UNIVERSITY OF CALIFORNIA

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"Won't Kill Me, Won't Kill Me. Throw the Hammer Down and We'll Be Free": How John Henryism Shapes Mental and Physical Health among African American and Caribbean Black Women

A dissertation submitted in partial satisfaction of the

requirements for the degree Doctor of Philosophy

in Community Health Sciences

by

Millicent Nicolle Robinson

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ABSTRACT OF THE DISSERTATION

"Won't Kill Me, Won't Kill Me. Throw the Hammer Down and We'll Be Free": How John Henryism Shapes Mental and Physical Health among African American and Caribbean Black Women

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Doctor of Philosophy in Community Health Sciences

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Professor Courtney S. Thomas Tobin, Chair

Given the distinct health risks Black women face, which are largely due to their marginalized status as both women and Black within the context of gendered racism, scholars have increasingly considered the role of culturally-relevant coping in shaping the distinct health patterns of this group. One form of coping that may have particular significance for Black women's health is *John Henryism*, defined as persistent and high effort active coping with psychosocial and environmental stressors. John Henryism reflects the broader societal, cultural, and historical context that shapes the lived experiences of Black populations navigating racism and capitalism in the U.S. Overall, high-effort coping can be physiologically strenuous, contributing to increased stress on the body that eventually results in poor physical health, while simultaneously helping individuals to effectively manage stressful experiences. Although John Henryism has been linked

to both mental and physical health, it has been primarily studied among Black men. Despite evidence demonstrating that ethnicity shapes health processes, ethnicity has not been widely considered in health-focused research on John Henryism with Black women. Therefore, the purpose of this dissertation was to evaluate how John Henryism shapes mental and physical health among African American and Caribbean Black women. This dissertation was a secondary analysis of the National Survey of American Life (NSAL 2001-2003), with an analytic sample of 1,580 Black women (1,209 African American women and 371 Caribbean Black women). 80% of the Caribbean Black women were U.S. born. Key measures for this dissertation included: mental health indicators (i.e., psychological distress, self-rated mental health, depressive symptoms, past-year major depressive disorder); physical health indicators (i.e., self-rated health, chronic health conditions), John Henryism, ethnicity, stress exposure indicators (i.e., chronic stress, everyday discrimination, goal-striving stress), and sociodemographic characteristics (i.e., age, SES). Logistic, multinomial logistic, and negative binomial regression were used. Findings indicate that John Henryism is seemingly harmful for the mental health of Black women overall, but protective for Caribbean Black women, while being largely neutral for the physical health of Black women overall but harmful for Caribbean Black women in particular.

The dissertation of Millicent Nicolle Robinson is approved.

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DEDICATION PAGE

This dissertation is dedicated to my familial lineage and ancestors, both those I know and those I don't have names for. You have been with me throughout this entire journey, even when I didn't know it: Robinson. Sullivan. Frye. Walker. Blakeney. Leak. LeGrande. Allen. Little. This is especially dedicated to all the Black women in my family lineage, both past and present. You have inspired me. I wouldn't be here without you. This is for you. This is also dedicated to my community.

This work is dedicated to all Black women. May we all find our ways to cultivate and thrive in peace, love, prosperity, joy, and fulfillment as we navigate a society and world that so often challenges us in these areas. May we all stand in the truth that we are deserving of these wonderful things and so much more. May we also find sincere and nourishing community that supports us in these endeavors. Asé.

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PREFACE

"This little hammer killed John Henry
Won't kill me, won't kill me
This little hammer killed your daddy
Throw it down and we'll be free"

-From *Polly Ann's Hammer* by Our Native Daughters (2019)

Motivating the title of this dissertation, the excerpt above contains lyrics from a song written and performed by Our Native Daughters, a Black female folk music group. While quite a few are familiar with the folk tale of John Henry, the "steel driving man", and one of the inspirations for the concept "John Henryism" (i.e., high-effort coping), the story and contributions of his wife, Polly Ann, are less widely known. Sadly, this is not shocking, as there are countless untold stories and examples of blatant disregard for Black women's contributions and sacrifices made on behalf of others. The brief selection above is a striking and powerful illustration of Polly Ann's struggle, as well as her desire to liberate not only herself, but future generations. After John Henry became ill and died from his battle with the machine, Polly Ann, without hesitation, took up the mantle of driving steel. As illustrated by her words, she is determined to not allow the fate of John Henry to befall her. Even more so, she is transparent with her child about what happened to their father. But what she says next is both cautionary and instructive. She tells her child, "Throw it down and we'll be free". Clearly, Polly Ann has no desire for her child to be caught in the same cycle that she and John Henry were in. She recognizes that it isn't healthy; however, Polly Ann is determined to surpass those odds.

The story of Polly Ann is a familiar and resounding echo of many Black women's lived experiences, both past and present. Historically and even today, Black women have faced seemingly insurmountable challenges and somehow "made a way out of no way". Though it may

appear as miraculous and awe-inspiring to the general public, what it takes to confront and overcome these feats is anything but effortless. Black women are often taught from a very young age to be strong, courageous, self-reliant, and innovative (hooks 1993). This type of socialization has been intergenerationally transferred from both family and society-at-large without cease. Nevertheless, there is a severe price Black women pay for this, not just in terms of financial resources, but for mental and physical health and well-being.

Many Black women engage in high-effort coping without knowing because it is so ingrained and may be perceived as a reliable way of coping with never-ending stressful and taxing circumstances. However, very little attention has been given to really understanding how life experiences lead Black women to engage in high-effort coping, what high-effort coping means and/or looks like for Black women, and how high-effort coping shapes mental and physical health for these women. Coupled with this is a recognition that Black women are not a monolith. Just as there are quite a number of similarities among Black women, there are also distinctions which necessitate further assessment. Recent estimates show that one in five Black individuals in the United States are either immigrants or children of Black immigrants, with Jamaica and Haiti, two Caribbean nations, being the top two places of origin for Black immigrants (Tamir 2022). Additionally, women compose 54% of this group (Thomas 2012). In other words, Caribbean Black women have a substantial presence within the United States; however, research on this population's stress, coping, and health experiences is scant. Given this group's experiences as not only Black and women, but also immigrant, they likely face instances of stress and discrimination which requires some level of high-effort coping to address these challenges. Nevertheless, their experiences may be similar to or slightly different than other Black women. Therefore, this dissertation seeks to bring attention to the legacy of Polly Ann Henry by examining the ways in

which John Henryism shapes mental and physical health among Black women (i.e., African American and Caribbean Black women) in the United States.

CHAPTER ONE: INTRODUCTION

1.1 Black Women's Health

A recent executive summary report revealed that despite being leaders in their communities and making significant contributions to the society and economy of the United States, Black women continue to be underpaid and consistently receive fewer benefits compared to the level of their labor productivity (DuMonthier, Childers, and Milli 2020), a reality that has persisted since enslavement. These conditions heavily contribute to the elevated health burden observed among this group, and growing evidence demonstrates that Black women face more health challenges than women of other races. For instance, Black women report disproportionate rates of chronic physical health conditions (e.g., obesity, heart disease, and autoimmune disorders) (Geronimus et al. 2010; Woods- Giscombé 2010) and are more than three times as likely to experience maternal mortality compared to White women (Melillo 2020). At the same time, Black women report relatively low rates of most psychiatric disorders (e.g., major depression), despite heightened feelings of non-specific psychological distress (e.g., depressive symptoms) (Mouzon et al. 2016; Barnes and Bates 2017; Hummer and Hamilton 2019).

Collectively, these health patterns are puzzling because psychological distress, psychiatric disorder, and physical health conditions have been generally linked and positively correlated within the general population (Pearlin et al. 1981; Payton 2009; Barnes and Bates 2017). Yet, since Black women face numerous risk factors (e.g., heightened exposure to trauma, financial strain, and chronic stress) typically associated with poor physical and mental health in the general population (Woods-Giscombé 2010; Woods-Giscombé et al. 2016; Amani et al. 2019), their observed health patterns suggest that these factors may differentially influence outcomes among this group. In other words, it is possible that the etiologies of mental and physical health may

operate differently among Black women. Therefore, to clarify the mechanisms that shape physical and mental health outcomes and to improve the overall health status of this group, there is a need to examine both physical and mental dimensions of health status among Black women.

When evaluating factors that shape health status among Black women, it is imperative to assess both mental and physical health dimensions. While scholars suggest that an individual's true health status may exist at the convergence of mental and physical health status (Sartorious 2013; Brown, Turner, and Moore 2016), there is also evidence to suggest that these patterns may not be consistent across social groups. Recent studies show that joint mental and physical health patterns may vary significantly by race, such that mental and physical health outcomes tend to be more consistent for White compared to Black Americans (Barnes and Bates 2017; Assari 2019). Additionally, scholars have increasingly challenged the "assumption of similarity," which posits that fundamental social and psychological processes operate universally for a variety of racial and ethnic groups (Hunt et al. 2000). Consequently, they argue that since cultural and historical experiences shape the various social contexts in which racial groups live, these groups likely encounter different risk exposures and access to resources that distinguish their health profiles (Gayman et al. 2014; Assari 2019).

Nevertheless, the specific factors that contribute to the paradoxical mental and physical health patterns observed among Black women remain unclear, as they have been underexplored in prior research. In a recent study, however, Erving, Satcher, and Chen (2021) demonstrated that the links between psychosocial resources and health among Black women differ from that of the general population. Interestingly, they found that stressors such as financial strain and resources such as mastery do not uniformly influence the mental and physical health outcomes of Black women. Specifically, while financial strain was directly linked to fewer depressive symptoms, it

was not associated with self-rated health (Erving et al. 2021). Similarly, mastery was not significantly associated with depressive symptoms, but it did contribute to lower self-rated health (Erving et al. 2021). Moreover, they observed that while some psychosocial resources (e.g., social support) were protective against the negative impact of stress exposure, others such as religious involvement (e.g., church attendance) exacerbated the effects of stress on the health of African American women (Erving et al. 2021). Collectively, these findings not only challenge the "assumption of similarity," but they also demonstrate that Black women's health does not always align with conventional knowledge about the predictors of health status and the connections between health domains. Given the unexpected health patterns found among Black women, in addition to the varied influence of risks and resources on mental versus physical health outcomes, examining both dimensions of health will shed new light Black women's overall health status and the potential factors and mechanisms that shape these trends.

