Racial Identity and Resilience as Predictors of the Psychological Health of
African American Men

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Ameena S. Mu’min

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This dissertation entitled
Racial Identity and Resilience as Predictors of the Psychological Health of
African American Men

by
AMEENA S. MU’MIN

has been approved for
the Department of Counseling and Higher Education
and the College of Education by

Yegan Pillay
Assistant Professor Counseling and Higher Education

__________

Renée A. Middleton
Dean, College of Education
ABSTRACT

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The purpose of this study was to explore the relationship between socioeconomic status, resilience, racial identity and the psychological health of African American men. The independent variables in this study were socioeconomic status, resilience, and racial identity. The dependent variable in this study was psychological health.

A sample of 105 African American men was surveyed using the Hollingshead Four Factor Index of Social Status (Hollingshead, 1975); the Resilience Scale (Wagnild & Young, 1993); the Black Racial Identity Attitudes Scale (Parham & Helms, 1981); and the Mental Health Index (Veit & Ware, 1983). Additional demographic data included asking participants to indicate: if they were born in the U.S.; whether they regularly attended church; if they lived with or near a close knit group of family and/or friends; whether they grew up in the Columbus area; and if they had a male role model while growing up.

A hierarchical regression analysis was used to analyze the data. The results of the regression analysis found that socioeconomic status accounts for 4.6% of the variance in psychological health. Resilience did not significantly account for any of the variance in psychological health, however, when racial identity was added to the regression, the model became significant. Supplemental analyses found that Pre-Encounter and
Encounter racial identity ego statuses were significant predictors of psychological distress, and that the Internalization ego status and resilience were significantly correlated to psychological wellness. Additional analyses found that psychological distress was significantly correlated to men who live with or near a close knit group of family and/or friends. A factor analysis was also conducted on each of the measurement instruments used in this study. A parallel analysis and scree plot supported just one factor in a principal component analysis for the RS-25 scale. Due to a smaller sample size a parallel analysis was not conducted for the RIAS-B, however, a scree plot supported seven components for the scale. For the MHI, a parallel analysis and a scree plot supported two components in a principal components analysis.

Overall, some findings are consistent and supportive of the current literature regarding socioeconomic status, resilience, racial identity, and psychological health as they pertain to African American men. Other findings challenge the current research thus concluding that more in depth studies with variables used in this study and samples of African American men are a necessity. Discussion of the measurement instruments, data analysis procedures, implications for counseling and further research are presented.

Approved: ______________________________________________________________

Yegan Pillay

Assistant Professor of Counseling and Higher Education
DEDICATION

This is dedicated to the lover of my soul; my Lord and Savior Jesus Christ.

Life is absolutely impossible without YOU!

I also dedicate this to my Grandmother & her legacy, the late,

Katherine Cozart-DeLoatch.

I love you, and I honor your modeling of a Christian woman in ways

I cannot wait to tell you!

Finally, I dedicate this project to all of the African American men who willingly gave of

their time and resources to support me in this endeavor. You are appreciated.
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CHAPTER ONE: INTRODUCTION

According to the 2004 U.S. Census Bureau, minority populations equal just over 30% of the population (U.S. Census Bureau, 2004). Hispanics are the largest minority population equaling approximately 12.5%; African Americans, 12.3%; Asian Americans, 4.4%, the fastest growing minority population; and Native Americans 1.5%. In addition, Arab immigrants living in the United States (U.S.) total between 1.5 million and 3.5 million, and have been growing in number each decade (Shah, Ayash, Pharaon, & Gany, 2008). Salient across the literature is the projection that minority populations in the United States will soon be the majority. For example, census projections for 2010 indicate that ethnic minorities will make up 36% of the U.S. population and that they will become the majority by 2050, totaling 52.3% of the U.S. population (U.S. Census Bureau, 2004). In addition, a report from the U.S. Government Accountability Office (GAO) states that the U.S. Census Bureau estimates that while the White population will grow from 195 million to 210 million by 2050, their share of the nation’s population will still decrease from 69.4% to 50.1%, and the Hispanic population would increase its proportion from 12.6% to 24.4% (Tucker, 2007). Though the racial and ethnic makeup of the U.S. is evolving rapidly, the disparities and disadvantages experienced by minorities remain incongruous to this demographic transformation.

American minorities have historically been and continue to be exposed to a barrage of unfavorable societal experiences relative to their minority status in this country (Carter, 2007; Oliver, 2008). Research suggests that people of color are stressed by individual, institutional, and cultural encounters (Landrine & Klonoff, 1996; Utsey, 1999;
Utsey & Ellsion, 2000). Collectively these experiences constitute forms of discrimination and racism. Although much of the de jure forms of racial discrimination were overturned through the civil rights movement of the 1960s, many African Americans are still forced to navigate forms of racial discrimination in their daily lives (Feagin, 1991; Swim, Cohen, & Hyers, 1998). In addition, African American men and women’s experiences of racism in the United States are believed to contribute to problems of anxiety and depression, substance abuse, low levels of self-esteem, life satisfaction, and academic success (Mahalik, Pierre, & Wan, 2006; Pierre, Mahalik, & Woodland, 2001). Thus, the psychological distress (anxiety and depression) that exist among minorities, specifically African Americans is also reflective in yet a narrower sub-population of minorities, namely African American men.

African Americans in the United States are an underrepresented group across multiple disciplines of research. Although they are the second largest minority population in this country (U.S. Census Bureau, 2004) African Americans remain oppressed in U.S. society (Harrell, 2000; Pierre, Mahalik & Woodland, 2001). African Americans documented levels of education, income, standards of living, and job opportunities all suggest that systemic oppression occurs at many levels of living in the African American community (Spraggins, 1999). For African Americans to be such a critical thread in U.S. society today, it cannot be ignored that their journey has been one of tumultuous challenge, struggle, and endurance. To grasp an understanding of the experiences of African Americans in the U.S., the current research will focus on a subpopulation of this minority group, African American men. The purpose of this study
is to explore the psychological health of African American men through the influence of factors such as racial identity attitudes, resilience, and socioeconomic status. This chapter provides an overview of critical disparities and disadvantages among African Americans and African American men specifically, relative to the aforementioned constructs of exploration for this study. In addition, the chapter will include the research hypotheses, the significance of the study, delimitations and limitations, as well as the definitions of terms.

**Background of Study**

Healthcare is a critical component of life and an issue where minorities in the U.S. are known to be disproportionately disadvantaged (USDHHS, 2001). The disadvantages contribute to vast disparities among minorities in healthcare and are an essential aspect to our ongoing understanding of theory and research regarding SES, racial identity development, resilience, and the psychological health of African American men in the U.S (Carter, 2007; Hoyert, 2006; Satcher, et al, 2005; Williams & Williams-Morris, 2000).

The associations among good health, educational attainment, and economic well-being have long been recognized, and research indicates that there are still serious health disparities among minority groups in America (Lillie-Blanton, Maleque, & Miller, 2008; Smedley, Stith, & Nelson, 2003). Studies have demonstrated the existence of health disparities in the experiences of African Americans, Hispanic Americans, Asian Americans, and Native Americans in terms of healthcare quality and access (Hoyert, 2006; Satcher et al, 2005). Due to focus shifts in politics and economics (funding),
socioeconomic status (SES) has become the mainstream framework for discussing population health, and it is the dominant theoretical framework for the study of racial and ethnic health disparities today (Oliver, 2000).

Health disparities among minority groups in the U.S. are also compounded by language. Over the last 20 years, the number of people who speak a language other than English at home has more than doubled (Shin & Bruno, 2003). By 2004, this population comprised approximately 20% of the total U.S. population and one fifth of children and adolescents (U.S. Census Bureau, 2004). Given the increase in the number of children and adolescents who do not speak English at home, healthcare providers in both physical and mental health are increasingly likely to encounter these children and adolescents in their practice, and are being challenged to deliver appropriate healthcare and promote optimal health status (Hahm, Lahiff, Baretto, Shin & Chen, 2008). In addition to this, parents may also experience language barriers when seeking assistance with housing, education and/or social services.

As healthcare continues to be a prominent issue faced by the U.S. government, it is important to note that several general health conditions are more likely to be experienced by African Americans than any other racial/ethnic minority group. For example, in a 2007 report issued by the American Obesity Association (AOA), Mexican Americans and White (non-Hispanic) Americans had obesity rates of 34.4% and 28.7% between 1999 and 2000, while African Americans reached up to 39% (AOA, 2007). These prevalence rates among African Americans are also inclusive of socioeconomic status and sex. For example obesity rates for African American males are approximately
28.8%, and 50.8% for females. Further explanation of these health disparities includes diabetes, cancer, heart disease, and hypertension (high blood pressure).

Disparities in hypertension, which is estimated to cause more than three times as many deaths among African Americans than White Americans, is a major reason why life expectancy is years less for African Americans (AHA, 2009; Levine, et al, 2001; Wong, Ettner, Boscardin, and Shapiro, 2009). Barksdale, Farrug, and Harkness (2009) recap a more recent report from the American Heart Association (AHA) which states that hypertension is a major problem for Black Americans in particular because this group has the highest rate of hypertension in the world. In addition, Oliver (2008) states that African Americans die at a younger age and are sicker than Whites in the U.S. due to a number of diseases, similar to those previously mentioned. In contrast, other research has shown that when accounting for SES, and other diabetes risk factors there is not strong support for higher diabetes prevalence rates among African Americans than among Whites (Signorello et al, 2007). Though physical health is a critical aspect of healthcare, mental health is also receiving attention in the literature (Banks, Kohn-Wood, & Spencer, 2006; Mizell, 1999).

The 2001 Surgeon General’s report on Mental Health: Culture, Race and Ethnicity, provided by the Department of Health and Human Services stated that people of color have less access to and are less likely to receive needed care, and the care they ultimately receive is often of poor quality (Carter, 2007; USDHHS, 2001). The report also raised important issues about racial/ethnic disparities in the availability, utilization, and quality of mental health services; indicating that racial ethnic minorities have less
access than Whites to mental health care (Richardson, Anderson, Flaherty, & Bell, 2003; USDHHS, 2001). For example, Blanchard and Lurie (2004) examined factors in the health care encounter of African Americans, Hispanics, Asians, and Whites in efforts to model how negative perceptions of this encounter may influence healthcare utilization. The researchers found that the African Americans (14.1%) in their sample were significantly more likely to report being treated with disrespect or being looked down upon than their White counterparts (9.4%) (Blanchard & Lurie, 2004). The Surgeon General’s report further documented that “disparities also stem from minorities” historical and present struggle with racism and discrimination, which affect their mental health and contribute to their lower economic, social, and political status (USDHHS, 2001, p. 4). In an analysis of eight different epidemiological surveys, Kessler and Neighbors (1986) assert that the effects of race and social class on psychological health are interactive and emphasize that poor African Americans tend to be more psychologically distressed than poor Caucasians. Although the authors do not presume to understand all of the interactive influences of race and class on one’s mental health, they do reject the conventional notion that the associations between race and mental health are only reflective of social class influences by stating that “race is important for mental health even when social class is held constant” (Kessler & Neighbors, 1986, p. 113). Overall, a major finding of the Surgeon General’s report is that racial and ethnic minorities bear a greater burden from unmet mental health needs and thus suffer a greater loss to their overall health and productivity (USDHHS, 2001).
As both a racial and ethnic minority, the mental health status of African Americans remains uniquely impacted on a daily basis. It is fairly well documented that a considerable number of adult African Americans in the U.S. encounter stressful life conditions including consistent exposure to various forms of racism (Feagin, 2001). Research suggests that 60% or more of African American adults typically encounter racial discrimination (Sellers & Shelton, 2003). For African Americans in the U.S. the inferiority that racism evokes has been primarily driven by acts of discrimination, segregation, and negative stereotypes of this minority group. Racism is described here as an organized system that leads to the subjugation of some human population groups relative to others, in which studies have found to have negative effects on mental health (Fischer & Shaw, 1999; Williams & Williams-Morris, 2000).

In the past decade, there has been a significant increase in empirical studies focusing on the relationship between racism-related life experiences and psychological health among African Americans (Banks, Kohn-Wood, Spencer, 2006; Clark, Anderson, Clark, & Williams, 1999; Harrell, 2000; Pieterse & Carter, 2007; Rollock & Gordon, 2000). Research also indicates that experiences of discrimination are generally associated with poorer health status and that this association is the strongest in the case of mental health (Williams, Neighbors, & Jackson, 2003). In the first wave of the National Study of Black Americans (NSBA), Williams and Chung (in press) documented that even the perception of racial discrimination was related to higher levels of psychological distress and lower levels of life satisfaction and happiness, as well as with poorer physical health. It is also asserted that African Americans also experience greater
psychological distress than Whites because they suffer the combined effects of economic barriers and racial discrimination (Kessler and Neighbors, 1986).

Current theoretical models suggest that the most powerful forms of discrimination experienced by African Americans in the post Jim Crow era are subtle and unconscious forms of discrimination that are experienced on a daily basis (Harrell, 2000; Pierce, 1995; Tougas & Desruisseaux, 2004). For example, personally mediated racial discrimination might present as overt acts (direct verbal slurs, innuendos, or physical action), or less obvious covert acts (being perceived as less capable, worthy or deserving of success, opportunities or rewards) (Barksdale, Farrug, & Harkness, 2009). This is uniquely so for African American men on a daily basis as they navigate through the multiplicities of their life experiences. For African American men to experience acts of covert and overt discrimination only endorses the psychosocial stressors that contribute to the various disparities among this population and are not atypical as they have grown to be the norm versus the exception in society.

As a racial minority, African American men experience more psychosocial stressors (e.g., suicide, unemployment, and interpersonal violence) than members of other racial groups (Mizell, 1999). For example, between 1976 and 1998 African American men had a seven times higher likelihood of being murdered than their White counterparts (Blumstein & Wallman, 2000). When discussing the current status of African American males, social scientists often reference indicators of social participation: employment and rates of incarceration (Pieterse & Carter, 2007). For example, African American men are more likely to be pulled over by a police officer while driving (racial profiling); more
likely to be arrested than their White counterparts; they account for more than 49% of the U.S. prison population, and are six to eight times more likely to be in prison than Whites (Meehan & Ponder, 2002; Oliver, 2000; Western, 2007). In addition, African American men in their early thirties are about seven times more likely than their White counterparts to have a prison record and in general, are more likely to have a prison record than military records, or a bachelor’s degrees (Western, 2007).

Manhood is often defined by how much a man works, his job title, and how well he and others perceive that he does his work (Mizell, 1999), and African American men have always maintained a strong work ethic as part of their psychological repertoire (Pierre, Mahalik, & Woodland, 2001). African American men, as potential workers, are likely to encounter problems in obtaining legitimate employment, which would allow them to make decent living wages for themselves and their families (Spraggins, 1999). For example, when one looks at employment rates, it is evident that not only do African American men experience higher rates of unemployment but even when they are employed their incomes are significantly less than those of their White counterparts (Western & Pettit, 2005). Additionally, the rates of unemployment for young African American men are staggering in comparison with Whites of both genders and all ages (Spraggins, 1999). Finally, there is a shortage of employment and a lack of employment opportunities due to a lack of equality in hiring practices of African American men (Pierre et al, 2001).

Further compounding the psychological health of African American men is their physical health. The average life expectancy of African American men in the U.S. is 69
years of age (Cheatham, Barksdale & Rodgers, 2008). On average, this is 6 years less than White men, 7 years less than African American women, and 11 years less than White women (Minino, Heron, & Smith, 2006). In addition, reports that African American middle-aged men suffer disproportionately from hypertension, diabetes, stroke, arthritis, depression, and vision and hearing problems is common (Hayward & Heron, 1999). A report by the Center for Disease Control (CDC) comparing leading causes of death for African Americans and African American men in 1980 and later in 2005 states the leading cause for African Americans in both years is heart disease.

Theory about the masculinity of African American men has primarily been researched in its relation to the dominant group. Franklin (1999) proposed that African American men are constantly struggling with the notion that their feelings, ideas, personality, and self are not valued or even recognized because of racism and prejudice and thus leads them to feel invisible. In addition, African American men are often forced to internalize their frustration and anger toward this notion of invisibility for fear of losing their job and/or means of supporting their family (Johnson & Greene, 1991). It is then proposed that this process of internalization is what leads to psychological distress of African American men, and what in turn contributes to hypertension, sleep disturbance, obesity, and substance abuse in African American men (Johnson & Greene, 1991).

The concept of masculinity of African American men is essential to understanding the view that African American men are expected to conform to the dominant culture’s gender role expectations —success, competition, and aggression—as
well as culturally specific requirements of the African American community that may offer conflict (e.g., cooperation, promotion of group, and survival of group), (Pierre, Mahalik, & Woodland, 2001). Theoretically, a theme for understanding masculinity and the experiences of African American men is found in the contrast of their role expectations in the milieu of the general population and their own community. The separate expectations presented within each contrasting role are fundamental to understanding the identity development of African American men.

The identity development of minorities is primarily in direct comparison to the dominant White culture. In essence, many conceptualizations of optimal human functioning are based on Western European notions of healthy and unhealthy developmental and daily living (Constantine & Sue, 2007), to which minority groups are consistently compared. Developing healthy cultural identities and self-esteem is challenging for many people of color as they continuously combat an oppressive U.S. society (Constantine & Sue, 2007). However, as research progresses, theories and models based on White middle-class male values have been challenged as inappropriate for American minorities who may not share the assumptions, norms, or world-views of the majority (Leong & Wagner, 1994).

Over the last two decades research expanding our knowledge and understanding on the complexities of race, racial identity and racial identity development has increased (Carter, 1995; Cross, 1991; Hays & Chang, 2003; Helms, 1984; 1990; 1995; Ponterotto, & Mallinckrodt, 2007; Smedley & Smedley, 2005). Race is conventionally linked to visible features that in turn are linked with certain moral, intellectual, and cognitive
dispositions although, race is a socio-cultural construct, with no biological merit (Byrd & Clayton, 2000; Carter, 1997; DeGruy-Leary, 2005). Helms (1990) defines racial identity as “the sense of group or collective identity based on one’s perception that he or she shares a common racial heritage with a particular racial group” (p. 3). Therefore, the process of racial identity development involves the shift of a person’s world view as a byproduct of their life experiences, self reflections, and moral decision-making (Carter, 1997). The overall goal of racial identity development is for one to develop a fuller and integrative racial identity (Carter, 1997).

In recent years, researchers have expanded on the construct of racial identity by exploring its relationship to psychological health. Helms, Jernigan, & Mascher, (2005) state that racial groups or categories are not psychological constructs because they do not connote any explicit behaviors, traits, or biological or environmental conditions. Instead racial categories are sociopolitical constructions that society uses to aggregate people on the basis of ostensible biological characteristics (Helms, 1990).

Models of racial identity development began as early as 1971 with Black racial identity development. Cross (1971) felt that the neutral value paradigms currently being used to evaluate and conceptualize the behavior of African Americans were weighted towards the conditions and values of White middle-class America. Cross’ work in racial identity development became a critical foundation to later models of its type. For example, subsequent to Cross, was Rita Hardiman’s (1982) White Identity Development Model. Hardiman’s work preceded that of Janet E. Helms’ (1990) focus on White Racial Identity Development (WRID), to which became the first of its kind to be empirically
tested. Helms asserts that in order to develop a healthy White identity virtually every White person in the United States needs to overcome one or more of the following aspects of racism: individual (personal level), institutional (social and institutional policies), and cultural (cultural practices of superiority) (Helms, 1990; Jones, 1997). From this belief evolved the stages of WRID.

Theories and models of Black racial identity began to appear in the counseling psychology and psychotherapy literature around the early 1970s in response to the Civil Rights Movement of the era (Helms, 1990). These models suggest that African Americans progress through four ego statuses in efforts to construct a positive racial identity: Pre-Encounter, Encounter, Immersion-Emersion, and Internalization. In a Pre-Encounter ego status an individual is unaware of their race, and views the world through a dominant White cultural lens while devaluing or denying Blackness. An Encounter ego status individual begins to explore their identity as a Black person as a result of a critical incident regarding race. In the Immersion-Emersion ego status an individual transitions into a deep awareness and immersion of Black culture (immersion), while later gaining control of their immersion views on race and becomes open to critical analysis of the Black community (emersion). Finally, an Internalization ego status individual is comfortable in the acknowledgement of their Black identity and begins to appreciate the racial/cultural heritage of others. A positive racial identity is found in higher ego statuses and is synonymous with an individual finding security in themselves as a racial being, as part of a racial group, and they possess the ability to respond objectively to members outside of their own racial group (Helms, 1990; Helms 1995; Carter, 1997). A negative
racial identity is when an individual devalues their own racial group while exalting that of others. History and present day experiences of minorities in the U.S. attest to what Smedley (1999) stated, which is that the problem for lower status races in developing a positive racial identity is how to develop this ‘racial’ identity in lieu of the ‘racial’ identity being imposed on them by the dominant society.

The construction of an established and affirmed identity for African Americans continues to be a challenge of profound exertion. However, despite this and ongoing exposures to racism and discrimination, many people of color do have positive racial and ethnic perceptions of themselves (e.g. high racial ethnic pride) and, subsequently, high levels of well-being (Utsey, Ponteotto, Reynolds, & Cancelli, 2000). Accordingly, while African Americans are at risk for poor developmental outcomes, there are many who are able to overcome the negative consequences of their environments and experience a healthy quality of life (Miller & MacIntosh, 1999). In essence, the capacity of African Americans to overcome systematic exposure to identifiable risk factors connotes a positive adaptation trait found in multiple characterizations of resilience.

The construct of resilience has faced much scrutiny and has thus far been viewed primarily as a composite of two distinct areas: terminology and conceptualization. Theorists, such as Masten (1994) assert that resilience has three groups of phenomena: (1) at-risk individuals show better-than-expected outcomes (2) positive adaptation is maintained despite the occurrence of stressful experiences, and (3) there is good recovery from trauma. However, empirical research has focused more on the operationalization of resilience. For example, adverse conditions examined have ranged from single
stressful life experiences—such as exposure to war—to aggregates across multiple negative events (Luther, Cicchetti, & Becker, 2000). Essentially between both assertions lie varying definitions and uses of terminology. The conceptualization of resilience has also been divided; resilience as a personal trait versus a dynamic process. The primary crux of this debate stems from the personality construct of ego-resilience—the general capacity for flexible and resourceful adaptation to external and internal stressors (Block & Block, 1980; Klohn, 1996). In contrast, when the term resilience is used to refer to a process, the experience of significant adversity is already implied.

As previously stated, resilience has been defined in multiple ways across diverse avenues of research. Rutter (1993) stated that resilience is a combination of abilities and characteristics that interact dynamically to allow an individual to bounce back, cope successfully, and function above the norm in spite of significant stress or adversity. Wagnild & Young (1990), assert that resilience is an emotional stamina used to describe persons who display courage and adaptability in the wake of life’s misfortunes. Furthermore, even the quality of resilience has been attributed to individuals who, in the face of overwhelming adversity, are able to adapt and restore equilibrium to their lives and avoid the potentially deleterious effects of stress (Beardslee, 1989; O’Connell & Mayo, 1990; Richmond & Beardslee, 1988). Finally, resilience as a personality characteristic moderates the negative effects of stress and promotes adaptation; a construct that for African American men, lends its support to their overall survival in the wake of slavery, disenfranchisement, emancipation, Jim Crow, and the Civil Rights movements.
African American males have a history of enduring and functioning in the face of racism and oppression, and are probably the most highly stigmatized and stereotyped group in America (Cunningham, 2001; Pierre, et al, 2001). However, not even the assaults of slavery, segregation, and poverty were enough to destroy the institution of family from which African American male leaders and achievers have come (Bryant, 2000). In response to this, African American men maintain a tough and emotionless exterior that assists them in retaining their sanity and ‘manhood’ within a culture that attempts to strip them of it (Billson & Majors, 1992). Therefore, the construct of resilience is additionally relevant because the use of protective factors may in turn be what manifests in African American men as this outward appearance of a tough exterior. Protective factors operate as mediators to protect persons at risk from risk factors that may impact their life. Protective factors may be individual or environmental and they contribute to positive outcomes regardless of the risk status (Howard, Dryden, & Johnson, 1999). Individual protective factors are personal features that include an individual’s positive engagement (i.e. high self-confidence). Environmental protective factors are external (i.e. family support, mentoring relationships, community cohesion).

Research suggests that in order to help mediate stress, African American men must dispel learned helplessness, and adapt an external locus of control (Gurin & Epps, 1975; Pierre et al, 2001; Seligman, 1975). This theory suggests that such an external locus of control may help to protect minorities from attributing personal responsibility to inequities and racism in American society (Gurin and Epps, 1975). Furthermore, the concept of learned helplessness states that if an individual can escape an aversive event,
later instrumental behavior becomes normal, but that inescapable aversive events result in profound interference with later instrumental learning (Hiroto & Seligman, 1975). Accordingly, Seligman (1975) found that individuals responded to an aversive situation based on their ability to escape harmful experiences in the past. Individuals who were not able to escape a previous aversive event, found themselves not attempting to escape a new aversive situation.

Conversely, Gurin and Epps (1975) stated that adapting an external locus of control may be beneficial for ethnic minorities as a result of the powerful effects that racism exerts on their lives. The authors emphasize that the experience of different racial groups in America seems to matter more in how they perceive their opportunities and possibilities for success than in how committed they are to the values that are instrumental to achievement (Gurin & Epps, 1975). Furthermore, the dispelling of learned helplessness and the adaptation of an external locus of control may be helpful in mediating the daily encounters of psychological stress in the lives of African American men. In essence, African American men must attempt to take control of certain aspects of their lives in which they do have control, while recognizing the aversive affect of racism and oppression (Pierre et al, 2001).

**Research Question**

This study seeks to examine the following question: Does the socioeconomic status (education and occupation), racial identity attitudes and resilience predict the psychological health of African American men?
Research Hypotheses

**Hypothesis 1:** Socioeconomic status (SES) as measured by the Hollingshead Four Factor Index of Social Status, contributes to the variance in the psychological health of African American men, as measured by the Mental Health Inventory (MHI).

**Hypothesis 2:** Resilience, as measured by the Resilience Scale (RS-25) contributes to the variance of psychological health of African American men above and beyond that accounted for by SES.

**Hypothesis 3:** Racial Identity, as measured by the four subscales of the Black Racial Identity Attitude Scale-Revised (RIAS-B), namely Pre-encounter, Encounter, Immersion/Emersion, and Internalization scales, contributes to the variance of psychological health of African American men above and beyond the variance accounted for by SES and resilience.

Significance of the Study

As the descendents of African slaves, African Americans have withstood turbulent life experiences. African American men specifically have undeniably worked for 300 years without pay and through their labor have almost single-handedly supported the U.S. economy (Marrable, 1983). Yet even though the U.S. is steadfast toward becoming a more diverse nation, there is still limited research that focuses on African American men.

