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Intersecting Inequalities: Exploring the Relationship between Subjective Social Status, Intersections of Racism and Sexism, and the Health Status of Black Women in Philadelphia

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Dedications

I would like to dedicate this work to all of the women who participated in the focus groups and surveys. Thank you for your time and willingness to share your strengths, vulnerabilities, pain, challenges and visions for a healthier future with me. Although I am saddened by the depth of discrimination experienced, I am also encouraged by your hope and belief that we can make a difference. You are all such amazing women. This work is a reflection of your varied experiences and their contribution to the health and wellness of Black women.

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Abstract

Socioeconomic status (SES) is commonly used to assess social status and is a key determinant of health outcomes (Adler et al., 1994; Adler & Ostrove, 1999; Williams & Collins, 1995). However, there are limitations to the objective assessment of SES using (income, education or occupation) (Braveman et al., 2005; Krieger, Rowley, Herman, & Avery, 1993). SES does not typically take into account institutional racism and sexism that creates differences in the social status gained by one's education, income or occupation (Krieger, et al., 1993). Subjective social status (SSS), people's perceptions of their social standing in comparison to others may capture more subtle aspects of SES, and reflect individuals' perceptions of inequalities such as racism and sexism (Ghaed & Gallo, 2007; Lundberg & Kristenson, 2008; Singh-Manoux, Adler, & Marmot, 2003). Thus, SSS may be useful in exploring the role of social status in the disparate health of Black women. This study is one of the first to use an intersectionality framework of racism and sexism to explore the perception of SSS in 200 Black women between the ages of 18 – 70 (M= 43, SD= 12.8) as well as the role of SSS in their self reported health. Using a sample of adult Black women in Philadelphia the study used questionnaires and focus groups to investigate how Black women: (1) perceive and experience their social status (SSS); (2) experience and make meaning of racism, sexism and the intersection of racism and sexism; and (3) conceptualize experiences and perceptions of racism and sexism in their subjective social status, and in turn their self-reported health status.

The women in the focus groups discussed several themes including: 1) the intersectional nature of racism and sexism; 2) discrimination based on intersectional racism and sexism in healthcare; and 3) contributors to subjective social status. They provided examples of how intersectional experiences of racism and sexism influenced their health. There was a positive correlation between SSS and self reported health status but there was no association between SES and health status. These findings support the role of subjective social status in the health of Black women.

Chapter 1: Introduction

Social inequalities have long been associated with increased morbidity and mortality among populations in the U.S., especially racial and ethnic minorities (Du Bois, 1899; Fiscella & Williams, 2004; Jemal, Ward, Anderson, Murray, & Thun, 2008; Krieger, et al., 1993; Michael Marmot, 2001a, 2001b; Michael Marmot, Shipley, Brunner, & Hemingway, 2001; M Marmot & Wilkinson, 2006; Nettleton, 2006; B. Smedley, Stith, & Nelson, 2002). Gaps remain in research regarding the specific ways in which inequalities in social status influence health, particularly among racial minorities such as Black women (Karlsen & Nazroo, 2002; Krieger, et al., 1993). Black[1] women have disproportionately high rates of morbidity and mortality compared to White women (Cozier, 2006; Krieger & Sidney, 1996; Lillie-Blanton, Martinez, Taylor, & Robinson, 2005). Significant gaps in life expectancy exist and Black women have some of the lowest life expectancies of all women in the US (Murray, Kulkarni, Michaud, Tomijima, & Bulzacchelli, 2006). Such disparities may be a result of structural inequalities such as racism and sexism and ideologies of discrimination based on race and sex. Moreover, theoretical and empirical research suggests that Black women are influenced by both racism and sexism and that it is impossible to separate the effects of racism and sexism on Black women (Collins, 1989, 2004; Crenshaw, 1989, 1991; Guy-Sheftall, 1995). This is a core component of intersectionality theory and underscores the importance of

[1] The term Black will be used in this proposed study to reflect the historical social, cultural, and political experiences of women of African descent in the U.S. regardless of nationality.

considering both racism and sexism in studies with Black women (Collins, 1989; Crenshaw, 1989, 1994; Segal & Martinez, 2007; Weber & Parra-Medina, 2003).

Socioeconomic status (SES) is commonly used to assess social status and is a key determinant of health outcomes (Adler, et al., 1994; Adler et al., 2008; Krieger, et al., 1993; Singh & Yu, 1996; Williams & Collins, 1995; Winkleby, Jatulis, Frank, & Fortmann, 1992). However, the positive health benefit of increasing social status as assessed through income, education and occupation experienced by Whites seems to provide less of a benefit to Black women (Farmer & Ferraro, 2005; Krieger, et al., 1993). Additionally, inconsistencies in the established SES and health relationship (increasing SES leads to increasing health status) are found when multiple social factors such as race, gender and SES are considered. Such inconsistencies reflect the complex relationships between these social determinants of health (Jackson & WillIams, 2006; LaVeist, 2002). For instance, some Latino and Asian groups have a high health status despite their SES, immigration and histories of discrimination in the US (Jackson & WillIams, 2006). Moreover, many Black women have a disproportionately low health status despite their SES (Farmer & Ferraro, 2005). These intersectionality paradoxes suggest that race, class, gender and other social factors intersect to create new experiences for individuals that may protect or undermine (as in the case of Black women) their health progress (Jackson & WillIams, 2006; LaVeist, 2005, 2002).

There are limitations to the objective assessment of SES through income, education or occupation (Braveman, et al., 2005; Krieger, et al., 1993). Thus, the role of

social status in the health status of Black women remains both underexplored and unclear. Subjective social status (SSS) is defined as people's perceptions of their social standing in comparison to others. It may capture more subtle aspects of SES, such as why affluent Blacks are more likely than affluent Whites to live in lower income neighborhoods (Morello, 2011). It may also reflect individuals' perceptions of inequalities such as racism and sexism and include components of self esteem and locus of control (Adler, Epel, Castellazzo, & Ickovics, 2000; Archana, Adler, & Marmot, 2003; Singh-Manoux, et al., 2003). For instance, studies have shown that the 'economic return' of educational achievement is lower for Blacks compared to Whites as well as women compared to men in each racial group, reflecting the limitations of SES (Krieger, et al., 1993). SSS may be useful in exploring the role of social status in the disparate health of Black women. This dissertation explored subjective perceptions of social status in Black women, how perceptions of racism and sexism influence their subjective social status, and the role of subjective social status in the self reported health status of Black women.

Objective Socioeconomic Status & Health

Socioeconomic status (SES) is an integral component of health. SES reflects a composite of various assessments of social standing which most traditionally include income, educational attainment, and work status; often assessed as income, education and occupation (Adler, et al., 1994; Braveman, et al., 2005; Krieger, et al., 1993; Winkleby, et al., 1992). SES represents levels of social stratification within a society

(Adler & Ostrove, 1999), is a key determinant of health outcomes such as high blood pressure, and diabetes (Brummett et al., 2011; CDC, 2002, 2007; Lam, 2011; Lehman, Taylor, Kiefe, & Seeman, 2005; Mensah, Mokdad, Ford, Greenlund, & Croft, 2005; Robbins, 2001; Saydah & Lochner, 2010; Wilson, Kliewer, Plybon, & Sica, 2000), and has been associated with mortality as well as morbidity rates for both Black and White Americans in numerous studies (Adler, et al., 1994; Adler, et al., 2008; Cohen, Doyle, & Baum, 2006; Fiscella & Williams, 2004; Lehman, et al., 2005; Michael Marmot, 2001a, 2001b; Ostrove, Adler, Kuppermann, & Washington, 2000). SES influences health by shaping one's exposure to physical and social environments, access to resources and support, knowledge, money, prestige and beneficial social connections (Adler, et al., 1994; Phelan, Link, & Tehranifar, 2010). Thus as a cause of health inequalities, SES influences multiple diseases, risk factors, access to care and other resources used to avoid risk or effectively manage disease (Phelan, et al., 2010).

Numerous studies have reported negative health outcomes associated with low SES. Such outcomes include lower life expectancy and increased morbidity and mortality, with the highest risk among people who are poor (Adler, et al., 2000; Krieger, 1999; N. Oliver, 2005; Sacker, Bartley, Firth, & Fitzpatrick, 2001; Seeman & Crimmins, 2001; Williams & Collins, 1995). In fact, one explanation for the existing disparities in health is that Blacks are disproportionately represented among the poor with Black women (26.5%) more likely to live in poverty compared with both White women (11.6%) and Black (22.3%) and White men (9.4%) (DeNavas-Walt, Proctor, & Smith,

2011; US Census Bureau, 2008). Moreover, the poverty rate of White Americans in 2010 was 13.0% compared to 27.4% for Black Americans (DeNavas-Walt, et al., 2011). Nevertheless, the association between SES and health is not solely observed between poor and wealthy groups as one might expect, but differences persist at higher levels of SES as well (Adler, et al., 1994; Krieger, et al., 1993; Michael Marmot, et al., 2001; Michael Marmot et al., 1991; Seeman & Crimmins, 2001). This is known as the social gradient of health (Adler, et al., 1994). SES is not only important for individuals in poverty but it is also important for individuals at all SES levels. As SES increases, health status also improves, such that the health of upper SES people is superior to that of middle SES people (Adler, et al., 1994; Adler & Ostrove, 1999). For instance, Jemal and colleagues (2008) in their analysis of national data of the seven leading causes of death by educational level found a linear relationship between death rates and educational level for Blacks and Whites between the ages of 25-64 in the US. Instead of observing a plateau indicating a minimal change in death rates among Black and White Americans once reaching a certain educational level, educational level continues to influence death rates at all levels of education suggesting a social gradient of health (Jemal, et al., 2008). That is, there were observed differences even among higher educational groups such as between those with bachelor and graduate degrees. Moreover, it is important to consider the intersection of race, sex and SES. Although, death rates decreased as educational level increased, Black men had higher death rates compared to White men and Black women had higher death rates compared to White women despite educational achievement in all groups (Jemal, et al., 2008). These findings continue to

support an intersectional paradox in that increasing SES provides less of a health benefit for Black men and women than it does for White men and women.

Also, morbidity rates for conditions such as osteoarthritis, hypertension, cervical cancer, and other chronic diseases are associated with SES. The higher one's SES (e.g,. income), in general, the lower the prevalence of disease (Adler, et al., 1994). However, Krieger and colleagues (2010) in their study of declining breast cancer rates after the Women's Health Initiative (WHI) only found a decrease in the incidence of breast cancer in affluent white women with estrogen positive tumors, indicating that the changes in health care practices as a result of the WHI were not equally beneficial for all women or even all affluent women with estrogen positive tumors (Krieger, 2010). These relationships present an interesting problem because while it is known that SES influences health through lack of access to resources such as medical care, housing, and nutrition (Adler, et al., 1994; Mays, Coleman, & Jackson, 1996; Sacker, et al., 2001; Williams & Collins, 1995), these factors alone, do not account for the differences between those with the highest SES and those just below them as well as differences between those of different racial and ethnic groups within the same SES categories (Adler, et al., 1994; Michael Marmot, et al., 1991). For example, access to resources cannot account for differences in health outcomes between those making $100,000 per year and those making $200,000 per year, yet such differences have been found (Adler, et al., 1994). Both groups have adequate access to resources. Such differences between these groups suggest that there are other components of objective SES, such as a sense

of control over one's life and self esteem, that influence health and have yet to be determined (Adler, et al., 1994; Archana, et al., 2003; Kopp, Skrabski, Rethelyi, Kawachi, & Adler, 2004; Singh-Manoux, et al., 2003). Moreover, differences associated with the intersection of race and other social factors may influence how one is able to access or use one's resources. Lastly, the intersectional paradox in which some racial and ethnic groups such as Mexican Americans have improved health status despite lower SES and experiences of discrimination further complicates the understanding of these relationships (Franzini, Ribble, & Keddie, 2001; Gould, Madan, Qin, & Chavez, 2003; Jackson & WillIams, 2006; LaVeist, 2002). This intersectional paradox represents an important gap in research exploring the role of social status in health.

In addition Farmer and Ferraro (2005) in their analysis of a 20 year cohort of White and Black adults found that Black adults reported higher rates of illness and poorer self rated health among all employment groups compared with White adults and that racial gaps in self rated health were actually largest among those with the highest incomes (Farmer & Ferraro, 2005). Moreover, while White women had the highest prevalence of heart disease, Black women experienced the greatest mortality from heart disease compared with White women (U.S. Department of Health and Human Services & Health Resources Services Administration (HRSA), 2007). Black women also have increased infant mortality rates compared with White women at every level of education. In fact, White women who did not complete high school have a lower infant mortality rate than Black women who graduated from college (Williams, 2008). Thus,

Black women with higher education have poorer health outcomes (infant mortality in the example above) than White women of a lower SES status. This provides another example of the intersectionality paradox (Jackson & WillIams, 2006).

Thus, it is important to consider the role of both interpersonal and institutional racism and sexism on health and that there are other variables, (such as perceptions of racism and sexism, locus of control, and self esteem), that have been proposed by some of the preliminary SSS research, which may limit the influence of higher SES status on health outcomes for Black women (Adler, et al., 2000; E. Goodman, Huang, Schafer-Kalkhoff, & Adler, 2007; Singh-Manoux, et al., 2003). This underscores the importance of the findings of the unequal treatment Institute of Medicine Report (2002) that concluded that disparities in health based on race/ethnicity persisted even after analyses adjusted for SES. Clearly there are other variables such as those listed above (perceptions of racism and sexism, locus of control and self esteem) that influence health and contribute to disparities. Thus gaps remain in our understanding of SES and how it influences the health of Black adults in general, and in particular Black women.

Moreover, there are limitations to the assessment of SES using the objective measures of income, education or occupation (Krieger, et al., 1993). For instance, educational level attained does not completely predict work status or income level received (Adler, et al., 1994). Black and White women and men with the same educational attainment may have very different yields for their achievement due to the quality of education received and available opportunities. According to the National

Center for Education Statistics (2005) for all racial/ethnic groups, men typically had higher median incomes earned for each level of educational achievement. For instance, as represented in Table 1 below, in considering those with less than a high school diploma, men earned more annually than women (KewalRamani, Gilbertson, Fox, & Provasnik, 2007). Similarly, White men with less than a high school diploma earned more annually than Black men and Black and White women with less than a high school diploma (KewalRamani, et al., 2007). Thus, using a Black/ White comparison, Black women earn less than White women and men of all ethnicities due to structural inequalities such as the intersection of racism and sexism.

Furthermore, in considering those with graduate degrees, White men earned more than Black men and White women earned more than Black women (Table 1) (KewalRamani, et al., 2007). Again, this illustrates the role of structural inequalities such as racism and sexism in gender and race/ ethnic disparities in average annual income earned by highest educational level achieved. Thus, Black women may receive the lowest average annual income because of experiences of intersecting inequalities such as racism and sexism.

Table 1. Average Annual Earnings for Highest Level of Education Achieved for Black & White Men and Women, National Center for Education Statistics, 2005 (KewalRamani, et al., 2007).

	< High School Diploma	**Graduate Degree**
Men		
White Men	$30,000	$80,000
Black Men	$23,000	$61,000
Women		
White Women	$20,800	$53,500
Black Women	$18,700	$52,000

Income measures may not adequately reflect the economic resources available and the utility of those resources may vary greatly for individuals (Adler, et al., 2008; Braveman, et al., 2005; Michael Marmot, 2001a). For instance, discrimination in mortgage lending based on race provides less opportunities for home ownership to Blacks regardless of their income (M. Oliver & Shapiro, 2006). So a Black woman who earns $100,000 annually may not live in the same type of environment as a White woman who earns that same amount annually due to discriminatory practices. In addition, Black women's perceptions of their status as based on income may vary considerably from their actual status (Wyche, 1996). That is, Black women who are

affluent or upper class may be more likely to consider themselves to be middle class despite their higher incomes (Wyche, 1996). Potential contributing factors could include the vulnerabilities and challenges Black women face despite their increasing status. Although Black women have increased their status based on traditional measures of education, income or occupation, many have very low or no wealth (Chang et al., 2010). This self perception of status may play a role in disparate health status even among those with higher status by influencing lifestyle and behavioral factors that promote health. That is, self perception may influence perceptions of opportunities for health promotion that others with a higher status may be more likely to adopt. Lastly occupation, as an assessment of SES is also problematic due to the great variation between similar jobs in different occupations (Adler, et al., 2008; Braveman, et al., 2005; Winkleby, et al., 1992). For example, an administrative assistant at a nonprofit organization is likely to have a very different status and income compared with an administrative assistant in a major law firm.

An additional limitation of the current SES framework is its failure to consider differences in how racial/ethnic groups may subjectively experience SES. Many studies often assume that SES as a variable has the same meaning for all racial/ethnic subgroups (E. Goodman, et al., 2007). But, each of the components of SES -- income, occupation and education -- may be influenced by experiences of institutional racism and sexism (Williams, 1999). For example, White women, racial/ethnic minorities and

racial/ethnic minority women may be discouraged from taking certain advanced classes in school and from pursuing careers in math and science.

Objective measures of SES intersect with race to influence the meaning and contribution of each SES indicator to the lives of Black adults (e.g., Blacks earn less for each level of education received compared with Whites). Objective SES does not take into account institutional racism or sexism, nor does it address how one's perceptions of discrimination and inequality based on race and sex influence these objective indicators. That is, objective SES indicators do not include any assessment of perception of status and how such perceptions may influence the relationship between SES and health. For example, a Black woman's perception of her low SES status may influence the types of jobs that she perceives to be available to her and that she pursues. She may be more likely to pursue jobs that may not be representative of her education and level of experience. Thus, even though she has a higher level of education (SES) she may not experience the benefit that others do (improved health status).

Differences in health outcomes remain between Black women with a high SES and their White female counterparts (Farmer & Ferraro, 2005). The increase in social status through income and education in particular does not provide the same level of protection and health benefit as it does for White women. Thus, in order to better reflect the realities of Black women's lives, research exploring the relationship between SES and health must consider experiences at the intersection of racism and sexism (Williams, 1999). For example, Black woman continue to have some of the highest

rates of infant mortality compared to White, Latino and Asian women (Philadelphia Department of Public Health, MCFH, 2009) reflecting individual and structural inequalities rooted in the intersections of racism and sexism. Thus, research that defines SES solely in terms of income, education, or occupation is limited because it often fails to address how racism and sexism intersect in the lives of groups such as Black women. Therefore, this dissertation explored the role of subjective social status in the self reported health status of Black women as well as how racism and sexism intersect to influence how Black women subjectively experience their social status.

Although most of the top leading causes of death in the US are similar for Black women as compared to White women and Black and White men (and others), Black women continue to be disproportionately affected by several of these health conditions (see Appendix 1) (CDC, 2008; National Center for Injury Prevention and Control, 2006). In 2008, for example, 63.7% of Black women reported a diagnosis of diabetes compared to 49.1% of White women (U.S. Department of Health and Human Services & Health Resources Services Administration (HRSA), 2011). Black women similarly experienced increased rates of hypertension with a rate of 354 (per 1,000) compared with 265 for White women and 200 for Latina women (HRSA, 2007). Moreover, most recent data indicate that 39.4% of Black women have hypertension compared to 31.3% of White women and 19.9% of Latina women (U.S. Department of Health and Human Services & Health Resources Services Administration (HRSA), 2011). Of women living with HIV/AIDS, Black women accounted for 57% in 2009 and HIV is one of the top 10 leading

causes of death for Black women between the ages of 15 – 64, ranging from the 3rd leading cause of death for Black women between the ages of 35-44 to the 10th leading cause of death for Black women between the ages of 55-64 (CDC, 2011; National Center for Injury Prevention and Control, 2006).

In addition, although White women had the highest incidence of breast cancer, Black women have the highest mortality rates from breast cancer compared with White, Latina, Asian, Pacific Islander, American Indian and Alaskan native women (NCI, 2008). Moreover, Krieger and colleagues (2010) in their study of declining breast cancer rates after the Women's Health Initiative (WHI) found a decrease in the incidence of breast cancer only in affluent White women with estrogen positive tumors, indicating that the changes in health care practices as a result of the WHI were not equally beneficial for all women or even all affluent women with estrogen positive tumors (Krieger, 2010). Disparities in access to care and barriers to early detection, screening and optimal treatment are among the contributors of the increased mortality rate of breast cancer in Black women of all economic backgrounds (NCI, 2008). Experiences of racism and sexism also intersect to deny Black women the same access to prevention and treatment that many White women have (Brondolo, Gallo, & Myers, 2009). Continued exposure to structural inequalities such as racism and sexism may disproportionately expose groups such as Black women to various health risks and thereby influence observed disparities in health. This is the premise of embodiment theory (Krieger, 2001).

Krieger (2001) describes embodiment as the process by which people incorporate their social experience as part of their physiology. That is, experiences of racism and sexism for Black women for example can lead to an increase in the prevalence of high blood pressure experienced by the group as a result of chronic exposure to these stressors. Thus, social pathways of embodiment may include chronic exposure to racism and sexism that influence how individuals are able to relate to their environments as well as their exposure to risk and protective factors (Krieger, 2005). Krieger (1999, 2001) also describes the influence of discrimination in chronically triggering the 'flight or fight' mechanism and provides evidence that experiences of racism and sexism can lead to adverse physiological changes (Chin, 2010; Krieger, 1999, 2001). Other theories such as those on allostatic load also describe how the chronic activation of the stress response can lead to physiological changes that can result in disparate health outcomes for groups such as Black women (Barr, 2008; McEwen & Seeman, 1999).

Allostatic load is the physiological consequence of the chronic activation of the stress response (Barr, 2008; McEwen & Seeman, 1999). The chronic activation of the stress hormones cortisol and epinephrine has damaging effects on the body (Barr, 2008; McEwen & Seeman, 1999). Research on allostatic load suggests that cumulative exposure to adverse environments and stressors are associated with cumulative physiological risks and the inefficient regulation of physiological systems which can lead to poor health outcomes such as cardiovascular disease (McEwen & Seeman, 1999;

Nielsen & Seeman, 2007). Thus Black women's chronic exposure to racism and sexism may lead to the chronic activation of the stress response which, in turn, may lead to disparate health outcomes due to the cumulative exposure of their overtaxed physiological systems (Chin, 2010; Clark, Anderson, Clark, & Williams, 1999; Lekan, 2009). However, due to the longitudinal studies needed for a rigorous assessment of embodiment and allostatic load as well as the biological samples needed for study (e.g., taking blood samples to test for cortisol), an analysis of the role of embodiment and allostatic load is beyond the scope of this research.

In an attempt to address the significant health disparities in Black women it is essential that public health researchers revisit limitations in the current SES frameworks as well as adopt new models to enhance understanding of how social status is associated with the health of Black women. SES concepts are not well researched in US Public Health systems and the limitations that exist in the current framework such as the failure to acknowledge the role of social inequalities in traditional SES metrics as well as differences in how the traditional SES indicators (income, education and occupation) are experienced by racial/ethnic subgroups based on inequality and discrimination are not often addressed (Krieger, et al., 1993). Black women die at increased rates compared to White women at every income level (Barr, 2008). Thus, it is not enough to assume that improvements in social status will lead to improved health outcomes. Indeed the data presented by Farmer and Ferraro (2005) regarding the persisting disparities in health status despite higher SES above argue against this

(Farmer & Ferraro, 2005). It is clear that other factors such as those that explore the meaning of these intersections in the creation and maintenance of these disparities should be considered in discussions about health disparities. Accordingly, this dissertation explored how Black women perceive, experience and make meaning of racism, sexism and the intersection of racism and sexism.

Barr (2008) argues that perceptions of control over one's life (locus of control) significantly contribute to health and wellness (Barr, 2008). Locus of control represents the degree to which individuals attribute outcomes to be a consequence of their behavior or within their control (S. Goodman, Cooley, Sewell, & Leavitt, 1994). Individuals with an internal locus of control believe that outcomes are associated with their own behaviors or actions (within their control) and individuals with an external locus of control believe that outcomes are associated with chance or powerful others (not within their control) (S. Goodman, et al., 1994; Lefcourt, 1982; Wenzel, 1993). External locus of control has been associated with a perceived lack of control over circumstances as well as a decrease in behaviors associated with reaching goals (S. Goodman, et al., 1994).