1.2 Health Risks among Black Women

Aside from risk factors that are typically associated with poor mental and physical health in the general population, Black women also encounter distinct risks across the life course that may contribute to their unexpected health patterns. For instance, research suggests that the health risk associated with certain sociodemographic characteristics may be different for Black women. While being married often confers physical health benefits, a recent study found that being married poses significant physical health risk for Black women (Thomas Tobin, Robinson, and Stanifer 2019). In addition, Black women report increased exposure to trauma, financial strain, and chronic stress compared to other racial groups (Woods-Giscombé 2010; Woods-Giscombé et al. 2016; Amani et al. 2019), and research shows that these exposures are significantly and positively associated with a range of adverse health outcomes including cardiovascular disease, physiological

dysregulation, obesity, and depression (Woods-Giscombé 2010; Woods-Giscombé et al. 2016; Amani et al. 2019).

While other groups encounter these stressors as well, scholars also note that the stress experiences of Black women are a distinct consequence of a larger system and process grounded in white supremacy, which subjugates and oppresses Black women, particularly within the social context of the United States (Collins 2000). In fact, scholarship has increasingly recognized the role of gendered racism in shaping the life chances and experiences of Black women. Gendered racism is defined as, the intersection of both racism and sexism experienced by Black women (Essed 1991; Thomas, Witherspoon, and Speight 2008), as it "…shapes the allocation of resources along racially and ethnically ascribed understandings of masculinity and femininity as well as along gendered forms of race and ethnic discrimination" (Essed 2001, pg. 1). As such, gendered racism significantly changes how health risks are experienced and ultimately contribute to the varied outcomes observed among Black women. Since these mechanisms are poorly understood, we need to investigate the specific pathways among Black women to better understand these health patterns and the factors that shape them.

1.3 John Henryism as a Form of Coping

Evaluating the role of coping may provide a more comprehensive understanding of how stressful experiences across the life course shape health among Black women. The Social Stress Paradigm, a prominent theoretical framework in the field of Medical Sociology, indicates that coping is an integral component of the stress process and posits that an individual's access to a variety of coping resources may influence the ways in which stress ultimately impacts their health (Turner, Taylor, and Van Gundy 2004). Importantly, an individual's social position determines the types of coping strategies accessible to them and the effectiveness of these coping strategies

for health (Pearlin et al. 1981; Meyer, Schwartz, and Frost 2008). Thus, evaluating the significance of coping may provide a more comprehensive understanding of how stressful experiences across the life course shape health among Black women.

While gender-specific forms of coping such as the Superwoman Schema, have gained growing attention, far less is known about the impact of other racially relevant forms of coping, including John Henryism (James, Hartnett, and Kalsbeek 1983; Greer 2007; Woods-Giscombé 2010; Woods-Giscombé et al. 2016; Woods-Giscombé et al. 2019; Allen et al. 2019;). One of the few empirically-tested constructs that considers the social and cultural experiences of Black Americans (Trawalter et al. 2009), *John Henryism* is defined as persistent, high-effort coping with psychosocial and environmental stressors (James et al. 1983; James 1994). Thus, an individual whose coping style is characterized by "high" John Henryism is more likely to endorse efficient mental and physical stamina, an obligation to work hard, and a focused resolve to achieve (James 1994). In other words, an individual who engages in high levels of this coping style may be more apt to address stressors and challenges with determination (Robinson and Thomas Tobin 2021). Conversely, someone whose coping style is characterized by "low" John Henryism is less likely to endorse these characteristics (James 1994). That is, a person who engages in low levels of John Henryism may be easily overwhelmed by life's challenges (Robinson and Thomas Tobin 2021). Thus, while John Henryism is not inherently harmful, research suggests that prolonged engagement in this coping style, particularly within the context of low SES and high stress exposure, may ultimately contribute to heightened health risk (James 1994; James 2019).

Although John Henryism is deemed culturally-relevant for Black Americans, the original conceptualization of this construct was primarily based on the experiences of Black men. As such, the ways in which this coping style develops and shapes health among Black women has been less

clear. For instance, a recent study demonstrated that two items that denote responsibility for completing jobs or responsibilities on the validated scale used to assess John Henryism may not be relevant for Black women, who face societal constraints that limit opportunities to exercise agency and autonomy in making decisions that are perceived as "choices" by other groups (Adkins-Jackson and Levine 2020). Moreover, although Black women and men tend to report similar levels of John Henryism (James et al. 1983; James 2019), the unique experiences of Black women may shape both how John Henryism develops among this group, in addition to how this coping style differentiates Black women's health from the health of Black men. For example, while John Henryism reportedly increases the risk of cardiovascular disease among Black men, engaging in this coping style generally decreases risk among Black women (Dressler et al. 1998). In turn, these experiences may shape the coping process in unique ways for Black women that (1) do not necessarily occur for Black men, and (2) influence the ways that John Henryism may differentially shape both physical and mental health among this group. However, several gaps limit our understanding of John Henryism's influence on physical and mental health outcomes among Black women, which may shed light on the paradoxical health patterns seen among this group.

1.4 Research Gaps

Research Gap #1: John Henryism has not been examined extensively among women. An individual's social position shapes the types of coping strategies accessible to them and the effectiveness of these coping strategies for health (Pearlin et al. 1981; Meyer, Schwartz, and Frost 2008). Although coping resources may be particularly impactful among socially disadvantaged individuals, there has been limited consideration of these processes among Black women. This is especially evident within the literature on John Henryism, as less is known about the potentially divergent mechanisms through which John Henryism may shape the physical and mental health of

Black women. Given this dearth of knowledge, additional research is needed to clarify the determinants and health consequences of John Henryism among Black women. Clarifying these processes will identify at-risk subgroups, while also distinguishing effective points of intervention in efforts to offset subsequent health risks for Black women.

Research Gap #2: Very little empirical scholarship has been dedicated to understanding how John Henryism may influence mental health. Studies demonstrate that John Henryism may be harmful for physical health, with most scholarship focusing on chronic conditions such as hypertension (James et al. 1983; James 1994; Bennett et al. 2004). However, far less is known about how John Henryism may shape mental health outcomes. According to previous work, a few have found that John Henryism is protective for mental health (Bennett et al. 2004; Kiecolt, Hughes, and Keith 2009; Bronder et al. 2014). In a more recent study, I explored how John Henryism shapes both mental and physical health among Black Americans, finding that it was protective against mental health challenges such as depressive symptoms. At the same time, however, high levels of John Henryism were harmful for the physical health (i.e., allostatic load) of this group (Robinson and Thomas Tobin 2021). Collectively, these findings demonstrate that John Henryism can serve as both a health risk *and* resource for Black Americans, a nuance that is often obscured when physical and mental health domains are not explored in tandem, which has been a common practice. Although my recent study assessed both mental and physical health, I did not assess the mechanisms among Black women specifically. Therefore, to address this gap and to extend prior work, examining the mental *and* physical health implications of John Henryism among Black women is needed.

Research Gap #3: Ethnic differences in John Henryism and its impact on health among Black Americans and women remains unclear. Most health research, including work

focused on John Henryism, considers Black women as a monolith and does not explicitly evaluate the role of ethnicity. However, there are several reasons why consideration of ethnicity would advance our understanding of how John Henryism shapes Black women's health. First, ethnicity has a significant influence on health processes that is distinct from racial and cultural influences. Scholars have noted that race, ethnicity, and cultural influences are important factors to consider when assessing health status (Brown et al. 2013). Although race and ethnicity are habitually conflated, these constructs are, in fact, theoretically distinct. For instance, race is defined as, "a social construct, a social classification based on phenotype, that governs the distribution of risks and opportunities in our race-conscious society" (Jones 2001:300). In contrast, ethnicity refers to "the voluntary grouping of individuals according to shared geographic birth-place and national heritage" (Anderson, 1991; Berreman, 1991; Waters, 1999; Brown et al. 2013: 258).

Thus, ethnicity is a multi-layered status that is reified through socialization processes (Brown et al. 2013). For example, in terms of Black women collectively, this group is considered Black from a racial standpoint, while individual Black women may vary on ethnic backgrounds (i.e., African American women and Caribbean Black women). Both race and ethnicity predispose individuals to a variety of social stressors, given that these components are indicators of social stratification (Brown et al. 2013). Notably, race and ethnicity heavily rely upon both micro and macro-level cultural influences (Brown et al. 2013). These cultural influences shape the ways in which someone sees themselves in relation to their environment and include ways of life that individuals draw upon to address psychological and social circumstances (Brown et al. 2013). The inability to identify existing variation within racial groups is facilitated by subsuming multiple ethnicities into a racial category, thereby fostering an illusion that all individuals categorized as a particular race are identical, which is untrue (Brown et al. 2013). Moreover, within racial groups,

ethnic subgroups have varying cultural influences that they utilize, which can shape health in unexpected ways (Brown et al. 2013).

Second, ethnicity, race, and cultural influences alter the associations of empirically supported determinants of health. Studies have recognized that empirically supported predictors, such as gender, age, and socioeconomic status (SES), vary by race, ethnicity, and cultural influences (Brown et al. 2013). While there have been contributions to the literature in terms of examining the role of ethnicity in shaping health among Black populations (Jones et al. 2020; Erving and Smith 2021; Taylor et al. 2021), particularly through use of the NSAL (2001-2003), additional work is needed. In response to this, scholars have called for more work that assesses within-group variation to clarify trends (Brown et al. 2013). Studies have also documented disparate mental and physical health trends between African American and Caribbean Black women. For example, a significantly higher proportion of African American women report increased odds of obesity and regular alcohol consumption compared to Caribbean Black women (Barrington, James, and Williams 2020). Additionally, African American women report increased rates of PTSD, substance use disorder, anxiety disorder, and suicide ideation compared to Caribbean Black women (Lacey et al. 2015). Researchers have noted that factors such as selection processes, resilience, and cultural practices may, in fact, provide health protection for Caribbean Black individuals from social and environmental stressors (Williams et al. 2007). John Henryism has origins linked to the experience of Black individuals devising a way to address challenges associated with structural racism, and a desire to achieve upward mobility, within the context of the United States following freedom from enslavement (James 1994; James 2019). Given the historical, racial, and sociopolitical context of the construct of John Henryism, in addition to recognition that race, ethnicity, and culture shape stress, coping, and health, it is very possible that:

(1) Black women of different ethnicities engage in John Henryism at varying levels; (2) the factors shaping development of this coping style among Black women vary by ethnicity; and (3) the mechanisms that influence John Henryism's relationship to health among Black women differ by ethnicity; however, this is an underexplored area of research.

