COPING WITH DISCRIMINATION: AN INVESTIGATION OF MENTAL AND PHYSICAL HEALTH OF AFRICAN AMERICANS AND AFRO-CARIBBEANS

A Thesis

Presented to the faculty of the Department of Sociology

California State University, Sacramento

Submitted in partial satisfaction of the requirements for the degree of

MASTER OF ARTS

in

Sociology

by

Joanie Marie Mitchell

SUMMER 2015
COPING WITH DISCRIMINATION: AN INVESTIGATION OF MENTAL AND PHYSICAL HEALTH OF AFRICAN AMERICANS AND AFRO-CARIBBEANS

A Thesis

by

Joanie Marie Mitchell

Approved by:

Ava Kimura Ida, PhD., Committee Chair

Manual Barajas, PhD., Second Reader

Date

August 3, 2015

ii
Student: Joanie Marie Mitchell

I certify that this student has met the requirements for format contained in the University format manual, and that this thesis is suitable for shelving in the Library and credit is to be awarded for the thesis.

Manuel Barajas, Ph.D.

, Graduate Coordinator 8-3-15
Date

Department of Sociology
Abstract

doCoping with Discrimination: An Investigation of Mental and Physical Health of African Americans and Afro-Caribbeans

by

Joanie Marie Mitchell

This research utilized data from the National Survey of American Life (NSAL) to examine the effect of discrimination on health among various sub-groups in the black population: African American and Afro-Caribbean women and men. The stress process model was used to investigate whether anger inflicted by discrimination, had a negative impact on mental and physical health. In addition, the stress process model was also used to investigate protective influence of various forms of coping in face of such an unfair treatment. Results indicated that anger inflicted by discrimination was indeed harmful for one’s health consistently across the gender and ethnic subgroups in the black population except for Afro-Caribbean men. In addition, the most common forms of coping were not necessarily helpful in reducing the negative impacts of discrimination on health or promoting health directly.
The importance of more systematic and long-term focused research on coping with discrimination to reduce the negative health effects of anger is discussed.

Ayako Kimura Ida, Ph.D.  Committee Chair

August 3, 2015  Date
ACKNOWLEDGEMENTS

First and foremost, I am grateful to God for the many blessings along this journey. They have come in many ways including the various forms of support from professors, colleagues in the program, family and friends.

I would like to express my most sincere gratitude and endless appreciation to my thesis chair, Dr. Aya Kimura Ida. Words cannot convey how fortunate I feel for your patience, passion, brilliance, motivation and your unwillingness to ever give up on me. Thank you for always making time for me no matter how busy your schedule was. Your guidance has been priceless and I could not have envisioned a better mentor for this project. Thank you for being my thesis chair, advisor, role model, and friend.

Thank you to my second reader, Dr. Manuel Barajas. Your insightful feedback and encouragement were most appreciated. Your passion for what you do is an inspiration. Thank you for always sharing your boundless wisdom.

I would also like to thank Dr. Elvia Ramirez for encouraging me years ago to use my voice for progressive change no matter how small the platform or how many people in the room would be against me. I follow your work in awe and hope to one day help both students and society the way you do.

In addition to these amazing professors, I would like to express my love and gratitude to my dear friend, Yesenia Sandoval-Lopez. Your support has come in so many forms.
You have stood with me in every decision I have made these last few years without judgment or criticism, while continuously offering understanding and careful discernment. You are an incredible friend, researcher, mother, wife, activist and quiet force. Please never forget that. Nothing I have been able to accomplish would have been possible without you. You gave me courage when I had none. Thank you for being in my corner.

Last but not least, I would like to thank the numerous family and friends who helped me through this process. Lisa, your gentle nudges have been invaluable. Mama Terry, thank you for reminding me what it meant to complete this project. Thank you to so many who helped by offering encouragement and believing in me.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgements</td>
<td>vi</td>
</tr>
<tr>
<td>List of Tables</td>
<td>ix</td>
</tr>
<tr>
<td>List of Figures</td>
<td>x</td>
</tr>
<tr>
<td><strong>Chapter</strong></td>
<td></td>
</tr>
<tr>
<td>1. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>2. LITERATURE REVIEW</td>
<td>8</td>
</tr>
<tr>
<td>3. METHODS</td>
<td>25</td>
</tr>
<tr>
<td>4. RESULTS</td>
<td>31</td>
</tr>
<tr>
<td>5. DISCUSSION</td>
<td>40</td>
</tr>
<tr>
<td>Appendix A. Correlation Analyses for African American Women and Men</td>
<td>46</td>
</tr>
<tr>
<td>Appendix B. Correlation Analyses for Afro-Caribbean Women and Men</td>
<td>46</td>
</tr>
<tr>
<td>References</td>
<td>47</td>
</tr>
</tbody>
</table>
LIST OF TABLES

<table>
<thead>
<tr>
<th>Tables</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Table 1. Measurement Descriptions and Comparisons of Means and Proportions: The National Survey of American Life</td>
<td>31</td>
</tr>
<tr>
<td>2. Table 3. Regression Models Predicting Mental Health: Effects of Anger</td>
<td>34</td>
</tr>
<tr>
<td>3. Table 4. Regression Models Predicting Physical Health: Effects of Anger</td>
<td>35</td>
</tr>
<tr>
<td>4. Table 5. Regression Models Predicting Mental Health: Effects of Coping</td>
<td>36</td>
</tr>
<tr>
<td>5. Table 6. Regression Models Predicting Physical Health: Effects of Coping</td>
<td>38</td>
</tr>
</tbody>
</table>
CHAPTER 1
INTRODUCTION

Perceived discrimination is a unique form of stress experienced by ethnic minorities, woman and other socially subordinate groups in the United States (Brown et al. 2010; Brondolo et al. 2008; Williams 2003; Williams 2002; Noh et al. 1999; Williams, et al. 1997; Ruggiero and Taylor 1995). When facing discrimination, individuals engage in various types of coping strategies to prevent this stress from interfering with their daily lives, and ultimately, from affecting their mental and physical health. By focusing on the Black population in the United States, this thesis aimed to 1) test whether anger inflicted by discrimination will exacerbate one’s health, 2) identify the potential ethnic and gender variations in some of the most commonly used coping strategies in the face of discrimination, and 3) examine if these coping strategies are beneficial in protecting overall mental and physical health.

This study was important for several reasons. First, it was important to understand the factors that impact health of Black Americans. Studies have shown that Black Americans report worse health outcomes compared to other racial groups (Williams and Mohammed 2009; Williams, Neighbors, and Jackson 2003). Black Americans suffer from worse mental and physical health conditions and possess less access to healthcare than Whites in the U.S. (Pasco and Richman 2009; Pearlin et al. 2005). Despite a great deal of previous research that has focused on behavioral choices as a possible source of worse health outcomes, research that focused on social conditions as well as behavioral choices often acknowledged the role of stress in these worse health
outcomes (Pearlin et al. 2005). A person’s mental and physical health can be affected adversely by stress (Kleinke 2007; Pearlin 1985). Daily hassles and major life events can produce stress that can worsen health over a period of time. When daily encounters with discrimination are conceptualized as a source of stress, Blacks in the United States are at higher risk of lowered life satisfaction and deteriorated health (Broman, Mavaaddat and Hsu 2000; Broman 1997; Krieger 1996). This study has identified the risk and protective factors of Black American’s health and wellbeing.

Second, more studies were necessary to fully understand the role that coping response plays in enhancing or limiting one’s health (Thoits 1995; Folkman 1984). When we experience stress in our lives, we engage in different types of cognitive and behavioral responses in order to cope. These responses are efforts made by a person to manage external situations that are stressful, commonly referred to as coping strategies (Monat and Lazarus 1985). Based on common social norms, a given coping response may be perceived as being negative or positive behavior choice in society (Monat and Lazarus 1985). For example, in the United States, managing stress by smoking, overeating, or being angry are seen as negative, while seeking professional help from a therapist or social support from loved ones is often seen as positive ways to deal with stress. However, the ways in which individuals cope may have more to do with their social location in society and what forms coping are available to them as a result of that status (Thoits 1995; Monat and Lazarus 1985; Folkman 1984; Pearlin 1978). Therefore, due to inequality and variations of norms surrounding one’s status, he/she may or may not have access to the socially appropriate ways of coping. Rather than relying on social
norms to define what is considered as appropriate ways of coping, the nature of a coping strategy should be investigated based on how effective it is in promoting health (West, Donovan and Roemer 2010; Greer 2010; Klienke 2007). Positive coping will result in better mental and even physical health, while negative coping would be those behaviors that ultimately prove damaging to one’s overall health.

Third, this study has added to the previous literature on coping by focusing on coping styles used by minorities in the face of discrimination. A great deal of coping research has focused on how individuals cope with everyday stress at work, in marriage, while raising children, and being in public or crowded places (Thoits 1995; Pearlin 1985; Pearlin and Schooler 1978). Some research specifically addresses the ways in which people cope with unforeseen circumstances such as health problems, terminal illnesses in the family, issues from aging, and death. There is limited research, however, that focuses on coping styles used when minorities experience discrimination. Research that focused on ethnic minority groups’ coping has explored the variation of coping strategies used (Brown et al. 2010; Forsyth and Carver 2012). However, more research was necessary to understand how effective coping strategies are as possible positive facilitators to physical and mental health. Daily discrimination is a common experience of many Blacks in the United States that has been found to lower life satisfaction and deteriorate health (Broman, Mavaaddat and Hsu 2000; Broman 1997; Krieger 1996). By focusing on Blacks, this paper has enhanced knowledge about health outcomes potentially influenced by specific types of coping style in the face of discrimination.
Fourth, this study focused on discrimination as a stressor, allowing for an investigation of anger as a form of stress. Previous research has focused on discrimination and racism as forms of stress, or as stressors not attached to a specific form of stress (Pasco and Richman 2009, Paradies 2006; Noh 2003; George and Lynch 2003; Contrada et al. 2000). However, this paper aimed to explore an understandably common outcome when an individual faces discrimination: anger. Anger is a form of stress in that it affects a person mentally and physically. It is a common response to discrimination, both in the form of being expressed anger and repressed anger (Williams 2008; Brown 2003). By focusing specifically on anger as a form of stress, this paper added to the understanding of one common outcome of discrimination and its health outcome.

