EXAMINING THE RELATIONSHIP BETWEEN RACIAL IDENTITY AND POSITIVE HEALTH BEHAVIORS AMONG AFRICAN AMERICAN EMERGING ADULTS

A Dissertation by

Jamilia Raki Sly

Master of Arts, Wichita State University, 2007

Bachelor of Arts, University of South Florida, 2004

Submitted to the Department of Psychology
and the faculty of the Graduate School of
Wichita State University
in partial fulfillment of
the requirements for the degree of
Doctor of Philosophy

December 2010

EXAMINING THE RELATIONSHIP BETWEEN RACIAL IDENTITY AND POSITIVE HEALTH BEHAVIORS AMONG AFRICAN AMERICAN EMERGING ADULTS

The following faculty members have examined the final copy of this dissertation form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree Doctor of Philosophy, with a major in Psychology.

_____
Rhonda K. Lewis-Moss, Committee Chair

_____
Darwin Dorr, Committee Member

_____
Ron Matson, Committee Member

_____
Gregory Meissen, Committee Member

_____
James Snyder, Committee Member

Accepted for the College of Liberal Arts and Sciences:

_____
William D. Bishoff, Dean

Accepted for the Graduate School:

_____
J. David McDonald, Dean

DEDICATION

To my grandmother Vernice Sly and to the memory of my late grandparents and aunt:
Mary Virginia Avery Chatman
Charles Elijah Chatman, Jr.
Cleotha Sly
Marsha Ann Chatman Hathaway

ACKNOWLEDGMENTS

To my heavenly Father, thank you! With you, I can accomplish anything. I would like to thank my advisor, Dr. Rhonda K. Lewis-Moss, for her invaluable time, expertise, guidance and patience during this process. I am forever grateful to you. I would also like to thank my committee members, Darwin Dorr, Ron Matson, Greg Meissen and James Snyder, for their insight and helpfulness. To my parents, Rayford and Jocelyn Sly, thank you for your support and encouragement throughout my life. Lastly, I want to acknowledge my family and friends for their thoughts, prayers and support throughout the years. You are truly appreciated.

ABSTRACT

Racial identity is an important factor in predicting health behaviors, especially among African Americans. The history of African Americans in the United States makes racial identity an important concept to study. Racial identity can be described as the degree to which a person feels connected to or shares commonalities with an ethnic racial group (Helms, 1990). African Americans fare much worse than other racial and ethnic minorities in the United States in many areas of health. The purpose of this project was to investigate the relationship between racial identity and health behaviors of African American adults aged 18-25 years old.

Two hundred African American emerging adults (18-28 years old) (50% female) were recruited from a university campus and community arts festival to participate in the study. Results yielded three distinct identity profiles (multicultural, integrationist and marginalized). Race was a defining feature of identity for the integrationist cluster. The multicultural profile embraced blending with mainstream culture and other minority groups and the marginalized profile did not identify with any group or ideology. The three profiles were assessed for differences in health behaviors (i.e. substance use, mental health, exercise, number of sexual partners). The marginalized profile displayed lower positive affect, more cigarette smoking and more sexual partners in the past year than the other two profiles.

Racial identity may be one way of assessing how participants view the world. The information about why they identify with a certain racial identity profile might help researchers tailor preventive interventions to reducing health disparities. Our findings, however, have shown that racial identity alone is not sufficient in explaining how or why people choose to engage in unhealthy behaviors.

TABLE OF CONTENTS

TABLE OF CONTENTS (continued)

LIST OF TABLES

LIST OF FIGURES

Chapter I

INTRODUCTION

The history of African Americans in the United States makes racial identity an important concept to study. Identity can be defined as one part of an individual's overall self concept (White & Parham, 1990). Racial identity then, can be described as the degree to which a person feels connected to or shares commonalities with an ethnic racial group (Helms, 1990). African Americans, as a people, have encountered years of oppression through forces such as slavery, racism, segregation and discrimination which have proven to be a unique set of experiences for African Americans in this country. Because of this, race is a concept that many African Americans think about every day when making decisions and engaging in behavior. There is evidence to support this perspective. For example, Thompson and Chambers (2000) suggest that racial identity is an important factor in predicting health behaviors, especially among African Americans.

Although the overall health of the U.S. population has improved over the past decade, African Americans are faring much worse than other racial and ethnic minorities in the United States in many areas of health. Significant health disparities still exist between African Americans and Caucasians. African Americans suffer disproportionately from health conditions such as diabetes, heart disease, HIV/AIDS, STD, obesity and overweight, cancer and cardiovascular disease (National Center for Health Statistics [NCHS], 2008). Furthermore, much of the data from the research regarding the health of the U.S. population is often obtained by using a population of either adolescents or adults. Identity development and exploration is said to occur sometime between adolescence and adulthood (Erickson, 1968) and many of the behaviors associated with chronic disease may also be developed during this time.

The purpose of this project was to investigate the relationship between racial identity and health behaviors of African American adults aged 18-25 years old. It is important for researchers to understand how racial identity influences health behaviors, particularly among this age group. Thus, the present study will examine the role that racial identity plays in the expression of certain health behaviors of African American emerging adults.

CHAPTER II

LITERATURE REVIEW

Emerging Adults

Emerging adulthood, introduced by Arnett (2000), is a new theory of development that covers the span of experiences from the late teens through the twenties, in particular ages 18-25 years old. Arnett suggests that this period of development is "theoretically and empirically distinct" from adolescence and young adulthood because of its "relative independence from social roles and from normative expectations" (Arnett, 2000).

According to Arnett (2000), emerging adulthood is a distinct developmental period in three major ways: demographic composition, subjective perspectives, and in identity explorations. First, emerging adulthood is distinct because of the demographic composition of people between 18-25 years old. People in this age group vary greatly in terms of education, marital status and residential status, especially when compared to adolescents and adults (Arnett, 2000). For example, most emerging adults enter higher education immediately after high school, and may or may not complete their degree in the traditional 4-year time frame. However, a significant portion chooses to go straight into the workforce. Additionally, even though most people move out of their parents' homes at 18 or 19 years old, this age group has the most unstable residential status of any age group because their living situations change frequently due to moving away to college, moving out on their own, and moving back in with parents after moving out (Arnett, 2000). The majority of emerging adults are single, but there is some variation (by age) in these rates. According to the United States Census Bureau (2001), between 78.8% - 95.8% of males 15 – 24 years old have never been married. Women are characterized by similar rates during this age period with between 69% -94% having never been married (US

Census, 2001). Because of these variations, it is difficult to predict one's marital status, where one lives, and occupational status on the basis of age alone during this period, which is a factor that distinguishes this group from adolescence and young adulthood (Arnett, 2000). Furthermore, it is difficult to find research about this age group in the literature because there is not a clear consensus as to when adolescence ends and adulthood begins. Some research classifies adolescence between 13 – 18 years; some classifies adolescence (or youth) between 15-24 years, while other research classifies young adults as 18-35 years. There is significant overlap in these age ranges and many times data about emerging adults is grouped together with adolescents and/or adults.

Second, emerging adults themselves do not define themselves as adolescents, nor do they feel that they have reached adulthood (Arnett, 2000). This is an indication that people in this age group feel they have moved from adolescence but have not yet reached full adult status. This attitude may reflect that many emerging adults feel less self-sufficient than an adulthood status would indicate (Arnett, 2000).

Third, identity exploration is an attribute that has been associated with adolescent development. However, it is believed that this process extends past adolescence into the twenties (Valde, 1996) during which the identity issues that most emerging adults will focus on are love, work and worldviews (Arnett, 2000). Emerging adults may also explore their identity by engaging in risky behaviors, including ~~"u~~nprotected sex, most types of substance use, and risky driving behaviors" (Arnett, 1992). Emerging adulthood theory emphasizes the changes in role status that young adults experience during this time period and the potential that those changes have for explaining increases and decreases in risk behavior (Kogan, Brody, Gibbons, Murry, Cutrona, Simons, et al., 2008). It is crucial for researchers to examine and develop solutions to

decrease these risk behaviors. It is equally important to examine racial differences in the transition to adulthood.

Arnett has reported evidence that African American emerging adults have specific ideas about the transition to adulthood and what it means to be an adult (Arnett, 2008). Compared to Whites, African American emerging adults were more likely to think that achieving certain role transitions (marriage, completing education, becoming a parent, full-time employment), complying with certain norms (avoiding substance abuse, practicing safe sexual behaviors), and being capable of supporting a family indicate one had reached full adulthood status (Arnett, 2003).

Arnett (2008) acknowledged these racial differences and proposed the following idea about African American emerging adults:

> ~~"~~identity issues are more complicated and difficult for African American emerging adults than for emerging adults in other American ethnic groups because they must overcome the negative assumptions that others have about them as young Black people" (Arnett & Brody, 2008).

People of different racial and ethnic backgrounds in America have very different social experiences. These experiences influence the developmental process, especially identity exploration, which is a defining feature of the emerging adult developmental period. African Americans have very different experiences than Caucasian Americans and this manifests itself in their lives in many ways. How and why these groups differ is important to examine. Issues in health care, quality and access are an example of the differences that exist between African Americans and Caucasians.

The Health of African Americans

The health of African Americans is poor and while the health of African American children and teens is relatively good, most health problems do not surface until later in life. As a whole, African Americans have high mortality and morbidity rates (Johnson, 2002a). Although African Americans make up just 13% of the United States population, they account for a larger percentage of mortality associated with premature causes of death for this country. Heart disease, cancer and stroke are the leading causes of death for African Americans and Caucasians, but mortality rates due to these causes are much higher for African Americans (CDC, 2005a). For example, in 2004, the average life expectancy of African Americans (73 years) was 5 years less than White Americans (78 years) (NCHS, 2008).

The majorities of deaths occur later in life and result from unhealthy behaviors that are acquired and are practiced earlier in life. During the adolescent and emerging adult stages of development most people are in good health. Although young adults are generally healthier than older adults, young adults engage in unhealthy behaviors related to chronic disease, substance use, and sexually transmitted diseases and when mortality rates are broken down by race, African Americans have higher rates compared to other racial groups (NCHS, 2008).

Compared to other racial and ethnic groups, African Americans in the age group 18-25 years have lower levels of substance use. For example, fewer than 30% of African Americans smoke cigarettes (28.5%) and binge drink (24.2%) and only 20% of African Americans 18-25 use illicit drugs (Park, Mulye, Adams, Brindis & Irwin, 2006). African American adolescents have lower rates of alcohol and marijuana use compared to White adolescents (Johnston, 2003). However, when comparisons of rates of alcohol and drug use for African American by age are made, there is a marked increase in substance use for 18-25 year olds. In 2002, alcohol use (in

the last month) rates for 8-12th grade African American students ranged from 15% to 30%; binge drinking rates ranged from 4% -12% (Windle, 2003; Johnston, 2003). The increase in alcohol consumption from adolescence to adulthood is clear when compared to African American adults' (18 and older) rates: 45% and 24% (SAMHSA, 2010) respectively, for alcohol use and binge drinking in the previous month.

The rate of HIV/AIDS among African Americans is alarming, particularly for the 18-25 year old age group. In 2005, African American youth (13-24 years) accounted for 55% of all HIV infections (CDC, 2005b) in this age group. Most cases of HIV/AIDS are contracted through unprotected sexual intercourse. African American emerging adults have higher rates of sexual activity than their Caucasian and Hispanic counterparts. For example, 88% of African American emerging adult males report being sexually active; 87% of African American emerging adult females report sexual activity (Park, et al., 2006). Twenty-eight percent of African American emerging adults report having had sexual intercourse with six or more people (Kaiser Family Foundation [KFF], 2003). In contrast, although African Americans report high rates of sexual activity, they also report using contraceptives more than other ethnic groups. Fifty-nine percent of African American youth (15-24) who had engaged in sexual intercourse reported using birth control all of the time. More than 90% of African American youth (12-24 years old) reported using condoms during sexual intercourse and 72% of African American young adults reported using condoms regularly (KFF, 2003). These rates exceeded the Healthy People 2010 target rate (65%) for sexually active adolescents who used a condom the last time they had sexual intercourse (Park, Brindis, Chang & Irwin, 2008).

Physical activity is a protective factor against the development of many chronic diseases (obesity/overweight, diabetes, hypertension, cardiovascular disease, etc.). According to the

NCHS (2008), one-half of African American adults (18 and older) are physically inactive. This is one factor that has contributed to the particularly devastating rates of chronic diseases among African Americans. One consequence of physical inactivity is obesity/overweight. For example in 2006, among persons 20-74 years old, seventy-two percent of African American men and 81% of African American women were overweight (NCHS, 2008). Moreover, 36% of African American men were obese and more than half (54%) of African American women were obese in 2006 (NCHS, 2008).

Most young adults report engaging in physical activity; however, in the African American community, there are significant gender differences. One study by Kelley (1995) found that among African Americans, males self-report more physical activity than females (81.7% and 66.2%, respectively) (Kelley, 1995). Male participants in the study, however, reported being more overweight and obese than the females. This is in contrast to national statistics regarding overweight and obesity among African Americans 20 years and older that show that African American females are more overweight and obese than their male counterparts.

In addition to the aforementioned physical health concerns, emerging adults also deal with psychological health issues, such as depression and anxiety. The National Co-Morbidity Survey-Replication (NCS-R, 2007) estimated that 59% of adults 18-29 years old have experienced a mental disorder (anxiety, mood, impulse-control or substance disorders) at some point in their lives. Depression (16%) and nicotine dependence (26.5%) were the most common disorders faced by this population (NCS-R, 2007). Incidence and prevalence rates specifically for African American emerging adults are not widely available, but it is estimated that about 6%

of this population report suffering from a serious mental illness (Office of Applied Studies, 2008).

Risk and Protective Factors in Emerging Adulthood

Risk and protective factors may contribute to the rates of unhealthy behaviors displayed by emerging adults. Protective factors are defined as those behaviors or attitudes that mitigate the exposure to risk (Cowen & Work, 1988), in this case, unhealthy behavior. Unhealthy behaviors can include: substance use, unprotected sexual activity, infrequent use of contraceptives, physical inactivity and poor diet. Some protective factors for ethnic minorities (18 years and older) include: (1) culturally relevant health education, (2) cultural identity integration, (3) protective family processes including close, satisfying relationships with parents, communication about risk behavior, and clear parental norms that discourage such behavior (Kogan, et al., 2008), (4) adaptive coping skills (that aid in prosocial behavior), (5) strong, energetic focus on a higher life goal, (6) family support and other external support systems (religion, friendships, etc.), (Yee, Castro, Hammond, John, Wyatt, & Yung, 1995), (7) racial or ethnic identity and Afrocentric orientation (Rowley, Sellers, Chaos & Smith, 1998; Sellers, Caldwell, Scheele-Cone & Zimmerman, 2003; Brook & Pal, 2005; Pugh & Brie, 2007).

In contrast, risk factors are behaviors or attitudes that promote people negative health outcomes. There are several risk factors for unhealthy behavior in emerging adults. The literature concerning risk factors for emerging adults is limited and most often focuses on drug and alcohol use and sexual activity. Risk factors for unhealthy behaviors among emerging adults can be categorized as deriving from individual factors or contextual/environmental factors. Contextual or environmental risk factors include: laws and norms favorable toward risky/unhealthy behavior. This can also include cultural/ethnic norms, in which the cultural

group may prescribe certain types of attitudes, beliefs or ideas regarding how its members should behave (i.e. racial identity). Extreme economic deprivation is another risk factor for drug and alcohol use, as well other unhealthy behaviors (Hawkins, Catalano & Miller, 1992).

Individual and interpersonal risk factors include: physiological factors such as genetic determinants of alcoholism and other diseases and health issues. Increased independence and increased availability of alcohol is another risk factor for substance use. During the emerging adult period, many individuals attain legal age to drink alcohol and thus increase their consumption of alcohol. Other individual risk factors include initiation of new roles, development of new friendship networks, separation from families and old friends, and less parental support, guidance and monitoring (Moggs, 1997; Schulenburg & Moggs, 2002).

There is a need to understand how the impact of all of these health behaviors is moderated by racial identity. Theorists have suggested examining the role of positive racial identity as a protective factor and examining what impact racial identity might have on engaging in risky behaviors. This next section summarizes the most widely cited racial identity theories.

Racial and Ethnic Identity Theories

Racial identity is a concept that has been studied widely among people of color, especially African Americans. The concept of racial identity was first introduced with the Black and White doll study (Clark & Clark, 1947), in which researchers aimed to assess the self-esteem of African American children by investigating their preference for playing with White dolls or Black dolls. African American children preferred not to play with the Black dolls and White children in the study preferred to play with White dolls. The researchers interpreted Black children's preference for White dolls as self-hatred or low self-esteem. Later, in the 1960s, when self-esteem measures were developed and used to assess self-esteem of African Americans,

research showed that African American children actually had higher levels of self-esteem compared to White children (Marks, Settles, Cooke, Morgan, & Sellers, 2004). These findings, along with an increase in the number of African Americans in higher education and research, lead to a new conceptualization of racial identity, in which African Americans had an active role in defining what it means to be African American and how African Americans came to identify with their racial group (Marks, et al., 2004).

Many models and theories of racial identity have been developed to describe and explain how African Americans identify with their racial group. They each emphasize different aspects of identity (i.e., experiences, culture, access, attitudes, and beliefs). Racial identity theories can be placed into two categories: developmental or multidimensional. A developmental theory attempts to define one's identity as a developmental process, in which an individual moves through several different identity stages, until he or she has reached an ideal Black identity and consequently moves away from a ~~"p~~sychologically-enslaved Negro identity" (Marks, et al., 2004). Multidimensional theories conceptualize identity in terms of experiences, beliefs and attitudes. Identity is not viewed as stage process; rather it is comprised of several components or dimensions, is non-linear, and is based on attitudes and beliefs that an individual holds in relation to their racial group (Helms, 1991; Marks, et al., 2004). Table 1 provides an overview of several theories of racial identity and their associated measures.