African Americans as well as lower income adults are more likely to have an external locus of control due to experiences of poverty and racial discrimination (S. Goodman, et al., 1994; Wenzel, 1993). Research suggests that perceptions of control, particularly over adverse situations can reduce psychological distress in individuals (Lefcourt, 1982). In fact situations or stimuli that cause pain have been shown to have

less of an impact on individuals who believe they have a level of control over the situation (Lefcourt, 1982). But, perceptions of a lack of control, particularly over valued outcomes, may lead to the acceptance of adverse situations (Lefcourt, 1982). However, the racial characteristics of many of the early study populations were not reported and limited research exists about locus of control in Black women.

Early research on locus of control theorized that individuals' reactions to adverse situations are determined by perceptions of control and ability to cope (Lefcourt, 1982; Rotter, 1966). Therefore, perceptions of control seem to play an important role in individual responses to adverse situations (Lefcourt, 1982). Thus a Black woman with more experiences and perceptions of racism and sexism may perceive a lack of control over her ability to access optimal care, healthy foods, housing and other social and environmental factors that promote health. Moreover, such perceptions, which may influence subjective SES, may play a role in health status despite one's actual status (SES) or ability to control access to health promoting factors.

Thus, research is needed to explore how these variables (perception of status, self esteem, and locus of control) influence health. A model exploring subjective social status may provide useful information regarding important contributors to the disparate health outcomes of Black women. To this end, this dissertation explored the role of subjective social status in the health of Black women.

Subjective Social Status

Subjective social status (SSS) involves people's perceptions of their social standing in comparison to others including their current economic and social situation, socioeconomic characteristics, and perceptions of future opportunities for economic and social advancement (Ghaed & Gallo, 2007; Lundberg & Kristenson, 2008; Singh-Manoux, et al., 2003). SSS captures more subtle aspects of SES (Operario, Adler, & Williams, 2004) such as people's subjective feelings and perceptions of social status in society as well as their communities (Ghaed & Gallo, 2007; Gruenewald, Kemeny, & Aziz, 2006; Reitzel et al., 2007). SSS may better reflect the utility of SES, that is how people can use their education, income and occupation to achieve their desires and overall well being (Adler, et al., 2008; Ghaed & Gallo, 2007). For example, a White woman with a doctorate degree may have a lifestyle that is representative of a more affluent social status, while a Black woman with a doctorate degree may have a lifestyle that is more representative of the middle class. SSS also reflects individuals' perceptions of inequalities such as racism and sexism that may in turn influence their feelings of shame, inferiority and stress (Ghaed & Gallo, 2007; Lundberg & Kristenson, 2008; Reitzel, et al., 2007; Smith, 1999).

Feelings of inferiority and stress may influence health behaviors and practices such as whether and when to access care. For instance, Black women, due to the intersections of racism and sexism may choose not to access care based on previous negative experiences, perceptions of discrimination or stories of discrimination

experienced by others, perceptions or experiences of inadequate care and biases and stereotypes about Black women that influence interactions with healthcare providers.

Lastly, SSS reflects individuals' membership and social standing within groups to which they may belong and more importantly find value in such as churches and community organizations (Ghaed & Gallo, 2007; Reitzel, et al., 2007). While improvements in SES are more dramatically linked to improved health outcomes in White adults (Farmer & Ferraro, 2005), social standing in groups such as church and community organizations may provide more protection for Black women by enhancing efficacy and perception of control over their lives. For example, a Black woman who by objective standards may have a low social status but who is a leader in her church may in fact perceive herself to be of higher status subjectively because of her position of importance in an organization that both she and her community of reference value. Therefore, for groups such as Black women, SSS may be a more direct and culturally relevant assessment of social standing beyond the objective components captured by SES traditionally (Adler, et al., 2008).

There has been minimal empirical research on SSS. Singh-Manoux and colleagues (2003) in their research found six predictors of SSS: education, employment, household income, satisfaction with standard of living, feelings of financial security, and perceptions of current and future SES. They acknowledge however that the variables described above only predict half the variance in subjective status and that other predictors remain to be determined. Several variables were not assessed including the

role of self esteem and locus of control as well as perceptions of inequalities such as racism and sexism as potential contributing factors. This dissertation attempted to address this gap in the literature by exploring variables such as experiences of racism and sexism, locus of control and self esteem that may be associated with subjective social status in Black women.

Lower SSS has been associated with poorer self rated health, functional status, obesity, and smoking in Black and White adults in the U.S. and England (Adler, et al., 2008; Reitzel, et al., 2007). Lower SSS has also been associated with poor mental health outcomes including anxiety, depression and self esteem with multiethnic samples (Adler, et al., 2008; Gruenewald, et al., 2006 albeit a small number of Black women in the Gruenewald study). In addition, research exploring the relationship between SSS and psychosocial factors with adults in Sweden found that SSS is associated with locus of control and self esteem (Lundberg & Kristenson, 2008). Thus although, SSS is influenced by objective SES, it is also independently associated with health outcomes such as cardiovascular disease (Ghaed & Gallo, 2007; Lundberg & Kristenson, 2008; Operario, et al., 2004).

However, many of the research studies have not been with Black women, and none have exclusively researched SSS in Black women. Thus, further exploration into the relevant determinants of SSS in Black women as well as the role of SSS in the health status of Black women may explain the diminishing effect of SES on health status as well as provide implications for decreasing disparities. This dissertation addressed the dearth

of research on this topic through an empirical examination of the role of SSS and SES on Black women's health status.

SSS & Black Women.

Although preliminary research to date utilizing SSS seems to demonstrate its promise for enhancing understanding of social status, its role in racial minority groups such as Black women remains unclear because Black women have either not been represented in these studies or otherwise have been included in numbers too small for meaningful analysis. As for those studies that have included Black women, the results often conflict. For example, one study reported no difference in SSS by race/ethnicity (Ghaed & Gallo, 2007), while another reported that SSS was associated with SES for all groups except Black women (Ostrove, et al., 2000). This divergence between SES and SSS in Black women suggests that subjective perceptions of social status are not as strongly linked to traditional SES components and that other variables likely contribute to SSS in Black women. Using a mixed method design, this dissertation explored the variables that contribute to SSS in Black women and how SSS is associated with SES as well as self-reported health status for Black women.

Another study reported differences in the determinants of SSS for Black women compared to White women, Black and White men (Adler, et al., 2008). The researchers concluded that the observed differences in determinants of social status for Black adults were due to experiences of racism (Adler, et al., 2008). There are several possible ways in which experiences and perceptions of racism and sexism can influence SSS in Black

women. These include internalized feelings of inferiority, negative group images, stereotyping, and the beliefs that there are limitations that restrict progress and advancement beyond a certain level (e.g., the glass ceiling effect) (Barreto, Ryan, & Schmitt, 2009). While the quantitative focus of the studies noted above are useful in delineating differences in SSS in Black women compared with other groups, a qualitative approach may provide a richer and more culturally grounded understanding of SSS and its related implications for the health of Black women. Accordingly, this study utilized a mixed methods approach (QUAL + quan) in which qualitative methods (namely focus groups with Black women) will be the dominant method of inquiry.

This study expanded on prior research on SSS by being one of the first to use an intersectional framework of racism and sexism to explore the perception of SSS in Black women as well as the role of SSS in their self reported health. This dissertation utilized an intersectional theoretical framework to better understand the role of subjective social status in the self reported health of Black women. Using a sample of adult Black women in Philadelphia recruited from faith based, social service and educational organizations, the study used questionnaires and focus groups to investigate: (1) how Black women perceive and experience their social status (i.e., subjective social status); (2) how Black women experience and make meaning of racism, sexism and the intersection of racism and sexism; and (3) how experiences and perceptions of racism and sexism are associated with Black women's subjective social status, and in turn their self-reported health status.

Chapter 2: Literature Review

This chapter will review the literature relevant to the main variables of interest (i.e., SES and SSS), and theoretical framework (i.e., intersectionality). This will include a description of the structural inequalities of focus: racism and sexism as well as how these constructs intersect to create disparate health experiences for Black women.

Racism and sexism represent forms of discrimination that Black women may experience simultaneously. In turn, each of these forms of discrimination may adversely influence health status (Collins, 1989; Crenshaw, 1989, 1991, 1994; Fiscella & Williams, 2004; Krieger, 1999). For example, the National Center for Health Statistics reported that the mortality rate (per 100,000) from HIV/AIDS in 2007 was 3.1 for White males compared to 0.7 for White females and 24.5 for Black males compared with 11.3 for Black females (NCHS, 2010). These data illustrate the intersection of race, gender and social status, as Black women have disproportionately high mortality rates associated with HIV/AIDS compared with White females and White and Black males. That is, while Black women comprise 13% of the population, they comprise 64% of HIV/AIDS related deaths (National Center for Health Statistics, 2010). Suggested pathways by which such experiences of discrimination may influence health status include economic and social deprivation, exposure to hazardous environmental conditions, trauma, violence, drugs and limited access to quality health care (Washington, 2006; Zierler & Krieger, 1997)

Race & Racism

Scholars have traced efforts to categorize human groups in the U.S. to the late 16th century (A. Smedley, 1999). By the mid 17th century, taxonomists began to classify human groups based upon stature, shape, food habits, skin color, hair texture and appearance (A. Smedley, 1999). In the mid to late 18th century classification systems began to include perceived physical, behavioral and psychological traits and race was used to describe beliefs about human differences (A. Smedley, 1999) . These beliefs about human differences and characteristics associated with racial subgroups were influenced by power, politics and economics (A. Smedley, 1999). While, there remains criticism of the use and meaning of race in the US (American Anthropological Association, 2000), race is conceptualized for the purposes of this project as a social, political and cultural construct with no biological basis (Braun, 2002; Jones, 2001).

Race

The construction of race, particularly as applied to Blacks, has occurred over a long process of enslavement, enactment of oppressive laws and policies, hostile political and social environments, legal segregation and other societal atrocities (Brush, 2001). Race persists as a proxy for historical experiences and represents a powerful marker of social and economic experiences that influence exposure to risks in Black women such as violence, trauma, and chronic stress (A. Smedley, 1999; Sokoloff, 2005; Waltermaurer, 2006; Williams & Collins, 1995; Zierler & Krieger, 1997). This notwithstanding, it is important to acknowledge that although groups within racial

categories may share similar experiences and perceptions based upon a shared social and historical experience there is great heterogeneity within racial groups (Dressler, 1993). As there is not one singular experience of Black women, the qualitative methods used in this study will attempt to highlight a diversity of experiences and perceptions that influence health status in Black women.

Racism

Racism is an ideology that reflects a belief of inferiority based on characteristics associated with racial groups (Fiscella & Williams, 2004). Racism is a determinant of disparities in health and operates through several pathways including, institutionalized policies and practices that promote systemic discrimination, interpersonal racial prejudice and discrimination, and through internalization (Fiscella & Williams, 2004). Institutional racism describes the "societal ideologies, practices, and policies concerning race that are sustained in organizations and systems through customs, standards and regulations" (Wyatt, et al., 2003, p. 316). Institutional racism, through the creation of discriminatory and oppressive policies (such as policies created as part of the War On Drugs which disproportionately incarcerate Blacks and Latinos), creates differences in access to resources and opportunities (Jones, 2001; Williams, 1999). Interpersonal racism describes discrimination that occurs between individuals (Jones, 2001; Sue, 2010; Wyatt, 2003) such as a guidance counselor who laughs when a Black female student says that she wants to become a doctor and tells the student that she will never become a doctor because she is Black and not smart enough, and then makes a racial

slur as the student exits the room. Such examples of microaggressions, commonly experienced by Blacks have negative consequences (Sue, 2010). Black men and women who report more experiences with interpersonal racism have increased prevalence of psychological and physical health conditions such as depression and high blood pressure (Krieger & Sidney, 1996; Landrine, Klonoff, Corral, Fernandez, & Roesch, 2006; Williams, 2008).

Internalized racism describes the “acceptance of cultural stereotypes of inferiority by a marginalized social group” (Wyatt, et al.,2003, p. 325). This internalization of stereotypes comes through the socialization processes imposed through family, school, community, mass media and society (Kowalewski, McIlwee, & Prunty, 1995). Individuals who internalize negative experiences and perceptions of discrimination, may be more likely to have negative health consequences perhaps due to subjective perceptions of social status (Landrine, et al., 2006; Parker, Botha, & Haslam, 1994; Thompson, 2002). Social support, self esteem, and SES each mediate the impact of experiences with discrimination on health in Black men and women (Branscombe, Schmidt, & Harvey, 1999; Fischer & Shaw, 1999; Prelow, Mosher, & Bowman, 2006). These variables may mediate the relationship between discrimination and health through their influence on SSS. Individuals with high social support and self esteem for example may be less likely to internalize and/or perceive discrimination as suggested by Prelow and colleagues’ study (2006) with Black college students.

There is a long history of medical exploitation of Blacks in this country (Gamble, 1997; Washington, 2006). Although many recognize, Tuskegee as a symbol of abuse and exploitation that contributes to attitudes of distrust in the Black community, there are numerous examples of egregious acts conducted by various researchers and physicians (Gamble, 1997; Washington, 2006). In fact, "dangerous, involuntary and non-therapeutic experimentation upon African Americans has been practiced widely and documented extensively since the 18th century (Washington, 2006, 7)." Black slaves were bought for the purpose of medical experimentation, African American bodies were stolen for use in physician training and Blacks were used in radiation and involuntary sterilization experiments and the testing and development of numerous surgical procedures as well as medicine and vaccine development (Gamble, 1997; Washington, 2006). Unfortunately abuses in the research and medical community remain in the 21st century, as academic health centers, often located in urban centers, have been investigated for falsifying data and research protocols, adherence to informed consent guidelines, and other human subject abuses with Black participants (Washington, 2006).

Racialized images of health and disease have historically influenced the health care received by Black Americans (Wailoo, 2001). Racism and stereotypes about Blacks influenced popularly held assumptions that Blacks were "naturally diseased people" (Wailoo, 2001, 56). Moreover, segregation in health insurance, medical care and medical education has led to poor quality healthcare (Wailoo, 2001). Thus racism has

influenced Black's access to care, diagnosis and treatment as well as the meaning of pain, sickness and disease in African Americans (Wailoo, 2001).

Although an abundant empirical base documents that racism negatively influences health in Black adults (Brondolo, et al., 2009; Clark, et al., 1999; Karlsen & Nazroo, 2002; Krieger & Sidney, 1996; Peters, 2004; Williams, 1999), it is not as well understood how experiences and perceptions of racism influence SSS (Karlsen & Nazroo, 2002). For example, results from one study with a sample of Black and White men and women suggests that racial discrimination may have a more negative effect on working class Blacks who internalize experiences and accept them as a natural part of life rather than those who are able to articulate and challenge them (Krieger & Sidney, 1996). In the study, working class Black women who perceived discrimination as a natural part of their lives compared with those who did not had higher blood pressure (Krieger & Sidney, 1996). Moreover, Black women were more likely than White women to report that they kept experiences of unfair treatment to themselves (Krieger & Sidney, 1996).

These findings suggest that women who perceive discrimination to be a natural component of their existence may internalize these feelings. The internalization of these perceptions of discrimination may be embodied, that is become incorporated in their biology and physiology, leading to poorer health outcomes such as high blood pressure which, in turn, is a risk factor for other chronic disease (Krieger, 1999). Furthermore, higher blood pressure was found in women who not only perceived discrimination to be a natural part of life but who also did not disclose their experiences to others. This

suggests that perceptions of discrimination, as well as disclosure to others, may play an important role in protecting Black women from the deleterious health effects of discrimination.

Moreover, the construction of self esteem as well as its role in the overall health and wellbeing of Black women is unclear. Some research suggests self esteem is associated with mental and physical health outcomes in Black women (Belgrave, 1991; Lee, 2005). But, a meta-analysis of over 260 studies published between 1960 and 1998, explored racial and gender differences in self esteem as well as potential theoretical explanations for such differences (Gray-Little & Hafdahl, 2000). The authors reported a "Black Advantage" in that Black females have higher self esteem compared to Black and White males and White females (Gray-Little & Hafdahl, 2000). However, the reviewed studies solely included children, adolescents and young adults. No studies of middle aged or older adults were reviewed. Thus, the implications of the results for Black female adults of varying age groups and demographics may be limited. This study explored the role of self esteem in Black women's SSS.

In addition, although the Gray-Little and Hafdahl (2000) study discussed several theories and possible explanations for this observed higher self esteem among Black women, the role of social status, perceptions or experiences of racism and sexism or religion and cultural norms and beliefs were not reported. Thus women of higher SSS, who have higher self esteem, and perception of control over their lives may be less likely to internalize these feelings, or be more likely to share such experiences with

others. For instance, a Black woman who believes that discrimination is natural may feel that she does not have the ability to control her life (i.e., low locus of control) and achieve her desires for her future. She may in turn feel more isolated, have lower self esteem, have feelings of hopelessness, perceive fewer opportunities for advancement, and have increased stress about how she will survive given the discrimination she faces continually, may have poorer health behaviors (poor diet, low physical activity, etc.) and may be less likely to access care. Even if she receives a graduate degree and makes a salary that would afford her the opportunity to accomplish some of her goals, her subjective perceptions of her social standing in society may minimize the positive health benefit she may receive from her increased objective status (education and income).

On the other hand, the ability to make an external attribution for one's social status (i.e., that it is due to discrimination rather than lack of ability) may be protective. Crocker and colleagues (1991) in their studies of attributional ambiguity found that Black students who received negative feedback from White evaluators who knew they were Black attributed the negative feedback they received to their evaluators' prejudice; thus the criticism had no impact on their self esteem (Crocker, Voelkl, Testa, & Major, 1991). Also, women who attributed negative outcomes to prejudice experienced less depression after receiving negative feedback if they believed the evaluator was sexist. Women who did not attribute negative feedback to prejudice were more likely to internalize the negative feedback (Crocker, et al., 1991).

Thus, Black women who are able to attribute negative outcomes to discrimination may be less likely to internalize them. This is also consistent with the stress buffering hypothesis (Cassel & Cobb, 1976), which suggests that individuals with certain resources or traits (i.e., who may be more likely to attribute negative outcomes to discrimination) will be less likely than those with fewer resources, to experience adverse consequences to stressors (i.e., internalize the experienced discrimination). Thus such characteristics or traits may buffer against stressful experiences (N. Anderson, 2004; Cohen, Gottlieb, & Underwood, 2000).

However, the role of coping styles and resources available to handle stressors, an important determinant of one's response to stressors such as discrimination were not explored in the Crocker study (1991). The studies conducted by Crocker and colleagues (1991) may also be limited by the fact that they were conducted solely with college students. College represents a snapshot of adolescent and young adult development that is not necessarily representative of other developmental stages (H. Betancourt & Lopez, 1993). The research explored these concepts in limited and isolated situations related to grades received and perceptions of racism and sexism. These results may not be generalizable to other life situations such as seeking employment or housing. Moreover, the researchers did not examine the cumulative effects of perceived racism and/or sexism on specific outcomes; nor did they assess attributional ambiguity in the context of opportunities for economic and social advancement. This dissertation provides some clarity on the role of perceived discrimination as it explored the role of

perceptions of racism and sexism in Black women's SSS. However, an assessment of attributional ambiguity specifically was beyond the scope of this dissertation.

Gaps exist in the literature about exactly how adult Black women's perceptions of structural inequalities such as racism and sexism are associated with their subjective perceptions of social status and how these perceptions influence their health. Thus, research is needed to explore how SSS is associated with the health status of Black women. To this end, this dissertation aimed to address this gap in the literature by: (1) examining how experiences and perceptions of the intersection of racism and sexism are associated with SSS in Black women; and (2) based on the findings, developing a conceptual model of the intersections of racism, sexism on Black women's SSS, and self-reported health status. The research explored the role of self esteem and locus of control in Black women's SSS in the context of their relationship to Black women's perceptions of racism and sexism, and how racism and sexism intersect to influence SSS.

Sex, Gender, Sexism

Although the final Civil Rights Act of 1964 outlawed discrimination based on both race and sex, the Act originally did not include sex (National Archives and Records Administration, 2009) illustrating the continued acceptance of sexism as well as the invisibility of women of color.[2] Sexism is an ideology of discrimination solely on the

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[2] Sex is defined as the biological classification of living organisms according to their reproductive organs while, gender is defined as an individual's self identification as male or female. Although rooted in biology, gender is greatly influenced by culture and social environment (IOM, 2001).

basis of sex and may include attitudes, behaviors, stereotypes and messages that relegate women to devalued social, familial and occupational roles (Marable, 2004). Sexism includes the subordination of social, political and economic rights as well as inequalities in the distribution of power and resources based on sex and gender[2] (Marable, 2004).

Sexism can take a variety of forms. Interpersonal sexism includes unequal and unfair treatment by spouses, family, teachers, professors, colleagues and others. Institutional discrimination against women occurs through inequities in opportunities, loans, salaries and promotions) (Klonoff & Landrine, 1995). Internalized sexism also occurs when women internalize negative gendered stereotypes and messages (hooks, 2000). For example, women may internalize or believe messages about limitations in their abilities, such as their ability to lead an organization as the Chief Executive Officer, serve as a partner in a major law firm or even become a legislator or president of the US. Similar to internalized racism, internalized sexism may influence SSS in women by influencing feelings of control and esteem.

A substantial body of research has confirmed the existence of sex differences in health and disease (IOM, 2001; Pinn, 2003). While, early research on sex differences focused on validating claims that women were cognitively and intellectually inferior to men (e.g. studies examining differences in brain size) as well as medicalizing women, later research has focused on identifying physiological differences between women and men in order to enhance health outcomes (Theriot, 1996). Men and women exhibit

distinct patterns of disease based upon physiological differences as well as environmental, behavioral, cognitive, experiential and social differences (IOM, 2001). Perceived experiences of sexism have also been linked with receiving substandard health care (Schulman et al., 1999) and have been associated with psychological distress as well as psychiatric symptoms in women (Klonoff & Landrine, 1995; Krieger, et al., 1993; Moradi & Funderburk., 2006). In addition, sexism influences the health of women through women's experiences of domestic violence, sexual violence, abuse, assault, gender segregation in the workplace, and healthcare provider bias (e.g., the tendency for some health care providers to discount women's symptoms) (Krieger, 1999; Krieger, et al., 1993). These experiences may contribute to the aforementioned increased prevalence of psychological distress in women (Crenshaw, 2005; IOM, 2001; Klonoff & Landrine, 1995).

Women experience several types of sexism. In a multiethnic study with women between the ages of 18 and 73, 99% of women reported experiencing at least one sexist event in their lifetime (Klonoff & Landrine, 1995). In fact, women in the study most often reported lifetime experiences of sexism in the following areas: sexual harassment, being called sexist names, being treated disrespectfully because of their sex, and being discriminated against by personnel in service jobs, and by intimate partners (Klonoff & Landrine, 1995). When describing experiences of sexism in the previous year many of the women frequently noted experiences in the areas described above as well as sexism by employers and being physically hit, pushed or threatened

because they were women (Klonoff & Landrine, 1995). Moreover, Black women reported more sexist events in their relationships (close and distant) compared with White women (Klonoff & Landrine, 1995). Although the study included a multiethnic sample, there were few Black women participants. Thus, study conclusions may be limited by the relative small number of Black women participants. In addition, the role of perceived sexism in shaping Black women's SSS was not addressed. Moreover, in another study with a multi-ethnic sample (with few Black women participants), sexism was associated with sexual risk behaviors through psychological distress and experiences of difficult sexual situations (Choi, Bowleg, & Neilands, 2011). More research is needed to explore how Black women experience and perceive sexism, how these perceptions and experiences intersect with experiences and perceptions of racism and how both racism and sexism shape subjective perceptions of social status in Black women (Krieger, et al., 1993). To this end, this dissertation explored Black women's experiences and perceptions of sexism (sexist experiences) and the role of sexism in shaping their SSS.

Despite the fact that research on sexism has historically focused on predominantly White women (Collins, 1986; hooks, 2000), sexism has also been linked to poor health outcomes in Black women (Moradi & Subich, 2003). A study focused on exploring the association between perceptions of racism and sexism in 133 Black women found an association between the frequency of perceived racist and sexist experiences and psychological distress (Moradi & Subich, 2003). When perceptions of

racism and sexism were examined separately each was correlated with psychological distress. When experiences of racism and sexism were examined concomitantly however, only sexist events predicted psychological distress (Moradi & Subich, 2003).