To address these limitations, this dissertation examined the relationships between John Henryism and health among African American and Caribbean Black women collectively, while also exploring these relationships among Caribbean Black women specifically.

CHAPTER TWO: BACKGROUND

2.1 The Origins of John Henryism

Dr. Sherman James, an epidemiologist, developed the construct of John Henryism in the early 1980s. He was inspired by several sources, including the folk tale of John Henry the "steel-driving man," a Black rail worker, who notably competed with a machine to drive steel for railroad construction. As this was during the period of industrialization in the U.S., some propose that John Henry's actions were an attempt to reify the necessity of human beings in the workforce and were likely driven by a need to maintain gainful employment and financial resources (James et al. 1983; James 1993; James 1994). Although he ultimately beat the machine, John Henry supposedly collapsed and died right after the challenge from expending all his mental and physical resources (James et al. 1983; James 1994). For Dr. James, this tale underscored the long-term, and often detrimental, consequences of high effort coping for the body.

Another source of inspiration for the John Henryism construct was a former sharecropper coincidently named John Henry Martin, who Dr. James met in North Carolina. By the time Dr. James met Mr. Martin in the late 1970s, his health had already prematurely deteriorated due to his persistent efforts to achieve upward mobility during the Jim Crow era (James 1994; James 2019). By the age of 40, Mr. Martin notably owned almost 80 acres of farmland (James 1993). However, before he reached the age of 60, Mr. Martin had already suffered from multiple chronic health conditions, including cardiovascular disease and peptic ulcer disease (James 1993). A year after meeting Mr. Martin, Dr. James came across a commentary published by Dr. Leonard Syme. The article posited a causal relationship between persistent high-effort coping and increased risk for cardiovascular disease among Black Americans, particularly Black American men (James 2019); however, there was a need to complete an empirical evaluation of this hypothesis. This call-to-

action motivated Dr. James to develop the construct of "John Henryism" to pay homage to John Henry Martin and to bring awareness to the broader societal, cultural, and historical context that shaped Mr. Martin's life, as well as the complex realities and health status of Black people in America (James 1993; James 1994).

2.2 Determinants of John Henryism

2.2.1 Sociodemographic Characteristics

Previous research has outlined the ways that variations across sociodemographic characteristics influence the availability of psychosocial resources and coping styles such as John Henryism (Turner and Roszell 1994; Turner et al. 2004). Studies note that individuals who hold a disadvantaged social status (e.g., members of minoritized racial-ethnic groups, women, and low SES individuals) typically report having fewer coping resources available (Turner and Roszell 1994; Thoits 1995). Despite scholarship demonstrating the ways in which John Henryism shapes mental and physical health, there has been limited consideration of factors that shape the development of this coping style, particularly among ethnic subgroups of Black women. Since Black women experience distinct risks that uniquely shape their health, identifying these factors will provide important new insights for promoting mental and physical well-being among these groups.

Relatedly, SES has been shown to be important for the development of John Henryism. Those with low educational attainment or blue-collar employment typically report higher John Henryism scores compared to individuals with high educational attainment or white-collar employment (James et al. 1983; Subramanyam et al. 2013; James 2019). Additionally, the John Henryism Hypothesis (*JHH)* suggests that low SES individuals who consistently engage in this form of high-effort coping experience an increased risk of developing cardiovascular disease, in

part, due to engaging in active coping without adequate financial resources to overcome challenges (James et al. 1983; James 1994; James 2019). Yet, only a few have considered the *JHH* among Black women. Interestingly, two studies found that among low SES (but not among high SES) African American women, engaging in low John Henryism contributed to an elevated risk for hypertension (Dressler et al. 1998; Subramanyam et al. 2013). These nuances emphasize the need for further research to evaluate the extent to which the *JHH* extends to Black women, while also considering a broader range of health outcomes.

Age is an additional sociodemographic characteristic that may impact the development of John Henryism; however, this, too, has been underexplored in prior research. Most studies that evaluate John Henryism simply adjust or control for age rather than assessing the age patterns in this coping style. In one exception, Mujahid and colleagues (2017) found that John Henryism scores are highest among older men in Finland as compared to middle-aged men. However, it is unclear whether these patterns extend to Black women in the United States. Nevertheless, since John Henryism is considered a form of problem-focused coping, the broader literature on the age patterning of problem-focused coping may provide valuable insight into to age patterns of John Henryism for this population. For instance, previous findings demonstrate that older adults are less likely to engage in problem-focused coping compared to younger adults (Folkman et al. 1987; Chen et al. 2018). One study also found no relationship between age and problem-focused coping; however, this study's sample was limited to individuals aged 45-64 (Folkman and Lazarus 1980). Given these inconsistent findings, it is unclear whether John Henryism scores may increase, decrease, or remain stable over time among Black women, or whether these trends differ across ethnic subgroups. To this end, there is a need to evaluate the ways in which age shapes the development of John Henryism among Black women.

2.2.2 Social Stressors

In addition to sociodemographic characteristics, psychosocial factors such as social stressors may also be important determinants of John Henryism among ethnic subgroups of Black women. Although this has not been previously examined, scholars have identified that both everyday stress experiences and early life socialization processes heavily influence the development of one's psychosocial resources and coping styles (Pearlin et al. 1981; Pearlin 1989; Thoits 2010; Gayman et al. 2014). Prior work has shown that individuals who engage in high levels of John Henryism tend to report low levels of perceived stress (James et al. 1992; James 2019). Additionally, a recent study found that high goal-striving stress is associated with increased levels of John Henryism among African Americans (DeAngelis 2020). Considering that Black women face distinct risks and social experiences, it is possible that these linkages are distinct among Caribbean Black women. Nonetheless, the associations between social stressors and John Henryism have not been examined among African American and Caribbean Black women specifically. Consequently, there is a need to clarify the social stressors that shape development of John Henryism among these groups. Doing so will not only provide knowledge about the shared and distinct social stressors that Black women face, but it would also elucidate how these factors may differentially shape the development of John Henryism among these groups.

2.3 John Henryism and Health among Black Americans

2.3.1 Mental Health

Only a handful of studies have examined the association between John Henryism and mental health and their findings are mixed. Previous research has hypothesized that high levels of John Henryism are psychologically protective because it provides individuals with greater mental fortitude to persevere through difficult times (Bennett et al. 2004; Robinson and Thomas Tobin

2021). This is consistent with the findings of several studies. For example, Kiecolt and colleagues (2009) found that higher levels of John Henryism are linked to improved mental health for low SES Black Americans. Similarly, Bronder and colleagues (2014) found that John Henryism is negatively related to depressive symptoms among Black women. However, others posit that John Henryism may adversely impact mental health for the same reasons, given that persistent, high-effort coping requires a great deal of control, which may become psychologically taxing overtime. For instance, Hudson and colleagues (2016) found that high levels of John Henryism are positively associated with depression among Black Americans. Given these mixed findings, it is unclear how John Henryism shapes the mental health of Black individuals. Moreover, since Black women face distinct health risks, it is possible that the experience of these challenges impacts the processes that shape Black women's mental health in ways that diverge from documented patterns. Taken together, there is a need to clarify how John Henryism shapes mental health among Black women.

2.3.2 Physical Health

Research assessing the links between John Henryism and physical health generally indicates that John Henryism is detrimental for physical health. Some studies suggest that high-effort coping can be physiologically strenuous, which contributes to increased stress on the body that eventually results in less-than-optimal physical health (James 1983; James 1994; Bennett et al. 2004; Robinson and Thomas Tobin 2021). Others have emphasized the role of John Henryism in helping individuals to effectively manage stressful experiences (Kiecolt et al. 2009; Robinson and Thomas Tobin 2021). However, most only focus on specific physical health outcomes such as hypertension. For example, prior work has demonstrated that John Henryism increases risk for hypertension and cardiovascular disease-related outcomes (James et al., 1983; James, 1994).

At the same time, John Henryism may indirectly shape physical health by influencing health behaviors. For instance, Lehto and Stein (2013) found that John Henryism is beneficial for health behaviors, as it promotes healthy diet, management of stress, consistent medical check-ups, alcohol consumption, smoking, and exercise among Black American men. Nevertheless, the ways in which John Henryism shapes physical health among Black women is poorly understood. Since Black women navigate multiple systems of oppression simultaneously and face distinct social stressors, it is possible that collectively, these circumstances condition the physical health impact of John Henryism in ways that conflict with previous knowledge.

2.3.3 Joint Mental and Physical Health

Largely, these findings underscore the need to evaluate the ways that John Henryism shapes both mental and physical health among Black women. Prior work that examines John Henryism's association with health among Black individuals has largely demonstrated that this coping style is protective for mental health, yet harmful for physical health. For instance, Hudson and colleagues (2016) found that John Henryism is protective against depression among Black Americans, while John Henryism has been shown to increase the risk for cardiovascular disease via hypertension in many studies (James et al. 1983; James 1994; Bennett et al. 2004). A recent study examining John Henryism's association with mental and physical health among Black Americans also found that John Henryism is protective against depressive symptoms, while also linked to higher allostatic load or physiological dysregulation among this group (Robinson and Thomas Tobin 2021). While these findings collectively demonstrate that John Henryism can be both a protective and risk factor for Black American health, these trends may not accurately account for the divergent realities of ethnic subgroups of Black women.

