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An Exploratory Investigation of the Relationship between Racism, Racial Identity, Perceptions of Health, and Health Locus of Control among Black American Women

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Abstract: This exploratory investigation examined the relationship between racial identity and perceived racism as predictor variables and perceptions of health status and health locus of control as criterion variables in a sample of 90 Black American women. Results of a canonical correlational analysis indicated a shared variance of 37% between these two sets of variables. This finding highlights the need to focus on perceived racism and racial identity attitudes as potentially important factors for consideration when seeking to understand health disparities in the United States.

Key words: Racism, racial identity, health, locus of control.

In recent years, a large body of research has focused on significant disparities in both physical and mental health outcomes and access to adequate health care across racial groups within the United States.[1,2,3] While the focus on health disparities has largely been within the purview of epidemiology and public health,[4] psychologists have for a long time recognized the unique health needs of people of color, particularly those with low incomes and educational levels.[5]

Recently, psychologists and other mental health professionals have started to contribute to a greater understanding of the complex issues associated with health disparities.[6] One significant area for psychologists has been the extent to which race and culture can be viewed as factors that are associated with health and mental health disparities. Scholars have contended that various forms of racism (e.g., individual and institutional racism) represent barriers to adequate care for oppressed racial groups, including African Americans[7] and that cultural variables such as racial identity may be an important determinant of health care utilization.[8] An examination of health disparities across racial groups reveals that the differences are often greatest between Blacks and Whites.[1] In comparison with White Americans, Black Americans are more likely to die

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from cardiovascular disease; are more likely to be affected by chronic diseases such as diabetes and hypertension; and are less likely to receive standard or timely treatment for cancer and related illnesses.[2,9] While institutional racism and social class have been identified as a significant contributors to health disparities,[10] there has been less focus on the psychological processes associated with racial experiences and the degree to which these process might be associated with health related attitudes among racially diverse groups.[10] The current investigation therefore sought to examine the influence of perceived racism and racial identity attitudes on the self-reported health status and health locus of control (i.e., the degree to which individuals believe they have control of their health status) in a sample of Black American women. In particular, we wanted to know whether self-reported health status and locus of control were influenced by people's racial perceptions of their environments and/or by their psychological orientation to their racial group. Our specific focus on Black American women was driven by the unique experiences of this group in the United States. Recent research suggests that, for Black American women, psychological stress includes generic life stress, race-related stress, and gender related stress.[11] While the extent to which experiences of racism might influence health status has not been clearly established in the literature, the current investigation builds on prior research indicating that racism-related stress does appear to have negative health consequences for Black women.[12]

Racism and Racial Identity

Racism, life stress, and health status among African American women. Experiences of racism and racial discrimination have been identified as a significant source of stress for Black Americans.[13,14] Jones has provided a useful model of the relationship between racism and health,[15] identifying three levels of racism: (1) Institutional racism—the differential allocation of resources by race; (2) Personally mediated racism—prejudice and discrimination; and (3) Internalized racism—accepting and internalizing the negative messages associated with one's racial group. These levels of racism are thought to have an intersecting and reciprocal relationship with one level reinforcing the others, together influencing how people view and interact with institutions and processes of health care. Empirical examinations of racism and health indicate that the experience of racism is associated with adverse health outcomes, particularly in the area of mental health.[16,25] For example, studies have found that perceptions of racism are positively related to lower levels of self-esteem and depressive symptomatology.[17,18] Additionally, studies indicate that racism is positively associated with such stress-related conditions as hypertension and cardiovascular dysfunction.[19]

