly impacts each partner's health and well-being. Coping is viewed as an important moderator of the relationship

between stress and negative outcomes on heath and marital functioning. Dyadic coping is an interdependent effort to address a concern toward a mutual goal (Bodenmann, 2005).

More recent writings on Bodenmann's model posit that it is important to differentiate between three dimensions of stress: intensity (major or minor), origin (external or internal), and duration (acute or chronic) (Randall & Bodenmann, 2009). In the case of this study, racial discrimination is an external stressor, originating outside couple relationships, which has a spillover effect into marital interactions. Racial discrimination is unique in its conceptualization in terms of intensity and duration as writings on this theory seem to suggest that daily (chronic) stressors are minor in their intensity (Randall & Bodenmann, 2009). This does not adequately capture the experience of racial discrimination because while most daily stressors are considered minor, the daily experience of discrimination is harsh, stressful, and energy-consuming (Carroll, 1998). In summary racial discrimination is conceptualized as an external, chronic, major stressor which can negatively impact the relationship as well as health and well-being of each partner. Coping may play an important protective role in this process.

Bodenmann's Stress Theory is systemically based in that the stress and coping efforts of one partner cannot be examined without considering the coping of the other partner and the impact on the relationship (Bodenmann, 2005). If a sufficient amount of coping does not occur to buffer the negative effects, the couple system may experience a decline in marital quality (Bodenmann, 1995; Bodenmann & Cina, 2006) and partner's health and well-being may suffer (Bodenmann, 2005). Three types of coping occur within this model: individual, dyadic, and seeking social support. In this study we focus

on dyadic coping, specifically positive dyadic coping, as a coping strategy that will protect partners and the relationship from the stress of racial discrimination. Positive dyadic coping involves efforts to help one's partner and doing so with the intent of reducing one's own stress in the process. In this way dyadic coping is differentiated from simply providing social support to others which is typically viewed as an altruistic act (Bodenmann, 2005). Positive dyadic coping is also unique in that it creates a sense of we-ness based on mutual trust and should be helpful in confronting many different kinds of stressful situations.

This theory has important clinical implications for Marriage and Family Therapists (MFTs). Positive dyadic coping is an important goal to help couples work toward, especially when they are confronted with many stressors. The limitation with research on this theory is that dyadic coping can be measured in many ways. Also Bodenmann's model says nothing about differences in experience of stress or dyadic support in terms of gender. In this study dyadic coping will be measured using a specific model of relational support.

Socio-emotional Relational Therapy (SERT)

Socio-emotional relational therapy (SERT), although not developed specifically for African Americans, is a culturally relevant model of couples therapy (Knudson-Martin & Huenergardt, 2010). Using SERT as a conceptual framework for this study allows us to view African American marriages within their unique cultural, racial, and historical context. SERT therapists conceptualize relational support between couples as a key factor in successful, healthy relationships. Relational support between partners is

conceptualized as a buffer against external stressors such as racial discrimination. Partners often do not mutually benefit from support in relationships because of power differences. Gender is viewed as one of the main factors contributing to inequalities in heterosexual relationships (Knudson-Martin & Huenergardt, 2010).

Power associated with gender identities, particularly with masculinity, is viewed as an impediment to equality in relational support (Hare-Mustin, 1987; Knudson-Martin & Huenergardt, 2010; Knudson-Martin & Mahoney, 2009). SERT is based in a social constructionist paradigm which is important in understanding how the influence of gender is conceptualized in this study.

Social Constructionism

SERT was designed out of the need for an approach that placed central importance on socially constructed relational inequalities (Knudson-Martin & Huenergardt, 2010). The social constructionist view of gender is one in which social and psychological entities bring certain advantages and disadvantages to each gender. In this view gender is not seen as a biological certainty or a social "given" but an interpersonal process that is fluid and changeable (Airhihenbuwa & Liburd, 2006; Knudson-Martin, 1995; Levant & Philpot, 2002). Societal messages are communicated to individuals through social discourses.

Discourses are the medium through which the larger societal context shapes personal identity and relationships (Knudson-Martin & Huenergardt, 2010). Social discourses are shared ways of understanding based on common meanings and values (Hare-Mustin, 1987). Discourses give meaning to experience and inform us of

appropriate ways to think, act, and feel (Knudson-Martin & Huenergardt, 2010). The intersection of multiple discourses informs each person's identity. For example African American men get different messages on appropriate ways to be which are different than African American women. Not all discourses have equal impact on practices and beliefs, some have privileged and dominant influences on thoughts, behavior, and language (Hare-Mustin, 1994). Dominant discourses are widespread and uncritically accepted as "common sense" and "normal" (Gavey, 1989; Zak-Hunter et al., 2010). Masculine discourses of independence, strength, and decisiveness are assigned more power in our society than feminine discourses of caring, supporting others, being vulnerable, and accommodating (Hare-Mustin, 1994). Gender discourses adopted by a particular individual will inform how they think and feel about not only their own gender, but also the opposite gender.

Power is established and exercised through dominant social discourses related to gender (Gavey, 1989). Differences in power based on gender contribute to relational inequalities as conceptualized in this study. Discourses are also influenced by other societal contexts such as race and culture (Knudson-Martin & Huenergardt, 2010) which is why it is important to study different ethnic cultures independently as these unique cultures change the couple level discourse. For example, discourses related to gender equality inform men that they should be involved in tasks typically assigned to women such as providing emotional support to others. The probability of adopting these tasks is likely affected by the cultural discourse within the couple's ethnic heritage. In some groups these might be tasks more easily adopted than in other ethnic groups. In this way social discourses are shared by society, but have a unique impact through their

intersection with other cultures at the macro level of society, but also within the couple dyad (Knudson-Martin & Huenergardt, 2010).

Gendered Power

A key assumption to the SERT model is that masculine constructions of autonomy and strength often hold more power than feminine constructions of connection and relationship (Crawford, 2004; Keeling, Butler, Green, Kraus, & Palit, 2010; Knudson-Martin, 2003), especially in cultures that endorse patriarchy. This distribution of power based on gender has major implications for couples' efforts to connect in mutually supportive ways (Knudson-Martin & Huenergardt, 2010; Knudson-Martin & Mahoney, 2009). Relationships can become skewed in the provision of support because of dominant gender discourses related to how men and women should be in relationship with one another (Knudson-Martin & Huenergardt, 2010). For example, the discourse that women should care for others at their own expense informs female partners that they need to self-sacrifice and put their own needs aside to care for their male partners and families. Male partners typically do not sacrifice to the same extent, especially in terms of providing emotional support (Hare-Mustin, 1987). This leads to power inequities because one partner's needs for support are being prioritized.

The Circle of Care

Central to this study is the idea of relational support. Knudson-Martin and Huenergardt (2010) outlined four conditions that facilitate supportive relationships (see

Figure 3) and make up what they call the circle of care. These constructs will form the basis for the relational support latent construct in the SEM models.

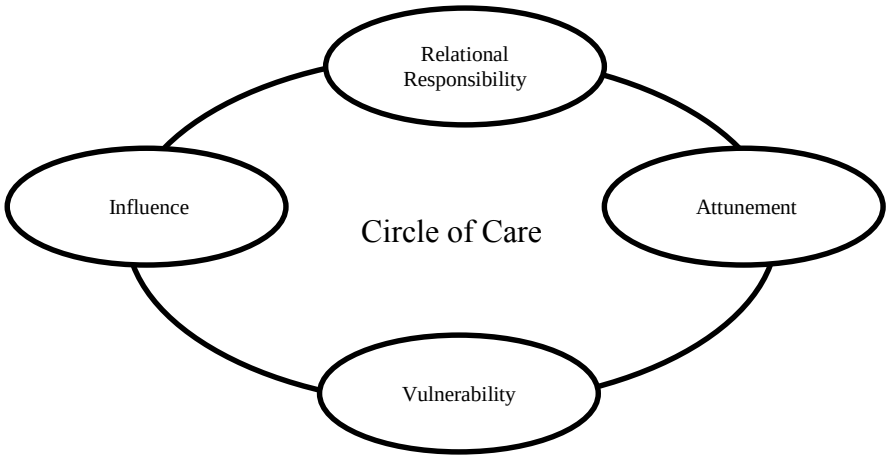

Figure 3. The Circle of Care

The Circle of Care: Components of Supportive Relationships.

- Attunement: Attunement is the ability to feel and understand another's experiential world; it's feeling 'felt' by another. When a partner is deeply attuned she understands her partner's emotional experience, sometimes just by looking at his body language. Women are typically more attuned to their partner's emotional experience and listen more attentively. Listening is a central component of attunement, but it is more than just listening. It's about listening with the purpose of wanting to feel your partner's experience so you understand it from their perspective. To the extent that one is able to understand the struggles of others they will be more likely to approach them from a framework of acceptance and caring (Philpot & Brooks, 1995).

- Relational Responsibility: Relational responsibility is each member directing their energy to maintaining and bettering the relationship. It also involves being responsible for raising issues about the relationship and managing the emotional risk. Active caring for another's well-being, acting on their behalf, and validating the partner and their experience are fundamental actions toward relational responsibility. Women are taught early on to pay attention and to take responsibility for fixing relationship problems. Men typically have less awareness of when there are issues needing attention in the relationship or if they are aware, of knowing what to do about it. Men are also more uncomfortable with relational conflict with their partners (Mirgain & Cordova, 2007). Taking responsibility for changing for the sake of the relationship puts that partner in a one-down position.
- Vulnerability: Vulnerability is the act of sharing one's person with others. Being vulnerable inherently requires taking a one-down position because exposing weaknesses or needs leaves a person open to being rejected (Knudson-Martin, 2013). Men are less likely to show weakness to others and feel comfortable taking this position. Being vulnerable includes actions such as sharing weaknesses, feelings, crying, or even sharing positive emotions. A critical part of vulnerability in the circle of care is being able to share one's relational needs with their partner. This is a particularly vulnerable position because if one's partner does not validate those needs, this can be extremely hurtful.

- Influence: Influence includes openness to being changed by one's partner and accommodating to their needs. Influence also includes taking your partner's feelings and desires into account when making important decisions.

Before therapists help couples attain equality in the provision of support, they must assess how each member of the couple thinks about the components of the circle of care. Since each couple is situated in a unique context, SERT therapists assess the context that influences each partner's ability to engage in the circle of care. This is done through socio-cultural attunement.

Sociocultural Attunement

The intersection of various discourses related to gender, race, ethnicity, and socioeconomic status are crucial to understanding behavior (Airhihenbuwa & Liburd, 2006; Watkins, Walker, & Griffith, 2010). Messages about independence and connection, position and hierarchy, sources of personal worth and value, the meaning of accommodating and attending to others, and expectations about roles and decision making are listened to and reflected back (Knudson-Martin & Huenergardt, 2010). SERT therapists socio-culturally attune to social discourses that make it difficult for partners, especially men, to engage in components of the circle of care (Knudson-Martin & Huenergardt, 2010). For example, discourses about masculinity make vulnerability and attunement difficult for some male partners. What typically ends up happening in heterosexual relationships is that women attune to their male partners, care for the relationship, and risk vulnerability for connection (Crawford, 2004). By doing so, women are more easily influenced by male needs and desires. Men's lack of

responsibility for emotional connection and support leads to relational inequalities. When support flows unevenly to male partners they benefit more from the relationship and this could be one of the reasons why men are happier in marriage than women (Crawford, 2004).

Using SERT as a conceptual framework helps us to understand why inequalities may exist in the provision of support and how they can prevent marriage from being a rich source of support for *both* spouses. It also raises consciousness of how the connections in our hypothesized models may be influenced by the gender of spouses.

CHAPTER THREE

LITERATURE REVIEW

Married African American couples have received relatively little attention in the literature on marital quality and stability (Cutrona et al., 2003). The frequency of marriage among African Americans is declining (Ali & Ajilore, 2011; Curran et al., 2010; Pinderhughes, 2002) and African Americans are divorcing at one of the highest rates (49%) in this country (U.S. Census Bureau, 2011). They also have some of the lowest health outcomes (Staples & Johnson, 1993). Considering the benefits to both physical and mental health found in those married (Ali & Ajilore, 2011), and more specifically among those happily married (Gabriel, Beach, & Bodenmann, 2010), it is important that we focus specifically on African American marriages and health (Bryant et al., 2010).

One of the larger limitations in the current study of marriage and health is that these studies often draw conclusions from heterogeneous samples, disproportionately consisting of white participants. We cannot assume this research generalizes directly to African Americans, as these couples share a unique history and context due to the lasting effects of slavery and more current effects of racial discrimination (Hill, 1989). Because of the societal disadvantages afforded by African American couples, they have adapted to unfavorable circumstances by adopting different gender discourses, in comparison to white couples. For example, many African American parents raise their sons to live in a racist society and their daughters to not depend on a man emotionally or financially (McAdoo, 1997). Their adaptation to living in this society, particularly in regards to gender, may lead to differential effects of racial discrimination. Racial discrimination is

defined as "beliefs, attitudes, and institutional arrangements, and acts that tend to denigrate individuals or groups because of phenotypic characteristics or ethnic group affiliation" (Clark et al., 1999, p. 805). Racism is pervasive; up to 98.5% of African Americans report experiencing a discriminatory act in the past year and 64% experienced more than six events (Prelow, Mosher, & Bowman, 2006).

The purpose of this literature review is to provide the reader with an overview of the research that informed the construction of the structural models and hypotheses being tested in each phase of this study. First, research on the effects of racial discrimination on marriage will be discussed. Secondly, the links between racial discrimination, support, and health will be discussed. Third, the differential effects of gender will be discussed in regards to points one and two above. This literature review will then conclude with a summary of the gaps and limitation in the existing literature.

Racial Discrimination and Marriage

Marriage requires the formation of an intimate bond; this is made difficult by the social, political, and economic environment of oppression, frustration, and tension African American couples live in and have to cope with (Lawrence-Webb et al., 2004). An extensive review of the literature on the impact of racism on marriage did not cite studies looking at the impact on spouses (Clark et al., 1999). Specifically looking at the impact of racial discrimination on marriage is important considering how pervasive these experiences are for African Americans. A review of the literature on African American marriages concluded that chronically stressful situations, such as racial discrimination, have negative effects on marital well-being (Bryant et al., 2010). Some of the negative

effects on marriage include increased negative affectivity and irritability of partners. Bryant et al. (2010) concluded that little is known about relational resources that contribute to martial quality and stability in this population. How well each partner has overcome social factors that marginalize them is a critical factor in how they deal with one another's experience of discrimination (Franklin, 2004). There has been more research on the impact of racial discrimination on health.

Racial Discrimination and Health

"Stress has been associated with many diseases such as cancer, cardiovascular disease, and substance abuse and these diseases are killing African Americans in record numbers" (Outlaw, 1993, p. 407). Racial discrimination adversely impacts the health of African Americans in many ways. Many studies have focused on the effects to cardiovascular health because African Americans suffer disproportionately from heart and cardiovascular disease (Office of Minority Health, 2005). A large scale study, Coronary Artery Risk Development in Young Adults (CARDIA), examined blood pressure differences between African Americans and Caucasians. They found that 80% of the 1974 African American participants reported experiencing racial discrimination which was related to significant increases in blood pressure (Krieger & Sidney, 1996). An earlier study focusing on African American women also found significant increases in blood pressure in response to racial discrimination (Krieger, 1990). Disparities in preterm and low-weight deliveries, related to racial discrimination, have also been noted (Mustilio et al., 2004). Given these conclusions, as well as many others, one certainly can argue that racial discrimination has a direct effect on health outcomes.

While there is sound evidence of the negative impact on physical health, there is also evidence of negative mental health outcomes. Racial discrimination has been linked to mental health outcomes such as anxiety and depression (Kessler et al., 1999; Outlaw, 1993; Prelow et al., 2006; Wickrama, 2007). Furthermore, a comprehensive literature review on the effects of racism on mental health (incidence of psychiatric illness, depression, negative emotional reactions, anxiety, lower self-esteem, and alcohol abuse) concluded that racism can adversely affect mental health in 3 ways: 1) stunting socioeconomic mobility and limiting access to desirable resources; 2) the experience of discrimination itself produces negative psychological responses; and 3) acceptance of negative racial stereotypes leads to lower self-evaluation (Williams & Williams-Morris, 2000). The impact on mental health appears to be quite extensive particularly in regards to feelings of self-worth and depression.

