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COLLEGE OF GRADUATE STUDIES AND RESEARCH

RACE AS A FACTOR IN HEALTH RISK BEHAVIORS OF AFRICAN AMERICAN,
CARIBBEAN, AFRICAN, AND EUROPEAN AMERICAN WOMEN

by

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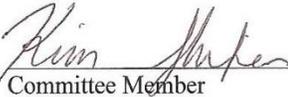
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THESIS APPROVAL PAGE**

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ABSTRACT

RACE AS A FACTOR IN HEALTH RISK BEHAVIORS OF AFRICAN AMERICAN, CARIBBEAN, AFRICAN, AND EUROPEAN AMERICAN WOMEN

Janae Brown

This study focused on the relationship between health risk behaviors and racial and gender discrimination, of interest was the relationship between the risk and benefit evaluation of engaging in health risk behaviors and discrimination. Findings indicated that Black (African American, African, and Caribbean) females engaged in fewer risk behaviors than European American females. In addition, Black females reported more racial discrimination than European American females. However, there were no significant differences in gender discrimination. There was no support of a relationship between risk and benefit evaluation and race or discrimination. Sensation seeking was supported as the most pertinent factor in exploring risk behaviors.

TABLE OF CONTENTS

LIST OF TABLES	vi
LIST OF FIGURES	vii
INTRODUCTION	1
LITERATURE REVIEW	2
METHODS	17
RESULTS	21
DISCUSSION	25
APPENDIX	29
REFERENCES	34
CURRICULUM VITAE	39

LIST OF TABLES

<i>Table 1.</i> Summary of Means, Standard Deviations, and Internal Consistency for the Risk Behavior, Discrimination, Stress, and Sensation Seeking Scales	29
<i>Table 2.</i> Past Frequency of Health Risk Behavior by Race	29
<i>Table 3.</i> Racial and Gender Discrimination by Race	29
<i>Table 4.</i> Bivariate Correlations between Racial Discrimination, Gender Discrimination, and Stress	30

LIST OF FIGURES

Figure 1. Main Effect of Race.

30

INTRODUCTION

Large disparities exist in the physical well-being of European Americans and African Americans in the United States. According to the CDC (2001), African Americans suffer disproportionately from new infections of HIV, cancer, diabetes, heart disease, and stroke. There has been growing concern for discerning the origin of these disparities such that researchers have put forth goals in reducing them through initiatives such as *Healthy People 2010* (U.S. Department of Health and Human Services, 2000). Past research has supported various theories to explain these disparities.

The current research aims to explore health disparities and the relevance of the psychosocial model. Of specific interest in the current research, is the relationship between racism in the form of discrimination, and exposure to risk factors in the form of engaging in health risk behaviors. The population of current interest consists of Black women (African American, Caribbean, and African) and European American women. This literature review will cover past research on explanations of the correlation of race and health. I will emphasize racial discrimination as the primary explanation for these differences.

LITERATURE REVIEW

Explaining Racial Disparities in Health

A review of racial health disparities by Dressler, Oths, and Gravlee (2005) revealed that several models emerge in the literature to explain racial differences in health. These models include the racial-genetic model, health behavior model, socioeconomic status model, and psychosocial stress model. The racial-genetic model emphasizes genetic differences between races to explain disparities. There is much criticism surrounding the racial-genetic model, because evidence suggests that genetically similar populations living in different environments show variability in prevalence rates of different health outcomes (Dressler, et al., 2005). The health behavior model suggests that race differences are due to “individual behaviors such as diet, exercise, and tobacco use” (Dressler, et. al., 2005, p. 234). However, Dressler et al. review evidence against this model, reporting that in some instances, when researchers controlled for differences in health behaviors significant disparities still existed between African Americans and European Americans. Nevertheless, Dressler (1993) continues to suggest that health behaviors contribute significantly to risk for disease. The socioeconomic status model suggests that the relationship between socioeconomic status and race also affects the relationship between race and health. Furthermore, this model suggests that because African Americans are more likely to belong to lower socioeconomic groups, they are more likely to have a lower health status. Yet, research has failed to show that SES

completely accounts for the differences in African American and European American health (Dressler, et al., 2005; Williams, Lavizzo-Mourey, & Warren, 1994).

The final model, the psychosocial stress model, associates health disparities with the experience of racism and discrimination. Dressler and colleagues suggest that this model is superior to the models previously discussed; the model “integrates what is unique about the African American community in the United States and how that experience generates stressors that is associated with health and disease” (Dressler, et al., 2005, p 241). In other words, the experience of discrimination and racism by African Americans can create stress that ultimately contributes to their health outcomes. The validity of this model will be further explored in the current research.

Psychosocial Stress Model

Many researchers have conducted research in support of the psychosocial stress model. Williams, Lavizzo-Mourey, and Warren (1994) composed a model relating race and health status in America. This framework describes racism, macrosocial factors, and geographic origins and biological factors as contributors to health status. In the current framework, racism is described as prejudice or discrimination based on race. Whereas prejudice is an attitude of negativity about a group, discrimination is characterized by negative or unfair actions against a group by individuals or institutions. Macrosocial factors are historical conditions, economic structures, political order, legal codes, and social cultural institutions. Finally, risk factors and resources include health behaviors, stress, medical care, social ties, or psychological, cultural, or religious factors.

However, out of all of these factors affecting health status, these researchers suggest that racism and consequently discrimination are the central contributors to health

status. The ways in which these factors can affect health are as follows, “it can transform social statuses, determine the degree of exposure to risk factors and resources, and directly affect health through its effects on psychological and physiological functioning” (Williams, et al. 1994, p. 29). Research supports that the experience of racism and discrimination is detrimental to the health status of minorities, specifically African Americans. This implication requires further examination.