In addition to the findings noted above, racist and sexist events were strongly correlated with each other (Moradi & Subich, 2003). These findings suggest that Black women are influenced by both racism and sexism and that it is difficult to separate out the effects of racism and sexism, a central tenet of intersectionality theory (Collins, 1989; Segal & Martinez, 2007; Weber & Parra-Medina, 2003). Rather than having an interactive or additive effect, the study's results indicated that racism was inextricably linked to sexism in Black women. This dissertation underscores the importance of considering the role of both racism and sexism in studies with Black women. Thus, I review the intersectional framework below. This dissertation used the intersectional framework to empirically investigate the intersection of sexism and racism and their influence on SSS in Black women.

Additional challenges exist with assessing experiences of sexism in research. Women may not acknowledge or report personal experiences with sexism even though they may have experienced it (Choi, et al., 2011; Crosby, 1984). A study of women who worked within the home and those in the workforce, and men found that although women were discriminated against (as assessed by sex differences in salary) and were aware of sexism, they did not acknowledge personal experiences of sexism (Crosby, 1984). Crosby's study conducted with residents of a Boston suburb, did not report the

racial/ethnic characteristics of the sample. Crosby explained the discrepancy by noting that although women in the study were able to acknowledge the existence of sexism, they perceived that they were exempt from it. Instead, women in the study were more likely to make internal attributions for salary differences, rather than attribute the inequality to sexism (i.e., an external attribution). Crosby also posited that the act of acknowledging sexism may induce a level of emotional discomfort that some women may be motivated to avoid. This dissertation utilized a mixed methods approach that relies heavily on qualitative research in order to assess the role of sexism (and racism) in the SSS of Black women.

Intersectionality

Intersectionality is a theoretical approach that emphasizes the intersection of social categories of difference (e.g., race, gender, class) (Hancock, 2007). The intersectional approach originates from Black feminist scholarship (Collins, 1989; Crenshaw, 1989, 1991, 1994; Guy-Sheftall, 1995; hooks, 2000) and acknowledges social discrimination such as racism and sexism as inseparable systems (Weber & Parra-Medina, 2003). For instance, intersectionality scholars posit that Black women experience racism and sexism (as well as other forms of discrimination) simultaneously, and that one form of discrimination is not more salient than another (Collins, 1989; Crenshaw, 1989, 1991; Guy-Sheftall, 1995). That is, it is difficult to attribute Black women's experiences of discrimination solely to racism or sexism. Although Black women may experience each type of social discrimination independently (e.g., sexism)

all forms of discrimination intersect (e.g., racism, sexism, etc.) to shape Black women's experiences, perceptions, thoughts about their place in society (Collins, 1989, 2004; Segal & Martinez, 2007), and as I theorized in this dissertation, their perceptions of objective SES and SSS. As such, intersectionality provided a useful conceptual and analytical framework for this study (Weber & Fore, 2007; Weber & Parra-Medina, 2003). The intersectional framework was an integral component in this research on how the role of racism and sexism in Black women's SSS was assessed.

Despite the utility of intersectional theory for advancing knowledge about the health disparities that adversely impact Black women, the vast majority of health disparities research is often uni-dimensional in focus (Weber & Fore, 2007; Weber & Parra-Medina, 2003). That is, most studies focus on one aspect of discrimination (e.g., racism) thereby neglecting the ways that multiple forms of discrimination intersect to produce disparities in health (Brondolo, et al., 2009; Clark, et al., 1999; Peters, 2004; Weber & Fore, 2007; Weber & Parra-Medina, 2003). The HIV/AIDS epidemic aptly exemplifies how racism and sexism intersect to produce a disproportionate impact in Black women. As stated previously, Black women have higher prevalence rates of HIV compared to White and Hispanic women (CDC, 2008).

Gender roles, norms and power differentials grounded in sexist and racist ideology contribute to sexual decision making and are barriers to risk reduction in Black women (Amaro, 1995; Collins, 2004). Risk reduction models emphasizing condom use (which is influenced by gender role norms and relationship power differentials, and for

women, requires partner negotiation) are ineffective for women who are unable to control sexual encounters (Amaro, 1995; Lichtenstein, 2005). Black feminists such as Patricia Hill Collins (2004) and Gail Wyatt (1997), have theorized that racism and sexism may influence sexual norms and behaviors in Black women (e.g. promiscuous or hypersexualized Black female image).

Thus research exploring diseases such as HIV in Black women must consider how racism and sexism intersect to influence the increased prevalence of the disease. A uni-dimensional identity approach ignores how these constructs intersect to influence Black women's health. This dissertation utilized an intersectional framework to explore how experiences of racism and sexism influence subjective social status in Black women and how SSS subsequently influences their self-reported health.

Although Black women often experience multiple forms of discrimination concurrently, each form may not be equally visible or recognized as important (Collins, 1986, 1989, 2004). Take the example of a Black woman who is refused a promotion because she is Black, sexually harassed by her manager, and ostracized because she does not have enough money to contribute to the office lunch pool. Even though she may experience multiple forms of discrimination based on race, sex and class, she may focus on just one form of discrimination (e.g., racism), she may rate one type of discrimination (e.g., sexism) as more significant than others, or she may not be conscious of the role of one or more of the forms of discrimination (e.g., classism). This challenge is addressed by the intersectional framework in that the intersectional

framework assumes that racism and sexism are operating simultaneously even if just one of these appears to be more dominant (Collins, 1989, 1991). Applied to health, a middle aged Black woman's hypertension may be poorly controlled due to her inability to consistently pay for her medications despite having a graduate degree (classism); her physician's frustration with her weight gain and perceived lack of compliance with health directives to lose weight that the physician generalizes to all Black patients (racism); and her familial structure in which she has primary responsibility for child rearing and many other familial duties despite being married (sexism).

The utility of the theoretical construct of intersectionality notwithstanding, several methodological challenges exist in examining intersectionality empirically. Such challenges include asking questions that are consistent with the intersectional framework (i.e., questions designed to explicitly measure the intersection of racism and sexism) rather than an additive approach that implicitly treats specific identities as separate and rankable; and critiquing and interpreting data within the context of social, economic, political, and historical factors regardless of whether participants explicitly articulate those factors (Bowleg, 2008b; Cuadraz & Uttal, 1999). This dissertation utilized intersectionality as a framework to guide the development of a conceptual model of the role of subjective social status in the health of Black women.

This dissertation used a mixed methods approach with questionnaires and focus groups to investigate: (1) how Black women perceive and experience their social status (i.e., subjective social status); (2) how Black women experience and make meaning of

racism, sexism and the intersection of racism and sexism; and (3) how experiences and perceptions of racism and sexism are associated with Black women's subjective social status, and in turn their self-reported health status. In addition, the research investigated the effects of self esteem and locus of control on Black women's perceptions of racism and sexism, and how racism and sexism intersect to influence Black women's SSS.

Chapter 3: Methods

Study Design

This study utilized a concurrent transformative mixed methods design (QUAL + quan), with greater emphasis on the qualitative component. Mixed method approaches to research emerged in the 1960s and have become increasingly popular in the behavioral and social sciences (Creswell, Klassen, PlanoClark, & Smith, 2011; Tashakkori & Teddlie, 1998). These studies combine qualitative and quantitative approaches to enhance the depth and breadth of data explored in response to a research question. Mixed method studies are used to research different aspects of a phenomenon and explore contradictions or to gain a new perspective of it (Creswell, et al., 2011; Tashakkori & Teddlie, 1998). Thus, this methodological approach was appropriate for this research because the primary goal of the research was to investigate the role of subjective social status on Black women's health (which differs from how social status is often studied) as well as explore potential contradictions between objective and subjective social status. The findings promote better understanding of the effects of racism and sexism on subjective social status and the subsequent self-reported health status of Black women.

Creswell (2003) described four categories of mixed methods research based on how the research is implemented, priority to qualitative or quantitative methodology, stage of integration of data and the theoretical perspective. Based on Creswell's categories, this research utilized the concurrent transformative mixed methods

approach (QUAL + quan) (Creswell, 2003). The concurrent transformative approach is determined based on the use of a theoretical perspective, reflected throughout the research question and design that is transformative in nature (Creswell, 2003). Consistent with Creswell's description of this approach, this dissertation utilized a specific theoretical framework (intersectionality) that guided the study purpose, research question, data collection and analysis with the ultimate goal of enhancing understanding of the role of subjective social status in Black women's health. This dissertation sought to expand understanding of the role and contributors of subjective social status in Black women's health status and used the theoretical framework of intersectionality, with the goal of highlighting individual, institutional and systemic recommendations that will ultimately provide vehicles of advocacy for Black women's health. This goal of advocacy is also consistent with the transformative approach (Creswell, Plano Clark, Gutmann, & Hanson, 2003). This mixed methods approach involved collecting qualitative and quantitative data simultaneously with the qualitative component receiving priority. As it was not the intent of this research for one component to specifically inform another component (i.e. for the quantitative component to inform the construction of the qualitative component), a concurrent rather than a sequential design was used. The qualitative component was given priority because of the exploratory nature of this dissertation. The two approaches (QUAL + quan) were integrated during the interpretation phase (Creswell, 2003; Tashakkori & Teddlie, 1998).

This research also utilized triangulation. Triangulation is the exploration of a research problem from a minimum of two different but complementary perspectives (Creswell, 2003). The utilization of diverse data collection strategies maximizes the strengths of both qualitative and quantitative approaches (Creswell, 2003). Studying a research question from multiple perspectives also enhances validity as well as allows areas of convergence and divergence to be identified that may further enhance understanding of the research question (Creswell, 2003). Of the four types of triangulation (data, investigator, theory and methodological), this dissertation used methodological triangulation (Creswell, 2003; Denzin & Lincoln, 2000; Flick et al., 2004). Methodological triangulation uses different methods in order to research a problem (Flick et al., 2004; Denzin & Lincoln, 2000). The data are collected individually and then combined into one overall interpretation (Creswell, 2003). This approach is consistent with the mixed methods design described above. Triangulation has also been described as a technique to enhance the trustworthiness of a study (Denzin & Lincoln, 2000). This is described in further detail below.

Qualitative Phase

The qualitative phase consisted of 6 focus groups with a sample of 43 adult Black women between the ages of 22-64 (M = 40.65, SD = 11.6). Focus groups are group interviews that are used to gain the perspectives, thoughts, beliefs and attitudes on a specified topic (Krueger & Casey, 2000; Madriz, 2000). Focus groups are used for obtaining information on a topic, generating hypotheses, learning how individuals

discuss a particular topic of interest and to interpret quantitative results (Stewart, Shamdasani, & Rook, 2007). Focus groups are particularly useful in addressing topic areas that may be sensitive or for topics that individuals feel uncomfortable discussing (Madriz, 2000).

Madriz (2000) argues that focus groups are especially appropriate for discussing sensitive topics with women of color because of the support they may receive from talking with others. The strength of the focus group approach is the interaction the researcher is able to observe between participants as they respond to one another (Morgan, 1988; Stewart, et al., 2007). Participants' responses not only provide insight on perspectives about the topic of the discussion but their responses to others may highlight perspectives that they may not have expressed in an individual interview (Morgan, 1988). In addition, the degree to which participants agree with or challenge each other's comments provides additional perspective on the topic (Morgan, 1988; Stewart, et al., 2007). Thus, focus groups are quite useful in highlighting not only what participants think but also why they think or believe what they do (Morgan, 1988). Thus, focus groups were an ideal method for this study as they were used to provide insight on Black women's perspectives on subjective social status as well as how perceptions of racism and sexism influence SSS and health status. Additionally, because these complex concepts may initially be challenging to discuss, the group process as well as the level of agreement or disagreement shared, may better highlight additional perspectives.

Focus groups in this study were used to: (1) gather group interview data on study questions, and (2) to elaborate findings from the quantitative component. Typically, the number of focus groups conducted is determined by the saturation of the data. That is, ideally groups are conducted until additional discussions cease to produce new ideas (Morgan, 1988). Sample saturation usually occurs in 3-4 groups when a more structured group interview is conducted compared to groups that utilize more open questions about a topic or theme (Morgan, 1988). In addition the number of groups to be conducted is determined by the homogeneity of the groups. Fewer focus groups may be conducted for more homogenous groups (with members of the same gender, race/ethnic group, etc.) and more groups may be needed for more heterogeneous groups (with members of differing gender and racial/ ethnicities, etc.) (Morgan, 1988). Although, fewer groups were originally planned to be conducted based on Morgan's criteria, an additional two groups (for a total of 6) were added to ensure that the groups would capture differences between higher income compared to lower income Black women.

In general for all focus groups, moderately sized groups with between 6-10 participants are recommended to enhance the contributions of each participant (Morgan, 1988; Stewart, et al., 2007). Additional participants (at least 20% above the ideal) should be recruited in order to ensure that the ideal number of participants is reached (Morgan, 1988). For this research, nine Black women were recruited (an additional 2) for each of the six focus groups resulting in approximately seven Black

women participants each. The number of participants is also within the recommended range of between 6 to10 participants. Sample questions from the focus group interview guide are included in the measures section below. The entire focus group guide is provided in Appendix 2.

As the primary goal of this research is to investigate the role of subjective social status on Black women's health an approach that utilized strategies adapted from grounded theory was used as an analytical framework for the qualitative phase of this research. Grounded theory is an approach used to generate theory from qualitative data using a systematic process (Chamberlain, 1999; Glaser & Strauss, 1967). It is first used to generate conceptual categories from the data that lead to the development of theory (Glaser, 1992; Glaser & Strauss, 1967). Strategies from grounded theory, such as coding and memoing were used to identify key themes elicited from the focus group participants related to the study's research questions.

Quantitative Phase

The quantitative phase utilized a cross sectional design in which 160 adult Black women completed a self administered paper questionnaire to assess objective and subjective social status, self reported health status, experiences of racism and sexism, locus of control, and self esteem. The number of participants was determined by the power analysis described below. Study questionnaires included previously validated instruments used to assess subjective social status, locus of control, self esteem and

experiences of racism and sexism. The instruments are described below in the measures section.

Power Analysis

The power of a statistical test represents the probability of correctly finding a difference or association that actually exists in the population. Technically, power is the probability of avoiding a type II error, that is, a false negative error (Dawson-Saunders & Trapp, 1994; Murphy & Myors, 2004). Power is most often not achieved because the sample size is not large enough to detect the effect (Dawson-Saunders & Trapp, 1994). The power in this project was determined by the G*Power 3 statistical power analysis program (Faul, Erdfelder, Lang, & Buchner, 2007). Power estimates were calculated for correlations and linear regression analyses. Due to the dearth of studies on SSS, it is difficult to estimate the exact effect size to be used for the power calculation. The effect size is the size of the correlation that is relevant to the research (Dawson-Saunders & Trapp, 1994). For example, studies on SSS have typically reported significant correlations with r values between 0.2 – 0.7 compared with independent variables such as education, income, and self reported health status (Kopp, et al., 2004; Singh-Manoux, et al., 2003).

In addition, Singh-Manoux and colleagues (2003) reported similar findings for their regression models predicting SSS. The preliminary power estimates were calculated using a small/ moderate effect size (0.3) for both the correlation and regression. The a priori sample size calculated using the effect size of 0.3 an alpha of

0.05 and a power of 90% for a two tailed test results in a sample size of 109. The a priori sample size calculated using the effect size of 0.3 and an alpha level of 0.05 and a power of 80% for 5 predictors results in a sample size of 145. Both of these calculations were determined by the G*Power 3 .1.0 software program. Therefore, the sample size of 160 was more than sufficient to provide a power of 0.90 for the correlations and 0.80 for the linear regressions with a 0.3 effect size. This is within the commonly acceptable minimum power of 0.8 (Murphy & Myors, 2004).

Participants & Recruitment

Participants for this study were recruited from participating sites of the Philadelphia Ujima Project. Philadelphia Ujima is a health education and promotion project that utilizes a community participatory approach. Specifically, this initiative seeks to work with various community partners to decrease health disparities among Philadelphians in order to reach targeted Healthy People 2010 (HP2010) objectives. These include: health care access, heart health, stroke prevention, diabetes prevention and control, hypertension control, fitness / obesity and cancer screening. Although the focus of the Philadelphia Ujima project is health education and promotion, this is not the core mission or focus of most of the partnering community sites. Participating sites included faith based, social service and educational agencies. Each of the sites, (even those with predominately African American participants) serve diverse groups (e.g., age, SES, geographic locations throughout the city).

Study participants included adult women between the ages of 18 and 70, as this represented the age range of members of the sites where participants were recruited from (Philadelphia Ujima program described above - True Vine Baptist Church, Greater Exodus Baptist Church, People for People Institute, People for People EARN center, Drexel University College of Medicine and Drexel University Clinical Practices), who self identified as Black or African American, were English speaking and were born and raised in the US.

Black women who were born and raised in the US were recruited for this study because the research aims included exploring how experiences and perceptions of the intersections of racism and sexism are associated with subjective social status and health status in Black women. Black women who were not born and raised in the US would not be able to identify with the perspectives of racism and sexism (intrinsic to the social, political and cultural environment of the US) of Black women who were born and raised in the US (Dominguez, Strong, Krieger, Gillman, & Rich-Edwards, 2009). Black women who were not born and raised in the US may share a different perspective, experience and understanding of racism and sexism. In turn, their health status may be influenced by different variables such as level of acculturation (Dominguez, et al., 2009). In addition, Black women who were not born and raised in the US may be more likely to identify as immigrants and share perspectives on bias and inequality associated with immigrant status rather than the structural inequalities based on race and sex rooted in the historical fabric of this country (Dominguez, et al., 2009).

A convenience sample of 43 Black women for the qualitative phase of the study was recruited from the *Philadelphia Ujima: Mind Spirit Body Health (MSBH) Collaborative* (Philadelphia Ujima) project's participating sites to participate in six 2 hour focus groups (approximately 7 participants in each group). The 2 hour time allotment included informed consent, focus group, completion of the demographic questionnaire and administration of incentives. An additional 2 participants for each group, which may have resulted in an additional 12 participants overall (extra 28%), were recruited to ensure that the target number of 7 participants in each group (total of 42 overall) was met. Participants who were interested in participating in both components (i.e., the survey and focus group) were asked to complete the survey prior to participating in the focus group to avoid biasing their survey results.

As members of the recruitment sites are predominantly lower and middle class, two separate groups (2 of the total 6 to be conducted) with middle and upper middle class Black women were conducted. Participants for this group were recruited from the same Ujima sites described above. The separate groups were conducted because focus groups should not include people from extremely different SES levels especially in situations where these differences can represent vastly different perspectives regarding the research question (e.g., Black women who are low SES and upper middle SES)(Greenbaum, 1998). As the goal of this research was to investigate SSS in Black women, those in divergent class situations may have different perceptions of SSS which would best be addressed in a separate group.

In this dissertation, based upon definitions of the middle class provided by Gilbert (2002), Black women with a doctoral degree or an annual income over $50,000 were recruited to participate in the middle and upper middle class focus groups as determined by a screening questionnaire. There is no one acceptable definition of middle class but many include income, education, values and aspirations of individuals and families (US Department of Commerce & Economics and Statistics Administration, 2010). Some of the commonly used income based definitions include median per capita income levels and median household income (US Department of Commerce & Economics and Statistics Administration, 2010). Moreover, due to limitations of solely using income as a determinant of middle class (lack of congruence between individual identification as middle class and actual income, in a Pew Research Study individuals with incomes under $20,000 and over $150,000 all self identified as middle class), definitions of upper middle class proposed by Gilbert (2002) include both a description of individuals who are both highly educated and who have a certain level of income (often defined by median income levels) (US Department of Commerce & Economics and Statistics Administration, 2010). The median per capita income for the overall total population is $26,059 and is $17,569 for the Black population (US Census Bureau, 2010). Based on this information as well as the criteria established by Gilbert (2002), a doctorate or equivalent degree was used as the educational requirement and $50,000 and above was used as the income criterion for Black women in the upper middle class.

Focus groups were conducted at Philadelphia Ujima partner sites and were digitally recorded and professionally transcribed. The groups began with the informed consent process. After all participants completed the consent process and had an opportunity to ask questions, the focus group began. I asked, the participants to complete the demographic questionnaire at the end of the session.

I distributed a recruitment flyer (see Appendix #7) to all partnering sites. The flyer stated that the purpose of the study was to explore Black Women's perceptions of their social status and how Black women's experiences of racism and sexism influence their perceptions of social status as well as their health status. The flyer was used to inform individuals that they may be eligible to participate in either a focus group or survey. Adult Black women of the participating sites meeting the criteria described above were eligible to participate.

For the qualitative portion of the study, interested women were instructed to contact me by phone or email. Upon initial contact, I screened prospective participants by phone or in person (depending on initial contact) to confirm their eligibility for the study. The screening questionnaire also included questions on income and highest level of education achieved. Participants of the qualitative portion of the study (focus groups) participated in a raffle at the conclusion of the group. The winner of the raffle received a $50.00 gift card as an incentive for participation.

For the quantitative component interested participants completed the screening questionnaire at the sites where the surveys were administered. Participants who met

the study criteria were given the self administered study questionnaires to complete. Participants who completed the study questionnaires received a unique identifier for a number that was entered in to a raffle for two free movie vouchers as an incentive.

The Drexel University Institutional Review Board (IRB) approved all study procedures.

Measures

Qualitative Component

The specific aims for the focus groups were to determine: (1) what factors are associated with SSS; (2) what factors are associated with self reported health status; (3) how experiences of racism and sexism influence SSS; (4) how traditional SES indicators are related to SSS; and (5) how SSS is related to Black women's self reported health status. Open ended questions were developed based upon the key areas of exploration outlined in the research questions. Please see Appendix 2 for the complete focus group guide. Sample questions included the following:

- In general, how would you describe the health status of Black women in the U.S.? How does the health of Black women compare to the health of White women? Other ethnic minority women such as Latino, Asian, etc.?
- How does the health of Black women compare to the health of Black men? White men? Men from ethnic minority groups such as Latino, Asian, etc.?

A demographic questionnaire (Appendix 7) was administered after the groups assessing age, relationship/ marital status, highest level of education, personal and household income, number of children, sexual orientation and employment status.

Quantitative Measures

Several previously validated tools were used to assess key study variables. All questionnaires were self administered in paper format.

Dependent Variables

Health status. Health Status was assessed by the general health subscale of the SF-36 as used by Adler (2000). The SF36 is a 36 item scale and consists of eight domains which include both physical and mental health and are as follows: physical functioning, role limitations because of physical health, physical pain, social functioning, mental health, role limitations due to emotional distress, energy/fatigue and general health (Ware & Sherbourne, 1992). It was developed based on research supporting the utility of individual perception of health status in health research (Ware & Sherbourne, 1992). It utilizes a generalist approach to health rather than assessing specific health conditions, illnesses or risks (Ware & Sherbourne, 1992). This tool can be used with people 14 and older and can be either self or telephone administered or administered through interview (Ware & Sherbourne, 1992). It was self administered in this study. The general health subscale was used. A sample item from the general health subscale is, "I seem to get sick a little easier than other people" (1 = definitely true; 5 = definitely false). Higher scores reflect better perceptions of personal health status. Self report of health status has been associated with objective health measures and mortality rates (Idler & Angel, 1990; Idler & Kasl, 1991).

In addition to the general health subscale of the SF-36, an additional item on long standing illness or disability was used. Long standing illness or disability was assessed as measured by Demakakos and colleagues (2008). This measure was assessed by one question. “Do you have any long standing illness, disability, or infirmity? Long standing means anything that has troubled you over a period of time or that is likely to affect you over a period of time? “ (Demakakos, Nazroo, Breeze, & Marmot, 2008). Responses were yes and no.

Subjective Social Status (SSS). Subjective social status was assessed with the MacArthur Scale of Subjective Social Status (Adler, et al., 2000). In this measure, participants were shown two 10 rung ladders. Participants were then presented with the first ladder and told that the top of the ladder represents people in the U.S. who are best off – those with the highest education and most money. The bottom of the ladder represents those who are the worst off and have the least amount of education and money (Adler, et al., 2000; Demakakos, et al., 2008). Participants were then asked to place a check mark on the rung on the ladder where they would place themselves (Adler, et al., 2000; Demakakos, et al., 2008). The score is determined by the number of the rung chosen by a participant. Participants were then given the second ladder and asked to rank themselves relative to others in their community (however they choose to define community) (Ghaed & Gallo, 2007).