The negative impact of racial discrimination on mental and physical health has been observed even after controlling for other factors that commonly influence health outcomes. After Socio-economic status (SES) is controlled racial discrimination still seems to have a pervasive impact on health (Lillie-Blanton, Parsons, Gayle, & Dievler, 1996). Kessler et al. (1999) found that racial discrimination strongly predicted generalized anxiety disorder and depression even when controlling for marital status, gender, age, race, education, and income. These findings are intriguing as they begin to pull apart the interdependent relationships between racial discrimination, marriage and support as well as gender differences.

Discrimination and Social Support

Interpersonal relationships have a significant influence on physiological and psychological responses to stress (Kennedy, Kiecolt-Glaser, & Glaser, 1988). Lacking a supportive network is related to poorer prognosis of heart disease (Barth, Schneider, & Von Kanel, 2010) and cancer (Nausheen, Gidron, Peveler, & Moss-Morris, 2009), depression following a stroke (Salter, Foley, & Teasell, 2010), and poor management of chronic illness (Gallant, 2003). The perceived quality of support is more important than the availability of support (Cohen & Hoberman, 1983) to both physical and mental health (VanderVoort, 1999). Just as a good marriage can provide plenty of benefits, a bad marriage has the power to have negative effects on health (Robles & Kiecolt-Glaser, 2003). So much so, that being in a bad marriage has worse health consequences than being unmarried. The perplexing part of this body of research is that the supportive processes between marital partners are seldom examined. Few studies focus on the primary source of support for married partners, the partner. The limitation to these studies is that they often equate having a spouse with quality spousal support (Alloway & Bebbington, 1987), which is an assumption that is often held, but not always true (Knudson-Martin & Mahoney, 2009). Many partners have to work to overcome the inequalities that prevent partners, usually male partners, from providing quality spousal support (Knudson-Martin & Mahoney, 1998).

Further understanding of the linkage between racial discrimination and support is therefore required to understand the interdependent relationship between racial discrimination, health outcome and relational support. One step in this direction is research on the buffering effect of support between partners in the context of African

American marriages. In these studies couples have reported turning toward one another in times of stress and marital conflict and using role flexibility and faith to persevere in the face of hardships (Marks et al., 2008). Another study did not specifically examine relational support, but they found having support was important in the self-care behaviors of chronically ill African Americans, regardless of social class or income (Becker, Gates, & Newsom, 2004). Most researchers have agreed that it is emotional support in close relationships that is responsible for preserving psychological and physical well-being (Alloway & Bebbington, 1987).

To summarize much of the research regarding the role of support one can turn to a critical review of 81 studies on the connection between social support and physiological processes (Uchino, Cacioppo, & Kiecolt-Glaser, 1996). In this review the authors concluded that: "familial sources of support appear to be important and emotional support appears to be at least one important dimension of social support" (p. 488). They also conclude that, across varying cultural contexts, higher social support is correlated with lower blood pressure and improved cardiovascular regulation in men and women (Uchino et al., 1996).

The Gendered Experience of Racial Discrimination

While it is clear from the literature that health disparities exist for African Americans, and this effect has been isolated from the confounding effects of SES, there have been few studies that directly differentiate the gender differences in African American couples. One study has examined the impact of racial discrimination on depression in husband and wives and found that only male depressive symptoms were

directly affected by racial discrimination (Wickrama, 2007). From this study it seems that the relationship between racial discrimination and health may be influenced by dominant gender discourses of what it means to be male and female in our society.

One potential source of the differential effect of racial discrimination on partners is the tendency of each to deal with discrimination in ways consistent with their gender. Evidence also suggests that dealing with racial discrimination in very traditional ways for their gender can amplify the negative impact. For example, the association between racial discrimination and high blood pressure in women is influenced by internalization of the experience (Krieger, 1990). Although internalization is a common coping strategy for all women, African American women were 5.9 times more likely than white women to internalize their experiences and they had significantly higher blood pressure readings (Krieger, 1990). Higher increases in blood pressure have also been found in African American men who adhere strictly to dominant gender discourses about masculinity. Similar effects have been found for men who adhere to extremes of masculinity. A study of the effects of racism on African American men found higher increases in blood pressure for those with Type A personalities characterized by excessive drive, aggressiveness, and competitiveness (Clark et al., 1999). Although this study did not directly measure masculinity, Type A personality traits are similar to a hyper-masculine gender identity (Riska, 2002). Excessive use of internalization may also be seen as adhering rigidly to gender discourses about femininity. It could be that adhering to extremes of masculinity or femininity decreases the capacity for coping with the stress associated with racial discrimination. Indeed one study found that African American women who endorse more traditional ideas about femininity reported more stress than

those who adopted both masculine and feminine traits (Littlefield, 2003). T herefore this study hypothesizes that racial discrimination may impact relational support more through husbands' experiences of racism.

African American families have survived several periods of hardship in America including slavery, adjustment to emancipation, geographical separation, and de-industrialization. When one considers what these families have been through historically, their adaptive capabilities are really quite remarkable. They managed against all odds to keep their families connected while being forced apart by slave owners and traders in an attempt to gain control over their 'property' (Aldridge, 2008). Men and women experienced great deals of powerlessness in their lives and in relation to their families. They have also had to adapt in terms of gender roles throughout their history in America and many of those roles were shaped by experiences with discrimination.

Forming partnerships in the Black community is influenced by a particularly distinctive circumstance not faced by whites. More females are available for meaningful intimate relationships than there are men (Aldridge, 2008). This is a serious issue for Black women, especially those that are college educated. The shortage of men creates serious competition between females for African American men and contributes to many settling for less than satisfying relationships (Aldridge, 2008) and less than desirable partners (Zollar & Williams, 1987). This is a potential source of inequalities in the provision within relationships because women may have more anxiety about the relationship and may be more willing to ensure her partner sticks around (Cowdery et al., 2009). Males may not feel as much anxiety about finding or keeping a partner because of the over-availability of suitable women.

There seems to be an emphasis on the men in African American families and helping him to reach the ideals of masculinity in our society. Ensuring male happiness in the relationship may contribute to marital stability and one way of doing that is to support the male role in the family. One qualitative study found that African American men and women expect and support the man to be the provider in the family because they believe that this is how he derives self-worth (Haynes, 2000). In combination with the scarcity of eligible African American men, this creates a context in which inequalities are likely to occur.

Current Limitations in the Literature

There are serious gaps in the literature on the effects of racial discrimination on the marriages and health of African Americans. Support between partners is an important area in need of attention, but there are not many measures that focus on support in terms of caring for the relationship and one's partner. Examining relational support may be particularly important in an African American population because of the cultural emphasis on kinship.

Methodology

Many methods are available for the study of the connections between relational support, racial discrimination, and health and marital stability. Qualitative research has been under-utilized in this area, but it may be difficult to make conclusions about these complex relationships with research using this method. Consider for a minute how you would have people describe their experiences in this area. Even if they could talk about

how racial discrimination affects their marital relationship, would they be able to articulate how they think this then influences the health of each partner? Qualitative may be more appropriate for a study of how couples believe racial discrimination impacts their relationship, this focuses on a process that is likely accessible to the couple to relate to a researcher. The use of quantitative allows us to concisely test the relationships between several variables based on theory. The use of quantitative methods also allows us to study dyadic processes on a larger level than qualitative would permit. Findings from this study may provide a baseline from which to investigate the relationships we examined in depth with qualitative interviews.

Limitations of Quantitative Research

A major limitation of using a quantitative design to examine our research question is focusing on the similarities of our participants. Our design will not allow us to make conclusions about how participants differ in the process we are investigating. Many contextual factors may be intersecting to influence the gender beliefs of this group other than just race and gender (Kane, 2000), but we try to limit this by controlling variables shown in previous research to influence the relationships under investigation.

Conclusions

Research on African American marriages has failed to examine the impact of racial discrimination and support between partners. Having a safe haven, based on relational support, may be particularly important for African American couples because of the stress they experience from racial discrimination (Cutrona et al., 2011; Guyll,

Cutrona, Burzette, & Russell, 2010). Equality appears to be valued and important to African American couples. Racial discrimination may increase the pressure on African American men and women to support men so they feel masculine in our society. This in turn may contribute to skews in the provision of support which prevent the relationship from being mutually beneficial. This has not yet been verified by research and if relational support does indeed predict better health outcomes it is important for therapists and researchers to understand how contextual factors such as racial discrimination and gender discourses impact this association.

CHAPTER FOUR

METHOD

This study is part of the larger Study of African American Marriage and Health at the University of Georgia, Athens (Principal investigator: Dr. Chalandra M. Bryant). It is a longitudinal study funded by the National Institute of Child and Human Development (NICHD) examining the effect of social, familial, economic, occupational, and psychological factors on marital and health outcomes of African Americans.

A secondary data analysis from the larger project will be utilized for this investigation. This study of African American couples will take place in two phases representing separate publishable studies. Each article will stand in place of the traditional results and discussion sections of a dissertation. This will ensure that the results of this study will be accessible for dissemination to researchers and more importantly, family therapists working with African American couples. In Phase I, the relationships between racial discrimination, relational support, and marital stability will be tested using structural equation modeling. In Phase II structural equation modeling will be used to test the relationships between relational support, racial discrimination, and health. This method section will be organized in terms of these two phases of the study.

Recruitment

Newlyweds were identified through the marriage license bureau of a southern state. Letters were mailed asking if they would be interested in participating in the study. Recruitment of couples for the study was from two counties in Alabama (See table 1 for population demographics in the counties), the names of which are kept confidential to

protect the privacy of the couples. Follow-up phone calls were made to schedule face to face interviews with those couples who agreed to participate in the study. To be eligible for the study participants needed to be African American, at least 20 years of age, married less than one year, and each member of the couple dyad had to agree to participate. Two interviewers were sent to each home and one interviewed the wife while the other interviewed the husband in a separate room. The survey consisted of over 800 questions and took approximately 2 hours to complete.

Table 1.

Population Demographics

	County One (%)[SE]	County Two
Population	658, 466	195, 111
Male	311, 813(47.4)	91, 783(47.0)
Female	346, 353(52.6)	103, 328(53.0)
African American	276, 525(42.0)	98,691(50.6)
Wife-Husband Family	110, 228(41.8)	28, 073(35.6)
Population over 25 years	436, 589	125, 481
High school	122, 668(28.1)[0.5]	37, 176(29.6)[2.2]
Some College	99, 081(22.7)[0.4]	28, 233(22.5)[1.8]
Associates Degree	30, 458(7.0)[0.3]	9, 398(7.5)[1.3]
Bachelor Degree	78, 995(18.1)[0.5]	23, 211(18.5)[1.5]
Graduate or Professional Degree	46, 676(10.7)[0.3]	11, 307(9.0)[1.3]

Table 2

Sample Demographics

	Husbands	Wives
	Employment	
Employed Full-time	79.4%	68.8%
Employed Part-time	5.2%	7.6%
Unemployed	5.2%	8.6%
Retired	2.6%	1.0%
Keeping house full-time	0.1%	8.6%
	Income	
Percent making less than 40,000	67.8%	78.9%
Interquartile range	15, 000 – 34, 999	10,000 – 29, 999
Percent making more than 40,000	32.2%	20.1%
Interquartile range	40,000-74,999	40,000-74,999
	Education	
Some high school	7.9	7.3
High school	25.9	22.6
Technical or Trade school degree	12.2	4.4
Some college	22.6	28.9
Associates degree	7.2	10.2
Bachelor Degree	12.7	18.7
Masters	3.3	6.7
Doctorate/PhD	.1	.3
Medical doctor/M.D.	0	.1

Sample Characteristics

There were a total of 1398 participants in the study making up 699 couples (See table 2 for demographics). This was the first marriage for 74.7% of females and 67.7%

of males and the second marriage for 25.3% of females and 32.3% of males. Couples had been married an average of 11.7 months, which is expected being a study of newly married couples. The mean age for wives was 33.8 years of age and 36.1 for husbands. These numbers are higher than the median age of first marriage for African Americans in the U.S. which was 30.6 for men and 30.0 for women (Elliot, Krivickas, Brault, & Kreider, 2012). At the time of the study 20.3% of wives and 7% of husbands were in school. The majority of the sample, 74%, identified as religious and 93 % of those were Protestant.

Pre-analysis Data Screening

Before validating the measures used in this study and subsequently testing relationships of variables with structured regression SEM, the data was screened for any missing data. Specifically, the data was tested for missing completely at random (MAR), missing at random (MAR), or missing systematically. After this investigation the appropriate modifications and cleaning were employed (Tabachnick & Fidell, 2007). Prior to building each structural equation model, univariate and multivariate assumptions of SEM were checked with SPSS 20. Estimation with full maximum likelihood in SEM rests on the assumption that continuous outcome variables are normally distributed, bivariate scatterplots are linear, and distribution of paired variables is bivariate normal (Kline, 2011). The data was also checked with t-tests to assure that there are no between county differences on any of the test variables as well as demographic characteristics.

Analytic Strategy

Each phase of this study required a few common steps although done with different variables. The hypothesized relationships between variables in each phase was tested with structural equation modeling (SEM), specifically structured regression. I used EQS (Bentler, 2006) to run the structured regression analysis. This method is appropriate when theory dictates specific explanatory relationships between variables (Raykov & Marcoulides, 2006). Structured regression SEM was used to confirm (or disconfirm) those relationships (Kline, 2011).

Before building the SEM models, the validity of each measurement model was tested using confirmatory factor analysis (CFA) (Kline, 2011). Additionally, steps for assessing the discriminate and convergent validity of latent factors was followed (Hair, Anderson, Tatham, & Black, 2006). A few of the measures that was used in this study have not been tested in other studies. Pools of items thought to theoretically represent relational support, marital stability, and health were tested for applicable use in this study. These are addressed in more detail below.

Measures

Each scale is described below in detail with information available from the literature on reliability and validity when available. For measures not previously utilized and tested, the rationale for choosing the pool of items is described.

Racial Discrimination

Experience with racial discrimination was measured using an adaptation of McNeilly et al. 1996's scale used by Murry et al. (2001). The modified scale is comprised of 10 questions (See Table 3). Items were rated on a Likert scale ranging from 1 (never) to 5 (more times than I can count). A mean composite measure of racial discrimination was created from the items by summing the responses as has been done in other studies (McNeilly et al., 1996; Murry et al., 2001). Higher scores on this measure indicate more experiences of racial discrimination. Murry et al. (2001) found a Cronbach's alpha of .92 for the scale.

Relational Support

Relational support in this study was measured using items consistent with SERT's definition of support between partners (Knudson-Martin & Huenergardt, 2010) based on the components of the circle of care: relational responsibility, attunement, vulnerability, and influence. The first author of this study has been extensively trained in the concepts of SERT and has been practicing the model for two years. As well, she has been involved in another study providing evidence for the usefulness of SERT in healing the relational damage of infidelity (Williams et al., 2012). Items were chosen by the author along with eight other SERT trained clinicians on the basis of application in clinical practice. For example, the question, "how carefully does your partner listen to your point of view?" is thought to capture attunement processes. Similarly, relational responsibility is captured by the question, "how often do you and your partner talk about your relationship?"

Marital Stability

Spouse's perceptions about the longevity of the relationship are used in the study of marital stability (Booth, Johnson, & Edwards, 1983). Marital stability was assessed using three items. Initially, three items were used in the study, "how likely is it that your marriage will last another 5 years? How likely is it that your marriage will last forever? Since your wedding, how often have you ever thought that getting married was not such a good idea?" The original validation study reported that the index has high reliability with Cronbach's alpha = .93 and showed validity with national rates of divorce of four different cultural groups, including African Americans. Since we are using a modified version that has not been validated we evaluated the reliability of these items, and their total scale scores, prior to use in this study.

Health

Health was measured using multiple self-rated global indicators including an assessment of one's own physical health, mental health, and perception of one's health compared to others. Self-reported ill-health is a common measure of health and has been found to be strongly related to objective measure of health and mortality (Haddock et al., 2006; Williams et al., 1997). In large scale study of over 1100 respondents Williams et al. (1997) used it to assess the relationship between racial discrimination and health. An even larger study of over 30,000 culturally diverse participants examined the validity of self-reported health measure and found that those who engaged in negative health behaviors such as smoking, abusing alcohol, and overeating rated themselves as having poorer health (Haddock et al., 2006). Refer to Table 3 for a list of the possible items for each construct, including those from previously validated instruments.