Williams and Jackson (2005) discuss the psychosocial factors that influence the racial health disparities. They examined mortality records of African Americans and European Americans from the period of 1950 to 2000. They found that disparities existed for 50 years consistently in homicide, heart disease, and cancer. In other words, African Americans died disproportionately higher than European Americans from homicide, heart disease, and cancer. The researchers surmise that socioeconomic status, racial segregation, and medical care were contributors to these disparities. However, the underlying factors contributing to differences in socioeconomic status, racial segregation, and medical care were links to racial inequality. Furthermore, when discussing socioeconomic status, Williams and Jackson suggested that discrimination often explains the elevated disease prevalence in middle class African Americans. As evident in this research, disparities have persistently existed between African Americans and European Americans, thus it is pertinent to conduct research in an effort to eliminate these disparities.

The current research follows previous research that aimed to identify the racial disparities in health between African American and European American women. Schulz, Israel, Williams, Parker, and James (2000) examined the relationship between social

inequalities, stress, discrimination, and health status in African American and European American women. In general, their findings suggested that socioeconomic status, discrimination, and acute life events contribute to disparities in the health status of African American and European American women. This research provides support for the psychosocial model of explaining disparities; discrimination was a factor in the differential health statuses of African American and European American women.

Racial differences in Health Risk Behaviors

According to government surveillance surveys, racial differences exist not only in terms of health status, but also in terms of health behaviors. Health risk behaviors are those that contribute to the leading causes of morbidity and mortality (CDC, 2007). More specifically, these behaviors include behaviors that contribute to unintentional injuries and violence; tobacco use; alcohol and other drug use; sexual behaviors; unhealthy dietary behaviors; and, inadequate physical activity (CDC, 2007). The Youth Risk Behavior Surveillance System is a survey used by the CDC to monitor the prevalence of these behaviors in youth and adolescents.

According to the most recent survey conducted nationally in 2007, significant differences exist in the prevalence of African American and European American youth engaging in various risk behaviors. According to the survey, African American students were more likely than European American students to engage in the following risk behaviors: violent behaviors (i.e., being in a physical fight, or domestic abuse), sexual behaviors (i.e., having intercourse for the first time before age 13, or with 4 or more persons during their life), unhealthy dietary behaviors (i.e., drinking less than 3 glasses per day of milk), and inadequate physical activity (i.e., using the computer or watching

television 3 or more hours per day). In addition, African American students were more likely than European American students to have lifetime asthma or current asthma.

However, African American students were less likely than European American students to engage in the following risk behaviors: tobacco use (i.e.-current cigarette and cigar use, or did not try to quit smoking cigarettes), alcohol and other drug use (i.e.-drove when drinking alcohol, episodic heavy drinking, and current cocaine use). Interestingly, African American and European American students were equally likely to engage in the following risk behaviors: carrying a weapon, marijuana use, and not attending physical education classes regularly (CDC, 2007). The differing prevalence of certain risk behaviors between African Americans and European Americans show that there is a need to examine factors contributing to these disparities in order to dispel them. It is especially important to examine these disparities in youth and their cause, in effort to combat these behaviors and prevent them from continuing to contribute to higher morbidity and mortality rates.

Blum et al. (2000) shared similar efforts with the CDC in examining risk behaviors among youth. However, these researchers specifically examined three variables in relation to risk behaviors: race/ethnicity, income, and family structure (1 or 2 parent home). The researchers interviewed 10,803 adolescents from 7th to 12th grade and their parents using the National Longitudinal Study of Adolescent Health. The risk behaviors of interest were cigarette smoking, alcohol use, weapon-related violence, suicide risk, and sexual intercourse. The researchers found that European Americans were more likely to smoke cigarettes, drink alcohol, and attempt suicide than African American and Hispanic youth. In contrast, African American youth were more likely than European American

youth to engage in sexual intercourse and violence. In addition, adolescents from single parent homes were more likely to engage in all risk behaviors excluding suicide risk.

However, the researchers concluded that race/ethnicity, income, and family structure were able to account for only 10% of the variance in young adolescents' and 7% in older adolescents' health behaviors (Blum et al., 2000). The researchers furthermore suggest, "demographic factors do not predict health risk behaviors well" (Blum et al., 2000, p. 1883). These findings suggest that additional factors could account for the variance in risk behaviors.

Discrimination and Health in Women

As previously discussed, disparities exist in women's health. The race disparities in women are similar to those that exist among youth. As briefly discussed above, Schulz et al. (2000) examined these disparities and their relationship to social inequalities, stress, and discrimination in African American and European American women. The researchers used a sample of Detroit women surveyed through the 1995 Detroit Area Study (DAS) and the 1996 Village Health Worker survey (VHW). The DAS was used to survey subjects concerning social inequality and health and the VHW was used to measure stressful life conditions and health protective factors. The variables used to predict health status included education and income (SES), daily encounters of discrimination and acute life events (stressors).

In terms of health status, Schulz et al. (2000) reported that European American women reported better health status than African American women. In addition, African American women reported more experiences of discrimination or unfair treatment and acute life events (i.e.-physical attacks) than European American women reported.

However, when the researchers examined the relationship of discrimination and acute life events to health status, they found a conditional relationship; only African American women living in Detroit (in contrast to those living in the metropolitan area) had a significant and negative relationship between stressors (discrimination and acute life events) and health status. Furthermore, through additional analysis the researchers were able to suggest that “the relationship of race to general health status is associated with, but not entirely accounted for by, differentials in unfair treatment (discrimination) and acute life events” (Schulz et al. 2000, p 1648). This line of research suggests that perhaps the gap in health between African American and European American women can be partially accounted for in the varied experience of stressors in the form of discrimination and acute life events.