Ruth Horowitz is credited with conducting the first methodological and theoretical study on racial identity (Cross, 1991). Since then, racial identity has been linked to the psychological health of African Americans, and studies have shown that
group identification can buffer the psychological harm caused by feelings of unjust treatment among disadvantaged groups (Alim, et al, 2008; Sellers, Caldwell, Schmeelk-Cone, & Zimmerman, 2003). For that reason, this study seeks to determine if the racial identity attitude ego statuses of a sample of African American men is significantly predictive of their overall psychological health.

While resilience research has increased steadily over the years, further examination of the resilience of racial minorities, such as African Americans, is still needed (Miller, 1999; Miller & MacIntosh, 1999). In addition to the paucity of resilience research among minority groups is the lack of research using samples of adults versus its original and most common samples of young children. Furthermore, many of those studies are primarily relevant to children who grow up in aversive environments and avoid psychiatric disorders later in life (Masten & O’Connor, 1989; Richmond & Beardslee, 1988; Werner & Smith, 1982). This study seeks to add to the resilience literature by accessing a U.S. minority sample of adult African American men.

Though progress has been made on multiple societal levels of inequality, our country is still not void of unfair employment practices. Therefore, African American men, as a result of their inability to locate employment, are often left vulnerable to the multiple stressors that afflict individuals in the low socioeconomic status brackets (Pierre, et al, 2001). Furthermore, Smith (1985) asserts that a stable middle-class income mediates daily life stress; however, low income can be a significant cause of stress in the life of African American men. Therefore, this study also seeks to explore the variable of socioeconomic status as an attempt to determine how much this variable can be
predictive of the psychological health of this population sample of African American men.

**Delimitations**

A delimitation of this study is that the research is limited to focus on the psychological health, racial identity attitudes, resilience and socioeconomic statuses of African American men only. Therefore each of these constructs was only addressed as they related to the sample of African American men participating in this study. The African American men participating in this study are currently involved in a program that seeks to enhance their lives through varying areas such as, parenting skills, career development, and community leadership. In addition, the sample of African American men is limited to only one region of the Mid-West, and was accessed primarily through one location and organization.

**Limitations of the Study**

The current literature on African American men and the construct of resilience is meager. Thus, most of the literature to date regarding African American men and resilience, with the exception of a sparse number of recent dissertations is almost obsolete. A second limitation is that the sample of African American men accessed is in the mid-west, and are considered a purposeful sample; therefore the results of this study are not generalizable to all African American men. A third limitation is that due to the historical mistreatment of African American men in research which may have been a factor in the low number of participants in this study. A fourth limitation is the understanding that measuring racial identity is complex and involves the assessment of a
persons’ social attitude. Because of this, participants may have provided a more socially
desirable response versus what they may actually believe. A fifth limitation is that the
mental health inventory is a self-report instrument and may not be accurately indicative
of the participant’s true mental health status. A sixth limitation is that the social status
index is self-report and also may not be an accurate estimate of the participant’s
socioeconomic status.

**Definition of Terms**

The following terms are defined as they will be used in this study:

**African American:** is defined as persons who self-identify as having origins in any of the
Black racial groups of Africa (e.g. “people who indicate their race as Black, African
American, Negro, or provide written entries such as African American, Afro American,
Kenyan, Nigerian, or Haitian” (US Census Bureau, 2000).

**Psychological health:** is defined as the presence or absence of emotions such as,
depression, anxiety, low self-esteem and self-acceptance, symptomatic distress,
regulatory moods, emotional intelligence, environmental frustration, and overall life
satisfaction (Bell & Tracey, 2006; Salovey, Rothman, Detweiler, & Steward, 2000;
Taylor, 2001).

**Psychological Well-being:** is defined as optimal psychological functioning and
experience (Ryan & Deci, 2001).

**Psychological Distress:** is defined as an unpleasant subjective state that promotes
depression and anxiety (Mirowsky & Ross, 1989; Gaines, 2007)
Racial identity: is defined as “the sense of group or collective identity based on one’s perception that he or she shares a common racial heritage with a particular racial group” (Helm’s, 1990, p. 3).

Resilience: is defined as a personality characteristic that moderates the negative effects of stress and promotes adaptation (Wagnild & Young, 1993).

Socioeconomic Status (SES): Social class is defined as the layer that people occupy in a socioeconomic hierarchy (Long, 2001). Social class is usually determined by level of education and job prestige (Hollingshead, 1971).

Summary

Racial stratification and systemic racism have been and continue to be endemic and ingrained in all aspects of American life: in customs, laws, and traditions (Carter, 2007). Even though the fiber of this country is woven by the injustices that negatively affect minority groups, most specifically African American men, research on this subpopulation is limited. Therefore, in efforts to contribute to the literature, this study examined the socioeconomic status, resilience, racial identity, and psychological health of a sample of African American men. The following chapter is a literature review that will explore socioeconomic status, racial identity, resilience, and psychological health through critical examination of historical content, construct measurement, and previous research outcomes.
CHAPTER TWO: LITERATURE REVIEW

This chapter provides an introduction and review of the literature regarding psychological health, racial identity, and resilience. The review of the literature examines the following major areas: psychological health, well-being, and distress among minority populations, African Americans, and African American men; racial identity, and Black racial identity development; and resilience as a personality trait and a dynamic process. In addition, each section will discuss instruments used to measure each construct.

**Socioeconomic Status**

Research reports diverse outcomes as it pertains to health and socioeconomic status (SES) (Braveman et al., 2005; Williams, Mohammed, Leavell, & Collins, 2010). In the literature, SES is widely used as a proxy for social class in studies that researchers conduct regarding health and the distribution of disease (Williams & Collins, 1995). The term *SES* is commonly used interchangeably with the term *social class* throughout much of the social science literature. Overtime, SES has been measured by collecting data on education, income, marital status and or/occupation. In addition, social science literature treats SES as a multidimensional construct using factors such as economic resources power, and/or prestige as a guide to understanding SES (Breaverman et al., 2005; Lynch, Kaplan, & Salonen 1997). Other literature on SES recognizes that different SES factors could also affect an individual (or group of people) at different time in their life (Lynch, Kaplan, & Salonen, 1997; MacIntyre, Ellaway, Der, Ford, & Hunt, 1998); and operate at different levels (individual, household, community). Overall, there is no consensus on
exactly what social class or SES means or how it should be measured, the construct itself has proven to be a robust factor in predicting variations among social groups, life conditions, skill levels, privilege, and power (Williams & Collins, 1995).

Socioeconomic factors can also interact with social characteristics, such as sex and racial/ethnic group (Braverman et al., 2005). For example, research suggests two trends in the earning disparities among Blacks and Whites in the U.S. The first trend indicates that the gap between Black and White workers is attributable to differential levels of human capital resources, such as skill, education and cognitive abilities (Card & Krueger, 1992; Farkas & Vicknair, 1996; Neal & Johnson, 1996). The second trend suggests that these same disparities result from an overconcentration of minority workers in low-status and low-paying occupational labor markets (Huffman & Cohen 2004; Kaufman, 1983).

Another common research interest in the use of SES is in its relation to psychological health. Dohrenwend (1990) reported that research on the association between mental health and SES as declining, however SES more recently remains consistent in the literature of SES and mental health (Adler & Ostrove, 1999; Williams & Collins, 1995). Overall, similar to the amount of attention given to social class in the literature are the constructs of race and psychological health. (Williams & Collins, 1995).

**Psychological Health**

**Psychological Well-being**

The concept of well-being refers to optimal psychological functioning and experience (Ryan & Deci, 2001). The study of psychological well-being has been guided
for three decades by two primary conceptions of positive functioning: hedonic and eudaimonic well-being (Keyes, Shmotkin, & Ryff, 2002; Ryff & Keyes, 1995; Waterman, 1993). Hedonic well-being is described as the maximum amount of pleasure, and happiness is the totality of one’s hedonic moments (Ryan & Deci, 2001). Eudaimonic well-being is found in the expression of virtue, that is— doing what is worth doing (Aristotle, 1985; Ryan & Deci, 2001; Waterman, 1993). These two philosophical views of well-being have been at the crux of debate among many theorists defining individual well-being.

Aristotle (1985) describes happiness as the English word translation for eudaimonia. Norton (1976) states that eudaimonism is an ethical theory that calls people to recognize and live in accordance with the daimon or ‘true self’. The daimon refers to the potentialities of each person, the realizations that represent the greatest fulfillment in living of which each is capable (Waterman, 1993). Hedonic philosophers, like Cyrene, believe that happiness lies in the successful pursuit of our human appetites, sensations, and pleasures. Hedonism, as a view of well-being, has thus been expressed in many forms and has varied from a relatively narrow focus on bodily pleasures to a broad focus on appetites and self-interests (Ryan & Deci, 2001). The predominant view among hedonic psychologists is that well-being consists of subjective happiness and concerns the experiences of pleasure versus displeasure broadly constructed to include all judgments about good/bad elements of life (Ryan & Deci, 2001). In essence, an individual’s happiness or well-being is viewed in terms of the degree to which pleasure predominates over pain in their life experiences (Bradburn, 1969). Contrary to Cyrenaic
beliefs of hedonic happiness Aristotle believed that happiness is more than life gratification, but also of virtue. Aristotle’s view of hedonic happiness is one of slavish self-satisfying happiness, lacking feelings of personal expressiveness.

Hedonic and eudaimonic well-being are both a form of happiness, however distinctly separate because of the way happiness is debated to be achieved and experienced. In an analysis of the philosophical underpinnings of constructs put forth by well-known theorists such as Erikson, Maslow, Rotter, Gilligan, and Kohlberg, Waterman (1993) conducted a study in an effort to understand the differences of these two concepts. The analysis revealed that these two concepts of happiness are related but distinguishable and that personal expressiveness, not hedonic enjoyment, signifies success in the process of self-realization (Waterman, 1993).

More recently, an extension of these two constructs has been developed and is described as: subjective well-being (SWB) (hedonic) and psychological well-being (PWB) (eudaimonic). SWB consists of three components: life satisfaction, the presence of positive mood, and the absence of negative mood, which together summarize happiness (Ryan & Deci, 2001). SWB emerged in the late 1950s in search for useful indicators of quality of life to monitor social change and improve social policy (Land, 1975). Campbell, Converse, & Rogers (1976) state that life satisfaction reflects an individual’s perceived distance from their aspirations. In addition, among sociologists, life satisfaction is a key indicator of psychological well-being (Ryff & Keyes, 1995). The seminal work of Bradburn (1969) distinguished between positive and negative affect and defined happiness as the balance between the two. His research was concerned
primarily with understanding the psychological reactions of Americans to the everyday stresses and strains of life in pursuit of life goals. Bradburn’s (1969) model of psychological well-being suggests that a person’s position on the dimension of psychological well-being is seen as a resultant of the individual’s position on two independent dimensions— one of positive affect and the other of negative affect. Although happiness is viewed as adjustment and unhappiness as maladjustment to one’s environment, it subtly leads to equating unhappiness with at least the milder forms of mental illness, and happiness with mental health (Bradburn, 1969). Therefore, happiness alone cannot be sufficient criterion of positive mental health because there are clearly situations in which being happy would be inappropriate and a sign of psychological disturbance (Jahoda, 1958).

PWB draws heavily on the formulation of human development and existential challenges of life (Keyes, Shmotkin, & Ryff, 2002). The multidimensional model of PWB describes challenges individuals encounter in an attempt to function positively. Ryff (1989) outlines the model as follows: self-acceptance, people attempt to feel good about themselves even while aware of their own limitations; positive relations with others, people seek to develop and maintain warm and trusting interpersonal relationships; environmental mastery, people shape their environment so as to meet personal needs and desires; autonomy, seeking a sense of self-determination and personal authority; purpose in life, a vital endeavor to find meaning in one’s efforts and challenges; and personal growth, making the most of one’s talents and capacities.
According to the author, these six aspects of PWB theoretically and operationally specify what promotes emotional and physical health (Ryff & Singer, 1998).

Overall, how we define well-being influences our practices of government, teaching, therapy, parenting, and preaching, as all such endeavors aim to change humans for the better, and thus require some vision of what “the better” is (Ryan & Deci, 2001, p. 142). The two philosophic views and more recent extensions of them both indicate happiness and well-being as essential factors of human life.

**Psychological Distress**

Psychological distress is salient in social science literature, and primarily references its impact on diverse populations of minority groups (Banks et al, 2006; Mahalik et al, 2006; Neville & Lilly, 2000; Sellers et al, 2003; Wester, Vogel, Wei, & McLain, 2006). This commonality among the research suggests that individuals belonging to minority groups experience unique levels of psychological distress in multiple aspects of their lives. Psychological distress is defined as an unpleasant subjective state that takes two major forms: depression and anxiety (Mirowsky & Ross, 1989; Gaines, 2007). According to the Diagnostic and Statistical Manual of Psychiatric Disorders IV-TR (2000) depression is a disorder that may include both psychological and biochemical factors. For example, persons who are depressed may experience sadness, hopelessness, and worthlessness. Persons who experience anxiety may become agitated, uptight, or scared and experience an increased heart rate or tensed muscles. The latter is more closely associated with the phenomenon of “fight or flight”, a natural body reaction to either fight to protect, or flee from a potentially dangerous environment or situation.
In essence, psychological distress can affect both mental and physical health (Gaines, 2007).

**Measuring Psychological Health**

Instruments that measure psychological health focus a myriad of dimensions (i.e. happiness, life satisfaction, wellness, distress). Due to the multiplicities of the two happiness domains of subjective and psychological well-being there are very few instruments that attempt to explore the construct empirically. However, vast are the instruments that explore psychopathology in general. Most commonly among them are the Beck Depression Inventory (BDI); Brief Symptoms Inventory (BSI); Collective Self-Esteem Scale (CSE); Hopelessness Scale; Personal Orientation Inventory; and the Mental Health Inventory (MHI).

The *Mental Health Inventory (MHI)* (Veit & Ware, 1983) is a 38-item instrument that measures both psychological well-being and distress in adults. There are two global scales (Psychological Well-being and Psychological Distress); six subscales (Anxiety, Depression, Loss of Behavioral/Emotional Control, General Positive Affect, Emotional Ties, and Life Satisfaction); and an overall Mental Health Index (Davies, Sherbourne, Peterson, & Ware, 1988). Higher scores on the General Positive Affect, Emotional Ties, and Life Satisfaction subscales indicate positive states of mental health, whereas higher scores on the remaining scales, Anxiety, Depression, Loss of Behavioral/Emotional Control indicate negative states of mental health (Davies et al, 1988). Internal consistency reliability using Cronbach’s alpha for the overall Mental Health Index score is (.96). Scores on the remaining scales are as follows: Psychological Well-Being (.92);
Psychological Distress (.94); Anxiety (.90); Depression (.86); Loss of Behavioral and Emotional Control (.83); General Positive Affect (.92); and Emotional Ties (.81). These findings constitute a strong psychometric basis for a multidimensional measurement of mental health as defined by this instrument.

The MHI has been used across diverse populations and is a widely used instrument to assess psychological health (Pieterse & Carter, 2007; Waterman, 1993). For example, Pieterse and Carter (2007) conducted a study to examine the relationship between general life stress, racism-related stress and psychological health in Black men. The purpose of the study was to investigate the predictive nature of psychological health and racism-related stress while controlling for general life stress. A sample size of 220 Black men yielding a mean age of 29.73 were administered the Perceived Stress Scale (PSS) (Cohen, Kamarck, & Mermelstein, 1983); the original Schedule of Racist Events (SRE) (Landrine & Klonoff, 1996); the Mental Health Index (MHI) (Veit & Ware, 1983); and a demographic questionnaire. Cronbach’s alpha reliability coefficients on the MHI were .93 for psychological wellness and .89 for psychological distress. Overall, the study indicated that racism-related stress did play a role in the psychological health of Black men in this sample. For working class participants, when researchers controlled for perceived stress, racism-related stress was a predictor of psychological distress but held no predictive value for psychological well-being. For middle-upper class participants, when researchers controlled for perceived stress, racism-related stress was predictive of both psychological well-being and psychological stress. Although racism-related stress was a significant predictor for both working class, and middle-upper class participants
general life stress accounted for a more of the variance in both psychological well-being and psychological distress (Pieterse & Carter, 2007). The study further explains that racism-related stress influences psychological health but is linked to social class status (Pieterse & Carter, 2007).

Because the very definition of psychological health and well-being raises cultural questions about the meaning and equivalence of constructs, quantitatively oriented researchers have often been respondents to criticisms of cultural bias (Ryan & Deci, 2001). In addition, given the historical and contemporary existence of racism in American society, one might suspect there would be equally substantial literature examining the effects of racism on the psychological health of African Americans (Clark et al., 1999). Unfortunately, tools of measurement for the psychological health of African Americans are almost nonexistent.

**African American Psychological Health**

The long history of racial inequality in North America is well documented and needs little elucidation here: over three hundred years of slavery, Jim Crow laws, segregation, and the civil rights revolution of the late 1950s and early 1960s (Goddard, 2006). There are several factors that impact the psychological health of African Americans such as racism, racism-related stress, and racial discrimination. Each of these factors cannot be ignored when discussing the psychological health of African Americans.

Racism is defined in multiple ways across the literature and there is no consensus on a universal definition. Racism is a belief and action potential that can erode the mental
health status of its individual victims and dominate the institutional and cultural mechanisms through which it operates (Rollock & Gordon, 2000). Harrell (2000) defines racism as:

- a system of dominance, power, and privilege based on racial-group designations;
- rooted in the historical oppression of a group defined by or perceived by dominant-group members as inferior, deviant, or undesirable; and occurring in circumstances where members of the dominant group create or accept their privilege by maintaining structures, ideology, values, and behavior that have the intent or effect of leaving nondominant-group members relatively excluded from power, esteem status, and/or equal access to societal resources (p. 43).

Racism-related stress is often connected to stress theory which suggests that adaptational outcomes of individuals can be linked to stress exposure and a variety of mediating factors (Lazurus & Folkman, 1984). The relevance of stress theory to racism is in the centrality of the transaction between person and environment, whereby the environment affects individual functioning and the behavior of individuals contributes to environmental demands (Lazurus & Lanier, 1978). Racial discrimination refers to actions or practices carried out by members of dominant racial or ethnic groups that have a differential and negative impact on members of subordinate racial and ethnic groups (Feagin & Eckberg, 1980). For example, 50% of African Americans attribute substandard housing, lack of skilled labor and managerial jobs, and lower wages for African Americans to racial/ethnic discrimination (Sigelman & Welch, 1991). Although these experiences are implicitly part of daily life for African Americans, researchers have
yet to agree on the severity of their impact. Most of the incongruous variation lies in the measuring of other constructs with forms of racism, racism-related stress and/or racial discrimination, namely socioeconomic status (SES).

Some research has found that a positive relationship exist between SES and discrimination, whereas other studies suggest that SES is inversely related to experiences of discrimination among African Americans (Sigelman & Welch, 1991). For example, Dohrenwend and Dohrenwend (1969) examined the distribution of stressors in the general population according to race and SES. In racial comparisons they found that both frequency and severity of stress exposure is greater for African Americans in comparison to Whites. However, when including SES they found that there was no difference. A reason for this may be that some of the scales used across studies examining these constructs of racism, race-related stress, and discrimination may only tap subtle expressions of racism and discrimination (Clark et al, 1999). In addition, it is probable that African Americans with higher socioeconomic statuses reported their environments as more discriminatory because of their tendency to have to negotiate environments where racism is more covert (Clark et al, 1999; Kessler & Neighbors, 1986).

The psychological and physiological responses to perceptions of racism may, over time be related to numerous health outcomes for African Americans. For example, Bynum, Best, Barnes, & Burton (2008) found that racist experiences were positively associated with greater anxiety and depressive symptoms in a sample of African American males. In addition, Williams and Williams-Morris (2000) indicated that racism has negative effects on mental health. Untangling and explaining the relationship
between social class and racism and their respective roles in creating and maintaining racial and ethnic health inequalities remains a largely unanswered challenge of research (Oliver, 2008). It is this historical separateness that potentially affects both the individual and collective affirmation of identity for African Americans in the United States. Consequently, the manner in which African Americans construct a racial identity has implications for understanding their psychological functioning and by extension their experiences of internalizing problems (Bynum et al, 2008).

**Racial Identity**

**Race**

The word race is often avoided in the field of psychology because of the wide disagreement as to what is meant when the word race is used to describe a population of individuals (Zuckerman, 1990). The two dominant definitions of race are based on either a constellation of biological and physical traits or an internal/external social perspective (Sue et al., 1998). The definition of race adopted for this study and explained in brief, is the sociopolitical position asserting that race is a product of human invention (Smedley, 1999).

The term ‘race’ was not yet part of the English language until the 16th century; a time when African slavery in the New World was already in existence. During the earlier portion of the African slave trade, neither slaves nor other people of differing physical features were delineated to a specific ‘race’, but were instead referred to as ‘stock’; ‘kind’; or ‘type’ (Smedley, 1999). Since this time, race has conventionally been linked to physical features which have in turn been linked to a person’s physical, intellectual and
cognitive dispositions (Carter, 1997). Although this has been the societal trend, people cannot be separated into racial groups based upon their physical characteristics (Mu’min, Robinson, & Davis, 2008). James King (1981) states that:

Race is a concept of society that insists there is a genetic significance behind human variations in skin color that transcends outward appearance. However, race has no significant merit outside of sociological classifications. There are no significant genetic variations within the human species to justify the division of “races” (p. 118).

Historically, race has served as a classification tool created by Whites to protect their privilege, to create social and cultural distance, and to perpetuate and explain exploitation (Hays & Chang, 2003). Therefore, synonymous to race as a sociopolitical construct, is White privilege— the belief that only one's own standards and opinions are accurate to the exclusion of all other standards and opinions and that these standards and opinions are defined and supported by Whites to continually reinforce social distance between groups (Hays & Chang, 2003). Sue & Sue (2003) explain White privilege as an invisible knapsack of unearned assets that can be used to cash in each day for advantages not given to those who do not fit this mold. Each definition stands in direct opposition to the diverse and complex sociocultural differences reflective in the U.S. today. As a result, White privilege allows Whites to dominate, control access to, and escape challenges from racial and ethnic minorities (Hays & Chang, 2003). This reemphasizes the hierarchal structure of U.S. society across multiple domains, ultimately placing
minorities in a position of oppression and inferiority, thus impacting their individual and collective identity.

**History of Racial Identity Theory & Development**

The term ‘racial identity’ refers to a sense of group or collective identity based on one’s *perception* that he or she shares a common racial heritage with a particular racial group (Helms, 1990). Racial identity models are psychological models because they intend to explain an individual’s intrapsychic and interpersonal reactions to societal racism in its various manifestations (Helms & Cook, 1999). Overall, racial identity theory contends that people traverse through ego statuses in efforts to achieve a healthy racial identity.

Racial identity theory began with an attempt by White psychiatrist and psychologists to better understand African Americans (Cross, 1991). Racial identity development theory is noted to have begun as early as 1913, when psychiatrists Lind and Evarts began heavily researching Negro-Americans. Published in the *Psychoanalytic Review*, they were said to have called themselves ‘students of the Negro mind’ (Cross, 1991). The premise of their research was the belief that by researching Negros they would be better able to understand how the mental processes of Whites worked at a more primitive time in evolutionary history.

In 1939, Ruth Horowitz, conducted the first modern empirical study of racial identity in Black and White children. The focus of the study was on racial consciousness as a function of ego development, and the purpose was to gauge if racial consciousness
transcends surface issues to touch innate dimensions of one’s personality (Cross, 1991; Horowitz, 1939). Her study involved 2-5 yr old White and Negro preschool children. The age of the children was fundamental in the purposes of the study, as Horowitz believed this to be a time of development where children are still in the process of idea formation.

Twenty-four children were involved in the study. Of this, 17 were White (11 boys and 6 girls) and 7 were Negro (5 boys and 2 girls) (Cross, 1991; Horowitz, 1939). Children were administered two projective techniques. First, the Choice Test, where children were asked to self identity with both photographs and drawings of Negro and White children, as well as a line drawing of a Negro boy, a White boy, a clown and a chicken (Cross, 1991). For example, once girls self identified on the first drawing (of a Negro or White child) they were asked to identify the remaining photographs and drawings as relative to a brother or cousin. Children were asked, “Show me which one is you.” and “Which one is ——— (name of child)?” (Horowitz, 1939, p. 92). The Portrait Series was the second technique, to which children were shown ten portraits one at a time and asked: “Is this you?” Is this ——— (name of child)?” (Horowitz, 1939, p. 92). Results showed that Negro and White children making incorrect self-identifications was nearly identical, however emphasis on the boys choice tests was analyzed more thoroughly by Horowitz because the girls results did not yield as clear of a contrast (Cross, 1991; Horowitz, 1939). Results from this analysis indicated that on the whole, White boys presented a more confused picture than Negro boys. In the Choice Test, “Negro children seemed to have a more definite concept of their difference from one
group and similarity to another than the White group” (Horowitz, 1939, p. 97). For example, two White boys consistently identified with Negro boys, and chose Negro girls as representative of their sisters, whereas no Negro boys consistently identified himself with pictures of White boys (Horowitz, 1939). Overall, Negro boys made 33% consistently correct identifications and White boys made 20% consistently correct identifications (Horowitz, 1939).

In addition to the perceptions of similarities and differences as purposed in the Choice Test and the Portrait Series, children also identified themselves by criteria other than skin color. For example, when the restriction of the forced choice was removed, in the Portrait Series, the Negro children identified more freely with members of both groups (Horowitz, 1939). Although the researcher indicates that an interpretation of this activity can at the time only be assumed, Horowitz continued by interpreting it as ‘wishful activity’ (p. 97). The concept of wishful activity:

may mean a desire to share in the selfhood of others without the restriction of the color value of a skin, a preference for essential similarities. Or it may mean that the definition of the self is not so much in terms of what one is as it is in terms of what one is not, the delimiting process, the negation being more formidable than the assertion. In that case the compulsion of the choice situation would drive one to assert identity after denial — one is not White; then one is Negro (Horowitz, 1939 pp. 98-98).