Independent Variables

Experiences of racism. The Schedule of Racist Events (SRE) is an 18 item scale developed by Landrine and Klonoff (1996) to assess the frequency and appraisal of racial discrimination. Racism as conceptualized here includes interpersonal and institutional racism of varying types and forms (Landrine & Klonoff, 1996). Experiences of racism are conceptualized as culturally specific negative stressors (Landrine & Klonoff, 1996). The SRE was designed based on a stress framework and patterned after the two dominant approaches to assessment in stress research, assessing the frequency of experiences and the appraisal of events as stressful. The SRE scale assesses the frequency of experiences with racial discrimination as well as the appraisal of the events as stressful both over the course of one's lifetime as well as in the past year (recently). Respondents to the SRE are asked to respond to each item regarding frequency of the event over the past year, frequency over the lifetime and appraisal of stressfulness (Landrine & Klonoff, 1996). A sample item from the scale is, "How many times have you been treated unfairly by your employers, bosses and supervisors because you are Black?" Response categories include: never, once in awhile, sometimes, a lot, most of the time and almost all of the time (1 = not at all stressful to 6 = very stressful).

The scale was validated with a sample of 153 African American students, faculty, clerical and janitorial staff at a local University. The mean age of participants was 30.14 and annual incomes ranged from 0 - $80,000 with a mean of $21,451 (Landrine 1996). The SRE had a high internal consistency with alphas of .95, .95 and .94 for each of the subscales (recent racist discrimination, lifetime discrimination and appraisal) (Landrine & Klonoff, 1996). Concurrent validity was established as respondents who reported

greater frequency of experiences of racial discrimination reporting greater stress related symptoms and appraised events as more stressful (Landrine & Klonoff, 1996). Questions assess the frequency (never, once in a while, sometimes, a lot, most of the time, almost most of the time) of racist experiences in certain situations such as getting a job, from employers, police, etc.

Experiences of sexism. The Schedule of Sexist Events (SSE) is a 20 item scale developed by Klonoff and Landrine (1995) to assess the frequency and impact of experiences of sexism, described as sexist events in a variety of settings (Klonoff & Landrine, 1995). The SSE assesses the frequency of experiences of sexism across several domains both chronically, over one's lifetime and acutely, more recent experiences throughout the past year (Klonoff & Landrine, 1995). Experiences of sexism are conceptualized as gender specific, negative events that women experience solely because they are women (Klonoff & Landrine, 1995). A sample item from the scale is, "How many times have you been treated unfairly by your employers, bosses and supervisors because you are a woman?" (1 = never to 6= almost all of the time)

The scale was validated with a total sample of 631 women (294 college students and 337 women from the community). The college student sample was recruited from classes and sororities. The community sample was recruited from office buildings and the local airport (Klonoff & Landrine, 1995). Participants ranged in age from 18 to 73 (*M* = 32), were predominantly White (*n* = 403) as well as multiethnic (n = 228; Latina = 117; African American = 38; Asian American = 25; Other = 46) ,and had annual incomes that ranged between 0 and $400,000 (*M* = $34,058) (Klonoff & Landrine, 1995).

Results of the factor analysis revealed four factors: (1) sexist degradation and its consequences; (2) sexist discrimination in distant relationships; (3) sexism in close relationships (factors two and three were combined in the analyses for the women of color;and (4) sexist discrimination in the workplace (Klonoff & Landrine, 1995). The scales indicated a high internal consistency with Cronbach's alpha was .92 (SSE – lifetime) and, 90 (SSE – recent) (Klonoff & Landrine, 1995). A validity assessment was conducted by comparing the SSE to other well established previously validated scales measuring the frequency of general stressors (PERI-LES and the Hassles-F scales) (Klonoff & Landrine, 1995). This comparison indicated evidence of validity, as the SSE correlated to the PERI-LES and the Hassles –F (Klonoff & Landrine, 1995). The reliability and validity data support the utility of the Schedule of Sexist of Events. Reported limitations included that the SSE assesses the frequency of sexist events experienced and not the appraisal of the events as stressful (Klonoff & Landrine, 1995). Items assess the frequency (never, once in a while, sometimes, a lot, most of the time, almost most of the time) of specific sexist experiences (e.g. by employers, teachers or professors). Participants described the frequency of these experiences for the past year as well as their lifetime.

Objective SES. Measures used in other studies exploring relationships between objective SES and subjective social status (SSS) were used in this study (Adler, et al., 2000; Demakakos, et al., 2008). Three measures of SES were used.

Education was assessed as the highest level of education completed. Responses included: less than high school, high school or GED equivalency, some college/

vocational/ technical, college degree, master's degree and higher degree (doctorate, law degree, etc) (Adler, et al., 2000; Demakakos, et al., 2008; Watson, Scarcini, Klesges, Slawson, & Beech, 2002). Additional questions were included to ask about the highest educational level achieved by the participants' mother and father. Response options included those listed above as well as "don't know."

Both individual and household income was assessed in increments of $10,000 using from $9,999 or less to $100,001 or more (Operario, et al., 2004).

Occupation was assessed using the U.S. Census Bureau's (2002) occupation classification system. The response categories include: (1) professional, technical and related occupations; (2) executive, administrative and managerial occupations; (3) sales occupations; (4) administrative support occupations including clerical; (5) precision, production, craft and repair occupations; (6) machine operators, assemblers and inspectors; (7) transportation and material movers; (8) handlers, equipment cleaners, helpers, laborers; (9) and service occupations. Consistent with the approach utilized by Adler and colleagues (Adler, et al., 2000) women who were full-time students, homemakers or unemployed were not included in the occupation analyses.

Locus of Control. Locus of control was assessed by the commonly used Rotter (1966) 29 item Locus of Control scale. The scale was originally validated with a sample of 400 (200 males and 200 females) and an adequate internal consistency as well as 1 month test retest reliability and construct validity was found (Rotter, 1966). The scale is a forced choice scale and participants choose which one of two statements they agree

with most for each question. External items are scored and receive a point each. The scale also includes 6 filler items which are not scored. A low score indicates an internal locus of control and a high score indicates an external locus of control (Rotter, 1966). In the following sample item from the scale participants are asked to identify which statement they agree with most, “Many of the unhappy things in people’s lives are partly due to bad luck,” and “People’s misfortunes result from the mistakes they make.” (1=external, 2=internal)

Self Esteem. Self esteem was assessed with the commonly used 10 item Rosenberg (1965) Self Esteem Scale. The scale was originally developed and validated with a sample of 5000 adolescents but has been used frequently with adult populations (Rosenberg, 1965). The scale has a high reliability, test retest correlation, and a Cronbach’s alpha between 0.77-0.88 in several studies (Robinson & Shaver, 1973; Rosenberg, 1965). Research exploring the psychometric characteristics of the scale with Black women also indicates adequate internal consistency and reliability with a reported Cronbach’s alpha of 0.83 (Hatcher & Hall, 2009). A sample item is, “I feel that I have a number of good qualities.” Responses include a Likert scale (1 = strongly agree; 4 = strongly disagree). Scores range from 0-30 with a 30 representing the highest self esteem score (Robinson & Shaver, 1973; Rosenberg, 1965).

Data Analysis

Qualitative Phase

The focus group transcripts were stored and organized in ATLAS, ti, a qualitative research software program. Data analysis included data reduction, display and organization and drawing conclusions (Punch, 2004). Data reduction included coding and memoing (Punch, 2004). The analysis began with coding, that is the labeling of words or phrases in order to attach meaning (Punch, 2004). I coded the text in order to identify meaningful themes based on my research questions (Glaser & Strauss, 1967; Miles & Huberman, 1994; Punch, 2004). For example, themes such as self esteem, experiences of discrimination, and feelings of self worth were identified from the focus group discussions.

The analysis began with an initial list of codes (Apriori codes), such as discrimination in the healthcare system and SSS contributors, which were based on the research questions (Miles & Huberman, 1994). The transcripts were uploaded into ATLAS, ti and then read twice initially. Coding began during the second reading. Segments of text that were consistent with the initial codes, such as the examples provided above were coded as such. Additional codes were added based upon the additional text reviewed from the transcripts. The transcripts with the codes were read several times to confirm the identified codes. Memos were recorded as part of the analysis and included my initial ideas and thoughts about the codes and their relationships to one another, such as the relationship between discussions of the superwoman complex to experiences of racism and sexism. These memos were recorded as notes throughout the initial analysis of the text in ATLAS-ti.

The intersectional framework was used as an analytical framework. That is, categories that were constructed from the data were also assessed by considering how they were associated with racism and sexism. The data were analyzed by considering the social context in which it is embedded (Cuadraz & Uttal, 1999). That is, while participants may not have specifically identified experiences as racist or sexist, I coded phrases that I deemed to be rooted in racism or sexism as such. For example, experiences described by some of the Black women about the pressure they felt to wear their hair in a more European style (straightened/ relaxed) in order to be professional based upon comments that were made to them by a supervisor or coworker were coded as intersectional racism and sexism.

The last stage of the qualitative analysis included drawing conclusions about 1) the contributors to subjective social status in Black women 2) the role of racism and sexism in Black women' subjective social status and 3) the role of subjective social status in the health status of Black women.

Trustworthiness of Analysis

While the assessment of validity and reliability is an important component of all research, it is assessed differently in qualitative research as the goal of the research is different (Kirk & Miller, 1986; Lincoln & Guba, 1985). Rather than assessing the validity or reliability of a specific measure or existing reality of a relationship between two variables, qualitative researchers accept that there may be several existing realities (Kirk & Miller, 1986; Lincoln & Guba, 1985). Thus the goal in qualitative research is to assess

the trustworthiness of the analysis (Kirk & Miller, 1986; Lincoln & Guba, 1985). Merrick (1999) proposed three concepts in assessing the quality of qualitative research. These include trustworthiness, reflexivity and representation (Hartmann, Pelzel, & Abbott, 2011; Merrick, 1999). Trustworthiness is used to assess the credibility of the research (Merrick, 1999). Disclosure of the theoretical framework, intense and prolonged engagement with the data (which may include reviewing data multiple times), triangulation of the data (which enhances interpretation of data), and peer feedback are all components of establishing trustworthiness (Hartmann, et al., 2011; Merrick, 1999). Reflexivity calls for the researcher to acknowledge and reflect upon his/her background and how his/her background may have influenced the study and the analysis (Hartmann, et al., 2011; Merrick, 1999). Representation allows for consideration of how the individual participants of the study will be represented as study findings are disseminated as well as an acknowledgement that study findings incorporate both participant and investigators perspectives (Hartmann, et al., 2011; Merrick, 1999).

As the researcher, I disclose that I am a Black woman. This undoubtedly has shaped my interest in pursuing this research as well as the theoretical perspective that was utilized. The use of the theoretical framework of intersectionality is appropriate for this study as it originated in Black women's studies and provides a framework to acknowledge the role of multiple social inequalities that Black women may face. The mixed methods approach and triangulation of data enhances the credibility of the study findings (Hartmann, et al., 2011). I have also thoroughly studied the data and reviewed

the transcripts several times, which included both multiple readings of the transcripts as well as review and revision of the codes. My notes and memos were also reviewed and codes were further revised. The transcripts and codes were reviewed again prior to the interpretation of the data. In addition, the interpretation of findings was evaluated by ensuring that they were 'grounded' in the data (Merrick, 1999). Quotations were provided as examples of the comments made by participants representing the various themes that emerged from the focus groups. The reviews of themes, supporting quotations and my interpretations by my committee chair, an expert in intersectionality research, served as a peer debrief. The interpretation of the themes and the supporting quotations that were challenged were revised. Triangulation (use of quantitative & qualitative methodologies) was also used as a means to capture different aspects of the research question (Lincoln & Guba, 1985; Miles & Huberman, 1994). Lastly, a detailed description of study participants is provided for a better understanding of the context in which the study was conducted so that others can determine the applicability (transferability) of study findings (Hartmann, et al., 2011).

Quantitative Component

Specific Aim 1: Determine if SES indicators (education, income and occupation) are associated with SSS after adjusting for age.

Hypothesis 1 –Participants with higher levels of education and higher incomes will have higher SSS as compared with those with lower levels of education and income after adjusting for age. I hypothesized that occupational categories (census categories

described above) will not be correlated with SSS overall (as compared to income and education). Previous research with SSS has indicated that it's minimally correlated or not correlated at all with occupation (Adler, et al., 2000; Demakakos, et al., 2008) . Participants in professional, executive and managerial occupations (census occupational categories) may report higher SSS compared to those in other service and administrative related occupations.

Specific Aim 2: Determine if SES indicators (education, income, and occupation) are associated with self reported health status after adjusting for age.

Hypothesis 2 – Participants with higher levels of education and incomes will report better health status compared with those who have lower levels of education and income after adjusting for age. I hypothesized that occupational categories will not be significantly correlated with self report health status. Participants in professional, executive and managerial occupations may report better health status compared to those in other service and administrative related occupations.

Specific Aim 3: Determine if experiences of racism and sexism, locus of control and self esteem are associated with SSS after adjusting for SES indicators.

Hypothesis 3 –Participants who report fewer experiences of racism and sexism, a more internal locus of control and higher self esteem will report higher SSS compared with those who report greater experiences of racism and sexism, external locus of control and lower self esteem after adjusting for SES indicators.

Specific Aim 4: Determine if there is an interaction between Black women's experiences of racism and sexism and SSS.

Hypothesis 4-I hypothesized that there will be an interaction between experiences/perceptions of racism and sexism and SSS.

Specific Aim 5: Determine if SSS is associated with self reported health status.

Hypothesis 5 –Participants with higher SSS will report better health status compared to those with lower SSS.

Data Analysis

SPSS version 18 was used for the quantitative data analysis. A descriptive analysis of the demographic variables of interest (participant age, highest level of education achieved, parental highest level of education achieved, individual and household income, marital status, sexual orientation, employment status and occupation) was conducted. Statistics such as means and standard deviations were provided for key demographic variables as well as SSS and self reported health. A *p* value of <=.05 was used to determine statistical significance for all analyses.

Bivariate Analyses. Correlation analyses were used to determine the relationships between each SES variable (Education, Income, and Occupation) SSS and self reported health status. Correlation analyses were also used to determine the relationships between experiences of racism, sexism, locus of control, self esteem and SSS and self reported health status.

Multivariate Analysis. A general linear regression was used to determine the contributors to subjective social status and self reported health status (dependent variables). The independent variables included the three SES indicators, education, income and occupation, locus of control, self esteem, racism and sexism. A test for two way interaction between racism, sexism (independent variables) and SSS (dependent variable) was conducted as part of the regression model.

Integration of Qualitative & Quantitative Phases

As described above, the methods were integrated during the interpretation phase and are described below in the results section. The data gathered from both the qualitative and quantitative components were used to make conclusions about the study aims. The qualitative findings were compared to the quantitative findings for each aim. Specifically areas of similarities (where both the quantitative and qualitative results suggest the same conclusions) as well as areas of divergence (areas where the quantitative and qualitative results were contradictory) and “complementarity” (areas in which the qualitative component was used to better understand the quantitative component) were explored for each aim (Andrew & Halcomb, 2007). After these comparisons, the remaining qualitative findings were analyzed, adding to and providing an additional context for the study findings.

Chapter 4: Results

Quantitative Phase

Participants

A total of 160 Black women between the ages of 18 and 70 (*M* = 43.32, *SD* = 12.8) completed the survey. Table 2 below illustrates the highest level of education achieved by participants and their parents. Over 42% of participants reported some college/vocational or technical education as the highest level of education achieved. Participants' parents were most likely to have a high school diploma or GED equivalent (participant's mother – 32% and participant's father 30.2%) as their highest level of education received. Almost 20% of participants did not know the highest level of education achieved by their father.

Table 2. Highest level of education achieved by participants and their parents

Highest level of education	**Participant**	**Participant's Mother**	**Participant's Father**
Less than high school	0.6	21.4	23.3
HS graduate or GED equivalent	11.9	32.1	30.2
Some college/vocational/technical	42.5	25.8	18.9
College degree	24.4	11.3	5.7
Graduate degree	1.3	1.3	.6
Graduate degree - masters	15.6	2.5	1.3
Graduate degree – doctorate, law, etc.	3.8	1.3	1.3
Don't know		4.4	18.9

Table 3 illustrates the marital status and sexual orientation of participants. Most of the participants were either single/never married (41.5%) or married (37.1%) and most (97.3%) reported that they were heterosexual.

Table 3. Marital Status and Sexual Orientation

Marital Status		**Sexual Orientation**	
Single/never married	41.5	Straight/heterosexual	97.3
Married	37.1	Lesbian	0.7
Living with Significant Other	1.3	Bisexual	2.0
Separated/Divorced	15.7		
Widowed	2.5		
Other	1.9		

Table 4 displays the employment and occupation characteristics of the participants. Most (88.5%) of the women were employed. The nine occupational categories that were assessed were collapsed into 4 categories based on the distribution. The most commonly reported occupation was sales/administrative support (41.5%).

Table 4. Employment and Occupation

Employment status		**Occupation**	
Employed	88.5	Executive/managerial/professional, technical and related	36.6
Unemployed	9.0	Sales/Administrative Support	41.5
Homemaker	.6	Precision/machine/transportation	4.9
Retired	1.9	Service/military	16.9

Table 5 displays the annual individual and household income of participants. The majority of the participants (64.3%) reported an annual income between $20,000 - $60,000 with almost 6% reporting an annual income of $100,000 or more. Participants' annual household income was similarly represented within the various income categories ranging between $20,000 - $100,000 with 18% reporting an annual income of more than $100,000. Annual individual income and annual household income were positively correlated (r=.72, p<.001).

Table 5. Annual Individual and Household Income

	% Annual Income	**% Annual Household Income**
$9999 or less	10.4	7.2
$10,000-20,000	6.5	5.8
$20,001 - 30,000	14.9	8.7
$30,001 - 40,000	15.6	8.7
$40,001 - 50,000	18.2	10.1
$50,001 - 60,000	15.6	8.7
$60,001 - 70,000	7.1	10.9
$70,001 - 80,000	4.5	8.0
80,001 - 90,000	0.6	7.2
$90,001 - 100,000	0.6	6.5
$100,001+	5.8	18.1

Study Variables

Health Status

General health status was measured using the SF36 (Ware & Sherbourne, 1992). The domains analyzed included: physical functioning, role limitations because of physical health, physical pain, social functioning, mental health, role limitations due to

emotional distress, energy/fatigue and general health. The original scores are recoded and domains are scored on a scale from 0 -100, with higher scores reflecting better perceptions of personal health status. The mean score for each domain is displayed in Table 6. Overall, participants reported a high personal health status, specifically regarding physical functioning, role limitations due to physical functioning, role limitations due to emotional problems, social functioning and pain. However, there was a large standard deviation (36.19) for role limitations due to emotional problems indicating a large range of responses. Participants rated themselves more poorly regarding energy and fatigue, emotional wellbeing and perceptions of general health.

Table 6. Health Status as Assessed by SF 36 Domains

	Physical Functioning	Role Limitations due Physical	Role Limitations Emotional Problems	Energy & Fatigue	Emotional Wellbeing	Social Functioning	Pain	General Health
Mean	86.24	87.53	80.08	60.59	78.21	86.32	82.23	73.44
Std. Deviation	19.15	26.99	36.19	18.516	17.85	21.04	19.56	15.93
Minimum	20.00	0	0	0	0	0	10.00	15.00
Maximum	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

In addition to the health domains of the SF-36, an additional item on long standing illness or disability was used. Over a third of participants (33%) reported having a long standing illness, disability, or infirmity.

Experiences with Racism

Of the 160 women participants, 4.4% (n=7), reported never experiencing a racist event in their lifetime. Most women (95.6%) reported experiencing a racist event at

least once in their lifetime. The most common racist events experienced at least once included being treated unfairly by people in service jobs (87.9%) and strangers (88.1%), wanting to tell someone off for being racist (82.9%) and feeling really angry about something racist (81.6%). Over 70% of the participants also reported being treated unfairly by teachers/professors (70.4%), employers (74.8), colleagues (76.1%) and institutions (70.9%). About 2 in 5 participants reported (44.6%) reported being made fun of or harmed (picked on, pushed, shoved, hit, threatened) in some way because of being Black. Most women (62%) reported that their life would be different if they had not experienced racism.

With respect to the past year, of the 160 women participants, only 17% (n=27) reported not experiencing any racist events. Most women (83%) reported experiencing some type of racist event at least once in the past year. The most common racist events experienced at least once in the previous year included being treated unfairly by strangers (71.5%) and people in service jobs (64.1%). About 2 in 5 women (41.8%) reported that their life would be different if they had not experienced racism in the previous year.

There were no statistically significant age differences observed in racist experiences. There was a positive correlation between lifetime racist events and highest level of education received, with women with higher educational achievement reporting more racist events ($r = .269$, $p = .001$). However, there was no significant association between recent racist events and highest level of education received. There

were no significant income differences in lifetime or recent racist experiences. There were also no differences between occupation and recent racist experiences. There was a negative correlation between lifetime racist events and occupation (r = -.192, p =.022), with more racist events reported in women with higher status occupations.

Experiences with Sexism

Of the 160 women participants, 2.5% (n=4), reported never experiencing a sexist event in their lifetime. Most women (97.5%) reported experiencing a sexist event at least once in their lifetime. The most common sexist events experienced at least once included sexist jokes (85.3%), inappropriate or unwanted sexual advances (81.1), not receiving the respect deserved due to sexism (80.5) and wanting to tell someone off for beings sexist (80.5%). Over half of the women reported being treated unfairly by a teacher, employer, colleagues, people in service jobs, people in helping jobs, boyfriends and husbands and even strangers because of sexism in their lifetime. Almost half of women (49.7%) reported being harmed in some way (picked on, hit, shoved or threatened with harm) because of being a woman. Most women (53%) reported that their life would be different if they had not experienced sexism.

Of the 160 women participants, 9.4% (n=15) reported not experiencing any sexist events in the past year. Most women (90.6%) reported experiencing some type of sexist event at least once in the past year. The most common sexist events experienced at least once in the previous year included sexist jokes (66.7%), being treated unfairly by people in service jobs (64.1%) and not receiving the respect deserved due to sexism

(62.2%). Over half of women also reported being treated unfairly by strangers (55.7%), inappropriate or unwanted sexual advances (57.3%), wanting to tell someone off for being sexist (58.7%) in the past year. Slightly more than a third of women (35.2%) reported that their life would be different if they had not experienced sexism in the previous year.

The frequency of sexist events experienced by women both throughout their lifetime and in the past year suggests that experiences of sexism are common. Specific types of sexist events such as being the brunt of sexist jokes or not being respected are more common than others. There were no statistically significant age differences observed in sexist experiences as was reported in the original validation study by Klonoff and Landrine (1995). There were also no significant income and education differences observed in sexist experiences. This is also consistent with the findings reported by Klonoff and Landrine (1995). There was a negative correlation (r = -.266, p = .001) between lifetime sexist events and occupation, with more sexist events reported by women in higher status occupations.

SSS

Individual SSS (i.e. status in relationship to others in society) and community SSS (i.e. status in relationship to others in your community) were assessed. Participants ranked themselves on a 10 rung ladder. The mean for individual SSS was 6.39 with a standard deviation of 1.721 (minimum ranking was 1 and maximum ranking was 10). The mean for community SSS was 6.71 with a standard deviation of 1.862 (minimum

ranking was 1 and maximum ranking was 10). SSS was positively correlated with income, with community SSS being most strongly correlated with individual income (*r* = .344, *p*<.001).

Self Esteem

The Rosenberg Self Esteem scale (Rosenberg, 1965) was used to assess participant self esteem. The scale scores range from 0-30 with scores of 15 – 25 within a normal range. The mean self esteem score for participants was 25.6 (SD = 4.66), indicating that most participants have a normal or high self esteem. Only 2.5% (n = 4) of participants had a low self esteem based on this scale. While, there was a statistically significant association between self esteem, income (individual *r* = .25, *p* = .002, household *r* = .28, *p* = .001) and occupation (*r* = -.21, *p* = .013) in the bivariate analysis, none of these associations remained significant in the multivariate analysis.

Locus of Control

Locus of control was assessed using Rotter's Locus of Control Scale (Rotter, 1966). Scale scores range from 0- 13, with low scores representing an internal locus of control and high scores indicating an external locus of control (M = 6.86, SD = 2.69). Forty percent (n = 64) of participants scored a 6 or below, indicating an internal locus of control and 59.7% (n = 95) of participants scored a 7 or above, indicating an external locus of control. There were no statistically significant associations between locus of control and age, education, income, or occupation.

Study Aims

Aim 1. Determine if SES indicators are associated with SSS.

I hypothesized that participants with higher levels of education and income would have higher SSS compared with those with lower levels of education and income. I also hypothesized that occupation would not be correlated with SSS.