Table 3

Pool of Questions to be Tested

Variable	Possible Questions
Racial Discrimination	During the past year, how often has someone said something derogatory or insulting to you just because you are African American?
	During the past year, how often has a store owner, sales clerk, or person working at a place of business treated you in a disrespectful manner just because you are African American?
	During the past year, how often have the police stopped you just because you are African American?
	During the past year, how often has someone ignored or excluded you from some activity just because you are African American?
	During the past year, how often has someone suspected you of doing something wrong just because you are African American?
	During the past year, how often has someone yelled a racial insult at you?
	During the past year, how often has someone threatened to harm you physically just because you are African American?
	During the past year, how often have you been treated unfairly just because you are African American?
	During the past year, how often have you encountered anyone who did not expect you to do well just because you are African American?
	During the past year, how often has anyone discouraged you from trying to achieve an important goal just because you are African American?
Relational Support	Let you know that he or she appreciates you? Relational Responsibility
	Listen carefully to your point of view? Attunement
	Help you do something that is important to you? Mutual Influence

	I feel our love is based on a deep and abiding friendship. Relational Responsibility
	My spouse is primarily interesting in his or her own welfare. Relational Responsibility
	I want my spouse to know me – my thoughts my fears and my hopes. Vulnerability
	How often does your spouse listen to your ideas about how to solve problems? Influence
	How often does your spouse ask what you would do to solve a problem? Influence
	How often does your spouse consider your ideas about how to solve a problem? Influence
	Talk about your relationship with one another? Relational Responsibility/Mutual Attunement
	Talk about your personal problems? Relational Responsibility
	Talk about sad or bad things that have happened to you? Vulnerability
	Talk about happy or good things that have happened to you? Vulnerability
	Talk about work or school? Relational Responsibility
	Talk about friends? Relational Responsibility
Physical Health	How would you rate your overall physical health?
	How would you rate your overall physical health compared to others?
	How would you rate your overall mental health?
Marital Stability	How likely is it that your marriage will last at least another 5 years?
	When some people get married they have second thoughts about their decision to get married. Since your wedding, how often have you ever thought that getting married was not such a good idea?
	How likely is it that your marriage will last forever?

Testing Measurement Models

Once appropriate items for each measurement were determined, the measurement model of each observed and latent variable was tested using EQS (Bentler, 2006) and the method outlined in Kline (2011). The contribution of each scale item was assessed and must load substantially to the specified factor (e.g., <.40). The factor structure of each variable was tested using chi-square, CFI, and RMSEA as indicators of model fit. One factor structures were tested first and then each subsequent model was compared with that model fit. The structure of subsequent models was determined by areas of misspecification by examining the absolute correlation residuals which should be <.10). The best measurement model was determined to be the most parsimonious with the best model fit statistics.

Control Variables

In order to isolate the effects on health and marital stability we are hypothesizing in this study, it is important that we control for factors commonly found to be related to health and marital instability. Lower SES African Americans may be more vulnerable to negative health outcomes than those with higher SES (Clark, Anderson, Clark, & Williams, 1999; Krieger & Sidney, 1996). One study found that higher educated African Americans reported more experiences of racial discrimination, but no differences in terms of SES (Kessler et al., 1999). SES based on family income was controlled. Age is another important factor related to health that was controlled. Since all participants are married, African Americans we did not need to control for marital status or race. Since

we examined gender differences we did not control gender. Each control variable was regressed on the outcome variables in each model.

Structural Regression Equation Modeling

The use of structural regression allowed us to test the stress-buffer hypothesis, while also examining relationships between our variables. It also allowed us to investigate pathways on a dyadic level. It can be performed using the couple as a dyad by utilizing the Actor-partner independence model (APIM) (Kenny, Kashy, & Cook, 2006).

Phase I

First the measurement model was tested including measures of racial discrimination, relational support, and marital instability. After the measures were validated, the first model built tested the direct effects of racial discrimination on marital instability (Figure 4). In the next step the indirect effects of racial discrimination on marital instability through relational support were examined. The two variations of the model built were tested to determine the best fitting model. Goodness of fit statistics (Chi-square, RMSEA, and CFI) were used to determine the best fitting model. Utilizing an APIM allowed us to examine gender differences in the impact of racial discrimination as well as relational support on each partner's marital stability. For example, a wife's experience of racial discrimination may impact her perception of relational support as well as her husband's.

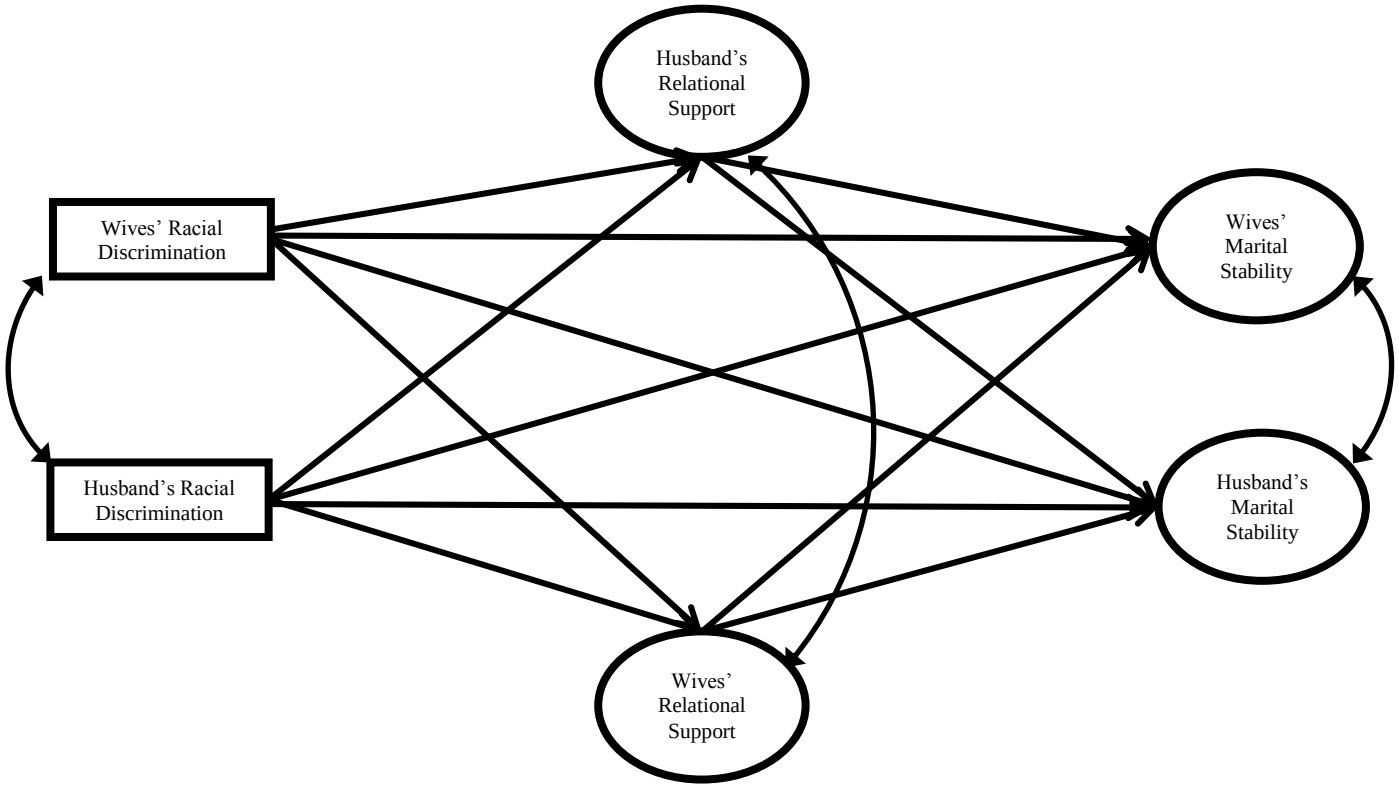

Figure 4. APIM of Relational Support and Marital Stability

Phase II

First the measurement model will be tested including measures of racial discrimination, relational support, and health (Figure 5). After the measures have been validated, the first model built will test the direct effects of racial discrimination on health. In the next step the indirect effects of racial discrimination on health through relational support will be added. The two variations of the model built will be tested to determine the best fitting model. Chi-square and goodness of fit statistics (RMSEA, CFI, AIC) will determine which is best. Utilizing an APIM will allow us to examine gender differences in the impact of racial discrimination as well as relational support on each partner's health. For example, a wife's experience of racial discrimination may impact her perception of relational support as well as his.

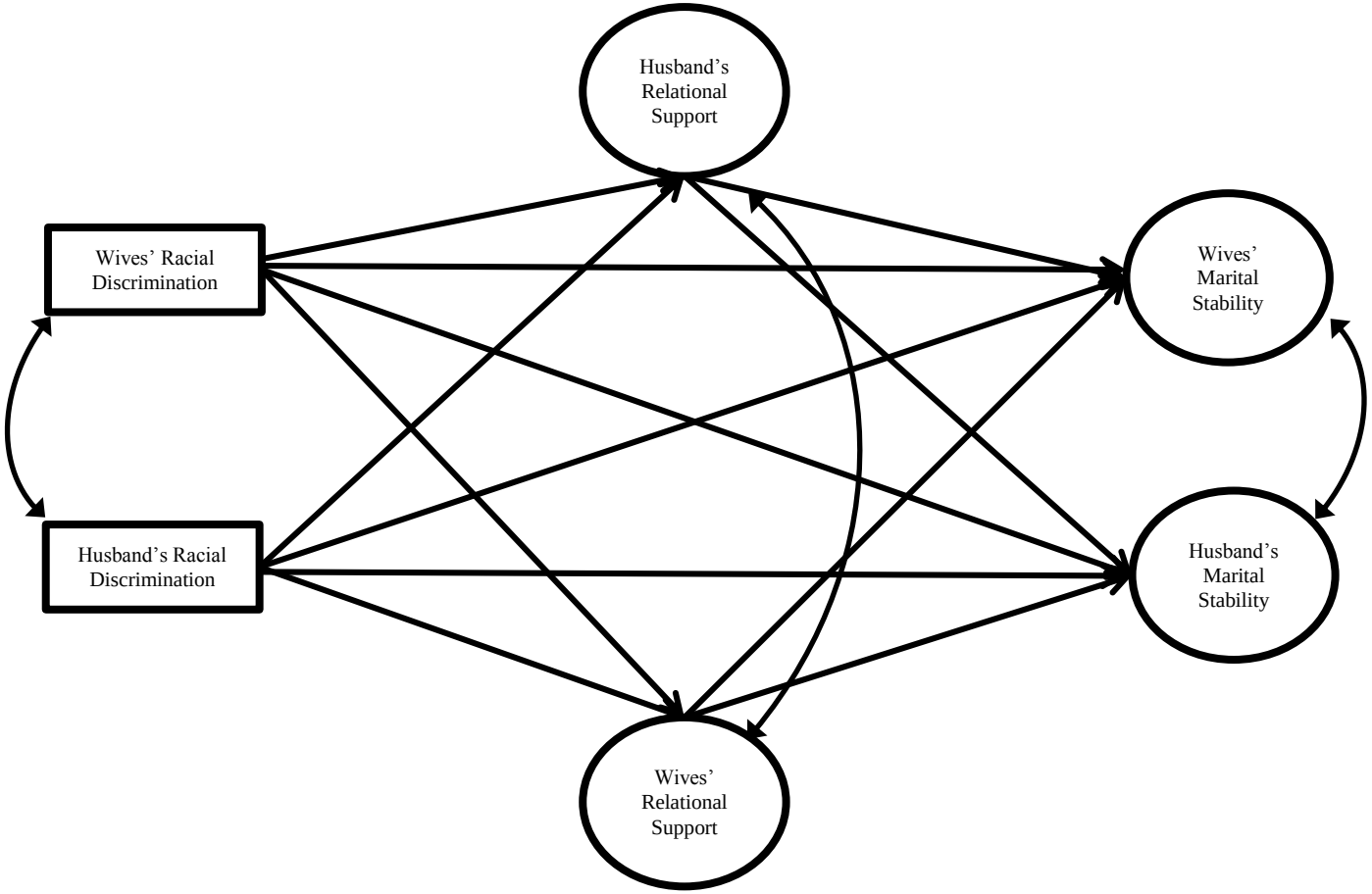

Figure 5. APIM of Relational Support and Health

CHAPTER FIVE

THE ASSOCIATION BETWEEN RACIAL DISCRIMINATION, RELATIONAL SUPPORT, AND MARITAL STABILITY IN AFRICAN AMERICAN MARRIAGES

Abstract

Racial discrimination is a significant stressor in the lives of African Americans. This experience may negatively impact African American marriages, but few empirical studies have actually examined the link. Relational support may be an important dyadic coping response to stressors like racial discrimination. The purpose of this study was to examine the potential buffering effect of relational support on marital stability when couples experience racial discrimination. Using structural equation modeling and an actor-partner interdependence model we tested the direct and indirect associations among these variables. Husband's experiences of racial discrimination negatively impacted both partner's relational support and marital stability. Relational support buffered the negative impact of racial discrimination. Evidence for gender differences in the provision of relational support was also found. Implications for Marriage and Family Therapy are discussed.

Introduction

Most African American couple relationships were marriage-based between 1940 and 1960; the number of married African Americans peaked during that time (McAdoo, 2007; U.S. Census Bureau, 1978; Wilkinson, 1999). Today fewer African Americans are married (Ali & Ajilore, 2011; Curran et al., 2010; Pinderhughes, 2002) and the rate of divorce among African Americans is (49%) in the U.S. (U.S. Census Bureau, 2011). Racial discrimination is a significant stressor on African American marital well-being (Bryant et al., 2010) and may be a threat to marital stability. In the early years of marriage couples are forming an intimate bond. This is made more difficult by the social, political, and economic environment of oppression, frustration, and tension African American couples experience (Lawrence-Webb et al., 2004). Few studies explore relational protective factors for African Americans, that is factors that promote and support marital stability. Overwhelming evidence suggests that marriage creates an environment of support which protects against the negative effects of stress (Alloway & Bebbington, 1987; Coombs, 1991; Graham et al., 2006). Therefore, having a safe haven, based on relational support, may be particularly important for African American couples who experience racial discrimination (Cutrona et al., 2011; Guyll et al., 2010). Strengthening relational support between African American partners may be an important area of intervention for family practitioners and marriage and family therapists (MFTs), particularly in the early years of marriage as a prevention effort. The purpose of this study is to examine direct and indirect effects of relational support within African American newlyweds.

Conceptual Frameworks

Two theoretical frameworks provide the basis for our theoretical model and hypotheses. First we used Bodenmann's stress-divorce model (1995) to conceptualize the connection between racial discrimination, relational support, and marital stability. Second we used Socioemotional Relational Therapy (SERT) (Knudson-Martin & Huenergardt, 2010) to define relational support and interpret gender differences in the provision of support. SERT also allows us to examine the gendered provision of support in the marital relationship. The emphasis on the intersection of multiples contexts such as gender *and* culture makes SERT a relevant approach for working with African American couples.

Bodenmann's stress model (1995) posits that external stressors can have a negative impact on couple stability and functioning (Bodenmann, 2005). Within this study racial discrimination was conceptualized as a contextual, chronic stressor that is harsh, stressful, and energy-consuming (Carroll, 1998; Murry, Brown, Brody, Cutrona, & Simons, 2001). Racial discrimination has been defined as "beliefs, attitudes, and institutional arrangements, and acts that tend to denigrate individuals or groups because of phenotypic characteristics or ethnic group affiliation" (Clark et al., 1999, p. 805). Bodenmann's model is a useful conceptual tool to delineate positive dyadic coping that accounts for differences in how couples adapt to stressors. Relational support may be one such dyadic coping mechanism which acts to reduce the impact of stress on marital stability (Karney & Bradbury, 1995; Lavee, McCubbin, & Olson, 1987). In this study we examine relational support as a specific type of positive dyadic coping and operationalize it as an important adaptive process.

In an effort to understand the role of gender and relational support in marital relationships, this study uses the theoretical lens of Socio-emotional relational therapy (SERT). According to SERT, relational support is a key component of healthy, successful relationships (Knudson-Martin & Huenergardt, 2010). The circle of care provides a model of relational support and consists of four elements: attunement, relational responsibility, vulnerability, and influence (Knudson-Martin & Huenergardt, 2010). Attunement is about spouses orienting themselves to feel their partners' experience or to feel their feelings in the moment. Relational responsibility involves partners directing their energy to maintaining and improving their relationship, as well as, partners caring for one another's well-being, acting on one another's behalf, and acknowledging one another's experience. Vulnerability involves self-disclosure of one's weakness or faults and putting oneself in a vulnerable position where they may be rejected or criticized. Influence is openness to being changed and influenced by one's partner and accommodating to their needs (Knudson-Martin & Huenergardt, 2010). These components are not mutually exclusive and often the presence of one depends on the presence of others. For example when partners are attuning to one another, they are also demonstrating shared relational responsibility. Within this model it is also important that both partners engage in the relationship and the circle of care in a mutual manner, otherwise the provision of support will be skewed and one partner may benefit at the expense of the other (Knudson-Martin & Huenergardt, 2010).