Employing what she referred to as a theory of “wishful activity” to Negro children, Horowitz, further attributed the superior performance by the Negro boys to their age, and
the constriction of an adult environment as reflected in the home of Negro children, stating that Negro children become aware of race at an earlier age due to the reality of the racial constraints that they face (Cross, 1991; Horowitz, 1939). In critique of Horowitz’s study, Negro identity theorists Kenneth and Mamie Clark, pointed out that emphasis in her study was primarily on racial self-identification tasks versus color preferences (Cross, 1991). A modified version of the techniques used by Horowitz was administered to 150 Negro children ages 3-5 years (50 three year olds; 50 four year olds; and 50 five year olds). When controlling for age and skin color, Clark and Clark (1939) found that children were not orienting themselves according to an awareness of belonging to a socially defined group, but instead were making comparisons and achieved greater degree of self-identification based on properties of their bodies (Cross, 1991). Although Horowitz’s ‘wishful activity’ theory has yet to be supported, she is still attributed to conducting the first methodological and theoretical study on racial identity (Cross, 1991).

Between the late 1930s and 1950s Horowitz’s theory of ‘wishful activity’ more commonly known as ‘wishful thinking’ quickly became asserted as Negro self-hatred theory. This theory took on presence in both lay and psychological literature. In 1951 psychologists Kardiner and Ovesey popularized the term self-hatred by introducing it into the current discourse of psychology literature about Negros, going beyond that which had formerly been considered low self-esteem (Cross, 1991). Kardiner and Ovesey’s research concluded that Negro’s did in fact suffer from the Negro self-hatred, a term of pathology that originally followed the course of European anti-Semitism in the mid nineteenth century (Bean, 2000; Gilman, 1986). Negro (or Black) self-hatred is defined
as a Negro’s hatred of themselves due to their race (Vandiver, Fhagen-Smith, Cokley, Cross, & Worrell, 2001). Even regardless of social class or life conditions, Kardiner and Ovesey contended that “the Negro has no possible basis for a healthy self-esteem and every incentive for self-hatred” (Kardiner & Ovesey, 1951, p. 197).

Kurt Lewin influenced the study of minority identity in the United States, and based on his controversial argument on Jewish self-hatred in the 1940s. His proportions evolved from an earlier proposed theory by Horowitz which states that an individual’s self concept (SC) is indicative of their personal or personality identity (PI) and group identity (GI). In essence, the formula is as follows:

\[ SC = PI + GI \]

(Cross, 1991; Kardiner & Ovesey, 1951; Lewin, 1941). Lewin proposed that minority group members who possess a negative group identity (GI) will likely suffer from self-hatred at the personal(ity) identity (PI) level as well (Lewin, 1941). Lewin’s assertions were later supported by Kardiner and Ovesey in their research on Negro identity, and became the foundation by which researchers developed doll studies to explore the concept of Negro self hatred further (Cross, 1991).

Kenneth Clark’s position on Negro self-hatred theory evolved from what he understood as the psychological effects of racial discrimination. In efforts to explore differences in self-identification and racial preference, Clark and his colleagues conducted the infamous Doll Test in two different regions of the U.S. (South and North). The purpose of the study was to help determine whether or not children were affected by the social ills of racial discrimination in their environment. Participants in the Doll Test consisted of 253 Negro children (134 Southern; 119 Northern) between 3 and 7 years of age.
age. Clark’s research team presented children with 4 dolls (2 white; 2 brown) and asked them to point to the doll they preferred based on questions by the researcher, such as: ‘Give me the doll that you like to play with or that you like best’; ‘Give me the doll that is the nice doll’; and ‘Give me the doll that looks bad’ (Powel-Hopson & Hopson, 1992, p. 184). In the South more Black children picked dolls that were brown versus in the North the opposite was the case. Overall, the results yielded that not only does a child’s racial awareness begin around age 3, but that children are also aware of advantages and negative attributes socially assigned to Black and White racial groups (Powel-Hopson & Hopson, 1992). As the proportions grew about Negro self-hatred theory, psychologists and psychiatrists began to look further into the theory, and attempted to ascribe stages that the Black individual traverses through in search of an identity.

**Black Racial Identity Development**

In the Black community, the recognition of two movements of Black Identity Development were said to have evolved between 1954 and 1975 (Cross, 1995). The first, regarded as the Civil Rights or Black Power Movement (1954-1965) was considered a reaffirmation of Blacks to America. The second, a Black Consciousness Movement (1965-1975) was considered a time of personal identity transformation. Early on, independent observers, most of whom were Black psychologists, started codifying the movements as stages they felt the Black community was navigating through in search of an identity (Cross, 1995). Emergent among them was William E. Cross, Jr. who developed the Negro-to-Black Conversion Model (1971). The model was a response to Black psychologist Joseph White (1970) who challenged Black
scholars by saying that Blacks needed a Black psychology that focuses on the realities of the Black community in search of an identity in light of the oppression experienced daily. White (1970) goes on to say that the so-called neutral value paradigms currently being used to evaluate and conceptualize the behavior of Black Americans are in reality weighted towards the conditions and values of White middle-class America. In response, Cross developed stages for what he called Nigrescence—a French term that means process of becoming Black (Cross, 1995; Helms, 1990) and is analogous to the Negro-to-Black Conversion model (Cross, 1971). The premise of the term describes a process of accepting and affirming a Black identity in an American context by moving from Black self-hatred, as purported by earlier theorists, to Black self acceptance (Vandiver, 2001). Cross used his interviews with African Americans as they were “going through changes as a consequence to their participation in the modern Black movement” (Cross, 1971, p. 14), as the theoretical framework for the development of the model. The author further specifies that the process should be viewed as a model for self-actualization under conditions of oppression.

The Negro-to-Black Conversion model consists of five stages. Stage one, Pre-Encounter, describes an individual who is anti-Black and views White cultural standards as superior. Stage two, Encounter, prompts one to reinterpret their Black experience as a result of an event that awakens them to consider the Black condition in America. For example, this person may ask the question: “Have I always been unaware of the Black experience, or have I just been programmed to be disgusted by it?” (Cross, 1971, p. 17). As a result of the encounter the person’s abandonment of the previous world view leaves
them virtually ‘identity-less’ (Helms, 1990). Thus progressing to stage three, Immersion/Emersion, where one becomes immersed in all things associated with Black culture, while rejecting and dehumanizing things relevant to White culture. The Emersion individual then gains control of their views, begins to re-humanize things associated with White culture, and becomes open to critical analysis of the Black community. The Internalization status individual puts aside the anger and guilt felt in the Immersion/Emersion status and begins to feel safer and secure about their identity. Essentially this individual is open to action plans about how to change, but does not commit to a plan. Finally, the Internalization-Commitment individual is considered to have a new Black identity and is committed to plans of action thus becoming involved in activism.

Cross’s model is to be viewed as an adult experience that emphasizes “psychological liberation”. It is a model designed with intent to understand how African Americans process identity formation in light of exposure to social oppression. The model is not simply a contemporary phenomenon, but is instead one of the most powerful interpretive lenses through which to view the historical reality of African-decent people in this country (Cross, Parham, & Helms, 1998). Overall, Cross’s model is parsimonious, easily understood, and resonates for many members of oppressed communities (Vandiver, 2001).

Since the inception of the Negro-to Black Conversion model, Cross has revisited the model to include substantive changes in the Pre-Encounter, Immersion/Emersion stage, and Internalization stages. The expansion of the model newly became referred to
as *Nigrescence Theory-Extended (NT-E)*. In addition, changes were highlighted between personal identity, and reference group orientation. Personality identity reflects the general personality or overall self-concept common to the psychological makeup of all human beings and is considered a minor component in nigrescence theory (Cross & Vandiver, 2001). In contrast, reference group orientation, the basis of nigrescence theory, “defines the complex of social groups used by the person to make sense of oneself as a social being” (Cross & Vandiver, 2001).

Changes made in the Pre-Encounter stage are introduced through the concept of race salience. Race salience refers to the importance or significance of race in a person’s approach to life and is captured across two dimensions: degree of importance, and the direction of the valence (Vandiver, 2001). Race salience can also range from high to low, and positive to negative. For example, a person can have a high salience for race and a positive (pro-Black) valence or a high salience for race with a negative (anti-Black) valence (Vandiver, 2001).

Changes in the Pre-Encounter stage indicate two distinct identities and are described as *Pre-Encounter Assimilation* (adopt a pro-American/mainstream identity), and *Pre-Encounter Anti-Black* (hate Black and being Black). Cross describes the Pre-Encounter Anti-Black individual as one who is miseducated and inflicts self-hatred. This self-hatred then becomes detrimental to ones self-esteem as it is internalized as hating themselves because they are Black. In contrast, the Pre-Encounter-Assimilation identity is not considered to have a relationship with ones self-esteem because race is not viewed as important and has low salience (Vandiver, 2001).
stage originally possessed strong Pro-Black and anti-White attitudes mostly found in the Immersion individual. These attitudes at the time suggested Black Nationalism, whereas now the attitude is viewed as a constructive internalization of being Black which allows for smoother a transition to the Internalization stage.

Theorists have suggested the collapse of the Internalization and Internalization-Commitment stages into one stage (Helms, 1989; Helms & Parham, 1985). The critique leading to this change is the difficulty in distinguishing motivation (Internalization) from behavior (Commitment) (Helms, 1990). Cross’ revised model reflects this change as the author states “few differences” between the psychology of Blacks at the Internalization and Internalization-Commitment stages (Cross, 1991); referred to now only as the Internalization stage. Similar to the Helms’ (1990) WRID critique, Parham (1989) viewed the progression of Black racial identity through a cyclical versus a linear process. In addition, lifespan development stages may interact with these ethnic identity stages to form different patterns of opportunity to confront ethnic identity issues (Okech & Harrington, 2002).

Cross’s seminal work has been influential in multiple fields of study and has impacted the development of many other models of racial, cultural, ethnic, gender, feminist, and lesbian/gay identity (Atkinson, Morten & Sue, 1979; Hardiman, 1982; Helms, 1990). Subsequent to Nigrescence theory evolved White Racial Identity Development theory (WRID) (Hardiman, 1982; Helms, 1990) and later the People of Color (POC) Model (Helms, 1995). The distinct difference between the POC and other models of its kind, are that the POC is focused primarily on the experiences of oppression
by minority groups in the U.S., and is not centered on the establishment of one’s integrated racial identity.

Helms’ (1990) model of WRID resembles a stage wise process similar to Cross’s initial model of racial identity development. Though the model became the first model of racial identity to be empirically tested, Rowe, Bennett, and Atkinson (1994) put forth three primary critiques. First, is the belief that Whites and people of Color are both affected by racism but that it is experienced differently. Second, the WRID model does not provide enough explanation about White identity, but instead is more about the sensitivity levels of Whites to other racial groups. Finally, a most notable challenge to the directionality of the model indicating that racial identity is static (stage) versus nonlinear (status). The authors then assert a change in the terminology from ‘stage’ to ‘status’, as an individual’s ego-status, which ultimately shapes the construction of their racial identity, may vary throughout their lifetime depending on their environment and life experiences. Helms contends that the change was necessary to encourage mental health workers who use racial identity models to conceive of the process of development as involving dynamic evolution rather than static personality structures or types (Helms & Cook, 1999).

The People of Color Model (POC) (Helms, 1995) is representative of persons who are Asian, Latino, African, and Native American. The model’s common thread among these groups is that of experiential oppression in the U.S., versus a focus on race. The commonality of oppression experienced by these visible racial groups is one that becomes a tradition in which minorities must learn to survive (Helms & Cook, 1999).
Measuring Black Racial Identity

Racial identity development is conceptualized as a series of stages through which individuals pass as their attitudes toward their own racial group and the White population develops, ultimately achieving a ‘healthy’ identity (Rowe, Bennett & Atkinson, 1994, p.130). To reach a health identity current research suggests that an individual’s racial identity is not stagnate, or restricted to one stage (Helms & Cook, 1999). Instead one’s racial identity is more recently referred to as an ego status because it has the ability to fluctuate. The purpose of measuring racial identity is to operationalize theory thus producing empirical evidence for its ability to assess the racial identity attitudes of individuals. Helms proposes that there are at least three theoretical assumptions that are implicit in racial identity development models and consequently, are inherited by any measure that purports to operationalize the models: (a) racial identity occurring in a stage wise process is assessed; (b) racial identity is bi-dimensional such that a Black person incorporates attitudes about Blacks as well as Whites into her or his identity, and (c) racial identity is relatively stable (though not necessarily permanent) (Helms, 1990, p. 36).

Over the years a variety of instruments have been developed to measure the identity of African Americans. For example, the Developmental Inventory of Black Consciousness (DIBC) (Milliones, 1980) measures an individual’s progression through four stages of Black consciousness; A Multidimensional Inventory of Black Identity (Sellers, Rowley, Chavous, Shelton, & Smith, 1997) measures Centrality (the perceived importance of race in one’s self-concept which also determines the priority race is given
in defining the self); Ideology (collective attitudes, beliefs, and opinions that individuals have about African Americans); and Regard (one’s positive or negative evaluation of being African American and occurs at two levels, private and public). Inclusively, and for the purposes of this study, the *Black Racial Identity Attitudes Scale (RIAS-B)* measures four racial identity attitudes—pre-encounter, encounter, immersion/emersion, and internalization. Each aforementioned scale represents a developmental process from lack of knowledge and appreciation of one’s race to both awareness of and satisfaction with one’s race (Cross, 1971). Although each scale is constructed to measure the identity of African Americans, the RIAS-B (Parham & Helms, 1981) is widely used thus providing reliability and validity information across diverse populations of African Americans.

The original sample for the RIAS-B was 250 college and university students ranging in age from 17-72 years. The study yielded the following sub-scale reliability coefficients: Pre-encounter = .76; Encounter = .51; Immersion/Emersion = .69; Internalization = .80. Noticeably the Encounter subscale is quite modest in comparison to the other reliability subscale scores. In reflection, the encounter ego status is when an individual has a critical incident involving race (i.e. hearing a racial slur by a White counterpart or witnessing a racially charged event). As a result of this encounter the individual makes a conscious decision to develop a Black identity and begins viewing the world through the lens of a Black experience (Plummer, 1996). Due to this critical incident or event, an individual in the encounter ego status is continuously interpreting the condition of Blacks in America (Cross, 1971). To this, Helms points out that lower
scores on the *Encounter* subscale are attributable to the changeable nature of attitudes found in this ego status, further indicating the difficulty in “measuring a phenomenon consistently if the phenomenon itself is not consistent” (Helms, 1990, p. 44). Overall, Anastasi (1988) indicates that the reliability scores of the RIAS-B are moderate and favorably compare to those of other non-culture specific personality measures.

Since this initial study, multiple studies using the RIAS-B have produced similar sub-scale reliability results. For example, Pope-Davis, Liu, Ledesma-Jones & Nevitt (2006) examined the relationship between racial identity and acculturation among African Americans. For the purposes of their study, acculturation was defined as the psychological adaptive process that occurs when an individual interacts with another culture (Pope-Davis et al, 2006). The participants were 138 female (mean age = 20.09) and 56 male (mean age = 18.95) college students from two universities. The researchers indicated that a previous study by Landrine and Klonoff (1994) showed African American culture as dually associated with one’s identification with one’s race. Therefore, the purpose of the Pope-Davis et al (2006) study was to explore whether the RIAS-B and the African American Acculturation Scale (AAAS) assess different or similar constructs; in essence, agreeing or disagreeing with the notion that racial identity and acculturation are similar. RIAS-B Cronbach alphas for their study were .70 (Pre-Encounter), .59 (Encounter), .67 (Immersion), .49 (Emersion), and .60 (Internalization).

In an exploratory design, a simultaneous regression was conducted between the subscale scores of the RIAS-B, as predictors, and the AAAS as the criterion variable. Results yielded that the regression accounted for 18% ($R^2 = .18$) of the variance, with
pre-encounter and immersion as significant predictors. Overall, the authors’ findings indicated that when one's race is meaningful, African American culture is also meaningful, in this case, further suggesting that there is a similar relationship between Black racial identity and acculturation (Pope-Davis et al, 2006).

When racial identity subscales were used as predictors in the aforementioned study only two subscales accounted for a significant amount the variance of the similar construct of acculturation. For the purposes of the current research it is not hypothesized that racial identity is similar to psychological health, but that attitudes found within the racial identity ego statuses are predictive of the psychological health of African American men. Although the hypothesis is that racial identity will too account for a significant amount of the variance of the psychological health of African American men, above and beyond that of the other predictors (i.e. SES, and resilience), it is also recognized that the significance of the variance may or may not be representative of all racial identity subscales.

In another study of 124 self-identified African American young adult males (mean age =20.35), Mahalik et al, (2006) examined racial identity and masculinity as correlates of self-esteem and psychological distress. Prior to this study, only research on masculinity and White male populations was conducted, thus making their findings non-generalizable to a minority population of African American men. Using the RIAS-B, the authors reported reliability coefficients alphas of: .81 (Pre-Encounter); .37 (Encounter); .70 Immersion/Emersion; and.64 (Internalization). The reliability for Encounter was so low that it was not used in further analysis. However, in an examination of racial identity
and masculinity, Pre-Encounter scores were significantly related to masculinity. The researchers suggest that this correlation indicates that the more Black males devalued their own racial group and considered White people their preferred racial reference group, the more likely they were to conform to the masculinity norms of this group in the U.S. (Mahalik et al, 2006).

The study also included a two hierarchical regression analysis. In the first step, psychological distress was not indicative of group membership. In the second step Pre-Encounter scores and Immersion/Emersion scores were significant predictors of psychological distress (Mahalik et al, 2006). These findings are consistent with results from previous racial identity literature which suggest that racial identity ego statuses are related to the self-esteem and psychological distress experienced by African Americans (Cross, 1971). The findings also reflect that the more Black men endorsed items on the Pre-Encounter subscale the more they tended to report psychological distress (Mahalik et al, 2006). This is consistent with reports that Pre-Encounter attitudes are related to lower levels of self esteem, higher levels of anxiety, (Parham & Helms, 1985) and lower levels of psychological health (Pillay, 2005). In addition, the results suggested that racial identity and conformity to masculine norms in the dominant culture explained unique variance in Black men’s self-esteem and psychological distress (Mahalik et al, 2006).

Neville, Heppner, & Wang (1997) examined the predictability of racial identity attitudes on both general and cultural-specific stressors among 90 (29 men and 61 women) African American college students at a predominantly White mid-west university. One purpose of their study was to extend Black racial identity theory through
an understanding of the unique variance in racial identity ego statuses as predictors of different types of stressors. A second purpose of their study was to explore the relationship between racial identity attitudes and models of coping. The authors believed that the examination of this relationship would bring about greater understanding of complexities in the coping process, as well as explore what potential role racial identity attitudes may play in this process (Neville et al., 1997). Participants were administered a modified version of the Black Student Stress Inventory (BSSI) and the RIAS-B. Alpha coefficients for the RIAS-B were: Pre-Encounter (.86), Encounter (.27), Immersion/Emersion (.60), and Internalization (.58).

As expected, RIAS-B scores were significantly associated with perceived stress and coping styles. More specifically, Immersion/Emersion scores were significantly associated with both general and cultural-specific stressors, such that higher scores on these two subscales were also indicative of lower problem solving appraisal and problem-focused coping (Neville, et al., 1997). In addition, higher Encounter scores were related to greater perceived general stress. To address the second hypothesis, the researchers found the RIAS subscale scores to be predictive of cultural-specific stress. For example, the Internalization subscale score was predictive of cultural-specific stressors in a negative direction, whereas, the Encounter subscale score was predictive of cultural specific stressors in a positive direction (Neville et al., 1997).

Nghe and Mahalik (2001) examined the relationship between racial identity ego statuses and the use of psychological defenses in 80 (44 women; 36 men) African American college students. For the purposes of their study psychological defense
mechanisms are similar to that of ego defense mechanisms and are “believed to maintain homeostasis by preventing painful ideas, emotions, and drives from forcing their way into consciousness” (p. 11). Nghe & Mahalik (2001) hypothesized that immature developmental levels of ego defenses would be associated with less sophisticated ego statues of racial identity, and that more mature levels of ego defense would be associated with more mature racial identity ego statuses. Researchers administered both the Defense Mechanisms Inventory (DMI), the Defense Style Questionnaire (DSQ) and the RIAS-B. The authors report internal consistency estimates for the RIAS-B as .79 (Pre-Encounter); .63 (Encounter); .61 (Immersion); .64 (Emersion); and .23 (Internalization). Results supported the researcher’s hypothesis that racial identity ego statuses are predictive of psychological defense mechanism maturity levels. For example, encounter ego status attitudes correlated strongly with neurotic defenses which are commonly associated with adult distress (Nghe & Mahalik, 2001). The authors believe this to be supportive of Helm’s model in that the encounter ego status is characterized by the rejection of a previous identification of White culture, and search for identification with Black culture (Cross, 1971; Helms, 1990). The authors also believe the results to indicate that the ego statuses of Helms’ model predict how African Americans manage painful conflict (Nghe & Mahalik, 2001).

Each of the aforementioned studies that used RIAS-B indicate similar alpha levels of reliability across the measures four subscales. The lower reliability scores in the Encounter stage are synonymous to Parham & Helms’ (1981) original study. Although reliability improved with the long version of the RIAS-B as used in these studies (50-item
versus the 30-item inventory) the authors acknowledge lower scores on the Encounter subscale due to the difficulty in measuring a continuously changing phenomenon.

While the RIAS-B is a widely used tool for measuring racial identity attitudes of African Americans there are genuine concerns regarding the validity of this instrument. The most common critique is that the measure was development based on Cross’ (1971) model of Black Racial Identity. Two areas of concern are (1) the Cross (1971) model may be outdated, and that changes have evolved over time in the African American community; (2) the original model has undergone critique and the expansion of four stages, of which two (Internalization and Internalization-Commitment) were collapsed into one construct. In addition, there is an overreliance on college and university student populations used to operationalize racial identity theory therefore the theory needs exposure among more diverse samples of individuals.

Racial identity has been the topic most frequently published about in the 5-year period from 1985 to 1999 (Cokley, Caldwell, Miller & Muhammad, 2001). Measurement of such a construct has in addition spanned across multiple disciplines of the social sciences and education. Although racial identity has gain respect over the years among theorists and researchers alike, there remains a paucity of research that addresses the relationship of racial identity and resilience.

**Resilience**

Resilience literature and research has primarily focused on children and adolescents (Cicchetti, Rogosch, Lynch, & Holt, 1993; Miller, 1999; Pinquart, 2009; Rutter, 1981; Stacey, Dearden, Pill, & Robinson, 1970). However over the last 15 years
resilience literature among adult populations has increased. Regardless of the population, resilience studies focus on factors that allow an individual to thrive in the wake of adversity. Put into more operational terms it means that there has been a relatively good outcome for someone despite their experience of situations that have been shown to carry a major risk for the development of psychopathology (Rutter, 1999).

The term resilience is derived from the Latin word *resilio*, meaning to ‘jump back’ (Klein, Nicholls & Thomalla, 2003). Some contend its original use in the field of ecology while others declare physics (Batabyal, 1998; Van der Leeuw & Leygonie, 2000). Use of the word *resilience* is secondary to its original name *invulnerable*. Widely used in the field of psychiatry the term *invulnerable* frequently described the ability of children to successfully overcome negative exposures to environmental stressors that put them at developmental risk of achievement.

Resilience has been viewed as a continuum of adaptation or success (Hunter & Chandler, 1999). In the social sciences, the roots of the construct of resilience are in two bodies of literature: (1) psychological aspects of coping, and (2) physiological aspects of stress (Tusie & Dyer, 2004). From the psychological literature on stress and coping, observations of individuals coping better than expected and actually improving as a result of adversity laid the groundwork for the construct of resilience (Tusaie & Dyer, 2004).

There is no standard definition for resilience though extensive research shows the construct conceptualized in various ways. Rutter (1993) states that resilience is not a fixed characteristic but rather one that changes with developmental life experiences and is dependent on risk factors, adversity, and the social environment. Dyer and McGuiness
(1996) view resilience as a dynamic process that is highly influenced by protective factors, such as internal resources, skills, and abilities. Bernard (1991) describes specific qualities associated with resilience such as social competence, problem-solving skills, autonomy, and sense of purpose. Wolin and Wolin (1993) suggest that the path to resilience requires insight, independence, creativity, humor, initiative, values orientation, and relationships. While there are numerous definitions of resilience, all of the definitions include a discussion of risk factors that negatively impact quality of life and an identification of protective factors that reduce or eliminate risk factors (Rogerson & Emes, 2008).

Resilience theory highlights three sets of factors, namely risk factors, protective factors, and outcome variables, as important to understanding adjustment and competence in the face of adversity (Masten, Best & Garmezy, 1990; Rutter, 1993). The presence of risk factors means that an individual has been identified with a group that is more likely than other groups to develop a specific difficulty (Tusaie & Dyer, 2004). For example, many African American communities are disproportionately beset with violent crime, drug abuse problems, teenage pregnancies, out-of-wedlock births, female-headed households, and welfare dependencies (Wilson, 1987). Furthermore, studies have shown that African American individuals living in central-city areas have high rates of exposure to trauma and in particular assaultive trauma (Breslau, Kessler, Chilcoat, Schultz, Davis, & Andreski, 1998). Risk factors in these two particular instances are the environmental aspects of the community that have influenced the physiological and psychological aspects of the people living there. For that reason, risk factors do not predict a particular
negative outcome with absolute certainty; they only expose individuals to circumstances associated with a higher incidence of that outcome (Tusaie & Dyer, 2004).

As annotated in the previous example, risk factors can be single, multiple or cumulative life events. Explained further risk factors are the biological, environmental, and psychosocial hazards that increase the likelihood that a maladaptive outcome will occur (Werner, 1990). Pinquart (2009) explains that for adolescents these may be encountered in their daily routine. For example, academic difficulties, disappointments by friends, disagreements with teachers, conflicts with parents, and problems mastering the school-to-work transition (Pinquart, 2009). Rogerson and Emes (2008) conducted a study that explored the concept of resilience from the perspective of 15 adult day support program participants, using grounded theory. In this study, vulnerability, an individual’s susceptibility to a negative outcome (Werner 1990), was described as the overarching feeling where multiple risk factors manifested. Risk factors in this study included physical decline, a shrinking social support network, and increasing reliance on community support (Rogerson & Emes, 2008).

Resilience represents the interaction between risk factors (vulnerability) and protective factors (protection) (Ahern, Kiehl, Sole, & Byers, 2006). Once an individual has been exposed to varying risk factors that challenge their environmental, biological and/or psychological stability, protective factors are developed. Werner and Smith (1982) conducted a landmark longitudinal study which marks the beginning of resilience research because the single most common characteristic of each resilient individual in the study is protective factors. Protective factors refer to influences that modify, ameliorate,
or alter a person’s response to some environmental hazard that predisposes them to a maladaptive outcome (Rutter, 1985). They enable an individual to adapt successfully to the environment, notwithstanding challenging or threatening circumstances (Masten, Best & Garmezy, 1990). Overall, protective factors are the specific competencies that are necessary for the process of resilience to occur (Dyer & McGuinness, 1996). Findings from the Werner and Smith (1982) study revealed provocative insights into the drastically different outcomes among individuals raised in similar environments (Earvolins-Ramirez, 2007).