Fifth, this study investigated often-neglected ethnic group variations among Blacks in the United States: African Americans and Afro-Caribbeans. Ethnicity refers to a group that has a shared culture and ancestral heritage (Caldwell, Guthrie, and Jackson 2006; Waters 1991). This is different from race, which refers to a social category of identification primarily based on of physical attributes (Caldwell, Guthrie, and Jackson 2006; Waters 1999; Waters 1991). “Blacks” is the term used in this research to refer to people of African decent in the United States. Coping research on Blacks has been focused primarily on the experiences of African Americans as a racial group, specifically in institutions (such as colleges) where racial identity and the regular experiences of racial discrimination are more openly discussed (Scott 2003). There is also an abundance of research focused on coping with discrimination among African Americans, again as a
racial group, in relation to their quality of life and well-being (Greer 2010; Utsey et al. 2000). Still, no research up to this point addressed possible variations in coping between ethnic groups within the racial category of Blacks in the United States. Using the National Survey of American Life, which contains data from African American and Afro-Caribbeans, this research sought to understand whether there were differences in types of coping styles used and effectiveness of the coping styles between the two groups.

African Americans and Afro-Caribbeans are often lumped together as one racial group, Blacks in the United States. However, they have important cultural, historical, and socioeconomic differences. As an ethnic group, Afro-Caribbeans have higher socioeconomic statuses, levels of education and better physical health outcomes than African Americans who are born in the United States (Logan 2007). Afro-Caribbean populations are also comprised of many newly immigrated people, creating a different life experience from African-Americans that have several generations in the same country (Logan 2007). The Afro-Caribbean population continues to grow in the United States (Caldwell, Guthrie, and Jackson 2006; Waters 1991). As this happens, more research should focus on the diversity of experiences between ethnic groups within the racial category of Black Americans. It is possible that the two groups face a similar frequency of racial discrimination, but may practice different coping strategies. It is also possible that there are variations in how African Americans and Afro-Caribbeans respond to experiences of perceived discrimination due to the different socioeconomic circumstances.
Finally, this study contributed to the body of research on how men and women cope differently. This research investigated potential gender differences in coping strategies in the face of discrimination and as well as the possibility of differential impact of the coping mechanism on health outcomes by gender. Research has shown within Whites and Black populations that women are more likely than men to utilize coping styles that rely on social support, including talking with family and friends about their experiences (Brown et al. 2011; Greer 2010; Williams 2003). Additionally, African-American women often utilize spiritual support, such as prayer, when coping with discrimination (Greer 2010; West, Donovan and Roemer 2010; Shorter-Gooden 2004; Utsey et al. 2000). Very little research has been produced regarding potential gendered pattern for Afro-Caribbean adults when dealing with perceived discrimination. A small amount of the available research is focused on Afro-Caribbean youth coping with discrimination as newer generations in the United States, with a short introduction into the differences between young men and young women (Caldwell, Guthrie and Jackson 2006). It is imperative that research be conducted to understand the differences in gender where coping is concerned. For this reason, this research considered the role of gender in the analysis of coping and health.

In summary, the purpose of this study was to investigate the kinds and effectiveness of coping strategies African Americans and Afro-Caribbeans used when experiencing discrimination. More specifically, I examined 1) whether stress, namely anger, resulting from discrimination would harm Black American’s health; 2) whether there was any ethnic and/or gender difference in the coping strategies used in face of
discrimination; and 3) if there were any associations between coping strategies used and overall physical and mental health ratings.
CHAPTER 2

LITERATURE REVIEW

In this chapter, I present a review of literature on diversity in the Black American population, the stress process model, discrimination as a stressor, and coping with discrimination.

*Diversity Among Black Populations In The United States – African American And Afro-Caribbeans*

While African Americans and Afro-Caribbeans are often lumped together as Black Americans, research has shown that these two groups have important differences (Shaw-Taylor and Hutch 2007; Logan 2007; Caldwell, Guthrie, and Jackson 2006; Waters 1991). The research on diversity of Black Americans in the U.S. has examined differences among African Americans, Afro-Caribbeans, and Africans who were born in Africa and immigrated to the United States. For the purpose of this study, the primary focus was on African Americans and Afro-Caribbeans as two distinct ethnic groups in one racial category. African American refers to Americans who trace their ancestry to Africa, but is commonly applied to all Blacks in the United States. Afro-Caribbeans are people who identify ethnically as having a cultural and ancestral foundation from the Caribbean (e.g. Jamaica, West Indies, Haiti), but whose heritage is primarily traced to Africa (Jackson et al. 2004; Caldwell, Guthrie, and Jackson 2006; Shaw-Taylor 2007; Logan 2007). Racial groups are defined by the socially constructed similarities of physical attributes (e.g., skin color, eye shape, hair color and form) while ethnic groups
are defined through socially constructed similarities of cultural attributes (e.g., language, customs, and beliefs) and ancestral heritage (Caldwell, Guthrie, and Jackson 2006; Waters 1999; Waters 1991). Therefore, in the United States, African Americans and Afro-Caribbeans are often treated as the same racial group of “blacks” based on the socially constructed similarities of physical attributes, even though each group claims unique cultural and ancestral identities.

It has long been shown that Blacks in the U.S. have a lower socioeconomic status than Whites or Asians. Yet, such studies tend to ignore the fact that there are socioeconomic differences between African Americans and Afro-Caribbeans. Based on information from the 1990 U.S. Census, African Americans had lower median household incomes, less years of education and higher rates of both unemployment and poverty than Afro-Caribbeans (Shaw-Taylor and Hutch 2007; Logan 2007). The gaps remained consistent ten years later, even with increases in median household income and college educations and decreases in unemployment and poverty for both groups (Logan 2007). One area where African Americans fair better than Afro-Caribbeans is home ownership. This may be due to the areas of the country where Afro-Caribbean live, which tends to be cities where home ownership is limited, such as New York (Logan 2007). It may also be a reflection of African Americans’ benefit of living the U.S. for more generations, as Afro-Caribbeans tend to be recent immigrants themselves or descendants of recent immigrants (Shaw-Taylor and Hutch 2007; Logan 2007). U.S. Census 2010 estimated that close to 4 million recent immigrants were from Caribbean countries (Acosta and de
la Cruz 2011). In addition, the largest population of Black immigrants is from the Caribbean, not Africa (Shaw-Taylor and Tuch 2007).

In addition to aforementioned differences in economic capital, it was important to explore the role of social capital and cultural capital maintain socio-economic gaps distance between African Americans and Afro-Caribbeans (Shaw-Taylor and Tuch 2007; Waters 1999; Waters 1991). Cultural capital is the ability to know and behave in ways that reflect the value system of the dominant culture (Shaw-Taylor and Tuch 2007). Because the United States is a racialized and capitalist society, knowing how to navigate social life as a minority among the mainstream population to gain wealth is very important. As Afro-Caribbeans increase their knowledge in this area, they loose much of their “otherness” and increase their social capital and cultural capital, which may lead to an increase in economic capital (Shaw-Taylor and Tuch 2007; Waters 1999; Waters 1991). Social capital refers to the social networks people are able to develop that help them gain access to economic success ((Shaw-Taylor and Tuch 2007). With regard to social capital, Afro-Caribbeans have been found to better develop social capital, and more economic power because they are viewed by white business owners as being more hard working and more reliable than African Americans (Shaw-Taylor and Tuch 2007; Logan 2007; Waters 1999; Waters 1991). There is also evidence that African Americans and Afro-Caribbeans socially distance themselves from immigrant populations, and this distance creates more distinct experiences in capital attainment among Black Americans (Shaw-Taylor and Tuch 2007; Jackson and Cothran 2003). This social distance felt between these two groups may prevent extending social networks into each other’s
communities, allowing for the consequences of Afro-Caribbeans not sharing social capital within Black communities, from which they often segregate themselves (Jackson and Cothran 2003; Waters 1999; Waters 1991).

Social distancing between African Americans and Afro-Caribbeans as a result of believing stereotypes about the other group is another important factor in the difference experiences of the two groups as Blacks in the United States. A survey-based study found that African Americans and Caribbean Americans experience social distance from another in terms of close personal relationships (Jackson and Cothran 2003). The two groups tend to believe negative stereotypes about each other, and have little knowledge about each other outside of those stereotypes (Jackson and Cothran 2003; Waters 1991). This lack of personal relationships between African Americans and Afro-Caribbeans negotiates a lack of shared experiences in the United States. In addition, African Americans and Afro-Caribbean report distinct relationships, negative stereotypes and a lack of knowledge about their similarities between the two groups (Jackson and Cothran 2003; Waters 1999; Waters 1991). This social distance between the two ethnic groups further reveals areas where their experiences in the United States vary, and it may be that their experiences with discrimination are different as well.