Bivariate Analysis - Table 9 (page 87) illustrates the statistically significant correlations between the SES indicators (income, education and occupation) and both individual and community SSS. Income and education were positively correlated with SSS (individual and community), offering initial support for my hypothesis, with individuals with higher income and education reporting higher SSS. As I hypothesized, occupation was not correlated with SSS ranking. There was no association between SSS (individual or community) and age or marital status. There were positive correlations between age and annual income ($r = .25$, $p = .002$) as well as household income ($r = .21$, $p = .014$). There were also positive correlations between education and annual income ($r = .42$, $p < .001$) and household income ($r = .37$, $p < .001$).

Multivariate Analysis - Individual & Community SSS – A linear regression was conducted with annual income, household income and education (variables that were statistically significant from the bivariate analysis as described above). The model with the best fit for individual SSS included household income and education, adjusting for age. The results of the regression indicated that only one predictor explained 10% of the

variance (R = .321, R^2=.10, $F(3,131) = 5.03$, $p = .002$). Only annual household income predicted individual SSS (β= .205, p =.029).

The model with the best fit for community SSS included individual and household income and education, adjusting for age. The results of the regression indicated that only one predictor explained 19% of the variance (R=.43, R^2=.19, $F(4,128)$, p=.000). Only education significantly predicted community SSS (β= .210, p=.023). Thus, my hypothesis was partially supported by these findings. Household income is associated with individual SSS and education is associated with community SSS.

*Aim 2. D*etermine if SES indicators are associated with self reported health status.

I hypothesized that participants with higher levels of education and income would report better health status compared to those with lower education and income. I also hypothesized that occupation would not be correlated with self reported health status.

Bivariate Analysis - A correlation analysis was used to determine the relationships between each SES variable (Education, Income, and Occupation) and self reported health status (SF36 general health scale). Table 9 (page 87) includes the correlation coefficients for general health status, education, income, household income and occupation. General health status was significantly correlated with household income (r=.197, p=.021). This offers preliminary partial support for my hypothesis that

both education and income would be correlated with general health status. As hypothesized, occupation was not correlated with health status. In additional analyses of the other SF-36 subscales, education was positively correlated with physical functioning (r=.219, p=.006). Household income was positively correlated with physical functioning (r=.214, p=.012), energy and fatigue (r=.212, p=.013), emotional well being (r=.205, p=.016). These findings suggest that while education was not positively correlated with general health status, there are other health components such as physical functioning that education is correlated with. Income is correlated with several components of health status.

Multivariate Analysis – The results of the linear regression indicated that household income was not significantly correlated to general health after adjusting for age (R=.24. R^2=.056, F=(2,133) = 3.98), β= .16, p=.07). These results indicate that my hypothesis, that income and education was positively correlated with general health status, was not supported.

Aim 3. Determine if experiences of racism, sexism, locus of control and self esteem are associated with SSS.

I hypothesized that participants who report fewer experiences of racism and sexism, a more internal locus of control and higher self esteem will report higher SSS compared with those who report greater experiences of racism and sexism, external locus of control and lower self esteem.

Bivariate Analysis - Correlation analysis was used to determine the relationships between experiences of racism, sexism, locus of control, self esteem and SSS and is reported in table 9 (page 87). Self esteem was positively correlated with individual SSS (r=.174, p=.03) and community SSS (r=.218, p=.006) with individuals reporting a higher self esteem also ranking themselves higher in SSS, preliminarily supporting my hypothesis. Recent (in past year) sexism (r=-.179, p=.026) and racism (r=-.210, p=.009) were negatively correlated with individual SSS and community SSS (sexism (r=-.195, p=.015) and racism (r=-.196, p=.015). Individuals with a higher SSS reported lower rates of recent racism and sexism, also preliminarily indicating support for my hypothesis. Lifetime racism and sexism was not correlated with individual or community SSS. Locus of control was only significantly correlated with community SSS (r=.24, p=.003), with individuals with a higher community SSS reporting an external locus of control. This finding does not support my hypothesis that internal locus of control would be positively correlated with SSS.

Statistically significant bivariate correlations (self esteem, sexism in past year, racism in past year) were included in a linear regression model for individual SSS. The results of the regression indicated that only one predictor explained 7% of the variance (R=.267, R^2= .071, F(3,151) = 3.86, p=.011). Only self esteem (β= .158, p=.047) predicted individual SSS. The model was then run adjusting for the SES variables (income – household and individual-run together and in separate models, education and occupation). The model with the best fit included recent racism, education, household

income, and occupation. The results of the regression indicated that three predictors explained 18% of the variance (R=.43, R^2=.18, F (6,117) = 4.38) for individual SSS. Recent racism (β= -.24, p=.042), education (β= .18, p=.045) and household income (β=.24, p=.023). The results of the regression analysis for community SSS indicated that four predictors explained 30% of the variance (R=.55, R^2=.30, F(7,116) = 7.043, *p*=.000). Self esteem (β=.18, p=.029), education (β=.28, p=.001), household income (β = .24, p=.013) and recent racist events (β = -.21 and p=.058). This partially supports my hypothesis that self esteem and racism were associated with SSS. My hypothesis that locus of control and sexism was associated with SSS was not supported.

Aim 4. Determine if there is an interaction between Black women's experiences of racism, sexism and SSS.

I hypothesized that there would be an interaction between experiences/ perceptions of racism and sexism and SSS.

Correlation analysis was used to determine the relationships between racism, sexism and SSS. Experiences of recent racism and sexism were significantly correlated with individual SSS (recent racism (r=-.21, p =.009) and sexism (*r* =-.18, *p*=.026) and community SSS (racism *r*=-.196, *p*=.015) and sexism (*r* =-.195, *p*=.015).

Multivariate Analysis. A test for two way interaction between racism, sexism (independent variables) and SSS (dependent variable) was conducted as part of the regression model. An interaction variable was created based on the score means and

included in a linear regression. In order to center the means, a variable was created that subtracted each individual score from the mean. The two variables were then multiplied. The regression indicated that there is an interaction between recent sexism and racism events for both individual ($\beta = -.414$, $p=.002$) and community ($\beta=-.322$, $p=.017$) SSS, supporting my hypothesis that there would be an interaction between experiences/perceptions of racism and sexism and SSS. Participants who reported high rates of both sexism and racism reported the lowest SSS.

Table 7. Mean Individual SSS by Racism (high/low) and Sexism (high/low)

	Recent Sexism High	Recent Sexism Low
Recent Racism High	3.0	6.7
Recent Racism Low	6.0	6.4

Table 8. Mean Community SSS by Racism (high/low) and Sexism (high/low)

	Recent Sexism High	Recent Sexism Low
Recent Racism High	4.0	7.7
Recent Racism Low	6.0	6.7

Figure 1. Interaction between Racism, Sexism and Individual SSS

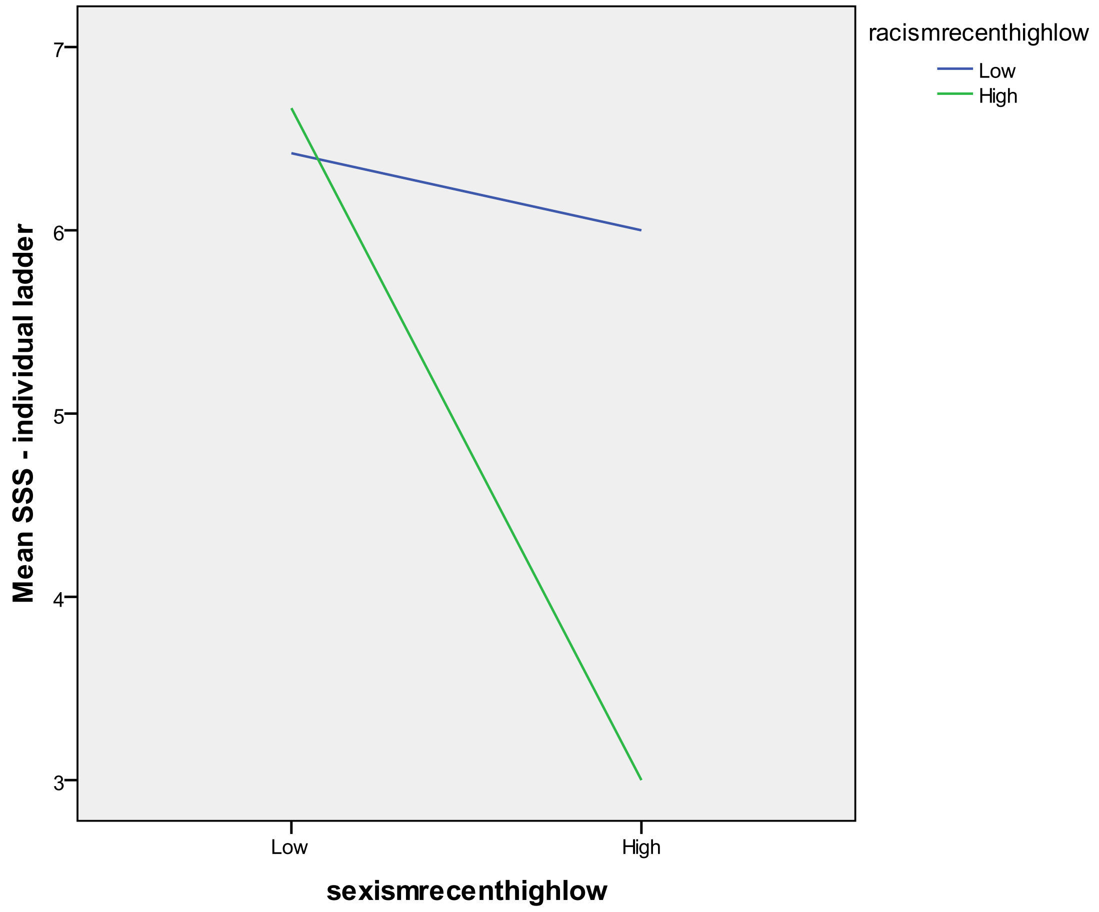
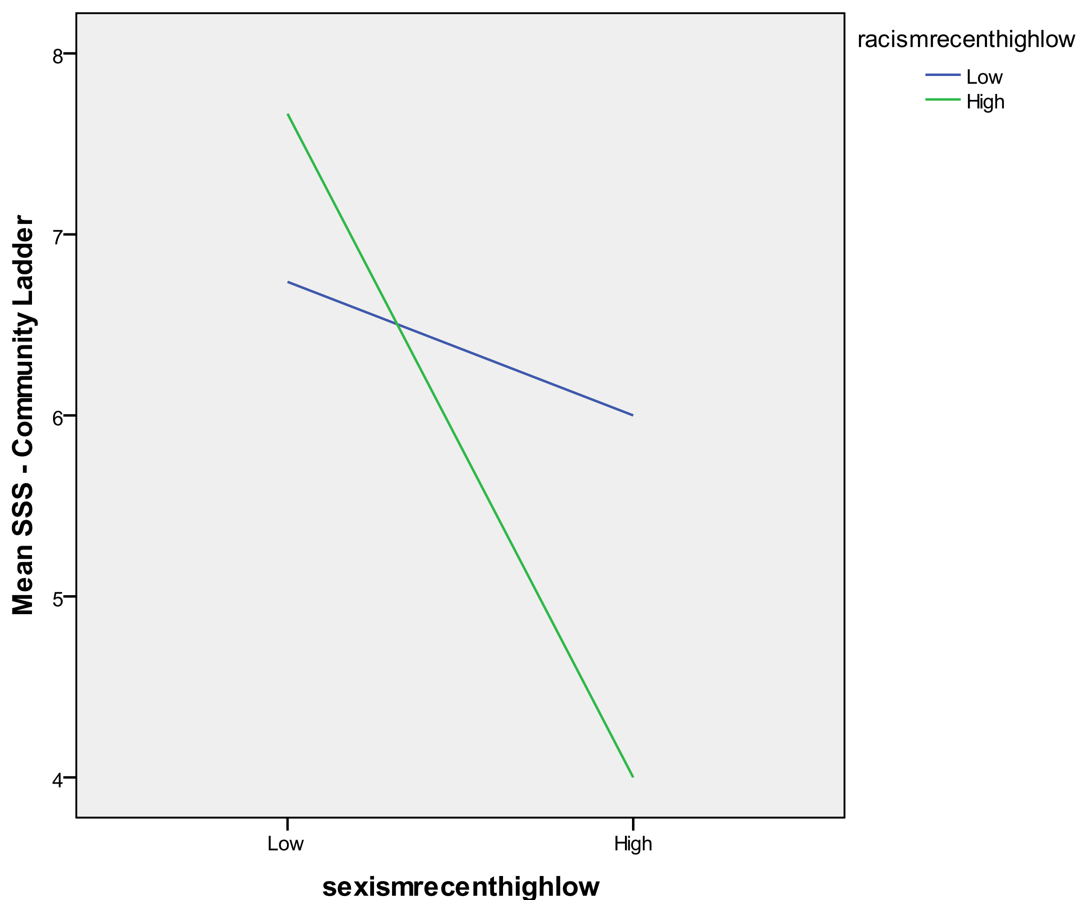


Figure 2. Interaction between Racism, Sexism and Community SSS



Aim 5, determine if SSS is associated with self reported health status.

I hypothesized that participants with higher SSS would report better health status compared to those with lower SSS.

Correlation analysis was used to determine the relationship between self reported health status and SSS. All health status domains were positively correlated with individual and community SSS (Table 10), supporting my hypothesis that SSS would be

positively correlated with self reported health status. Participants with higher SSS reported a higher health status according to the represented domains.

Table 9. Correlation Matrix with Study Variables

	occupation	Income	Household Income	Education	SSS - individual	SSS - Community	General Health	LOC	Self Esteem	Sexism Life	Sexism Yr	Racism Life
Occupation												
Income	-.35**											
Household Income	-.39**	.73**										
Education	-.10	.42**	.37**									
SSS - individual	.04	.25**	.28**	.20*								
SSS - Community	-.07	.34**	.33**	.32**	.73**							
General Health	.00	.12	.20*	.14	.25**	.27**						
Locus of Control	.09	.14	.14	.12	.13	.24**	.25**					
Self Esteem	-.21*	.25**	.28**	.01	.17*	.22**	.22**	.05				
Sexism Life	-.26**	.15	.14	.19*	-.08	-.10	-.06	-.08	-.02			
Sexism Yr	-.15	.00	.02	.03	-.18*	-.20*	-.06	-.19*	-.11	.75**		
Racism Life	-.17*	.23**	.26**	.27**	-.09	-.03	.01	-.11	.03	.72**	.54**	
Racism Yr	-.11	.10	.17*	.12	-.21**	-.20*	.01	-.19*	-.07	.51**	.66**	.73**

Note. *p<.05, **p<.01

Table 10. Correlation Coefficients for Individual and Community SSS and Self Reported Health Status (SF36 Subscales)

	SSS - individual	SSS - Community	Physical Functioning	Role Limitations Physical	Role Limitations Emotional	Energy/ Fatigue	Emotional Wellbeing	Social Functioning	Pain
SSS - individual ladder									
SSS - Community Ladder	.73**								
Physical Functioning	.27**	.34**							
Role Limitations - Physical	.26**	.30**	.32**						
Role Limitations - Emotional	.18*	.21**	.17*	.55**					
Energy/Fatigue	.28**	.32**	.23**	.39**	.43**				
Emotional Wellbeing	.31**	.34**	.16*	.31**	.54**	.65**			
Social Functioning	.24**	.30**	.27**	.52**	.64**	.54**	.65**		
Pain	.16	.30**	.48**	.57**	.37**	.40**	.23**	.43**	
General Health	.25**	.27**	.29**	.22**	.18*	.41**	.26**	.35**	.30**

Note. *p<.05, **p<.01

Table 11. Summary of study aims and support for hypotheses

Study Aim	Study Hypothesis	Supported Hypotheses	Unsupported Hypothesis
1	• Participants with higher levels of education and higher income will have higher SSS compared to those with lower education and income • Occupation will not be correlated with SSS overall	• Annual household income predicted individual SSS • Education predicted community SSS • Occupation was not correlated with SSS	• Individual income did not predict individual SSS • Education did not predict individual SSS • Neither individual or household income predicted community SSS
2	• Participants with higher education and incomes will report better health status compared with those who have lower education and income • Occupation will not be correlated with self reported health status	• Occupation was not correlated with self reported health status	• Income (household and individual) and education was not correlated with self reported health status
3	• Participants who report less racism and sexism, internal locus of control and higher self esteem will report higher SSS compared to those who report greater experiences of racism and sexism, external locus of control and lower self esteem	• Recent racism, education and household income predicted individual SSS • Self esteem, education, household income and recent racism predicted community SSS	• Locus of control and sexism was not associated with SSS • Self esteem was not associated with individual SSS
4	• There will be an interaction between experiences of racism and sexism and SSS	• There is an interaction between recent racism and sexism for both individual and community SSS	

Study Aim	Study Hypothesis	Supported Hypotheses	Unsupported Hypothesis
5	• Participants with higher SSS will report better health status compared to those with lower SSS	• Participants with higher SSS reported higher health status	

Qualitative Phase

Participants

Forty three Black women participated in 6 focus groups (average of 7 women per group). The ages of the women ranged from 22 to 64 years old (M = 40.65, SD = 11.6). Over 40% of participants had a college degree; 30% reported a master's degree; and 7% reported a terminal degree. Participants' were most likely to report their parents with a high school diploma or GED equivalent (participant's mother – 35% and participant's father 30.8%) as their highest level of education received. Almost 15% of participants did not know the highest level of education achieved by their father. The annual income reported by most (67.5%) women was between $30,000 - $70,000, with 13% reporting an income of $100,000 or more. The household income reported by most (63.7%) women was between $30,000 - $90,000, with 30% reporting an income of $100,000 or more. The nine assessed occupational categories were collapsed into 4 categories based on the status associated with each (census). The most commonly reported occupation was executive, managerial and professional (63.9%). There were equal numbers of participants who were single (43.6%) and married (43.6%) and all of the women reported that they were heterosexual.

The aims of the focus groups were to determine: 1) what factors are associated with SSS; 2) what factors are associated with self reported health status; 3) how experiences of racism and sexism influence SSS; 4) how traditional SES indicators are related to SSS; and 5) how SSS is related to self reported health in Black women (The

complete focus group guide is included in Appendix 2). There were several themes that emerged from the data regarding the study aims. Major themes included 1) the intersectional nature of experiences of racism and sexism; 2) experiences of racism and sexism as a stressor; 3) experiences of discrimination based on intersectional racism and sexism in healthcare; 4) the role of intersectional racism and sexism in the Superwoman complex; 5) the generational legacy of discrimination; 6) intersectional racism and sexism and Black women's hair; 7) perceptions of locus of control; and 8) perceptions of contributors to and ranking of subjective social status. Overall, women in the lower and higher income groups discussed similar experiences and perceptions regarding the topics discussed with few differences.

Intersectional Nature of Experiences of Racism and Sexism

Women described experiences and perceptions of both racism and sexism. In particular women commented on the sexism women experience in jobs. One woman in a lower income group stated,

> "it's bad enough that you have to compete for a job where your skill set is concerned or your education is concerned … but then when it comes to discrimination you're competing not (only) with the other things but then you have to compete where a male is concerned."

Another woman from the same group described sexism in the workplace through the different pay received by men and women. She stated, "We don't get paid as much as our counter-parts do (referring to men) even if we have the higher education."

Women also commented on the racism that Black women experience. For example, in describing institutional racism a woman in a lower income group stated, “I think we’re slighted because we don’t have the proper facilities like, supermarkets. We have more corner stores and variety stores around in our areas (referring to predominately Black areas). We have more fast food restaurants in our areas.” Another woman in the same group stated, “in the markets that we do have in a lot of our neighborhoods, the merchandise is totally different (referring to more unhealthy foods). Another woman continued by adding, “and sometimes, even if it’s the same thing as the other neighborhoods… they’re not as fresh.”

Women also described experiences of racism and sexism continuously. Referring to not being hired for a specific job, one woman from a lower income group commented, “Maybe the person who is hiring you is someone who is petite, has long hair and she doesn’t like someone who is a dark complexion.” Another woman from a low income group commented, “being in the African American culture we are discriminated against as well as because we are women.” A woman in a higher income group, referring to Black women being stereotyped and discriminated against by healthcare providers commented,

> “I mean, every time I go to the doctor, I freak them out ‘cause I don’t have high blood pressure. It’s automatically assumed I have high blood pressure ‘cause I’m an African American female, overweight and all that kind of stuff. But, I don’t

have high blood pressure. So, they discriminate as soon as you walk in the door. Automatic assumptions are made of you."

Participants in these examples connected their perceptions and experiences to being a Black woman, rather than to being Black (racism) or being a woman (sexism) individually.

There are several ways in which the intersectional experiences of Black women were described by the participants. Black women experience both racism and sexism and are not able to separate them from one another. The women discussed the unique experience of Black women in this country due to this intersectionality. One woman in a lower income group discussed that experiences of racism and sexism cannot be isolated from one another. She stated, "You don't know if its discrimination because of racism, sexism or classism… All three play a role."

Although many women did acknowledge the intersectional nature of experiences of racism and sexism for Black women, some shared a double jeopardy perspective as well, that Black women will have increased experiences of discrimination based on belonging to multiple lower status groups, minority status (being Black) and gender (being a woman). For example, one woman in a lower income group described, "Black women face it on two fronts. You know, the fact that you're Black, you're the minority and the fact that you're a female; that adds a distress."

The women in both the lower income and higher income groups discussed the notion of the fight they are in because they are Black women. Women described their perceptions that they are in a fight against systems of inequality based on racism and sexism that influence them as Black women. This discussion centered on experiences of racism and sexism mainly and how Black women have to fight, specifically in the work place, to prove they are good enough and that they belong on a certain level of achievement. The women connected this fight to the intersectional experience of Black women and felt that it influences Black women's health care practices. One woman in the higher income group stated,

> "You're doing the fight every day. You don't have time to go to the doctor. Like I know in my environment, where I'm the only you know, I never take days off. I never take days off because I have to show I can do the job."

The women also described the added stress and pressure that they feel to achieve and to specifically be the first Black woman to achieve a certain level or position (e.g. first Black woman superintendent in a specific township). A higher income woman commented, "There's an extra tax that it takes to be the first… you know when you get in there (the position), the tax of achieving that level is, you represent the race. And I definitely feel that too being the only Black female." Several women in the higher income groups discussed paying the tax and the added pressure to succeed and prove oneself to employers as a Black woman. Because of racism and sexism as well as the unique history and experience of Black women, they described being in a constant fight

to show their worth and validate their occupational position as well as intolerance by employers or supervisors to any mistakes they may make. One woman in a higher income group commented,

> "With the fight, you know, the job is intense within itself, but … you do have the stressor of having to go in and prove yourself or having to go in and make sure everybody knows that you know how to do the job just as much as they do."

Intersectional Discrimination as a Stressor

Intersectional experiences of both racism and sexism in Black women were specifically discussed as an added stressor in 5 of the 6 focus groups (i.e. both the low and higher income groups). The lower and higher income women discussed how different racist and sexist experiences especially in the workplace contributed to their stress. Some women in both the lower and higher income groups described discriminatory experiences that created hostile work environments that were very stressful and directly influenced their health. In particular one woman in a lower income group discussed a hostile work environment due to her being a Black woman that caused some of her health issues. When she left the hostile work environment, her health issues subsided and her status improved to the status she had prior to that experience. She explained,

> "Now, over the course of time because of the stress of that situation, my health did begin to deteriorate in fact where I was in the hospital for a month with fevers that they never found out what the issue was. It was all stress related… So it plays a major part in a woman's stress level and your health."

The women in both the lower and higher income groups linked the sexism and racism experienced by Black women to increased stress which they in turn connected to poor health practices, including overeating and substance abuse as well as overall physical and mental health. “Stress and coping lead to poor health practices, i.e. eating practices… So we put on weight.” One woman in a lower income group remarked, “I think as Black women, we may internalize that stress and may not seek the right help. That definitely correlates to our health.” Another woman in a lower income group remarked, “Discrimination and stress also influence our mental health.” She commented, “A lot of us are depressed and don’t even know it.” Lastly, the women described the added stress felt because of stereotypes around health.

> “I think we’re often stereotyped. Because a lot of the Black population… we all seem to have high blood pressure… diabetes, heart disease, so we always stressed about keeping up with our weight and numbers and things of that nature. So, I think it can be stressful because of that.