Overall, several researchers have provided examples of protective factors common in resilience research. They are, but not limited to: communicates effectively, sense of personal worth, internal locus of control, flexibility, ability to have close relationships, assertive (asks for help), desires to improve, problem solving ability, decision making ability, future oriented, and sense of humor (Anthony, 1974; Bernard, 1991; Garmezy, 1991; Masten, 1994; Rutter, 1987; Werner, 1992). Each of these is considered a protective factor because they are resources that can modify the impact of risk exposure and can alter outcome status (Murray, 2003).

It is important to note that while protective factors are important to resilience, it is the protective process that is of greater value in determining approaches to enhancing resilience and thereby preventing negative outcomes (Rutter, 1987; Rutter, 1993). Protective factors that are present or beneficial for one individual may not be present or beneficial for a similar individual (Earvolino-Ramirez, 2007). Additionally, the same protective factors that lead to healthy outcomes for one individual in one situation may
not lead to healthy outcomes for the same individual in another situation (Johnson & Wiechelt, 2004). In essence, people may be resilient to some sort of environmental hazard, but not others; resilient in relation to some outcomes and not others; or resilient at one time period in their life and not others (Rutter, 2006).

Charney (2004) suggest that the exploration of resilience could offer a basis for clinical interventions with the potential to prevent poor or adverse outcomes. Schafer and Moos (1992) identified three broad categories of positive outcomes in relationship to health: enhanced social resources (supportive networks); enhanced personal resources such as insight and self-reliance; and development of problem-solving and help-seeking skills. It is therefore the lack of fit between a person's abilities and needs and environmental conditions and demands that leads to variability in adaptational outcomes (Brennan & Cardinali, 2000).

The exposure to disproportionate environmental, biological, and psychological risks among American racial minorities nationwide poses a threat to the likelihood of a positive outcome. For example, race is a predictor of post-school outcome status in its own right, with African Americans, Native Americans, and Latin Americans having poorer postschool outcomes than White Americans (Feagin & Feagin, 1996). Economically, the socioeconomic status (SES) of racial minorities has an impact on resilience outcomes. For example, in 2000, 24.6% of Hispanic earnings were in the lowest income quintile, compared to 31.3% of African Americans and 17.6% of Whites (O’Connor, 2009). Though Hispanic Americans are the largest minority population, African Americans still seem to be at a greater income disadvantage when compared to
Hispanics (O’Connor, 2009). These socioeconomic influences connote an indirect environmental effect of poverty which in turn may limit the opportunity for racial minorities to have access to the prosocial interactions necessary for the process of resilience to occur.

**Personality Trait or Dynamic Process**

Among the psychological and physiological roots of resilience, researchers primarily support one of two aspects of resilience (1) resilience as a personality trait or (2) resilience as a dynamic process (Luthar et al., 2000). As a personality trait, resilience is synonymous with *ego-resilience*, a construct developed by Jeanne and Jack Block (1980). Conceptualized in the context of personality development, ego-resilience is a set of traits reflecting general resourcefulness and sturdiness of character, and flexibility of functioning in response to varying environmental circumstances (Luther et al., 2000). More specifically, ego-resilience is a personality resource that allows individuals to modify their characteristic level and habitual mode of expression of ego-control so as to most adaptively encounter, function in, and shape their immediate and long-term environmental contexts (Khlonen, 1996). The opposite end of the ego-resilience continuum (ego-brittleness) implies little adaptive flexibility; an inability to respond to the dynamic requirements of the situation; a tendency to perseverate or to become disorganized when encountering changed circumstances or when under stress; and a difficulty in recouping after traumatic experiences (Block & Block, 1980).

The main antecedent to resilience is adversity. Adversity is the feature that separates the concept of resilience as a dynamic process from the personality trait of ego-
resilience (Earvolino-Ramirez, 2007). When the term resilience is used to refer to a process, the experience of significant adversity is a given (Luther et al., 2000). Rutter (2006) contends that because resilience is not a general quality that represents a trait of the individual, research needs to focus on the process underlying differences in response to environmental hazards, rather than resilience as an abstract entity.

Masten (1994) commenting on the use of terminology, states that any scientific representation of resilience as a personal attribute can inadvertently pave the way for perceptions that some individuals simply do not have what it takes to overcome adversity. Therefore, originally referred to as a personality trait, over the past decade or two, resilience has been redefined as a dynamic process (Luther et al., 2000). As a dynamic process, resilience is the capacity for, or outcome of successful adaptation despite challenging or threatening circumstances (Garmezy, 1990). For example, resilient people adapt by allowing themselves to feel grief, anger, loss and confusion when hurt and distressed, without allowing such emotions to become a permanent feeling state (Edward, Welch, & Chater, 2009).

Researchers contend that progress in the area of resilience will remain seriously constrained as long as studies remain largely empirically driven as opposed to theoretically based (Luther et al., 2000). However, when resilience is studied as a dynamic process it allows for the development of resilience-based interventions and the ability to empirically study the outcomes of such interventions (Earvolino-Ramirez, 2007). A benefit of such interventions would serve the purpose of increasing the
knowledge base of practitioners working with diverse populations on potential risk factors, protective factors, and outcomes.

**Measuring Resilience**

Some researchers believe that resilience can only be studied if there is a thorough measurement of risk and protective factors (Friborg, Barlang, Martinussen, & Rosenvinge, 2003; Rutter, 2006; Wagnild & Young, 1993). Thus, empirical evidence has lead to the development of models of resilience and instruments to operationalize the concept (Ahern, et al, 2006). For example, Richardson, Neiger, Jensen, & Kumpfer (1990) developed *The Resiliency Model* which proposes that individuals reacting to disruptive life events, choose consciously or unconsciously to reintegrate. It is the disruption that allows an individual to learn or tap into resilient qualities and achieve resilient reintegration (Richardson, 2002). The *Adolescent Resilience Model* (Haase, 2004) includes individual, family, and social protective factors. Developed with a sample of chronically ill (primarily cancer) adolescents, the model depicts outcome factors such as resilience (self-esteem, self-interdependence, and confidence/mastery) and quality of life (sense of well-being) (Haase, Heiney, Ruccione, & Stutzer, 1999).

Multiple instruments have been developed to operationalize resilience theory. The *Baruth Protective Factors Analysis (BPFI)* is designed to measure four primary factors that support resiliency (adaptive personality, supportive environment, fewer stressors, and compensating experiences) (Baruth & Carroll, 2002; Gardner, Huber, Steiner, Vazquez, & Savage, 2008). The BPFI is a 16-item, 5-point Likert scale instrument that was developed using a sample of undergraduate students. The BPFI
contains 3 subscales with internal consistencies ranging from .76 to .98. An advantage of the instruments use is its usefulness for educators and counselors. Conversely, disadvantages include: reliability and validity need further exploration; other factors of resilience are not measured; and findings cannot be generalized to all ages and ethnic groups (Ahern et al, 2006). The Connor-Davidson Resilience Scale (CD-RISC) (2003) is a 25-item, 5-point Likert scale instrument with a theoretical base of resilience as stress, coping, and adaptation, and therefore views the constructs measurement as successful coping ability (Connor & Davidson, 2003). The CD-RISC has 5 subscales and the full scale Cronbach Alpha score of .89. Advantages of the instrument include good internal consistency and test retest reliability. A noteworthy disadvantage however is that even though it assesses characteristics of resilience, it does not assess the resilience process (Ahern et al, 2006).

The Resilience Scale (RS-25) (Wagnild & Young, 1993) is a 25-item measure and is widely used to measure the construct of resilience. Scaling of each item is Likert scale format and responses ranging from (1) disagree to (7) agree. The purpose of the RS-25 is to identify the degree of individual resilience, considered a positive personality trait characteristic that enhances individual adaptation. A factor analysis of the RS-25 yielded two subscales—Personal Competence (Factor I) and Acceptance of Self and Life (Factor II). Factor I (17-items) suggests self-reliance, independence, determination, invincibility, mastery, resourcefulness, and perseverance. Factor II (8-items) represent adaptability, balance, flexibility, and a balanced perspective of life. These items reflect acceptance of life and a sense of peace in spite of adversity (Wagnild & Young, 1993). The subscales
of this multidimensional construct reflect the theoretical definition of resilience providing support to the construct validity of the RS-25 (Wagnild & Young, 1993).

Overall, the strength of the RS-25 include its internal consistency reliability, concurrent validity with established measures of adaptation, and preliminarily construct validity indicated by factor analysis (Wagnild & Young, 1993). At the time of its development, the authors report the internal reliability consistency to range between .76 and .91. The RS-25 has also been translated into Spanish by a team of bilingual and bicultural translators to enhance the scales accuracy in another language. The Resilience Scale became a 23-item instrument and internal consistency reliability was estimated with Cronbach's alpha ($\alpha = 0.93$) which was acceptable for the 23-item RS as well as its subscales (Heilemann, Lee, & Kury, 2003). Furthermore, in a study by Miller and Chandler (2002), the RS-25 was translated into Russian and modified to 12-items. In this study Cronbach’s alpha was 0.91.

Although the authors created the RS-25 to measure resilience as a personality trait it has been used in a diverse number of resilience studies in order to understand risk and protective factors. For example, Moorhouse and Caltabiano (2007) used the RS-25 to measure resilience in a population of 88 unemployed participants while exploring risk and protective influences for outcome variables associated with depression and assertive job seeking. In this particular research study, the authors acknowledge resilience as a process, yet also presume that positive outcomes are the result of resilient qualities (personal competence and attitudes) that moderate the adverse effects of unemployment. (Moorhouse & Caltabiano, 2007). The purpose of their study was to increase
understanding of resilience throughout adulthood while dually increasing an understanding of adversities faced in unemployment. Of their three hypotheses, two addressed the moderating role of resilience qualities among the unemployed in their sample.

Study participants were recruited from two employment agencies, and ranged in age from 16-58 with 39% under the age of 24. Participants were administered the Assertiveness Job-Hunt Survey (AJHS) (Becker, 1980), the Center for Epidemiological Studies-Depressed Scale (CES-D) (Radloff, 1977) and the Resilience Scale (RS-25) (Wagnild & Young, 1993). Cronbach’s Alpha for the RS-25 in their study was .94.

Results of a product-term regression using depression as the dependent variable, found that persons who possessed resilient qualities (personal competence, acceptance of life and self) were less depressed even though they had been job searching for a long time (Moorhouse & Catabiano, 2007). In addition, when job assertiveness was used as the dependent variable, persons who possessed resilient attitudes such as, self-reliant, independence, determination, and resourcefulness were more likely to be assertive in their job search.

In another study, Linderberg et al., (2002), evaluated effects of two prevention interventions on knowledge, attitudes, intentions, and behaviors to prevent and/or reduce risky sexual behavior, and substance use among 50 predominantly Mexican-American, low-income women. Researchers used the RS-25 to measure resilience behaviors of their sample, in which the RS-25 was reduced to a 4-point Likert scale with scores ranging from 25-100, and Cronbach’s alpha for this study was 0.86. Participants ranged in age
from 19-24, with an average age of 19 and were engaged in a pre-post test method. In addition, 72% reported a lifetime use of alcohol and 34% a lifetime use of cigarettes; 14% reported never being sexually active, whereas 82% had already given birth at least once, and 32% were currently pregnant (Lindeberg et al, 2002). Twice a week for two and a half weeks, participants attended risk and resilience intervention workshops at a local leadership center. The curriculum developed was for specific use with inner-city, low-income, young Hispanic women. In addition, the curriculum was modified to address their socioeconomic status, cultural, and linguistic realities (Lindeberg et al, 2002). The content of both prevention interventions used addressed both substance abuse and risky sexual behaviors.

Between the pre and post-test assessments on risky behaviors and resilience, results show that women with higher resilience scores reported lower uses of alcohol, tobacco, and other drug use. In addition, resilience scores increased significantly (Linderberg, et al, 2002). Overall, the authors suggest that by increasing the knowledge of study participants in specific areas such as substance abuse, and sexual behavior (health risks) the young women perceived themselves to have gained a heightened sense of competence thus increasing their ability to confront future risky behaviors effectively. In addition, the authors assert that this newly gained sense of competence may have also promoted greater self-confidence in their ability to manage their lives more effectively (Linderberg, 2002).

Advantages of the RS-25 include its multiple application use of the scales with men and women, multiple ages, and ethnic groups, with good reliability and validity.
(Ahern et al, 2006). Disadvantages include item wording was developed from an original sample of women only therefore further piloting of words is necessary. In addition the wording of the items is all positive to which may reflect bias in the statements. Finally, although the authors developed a shorter version of the Resilience Scale (RS-14) all items are still worded to reflect the verbatim statements of study participants in the original study.

The purpose of developing instruments to measure resilience is to identify risk factors that impact individuals and the resulting protective factors used to by individuals in efforts to develop interventions and/or supportive programs as proactive initiatives that will assist in the prevention of psychological problems. For racial minorities in America the concept of resilience and the implementation of such interventions are of great importance. While the concept of resilience and the factors that promote it has received considerable attention in the social science literature, far fewer studies have examined the development of resiliency among members of racial minority groups (Miller, 1999). In light of the fact that African Americans have generationally triumphed over the physicality of slavery, the psychological burdens of history remain influential aspects of daily life.

**Psychological Health, Racial Identity, and Resilience**

**Counseling African American Men**

The National Urban League 2007 *Equality Index* shows that African American men continue to lag behind their White counterparts in every major category; a disproportionate number of African American men are underperforming in our society in
a variety of areas for a variety of reasons (The State of Black America, 2007). In addition, the larger societal dynamic for African American males is that they are expected to function within a culture that silences, abuses, and devalues their existence (Pierre et al., 2001). For counselors working with African American men, it is imperative for them to continue to increase their awareness on how to work effectively with diverse groups of this population.

Understanding African American men requires taking into account the unique risks and stressors they experience (Pierre et al., 2001). In fact, the risk factors and psychological distress in the lives of African American men begin at an early age. Research suggests that exposure to various forms of racism (i.e. institutional, cultural, individual) enhances the risk of psychopathology in African American boys (West, 1993). As African American boys grow into adolescence and young adulthood, many are increasingly subjected to racial stereotypes that cast them as aggressive and violent (Judd, Blair & Chapleau, 2004). Furthermore, African American adolescent males residing in urban, disadvantaged communities are often exposed to community violence; an additional risk for anxiety problems such as posttraumatic stress disorder (Barnes, 2005; West, 1993). Overall, etiology studies have indicated that depressive and anxiety symptoms in African American males place them at elevated risk for the internalization of problems (Bynum et al., 2008). The internalization of these stressful life events leads one to initiate a coping mechanism in efforts to mediate the negative messages they receive. The construct of resilience terms these mechanisms protective factors that in
essence act as a buffer in order that an individual’s chance of succeeding may increase over time.

An interesting perspective in counseling African American men that coincides with understanding resilience (protective factors), is from an ecological counseling perspective which proposes that development includes that of the person, the environment and the interaction between the two. For example, Bronfenbrenner (1979) suggests that a person’s development is profoundly affected by “events occurring in settings in which the person is not even present” (p. 3). For any individual this would be the effects of various events around the world that impact our lives, even if we are not a physical part of those particular events. For the African Americans these events are represented in the history of racism, racial discrimination, oppression, and multiple other acts of inequality. This is also representative in a history of positive movements (i.e. Civil Rights) that African Americans have participated in that decades later have a significant impact on the world, namely the development of this minority group. In essence, an ecological perspective suggests that African American men are not solely individuals in the world, but that their development is also mediated by their community and systems in which they live (Goodrich, 2009).

Summary

This chapter examined a literature base of psychological well-being and distress; racial identity and Black racial identity development; resilience as a personality trait and a dynamic process; and the psychological health of African Americans, and African American men. The chapter also outlined common measuring tools used to
operationalize theory for each construct, as well as the specific scales chosen for use in this study. The following chapter will outline the methodology, research design, and data analysis procedures for this study.
CHAPTER THREE: METHODOLOGY

This chapter describes the research design, participants, sampling plan, instrumentation, and the pilot study. In addition, an outline of the data collection and data analysis procedures is provided.

Research Design

The purpose of this study was to examine the relationship between racial identity attitudes, resilience, and the psychological health of African American men. The research also explored the influence of socioeconomic status (SES) on psychological health. Following are the hypotheses for the study:

**Hypothesis 1:** Socioeconomic status (SES) as measured by the Hollingshead Four Factor Index of Social Status, contributes to the variance in the psychological health of African American men, as measured by the Mental Health Inventory (MHI).

**Hypothesis 2:** Resilience, as measured by the Resilience Scale (RS-25) contributes to the variance of psychological health of African American men above and beyond that accounted for by SES.

**Hypothesis 3:** Racial Identity, as measured by the four subscales of the Black Racial Identity Attitude Scale-Revised (RIAS-B), namely Pre-encounter, Encounter, Immersion/Emersion, and Internalization scales, contributes to the variance of psychological health of African American men above and beyond the variance accounted for by SES and resilience.
Participants

This study utilized a sample of African American males from outreach programs offered through the Columbus Urban League’s (CUL) African American Male Initiative (AAMI) program. CUL’s main facility is located approximately five miles east of downtown Columbus, Ohio. CUL is a local branch of the National Urban League (NUL) that has been a pillar of support to its consumers, through civil rights advocacy, fiscal accountability, and community trust in Central Ohio for 91 years. This particular facility was chosen for the study because of its ability to provide the much needed support to large numbers of African American men through their outreach programs. For example, their African American Male Initiative program (AAMI) is a division of the organization that is centered on empowering African-American males to help reduce contact with the criminal justice system, increase physical health, and improve connections with children and families. Although there are many services offered to the community through AAMI, this division consists of three primary programs: (a) Urban Warriors- a youth peer group mentoring program operating in partnership with Columbus City Schools to provide participants with a positive male influence, positive community outlets, and an Afrocentric based education; (b) Father to Father- a nationally recognized program that assists men in becoming instinctive, responsible and nurturing fathers; and (c) the Transitions program assists formally incarcerated individuals in the community by helping them strive toward the reduction of the penal system recidivism rate.

The researcher contacted participants currently enrolled in the Father to Father AAMI program. The Father to Father program serves an average of 100 individuals per
fiscal year, and offers courses every winter/spring, summer, and fall. Persons enrolled in this program are involved in a 12-week course designed to empower participants in areas such as: diverse cultural styles of fatherhood; self-nurturing skills; male nurturance; fiscal responsibility; overcoming barriers (unemployment, substance abuse, intergenerational learning); fathering without violence; and relationship building. Program participants are engaged in dialogue twice a week by educators, medical doctors, attorneys, child support specialists, and clinical specialists from local community action organizations, hospitals, and financial institutions. The goal of program is to allow participants to gain awareness on how to cultivate and support the attitudes and skills of proper male nurturance in hopes to benefit men, women, and children in familial relationships. Additional study participants were accessed through special events in the community sponsored by the CUL through the AAMI program and other community based organizations that promote the success and achievements of African American males.

**Sampling Plan**

The researcher is a contract employee serving as a Mental Health Consultant of the Head Start program and contacted the Director of the AAMI program. In an informal meeting the researcher informed the program director of the research project, and inquired about the appropriateness for AAMI program participants for this study. Participants were selected by the AAMI director and access to all individuals currently enrolled in the *Father to Father* program was made available to the researcher for voluntary participation. The researcher was invited by the AAMI program director to
attend workshops of the fatherhood program provided on-site at the CUL. Participants were administered coded survey packets to individuals who participated voluntarily.

**Instrumentation**

The participants of this study completed a demographic questionnaire that included the Hollingshead Four Factor Index of Social Status, the Black Racial Identity Social Attitudes Scale (RIAS-B), the Resilience Scale -25 (RS-25), and the Mental Health Inventory (MHI).

**Development of Instruments**

A demographic questionnaire was provided for participants to complete. The *Hollingshead Four Factor Index of Social Status* developed by Hollingshead (1971) was used to establish socioeconomic levels of the participants. The index has been used to determine social standing in studies of patient and non-patient populations as well as studies comparing ethnically diverse groups including African American males (Bardwell et al, 2006; Duncan, 2003).

Major points of criticism for the original Two Factor Analysis of Social Position were that it no longer accounted for social and cultural changes; the range of occupations used was too narrow; and the family’s status position was based on the head of the household only (Hollingshead, 1975). The Hollingshead’s Four Factor Index of Social Position uses education (the years of schooling an individual has completed that are reflective of their acquired knowledge and cultural tastes); occupation (the skill and power individuals possess as they perform the maintenance functions in society), sex (male or female), and marital status (the relationship of an adult male or female to the
family system) to determine a combined score. This score classifies people into one of five categories: (a) major business and professional; (b) medium business, minor professional, technical; (c) skilled craftsmen, clerical, sales workers; (d) machine operators, semiskilled workers; and (e) unskilled laborers, menial service. It is important to note that this scale also takes into account the differences in the ways adult family members participate in the economic system. For example, Hollingshead (1975) states that one spouse may be a full-time participant in the labor force while the other is not gainfully employed outside the home, yet as years pass both spouses may be gainfully employed. Also, other families may be headed by a single, widowed, separated, or divorced male or female who is now or in the past been gainfully employed (Hollingshead, 1975).

Previous research reports that African Americans living in close proximity to friends experience lower symptom/dysfunction levels of psychological stress or illness; that social and parental support help mitigate stressful life events of African American males; and church attendance by African Americans has been linked to optimism (Mattis, Fontenot, Hatcher-Kay, 2002; Warheit, Vega, Shimizu, & Meinhardt, 1982; Zimmerman, Ramirez-Valles, Zapert, & Matton, 2000). Therefore, in addition to the Hollingshead *Four Factor Index of Social Status* on the demographic questionnaire the researcher solicited responses to the aforementioned areas. The demographic questionnaire also asked participants if they were born in the U.S., and grew up in the local Columbus, Ohio community.
The Black Racial Identity Attitudes Scale (RIAS-B) was developed by Parham and Helms (1981). The RIAS-B was developed to operationalize Black racial identity theory. The original sample consisted of Black college and university students and diversity in the sample was reflective of gender (approximately balanced); geographic region (North, South, East and West); type of educational institute (private colleges as well as state universities and community colleges); and racial composition of the respondents’ environments (predominantly Black versus predominantly White). Diversity in the samples’ ages ranged from 17 to 72 years. Prior to this effort by Parham and Helms (1981) to quantify Black racial identity, Hall, Cross, and Freedle (1972) used interviews and a Q-sort methodology to assess levels of Black racial identity. Seeing this process as costly and time consuming, Parham and Helms (1981) asserted that more economical and transportable methods of assessment were needed if the models of racial identity were ever to gain a foothold in the counseling and psychotherapy diagnostic literature (Helms, 1990).

The RIAS-B measures the four central themes of Cross’ (1971) theory of Black racial identity: Pre-encounter, Encounter, Immersion/Emersion, and Internalization. The fifth stage, Internalization/Commitment was not operationalized because it describes a style of behaving with respect to identity issues that did not seem to be unique to a single stage, but might be present in some of the earlier stages, albeit due to different motivations (Helms, 1990). The RIAS-B short form has a total of 30 items and the long form a total of 50 items. Participants respond in a 5-point Likert scale format that ranges from (1) strongly disagree to (5) strongly agree. It is proposed that the long form be used
for this study as psychometric information about the properties has accumulated over time.

Parham and Helms (1981) did the original item analysis and reliability studies of the scale using a sample of 58 Midwestern university students. Later, Parham and Helms (1985) conducted a factor analysis and additional reliability investigations of the scale using a sample of 250 university students, which subsequently lead to further item deletions. RIAS-B long form sub-scale reliability scores were reported as follows: Pre-encounter = .76; Encounter = .51; Immersion/Emersion = .69; Internalization = .80. Although the original sample consisted of Black college/university students’, studies using different populations have yielded similar reliability scores. Reliability scores for the current study were: Pre-Encounter = .79; Encounter = .77; Immersion/Emersion = .82; and Internalization = .63.

Studies by Grace (1984) and Helms and Parham (1985) assess the construct validity of the RIAS-B. Helms and Parham (1985) in several separate analyses found that four orthogonal factors were reflective of the four types of racial identity attitudes (Helms, 1990). Another validity study involved Milliones’ (1980) Developmental Inventory of Black Consciousness (DIBC) examined the relationship between the RIAS – B and the DIBC. In this study (Grace, 1984) found that parallel scores on the two measures were appropriately correlated with respect to direction (Helms, 1990). Overall, it seems fair to state that the RIAS-B does predict racial identity constructs in a manner that is consistent with racial identity theory (Helms, 1990).
The Resilience Scale (RS-25) was developed by Wagnild & Young (1990). The purpose of this scale is to identify the degree of individual resilience, considered a positive personality characteristic that enhances individual adaptation (Wagnild & Young, 1993). The RS-25 was available and pretested in 1988 and initially developed from a qualitative study of 24 women who successfully adapted after a major life event. Participants were prescreened for positive psychosocial adaptation as indicated by mid-to-high levels of morale and social involvement (Wagnild & Young, 1993). Since its development, the RS-25 has been used with diverse populations including, caregivers of spouses with Alzheimer’s (Wagnild & Young, 1988); graduate students (Cooley, 1990), and residents in public housing (Wagnild & Young, 1991).

During its development, participants were asked to describe how they managed a self-identified loss and from these narratives emerged five interrelated components that were identified and constituted resilience: (1) Equanimity, a balanced perspective of one’s life and experiences; equanimity connotes the ability to consider a broader range of experience and to ‘sit loose’ and take what comes, thus moderating extreme responses to adversity; (2) Perseverance, the act of persistence despite adversity or discouragement; perseverance connotes a willingness to continue the struggle to reconstruct one’s life and to remain involved and to practice self-discipline; (3) Self-reliance, a belief in oneself and one’s capabilities; self reliance is the ability to depend on oneself and to recognize personal strengths and limitations; (4) Meaningfulness, the realization that life has a purpose and the valuation of one’s contributions; meaningfulness conveys the sense of having something for which to live; (5) Existential aloneness, the realization that each
person’s life path is unique; while some experiences are shared, there remain others that must be faced alone; existential aloneness confers a feeling of freedom and sense of uniqueness (Wagnild & Young, 1993, p. 167).

Although preliminary studies supported both the reliability and validity of the RS-25, exploring the psychometric properties of this instrument in a large randomly selected sample was a necessary next step (Wagnild & Young, 1993). A random sample of 1,500 community-dwelling older adults from the readership of a senior citizen periodical were selected and the response rate was 54% (N= 810) were anonymously returned. Survey packets included demographic information, the RS, and two other instruments to assess concurrent validity by exploring relationships between the RS and measures of adaptation (morale, life satisfaction, depression, and somatic health) (Wagnild & Young, 1993). The age ranges of the participants were between 53-95 years. The majority of respondents was White (98.3%), female (62.3%), educated beyond high school (66.2%) and retired (79%).