Nigrescence Theory

One of the first and most widely recognized theories of racial identity is the Nigrescence model which approaches racial identity from a developmental perspective. Nigrescence, refers to the ~~"d~~evelopmental process by which a person ~~"b~~ecomes Black" where Black is defined in terms of one's manner of thinking about and evaluating oneself and one's reference groups rather

than in terms of skin color" (Helms, 1991). It is a five stage theory of Black identity development, where each stage is characterized by self-concept issues concerning race as well as attitudes about Black and Whites. Cross proposed that each stage has different implications for a person's feelings, thoughts and behaviors. Since the conceptualization of the first model in 1971, Cross has revised the model to include a change in how the Nigrescence process is viewed. Cross (1971) first perceived Nigrescence as a process of moving from a self-hating to an affirming ~~h~~healthy" self-concept.

In the revised model, Nigrescence is defined as the transformation from a preexisting (non-Afrocentric) identity into one that is Afrocentric (Cross, 1991). The first stage of Nigrescence is Pre-encounter, where race is not important in an individual's life and his or her focus is on membership in other groups such as religion, social class, or sexual orientation. The second stage is Encounter during which individuals face situations that cause them to challenge current feelings about themselves and their interpretation of the conditions Black people face in America. The third stage, Immersion-Emersion occurs when one immerses himself in blackness and feels liberated from whiteness. Internalization is the fourth stage of racial identity and happens when there is a psychological change in which the individual learns to balance his or her Black identity with other group memberships (gender, religion, sexual orientation). The last and final stage of Nigrescence is Internalization-Commitment and in this stage the individual commits to a plan of action and begins to live in accordance with his or her new self-image (Cross, 1991).

TABLE 1

SUMMARY OF RACIAL AND ETHNIC IDENTITY THEORIES

Name of Theory	Author	Type of Theory	Description	Associated Measure
African Self-Consciousness (ASC)	Baldwin, 1985	Developmental	The Black personality's core structure – ACS- is common to all Black people. A healthy ACS is determined by awareness of African identity, prioritizing African survival and development, respect for all things African and a standard of conduct toward all things non-African.	African Self Consciousness Scale (Baldwin & Bell, 1985)
Ethnic Identity	Phinney, 1992	Developmental	Ethnic identity is the part of the self-concept that pertains to a person's knowledge of group membership and the value and significance one places on being a member of that group. Identity development occurs in linear fashion through three stages: diffused/foreclosed, moratorium, and achieved identity. The model acknowledges unique characteristics for different ethnic groups, but also focuses on the aspects of ethnic identity that are present across all ethnic groups.	Multi-Group Ethnic Identity Measure (Phinney, 1992)

Multidimensional Model of Racial Identity (MMRI)	Sellers, et al., 1997	Multidimensional	The MMRI draws upon many pre-existing racial identity models. It focuses on describing the status of one's racial identity at a specific moment in time and is comprised of four dimensions: racial centrality, racial salience, racial ideology and racial regard. Three major assumptions are the guiding framework for this model: (1) identity is stable, but can be influenced by situations, (2) a person can have multiple identities that have differing levels of significance, (3) one's perception of what it means to be Black is the most valid; thus one's identity is neither healthy nor unhealthy.	Multi-dimensional Inventory of Black Identity (Sellers et al., 1997)
Multidimensional Structure of Racial Identification	Sanders-Thompson, 1991, 1995	Multidimensional	Racial identity is perceived as having multiple components and that racial identity is not an ~~-a~~ll-or-none" concept. According to this model a person may identify with various components of racial identity and at different levels. The model is composed of four dimensions and is strongly influenced by Hillard's (1985) four dimensional model: physical, cultural, sociopolitical and psychological.	Multidimensional Racial Identification Scale (Sanders-Thompson, 1991)
Nigrescence Model	Cross, 1971, 1991	Developmental	Nigrescence refers to the process of ~~-be~~coming Black-oriented." The original model (1971) suggested that during this process an individual moves from self-hatred to self-acceptance. Cross revised the model in 1991 and defined Nigrescence as the ~~-tr~~ansformation from a pre-existing (non-Africentric) identity to an Africentric identity. The revised model consists of five stages: pre-encounter, encounter, immersion/emersion, internalization, and internalization-commitment.	Cross Racial Identity Scale (Cross, 1972); Racial Identity Attitudes Scale (Parham & Helms, 1981);

African Self-Consciousness

African Self Consciousness (ASC) is a model of racial identity that describes the nature and structure of the Black personality. In this model, the authors suggest that African Self Consciousness is the core component of the Black personality that is most representative of racial identity. ASC refers to the perspective and approach to life that African people embrace. The model makes a determination of what characteristics constitute a healthy ASC, which includes believing and engaging in behaviors such as: awareness of African identity and cultural identity, recognition of African survival and proactive development as a first priority, respect for and active perpetuation of African life and institutions, and a recognition of the role of racial oppression as a hindrance to the development and survival of Black people (Baldwin & Bell, 1985; Marks et al., 2004).

Ethnic Identity Model

Jean Phinney (1992) conceptualized a model of ethnic identity that is based on Erikson's (1968) stages of identity development. According to Phinney, ethnic identity is the part of the self-concept that demonstrates a person's knowledge of his or her group membership and the value and significance that person places on being a member of that group (Marks et al., 2004). Ethnic identity is a process that is accomplished in stages beginning in adolescence and ends with an achieved or optimal identity. Phinney's model is comprised of three identity stages: diffuse/foreclosed (little to no understanding of ethnic/racial identity), moratorium (actively searching for meaning in ethnic group identity but no accepted meaning) and achieved (finding and accepting group identity, sense of belonging, acceptance of group). In addition to these stages, Phinney's model also includes four universal (characteristics that are applicable to any ethnic group) components of ethnic identity: self-identification (identifying one's self as a

member of a particular ethnic group), ethnic behaviors and practices (participation in cultural traditions and social activities with other group members), affirmation and belonging (feelings of ethnic pride), and achievement (current identity state, i.e., diffused, moratorium, achieved).

Multidimensional Structure of Racial Identification

In an attempt to move away from characterizing racial identity as an "all-or-none" phenomenon, Sanders-Thompson proposed a multidimensional, non-developmental model of racial identification. Racial identification, as she defines it is a "psychological attachment to one of several social categories available to individuals when the category selected is based on race or skin color and/or a common history" (Sanders-Thompson, 2001). The model is composed of four identity dimensions: psychological, sociopolitical, cultural and physical. The psychological identity refers to one's sense of belonging, commitment to and pride in the racial group. Sociopolitical identity refers to an individual's attitude toward social, political and economic issues in the person's ethnic community. Cultural identity refers to an individual's awareness and knowledge of and commitment to the language, art, literature and social traditions of one's ethnic community (Sanders-Thompson, 1995; 2001).

Multi-dimensional Model of Racial Identity

The Multi-dimensional Model of Racial Identity (MMRI) was developed by Sellers and colleagues in the late 1990s. This particular model of racial identity was selected for use in the present study for many reasons. First, Sellers' model represents an integration of several existing theories on African American racial identity which are sensitive to the historical and cultural experiences that help form the unique of identity of African American people (Sellers, Smith, Shelton, Rowley & Chavous, 1998). Unlike other racial identity models such as Phinney's (1992) model of ethnic identity, the MMRI provides a detailed view of the meaning of being

Black because it was developed within the context of the unique experiences associated with African American history. The ethnic identity model (Phinney, 1992) does not distinguish between the diversity of defining what it means to be Black. For instance, it focused on the commonalities regarding ethnic identity across different ethnic groups so that a person who is Hispanic and one is African American would be evaluated in the same way, using one measure of ethnic identity. Second, the MMRI allows for multiple dimensions regarding racial identity to be appreciated within one individual. Other models (Cross, 1971; Baldwin, 1985) view African American racial identity from a one-dimensional perspective, which consequently marginalizes a significant portion of the African American community who do not fit this perspective. Another strength of the MMRI is the way in which it addresses the ~~"o~~optimal" racial identity. Other models (Cross, 1971; Baldwin, 1985; Phinney, 1992) attempt to define the optimum African American racial identity, which have been defined based on assumptions that are not testable or unverifiable. The MMRI, because of its conceptualization of the different dimensions of racial identity allows for richer and more nuanced empirical hypothesis testing. Finally, the MMRI provides a contribution to the literature in that it outlines a process that explains how racial identity may influence behavior at the level of the event. In this model, racial identity of African Americans is defined as ~~"th~~he significance and qualitative meaning that individuals attribute to their membership within the black racial groups within their self-concepts." (Sellers, et al., 1998).

Rationale for Not Choosing Other Racial Identity Theories

Though the aforementioned models of Black/African American racial identity have all made significant contributions to the literature concerning black identity and our understanding of the Black psyche, there are several reasons these models were not chosen to be used in this

study. First, with the exception of Sanders-Thompson's Multidimensional Structure of Racial Identification (MRI), racial identity is viewed from a developmental perspective (Cross, 1971, 1991; Baldwin & Bell, 1985; Phinney, 1995). A multidimensional approach is best suited for the emerging adult population of the current study because this approach seeks to provide an accurate representation of the racial identity of all study participants. Although the MRI (Sanders-Thompson, 1995; 2001) proposes a multidimensional approach, it is not as detailed as the multidimensional model developed by Sellers and colleagues (1997, 1998). Second, many of these models (Cross, 1971; Baldwin & Bell, 1985; Phinney, 1995) support the notion of a healthy or optimal racial identity, which is not the goal of this research. The interest is in identifying relationships between racial identity and health behaviors. Therefore, the author has chosen to use the Multidimensional Model of Racial Identity (MMRI) (Sellers et al., 1997, 1998) as the guiding theory of racial identity for this study.

Assumptions of the MMRI

The MMRI is grounded in four assumptions. The first assumption is that an individual's identities are influenced by situational or contextual factors, but that identity can also be a consistent property of the person. Secondly, the MMRI assumes that an individual can have multiple identities that are hierarchically ordered. This assumption allows race to be examined within the context of other identities that an individual may possess such as gender or sexual orientation. Third, the MMRI assumes that whatever a person perceives their identity to be is the most valid indicator of their personal identity because the focus of the model is on the individual's conception of his or her identity. In taking this approach the MMRI moves away from making value judgments about healthy and unhealthy racial identity. This concept is a break from earlier stage models of racial identity (Cross, 1971; Baldwin & Bell, 1985). The

fourth and final assumption of the model is that racial identity is viewed as a status for a particular moment in time rather than as a stage in a developmental sequence.

The last assumption is really what differentiates Sellers' model from many of the other well known racial and ethnic identity models (i.e., Cross, Phinney, Milliones). The MMRI, unlike the stage models, describes the importance of race at various points in an individual's development. Evidence of this is seen in other studies (Belgrave, Brome, & Hampton, 2000; Townsend & Lanphier, 2005) that have used modified version of the MMRI to assess children's and adolescents' racial identity. Because emerging adulthood is a relatively new period of development, there are understandably few studies that focus exclusively on the 18-25 year old age. Much of the research on the MMRI has focused either on adolescent samples (12-18 years old), college-aged students (18-30 years old), or adult samples (18 and older). There is significant overlap in the age ranges of all of these samples. Research has shown that the emerging adult period is different than adolescence and is also different from adulthood and should be studied separately because of the distinct experiences of people in this age group (Arnett, 2000, 2004).

Dimensions of the MMRI

The MMRI is composed of four dimensions that address the significance and qualitative meaning of race in the self-concept of African Americans (Sellers, 1998). The four dimensions are racial *salience*, *centrality* of the identity, *regard* in which the person holds the group associated with the identity and the *ideology* associated with the identity (See Figure 1). Table 2 summarizes each dimension and sub-dimension of the model. Racial salience and centrality refer to the significance and meaning that an individual ascribes to race in defining him or herself. Racial regard and ideology refers to the individual's perception of what it means to be Black

(Sellers, et al, 1998). None of the dimensions are thought to equal to racial identity on their own. Rather, it is the pattern of all four dimensions that represent the various ways that racial identity can be manifested among African Americans.

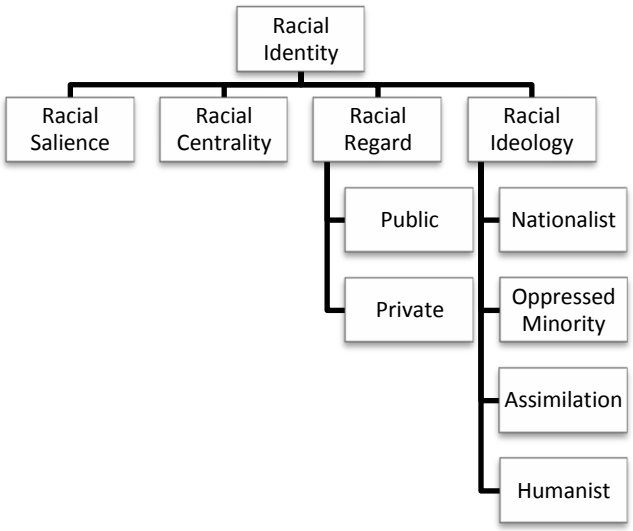


Figure 1. Diagram of Multidimensional Model of Racial Identity

Racial Salience.

Salience, which emphasizes an event or situation as the unit of analysis, refers to how important race is to a person's self-concept at a particular moment or in a particular setting (Sellers, et al, 1998). Sellers et al. (1997, 1998) describe salience as a mediating process between the stable properties of identity and the way in which people perceive and behave in a particular situation. For example, an African American student who is the only person of color in a class at a predominately white institution may experience an increase in racial salience, whereas another African American in the same situation would not experience increased racial salience (because race isn't as important to his or her self-concept at that point in time). Conversely, the latter person may attend a predominantly black church and have decreased racial salience at that particular moment and situation.

TABLE 2

SUMMARY OF IDENTITY DIMENSIONS OF THE MMRI

Identity Dimension	Description
Racial Salience	Refers to how important race is to a person's self-concept at a particular moment or in a particular setting.
Racial Centrality	The extent to which a person typically defines himself in terms of race (is relatively stable across situations)
Racial Regard	Refers to how negative or positive an individual feels about her race.
Public Regard	The extent to which individuals feel that others view African Americans positively or negatively.
Private Regard	The extent to which an individual feels positively or negatively towards African Americans as well as they feel about being African American.
Racial Ideology	Composed of four different philosophies concerning individuals' beliefs, opinions and attitudes with respect to the way that members of the Black race should live and interact with society.
Nationalist	Emphasizes the uniqueness of the experiences of African Americans and that African Americans should be in control of their own destiny with very little from other groups.
Oppressed Minority	The oppressed minority ideology focuses on the similarities between the oppression that African Americans face and that of other marginalized, minority groups.
Assimilationist	Focuses on the similarities between African Americans and the rest of American society; acknowledges and wants to be a part of the mainstream American culture.
Humanist	One with a humanist perspective does not think in terms of race, gender, class or other distinguishing characteristics, but prefers to focus on characteristics of individuals regardless of race.

Racial Centrality.

Racial centrality is the extent to which a person typically defines himself in terms of race and is relatively stable across situations (Sellers, et al., 1997, 1998). In this dimension of racial identity, the unit of analysis is how one perceives himself in terms of race across many, different situations. The hierarchical order of identities is also important to this dimension because the identity that is at the top of the hierarchy is the focal point of self definition and also has the most influence on behavior (Sellers et al, 1998). For example, an African American Catholic for whom religion is more of a defining characteristic would have a lower sense of racial centrality compared to an African American Catholic who felt that being Black defined him or her more so than religion.

Racial Regard.

This dimension refers to how negative or positive an individual feels about her race. The regard dimension consists of a private and public component. Private regard is the extent to which an individual feels positively or negatively towards African Americans as well as how positively or negatively they feel about being an African American (Sellers, et al, 1998). Public regard is defined as the extent to which individuals feel that others view African Americans positively or negatively. In other words, it is an individual's evaluation of how African Americans are viewed by the mainstream society. For example, a person who feels positively about African Americans and about being African American has a high sense of private regard. Someone who thinks that the mainstream society believes that all black males are thugs would have a low sense of public regard.

Racial Ideology.

Racial ideology is composed of four different philosophies concerning individuals' beliefs, opinions and attitudes with respect to the way she or he feels that members of the Black race should live and interact with society (Sellers, et al, 1998). The ideologies are manifested across four areas of functioning consisting of individuals' attitudes regarding political/economic development, cultural/social activities, intergroup relations and perceptions of the dominant group. Within the ideology dimension individuals can be described in terms of one specific ideology, but it is more likely that most people will possess more than one philosophy that varies according to function. For instance a person could endorse a nationalist philosophy (Blacks should send their children to African-centered schools), but also have an assimilation philosophy (Blacks should work at White companies or institutions).

Nationalist Ideology. The nationalist ideology emphasizes the uniqueness of the experiences of African Americans. This ideology suggests that African Americans should be in control of their own destiny with very little or no input from other groups. Some other characteristics of individuals with a nationalist ideology include: a propensity to participate in and prefer African American organizations (fraternities and sororities, Urban League, NAACP, etc.) and social environments and an appreciation and awareness of the culture and accomplishments of African Americans.

Oppressed Minority Ideology. The oppressed minority ideology focuses on the similarities between the oppression that African Americans face and that of other marginalized, minority groups. An individual who is characterized as having an oppressed minority philosophy is likely to view coalition building as the most appropriate strategy for social change, is interested in the nature of oppression and is interested in the culture of other minority groups.

Assimilationist Ideology. The assimilation ideology focuses on the similarities between African Americans and the rest of American society. A person who endorses an assimilationist ideology acknowledges and wants to be a part of the mainstream American culture. This does not however, imply that being African American is not important to those that endorse this ideology nor that there is no recognition of racism in our society. It does imply that these individuals are more likely to believe that it is important to interact socially with Whites.

Humanist Ideology. The humanist ideology emphasizes the similarities of all humans (i.e., we are all human beings). Individuals with a humanist perspective do not think in terms of race, gender, class or other distinguishing characteristics, but prefer to focus on characteristics of other individuals regardless of race. Those who endorse this ideology concern themselves with ―larger" global issues that the entire world is facing (world hunger, global warming, etc.).

Research Studies using the Multidimensional Model of Racial Identity

Given the strengths of the MMRI and its associated inventory, the Multidimensional Inventory of Black Identity (MIBI) (Sellers, et al., 1998), has been used in various studies to examine how racial identity is related to a number of factors (academic achievement, psychological health and well-being, discrimination, prejudice and racism and alcohol use) and how racial identity may influence the manifestation of those behaviors. This next section will review findings from these studies.