2.3.4 John Henryism and Black Women's Health

Among the limited body of research focused on Black women, scholars have found that John Henryism is generally protective for mental health (Bronder et al. 2014). However, findings are somewhat mixed with respect to John Henryism's association with physical health among Black women. For example, one study found that while John Henryism increased the risk for hypertension among Black men, John Henryism decreased the risk for hypertension among Black women (Dressler et al. 1998). Conversely a systematic review that assessed findings focused on examining the *John Henryism Hypothesis (JHH)* among Black women found that while some studies empirically support the *JHH*, others find evidence opposite of the *JHH*, and others do not find an association at all (Felix et al. 2019). Considering these trends, our understanding of how John Henryism shapes health among Black women remains limited because no studies have assessed how John Henryism shapes the health of ethnic subgroups of Black women, such as Caribbean Black women. Given that race, ethnicity, and cultural influences change the relationships of empirically supported predictors of health status (Brown et al. 2013), and contributes to differences in how resources and coping styles develop (Gayman et al. 2014; Assari 2019), there is a clear need to clarify how John Henryism may distinguish the health of Caribbean Black women.

2.4 Caribbean Black Immigration and the Second-Generation

To elucidate how ethnicity may influence links between John Henryism and the health of among Caribbean Black women in the United States, it is important to understand the history and immigration processes of Caribbean Black women. Historically, many Caribbean Black immigrants have migrated to the United States for opportunities to achieve upward mobility (Ho 1995). This is of particular importance, given that in the Caribbean, higher SES confers significant social benefits, and the United States has a reputation of being a place for opportunities (Ho 1995).

Most Caribbean Black immigrants to this country are from Haiti, Jamaica, the Dominican Republic, and Trinidad and Tobago (Thomas 2012). Although Caribbean Black immigrants come from different countries, there is often a shared Caribbean experience and identity that research suggests contributes to their distinct social patterns and outcomes relative to African Americans (Turner 2013; Brown et al. 2013). Black immigrants, particularly Caribbean Black immigrants who arrived in the U.S. between the 1960s and 1990s, gave rise to a 25% increase in the Black population in the U.S. (Lorick-Wilmot 2014). Notably, there are 4.4 million Caribbean Black immigrants in the U.S., and women comprise a large proportion (over 50%) of this group (Thomas 2012; Zong and Batalova 2019; Erving and Smith 2021). While there has been a plethora of work assessing the experiences of first-generation immigrants from the post-1965 "new immigration wave", there has been limited examination of the new second-generation (U.S. born children of post-1965 immigrants), with even fewer focusing on the experiences of second-generation Caribbean Black immigrants from their perspectives (Portes and Zhou 1993; Lorick-Wilmot 2014).

At the same time, the work that has focused on second-generation immigrants, particularly Caribbean Black immigrants has been somewhat problematic. For example, the concept of segmented assimilation, put forth by Portes and Zhou (1993) posits that since second-generation immigrants navigate distinct societal contexts, developments, and challenges compared to their first-generation parents (Rumbaut 1994), the process for assimilation into mainstream society (U.S.) is segmented with three possibilities. One possibility is "upward assimilation" into the middle class, a second is "downward assimilation" into the lower class, and a third is achieving upward mobility while maintaining ties to one's culture and heritage (Portes and Zhou 1993). With respect to second-generation Caribbean Black immigrants, Portes and Zhou (1993) suggest that

because these groups reside in neighborhoods where disenfranchised minoritized individuals live, such as African Americans, second-generation Caribbean Black immigrants are exposed to the "adversarial subculture" developed by these groups to navigate these challenges, which leads them to downward assimilation. Nevertheless, this is an oversimplification of the situation at hand. For instance, other work conducted in this area has found that experiences of racism, and pressure to assimilate by white individuals and other racial and ethnic immigrant groups is extremely impactful for (Caribbean) Black immigrants (Lorick-Wilmot 2014). More specifically, researchers acknowledge that these stark contradictions are most felt by Caribbean Black immigrants and their children, given that the process for assimilation in the U.S. for them connotes being categorized with African Americans, who have been historically marginalized (Portes and Rumbaut 1996; Waters 1999; Kasinitz, Mollenkopf, and Waters 2002; Rumbaut 2004).

Given these experiences, second-generation Caribbean Black immigrants often report that they occupy a unique space of "in-betweenness" because they do not always ascribe to their first-generation parents' worldview on a variety of topics (Lorick-Wilmot 2014). Due to a lack of blatant signifiers of their immigrant status, this group is also often assumed to be African American, which significantly impacts how they navigate American society (Lorick-Wilmot 2014). Consequently, second-generation immigrants often gain a sense of transnational racial consciousness, or double consciousness. Double consciousness refers to an ongoing psychological process for Black individuals that involves negotiating and navigating the world as a racialized individual, with a keen awareness of how one is externally perceived, how one views themselves, and the ways in which these two perspectives conflict (DuBois 1903; Itzigsohn and Brown 2020).

Thus, despite achieving upward mobility, many second-generation Caribbean Black immigrants report that persistent feelings of "in-betweenness" poses significant challenges for

navigating society. On the one hand, this group can achieve economic success and have access to opportunities as their first-generation immigrant parents have desired (Lorick-Wilmot 2014). On the other hand, these successes and opportunities are juxtaposed with changing racial and economic systems that have been designed to limit the success of second-generation Caribbean Black immigrants and other groups (Lorick-Wilmot 2014). For second-generation Caribbean Black women, this discrepancy is further convoluted by the pressure to adhere to expected gender roles that differ from men (Lorick-Wilmot 2014), which is most pronounced in terms of being a wife, daughter, mother, and how these roles have been used to define womanhood by their first-generation immigrant parents and other family. Taken together, it is possible that with these unique experiences and histories, John Henryism may distinctly shape the mental and physical health of Caribbean Black women.

CHAPTER THREE: THEORETICAL APPROACHES

To address the limitations of prior research, there is a need for a new theoretical approach to understand how John Henryism shapes the mental and physical health of African American and Caribbean Black women. As such, this dissertation draws upon four theoretical perspectives (see Figure 1): (1) Modern African Diaspora, (2) Black Feminist Thought, (3) Transactional Theory of Psychological Stress and Coping (TTPSC), and (4) Social Stress Theory (SST). Modern African Diaspora and Black Feminist Thought provide the broader cultural and historical context needed to address these issues, while TTPSC and SST help to explain the psychosocial processes that shape John Henryism and subsequent health. As such, the integration of these perspectives provides a more comprehensive way of evaluating the development and health significance of John Henryism among ethnic subgroups of Black women.

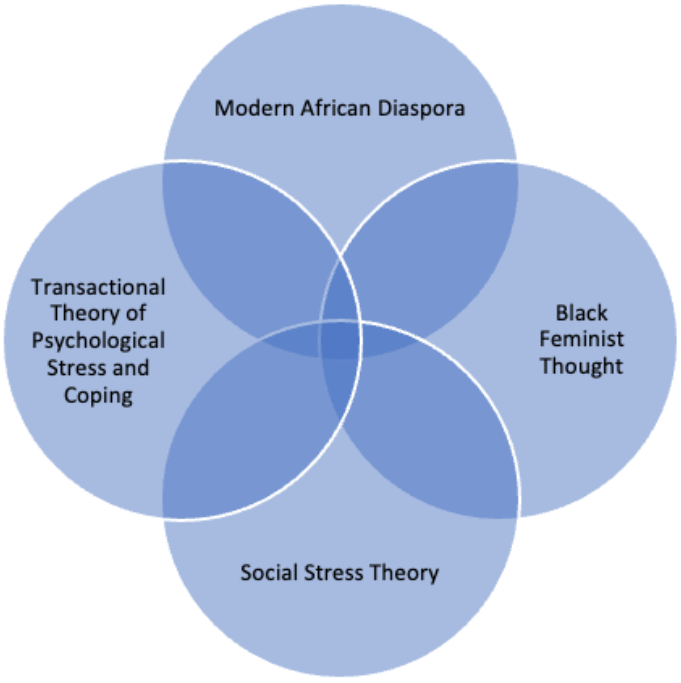


Figure 1: Integrated Perspectives Guiding this dissertation.

3.1 Modern African Diaspora

> *The modern African diaspora, at its core, consists of the millions of peoples of African descent living in various societies who are united by a past based significantly but not exclusively upon "racial" oppression and the struggles against it and who, despite the cultural variations and political and other divisions among them, share an emotional bond with one another and with their ancestral continent and who also, regardless of their location face broadly similar problems in constructing and realizing themselves (Palmer 2000:30).*

As can be gathered from the quoted definition, the modern African diaspora is vastly complex. The most notable diasporic avenue has been the Trans-Atlantic Slave Trade, which took place between the years of 1529 and 1850 (Bertocchi 2016; Jones 2018). More than twelve million African people, primarily from the coasts of West Africa, were kidnapped, ripped away from their loved ones, and forcibly shipped like chattel through the Middle Passage over the Atlantic Ocean to endure hundreds of years of involuntary servitude (Bertocchi 2016; Jones 2018). This process has fostered the intergenerational geographic separation of people of African descent and has produced an unknown degree of trauma. Despite these challenges, people of African descent have largely been able to recreate their culture(s) in ways that honor their ancestry and lived experiences.

Nonetheless, the historical legacies of racial capitalism and exploitation have prompted many throughout the Caribbean to relocate to areas that are thought to provide more substantial opportunities for upward mobility, such as the United States (Portes and Zhou 1993; Ho, 1995; Waters 1999). Immigration processes distinctively shape, and sometimes alter the life chances and health of those who relocate, as well as subsequent generations (Bashi and McDaniel 1997). However, given the existence of the modern African Diaspora, there is a level of shared consciousness and linked fate (Collins 2000) among people of African descent. This shared consciousness and linked fate is important to consider, particularly among Black women overall and Caribbean Black women more specifically. As their life experiences and socialization

processes may differentially shape the development of unique coping tools (Pearlin et al. 1981; Thoits 2010; Gayman et al. 2014). Black Feminist Thought provides the modern context for understanding these linkages.