Similar to the link between discrimination and general health status in the previous study, researchers were able to link discrimination to poorer mental health status. Schulz et al. (2006) examined the latter relationship in a sample of African American women using longitudinal data from the above-mentioned VHW survey. Using information from the 1996 and 2001 waves of the VHW, the researchers investigated the relationship between discrimination, self-rated health, and depression symptoms. Education and income were also considered for measurements of SES. The results of the analysis revealed that the change over time in discrimination was associated with both self-rated health physical and depression. More specifically, discrimination was positively related to depression and negatively related to self-rated health. It is also important to consider that these findings occurred independent of socioeconomic factors of income and education, suggesting that discrimination is more important to consider

than SES. Moreover, these findings suggest that there is credibility to the psychosocial model.

Likewise, discrimination has been linked to specific physical health status. In one example, discrimination has been linked to cardiovascular disease. Troxel, Matthews, Bromberger, and Sutton-Tyrell (2003) conducted a study to examine the associations between cardiovascular disease and an index of stress that included life events, ongoing stress, discrimination, and economic hardship. This research was conducted in an effort to validate the weathering hypothesis, which is similar to the psychosocial model. The weathering hypothesis, coined by Geronimus (1992), states that African American women's more rapid deterioration in health status could be attributed to exposure to stress (Troxel et al., 2003). Exposure to discrimination can be considered as exposure to stress for African American women.

In Troxel and colleagues (2003) study, the 334 African American and European American women participants were drawn from an ongoing longitudinal study, the Study of Women's Health Across the Nation (SWAN). Participants completed the composite stress measure as well as undergoing an ultrasound to evaluate cardiovascular disease, more specifically, carotid measurements. The researchers' results revealed that African American women experienced significantly higher stress than European American women. In addition, there was a positive relationship found between stress (which includes unfair treatment) and carotid intima-media thickness (IMT) in African Americans, but not in European Americans. Carotid IMT is an indicator of cardiovascular disease, suggesting that African Americans cardiovascular disease was associated with stress. These results suggest that although European American women and African

American women may both experience discrimination based on gender or race, discrimination has more of an impact on African American women.

Comparable results were found in relation to cardiovascular health measured in terms of blood pressure. Again using a sample from the SWAN study, Guyll, Matthews, and Bromberger (2001) examined the relationship of discrimination to blood pressure in a sample of African American and European American women. Systolic and diastolic blood pressure were measured, additionally a questionnaire was administered that measured interpersonal mistreatment. Following the interpersonal mistreatment questionnaire was one item on which if the participant reported mistreatment, they were asked to attribute that mistreatment to causes including race, ethnicity, gender, age, income level, language, physical appearance, sexual orientation, or other. Indicating race allowed the researchers to classify the participant as experiencing racial/ethnic discrimination. The subsequent findings indicated that racial discrimination could have a negative effect on blood pressure. Particularly, African Americans who reported racial discrimination had higher diastolic blood pressure. However, this effect was not present in the European American sample. The evidence from this study maintains the idea that discrimination contributes to the race differences in health between African American and European American women.

Racial discrimination also has been cited to contribute to race differences in preterm and low-birthweight deliveries in African American and European American women. Using the birth outcomes of 352 women in the Coronary Artery Risk Development in Young Adults Study (CARDIA), researchers examined the odds that racial discrimination was associated with preterm and low-birthweight deliveries

(Mustillo et al., 2004). Preterm birth is defined as less than 37 weeks gestation and low-birthweight is less than 2500 grams (Mustillo et al., 2004). The researchers took measures of self-reported birth outcomes, self-reported experiences of racial discrimination, and other factors that could potentially affect birth outcomes such as depression, substance abuse, maternal health factors, and sociodemographic factors. The results revealed that more African American women with preterm birth and low-birthweight infants have experienced discrimination than European American women with preterm and low-birthweight infants. In general, African American women had experienced preterm birth and low-birthweight infants in more instances than European American women. These findings support the psychosocial hypothesis; however, the authors noted that the results were limited because of the small sample size (n=352) and inability to measure potential confounds.

In summary, these studies all examined discrimination as a factor in contributing to the difference in women's health. They suggest that discrimination is an important factor associated with these race differences. More specifically, African American women's experience of discrimination contributes to their poor health status in comparison to European American women.

Discrimination and Health Behaviors

As previously discussed, racial differences exist in health risk behaviors. According to some past research, these differences can also be associated with discrimination. The following studies provide evidence for the psychosocial model of explaining health disparities between African American and European American populations.

Krieger, Smith, Naishadham, Hartman, and Barbeau (2005) illustrated the relationship between health risk behaviors and discrimination in a study to validate a measure of experiences of discrimination. The measure being validated was the Experiences of Discrimination (EOD) measure. African American, European American, and Latino participants were surveyed using the EOD and the Williams Major and Everyday discrimination measure. They were surveyed on psychological distress and cigarette smoking. The findings indicated not only that the EOD was a valid and reliable measure of discrimination, but also that the risk behavior of cigarette smoking was positively associated with experiences of discrimination for minority groups of African Americans and Latinos, but not European Americans. The results of the current study indicated that the EOD measure is valid to use for all races/ethnicities and in addition, established a relationship between discrimination measured in this method and the risk behavior of cigarette smoking. However, this study was limited in that it only examined one risk behavior. In addition, the study did not rule out possible confounds such as SES.

In a similar study, discrimination was cited as the most important contributor to cigarette smoking. In this research, the General Ethnic Discrimination Scale (18 items), a measure of cigarette smoking, and a measure of psychiatric health were used in a sample of 1569 college students and community adults including African Americans, Latinos, Asians, and European Americans (Landrine, Klonoff, Corral, Fernandez, & Roesch, 2006). The findings suggested relationships between discrimination and psychiatric symptoms and cigarette smoking for all races/ethnicities; minorities had stronger relationships. In addition, minorities experiencing discrimination were more likely to smoke than their European American counterparts. Interestingly, African Americans

reported more discrimination than the other minority groups. This research supports that the experience of discrimination and its' relation to health may be more central to African Americans than other races/ethnicities.