Racial Identity and Psychological Well-Being

Much of the research about racial identity has examined its relation to the psychological health and well-being of African Americans. Researchers who have adopted a developmental stage approach (Munford, 1994; Neville & Lilly, 2000; Phelps, Taylor, & Gerard, 2001; Johnson, 2002b; Pillay, 2005; Franklin-Jackson & Carter, 2007; Whittaker & Neville, 2009)

have found evidence to support a relationship between one's racial identity stage and their psychological health. Researchers using the MIBI have also found significant relationships between psychological health and well-being and racial identity using the MIBI (what were the relationships). Many researchers have examined the relationship between racial identity and self-esteem. For example, a study by Rowley, Sellers, Chavous & Smith (1998) found that for African American students at a Southeastern college, there was an association between positive self-esteem and having positive feelings about African Americans (private regard) as well as race being an important aspect of their self-identity (racial centrality). The authors also discovered that an individual's evaluation of their racial group was a significant predictor of self-esteem (Rowley, et al., 1998). The study was replicated in a high school sample in the Midwest, with students whose ages ranged from 16-18 years. Like the college-aged sample, the importance one placed on race in defining his or her identity was related to having positive feelings toward African Americans and personal self-esteem. The high school sample was different from the college sample in that none of the racial identity dimensions (racial centrality and racial regard) significantly predicted self-esteem, except for students with high levels of racial centrality, in which feeling positively toward African Americans significantly predicted greater self-esteem (Rowley, et al., 1998). Although specific age ranges were not provided, only two dimensions of the MMRI were examined and a convenience sample composed only of students was used, this study provides some support for the argument that adolescence and emerging adulthood are two distinct developmental periods that merit evaluating racial identity separately for each group.

Another study (Sellers, Caldwell, Schmeelk-Cone & Zimmerman, 2003) analyzed the relationship between racial identity (centrality and public regard) and racial discrimination, stress, and psychological distress in a longitudinal study of 555 African American high school

students in the Midwest. The authors used data from participants during high school (mean age = 17.8 years) and two years after high school (mean age = 20 years). About 26% of the older sample had not attained a high school diploma and were not currently enrolled in school. They found that the importance one places on defining him/herself in terms of race was related to less stress, less depression and less anxiety. Participants who felt that other racial groups viewed African Americans positively were more likely to report fewer instances of racial discrimination and reported experiencing less stress, anxiety and depression. In contrast, higher levels of racial group identification and feeling that other groups view African Americans negatively were associated with more racial discrimination, but less stress, less anxiety and less depression. This study has important findings for the emerging adult literature as it provides information regarding the transition from adolescence to emerging adulthood about the relationship between racial centrality and public regard and its relationship to stress, depression and anxiety. There is a need for a broader emerging adult sample and more geographic diversity; this research should be expanded to examine whether the same results are found for all subscales of the MIBI as well as for other variables, such as health-promoting behaviors.

Banks and Kohn-Woods (2007) utilized the multidimensional approach to assess racial identity and psychological health by examining the relationship between racial discrimination, depression and racial identity among African American students (mean age = 20.41 years) at a Midwestern university. The authors conducted a cluster analysis using all seven subscales of the MIBI and analyzed for differences in reported instances of racial discrimination and levels of depression between clusters. Four clusters were identified: *Integrationist* (blending with mainstream and focusing on shared human qualities rather than perceiving race to be a core ideological self-concept), *Multiculturalist* (awareness of race and oppression in society, but

focused on commonalities between oppressed groups and all humans rather than issues specific to African Americans), *Undifferentiated* (did not conceptualize the world in terms of race), and *Race-Focused* (focused on issues specific to African Americans and believe that others do not think positively of African Americans). The authors found no significant differences among cluster groups for racial discrimination or depression, but they did find that those endorsing the Integrationist cluster reported experiencing more discrimination and more depressive symptoms than the other clusters. This study suggests that examining all seven subscales of the MIBI together may provide a clearer, more comprehensive evaluation of the relationship between racial identity and other variables, such as health-promoting behaviors. However, the findings are limited because of threats to external validity: the study was conducted in only one geographic location and it focused only on individuals currently attending college.

There are mixed findings regarding the influence of racial identity on psychological well-being. In general, these findings suggest that a positive personal evaluation of African Americans and higher racial identification is related to more positive psychological well-being (including self-esteem, less stress, less depression and less anxiety). Yet, some research has shown that people who are less race focused experienced more discrimination and depression. Still others have shown that there are no differences in psychological well-being for different racial identity dimensions.

Racial Identity and Racial Discrimination

Many of the major racial identity theories were predicated on the fact that an experience of racial discrimination could lead to an awareness and exploration of one's racial identity belief system. As such, racial discrimination has been found to be related to racial identity in many studies. A study by Caldwell, Kohn-Wood, Schmeelk-Cone, Chavous and Zimmerman (2004)

looked at the relationship between racial identity (centrality, private regard and public regard), racial discrimination (racial hassles) and violent behavior (fighting, carrying or using a knife or gun, inflicting bodily harm) in a sample of 325 African American emerging adults from a Midwestern city. The sample was relatively diverse in terms of employment status and current school enrollment. The authors found that racial identity was not related to violent behaviors, but interestingly, that higher levels of public regard (perception that other groups view African Americans positively) and more experience of racial discrimination predicted more violent behaviors. In addition, one's perception of other groups' negative evaluation of African Americans was associated with more reports of racial discrimination. Though this study adds to the body of literature about racial identity, it is important to note that like other studies, the findings are less generalizable because it is restricted to one geographic location and the study sample is composed mostly of students at-risk for school dropout and substance use (Caldwell et al., 2004).

Sellers and Shelton (2003) found that one's positive evaluative judgment of how others perceived African Americans, along with positive beliefs regarding how African Americans should behave in society was associated with feeling less bothered by instances of discrimination. This suggests that higher public regard and higher racial ideology served as protective factors against negative mental health outcomes. This study was sound in terms of methodology in that their sample consisted of African American college students from three different universities in the Midwest and Southeast regions of the country. However, the findings are limited to a college student sample. Emerging adults who are not currently enrolled in college may have different experiences than those who are in college which reduces the external validity of the study.

Other researchers (Seaton, Yip & Sellers, 2009) have examined the association between racial identity and racial discrimination in an African American adolescent sample. Seaton and colleagues (2009) conducted a longitudinal study that followed participants from 14 -18 years old. There were no significant relationships between the importance of race on identity, personal evaluation of African Americans and instances of racial discrimination (Seaton et al., 2009). These findings contrast with previous studies examining this relationship. For example, a study by Smalls, White, Chavous and Sellers (2007) found that African American adolescents who reported experiencing more racial discrimination placed more significance on race as the defining feature of their self-concept and reported more nationalism (~~–b~~eing Black is a unique experience") beliefs. However, Seaton et al., (2009) did find that there were variable relationships at different developmental periods; as participants' matured, racial discrimination increased and personal evaluation of African Americans became more negative. While this is a significant contribution to the research literature on racial identity, future research could benefit from examining participants during emerging adulthood, as circumstances and experiences during this developmental period may be different.

There are mixed findings about the relationship between racial identity and racial discrimination. In sum, people who are more focused on race and issues important to the African American community experienced more discrimination. Yet, those who feel that others view African Americans' positively also experienced more discrimination. Some research, though, has shown that there is no relationship between racial identity and discrimination.

Racial Identity and Academic Achievement

A number of studies have focused on investigating the relationship between racial identity and academic achievement (Oyserman, Gant & Ager, 1995; Sellers, et al., 1998, Smalls

et al., 2007). There have been mixed findings regarding whether specific aspects of racial identity are positively associated with higher academic achievement. Sellers, Chavous, & Cooke (1998) examined the relationship between self-reported GPA, racial group identification and attitudes of African Americans. The sample consisted of 248 African American undergraduate students in the mid-Atlantic region of the United States. They found that students less likely to endorse assimilating to mainstream American society had higher GPAs. Students who felt race was an important part of their identity reported higher GPAs. More specifically, students with higher levels of racial centrality and who believed that other oppressed groups should be treated as allies (minority ideology) had higher GPAs. In contrast, for students with higher levels of racial centrality, assimilation and nationalist (belief in the uniqueness of black experience) beliefs were related to lower GPAs. These findings suggest that students who place race at the forefront of their self-concept and feel that there were similarities between African Americans and mainstream America performed better in school.

Another study (Smalls et al., 2007) focused on the ideology dimension (one's attitudes, beliefs and values about being Black) of racial identity, found that assimilation beliefs ("Blacks should be more like Whites") were related to lower academic engagement. They also discovered that students who endorsed the shared experiences with other oppressed minority groups had better academic outcomes (more academic persistence and less fear of being viewed by peers as academically oriented).

Chavous, Bernat, Schmeelk-Cone, Caldwell, Kohn-Wood and Zimmerman (2003) conducted a longitudinal study of 606 African American 12th grade students from the Midwest. The authors found students who felt that others view African Americans positively had more attachment to school and increased feelings about the relevance of school in their lives. Students

who placed race at the forefront of their self-concept were more likely to feel personal value for school and were more likely to believe that they could learn. The authors also performed a cluster analysis which resulted in a four-cluster solution. Only three of the clusters produced were reliably related to school measures. Students who felt good about African Americans and felt that race was an important aspect of their identity (buffering/defensive cluster) were more likely to attend post-secondary institutions and less likely to drop out of high school. Students for whom race was the defining feature of their self-concept, who did not feel good about African Americans and who felt that others viewed African Americans positively (idealized cluster) had more personal value for school. The alienated group (low race centrality, felt others devalued African Americans, and did not feel good about African Americans) displayed more negative outcomes than the other clusters, including less interest in school, fewer efficacy beliefs, more school dropout and lower enrollment in post-secondary institutions. Harper and Tuckman (2006) conducted a similar study with 289 African American high school students in the Midwest. They found similar clusters as Chavous et al. (2003), but very different results regarding the level of academic achievement for the alienated cluster. Students in the alienated group actually had higher GPAs than the idealized group.

In summary, research suggests that there are mixed findings regarding the relationship between racial identity dimensions and academic achievement. On one hand, higher levels of academic achievement has been related to more racial identification, other groups' positive evaluation of African Americans, low assimilation beliefs and high minority beliefs. However, some studies have found that endorsing the assimilation ideology is related to lower achievement. The combination of several dimensions of racial identity as predictors of academic achievement seems to also have an influence on achievement. For example, Chavous et al.

(2003) identified cluster profiles and those who were more race central (buffering and idealized) displayed more academic achievement. This was also true in a replicated study by Harper and Tuckman (2006) where the cluster with lower levels of racial identification had negative achievement outcomes.

Racial Identity and Alcohol Use

Few studies have addressed the relationship between the MMRI and alcohol/substance use. Researchers have, however, used other identity theories to explore this relationship. High ethnic identity, for example, has been positively associated with less alcohol and drug use. This association has been seen early, in children as young as 9 years old (Burlew, Neely, Johnson, Hucks, Purnell, Butler, et al., 2000; Belgrave, Brome, & Hampton, 2000). These findings are also true for emerging adult populations. A study by Pugh and Bry (2007) used the Multi-Ethnic Identity Model (MEIM, Phinney, 1992) to examine the relationship between ethnic identity and alcohol and marijuana use by African American young adults (18-23 years old). They found that ethnic identity was a strong protective factor against substance use and was negatively related to marijuana, beer/hard liquor and wine use. Another study (Brook & Pahl, 2005) also identified racial/ethnic identity (combined with Africentric orientation) as a protective factor against drug use among Hispanic and African American young adults (18-25 years).

Caldwell, Sellers, Bernat, & Zimmerman (2004) used the MMRI to assess the relationship of racial centrality and private regard to alcohol use by 488 African American high school adolescents (mean age 17.49) in the Midwest. Adolescents who felt positively about African Americans were less likely to use alcohol, especially those for whom race was a central aspect of their self-concept. It is clear that more research is needed concerning the relationship between racial identity and alcohol use. Alcohol use among African American adolescents is

very low compared to other racial groups (Windle, 2003; Johnston, 2003); therefore it may be prudent to examine this relationship in an older sample, when the rate of alcohol use increases as individuals attain legal drinking age.

In sum, racial identity and ethnic identity are negatively related to substance use. More specifically, higher levels of racial identification and one's positive evaluation of being African American have been associated with less substance use, including alcohol use.

Given the connection between racial identity racial discrimination, psychological health, academic achievement, alcohol/substance use, the current study aimed to identify how racial identity might influence other types of behavior that have not been thoroughly examined in previous studies, such as drug and alcohol use, physical activity, fruit and vegetable intake, sexual behavior, and psychological affect. The current study also aimed to evaluate health behaviors according to racial identity patterns, where responses to all of the measureable dimensions of racial identity are considered. This next section describes how specific dimensions of racial identity measured by the MMRI may influence behavior.

How does racial identity influence behavior?

Racial disparities in health are very large despite the fact that health and the health care system have improved drastically in the last century. In an effort to better understand these disparities, for which race (genetic features) explains only a small proportion of the problem, researchers have begun to look at the health behaviors (i.e., how food is prepared and eaten) associated with certain racial groups. These behaviors are a representation of the cultural or ethnic practices of a certain racial group. In order to "improve] the health status of African Americans, [researchers] must fundamentally address the intricate relationship between health and culture" (Bowen-Reid & Smalls, 2004). The purpose of this study was to identify and

generate racial identity profiles and to investigate differences in health behaviors reported by participants in each identity profile.

Sellers et al. (1998) framework is presented below to illustrate how the MMRI's racial identity dimensions may serve as predictors of behavior in general. According to Sellers (1998), racial centrality ("when I think of who I am, I think of my race first") and situational cues (having an awareness that you are the only Black person in a room) interact to determine an individual's level of racial salience (centrality of race at a specific moment in time) during a particular event. From there, salience during that event influences the extent to which an individual's opinions, attitudes and beliefs about how Black people should behave and the extent to which one feels negatively or positively about his or her race. These two dimensions then influence the individual's interpretation of the particular event as well as his or her subsequent behavior at the level of the event (Sellers, et al, 1998). Figure 2 illustrates the underlying framework regarding how racial identity might influence behavior. This framework was not used in the current study. Instead a modified version that incorporates the complexity of how all the dimensions interact (through cluster analysis) was used. The current study focused on the combined influence of the racial identity dimensions (centrality, ideology and regard) on behavior rather than assessing how their individual contributions may negatively affect behavior.

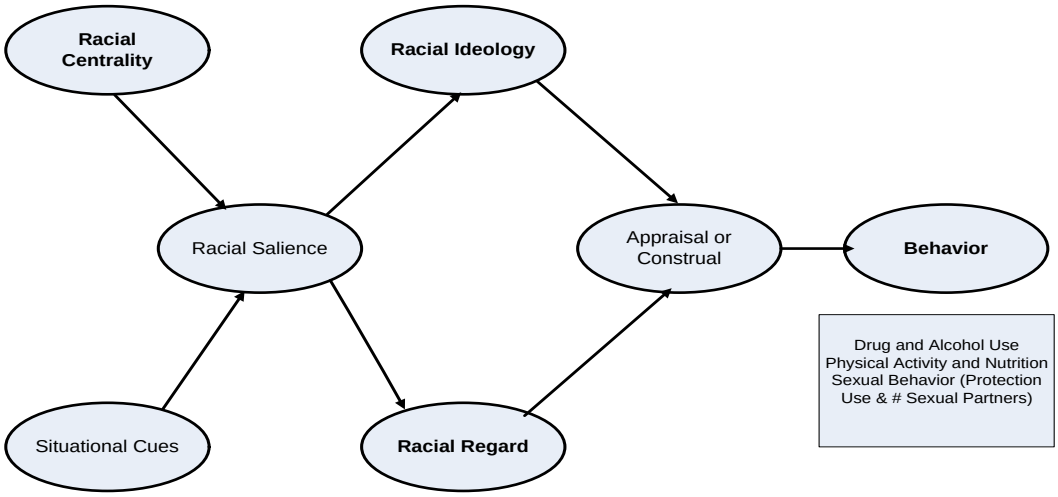


Figure 2. How racial identity influences behavior (Sellers, 1998)

A study by Thompson and Chambers (2000) supports Sellers' model for how identity may influence behavior. They concluded that culture is an important factor in predicting health behaviors, especially among African Americans. Using the African Self-Consciousness Scale (Baldwin and Bell, 1985), they found a relationship between African self-consciousness and the health behavior of 95 African American college students (18-25 years old). Regression analyses showed African self-consciousness (along with health consciousness) ($R^2 = .62$, $F(2, 77) = 24.0$, $p < .001$, beta weights .24 and .55, respectively) contributed to health promoting behaviors (health responsibility, spiritual growth and interpersonal relations) (Thompson & Chambers, 2000).

Moreover, Oyserman, Fryberg, and Yoder (2007) proposed the concept of identity-based motivation to explain why ethnic and racial minorities may or may not engage in health promoting behaviors. Identity-based motivation suggests that:

~~–~~if health promotion is perceived as part of White, middle-class social identity, then unhealthy lifestyle behaviors are more likely to be incorporated into one's own identities, reducing engagement in health behavior…this association of health promotion with being White and

middle class increases the likelihood that in-group social identities of racial-ethnic minorities and working-class Americans will incorporate risky health behaviors as part of an in-group identity" (Oyserman et al., 2007).

Furthermore, the authors suggest that considering the two ideas above, African Americans who associate risky health behaviors with being African American, are more likely to feel conflicted about the personal relevance and efficacy of engaging in healthy behaviors. Oyserman et al. (2007) tested this theory and indeed found that health and health promotion are perceived to be White (middle-class) behaviors and as a consequence racial and ethnic minorities are more likely to see unhealthy behaviors as part of their identity. Additionally, racial and ethnic minorities in their sample viewed unhealthy behavior as defining their social identity more so than healthy behaviors (Oyserman, et al., 2007).

The health of African Americans in this country continues to suffer from disproportionate health disparities despite advances in the overall healthcare of Americans over the last 40 years. Many of the health practices that lead to high rates of disease and other ailments in African Americans are learned at a very young age. There is a paucity of data and research regarding the behaviors and attitudes of emerging adults aged 18-25 years old. As such, it is prudent to investigate the relationships between racial identity attitudes and health behaviors of individuals during emerging adulthood. The purpose of this dissertation was to identify racial identity profiles among an African American emerging adult population and examine the relation of those profiles to health behaviors. Thus, the researcher answered the following research questions:

1. What racial identity profiles exist within an African American emerging adult population?
2. Do these racial identity cluster groups differ in terms of their self-reported health behaviors?