Differences exist between African-Americans and Afro-Caribbeans with consideration to identity formation (Jackson and Cothran 2003; Waters 1999; Waters 1991). It has been found that most Blacks in the United States do not have ancestral knowledge as a part of their identity (Waters 1999). Historically, this has been a result of having African culture stripped away as a means of controlling slaves as labor and later
on, in response to the “one drop rule” that gave Blacks only one ethnic and racial identity options, regardless of their potential mix (Caldwell, Guthrie, and Jackson 2006; Waters 1999; Waters 1991). For this reason, Black identity tends to be seen as synonymous with African-American identity. Foreign-born Blacks, despite being identified as Black in the United States, are more likely to identify with specific ancestry than African-Americans. As a group consisting of relatively recent immigrants and their descendants in the United States, Afro-Caribbeans also see their identity as distinctly Caribbean and different from other Blacks in the United States (Caldwell, Guthrie, and Jackson 2006; Waters 1999; Waters 1991). Since 1965, immigration from Africa and the Caribbean has increased as a result of the Immigration and Naturalization Act of 1965 (Waters 1991; Waters 1999). This increase in population has meant changes for the second and third generations of Afro-Caribbeans. It is possible that more of the second- and third-generations relate to African Americans when it pertains to experiences of discrimination (Waters 1999).

Identity formation as a result of historical experiences is also a difference between African Americans and Afro-Caribbeans. African Americans were brought to the United States involuntarily. The end of slavery in the United States is often tied to the Civil War or the result of Abraham Lincoln ending slavery. Many Afro-Caribbeans identify with the Haitian Revolution (1791-1803), in which freedom from slavery was a result of rebellion ignited by slaves in Haiti (Waters 1999; Waters 1991). Afro-Caribbeans came to the United States voluntarily as well. This difference in identity as a result of how historical events are told to generations may result in a different response to discrimination as it is experienced today. In sum, as shown above, there were many
important factors leading to different social, psychological, historical, and cultural experiences between African Americans and Caribbean blacks, but these two groups have been lumped together as one racial group in the previous studies disregarding the within-group diversity. In this thesis, specific attention was paid to capture the potential differences between the two groups in terms of stress, coping, and health.

The Stress Process Model

The stress process model was used in this research to investigate the effects of anger when African Americans and Afro-Caribbean cope with discrimination. Pearlin (1989), a leading scholar of stress research in sociology, discussed that sociologists should seek to understand the structural influences on, as well as the outcomes of, stress in society. The stress process model demonstrates that exposure to stress can result in health problems and that the stressors are not distributed equally across all populations (Kathendalh and Parchmen 2002; Pearlin 1991; Pearlin 1989). Structural disadvantages tend to expose individuals to more stressors. Stressors refer to events or situations that give rise to stress (Monat and Lazarus 1985; Pearlin 1989). They are triggers for stress. Stress by definition, is any uncomfortable emotional experience accompanied by biochemical, physiological or behavioral changes. The more stressors one has in his/her life, the more stress he/she must manage, and the more likely that he/she will develop health problems. However, not everyone will inevitably develop health problems due to experience of stress. Some cope with stress more effectively and mitigate the detrimental effects of stress while others are not able to cope with the stress as effectively, resulting
in worsening health level (Pearlin et al. 1981). *Coping* refers to behavioral and cognitive efforts to manage the stressful, threatening, and/or harmful situations (Monat, Lazarus, and Reevey 2007; Folkman 1984; Pearlin et al. 1981).

In this study, I conceptualized anger as a form of stress one may experience after facing a discriminatory treatment (i.e., stressors). Anger is a common response to discrimination (Williams 2008; Brown 2003). It can be expressed anger where the person lets it be known that they are angry about the incident or it can be repressed when the individual chooses not to express the anger (Williams 2008; Brown 2003). Researchers have shown that stress resulting from discrimination can worsen physical and mental health (Perry, Harp and Oser 2013; Williams 2009; Williams 2003; Williams 2002). However, it is important to note that most studies on discrimination and health automatically assume experience of discrimination itself as stress rather than recognizing that it is in fact a stressor. This study focused on anger as a stress response to discrimination as a stressor. Anger is a form of stress in that it may potentially harm one’s physical and mental health. I also examined the role of coping mechanisms in alleviating the effects of anger caused by discrimination.

*Discrimination as a Stressor.* Research about health and discrimination place special emphasis on the fact that discrimination is a form of stressor that disproportionately targets minorities (Williams and Mohammed 2009; Krieger and Sidney 1996; McNeilly et al. 1996; Krieger 1990). Blacks experienced more forms of stressors than Whites, often as a result of racial discrimination and socioeconomic status differences (George and Lynch 2003). Women who hold a racial minority status face
stress from discriminatory acts that negatively impacts health (Anderson 2013; Perry, Harp and Oser 2013; Williams and Mohammed 2009; Williams 2003; Williams 2002; Contrada et al. 2000; Utsey 2000; Krieger 1990). It is shown that being a member of a marginalized racial group or being a woman means having common day-to-day life stressors and additional stressful experiences when facing discrimination (Utsey 2000; Krieger 1990). There are also stressors experienced by ethnic minorities and women that often have lasting effects and can lead to having lower socioeconomic status over a lifetime. These include discriminatory events such as being passed over for a job promotion or facing discrimination in purchasing a home in a nice neighborhood (Pearlin et al. 2005; Brown 2003; Utsey 2000). This, in fact, can cause more stress and more negative health outcomes as a result.

Discrimination is one source of stress experienced by racial minorities. However, it is important to note discrimination is not limited to overt actions. Racism in the U.S. has become covert, and systemic, ethnic discrimination occurs institutionally (such as in hiring practices) and in subtle forms in daily life (such as being followed in a store for being suspected of shoplifting) (Contrada et al. 2000; Bonilla-Silva 1997). In addition, a focus on discrimination must include the response to the discrimination experienced. There is evidence that these stresses play a key role in both the mental and physical health of ethnic minorities (Contrada et al. 2000). As mentioned previously, discrimination is associated with high blood pressure, depression, and anxiety (Pearlin et al. 2005; George and Lynch 2003; Krieger and Sydney 1996; Krieger 1990). In addition,
research has shown physical health behaviors, such as smoking, are also a common outcome to gender and race-related sources of stress (Pearlin et al. 2005).

Both African Americans and Afro-Caribbeans as members of the Black population have more health problems due to facing discrimination and the stress they experience as a result (Perry, Harp and Oser 2013; Williams and Mohammed 2009; Williams 2003; Williams 2002; Contrada et al. 2000; Utsey 2000; Krieger 1990). However, there is limited research, and therefore limited conclusion as to who faces more health threats as a result. One study found Afro-Caribbean men to have higher rates of mental health disorders, such as major depression and anxiety, than African Americans over a 12-month period (Williams 2007). In that same study, Afro-Caribbean women had lower risks for both lifetime and 12-month mental health issues than African American women (Williams 2007). Still, other key factors such as generation status and age at the time of immigration for Afro-Caribbeans were key factors in the mental health of the participants. First-generation Afro-Caribbeans had lower rates of mental health disorders than second- or third-generation Afro-Caribbeans, with third-generation reporting incredibly high levels of mental health problems compared to the two other groups (Williams 2007). There were mixed results in the same study pertaining to mental health and the age at the time of immigration among first-generation Afro-Caribbeans; however, those who immigrated between age 18 and 34 reported the lowest risk of mental health problems (Williams 2007). A pivotal outcome of this study was the recommendation to further explore how the stress of discrimination might be a leading cause of these mixed results. Due to the limited results and research, there have been few
conclusions about the relationship between the experiences as an Afro-Caribbean in the United States, exposure to stress as a result of discrimination, and possible coping used by this population.

Most of the health research up to this point has focused on African-Americans and the negative mental and physical health challenges. African-Americans have increase rates of diabetes, hypertension, obesity, major depression, and anxiety than Whites (Brown 2003; Williams, Neighbors and Jackson 2003; Krieger and Sidney 1996; Krieger 1990). African-American men in some studies have worse reported health than African-American women, with struggles relating to low socioeconomic status, marginalization at work, and less socially-acceptable forms of coping being accessible (Williams 2003).

Other studies focus on the discrepancies of health when focusing on African-American women. In addition to physical and mental health problems listed above, African-American women also reported lower birth weights that White women (Williams 2003). In addition, African-American women face possible additional physical and mental health outcomes in that they also experience sexism in society (Perry, Harp and Oser 2013). Some studies report higher levels of depression and anxiety over White women and men of all races (Williams 2002). As a sub-group, African-American women face discrimination in ways that other groups don’t as a result of the stereotypes about African-American women in society that have existed throughout history (Greer 2010). Images of African-American women, for instance, are often seen as angry, sexually
promiscuous, and violent all at the same time. It is no wonder this sub-groups may face discrimination in a different form from White women and African-American men.

For both African-American men and African-American women, perceived discrimination was found to be significant in relation to the health disparities. African-Americans were consistently in lower socioeconomic statuses that Whites, which has also been found to adversely affect overall health and access to healthcare (Broman, Mavaddat and Hsu 2000; Williams et al. 1997). In sum, discrimination for Blacks in the United States is an everyday occurrence, and it has important health consequences. Because daily exposure to stress can mean devastating negative ramifications on health, finding ways to manage the stress caused by discrimination is important.