The RS-25 is a 25-item scale that requires participants to respond to a 7-point Likert scale which ranges from (1) disagree to (7) agree. A factor analysis yielded two subscales, (Factor 1) Personal Competence – self reliance, independence, determination, invincibility, mastery, resourcefulness and perseverance; and (Factor 2) Acceptance of Self and Life- adaptability, balance, flexibility, and a balance life perspective. Combining scores of all the items in both scales indicates a total resilience score, where higher scores equal higher resilience. The strengths of the RS-25 include its internal consistency reliability, concurrent validity with established measures of adaptation, and
preliminary construct validity indicated by the factor analysis (Wagnild & Young, 1993; Ahern et al, 2006).

The internal consistency reliability of the RS-25 is respectable as demonstrated in a number of studies (.76-.91). Item-to-item correlations range from .37 to .75 with the majority between .50 and .70, ($p \leq .001$). In an ongoing study with pregnant and post-partum women, test retest reliability correlations have ranged from .67 to .84 ($p < .01$) which suggest that resilience is stable over time (Wagnild & Young, 1993). For the current study, the total RS-25 reliability score was .95. Concurrent validity was evaluated by its correlation to resilience theory. Higher resilience scores were associated with high morale, life satisfaction, better physical health, and a lower level of depression, supporting the concurrent validity of the RS-25 (Wagnild & Young, 1993).

Though originally tested with adult subjects, numerous studies have validated that the RS-25 is reliable and valid with all ages and ethnic groups. Diversity is represented in the following selected research study populations: low and high income older adults (Wagnild (2003); young, low income Mexican American women (Linderberg et al, 2002); midlife women from the former Soviet Union (Miller & Chandler, 2002); homeless adolescents (Rew, Taylor-Seehafer, Thomas & Yockey, 2001); Russian immigrants to Israel (Aroian & Norris, 2000); and Irish immigrants (Christopher, 2000). The RS-25 has also been successfully translated to Russian, Swedish, and Spanish languages.

The Mental Health Inventory (MHI) is a 38-item standardized instrument developed by Veit & Ware (1983) that is designed to measure general psychological
distress and well-being. The items in the MHI yield six subscales (Anxiety, Depression, Loss of Behavioral/Emotional Control, General Positive Affect, Emotional Ties, and Life Satisfaction); two global scales (Psychological Well-being and Psychological Distress); and an overall Mental Health Index (Davies et al, 1988). Each item asks the participant to respond based on the frequency or intensity of a psychological symptom during the past month. All item responses are indicated on a 5 or 6 point scale and score totals on the index can range from 38 to 226. Higher scores on the General Positive Affect, Emotional Ties, and Life Satisfaction subscales indicate positive states of mental health, whereas higher scales on the remaining scales, Anxiety, Depression, Loss of Behavioral/Emotional Control indicate negative states of mental health (Davies et al, 1988).

When estimated using Cronbach’s alpha in a sample of 5,089 participants, the overall Mental Health Index scores was high (.96). Scores on the remaining scales are as follows: Psychological Wellness (.92); Psychological Distress (.94); Anxiety (.90); Depression (.86); Loss of Behavioral and Emotional Control (.83); General Positive Affect (.92); and Emotional Ties (.81). These findings constitute a strong psychometric basis for a multidimensional specification of mental health as defined by the MHI. The total MHI reliability score for the current study was .59. Global and subscale scores for the current study were as follows: Psychological Well-Being (.87); Psychological Distress (.89); Anxiety (.86); Depression (.80); Loss of Behavioral and Emotional Control (.89); General Positive Affect (.89); and Emotional Ties (.80). For the purposes of this study the MHI as the dependant variable will constitute one total score.
**Design**

A survey method was used for this study because each of the measurement instruments is recommended for administration in a paper-pencil format. In addition, a hierarchical ordered regression model was used for the data analysis.

**Pilot Study**

The current literature does not provide adequate information regarding the use of the selected instrument’s with a community sample of African American men. After approval of this research study was provided by the Ohio University Institutional Review Board, the researcher conducted a pilot study. Participation in the pilot study was anonymous, voluntary, and pilot study participants were not included in the final data analyses for this study. The pilot study was used to assist the researcher in the following manner: exploring items in the scales being used; readability of the questionnaire packet by participants; determine approximate length of time to administer the questionnaire; develop a template for assessing the data (i.e. descriptive statistics, subscale correlations); and to receive feedback on the overall questionnaire. Participants in the pilot study were solicited via email to the local chapter of an African American male fraternity, a marriage and family small group from a local church, patrons of a local barber shop, doctoral students enrolled at two different Midwest universities and participants in the *Father to Father* program at the CUL.

Participants (N= 34) willing to complete the survey packet contacted the researcher by phone and or email and were given an online scheduling link to select their location and availability. Participants of the *Father to Father* program were contacted by
the AAMI Director. Participants completed survey packets in groups of four or more, and the researcher administered survey packets at one in-home small group church session, as well as reserved rooms at local restaurants, libraries, universities, and the CUL. Each survey packet included informed consent; the telephone number and address to a local community based mental health agency; a demographic questionnaire inclusive of the Hollingshead Four Factor Index of Social Status, the Black Racial Identity Social Attitudes Scale (RIAS-B), the Resilience Scale -25 (RS-25), and the Mental Health Inventory (MHI). The researcher informed participants verbally that their participation in the study was for dissertation research. In addition, the researcher informed participants that their responses were confidential and reminded them that their participation was voluntary and that anonymity will be strictly observed. Participants were also informed that they may willingly discontinue their participation at anytime. In addition, participants were compensated for their participation by way of a $25 drawing awarded after all pilot study survey packets were collected by the researcher.

**Data Collection Procedure**

The participants for this study were African American men ages 18-55 that are currently enrolled in the CUL’s *Father to Father* and *Transitions* programs in Columbus, Ohio. In efforts to explain at least 0.25 (25%) of the total variance of the psychological health of African American men participating in this study, the researcher sought to obtain 150 participants (n= 150). This is a sample size estimate based on the 7 independent variables (predictors) found in the total number of subscales to be used this study (Park & Dudycha, 1974). Due to multiple unexpected weather interferences
making travel at many times unmanageable, the researcher obtained a total of 105 survey completed surveys.

The Director of the Columbus Urban League’s (CUL) African American Male Initiative Program (AAMI) was contacted to discuss the available numbers of possible African American male participants from their programs. The study was conducted on-site at the CUL main location just east of downtown Columbus. The researcher informed the AAMI director of policies regarding research with human subjects as required by The Institutional Review Board at Ohio University. A statement of the purpose of the study inclusive of confidentiality by the researcher was given verbally, at which time participants were made aware that the study was for dissertation research. Participants were informed that their participation was voluntary and that anonymity will be strictly observed. Participants were also informed that they may willingly discontinue their participation at anytime.

Each survey packet contained the following: informed consent, the telephone number and address to a local community based mental health agency, a demographic questionnaire inclusive of the Hollingshead Four Factor Social Status Index, the Black Racial Identity Social Attitudes Scale (RIAS-B), the Resilience Scale -25 (RS-25), the Mental Health Inventory (MHI), and information regarding counseling services in the surrounding community. The researcher coded each survey packet and provided each participant with one packet inclusive of a standardized list of instructions. Responses by participants were made directly on the questionnaire for collection, scoring and data entry
by the researcher. All participants were instructed not to include any identifiable information on the questionnaire.

**Data Analysis Procedure**

This study examined whether racial identity attitudes, resilience, and the socioeconomic status in a sample of African American men were predictive of their psychological health. There were seven predictor variables, and one criterion variable. The predictor variables were racial identity (4 subscales), resilience (2 subscales), and socioeconomic status. The criterion variable was psychological health. It was hypothesized that socioeconomic status, resilience, and racial identity will account for the variance of psychological health for this sample of African American men.

The statistical analysis was completed using the Statistical Package for Social Sciences (SPSS) 17.0. Prior to the analysis the data was checked for missing values and to eliminate data entry errors. To accomplish this, the researcher used descriptive statistics (i.e. means, standard deviations), frequencies (i.e. histograms, bar charts, scatter plots). Univariate normality violations were assessed to test assumptions of normality, linearity and homoscedasticity. In this process the researcher was able to return to original questionnaires to check if possible discrepancies in the data were due to data entry errors.

The researcher used a hierarchical regression analysis to analyze the data. For this study each subscale was considered a predictor variable and was entered in the following order: First, a single total score for the Hollingshead Four Factor Social Status Index; second, two resilience subscales as defined by the RS-25 were entered as a block:
(1) Personal Competence (2) Acceptance of Self and Life; and third, the four racial identity subscales as defined by the RIAS-B: Pre-Encounter, Encounter, Immersion/Emersion, Internalization were entered as a block. Finally, psychological health as defined by a total score on the Mental Health Index (MHI) was entered as the dependent variable. In a hierarchical regression analysis the researcher predetermines the order in which the predictor variables will enter the regression equation. Based on previous literature surrounding the predictor variables in this study the researcher believed that the racial identity attitudes of participants will account for a larger amount of the variance in psychological health (Mahali et al, 2006; Pillay, 2005) above and beyond that accounted for by socioeconomic status and resilience. For this reason, the predictor variable racial identity was entered last into the equation. Although it was predicted that socioeconomic status and resilience will contribute to psychological health, there is not substantial literature available to suggest that these two variables will have a significant impact on the psychological health of African American men.

**Summary**

This chapter discussed the methodology used to explore the variables of socioeconomic status, racial identity, resilience, and psychological health in a sample of African American men. Outlined in this chapter were the seven predictor variables for this study, namely: the four subscales of the BRIAS (Pre-encounter, Encounter, Immersion/Emersion, Internalization); RS25 (Personal Competence and Acceptance of Self and Life); and socioeconomic status as measured by the Hollingshead Four Factor Index of Social Status. Also discussed in this chapter was the criterion variable,
psychological health, as measured by the MHI. The chapter outlined the research design, participants, sampling plan, instrumentation, and the pilot study. This chapter also provided an outline of the data collection and data analysis procedures. The following chapter presents the results and analysis of data.
CHAPTER FOUR: RESULTS

The purpose of this study was to investigate the relationship between racial identity, resilience, and the psychological health of African American men. The researcher hypothesized that racial identity attitudes, as measured by the RIAS-B would contribute to the variance in the psychological health of African American men, above and beyond that accounted for by socioeconomic status, or resilience. The section that follows presents results from the data analysis.

Data Analysis

A total of 105 participants completed survey packets that were collected and used for the data analysis. The statistical analyses were completed using the Statistical Package for Social Sciences (SPSS) Windows Version 17.0. Participants responded to a survey packet that included the Hollingshead Four Factor Index of Social Status; Resilience Scale (RS-25); Black Racial Identity Attitudes Scale (RIAS-B); and the Mental Health Index (MHI). Demographic information of participants included: age, marital status, highest level of education, and current occupation. The data was analyzed using descriptive statistics, frequencies, tests for normality assumptions, and a hierarchical regression model.

Descriptive Data for Demographic Variables

Part A (See Appendix A) of the survey was used to collect participant demographic information and included: age, highest level of education, current occupation, and marital status. In addition to this, participants also indicated whether they were born in the U.S.; frequency of church attendance; whether they live with or
near a close knit group of family and/or friends; whether they grew up in the Columbus, Ohio area; and if they had a male role model while growing up. A summary of the descriptive data is presented in Table 1.

**Age and Marital Status.**

For this study, a purposeful sample of 105 African American men ranging in age from 18 to 55 years participated. The mean age of participants for this study was 34.84 years (SD=9.34). The marital status distribution for this sample is as follows: Single (62.9%, n=66); Married (31.4%, n=33); Divorced (4.8%, n=5); Widowed (1.0%, n=1).

**Education.**

Participants were asked to indicate their highest level of education by selecting from categories outlined by the Hollingshead Four Factor Index of Social Status. The highest level of education distribution for this sample is as follows: category 1, Less than 7th grade, no participants indicated category 1 as an education level; category 2, Junior High School (9th grade) (2.9%, n=3); category 3, Partial High School (10th or 11th grade) (14.3%, n=15); category 4, High School (whether private, preparatory, parochial, trade, or public school) (16.2%, n=17); category 5, Partial College (at least one year) or specialized training (31.4%, n=33); category 6, Standard College or University Graduation (18.1%, n=19); category 7, Graduate Professional Training (graduate degree) (17.1%, n=18). The mean education category score for this sample was 4.99 (SD=1.36) and indicates that the average highest level of education is category 5 (partial college or specialized training).
**Occupation.**

Participants were asked to indicate their current occupation title. Occupation titles were then matched with titles outlined by categories on the Hollingshead Four Factor Index of Social Status. The occupation distribution for this sample is as follows: category 1, Farm Labor/Menial Service Workers (37.1%, n=39); category 2, unskilled Workers (6.7%, n=7); category 3, Machine Operators & Semiskilled Workers (21.9%, n=23); category 4, Small Business Owner (less than $25k), Skilled Manual Worker or Craftsman (3.8%, n=4); category 5, Small Farm/Business Owner ($25k - $50k), Clerical & Sales Workers (2.9%, n=3); category 6, Small Business Owner ($50k - $75k), Technicians and Semi-Professionals (9.5%, n=10); category 7, Small Farm/Business Owners ($75k-$100k), Managers and Minor Professionals (9.5%, n=10); category 8, Farm Owner/Proprietors of Medium Size Business ($100k-$250k), Administrators (4.8%, n=5); category 9, Higher Executives, Proprietors of Large Businesses (more than $250k) and Major Professionals (3.8%, n=4). The mean occupation category score for this sample was 3.41 (SD=2.55) and indicates that the average occupation level is Category 3 (machine operators & semiskilled workers).

**Social Class.**

Social class of the participants was collected using the Hollingshead Four Factor Index of Social Status. The Hollingshead instructions are to multiply the scale values for education by a weight of 3 and occupation scores by a weight of 5. Once the scores are weighted, the sum equals the social class score for each individual. Computed scores for the scale range from a low of 8 and a high of 66. This range remains constant whether
the computed score is based on the occupation of one or two members of a household (Hollingshead, 1975). For the purposes of this study social class of only the participating individual was collected. Social class score for this sample ranged from 11 to 66, and the mean was 32.06 (SD=15.84). Details of the social class index are outlined in Table 1.

**Additional Demographic Data.**

As part of the demographic section of the survey participants were asked to indicate if they were born in the U.S.; whether they attend church regularly; whether they lived with or near close knit group of family/and or friends; whether they grew up in Columbus area; and if they had a male role model while growing up. These responses indicate that 98% were born in the U.S.; 56% attend church regularly; 82% lived with or near a close knot group of family and/or friends; 76% grew up in the Columbus area; and 83% had a male role model while growing up.

**Descriptive Data for Independent and Dependent Variables**

**Resilience (RS-25).**

The RS-25 is a 25-item scale that required participants to respond on a 7-point Likert scale which ranges from (1) disagree to (7) agree. Total scores for the RS-25 were calculated by adding the Likert scale score for each item. Individual scores for the RS-25 ranged from 25-175. Scores of 145 and greater indicate a moderately high-to-high level of resilience. Scores from 126 to 145 indicate a moderately-low to moderate level of resilience, and scores of 125 and below indicate a low level of resilience. The mean score for this sample on the RS-25 is 140.45 (SD=27.79) and falls in the moderately-low
to moderate level of resilience category. Mean subscale scores are as follows: Personal Competence 96.69 (SD=19.64); Acceptance of Self and Life 43.75 (SD=9.12).

**Racial Identity.**

Due to the nature of this study, all individuals that participated were African American and completed the RIAS-B (long form). The RIAS-B is a 60-item scale that required participants to respond in a 5-point Likert scale format that ranged from (1) strongly disagree to (5) strongly agree. Scores on the RIAS-B were calculated by adding the Likert scale score for each item of each subscale and dividing by the number of items representing that subscale. Once scores were weighted, means were computed for each subscale and were as follows: Pre-Encounter, 2.14 (SD=.620); Encounter 2.12 (SD=.823); Immersion/Emersion 3.15 (SD=.572); Internalization 4.12 (SD=.455).

**Psychological Health.**

The Mental Health Index (MHI) is a 38-item standardized instrument that asks the participant to respond based on the frequency or intensity of a psychological symptom during the past month. All item responses were indicated on a 5 or 6 point scale and score totals range from 38 to 226. Some items on this scale required recoding. Once those items were recoded the responses were summed to calculate the MHI score for each individual. Higher scores on the MHI indicate greater psychological well-being. For this sample the mean MHI total score was 116.47 (SD=13.00). Further details of the MHI and subscale scores can be found in Appendix E.
Table 1

Descriptive Data of Demographic, Predictor, and Dependent Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Median</th>
<th>Std. Dev.</th>
<th>Range</th>
<th>Min.</th>
<th>Max.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>34.84</td>
<td>34.00</td>
<td>9.34</td>
<td>37.00</td>
<td>18.00</td>
<td>55.00</td>
</tr>
<tr>
<td>Marital Status</td>
<td>1.43</td>
<td>1.00</td>
<td>.619</td>
<td>3.00</td>
<td>1.00</td>
<td>4.00</td>
</tr>
<tr>
<td>Education</td>
<td>14.93</td>
<td>15.00</td>
<td>4.09</td>
<td>15.00</td>
<td>6.00</td>
<td>21.00</td>
</tr>
<tr>
<td>Occupation</td>
<td>17.28</td>
<td>15.00</td>
<td>12.71</td>
<td>40.00</td>
<td>5.00</td>
<td>45.00</td>
</tr>
<tr>
<td>Social Status</td>
<td>32.06</td>
<td>27.00</td>
<td>15.84</td>
<td>55.00</td>
<td>11.00</td>
<td>66.00</td>
</tr>
<tr>
<td>PCompetence</td>
<td>96.69</td>
<td>102.00</td>
<td>19.64</td>
<td>100.00</td>
<td>19.00</td>
<td>119.00</td>
</tr>
<tr>
<td>Accept S&amp;L</td>
<td>43.75</td>
<td>46.00</td>
<td>9.12</td>
<td>46.00</td>
<td>10.00</td>
<td>56.00</td>
</tr>
<tr>
<td>PreEncoun</td>
<td>2.14</td>
<td>2.00</td>
<td>.620</td>
<td>3.71</td>
<td>1.29</td>
<td>5.00</td>
</tr>
<tr>
<td>Encounter</td>
<td>2.12</td>
<td>1.87</td>
<td>.823</td>
<td>4.00</td>
<td>1.00</td>
<td>5.00</td>
</tr>
<tr>
<td>Imm/Em</td>
<td>3.15</td>
<td>3.13</td>
<td>.572</td>
<td>3.00</td>
<td>1.82</td>
<td>4.82</td>
</tr>
<tr>
<td>Internalization</td>
<td>4.12</td>
<td>4.15</td>
<td>.455</td>
<td>2.54</td>
<td>2.46</td>
<td>5.00</td>
</tr>
</tbody>
</table>

Correlations

This study consisted of seven predictor variables and one criterion variable. The predictor variables were socioeconomic status (SES), two resilience subscales (Personal Competence, Acceptance of Self and Life), and four racial identity subscales (Pre-Encounter, Encounter, Immersion/Emersion, Internalization). The single criterion variable was psychological health. SES was measured using the Hollingshead Four Factor Social Status Index which was determined by the weighted sum of education and occupation responses. Resilience was measured using separate composite score totals of
the instruments two subscales (Personal Competence, Acceptance of Self and Life).

Racial identity was measured using the separate composite scores of four subscales of the RIAS-B (Pre- Encounter, Encounter, Immersion/Emersion, Internalization).

Psychological health was measured by a single total score on the MHI.

A correlation analysis of the aforementioned variables was conducted. MHI scores were significantly correlated in a negative direction to SES, \((r (101) = -0.215, p=0.031)\). MHI scores were also significantly correlated in a positive direction with two racial identity scales, Pre-Encounter, \((r (101) = 0.334, p=0.001)\) and Encounter \((r (101) = 0.344, p=0.000)\).

Correlation analysis among the independent variables indicated a positive significant correlation between SES and resilience subscale scores of Personal Competence \((r (101) = 0.339, p=0.001)\) and Acceptance of Self and Life \((r (101) = 0.206, p=.039)\). SES was significantly negatively correlated to two racial identity subscales, Pre-Encounter \((r (101) = -0.316, p=.001)\) and Encounter \((r (101) = -0.322, p=.001)\) and significant in a positive direction to Internalization \((r (101) = 0.269, p=.007)\). Resilience subscales were significantly correlated in a positive direction to three of the racial identity subscales. Personal Competence was significantly correlated to Internalization \((r (101) = 0.307, p=.002)\) and Acceptance of Self and Life was significantly correlated to Immersion/Emersion \((r (101) = 0.201, p = .044)\) and Internalization \((r (101) = 0.332, p = .001)\).

Inter-subscale correlations indicate a positive significant correlation between both resilience subscales. Personal Competence was significantly correlated to Acceptance of
Self and Life (r (101) = .709, p = .000). Significant racial identity subscale correlations in a positive direction were among Pre-Encounter and Encounter (r (101) = .801, p = .000); Encounter and Immersion/Emersion (r (101) = .260, p = .009); and Immersion/Emersion and Internalization (r (101) = .362, p = .000). One significant correlation in a negative direction among the racial identity subscales existed between Pre-Encounter and Internalization (r (101) = -.230, p = .021) (See Table 2).

Table 2

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
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<td>1.</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
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<td>2.</td>
<td>PComp</td>
<td>.339**</td>
<td></td>
<td>.206*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Accept Self &amp; Life</td>
<td>.206*</td>
<td>.790*</td>
<td>1</td>
<td></td>
<td>-.038</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>PreEnc</td>
<td>-.316**</td>
<td>-.141</td>
<td>-.038</td>
<td>1</td>
<td>.801**</td>
<td>.193</td>
<td>-.230*</td>
</tr>
<tr>
<td>5.</td>
<td>Encoun</td>
<td>-.322**</td>
<td>-.125</td>
<td>-.042</td>
<td>.801**</td>
<td>1</td>
<td>.260**</td>
<td>-.193</td>
</tr>
<tr>
<td>6.</td>
<td>Imm/E</td>
<td>-.051</td>
<td>.160</td>
<td>.201*</td>
<td>.193</td>
<td>.260**</td>
<td>1</td>
<td>.362**</td>
</tr>
<tr>
<td>7.</td>
<td>Internl</td>
<td>.269**</td>
<td>.307*</td>
<td>.332**</td>
<td>-.230*</td>
<td>-.193</td>
<td>.362**</td>
<td>1</td>
</tr>
<tr>
<td>8.</td>
<td>MHI Total</td>
<td>-.215*</td>
<td>-.051</td>
<td>-.035</td>
<td>.334**</td>
<td>.344**</td>
<td>.101</td>
<td>-.103</td>
</tr>
</tbody>
</table>

**Correlation is significant at the 0.01 level (2-tailed)
*Correlation is significant at the 0.05 level (2-tailed)
Analysis of Primary Variables

Missing Values

Missing values for all primary variables were replaced with each participant’s own mean score of responses for each particular measurement. Missing values for demographic questions were replaced with the sample mean for that particular demographic question.

Outliers and Collinearity

The data was initially screened for outliers by using the linear regression procedure in SPSS 17.0. Outliers are defined as extreme data points on a single or combination of variables and often require special consideration (Hinkle, Wiersma, and Jurs, 2003). For this study, Mahalanobis’ distance was selected to detect possible multivariate outliers in the data. Mahalonobis distance measures the multivariate distance between each case and the group multivariate mean (Myers, Gamst, and Guarino, 2006). The chi square critical cut-off point for Mahalanobis’ distance is 24.322 (p < 0.001). Case numbers 2 (25.43) and 40 (27.66) were removed because they exceeded the critical cut-off point therefore representing extreme values. Box plots are also a useful way to detect outliers in the data screening process (Hinkle et al, 2003). The Mahalanobis distance box plot also indicated case number 97 as an extreme value and this case was also removed. The casewise diagnostics function in SPSS displays residual outliers and recognizes cases with standardized residuals greater than 3. In this data sample case number 49 represented a standardized residual score above 3 (3.419) and was also removed. Cooks distance for the data did not exceed 1.0.
Multicollinearity exists when more than two predictors are highly correlated thus causing a distortion of the multiple regression results (Myers et al., 2006). Multicollinearity can reduce the size of the multiple correlations, make interpretation problematic, and can increase the regression coefficient variance, thus resulting in an unstable regression equation (Stevens, 2002). Multicollinearity for this study was assessed by examining the inter-correlations among predictor variables using the bivariate correlations matrix, and the Tolerance and Variance Inflation Factor (VIF) statistics. Tolerance levels of .01 or less, or VIF values greater than 10 indicate multicollinearity (Myers et al, 2006; Stevens, 2002). The bivariate correlation matrix and the Tolerance and VIF statistics for this sample suggest that multicollinearity was not a problem in this analysis. Additionally, the Condition Index and Variance Proportions matrix on the Collinearity Diagnostics table were examined. The Condition Index measures how dependent one independent variable is on another and is associated further with the display of the variance proportions table for each variable (Myers et al, 2006). Multicollinearity is present if the Condition Index is equal to or greater than 30 and at least two variance proportions for a particular independent variable are greater than 50 (Tabachnick & Fidell, 2001). Review of the Condition Index and Variance Proportions did not suggest multicollinearity in this analysis.

Multiple Regression Assumptions

Assumptions of normality, linearity, and homoscedasticity are important to the multivariate analysis. The violation of one or more of these assumptions may cause bias or distortion of statistical results in the analysis (Tabachnick & Fidell, 2001). Therefore
tests for the violation of any of these three assumptions should be conducted prior to a multiple regression analysis.

Normality was assessed by examining the standardized residual histogram (Figure 1), and the normal probability plot (Figure 2). Normality is assumed if data follow the diagonal line of the normal probability plot and if the frequency distribution of variables indicates a bell-shaped curve on the standardized residual histogram. For this sample, both plots indicate that there is no violation of the assumption of normality.

Linearity was assessed through the use of a bivariate scatterplot matrix and also by running a regression analysis to examine the residuals plot. Variables that are both linearly related and normally distributed produce scatter plots that are oval or elliptical in shape (Myers et al, 2006). A scatterplot that displays points neither in an upward or downward trend occurs when there is zero or near-zero correlation (Hinkle et al, 2003). For this sample some of the scatterplots resulted in a circular pattern which may be caused by some of the low correlations among the independent and dependent variables. Residuals however, depict the portion of the dependent variables variance not explained by the regression analysis and is also an approach used to assess linearity among the independent and dependent variables (Myers et al, 2006). For this sample, points on the standardized residual plot appear to not be in violation of the assumption of linearity. (See Figure 3).