When incorporating gender as a variable, some researchers suggest that in view of the combined effects of racism and sexism, the experience of racism of Black women might differ from that of their male counterparts.[20,21] Black American women have been described as one of the most vulnerable population groups in relation to health status,[22] a state that may be attributable to such social factors as role strain, disproportionate experiences with poverty, and the intersection of race and gender oppression.[12,38] To illustrate, a recent study documented an increase in the incidence of breast cancer among African American women who were in a younger age group and who reported

more frequent experiences of racial discrimination.[23] Another study explored the role of racism in connection with birth weight. In this study 314 African American mothers were surveyed within 72 hours of giving birth and recorded their experiences of racism during their pregnancy as well as experiences of racism over their lifetime. A positive correlation was found between lifetime racism experiences and very low birth weight children in this sample.[24] Researchers who have explored the role of racism in the lives of Black women have consistently found that experiences of racism and discrimination tend to be associated with adverse physical and mental health outcomes,[12,21] a finding that is consistent with the larger racism-related health outcomes literature.[25,26] Notably, however, these studies have tended to treat all Black American women as similar in terms of race and culture. Scholars such as Helms[27] have argued for considering within-group variation among racial groups and not treating all individuals from a particular racial group as the same. Thus, the construct of *racial identity* is an important variable to consider in relation to within-group variability associated with race-related attitudes and experiences.[28]

Racial identity. Racial identity theories concern how individuals identify with members of their own racial-cultural group and how they identify with the dominant racial-cultural group.[29,30] As outlined in Cross's original model of psychological nigrescence, the process of socialization associated with assuming a Black identity incorporates four stages, or what are now referred to as *statuses*, namely Pre-encounter, Encounter, Immersion-Emersion, and Internalization. *Pre-encounter* is a status in which race has low salience and individuals might conform to attitudes and behaviors associated with the dominant White culture including anti-Black attitudes and the adoption of a Eurocentric worldview. *Encounter* status marks the beginning of an identity shift, often initiated by some personal experience or series of encounters with racism. This status may be marked by confusion, emotional turmoil, guilt and anger. *Immersion-Emersion* involves a phase in which the individual explores new sides of his or her Black identity and where the Black identity assumes great salience. This period may also be accompanied by an increasingly negative view of White culture and White people. Finally, *Internalization* is a state in which the individual has integrated his or her Black identity, the sense of being Black having become both salient, positive, and natural, and the individual being able to appreciate other racial and cultural groups.[28,29] Each racial identity status is thought to correspond to varied behaviors and affective states reflective of how individuals process race-related stimuli.[29]

Psychosocial correlates of racial identity. Empirical research has provided clear evidence of the influence of racial identity status attitudes on a wide array of variables, such as psychological functioning and perceptions of discrimination.[28,31] Moreover, there is emerging evidence that racial identity status attitudes might moderate the relationship between racial discrimination and psychological distress, in addition to influencing attitudes toward participation in health care.[32,33] The results of research that exploring the relationship between racial identity and health-related variables have mainly proven inconclusive. In a study of young Black American adults, Williams and colleagues[34] found that racial identity was not associated with perceived health status. However, a recent study exploring racial identity and health care[33] found that racial centrality, the degree to which being African American is central to one's identity, was inversely

associated with seeking health care in a sample of African Americans diagnosed with sickle cell anemia. Finally, in exploring the relationship between racial identity and health promoting behaviors, Johnson[35] found that in a sample of Black Americans the Internalization status of racial identity was positively associated with health promoting behavior, although the strength of the relationship was weak. In sum, racial identity status attitude research has provided evidence indicating that racial identity is an important psychological construct, is associated with perceptions of racism, and might play a role in health-related attitudes and behaviors.

Purpose of study. The ongoing nature of racism in American society has been well-documented,[36,37] as has the presence of significant health disparities disfavoring Black Americans, and Black American women in particular.[1] In addition, the relationship between perceived racism and health status among African American women has also been clearly established.[12,21–23,38] The current investigation, therefore, sought to extend the understanding of perceived racism and health by focusing on the manner in which racism-related experiences were associated with perceptions of individual health status and perceived sense of control of one's health, i.e., health locus of control. Additionally, given the need to recognize within-group variation associated with racial group membership, we included a focus on racial identity status attitudes, noting that some scholars have contended that racial identity could be an important variable influencing health-related attitudes and behaviors.[39,40] Although exploratory in nature, our investigation was guided by the following hypotheses:

1. We expected that perceived racism would be inversely correlated with perceptions of health status and positively associated with a health locus of control.
2. We assumed that mature racial identity status attitudes such as Internalization would be positively related to both perceptions of health status and internal health locus of control, and that immature racial identity status attitudes such as Pre-Encounter would be positively associated with a health locus of control that was externally-oriented, such as powerful other and chance.