Intersectionality & Black Women’s Access to Care

There were several characteristics that seemed to be associated with Black women’s healthcare practices including perceptions and experiences of racism, distrust of the medical system, lack of a diverse workforce and insensitivity of healthcare providers. Barriers to accessing healthcare included feelings that health care providers treat Black women differently from White women and White and Black men. The women in both the higher and lower income groups discussed this sentiment. One

woman in the lower income groups stated, “It causes Afro-American women not to go to the doctor because sometimes they feel as though they don’t get the same treatment or that their healthcare provider is not a good health care provider.” Previous experiences with the health care system also seemed to influence health care practices. While, women in all of the groups (lower and higher income) provided examples of negative healthcare experiences some articulated how these experiences negatively influenced future healthcare practices, while others discussed how they have advocated for themselves expressing needs or switching providers. For example, one woman in a lower income group remarked, “We let, you know, like one bad thing happen and I ain’t ever going again.” Another woman commented:

> Even if I don’t have any questions, I’ll think of something because I want her to know, I’m paying you. This is your job. If I’m telling you that something is wrong with me then you need to check it out and check everything out.

A few of the women in one of the lower income groups also referenced a historical legacy of discrimination in the medical system. Distrust seems to influence interactions with healthcare providers as well as the healthcare system overall. “We have distrust so, if you jacked us up at one time, we’re done with the system.” Lastly, overall perceptions of discrimination in the workplace were also associated with Black women’s decisions to access care. Due to racism and sexism, some of the black women in both of the higher income groups stated that they have to be better than others at work and connected this with decisions to take time off from work in order to access care. One woman in a higher income group described:

> I feel like I should have gone to the doctor two days ago. But I can't because I haven't felt like I've had the means to be able to take the time off from my job because I mean, I am a first year attorney, but I'm also Black. So I know that my slip ups count more than other people. I mean there's just always an eye out.

This example illustrates how one Black woman's pressures as a first year attorney due to perceptions of discrimination are associated with her decision to access to care.

Intersectionality and Black Women's experiences with Discrimination in Healthcare

Women in all of the groups felt that Black women receive a poorer quality of health care because of intersectional experiences of racism and sexism. Discrimination influences quality of care, health care provider bias, stereotyping and assumptions made by healthcare providers about Black female patients. Several women described experiences where they were treated poorly by health care providers. Many of the women attributed this to being a Black woman and provided examples of experiences where they perceived that they were treated poorly because of their intersectional experiences of racism and sexism. For instance, one woman in one of the lower income groups stated, "it was a perception, when I walked in the door. I'm in the package I'm in. They see that and they think that they can do anything or treat me any way." Another woman in one of the higher income groups stated, "The people who provide care also think that's the kind of care we deserve, horrible, substandard care and we don't advocate for ourselves."

Some of the women in the higher income groups discussed their perceptions that intersectional experiences of racism and sexism are associated with how Black women are viewed by some healthcare providers and the quality of care received. Two of the women in the higher income groups who worked in health care shared that they had experienced numerous instances where health care providers they worked with provided a different standard of care for Black women compared to White women. A health care provider shared:

> I think for me, one of the things in being a physician what I find is that African American women, in particular, are kind of just viewed as sexual beings. So much of the healthcare for us is solely focused on their reproductive system and as a physician I find myself struggling to make sure that people understand that there's more to us than that.

Racism, Sexism, the Superwoman Complex and Black Women's Health

The role of the superwoman complex in Black women as a contributor to health status was discussed in all of the groups. The superwoman complex was created in part as a result of intersectional experiences of sexism and racism, and describes the pressure for Black women to successfully meet multiple demands and excel in multiple roles simultaneously (Woods-Giscombe, 2010). Respondents discussed this theme from a historical context in which Black women were forced to be superwomen because of the racism experienced by Black men which limited their role in the family. Many women expressed their perceptions of the superwoman complex as it related to

overextending one's self in order to provide for their family and meet multiple needs. One woman in a lower income group described:

> We walk around with the 'S' on our chest and it's from generation to generation that you feel like you've got to take care of the house, take care of the cleaning, the work, the kids, the school, do this, do that and that's from generation to generation

While, the women acknowledged that all women have multiple roles and responsibilities in our society that can lead to a feeling of superwoman, they felt that this was more exaggerated for Black women because of its association with racism and sexism. For instance, one woman in a lower income group commented, "We've lost some of our culture, a lot of it. Basically what we have is just some traditions and that 'S' (referring to superwoman) on the chest or how we're perceived." Some of the women in the groups discussed how Black women identify with and are perceived by men and other White women because of the superwoman complex (wearing the S on their chest). The historical legacy of racism in this country seemed to influence perceptions of a "lost culture" so that now some Black women have traditions that they hold on to such as the superwoman complex.

Many women described the superwoman complex as playing a major role in the health and health care practices of Black women. As a result of feeling like Black women have to do it all, they are often overwhelmed by their responsibilities and consequently neglect their health, delay care and may use coping strategies that put them at risk for

health issues. Several women described how this perception is detrimental to the health of Black women and leads them to delay care and ignore signs and symptoms of serious health issues.

> As Black women, we should be going to preventive health, going to get your yearly exams… but we keep telling ourselves, "we don't got time to get sick." We can't get sick because we're basically saying, you're not important. Everything else around you is important but you're not important.

Some of the women linked the superwoman complex and neglect of health to poor self worth and not feeling important. The women described how the superwoman complex contributes to Black women feeling like it is difficult for them to advocate for themselves because self advocacy would be a sign of weakness, "to admit that you can't do it all". Some of the women in the groups discussed how this internal conflict felt by some Black women is a contributor to poor health outcomes. Lastly, some Black women described being ostracized for attempts to advocate for themselves. For instance, one woman in a general group described:

> I almost find when a woman prioritizes herself she's ostracized almost. You know because she goes to the doctor. She tries to take care of herself. I think those things help her to be a better mother and care provider. But you know somehow that's almost as though it's selfish. I always think that's really unfortunate.

Intersectionality & Generational Legacy of Discrimination

Several women described the role of health and health care practices that have been passed down from generation to generation of Black women. While, some of the

women admittedly have not had overt experiences of discrimination, they still were adopting the practices and messages of the mothers and grandmothers who may have had those experiences. They described how their mothers' perspectives on health care had influenced their own health care practices. For instance, one woman in a lower income group stated:

> A lot of it can be passed down from our mothers who may have experienced that type of discrimination. Like …I've never been in that situation, but my mother, she's experienced some type of discrimination, doesn't seek preventive care in certain neighborhoods. Or she'll just tell me, "Don't go to these areas or these doctors are like this and avoid this type of care." It definitely has an impact on just my outlook on the medical field and seeking care.

Intersectionality and Black Hair

The issue of hair was also discussed as a contributor to health and was linked to discrimination, self esteem and perceptions of subjective of social status in half of the groups (both of the higher income groups and 1 lower income group). Many of the women felt that one experience that is truly unique to Black women and intricately linked to their intersectional experiences of racism, sexism and health is the issue of hair. Women in these three groups described issues related to hair as influencing Black women's self esteem and perceptions of self image. Many of the women in these groups discussed their perceptions of how Black women's hair is less acceptable by our society in its natural state. They shared how their hair care also influenced their finances

through the amount of money that is spent on relaxing hair and in salons (women stated how it is expensive). Lastly, the women discussed how issues around hair influenced social status by affecting one's ability to climb the professional ladder as well as health by increasing stress due to intersectional experiences of racism and sexism that have given Black women the message that they are not accepted with their hair in its natural state. For instance, one woman in a lower income group described, "We all know that physical appearance is a big thing… and we all have to face it regardless of race, but because we are not okay as we are, you know… we're not okay."

The women discussed how the pressures they felt to prove themselves in the workplace as described above, caused them to be more proactive in addressing external characteristics, such as hair rather than internal characteristics such as health. A woman from a lower income group commented:

> They're (employers/ supervisors) waiting for you to slip up. So because we're told that (message), means we prioritize how we look on the outside over how we feel on the inside and we would rather invest in that than invest in what's most important, in keeping ourselves healthy.

Women described a direct link between a historical legacy of intersectional experiences of racism and sexism and their overall health.

> We've been told that we need to look a certain way and have a certain image in order to look like we are five times better than the person next to us, who

> doesn't look like us and can walk in and still be taken seriously because their skin doesn't look like ours.

Hair and the related pressures to conform to a European model of beauty seemed to be associated with the health of Black women. For example, decisions about physical fitness were often linked to issues with hair care. Women discussed hair issues, such as the changing texture related to exposure to moisture and the amount of time, needed for hair care, as a very real barrier to exercise. "It adds to our not exercising because we have to keep it this way (straightened or relaxed) and we have to do so much to maintain that." In addition, some of the women shared that their hair influenced other decisions around activities such as swimming. A higher income woman commented, "I didn't go swimming. I didn't go to the gym. Because my hair was one of those textures, if it smelled moisture I was going to have a big old cotton ball." Several women shared that they never learned to swim because of their hair texture. As women described the pressures to maintain a certain image, especially as one climbs the professional ladder, this was seen as an increasing barrier to fitness in Black women. Moreover, given the resources spent on hair, fitness was viewed as a direct obstacle as it would ruin hair styles (straightened). For instance a woman from the lower income group stated:

> It costs a lot to look presentable and it's a sacrifice of time and money. And then, it's like, if you have to pay this much for your hair, like I'm not going to work out and just totally shred that.

However, a few women did discuss ways in which they addressed the hair and fitness conflicts by exercising the day before they go to the salon or by wearing hair styles that are not as sensitive to moisture. One woman in a lower income group stated:

> I exercise every day. It's like, oh my hair and I'm spending an hour. Every single morning, got to rewash it, twist and set. I tried to find every other possibility. No matter what I did, I was stressing, mentally about it every single day and stressing my hair itself. So, then I decided the only way I was going to have a no excuses commitment was to change (my hair) and either go natural, cut it all off, or get braids.

Women described how intersectional experiences of racism and sexism are associated with the values and priorities of Black women. Some of the women surmised that these intersectional experiences of racism and sexism can explain why many Black women may value external characteristics over internal characteristics. Hair represented an external characteristic that could not be hidden compared to internal characteristics related to health such as high cholesterol or blood pressure. "One woman from the lower income group shared, "You can hide high blood pressure or high cholesterol but you can't hide a bad hair day."

Women discussed feeling more noticed and respected if their hair was straightened or relaxed and better matched mainstream expectations of beauty and professionalism. They also described situations in the workplace in which coworkers and supervisors made comments that validated these feelings and perceptions. For

instance, one woman in a lower income group shared, "I normally had my hair in a big afro and then one time, I went and got it straightened and a co-worker said it would be nice if you wore your hair like this every day." This reinforces the pressures felt by some Black women due to intersectional racism and sexism, confirming that they need to look a certain (more European standard of beauty) way professionally. The participants also discussed how decisions regarding their hair were influenced by different opportunities at work like being up for a promotion, or interviewing for a new position. These situations caused people to prolong decisions about adopting a natural hair style. Several women also discussed supervisors and coworkers making negative comments regarding hair under the guise of professionalism. One higher income woman commented, "When my daughter started locking her hair she had a supervisor tell her, that's not appropriate." Some women felt that the pressures concerning hair increased as Black women climbed the professional ladder and others felt that Black women had more protections and freedoms as they climbed the professional ladder. For instance, a higher income woman remarked:

> I think the higher you get in your profession you may have some more pressures to look in a certain way [European standards]. But you also have more protections because you work in a professional area. Being at a higher level [professionally] you may have a little bit more freedom.

Black women receive external and internal messages that relaxing or straightening their hair is more professional. Many feel pressured to conform in order to be accepted in the workplace and are challenged by thoughts that Black women's hair

may not be accepted in its natural state. For instance, one woman in the lower income group passionately commented, “Is it so weird to believe that I would wear my hair the way it comes out of my head?”

Locus of Control

The women in all of the groups acknowledged the importance of the perception of control over one’s circumstances (locus of control) in Black women’s health. Several women described that Black women must perceive they are in control of their circumstances (internal locus of control) in order for them to challenge some of their experiences due to the intersectional experiences of racism and sexism. For instance, one woman in the higher income group stated:

> I think that’s major [locus of control]. I think when you know you have control, that’s real… that internal locus of control they call it, that’s so important to have that because they just can’t mess with your mind anymore.

While perceptions of control over circumstances were perceived as important by many women, some also discussed the importance of external motivators in helping Black women to act on their perceptions. One of the women in the lower income groups stated, “Sometimes there is an external stimulus that motivates Black women to act. Where my health is concerned, it’s because the doctor told me something.”

Although some Black women may have an external locus of control because of the discrimination they have experienced based on the intersection of racism and

sexism, the women in all of the groups agreed that perceptions of control over one's circumstances (internal locus of control) is necessary for self advocacy and health promotion. For instance, One HIV doctor, described:

> They're (Black women patients) seeing a doctor and they die because they're unable to appear that they have any power over what's happening. And honestly powerlessness makes you unable to do, not just health care. Nothing in your life is possible, if you don't feel that you have a little bit of power over what happens to you.

SSS Ranking

The women were asked to describe where they feel most Black women rank themselves compared to others in society on a 10 rung ladder, considering those who are best off (income, education, etc.) at the top of the ladder and those who are worst off (income, education, etc.) at the bottom of the ladder. Most of the women placed Black women in the middle of the ladder. Many acknowledged that Black women as a group have made significant progress in educational achievement and income. However, some felt that while progress (educational and financial) has been made overall, that this is less true in the area of health. Some felt that when specifically considering health, they would rank Black women a little lower on the ladder. For instance one woman in the lower income group commented:

> Positions [professional/ careers] that we hold now are a little bit higher than what we would have been in previous years and we're making maybe slightly more [income] but as far as health I think it would be a little bit further down because the more you do, the more your job and your family demands of you, the less you do for yourself. As far as health, because everything is hitting you at one time and you don't take care of things until your body says, okay, I've had enough.

Some felt that Black women were represented on every rung of the ladder and still others acknowledged the role of race and sex in one's social standing as they felt that compared to Whites, Black women are lower on the ladder, but compared to Black men, Black women are higher on the ladder. They discussed how experiences of discrimination based on race and sex have allowed more Black women to receive college degrees which may also lead to higher status professions for instance compared to Black men, whose experiences with intersecting systems of inequality has limited educational achievement.

SSS Contributors

The women described many variables that they felt are associated with SSS in Black women. These included the traditional SES indicators, income, occupation and education. Women in all of the groups (lower and higher income) elaborated on the role of these indicators (income, occupation and education) in Black women's SSS. Perceptions of social status that included occupation integrated one's actual occupation

with perceptions of its importance. Perceptions of social status that included education, integrated the highest level of education achieved with the academic prestige of the institution. For example, some women shared that while two Black women can have Bachelor's degrees, if one received her bachelor's degree from Yale she would have a higher sense of status, compared to another Black woman who had received her degree from a local college. These examples illustrate the relevance of perceptions of importance or prestige in shaping subjective social status. Where one lives and works, self esteem and perceptions of self worth, marital status, children, being from a single parent or two parent household and external affiliations such as sororities and church were also identified as major contributors to SSS in Black women in most groups. For instance one woman in a lower income group stated, "Where you live and where you work are two factors, I think that lead to people's sense of what their personal status is." Another woman from a lower income group offered her perceptions of additional contributors to SSS. She commented "external affiliations, so are you in a sorority? Which one? What church do you go to? You know, there's status in that."

One of the higher income groups felt that for some Black women, the accomplishments and perceived social status of one's significant other is an important contributor to SSS. They described their perceptions that some women and especially some younger women classify and rank themselves based on their significant other. One higher income woman commented, "They don't categorize themselves based on their own accomplishments, but whatever their significant other is doing." Related to the importance of education, income and where people live, another group described how

people identify themselves based on these factors as being linked to their SSS ranking. They described possible conflicts between the neighborhood that people may live (lower status – income) in and their actual income and education level achieved and described how concerns over safety and perceptions of guilt may influence how people identify and rank themselves based on these social factors. For instance, a higher income woman commented:

> Do I identify with my neighborhood or do I identify with my diplomas and with my salary? Most are going to identify with their neighborhood. One, as a safety matter because they don't want to seem stuck up, but too, some of them do it out of guilt.

This underscores the internal conflict that some Black women feel and provides a possible explanation for why Black women of a higher objective social status (income, education, occupation) may have perceptions of subjective social status that are not congruent.

Recommendations from Black Women

Intersectional Approaches

The women acknowledged the intersectional realities of their experiences with racism and sexism. As Black women, intersectional experiences of racism and sexism create a unique set of risks that are associated with health that may differ from men and other ethnic minority women. One woman commented, "We're a product of all of the

different things [social inequalities] that are happening in our nation." Another woman commented, "There are a lot of inequities in our system that need to be addressed."

The women recommended adopting an intersectional approach that considers the unique experience of Black women and the racism and sexism experienced as a first step to addressing the disparate health of Black women. One woman in a lower income group remarked, "Those things are all interconnected and the more we try to silo them, the worse things get. We have to de-silo the conversations that are happening to come up with solutions." The women recommended deliberate individual and institutional level interventions to promote acceptance including promoting messages that target hair. One woman commented, "you can do different things because your hair is that way [natural]. So, it's [important to] build in a confidence so, that they [future generations of young black women] don't feel the same pressures that we do." The women also recommended targeting messages that pressure Black women to feel that they can't take off time from work because they are being "watched" or "have to prove themselves." One woman discussed implementing systems of protection at the workplace as she commented, "[employers should] have some systems put into place where you work …to protect your job, so you don't have to choose between your health and being able to pay your bills."

Health Care

Several women felt that a national health care program is an important solution to institutional racism/sexism that limits Black women's access to high quality health

care. In addition, improving the health care system so that it is easier to navigate for Black women was suggested in one group. Other women discussed the need for high quality health care providers in communities where Black women “can go and be treated well.” The women provided examples of institutional and interpersonal level racism and sexism throughout the health care system that needs to be addressed in order for health status to be improved. The women suggested higher quality standards for health care practices, better training in diversity and cultural sensitivity for health care providers, allied health personnel and all other staff and better accountability measures that address provider bias and the application of differential treatment and standards. The women also felt that programs targeting youth and other initiatives to increase the diversity of the healthcare work force also could play an important role in developing a workforce that better reflects the experiences and needs of Black women. One woman commented, “having programs that will encourage and nurture [young black girls] from an early age or stage, that will cover the costs [educational] to ensure that there are health professionals of color on every level [is important].”

The women also recommended increased funding for effective evidence based (“programs that have been proven to work”) community level interventions targeting Black women. The women described that community based participatory approaches [“programs rooted in the community and like this [referring to focus group] give us a chance to give input and feedback”] to health promotion are critical. Health promotion interventions should be informed by diverse groups of Black women and opportunities

for women to share their experiences should be provided by health promotion researchers. One woman commented, “Having things like this, like getting the voices of people that you’re trying to help, not just assuming that you know what they need [is important].” Other suggestions included, partnering with health providers and program planners to better inform programs of the needs of Black women. The women also discussed the importance of being represented on essential committees, such as city wide health promotion program planning committees, and other positions of leadership within local government and health care in order to take an active role in contributing to health related policies and programs at all levels (local, state, regional, federal) .

One lower income group suggested increasing government funding for health education and promotion opportunities and providing incentives for Black women to participate in health education programming. One woman remarked, “not only funding and supporting programs, just in general, but ones that work, putting them out there in the forefront and saying, ok, here’s an incentive for you to do this in your area.”

Policies

Lastly, the women recommended effective federal policies that can address some of the institutionalized level racism and sexism that Black women experience. These included suggestions for policies that can address Black women’s access to affordable food options, health care insurance gaps, inequities in the health care system and discrimination in the workplace related to redefining concepts of professionalism

that recognize cultural differences. For instance, one woman in a higher income group stated:

> The other thing I think that we could change is access for particularly lower income African-Americans and minority women to good health care. To a facility that you go to and feel respected and treated well. It's like you're relegated to sub-par health care because you don't have insurance or you can't afford better. So investing in positive health care facilities [is important].

Another woman in the same group stated:

> It's also political resources, too. Because they're not investing in the healthy meals program or the nutritional workshops for parents or for the stay-at-home moms, like they're doing in the suburbs. You know they're not the same. They're not making an effort to educate our [Black] children, our adults.

Chapter 5: Discussion

This mixed methods dissertation aimed to investigate 1) how Black women perceive and experience their social status (i.e. subjective social status); 2) how Black women experience and make meaning of racism, sexism and the intersection of racism and sexism; and 3) how experiences and perceptions of racism and sexism are associated with Black women's subjective social status, and in turn their self reported health status. This dissertation also investigated the role of self esteem and locus of control on Black women's perceptions of racism and sexism, and how racism and sexism intersect to influence Black women's SSS.

Summary of Major Findings

In the quantitative phase of this study, only annual household income predicted Black women's perceptions of their social status compared to others in society (individual SSS) and education predicted their perceptions of their social status compared to others in their community (community SSS), partially supporting my hypothesis that income and education are associated with SSS in Black women (Aim 1). Surprisingly, neither income nor education was correlated with self reported health status, as I hypothesized (Aim 2). Also, as hypothesized, recent racism, education and household income predicted both individual and community SSS, and self esteem predicted community SSS (Aim 3). There was an interaction between recent racism and sexism for both individual and community SSS in that participants who reported higher

experiences of both racism and sexism also reported the lowest SSS as hypothesized (Aim 4). Lastly, SSS was positively correlated with self reported health status as hypothesized (Aim 5). Perceptions of contributors to SSS included income, education and occupation as well as recent (within past year) racism, where one lives and works, self esteem, and external affiliations.

Black women in this study commonly reported experiencing racism and sexism. The women in the focus groups discussed the intersectional nature of their experiences of racism and sexism and described how acts of racism and sexism cannot be separated from one another. The women also shared how their perceptions and experiences of racism and sexism created additional stress and pressure for them to prove themselves in the workplace which in turn influenced health care practices such as accessing care. Experiences and perceptions of racism and sexism and distrust of the medical system were associated with health care practices. The women in the focus groups felt that they receive poorer quality health care because of intersectional experiences of racism and sexism. The participants also discussed how the pressures Black women feel to have their hair straightened or relaxed instead of in a more natural state provided an additional barrier to Black women's health, particularly by influencing decisions to be physically active.

SES & SSS in Black women

The first aim of this study (Aim 1 as described above) investigated Black women's perceptions of their social status (SSS) and its association with the traditional SES

indicators (income, education and occupation). In this dissertation, only household income predicted individual SSS and education predicted community SSS, thus partially supporting my hypothesis that participants with higher levels of education and income will have higher SSS compared to those with lower education and income. Counter to my hypothesis, different SES indicators predicted individual and community SSS. Also, household rather than individual income predicted individual SSS, suggesting that one's perceptions of one's status compared to others in society (individual SSS) is linked to household characteristics such as income. This was further supported by the women in the focus groups who perceived that marital status and belonging to a single parent or two parent household were contributors to SSS. This suggests that household characteristics play a role in Black women's perceptions of their status as compared to others in society perhaps through a component of social support. As such, my findings are consistent with those of Shapiro and Keyes (2008), who conceptualized marital status as a component of a network of indicators that may influence perceptions of social well being. In addition, research suggests that marital status is associated with psychological well being. For instance, Kim and McHenry (2002) found that marital status was associated with psychological well being in a large multi-ethnic national sample of families and household panel data. Thus household characteristics such as income and marital status may influence perceptions of status through enhancing social support and psychological well being (Kim & McHenry, 2002; Shapiro & Keyes, 2008).

Education rather than income predicted how Black women ranked themselves in comparison to others in their community (Aim 1). Perhaps, since the income inequality in neighborhoods in cities such as Philadelphia is relatively low (lower than national averages) (Weinberg, 2011), Black women are more likely to use educational achievement to rank themselves among others in the community. As hypothesized, occupation was not correlated with SSS. This is consistent with previous research in which occupation was minimally correlated or not correlated at all with SSS (Adler et al., 2000; Demakakos et al., 2008).