When faced with discrimination, research shows one common outcome is expressed and repressed anger (Brondolo et al. 2009; Brown 2003; McNeilly et al. 1996). This emotional response, whether obvious to outsiders or not, reveals another threat to physical and mental health. As a marginalized group facing not just the social reality of discrimination, but also the effects of the common and expected response of anger, Blacks face possible compounded experiences that may be detrimental to their health. This is because hypertension, heart disease, and increased depression have all been associated with both discrimination and experiencing anger (Davidson and Mostofsky 2010, Chida and Steptoe 2009). Thus, appropriate coping might not just act as a buffer to health outcomes when dealing with discrimination, but also when handling ones' own emotions in the face of discrimination.
Coping with Stressors. There has been a great deal of research focused on understanding how people cope with stress in their lives. Coping is defined as "the efforts we take to manage situations we have appraised as being potentially harmful or stressful" (Monat, Lazarus, and Reevey 2007:282). These efforts can be both behavioral and cognitive (Folkman 1984). Researchers' efforts to define key features of coping have been expansive in the last four decades. Two forms of coping have been established through the research of Lazarus and Folkman (1984): problem-focused coping and emotion-focused coping (Kleinke 2007; Monat and Lazarus 1985; Folkman 1984).

Problem-focused coping can be both outward actions and inward directions. Outward actions include any response that is aimed at altering a situation. Inward problem-focused coping includes how people assess situations and reconsider personal attitudes of the situation being coped with in an effort to develop appropriate responses to the situation. In the case of inward problem-focused coping, the individual still performs some action toward the situation (Kleinke 2007; Monat and Lazarus 1985; Folkman 1984). Emotion-focused coping refers to coping styles that are focused on the relief of pain or stress caused by the situation, but with no effort on the part of the victim to alter the situation. The goal in emotion-focused coping is to relieve the impact of the stress on the person without addressing any change to the situation (Monat and Lazarus 1985; Folkman 1984). Emotion-focused coping can consist of actions to keep one's attention from the situation (such as prayer or meditation) or it refers to altering one's interpretation of the event or the significance of the situation, without any focus or attention paid to how to change the situation. In many cases, the latter definition is also
called “defense mechanisms” (Monat and Lazarus 1985). Much research emphasizes the effectiveness of problem-focused coping over emotion focused coping (Kleinke 2007; Holahan and Moos 1987; Pearlin and Schooler 1978). People who rationalized, practiced avoidance or denial, or blamed themselves for a situation all practiced emotion-focused coping and showed greater amounts of emotional distress and anxiety (Holahan and Moos 1987, Pearlin and Schooler 1978). Thus, it may be plausible to argue that people who use problem-focused coping when experiencing discrimination would better manage the resulted anger and maintain wellbeing, while people who use emotion-focused coping would struggle managing anger, potentially leading to worsened health.

Given that problem-focused coping has been shown to be more effective than emotion-focused coping, research should examine antecedents of such coping styles. In other words, who would more likely use problem-focused coping than whom? Who tends to use emotional focused coping more than problem-focused coping? In assessing a variety of coping styles, most research still reveals the best forms of coping as those that are problem-focused and still flexible to give the best outcome in any stressful situation (Kleinke 2007; Amirkhan 1995; Amirkhan 1990). However, much of the research in this area is focused on personality style, not position in society. Research on coping styles based on position in society is necessary to address. Depending on social position, a person may not be limited in their chosen form of coping in any given situation (Thoits 1995; Pearlin 1985; Folkman 1984; Pearlin and Schooler 1978). For example, problem-focused coping may not always be the choice of women and ethnic minorities due to their subordinate status in the United States. On the other hand, men and ethnic/racial majority
group members may employ problem-focused coping due to their dominant statuses in this society.

Style of coping is at times a result of social status and what behavior a person of that social status can display at a given moment (Pearlin and Schooler 1978). Research shows that members of marginalized groups use different forms of coping than those in the dominant group (Brown 2011; Greer 2010; Carter and Forsyth 2010; Brondolo et al. 2009;). Additionally, the forms of coping used by marginalized groups tend to vary within group when applied to different settings and circumstances (Monat and Lazarus 1985). For instance, common coping strategies used in the workplace differ from those used at home in taking care of a dying loved one. In that same respect, coping strategies used in response to discrimination differ from those used in other forms of stress in life (Brown et al. 2011). Based on previous research, Blacks in the United States will most commonly practice avoidance, religious coping through prayer, work harder to prove others wrong, and speak-up (Forsyth and Carter 2012; Greer 2010). Speaking-up, although the most problem-focused form of coping, was not always common; this can be seen as a reflection of the limitations of coping as a member of a marginalized group. Black women differ slightly from Black men in that they tend to rely on social support as a coping strategy (Greer 2010). This reflects how a social norm in society translates into acceptable coping, as women more often than men are encouraged to talk about their feelings. Also, women were more likely than men to use spiritual coping through prayer (Greer 2010). Both groups report expressed or repressed anger as a result of facing discrimination (McNeilly et al. 1996). Based on research that recognizes how one
stressor can lead to stress and result in other stressors, this study will focus on the nature of discrimination as a stressor and anger as the subsequent form of stress. In this study, I examine whether there is any gender and ethnic difference in utilized coping mechanisms focusing on four groups: African American men, African American women, Afro-Caribbean men, and Afro-Caribbean women. Further, as mentioned previously, I test whether problem focused coping is indeed helpful in managing anger resulting from discriminatory experience compared to emotion-focused coping.

Summary and Hypotheses

In this chapter, I summarized literature on often-neglected differences between African Americans and Caribbean Americans within so-called “Black” population in the U.S. and discussed application of stress process model in this study. More specifically, following this model, I proposed that anger resulting from discrimination as a form of stress that can harm mental and physical health. Further, based on previous studies, I argued that problem-focused coping would be more helpful in managing anger in the face of discrimination and protecting health than emotion-focused coping. I also argued that those with a more dominant statues based on gender (e.g., men) would use problem-focused coping, while those group members who hold a more subordinate status (e.g., women) would use emotion-focused coping. More specifically, based on the literature, this study tests the following hypotheses.
H1: African American men and Afro-Caribbean men are more likely to use problem-focused coping mechanisms (i.e., tried to do something about it, worked harder to prove them wrong) than African American women and Afro-Caribbean women (test of gender differences in problem-focused coping).

H2: African American women and Afro-Caribbean women are more likely to use emotion-focused coping mechanisms (i.e., realized you brought it on yourself, accepting discrimination as a fact of life, seeking social support and using prayer) than African American men and Afro-Caribbean men (test of gender differences in emotion-focused coping).

H3: Perceived discrimination, those who experience anger as a result of discrimination would have worse mental health rating than those who do not (test of stress process model: discrimination as a stressor).

H4: Perceived discrimination, those who experience anger as a result of discrimination would have worse physical health rating than those who do not (test of stress process model: discrimination as a stressor).

H5: Problem-focused coping would be associated positively with mental health (test of stress process model: effectiveness of problem-focused coping).
H6: Problem-focused coping would be associated positively with physical health (test of stress process model: effectiveness of problem-focused coping).

H7: Emotion-focused coping would be associated negatively with mental health (test of stress process model: effectiveness of emotion-focused coping).

H8: Emotion-focused coping would be associated negatively with physical health (test of stress process model: effectiveness of emotion-focused coping).

Based on the stress process model and literature on coping, these hypotheses were developed. Figure 1 integrates the hypotheses and demonstrates the framework tested in this study.

Figure 1. Theoretical Model Tested in This Study
CHAPTER 3

METHODS

This chapter describes the data source, sample, and data collection process. Further, I explain measures that were used in this study and provide the analytical strategy used for completing the secondary-data analyses.

Data Source

This study utilized data from the National Survey of American Life (NSAL). With the funding from the National Institute of Mental Health (NIMH), the data were collected between February 2001 and June 2003 (Alegria et al. 2007; Williams 2007; Jackson et al. 2004). The data collection took place based primarily on face-to-face interviews with 6,082 people ages 18 and over (Alegria et al. 2007). The response rates based on racial and ethnic group were 72.3% for Whites, 70.7% for African Americans and 77.7% for Afro-Caribbeans respectively (Williams 2007). The sampling procedures excluded those who are institutionalized, living on military bases, and non-English speaking respondents. However, special measures were taken during the interviews to ask respondents about their relatives who were incarcerated or homeless, allowing for the data set to reflect some of the experiences of institutionalized individuals as described by their family (Jackson et al. 2004).

The NSAL is one of three surveys created as part of the Collaborative Psychiatric Epidemiology Surveys (CPES), established to investigate and provide data on mental health and the experiences of individuals in the United States (Jackson et al. 2004). The NSAL survey was specifically aimed at understanding the cultural experiences of Blacks.
in the United States (Jackson et al. 2004). The aim was to collect nationally representative data on mental health and mental illness on Americans of African descent (Jackson et al. 2004).

NSAL was designed from and built upon the National Survey of Black Americans (NSBA), which was one of the first data sets to emphasize the collection of data about the experiences of African Americans in the United States (Jackson et al. 2004). NSAL used the methodological screening design of the NBSA in order to gather data from African American households. However, the NSBA lacked the separation go multiple ethnicities within the Black population and did not emphasize the collection of data about the mental health experiences of Black Americans. NSAL was specifically designed to build upon the NSBA, with a special emphasis in a variety of areas. First, the NSAL included a nationally representative sample of African Americans, showing the data variation in groups by family structure or socioeconomic status (Jackson et al. 2004). No other dataset has been able to address as much variation in the population. Also, NASAL’s focus on the experiences of both African Americans and Afro-Caribbeans allows for the understanding of the diverse ethnic populations within the Black race in the United States. Previous research in other Western countries such as the United Kingdom and the Netherlands show that the mental health experiences of Afro-Caribbeans varies from those of native-born Blacks in the same country (Jackson et al. 2004).
Sample

The sample for the NSAL included a special supplement to ensure a larger population of Afro-Caribbeans and African Americans, making these data specific to addressing the experiences between the two ethnic groups within the Black population in the United States (Jackson et al. 2004; Caldwell, Guthrie, and Jackson 2006). This included 3,570 African Americans, 891 non-Hispanic Whites, and 1,621 Afro-Caribbeans. This study will use only Black samples, and non-Hispanic Whites will be eliminated from the analyses. The resulting sample size was 3,620 non-institutionalized blacks: 1,620 African American women, 945 African American men, 619 Afro-Caribbean women, and 436 Afro-Caribbean men.

