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Group Identity and Health Locus of Control in Black Adults with West African and Caribbean Immigrant Parents

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Group Identity and Health Locus of Control in Black Adults with West African and
Caribbean Immigrant Parents

by

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Presented to the Graduate and Research Committee

of Lehigh University

in Candidacy for the Degree of

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in

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Abstract

As the numbers of Black second generation immigrants (SGIs) in the United States increase because of increased numbers of immigrants from Africa and the Caribbean, more research is needed to explain how varying Black ethnic groups perceive and interpret illness to address health disparities (Ayalon & Young, 2005). General health locus of control (HLOC) helps to explain how people attribute the sources of control over their health (Masters & Wallston, 2005) and engage in help-seeking behaviors. HLOC has not been examined in SGIs because of a failure to examine group identity to account for within group differences among Black populations and a lack of culturally sensitive measurements of HLOC. The purpose of this study was to utilize a HLOC measure that included conventional and supernatural dimensions to examine the relationship between group identity, HLOC, and help-seeking in a sample of Black African and Caribbean SGIs. 157 second generation Black immigrants (72 West African and 85 Caribbean) were recruited for this study. No significant group differences in both types of HLOC were found. Multivariate multiple linear regression analyses did not find racial centrality, ethnic identity, and racism stress significantly predictive of health locus of control for either subgroup, but a significant relationship between perceived racial discrimination and supernatural HLOC was found only for the Caribbean subgroup. A significant relationship between supernatural HLOC beliefs and help seeking was found only for the West African subgroup. Qualitative responses regarding cultural identification as well as reported demographic characteristics suggested that acculturation levels and other forms of group identity may moderate associations with health locus of control and help-seeking. Limitations, implications, and contributions of the study are discussed.

Chapter I

Introduction

As the United States Black population becomes more diverse because of the increased numbers of immigrants from Africa and the Caribbean, the numbers of their children born and raised in the United States, or second generation immigrants (SGIs), continue to increase at high rates. This significant increase of SGIs largely contributes to the growing number of health disparities among Black populations in the United States. Generally, clinical and healthcare service providers have responded to health disparities by becoming increasingly aware of the “manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments” (Center on Health Disparities Research, 2006, p.1). One example of this increased awareness is examining the extent to which individuals can explain the sources of control over their health, or health locus of control (Masters & Wallston, 2005). Many research studies on health locus of control focus on differences between Blacks in comparison to other racial and ethnic groups and conclude that they are more likely to endorse an external locus of control regarding their general health (Galanos, Strauss, & Peiper, 1994; Landrine & Klonoff, 1992, 1994; Malcarne, Drahota, & Hamilton, 2005; Millet, Sullivan, Schwebel, & Myers, 1996; Wrightson & Wardle, 1997).

Although these between group differences are significant, accumulating evidence reveals that within group differences found among varying Black communities may yield a greater understanding of health related issues and outcomes (Arthur & Katkin, 2006). Within Black communities, meaningful differences exist because of variations in group identity such as the interplay between racial and ethnic identity and racial discrimination;

however, studies are lacking in examining these within group differences with respect to health locus of control, which results in the absence of Black SGIs in research.

Furthermore, the lack of cultural appropriateness of traditional health locus of control measures in previous studies inclusive of Black populations necessitates newer methods to account for health disparities of Black SGIs. Hence, the overall purpose of this study was to examine the extent to which aspects of group identity related to culturally sensitive health locus of control measures in varying groups of Black SGIs.

Theoretical Framework

The theoretical origins of this proposed study on health locus of control came from relevant research and theories on external-internal locus of control. The earliest work on external-internal locus of control comes from Rotter (1966) who explained that individuals with an external locus of orientation are more likely to attribute causes of events to forces such as others or fate. Individuals with an internal locus of control orientation, however, tend to explain the causes of events to characteristics of themselves (Rotter, 1966). With respect to where racial and ethnic minorities fall on the continuum of locus of control, an overwhelming consensus in research concludes that minority groups often report a more external than internal locus of control than White Americans (Graham, 1994; Hillman, Wood, & Sawilowsky, 1992; Jackson, 2006). Minority groups such as African Americans have a tendency to perceive control based on sociopolitical pressures (Sue & Sue, 2008) such as discrimination and socially constructed systemic barriers. Thus, higher identity statuses (i.e., racial and ethnic) have been found to be associated with higher levels of internal locus of control (Martin & Hall, 1992; Phinney, 1996; Sadowsky et al., 1998; Umana-Taylor, Yazedjian, & Bamaca-Gomez, 2004).

Health locus of control

Health locus of control is similar to general locus of control with the exception of a focus on the extent to which individuals believe they have control over their health on an external-internal continuum (Masters & Wallston, 2005). Examining health locus of control helps psychologists explain differences in individual perceptions that influence illness and health behaviors (Burroughs, Maxey, Crawley, & Levy, 2002; Lau, 1982). It is important for health professionals who treat or serve individuals from diverse racial and ethnic backgrounds to understand their perceptions of what causes illness as well as the methods of treatment they consider effective and acceptable. Gaining an understanding of health locus of control becomes increasingly important given the well documented help seeking disparities observed among minority groups, particularly with Black Americans in mental health and healthcare settings (Richardson & Kimberly, 1996). Thus, cognitive appraisal or attributions of illness may relate to help seeking behaviors (Ayalon & Young, 2005).

The attributions individuals make about the causes of their health are largely influenced by group identity. Group identity has a large effect on general health beliefs and behaviors because it influences attributions individuals make and forms etiological appraisal of psychological and health problems (Burroughs, Maxey, Crawley, & Levy, 2002; Chen & Mak, 2008). Racial and ethnic identities both form the basis of group identity (Phinney, 1996). Racial identity explores the continued developmental assessment of racial group membership (Thompson & Carter, 1997). The specific measure of racial centrality in contemporary models of racial identity (e.g., Multidimensional Model of Racial Identity) helps to explain the significance of race in an

individual's life (Sellers, Morgan, & Brown, 2001). Likewise, ethnic identity is similar to racial centrality in terms of adherence to membership but is viewed as feelings of belonging and identification with members because of cultural commonalities, shared customs, religions, and traditions (Chavez & Guido-DiBrito, 1999; Phinney, 1996).

Racial and ethnic identity have been found to have a positive association to health given that higher significance of both identities can lead to positive well-being (Phelps, Taylor, & Gerard, 2001; Rowley, Sellers, Caldwell, Schmeelk-Cone, & Zimmerman, 2003; Sellers, Chavous, & Smith, 1998); however, the significance of race and ethnicity to individual self-concept (i.e., racial and ethnic identity) is highly correlated with racism too. For example, as individuals explore their self-concept in terms of racial and ethnic identity, they can become more susceptible to discrimination (Sellers et al., 2003; Utsey et al., 2000). Hence, racism as a stressor becomes another important dimension of group identity.

Research has determined that group identity influences attributions (Burroughs, Maxey, Crawley, & Levy, 2002; Chen & Mak, 2008) and that higher statuses of racial and ethnic identity and lower stress levels from societal pressures may lead one to have more of an internal locus of control (Joiner & Walker; Marcia et al., 1999; Martin & Hall, 1992); however, "control" in this sense has more of a social justice or activist perspective in that conventional pressures lead one to "take" more control (Carter & Helms, 1997). In terms of health, Western cultures value personal control and often assume its loss as an etiology of illness (Landrine & Klonoff, 1992), and non-Western cultures value more external causes of illness.

Despite evidence that group identity affects health attributions, it is insufficient to rely on the research conducted primarily on Black Americans or Black immigrants to understand health locus of control perceptions of Black SGIs in the United States. One reason is that there may be differences in how Black SGIs negotiate the United States context as well as their identification. For instance, in comparison to Black immigrants, Black SGIs tend to be more susceptible to stereotype threat (Tormala & Deux, 2006). Unlike Black immigrants, they live in a society with a history of underachievement and inferiority stereotypes of African Americans because of their minority status, which makes them more conscious of race-related situations and oppression (Tormala & Deux). When compared to Black Americans, however, they often report an identity that is distinct from Black Americans where they can choose to identify with an American identity, immigrant identity or a fusion of both (Waters, 1994). Black SGIs often report differences from Black Americans in familial upbringings or child rearing, a sense of discipline, and value of education (Kasinitz, Mollenkopf, Waters, & Holdaway, 2008). This complexity of identity, however, is not often clear to others who may perceive them as “just Black,” which contributes to distress and health concerns for SGIs.

Thus, bicultural individuals challenge psychologists’ understanding of group identity given that they may internalize more than one culture which may be opposing in cultural orientations or may be integrated (Benet-Martinez & Haritatos, 2005; Haritatos & Benet-Martinez, 2002). SGIs may identify with parental country of origin or ethnicity as well as racial membership in terms of formulating their group identity, which makes them shift between these varying cultural aspects in order to respond to cues in the social environment (Cheng, Lee, & Benet-Martinez, 2006). It is because of this shift between

cultures that within group differences with regards to health concerns have been found in SGIs in comparison to other ethnic groups. For example, SGIs receive more diagnoses for internalizing disorders than first generation immigrants and U.S. born Americans (Aboud & Sheldon, 2008). SGIs also report increased daily hassles as well as great psychosocial pressures (Haritatos & Benet-Martinez, 2002).

As a group, SGIs are the fastest growing population in the United States because of recent immigration trends (Hernandez, Denton, & Macartney, 2008). For example, it is estimated that approximately four-fifths of children of immigrants are born in the United States (Hernandez, Denton, & Macartney, 2008), and one out of every six individuals ages 18 and over are SGIs (Kasinitz, Mollenkopf, Waters, & Holdaway, 2008). Specifically with the Black population, over one million Black SGIs are present in the United States with three-fifths coming from Caribbean families and two-fifths coming from African families (Kent, 2007). Thus, the likelihood of encountering a Black SGI in a clinical or healthcare setting is vast.

Despite their prevalence as well as reported health concerns, however, SGIs remain understudied in health-related research, especially regarding the topic of health locus of control. One explanation is that research studies tend to focus on group identity differences based on sociodemographic classifications. For example, most of research and literature regarding racial and ethnic differences in health locus of control reveal that Black Americans tend to attribute the causes of illness to external forces such as the supernatural or interpersonal interactions (Galanos, Strauss, & Peiper, 1994; Landrine & Klonoff, 1992, 1994; Malcarne, Drahota, & Hamilton, 2005). This research, however, tends to treat Black Americans as a monolithic group when examining health locus of

control because of a lack of measure of group identity, which increases their invisibility. Differences between varying ethnic groups, such as Black SGIs, are lost or not accounted for in research as a result.

Researchers argue that more aspects of culture need to be incorporated into types of health locus of control in order to fully examine group differences in addition to group identity in relation to health locus of control (Landrine & Klonoff, 1992, 1994; Shiloh, Rashuk-Rosenthal, & Benyamini, 2002). Acquiring knowledge of cultural and orientation beliefs are important as they have a crucial effect on health practices. Traditional methods of measuring health locus of control (e.g., Multidimensional Health Locus of Control) tend to focus on control on the basis of more individualistic conventions such as lifestyle habits as opposed to more culturally sensitive attributions of ethnic minority groups such as chance, faith, nature, and magic (Marguia et al., 2000; Shiloh, Rashuk-Rosenthal & Benyamini, 2002). Thus, culturally sensitive health locus of control is more inclusive of supernatural aspects with respect to the internal-external continuum. These aspects of health locus of control are likely to be predicted by racism as well as Black racial and ethnic identity (e.g. Jamaican, Nigerian, etc.) in Black SGIs given that these bicultural individuals may cognitively engage in cultural frame switching, which allows them to “move between different interpretative lenses rooted in their dual cultural backgrounds” (Haritatos & Benet-Martínez, 2002, p. 600); yet this relationship has not been examined to date.

Furthermore, as the Surgeon General Report stated, “clinical environments that do not respect, or are incompatible with, the cultures of the people they serve may deter minorities from using services and receiving appropriate care” (U.S. Department of

Health and Human Services, 2001). This lack of cultural sensitivity may pose a challenge to medical and health care providers trained to work primarily with Western or European American ideals (Abreu et al., 2000). Given that research shows that some African American communities view illness from a healing perspective as opposed to a curing perspective as evidenced with the medically trained (Landrine & Klonoff, 1992), gaining insight about how Black SGIs appraise illness may help to inform their help-seeking behaviors in healthcare settings as well as explain disparities (e.g., underutilization). This insight is imperative given that help seeking behaviors remain undocumented for this group. Furthermore, the established differences in identity from Black Americans warrants a need for understanding Black SGIs' views of illness that are derived from parental perceptions formed in their nonwestern countries of origin.

Overall, as the United States Black population becomes more diverse because of the increased numbers of immigrants from Africa and the Caribbean, the numbers of their children SGIs continue to grow daily. Research regarding the health of Black SGIs, however, is scarce despite their prevalence and reported health concerns related to their group identity struggle between two cultures. Given the increased understanding that culture influences perceptions of illness as well as help seeking patterns, the increased numbers of Black SGIs warrant more research from health care and mental health providers on the relationship between identity factors that influence perceptions of what control SGIs have over their health (i.e., health locus of control). The relationship has not been examined because of two limitations in research: 1) a tendency to treat Blacks as a homogenous group, which does not account for the significance of race, ethnicity, and

stress of racism on varying Black SGI experiences and 2) the use of non-culturally sensitive measures of health locus of control.

Purpose of Study

The purpose of this study was to examine the relationship between group identity and health locus of control in a sample of Black African and Caribbean SGIs with culturally sensitive measures (i.e., supernatural health locus of control and conventional health locus of control). This study also examined the predictive nature of both types of health locus of control on help seeking behaviors. Thus, this study drew from research on external-internal locus of control and racial and ethnic identity theories of Sellers' et al. (1998) and Phinney (1992) to explore the predictive nature of group identity on health locus of control. The following research questions and priori hypotheses were proposed:

1). Are there group differences between Black second generation African and Caribbean immigrants on both types of (i.e., conventional and supernatural) of health locus of control?

H₁. Significant group differences between Black SGIs on both types of health locus of control will occur. It is expected that the Caribbean subgroup will score higher on supernatural health locus of control than the West African subgroup.

2). What aspects of group identity (i.e., racial centrality, ethnic identity, and racism stress) are associated with both types of health locus of control between Black second generation African and Caribbean immigrants?

H₂. Racial centrality, ethnic identity, and racism stress (i.e., group identity) will significantly predict both types of health locus of control. Specifically, the following directional hypotheses were expected:

- Given the adverse health effects of racism stress, which is a response to unfair racial treatment because of systemic and power-based social constructions, higher scores on racism stress will be associated with lower scores on conventional health locus of control but higher scores on supernatural of health locus of control for each group of Black African and Caribbean SGIs.

- Given the health promoting aspects of racial and ethnic identity, a positive linear relationship is expected for each group of Black African and Caribbean SGIs where higher scores on racial identity and ethnic identity are associated with higher scores on conventional and supernatural health locus of control for each group of Black African and Caribbean SGIs.

- Ethnic identity, however, will account for a greater variance in supernatural than conventional health locus of control because of its involvement and commitment to cultural practices of an origin such as religion and tradition.

3) What are the associations between both types of health locus of control and types of help seeking for Black second generation African and Caribbean immigrants?

H₃. Given the healing aspects of supernatural health locus of control and curing aspects of conventional health locus of control (Landrine & Klonoff, 1992), lower scores on the supernatural but higher scores on conventional health locus of control will be associated with higher scores on help seeking from a medically trained professional. Higher scores on supernatural but lower scores on conventional health locus of control will be associated with higher scores on help seeking from a healer.

Studying group identity with regards to health locus of control is important for several reasons. Although Black second generation immigrants (SGIs) are among the

fastest growing population in the United States, they remain understudied in health-related research. As stated previously, their identification tends to differ from that of Black Americans, but they are often clustered into a blanket category of Black. This study is beneficial to society at large by providing SGIs a voice to increase their visibility in society. Many studies on health utilize Black populations treat them as a monolithic group by not defining them with respect to their racial or ethnic definitions or identities (e.g., second generation Blacks, Caribbean participants, etc.). Thus, this study offered increased understanding of the diversity within Black populations by broadening the perception of worldviews and group identity of Black people with regards to racial and ethnic identity as well as experiences with racism.

Black SGIs are absent in health locus of control research. Conducting this study with Black SGIs helps to fill gaps in research on health locus of control with SGIs. Given the growing need for more research on the large health disparities of Black individuals in the United States largely influenced by immigration (Arthur & Katkin, 2006), gathering these data also help to increase insights into help seeking behaviors to address health disparities, which research suggests is explained by health locus of control (Ayalon & Young, 2005). Thus, this study is beneficial on a macro level with implications on a micro level as well. Furthermore, examining group identity with health locus of control helps to integrate psychological and medical disciplines in order to provide culturally sensitive service delivery.