CHAPTER III

METHODOLOGY

Participants and Setting

This study consisted of 200 African American emerging adults (18-28). There were 100 male and 100 female participants. The study took place in Wichita, Kansas (population of 361,420) a mid-sized Midwestern city (US Census, 2007). The African American population in Wichita is about 12% and makes up as much as 13% of the population when bi-racial persons are included (US Census, 2007). Youth (15-24 years old) in Wichita, Kansas make up about 14% of the total population (US Census, 2007). The mean age of the sample was 20.60 years and 18 year olds represented the modal age. The eligibility criteria to be surveyed were that the participant had to identify as African American regardless of appearance and be between the ages of 18-25. Participants who did not appear to be between 18-25 years old were asked for a driver's license or other identification to verify their age. There were 3 participants who were older than 25 (26-28 years old). These participants were included in the analysis.

The majority of the sample identified themselves as African American (87%). For almost half of the sample (45%), high school was the highest level of education completed and 10% of the participants had completed a college degree (including associates, bachelors and masters degrees). Sixty-seven percent (N=133) of the participants said they were currently enrolled in school. Of those currently enrolled in school, most were classified as college freshman (82 participants completed between 1-30 credit hours). Eighty-eight percent of program participants were single, never married (N=170). Participants' annual income was very low; 42% reported earning less than $5,000 and 31% had an annual income ranging from $5,000 - $14,999. More detailed demographic information is provided in Table 3 (see below).

TABLE 3

DEMOGRAPHIC VARIABLES BY GENDER

Demographic Information	Percent (*Frequency)*	Gender	
Age		**Male**	**Female**
18	27% (54)	30% (30)	24% (24)
19	15.5% (31)	18% (18)	13% (13)
20	12% (24)	15% (15)	9% (9)
21	12.55 (25)	9% (9)	16% (16)
22	8% (16)	10% (10)	6% (6)
23	10.5% (21)	9% (9)	12% (12)
24	6.5% (13)	4% (4)	9% (9)
25	6.5% (13)	3% (3)	10% (10)
Race			
African American (AA) only	87% (174)	88% (88)	87% (87)
Bi-Racial[a]	11% (22)	10% (10)	11% (11)
Multi-Racial[b]	2% (4)	3% (3)	2% (2)
Highest Level of Education			
High School	44.4% (88)	45% (45)	41% (41)
GED or trade/technical school	10% (18)	9% (9)	11% (11)
College			
Some College	37.4% (74)	35% (35)	39% (39)
Associates Degree	7.6% (15)	10% (10)	5% (5)
Bachelor's Degree	2% (4)	1% (1)	3% (3)
Master's Degree	0.5% (1)	-- --	1% (1)
School/College Enrollment			
No college credit	33.5% (67)	31% (31)	11% (11)
Currently Enrolled	67% (133)	69% (69)	89% (89)
1 – 30 credit hours	28.5% (57)	34% (34)	48% (48)
31 – 60 credit hours	13% (26)	14% (14)	12% (12)
61 – 90 credit hours	12% (24)	8% (8)	16% (16)
91 or more credit hours	13% (26)	13% (13)	13% (13)
Marital Status*			
Single, never married	87.6% (170)	90% (90)	80% (80)
Married	4.1% (8)	3% (3)	5% (5)
Divorced	1% (2)	1% (1)	1% (1)
Single and cohabitating	7.2% (14)	3% (3)	11% (11)

TABLE 3 (continued)

Demographic Information	Percent (*Frequency)*	Gender	
Annual Income*			
Less than $5,000	41.7% (80)	36% (36)	44% (44)
$5,000 - $9,999	10.9% (21)	11% (11)	10% (10)
$10,000 - $14,999	20.3% (39)	25% (25)	14% (14)
$15,000 - $19,999	4.2% (8)	5% (5)	3% (3)
$20,000 - $29,999	15.1% (29)	10% (10)	19% (19)
$30,000 - $39,999	5.7% (11)	5% (5)	6% (6)
$40,000 and up	2.1% (4)	3% (3)	1% (1)

a. Biracial indicates the participant identified as African American and one other race.
b. Multiracial indicates the participant identified as African American and 2 other races.
* Note: Some totals do not equal 100 because of missing data.

Procedure

Participants were recruited from two major settings – a local predominately White university campus and an annual arts festival held in the local community (Wichita Black Arts Festival). At the university setting, participants were recruited at the Fall Student Activities Fair, African American Student Association meeting, University Student Center and the University's Athletic Facility. Participants from the university setting were also recruited through the university's online experiment database (SONA) system and, using the university's statistical information, potential participants were enlisted via email. About half of the participants were recruited at the annual Wichita Black Arts Festival. The festival is a 3-day cultural celebration introducing and educating communities to the artistic heritage of the African American culture through music, dance and food. In both settings (university and arts festival), a table with chairs and clipboards was setup with posters was used to solicit African American young adults to

participate. Participants from both settings were also recruited through word of mouth and through the snowball method.

The study was approved by the university's Institutional Review Board. Once a participant agreed to complete the survey, they were given a consent form to read. Participants were instructed that they could withdraw from the study at any time and they could keep the consent form once they completed the survey.

The research team consisted of graduate students in a doctoral psychology program and a faculty advisor, who approached potential participants directly and asked if they were interested in completing a survey to earn $15. Each person who completed the survey received $15.00 cash as an incentive to participate. After each participant completed their survey, the survey was checked for completeness and participants completed a form to receive their cash incentive. Participants were informed that participation was completely voluntary and that all information would be kept confidential and that aggregate reports would be used to describe the results.

Measures

A 129-item survey (see Appendix A) developed by the Behavioral Community Action and Research Team at Wichita State University was administered to participants. The survey consisted of several sections that asked questions about racial identity (Multidimensional Inventory of Black Identity-MIBI) developed by Dr. Robert Sellers, mental health (PANAS), physical and nutritional health, drug and alcohol use, sexual health behaviors, family structure, education and demographic information. Questions that were taken from other established and validated national surveys are described below.

Multidimensional Inventory of Black Identity (MIBI)

The survey included the Multidimensional Inventory of Black Identity (MIBI; Sellers, Rowley, Chavous, Shelton, and Smith, 1997) which is composed of fifty-six items that measure three of the four dimensions associated with the Multidimensional Model Racial Identity (MMRI): centrality, regard, and ideology. The MIBI has acceptable psychometric properties with Cronbach's α (for each scale) ranging from .60 to .79 (Sellers, Rowley, Shelton, and Smith, 1997). Reliability analyses were conducted for the present sample and the MIBI was shown to have acceptable internal consistency with Cronbach's α (for each scale) ranging from .39 to .76. The centrality dimension displayed the weakest reliability (.39), while the humanist dimension displayed the strongest reliability (.76).

The MIBI was scored based on the manual developed by Sellers et al (1997) included with the inventory. All items were measured using a 7-point Likert scale ranging from 1(strongly disagree) to 7(strongly agree). High scores (for each scale) indicated higher levels of each dimension. Once scored, there are 7 separate scores for the MIBI.

The Centrality scale consisted of 8 items. An example of an item from the Centrality scale is "In general, being Black is an important part of my self-image." The Regard scale is comprised of two six-item subscales: Private Regard and Public Regard. Sample items included: "I am happy that I am Black" (Private Regard) and "Overall, Blacks are considered good by others" (Public Regard). The Ideology scale is comprised of four nine-item subscales. An example item from Assimilation subscale is: "Blacks should view themselves as being Americans first and foremost." An example item from the Humanist subscale is: "Black values should not be inconsistent with human values." An example item from the Oppressed Minority subscale is: "There are other people who experience racial injustice and indignities similar to

Black Americans." An example item from the Nationalist subscale is: "Blacks would be better off if they adopted Afrocentric values." (See Appendix A for the entire inventory).

Positive and Negative Affect Schedule (PANAS)

The PANAS (Positive and Negative Affect Schedule; Watson, Clark & Tellegen, 1988) consists of 10 positive affects (interested, excited, strong, enthusiastic, proud, alert, inspired, determined, attentive, and active) and 10 negative affects (distressed, upset, guilty, scared, hostile, irritable, ashamed, nervous, jittery, and afraid). Participants are asked to rate items on a scale from 1 to 5, based on the strength of emotion where 1 = "very slightly or not at all," and 5 = "extremely". For example: "Indicate to what extent you have felt distressed during the past week"; "Indicate to what extent you have felt proud during the past week." The PANAS has been shown to have high internal consistency (.88 for Positive Affect; .85 for Negative Affect) (Watson et al., 1988). Scores were determined by summing positive and negative items, respectively. A higher score for positive items indicates more positive affect or the extent to which the individual feels enthusiastic, active and alert. A higher score for negative items indicates more negative affect, or the extent to which the individual feels aversive mood states or general distress (Watson et al., 1988). Reliability analyses were conducted for the present sample and the PANAS was shown to have high internal consistency. Positive affect items had a Cronbach alpha of .82. Negative affect items had a Cronbach alpha of .86. Appendix B shows the items from the PANAS. This measure has not been tested with an African American emerging adult population.

In addition to the PANAS scale, three questions were asked regarding the mental health of participants in the past 30 days (i.e., depressed, stressed, use of alcohol/drugs because of stress). Reliability analyses were also run for these three questions with a Cronbach alpha of .62.

Physical and Nutritional Health

Questions about physical health and nutrition were adapted from the 2007 Local and State Youth Risk Behavior Surveillance Survey (CDC). Participants were asked to indicate how often they participated in a given behavior in the last 7 days. The Cronbach alpha for the present study was .61. See Appendix C.

Drug and Alcohol Use

Questions about drug and alcohol use were taken from the GPRA (Government Performance and Results Act) a questionnaire developed Substance Abuse and Mental Health Services Agency (SAMHSA). Participants were asked to indicate on how many days in the past 30 days, they had used a substance (i.e., alcohol, marijuana, etc.). Reliability analyses revealed that there was moderate internal consistency for these questions in the present sample (Cronbach's a = .58). See Appendix D.

Sexual Health

Questions about sexual health behaviors were taken from the 2008 Local and State Youth Risk Behavior Surveillance Survey (CDC) and the Kaiser Family Foundation National Survey of Adolescents and Young Adults: Sexual Health Knowledge, Attitudes, and Experiences (2003). Reliability analyses were conducted for questions 1, 5 and 6 (see table 4 below); Cronbach's α was .75.

TABLE 4

SEXUAL HEALTH QUESTIONS FROM SURVEY

1. Have you ever had sexual intercourse? *
2. How many sexual partners have you had in the last year?
3. What forms of contraceptives, if any, do you use? (check all that apply)
4. How often do you use protection?
5. Have you been tested for HIV/AIDS in the last year? *
6. Have you been tested for other STD's in the last year? *
7. If yes, which STDs have you been tested for? (check all that apply)

*Note: reliability analyses conducted on these variables only

Data Analysis

Research Question (1). The subscales of the MIBI are theoretically independent of one another and should not be summed into an overall racial identity score. According to the MMRI, racial identity is a multi-dimensional concept and the scales of the MIBI are patterned rather than orthogonal. Therefore, this dissertation considers the contribution of all of the components of racial identity in influencing health behavior. This was examined through cluster or person-centered analysis.

The goal of cluster analysis is to classify cases into categories by identifying group membership. Cluster analysis is a technique that is similar to factor analysis. The major difference is that instead of grouping similar items, as in factor analysis, the interest is in grouping cases (or clusters of people) based on the similarity (measured in terms of distance) of responses to several variables. Cluster analysis produces results that can be influenced by the selection of variables, treatment of outliers and missing cases, and the clustering method used. The logical steps in conducting the cluster analysis were based on the work of Rapkin and Luke

(1993) and their suggestions for using cluster analysis as a tool for community research, which is a modification of Lorr's (1983) commonly followed steps involved in conducting a cluster analysis. These steps include (a) identifying cases for analysis, (b) selecting, reducing, and scaling variables, (c) deriving proximity measures to be used, (d) choosing a clustering method, (e) determining cluster stability, (f) interpreting cluster profiles, (g) determining cluster stability, (h) determining cluster validity, (j) and presenting cluster results.

Identifying Cases. The sample population was established; a convenience sample of 200 emerging adults was used. Data were cleaned and screened for outliers and missing values. Missing values were replaced by the mean score for each variable. Outliers may be important sources of information and could form a cluster unto themselves. Outliers represented less than 5% of the sample and therefore were included in the analyses.

Selecting, Reducing and Scaling Variables. The variables of interest were the seven subscale scores of the MIBI (centrality, public regard, private regard, nationalism, assimilation, humanist and oppressed minority ideologies). For the purposes of the current study, all seven of the subscale scores were included in the analysis in order to provide a more complete perspective regarding the contribution of the MIBI subscales to health behaviors. Scores were standardized based on previous research (Chavous et al., 2003; Harper & Tuckman, 2006; Banks & Kohn-Wood, 2007) and clustering guidelines (Hair & Black, 2000).

Selection of Cluster Method. There are several types of clustering techniques that can be used to create a profile. This study used agglomerative hierarchical clustering. This technique was used because it is most meaningful for small samples and is easier to examine solutions as clusters increase (Lorr, 1983; Hair & Black, 2000). Agglomerative hierarchical clustering begins with every case being a cluster unto itself, then at successive steps similar clusters are merged

until each case is included in one large cluster. Distance or similarity measures were generated by the SPSS CLASSIFY procedure, which identifies meaningful cluster profiles using Ward's method (Lorr, 1983; Hair & Black, 2000). Ward's method uses squared Euclidian distance and provides a series of linkages based on similarity across variables. This approach allows for better description and examination of identity patterns for those who have positive health behaviors and for those who have negative health behaviors.

Concurrent Analysis Decisions. The remaining steps (determining the number of clusters, interpreting cluster profiles and determining cluster stability) were performed concurrently during the analysis. Cluster analysis was performed and after examining and interpreting the dendogram tree plot (a diagram used to illustrate the arrangement of clusters produced in hierarchical cluster analysis) and agglomeration schedule for large decreases in the coefficients, the best of three different cluster profiles (ranging from 3 -5 clusters) was determined.

Cluster Validity. Because of the exploratory nature of the current study, establishing concurrent and predictive validity was not easily achieved. Usually cluster validity is established by selecting variables that were not used to form the clusters but which are known to vary across clusters. However, in this study, it was not known which variables vary across clusters. Cluster validity in the current study, then, was determined by comparison to previous research. Researchers have used cluster analysis to identify racial identity patterns (Harper & Tuckman, 2006; Banks & Kohn-Wood, 2007) and have identified three or four cluster profiles.

Research Question 2. Group differences in selected health behaviors were analyzed using non-parametric statistical analyses. Because this study was exploratory and utilized non-parametric statistics and had a small sample size, alpha levels were established at the .10 level

rather than the commonly used .05 alpha level. For the purposes of this study, the researcher was interested in assessing group differences for drug and alcohol use (alcohol use, binge drinking, marijuana use, cigarette smoking), sexual behavior (number of sexual partners, use of protection), physical activity, fruit and vegetable intake and positive and negative affect (PANAS). Table 5 displays the means and skewness of the health variables for this study.

TABLE 5

MEANS, STANDARD DEVIATIONS AND SKEWNESS OF SELECTED HEALTH VARIABLES FOR THE ENTIRE STUDY SAMPLE

Health Variables	**Mean**	**SD**	**Skew**	**SE Skew**
Alcohol use	**3.08**	**5.25**	2.65	0.17
Binge drinking	**1.88**	**4.05**	3.52	0.17
Cigarette	**2.64**	**7.52**	3.01	0.17
Marijuana	**2.61**	**7.82**	2.96	0.17
Physically Active	3.62	2.02	0.08	0.17
F&V	3.94	1.96	-0.10	0.17
Number Sex Partners	2.03	1.86	0.95	0.17
Protection	1.69	1.08	1.69	0.19
Positive Affect	35.95	7.20	-0.40	0.17
Negative Affect	20.06	7.26	1.04	0.17

Skewness figures that are closer to zero indicate normal distributions. The alcohol and drug use variables were especially skewed. Additionally, Kolmogorov-Smirnov and Shapiro-Wilk tests of normality revealed that all variables, except positive affect (.06), were significant (non-normal distribution). These variables were transformed so that participants' responses were dichotomous, dividing responses into some reported activity or no reported activity. Even after transforming these variables, the distributions were still non-normal. Therefore, the Kruskall-Wallis test – a non-parametric statistical procedure - was used to assess differences in health

behaviors for all health variables, with the exception of positive affect which was analyzed using ANOVA. Follow-up tests using the Mann-Whitney *U* (for Kruskal-Wallis analyses) and Tukey's HSD (for ANOVA) were conducted to assess how groups differed.

CHAPTER IV

RESULTS

Identifying Racial Identity Cluster Profiles

Ward's method for cluster analyses was used and after examining the dendogram plot and agglomeration coefficients a three cluster solution emerged. For a detailed examination of profile means (based on racial identity dimensions), see Appendix F. The three profiles were labeled based on the patterning of their z scores on the MIBI subscales. The labels that were used to describe the profiles were based on the findings of Banks and Kohn-Wood's study and the way that their cluster profiles were names. They are as follows: Multicultural, Integrationist and Marginalized/Obscure (See Figure 3).

Cross-tabs and one-way ANOVAs were conducted to determine whether there were any demographic differences (gender, marital status, number of participants with children, income, education level and current school enrollment) between clusters. Results indicated that there was a statistically significant difference for the number of participants that were married. There were more married participants in the Integrationist profile (χ^2 (2,194) = 5.28, p=.07) than were in the Marginalized profile and in the Multicultural profile. Five percent (N=12) of participants in the Integrationist profile were married compared to only two percent (N=2) of participants in the multicultural profile and five percent (N = 3) married from the marginalized profile. There were no other statistically significant differences for demographic variables. Each profile is now described in more detail below.