Homoscedasticity suggests that the dependent variable has equal levels of variability across the range of independent variables (Myers et al, 2006). For this sample homogeneity of variance (homoscedasticity) was examined by assessing the standardized
residuals scatter plot. Heteroscedasticity is present when residuals are not evenly scattered around the benchmark zero line (Myers et al, 2006). For this sample, points on the residuals plot appear to be randomly scattered around the zero benchmark indicating a relatively even distribution and suggests no violation of the assumption of homoscedasticity (See Figure 3).

**Multiple Regression Analysis**

The hypothesis of this study is that socioeconomic status, resilience, and racial identity attitudes of account for the variance in the psychological health of the African American men in this sample. Using the enter method in SPSS, a hierarchical regression was conducted and the seven predictor variables were entered into the regression equation in a predetermined manner by the researcher. The MHI score was entered as the dependent variable. The Social Class score was entered in the first step, followed by the two RS subscale scores of Personal Competence and Acceptance of Self and Life, and last, the four RID subscale score of Pre-Encounter, Encounter, Immersion/Emersion, and Internalization.

In the first step, social class accounted for 4.6% of the variance in the psychological health of this sample ($R^2 = .046$). The adjusted $R^2 = .037$, and $R^2$ change
Figure 1. Histogram of standardized residual distribution of normality.
Figure 2. Normal probability plot of regression standardized residual
Figure 3. Plot of standardized residuals and standardized predicted value
The change in $R^2$ was significant ($p = .031$). Social class also was found to be a significant predictor of MHI scores ($t (101) = -2.192, p = .031$).

In the second step, the two RS-25 subscales, personal competence and acceptance of self and life, were entered as a block. Personal Competence ($t (101) = .253, p = .801$) and Acceptance of Self and Life ($t (101) = -.138, p = .891$) were not found to be significant predictors of MHI scores. $R^2 = .047$, adjusted $R^2 = .018$, and $R^2$ change = .001. The change in $R^2$ was not significant ($p = .964$) and only .1% of the variance in psychological health was accounted for by resilience. There was no statistical significance found in the individual resilience subscale predictors of Personal Competence or Acceptance of Self and Life.

In the third and final step, the four subscales of racial identity were entered as a block. Racial identity accounted for 9.4% of the variance in psychological health. $R^2 = .141$; Adjusted $R^2 = .076$; and $R^2$ change = .094. The change in $R^2$ was significant ($p = .045$). Pre-Encounter ($t (101) = .922, p = .359$); Encounter ($t (101) = 1.115, p = .268$); Immersion/Emersion ($t (101) = .200, p = .842$); and Internalization ($t (101) = -.013, p = .909$), were found to not be a significant predictor of MHI scores. However, Pre-Encounter ($t (101) = 3.524, p = .001$) and Encounter ($t (101) = 3.642, p = .000$) subscale scores individually, were statistically significant predictors of psychological health.

The analysis of variance (ANOVA) table indicates statistical significance in the relationship that exists between social class and MHI scores $F (1, 99) = 4.806, p \leq .05$. (See Table 4). Model 3 (social class, acceptance of self and life, personal competence,
pre-encounter, encounter, immersion/emersion, internalization) also indicates statistical significance in the relationship between these predictor variables and psychological health \( F(7, 93) = 2.175, p \leq .05. \)

Table 3

*Model Summary*

<table>
<thead>
<tr>
<th>Model</th>
<th>R</th>
<th>R²</th>
<th>Adj R²</th>
<th>Std. Error of the Estimate</th>
<th>R² Change</th>
<th>F Change</th>
<th>df1</th>
<th>df2</th>
<th>Sig. F Change</th>
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</thead>
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<tr>
<td>1</td>
<td>.215</td>
<td>.046</td>
<td>.037</td>
<td>12.12067</td>
<td>.046</td>
<td>4.806</td>
<td>1</td>
<td>99</td>
<td>.031</td>
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<tr>
<td>2</td>
<td>.217</td>
<td>.047</td>
<td>.018</td>
<td>12.24036</td>
<td>.001</td>
<td>.037</td>
<td>2</td>
<td>97</td>
<td>.964</td>
</tr>
<tr>
<td>3</td>
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<td>11.87014</td>
<td>.094</td>
<td>2.536</td>
<td>4</td>
<td>93</td>
<td>.045</td>
</tr>
</tbody>
</table>

a. Predictors: (Constant), Social Class  
b. Predictors: (Constant), Social Class, Accept of Self & Life, Personal Competence  
c. Predictors: (Constant), Social Class, Accept of Self & Life, Personal Competence, Immersion/Emersion, Pre-Encounter, Encounter, Internalization  
d. Dependent Variable: MHI Total

In summary, only step one of the hierarchical regression was found to be significant. Resilience subscales, Personal Competence, and Acceptance of Life and Self together were not found to be a significant predictor of MHI scores. Individually, racial identity subscales Pre-Encounter and Encounter were found to make a statistically significant contribution to the variance in psychological health. Social class was found to be significant in its relation to psychological health. When all predictor variables are entered they are significant in their relationship to psychological health, however there is no predictive significance for this model.
Analysis of Research Hypotheses

This study sought to examine if socioeconomic status (education and occupation), racial identity, and resilience are predictive of the psychological health of a sample of African American men.

**Hypothesis 1:** Socioeconomic status (SES) as measured by the Hollingshead Four Factor Index of Social Status, contributes to the variance in the psychological health of African American men, as measured by the Mental Health Inventory (MHI).

The results support this hypothesis. Social class was found to be a significant predictor of MHI scores ($t (101) = -2.192, p = .031$), and accounted for 4.6% of the variance in the psychological health of this sample.

**Hypothesis 2:** Resilience, as measured by the Resilience Scale (RS-25) contributes to the variance in psychological health of African American men above and beyond that accounted for by SES. The results do not support this hypothesis. After accounting for SES, Resilience was not found to be a significant predictor of MHI scores. The two RS-25 subscales, Personal Competence ($t (101) = .253, p = .801$), and Acceptance of Self and Life ($t (101) = -.138, p = .891$), were not significant predictors and only accounted for .1% of the variance in psychological health of this sample.

**Hypothesis 3:** Racial Identity, as measured by the four subscales of the Black Racial Identity Attitude Scale-Revised (RIAS-B), namely Pre-encounter, Encounter, Immersion/Emersion, and Internalization scales, contributed to the variance in the psychological health of African American men above and beyond the variance accounted for by SES and resilience.
The results support this hypothesis. Racial identity accounted for 9.4% of the variance in psychological health. The racial identity subscales, Pre-Encounter ($t(101) = .922, p = .359$); Encounter ($t(101) = 1.115, p = .268$); Immersion/Emersion ($t(101) = .200, p = .842$); and Internalization ($t(101) = -.013, p = .909$), alone, were not found to be significant predictors of MHI scores (see Appendix G). However, when entered individually, Pre-Encounter ($t(101) = 3.524, p = .001$) and Encounter ($t(101) = 3.642, p = .000$) subscale scores were found to be statistically significant predictors of MHI scores.

### Table 4

**Analysis of Variance (ANOVA)**

<table>
<thead>
<tr>
<th>Model</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
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<td>706.024</td>
<td>4.806</td>
<td>.031</td>
</tr>
<tr>
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<td>99</td>
<td>146.911</td>
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<tr>
<td>Total</td>
<td>15250.172</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Regression</td>
<td>717.021</td>
<td>3</td>
<td>239.007</td>
<td>1.595</td>
<td>.196</td>
</tr>
<tr>
<td>Residual</td>
<td>14533.152</td>
<td>97</td>
<td>149.826</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>15250.172</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Regression</td>
<td>2146.461</td>
<td>7</td>
<td>306.637</td>
<td>2.176</td>
<td>.043</td>
</tr>
<tr>
<td>Residual</td>
<td>13103.711</td>
<td>93</td>
<td>140.900</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>15250.172</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- a. Predictors: (Constant), Social Class
- b. Predictors: (Constant), Social Class, Accept of Self & Life, Personal Competence
- c. Predictors: (Constant), Social Class, Accept of Self & Life, Personal Competence, Immersion/Emersion, Pre-Encounter, Encounter, Internalization
- d. Dependent Variable: MHI Total
Reliability Coefficients

Internal consistency reliability was conducted for each instrument in this study. Cronbach’s alpha coefficient was used and the results are as follows: Mental Health Index (MHI) .59; and Resilience (RS-25) .95. Subscale reliability scores for the RS-25 are .94 for Personal Competence and .81 for Acceptance of Self and Life. Reliability coefficients for the four subscales of the Racial Identity Attitudes Scale (RIAS-B) are .79 (Pre-Encounter); .77 (Encounter); .82 (Immersion/Emersion); and .63 (Internalization).

Factor Validity

A factor analysis was conducted for the RS-25, RIAS-B, and MHI measurement instruments. For the RS-25, parallel analysis and a scree plot supported just one factor in a principal component analysis. The sample size was not large enough for reliable components. Therefore because the original authors indicated there were two subscales (Personal Competence, Acceptance of Self and Life) this study used two subscales for item loading. A scree plot and rotated component matrix can be found in Appendix H.

For the RIAS-B, a scree plot suggested seven components. Sample size was not large enough to run a parallel analysis. Therefore, the four subscales (Pre-Encounter, Encounter, Immersion/Emersion, Internalization) were used. A scree plot and the loadings for the four factor solution are shown in Appendix I.

For the MHI, a parallel analysis and a scree plot support two components in a principal components analysis. However the sample size was not large enough for reliable components. The scree plot and eigenvalues supported two strong components.
The authors indicate that using one total MHI score is appropriate, which was used in the current study. Loadings for the two component solution are shown in Appendix J.

**Supplemental Analysis**

Supplemental analyses were conducted to explore the relationship between the primary independent variables (SES, resilience, and racial identity), the two MHI global scales (psychological distress, psychological wellness). Significant positive correlations existed among lower racial identity statuses and the Psychological Distress global scale. For example, Pre-Encounter was significant in a positive direction to Psychological Distress ($r (101) = .450, p= .000$), and Encounter was significant in a positive direction to Psychological Distress ($r (101) = .523, p= .000$). In addition, Internalization was significantly correlated to Psychological Wellness ($r (101) = .364, p=000$).

Resilience subscales were both significantly correlated to the Psychological Wellness global scale. Personal Competence was significantly correlated in a positive direction to Psychological Wellness ($r (101) = .269, p=.007$) and Acceptance of Self and Life was significantly correlated in a positive direction to Psychological Wellness ($t (101) = .264, p=.008$). Both resilience subscales were significantly correlated in a negative direction to Psychological Distress. SES was significantly correlated in a negative direction to Psychological Distress ($t (101) = -.357, p=.000$) but significantly correlated in a positive direction to Psychological Wellness, ($t (101) = .268, p=.007$).

An exploratory multiple regression analysis suggests that both Pre-Encounter and Encounter racial identity subscales were significant predictors of Psychological Distress, and that Internalization was a significant predictor of Psychological Wellness. For
example, in a regression analysis when both, Pre-Encounter and Encounter are in the same Model, Pre-Encounter was not a significant predictor of Psychological Distress, whereas, Encounter was a significant predictor, and accounted for 27.6% of the variance in Psychological Distress (t (101) = 3.146, p = .002). R² = .276, adjusted R² = .261, and R² change = .073. Individually, Encounter remained predictive of Psychological Distress and Pre-Encounter also became a significant predictor of Psychological Distress (t (101) = .3.524, p = .001). In addition, R= .334; R² = .111; Adjusted R² = .102; and R² change = .111. Immersion/Emersion was not a significant predictor of Psychological Wellness. However, when Immersion/Emersion and Internalization were both in the same Model, Internalization was a significant predictor and accounted for 14.6% of the variance (t (101) = .4.080, p= .000). R² = .146; adjusted R² = .128; and R² change = .145.

**Additional Analyses**

Additional analyses were conducted to examine if there was a significant relationship between psychological health, resilience, and men who lived with or near close knit family or friends. Results indicate neither resilience nor psychological health was significantly correlated to men who live with or near a close knit group of family and/or friends. Instead, psychological distress was significantly correlated to men who live with or near a close knit group of family and/or friends (r (101) = .202, p = .043). The additional analyses also found no significant correlation between men who regularly attend church and Personal Competence (r (101) = -.068, p = .501), Acceptance of Self and Life (r (101) = -.028, p=.779), or MHI scores (r (101) = -.075, p= .459). Finally,
there was no significant correlation found between psychological health and men who had a male role model while growing up (r (101) = .115, p=.253).

**Summary**

In this chapter, results of the study were presented. Socioeconomic status (SES) was a significant predictor of MHI scores and accounted for 4.6% of the variance in psychological health. Resilience accounted for only .1% of the variance in the psychological health and was not a significant predictor of MHI scores above and beyond that of SES. Racial identity accounted for 9.6% of the variance in the psychological health of the African American men in this sample; however it was not a significant predictor.

Supplemental analysis results indicate that a significant positive correlation exists between both resilience subscales and psychological wellness, and a significant negative correlation exists between both resilience subscales and psychological distress. Further analyses indicate that a significant positive correlation exists between lower racial identity attitude statuses, namely Encounter, and Psychological Distress. Additionally, a significant positive relationship exists between higher racial identity statuses, namely, Internalization and Psychological Wellness. Supplemental regression analyses suggest that lower racial identity attitude statuses, namely, Pre-Encounter and Encounter, were significant predictors of psychological distress, and that higher racial identity attitude statuses, namely, Internalization was a significant predictor of psychological wellness. The Encounter subscale appears to be the most significant predictor of Psychological Distress in this sample, whereas Internalization appears to be the most significant
predictor of Psychological Wellness in this sample. Furthermore, psychological distress was significantly correlated to men who live with or near close knit family and/or friends. The researcher will discuss these results in the chapter that follows.
CHAPTER FIVE: DISCUSSION

The purpose of this study was to examine the relationship between socioeconomic status, racial identity, resilience, and the psychological health of African American men. Data collection was in the form of a survey packet that included a demographic questionnaire outlined by the Hollingshead Four Factor Index of Social Status, the Resilience Scale (RS-25), the Black Racial Identity Attitudes Scale (RIAS-B), and the Mental Health Index (MHI). The independent variables were socioeconomic status (education and occupation), resilience (personal competence and acceptance of self and life), and racial identity (pre-encounter, encounter, immersion/emersion, internalization). The dependent variable of the study was psychological health. A hierarchical multiple regression analysis was conducted to examine the following research question: Does the socioeconomic status, racial identity attitudes and resilience predict the psychological health of African American men? This chapter will discuss the research hypotheses, significant results, limitations of the study, implications for counseling, and recommendations for future research.

Review

For decades psychological health has been at the root of many debates as it pertains to the overall psychological functioning of humans. Researchers have argued on its philosophical properties that range from definitions of happiness and well-being to depression and distress (Gaines, 2007; Mirowsky & Ross, 1989; Ryan & Deci, 2001; Ryff, 1989; Waterman, 1993). Throughout this time, however, the psychological health of African American men has primarily been investigated from a psychiatric and
pathological lens (Pierre et al, 2001). The scope of the literature has exhaustive use of mental illness versus the promotion of mental health as a foundation of which to generate hypotheses about the psychological health of this population (Mahalik et al., 2006; Neville & Lilly, 2000; Sellers et al, 2003; Wester et al, 2006). In addition, previous research in this area focuses primarily on the impact of variables such as racism, racial discrimination, and oppression; variables that view psychological health and functioning of African American men from the impacts of external influences on their psychological health (Banks et al, 2006; Clark et al, 1999; Gaines, 2007; Pierre et al, 2001; Pieterse & Carter, 2007). This study investigated the psychological health of African American men and their socioeconomic status, the perception of their ability to manage the impact of societal factors such as the aforementioned, and how they view themselves as a racial being. In essence, focus was placed on internal responses to their external experiences.

Previous research has stressed the ongoing need of studies that address the impact of socioeconomic status (SES) on the psychological health of African American males (Pieterse & Carter, 2007). Therefore as part of this study, SES was hypothesized as a predictor of the psychological health of this sample. Emphasis was also placed on the predictive value contribution to psychological health of resilience personality; the ability of African American men in this sample to mediate stress and overcome life’s challenges. Additionally, a primary focus of this study was to explore the impact of racial identity on the psychological health of African American men by way of their connectedness to how they see themselves as racial beings.
Socioeconomic status, resilience and racial identity were investigated by having participants complete a survey packet of instruments designed to measure each of these variables. Psychological health was measured using the Mental Health Index (MHI). Socioeconomic status (education and occupation) was measured using the Hollingshead Four Factor Index of Social Status. Resilience was measured using the Resilience Scale (RS-25), and Racial Identity was measured by the Black Racial Identity Attitudes Scale (RIAS-B). Each participant completed the pencil and paper survey packet in person with the researcher present.

The researcher hypothesized that socioeconomic status would be a predictor of psychological health. It was also hypothesized that resilience would be a predictor of psychological health above and beyond contribution of the variance by socioeconomic status. Finally, it was hypothesized that racial identity would be a predictor of psychological health above and beyond the variance contributed by socioeconomic status and resilience. Results of the data analysis are only supportive of socioeconomic status as a significant predictor of the psychological health of African American men in this sample.

**Research Hypotheses**

**Socioeconomic Status**

Socioeconomic status (SES) has primarily been studied among African Americans in comparison to Whites. For example, Williams & Williams-Morris (2000) reported the median family income for White households in 1996 as almost 1.7 times higher than that of African Americans, and that 40% of African American children under
the age of 18, compared to 11% of their White peers, were growing up poor. Additionally, a lower SES household where African Americans receive welfare have less access to education and childcare services than their White counterparts; and in the wake of welfare reform efforts, are less likely to leave welfare for decent-paying jobs (Gooden & Bailey, 2001). These within racial group social class variations are predictive of mental well-being (Neighbors, 1984; Williams, Takeuchi, & Adair, 1992).

Research with samples of African Americans and African American males assessing the relationship between SES and well-being primarily focuses on the impact of SES and psychological distress and/or the assistance seeking behaviors of mental healthcare utilization (Duncan, 2003; Kessler & Neighbors, 1986; Williams et al, 1992; Williams, 1999). For example, Duncan (2003) found a significant negative correlation between SES and assistance seeking behaviors of a sample of African American male college students. However, in another study, Dressler and Badger (1985) found social class to be unrelated to depressive symptoms. Additionally, in a national survey of Blacks, Neighbors (1988) reported both positive and inverse relationships between SES and psychological distress. In the current study, SES was inversely correlated to psychological distress thus positively correlated to psychological well-being.

Resilience

Historically speaking, resilience research has primarily focused on the environmental impacts of children and adolescents who managed to successfully navigate challenging life circumstances and avoid a mental health diagnosis later in life (Masten & O’Connor, 1989; Richmond & Beardslee, 1988; Werner & Smith, 1982). However,
resilience studies have overtime expanded their focus to consist of more underrepresented populations including the elderly, immigrants, and women (Christopher, 2000; Heilemann, Lee, and Kury, 2005; Wagnild and Young, 1990). Although resilience research has increased and improved its population diversity overtime, there is still considerable lack in resilience research involving African American men.

Defining resilience continues to fluctuate among the research. However common to resilience are, risk factors, protective factors, and outcomes (Murray, 2003; Rutter, 1993). Previous research suggests risk factors among diverse populations of African Americans to include: the disproportionate amount of community violence at diverse levels of socioeconomic status; teenage pregnancy; exposure to interpersonal trauma; single female headed households; and poor developmental outcomes (Breslau et al, 1998; Crouch, Hanson, Saunders, Kilpatrick, & Resnick, 2000; Kirby, 2002; Miller & MacIntosh, 1999; Wilson, 1987). More specifically, risk factors among African American males include: depression, substance abuse, imprisonment; violence; (Franklin, 1999; Western, 2007). Risk factors such as these may increase the likelihood of maladaptive outcomes (Werner, 1990).

The antitheses of risk factors are protective factors, which in the face of adversity develop to help mediate the effects of risk factor exposure. Protective factors as they pertain to African American men include societal and parental support to help mitigate the effects of stressful life challenges; close support systems that help African American males to organize their skills and resources in order to cope with stressful life events; and
support systems to share the burden of stress as well as provide emotional and sometimes monetary support (Zimmerman et al, 2000; Smith 1985).

The second research hypothesis examined the extent to which resilience is predictive of the psychological health of a sample of African American men. The two subscales (Personal Competence, and Acceptance of Self and Life) of the RS-25 were used to test this hypothesis. The hierarchical regression analysis indicated that resilience was not a significant predictor of the psychological health of the African American men in this sample. In the regression analysis neither Personal Competence or Acceptance of Self and Life was significant when combined in the same model, or when separated out as individual predictors of psychological health. Although resilience as defined by the two RS-25 subscales was not predictive of psychological health, resilience was significantly correlated to other variables in the study. For example, Personal Competence was significantly correlated to SES, and the Internalization racial identity subscale; and Acceptance of Self and Life was correlated to SES, and the Immersion/Emersion and Internalization racial identity subscales.

Use of the RS-25 for this study defines resilience as a personality trait. As a personality trait, resilience is most closely related to what researchers have referred to as ego-resilience, a set of traits that reflects resourcefulness, character stability, and flexibility in overall functioning when one is exposed to challenging environmental situations (Block & Block, 1980; Luther et al, 2000). Resilience as a personality trait also moderates negative effects and promotes psychological adaptation in the wake of difficult circumstances. Since resilience was not a significant predictor of psychological
health for this study, it may be that the construct of resilience personality is more useful for examining its impact on the psychological health of African American men with a narrower focus; based on the adversity of a specific set of life events, or health issue. For example, previous research on resilience with use of the RS-25 has specified its effect on the psychological health of diverse population samples in the wake of a specific set of life circumstances or health issue. For example, Heilmann et al., (2005) used the RS-25 to assess strength factors in a population of women of Mexican descent. The purpose of the study was to examine the relationship between strength factors, resources, risk factors and health status. Findings of this study indicate that 23% of the women who perceived themselves as having a health problem also reported lower levels of resourcefulness (Personal Competence) and lower levels of adaptability (Acceptance of Self and Life) (Heilmann et al., 2005).

Most studies used to address resilience have a much more specific attempt at understanding the construct of a clinically diagnosed sample, or based on a narrower set of life circumstances versus the broader construct of psychological health. Examples of studies with a more specified focus for this population would be use of the RS-25 with a sample of African American men post the Civil Rights movement of the 1960s; or assessing resilience personality among African American men of the Vietnam War diagnosed with posttraumatic stress disorder; or even resilience factors of African American men raised in single parent homes. Overall, it would be presumptuous to state that the results for this study were inconsistent with the current literature on resilience as defined by the RS-25 scale because the population sample under investigation in the
current study was not a clinical sample nor was the study designed to address a specific set of life circumstances. It should however be noted that though resilience was not a significant predictor of psychological health in this study, resilience subscales were significantly correlated to the psychological wellness of this population.

**Racial Identity**

African American males are one of the most stigmatized and misunderstood ethnic groups in the U.S. (Cunningham, 2001; Mizell, 1999). Further exploration on how African American men view themselves as racial beings is but one avenue to better understanding this population of men. The racial identity attitudes of African American males have yet to be examined on a consistent basis with population samples that are not of a clinical setting and/or from a college/university environment.

Previous research using the RIAS-B to assess racial identity attitudes and psychological health of African Americans indicate that racial identity ego statuses are correlated to and/or predictive of psychological distress. For example, in a study by Mahalik et al., (2006) racial identity was examined as a correlate to masculinity and psychological distress. Researchers found that Pre-Encounter scores and Immersion/Emersion scores were significant predictors of psychological distress in their sample of African American men. Authors further indicated that the Pre-Encounter scale was related to lower levels of self-esteem, and higher levels of anxiety (Mahalik et al., 2006). In another study by Neville et al., (1997) in a sample of African American men and women, researchers found that RIAS-B scores were significantly correlated to perceived stress and coping styles. The authors further indicated that higher Encounter
scale scores were related to greater perceived general stress. In examining the relationship between racial identity and psychological defenses, Nghe & Mahalik (2001) found in a sample of African American men and women that Encounter scale scores were strongly correlated to neurotic psychological defenses, which are associated with psychological distress.

Each of the aforementioned studies is consistent with the literature on the RIAS-B, which indicates that lower racial identity attitude scales are predictive of, or significantly correlated to psychological distress in African Americans (Parham & Helms, 1985; Pillay, 2005). In the current study, the Pre-Encounter subscale results were found to be consistent with the literature as having an impact on psychological distress of African American men. In addition, Pre-Encounter was found to be a significant predictor of MHI scores when entered individually into the regression.

Helms (1990) stated that when one is operating in a Pre-Encounter ego status, there is connectedness to an identity; an identity that values the White dominant culture. Whereas an individual who is operating in an Encounter ego status (due to an encounter they have experienced as a Black person in America), has abandoned their previous views of White culture, resulting in an individual who feels identity-less (Helms, 1990). Encounter subscale scores in this study are consistent with the literature as they were significant predictors of psychological distress. It is also important to note that the Encounter subscale scores variance of the current sample accounted for more variance in psychological distress than Pre-Encounter subscale scores. These results are consistent with the elevated reliability coefficient of the Encounter subscale for the current study.
As previously mentioned, researchers have in the past found reliability coefficients on the Encounter subscale to be significantly lower than the other racial identity subscales on the RIAS-B (Helms, 1990; Parham & Helms, 1981; Mahalik et al., 2006). This is due to the difficulty in measuring a phenomenon that is constantly changing. For example, the results of the current study indicate that the African American men in this sample are primarily functioning in an Encounter ego status with regard to psychological distress. Cross (1971) explains the encounter as a verbal or visual event that one experiences that shatters the persons current feelings about themselves and the condition of Blacks in America. The second phase of the encounter ego status is that after one experiences this encounter they begin reinterpreting their world view. In this status, Cross (1971) poses the question that one may ask as a result of the encounter experience which is: “Have I been unaware of the Black experience or was I programmed to be disgusted by it?” (p. 17). Covert and overt experiences of racism and racial discrimination are just two examples of what constitute an encounter. As a result, Encounter ego status persons experience a mixture of feelings such as hopelessness, confusion, depression, and anxiety (Helms, 1990), each of which coincide with the subscales of psychological distress (anxiety, depression, loss of behavioral/emotional control) as measured in this study by the Mental Health Index (MHI).

As previously mentioned, the psychological wellness of African American men is not often discussed in the current literature. Furthermore, research on psychological wellness and racial identity is even less. Although there is considerable lack of discussion on African American men and wellness, a few research studies that
incorporate racial identity and psychological wellness of this population will be discussed here.