Chapter II

Literature Review

The purpose of this chapter is to provide a review of relevant literature on the topic of group identity in relation to health locus of control. The chapter is divided into four sections. The first section discusses Black second generation immigrants, which is the population of interest for this study. The second section discusses group identity theories with a specific focus on race, ethnicity, and racism. The third section provides the theoretical framework on general locus of control theory with multicultural implications. The fourth and last section provides background information and pertinent studies on general health locus of control with considerations for culturally sensitive measures and applications of health attributions.

Second Generation Immigrants (SGIs)

The rapid influx of immigrants in the United States has greatly diversified its population. According to the United States Census Bureau, 33.5 million foreign born people are living in the United States (United States Census Bureau, 2004). The change in demographics that has resulted in an increased diversity in population is very apparent when looking solely at the population of “Black” people. For example, the number of Black immigrants in the United States more than tripled between 1980 and 2005, and by 2005, there were approximately 2,815,000 Black immigrants in the United States with two-thirds from the Caribbean and one-third from Africa (Kent, 2007).

The major reasons for Black immigration to the United States include personal safety, education, and economic and political relief (Kent, 2007). The majority of Black immigrants from Africa come from West African countries, particularly, Liberia, Sierra

Leone, Ghana, and Nigeria, and self-identified Black Caribbean immigrants mainly come from countries dominated by African influences such as Jamaica, Haiti, Trinidad and Tobago (Kent, 2007). In terms of commonalities, many Caribbean residents widely speak Creole, which is a language dialect mixed with African and English influences. In terms of primary differences between West Indian and African immigrants, however, the latter is observed as being slightly younger, male-dominated, and more educated (Kent, 2007).

The large increase in immigration leads researchers to examine health disparities within Black communities (Arthur & Katkin, 2006). One resultant population of immigration is second generation immigrants (SGIs) who are defined as children born and raised in the United States with at least one immigrant parent (Abad & Sheldon, 2008). Currently, one out of six individuals ages 18 to 32, and one out of four individuals under the age of 18 are characterized as SGIs (Kasinitz, Mollenkopf, Waters, & Holdaway, 2008). Specifically, the numbers of Black SGIs in 2005 approximated one million (Kent, 2007).

Most of the research on SGIs characterizes this population as bicultural individuals. Studying bicultural identity is particularly important for psychology as well as health-related fields because of the increased focus of gaining multicultural sensitivity in addressing the needs of growing diverse clinical populations. Studying bicultural individuals acknowledges their different perspectives of not only their identities but also their perspectives of how they relate to society. Examining their cultural values and expectations within themselves that may be conflicting (Phinney, 1996) acknowledges a self-concept that differs from traditional developmental models. Similarly, these individuals “may develop a different sense of community around national, cultural,

ethnic, and racial group membership,” which becomes important for group dynamics, personality, and culture (Benet-Martinez & Haritatos, 2005, p. 1017).

The bicultural portrayal of SGIs stems from the idea that they often internalize at least two cultures (i.e., host and parental country of origin) that is either integrated or opposing (Benet-Martinez & Haritatos, 2005; Haritatos & Benet-Martinez, 2002).

Bicultural individuals may feel a sense of pride and community while at the same time feel a sense of confusion (Benet-Martinez & Haritatos, 2005). Adapting to the host culture or preserving the heritage culture can vary independently, and they may not necessarily be conflicted in their identity between the two cultures (Devos, 2006).

Nevertheless, research indicates that this pull between cultures may lead to psychosocial pressures (Haritatos & Benet-Martinez, 2002) and other health concerns, evidenced in more reported daily hassles and internalizing disorders from this group (Aboud & Sheldon, 2008). Specifically with second generation Black African and Caribbean immigrants, they often struggle with dual identities that exist and often display multiple pathways to identity formation/enactment, selection, and resolution and operate under dual reference points, which are indicative of exposure, stereotype vulnerability, identity enactment, and socialization (Rumbaut, 1994; Tormala & Deux, 2006; Waters, 1996); yet studies on these identity aspects in relation to health are lacking for this population.

Part of this struggle relates to differences in the significance of race and ethnicity evidenced between Black second generation immigrants and their immigrant parents. For example, first generation Black African and Caribbean immigrants come from a cultural context where Blacks were in the majority and held positions of power, whereas, second generation immigrants as well as Black Americans, live in a cultural context where

Blacks are a minority, have less powerful positions, and race is a social construct for stratification in society (Tormala & Deux, 2006). Thus, “race has not had the equivalent consequence in the majority of African and Caribbean nations as it has had in the United States” (Tormala & Deux, p. 136), and racism therefore is not defining despite its prevalence (Waters, 1999).

Black second generation immigrants have reported differences from Black Americans as well with regards to identity formation. Although both groups tend to have personal encounters where race may serve as a barrier and they experience racism or discrimination as a result, the historical experiences of Blackness is more defining for Black Americans (Waters, 1999). In general, Black SGIs report a strong value of education and view differences in their child rearing and how social norms have been modeled for them that contrast an American approach (Brooks, Hanus, Winegard, Mogard, Williamson-Taylor, & James, 2008; Kasinitz et al., 2008). Thus, this population tends to show differences in how they perceive their identity. For example, in a study conducted by Waters (1994) where interviews were conducted with second-generation West Indian and Haitian Americans, it was reported that the identities of second generation immigrants tended to be classified into three categories of American, ethnic American with a degree of distancing from Black Americans, or a maintained immigrant identity. As a result, Black SGIs challenge and reconstruct Black identity dependent upon their socialization experiences regarding group identity aspects of race, racism, and ethnicity and the significance they attribute to those aspects.

Group Identity

In general, group identity refers to identification based on historical perspectives, a myriad of life experiences, and socio-cultural experiences of an ascribed group (Phelps, Taylor, Gerard, 2001). Regarding Black people living in the United States, group identity relates greatly to racial and ethnic classifications. Beginning with race, racial identity is defined as continuous assessment of ascribed reference group membership (Thompson & Carter, 1997). Although race is a social stratification that is based on physical attributes, it is also based on historical as well as political characteristics (Fouad & Brown, 2000). Racial identity also helps to describe or define the level of internalization of racial socialization of individual (Helms, 2007).

Historically, Black racial identity centers on the meaning and significance of race in the daily lives of Black people and its relation to mental health and self-concept. Early work on Black racial identity correlated a meaning of race with discrimination occurrences of African Americans, resulting in a perceived damaged self-concept or lowered self-esteem (Sellers, Morgan, & Brown, 2001). Thus, many early studies focused on “Negro self-hatred” (Cross, 1991). Subsequent models developed to redefine African American racial identity in response to societal racism but in positive psychological ways (Baldwin, 1984; Cross, 1971, 1991; Milliones, 1980; Parham & Helms, 1981).

Many contributors over time have received much acclaim for creating well-researched theories on Black identity that led to a positive Black identity development. For example, Cross (1971, 1991) formulated the five stage Nigrescence model derived from “The Negro-to-Black conversion experience.” Introduced as a process of “becoming Black,” the model dates back to slavery with the deracination of slaves and a devaluation of Blacks but valuation of Whites in their personal self-concept (Thompson & Carter,

1991). This model describes stages of healthy resocialization experience of racial identity in the African American experience. The stages are the following: pre-encounter, encounter, immersion-emersion, internalization, and internalization-commitment. In the first stage, pre-encounter, individuals do not perceive race as important to their identity, and they may idealize White society. Characteristics of individuals in this stage include low salience attitudes toward race and increased sensitivity to the negative stereotypes White people may have about them (Cross, 1991). In the second stage, encounter, individuals reexamine their previous identity and are faced with racialized experiences that may be positive or negative. Immersion-Emersion, which is the third stage, is representative of pro Black and anti-White sentiment. In the fourth stage of internalization, individuals begin to come to terms with positive and negative aspects of Whiteness and Blackness, and feel security and satisfaction with being Black. In the fifth and final stage of internalization-commitment, individuals internalize their identities and make a commitment to action.

Parham, a nigrescence theorist, and Helms (1981) extended the work of Cross by making the nigrescence model a continuous cycle that occurs over the lifetime of an individual. Parham accounted for occurrences in adolescence/early adulthood, middle age, and late adulthood. He introduced the concept of recycling, where a “person searches for new answers and continued growth in his or her thinking about what it means to be Black” (Cross, 1991, p. 221). Thus, new racial experiences may initiate a repeat of stages with the exception of preencounter, which is unlikely.

Helms also elaborated on Cross’ model. Helms (1995) created the People of Color Racial Identity Model. The People of Color Racial Identity Model grew out of Cross’

Nigrescence theory of Black Racial Identity Development (1971) and Atkinson, Morten, and Sue's (1989) Minority Identity Development. Unlike previous models, Helms conceptualized racial identity as statuses as opposed to sequential stages. For Blacks, preencounter, the first status, involves a devaluation of one's racial group and an idealization of White ideals. This stage includes active and passive modes, with the former involving displays of Black denigration and White idealization, and the latter involving ignorance of daily impact of sociopolitical racism (Helms, 1990). Encounter, the second status, is characterized by dissonance of racial group commitment and a confrontation of inferiority. The third status, immersion/emersion involves a pride in one's racial group followed but a denigration of White culture. The next status of internalization comprises internalizing a new identity with a salience of Blackness. The last status is integrative awareness, which is best described as social justice commitment and value of all identities.

Sellers et al. (1998) introduced the Multidimensional Model of Racial Identity (MMRI), which is one of the latest models. The MMRI draws from previously mentioned models of racial identity but with a focus on the strengths of different dimensions of a person's racial identity (Sellers, Morgan, & Brown, 2001). Thus, racial identity is an individual process that occurs on many dimensions as opposed to a "single developmental sequence" (Sellers, Morgan, & Brown, 2001, p. 31). The model assumes that individuals may change in their racial identity because of racist events or changes in life circumstances; therefore, the MMRI allows one to see influences that are normative or due to racism (Sellers, Morgan, & Brown, 2001). The model makes four assumptions: 1) identities are dynamic or situational as well as stable, 2) a number of identities may

exists in individuals that are ordered hierarchically, 3) individual perception of racial identity is the most valid indicator, and 4) racial identity is focused mostly on points in time rather than on developmental sequences (Sellers, et al., 1998). The MMRI has been operationalized in the development of the Multidimensional Inventory of Black Identity, or MIBI (Sellers, Rowley, Chavous, Shelton, & Smith, 1997).

The MMRI has independent but interrelated dimensions of racial identity: racial centrality, racial regard, racial ideology, and racial salience. Centrality assesses how salient race is to individual self-concept. Regard refers to the affective evaluations of a person's race on private and public components. Private regard represents positive or negative feelings toward race and corresponds with closeness and racial pride. Public regard represents how people feel others view their race in positive or negative ways. Ideology is the dimension based on beliefs and attitudes that consist on nationalist, minority, assimilation, and humanist perspectives. Salience describes how relevant race is to self-concept. The first three (i.e., centrality, regard, and ideology) are stable dimensions of racial identity, whereas salience changes based on situational demands.

Of the dimensions of the MMRI, centrality has received much attention in research and is an aspect of racial identity of main focus in this proposed study. One reason for its attention is that it has often been found to be significant in most studies compared to others dimensions on the MMRI and correlated with other identity constructs and measures related to an individual's self-concept. Another reason is that researchers often assume that race is central to all Blacks, which may inaccurately assess racial identity to various types of outcomes (Cross, 1991). How a person defines oneself

in terms of race and how significant it is to his/her core identity, however, is best relevant in its relation to health outcomes and racism.

For example, Rowley, Sellers, Chavous, and Smith (1998) studied personal self-esteem in a sample African American college and high school students and found that the relationship between private regard (i.e., feelings about racial membership) and self-esteem was moderated by racial centrality. These results indicate that the positive meaning of blackness in relation to psychological functioning was significant only when race was central to their identity (Sellers, Morgan, & Brown, 2001). In another study by Sellers, Caldwell, Schmeelk-Cone, and Zimmerman (2003) racial identity and discrimination, perceived stress, and psychological distress were examined in a sample of African American young adults. Sellers et al. found that the more central race was the less likely individuals were to report higher levels of psychological distress. Individuals with higher levels of racial centrality were likely to report higher levels of perceived discrimination but lower levels of stress from that perceived discrimination. Sellers and Shelton (2003) also found that racial centrality was positively associated with how much perceived discrimination African Americans experienced. Additionally, in a sample of Afro-Caribbean participants, Hall and Carter (2005) found that over time racial identity predicted perceptions of discrimination. Thus, centrality can be a risk factor for more experience with discrimination and a protective factor against the impact of discrimination dependent upon how the situation is appraised by the individual (Sellers et al., 2003; Utsey et al., 2000).

Accordingly, race centrality has a relation to racism and the stress attributed to it. Race-related stress is common among Black Americans and is best described as negative

life events (e.g., slurs and discrimination) that happen to individuals because of their membership and physical resemblance to an ascribed group (Landrine & Klonoff, 1996). Racism and discrimination affect health and mental health outcomes (U.S. Department of Health and Human Services, 2001) by making individuals susceptible to more stressors and hassles (Brondolo, Gallo & Myers, 2009). For example, William et al. (1997) found that race-related stress was associated to higher levels of physical and mental health distress despite racial differences in health statuses associated with socioeconomic status. Similarly, Landrine, Klonoff, and Ullman (1999) found that racist discrimination was the best predictor of half of the Blacks' psychiatric symptoms measured in their study, which was more powerful than social status and generic stressors.

A common characteristic in the racial identity models of Cross, Parham, Helms, and Sellers is the intersection between racism, or racial perception of others and racial perception of self (Chavez & Guido-DiBrito, 1999). Although all Black groups share a vulnerability to racial oppression (Rogers, 2006), racial identity development of Black people differs for those whose ancestry stems from countries in Africa or the Caribbean because of problems associated with the classification of race as a measure of a collective or sole sense of their group identity. Although most of the aforementioned studies and other studies on racial identity provide meaningful information, the majority of them include Black populations that fail to define within group variations of their "African American" sample, and assume they examine Blacks with an ancestry traced back to slavery in the United States, which makes their experiences homogenous. Thus, those whose history stems from a developed culture of racism filled with the repercussions of slavery and oppression from a dominant White population versus those from a culture

that is based on a minority of Whites where racism is not defining (Tormala & Deux, 2006; Waters, 1999) are not clearly defined. Consequently, racial experiences as well as racial centrality of SGIs that draw from both of these histories are most likely ignored.

Psychology lacks research on racial identity models specific to Black Caribbean Americans and first and second generation Black immigrants and instead utilizes existing racial identity models on both groups. It is likely that their racial identity development differs mainly because of problems with the classifications of race as a measure of a collective sense of their identity which may lead to appraise racist events differently (Richardson, Bethea, Williamson-Taylor, & Hayling, 2009; Waters, 1996). Furthermore, between groups differences occur because “the nature of the racial identities of American and immigrants or other nationals differs if they have not experienced the similar racial socialization during their lifetimes” (Helms, 2007, p. 236). For example, in her study with African and British Caribbean Americans of African descent inclusive of first and second generation individuals, Hunter (2008) found that African Americans were more likely to perceive racial discrimination when they endorsed horizontal individualism (i.e., individuality with an equality and self-reliance focus) than British Caribbean first and second generation Americans. Cokley (2007) stresses the importance of using additional measures that tap into the specific cultural group in question such as ethnic identity.

Examining ethnic identity in addition to racial identity becomes important as a result. Racial and ethnic identity involve the process of gaining knowledge of one’s group as well as a sense of membership or belonging but are studied differently (Phinney & Og, 2007). Whereas racial identity models mostly focus on individual response or internalization of racism (Helms, 2007) out of social construction of races, ethnic identity

models involve the identification with members because of socially constructed cultural commonalities and shared customs (Chavez & Guido-DiBrito, 1999). Within a given ethnic group, feelings of belonging exist as well as interest and involvement in traditions and activities such as food and religion (Phinney, 1996). Similar to racial centrality, ethnic identity is a part of one's self-concept (Phinney, 1992) but with an added evaluative component. It also traces the development of individual toward a "highly conscious identification with their own cultural values, behaviors, and traditions" (Chavez & Guido-DiBrito, 1999, p. 41).

Most research on ethnic identity development is based on the identity theorists Erikson (1968) and Marcia (1966). Erikson (1968) conducted much work on identity formation and described it as a process in the core of individuals and their cultures. Erikson's theory postulates that identity development undergoes a process of exploration and commitment. Erikson discussed an identity relationship between the inner self and the outer world, and described it as a progression in awareness of one's basic characteristics as well as position in the world (Marcia et al., 1993). Thus, as one explores and then resolves his/her self-concept, he or she has a conscious awareness of a unique self and community's recognition of that self (Erikson, 1968). This formation of an ego identity is described as a major event in developing a personality.