3.2 Black Feminist Thought

Black Feminist Thought, originally coined by Dr. Patricia Hill Collins (2000), is a domain of knowledge and knowledge production grounded and centered in the lived experiences of Black women that provides insight into the shared and distinct social experiences of African American and Caribbean Black women. Black Feminist Thought is characterized by a few distinguishing features, particularly that there exists a "Black *women's* collective standpoint" (Collins 2000). In other words, this collective standpoint, informed by intragroup tensions that develop into different ways of addressing common difficulties, is a way of challenging monolithic perspectives of Black women's oppositional knowledge (Collins 2000). When this perspective is considered from an African diasporic and transnational perspective, it suggests that despite being spread across the world in different contexts, Black women experience the same challenges no matter where they are, though these challenges may be expressed in different ways (Collins 2000). These struggles include violence, poverty, inequitable access to education, and other forms of ongoing chronic stress (Combahee River Collective 1977; Collins 2000; Erving and Smith 2021). A key distinction, however, lies in the specific historical context in which various groups of Black women navigate these challenges. For example, perceptions of womanhood from an African American perspective are specific to the history of involuntary migration to and enslavement in the U.S. (Collins 2000). Likewise, it would stand to reason that the perception of womanhood from a Caribbean Black perspective are specific to the history of involuntary migration to and enslavement in the Caribbean—a perspective and lived experience that may be particularly salient for second-

generation Caribbean Black women immigrants in the U.S. Consequently, it is possible that the ways in which shared challenges are expressed among African American and Caribbean Black women may perhaps shape the development of coping styles such as John Henryism in distinct ways, as well as how this coping style ultimately shapes mental and physical health.

As previously noted, scholars have identified that both everyday stress experiences and early life socialization processes heavily influence the development of one's psychosocial resources and coping tools (Pearlin et al. 1981; Pearlin 1989; Thoits 2010; Gayman et al. 2014). Given that second-generation Caribbean Black women do not experience the process of migration to the U.S., but instead are children of those who did, it is possible that the antecedents of this transition, along with feelings of "in-betweenness," pose unique challenges for this group in terms of navigating group identity and stressors within the U.S. context. On one hand, despite being racialized as "Black" in the United States, second-generation Caribbean Black women may remain connected to their parents' ethnic identities and origins (Ida and Christie-Mizell 2012). On the other hand, it is also possible that living in the United States socializes second-generation Caribbean Black women to develop coping styles like those of other Black women in the United States (e.g., John Henryism) to counter the adverse impacts of social and environmental stressors, including racism (Ida and Christie-Mizell 2012). However, this has been underexplored in the literature. To this end, additional work is needed to investigate how John Henryism may differentially influence the health patterns of Caribbean Black women. Assessing these patterns may shed light on the distinct coping and health mechanisms among ethnic subgroups of Black women. The Transactional Theory of Psychological Stress and Coping provides foundational context for understanding coping processes and how they shape health.

3.3 Transactional Theory of Psychological Stress and Coping

The Transactional Theory of Psychological Stress and Coping helps to further explain psychosocial coping processes and how they shape subsequent health and provides context for examining the direct links between John Henryism and health among African American and Caribbean Black women.

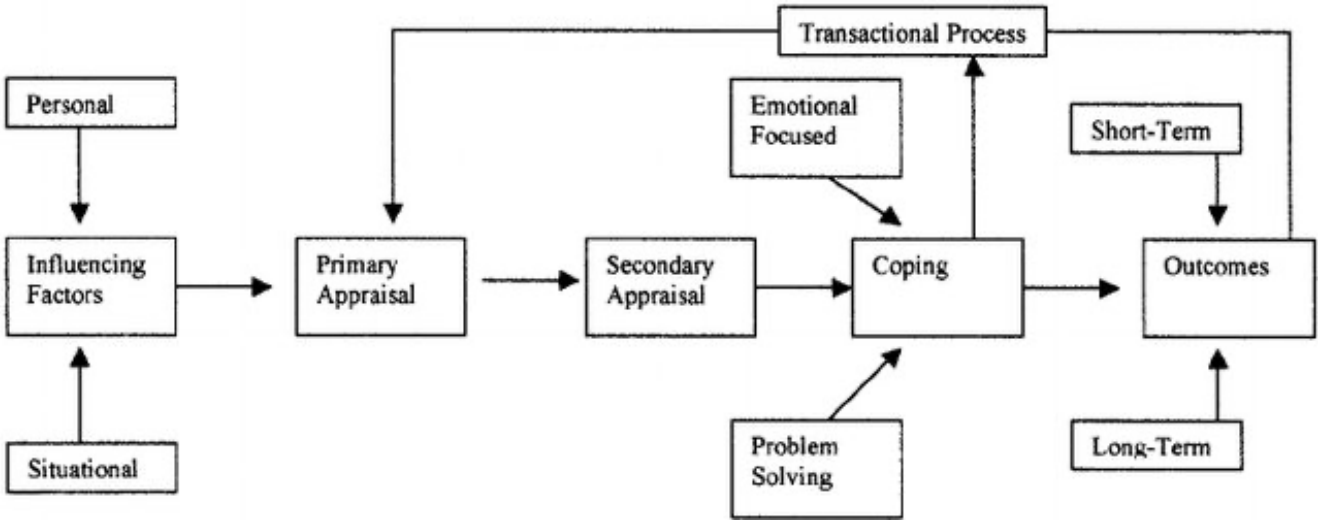


Figure 2: Transactional Theory of Psychological Stress and Coping (TTPSC; Lazarus and Folkman 1984; Schuster, Hammitt, and Moore 2003)

3.3.1 Overview of The Transactional Theory of Psychological Stress and Coping

The Transactional Theory of Psychological Stress and Coping (TTPSC) (Figure 2), developed by Lazarus and Folkman (1984), is a cognitive-relational metatheory of coping and emotion. This metatheory underscores the processes of stress and coping among individuals, while emphasizing the relationship between an individual and their environment. Specifically, the TTPSC posits that individuals consistently appraise their relationship with their environment to determine whether a threat is present (Lazarus and Folkman 1987). There are two different types of stress appraisal that an individual conducts when faced with a potentially stressful event: primary appraisal and secondary appraisal.

The primary appraisal process considers the importance of an event and whether it shapes—or could shape—an individual's well-being (Lazarus and Folkman 1987). Specifically, in primary appraisal, individuals assess whether there is harm (i.e., threat that has already been faced), threat (i.e., harm that an individual anticipates), or challenge (i.e., an opportunity for control or advantage) (Lazarus and Folkman 1984). Based on the results of this primary appraisal process, individuals then engage in secondary appraisal (Lazarus and Folkman 1984). Within secondary appraisal, an individual first assesses the coping styles to which they have access (Lazarus and Folkman 1984). Following this, individuals evaluate whether the available coping styles will help them to successfully address the circumstance (Lazarus and Folkman 1984). Lastly, the individual takes into consideration the likelihood that they can effectively utilize the coping style(s) identified to address the circumstance (Lazarus and Folkman 1984; 1987).

Lazarus and Folkman (1984) also identify two categories of coping styles: problem-focused coping and emotion-focused coping. Problem-focused coping occurs when an individual actively engages with themselves or their environment with the goal of changing the perceived unfavorable person-environment connection (Lazarus and Folkman 1984). Rather than actively addressing the issue, emotion-focused coping involves efforts taken by an individual to change their emotional response to the stressor, which may include minimizing the significance of or avoiding the challenge, despite overall circumstances remaining the same (Lazarus and Folkman 1987). Lazarus and Folkman explicitly note that between problem-focused and emotion-focused coping styles, one is not superior or more efficacious than the other (Lazarus and Folkman 1987). Rather, feelings of psychological distress may arise if an individual does not have access to coping styles to address the identified stressor, or if they feel concerned about their ability to successfully employ a particular coping style to address the stressor (Lazarus and Folkman 1984; 1987).

Nevertheless, utilizing any coping style still has significant implications for their mental and physical health.

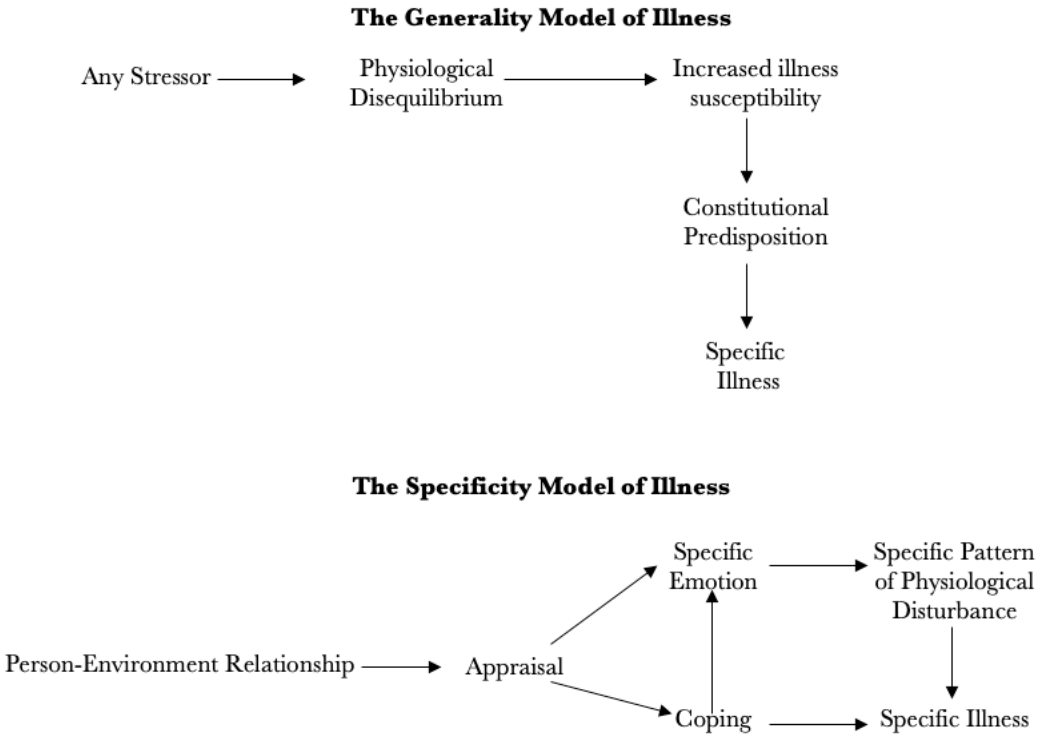


Figure 3: The Generality Model of Illness and The Specificity Model of Illness Source: (Lazarus and Folkman 1984)

3.3.2 John Henryism and the Pathways Linking Coping and Health

Lazarus and Folkman also highlight three distinct pathways linking coping to subsequent adverse health outcomes (Lazarus and Folkman 1984) (Figure 3), which sheds light on the ways that John Henryism impacts health. Pathway #1 suggests that coping can shape the "frequency, intensity, duration, and patterning of neurochemical stress reactions" (Lazarus and Folkman 1984: 215), and it operates via three different mechanisms: (1) by failing to avert or diminish the adverse environmental circumstances; (2) by failing to control emotional distress when encountering threat and/or harm in an environment that the individual can't change; and (3) when individuals hold

values and/or engage in a coping style that are themselves perpetually active in a detrimental way (Lazarus and Folkman 1984).