Gender inequalities between partners are thought to impede the couple's ability to support one another equally (Knudson-Martin & Huenergardt, 2010). SERT therapists focus treatment on helping couples overcome inequalities in the provision of support so

both partners benefit equally from the relationship. In this study, power is based in relationship maintenance patterns (Williams et al., 2012). When one partner is less emotionally engaged in the relationship they have more power than the more engaged partner. This is the Principal of Least Interest and has been linked to decreases in marital stability and relationship satisfaction (Sprecher et al., 2006). Support cannot be mutual under these conditions because only the powerful partner's experience is being attended to and subsequently supported. In this way, mutual support, or lack thereof, is a proxy for power. Achieving equality in intimate relationships is difficult and few couples ever reach this relational ideal (Knudson-Martin & Mahoney, 2009). Therefore we measure each partner's perception of the relational support they receive from their partner.

Racial Discrimination and Marital Stability

It is important to understand marital processes in the context of larger ecological circumstances and examine factors that promote or inhibit relationship stability (Bodenmann, 2005; Karney & Bradbury, 1995). Racial discrimination, as a marital stressor, has been largely overlooked (Trail, Goff, Bradbury, & Karney, 2012), even though African American couples cite racism as a significant, daily stressor in their marriages (Cervantes, 2012; Connor, 1998). An extensive review of the literature on the impact of racism on African Americans did not cite studies examining the impact on marriage (Clark et al., 1999). "Perceived discrimination might be one of the most endemic and enduring stressors facing African Americans" (Lincoln & Chae, 2010, p. 1084). Understanding the impact of racial discrimination on marriage is important considering how pervasive these experiences are for African Americans and the negative

impact it has on martial well-being (Bryant et al., 2010). Some of the negative effects on marriage include increased stress, frustration, negative affectivity, and irritability of partners (Bryant et al., 2010; Connor, 1998). In a study of Latino couples, higher incidences of racial discrimination contributed to decreases in marital quality (Trail et al., 2012). Racial discrimination can "marginalize emotional and social standing, subsequently compromising feelings of security and relational stability" (Cervantes, 2012, p. 264). Bryant et al. (2010) concluded that little is known about relational resources that contribute to martial stability in this population. The negative impact of racial discrimination on men and subsequently their family relationships is well-documented, but not well empirically studied. Specifically, how men overcome the marginalizing experience of racial discrimination may have important implications for marital stability in African American families (Pinderhughes, 2002).

Racial Discrimination, Relational Support, and Marital Stability

Intimacy has been found to moderate the association between daily stress and marital quality (Harper, Schaalje, & Sandberg, 2000). Yet, many studies investigating family stress and adaptation have failed to examine relational support and instead have focused on instrumental support. Researchers have agreed that it is emotional support in close relationships that is responsible for preserving psychological and physical well-being (Alloway & Bebbington, 1987; Cramer, 2004). Historically, connectedness has been an important characteristic of African American families (Cowdery et al., 2009; Hall & Greene, 2003). Unity, mutual commitment, and trust are viewed as paramount to African American couples (Marks et al., 2008), but may be difficult to attain because of

the effects of racism (Boyd-Franklin, 2003; McAdoo, 1997). We therefore, examine connectedness between husbands and wives as well as the degree to which connectedness may serve as a protective buffer against the negative effects of racial discrimination.

Racial Discrimination and Relational Support

Studies have linked relational support with increases in love (Jensen, Rauer, & Volling, 2013), but equality in the provision of support in marriage is elusive. Traditional ideas about gender tend to afford men more power within the relationship, and men have been found to benefit more, both physically and mentally from marriage (Jensen et al., 2013; Knudson-Martin, 2013; Robles & Kiecolt-Glaser, 2003). Power imbalances have been implicated in possible explanations for these differences (Knudson-Martin, 2013). "Power is relational and is reflected in how the needs, interests, and goals of partners influence the other" (Knudson-Martin, 2013, p. 6). Power is reflected in who notices the other's needs, who attends to whose needs, and who accommodates to the needs of the other (Knudson-Martin, 2013). It has been suggested African American men desire more power in the family because they are denied their dignity in society (Boyd-Franklin, 2003; Cowdery et al., 2009).

In relationships women are socialized to be nurturing and to focus on the needs of their male partners, while men are taught to be autonomous and more self-focused. Some suggest that husbands may need to receive relational support before they are willing to provide it to their partners (Wexler, 2012). Men also tend to view providing support as feminine (Samter, 2002) and see accommodation as a sign of weakness. These conditions create a situation where the balance of support can become highly skewed

leading to enduring power imbalances between partners over time. There are many factors that shape the provision of support in relationships, but few studies have examined the impact racial discrimination may have on this process.

Hypotheses and Theoretical Model

As illustrated in Figure 6 there are two main hypotheses in this study. The first is that racial discrimination will be directly and negatively associated with marital stability, particularly for husbands. Second, racial discrimination will be indirectly associated with marital stability through its reduction of relational support within the relationship.

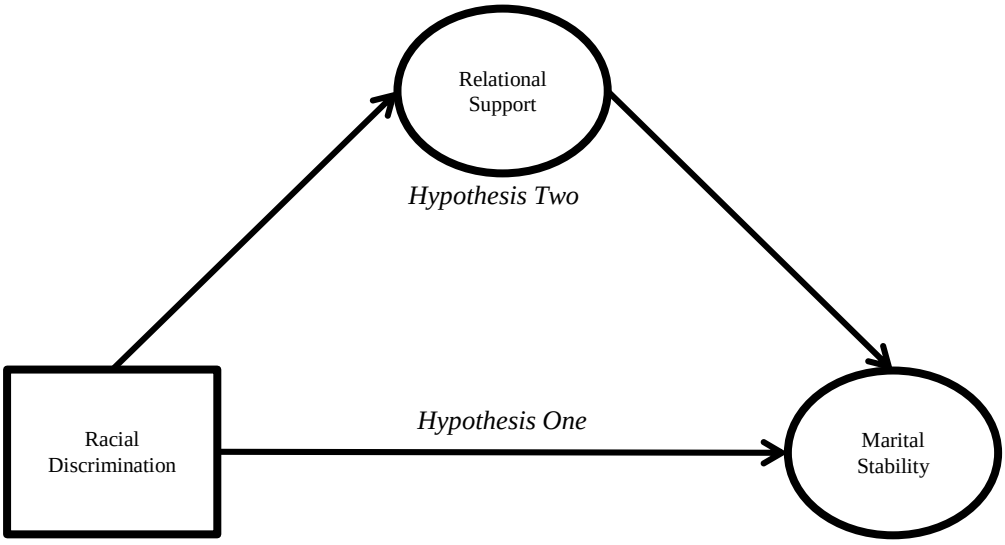

Figure 6. Theoretical Model of the Effect of Relational Support

Method

This study is part of the larger project A Study of African American Marriage and Health (Principal investigator: Dr. Chalandra M. Bryant) funded by a grant provided by the National Institute of Child and Human Development (NICHD). The purpose of this longitudinal study was to investigate the effect of social, familial, economic, occupational, and psychological factors on marital and health outcomes as African American couples as they transition through the early years of marriage. For the purposes of this study Phase One of the data, collected in 2006, was used.

Recruitment

Study participants were identified through the marriage license bureau of a southern state. Letters were then mailed asking if the couple would be interested in participating in the study and follow-up phone calls were made to schedule face to face interviews. To be included in the study, participants needed to be African American, at least 20 years of age and married less than one year; each member of the dyad had to agree to participate. After a couple agreed to participate, two interviewers were sent to each home and one interviewed the wife while the other interviewed the husband in a separate room. The interview survey consisted of over 800 questions and took approximately 2 hours to complete.

Sample Characteristics

There were a total of 1398 participants in the study making up 699 couples (See Table 4 for sample demographics). The mean age for wives was 33.8 years of age and 36.1 for husbands. This was the first marriage for 74.7% of females and 67.7% of males and the second marriage for 25.3% of females and 32.3% of males. Couples had been married an average of 11.7 months. The majority of the sample, 74%, identified as religious and 93 % of those were Protestant.

Table 4.

Sample demographics

	Husbands (699)	Wives (699)
Employment	%(n)	% (n)
Full-time	79.2(555)	68.6 (481)
Part-time	5.2(36)	7.6 (53)
Unemployed	5.2(36)	8.6 (60)
Retired	2.7(19)	1.2 (9)
Keeping house full-time	0.1(1)	8.6 (60)
Other	1.6(11)	2.4(17)
Income		
Percent making less than 40,000	67.9(476)	78.3(549)
Interquartile range	15, 000 – 34, 999	10,000 – 29, 999
Percent making more than 40,000	29.8(209)	15.3(107)
Interquartile range	40,000-74,999	40,000-74,999
Education		
Some high school	10.3(72)	7.3(51)
High school	36.7(257)	22.5(158)
Technical or Trade school degree	7.3(51)	4.4(31)
Some college	24.8(174)	28.8(202)
Associates degree	6.8(48)	10.1(71)
Bachelor Degree	11(77)	18.7(131)
Masters	1.1(8)	6.7(47)
Doctorate/PhD/MD	.4(3)	.4(3)

Measures

Racial Discrimination

Racial discrimination was measured using an adaptation of McNeilly et al. 1996's scale used by Murry et al. (2001). The modified scale is comprised of 10 questions rated

on a 5-point Likert scale, 1 (never) to 5 (more times than I can count). Items included, for example, "During the past year, how often has someone ignored you or excluded you from some activity just because you are African American?" A mean composite measure of racial discrimination was created as has been done in other studies (McNeilly et al., 1996; Murry et al., 2001). Higher scores on this measure reflect more experiences of racial discrimination. Murry et al. (2001) reported a Cronbach's alpha of α =.92 for the scale. Cronbach alpha in this study was α = .84 for wives and α = .87 for husbands.

Relational Support

Currently there are no validated measures of relational support so we created a measure based on SERT's definition (Knudson-Martin & Huenergardt, 2010). To create this measure, using the existing dataset, a team of SERT clinicians were assembled to identify items in the survey that were in line with the "Relational support" concept from the circle of care.

Items were chosen that captured the processes of relational support as represented by relational responsibility, attunement, vulnerability, and influence. Items included, "how often does your partner do something that is important to you?" which is thought to capture attunement and relational responsibility. Similarly, vulnerability is captured by the question, "how often do you and your partner talk about your personal problems?" The item "how often does your partner listen to your ideas for solving the problem?" reflects one partner's ability to influence the other. After the clinicians provided face validity for 17 items within the dataset these 17 items were evaluated through factor analysis to determine whether all 17 items loaded onto one latent factor of relational

support. Since the planned analysis intended to parse out the effects of each partner's relational support distinctly, the factor analysis process was run separately for each gender.

Three factors, each consisting of three items were retained in the exploratory factor analysis using an oblique rotation, scree plots, and the Kaiser rule. Sixty-six percent of the variance was explained for husbands and 63.3% of the variance for wives. This factor structure was then brought back to the SERT researchers, who labeled the factors as: influence, validation, and emotional connection. Influence indicates a husband or wife's perception of how much influence they have on their partner. The reliability of this scale was strong, $\alpha = .83$ for wives and $\alpha = .73$ for husbands. How validated husbands or wives feel by their partners comprises the validation subscale ($\alpha = .72$ for wives and $\alpha = .68$ for husbands). Lastly, the emotional connection subscale was defined as how much emotional connection spouses felt they had with their partners. The reliability of this subscale was $\alpha = .66$ for wives and $\alpha = .67$ for husbands. Subsequently, confirmatory factor analysis (CFA) was used to confirm the three factor structure through testing of the measurement model (See Table 6 for measurement model fit indices). Higher scores reflect greater relational support. The scale at an individual level represents each partner's perception of the relational support one receives from their partner.

Marital Stability

Spouse's perceptions about the longevity of the relationship are used in the study of marital stability (Booth et al., 1983). Marital stability was assessed using three items.

Initially, three items were used in the study, "how likely is it that your marriage will last another 5 years? How likely is it that your marriage will last forever? Since your wedding, how often have you ever thought that getting married was not such a good idea?" The original validation study reported that the index has high reliability with Cronbach's alpha = .93 and showed validity with national rates of divorce of four different cultural groups, including African Americans. Since we are using a modified version that has not been validated we evaluated the reliability of these items, and their total scale scores, prior to use in this study. The item asking if spouses thought their marriage would last forever was positively skewed and therefore not used in the subsequent analysis. Cronbach alpha of the two remaining items with this sample was $\alpha = .48$ for husbands and $\alpha = .63$ for wives.

Control Variables

Lower income has been found to negatively impact marital satisfaction for African Americans (Bryant et al., 2010). To control for income in this study family income was regressed onto the outcome variable of marital stability in all models. Family income was measured by combining husband and wives income from the past year.

Means and standard deviations for all variables in the model, along with significant differences are in Table 5. There were only two significant differences between husbands and wives. Wives reported talking more about personal problems than husbands, $t(696)=3.47$, $p<.01$ and husbands reported having fewer second thoughts about marriage, $t(691)=1.97$, $p<.05$ than wives.

Table 5

Means and Standard Deviations of all Study Variables for Husbands and Wives

	Husbands	Wives
Racial Discrimination	14.88(5.95)	14.43(4.98)
Perception of Influence on Partner (1)	3.27(.78)	3.22(.84)
Perception of Influence on Partner (2)	3.25(.83)	3.17(.91)
Perception of Influence on Partner (3)	2.99(.79)	3.04(.82)
Feeling Validated by Partner (1)	3.32(.79)	3.31(.83)
Feeling Validated by Partner (2)	3.05(.88)	2.98(.90)
Feeling Validated by Partner (3)	3.32(.82)	3.31(.80)
Emotional Connection (1)	3.70(.59)	3.71(.58)
Emotional Connection (2)	3.60*(.64)	3.71*(.54)
Emotional Connection (3)	3.61(.58)	3.59(.60)
Marital Stability(1)	3.56*(.73)	3.49*(.73)
Marital Stability(2)	4.67(.64)	4.63(.78)

** significant difference between husband and wives p<.05*

Pre-analysis Data Screening

Data were screened for missing responses. During this process, 117 cases were excluded in the analysis because they were missing values on one or more of the study variables. Prior to building each structural equation model, univariate and multivariate assumptions of SEM were checked with SPSS 20. Estimation with full maximum likelihood in SEM rests on the assumption that continuous outcome variables are normally distributed, bivariate scatterplots are linear, and that the distribution of paired variables is bivariate normal (Kline, 2011). All of the assumptions were met with the

exception of one of the marital stability items which was positively skewed and therefore removed from subsequent analyses in the measurement model phase of analysis. The item removed was, "how likely is it that your marriage will last another five years?" to which 96.1% of participants answered very or somewhat likely. This screening process produced the correlation table below (Table 6). This table was then input into EQS for analysis.