Erikson's work, however, was theoretical, and Marcia (1966) operationalized it by developing identity statuses in her work with adolescent identity formation. According to Marcia, individuals encounter four identity statuses: foreclosure, moratorium, identity diffusion, and identity achievement. Foreclosure is characterized by commitment to prescribed roles and values from parents. Thus, similar to preencounter of racial identity

stages, unquestioned actions exist. In the moratorium status, an individual experiments and delays the previous commitment. The next status, identity diffusion, is an apathy state (Weiten, 1998) where they may avoid identity struggle. In the last status of identity achievement, an individual has achieved a successful sense of self.

Marcia and Erikson both perceived identity formation important in psychological health (Weiten, 1998). However, the effects of ethnicity and its role in an individual's life in relation to identity formation was absent in research. Drawing from the aforementioned work on identity, Phinney (1992) created an ethnic identity model. In her model, Phinney distinguishes between two separate but interrelated concepts of content, which speaks more to ethnic behaviors, and process, which relates to the understanding of the role of ethnicity in one's life. Phinney's model has three stages in the development of ethnic identity in relation to one's own group and to others. The first stage is characterized as an unexamined ethnic identity very similar to pre-encounter. In this stage an individual may hold positive or negative attitudes toward his/her own ethnic group and to others dependent upon how their family socialized the experience. The second stage consists of a moratorium, or exploration similar to immersion/Emersion or resistance. In terms of one's own ethnic group, individuals begin to search and explore more about their group. In terms of relationships to other groups, individuals in this stage become increasingly aware of racism, become angry toward Whites, and have empathy for other minority groups (Phinney, 1992). Thus discrimination can lead to ethnic identity exploration. In the last stage, individuals achieve their ethnic identity, similar to internalization and have a rather secure group membership. In relation to others, however, some may engage in integration or separatism. It is from this theory that

Phinney (1992) formulated the Multigroup Ethnic Identity Measure, or MEIM, to assess ethnic identity on a continuum across racial groups.

Although earlier work on ethnic identity studied adolescents, much work on has extended to adults, particularly with respect to health outcomes in addressing the challenges of minority groups in health care utilization. One study by Sherry et al. (2006) accounted for the relation between ethnic identity and racism. Sherry et al. found that among low income African Americans, ethnic identity was found to be correlated with higher incidences with racist events, which was interpreted by the need to explore and engage in ethnic behaviors as discrimination increases. Other studies have examined the ethnic identity in relation to health status. For example, Walker, Wingate, Obasi, and Joiner (2008) found in their study of college students and depressive symptomatology and suicidal ideation that ethnic identity moderated the relationship between depression and suicide ideation for African Americans but not European Americans in the sample. Yet similar to other studies, the varying differences among ethnically diverse African Americans, such as second generation immigrants, were not identified or assessed. Similarly, Phelps, Taylor, and Gerard (2001) found in their study of Caribbean, African, and African American college students that cultural mistrust, ethnic identity, and racial identity accounted for 37% of the variance in self-esteem; however, the nature of the label “African American” in terms of any potential within-group differences was not indicated to describe ethnic identity.

In sum, racial and ethnic identity as well as racism stress are measures of an overall framework of group identity. These multiple identity variables are important concepts of examination for Black populations, specifically SGIs, with respect to health

behaviors and outcomes. Other variables, however, such as perceived control in health may account for certain health appraisals (Sellers, Morgan, & Brown, 2001).

Locus of Control

Before describing health locus of control, it is imperative to first describe tenets of general locus of control theory. Locus of control is credited to the social learning theorist Rotter (1966) and is described as a generalized expectancy construct of social learning (Wallston, 2004). Social learning theory is grounded in concepts of reinforcement, which refers to the extent to which a person is likely to engage in a number of behaviors in a particular situation and perceives an outcome to occur. Thus, individuals engage in a learning process dependent upon events where failure of reinforcement to occur will reduce expectancy, and occurrence of reinforcement will increase that expectancy.

Specifically, “a reinforcement acts to strengthen an expectancy that a particular behavior or event will be followed by that reinforcement in the future” (Rotter, 1966, p. 2). Therefore, individuals learn based on their history of reinforcement. If the reinforcement value and expectancy is low, a low probability of that individual engaging in that behavior is likely to exist. Likewise if there is high reinforcement value and high expectancy, the probability that the person will engage in that behavior will be high. According to Rotter (1966) individuals will develop a learning process that will help form a belief that control of certain reinforcements are dependent upon their actions (e.g., internal locus of control) or contingent upon forces independent of themselves (e.g., external locus of control). Thus the expectancy that a particular outcome will occur is dependent upon how much control individuals perceive to have over a situation. Externally oriented individuals are likely to attribute causes of events to external forces

such as others or chance, whereas internally oriented individuals tend to attribute causes of events to individual traits or characteristics, such as self-reliance. Internality is also associated with values such as mastery over environments, coping strategies, and higher achievement (Rotter, 1966).

Rotter conceptualized locus of control as a generalized concept because it has trait-like characteristics that guides behaviors (Wallston, 2004), thus making it a pertinent variable in personality (Rotter, 1966). A summation of early research findings that distinguished between those who have an internal belief of control versus those with an external belief of control such as fate or chance found that those with a high belief that they control their own destiny (i.e., internality) placed a greater value on skill or achievement reinforcements, made attempts to improve their environment, and had lower disposition toward anxiety (Lefcourt, 1966; Rotter, 1966). Furthermore, studies on groups with social positions possessing minimal power in society, such as Blacks, score higher on externality (Lefcourt, 1966). Subsequent research concluded that minority American groups often endorse a more external locus of control than White Americans (Hillman, Wood, & Sawilowsky, 1992; Jackson, 2006).

The tendency for Black individuals to explain their behavior by endorsing an external attribution may lead researchers to conclude that Whites have more desirable traits (e.g., higher achievement motivation and rewards determined by skill) than Blacks (Sue, 1978). However, merit attributions are indicative of individual effort and ability and not of other factors such as group membership (Foster, Slotter, & Ruby, 2006). Therefore, as Sue and Sue (2008) explain, marginalized groups tend to gain knowledge that control operates differently in their lives than in the lives of individuals from dominant groups.

That is higher externality, as a result, may indicate “realistic sociopolitical pressures of influence from powerful others” than a lack of self-reliance (Sue & Sue, p. 295). Graham (1994) conducted an extensive review of studies on Blacks and locus of control and concluded that although more investigations found greater externality among Black populations, this does not support that greater externality is motivationally maladaptive for these groups. Hence, externality may be considered more desirable if it assesses prospect for succeeding against systematic and realistic pressures (Sue, 1978); yet, positive consequences of perceived uncontrollability remained undocumented in the literature (Graham, 1994).

Racial and ethnic identity identification helps to better explain internal and external attributions. People with higher levels or statuses of racial and ethnic identity tend to have come to terms with group membership and understanding of oppressive systems and practices in the U.S. (Helms, 1995; Umana-Taylor, Yazedjian, & Bamaca-Gomez, 2004) particularly people of African descent who were borne out of history of racism. Individuals who feel less pressure from society are likely to endorse an internal locus of control (Joiner & Walker; 2002; Thompson, Anderson, & Bakeman, 2000). Thus, racism and the stress related to it is another factor of locus of control. The more likely people cognitively appraise (Lazarus & Folkman, 1984; Outlaw, 1993) having control over their situations in their lives, the more likely it is for them to buffer the effects of racism and discrimination (i.e., stress) that they may experience (Sellers, Morgan, & Brown, 2001).

For example, the only study to date that measured racial identity as a predictor of locus of control was Martin and Hall (1992) who examined racial identity and

designations, feminist beliefs, and locus of control in a sample of African American women. Martin and Hall found that the encounter stage was characterized by a chance locus of control belief but the internalization stage, where individuals are self-confident with a new African-American identity, was found to have an internal locus of control belief. Thus, individuals with a greater sense of race significance of their Black identity perceived a greater internal control over their lives. Similarly, Marcia et al. (1999) summarized findings on ethnic identity and demonstrated that individuals who have explored their ethnic identity tend to have more of an internal than an external orientation. No studies to date have examined the relation of racial and ethnic identity to locus of control in SGIs.

Health locus of control

Extending the concept of locus of control beliefs to the aspect of health is a major area of interest for psychologists and other healthcare providers. Health locus of control refers to the attributions individuals make regarding the sources of control over their health (Masters & Wallston, 2005). Conventional views on health locus of control define the concept as the extent to which individuals believe they have control over their health status and behavior on internal and external continua (Masters & Wallston, 2005). Internal health locus of control refers to individuals' belief that they have personal control over their health, such as the result of one's actions whereas external health locus of control refers to external forces having control and being responsible for individual outcomes, such as powerful others (e.g. physicians) or chance (Reich, Erdal, & Zautra, 1997; Saklofske, Austin, Galloway, & Davidson, 2007).

The application of locus of control to health care is often attributed to Wallston, Wallston, Kaplan, and Maides (1976). Wallston and colleagues observed that medical staff stressed the importance of having active roles in self-care to newly diagnosed diabetic patients. In response, they advocated the incorporation of social learning theories into patient education by looking at locus of control orientations as an individual difference variable that might be associated to exchanging information between patients and their health care professionals (Wallston, Wallston, Kaplan, & Maides, 1976). Despite medical professionals preference for examining patients' knowledge of the illness as opposed to psychological constructs such as locus of control orientations, Wallston et al. (1976) developed the Health Locus of Control (HLOC) measurement. HLOC recognized people as being either "internal" or "external" (Wallston, Wallston, & DeVellis, 1978).

Designating individuals into dimensions of "internal" or "external" made HLOC a "unidimensional" construct (Wallston & Wallston, 1981). After various studies on HLOC were conducted, Levenson advocated extending the notion of externality to include the dimension of fate and chance and provided discriminant validity between internal, powerful others, and chance constructs (Wallston & Wallston, 1981). Modeling after Levenson's relevant addition, Wallston, Wallston, and DeVellis (1978) revised the HLOC to the Multidimensional Health Locus of Control (MHLC), which attributed health orientations to internal, powerful others, and chance dimensions.

Health locus of control is an important aspect in research because it helps to provide information on the beliefs of individuals regarding their illness (Lau, 1982; Wallston, 1997). Gaining insight into the nature of the perceived control consumers have

over their health offers the health care provider with increased knowledge on the likelihood they will engage in various health behaviors related to their general or specific health condition or disease, participate in preventive health measures, and adhere to health regime or medication recommendations (Burroughs, Maxey, Crawley, & Levy, 2002; Wallston, 1997; Wallston & Wallston, 1981). According to Bandura (2005) the quality of health is determined by lifestyle habits, which enable people to exert control over their health status. It is therefore assumed that people who believe they have a sense of control over their health behavior (i.e., internalality) are more likely to engage in behaviors that are healthy, which leads to better health outcomes. Studies utilizing the MHLOC have confirmed this assumption (Marshall, 1991; Norman et al., 1998; Steptoe & Wardle, 2001; Wallhagen & Brod, 1997; Wallston, 2001, 2004). For example, higher internal locus of control has been shown to have an inverse relationship to smoking behaviors (Kaplan & Cowles, 1978; Bennett et al., 1997) and preventive risk measures for breast cancer (Rowe et al., 2005).

Studies measuring health locus of control using the Multidimensional Health Locus of Control measure with the purpose of its applicability to Black populations have been examined as well. For example, Galanos, Strauss and Piper (1994) examined sociodemographic predictors of health locus of control in a sample of Black and White community dwelling elders and found that higher socioeconomic status, Caucasian race, and higher levels of education predicted lower scores on chance subscales. Malcarne, Drahota, and Hamilton (2005) found in their study of health locus of control that African American children scored higher on attribution of health toward powerful others and chance than Caucasian American or Latino American children. In terms of health

behaviors, the same pattern has existed. Barzagan, Barbre, and Hamm (1993) found that internal health locus of control was associated with failure of Black elderly participants to have the prescriptions filled.

Although there are similarities in the findings of these studies utilizing the MHLC with Black populations, some significant limitations exist. One limitation is that these traditional measures of health locus of control, such as the MHLC, fail to examine cultural (or “folk”) beliefs that influence treatment patterns (Sue, 2000) and illness causes. Culture identity influences what an individual believes about personal health by shaping attitudes toward health behaviors such as help seeking and medicine compliance, which influences the etiology of mental illness and cognitive appraisal of psychological and health concerns (Chen & Mak, 2008; Burroughs, Maxey, Crawley, & Levy, 2002). It is based upon group identity because of race and ethnic identity as well as exposure to racism, which has direct as well as indirect effects on health (Sue, 2000). Thus, studies that examine Black population health attributions accounted for by their group membership without examining their group identity have the consequences of treating the racial/ethnic group as a monolithic group. Within group differences of health attributions such as second Black generation immigrants from the Caribbean and Africa are lost as a result.

Another limitation is the conventional measurements and conceptualizations of internality and externality, which fail to explain other cultural specific dimensions attributable to health and illness. Whereas conventional measures assess more Western, or individualistic concepts of control such as autonomy, they often fail to assess more non-Western and collectivist concepts of control such as character or fatalism/mystical

forces. For example, Wrightson and Wardle (1997) examined health locus of control using the MHLC measure with South Asian, Caucasian, and Afro-Caribbean women. Wrightson and Wardle completed interviews of the scale with the Asian participants who did not speak English and discovered that their higher internality scores were a result of them believing they had the power to control their health through Allah (e.g., “Yes, if I become ill, I, through belief in Allah, have the power to make myself well again” p. 18), which is more of an external concept.

Landrine and Klonoff (1992) explained in their review of health related schemas that Western culture, mainly White America, tend to focus on illness as more person centered on a microlevel caused by sources such as genes, stress, and bacteria. Ethnic minority groups, however, with more collectivistic values, tend to view illness interpersonally on a macrolevel and attribute to supernatural causes (Landrine & Klonoff, 1992, 1994). For example, Gyimah, Takyi, and Addai (2006) examined maternal health utilization in Ghanaian women and found that religion was a significant factor in maternal health use even after controlling for socio-economic factors. Similarly, in a study by Millet, Sullivan, Schwebel, and Myers (1996), 67 Black and 78 White undergraduates read and rated mental health vignettes and found that more Black American participants rated spiritual factors as more important in etiology and treatment than did the White participants. Other studies have found similar results when comparing African Americans to White Americans such as elderly Blacks endorsing more God-mediated control in relation to psychological well-being than Whites (Krause, 2005) and Black community college students reporting God’s control in health as related to more religious help seeking behaviors than White students (Ayalon & Young, 2005).

Some studies have opted to revise the MHLC to incorporate aspects of God or use the God Health Locus of Control (Wallston et al., 1999), which has yielded more reliable estimates. Landrine and Klonoff (1992) argue, however, that changing the content of instruments like the MHLC is insufficient given its low internal consistency (Wallston, 2004) as well as low predictive validity and instead advocate for structuring more culturally relevant instruments. For example, in their 1994 study, Landrine and Klonoff asked minority (mostly African American) and White undergraduate college students to generate a list of the causes of illness. After coding the responses, no gender or ethnic differences were found. The experimenters then generated the causes of illness from relevant literature and through the use of a principal-components analysis. The following factors emerged in order of greater variance: supernatural, interpersonal stress, lifestyles, personality, chance, substance use, nature, and weather. When the participants were asked to rate the sub-factors in level of importance, however, racial/ethnic changes emerged, and minorities then rated supernatural causes as more significant than Whites in the study. Landrine and Klonoff concluded that minority students may have felt less comfortable to disclose supernatural causes on their own as opposed to when it was provided for them. Similarly, Shiloh, Rashuk-Rosenthal and Benyamini (2002) examined causal attributions to illness with an Israeli population in an exploratory study and utilized a similar format based on generating themes from similar literature used by Landrine and Klonoff (1994) to create an *Illness Attribution Scale*.

The advantages of the work of both Landrine and Klonoff (1994) and Shiloh et al. (2002) is that they included minority American and international samples, incorporated themes from multicultural sensitive literature, and extended the notions of health locus of

control to encompass more mystical aspects such as Evil Eye, chance happenings, God's punishment, and payback; yet more studies are needed to examine these aspects with Black populations, particularly second generation immigrants who embody messages about the causes of illness from at least two cultures. In addition, extending the association between locus of control to group identity (i.e., racial/ethnic identity and racism) to health has not been examined to date given that most studies solely examine membership in relation to health outcomes (Galanos, Strauss & Piper, 1994) which is another limitation of current traditional methods of health locus of control.

Summary

A summary of the previous literature review reveals that the increased number of Black immigrants to the United States has increased the large number of their children (SGIs), which calls for more research on within group differences that affect their health disparities such as differences in health locus of control. Health locus of control is largely affected by group identity, which includes aspects of racial and ethnic identity and racism; yet, most studies have failed to examine these aspects in relation to health locus of control. Furthermore, traditional measures of health locus of control lack in incorporating culturally sensitive dimensions of health attributions, which calls for research to examine not only group identity predictors of culturally sensitive measures of health locus of control but also examine within group differences to be inclusive of SGIs.