Smoking was not the sole health risk behavior linked to discrimination. In a study of African American and European American college students, perceived discrimination was found to have a positive significant relationship with alcohol use (Broman, 2007). In other words, as perceived discrimination increased, alcohol use increased. Additionally, the researchers found gender and race differences in drinking; males and European Americans engaged in more alcohol use. These results were measured through questionnaires including measures of alcohol use, alcohol problems, demographics, and racial discrimination through the Schedule of Racist Events devised by Landrine and Klonoff (1996). Generally, the researchers were able to conclude that discrimination had the same effects on both African American and European American students. This finding was in contrast with previous research on cigarette smoking, suggesting that the association of race and discrimination may not hold constant for all health behaviors.

It is also important to note the relevance of gender discrimination in relationship to health risk behaviors. Zucker and Landry (2007) examined the relationship of gender discrimination to the risk behaviors of drinking and smoking. The researchers conducted a survey among 179 college females. They measured perceived sexism, binge drinking, smoking, and psychological distress. The researchers found that there were positive relationships between perceived sexism with binge drinking and smoking. With further analysis, they also found that these relationships were mediated by psychological distress. Zucker and Landry (2007) concluded that personal distress mediated the relationship

between sexism with binge drinking and smoking. This study suggests evidence for the notion that gender discrimination is important to consider when examining the link between race and health risk behaviors.

In summary, past research has been able to associate risk behaviors with discrimination. Past research has supported links between both racial and gender discrimination with increased alcohol use, and smoking. However, some studies suggest there is a differential association for African Americans and European Americans, while others suggest there is no such difference (Kreiger et al., 2005; Landrine et al., 2006; Broman, 2007). In addition, these studies are limited to alcohol use and smoking. More research is needed to clarify the relationship between race and health.

Conclusion

The psychosocial model aims to explain the health disparities between African American and European American populations. In support of the psychosocial model, the current literature suggests there is a definite link between discrimination and health. However, it is unclear how robust this link is between discrimination and health. Specifically, are there potential confounds such as SES that would eliminate the relationship between discrimination and health. Additionally, research has been limited in that only a correlational relationship can be examined; discrimination could lead to lower health, as well as lower health leading to discrimination. Finally, the research is limited due to the self-report measure experience of discrimination.

Despite the shortfalls in methodology to measure the link between discrimination and health, a relationship remains clear in the previous research. General health status has been negatively linked to discrimination in studies of the general population as well as in

studies of women's health. Concerning risk behaviors, only smoking and drinking have been linked to gender and racial discrimination (Kreiger et al., 2005; Landrine et al., 2006; Broman, 2007; Zucker & Landry, 2007). Further research is required to explore the link between race and health in women.

The current study sought to provide an improved measure of the relationship between race, discrimination, and health in a representative sample. Previous studies failed to examine the cognition behind engaging in risk behaviors. The current study used Cognitive Appraisal of Risky Events Revised (CARE-R), a measure based on the idea that "young adults involvement in risky activities despite warnings about the dangers is that these activities typically provide the potential for positive or beneficial outcomes" (Fromme, Katz, & Rivet, 1997, p422). In other words, participation in risky behavior is influenced by the nature of the outcome that one believes one can experience from that participation. Risky behavior could result in negative and positive consequences and taking the risk is based on the balance of these consequences. Moreover, a person may recognize that there are negative consequences to engaging in a risk behavior, but the positive consequences to that behavior such as peer acceptance or getting high may be more salient in determining their behavior (Fromme, Katz, & Rivet, 1997).

In addition, the current research assessed a population of Black women that included African American, Caribbean, African women. Dressler (2005) proposed that the psychosocial stress model "integrates what is unique about the African American community." In addition, many other researchers agree that the relationship between discrimination and health is a characteristic of the U.S. population, citing that Black women from the U.S. report more discrimination than foreign born Black women

(Dominguez, Strong, Krieger, Gillman & Rich-Edwards, 2009). Some research suggests that the difference in perceived discrimination is based on cultural socialization, thus foreign born Blacks may perceive fewer incidents of discrimination; however, foreign born Blacks “who lack their parents ethnic identity” may perceive discrimination similar to their African American counterparts (Seaton, Caldwell, Sellers, Jackson, 2008, p 1289). The current research included a sample of foreign born Black women as well as Black women born in America (African Americans) to represent the spectrum of Black women in the United States.

The current research explored race, discrimination, and risky behavior through the research question; does discrimination influence the cognitive appraisal of involvement in risky events? It is hypothesized that people who report more discrimination will report engaging in more risky behaviors than those who report less discrimination. Additionally, it is hypothesized that Black females will report more racial discrimination while European American females will report more gender discrimination. It is hypothesized that people who perceive more discrimination will appraise risky behaviors to be less risky than people who perceive less discrimination. In addition, it is hypothesized that people who perceive more discrimination will appraise risky behaviors to be more beneficial than people who perceive less discrimination.

METHOD

Participants

The participants consisted of 148 women recruited through the Towson University Research Pool, cultural clubs (Caribbean Students Association, African Diaspora Club, Black Student Union), and social networks such as Facebook. The racial breakdown of the participants was 54 African American females, 16 Caribbean females, and 5 African females for a total of 75 Black females. There were 73 European American participants. The participants' age ranged from 18 to 25 years old.

Materials and Procedure

The participants completed a survey battery online using Survey Monkey. The survey battery included a demographic questionnaire, CARE-R, the Race-Related Events Scale, the Schedule of Sexist Events, the Sensation Seeking Scale, and the Perceived Stress Scale. Table 1 presents the means, standard deviations, and reliabilities for each scale. The battery took approximately 30 minutes to complete.

The demographic questionnaire consisted of items asking participants to identify their racial/ethnic categorization, to estimate household income, and to indicate their perceived general health.

Cognitive Appraisal of Risky Events (CARE-R).