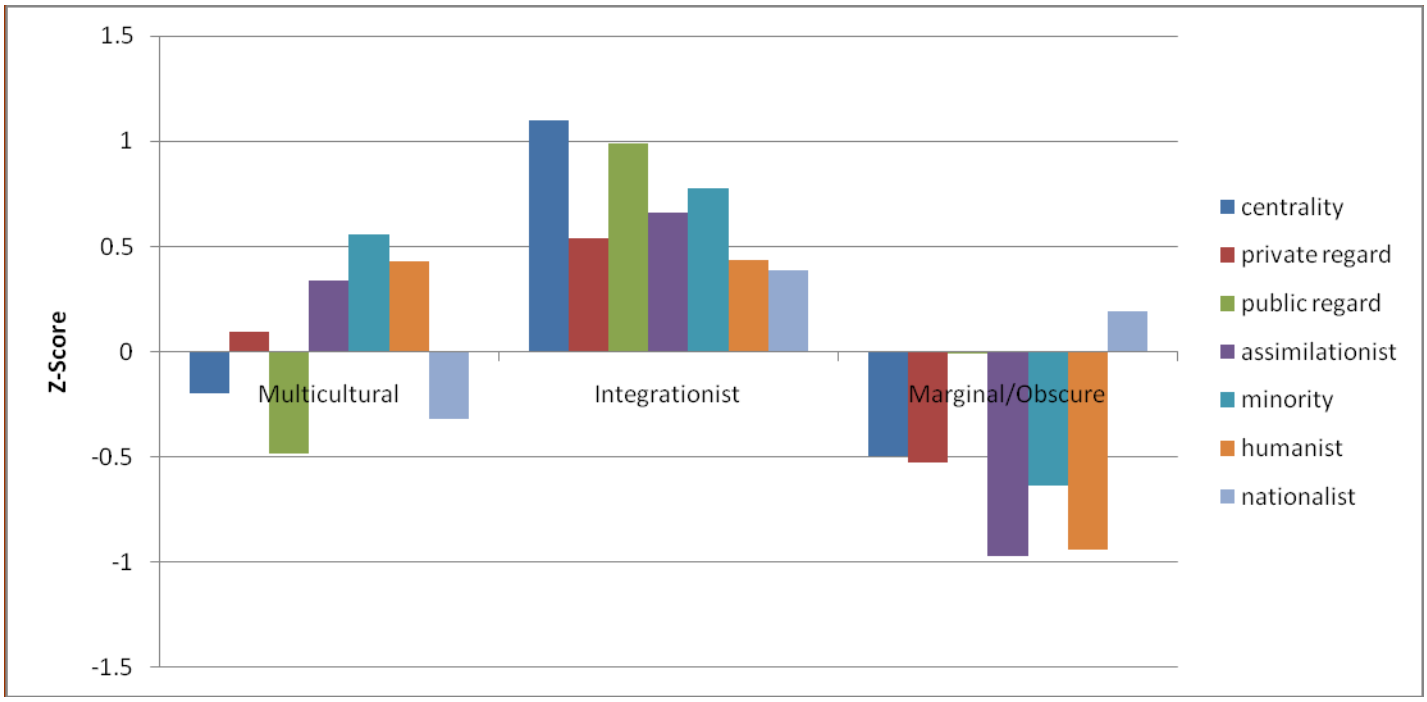


Figure 3. Bar graphs of the three cluster profiles.

Multicultural

Table 6 details the demographic composition of individuals who displayed the multicultural profile (See Appendix G for demographic composition of all three profiles). The mean age was 20.47 (2.33). This profile had the greatest number of participants (N=92) and had early equal number of males and females (51% male). Most people had completed high school or earned a GED (44%) and another 42% had earned an associate's degree. The majority of the sample was single (98%) and 22% had children. Most participants (73%) reported an annual income less than $15,000.

TABLE 6

DEMOGRAPHIC COMPOSITION OF MULTICULTURAL PROFILE

Multicultural Cluster		Percent	N
			92
Gender			
	MALE	51	47
	FEMALE	49	45
Education			
	HS/GED	44	40
	Associate's	42	38
	Bachelor's	8	7
	Master's	2	2
Attending school		71	65
Marital Status			
	Single, Never Married	98	88
	Married	2	2
Annual Income			
	< $15,000	73	64
	$15,000 - $30,000	22	19
	> $30,000	6	5
Number with Children		22	20

Table 7 lists the z-scores and standard deviations for the multicultural profile and figure 4 displays a bar graph of z scores for the profile. This first profile was identified as multicultural because z scores were highest on the minority (z =.56), humanist (z =.43), and assimilation (z = .34) ideology subscales and lowest on the public regard (z = -.48) and nationalist (z = -.32) ideology subscales. Participants were more likely to emphasize the similarity of experiences shared between African American and other minority groups (oppressed minority) as well as the commonalities that all human beings share (humanist) while endorsing blending in with the mainstream culture (assimilation). On the other hand, participants also felt that other groups held negative ideas about African Americans (public regard) and were less likely to focus on issues that are unique to the black experience (nationalist ideology). This group also did not identify

race as a core aspect of their identity (centrality), but felt moderately positive about being African American (private regard).

TABLE 7

MEANS, *z* SCORES AND STANDARD DEVIATIONS OF MULTICULTURAL PROFILE

Cluster	*Racial Identity Subscale*	*z Score*	*(SD)*	*M*	*(SD)*
Multicultural	Centrality	-0.20	0.83	1.67	0.66
(N=92)	Private Regard	0.10	0.96	4.19	0.67
	Public Regard	-0.48	0.79	1.13	0.68
	Assimilation	0.34	0.67	5.41	0.57
	Oppressed Minority	0.56	0.89	4.70	0.76
	Humanist	0.43	0.76	5.58	0.77
	Nationalism	-0.32	0.82	3.50	0.69

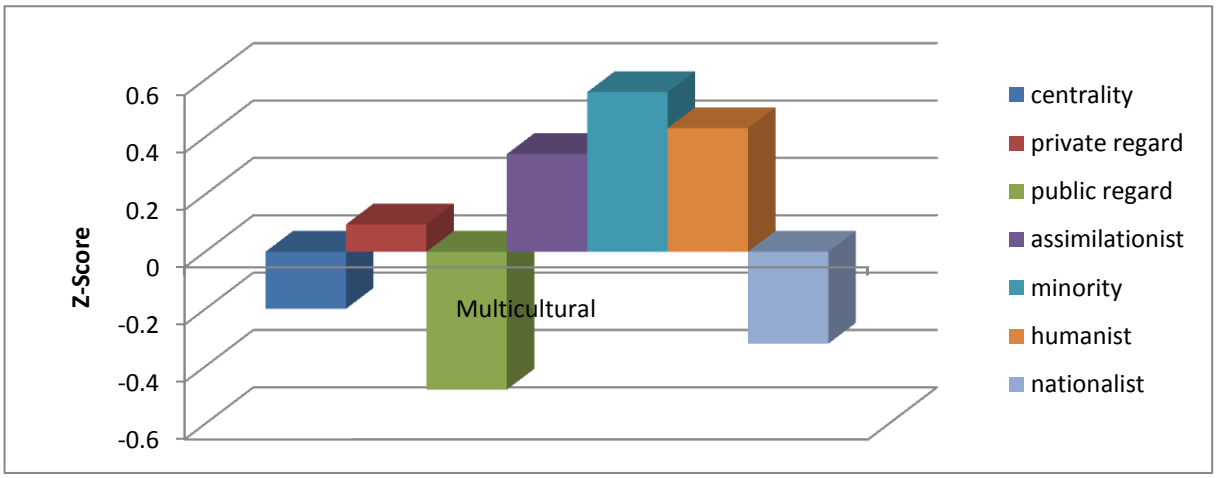


Figure 4. Bar graph of Multicultural profile

Integrationist

Table 8 details the demographic composition of the integrationist profile. The mean age was 20.96 (2.72). This profile had the fewest number of participants (N=45). The integrationist profile was comprised of slightly more females (53%) than males. Almost half the participants had completed high school or earned a GED (48%). Another 45% had earned an associate's or

bachelor's degree. This profile represented the largest number of married participants (N=12). More than one-fourth (27%) of the participants in this profile had children. Most participants (75%) reported an annual income less than $15,000.

Table 9 lists the z-scores and means and standard deviations for the integrationist profile and figure 5 presents a graphical representation of z scores for the profile. This profile was identified as integrationist because there were positive z scores for each subscale. Z scores were highest on the centrality (z =1.10) and public regard (z = .99) subscales and lowest on the nationalist (z = .39) and humanist (z = .43) ideology subscales. Participants viewed race (being African American) as a central part of their identity (centrality) and also felt that other racial groups had positive attitudes towards African Americans (public regard). Additionally, participants in the Integrationist cluster were less likely to focus on the unique experiences of African Americans (nationalist ideology) and less likely to focus on similarities that all humans share (humanist ideology). Participants also held moderately positive beliefs regarding about being African American (private regard) as well as integrating and participating in mainstream culture (assimilation).

Marginalized

Table 10 details the demographic composition of the marginalized profile. The mean age was 20.52 (2.23). This profile was composed of 63 participants. The marginalized profile had an almost equivalent number of males and females. More than half the participants had completed high school or earned a GED (54%). Participants in this profile had the smallest percentage of associate's and bachelor's degrees earned

TABLE 8

DEMOGRAPHIC COMPOSITION OF INTEGRATIONIST PROFILE

Integrationist Cluster	Percent	N
		45
Gender		
MALE	47	21
FEMALE	53	24
Education		
HS/GED	48	21
Associate's	34	15
Bachelor's	11	5
Master's	--	--
Currently attending school	64	29
Marital Status		
Single, Never Married	88	38
Married	5	12
Annual Income		
< $15,000	75	32
$15,000 - $30,000	21	9
> $30,000	4	2
Number with Children	27	12

TABLE 9

MEANS, *z* SCORES AND STANDARD DEVIATIONS OF INTEGRATIONIST PROFILE

Cluster	*Racial Identity Subscale*	*z Score*	*(SD)*	*M*	*(SD)*
Integrationist	Centrality	1.10	0.65	2.71	0.52
(N=45)	Private Regard	0.54	0.44	4.50	0.31
	Public Regard	0.99	0.74	2.40	0.63
	Assimilation	0.66	0.72	5.69	0.62
	Oppressed Minority	0.77	0.74	5.31	0.63
	Humanist	0.43	0.76	5.58	0.77
	Nationalism	0.39	1.10	4.10	0.93

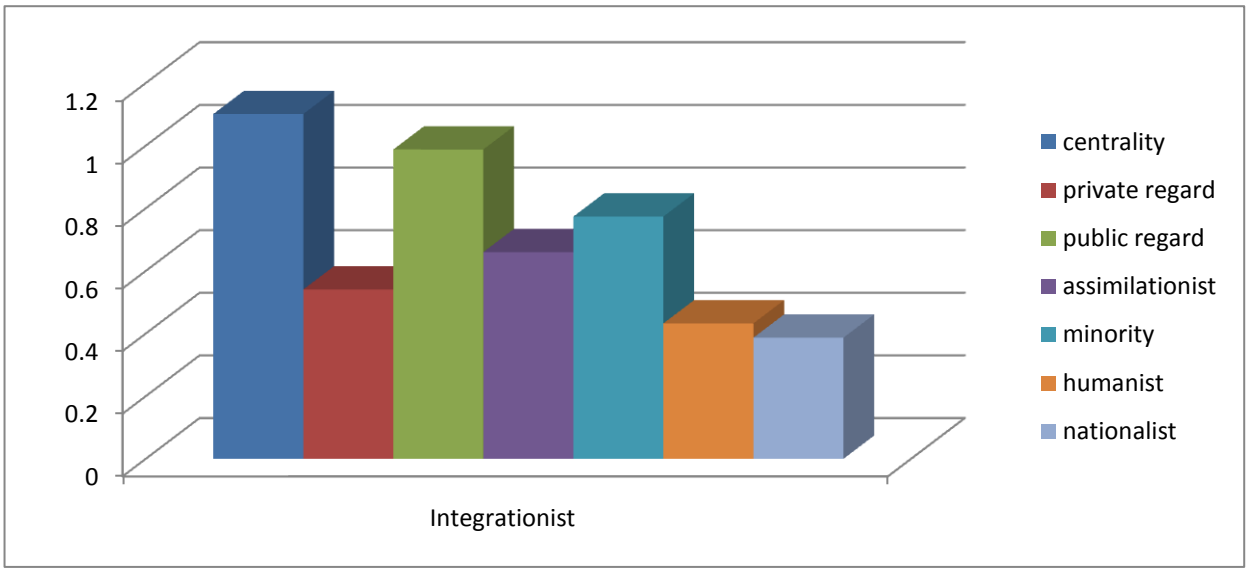


Figure 5. Bar graph of Integrationist profile

Ninety-five percent of participants were single, never married. More than one-fourth (27%) of the participants in this profile had children. Most participants (72%) reported an annual income less than $15,000.

Table 11 lists the z-scores and standard deviations for the marginalized/obscure profile and figure 6 displays a bar graph of z scores for the profile. The participants in this profile had negative z-scores on all racial identity subscales except for the nationalist ideology (z = .19), meaning they had a tendency not to endorse any of the racial identity subscales. This group held more negative feelings regarding blending with mainstream culture (assimilation ideology), less shared commonalities between African Americans and other minority groups (minority ideology) and less shared human commonalities (humanist ideology). Participants did not view race as a central part of their identity (centrality) and did not feel positive about African Americans (private regard) and did not feel that other groups held positive attitudes towards African Americans (public regard), but believed that issues specific to African Americans were important (nationalist ideology).

TABLE 10

DEMOGRAPHIC COMPOSITION OF MARGINALIZED PROFILE

Marginalized Profile	Percent	N
		63
Gender		
MALE	51	32
FEMALE	49	31
Education		
HS/GED	54	34
Associate's	33	21
Bachelor's	5	3
Master's	3	2
Currently attending school	62	39
Marital Status		
Single, Never Married	95	58
Married	5	3
Annual Income		
< $15,000	72	44
$15,000 - $30,000	15	9
> $30,000	13	8
Children?	27	17

TABLE 11

MEANS, *z* SCORES AND STANDARD DEVIATIONS OF MARGINALIZED PROFILE

Cluster	*Racial Identity Subscale*	*z Score*	*(SD)*	*M*	*(SD)*
Marginal/Obscure	Centrality	-0.50	0.85	1.43	0.68
(N=63)	Private Regard	-0.53	1.10	3.75	0.78
	Public Regard	0.01	0.92	1.55	0.79
	Assimilation	-0.97	0.87	4.28	0.75
	Oppressed Minority	-0.63	0.90	4.11	0.77
	Humanist	-0.94	0.80	4.19	0.81
	Nationalism	0.19	1.04	3.93	0.88

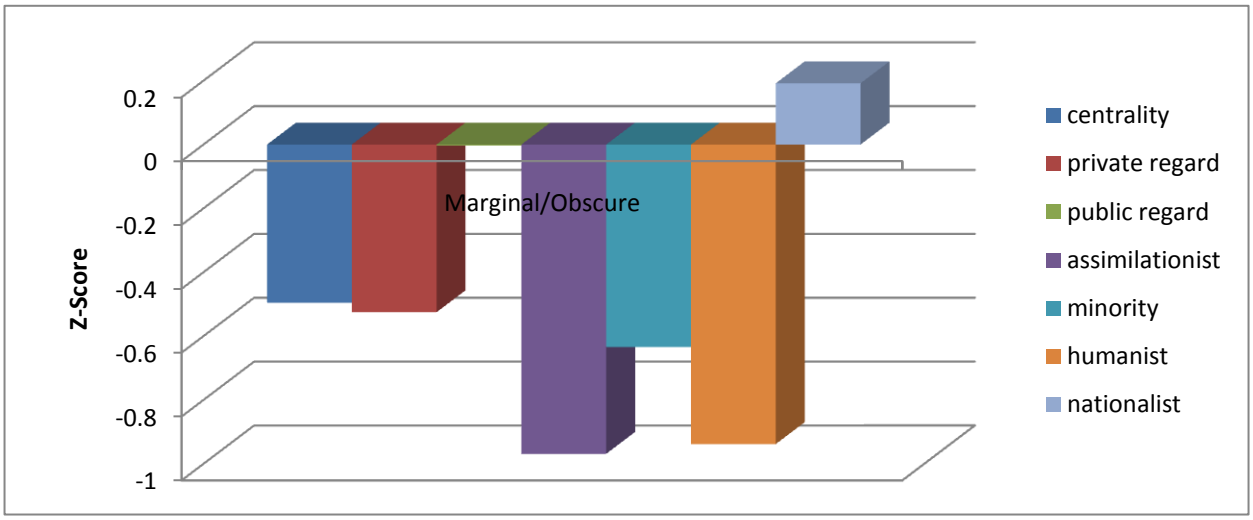


Figure 6. Bar graph of Marginalized profile

Racial Identity Profile Group Differences in Health Behaviors

Racial identity profile differences for positive affect were analyzed by conducting an ANOVA. There was a statistically significant difference for positive affect: $F(2, 198) = 8.76$, $p < .01$. A Kruskal-Wallis test was conducted to evaluate differences among the three racial identity profiles (Multicultural, Integrationist, Marginalized) on specific health behaviors (alcohol use, binge drinking, cigarette use, marijuana use, fruit and vegetable intake, physical activity, negative affect, number of sexual partners and use of protection during sexual activity). The test was statistically significant for only two variables - cigarette smoking ($\chi_2 (2, N = 200) = 5.13$, $p = .08$, $\eta^2 = .03$) and number of sexual partners ($\chi_2 (2, N = 200) = 6.83$, $p = .03$, $\eta^2 = .03$). Eta square statistics show that the effect size for each variable was small (see Table 13 for complete results).

Follow-up tests were conducted to evaluate pairwise differences among the three profiles, For positive affect, Tukey's HSD revealed a significant difference in positive affect between the

multicultural profile (mean = 37.38, SD = 6.26) and the marginalized profile (mean = 32.92 SD = 7.45) and also between the integrationist (mean = 37.24, SD = 7.47) and marginalized profiles. The marginalized profile had lower positive affect scores than both the integrationist and multicultural groups.

Pairwise comparisons were run for cigarette use and number of sexual partners, controlling for Type I error across tests by using the Bonferroni approach ($\alpha = 0.05$) revealed that participants from the marginal profile also reported more cigarette smoking than the multicultural and integrationist profiles. Individuals from the marginalized profile also had a greater number of sexual partners in the past year than the multicultural profile.