Chapter III

Method

Participants

Participants consisted of 157 Black West African (n=72) and Caribbean (n=85) second generation immigrants living in the United States. Second generation immigrants referred to participants who were born and raised in the United States with both biological parents born in West Africa or in the Caribbean. The term “Black person” referred to individuals of African ancestry. One hundred and twenty three participants (78.3%) were females, and thirty-four participants (21.7 %) were males. Criteria for selection were the following: 1) born in the United States, 2) two parents born and raised in a West African country for the African subgroup or Caribbean country, non-Spanish speaking, for the Caribbean subgroup, 3) at least 18 years old, and 4) lived in the United States for more than $\frac{3}{4}$ of his/her life. Participants’ ages ranged from 18 – 50, with a mean age of 25.48. The average amount of years participants lived in the United States was 24.34 years. The majority of participants were single (84.7%) and less than a quarter were married (14.6%).

In order to make a best estimate of the socioeconomic status of the sample, employment, education, and annual household income levels of participants were assessed in addition to education and annual household income levels of their biological parents. Overall, the sample was mostly educated. The breakdown for the highest degrees earned for the participants were the following: high school diploma (39.7%), associate’s degree (9.0%), bachelor’s degree (25.0%), master’s degree (21.2%) and doctorate (5.1%). Ninety-eight participants indicated they were students (10.8% part time and 51.6% full-

time) and of that number, 35.7% were undergraduates. Approximately 64% percent were employed. The sample consisted of 36.9% who earned an annual household income below \$30,000, 12.7% who earned between \$30,000-49,999, 23.6% earned between \$50,000-84,999, 15.9% earned between \$85,000-124,999, and 10.8% earned an income of \$125,000 and higher. The family combined level of income for their family of origin were 4.5% who earned an annual household income below \$30,000, 17.8% who earned between \$30,000-49,999, 23.6% earned between \$50,000-84,999, 29.9% earned between \$85,000-124,999, and 24.2% earned an income of \$125,000 and higher. The highest degree earned for both parents was a bachelor's degree. The majority of the sample was Christian (84.7%). See Table 1 for a summary of demographic results.

Participants were recruited with parental ethnic origins from the top countries in Africa and the Caribbean with the largest majority of Black populations immigrated to the United States (i.e., West Africa and Caribbean countries, non-Spanish speaking). Twenty-nine countries were represented (See p. 43 for a description of the recruitment procedure). For African SGIs, countries of origin included Cameroon, Gambia, Ghana, Guinea, Liberia, Mali, Nigeria, and Sierra Leone. The average years the mothers and fathers lived in the United States was 28.59 and 29.13 respectively. The majority of both parents were born in Nigeria. For Caribbean SGIs, countries of origin included Anguilla, Antigua, Bahamas, Barbados, Belize, Curacao, Dominica, Grenada, Guyana, Haiti, Jamaica, Martinique, Montserrat, Nevis, St. Kitts, St. Lucia, St. Thomas, St. Vincent, Trinidad and Tobago, Turks and Caicos' Islands, and the United States Virgin Islands (USVI). The average years the mothers and fathers lived in the United States was 32.58

and 33.54. The majority of both parents were born in Jamaica. Table 2 displays the percentages by country of origin of the parents of the participants in the sample.

Measures

Demographic Questionnaire (See Appendix F). Participants completed a demographic questionnaire that requested the following personal information: age, gender, marital/relationship status, years living in the United States, education, employment status, income level, and religion. The following familial information on each participant's biological parents was collected: country or countries of origin, gender, length of time lived in United States, highest level of education, and combined income.

Cultural identification. The investigator created three questions on the demographic questionnaire pertaining to cultural identification. Participants defined themselves in terms of their race, ethnicity, and nationality in an open-ended format. These questions were utilized in order to learn about identification of Black SGIs as well as screen for eligibility for the study.

Health questions. The investigator created questions on the demographic questionnaire in order to generate descriptive health characteristics of the sample. One question asked participants to rate their overall general health on a likert-type scale from one to five, where one represented poor, two represented fair, three represented good, four represented very good, and five represented excellent. Two separate questions asked how many times they sought help for their health from a medically trained health care professional and from a healer in the past twelve months. These questions were utilized for the analyses in order to address gaps in current research regarding help seeking. To

determine a response rate of sampling methods, participants were asked how they heard about the study in a likert-type manner.

Illness Attribution Scale (IAS; see Appendix G). The IAS is a 42-item scale created in an exploratory study by Shiloh, Rashuk-Rosenthal and Benyamini (2002). In their study, Shiloh et al. (2002) first analyzed a list of causes of illness from the *Inventory of Illness Causes* based upon relevant literature into three categories: behavioral, environmental, and hidden. Each scale has subscales: two for behavioral, two for environmental, and three for hidden. After their analysis, they created the IAS by asking participants to rate on a likert scale on one to six how important each factor of the subscale was in causing an illness personally or impersonally relevant with one being totally disagree and six being totally agree. Higher scores represent higher importance relating to that attribution. This study utilized the mystical subscale (six items) under the hidden category to assess supernatural causes and the lifestyle (eight items) subscale under the behavioral category to assess conventional causes in rating general perceptions of illness. Sample items on the mystical subscale are “Evil Eye” and “unexplained cause.” Sample items on the lifestyle subscale are “exercise” and “unsafe sex.”

In Shiloh et al.’s study, Cronbach alpha reliabilities for the mystical and lifestyle subscales were .73 and .76 respectively. In terms of validity, the constructs created for the causes of illness were established from a cluster analysis, and they tested the various indicators of those constructs with other representations and attributions of illness (e.g., Illness Perception Questionnaire (IPQ; Weinman et al., 1996), which yielded reportedly good concurrent validity. Their sample utilized was a collectivistic population (i.e., MHLC), and no other known published internal consistency estimates have been reported

for other samples; however, the literature used to generate categories were based on the same literature utilized by researchers using African American samples (Landrine & Klonoff, 1994). In addition, the researchers of this exploratory nature of the study called for more replications with larger and more diverse groups (Shiloh et al., 2002). This study conducted its own internal consistency reliability estimates for the mystical (i.e., supernatural health locus of control) and lifestyle (i.e., conventional health locus of control) subscales, which yielded good reliability estimates of .78 and .82 respectively. Thus, the estimates of the sample of this study utilizing Black SGIs were higher than the estimates of the originating Israeli sample.

Multidimensional Inventory of Black Identity (MIBI, see Appendix H). The MIBI (Sellers, Rowley, Chavous, Shelton, & Smith, 1997) is a 56-item measure that operationalizes the Multidimensional Model of Racial Identity (MMRI). The MMRI (Sellers et al., 1997) proposes interrelated dimensions of racial identity: racial salience, racial centrality, racial regard, and racial ideology. On the MIBI, participants respond to the extent to which they agree or disagree with each item on a seven point likert scale. Centrality refers to the significance of race in a person's life in terms of self-definition.

For the purposes of this study, centrality was the subscale of focus because of its applicability to racial identity in relation to ethnic identity. In addition, it is the most studied aspect of the MIBI in research. Centrality has eight items. A sample item on the centrality subscale is "Being Black is an important reflection of who I am." Higher scores on the centrality scale signify race as being more important as an aspect of the respondents' definitions of self whereas lower scores signify race as a less significant aspect of self. For this scale, a mean total score that ranges from one to seven was

calculated. Sellers et al. (1998) study on racial identity and self-esteem with African American colleges students yielded moderate reliability analyses for centrality subscales ($\alpha = .73$). In terms of the validity, the items on the MIBI were derived from existing validated scales of racial identity on African Americans (e.g., Milliones, 1980). Sellers et al. (1997) conducted a factor analysis that provided empirical support for the validity of the structures of the subscales including centrality, and the predictive validity of the measure was provided through significantly assessed relationships between subscales and race-related behaviors. In this proposed study, reliability estimates were reassessed for the centrality subscale, which yielded an internal consistency estimate of .71.

Multigroup Ethnic Identity Measure (MEIM; see Appendix I). The MEIM was developed by Phinney (1992) to assess ethnic identity on a continuum as opposed to stages. It is based on the developmental work of Marcia (1966) and ego identity of Erikson (1968). The MEIM assess affirmation/belonging and exploration in relation to developing ethnic identity. The MEIM is a 12-item four point likert scale where four represents strongly agree, three represents agree, two represents disagree, and one represents strongly disagree. This measure yields an overall score on ethnic group identity with higher scores representing a strong positive identification with one's ethnic group. The mean of the total 12 items is calculated for the scale score. The item also allows for individuals to indicate their ethnic culture of origin. Sample items are the following: "I have a lot of pride in my ethnic group and its accomplishments" and "I have a clear sense of my ethnic background and what it means to me." Studies on the MEIM with African Americans (Avery et al., 2007; Johnson & Arbona, 2006) yielded internally consistent scores ($\alpha = .89$ and $\alpha = .88$, respectively). Ponterotto et al. (2003)

reported moderate levels of criterion-related and construct validity of the MEIM in the review of twelve studies utilizing this measure. In this proposed study, reliability estimates were reassessed for the MEIM and yielded strong internal consistency with a Cronbach alpha level of .85.

Schedule of Racist Events (SRE; see Appendix J). Landrine and Klonoff (1996) developed the SRE to assess the frequency of perceived racial discrimination and appraisal of that discrimination as stressful. The SRE assesses racist events that occurred over the last year and over the course of one's lifetime. The scale consists of 18 items and has sets of scores. The first set is derived from participants rating the frequency of racist events once for occurring in the past year (recent) and once again for occurring in their lifetime on the following six-point Likert scale: 1= never happened, 2= happened once in awhile, 3=sometimes, 4=a lot, 5=most of the time, and 6= almost all of the time. Participants then rate how stressful the event was on a Likert scale, with one being not at all and six being extremely. Scores range from 18-108 for recent and lifetime racist events and from 17-102 for appraisal of racist events. A sample item is "How many times have you been treated unfairly by strangers because you are Black?" Internal consistency measurements with large samples indicated high reliability coefficients: .95 for recent racist events, .94, for lifetime racist events, and .94 for appraisal of racist events (Klonoff & Landrine, 1999). A study by Klonoff and Landrine (1999) with a sample of 520 African Americans tested cross-validation of the SRE and revealed high reliability and validity coefficients with a strong relation of racism to psychiatric symptoms. This study utilized the lifetime scale of appraisal of stressful events and conducted its own reliability

estimates yielding a high reliability for the racism stress measure with a level estimate of .91.

Procedure

Participants were recruited primarily through snowball sampling (Faugier, 1997) through multiple avenues. Specifically, the researcher sent email flyers and announcements of the study to a total of 107 leaders of listserves at college student organizations (e.g., Black Student Union, Caribbean Student Association, African Student Association), church leaders, members of professional and community organizations, professors at minority serving and historically Black Colleges and Universities, and African community associations in addition to personal colleagues and acquaintances who were likely to be in contact with Black adults of Caribbean and African descent. Potential participants were asked to complete the study if they fit the criteria, refer the researcher to potential participants or parties who were expected to be in the community's network, or distribute the information of the study to likely participants. Additionally, postings of the study's link were made on seven Facebook group pages that were likely to have participants that would meet the criteria for the study (e.g., African American or West Indian college student networks). Facebook members could post status updates on their individual pages that contained the link for the study as a method of recruitment, and the investigator can report that nine acquaintances posted status updates with a link of the study; however, it is unknown how many other members utilized this method.

For Facebook participation, an online group for Black SGI was created by the researcher (i.e., "Adult Children of West African and Caribbean Parents"), which asked

members to join and directed them to the Survey Monkey link. Twenty-eight members joined this group. Responses on surveys completed on Survey Monkey could not be matched to group membership on Facebook. The investigator could not determine if members who joined the group were SGIs or if they completed the survey. Additionally, recruitment to other potential SGIs from this method could not be determined. Thus, Facebook was utilized primarily as a snowball method. Table 3 shows the frequencies for the reported methods of recruitment for this study.

The completed survey packet was created in Survey Monkey, which is an online tool for creating web surveys (surveymonkey.com). The created online survey used the validated survey responses option to ensure that all items must be entered. Participants were asked to complete an online consent form in addition to a demographic form and questionnaires. The online consent form explained confidentiality in order to ensure privacy and anonymity. This form also explained that the purpose of the study was to gather information from adults whose parents were born in West Africa and the Caribbean regarding their attitudes about culture and health. Participants were advised that they may withdraw from the study at any time. After completing the forms, an online statement debriefed participants on the nature of the study with contact information provided for participants to obtain more information if desired.

In order to determine the number of participants recruited for online participation, the investigator used Google Analytics to insert a tracking code to track the number of visitors who accessed the webpage. According to Google Analytics, 546 unique visitors accessed the website. A unique visitor is defined as the number of unduplicated (i.e., only counted once) visitors to the website over the course of data collection.

Additionally, paper and pencil versions were made available for some community groups or individuals who may necessitate writing their answers or who may not have access to the internet. In this study, four paper and pencil versions of the study were completed at a university cultural student organization meeting that had an attendance of approximately 40 people. A slightly different procedure was executed for this method. A survey packet was given directly to the participants that included the introductory letter to the study, two copies of the informed consent form, the demographic questionnaire, and measures. The introductory letter explained the purpose of the study, asked participants to read and sign both online consent forms, and instructed them to keep a copy for their records. The informed consent form explained confidentiality and informed them that a four digit number would be assigned in order to ensure privacy of any identifying information and for record keeping purposes. Contact information was offered for participants who may want to request a summary of the study. All procedures described above were approved by the Institutional Review Board.

Design and Operationalization of Variables

The research design of this study was a passive research survey design, or nonexperimental. Descriptive statistics were computed to account for mean scores and intercorrelations between variables. Data were collected and entered into PASW Statistics (Predictive Analytics SoftWare) version 18.

For the first research question, a one-way MANOVA was conducted to examine group differences on both types of health locus of control for each Black SGIs. The dependent variables were supernatural and conventional health locus of control (HLOC) as predicted by two subscales (i.e., mystical and lifestyles) on the IAS. Mystical subscale

represented supernatural HLOC and the lifestyles subscale represented conventional HLOC. For the second research question, two multivariate multiple linear regressions were used to assess the association between group identity and health locus of control for each of the Black African and Caribbean SGI samples. The independent variables were racial identity, ethnic identity, and racism stress. Racial identity was measured by centrality, which is a subscale on the MIBI. Ethnic identity related to African or Caribbean origins and was measured by the MEIM. Racism stress was measured by the SRE. Correlations exist between the observed variables ethnic identity, racial identity, and racism stress as supported in research (Cole & Arriola, 2007; Fischer & Moradi, 2001; Sellers et al., 2003; Thompson, Andersen, & Bakeman, 2000). The dependent variables were supernatural and conventional HLOC as predicted by the IAS. For the third research question, two multivariate multiple linear regressions were conducted to assess the association between both types of HLOC and help-seeking behaviors. The two independent variables were supernatural and conventional HLOC as measured by the IAS. The dependent variables were help seeking as measured by two quantitative questions on the demographic questionnaire (i.e., “In the past 12 months, how many times did you seek help from a medical or health care professional about your health?” and “In the past 12 months, how many times did you seek help from a healer about your health [For example, minister, organic/root doctor, spiritual leader]?”).

Statistical Analysis

In order to test the study's hypotheses, multiple statistical procedures were employed. For the first research question, a priori power analysis using G-power 3 software (Faul et al., 2007) proposed a sample size of 68 with a medium effect size (.15),

alpha levels set to .05, and power levels set to .80 to conduct the one-way MANOVA. For the second research question, a priori power analysis by Cohen (1988) suggested a sample size of 51 for each group with a medium effect size (.15), alpha levels set to .05, and power levels set to .80 to conduct the multivariate multiple linear regressions. Univariate regression tests for each dependent variable and a formal comparative analysis (i.e., homogeneity of regression) were proposed a priori to examine significant relationships and examine SGI group differences between regression models. For the third research question, a priori power analysis using G-power 3 software (Faul et al., 2007) proposed a sample size of 43 for each group with a medium effect size (.15), alpha levels set to .05, and power levels set to .80 to conduct the multivariate multiple linear regressions. Univariate regression tests for each dependent variable and a formal comparative analysis (i.e., homogeneity of regression) were proposed a priori to examine significant relationships and examine SGI group differences between regression models.