The women participants in both the lower and higher income focus groups also discussed their perceptions of the role of all three SES indicators as contributors to SSS. However, both the level achieved (such as income or educational level) as well as the importance or prestige associated with the education and occupational position, was discussed as contributors to SSS. Thus, occupational prestige may serve as a better assessment of perceptions of status than occupational categories as it symbolizes perceptions of prestige associated with an occupation. My findings relevant to occupational prestige are similar to those of a 2010 study that demonstrated that, occupational prestige was associated with self reported health status (Fujishiro, Xu, & Gong, 2010). Fujishiro and colleagues (2010) also reported that occupational prestige can be used to differentiate the perceptions of status associated with different jobs within the same occupational category (e.g. In the service occupations category occupational prestige scores were higher for day care aides compared to hotel room

cleaners). More research is needed to assess the role of occupational prestige in the subjective social status of Black women. Walker and Tracey's (2012) research with Black and White college students found that perceptions of occupational prestige differed among Black and White students. Thus race and gender may play a role in how Black women determine occupational prestige (Walker & Tracey, 2012). Black women may perceive a different level of importance or prestige with a particular job compared to White women and Black and White men. This may further influence the discordant relationship between Black women's increased SES and health status.

SES & Self Reported Health Status in Black Women

In this dissertation, none of the traditional SES measures was associated with self reported health status (Aim 2). That is, neither income, education or occupation were associated with self reported health status. These findings do not support my hypothesis and contradict all of the research that links SES and health (Adler, et al., 1994; Adler & Ostrove, 1999; Krieger, et al., 1993; Williams, 1999; Williams & Collins, 1995). These findings also contradict the qualitative results in which women expressed their perceptions that both income and education are associated with health status in Black women. However, before adjusting for age, the analysis did indicate a relationship between household income and self reported health status. These findings suggest that in this study the initially observed association between household income and self reported health status was associated with age. In this sample, older individuals were more likely to have increased household income. Perhaps because the mean age of this

relatively healthy sample was 41, the differences in health status by income were more dependent on age. A sample with a higher mean age, may have observed different results as the prevalence of many chronic diseases increases with age. Thus, an older sample with multiple health conditions may have observed associations between income and health status.

Women in the focus groups discussed the contributing role of the traditional SES indicators (specifically income and education) in the health of Black women. The women discussed the role of income as it related to insurance status and access to care for example. The women also discussed the importance of education (both health promotion education and higher education) in making healthy lifestyle choices. The literature supports the role of SES as a fundamental cause of health inequalities through exposure to risks, access to resources and disease management (Link & Phelan, 1995; Phelan, et al., 2010). SES has been associated with adverse health outcomes and conditions in numerous studies (Crimmins, Hayward, & Seeman, 2004; Hemingway, Nicholson, Stafford, Roberts, & Marmot, 1997; Krieger, et al., 1993; Krieger, Williams, & Moss, 1997; Link & Phelan, 1995; Moss & Krieger, 1995; Williams, 1999) and is associated with self reported health status in research including Black women (U.S. Department of Health and Human Services & Health Resources Services Administration (HRSA), 2010). Thus, it is surprising that my hypothesis that income and education would be associated with self reported health status in Black women was not supported in this study.

One reason for the failure of this study to find an association between income and self reported health in Black women is that perhaps the economic crisis influenced the relationship between income and self reported health status by influencing perceptions of economic stability and health practices. The income distribution of participants of the sample was fairly evenly distributed throughout the income categories and less than 10% of the sample was unemployed. But, a study by the National Women's Law Center (2011) found that Black women have lost more jobs during the recovery period than they did during the recession. The study also found that Black women's unemployment rate has continued to increase in the recovery period, higher than White and Black men and White women as well as other racial and ethnic subgroups (National Women's Law Center, 2011). These threats to income could have potentially influenced Black women's perceptions of their economic stability as linked to their income as well as health care practices that would have been associated with differences in self reported health status.

Another reason for these findings could include the utility of the income measure for Black women. Researchers such as Hajat and colleagues (2011) propose that wealth (conceptualized as a person's net worth, assets minus debts) is a more stable measure of income. They also propose that wealth may also capture aspects of political power and prestige that income alone does not. In addition, researchers have demonstrated an inverse correlation between wealth and health indicators such as obesity as well as with mortality rates (Hajat, Kaufman, Rose, Siddiqi, & Thomas, 2010,

2011). However, a recent study conducted by the INSIGHT Center for Community Economic Development (2010) based on data from the 2007 Survey of Consumer Finances, found that excluding vehicles, single Black women have a median wealth of $100 compared to $7,900 for Black men and $41,500 for White women (Chang, et al., 2010). The report surmised that this meant that half of single Black women cannot afford to take an unpaid sick day (Chang, et al., 2010). Thus, although income was evenly distributed in this study, based on the findings of this report wealth may not have been. Black women who reported higher income may have also had low wealth, thus weakening the association between income and health status.

SSS in Black Women

While, education, income and recent racism, predicted individual and community SSS, only self esteem predicted community SSS, partially supporting my hypothesis that racism, sexism, locus of control, and self esteem would be associated with SSS (Aim 3). This suggests that self esteem may play more of a role in Black women's perceptions of their status compared to others in their community rather than others in society as a whole. This can perhaps be explained by the fact that self esteem in Black women may be influenced by relationships with others (Gilligan, 1993; Hughes & Demo, 1989). Hughes and colleagues (1989), in their study investigating the determinants of self esteem in a national sample of Black Americans, found that self esteem was strongly influenced by familial, social and community relationships. They also found that social class (as traditionally assessed by income and education) was not

associated with self esteem and surmised that instead of dependence on SES indicators for self esteem, Black women's self esteem is more connected to their families, friends and social networks (Hughes & Demo, 1989). This may explain why self esteem was associated with community SSS rather than individual SSS, as self esteem may be influenced by community level relationships.

In this study, self esteem was high, as in other studies assessing self esteem in Black women (Patterson, 2004; Wesley & Scoloveno, 2005). For instance, Patterson's (2004) longitudinal study of Black women and self esteem over a 14 year time period found that Black women maintained a high self esteem over the time period studied. Moreover, while Rosenberg's Self Esteem Scale is widely used there is a lack of data regarding the norms for Black women (Hatcher, 2007; Warren, 1997). Self esteem may also need to be defined differently for Black women who experience multiple systems of inequality such as racism and sexism (Hatcher, 2007). For instance, Hatcher (2007) in a review of the literature exploring the measurement of self esteem with Rosenberg's scale found that although the reliability (as assessed by the internal consistency and test re-test reliability) for the measure was supported with Black women, the validity was not fully supported. Hatcher concludes that self esteem is a multidimensional construct, for Black women, that is not fully assessed by Rosenberg's scale. Hughes and Demo's (1989) research on self esteem support this conclusion. Their conceptual framework of self esteem included personal self esteem, personal efficacy and racial self esteem (Hughes & Demo, 1989). In their research all three of these components of self esteem

were related. Black women scored high on personal self esteem and low on personal efficacy (Hughes & Demo, 1989). They concluded that personal efficacy is influenced by social inequalities such as racism and sexism and found that personal efficacy was associated with social status (Hughes & Demo, 1989). This underscores the need for additional research on the measurement of self esteem in Black women. Future research on SSS and self esteem in Black women should include measures of personal efficacy.

In the quantitative analysis, racism was associated with SSS but sexism was not (Aim 3). This underscores the challenges of quantitative approaches to intersectional experiences of racism and sexism. As described by Bowleg (2008), quantitative assessments which utilize an additive approach (e.g. race + sex) violate the key tenets of intersectionality which posit that experiences of discrimination based on race or sex cannot be separated from one another. While the women in the focus groups discussed the reality of their intersectional experiences of racism and sexism and how these experiences of discrimination based on race and sex could not be separated from one another, the quantitative assessment, forced them to identify discriminatory experiences based on race and sex. Moreover, Bowleg (2008) describes limitations in statistical methods which also utilize additive approaches. This could further explain why racism was associated with SSS while sexism was not. In the qualitative phase of this study, participants discussed how racism and sexism were inseparable. This further

underscores the importance of mixed methods approaches for intersectionality research.

The women in the focus groups acknowledged the contribution of the traditional SES indicators in shaping their subjective perceptions of social status and also described additional contributors to SSS such as self esteem and self worth, external affiliations and marital status. These additional contributors differed from those discussed in the previous research conducted by Sinhg-Manoux and colleagues (2003). Moreover, since Black women are least likely to marry (as they have the highest rate of never marrying) compared to White, Asian and Latina women (Elliott & Simmons, 2011; Kreider & Ellis, 2011) the role of marital status in shaping SSS may be an interest for further research on Black women and SSS. Perhaps since marriage rates are lower in this group, they contribute to perceptions of status. Household income rather than individual income was associated with SSS. Household income, which can potentially be increased by marital status, could be one mechanism through which marital status influences subjective perceptions of status.

The women in the focus groups identified external affiliations such as sororities and churches as additional contributors to social status. External affiliations such as these may provide both instrumental (tangible forms of support, e.g. financial) and affective (intangible forms of support, e.g. emotional) social support for Black women (Bailey, Wolfe, & Wolfe, 1996). Research by Bailey and colleagues (1996) suggests that the context or source of social support is important for Black women. These external

affiliations may influence social support by helping Black women to cope with their perceptions and experiences of racism and sexism. External affiliations may also be an important contributor to SSS and social support for Black women as other sources of support such as family members or friends may simultaneously serve as support and stressors (Everett, Hall, & Hamilton-Mason, 2010). For instance, Everett and colleagues (2010) found that higher status Black women acknowledged that others in their families turned to them for financial support in particular. They also reported that external affiliations in the community reinforce self esteem and self efficacy (Everett, et al., 2010). Thus, there may be multiple ways in which external affiliations contribute to perceptions of social status.

The women in the focus groups also described the internal conflict that some Black women feel that may cause them to subjectively perceive their status to be lower than their actual objective status based on self perceptions of how they may be viewed by others in their community. This is especially relevant as a recent study by John Logan (2011), based on the most recent census data, found that Blacks with income over $75,000 are more likely to live in lower income neighborhoods and neighborhoods with fewer resources compared to Whites. In fact, Blacks at every income level are more likely to live in poorer neighborhoods compared to Whites (Logan, 2011). The author describes the racial segregation that persists based on this data (Logan, 2011). While other racial and ethnic minority groups may be segregated, Blacks are more likely (than other racial/ethnic minority groups) to be segregated or hypersegregated with the

majority of Blacks living in Black neighborhoods (Landrine & Corral, 2009; Wilkes & Iceland, 2004). Residential segregation among Blacks has been linked to discrimination in housing and mortgage financing practices (Ross & Turner, 2005). Residential segregation determines inequalities in resources (e.g. education, employment, healthy food, health care), exposure to social conditions that may inhibit health and has been linked to disparities in health for Blacks (L. Anderson et al., 2003; Landrine & Corral, 2009; Osypuk & Acevedo-Garcia, 2010; White & Borrell, 2010; Williams & Collins, 2001). Residential segregation as well as the focus group participants' descriptions of the internal conflict that may be created suggests a possible explanation for why Black women's SES does not completely match their subjective perceptions of status. Thus, residential segregation that limits Black women's economic return and opportunities afforded by increasing education, contributes to disparities in health and further exemplifies the intersectional paradox (Jackson & WillIams, 2006).

Lastly, locus of control was not associated with SSS in the quantitative assessment (Aim 3) which contradicts previous research that found that locus of control contributes to SSS (Barr, 2008; Lundberg & Kristenson, 2008). However, that research did not include Black women. In addition, while all of the women in the focus groups acknowledged the importance of Black women's perceptions of control over their circumstances, none of them referenced this prior to being questioned about it. While, Rotter's Locus of Control Scale (Rotter, 1966) has been widely used with many diverse groups, there have been limited validation studies with Black women. Perhaps Rotter's

scale did not assess aspects of locus of control that are relevant to the subjective social status of Black women. Moreover, locus of control may not be an appropriate measure for this context as Black women have limited control over their experiences of racism and sexism. As described above perhaps personal efficacy is a better assessment of Black women's perceptions of their abilities and achievement capability (Hughes & Demo, 1989). More research is needed to determine the role of perceptions of control over circumstances and personal efficacy in the context of racism and sexism. While the women commented on the importance of perceptions of control over their circumstances, they also described numerous examples of situations in which they felt they had limited to no control because of experiences of racism and sexism.

Black Women and Intersectional Experiences of Racism and Sexism

One of the primary aims of this dissertation was to determine how Black women make meaning of racism and sexism, the intersection of racism and sexism and its contribution to SSS in Black women. The results indicated an intersection between racism and sexism in both individual and community SSS. While, the quantitative analysis confirmed the interaction between racism and sexism in SSS, the qualitative analysis provided a more in-depth understanding of the intersection of racism and sexism in the lives of Black women.

Qualitatively, women described that they were unable to truly separate acts of discrimination based on race and sex, validating the intersectionality framework. Their description of intersectionality was consistent with the theoretical and conceptual

framework that has been proposed by, early theorists, Kimberlé Crenshaw and Patricia Hill Collins (Collins, 1989, 1991; Crenshaw, 1989, 1991, 1994). These findings are also consistent with other qualitative research utilizing an intersectional framework, such as research exploring intersectionality among Black gay and bisexual men (Bowleg, 2012) as well as Black lesbian and bisexual women (Bowleg, 2008a; Bowleg, Huang, Brooks, Black, & Burkholder, 2003). Unlike some of the participants in other intersectionality research (Bowleg, 2012) who ranked their identities in statements such as 'I'm Black first', the women in the focus groups did not identify themselves as either being Black first or a woman first. While, they did provide examples of racism, sexism and intersectional experiences of racism and sexism they did not seem to rank them. This further exemplifies the intersectional nature of racism and sexism for Black women as it confirms a key tenet of intersectionality theory and research.

The participants described several examples of how intersectional experiences of racism and sexism influenced health in Black women. They described perceptions of being treated differently by health care providers because they were Black women. The women discussed how the assumptions and stereotypes (of Black women) held by providers contributed to the poor quality of care received. While many of the comments regarding provider bias, stereotyping, cultural insensitivity and differential treatment have been discussed in other studies (Baker, 1999; J. Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; B. Smedley, et al., 2002; Van Ryn, 2002; Van Ryn & Burke, 2000), these findings demonstrate the persistence of these perceptions in Black women.

There has been a long legacy of discrimination and exploitation of Blacks in medicine(B. Smedley, et al., 2002; Washington, 2006) and that legacy seems to be very much alive today. Perceptions of mistrust of the healthcare system found in other research (Gamble, 1997; Kennedy & Mathis, 2007; LaVeist, Nickerson, & Bowie, 2000) were also discussed by the women in the focus groups. The women described inappropriate experiences with health care providers and allied health professionals which caused them to feel disrespected as a result of the intersection of their race and gender. A safe grievance process that can enable women to report discriminatory experiences in the healthcare encounter (from encounters with the front desk staff to the health care provider) may help some Black women to feel more empowered.

Stronger systems of enforcement and more comprehensive training for healthcare providers to address discrimination, provider biases, stereotypes and cultural sensitivity continue to be needed to address these inequalities. For instance, Abrums (2001) describes that cultural competence training for nursing students often addresses culture, beliefs and values but fails to explicitly address issues related to systems of inequality such as racism and sexism. Moreover, the role of social inequalities in health is not well taught (Abrums & Leppa, 2001). Thus, health professions curricula that address the role of social inequalities in health are needed. The curricula should also address the role of historical and persistent social inequalities as influenced by racism and sexism as well as other forms of discrimination in health. Curricula that teach health care providers how to effectively partner with diverse population groups in order to

promote shared decision making and high quality healthcare are needed (Núñez, 2000). Cross cultural education that enhances self awareness and empathy are also needed (Núñez, 2000; Núñez & Robertson, 2006). In addition, clinical assessment of students' skills in effectively addressing diverse populations who may experience different forms of intersecting inequalities while avoiding stereotypes is important (Núñez, 2000; Núñez & Robertson, 2006).

The focus group participants also described experiences and perceptions of the intersection of racism and sexism as a stressor. The women particularly provided examples of how experiences of racism and sexism in the workplace led them to feel that they constantly have to prove themselves. They also described the additional stress of being the first Black or first Black woman to hold a particular position. This is consistent with other research that describes the role of multiple inequalities such as racism and sexism in the workplace as a chronic stressor for Black women (Bowleg, 2008a; Hall, Everett, & Hamilton-Mason, 2012).

One of the most surprising illustrations of intersectional experiences of racism and sexism was the issue of Black hair. Respondents perceived pressures that Black women feel to straighten or relax their hair to be connected to experiences of institutionalized, interpersonal, and internalized racism and sexism. Gender norms prescribe that beauty include attention to hair for all women, but experiences of racism and sexism intersect to affirm that many Black women do not meet the normative perceptions of beauty without straightening or chemically altering their hair (Harvey,

2005). In its natural state, many Black women's hair may not meet normative or mainstream standards of beauty, thus, enhancing the social significance of hair as well as its association with internal perceptions of self esteem, worth and inferiority as well as external rewards such as employment and income (Harvey, 2005; St Jean & Feagin, 1998). Implicit workplace norms that define images of professionalism as linked to mainstream standards of beauty (based on a European model) as well as derogatory comments regarding wearing more natural hairstyles provide additional stressors to Black women. In addition, these messages may be internalized to cause Black women to feel that they are not accepted without their hair being straightened or chemically altered. These are examples of how issues related to hair have contributed to the intersectional racism and sexism experienced by the focus group participants. Moreover, St. Jean and Feagin (1998) describe beauty as a status. This may explain the discussion of Black hair by the women as part of the discussion of intersectional experiences of racism and sexism and perceived social status.

Jennifer Nash (2008) argues, that a tenet of intersectionality is that research should begin with the vantage point of the marginalized group rather the established norms based on the dominant group. The findings of this dissertation further underscore the importance of this tenet. Subjective social status in Black women undoubtedly is constructed differently than White women for instance. This research illustrated that subjective social status in Black women includes perceptions of beauty (which includes hair), household characteristics (such as marital status), self esteem

(personal efficacy), external affiliations (such as sororities and churches) and perceptions of intersectional racism and sexism. Thus, an intersectional framework provides a more comprehensive understanding of subjective social status in Black women.

The findings of this dissertation not only support other studies on the pressure many Black women feel to meet European standards of beauty (St Jean & Feagin, 1998) but is one of the first to link those pressures to both SSS and health in Black women. Issues related to hair cause many Black women to limit or omit physical activity from their daily routines, avoid activities such as swimming, spend financial resources routinely for maintenance and value external characteristics over health. All of these negatively influence the health of Black women. In fact, even the US Surgeon General, Dr. Regina Benjamin (2011), a Black woman, commented on the role of hair in the health of Black women and acknowledged how wearing hair in straightened styles has influenced her own choice to exercise and participate in activities such as swimming (Bronner Bros. International Hair Show, CNN Interview, August 22, 2011). Moreover, while, beauty salon based health promotion initiatives have been proven to be successful in increasing knowledge and awareness of health messages as well as behavior change in Black women (Browne, 2006; Linnan & Ferguson, 2007; Linnan et al., 2005), policies and initiatives that challenge the social and institutional systems that promote intersectional experiences of racism and sexism in Black women must also be encouraged to promote messages of beauty and professionalism that include diverse

perspectives. The micro level experiences of discrimination discussed by the focus group participants reveal macro level structural inequalities in the employment discrimination of Black women. As both Collins (1991) and Crenshaw (1989) highlight, Title VII of the Civil Rights Act, allowed Black women to sue on the basis of sex or race, but not both. Thus, laws and policies addressing discrimination in employment and healthcare for Black women must recognize intersectionality and enforce antidiscrimination legislation and policies within an intersectional framework.

SSS and Health Status of Black Women

In this study, individual and community SSS was associated with all of the health domains (physical functioning, role limitations due to physical problems, role limitations due to emotional problems, energy and fatigue, emotional wellbeing, social functioning, pain and general health), supporting my hypothesis that SSS is associated with self reported health status in Black women. This is consistent with other literature suggesting the association between SSS and health (Adler, et al., 2000; Ghaed & Gallo, 2007; Gruenewald, et al., 2006; Operario, et al., 2004). In this dissertation, SSS was associated with all of the health status domains assessed by the SF36 in Black women.. Occupation was not associated with any of the health domains. This supports other research that occupation is less consistently associated with health status (Adler, et al., 2000; Demakakos, et al., 2008). As discussed above, occupational prestige rather than occupation categories may be associated with health status (Fujishiro, et al., 2010; Walker & Tracey, 2012). The variation in the association of education and income for

each of the domains indicates that the traditional indicators may have better utility for some domains (such as physical functioning) rather than others (such as general health status). As SSS was associated with all of the domains, this further underscores the potential importance of utilizing SSS as an indicator for social status in the health of Black women.

Limitations

Design

This study utilized a mixed methods approach in order to explore the role of SSS in Black women's health utilizing an intersectional framework (racism and sexism). Because there are no validated instruments to assess (from an intersectional construct) the intersectional experiences of racism and sexism, the assessment instruments utilized traditional approaches, which forced women to attribute experiences of discrimination to racism or sexism (an additive approach). This additive approach violates the major tenets of intersectionality (Bowleg, 2008b). Assessing these social inequalities as independent variables represents what McCall calls the categorical approach to intersectionality (McCall, 2005), an approach inconsistent with the theoretical framework of intersectionality. Limitations arise in asking Black women to determine if experiences of discrimination are linked to racism as separate from sexism. This contradicts the intersectional theoretical framework that multiple social identities are interdependent, experienced concurrently and cannot be separated from one another (Collins, 1989, 1991; Crenshaw, 1989, 1991).

This study may not be generalizable to all Black women. Firstly, a non randomized study design was used in the quantitative component so the results may be susceptible to selection bias. Participants were recruited from partner sites which included health and wellness institutions as well as community and faith based organizations. The women who participate in these programs, groups and organizations may be different from those who do not. In addition, there were certain subgroups of Black women (e.g. Black Muslim women and Black lesbian or bisexual women) that were undoubtedly not well represented in the study. Jennifer Nash (2008) critiques intersectionality research for often solely focusing on racism and sexism which obscures other dimensions of identity such as religion and sexual orientation. But, due to the exploratory nature of this research, the number of variables studied and the lack of methodological tools, I thought it was most appropriate to focus this research on intersections of racism and sexism and include other dimensions of intersectionality in future research. While participants' age ranged from 18 – 70 (quantitative phase), the mean was 43. Perhaps study findings that income and education is not associated with self reported health status was influenced by the younger age of individuals. A study with a mean age of 65, for example may have had different findings. Overall, the participants in this study were relatively healthy. As the prevalence rate of chronic diseases such as heart disease, hypertension and diabetes increases with age, an older sample may have had a higher prevalence rate of disease. Thus, differences in health practices and health care associated with these diseases may have been more likely to be influenced by differences in education and income. Few participants in the

quantitative phase reported having less than a high school education as the highest level of educational achievement. Study findings may not be generalizable to Black women without a high school diploma. Lastly, experiences of social inequalities as well as their meaning for individuals can differ geographically (Cole, 2009; Shih, Pittinsky, & Ambady, 1999). For instance, the women reported (quantitative phase) and described (qualitative phase) intersectional experiences of racism and sexism in healthcare encounters in Philadelphia. This may not be generalizable to the experiences of Black women in other parts of the country. The findings of this study may not be applicable to Black women living in rural areas for instance, or other areas that are different from urban centers such as Philadelphia.

There were also limitations to the qualitative phase. For instance, this study focused only on intersections of racism and sexism. As discussed above, the sole focus of intersectionality research on racism and sexism has been a major critique (Collins, 1991; Nash, 2008). There are multiple other identities, such as sexual orientation, age and religion, described by Patricia Hill Collins (1991) that were not explored in this study. In addition, all participants reported at least having some college as their highest level of educational achievement. Thus, results may not be applicable to Black women with a high school or less than a high school education. Participants' age ranged from 22- 64 with a mean of 41. Study findings may not be applicable to Black women over the age of 64 or younger than 22. More research is needed to explore a broader array of intersectional social identities.

Occupation

Occupation was assessed using the US Census Bureau classification system (Bureau of Labor Statistics, 2002). During the administration of the survey a few of the women asked questions and expressed that they were not sure how to classify their occupation within the provided system. This could have biased the results as women may have misrepresented their occupation in the study questionnaire. This study's findings related to occupation were consistent with others that showed limitations in the utilization of occupation as an indicator of social status (Adler, et al., 2008; Braveman, et al., 2005; Winkleby, et al., 1992). As discussed above, occupational prestige may provide a better indicator of the role of occupation in Black women's perception of status as well as their health. Future research assessing the role of occupational prestige in Black women's SSS may be useful.