Table 6

Bivariate correlations, means, and SDs for all study variables

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
1. Racial Discrimination^{w}	-																							
2. Racial Discrimination^{h}	.06	-																						
3. Influence (I1)^{w}	.01	.05	-																					
4. Influence (I1)^{h}	-.02	-.10*	.21**	-																				
5. Influence (I2)^{w}	-.00	.07	.68**	.17**	-																			
6. Influence (I2)^{h}	-.03	-.06	.20**	.62**	.14**	-																		
7. Influence (I3)^{w}	.05	.02	.60**	.19**	.60**	.20**	-																	
8. Influence (I3)^{h}	.04	-.08*	.20**	.43**	.19**	.38**	.15**	-																
9. Validation1^{w}	.00	.01	.39**	.13**	.40**	.12**	.37**	.06	-															
10. Validation1^{h}	-.01	.06	.21**	.34**	.19**	.29**	.23**	.26**	.22**	-														
11. Validation2^{w}	-.04	.01	.48**	.15**	.45**	.16**	.44**	.10**	.47**	.19**	-													
12. Validation2^{h}	-.06	.04	.20**	.44**	.19**	.35**	.21**	.32**	.22**	.45**	.16**	-												
13. Validation3^{w}	-.00	-.01	.37**	.11**	.35**	.13**	.35**	.06	.48**	.19**	.44**	.16**	-											
14. Validation3^{h}	-.06	.01	.18**	.23**	.15**	.30**	.13**	.23**	.16**	.42**	.15**	.39**	.12**	-										
15. Connection1^{w}	-.02	.05	.25**	.08*	.25**	.10**	.18**	.04	.25**	.13**	.22**	.14**	.19**	.08*	-									
16. Connection1^{h}	.02	.06	.08*	.11**	.10**	.14**	.07	.06	.10*	.13**	.05	.14**	.04	.12**	.05	-								
17. Connection2^{w}	.03	.04	.27**	.06	.25**	.11**	.24**	.01	.26**	.10*	.22**	.11**	.17**	.11**	.43**	.06	-							
18. Connection2^{h}	.04	.04	.09*	.22**	.12**	.19**	.04	.12**	.11**	.11**	.03	.18**	.03	.13**	.10**	.46**	.06	-						
19. Connection3^{w}	-.01	-.02	.22**	.06	.23**	.09*	.21**	.07	.25**	.12**	.27**	.09	.22**	.11**	.34**	.06	.42**	.10**	-					
20. Connection3^{h}	-.00	.03	.12**	.23**	.10*	.24**	.08*	.17**	.16**	.21**	.10**	.22**	.10*	.20**	.05	.30**	.02	.44**	.11**	-				
21. Marital Stability (MS1)^{w}	-.04	.03	.31**	.20**	.29**	.15**	.25**	.13**	.33**	.17*	.29**	.12**	.26**	.11**	.13**	.08*	.13**	.13**	.19**	.13**	-			
22. Marital Stability (MS1)^{h}	.01	-.06	.20**	.23**	.15**	.23**	.15**	.18**	.19**	.24**	.16**	.23**	.16**	.23**	.07	.12**	.10*	.08*	.06	.11**	.23**	-		
23. Marital Stability (MS2)^{w}	-.06	-.03	.34**	.22**	.30**	.18**	.33**	.13**	.38**	.24**	.34**	.17**	.33**	.17**	.24**	.06	.18**	.11**	.26**	.17**	.47**	.25**	-	
24. Marital Stability (MS2)^{h}	-.03	-.07	.21**	.33**	.16**	.28**	.20**	.23**	.24**	.35**	.20**	.31**	.16**	.32**	.16**	.17**	.12**	.22**	.13**	.30**	.27**	.32**	.39**	-
25. Family Income	.12**	.14**	.03	-.03	.04	.00	.03	.01	-.02	.03	.04	.03	-.01	.02	.11**	.02	.08	.03	.05	.03	.01	.01	.09*	.04
Mean	14.4	14.9	3.22	3.27	3.20	3.25	3.05	3.00	3.31	3.32	2.98	3.31	3.32	3.71	3.70	3.71	3.60	3.60	3.61	3.49	3.56	4.62	4.66	13.8
SD	4.9	5.9	.84	.78	.91	.83	.82	.79	.83	.79	.90	.88	.82	.58	.59	.54	.65	.60	.58	.73	.73	.78	.65	4.6

**p<.05, **p<.01*

Results

Using EQS (Bentler, 2006) we tested the hypothesized associations between variables using structural equation modeling (SEM), specifically structured regressions (Kline, 2011). This method allows us to test the stress-divorce model and the relationships between racial discrimination, relational support, and marital stability. To capitalize upon the dyadic nature of the data the Actor-partner interdependence model (APIM) was used (Kenny et al., 2006). APIM affords us the opportunity to examine associations between racial discrimination and one's own marital stability (actor effects), as well the links between spouses' experiences with racial discrimination and their partners' marital stability (partner effects) (Kenny et al., 2006). Use of APIM facilitates an examination of the role relational support plays on the marital stability of spouses and their partners.

Constructing the Measurement Model

Before testing our hypothesized model we first fit the measurement model to ensure measurement of each latent variable was psychometrically sound (Byrne, 2006). The measurement model of each observed and latent variable was tested in EQS using confirmatory factor analysis procedures outlined in Byrne (2006). The most parsimonious model with the best model fit statistics was determined to be the measurement model. We used Chi-square, comparative fit index (CFI), and root mean square error of approximation (RMSEA) as indicators of model fit and factor structure. Since it can be difficult to obtain a non-significant chi-square with a large sample size (Raykov & Marcoulides, 2006), we also relied on the relative chi-square χ^2/df which is

less dependent on sample size and should be equal to or less than two chi-squared values per degree of freedom (Byrne, 1992). The contribution of each scale item was assessed to verify that each item loaded substantially on the specified factor (e.g., <.40).

Table 7

Measurement Model Fit Indices

Model	χ^2	*df*	χ^2/df	CFI	RMSEA[CI]
Model 1 (One Factor)	2618*	298	8.78	.53	.11[.10,.11]
Model 2 (One Factor – kurtosis)	1678*	275	6.1	.575	.094[0.089,.098]
Model 3 (Two Factor)	1097*	273	4.02	.75	.072[.067,.076]
Model 4 (Two Factor – covariance)	736*	267	2.77	.86	.055[.050,.06]
Model 5 (Four Factor)	629*	249	2.5	.885	.051[.046,.056]
Model 6 (Eight Factor)	331*	230	1.4	.969	.028[.021,.034]

p<.05

We started the model building process with a one factor model where all items of interest were loaded on one factor (Table 7). This model was a poor fit ($\chi^2(298) = 2618$, $p<.001$, CFI=.53, $\chi^2/df = 8.78$, RMSEA= .11). Model 1 output also showed high kurtosis for the martial stability item which we mentioned in the pre-analysis data screening section of this study. Therefore this item was removed and the model was run again. This modified model (Model 2) also had poor fit ($\chi^2(275) = 1678$, $p<.001$, CFI=.575, $\chi^2/df = 6.1$, RMSEA= .094). Next all wife variables were loaded on one factor and all husband variables on a second factor (with a covariance between the two factors). This model (Model 3) also demonstrated a poor fit to the data, but suggested covariances between

relational support items would improve the fit, this became Model 4. This model had a poor fit ($\chi^2(267) = 736$, $p<.001$, CFI=.86, $\chi^2/df = 2.77$, RMSEA= .055). In the four factor model (Model 5) we parsed out factors for relational support and marital stability for each partner. This model still offered a relatively weak fit to the data overall as demonstrated by the CFI = .885 and RMSEA = .051. In the final model (Model 6) we divided the one relational support factor into the three latent factors, creating a total of eight factors. This was determined to be the best fitting model ($\chi^2(230) = 331.4$, $p<.05$, CFI=.97, $\chi^2/df = 1.4$, RMSEA= .028) and a tenable measurement model by which the proceeding structured regression models could be tested against. In this model the factors comprising relational support are interrelated for both husbands and wives as evidenced by significant covariance across all three relational support factors.

Given that the best fitting latent structure of the data was the APIM with eight factors, we moved on to test whether all factors had a direct effect on marital stability, or whether racial discrimination had an indirect effect on marital stability through the relational support factors.

Structural Equation Model Building Process

The model fit indices for this model building process are in Table 8. In the first model we tested the direct effects of relational support and racial discrimination on marital stability. This model fit had a good fit ($\chi^2(244) = 328.3$, $p <.05$, CFI=.974, $\chi^2/df =$ 1.3, RMSEA= .024). In the next model (Model two) we tested the indirect effects of racial discrimination on marital stability through relational support. This model had a poorer fit ($\chi^2(237) = 355.1$, $p <.05$, CFI=.964, $\chi^2/df = 1.5$, RMSEA= .029) than Model

one. In Model three we tested the hypothesis of directional relationships from the husband's relational support to the wives' relational support (rather than the standard covariance relationship within the APIM process). Therefore the indirect model was fit again, with the directional pathways. This model fit the data well ($\chi^2(231) = 290.3$, $p < .05$, CFI=.982, $\chi^2/df = 1.3$, RMSEA= .021). We tested the same model with pathways from wives' relational support to husband's relational support, but this model was so poor a converged solution could not be obtained. Model three was retained as the final model because it is the best-fitting most parsimonious model (Figure 7).

Table 8

Model Fit Indices

Model	χ^2	*df*	χ^2/df	CFI	RMSEA[CI]
Model one	328.3*	244	1.35	.974	.024[.017,.031]
Model two	355.1*	237	1.50	.964	.029[.023,.035]
Model three	290.3*	231	1.25	.982	.021[.012,.028]
Model four	328.7	260	1.26	.979	.021[.013,.028]

p<.05

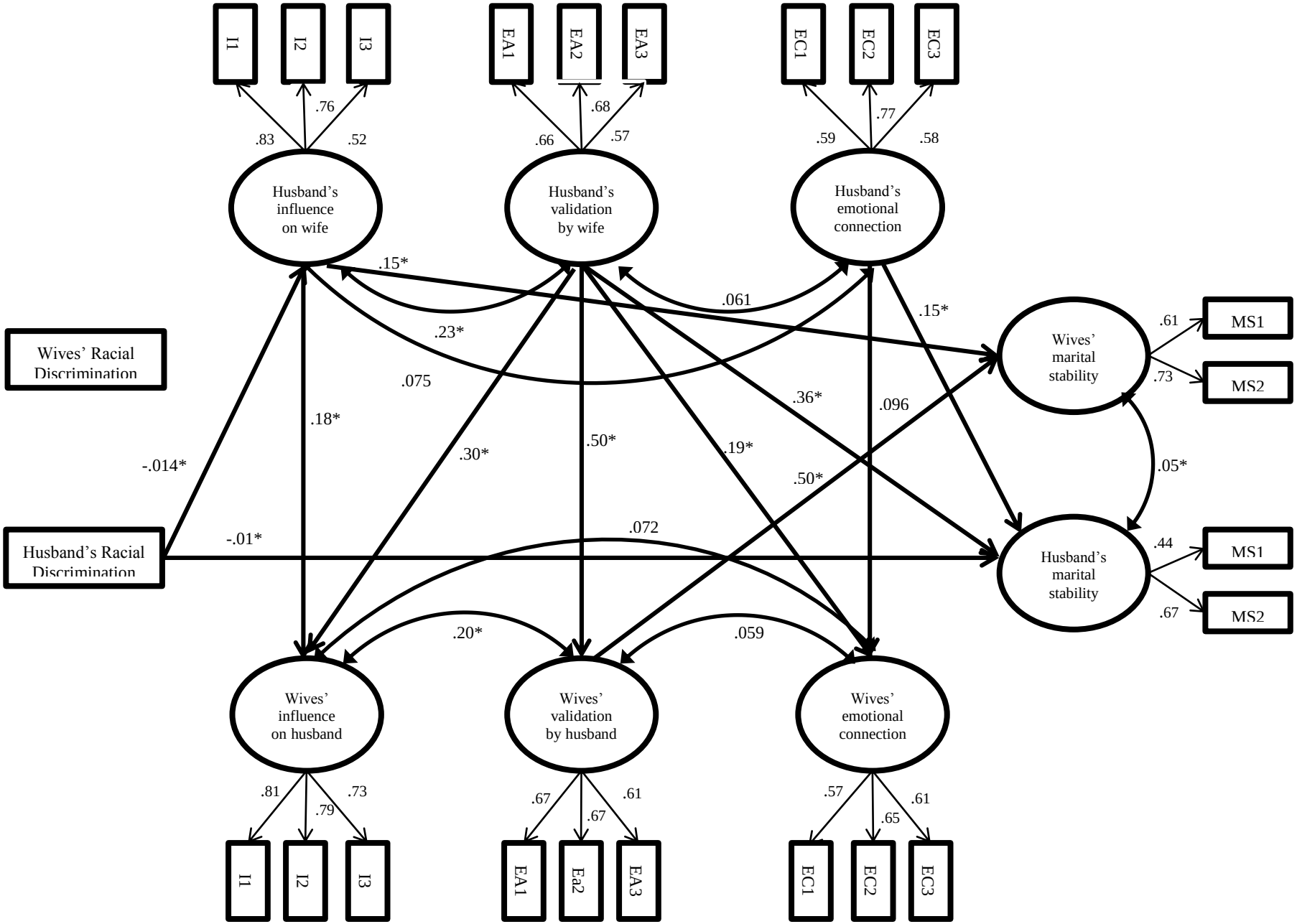

Figure 7. APIM model

Direct Effects

Overall, marital stability was directly associated with relational support and racial discrimination, but the effects were different for husbands and wives. Husband's marital stability was directly associated with racial discrimination (β= -.19, $p<.05$), as well as relational support. Specifically, husbands report being validated by their wives (β=.73, $p<.05$), as well as, husbands' reports of emotional connection (β=.15, $p<.05$) in the relationship. For wives on the other hand, experiences of racial discrimination were not associated with marital stability, rather relational support was associated with stability. For wives relational support in the form of feeling validated by their husbands (β=.62, $p<.05$) was particularly important to stability. Also, husbands' perception of influence on their wives (β=.19,$p<.05$) was related to wives marital stability. As expected, husbands and wives marital stability were significantly correlated (r =.83, $p<.05$). Husband's, but not a wife's, reports of discrimination were associated directly with stability. For both, husbands and wives relational support contributed to stability. For both husbands and wives had a direct effect from the level of validation they received from their spouse, however husbands also relied on the emotional connection to their wives, while female relied on their husband's level of influence on them.

Indirect Effects

While husbands' reports of racial discrimination had a direct effect on their marital stability, it was also indirectly linked to husbands' and wives' reports of marital stability through a few pathways. First, husbands' reports of racial discrimination were associated with their relational support. This effect is then directly associated with

wives' marital stability. The APIM suggests that husbands' and wives' individual reports of relational support were associated with one another. Hence, husbands' reduction of relational support reduces wives' levels of relational support through their combined relational support. Therefore, relational support, particularly validation by one's partner, contributes to both partners' marital stability. Overall, husbands' experiences of discrimination have a profound effect on both husbands' and wives' marital stability. This effect can be decreased by relational support, but unfortunately husbands' experiences of discrimination also lessen the relational support both spouses experience.

Discussion

This study provides support for the negative association between racial discrimination and marital functioning. In this study, husbands' experiences of racial discrimination, but not wives' experience, were significantly associated with both husbands' and wives' marital stability directly and indirectly. Experiencing racial discrimination was associated with lower levels of marital stability for husbands. It may be that experiencing racial discrimination does not affect relational support or marital stability for wives because the stereotype of the "strong black woman" influences them to internalize their negative experiences. Indeed, one study found that African American women cope with discrimination by internalizing their experiences (Krieger, 1990). It is also possible that relational support is a more salient source of marital stability than external factors for women. This is supported by our finding of a direct association between relational support and marital stability for wives. More research is needed to understand the impact racial discrimination has on women and factors that may buffer

negative effects. Men may rely more on the marital relationship as a source of support than women. This may explain why husbands' reports of racial discrimination have the power to decrease both husbands' and wives' relational support and marital stability. Husband's experiences of racial discrimination appear to negatively spillover into the relationship. Husbands who experience discrimination may perceive themselves as having less influence on their wives which can negatively affect the shared experience of relational support. This corresponds with previous theories which suggest the systematic denial of male privilege can add to family stress through the displacement of feelings of powerlessness and hostility in African American men (Hall & Greene, 2003; Pinderhughes, 2002).

Relational support appears to buffer the marital stability of African American couples from the negative effects of racial discrimination. This finding provides support for the stress-divorce model which asserts that positive dyadic coping is strongly associated with marital stability (Bodenmann, 2005). Our findings are contradictory to some literature on gendered effect of stress. For example, Harper et al. (2000) found that daily stress was more related to wives marital quality than husbands and intimacy was a stronger moderator of this relationship for wives. This is opposite to what we have found. It could be that racial discrimination is a unique stressor that influences the couple subsystem in a different way than other daily stressors. However the Harper et al. (2000) study did not take into account the dyadic nature of the data and ran two separate regression analyses. Our study provides important insight into how findings may change when a husband and wives support is taken into account simultaneously.

Also interesting are the directional paths found in this study which suggests that

husbands' perceptions of support influences their wives' perception of support. The model indicates that men need to feel supported before they can give support to their wives in the context of racial discrimination. It could be that husbands need to feel that their wives are there for them before husbands can be there for their wives. This explanation is supported by Wexler (2012) who claims that most men need to feel respected and needed before they can be emotionally generous. This also supports the notion that men have more power in marriage than women (Bulanda, 2011; Knudson-Martin, 1995) when it comes to getting support from their partner. However, power is an intricate concept that is difficult to capture in a cross-sectional study. More research is needed to understand how power influences relational processes in African American couples.