A total of 157 completed the survey. An additional 49 respondents were excluded for the analysis for three reasons. One reason is that their responses were incomplete. Another reason is that their demographic data entered excluded them from the criteria (e.g., both parents born in the United States). One more reason is that the study investigator's determined that the amount of missing data on some responses of the Illness Attribution Scale were too extensive for a clinical relevance. Although a validated survey responses option was enforced to ensure that all items must be entered, a technical error in downloading data occurred were a few items were missing. Thus, those responses were excluded. Given Cohen's conservative and large effect size estimates, the total

sample for the study was increased from the suggested sample size by the power analysis conducted, which also provided an ample size for the several cases that were excluded.

Chapter IV

Results

The purpose of the study was to examine the following with Black West African and Caribbean second generation immigrants (SGIs): (a) group differences on conventional and supernatural health locus of control, (b) associations between aspects of group identity variables (i.e., racial centrality, ethnic identity, and racism stress) with conventional and supernatural health locus of control, and (c) associations between conventional and supernatural health locus of control and types of health help seeking. The results are presented in the following order: (a) exploratory data analysis, which is inclusive of descriptive statistics, (b) preliminary analyses, (c) primary analyses that include multivariate analysis of variance (MANOVA) and multivariate multiple linear regression (MMLR) statistics to test hypotheses, and (d) additional analyses that examine self-defined cultural identification and perceived racial discrimination with conventional and supernatural health locus of control as well as the self-reported general health of respondents.

Exploratory Data Analysis

Exploratory data analysis (EDA) served to explore potential problems or errors with the data, assess whether assumptions were met for statistical procedures, and provide descriptive statistics and intercorrelations (Leech, Barrett, & Morgan, 2005). All variables were examined in PASW Statistics 18 for accuracy of data, and were corrected for errors when deemed necessary. Using the frequency command, small displays of missing data were found on two measures: Schedule of Racist Events, or SRE, (i.e., racism stress measure) and Illness Attribution Scale, or IAS, (i.e., supernatural health

locus of control measure). On the SRE measure, items 16 and 17 each had one missing item, which did not cause any problems in data analyses.

On the mystical subscale that was utilized as the supernatural health locus of control measure, random missing data were found on various responses for the six item scale due to a technical error that occurred during the first stage of data collection which resulted in blank responses being downloaded for 63 participants. Recall that the mystical subscale had the following six items: God's punishment, evil eye, fate/destiny, chance, sinful thoughts/deeds, and unexplained cause. Participants were asked to rate the extent to which they agreed with those items as being the causes of illness on a likert scale from one to six, with one being strongly disagree and six being strongly agree. When downloading the data during the beginning stages of data collection, however, only participants' endorsement of number one for strongly disagree and number six for strongly disagree were shown. Endorsements of two, three, four, or five for those six items were not shown and downloaded blank. Only endorsements of the extremes in agreement (i.e., strongly agree and strongly disagree) were made available for those 63 participants as a result. Thus, the following outcomes were possible for these participants: 1) rating all six items with strongly agree (6), strongly disagree (1), or a combination of both, 2) rating the six items with any of the numbers two to five, or 3) rating the six items with any of the numbers two to five in addition to the numbers six or one for strongly agree or strongly disagree.

Therefore, in order to determine a clinically meaningful score, the following steps were taken. First, a data check occurred to find individual responses for the six-item scale that were missing half or more items (i.e., three or more blank items for the supernatural

health locus of control scale). Second, those participants' responses for that scale ($n=37$) were excluded and dropped from the entire study, and the amounts of missing data left for participants on the health locus of control measure decreased to less than a quarter ($n=26$) and yielded enough responses to maintain power. In order to test if a clinically meaningful score could be obtained for the remaining 26 items with missing data, an identical variable of the supernatural health locus of control measure was created where mean substitutions for missing values were imputed. Then, a paired sample t-test compared the means of both variables in order to test if they were significantly different from each other. The results revealed that there were no significant differences in the mean scores between the original and newly created supernatural health locus of control variables ($p >.001$). Thus, given the small percentage of missing data and results of the t-test, it was determined it was appropriate to utilize the original supernatural health locus of control scale.

Prior to running analyses for the multivariate multiple linear regressions and MANOVA statistics, assumptions for each analysis were tested as well as assessment for multivariate normality of the distribution. For the MANOVA, a Box's test of equality of covariance matrices was conducted to check the assumption of the homogeneity of covariances across groups for the supernatural and conventional health locus of control dependent variables. The test was not significant ($p =.488$); thus, the assumption for homogeneity was met. Multivariate normality of the distribution was assessed by checking bivariate and univariate normality. Bivariate normality was examined by visually examining scatter plots. Scatter plots revealed elliptical shapes of the dependent variables with the exception of the two variables of health help seeking behaviors (i.e.,

“In the past 12 months, how many times did you seek help from a medical or health care professional about your health” and “In the past 12 months, how many times did you seek help from a healer about your health?”).

Univariate normality was assessed with computing skewness and kurtosis statistics and visually examining probability plots. Unacceptable values of skewness and kurtosis (i.e., $> +2$) and relatively non straight lines for the probability plots were found for the two health help-seeking behaviors. Transforming variables to reduce skewness and kurtosis with a logarithm (10) transformation was considered; however, the values displayed right skewness and leptokurtic values, which are very common for variables regarding time or duration. Interpretability would become difficult because of a considerable change in the relationship of the variables. Additionally, an ample sample size was provided to aid in the confidence of estimates of the population parameters. Thus, these reasons were sufficient to continue without conducting the transformation and interpret with caution the regression results that included those two variables.

Descriptive statistics. The primary variables for this study were racial centrality, ethnicity identity, racism stress, supernatural health locus of control, conventional health locus of control, help seeking from a medically trained professional, and help seeking from a healer. Table 4 displays the means, standard deviations, and intercorrelations for these measured variables. Racial centrality was measured by the Multidimensional Inventory of Black Identity (MIBI) and had a mean score of 4.46 ($SD = 1.14$). Ethnic identity was measured by the Multigroup Ethnic Identity Measure (MEIM) and yielded a mean score of 3.49 ($SD = .40$). Racism stress was measured by the Schedule of Racist Events (SRE) and had a mean score of 2.38 ($SD = 1.01$). Supernatural health locus of

control was measured by the Illness Attribution Scale (IAS) and yielded a mean score of 2.53 ($SD = 1.27$). Conventional health locus of control also was measured by IAS and yielded a mean score of 4.60 ($SD=.96$). Help seeking from a medically trained professional was measured by a question on the demographic questionnaire, and yielded a mean score of 4.29 ($SD=7.36$). Help seeking from a healer was measured by a question on the demographic questionnaire as well, and yielded a mean score of .98 ($SD=3.63$). Intercorrelations were assessed for the multivariate regressions by examining the correlations between these variables, and significant associations were found. The MIBI scale was significantly associated with the conventional health locus of scale measure ($r=.152, p=.029$). The SRE scale was significantly associated with the MIBI scale ($r=.248, p=.001$). Multicollinearity was not found by assessment of intercorrelations.

Preliminary Analyses

Furthermore, demographic variables (i.e., gender, age, years living in the United States, marital status, mother's years living in United States, father's years living in United States, education, income, and religion) were assessed for their influence on the dependent variables in the study. Religion, education, and income were dummy coded into separate variables. A number of multivariate multiple linear regression analyses were conducted to examine the relationship between the demographic variables and the HLOC dependent variables. No statistical differences were found between the demographic variables and both types of HLOC ($p>.05$). A number of multivariate multiple linear regression analyses were also conducted to examine the relationship between the demographic variables and both types of health seeking, and a statistically significant difference between marital status, years mother lived in the U.S., years father lived in the

U.S., and help-seeking was found, $\Lambda = .786$, $F(6, 284) = 6.13$, $p = .000$. Follow-up parameter estimate comparisons revealed that the single participants had a significantly higher mean for help seeking from a healer, and married people had a significantly higher mean for help seeking from a medical professional. Univariate tests revealed that these predictors explained a significant amount of variability in help seeking from a healer (9%, $p = .004$) and from a medical professional (18%, $p = .000$). Greater amount of the mother's length of time ($\beta = .18$, $p < .05$) and lower amounts of father's length of time ($\beta = -.13$, $p < .05$) were related to help seeking from a healer. Similarly, greater amounts of the mother's length of time ($\beta = .17$, $p < .05$) and lower amounts of father's length of time ($\beta = -.30$, $p < .05$) were related to help seeking from a medical professional.

Multiple ANOVAs were also conducted to explore any significant differences between the two subgroups (i.e., West African and Caribbean) with the demographic variables. Significant differences were found between subgroups for the length of time their parents lived in the United States ($p < .05$). Mean comparisons revealed that more Caribbean mothers and fathers lived in the United States longer than the West African mothers and fathers of the study. T-tests and mean comparisons also were conducted to examine any overall differences between conventional and supernatural dimensions of HLOC. Both groups reported higher internal, or conventional HLOC ($m = 4.60$) than external or supernatural HLOC ($m = 2.53$).

Primary Analyses

In this study, three hypotheses were tested to examine group differences in health locus of control, group identity, and health help seeking behaviors in a group 157 second generation Black immigrants. These hypotheses were examined by first examining group

differences in supernatural and conventional health locus of control between 72 West African second generation immigrants and 85 Caribbean second generation immigrants. Second, the predictive nature of group identity to supernatural and conventional health locus of control was assessed. Group identity consisted of racial centrality (i.e., a measure of significance of race), ethnic identity (i.e., identification with cultural commonalities) and racism stress (i.e., negative life events because of racism). Last, supernatural and conventional health locus of control beliefs were examined in relation to help seeking from a medically trained professional and a healer.

H₁. Significant group differences exist between Black SGIs on both supernatural and conventional health locus of control. It was expected that the Caribbean subsample would score higher on the supernatural dimension than the West African subsample. To examine significant group differences between Black second generation African and Caribbean immigrants on both conventional and supernatural dimensions of health locus of control, a one-way MANOVA was conducted. A significant difference was not found, $\Lambda = .146$, $F(2,154) = .998$, $p = .864$. Thus, the research hypothesis was not supported.

H₂. Racial centrality, ethnic identity, and racism stress will significantly predict both types of health locus of control. To test what aspects of group identity, specifically racial centrality, ethnic identity, and racism stress were associated with both types of health locus of control, two multivariate multiple linear regressions were conducted for both groups of Black second generation immigrants. The results showed for the West African subgroup, racial centrality, ethnic identity, and racism did not significantly predict supernatural or conventional health locus of control, $\Lambda = .953$, $F(6,132) = .542$, $p = .775$. For the Caribbean subgroup, racial centrality, ethnic identity, and racism also did

not significantly predict both types of health locus of control, $\Lambda = .884$, $F(6,158) = 1.69$, $p = .127$. Thus, the research hypotheses for both groups were not supported.

H₃. A significant relationship between health locus of control (i.e., supernatural and conventional) and help-seeking will be found. Lower scores on supernatural health locus of control but higher scores on the conventional health locus of control will be associated with higher scores on help seeking from a medically trained professional.

Higher scores on the supernatural but lower scores on the conventional health locus of control will be associated with higher scores on help seeking from a healer. To

investigate the associations between both types of health locus of control and types of help seeking for Black second generation West African and Caribbean immigrants, two multivariate multiple linear regressions were conducted for both groups. A significant association was found between help seeking and health locus of control for the West African subgroup only, $\Lambda = .867$, $F(4,136) = 2.51$, $p = .04$. Univariate tests revealed a significant relationship between supernatural (but not conventional) health locus of control and help seeking from a healer (but not a medically trained professional).

Specifically, supernatural health locus of control explained a significant amount of help seeking from a healer (9.7%, $p = .029$). Higher scores on supernatural health locus of control ($\beta = .31$, $p < .05$) were significantly related to higher scores of help seeking from a healer. Thus, the research hypothesis was partially supported. Tables 5, 6, 7, and 8 display the regression summaries for the group identity and health locus of control predictors.

Additional Analyses

In this study, information was collected on the demographic questionnaire from participants regarding their cultural identification via self-reported race, ethnicity, and nationality definitions in an open-ended format. These self-defined responses were organized by frequency and pattern for categorical meaning by group membership. Each subgroup (i.e., West African and Caribbean) provided responses for how they defined race, ethnicity, and nationality. Beginning with race, the majority of the West African subgroup defined their race as African American (41.7%) followed very closely by Black (37.5%). In contrast, a larger percentage of the Caribbean subgroup defined their race as Black (74.1%).

Regarding ethnicity, larger variations were revealed. For the West African subgroup, 29.3% reported their ethnicity with regards to the country of origin of their parents (e.g., “Nigerian,” “Sierra Leone”). Approximately 26.4% reported their ethnicity as African, 13.9% reported African-American, 11.2% reported their tribe (e.g., Yoruba, Igbo), and 11.1% reported Black. For the Caribbean subgroup, 29.5% reported their ethnicity with regards to the country of origin of their parents (e.g., Jamaican, Guyanese). Around 14% reported their ethnicity as Caribbean, 11.8% reported Black, and 8.2% reported West Indian. Approximately 9.4% reported they were African American, 8.2% reported Caribbean American, and 7.1% connected their parents’ country of origin with America for identification (e.g., Jamaican American).

For nationality identification, 33.4% of the West African subgroup reported their identity as American or United States, 30.7% reported the country of origin of their parents (e.g., Liberia). Approximately 15.4% reported their nationality with regards to

their parents' country of origin associated with America (e.g., Ghanaian American), and 13.9% reported African. For the Caribbean subgroup, 49.5% reported their nationality as American, 16.6% reported the country of origin of their parents (e.g., Bahamian), 15.4% reported American associated with their parents' country of origin (e.g., Haitian-American), 2.4% reported Black, and 2.4% reported West Indian.

Great variations were found among participants regarding cultural identification. Thus, additional analyses were conducted to examine the likelihood that self-defined cultural identification, as a measure of group identity, may be a better predictor of supernatural and conventional health locus of control beliefs. One multivariate multiple linear regression was conducted to examine the association between race, ethnicity, and nationality and both types of health locus of control (i.e., supernatural and conventional). Given that these analyses were post hoc and exploratory in nature, the subgroups were collapsed into one large sample to increase the sample size for increased power, and only the reported commonalities between the West African and Caribbean subgroups for each type of cultural were examined collectively. Prior to running analyses for the multivariate multiple linear regressions, various steps were conducted to insure that the results would be interpretable. Given that the self-reported cultural identification variables of ethnicity and nationality were categorical, they were dummy coded into separate dichotomous variables. Hence, race was dummy coded and became two variables of Black and African American. Ethnicity became three variables of African American, Black, and parental county of origin. Nationality became three variables of American, parental county of origin, and American associated with parental county of origin.

However, linear dependence of the covariances was a concern because of the same cultural terms identified across definitions of race, ethnicity and nationality, which creates high intercorrelations. To avoid multicollinearity, the regression analysis only consisted of predictors of race, ethnicity, and nationality that were the highest reported percentages for both West African and Caribbean respondents that did not share the same definition (e.g., ethnicity defined as Black and race defined as Black). Thus, country of origin of their parents became the variable of interest for ethnicity, American for nationality, and race remained dichotomous, with levels of African and Black.

Multivariate normality of the distribution was assessed by computing skewness and kurtosis statistics, examining intercorrelations, and visually examining probability plots for univariate normality. Acceptable values of skewness and kurtosis (i.e., $< +2$) and straight lines for the probability plots provided no evidence of problems with normality, and no evidence of multicollinearity was found. The results of the multivariate multiple linear regression showed that race, ethnicity defined as parental country of origin, and American nationality did not significantly predict supernatural or conventional health locus of control, $\Lambda = .876$, $F(6,86) = .949$, $p = .458$. See Table 9 for the regression analysis summary.

On the Schedule of Racist Events scale, participants rated the frequency of perceived racial discrimination in their lifetime on a six-point likert scale (1= never happened, 2= happened once in a while, 3=sometimes, 4=a lot, 5=most of the time, and 6=almost all of the time). Additional analyses were conducted to examine the likelihood that perceived racial discrimination may be a better group identity variable that predicted supernatural and conventional health locus of control beliefs for the West African and

Caribbean subgroups. The sample's scores on the SRE ($M=35.66$, $SD=11.70$) revealed considerable variations in experiences with discrimination. Multivariate normality of the distribution was assessed by computing skewness and kurtosis statistics, examining intercorrelations, and visually examining probability plots for univariate normality. Acceptable values of skewness and kurtosis (i.e., $< +2$) and straight lines for the probability plots provided no evidence for problems with normality, and no evidence of multicollinearity was found. Intercorrelations were assessed by examining the correlations between the perceived discrimination, supernatural health locus of control, and conventional health locus of control variables, and a significant association was found between supernatural health locus of control and perceived discrimination ($r=.21$, $p=.01$). Two multivariate multiple linear regressions were conducted to examine the relationship between perceived racial discrimination and types of health locus of control (i.e., supernatural and conventional) for both subgroups. For the West African subgroup, perceived racial discrimination did not significantly predict supernatural or conventional health locus of control, $\Lambda = .982$, $F(2, 69) = .643$, $p=.529$. For the Caribbean subgroup, a significant relationship was found between perceived racial discrimination and health locus of control, $\Lambda = .904$, $F(2, 81) = 4.29$, $p=.017$. Univariate tests revealed a significant relationship between supernatural (but not conventional) health locus of control and racial discrimination. Specifically, racial discrimination explained a significant amount of supernatural health locus of control (9.1%, $p=.005$). Higher scores on supernatural health locus of control ($\beta=.08$, $p<.05$) were significantly related to higher scores of racial discrimination. See Tables 10 and 11 for regression analyses.