Measures

Dependent Variables. To examine health outcomes, this study used the respondent’s own assessment of their overall physical and mental health. To measure physical health, participants were asked, “How would you rate your overall physical health at the present time?” The response to this question was coded as excellent (=5), very good (=4), good (=3), fair (=2) or poor (=1). The similar question was also used for mental health, “How would you rate your overall mental health at the present time?” The responses were coded in the same manner, ranging from 1 (poor) to 5 (excellent).

Gender and Ethnicity. Gender is conceptualized in this study as influencing the type of coping mechanisms used when facing discrimination. Gender was recoded into Male (=0) and Female (=1). To test the specific group variations, four groups based on
gender and ethnicity were created: African American women, African American men, Afro-Caribbean women, and Afro-Caribbean men. Initially, ethnic identity was measured by the respondent’s answer from the following options: (1) Vietnamese, (2) Filipino, (3) Chinese, (4) All Other Asian, (5) Cuban, (6) Puerto Rican, (7) Mexican, (8) All Other Hispanic, (9) Afro-Caribbean, (10) African American, (11) Non-Latina Whites, (12) All Other. For the purposes of this study, ethnicity was recoded as Afro-Caribbean (=0) and African American (=1), with all other ethnic categories being removed from analyses. This ethnicity variable was combined with the gender variable to create the four categories based on gender and ethnicity, which were used in subsample analyses: African American women, African American men, Caribbean women, and Caribbean men.

Anger. Because anger as an emotional response was frequent in the literature, anger was conceptualized in this research as stress outcome of discrimination that possibly exacerbates physical and mental health. Participants were first asked whether they have experienced discrimination due to ancestry/origins, gender, race, age, height or weight, shade of skin color, medical condition, religion, or sexual orientation (Alegria et al. 2007). Then, for the respondents who reported yes to the experience of discrimination, a series of follow-up questions were asked to capture how they responded to each of the discriminatory experiences. The respondents were asked whether they “expressed anger or got mad” as a response to discriminatory experience and reported either Yes (=1) or No (=0).
Coping Mechanisms. This study focused on two types of coping mechanisms: problem-focused coping and emotion-focused coping. The operationalization of these variables is based on the definitions of both forms of coping and if the action involved sought to directly and immediately change the outcome of the situation. The respondents who reported experience of discrimination were asked to respond either Yes (=1) or No (=0) to each of the following items: “tried to do something about it,” “accept it as a fact of life,” “worked harder to prove them wrong,” “realized you brought it on yourself,” “talk to someone,” and “prayed about the situation.” As the coping research reflects, many of these responses can be categorized into either problem-focused or emotion focused coping. For the purposes of this study, “tried to do something about it” and “worked harder to prove them wrong” have been categorized as Problem-Focused Coping. “Accept it as a fact of life”, “realized you brought it on yourself”, “talked to someone” and “prayed about the situation” were categorized as Emotion-Focused Coping.

Control Variables. Research shows that a coping strategy may be a function of one’s socioeconomic status, other social positions held in society, as well as simply personality style (Brown et al. 2010; Kleinke 2007; Pearlin 1978). For this reason, demographic information will be included in the models to control for a variety of factors that may also influence coping strategies and consequently health outcomes. These include education level, marital status, age, employment status, and income. Education level has been recorded as number of years of education completed from elementary through college. Social support from a partner in the home is important in consideration
of how stress is handled (Kleinke 2007). For this reason, marital status has been recoded into married/cohabitating (=0) and all other options (=1). Age has been recorded in number of years. Employment status has been recoded in to employed (=1) and all other options (=0). Household income is reported $10,000s.

**Analytical Strategy**

Analyses were performed to explore the relationship between stress as a result of discrimination and health. All analysis will be conducted using the following subgroups: African-American women, African-American men, Afro-Caribbean women, and Afro-Caribbean men. First, univariate analyses were performed to illustrate the characteristics of each of the subgroups. Then, bivariate analysis were conducted to test the relationship among the variables with specific attention paid to comparisons of the gender/ethnicity subgroups. Finally, multiple regression models were utilized to test the aforementioned hypotheses. The series of regression models will be done for each subgroup, testing each individual model first for physical health and then mental health outcomes. After exploring the possible direct relationship between anger and health, models tested the forms of coping for moderating effects on both physical and mental health for both problem-focused and emotion-focused coping.
CHAPTER 4

RESULTS

This chapter describes the results based on the hypotheses that were tested.

Factors associated with altering health outcomes when coping with discrimination have been analyzed. I will present descriptive and bivariate findings followed by multivariate analyses.

Descriptive and Bivariate Findings

Table 1. Measurement Descriptions and Comparisons of Means and Proportions: the National Survey of American Life

<table>
<thead>
<tr>
<th>Variables</th>
<th>Description</th>
<th>Range</th>
<th>Means &amp; Proportions</th>
<th>Entire Sample</th>
<th>African American Women</th>
<th>African American Men</th>
<th>Afro-Caribbean Women</th>
<th>Afro-Caribbean Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health</td>
<td>Self Reported Level of Physical Health</td>
<td>1-5</td>
<td></td>
<td>3.45</td>
<td>3.35</td>
<td>3.48</td>
<td>3.48</td>
<td>3.75</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Self Reported Level of Mental Health</td>
<td>1-5</td>
<td></td>
<td>3.86</td>
<td>3.78</td>
<td>3.93</td>
<td>3.90</td>
<td>4.10</td>
</tr>
<tr>
<td>Stress from Discrimination</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anger (Yes=1)</td>
<td>Respondent got angry when experiencing discrimination</td>
<td>0-1</td>
<td></td>
<td>451</td>
<td>461</td>
<td>3.82</td>
<td>3.94</td>
<td>3.40</td>
</tr>
<tr>
<td>Problem-Focused Coping</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tried to do something about it (Yes=1)</td>
<td>Respondent tried to do something about it when experiencing discrimination</td>
<td>0-1</td>
<td></td>
<td>289</td>
<td>292</td>
<td>0.27</td>
<td>0.26</td>
<td>0.21</td>
</tr>
<tr>
<td>Worked harder to prove them wrong (Yes=1)</td>
<td>Respondent tried to prove perception of them wrong when experiencing discrimination</td>
<td>0-1</td>
<td></td>
<td>472</td>
<td>476</td>
<td>0.49</td>
<td>0.45</td>
<td>0.49</td>
</tr>
<tr>
<td>Emotion-Focused Coping</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Realized you brought it on yourself (Yes=1)</td>
<td>Respondent realized they brought it on themselves when experiencing discrimination</td>
<td>0-1</td>
<td></td>
<td>0.04</td>
<td>0.04</td>
<td>0.03</td>
<td>0.03</td>
<td>0.06</td>
</tr>
<tr>
<td>Accept it as a fact of life (Yes=1)</td>
<td>Respondent accepted discrimination as a fact of life when experiencing discrimination</td>
<td>0-1</td>
<td></td>
<td>604</td>
<td>604</td>
<td>5.35</td>
<td>5.25</td>
<td>6.24</td>
</tr>
<tr>
<td>Prayed about it (Yes=1)</td>
<td>Respondent prayed about it when experiencing discrimination</td>
<td>0-1</td>
<td></td>
<td>607</td>
<td>692</td>
<td>5.36</td>
<td>5.78</td>
<td>4.63</td>
</tr>
<tr>
<td>Talked to someone (Yes=1)</td>
<td>Respondent talked to someone when experiencing discrimination</td>
<td>0-1</td>
<td></td>
<td>465</td>
<td>458</td>
<td>0.41</td>
<td>0.47</td>
<td>0.45</td>
</tr>
<tr>
<td>Control Variables</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education Level</td>
<td>Highest level of education completed in years</td>
<td>4-17</td>
<td></td>
<td>12.53</td>
<td>12.35</td>
<td>12.26</td>
<td>12.17</td>
<td>12.83</td>
</tr>
<tr>
<td>Marital Status or Cohabiting</td>
<td>Respondent was either married or cohabitating at the time of the data collection</td>
<td>0-1</td>
<td></td>
<td>367</td>
<td>292</td>
<td>4.35</td>
<td>365</td>
<td>520</td>
</tr>
<tr>
<td>Age</td>
<td>Age in years of respondent at the time of the data collection</td>
<td>18-94</td>
<td></td>
<td>42.54</td>
<td>42.93</td>
<td>42.53</td>
<td>41.27</td>
<td>40.69</td>
</tr>
<tr>
<td>Employment Status</td>
<td>Respondent was employed either full time or part time at the time of data collection</td>
<td>0-1</td>
<td></td>
<td>680</td>
<td>631</td>
<td>700</td>
<td>723</td>
<td>774</td>
</tr>
<tr>
<td>Household Income</td>
<td>Annual income in thousands at the time of data</td>
<td>0-200</td>
<td></td>
<td>34.50</td>
<td>28.17</td>
<td>37.71</td>
<td>38.34</td>
<td>47.24</td>
</tr>
</tbody>
</table>

Note:

Tests of Hypotheses 1 and 2

* Significant difference with African American Women (p<.05)
* Significant difference with African American Men (p<.05)
* Significant difference with Afro-Caribbean Women (p<.05)
* Significant difference with Afro-Caribbean Men (p<.05)

Table 1 shows that this sample reported relatively favorable health status (3.5 and 3.9 on 5 point scale of physical and mental health status respectively). In response to discriminatory incident, about 45% respondents reacted with anger, 29% tried to do...
something about it, 47% worked harder to prove them wrong, 5% realized they brought it on themselves, 60% accepted it as fact of life, 61% prayed about it, and 47% talked to someone about the incident. To describe the sample further, respondents completed 12.5 years of education, 42.5 years old, and had about $34,500 household income on the average. Of all, 37% were married or cohabiting, and 68% were employed.