Health

This dissertation focused on general health status as a whole rather than a specific health issue (such as Hypertension or HIV). While, overall health status as assessed by the SF-36 has been correlated with specific health outcomes (Ware & Sherbourne, 1992), this study may have limited applicability to understanding the role of Black women's SSS as it relates to specific health conditions, such as HIV or Hypertension. Future research assessing the role of SSS in either acquiring or managing a specific health condition may provide additional information regarding the role of SSS in Black women's health.

Implications for practice

The elimination of health disparities has been an important priority for the US (Satcher, 2000; U.S. Department of Health and Human Services, 2011). Yet, health disparities research and discourse often fails to consider the multiple and intersecting social identities as well as the intersection of multiple inequalities that play a role in disparate health at both the micro and macro level (Bowleg, in press; Weber & Parra-Medina, 2003). This dissertation enhances understanding of the role of subjective social status in the health of Black women and provides a better understanding of how Black women make meaning of racism, sexism and intersectional experiences of racism and sexism. Important components of intersectional racism and sexism are associated with health in Black women through both interpersonal and systemic factors, underscoring the need for multi level approaches to health disparities in Black women.

Intersectionality allows public health and other researchers to not only explore how differences in individual behaviors, influenced by social systems of inequality, are associated with health outcomes, but it also allows us to assess the role of social inequalities at the institutional level and their role in poor and disparate health outcomes (Bowleg, in press; Cole, 2009). For example, intersectional approaches can be used to assess the role of schools, places of employment and laws in influencing gender and racial disparities in health (Cole, 2009). The Black women in this dissertation provided recommendations that included health promotion efforts addressing the intersectional experiences of discrimination as well as addressing institutional discrimination in health care, for example. Although a long history of research connects

social status (income, education, occupation) to health outcomes, this dissertation suggests that perceptions of social status that are influenced by intersectional experiences of racism and sexism also influence health in Black women.

Although intersectionality is increasingly being used as a theoretical framework, little guidance has been given regarding appropriate methodological approaches to be considered for empirical utilization of this theoretical construct (Bowleg, 2008b, in press; Kelly, 2009; McCall, 2005; Nash, 2008; Winker & Degele, 2011). This dissertation adds to a limited body of empirical research on the role of Black women's intersectional experiences of racism and sexism on their subjective perceptions of status.

The intersectional framework allows for the comparison of the role of multiple social identities and inequalities in health. Cole (2009) argues that it is important to explore both commonalities as well as differences in intersectional research in order to gain a full understanding of how multiple and intersecting social identities influence behavior. Certainly, the role of additional social inequalities (e.g. age, religion, sexual orientation) can be assessed in future research with Black women. While focusing intersectionality research on Black women solely has been a critique of some like Jennifer Nash (2008), this dissertation made only within group comparisons as it focused solely on Black women, however, future research with other groups such as Black men or Asian women may reveal additional information about the role of intersectional experiences of racism, sexism and discrimination based on ethnicity in subjective status, highlighting both similarities and differences. Future research that includes Black men

will also further expand upon the findings of this dissertation, by highlighting both similarities as well as differences related to the role of SSS in health as well as the intersection of multiple social systems of inequality for groups of Black men and women. Research by Bowleg (2012 and in press) that utilized the intersectional framework with Black heterosexual (Bowleg, Teti, Malebranche, & Tschann, in press) and bisexual and gay (Bowleg, 2012) could inform subsequent research that would compare Black women and men's experiences of intersectionality (Bowleg, 2012; Bowleg, et al., in press).

Lastly, there were several recommendations that were provided by the focus group participants for improving the disparate health status of Black women. Recommendations included institutional, systemic and individual level changes to promote health in Black women. In order to more effectively address the disparate health of Black women, the multiple and intersecting inequalities that influence health must be considered in research (Rogers & Kelly, 2011). Rogers and Kelly (2011) argue that by addressing multiple systems of inequality, intersectionality approaches to research become a form of social action that promotes social justice. Moreover, intersectional approaches to health research can enhance the effectiveness and utility of biomedical research by providing a better understanding of individuals' lives and the multiple inequalities experienced as well as provide a mechanism to promote social justice (Kelly, 2009; Rogers & Kelly, 2011; Weber & Parra-Medina, 2003). While the women described numerous examples of how intersectional racism and sexism

influenced their lives and health, many were hopeful that policies and programs could be implemented to strengthen communities and address the inequalities they discussed. Focus group participants commented that we need more advocacy programs, education, health care providers to change their attitudes (not just a paycheck), to deal with insurance issues (marketing specific types of insurance to low income communities), change USDA requirements regarding marketing and sales of food and the amount of salt that is added to food, eat healthier, exercise consistently and relieve stress (including stressors from intersectional racism and sexism). National initiatives to address health disparities such as the CDC Health Disparities and Inequalities report (2011), National Partnership for Action to End Health Disparities and the Affordable Care Act must first acknowledge intersectionality and then develop policies and initiatives to address micro and macro level inequality and discrimination. Unfortunately, these important initiatives aimed at eliminating disparities in health fail to consider the unique vantage points of multiple oppressed groups such as the Black women in this study. The intersectional approach utilized in this study, revealed the importance of addressing the systemic, institutional and individual level discrimination and inequalities experienced by Black women. Without deliberate attention in our laws, workforce, food, health care and other policies and programming to these inequalities, little gain will be made in our fight to eliminate disparities in health in groups such as Black women. As one of the focus group participants described, we "…live in our own separate world…[I wonder] what has been lost concerning our health along the way." Failure to consider the unique experiences of multiple oppressed groups further isolates

and invalidates their perspectives, providing little more than lip service to addressing their health and health care needs.

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Appendix 1

10 Leading Causes of Death Table

(Rates per 100,000 population)

Rank	White Males	White Female	Black Male	Black Female	Hispanic Males	Hispanic Females
1	Heart Disease 254.9	Heart Disease 244.0	Heart Disease 191.3	Heart Disease 174.4	Heart Disease 63.9	Cancer 59.8
2	Cancer 241.1	Cancer 212.6	Cancer 178.7	Cancer 152.8	Cancer 63.0	Heart Disease 59.3
3	CLRD 59.8	CLRD 65.1	Accidents 45.3	Stroke 46.9	Accidents 34.5	Stroke 16.5
4	Accidents 59.7	Stroke 63.4	Stroke 39.0	Diabetes 32.7	Stroke 13.9	Diabetes 14.2
5	Stroke 41.5	Alzheimer's Disease 50.1	Assault 38.6	Kidney Disease 23.3	Diabetes 13.7	Accidents 12.0
6	Diabetes 25.5	Accidents 34.6	Diabetes 29.4	CLRD 20.9	Liver Disease 11.8	Alzheimer's Disease 9.0
7	Self Harm 24.1	Influenza 24.6	CLRD 24.6	Accidents 19.6	Assault 11.4	CLRD 8.5
8	Alzheimer's Disease 22.0	Diabetes 23.5	Kidney Disease 21.3	Alzheimer's Disease 18.1	CLRD 8.3	Influenza 7.2
9	Influenza 20.7	Kidney Disease 17.4	HIV 20.4	Septicemia 17.6	Self Harm 8.1	Kidney Disease 6.4
10	Kidney Disease 17.7	Septicemia 14.2	Septicemia 15.5	Influenza 14.2	Perinatal Conditions 6.8	Liver Disease 5.5

Source: CDC/NCHS, 2008; CLRD – Chronic Lower Respiratory Disease

Appendix 2

The specific aims for the focus groups are to determine 1) what factors are associated with SSS 2) what factors are associated with self reported health status 3) how experiences of racism and sexism influence SSS, 4) how traditional SES indicators are related to SSS and 5) how SSS is related to self reported health in Black women. Specifically The following opening statement will be used for the focus group.

Introduction to the group

I will welcome participants and introduce myself. The purpose of the group will be described and all participants will be consented appropriately and given a chance to ask questions. I will explain the presence and purpose of the digital tape recorder. I will also reiterate that the discussion will be analyzed as a whole and no individual responses will be recorded or noted using names.

"Today you are here to participate in a focus group. A focus group works by asking a number of questions to a group of people that have knowledge on a topic of interest and then hearing all of the different thoughts and responses from the group. There are no right and wrong answers. All of your thoughts and opinions are important. The purpose of this focus group is to explore Black Women's perceptions of their social status (their position or rank within our society) and how Black women's experiences of racism and sexism influence their perceptions of social status as well as their health." I have also provided some note cards for each of you. Please feel free to jot down any

comments you may have that you may forget or comments you don't wish to share with the group.

Focus group guiding questions

- General/Intro
  - I'd like to begin by having you share with me your ideas about what influence you think discrimination has on Black women's health.
  - Probe: How do you think factors such as interactions with health care providers, access to health care, having too many responsibilities, lack of access to health communities (parks, healthy food, etc.) and Cultural norms (about weight, food, etc.) in Black communities influence the health of Black women (each probe will be asked separately).
- Black Women's Health
  - In general, how would you describe Black women's health (Probes: Think about yourselves or some of the Black women in your lives)
  - Now, I want you to consider other groups of women. How would you compare White women's health with Black women's health? What about other groups of ethnic minority women such as :
    - Latina women or Asian women

- Probe: What are some of the similarities? What are the reasons for these similarities?
- Probe: What do you see as some of the differences? What are some of the reasons for these differences?

- Now, I would like you to consider Black women in the US compared to Black women from other parts of the world such as the Caribbean, Africa, etc. How do you think Black women's health in the US compares to the health of Black women from other parts of the world?
  - Probe: What are some of the similarities? What are the reasons for these similarities?
  - Probe: What do you see as some of the differences? What are some of the reasons for these differences?

- Now, I'm going to ask you the same question that I just asked you when I asked you to compare Black women's health to other women's health. But this time, I want you to compare Black women's health to Black men's health?
  - Probe: What are some of the similarities? What are the reasons for these similarities?

        - Probe: What do you see as some of the differences? What are some of the reasons for these differences?
    - Now, I want you to consider other groups of men. How would you compare Black women's health to White men's health? What about other groups of ethnic minority men such as :
        - Latino men or Asian men
            - Probe: What are some of the similarities? What are the reasons for these similarities?
            - Probe: What do you see as some of the differences? What are some of the reasons for these differences?
- Black women & SSS
    - Participants will be shown a diagram of a 10 rung ladder. The top of the ladder represents people in the US who are best off, those with the highest education and most money. The bottom of the ladder represents those who are the worst off and have the least amount of education and money.
    - Where do you think Black women you know would rank themselves on this ladder?

- How is that position on the ladder (where Black women may put themselves as we just discussed) related or connected to their health (the health issues or conditions they may experience)?
- What factors contribute to where Black women may rank themselves on the ladder?
- Some feel their experiences as Black women have nothing to do with how they rank themselves on the ladder. Others feel that their experiences greatly influence their ranking on the ladder. How do you feel that being both Black and a woman influences how Black women may rank themselves on the ladder?
- Okay, so now I'm interested in getting your thoughts about how specific factors may influence where Black women rank themselves on this ladder. First, what are your thoughts about how education may influence where Black women rank themselves?
    - Okay, what about income (how much money a woman makes)?
    - Alright, now what about the kind of work a woman does, her occupation?
    - Finally, what about her self-esteem? How might this influence where a woman ranks herself?

        - What are some other factors that we have not already talked about that you think may influence where a Black woman ranks herself on this ladder?

- Break
- Locus of Control
    - So now I want to ask you questions about how Black women respond to discrimination. For some Black women, whether or not they have control in a situation may influence how they feel about discrimination. I'd like to hear some of your thoughts about how the issue of control, that is whether one has control over what happens in a situation might influence how a Black woman responds to discrimination.
    - Are there any types of discrimination that Black women may experience that you believe they may have the power to control the outcome?
    - Probe for obstacles related to the following if not mentioned:
        - Racism
        - Sexism
        - Classism
        - Intersection of Racism & Sexism
- Black women & racism

        - How do experiences of racism influence how Black women rank themselves on the ladder?
        - How do experiences of racism influence Black women's health (the health issues or conditions they may experience)?
    - Black women & sexism
        - How do experiences of sexism influence how Black women may rank themselves on the ladder?
        - How do experiences of sexism influence Black women's health (the health issues or conditions they may experience)?
    - Conclusion
- What needs to happen for Black women's health to be improved?
- Are there other questions about Black women's health and the intersections of different forms of discrimination on Black women's health that I should have asked you, but did not think to ask?

Appendix 3

Scale Items from: Schedule of Sexist Events

Please think carefully about your life as you answer the questions below. For each question, read the question and then answer it twice: once for what your entire life has been like and once for what the past year has been like.

	Never	Once in a while	Sometimes	A lot	Most of the time	Almost all of the time
1. How many times have you been treated unfairly by teachers or professors because you are a woman?						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
2. How many times have you been treated unfairly by your employer, boss or supervisors because you are a woman						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
3. How many times have you been treated unfairly by your co-workers, fellow students or colleagues because you are a woman						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
4. How many times have you been treated unfairly by people in service jobs (store clerks, waiters, bartenders, waitresses, bank tellers, mechanics or others) because you are a woman						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
5. How many times have you been treated unfairly by strangers because you are a woman						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						

	Never	Once in a while	Sometime s	A lot	Most of the time	Almost all of the time
6. How many times have you been treated unfairly by people in helping jobs (doctors, nurses, dentists, counselors, therapists, school principals) because you are a woman						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
7. How many times have you been treated unfairly by neighbors because you are a woman						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
8. How many times have you been treated unfairly by a boyfriend, husband or other important man in your life because you are a woman						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
9. How many times were you denied a raise, promotion, tenure, a good assignment, a job, or other such thing at work that you deserved because you are a woman						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
10. How many times have you been treated unfairly by your family because you are a woman?						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
11. How many times have people made inappropriate or unwanted sexual advances to you because you are a woman						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						

	Never	Once in a while	Sometime s	A lot	Most of the time	Almost all of the time
12. How many times have people failed to show you the respect that you deserve because you are a woman						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
13. How many times have you wanted to tell someone off for being sexist						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
14. How many times have you been really angry about something sexist that was done to you						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
15. How many times were you forced to take drastic steps (such as filing a grievance, filing a lawsuit, quitting your job, moving away and other actions) to deal with some sexist thing that was done to you						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
16. How many times have you been called a sexist name like a bitch, cunt, chick, or other names						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
17. How many times have you gotten into an argument or a fight about something sexist that was done or said to you or someone else						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
18. How many times have you been made fun of, picked on, pushed, shoved, hit, threatened or harm because you are a woman						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						

	Never	Once in a while	Sometimes	A lot	Most of the time	Almost all of the time
19. How many times have you heard people making sexist jokes or degrading sexual jokes						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
	The same as it is now	A little different	Different in a few ways	Different in a lot of ways	Different in most ways	Totally different
20. How different would your life be now if you had not been treated in a sexist and unfair way						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						

Appendix 4

Schedule of Racist Events

We are interested in your experiences with racism. As you answer the questions below, please think about your entire life, from when you were a child to the present. For each question, please check the box that best captures the things that have happened to you. Answer each question twice, once for what has happened to you in the past year, and once for what your entire life has been like.

	Never	Once in a while	Sometimes	A lot	Most of the time	Almost all the time
1. How many times have you been treated unfairly by teachers or professors because you are Black?						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
2. How many times have you been treated unfairly by your employer, boss or supervisors because you are Black?						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
3. How many times have you been treated unfairly by your co-workers, fellow students or colleagues because you are Black?						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
4. How many times have you been treated unfairly by people in service jobs (store clerks, waiters, bartenders, waitresses, bank tellers, mechanics or others) because you are Black?						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						

	Never	**Once in a while**	**Sometimes**	**A lot**	**Most of the time**	**Almost all the time**
5. How many times have you been treated unfairly by strangers because you are Black?						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
6. How many times have you been treated unfairly by people in helping jobs (doctors, nurses, dentists, counselors, therapists, school principals) because you are Black?						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
7. How many times have you been treated unfairly by neighbors because you are Black?						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
8. How many times have you been treated unfairly by institutions (schools, universities, law firms, police, courts, department of social services, unemployment office and others) because you are Black?						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
9. How many times have you been treated unfairly by people that you thought were your friends because you are Black?						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						

	Never	Once in a while	Sometimes	A lot	Most of the time	Almost all the time
10. How many times have you been accused or suspected of doing something wrong (such as stealing, cheating, not doing your share of the work or breaking the law) because you are Black?						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
11. How many times have people misunderstood your intentions and motives because you are Black?						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
12. How many times did you want to tell someone off for being racist but didn’t say anything?						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
13. How many times have you been really angry about something racist that was done to you?						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
14. How many times were you forced to take drastic steps 9such as filing a grievance, lawsuit, quitting a job, moving away, and other actions) to deal with some racist thing that was done to you?						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						

	Never	Once in a while	Sometimes	A lot	Most of the time	Almost all the time
15. How many times have you been called a racist name like a N_____, coon, jungle bunny or other names?						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
16. How many times have you gotten into an argument or a fight about something racist that was done to you or done to somebody else?						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
17. How many times have you been made fun of, picked on, pushed, shoved, hit or threatened with harm because you are Black?						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						
	Same as now	**A little Different**	**Different in a few ways**	**Differ ent in a lot of ways**	**Different in most ways**	**Totally different**
18. How different would your life be now if you had not been treated in a racist or unfair way?						
How often in your ENTIRE LIFE						
How often in the PAST YEAR						

Appendix 5

Self Esteem

BELOW IS A LIST OF STATEMENTS DEALING WITH YOUR GENERAL FEELINGS ABOUT YOURSELF. IF YOU **STRONGLY AGREE**, CIRCLE **SA**. IF YOU **AGREE** WITH THE STATEMENT, CIRCLE **A**. IF YOU **DISAGREE**, CIRCLE **D**. IF YOU **STRONGLY DISAGREE**, CIRCLE **SD**.

		Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**
1	**I feel that I'm a person of worth, at least on an equal plane with others.**	SA	A	D	SD
2	**I feel that I have a number of good qualities.**	SA	A	D	SD
3	**All in all, I am inclined to feel that I am a failure.****	SA	A	D	SD
4	**I am able to do things as well as most other people.**	SA	A	D	SD
5	**I feel I do not have much to be proud of.****	SA	A	D	SD
6	**I take a positive attitude toward myself.**	SA	A	D	SD
7	**On the whole, I am satisfied with myself.**	SA	A	D	SD
8	**I wish I could have more respect for myself.****	SA	A	D	SD
9	**I certainly feel useless at times.****	SA	A	D	SD
10	**At times I think I am no good at all.****	SA	A	D	SD

Appendix 6

Locus of Control

The Locus of Control is a 13 item questionnaire developed by Rotter (1966). It measures generalized expectancies for internal versus external control of reinforcement. People with an internal locus of control believe that their own actions determine the rewards that they obtain, while those with an external locus of control believe that their own behavior doesn't matter much and that rewards in life are generally outside of their control. Scores range from 0 to 13. A low score indicates an internal control while a high score indicates external control.

Locus of Control

Check the box next to the one statement that best describes how you feel.

	Statement you most agree with	Statements
1		Many of the unhappy things in people's lives are partly due to bad luck
		People's misfortunes result from the mistakes they make.
2		One of the major reasons why we have wars is because people don't take enough interest in politics.
		There will always be wars, no matter how hard people try to prevent them.
3		In the long run, people get the respect they deserve in this world.
		Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.
4		The idea that teachers are unfair to students is nonsense.
		Most students don't realize the extent to which their grades are influenced by accidental happenings.
5		Without the right breaks, one cannot be an effective leader.
		Capable people who fail to became leaders have not taken advantage of their opportunities.

6		No matter how hard you try, some people just don't like you.
		People who can't get others to like them don't understand how to get along with others.
7		I have often found that what is going to happen will happen.
		Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.
8		In the case of the well prepared student, there is rarely, if ever, such a thing as an unfair test.
		Many times exam questions tend to be so unrelated to course work that studying is really useless.
9		Becoming a success is a matter of hard work; luck has little or nothing to do with it.
		Getting a good job depends mainly on being in the right place at the right time.
10		The average citizen can have an influence in government decisions.
		This world is run by the few people in power, and there is not much the little guy can do about it.
11		When I make plans, I am almost certain that I can make them work.
		It is not always wise to plan too far ahead because many things turn out to be a matter of luck anyway.
12		In my case, getting what I want has little or nothing to do with luck.
		Many times we might just as well decide what to do by flipping a coin.
13		What happens to me is my own doing.
		Sometimes I feel that I don't have enough control over the direction my life is taking.

Appendix 7 – **Demographic Questionnaire**

Part A. Please answer the questions below in the space provided.

1. Age ____ 2. Number of children _____ 3. Number of children caring for _____

4. Country your parents were born in _________________ 5. Are you biracial/ bicultural ___ Yes ___ No

Part B. Please check the appropriate answer to the questions below.

1. Marital Status

_____ Single/ never married
_____ Married
_____ Living with significant other
_____ Separated/ Divorced
_____ Widowed
_____ Other

2. Sexual Orientation

____ Straight/ heterosexual
____ Lesbian
____ Bisexual
____ Other

3. Education

What is **YOUR** highest level of Education achieved?
____ Less than high school
____ High school graduate or GED equivalency
____ Some College/ Vocational/ Technical
____ College Degree
____ Graduate Degree
____ Master's Degree
____ Doctorate, Law Degree, etc.

4. Education

What is the highest educational level achieved by **YOUR MOTHER**?
____ Don't Know
____ Less than high school
____ High school graduate or GED equivalency
____ Some College/ Vocational/ Technical
____ College Degree
____ Graduate Degree (please specify below)
____ Master's Degree
____ Doctorate, Law Degree, etc.

5. Education

What is the highest educational level achieved by **YOUR FATHER**?
____ Don't Know
____ Less than high school

6. Employment
____ Employed
____ Unemployed
____ Homemaker

____ High school graduate or GED equivalency
____ Some College/ Vocational/ Technical
____ College Degree
____ Graduate Degree
  ____ Master's Degree
  ____ Doctorate, Law Degree, etc.

7. School

Are you currently a student? ___ Yes ___ No

8. Income

What is your annual income?

____ $9999 or less
____ $10,000-20,000
____ $20,001 – 30,000
____ $30,001 – 40,000
____ $40,001 – 50,000
____ $50,001 – 60,000
____ $60,001 – 70,000
____ $70,001 – 80,000
____ $80,001 – 90,000
____ $90,001 – 100,000
____ $100,001+

9. Income

What is your annual Household income?

____ $9999 or less
____ $10,000-20,000
____ $20,001 – 30,000
____ $30,001 – 40,000
____ $40,001 – 50,000
____ $50,001 – 60,000
____ $60,001 – 70,000
____ $70,001 – 80,000
____ $80,001 – 90,000
____ $90,001 – 100,000
____ $100,001+

10. Occupation

____Professional, technical and related occupations
____ Executive, administrative and managerial occupations
____ Sales occupations
____ Administrative support occupations including clerical
____ Precision, production, craft and repair occupations (e.g. mechanics, construction, production)
____ Machine operators, assemblers and inspectors
____ Transportation and material movers
____ Handlers, equipment cleaners, helpers, laborers
____ Service occupations

Appendix 8 – Study Recruitment Flyer

Drexel University

Recruiting Volunteers for a Research Study

Research Title

Intersecting Inequalities: Exploring the Relationship between Subjective Social Status, Intersections of Racism and Sexism, and the Health Status of Black Women in Philadelphia

Research Objectives

Black women have higher rates of several health conditions and much research has been focused on understanding why these disparities exist. Social conditions play an important role in influencing the health of populations. Research that helps us to better understand the role of social conditions such as social status and experiences of inequalities such as racism and sexism as well as perceptions of status may provide useful information to address health disparities for Black women.

The purpose of this study is to explore Black women's perceptions of their social status (their position or rank in society) and how Black women's experiences of racism and sexism influence their perceptions of social status as well as their health.

You may be eligible to participate in a focus group or a survey!

Information for Research Studies Eligibility

To be included in this study you must be 1) 18 years or older; 2) self Identify as Black or African American woman; 3) English speaking; and have been born & raised in the U.S. If you meet the criteria, please contact Candace at the number or email below.

Remuneration

- Participants who complete the survey will be entered into a lottery to receive 2 movie vouchers.
- Participants who complete the focus group will be entered into a lottery to receive a $50.00 gift card.

Location of the research and person to contact for further information

If you are interested in participating in this study, please contact
Candace Robertson, MPH at 215-991-8451, 215-287-2765 or croberts@drexelmed.edu

This research is approved by the Institutional Review Board and is conducted by a researcher who is a member of Drexel University