Methods

Participants. The participants were 90 Black American female adults recruited from hair salons in New York City and Washington, D.C. The age of the participants ranged from 18 to 67 years (M=32.44, SD=8.71). Participants described themselves as working class (41%, n=37), middle class (49%, n=44) and upper class (10%, n=9). Twelve percent (n=11) of the participants had obtained an associates degree, 24% (n=22) had an undergraduate degree, and 11% (n=10) a graduate degree. The educational status of the remaining participants ranged from a high school diploma or equivalent (20%, n=18) to some college courses taken (32%, n=29). Participants identified their religious orientation as Christian (30%, n=27), Baptist Christian (37%, n=33), Catholic Christian (10%, n=9), and a category entitled Other (11%, n=10). Concerning ethnic group affiliation, 76% (n=68) identified as African American, 13% as American (n=13), and 8% (n=7) as Caribbean. All demographic data were self-reported by the participants.

Instruments. *Health Perceptions Questionnaire (HPQ)*. The HPQ is a seven-item

measure taken from the Medical Outcomes Study,[41] a self-report survey designed to assess global perceptions of mental and physical health status and more specific characteristics of physical functioning, such as levels of fatigue or quality of pain.[40] The HPQ limits questions to individuals' perceptions of their current health status, with higher scores indicating a more positive perception of health status. Items include such statements as "I feel about as good now as I ever have," and "I am in poor health," with participants responding using a Likert type scale ranging from 1 = *definitely true* to 5 = *definitely false*. Reliability as measured by Chronbach's alpha was .83 for the current participant group.

Multi-dimensional Health Locus of Control (MHLC).[42] The MHLC is an 18-item self-report measure designed to assess beliefs about the sources of reinforcement for individuals' health-related behaviors. Attitudes are assessed via three domains, (a) Internal health locus of control, (b) Matter of Chance, and (c) Powerful Other locus of control. According to Wallston and colleagues,[42] Internal corresponds to the extent to which an individual believes that he or she is responsible for their health status; Chance corresponds to the belief that health or illness is a matter of fate or luck; and Powerful Other corresponds to the belief that one's health is determined by other individuals in positions of power. The MHLC is scored such that higher scores reflect more of the particular construct being assessed. The MHLC has displayed variable reliability across racial and ethnic groups. Malcarne and colleagues[43] reported reliability coefficients for three ethnic/racial groups as follows: for White Americans, alpha ranged from .55 for Chance to .66 for Internal; for Filipino Americans, from .52 for Chance to .76 for Internal; and for Latino Americans, from .50 for Powerful Other to .68 for Internal. For African American samples, reliability ranges have also displayed significant variability, with one study reporting alpha coefficients ranging from .66 for Internal to .79 for Powerful Other,[44] and another reporting alphas ranging from .38 for Internal to .54 for Powerful Other.[45] Reliability coefficients for the current sample were .51 for Chance, .64 for Powerful Other, and .50 for Internal locus of control, thus falling within the range of alpha coefficients for African American and other samples of people of color. While it is evident that the reliability coefficients for the MHLC scale tend to be on the lower range of acceptability, it is important to note that some scholars contend that adequate reliabilities should be viewed as being relative to the specific investigation and tend to be influenced by sample characteristics and psychological processes, such as individual interpretations of the items.[46,47] As a result, lower-range alpha reliability coefficients may not suffice to show that items on a measure are not accessing the corresponding construct. Finally, the validity of the MHLC scales have been well established via numerous studies indicating convergent validity with measures assessing similar constructs such as Levenson's Locus of Control scales.[48]