Additionally, participants reported on the demographic questionnaire their

overall health. The majority of participants reported optimal general health. Specifically, 27.4% reported excellent general health, 42.7% reported very good general health, 24.8% reported good general health, 4.5% reported fair general health, and .6% reported poor general health. Ranges revealed that the participants sought help three times more from a medically trained professional (0-60, $m=4.28$) than a healer (0-30, $m=3.64$).

In sum, the majority of participants reported optimal general health and extensive variations in self-defined cultural identifications of race, ethnicity, and nationality. The results revealed that no significant group differences existed between Black West African and Caribbean second generation immigrants on both supernatural and conventional health locus of control. Group identity, as measured by racial centrality, ethnic identity, and racism stress did not significantly predict both types of health locus of control. Additional analyses assessed other aspects of group identity in relation to health locus of control and found that self-defined cultural identification did not significantly predict health locus of control; however, perceived racial discrimination significantly predicted supernatural health locus of control for the Caribbean subgroup only. Furthermore, a significant association was found between help seeking and health locus of control where supernatural health locus of control predicted help seeking from a healer for the West African subgroup only.

Chapter V

Discussion

The overall purpose of this study was to provide a voice to Black second generation immigrants (SGIs) who are often absent in research regarding health concerns. Specifically, this study examined the topic of health locus of control (HLOC), which has been found in numerous studies to be a significant variable in understanding the beliefs and choices individuals make regarding their health behaviors (Wallston, 1997). This study aimed to address two limitations in research: treating Black populations as a homogenous group and the use of non-culturally sensitive measurements of HLOC. This study addressed these limitations by 1) assessing group differences between West African and Caribbean SGIs in HLOC measurements that were inclusive of conventional and supernatural aspects, 2) examining the relationship between group identity and HLOC, and 3) investigating the relationship between HLOC and help seeking behaviors.

Group Differences in Health Locus of Control

In this study, no significant differences between the West African and Caribbean subgroups were found on both conventional and supernatural health locus of control variables. It appears that in this study that both groups seem to endorse health locus of control beliefs in a similar fashion. A closer examination of the data revealed that both groups reported higher beliefs in more conventional aspects of HLOC than supernatural ones. The literature, however, suggests the very opposite and predicts that Black populations are more likely to report higher scores on external health locus of control than internal (Landrine & Klonoff, 1992, 1994; Malcarne, Drahota, & Hamilton, 2005). The differences in health locus of control found in this study do not seem to be explained

by potential problems in the Illness Attribution Scale utilized to measure health locus of control because reliability estimates revealed strong internal consistency of the measurements, which were stronger than estimates of other populations.

Hence, a few explanations are offered for these results. One explanation relates to the demographic nature of the sample. In general, the sample of the SGI population surveyed was mostly educated and from higher socioeconomic levels, which may affect their reports of external aspects of health locus of control. For instance, Galanos, Strauss and Piper (1994) found in their study of sociodemographic predictors of health locus of control that higher socioeconomic status and higher levels of education predicted lower scores on chance subscales. Thus, in this study it is possible that education and socioeconomic status may moderate the effects of health locus of control; however, these results may be more indicative of the general population of second generation immigrants than a characteristic of the sample studied. For example, 2009 data from the U.S. Census Bureau reported that second generation immigrants are found to be more educated and better earners than foreign-born populations (Calabrese, 2010). Similar education and socioeconomic features were observed in the sample of this study. Specifically, more than three-fourths of the sample earned an annual household income of \$50,000 or more, and more than half reported their highest level of education was at least an associate's degree or higher. Thus, it is important to recognize that Black SGIs may report high levels of conventional measures of HLOC because of inherent sociodemographic characteristics related to education and income (Kent, 2007).

Another reason for this finding may relate to the bicultural nature of second generation immigrants. Research results with other second generation populations (e.g.,

Mexican Americans) found a relationship between internal health locus of control and biculturalism (Guinn, 1998). Thus, the endorsement of internality of health locus of control found in this study may be indicative of the bicultural nature of Black second generation immigrants.

One more reason for this finding, however, may relate to the reported general health of the sample. Overall, the sample reported optimal health evidenced with approximately 92% indicating that they had excellent, very good, or good general health. This study examined beliefs about health locus of control with a sample that was reportedly healthy, as a result. Hence, it is possible that a higher report of a more internal health locus of control may relate to the health of the sample, and different results may exist if the sample reported less optimal general health. Future studies could benefit from further examination of the differences in HLOC with a sample with more varied reports of general health.

Group Identity and Health Locus of Control

This study attempted to extend previous efforts to explain health locus of control beliefs. Previous studies have examined group membership in relation to health attributions (Galanos, Strauss & Piper, 1994; Millet, Sullivan, Schwebel, & Myers, 1996). Group identity has been found to largely affect health locus of control; yet, studies have examined Black populations and health locus of control without accounting for within group differences related to racial and ethnic identity as well as racism stress. The results of this study, however, failed to find a significant relationship between these aspects of group identity and both of the types of health locus of control in the West African or Caribbean subgroups.

At first glance of the data, it may seem that scale measurement could be a factor in the lack of significant results in the relationship between group identity and health locus of control. The mystical and hidden subscales of the IAS utilized for the conventional and supernatural variables had only six and eight items respectively, which could alter results. Yet, evidence in this study counters this explanation. For instance, the reliability estimates of the health locus of control estimates were sufficient in this study. Additionally, health locus of control was found to be significant regarding other variables in this study (i.e., help-seeking).

Hence, an alternative explanation could be in the selection of predictive factors of health locus of control in this study. In this study, not much variance was explained by these predictors; thus, it is plausible that the variables chosen in this study may not be predictive of health locus of control. Racial centrality, ethnic identity, and racism stress were the specific variables selected to measure group identity, and moderate to high reliability estimates were found for all three measures. Although these estimates yielded acceptable levels of reliability, other measurements of group identity may not only be more appropriate for the sample of Black second generation immigrants in this study but also significantly better predictors of health locus of control, which would lessen construct validity concerns regarding the preoperational explanation of these group identity concepts. This premise is supported by the great variations in the open-ended responses of this sample regarding how they define their race, ethnicity, and nationality.

For example, the participants of West African and Caribbean descent in this study scored high on racial centrality, ethnic identity, and racism stress measures but varied greatly in their self-reported cultural identification of race, ethnicity, and nationality.

Although their responses may appear to be indicative of membership or identification, the varied responses may speak to how they define their identity. For example the participants were asked how they did they *define* their race, ethnicity, and nationality. Thus, participants may be responding to cultural identity in their responses or group membership as a result. A look at their answers shows similarities as well as differences in responding. Although the majority of West African and Caribbean participants reported their nationality as American or United States, the majority of West Africans defined their race as African American whereas the Caribbean subgroup reported it as Black. Ethnicity identification revealed similar responses in categorization with West Africans reporting it as their country of origin followed by African. Likewise, the Caribbean subgroup reported their ethnicity as their country of origin, followed by the term Caribbean.

Additional analyses were attempted to explore these self-defined variables in relation to health locus of control but did not produce significant findings. Some of the difficulty may relate to the within group similarities in definitions for race, ethnicity, and nationality that prevented statistical interpretability as well as the small sample size of the combined groups. It is important to note, however, that no measures specific to second generation immigrants' group identity exist, and this study provided an essential step in the direction of assessing racial and ethnic identity as well as experiences with racism for this population. Thus, future studies could benefit from investigating other measures or conducting factor analyses with a larger sample to capture the most appropriate measures of race, ethnicity, and national origin for this population in relation to health locus of control.

Furthermore, another potential predictor of group identity that was not originally hypothesized to relate to health locus of control in this study was the frequency of racist events. The Schedule of Racists Events (SRE) has two dimensions: frequency of racist events and appraisal of how stressful those events are (i.e., racism stress). In this study, the variable of interest was racism stress, but additional analyses were conducted to explore if a relationship existed between racial discrimination and health locus of control because of theoretical support found between racism and health outcomes. For example, Landrine, Klonoff, and Ullman (1999) found that racist discrimination was the best predictor of psychiatric symptoms with a Black population. Additional analyses found a significant relationship between racial discrimination and supernatural health locus of control for the Caribbean subgroup only. One interpretation of this relationship between health locus of control and racist events is that perceived racial discrimination affects health and mental health outcomes by making individuals susceptible to more stressors and hassles (Brondolo, Gallo & Myers, 2009). Thus, it is plausible that increased racial discrimination results in health beliefs that are external such as supernatural health locus of control because individuals who experience more pressure from society are likely to endorse more of an external locus of control (Joiner & Walker; 2002; Thompson, Anderson, & Bakeman, 2000). This explanation was originally hypothesized in this study for a significant relationship between racism stress and health locus of control, but these results provide empirical evidence for a significant relationship between perceived racial discrimination and health locus of control. In this study, however, this relationship was only found with the Caribbean subgroup. A possible explanation could relate to this

subgroup's parents living in the United States longer than the West African subgroup, which would make them exposed to more racism.

Furthermore, racial discrimination in relation to racial centrality may be worthy of exploration. Sellers, Caldwell, Schmeelk-Cone, and Zimmerman (2003) found that the more central race was the more likely participants were to report higher levels of psychological distress and levels of perceived discrimination but lower levels of stress from that perceived discrimination. In this study, racial centrality was the measure of group identity of which individuals reported the highest. Because racial centrality is significant for this population, future studies could investigate 1) whether racist discrimination in relation to centrality affects other aspects of health, such as health locus of control or 2) if other forms of discrimination may be measures of group identity that serve as predictors of health locus of control.

Although the relationship between racial centrality, ethnicity, and racism stress and health locus control was not found to be statistically significant in this study, the great variability in the responses of the participants regarding group identity helps support not only the notion of heterogeneity of the Black population but also of second generation immigrants. Benet-Martinez and Haritatos (2005) confirmed this notion when they proposed that second generation individuals may build a varying sense of community with respect to their cultural, national, ethnic, and racial group membership. Strong research evidence supports this heterogeneity with second generation Black African and Caribbean immigrants by reporting that they often struggle with dual identities as well as demonstrate numerous pathways to identity formation (Rumbaut, 1994; Tormala & Deux, 2006; Waters, 1996). Thus, the variations of group identity with

Black second generation immigrants identified in literature are supported in this study with West African and Caribbean second generation immigrants.

Health Locus of Control and Help Seeking

Help seeking disparities have been observed among minority groups, particularly with Black Americans in mental health and healthcare settings (Richardson & Kimberly, 1996). Cognitive appraisal or attributions of illness such as health locus of control have been presumed to relate to help seeking behaviors (Ayalon & Young, 2005). In this study, health locus of control was examined in relation to help seeking behaviors. A significant relationship between supernatural health locus of control and help seeking from a healer for the West African subgroup only was found. This finding supported the research hypothesis that higher scores on the supernatural aspect of HLOC would be associated with higher scores on nonconventional help seeking, such as a healer, because of the healing aspects of supernatural health locus of control (Landrine & Klonoff, 1992). Thus, individuals who hold supernatural beliefs regarding health locus of control are more likely to seek help from nonconventional providers, such as an organic doctor or minister. Significant findings of supernatural health locus of control with West African second generation immigrants support research that indicate the tendency of ethnic minority groups to endorse more collective, supernatural or spiritual values and view illness interpersonally (Gyimah, Takyi, & Addai, 2006; Krause, 2005; Landrine & Klonoff, 1992, 1994).

In this study, however, the relationship between supernatural health locus of control and help seeking was only found for the West African subgroup and not the Caribbean one. A few interpretations are offered for this finding. One interpretation

relates to the findings of the manipulation checks conducted prior to the primary analyses as well as the demographics of the entire sample. For example, the manipulation checks found that other variables were related to health locus of control. One variable found was the amount of time the parents of the participants lived in the United States. In this study, the parents of the Caribbean subgroup lived in the United States longer than the West African parents. This variable is greatly related to the concept of acculturation, which is known to affect health outcomes and well-being (Chen, Benet-Martinez, & Bonds, 2008).

The acculturation attitudes or strategies of either subgroups' parents could not be assessed in this study; however, the amount of time individuals spend living in the United States relates to acculturation (Berry, 1996). Tormala and Deux (2006) explain that first generation immigrants tend to maintain a collective identity and come from a society where Black people held many rights or were in a majority. This is most likely to affect the health beliefs and attitudes held by their adult children whose identity formation is derived from cultural values and traditions that is inclusive of parental values and traditions (Chavez & Guido-DiBrito, 1999; Marcia, 1966). In this study, a significant relationship was found in preliminary analyses between the length of time parents of the West African subgroup lived in the United States and help seeking from a healer.

Thus, it is plausible that these participants may draw from the collective identity maintained from their parents who reportedly have not lived in the United States as long as the Caribbean subgroup, which would account for why that nonwestern aspect (i.e., supernatural) of health locus of control related to a nonwestern aspect of help seeking (i.e., services provided by a healer). Although statistical significance was found between supernatural HLOC and help-seeking from a healer, the variance reveals a weak

association. Thus, not much variance in non conventional help-seeking is explained by supernatural HLOC, which postulates other factors could better account for a stronger association.

Limitations

Several limitations existed in this study. One limitation relates to validity regarding measurement. All of the measures in the study were self-report questionnaires, which cause the potential for mono-method bias to occur. Low reliability of some of the measures complicates the ability to find statistical significance in this study. Although the alpha estimates of the mystical and lifestyle subscales of the IAS used to assess health locus of control yielded higher internal consistency than the sample utilized in the exploratory study by originators Shiloh, Rashuk-Rosenthal, and Benyamini (2002), the IAS measure has not been normed on a population of Black second generation immigrants. Furthermore, low consistency lowers the confidence of the accuracy of the measure which weakens construct validity regarding the concept of illness perceptions. Although evidence exists for predictive validity, low correlation coefficient raises concerns about the criteria assessed as well as potential problems with discriminative validity.

Another limitation of the study relates to the demographic characteristics of the sample. The sample was rather homogenous regarding gender, religion, and education. In terms of gender, the sample was largely female, which does not allow for gender comparisons in help seeking or health locus of control. Over three-fourths of the sample reported that they were Christian, which may not be fully representative of the beliefs of all second generation immigrants. The sample was also disproportionately educated. As

mentioned earlier, this characteristic of education, however, is rather representative of the population of Black second generation immigrants. Although gender, religion, and education did not influence health locus of control or help-seeking evidenced in manipulation checks, their disproportionate distribution represents only a fraction of the second generation immigrant population as a result. Similarly, demographic characteristics of the parents of the participants appeared to moderate the results related to help-seeking; yet, moderators were not accounted for in this study. Furthermore, the West African subgroups consisted mainly of parental countries of origin of three countries: Nigeria, Sierra Leone, and Ghana. Likewise, the Caribbean subgroup consisted mainly of parental countries of origin of three countries: Haiti, Jamaica, and Trinidad and Tobago. Thus, differences in health locus of control, group identity, and help seeking may be more representative of characteristics of those countries. Additionally, regional or tribal differences within countries of origin were not accounted for in this study.

One further limitation in this study relates to potential problems with the mystical subscale. As stated earlier, a technical error occurred where only ratings of extremes in agreement, such as strongly agree and strongly disagree, were made available for some of the items of the subscale for 63 participants. This error resulted in dropping 37 participants from the study where at least half of their responses were missing on these items and keeping 26 participants with missing data. It is plausible that the excluded participants may have responded differently and therefore provided a more complete picture of the sample. Thus, their exclusion in addition to the inclusion of missing data of some participants may have created response bias. This bias may have added to diminishing the representativeness of the sample and have led to distorted inferences

made about the population of Black second generation immigrants. However, it is important to note because the study promoted the use of validated survey responses that forced participants to rate every item, the data were missing because of randomness created by the primary investigator, and it was not because of nonresponse or dropouts made by the participants.

Furthermore, limitations existed in the type of sampling conducted in this study. Snowball sampling, also known as chain-referral sampling, was the primary method of data collection. Although snowball sampling is advantageous in providing referrals and accessing hard-to-reach populations, it creates a high potential for sampling bias and concerns for achieving a true distribution of the population, which affects the representativeness of the population in question.