The CARE-R is a questionnaire designed to assess risk through 3 domains: heavy drinking, illicit drug use, risky sexual activities, and being sexually coerced for women (Katz, Fromme, D'Amico, 2000). The purpose is to better understand the motivation

behind risk taking behaviors. CARE-R consists of 4 scales measuring Past Frequency, Expected Involvement, Expected Benefits, and Expected Risks of the above mentioned domains. The current research will omit the Expected Involvement scale. The Past Frequency scale asks about the number of times in the past 6 months the participant has engaged in a behavior (e.g. had sex with a regular partner or someone I just met or do not know well). Participant responses include 0 times, 1 time, 2-4 times, 5-9 times, 10-20 times, 21-30 times, 31+. The Expected Benefits and Expected Risks scales ask about the likelihood of positive consequences and likelihood of negative consequences respectively. Participants respond on a 7-point Likert scale, 1 (not likely) to 7 (extremely likely). A score for each scale is computed as well as a total score. The CARE-R has been tested for reliability and validity in previous studies on risky behaviors (Katz et al., 2000).

Race-Related Events Scale (RES)

The RES is a measure designed to assess exposure to stressful and traumatizing experiences of race-related stress. The measure has been validated across ethnicities (Waelde, Pennington, Mahan, Mahan, Kabour, & Marquett, 2010). The purpose is to measure race-related stressors that are classified as DSM-IV-TR type trauma as well as daily stressors (daily racism microstressors, vicarious racism experiences, racism-related life events, chronic-contextual stress, collective experiences of racism, and transgenerational transmission of group trauma as conceptualized by Harrell, 2000). Participants are instructed to indicate "yes" or "no" if something happened to them because of their race or ethnicity. A sample item is "treated rudely or coldly because of my race or ethnicity" or "harassed by police or security guards because of my race or

ethnicity.” The scale includes 23 items along with an open ended item that allows the participant to describe an event as “other (please specify).” A total score on the RES is computed by summing the endorsed items across the first 22 items on the scale. Waelde et al. (2010) reported a Cronbach’s alpha of .86 for the Race Related Events Scale.

Schedule of Sexist Events (SSE)

The Schedule of Sexist Events is aimed at measuring the experience of recent and lifetime sexist events that occur for women (Klonoff & Landrine, 1995). The SSE is reliable for use with the populations of interest. More specifically it is usable for African American women (DeBlaere & Moradi, 2008). The scale asks women to respond on a likert scale to questions about their “entire life” and the “past year”. Questions include “how many times have you been treated unfairly by teachers or professors because you are a woman?” and “how many times have you been treated unfairly by people in service jobs (by store clerks, waiters, bartenders, waitresses, bank tellers, mechanics and others) because you are a woman?” Participant responses are on a likert scale of 1 (this event has never happened to you) to 6 (the event happened almost all of the time). A total score as well as lifetime and recent scores are computed for each participant. Klonoff and Landrine (1995) reported that total SSE Lifetime scores had a Cronbach’s alpha of .92 and SSE Recent scores had a Cronbach’s alpha of .90.

Sensation Seeking Scale.

The Sensation Seeking Scale (Zuckerman, 1979) consists of four interrelated subscales. The scale consists of forty forced choice items on which the participant is asked to choose which “most describes your likes or the way you feel.” Each question consists of a choice A and a choice B (e.g. A: I like “wild” uninhibited parties, B: I prefer

quiet parties with good conversation). A total sensation score was computed for each participant. For each item, 1 point is added for the choice of a “High” sensation seeking behavior. Scores on the scale range from 0-40, a higher score indicates the participant is more likely to seek novel and intense sensations. Previous studies have linked sensation seeking to risky behavior (Zuckerman, 2007). See Table 1 for reliability.

Perceived Stress Scale.

The Perceived Stress Scale is a widely used ten-item scale that measures stress over the past month (Cohen, Kamarck, & Mermelstein, 1983). Items are aimed at assessing the amount of stress in the participants’ life (e.g. in the last month, how often have you been able to control irritations in your life?). Participants responses included: never, almost never, sometimes, fairly often, and very often. Cohen and Williamson (1988) reported a Cronbach alpha of .78.

After completing these measures, students were debriefed. Upon completion, students received class credit through the Towson University Research Pool.

RESULTS

Race Differences in Past Frequency of Risk Behaviors

To determine if race differences exist in health risk behaviors, independent samples t-tests were conducted for several outcome variables. The grouping variable was race (Black, European American). For the purpose of analysis African American, Caribbean, and African women were grouped into Black women. The outcome variables were the past frequency of each health risk behavior. The findings of the t-test indicated that there were race differences in past frequency of each risk behavior (see Table 2). Black participants ($M=2.02$, $SD=1.23$) engaged in significantly less risky sexual behavior with a regular partner than European American participants ($M=2.49$, $SD=1.34$), $t(146)=-2.19$, $p=.03$. Similarly, Black participants ($M=1.06$, $SD=.47$) engaged in significantly less risky sexual behavior with a new partner than European American participants ($M=1.24$, $SD=.60$), $t(134.70)=-2.07$, $p=.04$. Black participants ($M=1.06$, $SD=.48$) also were less sexually coerced than European American participants ($M=1.19$, $SD=1.19$), $t(146)=-2.00$, $p=.048$. Black participants ($M=1.03$, $SD=.41$) engaged in less drug use than European American participants ($M=1.32$, $SD=.54$), $t(133.88)=-3.65$, $p=.00$. Finally, Black participants ($M=1.51$, $SD=.84$) engaged in significantly less risky drinking behaviors than European American participants ($M=2.17$, $SD=.83$), $t(146)=-4.82$, $p=.00$.

Race Differences in Discrimination

An independent samples t-test was conducted to determine if racial differences in racial and gender discrimination (see Table 3). There were no significant differences

found for lifetime and recent gender discrimination. However, for racial discrimination Black participants ($M=5.08$, $SD=3.98$) reported significantly more experiences than European American participants ($M=1.95$, $SD=2.39$), $t(119.84)=5.81$, $p=.00$.