Schedule of Racist Events (SRE-M). Schedule of Racist Events—SRE.[49] The original SRE is an 18-item self-report measure that assesses the frequency and stressfulness of selected racist experiences faced by Black Americans. Respondents are asked to reflect on their racist experiences over the past year and over the lifetime. For the purposes of the current study and with the authors' permission, the time frame was modified from past year and lifetime to past month and past year. Scores for the SRE are computed

by totaling each response so that higher scores indicate a higher incidence of racist experiences and a higher appraisal of stress related to racist experiences. Chronbach's alpha internal reliability coefficients have been reported as.95 for the year, .95 for lifetime racist experiences scales, and .93 for the appraised stressfulness of racist events scale.[49] Alpha reliability coefficients for the subscales used in the current study were as follows: .90 for the past month racist experiences scale, .90 for past year racist experiences scale, .89 for stressfulness of racist events scale. The SRE is considered to be an effective instrument for assessing perceived racist events and the perceived stressfulness of those events.[50]

Black Racial Identity Attitude Scale—RIAS-B.[51] The RIAS-B is a 50-item self-report measure designed to measure racial attitudes of individuals towards themselves and others. The RIAS-B measures the four statuses associated with psychological nigresence, considered to reflect immature and mature racial identity attitudes. Respondents use a five-point scale (1 = *strongly agree* to 5 = *strongly disagree*) to indicate the extent to which each item reflects their experience. Subscale scores are obtained by summing the scores for each item within the relevant subscale. In their initial study, Parham and Helms[52] reported Cronbach's alpha for the four subscales as Pre-Encounter, .76; Encounter, .51; Immersion/Emmersion, .69; and Internalization, .80 (Parham & Helms, 1981). Reliability coefficients for the current study were as follows: Pre-Encounter, .79; Encounter, .51; Immersion/Emersion, .69; Internalization, .69. Concurrent validity of the RIAS-B has been established by positive correlations between racial identity statuses and related constructs such as *African American acculturation*, *ego-identity*, and *racial socialization*.[53–55]

Personal Data Form (PDF). The PDF was designed to gather personal information such as racial designation, ethnicity, educational level, age, gender, and socio-economic status.

Procedure. Data collection involved the following. A survey packet was created which included a cover letter, the personal data form, and the self-report instruments. The cover sheet included information pertaining to informed consent. Participants were recruited at hair salons and were informed that they would be participating in research focusing on the experience of discrimination and stress. Data collection was undertaken over 18 months and took place in New York City (NYC) and Washington D.C. The data collection in NYC was undertaken by the first author using the following procedure. A flyer describing the research as focusing on racial discrimination and stress was distributed to individuals within the hair salons. The flyer also promised a $5 reimbursement for participation. When individuals expressed interest they were provided with the survey packet and, on completion, were given $5 and a short debriefing form providing additional details about the research. The data collection in Washington D.C. followed a similar procedure but differed in that it was undertaken by a graduate assistant and the reimbursement for participation was increased to $10 in an attempt to attract more participants more quickly. The second data collection yielded 62 participants, resulting in a total of 112 participants. After an initial examination of the survey packets, 12 surveys were noted to be incomplete and therefore were discarded. Additionally, 10 subjects were dropped from the analysis due to the invalidity of their

responses (e.g., participants responded by marking the same value on all the survey items). Thus the final tally for data analysis was 90 participants. Institutional review board approval was given by George Mason University.

Results

Preliminary analysis. Prior to undertaking the primary analysis, a multivariate analysis of variance (MANOVA) was conducted in order to assess for significant differences on the independent variables (racial identity and past month racist incidents) across site of data collection and social class. Results indicated that there were no significant differences across these specific demographic variables, therefore the subsequent analysis was conducted on the entire sample as a whole. Descriptive statistics and reliability coefficients for all study variables are presented in Table 1.