Implications for Future Research

The aforementioned limitations in addition to the results from this study create many implications for future research. One direction for future research is to explore health locus of control with varying levels of general health or expand it to specific types of illness. Differences in health locus of control beliefs for Black second generation immigrants who report optimal health may be compared to those who have poorer health as a result. The notion of varying health statuses becomes important given that the help-seeking variables were skewed.

Another direction connects to the operationalization of group identity. Future studies should include measures of the frequency of racist discrimination as well as any other types of perceived discrimination measures that are appropriate for that population as a predictor of group identity. These measures could also be examined in relation to

health locus of control. Furthermore, the qualitative self-definitions of Black second generation immigrants necessitate the need to find or create measures of group identity for this population. This recommendation becomes important in order to examine what measures are appropriate for bicultural individuals. For instance, the MIBI, which was a measure of Black identity, had the lowest reliability of any other group identity measurement in this study although many participants qualitatively reported Black as a form of their group identity. Qualitative research designs that explore health locus of control and group identity beliefs may be beneficial for this population as well.

In this study, no significant differences were found between West African and Caribbean subgroups regarding health locus of control. It is plausible to combine both groups and measure their relationship to group identity and help-seeking on a larger scale in a structural equation model. In this type of measurement, more indicators of general concepts of group identity, health locus of control, and help-seeking could be investigated as a result through the use of indirect and direct relationships between multiple variables. Furthermore, the manipulation checks in the study found that other variables accounted for health locus of control results. For example, more single people reported conventional health locus of control, which is confirmed by health studies that account for health disparities observed in women because of their marital status (Schiller, Adams, & Coriat, 2005).

In this study, however, acculturation levels as identified by length of time the mothers and fathers of participants lived in the United States, seemed to be the variables that significantly affected the association to health locus of control. Future studies could examine parental acculturation levels as potential moderators of health locus of control. It

is essential to examine these group differences regarding acculturative levels because the nature of identities of individuals differs according to varying socialization experiences (Helms, 2007). Furthermore, health loci of control beliefs of the parents of the participants were not accounted for in this study. It is likely that children may adopt or be influenced by the beliefs in health locus of control of their parents in the formation of their perceptions of the causes of illness. Thus, parental beliefs in health locus of control are worthy of exploration in future studies.

Study Contributions

Despite study limitations and implications for future research, this study greatly contributes to the counseling psychology literature as well as other health professionals. For example, the referral nature of snowball sampling in this study provided an opportunity to locate a population that is difficult to sample despite the disadvantages of this sampling method. Establishing relationships and networks within communities of Black second generation immigrants aid in increasing the amount of information available for this population. Thus, this study established access to this population for future research.

To date, no studies have examined the association between group identity (i.e., racial/ethnic identity and racism stress) and health locus of control. Thus, this study provided the first investigation of this relationship by building on studies that linked general locus of control and cultural identity. The results of this investigation revealed that higher levels of perceived racial discrimination related to greater supernatural health locus of control beliefs for Caribbean second generation immigrants. The results also showed that greater supernatural health locus of control beliefs related to greater

nonconventional help seeking behaviors in West African second generation immigrants. These findings are helpful for professionals who attempt to address health disparities among diverse Black populations by demonstrating that individuals who maintain a more supernatural belief in health locus of control are more likely to seek help from a healer than a more conventional medical professional. They also show that these individuals are less likely to hold conventional health locus of control beliefs when they have experienced increased frequencies of racist events. The finding that the acculturation levels of parents may affect health locus of control beliefs demonstrates that is essential for providers to explore and account for cultural and familial history that may have an impact on an individual's identity and beliefs. Additionally, second generation immigrants have not been studied regarding health locus of control. Therefore, this study accounted for health locus of control beliefs for a specific sample of second generation immigrants.

In this study, participants were able to self-define in terms of race, ethnicity, and nationality. The results revealed great variations in their cultural identification as Black second generation immigrants (e.g., African American, Black, West Indian, and African). These descriptions help to break the pattern of treating Black populations as a homogenous group and help integrate psychological principles (e.g., the role of culture and identity) with service delivery. Additionally, these descriptions increase an understanding of Black second generation immigrants by broadening the perception of worldviews and group identity for Black populations. This study helps to increase their visibility in society at large as a result because they are traditionally understudied in health-related research despite how fast their population is growing in the United States.

Furthermore, this study aids in providing evidence for the importance of the perceptions of health and illness in response to health behaviors and help seeking with ethnic minority populations (Center on Health Disparities Research, 2006). With large health disparities of Black Americans in the United States largely influenced by immigration (Arthur & Katkin, 2006), finding a relation between health locus of control and help-seeking for Black second generation immigrants in this study help to fill gaps in health disparities.

Summary

Overall, this study highlights the diversity of Black second generation immigrant populations who are often overlooked or unaccounted for in research. Allowing these participants who are U.S. born but with foreign born parents to define themselves with regards to their racial, ethnic, and national identity revealed a great heterogeneity for this group who is often collectively defined as “African American” in studies. The within group differences observed as a result of foreign born parents from 29 countries in addition to large variations in cultural self-definitions of race, ethnicity, and nationality help to provide support for their great within group differences, which increases their visibility in not only counseling but also health and medical related arenas. This study provides evidence for a significant relationship between perceptions of health, illness, and help-seeking behaviors for this population by examining health locus of control in culturally sensitive ways. By doing so, this study offers empirical support for external health locus of control of beliefs (i.e., supernatural) as a predictor of nonconventional help seeking behaviors as well as an outcome variable for perceived racial discrimination. These significant relationships for Black second generation immigrants confirm and add

to the body of literature that endorses healing as well as interpersonal and collective views of illness for ethnic minority groups. Hence, this study provides a first step in the direction of addressing health disparities among various Blacks populations by examining their health locus of control beliefs.

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Table 1

*Demographic Characteristics of Participants (N=157)**

Characteristic	Percentage
Gender	
Male	21.7%
Female	78.3%
Marital status	
Single	84.7%
Married/Union	14.6%
Separated	0.7%
Highest education level completed	
High school	39.7%
Associates	9.0%
Bachelors	25.0%
Masters	21.2%
Doctorate	5.1%
Annual household income	
Below 30,000	4.5%
30,000 – 49,999	17.8%
50,000 -84,999	23.6%
85,000 – 124, 999	29.9%
125,000 +	24.2%
Student Status	
Full time	51.6%
Part-time	35.7%
Religion	
Christian	84.7%
Muslim	3.2%
Buddhist	1.3%
Atheist	.6%
Other	10.2%
Ethnic group	
West Africa	45.9%
Caribbean	54.1%

Mother highest level of education completed

Below high school	2.4%
High school equivalent	15.7%
Associates degree	16.9%
Bachelor's degree	26.3%
Master's degree	16.2%
Doctorate/professional	10.3%
Vocational	6.6%
Unknown/unspecified	3.1%

Father highest level of education completed

Below high school	1.8%
High school equivalent	19.1%
Associates degree	10.1%
Bachelor's degree	22.4%
Master's degree	19.5%
Doctorate/professional	13.5%
Vocational	2.4%
Unknown/unspecified	1.2%

Parents annual household income

Below 30,000	4.5%
30,000 – 49,999	17.8%
50,000 -84,999	23.6%
85,000 – 124,999	29.9%
125,000 +	24.2%

* N= total number of participants in sample. Percentages do not total 100% in some cases due to missing responses.

Table 2

Percentages for Country of Origin of the Parents

Country	Percentage	
	Mother	Father
Africa		
Cameroon	1.4%	1.4%
Gambia	2.8%	1.4%
Ghana	13.9%	15.3%
Guinea	1.4%	2.4%
Liberia	6.9%	5.6%
Mali	1.4%	1.4%
Nigeria	40.3%	40.3%
Sierra Leone	31.9%	32.2%

Country	Percentage	
	Mother	Father
Caribbean		
Anguilla	1.2%	0.0%
Antigua	1.2%	1.2%
Bahamas	1.2%	2.4%
Barbados	5.9%	3.5%
Belize	0.0%	1.2%
Curacao	0.0%	1.2%
Dominica	1.2%	2.4%
Grenada	4.7%	2.4%
Guyana	11.8%	12.9%
Haiti	17.6%	18.5%
Jamaica	29.1%	30.6%
Martinique	1.2%	0.0%
Montserrat	1.2%	0.0%
Nevis	0.0%	1.2%
St. Kitts	1.2%	1.2%
St. Lucia	2.4%	2.4%
St. Thomas	1.2%	1.2%
St. Vincent	2.4%	2.4%
Trinidad and Tobago	14.1%	12.9%
Turks and Caicos' Islands	1.2%	1.2%
USVI	1.2%	1.2%

Table 3

Percentages for Recruitment of Study

Method	Percentage
Snowball	
Family/Friend	54.6%
Facebook	8.9%
Study investigator	8.8%
Other (e.g., advisor, instructor)	1.2%
Organization listserv	14.5%
School listserv	11.5%
Community organization	0.6%

Table 4

*Means, Standard Deviations, and Intercorrelations between Measured Variables**(N=157)*

Variable	1	2	3	4	5	6	7
1. HLOC supernatural (IAS)	---						
2. HLOC conventional (IAS)	.10	---					
3. Racism Stress (SRE)	.07	-.00	---				
4. Ethnic Identity (MEIM)	.11	.07	.14	---			
5. Racial Centrality (MIBI)	.02	.15	.24**	.05	---		
6. Help seeking-medical	-.02	.10	.11	-.08	.12	---	
7. Help seeking-healer	.24**	.05	.08	-.13	.04	.39**	---
<i>M</i>	2.53	4.60	2.38	3.49	4.46	4.29	.98
<i>SD</i>	1.27	.96	1.01	0.40	1.14	7.36	3.63

*Correlation is significant at the 0.05 level; **Correlation is significant at the .01 level.

Note: HLOC=Health locus of control; IAS= Illness Attribution Scale; SRE =Schedule of Racist Events; MEIM=Multigroup Ethnic Identity Measure; and MIBI=Multidimensional Inventory of Black Identity

Table 5

Multivariate Multiple Linear Regression Analysis Summary for Group Identity

Predictors - West African Subgroup (N=72)

Predictors	Dependent Measures							
	HLOC-Con				HLOC-Sup			
	B	SE	β	<i>t</i>	B	SE	β	<i>t</i>
Racial centrality	.06	.10	.07	.59	-.15	.16	-.13	-1.02
Ethnicity	.24	.26	.11	.94	.27	.38	.08	.73
Stress	-.10	.10	-.12	-.94	-.01	.16	-.01	-.06
R ²	.02				.02			
F-value	.56				.53			

Note: * = $p < .05$; HLOC-Con=Conventional health locus of control; HLOC-Sup=Supernatural conventional health locus of control

Table 6

Multivariate Multiple Linear Regression Analysis Summary for Group Identity

Predictors - Caribbean Subgroup (N=85)

Predictors	Dependent Measures							
	HLOC-Con				HLOC-Sup			
	B	SE	β	<i>t</i>	B	SE	B	<i>t</i>
Racial centrality	.19	.09	.22	2.04	.13	.11	.12	1.15
Ethnicity	.13	.30	.05	.46	.48	.35	.15	1.37
Stress	-.00	.12	-.00	-.00	.18	.14	.14	1.30
R ²	.05				.07			
F-value	1.51				2.00			

Note: * = $p < .05$; HLOC-Con=Conventional health locus of control; HLOC-Sup=Supernatural health locus of control

Table 7

Multivariate Multiple Linear Regression Analysis Summary for HLOC Predictors - West

African Subgroup (N=72)

Predictors	Dependent Measures							
	Conventional Help-seeking				Nonconventional Help-seeking			
	B	SE	β	<i>t</i>	B	SE	β	<i>t</i>
HLOC-Con	.11	1.01	.01	.10	-.13	.66	-.02	-.20
HLOC-Sup	.00	.68	.00	.01	1.22	.45	.32	2.72
R ²	.00				.09			
F-value	.01				3.73*			

Note: * = $p < .05$; HLOC-Con=Conventional health locus of control; HLOC-Sup=Supernatural health locus of control

Table 8

Multivariate Multiple Linear Regression Analysis Summary for HLOC Predictors –

Caribbean Subgroup (N=85)

Predictors	Dependent Measures							
	Conventional Help-seeking				Nonconventional Help-seeking			
	B	SE	β	<i>t</i>	B	SE	B	<i>t</i>
HLOC-Con	1.25	.78	.17	1.60	.20	.10	.20	1.88
HLOC-Sup	-.33	.65	-.05	-.50	.11	.08	.13	1.25
R ²	.03				.06			
F-value	1.37				2.70			

Note: * = $p < .05$; HLOC-Con=Conventional health locus of control; HLOC-Sup=Supernatural health locus of control

Table 9

Multivariate Multiple Linear Regression Analysis Summary for Cultural Identification

Predictors - West African and Caribbean Subgroups Combined (N=47)

Predictors	Dependent Measures							
	HLOC-Con				HLOC-Sup			
	B	SE	β	<i>t</i>	B	SE	B	<i>t</i>
Race	-.29	.29	-.15	.33	.01	.39	.01	.01
Ethnicity	.03	.27	-.02	.12	.68	.37	.27	1.85
Nationality	-.03	.29	-.15	-.12	.68	.37	-.17	-1.16
R ²	.02				.10			
F-value	.39				1.61			

Note: * = $p < .05$; HLOC=Health locus of control; HLOC-Con = Conventional health locus of control; HLOC-Sup = Supernatural health locus of control; Race = Black or African American; Ethnicity = Parental country of origin; Nationality = American

Table 10

Multivariate Multiple Linear Regression Analysis Summary for Racial Discrimination –

West African Subgroup (N=72)

Predictor	Dependent Measures							
	HLOC-Con				HLOC-Sup			
	B	SE	β	<i>t</i>	B	SE	β	<i>t</i>
Racial discrimination	-.09	.16	-.06	-.57	.22	.24	.11	.89
R ²	.00				.01			
F-value	.33				.78			

Note: * = $p < .05$; HLOC-Con=Conventional health locus of control; HLOC-Sup=Supernatural health locus of control; Racial discrimination was measured by the Schedule of Racist Events (SRE)

Table 11

Multivariate Multiple Linear Regression Analysis Summary for Racial Discrimination –

Caribbean Subgroup (N=83)

Predictor	Dependent Measures							
	HLOC-Con				HLOC-Sup			
	B	SE	β	<i>t</i>	B	SE	β	<i>t</i>
Racial discrimination	.15	.19	.08	.78	.59	.21	.30	2.76
R ²	.00				.09			
F-value	.59				7.66*			

Note: * = $p < .05$; HLOC-Con=Conventional health locus of control; HLOC-Sup=Supernatural health locus of control; Racial discrimination was measured by the Schedule of Racist Events (SRE)

Appendix A (online version)

Instructions to Participants

Dear Participant:

You have been invited to participate in an online dissertation study conducted by Claudette Williamson-Taylor at Lehigh University. The purpose of this study is to gather information from Black adults whose parents were born in West Africa or the Caribbean regarding their attitudes about culture and health.

In order to participate in this study, you must meet ALL of the following criteria:

- 1) born in the United States
- 2) both parents born and raised in a West African or Caribbean country (non-Spanish speaking)
- 3) at least 18 years old
- 4) lived in the United States for the majority of your life (i.e., more than $\frac{3}{4}$ of life)

If you meet the criteria, the next steps are to read the following informed consent form that will explain confidentiality and privacy regarding participation in this study as well as any potential concerns that may arise. Then you will complete a few questionnaires. After completing the questionnaires, you will read an online statement that will explain the nature of the study, which will include contact information to obtain more information if desired. Your participation is voluntary and you may withdraw at any time. If you prefer to complete a paper and pencil version, please contact Claudette Williamson-Taylor at cew205@lehigh.edu

Thank you again for your interest in this study!

Claudette Williamson-Taylor, M. Ed.
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Appendix B (paper and pencil version)

Instructions to Participants

Dear Participant:

You have been invited to participate in an online dissertation study conducted by Claudette Williamson-Taylor at Lehigh University. The purpose of this study is to gather information from Black adults whose parents were born in West Africa or the Caribbean regarding their attitudes about culture and health.

In order to participate in this study, you must meet ALL of the following criteria:

- 1) born in the United States
- 2) both parents born and raised in a West African or Caribbean country (non-Spanish speaking)
- 3) at least 18 years old
- 4) lived in the United States for the majority of your life (i.e., more than ¾ of life)

If you meet the criteria, the next steps are to read the following informed consent form that will explain confidentiality and privacy regarding participation in this study as well as any potential concerns that may arise. Please sign both forms and keep one for your records and place the other one in the attached envelope. You will then complete a few questionnaires. Your participation is confidential and you may withdraw at any time. If you have any questions, please contact Claudette Williamson-Taylor at cew205@lehigh.edu

Thank you again for your interest in this study!