Evaluation of the Psychosocial Model

Correlations and a MANCOVA were used to determine if the psychosocial model applies in this population. Correlation coefficients were computed between stress, racial discrimination, and gender discrimination (see Table 4). The results of the correlational analysis showed no relationship between stress and racial discrimination. However, the results of the correlational analysis show that the correlation between lifetime gender discrimination and stress was significant and positive, indicating that the more gender discrimination experienced throughout a participant's lifespan the more stress experienced by the participants, $r=.32$, $p<.05$. Similarly, the correlation between recent gender discrimination and stress was significant, indicating that the more gender discrimination experienced in the past year by the participant the more stress experienced by the participant, $r=.33$, $p<.05$. The experience of racial discrimination was also related to the experience of gender discrimination. The results of the correlation analysis show that the correlation between lifetime gender discrimination and racial discrimination is statistically significant and positive, indicating the more lifetime gender discrimination experienced by a participant the more racial discrimination experienced by a participant, $r=.477$, $p<.05$. A similar relationship is true for recent gender discrimination and racial discrimination, the more gender discrimination experienced by a participant in the past year the more racial discrimination experienced by the participant, $r=.460$, $p<.05$.

A multivariate analysis of covariance was conducted on racial, lifetime gender, and recent gender discrimination dependent measures. The independent variable was race (Black, European American). The covariate was socioeconomic status (household income). The results of the analysis are presented in Figure 1. The MANCOVA indicated a significant difference in discrimination for Black participants and European American participants, $F(3,142)= 23.209, p<.001, \text{Wilks' } \lambda=.671, \text{partial } \epsilon^2=.33$. The plot shows that Black participants reported higher race related events than European American participants, $F(1,144)= 32.62, p<.001, \text{partial } \epsilon^2=.33$. This effect accounted for approximately 33% of the variance with 100% power. The effects of gender discrimination and race were not significant.

A multivariate analysis of covariance was conducted on past frequency of risk behaviors, perceived benefit of risk behaviors, and perceived risk of risk behaviors dependent measures. The independent variables were racial, lifetime gender, and recent gender discrimination. The covariate was sensation seeking. The model was not statistically significant.

Predicting Health from RES, SSE, SSS, and SES

A multiple regression regressed general health on discrimination, stress, sensation seeking, and SES. Findings indicated that the model significantly predicted general health, $r^2=.11, F(6,118)=2.42, p<.05$. Analysis of the individual predictor variables indicated the only predictor of general health was stress, $t=2.64, p<.01$. The multiple regressions regressed CARE-R scores on discrimination, stress, sensation seeking, and SES. Findings indicated that the models significantly predicted past frequency of risk behaviors and perceived benefits of risk behaviors, but not perceived risk of risk

behaviors. A multiple regression that predicted past frequency of risk behaviors was significant, $r^2=.20$, $F(6,117)=4.87$, $p<.01$. Analysis of the individual predictor variables indicated the only predictor of past frequency of risk behavior was sensation seeking, $t=5.20$, $p<.01$. A multiple regression that predicted perceived benefits of risk behavior was significant, $r^2=.16$, $F(6,118)=3.63$, $p<.01$. Analysis of the individual predictor variables indicated that sensation seeking was the only predictor of perceived benefit of risk behaviors, $t=4.55$, $p<.01$.

Multiple regressions were also conducted independently for Black participants and European American participants. Findings indicated that the models did not significantly predict risk behaviors for Black participants. However, for European American participants the model predicted past frequency of risk behaviors, $r^2=.23$, $F(6,61)=2.99$, $p<.05$. Analysis of the individual predictor variables indicated that sensation seeking was the only predictor of past frequency of risk behaviors, $t=3.90$, $p<.01$. The model also predicted perceived benefits of risk behaviors, $r^2=.23$, $F(6,62)=3.16$, $p<.01$. Analysis of the individual predictor variables indicated that sensation seeking was the only predictor of perceived benefit of risk behaviors, $t=3.82$, $p<.01$.

DISCUSSION

The current study sought to provide an improved measure of the relationship between race, discrimination, and health in a representative sample by examining the cognition behind engaging in risk behaviors. Overall findings indicated that the link between discrimination and cognitive appraisals of risky events was not supported.

The research hypothesis that Black females will report more racial discrimination, while European American females will report more gender discrimination was partially supported. Black females reported significantly more racial discrimination than European females. However, there were no significant differences in lifetime or recent gender discrimination. These findings suggest that Black women experience gender discrimination similar to that of European American women while experiencing racial discrimination as well. With both types of discrimination at work against Black women, double discrimination could explain the detrimental effects on health leading to health disparities.

The research hypotheses that people who report more discrimination will report engaging in more risky behaviors than those who report less discrimination, people who perceive more discrimination will appraise risky behaviors to be less risky than people who perceive less discrimination, and people who perceive more discrimination will appraise risky behaviors to be more beneficial than people who perceive less discrimination were not supported. Discrimination did not predict past frequency of risk behaviors. This was contrary to previous research suggesting that discrimination predicts

health for Blacks (Kreiger et al.,2005; Schulz et al.,2000; Schulz et al., 2005). The current findings also contradicted previous findings that cite discrimination as the most important contributor to health risk behaviors (Landrine et al.,2006). However, the current sample was composed of women from similar levels of income and education. Additionally, this sample of Black women from an educated background may naturally have more education surrounding the consequences of engaging in health risk behaviors; therefore they may have developed coping mechanisms in order to avoid engaging in such risk behaviors.