Primary analysis. After confirming assumptions of multivariate normality, a canonical correlation was conducted to assess the strength and direction of the relationships between the two sets of variables, namely perceived racism and racial identity as one set, with health status and health locus of control as the other set. Canonical correlation is a multivariate parametric procedure designed to assess the strength of relationship

Table 1.

CORRELATION MATRIX, DESCRIPTIVE STATISTICS AND RELIABILITY COEFFICIENTS OF STUDY VARIABLES

Variable	1	2	3	4	5	6	7	8	MN	SD	Alpha
1. HS									24.78	4.5	.83
2. IL	.13								25.42	4.79	.49
3. PO	.27	.22*							18.42	5.59	.64
4. CH	−.01	.05	.32**						15.24	4.98	.51
5. RRE	−.26*	−.05	.26*	.19					27.78	12.1	.90
6. PRE	−.19	−.08	.11	.31**	.28**				38.54	9.84	.79
7. ENC	−.17	.13	.08	.31**	.23*	.46**			14.32	3.88	.51
8. IEM	−.07	.07	.26*	.26*	.19	.36**	.65**		31.43	6.83	.69
9. INT	.19	.25*	.01	.06	−.03	−.19	.07	.17	54.46	7.14	.69

*p<.05
**p<.01
HS = health status
IL = Internal locus of control
PO = Powerful Other
CH = Chance locus of control
PRE = Pre-encounter
ENC = Encounter
IEM = Immersion/Emersion
INT = Internalization
RRE = past month racist incidents

between sets of variables.[56] Given the relatively small sample size and the exploratory nature of our investigation we decided to use canonical correlation in the hope of reducing the risk of Type I error (that is, finding a statistically significant relationship when none exists). Additionally, proponents of canonical correlation analysis (CCA) have argued that CCA more closely approximates the true relationship between variables given its ability to assess multiple variables in one analysis thereby providing some consistency with the idea that human behavior tends to have multiple influences and causes.[57]

The canonical correlation analysis yielded a statistically significant model Wilks Ω of .63 F (20, 269)=2.04 $p<.01$ and produced four functions with squared canonical correlations ranging from .24 to .01. An accepted calculation of the overall effect size for a canonical model can be derived by using the formula 1−Wilks.[57] Thus, by employing the calculation of 1−.63, the amount of shared variance between the two variable sets in the current analysis was observed to be .37 (or, 37%). The dimension reduction, an analysis employed to examine the canonical functions in a hierarchical manner, showed the first canonical function to be the only significant function accounting for 24% ($R_c^2=.24$) of variance in the variable sets. In order to assess which variables were most likely contributing to the overall model, an examination of the standardized canonical coefficients and the bivariate correlations between the observed variables (criterion and predictor) that constituted the canonical function was undertaken (see Table 2). A cut-off of .3 for the coefficients was adopted in order to establish the relevant individual predictors. For the predictor variables, the canonical coefficients suggest that

Table 2.

CANONICAL SOLUTION FOR RACIAL IDENTITY AND PERCEIVED RACISM PREDICTING HEALTH STATUS AND HEALTH LOCUS OF CONTROL—FUNCTION 1[a]

Variable	Coef	R_s	R_s^2 (%)
Health perceptions	−.61	−.62	38
Powerful Other	.51	.60	36
Internal	−.19	−.13	2
Chance	.46	.62	38
R_s^2 (%)			24
Racist events	.61	.78	60
Pre-encounter	.31	.68	46
Encounter	−.02	.53	28
Immersion/Emersion	.38	.58	33
Internalization	−.27	−.28	8

[a]Function 1 Eigenvalue = .32, $R^2=.24$, $p<.01$.
Coef = standardized canonical function coefficient
R_s = structure coefficient
R_s^2 = squared structure coefficient

past month racist experiences (.61) and the racial identity attitudes of Pre-Encounter (.31) and Immersion-Emersion (.39) were the relevant variables and were positively associated with the criterion set. For the criterion set, the coefficients indicated that perceived Health Status (−.61) was inversely associated with the predictor set, and the locus of control attitudes of Powerful Other (.51) and Chance (.47) were positively associated with racial identity attitudes and perceived racism.