Pathway #1. The first mechanism of Pathway #1 emphasizes the shortcomings of problem-focused coping. Specifically, Lazarus and Folkman note that failing to avert or diminish the adverse environmental circumstances could potentially heighten the unpleasantness of a circumstance, which could in turn intensify neurochemical stress reactions (Lazarus and Folkman 1984). The second mechanism of Pathway #1 linking coping to health focuses on emotion-focused coping. The specific challenges here generally relate to the inadequacies of emotion-focused strategies, such as disengaging, which at the core seek to reduce mobilization, or other strategies that promote either mobilization or stagnation (Lazarus and Folkman 1984). The third mechanism of Pathway #1 points to individuals who have certain characteristics, like a Type A personality, for example. Type A is thought of as both a personality type as well as a coping style. Individuals who are considered Type A typically cope with environmental challenges to be determined and to thrive by facilitating a way of life that helps them to manage potential difficulties, while internalizing these efforts (Lazarus and Folkman 1984). For instance, studies have demonstrated that the risk of cardiovascular disease and heart attacks is higher among Type A individuals, a relationship that is mediated through high blood pressure (Lazarus and Folkman 1984; Haynes, Feinleib, and Kannel 1980).

John Henryism fits within Pathway #1 via the first and third mechanisms. John Henryism is defined as a high-effort and active coping style that is employed to address psychosocial and environmental stressors (James et al. 1983). John Henryism would also be considered a form of problem-focused coping. To reiterate the first mechanism, failing to avert or diminish the adverse environmental circumstances can ultimately intensify neurochemical stress reactions (Lazarus and

Folkman 1984). Related to this point, the John Henryism Hypothesis (*JHH*) suggests that low SES individuals who engage in persistent high-effort coping may experience an elevated risk of developing chronic health conditions, such as hypertension (James et al. 1983), due to a lack of resources. As such, low SES individuals with a coping style characterized by high levels of John Henryism may be particularly vulnerable to subsequent poor health, further exacerbated by the adverse environmental circumstances that they face due to structural constraints.

Furthermore, the third mechanism considers how individuals cope with environmental challenges and thrive by facilitating a way of life that helps them to manage potential difficulties. Yet, as these efforts are not often sustainable, individuals may internalize these efforts (Lazarus and Folkman 1984), which is associated with increased risk for cardiovascular disease. Similarly, at its core, John Henryism is about hard work, determination, and perseverance in the face of environmental stressors (James et al. 1983; James 1994). Additionally, scholars previously posited that John Henryism could be a personality predisposition (James et al. 1983). Moreover, scholars have shown that John Henryism is associated with increased risk for cardiovascular disease, and allostatic load (i.e., physiological dysregulation) (James 1994; Bennett et al. 2004; James 2019; Robinson and Thomas Tobin 2021).

Pathway #2. The second pathway through which coping may influence health emphasizes the role of maladaptive health behaviors. Specifically, the authors note that "coping can affect health negatively, increasing the risk of mortality and morbidity, when it involves excessive use of injurious substances such as alcohol, drugs, and tobacco, or when it involves the person in activities of high risk to life and limb" (Lazarus and Folkman 1984:216). For example, an individual may engage in drinking alcohol, smoking cigarettes, and/or substance use in efforts to

diminish the adverse psychological impacts of stress exposure, while simultaneously increasing risk for physical health challenges (Lazarus and Folkman 1984).

A framework that posits a similar process and relationship is the Environmental Affordances (EA) Model, developed by the late Dr. James S. Jackson and colleagues (2010). This model suggests that health-related coping strategies that an individual monitors themselves, such as utilizing substances and eating an unhealthy diet are psychologically protective, while physiologically harmful (Mezuk et al. 2013). Thus, John Henryism may also reflect Pathway #2, given that evidence suggests that this coping style is simultaneously harmful for physical health, while protective for mental health (James et al. 1983; Kiecolt et al. 2009; James 2019; Robinson and Thomas Tobin 2021). More specifically, while John Henryism provides individuals with the mental fortitude to address stressors, this process is physiologically taxing. Thus, prolonged engagement in this coping style can pose significant challenges to physical health.

Pathway #3. The third and final pathway between coping and health suggests that, "emotion-focused forms of coping can impair health by impeding adaptive health/illness-related behavior" (Lazarus and Folkman 1984:217). Thus, this pathway emphasizes the ways that coping can shape health-protective behaviors. Although John Henryism is not considered emotion-focused, there is empirical evidence to suggest that this coping style falls within the purview of Pathway #3 discussed here. For example, a study found that Black women who engage in John Henryism are less likely to seek treatment for substance use disorder (Stevens-Watkins et al. 2016). In other words, pathway #3 operates via the avoidance of challenges, which diminishes feelings of emotional distress for an individual, while concurrently preventing them from actively addressing a challenge that is amenable to action.

Overall, the TTPSC strengthens our understanding of the relationship between John Henryism and health among Black women in several ways. First, the TTPSC underscores that the cognitive appraisal of stressors is important, given that all events may not be universally perceived as stressful, and as a result, have different influences on health across individuals. Second, the TTPSC conceptualizes coping as an ongoing process, as opposed to a state of being at a single point in time (Lazarus and Folkman 1984) and distinguishes two specific forms: emotion-focused and problem-focused (Lazarus and Folkman 1984). John Henryism is a form of a "problem-focused" coping, given that it involves an individual actively engaging with the environment or themselves to alter the adverse person-environment relationship (Lazarus and Folkman 1984). Thus, recognizing that John Henryism as a form of coping is also a process that is shaped by individuals' experiences across the life course, allows for a deeper understanding of its impact on health. Lastly, the TTPSC comprehensively outlines three specific pathways linking coping to the onset of adverse health outcomes (Lazarus and Folkman 1984). As such, this perspective also sheds light on the varied ways through which John Henryism may contribute to differential health patterns among Black women.

Despite these advances, the TTPSC has limitations as well. For example, this theory focuses primarily on individual-level processes, which means that the broader population health implications for coping are unclear. Additionally, this theory does not specify the roles of racism, race, or ethnicity in shaping coping and health processes, which is particularly important given the populations of interest for this dissertation. Nevertheless, some of these limitations have been addressed with Social Stress Theory.

3.4 Social Stress Theory (Stress Process Model)

Social Stress Theory also helps to explain psychosocial processes and how they shape subsequent health and will provide context for examining the links between John Henryism and health among Black women.

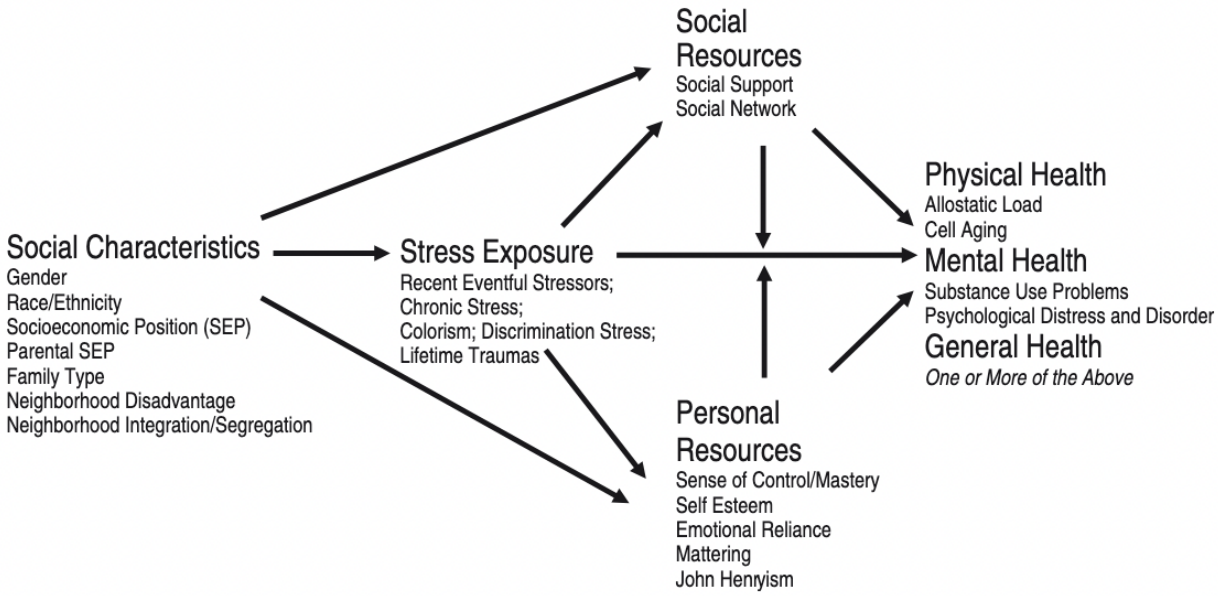


Figure 4: Stress Process Model (SPM; Turner 2010)

3.4.1 Overview of Social Stress Theory

The Social Stress Theory (SST) applies the TTPSC to understand how differential exposure to social stress can contribute to physical and mental health disparities at the population-level (Pearlin et al. 1981). To this end, the SST posits that those with a disadvantaged social status experience increased exposure to stressors and may be more vulnerable to its effects due to their limited access to psychosocial coping tools (Pearlin et al. 1981; it also proposes that these experiences place underprivileged groups at an increased risk to develop psychiatric disorder and other illnesses (Pearlin et al. 1981; Wheaton 1994). Moreover, the SST suggests that social structures and the positions in which people are located cannot be separated from their health (Pearlin et al. 1981), such that social structures are systems in which resources are unequally allocated, which in turn impacts the types, frequencies, ability to respond, and outcomes of social

stressors for various communities (Pearlin et al. 1981). Thus, the ability to identify these forms of stressors and their impact increases the ability to develop prevention and intervention measures.