Measuring specific aspects of power may be especially important with this population because they are often stereotyped as egalitarian or matriarchal (Haynes, 2000). The issue of equality is riddled with contradictions. Equality is often linked to higher quality marriages and marital stability for whites and African American women, but not for African American men (Hatchett, Veroff, & Douvan, 1995). It has been suggested that the family may be the only environment where African American men experience a position of power (Pinderhughes, 2002), and therefore attempts to achieve power balances in these relationship become more complex. Measures of power in relationships in research have not specified which areas of relationship they are studying, i.e. income, housework, childcare, caring for the relationship, etc. Also measures of power seem to be oversimplified. For example, Hatchett et al. (1995) measured power imbalances with one self-report question, "In general, who has more say in your

marriage, your (husband/wife) or you?" (p. 214). More research is needed to examine equality processes in this population, particularly in regards to the provision of relational support.

Ideally, providing and receiving support should be mutual where partners are equally concerned about providing support as receiving it and one's experience of support should not be a direct result of the others (Gottman, 2011; Wright & Aquilino, 1998). African American married couples cite equality and mutual respect as important to relationship resiliency (Brooks, 2007), but egalitarian practices, to which they have a cultural predisposition, may be eroded from living in Western culture (Hall & Greene, 2003). In Western culture, responsibility for the couple relationship, the well-being of her partner, and change often rests with the woman (Crawford, 2004; Keeling et al., 2010; Knudson-Martin, 2003). Also, the "strong Black woman" stereotype is often internalized by African American women and these women are prone to not attending to their own needs or feeling selfish for doing so (Hall & Greene, 2003). With women socialized into a supporting role, men in this culture may be used to being supported by women. Constructions of masculinity also inform men that being vulnerable is a sign of weakness (Wexler, 2012) so most men rely on their romantic partners for social and emotional support. Dominant ideas of femininity and masculinity intersecting with stereotypes of African American women and experiences of racial discrimination for men create an environment where the emotional needs of men may take precedence over those of women. Overall, when these needs are met for African American husbands and wives there are positive effects on marital stability.

Implications for Practice

The findings of this study have important implications for clinical practice with couples and family life education. The topic of racial discrimination may not be on the radar of many couples therapists and educators. First, because racial discrimination can have a negative impact on the couple relationship therapists should assess the impact with African American couples. This is an important intervention area for therapists who can help the couple understand how their experiences in society as a minority may be negatively influencing their relationship in ways outside of their awareness. How the provision of support is enacted in African American marriages may be influenced by racial discrimination. Therapists need to find ways to ensure the couple relationship is a source of relational support for both partners. Therapists can make the implicit, explicit, by inquiring as to each partner's expectation of support, specifically influence, validation, and connection. This can help partners to see how ideas, often outside of their conscious awareness, set them up for power differences in the provision of support.

Socioemotional Relational Therapy (SERT) is a relevant model that views enactments of gender and culture as important in influencing marital interactions and outcomes (Knudson-Martin & Huenergardt, 2010). Within this model the therapist assesses how larger contextual issues influence each partner's experiences within the relationship, and for African Americans, particularly males, racial discrimination may be one of those factors that needs clinical attention. SERT also provides a framework for equality in marriage characterized by relational support and the circle of care. Most couples in this day and age say that having a relationship based on equality is important to them (Kane, 2000; Knudson-Martin, 2013), but reaching this ideal is no easy task.

Limitations and Future Research

Since this is a study of newlyweds, our findings are limited in generalizability to newly formed marriages. Marital quality and stability tends to be higher during the first years of marriage. Some of our martial stability items had low inter-item correlations and future research should use a more comprehensive measure of stability. More longitudinal research on African American marriages is needed in order to fully understand the processes that lead to resilient, stable relationships over time and how this is influenced by racial discrimination and relational support. Longitudinal research is also needed to understand the balance of power in marriage and studies should look at power in terms of different areas of the relationship such as emotional support, childcare, and decision-making. Having a validated measure of mutual support would aid in the study of power in terms of the provision of support in marriage.

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CHAPTER SIX

THE ASSOCIATION BETWEEN RACIAL DISCRIMINATION, RELATIONAL SUPPORT, AND HEALTH IN AFRICAN AMERICAN MARRIAGES

Abstract

Over the past 30 years researchers have documented the negative impact of racial discrimination on the physical and mental health of African Americans. Many studies have examined protective factors for adolescents, adults, and men and women. The marital relationship has been overlooked as a potential buffer from the negative impact of racial discrimination on the health of partners. In this study we used structural equation modeling and an actor-partner interdependence model to test the direct and indirect associations between racial discrimination, relational support, and health in married African American couples. Results suggest that racial discrimination is negatively associated with wives' health, but relational support does not a buffer the association between reports of racial discrimination and health. Relational support is a buffer for husbands, this suggests that partners may not benefit equally from the relationship. Implications for the field of Marriage and Family Therapy are discussed.

Introduction

Along the entire life cycle people of color endure more health problems than whites and health disparities are increasing (Kagawa Singer, 2012). The negative effect of racial discrimination on physical and mental health through stress pathways (Williams, Neighbors, & Jackson, 2003) has been receiving increasing attention in the literature (Pieterse, Carter, & Ray, 2013). "Stress has been associated with many diseases such as cancer, cardiovascular disease, and substance abuse and these diseases are killing African Americans in record numbers" (Jones, Cross, & DeFour, 2007; Outlaw, 1993, p. 407; Webb & Beckstead, 2002). Marriage, particularly a good marriage, can be a protective barrier from the negative effects of stress (Robles & Kiecolt-Glaser, 2003). Surprisingly, few studies examine the context of African American marriage as a potential buffer from the negative effects of racial discrimination. The purpose of this study was to examine how support between partners protects African American couples from the negative effects of racial discrimination.

Theoretical Framework

Two frameworks were adapted for use in this study. First we used Bodenmann's stress model (1995) to examine couple processes that buffer against the negative effects of stress. Second we used Socioemotional Relational Therapy (SERT), an approach to couples therapy, to conceptualize *relational* support as an adaptive coping response that buffers the negative impact of stress on partners' health and well-being.

Adaptive coping responses are thought to moderate the effects of racial discrimination on psychological and physiological stress responses, reducing the negative

impact on health over time (Bodenmann, 2005; Clark et al., 1999). For the present study racial discrimination was conceptualized as a contextual, chronic stressor for African Americans that is harsh, stressful, and energy-consuming (Carroll, 1998; Murry et al., 2001). Racial discrimination was defined as "beliefs, attitudes, and institutional arrangements, and acts that tend to denigrate individuals or groups because of phenotypic characteristics or ethnic group affiliation" (Clark et al., 1999, p. 805).

While social support is known to be a helpful buffer against the negative effects of stress, research has failed to differentiate the social support received within the marital relationship from the social support received in other relationships. There are only a handful of models that examine adaptive coping at the couple level. Bodenmann's Stress Model (1995), adapted from McCubbin and McCubbin's Family Stress Process Model, posits that if marital partners do not adapt to stressors there may be negative consequences on individual *and* couple functioning. Dyadic support is one adaptive coping strategy thought to buffer against the negative effects of stressful events (Bodenmann, 2005). While this model is often used to confirm that negative couple processes contribute to impairments in marital functioning, we applied it to investigate the protective effect of relational support.

Dyadic coping is a conceptual idea which can be explained through many different theoretical lenses. In this study to explore the concept of dyadic coping through the lens of Socioemotional Relational Therapy (SERT) (Knudson-Martin & Huenergardt, 2010). SERT is a model of feminist family therapy which places couple equality in the provision of support at the center of therapy. Relational support between partners is theorized to help couples adapt to stressors and is a central goal of this approach. Using

the socioemotional framework the therapist attempts to understand the couple subsystem within their unique socio-cultural context. Special attention is paid to how power associated with societal constructs such as gender and culture impede a couple's ability to engage in equally supportive ways (Knudson-Martin, 2013; Knudson-Martin & Huenergardt, 2010). The emphasis on the intersection of gender *and* culture makes this a relevant theory for working with African American couples. Relational support within this framework is based in 4 fundamental relational actions: influence, relational responsibility, attunement, and vulnerability (Knudson-Martin & Huenergardt, 2010).

In this study, gendered power dynamics and relational support are relational concepts based in relationship maintenance patterns centered around the circle of care (Williams et al., 2012). When spouses equally allow themselves to be influenced by their partners, accommodate to their partner's needs, and validate their partner's reality, a relationship is said to be equal in the provision of relational support. Imbalances in relational support processes may reflect power differences with the person receiving more and giving less relational support, holding more power in the relationship. Typically, men have more power in the relationship as women are held responsible for caring for the relationship (Knudson-Martin, 2013).

The combination of these two frameworks led to three hypotheses (Figure 8). First, racial discrimination should be directly and negatively associated with the health. Second, relational support should moderate the association between racial discrimination and health. Third, there will be gender differences in the buffering effect of relational support.

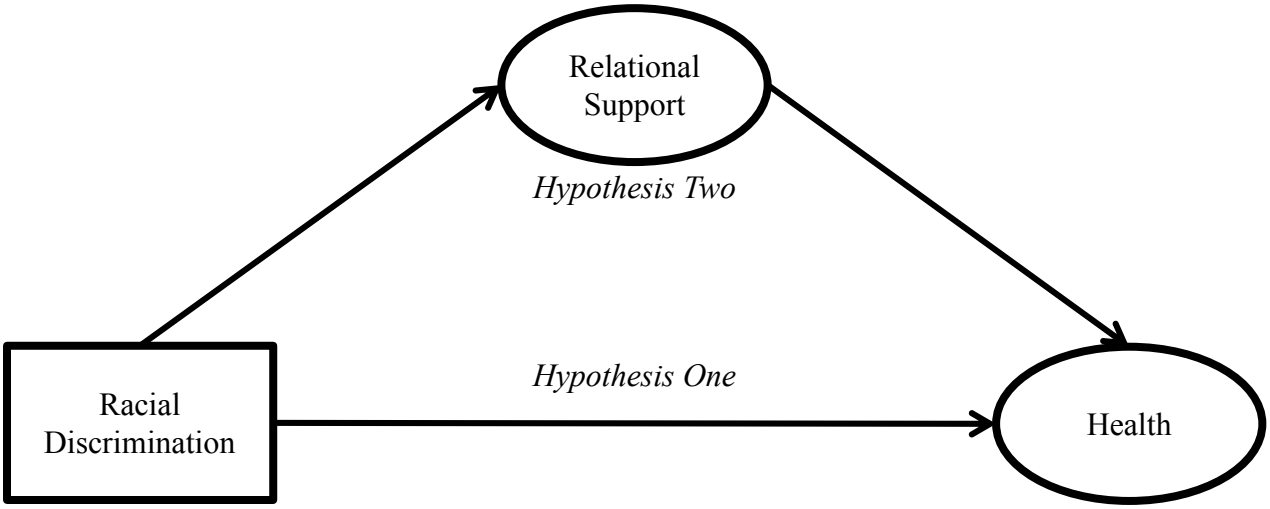

Figure 8. Theoretical Model of the Indirect Effect of Relational Support

Racial Discrimination and Health

The association between racial discrimination and negative health outcomes is well-established. The experience of racial discrimination is thought to trigger physiological stress responses in the body which can negatively impact health and mortality in many ways (Mays et al., 2007). Racial discrimination has been linked to significant increases in blood pressure, poorer self-rated health (Krieger, 1990; Krieger & Sidney, 1996), and cigarette smoking (Landrine & Klonoff, 2000). In addition, racial discrimination has been linked to another aspect of health, namely, preterm and low-weight deliveries (Mustilio et al., 2004).

While there is sound evidence of the negative impact on physical health, there is also evidence of negative mental health outcomes (Franklin-Jackson & Carter, 2007; Gibbons, Gerrard, Cleveland, Wills, & Brody, 2004). Racial discrimination has been

linked to mental health outcomes such as anxiety, depression (Kessler et al., 1999; Outlaw, 1993; Prelow et al., 2006; Wickrama, 2007), and substance abuse (Gibbons et al., 2004). Furthermore, a comprehensive literature review of the effects of racism on mental health (incidence of psychiatric illness, depression, negative emotional reactions, anxiety, lower self-esteem, and alcohol abuse) suggested that racism can adversely affect mental health in 3 ways: (a) stunting socioeconomic mobility and limiting access to desirable resources; (b) producing negative psychological responses; and (c) internalizing negative racial stereotypes which, in turn, leads to lower self-evaluation (Williams & Williams-Morris, 2000). Given these conclusions, as well as many others, we argue that racial discrimination has a direct effect on physical and mental health outcomes and relational support may be an important buffer.

Relational Support and Health

Interpersonal relationships have a significant influence on physiological and psychological responses to stress (Kennedy et al., 1988). Lacking a supportive network is associated with poorer prognosis of heart disease (Barth et al., 2010), cancer (Nausheen et al., 2009), depression following a stroke (Salter et al., 2010), and poor management of chronic illness (Gallant, 2003). Having good support is more important than the availability of support (Cohen & Hoberman, 1983) for physical and mental health (VanderVoort, 1999). "Good" support refers to any support that *feels* supportive to the person needing it. A person may have a spouse as a source of support, but the support offered may not match the support needed. There has been overwhelming evidence that a good marriage is beneficial to health and well-being because it creates an environment of

support which protects against the negative effects of stress (Coombs, 1991; Gabriel et al., 2010; Robles & Kiecolt-Glaser, 2003). There is also evidence that equality in relationships is also good for health (Gottman, 2011). The perplexing part of this body of research is that the supportive processes between marital partners are seldom examined in relation to gender or stressors affecting African American couples.

While the benefits of relational support are widely documented (Coombs, 1991; Graham et al., 2006), the effect of support differs as a function of gender. Men often benefit more from relational support than women (Kiecolt-Glaser & Newton, 2001). Feminist theorists and therapists attribute this discrepancy to power imbalances which skew the benefits in the direction of the more powerful partner which is often the man (Dolan-Del Vecchio, 2008; Knudson-Martin & Mahoney, 2009). Gender equality is thought to be a central component to the buffering effect within relationships, but achieving gender equality is elusive and may be difficult for African American couples because of the sociocultural context in America. Power balances in marriage may be a predictor of marital instability for men (Hatchett et al., 1995). There is some evidence that the pressure on men to live up to traditional constructions of masculinity and the inability to do so because of structural constraints, puts strain on marriages and in response families organize around supporting men (Pinderhughes, 1989). For this reason we hypothesize there will be imbalances in the provision of relational support between partners in the context of racial discrimination.

Method

Data for this project are from a study funded by the National Institute of Child Health and Human Development (Principal Investigator: Dr. Chalandra M. Bryant). The purpose of the larger study was to examine the effect of social, familial, economic, occupational, and psychological factors on marital and health outcomes. For this current study Phase One data, collected in 2006, was utilized.

Recruitment

Newlyweds were identified through the marriage license bureau of a southern state. Letters were then mailed asking if the couple would be interested in participating in the study. After follow up phone calls, face to face interviews were scheduled. To be included in the study, participants needed to be African American, at least 20 years of age, and married less than one year; each member of the dyad had to agree to participate. After each partner consented to participate, two interviewers went to each home where one interviewed the husband while the other interviewed the wife in a different room. The interview survey consisted of over 800 questions which took approximately 2 hours to complete (Bryant et al., 2010).

Sample Characteristics

There were a total of 1398 participants in the study making up 699 couples (See Table 9 for sample demographics). The mean age for wives was 33.8 years of age and 36.1 for husbands. This was the first marriage for 74.7% of females and 67.7% of males and the second marriage for 25.3% of females and 32.3% of males. Couples had been

married an average of 11.7 months. The majority of the sample, 74%, identified as religious and 93 % of those were Protestant.