In sum, the findings reveal that for the current sample of Black women, racist experiences were inversely related to perceptions of health and positively related to the health locus of control attitudes emphasizing powerful others and health status as reflecting of chance or fate. This could mean that African American women who experience racist incidents are more likely to believe that their health outcomes are either in the hands of people who they perceive to be in positions of power or that their health status is associated with fate or luck. It could also mean that African American women who experience racist incidents are less likely to see their health status in a positive light. Furthermore, the finding that the racial identity attitudes of Pre-Encounter and Immersion-Emersion were positively related to the external health locus of control scales of Powerful Other and Chance suggests that African American women who are either dismissive of race or are strongly affected by race are more likely to perceive themselves as having less control over their health status. Finally, contrary to our assumptions, the racial identity status of Internalization was not associated with health beliefs ($r=-.27$, $p=.06$) to the degree that we could comfortably make an interpretation.

Discussion

While the relationship between experiences of racism and psychological and physical health among Black Americans has received increased attention over the past few years,[13,16,17] the impact of racism on individual health-related attitudes and perceptions of health status has not. The current study explored the relationship between perceived racism, racial identity status attitudes, and perceptions of health status and control. The findings indicate that experiences of racism were associated with perceptions of health status and health locus of control, and that racial identity attitudes were associated with health locus of control.

Experiences of racism have been associated with a range of psychological and physiological outcomes.[25,58] Moreover, race-related variables have been strongly implicated in health disparities.[6] The results of the current investigation add to this body of literature. Undertaken with a socio-economically diverse sample, the findings highlight the potential of racism and racial identity to influence Black American women's sense of control over their health and provide support for the manner in which racism might affect health, as articulated by Jones.[15] By extension, experiences of racism and racial identity attitudes could also be important factors associated with health-related behaviors. Research indicates that Black American women are less likely than others to participate in such measures as colorectal cancer screening;[59] experiences of racism may influence such health-related behaviors. Additional evidence for this can be found in the pattern of relationships associated with the racial identity attitudes of the participants in the current sample. Those racial identity attitudes that are deemed

less mature have been consistently associated with negative psychological outcomes.[28] Individuals whose racial identity is categorized as Pre-Encounter might tend to view themselves as less powerful over their health status. Furthermore, for these individuals, the continued under-representation of Black Americans and other people of color in those medical professions traditionally associated with increased status and power (including physicians and psychiatrists) might reinforce the sense of not having control over their own health. In view of the history and ongoing presence of racism within the medical profession, the sense of having little control would be entirely consistent with the lack of control over their bodies and their health that African Americas have long experienced in the U.S.[36,60]

Institutionalized racism in the medical field has been well-documented[60] as it pertains to both medical research and quality of medical care. A notable and disturbing abuse of power by medical professionals is perfectly illustrated by the experimental research examining the outcome of untreated syphilis in Black men that took place over a 40-year period in Tuskegee, Alabama.[60] It is important to consider that the historical legacy of racism and the ongoing perception of racist experiences may be important psychological correlates of African American women's perceptions of their health status and the extent to which they enjoy a sense of control over their health. In view of the recent resurgence in racialized medicine, evident in the marketing of specific drugs to specific racial groups,[61] health psychologists and practitioners in general are encouraged to bear in mind and to engage African American women actively on their experiences of racism when working with them. The significant health disparities that exist across racial lines may be influenced by the psychological responses to racist incidents and the manner in which individuals process race-related stimuli. Being more aware of such matters might engender greater sensitivity on the part of health professionals, thereby increasing the likelihood of greater participation in health care and health maintenance by African American women.