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Appendix C (online version)

Informed Consent

I, _____ agree to participate in a dissertation study, which examines culture and health of adults whose parents were born and raised in West Africa or the Caribbean (sometimes referred to as “second generation”) conducted by Claudette Williamson-Taylor, under the advisement and supervision of Dr. Tina Q. Richardson.

It has been explained to me that the purpose of this to study is to learn more about Black second generation individuals’ attitudes regarding their cultural experiences and health.

The procedures used in this study will be self-report, which will require that I complete one demographic form and four brief questionnaires that will assess my views on health as well as my cultural experiences. I understand that this participation will require approximately 15 minutes of my time.

This study may produce a variety of feelings related to experiences as a second generation individual as well as reactions to racist-related events. I understand that the risks to me associated with this study are minimal, and nothing in this study will cause me any physical harm. If I experience any discomfort, I may contact the University Counseling Center associated with Lehigh University at (610) 758-3880 to seek more assistance or referrals.

I understand that I will not receive any direct benefits or be compensated for participation in this study; yet, sharing my cultural experiences will help to benefit others as well as be beneficial to myself.

I understand that my answers will remain anonymous and confidential and cannot be traced in anyway.

I understand that participation is voluntary, and I may withdraw from this study at any time.

If I have any question about this study and what is expected of me, I may call Dr. Tina Q. Richardson at (610) 758-3269.

I understand that I may report problems that may result from my participation to the Office of Research and Sponsored Programs at Lehigh University at (610) 758-3024.

I have read and understand the forgoing information.

.

Appendix D (paper and pencil version)

Informed Consent

I, _____ agree to participate in a dissertation study, which examines culture and health of adults whose parents were born and raised in West Africa or the Caribbean (sometimes referred to as “second generation”). This study is conducted by Claudette Williamson-Taylor, under the advisement and supervision of Dr. Tina Q. Richardson. It has been explained to me that the purpose of this study is to learn more about Black second generation individuals’ attitudes regarding their cultural experiences and health.

The procedures used in this study will be self-report, which will require that I complete one demographic form and four brief questionnaires that will assess my views on health as well as my cultural experiences. I understand that this participation will require approximately 15- 20 minutes of my time.

This study may produce a variety of feelings related to my experiences as a second generation individual as well as reactions to racist-related events. I understand that the risks to me associated with this study are minimal, and nothing in this study will cause me any physical harm. If I experience any discomfort, I may contact the University Counseling Center associated with Lehigh University at (610) 758-3880 to seek more assistance or referrals.

I understand that I will not receive any direct benefits or be compensated for participation in this study; yet, sharing my cultural experiences will help to benefit others as well as be beneficial to myself.

I understand that my answers will remain confidential and the survey packet will be assigned a number for record keeping and to ensure that any identifying information (i.e. name) will not be matched with my responses.

I understand that participation is voluntary, and I may withdraw from this study at any time.

If I have any question about this study and what is expected of me, I may call Dr. Tina Q. Richardson at (610) 758-3269.

I understand that I may report problems that may result from my participation to the Office of Research and Sponsored Programs at Lehigh University at (610) 758-3024.

I have read and understand the information above.

Date

Participant’s Signature

Date

Investigator’s Signature

Appendix E

Debriefing Statement

Thank you for taking the time to participate in this study. I would like to explain this study to you.

Research regarding the health of second generation individuals is scarce. As the United States population becomes more diverse because of the increased numbers of immigrants from Africa and the Caribbean, the numbers of their children who are born and raised in the United States continues to grow daily. Health care and mental health providers are learning how important it is to examine how factors such as racial identity, ethnic identity, and racism influence perceptions of what control they have over their health. This is especially important given the bicultural identity SGIs may have.

I appreciate you sharing your experiences with me, and I ask that you do not share this statement or the contents of the study with others in order to prevent biased responses and collect accurate data. If you have any questions or concerns, please do not hesitate to contact me. I also welcome any feedback you may have.

Thank you again!

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Appendix F

Demographic Questionnaire

Please check one

Age: _____

Gender: M _____ F _____

Marital/Relationship status:

Single _____ Married/Union _____ Divorced _____ Separated _____

Widowed _____

Years you have lived in the United States: _____

Highest degree earned:

High school diploma _____ Associates _____ Bachelors _____

Masters _____ Doctorate _____

Annual household income:

Below 30,000 _____

30,000 – 49,999 _____

50,000 -84,999 _____

85,000 – 124,999 _____

125,000 + _____

Employed: Yes _____ No _____ If yes, please list occupation _____

Student Status: Full time _____ Part-time _____

Not enrolled/does not apply _____

If you are currently enrolled, please indicate the following: Undergraduate: _____

Graduate _____

Religion:

Christian _____ Muslim _____ Buddhist _____ Jewish _____ Hindu _____

Atheist _____ Other (please specify) _____

What term would you use to describe your race? _____

What term would you use to describe your ethnicity? _____

What term would you use to describe your nationality? _____

Please share information about both of your parents. If one is unknown, type N/A. If any information is unknown type N/A

Parent #1- Mother

Country of origin:

Length of time living in the U.S. approximately (e.g., years, months):

Highest level of education completed: _____

Parent #2 -Father

Country of origin:

Length of time living in the U.S. approximately (e.g., years, months):

Highest level of education completed _____

Please share your combined annual income of your parents

Below 30,000 _____

30,000 – 49,999 _____

50,000 -84,999 _____

85,000 – 124,999 _____

125,000 + _____

In the past 12 months, how many times did you seek help from a medical or health care professional about your health (For example, primary care provider, health clinic professional, therapist/psychiatrist)? Enter a number:

In the past 12 months, how many times did you seek help from a healer about your health (For example, minister, organic/root doctor, spiritual leader)? Enter a number:

In general, how would you rate your health? Please circle one number.

1 poor 2 fair 3 good 4 very good 5 excellent

How did you hear about this study? Check one

Friend/family member _____

school listserve _____

organization listserve _____

Facebook _____

study investigator _____

community organization _____

medical office _____

other _____ please specify _____

Appendix G

Illness Attribution Scale

Instructions: The following is a list of factors believed to cause people to feel something is wrong with their body or mind or feel sick. This is also referred to as illness. Not all of them are equally important. Please mark on the scale (1 to 6) how important you think each of these factors is as a cause for illness ranging from 1 being totally disagree to six being totally agree.

Lifestyle subscale

Sleep (too little/much)							
Totally Disagree							Totally Agree
1	2	3	4	5	6		
Exercise (too little/much)							
Totally Disagree							Totally Agree
1	2	3	4	5	6		
Junk food							
Totally Disagree							Totally Agree
1	2	3	4	5	6		
Too much (little) food							
Totally Disagree							Totally Agree
1	2	3	4	5	6		
Vitamins shortage							
Totally Disagree							Totally Agree
1	2	3	4	5	6		
Non-adherence to medical recommendations							
Totally Disagree							Totally Agree
1	2	3	4	5	6		
Non-hygienic practices							
Totally Disagree							Totally Agree
1	2	3	4	5	6		
Unsafe sex							
Totally Disagree							Totally Agree
1	2	3	4	5	6		

Mystical subscale

God's Punishment							
Totally Disagree							Totally Agree
1	2	3	4	5	6		
Evil Eye							
Totally Disagree							Totally Agree
1	2	3	4	5	6		
Fate/destiny							
Totally Disagree							Totally Agree
1	2	3	4	5	6		
Chance							
Totally Disagree							Totally Agree
1	2	3	4	5	6		
Sinful thoughts/deeds							
Totally Disagree							Totally Agree
1	2	3	4	5	6		
Unexplained cause							
Totally Disagree							Totally Agree
1	2	3	4	5	6		

Appendix H

Multidimensional Inventory of Black Identity (MIBI) - Racial Centrality Subscale

Instructions: Please respond to the extent to which you agree or disagree with the following items. Please circle one number for each statement.

	Strongly Disagree		Neutral				Strongly Agree
Overall, being Black has very little to do with how I feel about myself.	1	2	3	4	5	6	7
In general, being Black is an important part of my self-image.	1	2	3	4	5	6	7
My destiny is tied to the destiny of other Black people.	1	2	3	4	5	6	7
Being Black is unimportant to my sense of what kind of person I am.	1	2	3	4	5	6	7
I have a strong sense of belonging to Black people.	1	2	3	4	5	6	7
I have a strong attachment to other Black people.	1	2	3	4	5	6	7
Being Black is an important reflection of who I am.	1	2	3	4	5	6	7
Being Black is not a major factor in my social relationships.	1	2	3	4	5	6	7

Appendix I

The Multigroup Ethnic Identity Measure (MEIM)

In this country, people come from many different countries and cultures, and there are many different words to describe the different backgrounds or ethnic groups that people come from. Some examples of the names of ethnic groups are Jamaican, Nigerian, Liberian, Guyanese, and many others. These questions are about your ethnicity or your ethnic group and how you feel about it or react to it.

Please fill in: In terms of ethnic group, I consider myself to be _____

Use the numbers below to indicate how much you agree or disagree with each statement.

(4) Strongly agree (3) Agree (2) Disagree (1) Strongly disagree

1- I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs.

(4) Strongly agree (3) Agree (2) Disagree (1) Strongly disagree

2- I am active in organizations or social groups that include mostly members of my own ethnic group.

(4) Strongly agree (3) Agree (2) Disagree (1) Strongly disagree

3- I have a clear sense of my ethnic background and what it means for me.

(4) Strongly agree (3) Agree (2) Disagree (1) Strongly disagree

4- I think a lot about how my life will be affected by my ethnic group membership.

(4) Strongly agree (3) Agree (2) Disagree (1) Strongly disagree

5- I am happy that I am a member of the group I belong to.

(4) Strongly agree (3) Agree (2) Disagree (1) Strongly disagree

6- I have a strong sense of belonging to my own ethnic group.

(4) Strongly agree (3) Agree (2) Disagree (1) Strongly disagree

7- I understand pretty well what my ethnic group membership means to me.

(4) Strongly agree (3) Agree (2) Disagree (1) Strongly disagree

8- In order to learn more about my ethnic background, I have often talked to other people about my ethnic group.

(4) Strongly agree (3) Agree (2) Disagree (1) Strongly disagree

9- I have a lot of pride in my ethnic group.

(4) Strongly agree (3) Agree (2) Disagree (1) Strongly disagree

10- I participate in cultural practices of my own group, such as special food, music, or customs.

(4) Strongly agree (3) Agree (2) Disagree (1) Strongly disagree

11- I feel a strong attachment towards my own ethnic group.

(4) Strongly agree (3) Agree (2) Disagree (1) Strongly disagree

12- I feel good about my cultural or ethnic background.

(4) Strongly agree (3) Agree (2) Disagree (1) Strongly disagree

Appendix J

SCHEDULE OF RACIST EVENTS

We are interested in your experience with racism. As you answer the questions below, please think about your ENTIRE LIFE, from when you were a child to the present. For each question, first please circle the number that best captures the things that have happened to you. Answer each question once for what YOUR ENTIRE LIFE HAS BEEN LIKE. Use these numbers:

- Circle 1 = If this has NEVER happened to you
- Circle 2 = If this has happened ONCE IN A WHILE (less than 10% of the time)
- Circle 3 = If this has happened SOMETIMES (10-25% of the time)
- Circle 4 = If this has happened A LOT (26% - 49% of the time)
- Circle 5 = If this has happened MOST OF THE TIME (50 – 70% of the time)
- Circle 6 = If this has happened ALMOST ALL OF THE TIME (more than 70% of the time)

Then rate how stressful each event was for you by circling the number on a scale ranging from 1 to 6 with 1 being not at all to 6 being extremely.

1. How many times have you been treated unfairly by *teachers and professors* because you are Black?

How many times in your entire life? 1 2 3 4 5 6
Not at all Extremely
How stressful was this for you? 1 2 3 4 5 6

2. How many times have you been treated unfairly by your *employers, bosses and supervisors* because you are Black?

How many times in your entire life? 1 2 3 4 5 6
Not at all Extremely
How stressful was this for you? 1 2 3 4 5 6

3. How many times have you been treated unfairly by your *coworkers, fellow students and colleagues* because you are Black?

How many times in your entire life? 1 2 3 4 5 6
Not at all Extremely
How stressful was this for you? 1 2 3 4 5 6

4. How many times have you been treated unfairly by *people in service jobs* (store clerks, waiters, bartenders, bank tellers and others) because you are Black?

How many times in your entire life? 1 2 3 4 5 6
Not at all Extremely
How stressful was this for you? 1 2 3 4 5 6

5. How many times have you been treated unfairly by *strangers* because you are Black?

How many times in your entire life? 1 2 3 4 5 6
Not at all Extremely
How stressful was this for you? 1 2 3 4 5 6

6. How many times have you been treated unfairly by *people in helping jobs* (doctors, nurses, psychiatrists, case workers, dentists, school counselors, therapists, social workers and others) because you are Black?

How many times in your entire life? 1 2 3 4 5 6
Not at all Extremely
How stressful was this for you? 1 2 3 4 5 6

7. How many times have you been treated unfairly by *neighbors* because you are Black?

How many times in your entire life? 1 2 3 4 5 6
Not at all Extremely
How stressful was this for you? 1 2 3 4 5 6

8. How many times have you been treated unfairly by *institutions* (schools, universities, law firms, the police, the courts, the Department of Social Services, the Unemployment Office and others) because you are Black?

How many times in your entire life? 1 2 3 4 5 6
Not at all Extremely
How stressful was this for you? 1 2 3 4 5 6

9. How many times have you been treated unfairly by *people that you thought were your friends* because you are Black?

How many times in your entire life? 1 2 3 4 5 6
Not at all Extremely
How stressful was this for you? 1 2 3 4 5 6

10. How many times have you been *accused* or *suspected of doing something wrong* (such as stealing, cheating, not doing your share of the work, or breaking the law) because you are Black?

How many times in your entire life? 1 2 3 4 5 6
Not at all Extremely
How stressful was this for you? 1 2 3 4 5 6

11. How many times have people *misunderstood your intentions and motives* because you are Black?

How many times in your entire life? 1 2 3 4 5 6
Not at all Extremely
How stressful was this for you? 1 2 3 4 5 6

12. How many times did you want to *tell someone off for being racist but didn't say anything*?

How many times in your entire life? 1 2 3 4 5 6
Not at all Extremely
How stressful was this for you? 1 2 3 4 5 6

13. How many times have you been *really angry about something racist that was done to you*?

How many times in your entire life? 1 2 3 4 5 6
Not at all Extremely
How stressful was this for you? 1 2 3 4 5 6

14. How many times were you *forced to take drastic steps* (such as filing a grievance, filing a lawsuit, quitting your job, moving away, and other actions) to deal with some racist thing that was done to you?

How many times in your entire life? 1 2 3 4 5 6
Not at all Extremely
How stressful was this for you? 1 2 3 4 5 6

15. How many times have you been *called a racist name like nigger, coon, jungle bunny or other names*?

How many times in your entire life? 1 2 3 4 5 6
Not at all Extremely
How stressful was this for you? 1 2 3 4 5 6

16. How many times have you *gotten into an argument or a fight about something racist that was done to you or done to somebody else*?

How many times in your entire life? 1 2 3 4 5 6
Not at all Extremely
How stressful was this for you? 1 2 3 4 5 6

17. How many times have you been *made fun of, picked on, pushed, shoved, hit or threatened with harm* because you are Black?

How many times in your entire life?	1	2	3	4	5	6
	Not at all			Extremely		
How stressful was this for you?	1	2	3	4	5	6

18. How *different* would your life be now if you *HAD NOT BEEN* treated in a racist and unfair way:

In your entire life?					
Same	A Little	Different	Different	Different	Totally
As now	different	a few ways	in a lot of ways	most ways	different
1	2	3	4	5	6

Biography

Claudette Williamson-Taylor was born in Baltimore, Maryland. She received her undergraduate degree in psychology with a women's studies concentration from the University of Maryland in 2002. After completing her degree, she conducted research and impact evaluation work on youth and families in nonprofit organizations and academic institutions in Baltimore. In 2005, she enrolled in a counseling psychology doctoral program at Lehigh University where she also received her master's degree in Counseling and Human Services. For three years, she served as the doctoral student representative for the Counseling Psychology program at Lehigh University and member of its College of Education Student Life Enhancement Committee in collaboration with the dean of the College. She has often presented at national and international conferences as well as local workshops. She has contributed to scholarly work and outreach on multicultural issues such as co-authoring a book chapter in the *Handbook of Multicultural Counseling* and providing peer mentoring through the Committee on Ethnic Minority Affairs of the American Psychological Association, which she holds a professional membership. Her clinical and work experiences include interagency collaboration, traumatic loss, women's issues, and multicultural influences on identity development. Currently, she is doctoral candidate completing her predoctoral internship at the University of Florida Counseling and Wellness Center.