Table 9

Sample demographics

	Husbands (699)	Wives (699)
Employment	%(n)	% (n)
Full-time	79.2(555)	68.6 (481)
Part-time	5.2(36)	7.6 (53)
Unemployed	5.2(36)	8.6 (60)
Retired	2.7(19)	1.2 (9)
Keeping house full-time	0.1(1)	8.6 (60)
Other	1.6(11)	2.4(17)
Income		
Percent making less than 40,000	67.9(476)	78.3(549)
Interquartile range	15, 000 – 34, 999	10,000 – 29, 999
Percent making more than 40,000	29.8(209)	15.3(107)
Interquartile range	40,000-74,999	40,000-74,999
Education		
Some high school	10.3(72)	7.3(51)
High school	36.7(257)	22.5(158)
Technical or Trade school degree	7.3(51)	4.4(31)
Some college	24.8(174)	28.8(202)
Associates degree	6.8(48)	10.1(71)
Bachelor Degree	11(77)	18.7(131)
Masters	1.1(8)	6.7(47)
Doctorate/PhD/MD	.4(3)	.4(3)

Measures

Racial Discrimination

Racial discrimination was measured using an adaptation of McNeilly et al. 1996's Perceived Racism Scale used by Murry et al. (2001). The modified scale is comprised of 10 questions. The scale assesses how often in the past year a person has experienced racial discrimination. Items included, for example, "How often have you been treated unfairly just because you are African American?" Items were rated on a 5-point Likert scale; 1 (never) to 5 (more times than I can count). A mean composite measure of racial discrimination was created as has been done in other studies (McNeilly et al., 1996; Murry et al., 2001). Higher scores on this measure reflect more experiences of racial discrimination. Murry et al. (2001) reported a Cronbach's alpha of $\alpha = .92$ for the scale and in this study we found $\alpha = .84$ for wives and $\alpha = .87$ for husbands.

Relational Support

Currently there are no validated measures of relational support so we created a measure based on the definition used in Socioemotional relational therapy (Knudson-Martin & Huenergardt, 2010). To create this measure, using the existing dataset, a team of SERT clinicians identified items within the survey that were in line with the "Relational support" concept from the circle of care.

Items were chosen that captured the processes of relational support as represented by relational responsibility, attunement, vulnerability, and influence. Items included, "how often does your partner do something that is important to you?" which is thought to capture attunement and relational responsibility. Similarly, vulnerability is captured by

the question, “how often do you and your partner talk about your personal problems?” The item “how often does your partner listen to your ideas for solving the problem?” reflects one partner’s ability to influence the other. After the clinicians provided face validity for 17 items within the dataset these 17 items were evaluated through factor analysis to determine whether all 17 items loaded onto one latent factor of relational support. Since the planned analysis intended to parse out the effects of each partner’s relational support distinctly, the factor analysis process was run separately for each gender.

Three factors, each consisting of three items were retained in the exploratory factor analysis using an oblique rotation, scree plots, and the Kaiser rule. Sixty-six percent of the variance was explained for husbands and 63.3% of the variance for wives. This factor structure was then brought back to the SERT researchers, who labeled the factors as: influence, validation, and emotional connection. Influence indicates a husband or wife’s perception of how much influence they have on their partner. The reliability of this scale was strong, $\alpha = .83$ for wives and $\alpha = .73$ for husbands. How validated husbands or wives feel by their partners comprises the validation subscale, $\alpha = .72$ for wives and $\alpha = .68$ for husbands. Lastly, the Emotional connection subscale was defined as how much emotional connection one felt they had with their partner. The reliability of this subscale was $\alpha = .66$ for wives and $\alpha = .67$ for husbands. Subsequently, confirmatory factor analysis (CFA) was used to confirm the three factor structure through testing of the measurement model (See Table 4 for measurement model fit indices). In total, a low score across all scales would indicate less relational support.

Health

Health was measured using global self-reports of physical and mental health. Physical health was measured using two indicators including a global assessment of one's own health and one's perception of his/her health compared to others. Self-reports of health have been used in other studies. Also included was a global measure of self-rated mental health. Questions were rated using a 5-point Likert scale ranging from very poor (1) to excellent (5). Self-reports of physical and mental health are commonly used (Erving, 2011) and have been found to be strongly associated with objective measures of health, mortality, and mental health (Fleishman & Zuvekas, 2007; Haddock et al., 2006; Williams et al., 1997). In a large scale study with over 1100 respondents, Williams et al. (1997) used self-reports of health to assess the association between racial discrimination and health. In an even larger study of over 30,000 culturally diverse participants, researchers examined the validity of self-reported health measures and found that those who engaged in negative health behaviors such as smoking, abusing alcohol, and overeating rated themselves as having poorer health (Haddock et al., 2006). Self-reported mental health has also been found to moderately correlate with other measures of mental health and reflect depressed mood and psychological distress (Fleishman & Zuvekas, 2007; Kim et al., 2011). Moreover, self-reports of mental health are strongly linked to physical health (Fleishman & Zuvekas, 2007); thereby supporting our decision to assess health using measures of both physical and mental health. Cronbach alpha of the scale with this sample was $\alpha = .65$ for husbands and $\alpha = .60$ for wives.

Control Variables

Socioeconomic status and health are linked in African Americans populations (Lillie-Blanton et al., 1996; Warner & Hayward, 2006). In an effort to isolate only the effect of racial discrimination on health outcomes we controlled for income on the endogenous variables of health. Specifically, family income was used as a predictor of the outcome variable of health in all models. Family income was measured by combining husband and wives income from the past year. Age was also as a control for health in the same way.

Means and standard deviations for all variables in the model, along with significant differences are presented in Table 10. Wives reported talking significantly more about personal problems than husbands, $t(696)=3.47$, $p<.01$ and husbands rated their physical health better than others significantly more than wives, $t(689)=3.83$, $p<.001$.

Table 10

Means and Standard Deviations of all Study Variables for Husbands and Wives

	Husbands	Wives
Racial Discrimination	14.88(5.95)	14.43(4.98)
Perception of Influence on Partner(1)	3.27(.78)	3.22(.84)
Perception of Influence on Partner (2)	3.25(.83)	3.17(.91)
Perception of Influence on Partner (3)	2.99(.79)	3.04(.82)
Feeling Validated by Partner (1)	3.32(.79)	3.31(.83)
Feeling Validated by Partner (2)	3.05(.88)	2.98(.90)
Feeling Validated by Partner (3)	3.32(.82)	3.31(.80)
Emotional Connection (1)	3.70(.59)	3.71(.58)
Emotional Connection (2)	3.60*(.64)	3.71*(.54)
Emotional Connection (3)	3.61(.58)	3.59(.60)
Self-rated health	2.38(1.0)	2.32(.99)
Self-rated mental health	3.82(.94)	3.68(.96)
Perception of health compared to others	3.96**(1.0)	3.77**(1.1)

*significant difference between husband and wives *p<.05, **p<.001*

Pre-analysis Data Screening

Prior to building each structural equation model, univariate and multivariate assumptions of SEM were checked with SPSS 20. Data were screened for missing responses and 118 cases were excluded in the analysis because they were missing values on one or more of the study variables. Estimation with full maximum likelihood in SEM

rests on the assumption of normal distributions of continuous outcome variables, linear bivariate scatterplots, and bivariate normal distribution of paired variables (Kline, 2011). All of these assumptions were met. See Table 11 for correlations among the variables (Table 11). This table was then input into EQS for analysis.

Table 11

Bivariate Correlation Table

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
TotRDW	-	.06	.01	-.02	-.001	-.03	-.05	.04	.002	-.005	-.04	-.003	-.02	-.06	-.02	.02	.03	.04	-.006	-.002	-.04	.004	-.01	-.04	-.01	-.01	.109**	-.07	-.07
TotRDH		-	.05	-.10*	.02	-.06	.02	-.08*	.01	.06	.01	.04	-.01	.01	.05	.06	.04	.04	-.02	.03	.03	.03	.05	.05	.06	.06	.14**	-.09*	-.11**
Influence1^{w}			-	.21**	.68**	.20**	.60**	.20**	.39**	.21**	.48**	.20**	.37**	.18**	.25**	.08*	.27**	.09*	.22**	.12**	.14**	.07*	.21**	.14**	.19**	.11**	.03	-.06	-.05
Influence1^{H}				-	.17**	.62**	.19**	.43**	.13**	.34**	.15**	.44**	.11**	.29**	.08*	.11**	.06	.22**	.06	.25**	.07	.09*	.08*	.15**	.01	.11**	-.03	.01	.02
Influence2^{W}					-	.14**	.60**	.19**	.40**	.19**	.45**	.19**	.35**	.15**	.25**	.01**	.25**	.12**	.23**	.01*	.13**	.05	.21**	.13**	.12**	.11**	.04	-.01*	-.08*
Influence2^{H}						-	.19**	.38**	.12**	.29**	.16**	.35**	.13**	.31**	.01**	.14**	.11**	.19**	.09*	.24**	.09*	.09*	.12**	.16**	.04	.06	.002	-.04	-.06
Influence3^{w}							-	.15**	.37**	.22**	.44**	.21**	.35**	.13**	.18**	.07	.24**	.04	.21**	.08*	.13**	.06	.19**	.10**	.13**	.13**	.03	-.00	-.01
Influence3^{h}								-	.06	.26**	.10**	.32**	.06	.23**	.04	.06	.01	.12**	.07	.17**	.03	.03	.07	.09*	.02	.06	.01	-.01	-.01
Validation1^{w}									-	.22**	.47**	.22**	.48**	.16**	.25**	.01*	.26**	.11**	.25**	.16**	.03	.01	.11**	.01	.16**	.06	-.02	.02	.02
Validation1^{h}										-	.19**	.45**	.19**	.42**	.13**	.13**	.01**	.11**	.12**	.21**	.08*	.15**	.11**	.13**	.07	.16**	.03	.04	.03
Validation2^{w}											-	.16**	.44**	.15**	.22**	.05	.22**	.03	.27**	.10**	.11**	.06	.14**	.05	.14**	.11**	.04	.006	-.02
Validation2^{h}												-	.16**	.39**	.14**	.14**	.11**	.18**	.09*	.22	.05	.06	.13**	.13**	.07	.14**	.03	.01	-.01
Validation3^{w}													-	.12**	.19**	.04	.17**	.03	.22**	.01*	.08*	.02	.10**	.03	.14**	.09*	-.01	.03	.02
Validation3^{h}														-	.08*	.12**	.11**	.13**	.11**	.2**	.04	.07	.09*	.06	.05	.12**	.02	-.03	-.01
Connection1^{w}															-	.05	.43**	.10**	.34**	.05	.13**	.07	.11**	.09*	-.04	.04	.11**	-.01*	-.08*
Connection1^{h}																-	.06	.46**	.06	.30**	.08*	.01**	-.02	.18**	.04	.09*	.02	.003	-.01
Connection2^{w}																	-	.06	.42**	.02	.01**	.07	.15**	.05	.00	-.04	.08*	-.08*	-.09*
Connection2^{h}																		-	.01**	.44**	.03	.05	.02	.09*	.002	.03	.03	-.06	-.06
Connection3^{w}																			-	.11**	.01**	.03	.15**	.05	.06	-.01	.05	-.05	-.04
Connection3^{h}																				-	.04	.09*	.05	.16**	.05	.02	.03	-.06	-.08*
Health1^{w}																					-	.16**	.55**	.12**	.34**	.08*	.17**	-.2**	-.15**
Health1^{h}																						-	.09*	.51**	.09*	.42**	.16**	-.19**	-.23**
Health2^{w}																							-	.1**	.12**	.04	.15**	-.18**	-.15**
Health2^{h}																								-	.05	.23**	.16**	-.16**	-.2**
Health3^{w}																									-	.12**	.05	.12**	.09*
Health3^{h}																										-	.14**	.07	.05
FamInc																											-	.12**	.11**
WAge																												-	.84**
HAge																													-

$^{*}p<.05$, $^{**}p<.01$

Results

Using EQS (Bentler, 2006) we tested the hypothesized associations between variables using structural equation modeling (SEM), specifically structured regressions (Kline, 2011). To capitalize upon the dyadic nature of the data the Actor-partner interdependence model (APIM) was used (Kenny et al., 2006). APIM affords us the opportunity to examine links between racial discrimination and one's own health (actor effects), as well the links between spouses' experiences with racial discrimination and their partners' health (partner effects) (Kenny et al., 2006). Use of APIM facilitates an examination of the role relationship support plays on the health of spouses and their partners.

Constructing the Measurement Model

Before testing our hypothesized model we first fit the measurement model to ensure measurement of each latent variable was psychometrically sound (Byrne, 2006). The measurement model of each observed and latent variable was tested in EQS using confirmatory factor analysis procedures outlined in Byrne (2006). The most parsimonious model with the best model fit statistics was determined to be the measurement model (See Table 12 for fit indices). We used Chi-square, comparative fit index (CFI), and root mean square error of approximation (RMSEA) as indicators of model fit and factor structure. Since it can be difficult to obtain a non-significant chi-square with a large sample size (Raykov & Marcoulides, 2006), we also relied on the relative chi-square χ^2/df which is less dependent on sample size and should be equal to or less than two chi-squared values per degree of freedom (Byrne, 1992). The contribution

of each scale item was assessed to verify that each item loaded substantially on the specified factor (e.g., <.40).

Table 12

Measurement Model Fit Indices

Model	χ^2	*df*	χ^2/df	CFI	RMSEA[CI]
Model 3 (Four Factors)	1023*	287	3.56	.81	.063[.059,.067]
Model 4 (covariance)	604*	281	2.15	.92	.042[.037,.047]
Model 5 (Eight Factors)	394*	257	1.53	.965	.029[.023,.034]
Model 6 (2^{nd} Order factor)	452*	280	1.61	.956	.031[.025,.036]

p<.05

We started the model building process with a one factor model; this model fit was poor and thus, a converged solution could not be reached. We then loaded all the wife variables on one factor and all the husband variables on a second factor (with a covariance between the two factors). This model (Model 2) was also a poor fit and would not converge to a solution. In the next model (Model 3) we created two factors for each partner, one with all relational support indicators and one with all health indicators. This model was a poor fit to the data ($\chi^2(287) = 1023$, $p<.05$, CFI=.81, $\chi^2/df = 3.56$, RMSEA= .069). Results from this model indicated covariances between some of the relational support items, so in Model 4 we covaried these. This model had an acceptable fit ($\chi^2(281) = 604$, $p<.05$, CFI=.92, $\chi^2/df = 2.15$, RMSEA= .042) . In Model 5 we parsed out the relational support factor into three separate factors for each partner and loaded the health indicators onto another. This model fit the data well ($\chi^2(257) = 394$, $p<.05$,

CFI=.965, χ^2/df = 1.53, RMSEA= .029). In the last model we created a second order factor for relational support, but this model demonstrated poorer fit by the CFI=.956 and RMSEA=.031. We concluded Model 5 was a tenable measurement model by which the proceeding structured regression models could be tested against. In this model the factors comprising relational support are interrelated for both husbands and wives as evidenced by significant covariance across all three relational support factors. We moved on to test whether all factors had a direct effect on self-rated health, or whether racial discrimination had an indirect effect on health through relational support. We also tested one additional hypothesis. Relational support is not only interdependent, but directional from husbands to wives. Three separate models were estimated to test our hypotheses.

Testing the Hypothesized Structural Model

The fit indices for the model building process used to test the hypotheses are presented in Table 13. In the first model we tested the direct effects of relational support and racial discrimination on self-rated health. This model fit relatively well ($\chi^2(355)$ = 612, p <.05, CFI=.94, χ^2/df = 1.72, RMSEA= .035). In the next model (Model 2) we added the indirect effects of racial discrimination on self-rated health through relational support. This model had a better fit ($\chi^2(342)$ = 564, p <.05, CFI=.948, χ^2/df = 1.65, RMSEA= .034) than Model 1. In Model 3 we tested the hypothesis of a directional relationship from the husband's support to the wives' support (rather than the standard covariance relationship within the APIM process). Therefore the indirect model (Model 2) was fit again, with the directional pathways. This model fit the data so poorly a converged solution could not be reached. Model two was retained as the final model

because it was the best-fitting model (Figure 9). Only significant pathways are illustrated in the model.