Figure 7 displays a graphical representation of the mean rank differences between racial identity profiles for each health variable. This graph shows that the health measures for all the profiles were fairly similar in that the participants who endorsed a marginalized racial identity profile tended to report engaging in more negative health behaviors than the other two profiles. Table 12 also highlights these differences. The marginalized profile displayed more cigarette smoking, greater number of sexual partners, more marijuana smoking, less physical activity and less fruit and vegetable intake than the other profiles. The only positive finding regarding this profile was for negative affect wherein individuals in this profile reported the lowest levels of negative affect. The multicultural profile had the most individuals that reported engaging in positive health behaviors such as less drug and alcohol use, more fruit and vegetable intake, fewer sexual partners and using protection more often during sexual intercourse. Participants endorsing an integrationist racial identity reported higher rates of alcohol use, binge drinking, using protection less often during sexual intercourse and had experienced more negative affect

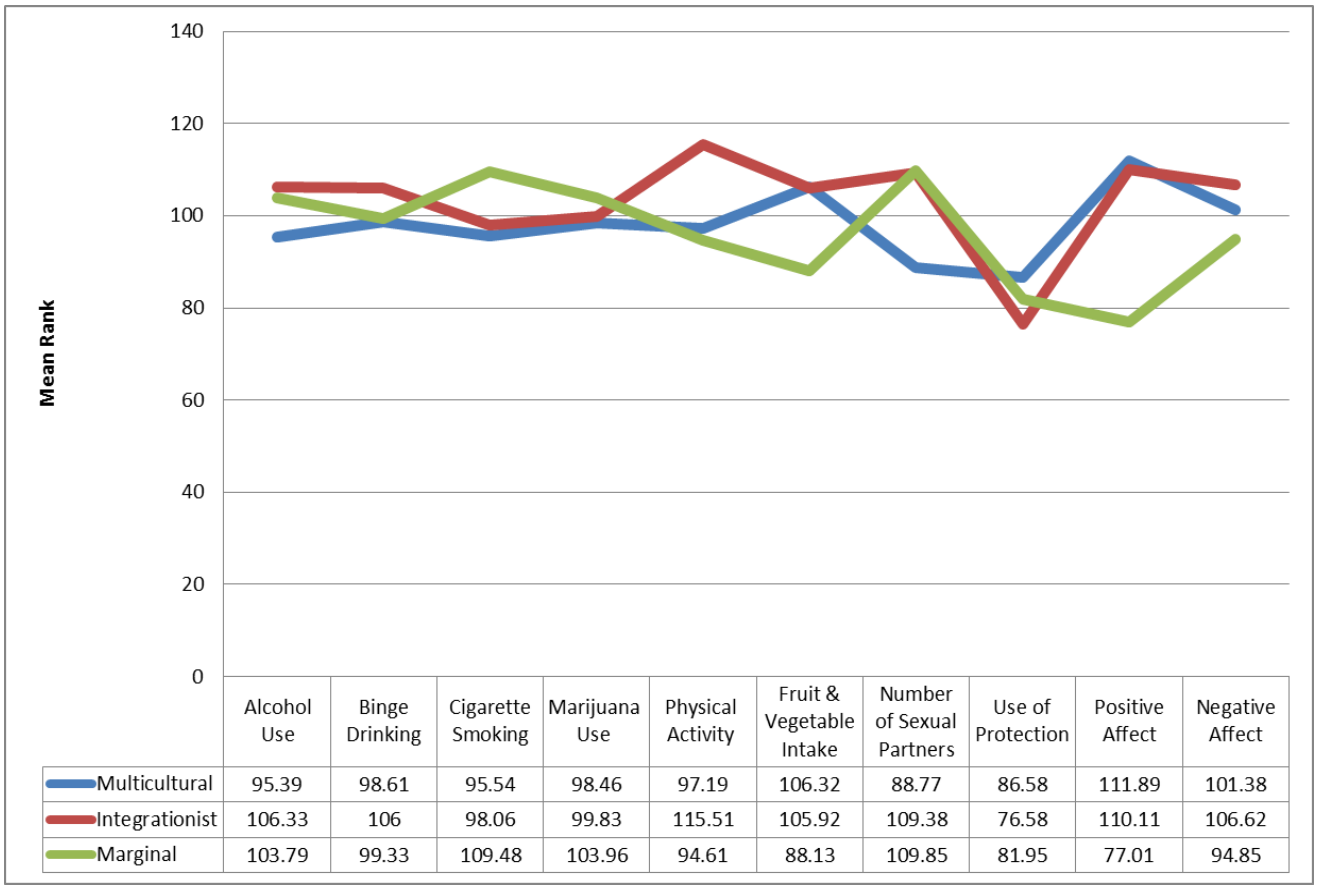
than the individuals from the other profiles. The integrationist profile had the greatest number of participants that reported engaging in regular physical activity.

TABLE 12

RESULTS OF KRUSKAL-WALLIS TEST WITH MEAN RANKS, CHI-SQUARE AND ETA SQUARE STATISTICS

Health Variable	**Mean Rank**	χ_2	**df**	**p**	η^2
Alcohol Use		1.84	2	0.40	0.01
Multicultural	95.39				
Integrationist	**106.33**				
Marginal	103.79				
Binge Drinking		0.78	2	0.68	0.00
Multicultural	98.61				
Integrationist	**106**				
Marginal	99.33				
Cigarette Smoking		5.13	2	0.08*	0.03
Multicultural	95.54				
Integrationist	98.06				
Marginal	**109.48**				
Marijuana Use		0.98	2	0.62	0.00
Multicultural	98.46				
Integrationist	99.83				
Marginal	**103.96**				
Physical Activity		4.07	2	0.13	0.02
Multicultural	97.19				
Integrationist	115.51				
Marginal	**94.61**				
Fruit & Vegetable Intake		4.30	2	0.12	0.02
Multicultural	106.32				
Integrationist	105.92				
Marginal	**88.13**				
Number of Sexual Partners		6.83	2	0.03*	0.03
Multicultural	88.77				
Integrationist	109.38				
Marginal	**109.85**				
Use of Protection		1.45	2	0.48	0.01
Multicultural	86.58				
Integrationist	**76.58**				
Marginal	81.95				
Negative Affect		1.13	2	0.57	0.01
Multicultural	101.38				
Integrationist	**106.62**				
Marginal	94.85				

Note: * Significant at .10 level



	Alcohol Use	Binge Drinking	Cigarette Smoking	Marijuana Use	Physical Activity	Fruit & Vegetable Intake	Number of Sexual Partners	Use of Protection	Positive Affect	Negative Affect
Multicultural	95.39	98.61	95.54	98.46	97.19	106.32	88.77	86.58	111.89	101.38
Integrationist	106.33	106	98.06	99.83	115.51	105.92	109.38	76.58	110.11	106.62
Marginal	103.79	99.33	109.48	103.96	94.61	88.13	109.85	81.95	77.01	94.85

Figure 7. Graphical comparison of mean rank differences among three racial identity profiles

CHAPTER V

DISCUSSION

This study had two research aims: (1) to identify racial identity cluster profiles among African American emerging adults and (2) to assess differences in the health behaviors of individuals endorsing different racial identity profiles. Overall, the results suggest that there are three clearly defined racial identity profiles in this sample and that there were statistically significant differences in positive affect (i.e. extent to which individual feels enthusiastic, alert, active, happy), cigarette smoking, and number of sexual partners among the three profiles, with the marginalized profile displaying the most negative scores. There were no statistically significant profile differences for any other health variable, suggesting that these three profiles do not have significant differences in their self-reported health behaviors. This study contributes to the racial identity literature by providing a description of the complex relationship among racial identity dimensions of the MMRI. It also replicated three of the cluster profiles identified in another study (Banks & Kohn-Wood, 2007). Moreover, this study contributes to the literature because it highlights the beliefs, attitudes and behaviors of a very specific group – African American emerging adults, both in college and from the community.

Previous research (Chavous et al., 2003 & Harper & Tuckman, 2006; Banks & Kohn-Wood, 2007) has utilized cluster analysis to identify racial identity profiles associated with the MIBI. Chavous et al. (2003) and Harper and Tuckman (2006) conducted a cluster analysis, but used only three (centrality, public regard and private regard) of the seven subscales of the MIBI and identified three and four cluster solutions, respectively. In Chavous and colleagues' study (2003), four clusters were produced: buffering/defensive (high private regard, high public regard, high centrality), idealized (high centrality, low private regard, high public regard), alienated (low

centrality, low public regard, low private regard) and low connectedness/high affinity (low centrality, low public regard, moderately high private regard). Harper and Tuckman (2006) replicated three of the clusters (buffering/defensive, idealized and alienated) identified by Chavous et al. (2003). Comparisons between the clusters of the current study and those clusters of the aforementioned studies are limited because of the differences in the number of subscales used to determine each cluster.

Only one empirical study (Banks & Kohn-Wood, 2007) has used cluster analysis to identify racial identity profiles associated with all seven of the subscales of the MIBI. Therefore comparisons between the current study's profiles and those identified by previous research will be limited to the study by Banks and Kohn-Wood (2007). The three clusters in the current study were consistent with three (Multicultural, Integrationist and Undifferentiated) of the four clusters identified by Banks & Kohn-Wood (2007), who also sampled African American emerging adult college students in the Midwest. However, their race-focused cluster was not replicated in the current study.

Their race-focused profile was characterized by high racial centrality beliefs and placing major importance on the issues of concern to the African American community. The individuals in this profile also reported much disagreement with African Americans blending with mainstream ideologies. While conducting the cluster analysis for the current study, a four and five-cluster solution emerged, however, the researcher's interpretation of the different cluster solutions revealed that the three cluster solution was the most parsimonious. More specifically, in the four and five-cluster solutions, the fourth and fifth profiles produced small sample sizes (4-7 participants). The clusters were differently labeled in this study because the researcher felt that the new names better represented the pattern of racial identity scores for each profile.

Comparisons between the current study's profile clusters and Banks and Kohn-Wood's (2007) cluster profiles will now be discussed.

The multicultural profile of the current study was most consistent with the integrationist profile identified by Banks and Kohn-Wood (2007). Scores were similar for the profiles of interest in that they did not consider race to be a significant part of their identity (racial centrality), felt moderately positive about being African American (private regard), felt that it was important for African Americans to blend with mainstream society (assimilation ideology) and wanted to view people in terms of shared human qualities (humanist ideology). In both studies, participants from each profile also felt that issues concerning the African American community were unimportant. However, Banks and Kohn-Wood's (2007) integrationist profile displayed much higher negative nationalist ideologies ($z = -.82$ vs. $z = -.32$). The two profiles differed for the public regard and minority ideology scales. In the Banks and Kohn-Wood (2007) study, their integrationist profile produced a slightly moderate positive score ($z = .14$) whereas the current study seemed to feel more strongly ($z = -.48$) that others did not have a positive evaluation of African Americans. The current study's multicultural profile beliefs about the similarity of experiences between African Americans and other minority groups also differed from the integrationist profile of the other study (Banks and Kohn-Wood) in that participants from our study felt that there were more similarities between African Americans and other minority groups.

The integrationist profile most closely resembled Banks and Kohn-Wood's (2007) multicultural profile. Both profiles had positive z-scores on all subscales of the MIBI. They differed regarding levels of each scale. The biggest the differences were related to how much individuals identified with being African American (centrality), how important they felt it was to

blend with mainstream society (assimilation), how similar they felt the experiences of other minorities are with African Americans' experiences (minority) and how important it is to judge people in terms of human qualities (humanist). The current study's integrationist profile identified more strongly (z =1.10) with being African American than Banks and Kohn-Wood's (2007) multicultural profile (.50). Also, participants in the current study did not feel it was as important to blend with mainstream society. Additionally, the Banks and Kohn-Woods (2007) multicultural profile participants had stronger views regarding commonalities between African Americans and other groups and human beings as a whole.

The marginalized profile of this study most closely resembled the undifferentiated profile of the Banks and Kohn-Wood (2007) study. The major difference between this study's marginalized profile and the undifferentiated profile is that our profile had much more pronounced negative scores on most ideology dimensions as well as for the centrality and private regard dimensions. Participants from the marginalized profile of the current study had very negative attitudes about African Americans integrating into mainstream culture (assimilation) and felt very strongly that people should not be judged according to their human characteristics (humanist ideology). They also had moderately negative thoughts about whether African Americans should align themselves with other minority groups to accomplish goals (minority ideology). Although individuals from both profiles did not feel that race was an important part of their identity and held negative beliefs regarding being African American (centrality and private regard), the marginalized profile in this study had much higher negative scores for these subscales. The two profiles had similar public regard scores, and nationalist ideology scores suggesting that both profiles felt similarly that others had no specific evaluation of African Americans and that issues of concern to the African American community were important.

In sum, the three profiles in the current study were distinct and were characterized by different patterns of racial identity beliefs. The multicultural profile seems to be focused on accepting the positive characteristics of all groups of people and did not want to be identified as just African American. Individuals from the integrationist profile are very proud of and defined themselves in terms of their group membership (African American), and they wanted to integrate this thought pattern in their interactions with others. The marginalized profile seems to have the most negative thoughts about African Americans and seem to be removed or disconnected from race altogether.

Major contributions

The first research aim of this study was to identify racial identity clusters among an African American emerging adult population. It highlights the racial identity patterns of a specific group of participants – African American emerging adults. This study identified three distinct cluster profiles. The identification of these cluster profiles is significant because it allows all the dimensions of the MMRI to be understood and examined together as a whole, which is how Sellers et al. (1997) intended the MMRI to be understood.

Multicultural Profile. The multicultural profile was characterized by moderately high racial ideology scores for assimilation, oppressed minority and humanist. This profile had low scores for centrality, public regard and nationalism. These pattern of scores suggest that participants in this profile did not view their race as a defining part of their self-concept and similarly felt that issues specific to the African American community were not important. Individuals who endorsed this profile had a tendency to focus on the commonalities between African Americans and other groups and they emphasized the shared commonalities of all humans. Despite their focus on shared characteristics, multicultural individuals do seem to feel

that other groups have negative beliefs about African Americans. The members of this profile seem to have an appreciation for all groups of people and do not feel particularly comfortable with being affiliated with only the African American community alone. They seem to want to take a multicultural approach to navigating through life, where positive aspects of people from different groups are accepted.

The racial identity pattern of individuals from the multicultural profile suggests that their education level and school enrollment status could explain how they differ from the other two profiles. Participants in this group had attained more education and more people were currently attending school than the other profiles. For many people college is a place where learning about different races, ethnicities and cultural practices occurs. Additionally, most of the individuals from the study attended a predominantly white university. Thus, it could be that multicultural participants had more day-to-day interaction with people from different racial and ethnic backgrounds (and perhaps more than people from their own race) than the other two groups. They probably have developed friendships with people from different racial and ethnic backgrounds as well, which may have lead them to want appreciate all cultures and not just African Americans.

Integrationist Profile. The integrationist profile was characterized by positive z-scores on all the MIBI subscales. The individuals in this profile had highest scores for centrality, public regard, and oppressed minority ideology and lower scores for humanist ideology, nationalist ideology and private regard. This pattern of scores indicates that the participants in this profile viewed race as a core defining aspect of their identity and felt strongly that others viewed African Americans positively. They felt moderately positive about being African American. With respect to how members of the African American community should behave and interact in

society, this profile believed that blending with mainstream culture and aligning with other minority groups is important. They also placed less emphasis on viewing others according to their human characteristics and did not feel that issues related to the African American community were important. The participants from this profile had moderately positive feelings about being African American but it was a crucial aspect of their identity. They also seem to want to integrate these feelings of pride and their focus on African American issues in their interaction with other groups of people.

The integrationist profile was comprised of more female participants and more married participants than the other two profiles. Perhaps, for African American married females, race is a more important part of the self-concept than for males. This profile was also characterized by having positive feelings toward assimilating into mainstream society. We speculate that African American females may be more amenable to integrating into mainstream culture than African American males. This suggests that African American males and females may have different experiences in this country. African American females may believe that they are viewed by society, in general, as less intimidating than their male counterparts and therefore they feel that assimilating into society is acceptable to accomplish goals. In short, it seems that African American married females from the integrationist profile may have more pride and focus on being African American more than participants from the other two profiles.

Marginalized Profile. The marginalized profile was characterized by negative z-scores on all of the subscales of the MIBI, with the exception of the nationalist ideology and public regard dimension. This pattern of scores reveals that the participants in this profile did not endorse any particular racial identity philosophy. They had the most negative scores regarding their thoughts about whether African Americans should assimilate into mainstream society,

aligning with other minority groups, and viewing others in terms of their human characteristics. The individuals in the marginalized profile also had moderately negative feelings regarding how important being African American was to their identity and had positive feelings about being African American. Members of this profile had positive scores for nationalist ideology and public regard. This suggests that while this group had negative feelings about being African American and did not view their race as a central part of their identity, they believed that issues concerning the African American community were somewhat important. They also felt that other groups did not have a specific evaluation of African Americans. This group seems to have the most negative feelings about African Americans and about being African American. The individuals from this profile seem to be removed from thinking about race or affiliating themselves with any group. They do not seem to want to identify with any specific group.

The marginalized profile's lack of identity and desire to be removed from a racial identity could be explained by answering two questions: what are the individuals in this profile running from? and what may they be running to? The negative feelings of the marginalized profile are clear and seem to be intentional. Perhaps individuals from this group do not want to be associated with the negative perception of African Americans in this country. They may feel that race, in general, is a topic that has negative implications in the workplace, at school, and in other areas in which they wish to excel. They may want to remove themselves from an identity altogether because they feel they may be better equipped to succeed in the world this way. This profile had more participants that reported earning more than $30,000 annually than the other two profiles. This may indicate that the marginalized participants were more upwardly mobile or were trying to be more upwardly mobile and may be looking for interpersonal ways to achieve this goal. Alternatively, if this group of participants wanted to be upwardly mobile during this

transitional period, they may feel more marginalized and negative in general because they don't see themselves as such due to the many transitions that occur during this period in one's life (school, work, relationships, children, living with parents, etc.).

In sum, the profiles all had their distinct characteristics. For example, the multicultural profile had more participants attending school and higher levels of education compared to the other two profiles. The integrationist profile differed in that there were more females and more married participants and the marginal profile had the largest percentage of individuals with an annual income of $30,000 or more. Perhaps these differences – education level, gender, and annual income – are more important in terms of predicting health behavior than racial identity. Alternatively, these factors could be confounding the influence of racial identity.