To sum up, the current findings are important, given the need to understand the varied psychological and social determinants of health-related behaviors and attitudes. In view of the fact that African American women appear to be particularly vulnerable to a range of adverse health-related outcomes,[38] the current findings underscore the role of perceived racism and racial identity attitudes in the context of their health status.

Limitations. This study has limitations that might preclude the generalizability of its findings. Given the rather small sample size and the fact that the data were collected predominantly in Black neighborhoods, the extent to which the findings can be generalized to the larger population of African American women is unclear. Additionally, the racism-related measure utilized in this study might have precluded a more precise description of racism-related experiences. Note that the SRE gives respondents a pre-determined set of types of racist incidents to which they respond. Consequently, there is a potential for the under-reporting of both the quality and quantity of racist encounters and, therefore, the true reach of racism in relation to physical health status might be underestimated. Finally, the manner in which the description of the study as focusing on discrimination and stress might have influenced the participant's responses is unclear, as is the potential for bias associated with self-report measures. The extent to which bias was a factor represents an inherent limitation of the survey

methodology employed in this investigation. Thus, given these limitations, we suggest caution in the interpretation of the results. We do believe that the findings provide an important stepping-stone for future research efforts in this area.

Implications and future directions. The experience of racism has been said to set off a cascade of psychological and behavioral responses that ultimately affect an individual's sense of well-being and autonomy.[38,62] For psychologists and health practitioners working with African American women, it is important to normalize these responses as expected and understandable reactions to noxious stimuli (racism) and not to treat them as pathological. Furthermore, while psychologists historically have been more interested in internal or intra-psychic processes, the results of the current study serve as a reminder that environmental factors such as racism continue to play important roles. As such, psychologists are called to be more active in challenging systemic oppression that directly and indirectly influences the lives of African American women and people of color in general.[7]

With regard to future research, we recommend three directions: first, more must be learned about the variables under consideration in the current investigation; second, more must be learned about the nature of the relationship between health locus of control and health behaviors; and third, more work is needed on the measurement of racism.

It should be noted that the current study has succeeded only in establishing that a relationship exists between perceptions of racism and racial identity as one set of variables and perceptions of health and health locus of control as another set of variables. While we have drawn attention to the direction and strength of the relationship as evidence by the individual predictors, the current analysis precludes an understanding of the manner in which the variables might interact. Thus, future investigations employing larger samples and more powerful statistical tools such as structural equation modeling could provide an additional understanding of how the variables relate to one another. Second, given that African American women are less likely than others to take some preventive health measures,[63] it might be useful to explore the relationship between health locus of control and specific health behaviors more precisely, especially in the context of racism and cultural mistrust.[64,65] While some research has focused on the relationship between racism and risk-taking behavior,[66] less research has focused on the influence of racism on health-enhancing behaviors. This could be an important area to pursue. In relation to health locus of control, an associated line of investigation could focus on factors that might moderate health beliefs among African American women, such as social support and the role of spirituality.[67]

Finally, the chronic and pervasive nature of racism within American society might mean that its true impact is hidden even to its targets. Prior research has consistently provided evidence of a positive relationship between experiences of racism and measures of general life stress.[13,68] Thus, examining perceptions of general life stress and associated health-related outcomes might also be useful when seeking a more complete picture of the manner in which racism as a type of life stressor influences health beliefs and health-related behaviors.

Summary and conclusions. There is now clear evidence of the influence of racism across a range of psychological and physiological outcomes.[25.58] The current investigation

highlights perceptions of health status and health locus of control as important constructs to consider in relation to perceptions of racism. Furthermore, this study emphasizes the role of individual-level variables such as racial identity attitudes and socially-based variables such as racism in seeking to understand further the antecedents of existing health disparities. Clinicians and researchers are encouraged to be more intentional in their exploration of racism-related phenomena with African American women and to be cognizant of the impact of racial identity attitudes as an important type of within-group variation that might have important implications for participation in health care and engaging in behaviors that promote and enhance health status.

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