Table 13

Model Fit Indices

Model	χ^2	*df*	χ^2/df	CFI	RMSEA[CI]
Model one – direct effects	612*	355	1.72	.940	.035[.031,.040]
Model two – direct effects	564*	342	1.65	.948	.034[.029,.038]

$p<.05$

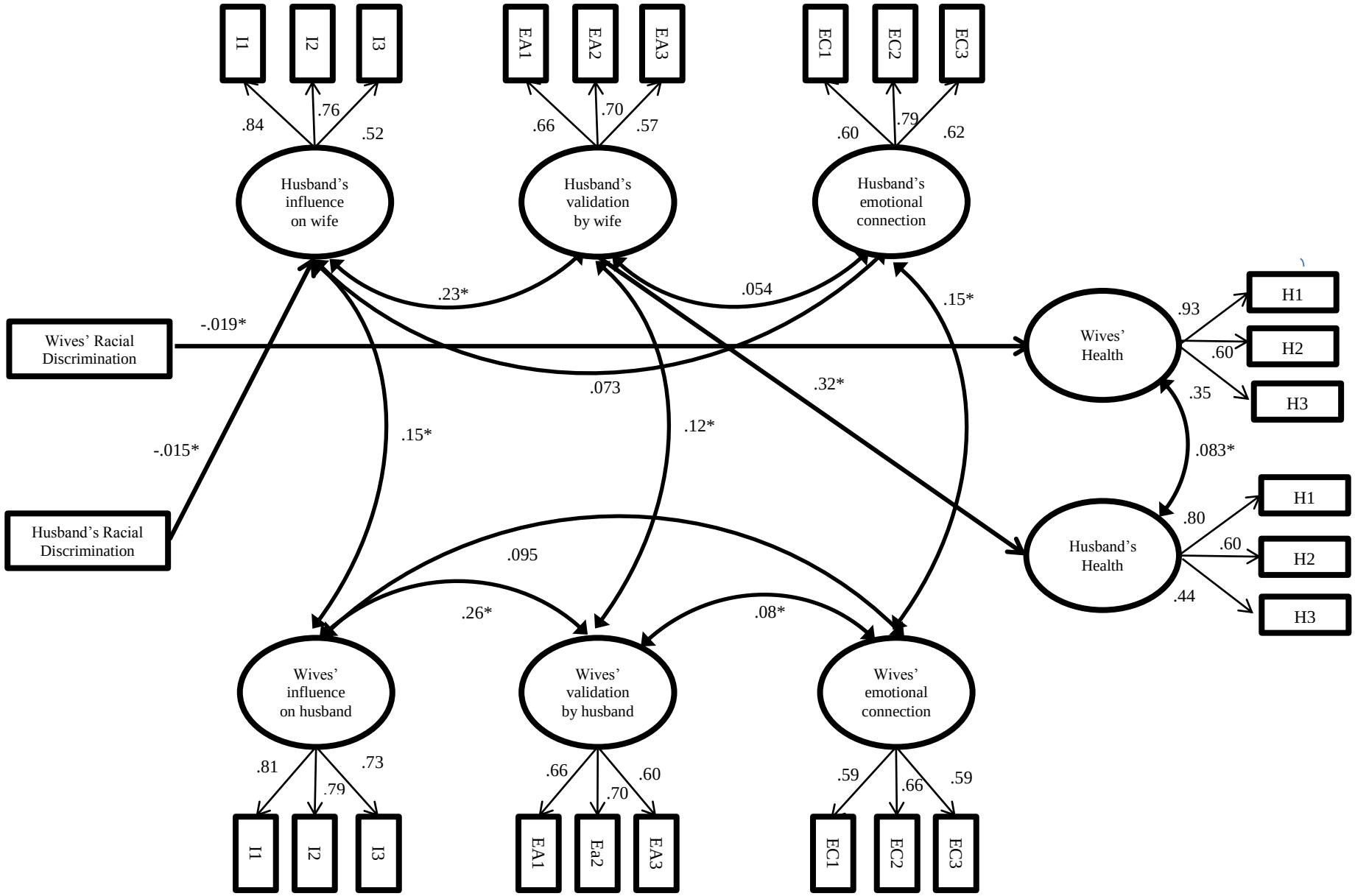

Figure 9. Final APIM model

Direct Effects

Overall, self-reports of health were associated with racial discrimination for wives and with relational support for husbands. For wives, the more racial discrimination experienced, the more likely they were to report lower health outcomes ($\beta = -.019$, $p < .05$). For husbands, on the other hand, in the presence of relational support, there was no direct effect from racial discrimination to health. Instead for husbands health was directly associated with relational support specifically feeling validated by his wife ($\beta = .32$, $p < .05$). In the presence of relational support, wives', but not husbands' experiences of discrimination were linked to health. For husbands, health was buffered by relational support.

Indirect Effects

While wives' experiences of racial discrimination had a direct effect on wives' health; husbands' experiences of racial discrimination were indirectly associated with their health through relational support. Overall, husbands' experiences of discrimination were directly associated with husbands' perceptions of available relational support and indirectly associated with wives relational support and husband's health. For husbands more experiences of racial discrimination were indirectly associated with health and this relationship was moderated by his perceptions of available relational support. Therefore, perceptions of relational support play a major role in buffering African American husbands' health from the negative effects of racial discrimination. The APIM suggests that husbands' and wives' perceptions of available relational support were correlated, so his reduction of support reduces her level of support through the interdependence of

relational support. Therefore, relational support can decrease the negative association between racial discrimination and husbands' health but, unfortunately husbands' experiences of discrimination were also associated with less support for both husbands and wives.

Discussion

In this study of newlywed couples racial discrimination negatively impacts African American husbands' and wives' health in different ways. In the presence of racial discrimination, men benefit from the marital relationship. Findings suggest that the experience of racial discrimination has a spillover effect on the marital relationship because when African American men experience racial discrimination they were also less likely to perceive they had influence over their wives. Others have posited a similar spillover effect where racial discrimination makes African American men more sensitive to needing to feel powerful in the family context (Franklin, 1984; Hatchett et al., 1995). Perhaps, the experience of powerlessness in society permeates their experiences in the family. Women also suffer the negative effects of racial discrimination through the marital relationship because husbands' experiences reduce the relational support wives receive from husbands.

Our findings provide support for the protective benefit of relational support for men, but not for women. Other studies have demonstrated that protective factors like social support differ based on gender (Cooper, Brown, Metzger, Clinton, & Guthrie, 2013). Perhaps men rely more on the marital relationship as a source of support than do women (Phillipson, 1997) because of differences in socialization. In this study the

benefits of relational support for women appear limited. Future research should further explore how relational support contributes to wives' health outcomes. Our findings are based on a general self-report of health and future research should examine this association with more specific measures of physical and mental health.

Our findings are supported by literature suggesting racism has negative consequences on women's physical and mental health (Krieger, 1990; Kwate, Vladimarsdottir, Guevarra, & Bovbjerg, 2003; Pieterse et al., 2013). Potential mechanisms underlying this association have been investigated using qualitative research. Racism impacts the health of African American women directly and indirectly -- directly through physiological arousal in response to the stressful situation and indirectly through negative coping strategies such as overeating (Wagner et al., 2011). We expected relational support to protect or buffer wives from the negative impact of racial discrimination on health, but our hypothesis was not supported. Pressure to be "strong" may make it difficult for African American women to reach out to their partners for support. In response to racial discrimination women have been found to internalize their experiences and this in turn has a negative impact on blood pressure (Krieger, 1990). Women may rely more on sources outside the relationship for support. For example, one study found that having a strong ethnic identity protected African American women from the negative impact of racism (Stevens-Watkins, Perry, Harp, & Oser, 2012). Since cooperation and interpersonal relationships are a strong part of African American identity, women who have strong ethnic identity may receive high levels of support from the community. The pressure of living up to male stereotypes may also contribute to the relational dynamics between husbands and wives. Learning how to support others is not

a traditional aspect of the male socialization process, so women may expect that men will be unavailable to them and learned to get their needs for emotional support met outside of the relationship when they experience stressors like racial discrimination.

Findings provide important insights into helpful directions for couples therapy with African Americans. First, discussing the impact of racial discrimination on the couple and each partner should be an important clinical goal. Socioemotional Relational Therapy (SERT) may provide a vehicle to guide this conversation (Knudson-Martin & Huenergardt, 2010). Therapists can use sociocultural attunement to better understand and help the couple better understand the contextual factors influencing their relationship. Also helping couples equally support one another may contribute to protective mechanisms to health, especially for men. SERT provides a model of relational support that therapists can use to help couples work toward equality and develop this important factor of healthy relationships. This information can also be useful for family life educators and for use in relationship enrichment programs.

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CHAPTER SEVEN

IMPLICATIONS

Given that racial discrimination is frequently experienced by African Americans and linked with poorer health outcomes and marital instability it is important to investigate mechanisms of risk and protection so that effective therapeutic interventions can be developed (Prelow et al., 2006). Stress can be hard on a marriage and racial discrimination is a source of stress to both partners and a contributor to marital instability and poorer health. Yet, it seems few models of therapy directly address the negative effects of racial discrimination on the couple. Our study raises awareness of an important clinical issue for African American couples.

Literature on the impact of racial discrimination on African American marriages and the well-being of partners is severely lacking. The findings of this study provide vital insights to the effect of stress on African American marriages and each spouse. We found racial discrimination negatively impacted the health and marital stability of these newly wed couples. Further, the impact was different for husbands and wives in terms of both marital stability and health. Across both studies husbands' benefited from relational support and wives did not. More importantly, wives' experiences of racial discrimination were not associated with any of the relational support factors or marital stability. It was negatively related to wives' health. This is interesting in light of the fact that wives in this study did not report experiencing significantly different levels of racial discrimination than their husbands. Many have theorized how gender differences may influence the impact of racial discrimination on the couple system, but there are few studies that actually examine these associations empirically.

Our study illuminates gender differences in the impact of racial discrimination and the protective mechanisms of relational support. Our findings provide support for the protective benefit of relational support for men, but not for women. Other studies have demonstrated that protective factors like social support differ based on gender for African Americans (Cooper et al., 2013). Gender socialization of both men and women create conditions in which support may be more beneficial for men in marriage (Huenergardt & Knudson-Martin, 2009). Women are socialized to support others and men are not so the flow of support often flows from wives to husbands in marriage (Phillipson, 1997). It is not surprising when a stressor like racial discrimination enters the couple system; men benefit more from relational support. There are other possible reasons for this finding including racial stereotypes specific to each gender. The stereotype of the "strong" Black woman may contribute to women not reaching out to their spouses for support. Women may internalize being strong to such a degree they feel shame when they experience a need for support from others, especially from their husbands whom they believe it is their duty to support (Cowdery et al., 2009). Masculine stereotypes suggest that giving support to others, particularly emotional support, is feminine which may deter African American husbands from engaging in this behavior (Phillipson, 1997).

Ideally, providing and receiving support should be mutual where partners are equally concerned about providing support as receiving it and one's experience of support should not be a direct result of the others (Gottman, 2011; Wright & Aquilino, 1998). Under certain circumstances wives' ratings of support depend on their husband's relational support. Unfortunately, some men may need to feel respected before they are willing to be emotionally generous with their partners (Wexler, 2012). The disrespect

resulting from discrimination in society can amplify experiences of disrespect in the home making spouses more sensitive to feeling disrespected by their spouse and men may be more vulnerable. This was supported in our study because the negative effects of racial discrimination entered the couple system through lessening husband's perceptions of having influence on their wives. African American wives appear to be sensitive to their husband's plight and want to protect them from the negative impact of racism (Cowdery et al., 2009). Wives are likely to notice when their husbands are hurt and subsequently adjust to meet their needs, give them space, or let them have power by purposely taking a one down position. In this position women may not question or correct their husbands. This process is invisible and may be out of the awareness of their husbands (Cowdery et al., 2009). Through this process women let their husbands have power, particularly in the emotional arena (Cowdery et al., 2009). Since our sample is largely religious men's power in the home may be reinforced by this context (Cowdery et al., 2009) and another reason why husbands benefit more from support in the marraige.

This study provides researchers and therapists with a unique understanding of how contextual factors such as race and gender come together to influence the couple system and health. Wives' health was negatively impacted by experiences with racial discrimination directly. Husbands' health, on the other hand, was only impacted through relational support. This provides evidence for a gendered experience and impact of racial discrimination. In a qualitative study, African American women believed racism impacted their health directly and indirectly -- directly through physiological arousal in response to the stressful situation and indirectly through negative coping strategies such as overeating (Wagner et al., 2011). We also found differences in protective factors

between husbands and wives. The impact of racial discrimination on health has been studied extensively, along with individual protective factors. Relational protective factors have been given less attention (Bryant et al., 2010), even though marriage is a common formation in this cultural group. In this study relational support buffered husbands', but not wives', health from the negative impact of racial discrimination. Women's health may be negatively impacted because they internalize their experiences of discrimination (Krieger, 1990). It appears that husbands may turn to their spouse for support, but wives do not. Also there is evidence that African American women have increased awareness of how racism affects their partner and subsequently offer support (Cowdery et al., 2009). Overall there are imbalances in the protective effect of relational support and this is a clinical issue that needs to be addressed.

Many mainstream therapies are based in Euro-American culture and may not be sufficient to heal a culturally diverse range of people (Falicov, 2010). Believing that human behavior is universal across cultures opens therapists to the danger of devaluing, overlooking, or misinterpreting the behavior of those different from the majority culture and leads to the possibility of different behaviors being labeled as pathological (McNair, 1992). "Psychotherapists do not function in a cultural vacuum" (p. 6); they bring their biases about personal experiences into therapy. There is a need to better understand African American families and couples so that we can provide better care in a way that is congruent with their perceived needs. Therapist's work with couples should be informed by research and this is especially true of work with African American couples because of the wide spread perpetuation of stereotypes about this population.

Bringing awareness of how marital interactions may be influenced by racial discrimination and gender is an important area of intervention for couples therapists. Raising awareness of inequalities in the provision and benefits of relational support and should be a goal of clinical work with African American couples who endorse mutuality and equality as paramount to a good marriage (Curran et al., 2010).

It is especially important that Marriage and Family Therapists (MFTs) have literature available to them providing evidence of the usefulness of relational protective factors as well as culturally relevant models to guide clinical practice. Socioemotional Relational Therapy is a culturally relevant model having distinct potential to impact Marriage and Family Therapist's work with African American couples. The focus on the unique sociocultural context of each couple system while still maintaining a critical awareness of how contextual factors impact the provision of relational support makes this model unlike any other model available to MFTs. Mutual support, as represented by the circle of care (Knudson-Martin & Huenergardt, 2010), is at the heart of SERT. Mutuality in the provision of relational support is assumed to be imperative to healthy and optimal couple functioning. Studies are needed to show specifically how specific models of relational support can benefit couple functioning and the well-being of each member in relation to common stressors. The findings of this study are important for providing evidence for the protective effects of relational support, not only for the health of partners, but also for the longevity of their marriage. Relational support appears to have the potential to be an important protective factor and therapy can help ensure that it is beneficial for both spouses. Other research has demonstrated the importance of equality in the provision of support. Inequalities in the giving and receiving of emotional support

have been linked to decreases in marital satisfaction and stability (Sprecher et al., 2006). Within the same study partners who give less support reported feeling they had more power in determining if and how the relationship would continue. Other research has demonstrated how inequalities between spouses can lead to negative health outcomes for the partner with less power (Kiecolt-Glaser & Newton, 2001). The evidence is mounting that working toward equality in marriage is a worthy goal and beneficial to each partner.

From a systemic perspective it would be difficult for couple's therapists to intervene on a societal level to change some of the factors that contribute to negative interactions within African American marriages. What is possible is that they assist couples in developing a new vision for their relationships, one based on relational support, respect, and love. This study provides therapists with an idea of how gender might influence the provision of relational support in the relationship which in turn can inform clinical goals of treatment. It is important to bring to awareness the unequal burden on African American women to maintain the relationship in the face of racial discrimination (Cowdery et al., 2009). SERT therapists also help their clients derive new sources of self-worth from the satisfaction that comes from being in a mutually beneficial, supportive relationship.

The circle of care is the model of mutuality, equality, and relational support in SERT (Knudson-Martin & Huenergardt, 2010). The circle of care is comprised of having influence on one another, attuning to one another's feelings, both partners being vulnerable, and both partners sharing responsibility for taking care of the relationship and each other. Being that there are no validated measures of mutual support, we relied on examining partner's perceptions of influence, validation, and connection in the

relationship. Interestingly, influence and validation had more influence on marital stability and health than emotional connection. Within relational support, feeling validated by one's partner was an important predictor of husbands' and wives' marital stability and husbands' health. Validation is not a specified part of the SERT model, but should be an outcome of mutual support. Future research with the SERT model may consider adding a measure of validation since it appears important particularly in regards to each partner's reports of marital stability. Therapists need to assess how validated each partner feels by their spouse and work towards equality in this area. It is also important that therapists are aware that they too can perpetuate inequalities in terms of validation of realities in session (Hare-Mustin, 1994).

Overall, SERT provides a helpful framework for working with African American couples. In light of the findings in this study, therapists may be pointed to important directions in session such as assessing the impact of racial discrimination, the provision of relational support, and the stability of the marriage and well-being of each spouse. Using SERT therapists attempt to understand each relationship from the unique intersection of factors like race and gender. It is important that therapists do not assume that the findings from this study will apply to every couple they work with, but to socioculturally attune to the uniqueness of each relationship. Our findings can be used as points from which to begin conversations with couples. Citing findings from research can help couples to externalize their problems and learn how factors like gender and race can intersect to produce a similar experience for many couples.

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