Discrimination, stress, and SES did not predict cognitive appraisals of risk behaviors. The only variable pertinent to predicting health risk behaviors in the current sample was sensation seeking. Sensation seeking was predictive of past frequency of risk behaviors and perceived benefits of risk behaviors. When separated into race, sensation seeking was predictive of past frequency and perceived benefits of health risk behaviors for only European American participants. These findings are contrary to past research linking racial and gender discrimination to health (Kreiger et al., 2005; Landrine et al., 2006; Broman, 2007; Zucker & Landry, 2007). However, the positive link between sensation seeking and risk behaviors supports past research (Zuckerman, 2007). The importance of sensation seeking in predicting the past frequency of health risk behaviors and perceived benefit of health risk behaviors suggests that personality variables such as sensation seeking could provide an important link to determining what makes women more likely to engage in risk behaviors.

Limitations

With the present research findings it is pertinent for further research to take into consideration the following limitations. Future research should consider recruiting more participants from the general population. The findings of previous research linking risk behaviors to discrimination may be limited to samples in the general population where education, background, and climate may not be as similar as for participants in a university setting. Perhaps a sample from the general population would yield differences in cognition about the perceived benefits and risks of engaging in risky events because of the various levels of education found in a general sample.

In addition, further research should examine Black women in separate groups of African American, Caribbean, and African women. Past research supports the psychosocial model is unique to the African American experience (Dressler, 2005; Dominguez, Strong, Krieger, Gillman & Rich-Edwards, 2009). By examining Black women in separate groups there may be differences in discrimination and health risk behaviors.

Implications for future research

This study proposed that experiences of racial discrimination would lead to engaging in risk behaviors. However, in this sample the threat or feeling of being discriminated against produced the opposite effect. Black women engaged in fewer risk behaviors than European American women. This suggests that perhaps because of the fear of being discriminated against, Black women may avoid engaging in risk behaviors. Other possibilities for engaging in fewer risk behaviors include protective factors such as religiosity, spirituality, and social support (Bachanas, Morris, Lewis-Gess, Sarett-Cuasay, Sirl, Ries, & Sawyer, 2002; Hubbard-McCree, Wingwood, DiClemente, Davies, &

Harrington, 2003). Future studies should consider the measurement of these factors to examine the operation of protective factors in this sample.

Because of the limited findings, the relationship between discrimination, health, and the cognition surrounding health risk behaviors remains unclear. It is pertinent to uncover the factors underlying the disparities in the health of Black and European American women. If cognitive appraisals of risky events are indeed a factor then further education about the factual risks and benefits of engaging in risky behaviors would benefit women. If discrimination is a factor, coping strategies must be developed and disseminated to close the current gap in health.

APPENDIX

Table 1. Summary of Means, Standard Deviations, and Internal Consistency for the Risk Behavior, Discrimination, Stress, and Sensation Seeking Scales

Scale	M	SD	Variance	α
CARE-R				
Past Frequency	7.52	2.82	7.94	.75
Benefits	8.58	3.76	14.12	.82
Risk	23.05	10.52	110.72	.95
Race-Related Events Scale	3.52	3.63	13.18	.86
Schedule of Sexist Events				
Lifetime	36.91	17.28	298.62	.95
Recent	31.21	14.99	224.59	.94
Perceived Stress Scale	19.41	5.84	34.16	.67
Sensation Seeking Scale	26.12	7.66	58.65	.91

Table 2. Past Frequency of Health Risk Behavior by Race

	Race		t	df
	Black	European American		
Risky Sex with a Regular Partner	2.02 (1.23)	2.49 (1.34)	-2.19*	146
Risky Sex with a New Partner	1.06 (.47)	1.24 (.60)	-2.07*	134.70
Sexual Coercion	1.06 (.41)	1.19 (.29)	-2.00*	146
Drug Use	1.03 (.41)	1.32 (.54)	-3.65***	133.88
Drinking	1.51 (.84)	2.17 (.83)	-4.82***	146

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

Table 3. Racial and Gender Discrimination by Race

	Race		t	df
	Black	European American		
Lifetime Gender Discrimination	35.04 (19.89)	38.82 (13.98)	-1.34	132.98
Recent Gender Discrimination	29.61 (16.93)	32.85 (12.60)	-1.317	146
Racial Discrimination	5.08 (3.98)	1.95 (2.39)	5.81***	119.84

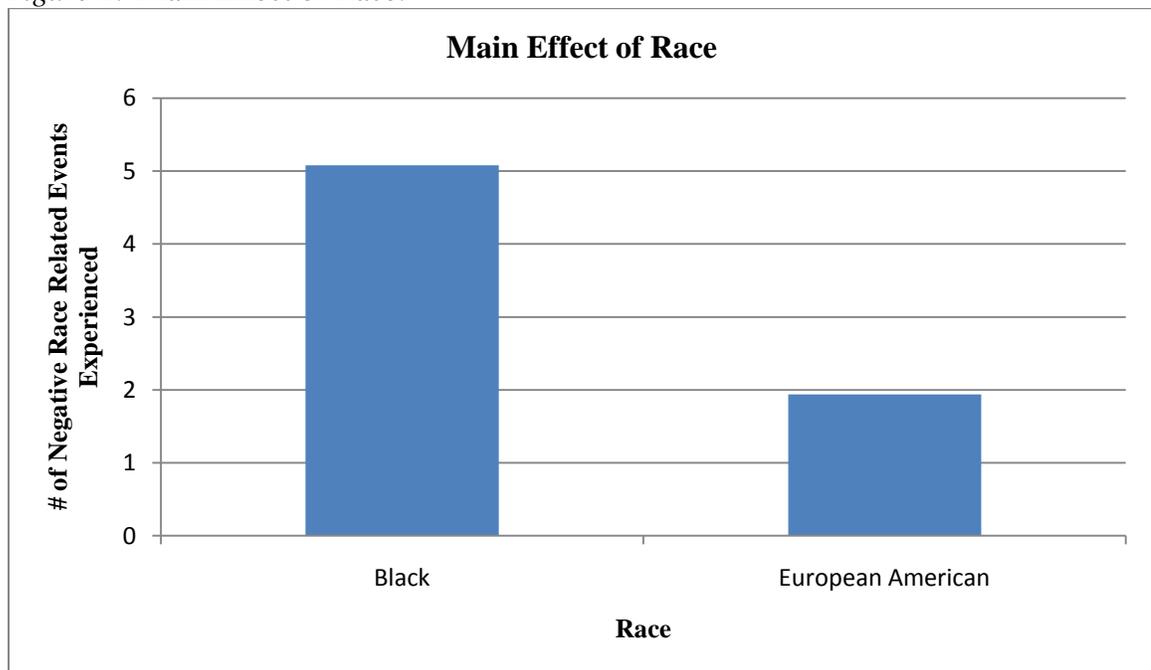
* $p < .05$, ** $p < .01$, *** $p < .001$