The Stress Process Model (Pearlin et al. 1981; 1989) (see Figure 4) provides a visual representation of SST and outlines its key constructs and pathways. There are three central elements highlighted within the stress process: stressors, moderators, and outcomes (Pearlin et al., 1981). Briefly, stressors include the issues or challenges that inhibit the ability for individuals to adapt to circumstances, which can include chronic or ongoing stressors, lifetime trauma, life events, or discrimination (Pearlin et al. 1981). Moderators are the personal and social resources individuals utilize to mitigate or buffer the impacts of these stressors. Examples of personal resources include constructs such as mastery (i.e., control), mattering (i.e., how much one believes they matter), racial identity (i.e., the degree to which someone's race is important to their identity; the closeness they feel to those of their race), and John Henryism (i.e., high-effort coping) (Pearlin et al. 1981; James, et al. 1983). The most commonly assessed social resource is social support, which is generally defined as the degree to which someone perceives support from their social networks (Pearlin et al. 1981). Overall, these resources exist on a continuum, and the level and/or presence or absence of these resources pose distinct risks for poor health outcomes among various individuals and communities. Finally, outcomes refer to the observed impacts of stressors that are present after accounting for available and accessible resources, which usually encompasses health outcomes such as (but not limited to) psychological distress, psychiatric disorder, physiological dysregulation, and chronic health conditions (Pearlin et al. 1981; Turner and Avison 2003).

3.4.2 Social Stress Theory and John Henryism

SST provides valuable insights for understanding the relationship between John Henryism and health among Black women. SST explicitly specifies the roles of sociodemographic

characteristics, such as race and ethnicity in shaping coping and health. This perspective is very important given the populations of interest for this dissertation are African American and Caribbean Black women. In addition, SST indicates that personal and social resources are moderators in the relationship between stress and health. This conceptualization is important for understanding potential pathways through which John Henryism shapes mental and physical health among Black women, as in the context of SST, John Henryism would be categorized as a personal resource that exists on a continuum. Lastly, SST underscores the broader population health implications for stress, coping, and health.

However, there are some limitations to SST that warrant discussion. For instance, while SST considers how stress exposure contributes to differential health outcomes, SST does not account for the appraisal of social stressors (Pearlin et al. 1981; Turner 2013). Additionally, it does not distinguish coping from resources, and since few have conceptualized "negative" resources (i.e., higher levels confer risk), the SST may not fully capture the role of John Henryism in the stress process. More specifically, given that prior research has indicated that John Henryism can be both a risk and resource for health (Robinson and Thomas Tobin 2021), it is possible that John Henryism more adequately fits within a separate domain for which SST does not currently account. Since Black women report increased exposure to social stressors such as gendered racism, financial strain, and everyday discrimination, in addition to disproportionate rates of chronic health conditions (Woods-Giscombé 2010; Woods- Giscombé et al. 2016; Erving et al. 2018), it is imperative that we assess John Henryism as a coping mechanism among this group to clarify the role of stress and coping in shaping health outcomes among this group.

Therefore, to shed light on the ways in which John Henryism shapes the health of Black women, a few limitations should be addressed. First, John Henryism's association with both

physical and mental health should be assessed among Black women, given the dearth of published findings and somewhat mixed information available on this topic. Second, this examination must be done with the explicit recognition of Black women as a heterogeneous group, which necessitates the assessment of ethnicity, among other factors. This has posed a major challenge because most research assessing the health challenges faced by Black women does not disaggregate by ethnicity, which masks trends. Finally, the factors shaping John Henryism among Black women need further elucidation, since present work does not typically disaggregate by gender. To address these gaps, a new theoretical and integrated approach is needed that draws upon TTPSC and SST.

CHAPTER FOUR: CONCEPTUAL FRAMEWORK

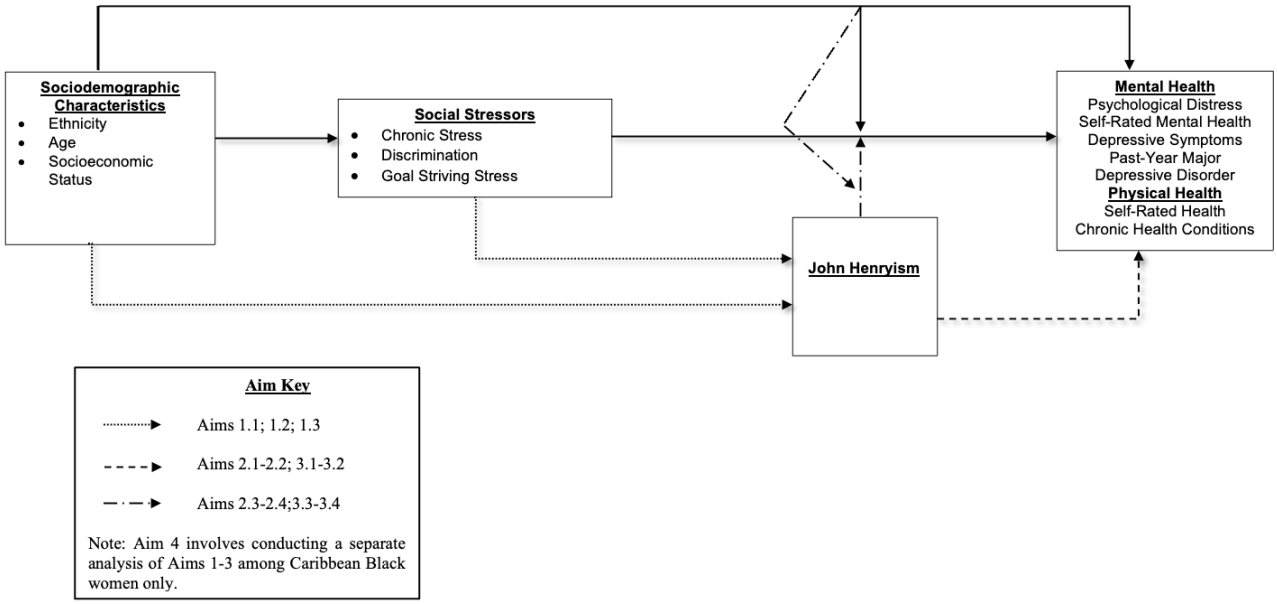


Figure 5: Conceptual Model for assessing the relationship between John Henryism and Mental and Physical Health among Black women.

4.1 Overview of Conceptual Model

The conceptual model (Figure 5) for assessing the relationship between John Henryism and health among Black women integrates SST and TTPSC. While it should be noted that John Henryism is importantly shaped by contextual factors and psychosocial resources, these linkages are beyond the scope of this dissertation, which will focus on clarifying primary health mechanisms. The proposed conceptual model includes four different components: (1) John Henryism as the key focal variable of interest; (2) mental and physical health outcomes; (3) sociodemographic characteristics; and (4) social stressors. The proposed linkages among the constructs in the conceptual model are based on the specific components of SST and TTPSC.

4.1.1 Health Outcomes

Given that the TTPSC indicates multiple pathways through which coping styles are associated with adverse health outcomes (Lazarus and Folkman 1984), and SST provides context

for the population level implications for stress and health (Pearlin et al. 1981), there is a proposed direct association between John Henryism and each of the physical and mental health outcomes. By examining both physical and mental health, we are less likely to encounter misclassification bias. Misclassification bias refers to the mis-categorization of individuals or groups as it relates to a particular outcome (Aneshensel, Rutter, and Lachenbruch 1991; Turner 2013). If a study evaluates one particular risk factor, individuals who have not officially been diagnosed with that outcome or risk factor but are impacted by others or have not presented with clinical levels will be misclassified as "well" (Aneshensel et al. 1991; Aneshensel 2005; Turner 2013). In doing so, the impact of certain risk and protective factors may be over or underestimated (Aneshensel 2005; Turner, 2013).

Psychological distress and depressive symptoms have been selected as mental health outcomes, in alignment with previous findings indicating an inverse association between John Henryism and these domains of mental health among Black Americans (Kiecolt et al. 2009; Bronder et al. 2014). However, this association has not been empirically assessed among Black women. *Self-rated mental health* has been selected as an additional mental health outcome, given that the association between John Henryism and this domain of mental health has not previously been assessed among Black women. Additionally, it is possible that this association may be akin to the association between self-rated physical health and John Henryism. *Past-year major depressive disorder* has also been selected as a mental health outcome given that prior scholarship has shown that high John Henryism is associated with higher odds of major depression among Black Americans (Hudson et al. 2016). Evaluating these different forms of mental health allows for assessing differences in the etiologies of distress, subclinical outcomes, and disorder.

In this dissertation, *self-rated health* has been selected as a physical health outcome due to prior research indicating an association between John Henryism and this domain of health (Bonham, Sellers, and Neighbors 2004; Lehto and Stein 2013; Čvorović and James 2018). However, this has not been examined among Black women. *Chronic health conditions* have also been selected as a physical health outcome given that majority of prior research assessing the link between John Henryism and physical health has focused primarily on hypertension (James et al. 1983; Bennett et al. 2004), particularly among men. Thus, less is known about how John Henryism may shape the onset of multiple chronic health conditions, particularly among women.

4.1.2 Social Stressors

Since both SST and TTPSC underscore the importance of stress exposure for shaping coping styles/personal resources and health, stressors have been included in this model. There is a proposed direct association between stressors and John Henryism, and between stressors and all health outcomes. *Chronic stress* has been selected as a stressor because chronic stress is conceptually and theoretically associated with John Henryism and health (James 1994; Bennett et al. 2004; Pearlin et al. 1981; Turner 2013). *Everyday discrimination* has also been selected as a stressor in alignment with previous findings indicating an association between this form of stress and poor mental and physical health outcomes (Paradies et al. 2015; Williams and Mohammed 2013). Additionally, the association between everyday discrimination and John Henryism has not been empirically assessed among Black women. *Goal-striving stress* has been selected as a third stressor, given that scholars posit goal-striving stress as a precedent for John Henryism (Sellers and Neighbors 2008). More specifically, as John Henryism is a way for individuals to achieve their optimal state of existence through actively addressing challenges, it would stand to reason that engaging in John Henryism can reduce goal-striving stress; thereby, promoting positive mental

health (Sellers and Neighbors 2008). Nonetheless, a recent study found that high goal-striving stress is associated with increased levels of John Henryism among Black Americans (DeAngelis 2020). Moreover, goal-striving stress is associated with hypertension, self-rated health, and BMI (Sellers et al. 2012; DeAngelis 2020). However, this has not been examined among Black women.