Spurgeon and Myers (2010) conducted a study designed to identify strengths of successful Black college students by examining relationships between racial identity, college type, and wellness of African American males. Participants were from both colleges, one a Predominantly White Institution (PWI) the other a Historically Black College/University (HBCU). Researchers hypothesized that there would be a statistically significant positive relationship between racial identity and wellness for students attending both PWIs and HBCUs. Results indicated that there was no significant relationship for any of the racial identity and wellness scale comparisons thus inconsistent with the literature discussion that equates higher racial identity statuses with higher levels of psychological wellness (Helms, 1990; Cross, 1971). Furthermore, Black males attending the PWI scored higher on the Internalization subscale than Black males attending the HBCU. Authors report this finding as “interesting and unexpected” due to the nature and social climate of an HBCU (Spurgeon & Myers, 2010, p. 536).

Another study using racial identity as a predictor of psychological health was conducted by Pillay (2005). The author used an ordered regression analysis with gender, acculturation and racial identity as predictors of the psychological health of a college sample of African American males and females at a Predominantly White University (PWI). Results indicated that all four subscales of racial identity (Pre-Encounter, Encounter, Immersion/Emersion, and Internalization) entered into the regression as a block were significant predictors of psychological health (Pillay, 2005). However,
individually only Pre-Encounter and Encounter scales were significant predictors of psychological health. Immersion/Emersion and Internalization subscales were not significant predictors of psychological health (Pillay, 2005). The current study is consistent with the aforementioned findings in that, Immersion/Emersion and Internalization subscale scores were not significant predictors of MHI scores. However, Internalization was a significant predictor of Psychological Wellness.

The internalization ego status is one where an individual has a greater feeling of inner security and are satisfied with themselves (Cross, 1971). Helms (1990) explained this individual as one who acknowledges Blacks as “the primary reference group to which one belongs, though the quality of belongingness is no longer externally determined” (p. 29). More importantly, what the Internalization ego status individual feels, thinks, or believes is not as important as how they believe; not denying the merit of his/her Blackness when confronting difficult issues (Helms, 1990). Therefore, in this study, Internalization as a significant predictor of psychological wellness is consistent with the literature that associates this stage with better psychological functioning (Helms, 1990; Cross 1971).

In addition to these findings, the current study indicates a significant positive correlation between African American men who lived with or near close knit family and/or friends and psychological distress. This finding is unique as the majority of the participants for the current study were enrolled in a fatherhood program to which some participants routinely experience stressors with regard to being in close relationship with family and/or friends due to child support issues and the court system. These findings are
consistent with research that suggests a link between psychological distress and the legal system. For example, in a sample of 377 African American males, Gaines (2007) found that there is a link between higher levels of psychological distress among adult African American males and lower levels of confidence in the courts and legal system. The author further attributes this link to multiple procedural and due processes one experiences while involved with the courts.

**Summary of Significant Results**

Only one out of the three research hypotheses for this study was found to be significant. Socioeconomic status (SES) was a significant predictor of psychological health for this sample of African American men. Resilience was not found as a significant predictor of psychological health. Racial identity as a block was not found to be a significant predictor of psychological health. SES accounted for 4.6% of the variance in psychological health. Resilience did not account for the variance in psychological health above and beyond that of SES. Racial identity did not account for the variance in psychological health above and beyond that of SES and resilience.

Individually, both Pre-Encounter and Encounter were significant predictors of psychological distress. Encounter accounted for the variance in psychological distress beyond that which was accounted for by Pre-Encounter. Internalization was a significant predictor of psychological wellness. Immersion/Emersion was not a significant predictor of Psychological Distress or Psychological Wellness.

Psychological health was significantly correlated in a negative direction to SES and was not significantly correlated to resilience. Psychological health was significantly
correlated in a positive direction to Pre-Encounter and Encounter though was not significantly correlated to Immersion/Emersion and Internalization. SES was positively significantly correlated to both resilience subscales and the Internalization racial identity subscale, though negatively correlated to Pre-Encounter and Encounter racial identity subscales. SES was not significantly correlated to Immersion/Emersion. Resilience was significantly correlated in a positive direction to Internalization and Immersion/Emersion.

**Limitations**

Study limitations have the potential to influence results of the research. The limitations for this study include the sampling method, data analysis, measurement instruments, and self-report data. Each of the limitations is discussed next.

**Sampling Method**

The sample of African American men accessed is considered a purposeful sample. A majority of the African American men that participated in the study were currently enrolled in a self enrichment program for men designed specifically to assist them in the development of their parenting skills, career development and community leadership skills. In addition, the program primarily serves lower income populations of men in an urban community setting. Men that participated who were not currently enrolled in the enrichment program were either graduates of the program, men in the community that have worked directly with the program in the past, or men of other community based organizations geared toward positive outcomes of African American males. Finally, the anticipated sample size of 150 African American men was not reached to which may
have had an impact on the overall results. Due to the restricted sample, the results of the study cannot be generalized to all African American men.

**Data Analysis**

A hierarchical regression analysis was the chosen method of examining the psychological health of this sample. The variables under investigation in this study were socioeconomic status, resilience, racial identity and psychological health. Not all of the variables were found to be significant predictors of psychological health in this sample and use of a hierarchical regression analysis limits a more comprehensive understanding of other variables that may impact the psychological health of the African American men in this sample.

**Instruments**

The Hollingshead Four Factor Index of Social Status was developed in 1975, and is based on occupation and education information from the 1970 U.S. Census. Overtime occupations in the U.S. have become much more diverse and although the 1970 Census may reflect a current employment position, the current occupation title may be more complex or refined. Occupation titles for this study had to be closely matched with those outlined in categories on the Hollingshead and managed for consistency across participant responses.

The original population sample of the RS-25 scale was developed with a qualitative study group of 24 women following a major life event. Although the RS-25 scale has been successful in its administration to diverse populations, research prior to this study, with use of an all male African American sample is nonexistent. In addition,
the specificity in the phenomenon being examined in other studies using the RS-25 was not present in the current study.

The RIAS-B is an instrument that was developed through the seminal work of Cross’ (1971) Negro-to-Black Conversion model. Research using the RIAS-B has overwhelmingly been used with much younger samples of African American males. In addition, a vast number of the reported populations using the RIAS-B are students attending college/universities in which the research is being conducted. Although these limitations exist the RIAS-B was chosen for use in this study primarily because it is still one of the most used scales in measuring Black racial identity. Finally, racial identity scales are attitudinal; they assess one’s attitude about who they are as a racial being. Any findings from the current population under investigated that may differ from the literature may be due to a difference in the mean age of the population. For example, the current study investigates racial identity attitudes of a sample of African American men whose mean age is 34.8 years. Previous research involving African American males and racial identity have a mean age between 18 and early to late 20s (Mahalik et al, 2006; Pope-Davis et al, 2006; Spurgeon & Myers, 2010).

The MHI is a self-report index of psychological functioning. For the purposes of this study, participant responses are not indicative of an individual’s true mental health status. Although the MHI has been used with diverse populations in the past, little research has used the MHI to examine psychological health with the variables of use for this study.
Self-Report

The measurement instruments used for this study were all self-report. Therefore a significant amount of subjectivity in responses must be taken into consideration when reading the results. Participants responded based on the way in which they perceive themselves and their lives, which by nature is subject to personal attitudes and beliefs. In addition, self report measures are not without the possibility of responses geared more toward social desirability.

Counseling Implications

There is no singular experience that constitutes ‘being a man’ (Goodrich, 2009, p. 192). Instead researchers have argued that being a man is based on diverse cultural variables including race, ethnicity, sexual orientation, religious and moral values, and political ideologies (Jandt & Hundley, 2007). Therefore, counselors seeking to understand African American men cannot forego understanding these diverse cultural variables and masculinity in general. The results of this study have implications for counseling practice that can be used to guide helping professionals in their work with and understanding of African American men.

Similar to race, socioeconomic status in America plays a role in categorizing and further marginalizing diverse populations of people. Although socioeconomic status was a significant predictor of psychological health in this study, the relationship between social class and psychological health overtime has been inconsistent (Duncan, 2003). The premise in this lack of consistency is found in mental health service utilization. For example, African American men are not regular seekers of mental health services and for
those who do seek outside help for dealing with a mental health issue, do so only when they believe the situation to be unbearable (Warfield and Marion, 1985).

Another important aspect of socioeconomic status and psychological health is the challenge in measuring SES and the counselor’s ability to work with African American males from diverse socioeconomic backgrounds without imposing further stigmatization. Levels of education and income have been the primary way of assessing an individual’s socioeconomic status. However, counselors working with African American men should dually note that in the African American community, for example, the ‘stability of one’s employment may reveal more about the person’s self-perceived and community ascribed status than the nature of their occupation’ (Helms and Cook, 1999, p. 23). Overall, despite the difficulties in partitioning out the effects of socioeconomic status on psychological health, it remains a variable worth further exploration for counselors seeking to understand help-seeking behaviors of African American men (Neighbors, 1991).

As previously mentioned gender role expectations in the African American community differ from that of the dominant culture. Historically, African Americans have aligned themselves primarily with ideals of community and cooperation, instead of competition and aggression. However, researchers argue that Black men can easily be found in a struggle amidst the polarities of these cultures (Pierre et al, 2001). For example, pressures to meet European standards of manhood are a dilemma for African American men. On one hand, African American men may view adapting to mainstream American culture as a way to gain access to opportunity, yet experience a cultural or
identity struggle when they realize that the very environment they are trying to ‘fit in’ does not validate their existence; as an individual, or a collective self (Blackwell, 1975; Gaines, 2007; Pierre et al, 2001). Correlation among highly endorsed Encounter racial identity subscale items and psychological distress support this view. Therefore, it is imperative for counselors to understand that for African American men trying to balance between two worlds in an environment where society has been taught to devalue their worth is cause for experiencing psychological distress. Finally, although the aforementioned deserves attention, it does not however mean that all African American men entering into a therapeutic relationship may be experiencing the dichotomy of this struggle. Therefore it is not appropriate for counselors to over generalize the results of this study by infusing this experience with all of their African American male clients.

Resilience personality as explored in the current study was significantly correlated to psychological wellness of African American men. Protective factors and an internal locus of control are both characteristic of resilience personality and what is believed to help mediate life stressors for African American men. Personality factors, such as resilience, may influence an individual’s successful response to stressful life events, just as individual’s may have psychological defenses and coping responses that may put them at higher risk for psychiatric symptomatology (Smith, 1985). Counselors working with populations of African American men should understand that an encounter with a stressful life event is in addition to the societal stressors already impacting their daily lives (i.e. race-related stressors; racial prejudice; institutional racism; racial discrimination). Therefore counselors should in addition seek to understand their client’s
individual coping mechanisms and approaches to stressful life events. Though it is not necessary to assume the aforementioned as a focus of treatment, counselors should seek to understand avenues that have been tried (both successful and unsuccessful) in order to assist African American men in creating better strategies to navigate stressful life events.

An alternative intervention that may be helpful for working with African American men is Afrocentric counseling. Afrocentric counseling is based on Afrocentrism and Afrocentric healing (Helms & Cook, 1999). According to Nobles (1980), an Afrocentric view represents a self-affirmation, reawakening, and rebirth of personal beliefs and behaviors. Essentially, "one can be pro-African and not anti-white” (Robinson & Hamilton-Howard, 1994). Exploring such an approach would require the counselors’ awareness of self as racial/ethnic being with the ability to receive their client with acknowledgement of their own personal attitudes and beliefs. This is especially important for White counselors working with African American male populations.

Nickerson, Helms, and Terrell (1994) stated that Blacks who reported high levels of mistrust toward Whites had a more negative attitude about seeking psychological services if the clinic was staffed primarily by Whites. Mistrust among African Americans and counseling services is not a new phenomenon. Epidemiological research involving African Americans and mental health services discuss incongruent symptomatology and diagnosis of African Americans seeking treatment for some form of a psychologically based issue (Heurtin-Roberts, Snowden, & Miller, 1997).
Recommendations for Future Research

The current study accessed a non-clinical community sample of African American men. The mean age of the current study is on average 10-15 years higher than that of other samples in the literature focusing on racial identity and psychological health, thus adding to the current literature discussion on racial identity and African American men. Future research on African American men with such variables as SES, resilience, and psychological health should expand outside of college/university and clinical populations to focus primarily on community samples of African American men.

The current study is consistent with the literature that implies that African American men operating in an Encounter racial identity status struggle with a connectedness to themselves as a racial being; thus indicative of experiencing psychological distress. However, over the course of the literature, and in the current study, Immersion/Emersion was not a significant predictor of psychological health (nor distress or wellness). The immersion/emersion ego status presents an intense and intentional deepening of awareness to whom one is as a racial being and significant emphasis is placed on group identity and rejection of White cultural norms. Later, throughout the emersion status, one begins to evolve and reassess themselves in a new way; as a more socially and racially accepting individual. Future research should look more in depth at the relationship between the Immersion/Emersion racial identity ego status and psychological health. In essence, further exploration on its impact, or lack thereof, to psychological distress and/or wellness of African American men.
Socioeconomic status is a difficult variable to assess. As mentioned, the longevity of employment for African Americans may be more substantially important than the actual occupation itself. Future research should seek to explore the relationship between psychological wellness and socioeconomic status of African American men and include variables such as years of service, and even access to employment.

Resilience personality for in the current study was measured using the Resilience Scale (RS-25). However, previous research exploring the construct of resilience uses a more specified population sample of participants. The RS-25 may be more helpful in exploring resilience personality of African American men among a clinical sample or group of participants who share a common stressful life event.

Finally, this study mentioned but was not designed to explore the relationship between resilience, psychological health and masculinity of African American men. The construct of masculinity is thorough in the literature, however adding resilience as a variable of exploration may have an impact on the perceptions of masculinity among a population of African American men.

**Conclusion**

This study explored the relationship of socioeconomic status, resilience, racial identity and psychological health in a community sample of African American men. The results of this study support the hypothesis that socioeconomic status is a significant predictor psychological health. The study also found no significant predictive value for resilience or racial identity in the psychological health of this sample. Lower racial identity attitudes (Pre-Encounter and Encounter) were significant predictors of
psychological distress, while Internalization was a significant predictor of psychological wellness. Resilience was significantly correlated to psychological wellness, and Internalization racial identity subscale scores.

Individuals, events, and circumstances create the phenomenon and statistics that researchers investigate in efforts to develop further knowledge and understanding. External factors that influence our psychological health have impacted all of us. However each individual and cultural experience is different, and internal responses to life circumstanced may vary. Therefore, it is critically important that ongoing research on African American men continues to investigate how this population views themselves as racial beings in a society where dominant views penetrate and perpetuate dominant cultural norms.
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APPENDIX A: SURVEY INSTRUMENT

Directions are given for each question. Please answer all questions. Please do not write your name or any other identifiable information on this questionnaire. Your answers will be held in the strictest confidence and will only be used for data analysis. Thank You!

Part A: Please provide the following information:

Age: _______

What is your highest level of education?

_______ Less than 7th grade   _______ Partial College (at least 1yr or specialized training)

_______ Junior High School (9th grade)  

_______ Partial High School (10th or 11th grade)  _______ Standard College (completed degree)

_______ High School graduate (whether private, preparatory, parochial, trade, or public school)

_______ Graduate Professional Training

What is your current occupation? ________________________________________________

What is your current marital status?

_______ Single   _______ Divorced

_______ Married   _______ Widowed

Were you born in the United States of America? Did you grow up in the Columbus area?

_______ Yes   _______ No   _______ Yes   _______ No

Did you have a male role model while growing up?

_______ Yes  _______ No   _______ Yes  _______ No

Do you regularly attend church anywhere?

_______ Yes  _______ No

Do you live with or near a close knit group of family and/or friends?

_______ Yes  _______ No
Part B: Please read the following statements. To the right of each you will find seven numbers, ranging from “1” (Strongly Disagree) on the left to “7” (Strongly Agree) on the right. Circle the numbers which best indicates your feeling about that statement. For example, if you strongly disagree with a statement, circle “1”. If you are neutral, circle “4”, and if you strongly agree, circle “7”, etc.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>When I make plans, I follow through with them.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>2</td>
<td>I usually manage one way or another.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>3</td>
<td>I am able to depend on myself more than anyone else.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>4</td>
<td>Keeping interested in things is important to me.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>5</td>
<td>I can be on my own if I have to.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>6</td>
<td>I feel proud that I have accomplished things in life.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>7</td>
<td>I usually take things in stride.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>8</td>
<td>I am friends with myself.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>9</td>
<td>I feel that I can handle many things at a time.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>10</td>
<td>I am determined.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>11</td>
<td>I seldom wonder what the point of it all is.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>12</td>
<td>I take things one day at a time.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>13</td>
<td>I can get through difficult times because I've experienced difficulty before.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>14</td>
<td>I have self-discipline.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>15</td>
<td>I keep interested in things.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>16</td>
<td>I can usually find something to laugh about.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>17</td>
<td>My belief in myself gets me through hard times.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>18</td>
<td>In an emergency, I'm someone people can generally rely on.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>19</td>
<td>I can usually look at a situation in a number of ways.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>20</td>
<td>Sometimes I make myself do things whether I want to or not.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>21</td>
<td>My life has meaning.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>22</td>
<td>I do not dwell on things that I can't do anything about.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>23</td>
<td>When I'm in a difficult situation I can usually find my way out of it.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>24</td>
<td>I have enough energy to do what I have to do.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>25</td>
<td>It's okay if there are people who don't like me.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>26</td>
<td>I am content.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
</tbody>
</table>
### BRIAS Social Attitudes Scale

**Instructions:** This questionnaire is designed to measure people's attitudes about social and political issues. There are no right or wrong answers. Different people have different viewpoints. So try to be as honest as you can. Beside each statement, circle the number that best describes how you feel. Use the scales below to respond to each statement.

<table>
<thead>
<tr>
<th>Item</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I believe that being Black is a positive experience.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. I know through personal experience what being Black in America means.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. I am increasing my involvement in Black activities because I don't feel comfortable in White environments.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I believe that large numbers of Blacks are untrustworthy.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I feel an overwhelming attachment to Black people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. I involve myself in causes that will help all oppressed people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. A person’s race does not influence how comfortable I feel when I am with her or him.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. I believe that Whites look and express themselves better than Blacks.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. I feel uncomfortable when I am around Black people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. I feel good about being Black, but do not limit myself to Black activities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. When I am with people I trust, I often find myself using slang words to refer to White people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. I believe that being Black is a negative experience.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. I am confused about whether White people have anything important to teach me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. I frequently confront the system and the (White) man.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15. I constantly involve myself in Black political and social activities (art shows, political meetings, Black theater, etc.)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16. I involve myself in social action and political groups even if there are no other Blacks involved.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17. I believe that Black people should learn to think and experience life in ways which are similar to White people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18. I believe that the world should be interpreted from a Black or Afrocentric perspective.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>19. I’m not sure how I feel about myself racially.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>20. I feel excitement and joy in Black surroundings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>21. I believe that Black people came from a strange, dark, and uncivilized continent.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>22. People, regardless of their race, have strengths and limitations.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>23. I find myself reading a lot of Black literature and thinking about being Black.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>24. I feel guilty or anxious about some of the things I believe about Black people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>25. I believe that a Black person's most effective weapon for solving problems is to become part of the White person's world.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>26. My identity revolves around being a Black person in this country.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>27. I limit myself to Black activities as much as I can.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>28. I am determined to find my Black identity.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>29. I like to make friends with Black people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>30. I believe that I have many strengths because I am Black.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>31. I feel that Black people do not have as much to be proud of as White people do.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>32. I am at ease being around Black people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>33. I believe that Whites should feel guilty about the way they have treated Blacks in the past.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>34. White people can't be trusted.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>35. In today's society if Black people don't achieve, they have only themselves to blame.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Statement</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>-----------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>36. The most important thing about me is that I am Black.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>37. Being Black just feels natural to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>38. Other Black people have trouble accepting me because my life experiences have been so different from their experiences.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>39. Black people who have any White people's blood should feel ashamed of it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>40. Sometimes, I wish I belonged to the White race.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>41. The people I respect most are White.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>42. I have begun to question my beliefs about my racial group.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>43. I feel anxious when White people compare me to other members of my race</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>44. I tend to bond easily with Black people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>45. A person's race may be a positive aspect of who he or she is.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>46. When I am with Black people, I pretend to enjoy the things they enjoy.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>47. When a stranger who is Black does something embarrassing in public, I get embarrassed.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>48. I believe that a Black person can be close friends with a White person.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>49. Sometimes I think that White people are superior and sometimes I think they're inferior to Black people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>50. I have a positive attitude about myself because I am Black.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>51. I participate in Black culture.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>52. I am not sure where I really belong racially.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>53. I believe that White people are more intelligent than Blacks.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>54. I speak my mind regardless of the consequences (e.g. being kicked out of school, being imprisoned, being exposed to danger).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>55. I can't feel comfortable with either Black people or White people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>56. I often feel that I belong to the Black racial group.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>57. I am embarrassed about some of the things I feel about my racial group.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>58. Most Blacks I know are failures.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>59. I am changing my style of life to fit my new beliefs about Black people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>60. I am satisfied with myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
**Part D:** These questions are about how you feel and how things have been with you mostly within the past month. For each question, please circle a number for the answer that comes closest to the way you have been feeling.

<table>
<thead>
<tr>
<th></th>
<th>HOW HAPPY, SATISFIED, OR PLEASED HAVE YOU BEEN WITH YOUR PERSONAL LIFE DURING THE PAST MONTH?</th>
<th>(Circle One)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Extremely happy, could not have been more satisfied or pleased</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Very happy most of the time</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Generally satisfied, pleased</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Sometimes fairly satisfied, sometimes fairly unhappy</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Generally dissatisfied, unhappy</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Very dissatisfied, unhappy most of the time</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>HOW MUCH OF THE TIME HAVE YOU FELT LONELY DURING THE PAST MONTH?</th>
<th>(Circle One)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>All of the time</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Most of the time</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>A good bit of the time</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Some of the time</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>A little of the time</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>None of the time</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>HOW OFTEN DID YOU BECOME NERVOUS OR JUMPY WHEN FACED WITH EXCITEMENT OF UNEXPECTED SITUATIONS DURING THE PAST MONTH?</th>
<th>(Circle One)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Always</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Very often</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Fairly often</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Almost never</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Never</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>DURING THE LAST MONTH, HOW MUCH OF THE TIME HAVE YOU FELT THAT THE FUTURE LOOKS HOPEFUL AND PROMISING?</th>
<th>(Circle One)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>All of the time</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Most of the time</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>A good bit of the time</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Some of the time</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>A little of the time</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>None of the time</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>HOW OFTEN DO YOU EAT TOO MUCH?</th>
<th>(Circle One)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Very often</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Fairly often</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Almost never</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Never</td>
<td>5</td>
</tr>
</tbody>
</table>
6. **HOW MUCH OF THE TIME, DURING THE PAST MONTH, HAS YOUR LIFE BEEN FULL OF THINGS THAT WERE INTERESTING TO YOU?** (Circle One)

<table>
<thead>
<tr>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of the time</td>
<td>1</td>
</tr>
<tr>
<td>Most of the time</td>
<td>2</td>
</tr>
<tr>
<td>A good bit of the time</td>
<td>3</td>
</tr>
<tr>
<td>Some of the time</td>
<td>4</td>
</tr>
<tr>
<td>A little of the time</td>
<td>5</td>
</tr>
<tr>
<td>None of the time</td>
<td>6</td>
</tr>
</tbody>
</table>

7. **HOW MUCH OF THE TIME, DURING THE PAST MONTH, DID YOU FEEL RELAXED AND FREE OF TENSION?** (Circle One)

<table>
<thead>
<tr>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of the time</td>
<td>1</td>
</tr>
<tr>
<td>Most of the time</td>
<td>2</td>
</tr>
<tr>
<td>A good bit of the time</td>
<td>3</td>
</tr>
<tr>
<td>Some of the time</td>
<td>4</td>
</tr>
<tr>
<td>A little of the time</td>
<td>5</td>
</tr>
<tr>
<td>None of the time</td>
<td>6</td>
</tr>
</tbody>
</table>

8. **DURING THE PAST MONTH, HOW MUCH OF THE TIME HAVE YOU GENERALLY ENJOYED THE THINGS YOU DO?** (Circle One)

<table>
<thead>
<tr>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of the time</td>
<td>1</td>
</tr>
<tr>
<td>Most of the time</td>
<td>2</td>
</tr>
<tr>
<td>A good bit of the time</td>
<td>3</td>
</tr>
<tr>
<td>Some of the time</td>
<td>4</td>
</tr>
<tr>
<td>A little of the time</td>
<td>5</td>
</tr>
<tr>
<td>None of the time</td>
<td>6</td>
</tr>
</tbody>
</table>

9. **DURING THE LAST MONTH, HAVE YOU HAD ANY REASON TO WONDER IF YOU WERE LOSING YOUR MIND, OR LOSING CONTROL OVER THE WAY YOU ACT, TALK, THINK, FEEL, OR OF YOUR MEMORY?** (Circle One)

<table>
<thead>
<tr>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, not at all</td>
<td>1</td>
</tr>
<tr>
<td>Maybe a little</td>
<td>2</td>
</tr>
<tr>
<td>Yes, but not enough to be concerned or worried about</td>
<td>3</td>
</tr>
<tr>
<td>Yes, and I have been a little concerned</td>
<td>4</td>
</tr>
<tr>
<td>Yes, and I am quite concerned</td>
<td>5</td>
</tr>
<tr>
<td>Yes, and I am very much concerned about it</td>
<td>6</td>
</tr>
</tbody>
</table>

10. **IN GENERAL, WOULD YOU SAY YOUR MORALS HAVE BEEN ABOVE REPROACH?** (Circle One)

<table>
<thead>
<tr>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, definitely</td>
<td>1</td>
</tr>
<tr>
<td>Yes, probably</td>
<td>2</td>
</tr>
<tr>
<td>I don't know</td>
<td>3</td>
</tr>
<tr>
<td>Probably not</td>
<td>4</td>
</tr>
<tr>
<td>Definitely not</td>
<td>5</td>
</tr>
</tbody>
</table>

11. **DID YOU FEEL DEPRESSED DURING THE PAST MONTH?** (Circle One)

<table>
<thead>
<tr>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, to the point that I did not care about anything for days at a time</td>
<td>1</td>
</tr>
<tr>
<td>Yes, very depressed almost every day</td>
<td>2</td>
</tr>
<tr>
<td>Yes, quite depressed several times</td>
<td>3</td>
</tr>
<tr>
<td>Yes, a little depressed now and then</td>
<td>4</td>
</tr>
<tr>
<td>No, never felt depressed at all</td>
<td>5</td>
</tr>
</tbody>
</table>
12. **DURING THE PAST MONTH, HOW MUCH OF THE TIME HAVE YOU FELT LOVED AND WANTED?**  
(Circle One)  
- All of the time ........................................... 1  
- Most of the time ........................................ 2  
- A good bit of the time .................................. 3  
- Some of the time ......................................... 4  
- A little of the time ....................................... 5  
- None of the time ......................................... 6  