Profile Differences in Health Behavior. The second research aim of this study was to investigate differences in health behaviors according to racial identity profiles. There were statistically significant differences between profile groups for positive affect (i.e. feeling happy, enthusiastic, alert, excited), cigarette smoking and number of sexual partners. Participants in the marginalized profile had more negative scores for each behavior. This indicates that the marginalized profile was more depressed, smoked more cigarettes and reported having sexual intercourse with more partners in the past year than the multicultural and integrationist profiles. These findings suggest that people who held marginalized racial identity beliefs were more likely to engage in negative health behaviors.

The significant finding regarding positive affect is inconsistent with research that associates positive affect with racial identity profiles. In contrast to the current study, Banks & Kohn-Wood (2007) found that those who blended with mainstream culture and focused on human commonalities rather than racial identification had experienced more depression and

discrimination. According to Watson, Tellegen & Clark (1988) low positive affect is an indicator of depression. This suggests that the attitudes about race of participants with marginal racial identity patterns may have an impact on their mood levels, namely depression. Members of the marginalized profile were characterized by a lack of identity and having no affiliation with any group. Perhaps the depression that individuals from this profile seem to be experiencing can be explained by not being connected to any group. Perhaps the more interesting question is: what is causing this finding? It may be that this group of individuals feels depressed because they are not connected to any group or it may be that their depression leads to isolation. Another explanation is that this group could be displaying more depression than the other two profiles because of past experiences that may be related to race, again leading them to be removed from thinking about racial issues.

The marginalized profile also reported more cigarette smoking than the other profiles. One explanation for this finding is that perhaps the thought patterns about race of the individuals from the marginalized profile are stressful and influence them to want to smoke more cigarettes to alleviate that stress. People that smoke cigarettes regularly often cite that stress or anxiety is a reason that they smoke. We also speculate that because participants from this group also reported feeling more depressed than the other two profiles the depressive symptoms this group is experiencing may be stressful and lead to more cigarette smoking.

Participants from the marginalized profile reported they had sexual intercourse with more individuals in the past year than participants from the multicultural and integrationist profiles. Individuals from the marginalized profile had negative feelings about being African American and also did not feel that African Americans should integrate into mainstream culture. Perhaps their negative feelings about being African American are related to their overall self-esteem.

Thus, the people in this profile need or want to have more sexual partners in order to feel more positively about themselves in general. This finding could also be explained by this group's strong feelings that African Americans should not blend in with mainstream American society. Having limited sexual partners is an ideal that many people feel is a mainstream or American norm. If this true for individuals in the marginalized profile, who feel that blending with mainstream culture is not ideal for African Americans, then having multiple sexual partners in one year may be seen as a way of further distancing themselves from being affiliated with a particular group.

Of the three profiles identified in this study, the marginalized profile displayed higher scores related to negative health behaviors (in addition to the statistically significant findings) than the other profiles. Table 12 shows that the marginalized profile had higher negative scores for six out of the ten health behavior measured in this study. It is interesting to note that the marginalized profile seems to be setting a trajectory for themselves of poor health behaviors throughout their lives. The participants in this study were emerging adults aged 18-28 years old and engaging in these poor behaviors at this age does not bode well for their future health. Smoking cigarettes, for example, is highly addictive and can lead to lung cancer and other health conditions (Hatsukami, Stead, Gupta, 2008; US DHHS, 2004). This behavior is not likely to get better as these participants age. In fact, it is likely that their smoking behaviors will not change easily without intervention, which would make this developmental period an ideal place for researchers to develop programs to change these behaviors.

Compared to the other two racial identity profiles, it seems that the marginalized profile's lack of identity or group affiliation has lead them to engage in more negative health behaviors. The multicultural and integrationist profiles have a definite identity, whether they identify with

African Americans or another group, and they had scores that displayed more positive health behaviors. It seems that having an affiliation with any group may serve as protective factor and that removing oneself from any racial affiliation lessens the buffering effect of a racial identity.

The notion that racial identity serves as a protective factor seemed true for the integrationist and especially the multicultural profile in this study, as the participants in this group had the highest positive scores for all health behaviors. It seems that having a racial identity that is not necessarily race-focused, but inclusive of many different identities may insulate individuals from negative health behaviors and encourage participation in more positive health behaviors. Self-pride and self-efficacy may explain the positive health behaviors displayed by the integrationist cluster. Participants in this cluster felt that race was very important and they also felt very positively about being African American (racial self-esteem). Racial self-esteem may influence their decisions about engaging in healthy or unhealthy behaviors. Additionally, having access to social and personal resources of support may be important consequences of having a racial identity, as was true for the multicultural and integrationist profiles. Individuals from these groups endorsed working with and interacting with people from other racial and ethnic groups, which would increase their opportunities to have access to social and personal resources. With increased resources, individuals may also feel more efficacious regarding their ability to engage in healthy behaviors.

Income/SES or education level may be more powerful indicators of behavior than racial identity. This may be especially true in the current study, as race was not a central aspect of identity for many participants in this sample. For instance, racial centrality scores were negative for the multicultural and marginalized profiles, which are inconsistent with other studies using the MIBI, indicating that much of the sample did not view race as a significant part of their

identity. An individual's income level and/or education status might influence the decisions he or she may make about exercise, eating healthy and nutritious meals, and overall well-being. Those with higher incomes and more education typically have more access to resources and information regarding healthy behaviors. Racial identity may have less influence on how people develop habits or on whether they engage in risky behavior. Healthy behaviors may be attributed to social factors such as economic factors, education, past trauma, or gender rather than to racial identity issues.

This does not negate the influence of racial identity on health behaviors, but suggests that for the current study, race was not an important part of identity for many participants in this sample. Thus, there were few relationships between racial identity and health behaviors in this sample. Other studies have discovered associations between racial identity and ethnic identity and health (Caldwell et al, 2003). Few studies, though, have found links between physical health behaviors (i.e. sexual activity, substance use, and physical activity and dietary intake) and racial identity.

Limitations

This study had several limitations. First, the sample may have been too small and had insufficient statistical power to detect statistical differences once the clusters were established. Second, the study was based on a convenience sample, which limits the ability to make causal inferences about the nature of differences between groups. Third, the length of the survey may have been a limitation. The total survey was 129 questions and this may have caused some participants to become fatigued. Most of the surveys conducted in the community were outdoors, at a festival where there were distractions and warm temperatures. The study could be strengthened by asking fewer self-reported questions. Participants may have responded to the

health questions in a socially desirable manner. By asking about attitudes regarding health behaviors, different results may be revealed. Fourth, the self-reported health data were highly skewed in that the patterns of behavior were not normally distributed. Most of the answers were either mostly no answers with a few people who having high rates of behaviors. Participants in this sample were not very diverse in terms of their behavior. This makes analyzing data for differences very difficult because skewed distributions are non-normal. This also violates the assumption of normality of distributions which is critical for most parametric statistics to detect statistically significant differences. Thus, this study used non-parametric statistics which are not as powerful as parametric statistics. Finally, the cross-sectional nature of the study is also a limitation. The author would like to note, however, that this study's interest was in examining the relationship of racial identity patterns to health behavior and not to infer causality. Therefore the author does not infer causality regarding any of the results of the current study.

Future Research

Future studies investigating racial identity patterns and health behaviors would benefit greatly from using mixed methodology and including qualitative analyses to gather rich, detailed information about participants from each profile. This is especially true for the marginalized profile. The participants in this group had the worst health behaviors and seemed to be alienating themselves from thinking about racial attitudes altogether. Qualitative interviews or focus groups with members from each profile would certainly provide more insight about the why individuals think about race in different ways.

Future research could benefit from having a larger sample size, which would in effect increase the power and potential effect size of the study. Future research could also benefit from including participants from different regions in the United States. Race may be more salient for

people in different regions of the country. Also, future research should focus on variations in racial identity profiles associated with age and college samples versus community-based samples. Investigating whether racial identity profiles may differ by setting (i.e., community setting or university setting) is another area to explore. Arnett (2000) discussed the convenience of sampling college students for research studies. This is beneficial for academic researchers on one hand because they have a readily available pool of research participants, but this approach leaves those individuals of college age (18-25 years) who are not enrolled in school out of research studies and skews research findings.

The development of racial identity patterns is also an area to investigate in future research. The manner in which racial identity profiles change with age (adolescence to emerging adulthood to adulthood) and the association of changing profiles with emerging health behavior may provide great insight into the underlying decision-making processes regarding health behaviors. This type of research could also provide more information about the distinctiveness of emerging adulthood in a specific racial group, for which studies are limited. How do African Americans emerging adults differ in terms of racial identity (as defined by Sellers using the MIBI) throughout development? This type of research could lead to more answers about how racial identity changes over time as well as whether it is prudent to begin to expose ideas about race and African American culture to individuals at different developmental stages. Additionally, perhaps different types of questions should be asked regarding what influences health behaviors. Differences in social class/SES and health behaviors may be a better place to begin when developing programs and policies regarding health disparities.

Given the tremendous health issues that African American emerging adults face it is important for researchers to develop interventions that are effective with this population.

Assessments are needed to tailor interventions to get the greatest impact at reducing risky behaviors. Racial identity may be one way of assessing participants for inclusion in different intervention treatment groups. For example, someone who has higher levels of racial identification may respond differently to a substance use intervention than someone who is less race central and tends to view people according to characteristics other than race (i.e., gender or religious affiliation). If researchers know what types of attitudes and ideas their participants have about race, they can design intervention groups that align with different racial identity profiles. Researchers should, however, take care to expose participants, regardless of identity profile, to all racial identity ideas, so as not to arbitrarily segregate individuals based on their preferences or thought patterns. Our research has shown, however, that racial identity alone is not sufficient in explaining how or why people choose to engage in unhealthy behaviors. Racial identity should be further explored in combination with educational factors, economic factors and gender as the interaction of these factors represents a more complete view of the self.

Conclusion

More research is needed to understand how racial identity influences behavior, especially health behavior. The current study has attempted to contribute to the literature by examining racial identity profiles of African American emerging adults and whether they differ in their health behaviors. Racial identity is complex and multi-dimensional and thus it is difficult to study its impact on behavior. However, our research has demonstrated that individuals have clear and distinct racial identity patterns and that these patterns may impact certain behaviors. More specifically, a lack of identity with which one can relate, may lead to negative health outcomes. This maybe important to consider when developing prevention and intervention programs for emerging adults.

In conclusion, the information regarding African American emerging adults is limited. Thus, it is important for researchers to continue to study this unique population. African American emerging adults are facing a wide range of issues such as high incarceration rates, health problems, unemployment, discrimination and prejudice. Interventions are needed to help this group make a smooth transition to adulthood. For example, a large percentage of this population had children and they will be shaping the next generation in regards to developing healthy eating habits, embracing physical fitness and having negative attitudes towards drugs. More research is needed in order to better understand what factors influence the healthy behaviors of this population. If we are going to address the health issues in this population, the attitudes and thought patterns of this population needs further development.

REFERENCES

List of References

Arnett, J. (1992). Reckless behavior in adolescence: A developmental perspective. *Developmental Review, 12*, 339-373.

Arnett, J.J. (1998). Risk Behavior and Family Role Transitions during the Twenties. *Journal of Youth and Adolescence, 27*(3), 301 – 320.

Arnett, J.J. (2000). A Theory of Development from the Late Teens through the Twenties. *American Psychologist, 55*(5), 469-480.

Arnett, J.J. (2003). Conceptions of the Transition to Adulthood among Emerging Adults in American Ethnic Groups. *New Directions for Child and Adolescent Development, 100*, 63-75.

Arnett, J.J. & Brody, G.H. (2008). A Fraught Passage: The Identity Challenges of African American Emerging Adults. *Human Development, 51*, 291-293.

Baldwin, J.A. & Bell, Y.R. (1985). The African Self-Consciousness Scale: An Africentric Personality Questionnaire. *The Western Journal of Black Studies, 9*(2), 61-68

Banks, K.H., & Kohn-Wood, L.P. (2007). The Influence of Racial Identity Profiles on the Relationship Between Racial Discrimination and Depressive Symptoms. Journal *of Black Psychology, 33*(3), 331-354.

Belgrave, F.Z., Brome, D.R., & Hampton, C. (2000). The Contribution of Africentric Values and Racial Identity to the Prediction of Drug Knowledge, Attitudes and Use among African American Youth. *Journal of Black Psychology, 26*(4), 386-401.

Bowen- Reid, T.L. & Smalls, C. (2004). Multidimensional assessment of spirituality, stress levels and health promoting behaviors amongst African- American college students. *Journal of Black Western Studies*, 28, 283-291.

Brook, J.S. & Pahl, K. (2005). The Protective Role of Ethnic and Racial Identity and Aspects of an Africentric Orientation against Drug Use among African American Young Adults. *Journal of Genetic Psychology, 166* (3), 329-345.

Burlew, K., Neely, D., Johnson, C., Hucks, T.C., Purnell, B., Butler, J. et al. (2000). Drug Attitudes, Racial Identity and Alcohol Use among African American Adolescents. *Journal of Black Psychology, 26*(4), 402-420.

Caldwell, C.H., Kohn-Wood, L.P., Schmeelk-Cone, K.H., Chavous, T.M. & Zimmerman, M.A. (2004). Racial Discrimination and Racial Identity as Risk or Protective Factors for Violent Behaviors in African American Young Adults. *American Journal of Community Psychology, 33*(12), 91-105.

Caldwell, C.H., Sellers, R.M., Bernat, D.H., Zimmerman, M.A. (2004). Racial Identity, Parental Support, and Alcohol Use in a Sample of Academically At-Risk African American High School Students. *American Journal of Community Psychology, 34*, 71-82.

Centers for Disease Control. (2005a). Health Disparities Experienced by Black or African Americans. *United States, Morbidity & Mortality Weekly Report, 54*(1): 1-3.

Centers for Disease Control. (2005b). *HIV Prevention in the 3rd Decade*. Atlanta: United States Department of Health and Human Services. Retrieved June 1, 2010 from: http://www.cdc.gov/hiv/resources/reports/hiv3rddecade/index.htm.

Chavous, T.M., Bernat, D.H., Schmeelk-Cone, K., Caldwell, C.H., Kohn-Wood, L., & Zimmerman, M.A. (2003). Racial Identity and Academic Attainment among African American Adolescents. *Child Development, 74*(4), 1076-1090.

Clark, K.B. & Clark, M.P. (1947). Racial identification and preference in Negro children. In T.M. Newcomb & E.L. Hartley (Eds.), *Readings in social psychology* (pp. 167-187). New York: Holt.

Cross, W.E. (1971). The Negro-to-Black Conversion Experience: Toward a Psychology of Black Liberation. *Black World, 20*, 13-27.

Cross, W.E. (1991). *Shades of Black: Diversity in African-American Identity*. Philadelphia: Temple University Press.

Cowen, E.L. & Work, W.C. (1988). Resilient Children, Psychological Wellness and Primary Prevention. *American Journal of Community Psychology, 16,* 591-607.

Erickson, E. (1968). *Identity: Youth and Crisis*. New York: Norton.

Franklin-Jackson, D. & Carter, R. (2007). The Relationship between Race-Related Stress, Racial Identity and Mental Health for Black Americans. *Journal of Black Psychology, 33*(1), 5-26.

Helms, J. (1990). An Overview of Black Racial Identity Theory. In J. Helms, (Ed.), *Black and White Racial Identity Theory, Research and Practice (pp. 9-32).* Westport, CT: Praeger.

Hair, J.F. & Black, W.C. (2000). Cluster Analysis. In Grimm, L.G. and Yarnold, P.R. (Eds.), *Reading and Understanding more Multivariate Statistics* (*pp. 147-205).* Washington, D.C.: American Psychological Association.

Harper, B.E. & Tuckman, B.W. (2006). Racial identity beliefs and academic achievement: does being black hold students back? *Social Psychology of Education, 9*, 381-403.

Hatsukami, D.K., Stead, L.F., Gupta, P.C. (2008). Tobacco addiction. *Lancet*, 371(9629), 2027–2038.

Hawkins J D, Catalano R F, Miller J Y (1992). Risk and Protective Factors for Alcohol and Other Drug Problems in Adolescence and Early Adulthood: Implications for Substance Abuse Prevention. *Psychological Bulletin, 112*(1), 64-105.

Johnson, R.L. (2002a). Racial Identity from an African American Perspective. *Journal of Cultural Diversity, 9*(3), 73 – 78.

Johnson, R.L. (2002b). The Relationship among Racial Identity, Self-Esteem, Sociodemographics and Health-Promoting Lifestyles. *Research and Theory for Nursing Practice: An International Journal, 16*(3), 193-207.

Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2009). *Monitoring the Future National Survey Results on Drug Use, 1975–2008: Volume II, College students and adults ages 19–*50, Bethesda, MD: National Institute on Drug Abuse. Retrieved June 1, 2010 from: http://monitoringthefuture.org/pubs/monographs/vol2_2008.pdf

Kaiser Family Foundation. (2003). National Survey of Adolescents and Young Adults: Sexual Health Knowledge, Attitudes, and Experiences. Retrieved June 1, 2010, from http://www.kff.org/youthhivstds/upload/National-Survey-of-Adolescents-and-Young-Adults-Sexual-Health-Knowledge-Attitudes-and-Experiences-Summary-of-Findings.pdf

Kelley, G.A. (1995). Gender Differences in the Physical Activity levels of Young African American Adults. *Journal of the National Medical Association, 87*(8), 545-548.

Kogan, S.M., Brody, G.H., Gibbons, F.X., Murray, V.M., Cutrona, C.E., Simons, R.L., Wingood, G., & DiClemente, R. (2008). The Influence of Role Status on Risky Sexual Behavior among African Americans during the Transition to Adulthood. *Journal of Black Psychology, 34*(3), 399-420.

Lorr, M. (1983). *Cluster Analysis for Social Scientists*. San Francisco: Jossey-Bass.

Maggs, J.L. (1997). Alcohol Use and Binge Drinking as Goal-Directed Action during the Transition to Postsecondary Education. In Schulenberg, J., Maggs, J.L., & Hurrelmann, K. (Eds.), *Health Risks and Developmental Transitions during Adolescence*. (pp.345-371). New York: Cambridge University Press.

Marks, B., Settles, I.H., Cooke, D.Y., Morgan, L. & Sellers, R.M. (2004). African American Racial Identity: A Review of Contemporary Models and Measures. In R.L. Jones (Ed.), *Black Psychology* (4th ed.), (pp: 383-404). Hampton, VA: Cobb & Henry.