Results of bivariate analyses can be also found in Tables 1 (for correlation analyses results, see the Appendices A and B). Recall that my first and second hypotheses tested the gender differences in the kinds of coping mechanisms used in the face of discrimination. In Table 1, one can see there was no support found for hypothesis 1. There were no significant differences found between gender and ethnic group in relation to problem-focused coping. This means that there were no significant gender differences in the use of problem-focused coping regardless of ethnic groups.

In the case of hypothesis 2 which stated that African American women and Afro-Caribbean women are more likely to have emotion-focused coping responses (i.e., realized you brought it on yourself, accepting discrimination as a fact of life, seeking social support and using prayer) than African American men and Afro-Caribbean men, the results greatly varied. Greater proportions of African American men than African American women felt they brought discrimination upon themselves. Specifically, 6.3% of African American men reported that they realized that they brought the unfair treatment on themselves, which is statistically significantly higher proportion than 4.1% of African American women who reported the same. When comparing the another emotion-focused coping response of “accepting discrimination as a fact of life” we see
that Afro-Caribbean men were more likely to engage in this thought process when facing discrimination than African American and Afro-Caribbean women. More specifically, 63.4% of Afro-Caribbean men reported accepting discrimination as a fact of life, compared to 60.4% of African American women and 53.5% of Afro-Caribbean women. These findings contradicted my prediction that women would be more likely to report emotion-focused coping compared to men. However, as expected, higher proportions of African American women (69.7%) and Afro-Caribbean women (57.8%) used emotion-focused coping by “praying when experiencing discrimination” than African American men (53.6%) or Afro-Caribbean men (46.3%). In addition, the expected gender difference was found for “talking to someone about the incident.” African American women were more likely to talk to someone about the discriminatory incident than African American men, though there was no significant gender difference among Afro-Caribbeans. Therefore, gender difference in the use of emotion-focused coping varied and results for hypothesis 2 are inconclusive.
Multivariate Findings

Table 3. Regression Models Predicting Mental Health: Effects of Anger

<table>
<thead>
<tr>
<th></th>
<th>African American Women</th>
<th>African American Men</th>
<th>Afro-Caribbean Women</th>
<th>Afro-Caribbean Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anger</td>
<td>-.194 **</td>
<td>-.200 **</td>
<td>-.254 **</td>
<td>-.173</td>
</tr>
<tr>
<td>Education Level</td>
<td>.042 **</td>
<td>.063 **</td>
<td>.050 **</td>
<td>.034 **</td>
</tr>
<tr>
<td>Marital Status or Cohabiting</td>
<td>-.009</td>
<td>.069</td>
<td>.149</td>
<td>.075</td>
</tr>
<tr>
<td>Age</td>
<td>-.010 **</td>
<td>-.011 **</td>
<td>-.007 **</td>
<td>-.008 **</td>
</tr>
<tr>
<td>Employment Status</td>
<td>.259 **</td>
<td>.402 **</td>
<td>.002</td>
<td>.187</td>
</tr>
<tr>
<td>Household Income</td>
<td>.003 **</td>
<td>.001</td>
<td>.002</td>
<td>.001</td>
</tr>
<tr>
<td>Adjusted R-square</td>
<td>.079</td>
<td>.130</td>
<td>.048</td>
<td>.043</td>
</tr>
</tbody>
</table>

*p<.05  **p<.01

The effects of anger on predicting levels of mental health are explained in Table 3 (Hypothesis 3). As anticipated, mental health was significantly worsened by anger resulting from discrimination for all groups, controlling for socio-demographic variables, with the exception of Afro-Caribbean males. These findings demonstrated a support for hypothesis 3. The mental health of each sub-group was also negatively affected by age. Education level had a positive impact on mental in each subgroup, with higher significance values for African American women, African American men, and Afro-Caribbean women (p<.01). Furthermore, being employed had a positive effect on mental health for African American women and African American men, and possessing a higher household income was positively associated with mental health for African American women only.
Table 4. Regression Models Predicting Physical Health: Effects of Anger

<table>
<thead>
<tr>
<th></th>
<th>African American Women</th>
<th>African American Men</th>
<th>Afro-Caribbean Women</th>
<th>Afro-Caribbean Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anger</td>
<td>-0.118 **</td>
<td>-0.146 **</td>
<td>-0.266 **</td>
<td>-0.136 **</td>
</tr>
<tr>
<td>Education Level</td>
<td>0.038</td>
<td>0.012</td>
<td>0.014</td>
<td>0.017</td>
</tr>
<tr>
<td>Marital Status or Cohabitating</td>
<td>-0.005</td>
<td>0.060</td>
<td>0.068</td>
<td>0.093</td>
</tr>
<tr>
<td>Age</td>
<td>-0.014 **</td>
<td>-0.016 **</td>
<td>-0.014 **</td>
<td>-0.015 **</td>
</tr>
<tr>
<td>Employment Status</td>
<td>0.320 **</td>
<td>0.059</td>
<td>0.455 **</td>
<td>0.342 **</td>
</tr>
<tr>
<td>Household Income</td>
<td>0.003 **</td>
<td>0.001</td>
<td>0.003</td>
<td>0.001</td>
</tr>
<tr>
<td>Adjusted R-square</td>
<td>0.104</td>
<td>0.147</td>
<td>0.075</td>
<td>0.072</td>
</tr>
</tbody>
</table>

*p<.05  **p<.01

There are similar trends found for physical health as shown in Table 4. As expected, anger as a result of discrimination worsens physical health for all groups, with the exception of Afro Caribbean men, controlling for sociodemographic variables. Hypothesis 4 is, therefore, supported for all groups, but Caribbean men. Older age is again associated with poorer physical health for all sub-groups. Higher level of education was only correlated with better physical health for African American women. However, being employed was positively associated with physical health for all groups, with higher significance for African American women, African American men, and Afro-Caribbean men. Increased household income had a positive impact on physical health for African American women, African American men, and Afro-Caribbean women.
Next, I examined the effects of the coping mechanisms. More specifically, I hypothesized that problem-focused coping would be associated positively with mental health (Hypothesis 5) and that problem-focused coping would be associated positively with physical health (Hypothesis 6). Further, I also anticipated that emotion-focused coping would be negatively associated with mental health (Hypothesis 7) and that emotion-focused coping would be associated negatively with physical health (Hypothesis 8). In Table 5, I tested the mediating effects of all types of coping mechanisms between anger and mental health. Again, it is revealed that the negative impact of anger resulted from discrimination had on mental health persisted for all sub-groups with the exception of Afro-Caribbean males, even after controlling for a series of coping mechanisms. This means that none of the coping mechanisms reduced the impact of anger on mental health. Coping mechanisms did not protect respondents' mental health from anger inflicted by
discriminatory treatment. This may imply that the anger caused by unfairness was so harmful and powerful that no matter what kinds of coping mechanisms one employed, it had detrimental impact on mental health. While these coping mechanisms did not intervene the effects of discrimination-inflicted anger on mental health, neither hypotheses 5 nor 7 were supported in this test. One exception to this finding for hypothesis 7 was with African American women. The emotion-focused coping style of realizing you brought it on yourself had a negative impact on African American women, worsening that sub-group’s mental health. No other coping style significantly predicted increased or reduced levels of mental health.

There were several other variables that significantly influenced mental health. Education level had a positive effect on mental health for African American women, African American men, and Afro-Caribbean women. Additionally, being employed had a positive impact on mental health for African American women and African American men. For African American women, an increase in household income also had a positive effect on mental health. Finally, an increase in age for each sub-group had a negative relationship with mental health.
Table 6. Regression Models Predicting Physical Health: Effects of Coping