13. **HOW MUCH OF THE TIME, DURING THE PAST MONTH, HAVE YOU BEEN A VERY NERVOUS PERSON?**  
(Circle One)  
- All of the time ........................................... 1  
- Most of the time ........................................ 2  
- A good bit of the time .................................. 3  
- Some of the time ......................................... 4  
- A little of the time ....................................... 5  
- None of the time ......................................... 6  

14. **WHEN YOU GOT UP IN THE MORNING THE PAST MONTH, ABOUT HOW OFTEN DID YOU EXPECT TO HAVE AN INTERESTING DAY?**  
(Circle One)  
- Always ...................................................... 1  
- Very often ............................................... 2  
- Fairly often ............................................. 3  
- Sometimes ............................................... 4  
- Almost Never ........................................... 5  
- Never ....................................................... 6  

15. **HOW OFTEN HAVE THERE BEEN TIMES IN YOUR LIFE WHEN YOU FELT YOU ACTED LIKE A COWARD?**  
(Circle One)  
- Very often ............................................... 1  
- Fairly Often ............................................. 2  
- Sometimes ............................................... 3  
- Almost Never ........................................... 4  
- Never ....................................................... 5  

16. **DURING THE PAST MONTH, HOW MUCH OF THE TIME HAVE YOU FELT TENSE OR "HIGH-STRUNG."**  
(Circle One)  
- All of the time ........................................... 1  
- Most of the time ........................................ 2  
- A good bit of the time .................................. 3  
- Some of the time ......................................... 4  
- A little of the time ....................................... 5  
- None of the time ......................................... 6  

17. **DURING THE LAST MONTH, HAVE YOU BEEN IN FIRM CONTROL OF YOUR BEHAVIOR, THOUGHTS, EMOTIONS, FEELINGS?**  
(Circle One)  
- Yes, very definitely ........................................ 1  
- Yes, for the most part .................................... 2  
- Yes, I guess so .......................................... 3  
- No, not too well .......................................... 4  
- No, I am somewhat disturbed .......................... 5  
- No, I am very disturbed .................................. 6
18. **DURING THE PAST MONTH, HOW OFTEN DID YOUR HANDS SHAKE WHEN YOU TRIED TO DO SOMETHING?**

(Circle One)
- Always .................................................. 1
- Very Often ............................................. 2
- Fairly Often .......................................... 3
- Sometimes .............................................. 4
- Almost Never ......................................... 5
- Never ..................................................... 6

19. **DURING THE PAST MONTH, HOW OFTEN DID YOU FEEL THAT YOU HAD NOTHING TO LOOK FORWARD TO?**

(Circle One)
- Always .................................................. 1
- Very often .............................................. 2
- Fairly often .......................................... 3
- Sometimes ............................................ 4
- Almost never ......................................... 5
- Never ..................................................... 6

20. **WOULD YOU SAY THAT YOU GIVE EVERY PENNY YOU CAN TO CHARITY?**

(Circle One)
- Yes, definitely ....................................... 1
- Yes, for the most part ............................... 2
- Yes, I try .............................................. 3
- No ....................................................... 4

21. **HOW MUCH OF THE TIME, DURING THE PAST MONTH, HAVE YOU FELT CALM AND PEACEFUL?**

(Circle One)
- All of the time ....................................... 1
- Most of the time .................................... 2
- A good bit of the time .............................. 3
- Some of the time ................................... 4
- A little of the time .................................. 5
- None of the time ..................................... 6

22. **HOW MUCH OF THE TIME, DURING THE PAST MONTH, HAVE YOU FELT EMOTIONALLY STABLE?**

(Circle One)
- All of the time ....................................... 1
- Most of the time .................................... 2
- A good bit of the time .............................. 3
- Some of the time ................................... 4
- A little of the time .................................. 5
- None of the time ..................................... 6

23. **HOW MUCH OF THE TIME, DURING THE PAST MONTH, HAVE YOU FELT DOWNHEARTED AND BLUE?**

(Circle One)
- All of the time ....................................... 1
- Most of the time .................................... 2
- A good bit of the time .............................. 3
- Some of the time ................................... 4
- A little of the time .................................. 5
- None of the time ..................................... 6
24. **HOW OFTEN HAVE YOU FELT LIKE CRYING DURING THE PAST MONTH?**
   (Circle One)
   - Always ......................................................... 1
   - Very often ................................................... 2
   - Fairly often .................................................. 3
   - Sometimes ................................................. 4
   - Almost never .............................................. 5
   - Never ......................................................... 6

25. **IN CHOOSING YOUR FRIENDS, HOW IMPORTANT TO YOU ARE THINGS LIKE THEIR RACE, THEIR RELIGION, OR THEIR POLITICAL BELIEFS?**
   (Circle One)
   - Always very important ................................... 1
   - Almost always important ................................ 2
   - Usually important ........................................ 3
   - Not too important ........................................ 4
   - Hardly ever important .................................... 5
   - Not important at all ...................................... 6

26. **DURING THE PAST MONTH, HOW OFTEN DID YOU FEEL THAT OTHERS WOULD BE BETTER OFF IF YOU WERE DEAD?** (Circle One)
   - Always ......................................................... 1
   - Very often ................................................... 2
   - Fairly often .................................................. 3
   - Sometimes ................................................. 4
   - Almost never .............................................. 5
   - Never ......................................................... 6

27. **HOW MUCH OF THE TIME, DURING THE PAST MONTH, WERE YOU ABLE TO RELAX WITHOUT DIFFICULTY?** (Circle One)
   - All of the time ............................................. 1
   - Most of the time .......................................... 2
   - A good bit of the time ................................... 3
   - Some of the time ......................................... 4
   - A little of the time ...................................... 5
   - None of the time ......................................... 6

28. **DURING THE PAST MONTH, HOW MUCH OF THE TIME DID YOU FEEL THAT YOUR LOVE RELATIONSHIPS, LOVING AND BEING LOVED, WERE FULL AND COMPLETE?** (Circle One)
   - All of the time ............................................. 1
   - Most of the time .......................................... 2
   - A good bit of the time ................................... 3
   - Some of the time ......................................... 4
   - A little of the time ...................................... 5
   - None of the time ......................................... 6

29. **HOW OFTEN, DURING THE PAST MONTH, DID YOU FEEL THAT NOTHING TURNED OUT FOR YOU THE WAY YOU WANTED IT TO?** (Circle One)
   - Always ......................................................... 1
   - Very often ................................................... 2
   - Fairly often .................................................. 3
   - Sometimes ................................................. 4
   - Almost never .............................................. 5
   - Never ......................................................... 6
### 30. How Much Have You Been Bothered by Nervousness, or Your ‘Nerves’ During the Past Month? (Circle One)
- Extremely so, to the point where I could not take care of things: 1
- Very much bothered: 2
- Bothered quite a bit by nerves: 3
- Bothered some, enough to notice: 4
- Bothered just a little by nerves: 5
- Not bothered at all by this: 6

### 31. During the Past Month, How Much of the Time Has Living Been a Wonderful Adventure for You? (Circle One)
- All of the time: 1
- Most of the time: 2
- A good bit of the time: 3
- Some of the time: 4
- A little of the time: 5
- None of the time: 6

### 32. If It Is More Convenient for You to Do So, How Often Will You Tell a Lie? (Circle One)
- Very often tell a lie: 1
- Fairly often: 2
- Sometimes tell a lie: 3
- Almost never: 4
- Never tell a lie: 5

### 33. How Often, During the Past Month, Have You Felt So Down in the Dumps That Nothing Could Cheer You Up? (Circle One)
- Always: 1
- Very often: 2
- Fairly often: 3
- Sometimes: 4
- Almost never: 5
- Never: 6

### 34. During the Past Month, Did You Ever Think About Taking Your Own Life? (Circle One)
- Yes, very often: 1
- Yes, fairly often: 2
- Yes, a couple of times: 3
- Yes, at one time: 4
- No, never: 5

### 35. During the Past Month, How Much of the Time Have You Felt Restless, Fidgety, or Impatient? (Circle One)
- All of the time: 1
- Most of the time: 2
- A good bit of the time: 3
- Some of the time: 4
- A little of the time: 5
- None of the time: 6
36. HOW OFTEN HAVE YOU DONE ANYTHING OF A SEXUAL NATURE THAT SOCIETY DOES NOT APPROVE OF? (Circle One)
   Very often .................................................. 1
   Fairly often .................................................. 2
   Sometimes ...................................................... 3
   Almost never ................................................... 4
   Never ............................................................ 5

37. DURING THE PAST MONTH, HOW MUCH OF THE TIME HAVE YOU BEEN MOODY OR BROODED ABOUT THINGS? (Circle One)
   All of the time ................................................. 1
   Most of the time ............................................... 2
   A good bit of the time ....................................... 3
   Some of the time ............................................. 4
   A little of the time .......................................... 5
   None of the time ............................................. 6

38. HOW MUCH OF THE TIME, DURING THE PAST MONTH, HAVE YOU FELT CHEERFUL, LIGHT-HEARTED? (Circle One)
   All of the time ................................................. 1
   Most of the time ............................................... 2
   A good bit of the time ....................................... 3
   Some of the time ............................................. 4
   A little of the time .......................................... 5
   None of the time ............................................. 6

39. DURING THE PAST MONTH, HOW OFTEN DID YOU GET RATTLED, UPTIGHT OR FLUSTERED? (Circle One)
   Always .......................................................... 1
   Very often ...................................................... 2
   Fairly often ................................................... 3
   Sometimes ....................................................... 4
   Almost never ................................................... 5
   Never ............................................................ 6

40. ARE YOUR TABLE MANNERS AT HOME JUST AS GOOD AS THEY ARE WHEN YOU ARE INVITED OUT TO DINNER? (Circle One)
   Yes, always just as good ...................................... 1
   Yes, with rare exceptions .................................... 2
   Yes, usually just as good ..................................... 3
   No, usually worse at home ................................... 4
   No, quite a bit worse at home ................................. 5
   No, very bad at home ......................................... 6

41. DURING THE PAST MONTH, HAVE YOU BEEN ANXIOUS OR WORRIED? (Circle One)
   Yes, extremely so, to the point of being sick or almost sick .... 1
   Yes, very much so .............................................. 2
   Yes, quite a bit ................................................ 3
   Yes, some, enough to bother me ................................ 4
   Yes, a little ..................................................... 5
   No, not at all .................................................... 6
42. DURING THE PAST MONTH, HOW MUCH OF THE TIME WERE YOU A HAPPY PERSON?
   (Circle One)
   All of the time ........................................... 1
   Most of the time ........................................... 2
   A good bit of the time .................................... 3
   Some of the time ........................................... 4
   A little of the time ....................................... 5
   None of the time .......................................... 6

43. HOW OFTEN DURING THE LAST MONTH DID YOU FIND YOURSELF HAVING DIFFICULTY TRYING TO CALM DOWN?
   (Circle One)
   Always ....................................................... 1
   Very Often .................................................. 2
   Fairly Often ............................................... 3
   Sometimes ................................................... 4
   Almost never ............................................... 5
   Never ......................................................... 6

44. DURING THE PAST MONTH HOW MUCH OF THE TIME HAVE YOU BEEN IN LOW OR VERY LOW SPIRITS?
   (Circle One)
   All of the time ........................................... 1
   Most of the time ........................................... 2
   A good bit of the time .................................... 3
   Some of the time .......................................... 4
   A little of the time ....................................... 5
   None of the time ........................................... 6

45. HOW MUCH DURING THE PAST MONTH, HAVE YOU BEEN WAKING UP FEELING FRESH AND RESTED?
   (Circle One)
   Always, everyday ......................................... 1
   Almost everyday ........................................... 2
   Most days ................................................... 3
   Some days, but usually not ................................ 4
   Hardly ever .................................................. 5
   Never wake up feeling rested ............................. 6

46. DURING THE PAST MONTH, HAVE YOU BEEN UNDER OR FELT YOU WERE UNDER ANY STRAIN, STRESS, OR PRESSURE?
   (Circle One)
   Yes, almost more than I could stand or bear ............ 1
   Yes, quite a bit of pressure ................................ 2
   Yes, some more than usual ................................ 3
   Yes, some but about normal ................................ 4
   Yes, a little bit ............................................ 5
   No, not at all ............................................... 6
APPENDIX B: PERMISSION TO USE INSTRUMENT

Huentity Psychological Consulting LLC, Newton MA

17 July 2009

Ameena S. Mumin
Ohio University Doctoral Candidate

Re: order no. 2006-003

Dear Ms. Mumin:

Enclosed please find 1 BRIAS scale and scoring key, and one PRIAS and scoring key. You are authorized to make 150 copies of the BRIAS. You agreed to provide raw data to Dr. Helms after your study is completed.

Should you have further questions or need further assistance please feel free to contact us at Huentity at huentityllc@gmail.com

Thank you,

[Signature]

Jacalyn Mindell
Huentity Psychological Services LLC
APPENDIX C: INSTITUTIONAL REVIEW BOARD APPROVAL

The following research study has been approved by the Institutional Review Board at Ohio University for the period listed below. This review was conducted through an expedited review procedure as defined in the federal regulations as Category(ies):

Project Title: Racial Identity and Resilience as Predictors of the Psychological Health of African American Men

Primary Investigator: Ameena Mu'min

Co-Investigator(s):

Faculty Advisor: Yeahn Pillay

Department: Counseling & Higher Education

Rebecca Cale, AAB, CIP
Office of Research Compliance

Approval Date: 6/30/09
Expiration Date: 6/29/10

This approval is valid until expiration date listed above. If you wish to continue beyond expiration date, you must submit a periodic review application and obtain approval prior to continuation.

Adverse events must be reported to the IRB promptly, within 5 working days of the occurrence.

The approval remains in effect provided the study is conducted exactly as described in your application for review. Any additions or modifications to the project must be approved by the IRB (as an amendment) prior to implementation.
APPENDIX D: LETTER OF SUPPORT


June 11, 2009

To Whom It May Concern:

My correspondence with you today is pertaining to the dissertation research proposed by Ms. Ameena S. Mu’min, M.S.Ed. On more than one occasion I have had the opportunity to discuss with her the upcoming research project that focuses on Racial Identity, and Resilience, as Predictors of the Psychological Health of African American Men. This brief correspondence to you is to inform you that I am supportive of this project and because of its importance, am willing to assist Ms. Mu’min in providing, and helping her locate appropriate participants for this study through our program.

As the Director of the Columbus Urban League’s African American Male Initiative (AAMI) program I can attest to the necessity and importance of this particular research going forth. Our AAMI program seeks to empower African-American males to help reduce contact with the criminal justice system, increase physical health, and improve connections with children and families. A significant effort underlying each of these areas is the assurance that the mental health needs of our program participants, are being served in a manner equivalent to their needs. I feel that Ms. Mu’min’s proposed project has great potential to have a quality impact on the African American male populations of whom we serve in this way. Furthermore, a study of this importance will contribute greatly to our current in-depth knowledge and awareness of the psychological impact and needs of the African American men that we serve in our community. I am confident that a project such as this will be successful on multiple levels.

Thank you for your time to review my letter of support. If you have any further questions please contact me using the information listed above.

Sincerely,

Glenn A. Harris
Director - AAMI
African American Male Initiative
Columbus Urban League
788 Mt. Vernon Ave
Columbus, Ohio 43203
O: 614.372.2341
F: 614.257.6327
GHarris@Cul.org
APPENDIX E: MENTAL HEALTH INDEX DESCRIPTIVES TABLE

Table 5

*Mental Health Index (MHI) and Subscale Scores*

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# APPENDIX F: COEFFICIENTS TABLE

Table 6

*Coefficients Table*

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a. Dependent Variable: MHITotal
APPENDIX G: RESILIENCE SCALE SCREE PLOT AND ROTATED COMPONENT MATRIX

Resilience Scale Rotated Component Matrix

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<th>Rotated Component Matrix&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Component 1</th>
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<tbody>
<tr>
<td>Can Get Thru Difficult Times</td>
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<td>Like Before</td>
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<td>Can Look at a Situation a</td>
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<td>Number of Ways</td>
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<sup>a</sup> Component 1 and Component 2 are the rotated components resulting from the principal component analysis.
| Keeping Interested in Things is Important | .697 | .340 |
| My Life Has Meaning | .672 | .342 |
| Can Be On Own If Have To | .668 | -.119 |
| When in Difficult Situation, Can Usually Find Way Out | .659 | .467 |
| In ER People Can Rely on Me | .642 | .299 |
| Can Handle Many Things at a Time | .620 | .314 |
| Usually Take Things in Stride | .565 | .562 |
| Take Things One Day at a Time | .394 | .152 |
| Am Friends With Myself | .432 | .734 |
| Can Find Something to Laugh About | .364 | .703 |
| Dont Dwell on Things Cant Do Anything About | .014 | .653 |
| I Keep Interested in Things | .544 | .614 |
| I Have Self Discipline | .499 | .595 |
| I Am Determined | .386 | .583 |
| Proud Have Accompl Things in Life | .401 | .557 |
| Make and Follow Thru with Plans | .473 | .535 |
| Enough Energy yo Do What I Have To | .409 | .522 |
| Belief in Self Gets Thru Hard Times | .404 | .485 |
| Its Okay if People Dont Like Me | .477 | .483 |
| Depend on Self More Than Anyone Else | .392 | .461 |
| Seldom Wonder What the Point of it All Is | -.136 | .427 |

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.

a. Rotation converged in 3 iterations.
APPENDIX H: RIAS-B SCREE PLOT AND ROTATED COMPONENT MATRIX

### Scree Plot

![Scree Plot Image]

RIAS-B Rotated Component Matrix

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<tr>
<th>Rotated Component Matrix$^a$</th>
<th>Component 1</th>
<th>Component 2</th>
<th>Component 3</th>
<th>Component 4</th>
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<td>Limit Myself to Black Activities</td>
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<td>Blks Should Think and Express Like Whites</td>
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<td>Whites Look &amp; Express Self Better than Blacks</td>
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<td>Speak Mind Regardless of Consequences</td>
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<td>Reading Black Literature</td>
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<td>World Interpret Black or Afrocentric View</td>
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<td>White People Can't Be Trusted</td>
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<td>Overwhelming Attachment to Blacks</td>
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<td>Use Slang Words to Refer to Whites</td>
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<td>Increasing Involv in Blk Activities</td>
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<td>Determined to Find My Black Identity</td>
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<td>Identity Revolves Around Being Black in this Country</td>
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<td>I Know What Being Black Means</td>
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<td>Changing Lifestyle to Fit Beliefs About Blacks</td>
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<td>Invlv in Blk Political Social Activities</td>
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<td>Being Black Feels Natural To Me</td>
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<td>Whites Superior &amp; Inferior to Whites</td>
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<td>I Participate in Black Culture</td>
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<td>.588</td>
<td>.171</td>
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<td>Often Feel Belonging to Black</td>
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<td>Most Blacks I Know Are Failures</td>
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<td>Like to Make Friends with Black People</td>
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<td>Whites More Intelligent than Black</td>
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<td>Persons Race Positive Aspect</td>
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<td>Blacks Can be Close Friends With White</td>
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<td>Social Political Groups Even Without Other Blacks</td>
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<td>All People Have Strengths and Limitations</td>
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<td>Black Stranger Embarassing I am Embarrassed</td>
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<td>Anxious Compared to Others of My race</td>
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<td>Positive Attitude because I'm Black</td>
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<td>Being Black is Positive Experience</td>
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<td>Feel Good About Being Black Don't Limit Self</td>
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<td>Often Embarassed Things Feel About Black Group</td>
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<td>Excitement and Joy in Black Surroundings</td>
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<td>Blacks Don't Achieve Have Self to Blame</td>
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<td>Persons Race is No Influence</td>
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<tr>
<td>I am Satisfied with Myself</td>
<td>-.066</td>
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Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.

a. Rotation converged in 8 iterations.
### APPENDIX I: MHI SCREE PLOT AND ROTATED COMPONENT MATRIX

#### Scree Plot

![Scree Plot Image]

#### MHI Rotated Component Matrix

<table>
<thead>
<tr>
<th>Rotated Component Matrix(^a)</th>
<th>Component</th>
<th>1</th>
<th>2</th>
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<tbody>
<tr>
<td></td>
<td></td>
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<tr>
<td>Been Anxious or Worried</td>
<td>.769</td>
<td>-.297</td>
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<tr>
<td>Get Rattled, Upset, or</td>
<td>.754</td>
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<tr>
<td>Flustered</td>
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<tr>
<td>Felt Restless, Fidgety, or</td>
<td>.723</td>
<td>-.279</td>
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<td>Impatient</td>
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<tr>
<td>How Often Become Nervous</td>
<td>.693</td>
<td>-.014</td>
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<tr>
<td>Bothered by Nervousness or Nerves</td>
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<tr>
<td>Felt Like Crying</td>
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<tr>
<td>Feeling</td>
<td>Score 1</td>
<td>Score 2</td>
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<tr>
<td>----------------------------------------------</td>
<td>---------</td>
<td>---------</td>
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<tr>
<td>Felt So Down Nothing Could Cheer You Up</td>
<td>.651</td>
<td>-.351</td>
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<tr>
<td>Felt Tense or High Strung</td>
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<tr>
<td>Difficulty Trying to Calm Down</td>
<td>.638</td>
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<tr>
<td>Felt Depressed</td>
<td>.633</td>
<td>-.414</td>
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<td>Losing Mind, Control over Act Think Feel Memory</td>
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<td>Been in Low or Very Low Spirits</td>
<td>.605</td>
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<td>Been Moody or Brooded About Things</td>
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<tr>
<td>Felt Downhearted and Blue</td>
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<tr>
<td>Been Under Felt Under Strain Stress Pressure</td>
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<td>Been a Very Nervous Person</td>
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<tr>
<td>Feel Had Nothing to Look Forward To</td>
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<td>Nothing Turned Out the Way You Wanted</td>
<td>.468</td>
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<td>In Firm Control, Behavior, Thoughts, Emotions, Feelings</td>
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<td>-.409</td>
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<tr>
<td>Able to Relax without Difficulty</td>
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<td>-.399</td>
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<td>Hands Shake When Trying to do Something</td>
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<td>Ever Felt Like Taking Your Own Life</td>
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<td>Table Manners at Home as When Out to Dinner</td>
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<td>Done, Sexual Nature that Society Doesnt Approve</td>
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<td>-.042</td>
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<td>Generally Enjoyed Things</td>
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<td>Relationships, Loving Being Loved Full &amp; Complete</td>
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<td>.721</td>
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<td>Item</td>
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<td>----------------------------------------------------------------------</td>
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<tr>
<td>Living Been A Wonderful Adventure</td>
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<td>Expect to Have an Interesting Day</td>
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<td>Were a Happy Person</td>
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<tr>
<td>Felt Loved &amp; Wanted</td>
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<tr>
<td>Life Full of Things of Interest</td>
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<td>How Happy</td>
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<tr>
<td>Relaxed Free of Tension</td>
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<tr>
<td>Waking Up Feeling Fresh &amp; Rested</td>
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<tr>
<td>Felt Calm &amp; Peaceful</td>
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<td>Felt Cheerful, Light Hearted</td>
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<td>How Much Time</td>
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<td>Felt Emotionally Stable</td>
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<td>Felt Furture Looks Hopeful</td>
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<td>Friends, Important Race, Religion, Political Beliefs</td>
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<td>Felt Others would Be Better Off if You Were Dead</td>
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<td>Morals Have Been Above Reproach</td>
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<tr>
<td>How Often Eat Too Much</td>
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<td>In life, Felt You Acted Like a Coward</td>
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<td>If Convenient, How Often Will You Tell a Lie</td>
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<td>Give Every Penny You Can to Charity</td>
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Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.
a. Rotation converged in 3 iterations.
APPENDIX J: INFORMED CONSENT

Ohio University Consent Form

Title of Research: Racial Identity and Resilience as Predictors of the Psychological Health of African American Men
Researchers: Ms. Ameena Mu'min

You are being asked to participate in research. For you to be able to decide whether you want to participate in this project, you should understand what the project is about, as well as the possible risks and benefits in order to make an informed decision. This process is known as informed consent. This form describes the purpose, procedures, possible benefits, and risks. It also explains how your personal information will be used and protected. Once you have read this form and your questions about the study are answered, you will be asked to sign it. This will allow your participation in this study. You should receive a copy of this document to take with you.

Explanation of Study
The objective of this study is to explore the impact of racial identity attitudes and resilience on the psychological health of African American men. For example, how much does your connection to your own race and your ability to overcome challenges you have experienced in your life, impact your overall mental health? You will be asked to complete a series of questionnaires that will take approximately 45 minutes.

Risks and Discomforts
There are no risks or discomforts anticipated.

Benefits
This study will benefit society by informing professionals who engage in work with diverse populations of African American men. In addition, a study assessing the combined impact of racial identity attitudes and the ability to overcome life's challenges on the psychological health of African American men has not been accomplished before.

Confidentiality and Records
You will be provided a questionnaire packet with a pre-assigned code. This code is not used to identify you in any way as a participant of this study, and is only used to help the researcher identify various materials.

Additionally, while every effort will be made to keep your study-related information confidential, there may be circumstances where this information must be shared with:
* Federal agencies, for example the Office of Human Research Protections, whose responsibility is to protect human subjects in research;
* Representatives of Ohio University (OU), including the Institutional Review Board, a committee that oversees the research at OU.

Compensation
For your participation in this study you will have the opportunity to collect a $25 gift card. Your approximate odds of winning are 1 in 30. Even if you chose not to participate your name can still be entered into the drawing.

Contact Information
If you have any questions regarding this study, please contact Dr. Yegan Pillay, PhD at 740.593.0427.

Office of Research Compliance

Rev. 05/2008
If you have any questions regarding your rights as a research participant, please contact Jo Ellen Sherow, Director of Research Compliance, Ohio University, (740)593-0664.

By signing below, you are agreeing that:
- you have read this consent form (or it has been read to you) and have been given the opportunity to ask questions
- known risks to you have been explained to your satisfaction.
- you understand Ohio University has no policy or plan to pay for any injuries you might receive as a result of participating in this research protocol
- you are 18 years of age or older
- your participation in this research is given voluntarily
- you may change your mind and stop participation at any time without penalty or loss of any benefits to which you may otherwise be entitled.

Signature________________________________________ Date________________

Printed Name______________________________________

Version Date: [insert mm/dd/yy]