Millones, J. (1980). Construction of a Black Consciousness Measure: Psychotherapeutic Implications. *Psychotherapy: Theory, Research and Practice, 17*(2), 175-182.

Munford, M.B. (1994). Relationship of Gender, Self-Esteem, Social Class, and Racial Identity to Depression in Blacks. *Journal of Black Psychology, 20*(2), 157-174.

National Center for Health Statistics (2008). *Health, United States, 2008*. Hyattsville, MD: United States Department of Health and Human Services. Retrieved June 1, 2010 from: http://www.cdc.gov/nchs/data/hus/hus08.pdf

National Co-Morbidity Survey Replication (2007). *Lifetime Prevalence of DSM-IV/WHM-CIDI Disorders by Sex and Cohort.* Retrieved July 5, 2010 from: http://www.hcp.med.harvard.edu/ncs/ftpdir/NCS-R_Lifetime_Prevalence_Estimates.pdf

Neville, H.A. & Lilly, R.L. (2000). The Relationship between Racial Identity Cluster Profiles and Psychological Distress among African American College Students. *Journal of Multicultural Counseling and Development, 28*, 194-207.

Office of Applied Studies (2008). *Results from the 2008 National Survey on Drug Use and Health: Detailed Tables*. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved June 1, 2010 from: http://www.oas.samhsa.gov/NSDUH/2K8NSDUH/tabs/Cover.pdf

Oyserman, D., Gant, L., & Ager, J. (1995). A Socially Contextualized Model of African American Identity: Possible Selves and School Persistence. *Journal of Personality and Social Psychology, 69*(2), 1216-1232.

Oyserman, D., Fryberg, S.A., & Yoder, N. (2007). Identity-Based Motivation and Health. *Journal of Personality and Social Psychology, 93*(6), 1011 – 1027.

Parham, T.A & Helms, J.E. (1985). Attitudes of Racial Identity and Self-Esteem of Black Students: An exploratory Investigation. *Journal of College Student Personnel, 26*(2), 143-146.

Park, M.J., Brindis, C.D., Chang, F., Irwin, C.E. (2008). A Midcourse Review of the Healthy People 2010: 21 Critical Health Objectives for Adolescents and Young Adults. *Journal of Adolescent Health, 42*, 329-334.

Park, M.J., Mulye, T.P., Adams, S.H., Brindis, C.D., & Irwin, C.E. (2006). The Health Status of Young Adults in the United States. *Journal of Adolescent Health, 39*, 305-317.

Phelps, R.E., Taylor, J.D. & Gerard, P.A. (2001). Cultural Mistrust, Ethnic Identity, Racial Identity and Self-Esteem among Ethnically Diverse Black University Students. *Journal of Counseling & Development, 79*, 209-216.

Phinney, J.S. (1992). The Multigroup Ethnic Identity Measure: A New Scale for Use with Diverse Groups. *Journal of Adolescent Research, 7*(2), 156-176.

Pillay, Y. (2005). Racial Identity as a Predictor of the Psychological Health of African American Students at a Predominantly White University. *Journal of Black Psychology, 31*(1), 46-66.

Pugh, L.A., & Bry, B.H. (2007). The Protective Effects of Ethnic Identity for Alcohol and Marijuana Use among Black Young Adults. *Cultural Diversity and Ethnic Minority Psychology, 13*(2), 187-193.

Rapkin, B.D. & Luke, D.A. (1993). Cluster Analysis in Community Research: Epistemology and Practice. *American Journal of Community Psychology, 21(*2), 1993

Rowley, S.J., Sellers, R.M., Chavous, T.M., & Smith, M.A. (1998). The Relationship between Racial Identity and Self-Esteem in African American College and High School Students. *Journal of Personality and Social Psychology, 74*(3), 715-724.

Sanders-Thompson, V.L. (1995). The Multidimensional Structure of Racial Identification. *Journal of Research in Personality, 29*, 208-222.

Sanders-Thompson, V.L. (2001). The Complexity of African American Racial Identification. *Journal of Black Studies, 32*(2), 155-165.

Schulenberg, J.E. & Maggs, J.L. (2002). A Developmental Perspective on Alcohol Use and Heavy Drinking during Adolescence and the Transition to Young Adulthood. *Journal of Studies on Alcohol*, *Supp 14*, 54-70.

Sellers, R.M., Chavous, T.M., & Cooke, D.Y. (1998). Racial Ideology and Racial Centrality as Predictors of African American College Students' Academic Performance. *Journal of Black Psychology, 24*(1), 8-27.

Sellers, R.M., Shelton, N.J., Cooke, D.Y., Chavous, T.M., Rowley, S.A. & Smith, M.A. (1998). A Multidimensional Model of Racial Identity: Assumptions, Findings, and Future Directions. In R.L. Jones (Ed.), *African American Identity Development: Theory, Research and Intervention* (pp. 275-302). Hampton, VA: Cobb and Henry.

Sellers, R.M., Smith, M.A., Shelton, J.N., Rowley, S.A., & Chavous, T.M. (1998). Multi-dimensional Model of Racial Identity: A Reconceptualization of African American Racial Identity. *Personality and Social Psychology Review, 2*(1), 18-39.

Sellers, R.M., Caldwell, C.H., Schmeelk-Cone, K.H., & Zimmerman, M.A. (2003). Racial Identity, Racial Discrimination, Perceived Stress and Psychological Distress among African American Young Adults. *Journal of Health and Social Behavior, 43*, 302-317.

Sellers & Shelton (Smalls, C., White, R., Chavous, T. & Sellers, R. (2007). Racial Ideological Beliefs and Racial Discrimination Experiences as Predictors of Academic Engagement among African American Adolescents. *Journal of Black Psychology, 33*, 299-330.

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2010). The *NSDUH Report: Substance Use among Black Adults.* Rockville, MD. Retrieved June 1, 2010 from: http://www.oas.samhsa.gov/2k10/174/174SubUseBlackAdults.htm

Thompson, S.N. & Chambers, J.W. (2000). African Self-Consciousness and Health-Promoting Behaviors among African American College Students. *Journal of Black Psychology, 26*, 330-345.

Townsend, T. & Lanphier, E. (2007). Family Influences on Racial Identity among African American Youth. *Journal of Black Psychology, 33*(3), 278-298.

United States Census Bureau (2001). *Marital History for People 15 years and over, by Age, Sex, Race and Hispanic Origin: 2001*. Retrieved June 1, 2010 from: http://www.census.gov/population/socdemo/marital-hist/p70-97/tab01.pdf

United States Department of Health and Human Services (2004). *The Health Consequences of Smoking: A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

Valde, G.A. (1996). Identity closure: A fifth identity status. *Journal of Genetic Psychology, 157*, 245-254.

Wakefield, W.D., & Hudley, C. (2007). Ethnic and Racial Identity and Adolescent Well-Being. *Theory into Practice, 46*(2), 147-154.

Watson, D., Clark, L.A., & Tellegen, A. (1988). Development and Validation of Brief Measures of Positive and Negative Affect: The PANAS Scales. *Journal of Personality and Social Psychology, 54*(6), 1063 -1070.

Whittaker, V.A., & Neville, H.A. (2009). Examining the Relation between Racial Identity Attitude Clusters and Psychological Health Outcomes in African American College Students. *Journal of Black Psychology,* 1-27.

Windle, M. (2003). *Alcohol Use among Adolescents and Young Adults*. Retrieved June 1, 2010 from: http://pubs.niaaa.nih.gov/publications/arh27-1/79-86.htm

Yee, B.W., Castro, F.G., Hammond, W.R., John, R., Wyatt, G.E., & Yung, B.R. (1995). Panel IV: Risk-Taking and Abusive Behaviors among Ethnic Minorities. *Health Psychology, 14*(7), 622-631.

APPENDICES

APPENDIX A

SCALES AND SUBSCALES OF THE MULTIDIMENSIONAL INVENTORY OF BLACK IDENTITY (MIBI)

Centrality Scale

1. Overall, being Black has very little to do with how I feel about myself. **(R)**
2. In general, being Black is an important part of my self-image.
3. My destiny is tied to the destiny of other Black people.
4. Being Black is unimportant to my sense of what kind of person I am. **(R)**
5. I have a strong sense of belonging to Black people.
6. I have a strong attachment to other Black people.
7. Being Black is an important reflection of who I am.
8. Being Black is not a major factor in my social relationships. **(R)**

Regard Scale
Private Regard Subscale

1. I feel good about Black people.
2. I am happy that I am Black.
3. I feel that Blacks have made major accomplishments and advancements.
4. I often regret that I am Black. **(R)**
5. I am proud to be Black.
6. I feel that the Black community has made valuable contributions to this society

Public Regard Subscale

1. Overall, Blacks are considered good by others.
2. In general, others respect Black people.
3. Most people consider Blacks, on the average, to be more ineffective than other racial groups. **(R)**
4. Blacks are not respected by the broader society. **(R)**
5. In general, other groups view Blacks in a positive manner.
6. Society views Black people as an asset.

Ideology Scale
Assimilation Subscale

1. Blacks who espouse separatism are as racist as White people who also espouse separatism.
2. A sign of progress is that Blacks are in the mainstream of America more than ever before.
3. Because America is predominantly white, it is important that Blacks go to White schools so that they can gain experience interacting with Whites.

4. Blacks should strive to be full members of the American political system.
5. Blacks should try to work within the system to achieve their political and economic goals.
6. Blacks should strive to integrate all institutions which are segregated.
7. Blacks should feel free to interact socially with White people.
8. Blacks should view themselves as being Americans first and foremost.
9. The plight of Blacks in America will improve only when Blacks are in important positions within the system.

Humanist Subscale

1. Black values should not be inconsistent with human values.
2. Blacks should have the choice to marry interracially.
3. Blacks and Whites have more commonalties than differences.
4. Black people should not consider race when buying art or selecting a book to read.
5. Blacks would be better off if they were more concerned with the problems facing all people than just focusing on Black issues.
6. Being an individual is more important than identifying oneself as Black.
7. We are all children of a higher being; therefore, we should love people of all races.
8. Blacks should judge Whites as individuals and not as members of the White race
9. People regardless of their race have strengths and limitations.

Oppressed Minority Subscale

1. The same forces which have led to the oppression of Blacks have also led to the oppression of other groups.
2. The struggle for Black liberation in America should be closely related to the struggle of other oppressed groups.
3. Blacks should learn about the oppression of other groups.
4. Black people should treat other oppressed people as allies.
5. The racism Blacks have experienced is similar to that of other minority groups.
6. There are other people who experience racial injustice and indignities similar to Black Americans.
7. Blacks will be more successful in achieving their goals if they form coalitions with other oppressed groups.
8. Blacks should try to become friends with people from other oppressed groups.
9. The dominant society devalues anything not White male oriented.

Nationalist Subscale

1. It is important for Black people to surround their children with Black art, music and literature.
2. Black people should not marry interracially.
3. Blacks would be better off if they adopted Afrocentric values.

4. Black students are better off going to schools that are controlled and organized by Blacks.
5. Black people must organize themselves into a separate Black political force.
6. Whenever possible, Blacks should buy from other Black businesses.
7. A thorough knowledge of Black history is very important for Blacks today.
8. Blacks and Whites can never live in true harmony because of racial differences.
9. White people can never be trusted where Blacks are concerned.

---

*Note: (R) items are reverse scored.

APPENDIX B

POSITIVE AND NEGATIVE AFFECT SCHEDULE ITEMS

Negative Items	Positive Items
Distressed	Interested
Upset	Excited
Guilty	Strong
Scared	Enthusiastic
Hostile	Proud
Irritable	Alert
Ashamed	Inspired
Nervous	Determined
Jittery	Attentive
Afraid	Active

APPENDIX C

PHYSICAL AND NUTRITIONAL HEALTH QUESTIONS FROM SURVEY

During the past 7 days, on how many days were you physically active for a total of at least 60 minutes per day? (Add up all the time you spend in any kind of physical activity that increases your heart rate and makes you breathe hard some of the time.)
On how many of the past seven days did you eat breakfast—that is, a meal within an hour of getting up?
On how many of the past seven days did you eat lunch?
On how many of the past seven days did you eat dinner?
On how many of the past seven days did you eat any fruits and vegetables?

APPENDIX D

DRUG AND ALCOHOL USE QUESTIONS FROM SURVEY

During the past 30 days how many days have you used (please circle the appropriate number):

...Any alcohol?
...Alcohol to intoxication (five drinks or more in one sitting)?
…Cigarettes?
…Cigars?
...Cocaine/Crack?
...Marijuana/hashish?
...Heroin?
...Non prescription methadone?
...Hallucinogens /psychedelics (PCP)?
...MDMA (ecstasy)?
...LSD (acid)?
...Methamphetamines or other amphetamines (crystal meth, speed, crank)?
...Benzodiazepines, barbiturates, or tranquilizers (downers, special K, roofies)?
...Inhalants (poppers, whippets)?
...Prescription Drugs?
...Any other drugs?

APPENDIX E

SEXUAL HEALTH QUESTIONS FROM SURVEY

---

8. Have you ever had sexual intercourse? *
9. How many sexual partners have you had in the last year?
10. What forms of contraceptives, if any, do you use? (check all that apply)
11. How often do you use protection?
12. Have you been tested for HIV/AIDS in the last year? *
13. Have you been tested for other STD's in the last year? *
14. If yes, which STDs have you been tested for? (check all that apply)

---

*Note: reliability analyses conducted on these variables only

APPENDIX F

MEANS, z SCORES, AND STANDARD DEVIATIONS FOR RACIAL IDENTITY PROFILES

Cluster	*Racial Identity Subscale*	*z Score*	*(SD)*	*M*	*(SD)*
Multicultural	Centrality	-0.20	0.83	1.67	0.66
(N=92)	Private Regard	0.10	0.96	4.19	0.67
	Public Regard	-0.48	0.79	1.13	0.68
	Assimilation	0.34	0.67	5.41	0.57
	Oppressed Minority	0.56	0.89	4.70	0.76
	Humanist	0.43	0.76	5.58	0.77
	Nationalism	-0.32	0.82	3.50	0.69
Cluster	*Racial Identity Subscale*	*z Score*	*(SD)*	*M*	*(SD)*
Integrationist	Centrality	1.10	0.65	2.71	0.52
(N=45)	Private Regard	0.54	0.44	4.50	0.31
	Public Regard	0.99	0.74	2.40	0.63
	Assimilation	0.66	0.72	5.69	0.62
	Oppressed Minority	0.77	0.74	5.31	0.63
	Humanist	0.43	0.76	5.58	0.77
	Nationalism	0.39	1.10	4.10	0.93
Cluster	*Racial Identity Subscale*	*z Score*	*(SD)*	*M*	*(SD)*
Marginal/Obscure	Centrality	-0.50	0.85	1.43	0.68
(N=63)	Private Regard	-0.53	1.10	3.75	0.78
	Public Regard	0.00	0.92	1.55	0.79
	Assimilation	-0.97	0.87	4.28	0.75
	Oppressed Minority	-0.63	0.90	4.11	0.77
	Humanist	-0.94	0.80	4.19	0.81
	Nationalism	0.19	1.04	3.93	0.88

APPENDIX G

DEMOGRAPHIC COMPOSITION OF ALL RACIAL IDENTITY PROFILES

	Multicultural Profile		**Integrationist Profile**		**Marginalized Profile**	
	N = 92		N = 45		N = 63	
	Percent	*Frequency*	Percent	*Frequency*	Percent	*Frequency*
Gender						
MALE	51	*47*	47	*21*	51	*32*
FEMALE	49	*45*	53	*24*	49	*31*
Education						
HS/GED	44	*40*	48	*21*	54	*34*
Associate's	42	*38*	34	*15*	33	*21*
Bachelor's	8	*7*	11	*5*	5	*3*
Master's	2	*2*	--	--	3	*2*
Attending school	71	*65*	64	*29*	62	*39*
Marital Status						
Single, Never Married	98	*88*	88	*38*	95	*58*
Married	2	*2*	5	*12*	5	*3*
Annual Income						
< $15,000	73	*64*	75	*32*	72	*44*
$15,000 - $30,000	22	*19*	21	*9*	15	*9*
> $30,000	6	*5*	4	*2*	13	*8*
Any Children?	22	*20*	27	*12*	27	*17*

APPENDIX H

GLOSSARY OF TERMS

1. **Racial identity** – the significance and meaning that individuals place on race in defining themselves (Sellers et al., 1998)

2. **Racial centrality** – the extent to which a person normatively defines himself or herself with regard to race

3. **Racial salience** – the extent to which one's race is a relevant part of one's self-concept at a particular moment or in a particular situation

4. **Racial regard** – refers to a person's affective and evaluative judgment of her or his race in terms of positive-negative valence; the extent to which the individual feels positively about his or her race

5. **Racial ideology** – the individual's beliefs, opinions, and attitudes with respect to the way she or he feels that the members of the race should act; the person's philosophy about the ways in which African Americans should live and interact with society with respect to political/economic development, cultural/social activities, intergroup relations and perceptions of the dominant group

6. **Private regard** - the extent to which individuals feel positively or negatively towards African American as well as how positively or negatively they feel about being an African American

7. **Public regard** - the extent to which individuals feel that others view African Americans positively or negatively; an individual's assessment of how his group is viewed (or valued) by the broader society

8. **Nationalist ideology** – stresses the uniqueness of the African American experience

9. **Assimilationist ideology** – characterized by an emphasis on the similarities between African Americans and the rest of American society; an acknowledgment of his or her status as an American and an attempt to enter, as much as possible, the mainstream American culture

10. **Oppressed Minority ideology** – emphasizes the similarities between the oppression that African Americans face and that of other groups

11. **Humanist ideology** – emphasizes the similarities among all humans; the person does not think in terms of race, gender, class, or other distinguishing characteristics; views everyone as belonging to the same human race

12. **Ethnic Identity** - an aspect of a person's self-concept that derives from his or knowledge of membership in a social group (or groups) together with the value and emotional significance attached to that membership (Tajfel, 1981)

13. **Nigrescence** – the developmental process by which a person "becomes Black" where Black is defined in terms of one's manner of thinking about and evaluating oneself and one's reference groups rather than in terms of skin color (Helms, 1991)

14. **Emerging adulthood** – an empirically distinct period of development after adolescence and before young adulthood, roughly between the ages of 18-25 years (Arnett, 2000)