Table 4. Bivariate Correlations between Racial Discrimination, Gender Discrimination, and Stress

	Stress	Lifetime Gender Discrimination	Recent Gender Discrimination	Racial Discrimination
Stress	1	.32**	.33**	-.01
Lifetime Gender Discrimination		1	.90**	.48**
Recent Gender Discrimination			1	.46**
Racial Discrimination				1

** $p < .01$

Figure 1. Main Effect of Race.





Date: 3/16/2011

NOTICE OF APPROVAL

TO: Janae Brown **DEPT:** PSYC

PROJECT TITLE: *Race as a Factor in Health Risk Behaviors of African American, Caribbean, African, and Caucasian*

SPONSORING AGENCY:

APPROVAL NUMBER: 11-A059

The Institutional Review Board for the Protection of Human Participants has approved the project described above. Approval was based on the descriptive material and procedures you submitted for review. Should any changes be made in your procedures, or if you should encounter any new risks, reactions, injuries, or deaths of persons as participants, you must notify the Board.

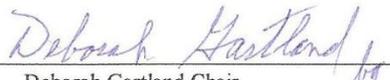
A consent form: is is not required of each participant

Assent: is is not required of each participant

Please use copies of any enclosed consent forms and recruitment flyers, approved by the IRB for your study, in lieu of the unstamped versions.

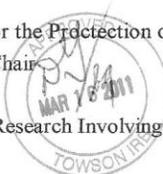
This protocol was first approved on: 16-Mar-2011

This research will be reviewed every year from the date of first approval.


Deborah Gartland, Chair
Towson University Institutional Review Board

**APPROVAL NUMBER: 11-A059**

To: Janae Brown
From: Institutional Review Board for the Protection of Human
Subjects, Deborah Gartland, Chair
Date: Wednesday, March 16, 2011
RE: Application for Approval of Research Involving the Use of
Human Participants



Office of University
Research Services

Towson University
8000 York Road
Towson, MD 21252-0001

t. 410 704-2236
f. 410 704-4494

Thank you for submitting an Application for Approval of Research Involving the Use of Human Participants to the Institutional Review Board for the Protection of Human Participants (IRB) at Towson University. The IRB hereby approves your proposal titled:

Race as a Factor in Health Risk Behaviors of African American, Caribbean, African, and Caucasian

Please note that this approval is granted on the condition that you provide the IRB with the following information, revisions, and/or documentation:
Before interviewing Morgan Students you must get their approval and send us a copy.

If you should encounter any new risks, reactions, or injuries while conducting your research, please notify the IRB. Should your research extend beyond one year in duration, or should there be substantive changes in your research protocol, you will need to submit another application for approval at that time.

We wish you every success in your research project. If you have any questions, please call me at (410) 704-2236.

CC: Evengeline Wheeler
File

Informed Consent

Principal Investigator: Janae Brown, Department of Psychology, Towson University

This is a study in which we are examining the relationship between health risk behaviors and stress. In this study you will be asked to complete a survey battery.

There are no known risks associated with participating in the study. Should you become distressed or uncomfortable, you have the right to discontinue the survey immediately. Although there are no direct benefits to you, we hope that the results of the study will reveal something about youth and health risk behaviors. The study should take no longer than 45 minutes to complete.

Participants should be 18-25 years old.

Your participation is entirely voluntary. You do not have to participate in the study. If you choose to participate, you may discontinue your participation at any time. Your decision to participate or not to participate will not influence your grade or class standing.

All information about your responses will remain confidential. We will not show your information to anyone outside of our research team unless you give us written permission. Your responses will never be linked to your name. If you have any questions, you may contact the experimenter via email, jbrown60@students.towson.edu. If you should have any questions after today, you can call (410) 704-3209 and ask for Dr. Evangeline Wheeler or call (410) 704-2236 and ask for Dr. Deborah Gartland, Chairperson of the Institutional Review Board for the Protection of Human Participants at Towson University.

THIS PROJECT HAS BEEN REVIEWED BY THE INSTITUTIONAL REVIEW BOARD FOR THE PROTECTION OF HUMAN PARTICIPANTS AT TOWSON UNIVERSITY.

Signature

Date

Signature of Investigator

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May 2009	Mae P. Claytor Symposium Morgan State University, Baltimore MD <i>Oral Presentation</i> -Does Money Make You Happy?: An Exploration of Cultural Implications in Material Aspirations and Happiness
April 2009	Carolinas Conference Meredith College, Raleigh, NC <i>Oral Presentation</i> - The Drinking Culture: An Exploration of Factors Influencing Drinking Among First Year College Students
November 2008	ABRCMS Orlando Florida <i>Poster Presentation</i> - Exploring Racial Differences in Depression in College Females: Self Salience as a Mediator
April 2008	Carolinas Conference Meredith College, Raleigh, NC <i>Oral Presentation</i> - Is My Name A Reflection of Me? The Impact of Racial/Ethnic Label Preference on Psychological Well Being
November 2007	NIMH-COR Conference Albuquerque, New Mexico <i>Poster Presentation</i> - Exploration of Ethnicity and Gender Differences Among Youth Engaging in Sexually Risky Behavior

AWARDS AND HONORS

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