<table>
<thead>
<tr>
<th></th>
<th>African American Women</th>
<th>African American Men</th>
<th>Afro-Caribbean Women</th>
<th>Afro-Caribbean Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anger</td>
<td>-0.090 .055</td>
<td>-0.075 .072</td>
<td>-0.310 ** .092</td>
<td>-0.179 .111</td>
</tr>
<tr>
<td>Tried to do something about it</td>
<td>-0.085 .065</td>
<td>-0.099 .080</td>
<td>-0.114 .102</td>
<td>-0.081 .125</td>
</tr>
<tr>
<td>Worked harder to prove them wrong</td>
<td>0.064 .055</td>
<td>-0.005 .071</td>
<td>0.234 ** .090</td>
<td>-0.034 .102</td>
</tr>
<tr>
<td>Realized you brought it on yourself</td>
<td>-0.119 .135</td>
<td>-0.219 .131</td>
<td>0.163 .227</td>
<td>-0.327 .205</td>
</tr>
<tr>
<td>Accept it as a fact of life</td>
<td>-0.333 .055</td>
<td>-0.083 .070</td>
<td>-0.095 .088</td>
<td>-0.095 .105</td>
</tr>
<tr>
<td>Prayed about it</td>
<td>-0.069 .057</td>
<td>-0.200 .067</td>
<td>0.137 .091</td>
<td>0.113 .103</td>
</tr>
<tr>
<td>Talked to someone</td>
<td>-0.024 .057</td>
<td>-0.123 .074</td>
<td>-0.046 .097</td>
<td>0.234 * .109</td>
</tr>
<tr>
<td>Education Level</td>
<td>0.038 **</td>
<td>0.012 .015</td>
<td>0.024 .018</td>
<td>0.005 .019</td>
</tr>
<tr>
<td>Marital Status or Cohabitating</td>
<td>-0.013 .061</td>
<td>-0.020 .069</td>
<td>0.069 .094</td>
<td>-0.015 .101</td>
</tr>
<tr>
<td>Age</td>
<td>-0.013 ** .002</td>
<td>-0.016 ** .002</td>
<td>-0.015 ** .003</td>
<td>-0.015 ** .004</td>
</tr>
<tr>
<td>Employment Status</td>
<td>0.323 ** .059</td>
<td>0.440 ** .080</td>
<td>0.202 * .102</td>
<td>0.300 * .121</td>
</tr>
<tr>
<td>Household Income</td>
<td>0.003 ** .001</td>
<td>0.003 ** .001</td>
<td>0.004 ** .002</td>
<td>0.002 .001</td>
</tr>
<tr>
<td>Adjusted R-square</td>
<td>0.104</td>
<td>0.149</td>
<td>0.087</td>
<td>0.074</td>
</tr>
</tbody>
</table>

*p<.05  **p<.01

The results in Table 6 show the results of the mediating effects of coping mechanisms between anger and physical health. One interesting finding in this model, however, is that stress from anger as a result of discrimination no longer has a negative impact on physical health for African American sub-samples, after controlling for coping mechanisms. Since none of the coping mechanisms were statistically significant, it is inconclusive, but may suggest that these coping mechanisms all together may have mediated the impact of the anger on physical health for African American sample. While the negative effect of anger on physical health persisted even after controlling for coping mechanisms, an act of proving them wrong improved physical health for Afro-Caribbean women. In addition, the emotion-focused form of coping talking to someone about it significantly helped the physical health of Afro-Caribbean men. These findings all together indicated inconclusive response for hypothesis 6, which stated that problem-focused coping would be positively associated with physical health. Hypothesis 8, which
stated that emotion-focused coping would be negatively associated with physical health, was also not supported consistently.

Table 6 also displays other findings related to the control variables. Education level had a positive impact on physical health for African American women. Age had a negative impact on physical health for all groups. Being employed had a positive impact on physical health in this model, especially for African American women and African American men. Household income had a positive impact for all sub-groups except Afro-Caribbean men. In the next chapter, I explain possible implications for these findings and explore greater detail possible future foci for this area of research.
By using the national representative data of African Americans and Caribbean Americans from National Survey of American Life, this thesis investigated the relationships between discrimination, coping, and stress and health. The past literature suggested that anger was detrimental to health and wellbeing (Davidson and Mostofsky 2010; Chida and Steptoe 2009; Diong et al. 2005; Linden et al. 1997). However, the past research did not seek to understand how anger resulting from discrimination affects health as a form of stress. This could possibly be because anger tends to be seen as a socially unacceptable emotion. Findings in this research showed that anger was a common response to discriminatory experience; about one third to one half of respondents reported anger when treated unfairly. Coping responses to mediate the effects of anger inflicted by discrimination had also yet to be examined in the past literature, especially on the sub-groups of the Black Americans in the United States. It is these specific gaps in the literature that this research tried to fill through the use of the stress process model.

This study first revealed that when coping with anger resulting from discrimination, social status did not predict the types of coping. More specifically, there was no clear pattern of gender differences in the type of coping mechanisms used. This is contradictory to other research, which shows that women are more prone to using social support as a means of coping (Brown 2011; Greer 2010; Carter and Forsyth 2010; Monat and Lazarus 1985). However, this finding is helpful because the groups that were
compared shared similar social status as far as race and socioeconomic status. Gender did not play a role in styles of coping in these subsamples, which may be a result of exposure to discrimination and socialization. The variations of accepting discrimination as a fact of life show that some level of socialization and racial identity may be impacting the coping style as well. That is, how one is raised to deal with discrimination may affect coping style and health outcomes as a result. While gender is a factor in socialization, race or ethnicity was potentially more salient identity over gender for Black Americans in the face of discriminatory experiences.

This research highlighted effects of gender and ethnicity on health among Black Americans. By looking closely at data for African American women, African American men, Afro-Caribbean women, and Afro-Caribbean men, this research revealed findings specific to the gender and ethnic intricacies in the Black community. African American women experienced the least amount of negative impact on health from stress, and were the only group to have worsened mental health as a result of emotion-focused coping. African American men had worsened mental and physical health as a result of stress, but no form of coping had any impact on health. Afro-Caribbean women also had worse health as a result of stress, but did experience some improved physical health through problem-focused coping. The most interesting results were reveals in the Afro-Caribbean sub-group.

Based on the stress process model, anger adversely affected the health of all subgroups except Afro-Caribbean males. Previous studies have shown the negative impact of discrimination on mental and physical health (Broman, Mavaaddat and Hsu
2000; Broman 1997; Krieger 1996), and this study adds to the past literature by specifying the pathways in which discriminatory experience is internalized into affecting one's body and mind; this study showed that it was through the negative emotion, anger that one’s health is compromised by discrimination. Future studies should continue investigating the specific ways in which discriminatory experience is internalized and impact one’s health. The findings in this research also suggested that there were other factors protecting the mental and physical health of Afro-Caribbean men when dealing with the stress of anger as a result of discrimination. Because neither the mental nor physical health of Afro-Caribbean men was lowered by anger after experiencing discrimination, it is possible that they have unique cultural experiences creating buffers from discrimination as they experience it. This could be a result of many things including spiritual practices, socialization, or practices supporting self-esteem. More research is needed to investigate what is protecting Afro-Caribbean men from deleterious effects of anger on their health.

A large number of respondents reported anger as a result to discrimination (ranging from 34% to 46%). This was also the case in previous research that acknowledged anger to be a common result of discrimination (Davidson and Mostofsky 2010; Chida and Steptoe 2009; Diong et al. 2005; Linden et al. 1997). In previous studies, anger resulting from other experiences had a negative impact on health (Davidson and Mostofsky 2010; Chida and Steptoe 2009; Diong, et al. 2005; Linden et al. 1997). Discrimination was also found to be detrimental to health (Anderson 2013; Carter and Forsyth 2010; Brondolo et. al. 2009; Brown 2003; Noh and Kasper 2003;
McNeilly et al. 1996; Krieger 1996; Krieger 1990). This study adds to the previous studies by suggesting anger as more proximal factor of mental and physical health problems rather than the discriminatory event itself. Thus, future studies should investigate more directly whether adverse emotion, such as anger, mediates the relationship between the experience of discrimination and health outcomes.

Former research has supported problem-focused coping as the most effective means of reducing the impact of stress (Kleinke 2007; Holahan and Moos 1987; Pearlin and Schooler 1978). Despite this, my research indicated other possibilities. Problem-focused coping did not prove to lessen any impact on health when dealing with discrimination and the anger that came as a result. This may have been due to the impact on mental health from stress experienced as a result of discrimination being so high at the time that the forms of problem-focused coping were not helpful. That is, the anger (whether accumulated over time or in that moment) did so much damage that health could not be improved by problem-focused coping. These inconclusive results provide a possible opportunity for the future research. This current research looked at a specific form of stress of anger as a result of discrimination. By focusing on more specific forms of coping possibly without categorizing them as problem-focused or emotion-focused, future research can predict the best responses to anger in the face of discrimination.

Emotion-focused coping did not have any impact on mental and physical health with the exception of African American women. When African American women felt responsible for the discrimination they experienced, they were finding themselves to blame and their mental health suffered. Therefore, emotion-focused coping was actually
detrimental to African American women’s health. This support current research that African American women has unique experiences dealing with discrimination because they are affected by both racism and sexism (Perry et al. 2013; Greer 2010; Shorter-Gooden 2004; Collins 2003). Future research focused on understanding the cultural differences of African American women specifically should be conducted to understand why this sub-group’s experience with emotion-focused coping was uniquely negative.

The other notable factors in predicting mental health included education level, having a job and overall household income. Similar results were found for physical health. These socioeconomic categories overall increased the ability for individuals who face discrimination to have better health outcomes. This research has social implications for groups who are prone to meet discrimination in life and how these socioeconomic factors are still beneficial when facing the common form of stress as a result of discrimination. These findings support current research on success and health that explain how these socioeconomic factors support a better quality of life and often that leads to better health (Brondolo et al. 2009; Mays 2007). Future research should also focus on how to make these factors more accessible for subordinate groups in society as access to these consistently improved health for most of the sub-groups.

It is important to address some of the limitations of this research. First, using cross-sectional data, this study was not able to examine the long-term impact of anger and coping on health. Future studies would benefit from collecting panel data to capture whether individual’s health would or would not change over time due to discriminatory experience and its resulting negative emotion (i.e., anger) and coping responses. The
data were also over 10 years old. Current data for Black Americans may reflect improved or worsened conditions as they pertain to anger, discrimination and coping.

Finally, the available measures capturing coping responses to discrimination were difficult to categorize in either problem-focused coping or emotion-focused coping.

Future research should focus more on intricate forms of responding and coping without the restrictions of categorizing problem-focused or emotion-focused coping.

This research has current applications, especially in the wake of such issues as state-sanctioned violence against black people in the forms of police brutality and discrimination and the United States current response of recent hate crimes. An understandable, common response is anger, but this anger had detrimental effects on health according to this thesis. This study would be useful for social workers, community activists, and even the general public in understanding discrimination can not only result in negative emotion like anger, but it has a serious physical and mental health consequences. Results in this study have shown another form of inequality, anger’s effect on health is another barrier Black Americans must face in life. As long as there is discrimination, members of subordinate groups need solutions to reduce the impact on their lives, including their health. Further studies on ways in which black Americans cope with such an unfair emotional state are necessary.
APPENDIX A. Correlation Analyses for African American Women (Upper Half; N=2,220) and African American Men (Lower Half; N=1,217): the National Survey of American Life (Table 2a)

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Physical Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Mental Health</td>
<td>.494</td>
<td>-.021</td>
<td>.025</td>
<td>.023</td>
<td>.053</td>
<td>-.004</td>
<td>.063</td>
<td>-.004</td>
<td>.178</td>
<td>.064</td>
<td>.241</td>
<td>.260</td>
</tr>
<tr>
<td>3</td>
<td>Anger</td>
<td>.050</td>
<td>-.081</td>
<td>.033</td>
<td>.003</td>
<td>-.077</td>
<td>-.026</td>
<td>.015</td>
<td>-.012</td>
<td>.167</td>
<td>.064</td>
<td>-.169</td>
<td>.202</td>
</tr>
<tr>
<td>4</td>
<td>Tired to Do Something About It</td>
<td>.051</td>
<td>-.080</td>
<td>.312</td>
<td>.147</td>
<td>.082</td>
<td>.102</td>
<td>.533</td>
<td>.347</td>
<td>.093</td>
<td>.037</td>
<td>.064</td>
<td>.058</td>
</tr>
<tr>
<td>5</td>
<td>Worked to Prove Them Wrong</td>
<td>.037</td>
<td>.015</td>
<td>.258</td>
<td>.191</td>
<td>.014</td>
<td>.299</td>
<td>.074</td>
<td>.343</td>
<td>.140</td>
<td>.002</td>
<td>.056</td>
<td>.036</td>
</tr>
<tr>
<td>6</td>
<td>Accepted as a Fact of Life</td>
<td>.003</td>
<td>.098</td>
<td>.844</td>
<td>.725</td>
<td>.116</td>
<td>.103</td>
<td>.273</td>
<td>.256</td>
<td>.947</td>
<td>.011</td>
<td>.107</td>
<td>.031</td>
</tr>
<tr>
<td>7</td>
<td>Married or Co-habitating</td>
<td>.076</td>
<td>.058</td>
<td>.046</td>
<td>.037</td>
<td>.125</td>
<td></td>
<td>.087</td>
<td>.076</td>
<td>.081</td>
<td>.108</td>
<td>.041</td>
<td>.010</td>
</tr>
<tr>
<td>8</td>
<td>Prayed about It</td>
<td>.027</td>
<td>.047</td>
<td>.038</td>
<td>.231</td>
<td>.090</td>
<td>.081</td>
<td>.036</td>
<td>.042</td>
<td>.065</td>
<td>.011</td>
<td>.028</td>
<td>.020</td>
</tr>
<tr>
<td>9</td>
<td>Talked to Someone About It</td>
<td>.100</td>
<td>.048</td>
<td>.367</td>
<td>.286</td>
<td>.396</td>
<td>.078</td>
<td>.060</td>
<td>.198</td>
<td>.125</td>
<td>.000</td>
<td>.031</td>
<td>.036</td>
</tr>
<tr>
<td>10</td>
<td>Education</td>
<td>.186</td>
<td>.294</td>
<td>.047</td>
<td>.094</td>
<td>.038</td>
<td>.081</td>
<td>.075</td>
<td>.045</td>
<td>.125</td>
<td>.199</td>
<td>.321</td>
<td>.437</td>
</tr>
<tr>
<td>11</td>
<td>Married or Co-habitating</td>
<td>.061</td>
<td>.034</td>
<td>.025</td>
<td>.074</td>
<td>.109</td>
<td>.013</td>
<td>.064</td>
<td>.062</td>
<td>.038</td>
<td>.014</td>
<td>.069</td>
<td>.036</td>
</tr>
<tr>
<td>12</td>
<td>Age</td>
<td>.275</td>
<td>.223</td>
<td>.025</td>
<td>.073</td>
<td>.080</td>
<td>.017</td>
<td>.023</td>
<td>.022</td>
<td>.013</td>
<td>.245</td>
<td>.118</td>
<td>.222</td>
</tr>
<tr>
<td>13</td>
<td>Employment Status</td>
<td>.330</td>
<td>.289</td>
<td>.004</td>
<td>.000</td>
<td>.040</td>
<td>.020</td>
<td>.038</td>
<td>.026</td>
<td>.013</td>
<td>.286</td>
<td>.068</td>
<td>.375</td>
</tr>
<tr>
<td>14</td>
<td>Household Income</td>
<td>.186</td>
<td>.145</td>
<td>.067</td>
<td>.046</td>
<td>.023</td>
<td>.065</td>
<td>.011</td>
<td>.022</td>
<td>.052</td>
<td>.357</td>
<td>.276</td>
<td>.032</td>
</tr>
</tbody>
</table>

* p<.05  ** p<.01

APPENDIX B. Correlation Analyses for Afro-Caribbean Women (Upper Half; N=856) and Afro-Caribbean Men (Lower Half; N=552): the National Survey of American Life (Table 2b)

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Physical Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Mental Health</td>
<td>.462</td>
<td>-.074</td>
<td>.082</td>
<td>.000</td>
<td>.032</td>
<td>-.041</td>
<td>.038</td>
<td>.086</td>
<td>.176</td>
<td>.089</td>
<td>.212</td>
<td>.173</td>
</tr>
<tr>
<td>3</td>
<td>Anger</td>
<td>-.032</td>
<td>.065</td>
<td>.255</td>
<td>.045</td>
<td>.054</td>
<td>-.152</td>
<td>.087</td>
<td>.309</td>
<td>.063</td>
<td>.033</td>
<td>.160</td>
<td>.071</td>
</tr>
<tr>
<td>4</td>
<td>Tired to Do Something About It</td>
<td>.007</td>
<td>.078</td>
<td>.371</td>
<td>.169</td>
<td>-.001</td>
<td>.295</td>
<td>.046</td>
<td>.338</td>
<td>.164</td>
<td>.054</td>
<td>.074</td>
<td>.038</td>
</tr>
<tr>
<td>5</td>
<td>Worked to Prove Them Wrong</td>
<td>.065</td>
<td>.031</td>
<td>.130</td>
<td>.142</td>
<td>.081</td>
<td>.039</td>
<td>.203</td>
<td>.285</td>
<td>.049</td>
<td>.016</td>
<td>.008</td>
<td>.019</td>
</tr>
<tr>
<td>6</td>
<td>Realized You Brought It On Yourself</td>
<td>-.086</td>
<td>.102</td>
<td>.072</td>
<td>.001</td>
<td>.060</td>
<td>.006</td>
<td>.080</td>
<td>.001</td>
<td>.008</td>
<td>.050</td>
<td>.006</td>
<td>.066</td>
</tr>
<tr>
<td>7</td>
<td>Accepted as a Fact of Life</td>
<td>.041</td>
<td>.081</td>
<td>.111</td>
<td>.308</td>
<td>.000</td>
<td>.048</td>
<td>.063</td>
<td>.115</td>
<td>.077</td>
<td>.017</td>
<td>.029</td>
<td>.003</td>
</tr>
<tr>
<td>8</td>
<td>Prayed about It</td>
<td>.030</td>
<td>.086</td>
<td>.072</td>
<td>.017</td>
<td>.214</td>
<td>.068</td>
<td>.062</td>
<td>.294</td>
<td>.111</td>
<td>.066</td>
<td>.021</td>
<td>.017</td>
</tr>
<tr>
<td>10</td>
<td>Education</td>
<td>.070</td>
<td>.155</td>
<td>.095</td>
<td>.066</td>
<td>.106</td>
<td>.010</td>
<td>.115</td>
<td>.111</td>
<td>.041</td>
<td>.017</td>
<td>.108</td>
<td>.004</td>
</tr>
<tr>
<td>11</td>
<td>Married or Co-habitating</td>
<td>-.072</td>
<td>.061</td>
<td>.018</td>
<td>.083</td>
<td>.092</td>
<td>.085</td>
<td>.008</td>
<td>.109</td>
<td>.036</td>
<td>.037</td>
<td>.027</td>
<td>.004</td>
</tr>
<tr>
<td>12</td>
<td>Age</td>
<td>-.282</td>
<td>.138</td>
<td>-.074</td>
<td>.024</td>
<td>.027</td>
<td>.017</td>
<td>.009</td>
<td>.126</td>
<td>.014</td>
<td>.125</td>
<td>.300</td>
<td>-.252</td>
</tr>
<tr>
<td>13</td>
<td>Employment Status</td>
<td>.214</td>
<td>.135</td>
<td>.034</td>
<td>.024</td>
<td>.010</td>
<td>.084</td>
<td>.033</td>
<td>.075</td>
<td>.067</td>
<td>.233</td>
<td>.270</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Household Income</td>
<td>.097</td>
<td>.110</td>
<td>.116</td>
<td>.058</td>
<td>-.029</td>
<td>.085</td>
<td>.029</td>
<td>.123</td>
<td>.045</td>
<td>.389</td>
<td>.165</td>
<td>.075</td>
</tr>
</tbody>
</table>

* p<.05  ** p<.01

46
REFERENCES