4.1.3 Sociodemographic Characteristics

Given that SST highlights that multiple axes of social stratification (i.e., gender, race, ethnicity, income, etc.) produce disparate population health outcomes through shaping exposure to stressors and coping styles (Pearlin et al. 1981; Turner, Wheaton, and Lloyd 1995; Turner 2013), the proposed associations are that sociodemographic characteristics are directly associated with John Henryism, stressors, and health, and that sociodemographic characteristics moderate the association between John Henryism and health. The sociodemographic characteristics assessed will include ethnicity, SES, and age.

Recognizing the significance of the modern African diaspora, and the transnational context put forth by Black Feminist Thought, *ethnicity* has been included as a sociodemographic characteristic for a few reasons. Namely, the populations of interest for this dissertation are Black women; however, they differ in ethnicity. Likewise, researchers have demonstrated that race, ethnicity, and cultural influences change the relationships of empirically supported predictors to health status (Brown et al. 2013). Taking this into consideration, it is possible that the association between predictors of John Henryism, and the association between John Henryism and health may vary by ethnicity. Similarly, *SES* has been included in this conceptual model because previous research has highlighted the *JHH* and has demonstrated a significant association between SES and John Henryism (James et al. 1983; James 1994; James 2019), in addition to its independent association with health (Williams and Collins 1995; Link and Phelan 1995).

Age has also been included as a sociodemographic characteristic since most studies that evaluate John Henryism simply adjust or control for age rather than assessing the age patterns in this coping style. Given that John Henryism is considered a form of problem-focused coping, the broader literature exploring the age patterning of problem-focused coping may provide valuable insight into to age patterns of John Henryism for Black women. For instance, previous findings demonstrate that older adults are less likely to engage in problem-focused coping compared to younger adults (Folkman, Lazarus, Pimley, and Novacek 1987; Chen et al. 2018). One study found no relationship between age and problem-focused coping; however, this study's sample was limited to individuals aged 45-64 (Folkman and Lazarus 1980).

Given these inconsistent findings, it is unclear whether John Henryism scores may increase, decrease, or remain stable over time. It is possible that John Henryism scores may increase with age among Black women due to this group's disproportionate exposure to social stressors across the life course (Turner and Avison 2003; Sternthal and Williams 2011; Walton and Shephard Payne 2016; Erving and Smith 2021). Alternatively, due to exposure to stressors that are more common for older adults, or disillusionment from engaging in this resource for years prior and recognizing that this form of coping may no longer be suitable in effectively addressing one's current challenges, John Henryism scores may reach a threshold at some point in the life course and then remain stable. Additionally, age is traditionally associated with mental and physical health, such that as age increases, the risk for developing adverse health conditions also increases (House et al. 1990; Ross and Wu 1996; Idler and Cartwright 2018). As the role of these factors has not been heavily assessed in relation to John Henryism and Black women, the first three aims focus on Black women overall. Given the significance of ethnicity, and the importance of understanding how this factor might distinguish health patterns among Black women, Aim 4

examines the ways in which John Henryism shapes mental and physical health among Caribbean Black women separately.

4.2 Present Study

Guided by this integrated conceptual model, this dissertation research addressed the following aims:

<u>Aim #1:</u> Assess the social distribution of John Henryism among Black women.

1.1 Examine the frequency of John Henryism dimensions among Black women.

1.2 Identify underlying factors in the John Henryism construct for Black women.

1.3 Assess the sociodemographic and stress-related correlates of John Henryism.

<u>Aim #2:</u> Examine the role of John Henryism in shaping mental health outcomes (i.e., psychological distress, self-rated mental health, depressive symptoms, and past-year major depressive disorder) among Black women.

2.1 Examine the direct association between John Henryism and mental health.

2.2 Assess the association between John Henryism and mental health, accounting for sociodemographic characteristics, and stressors.

2.3 Test the John Henryism Hypothesis by evaluating whether the John Henryism-mental health association is moderated by SES.

2.4 Assess the interactive association between stressors and John Henryism (i.e., does John Henryism buffer the impact of stress) on mental health.

<u>Aim #3:</u> Examine the role of John Henryism in shaping physical health (i.e., self-rated health and chronic health conditions) among Black women.

3.1 Examine the direct association between John Henryism and physical health.

3.2 Assess the association between John Henryism and physical health, accounting for sociodemographic characteristics, and stressors.

3.3 Test the John Henryism Hypothesis by evaluating whether the John Henryism-physical health association is moderated by SES.

3.4 Assess the interactive association between stressors and John Henryism (i.e., does John Henryism buffer the impact of stress) on physical health.

<u>Aim #4:</u> Explore the significance of John Henryism for the health of Caribbean Black women.

4.1 Examine the frequency of John Henryism dimensions among Caribbean Black women.

4.2 Identify underlying factors in the John Henryism construct for Caribbean Black women.

4.3 Assess the sociodemographic and stress-related correlates of John Henryism.

4.4 Examine the direct association between John Henryism and health.

4.5 Assess the association between John Henryism and health, accounting for sociodemographic characteristics, and stressors.

4.6 Test the John Henryism Hypothesis by evaluating whether the John Henryism-health association is moderated by SES.

4.7 Assess the interactive association between stressors and John Henryism (i.e., does John Henryism buffer the impact of stress) on health.

CHAPTER FIVE: DATA AND METHODS

5.1 Sample

This dissertation study utilized data from the National Survey of American Life (NSAL 2001-2003). The purpose of the NSAL study was to assess and understand the complexity of mental health disorders among subsamples of Black and non-Hispanic White populations in the United States (Jackson et al. 2004). The study disaggregated individuals according to ethnicity to include African Americans (n=3,570) and Caribbean Black individuals (n=1,623) (Jackson et al. 2004). The NSAL also includes 1,006 non-Hispanic White individuals (Jackson et al. 2004) (see Figure 6). The NSAL included wide-ranging assessments of social and neighborhood conditions, psychosocial risk and protective factors, psychological distress, and stress exposure (Jackson et al. 2004). The NSAL used multi-stage probability methods to obtain samples, as well as interviewers for the interview portion so that that the race and ethnicity of an interviewer would match that of the respondent (Jackson et al. 2004). The interview lasted approximately two and a half hours on average (Jackson et al. 2004).

The response rate for the NSAL was about 72% overall; however, among African Americans the response rate was 71%, 78% among Caribbean Black individuals, and 70% among Non-Hispanic White individuals (Jackson et al. 2004). African American and Caribbean Black women who were missing on any key study variables (i.e., self-rated mental health, self-rated health, goal-striving stress, and John Henryism) were excluded (n=188). NSAL respondents were also asked to complete a mail-in survey, after initial data collection. The mail-in survey is where key study variables (i.e., John Henryism) were assessed. Of the 6,199 NSAL participants, 3,438 completed the mail-in survey. The response rate for the mail-in survey was 56.5%. The mail-in survey response rate for African Americans was 59.9% (n=2,137). The mail-in survey response

rate for Caribbean Black individuals was 42.9% (n=695). The mail-in survey response rate for Non-Hispanic White individuals was 68% (n=606).

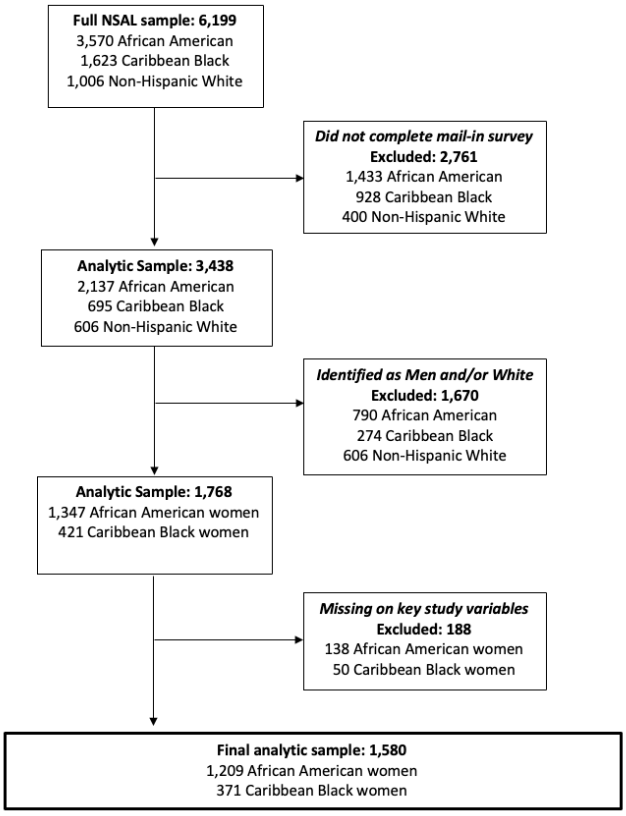


Figure 6: Analytic Sample Chart.

Analytic Sample. The process used to derive the analytic sample is illustrated in Figure 6. Given that the population of interest for this dissertation was Black women, White individuals and men of all races were excluded (n=1,670). This exclusion resulted in a sample of 1,768 Black women. Next, individuals missing on key study variables were excluded (n=188) for complete case analysis. Sensitivity analyses were conducted to identify potential distinctions between these excluded individuals (i.e., those missing on key study variables) and the remaining sample; results indicated that individuals who were missing were statistically similar in characteristics to those in the complete sample. The final analytic sample for this dissertation included 1,580 Black women, of which 1,209 were identified as African American and 371 as Caribbean Black (see Figure 6).

Approximately 80% of the Caribbean Black women in the analytic sample were born in the United States, which indicates these participants would classify as second-generation immigrants or higher.

5.2 Measures

5.2.1 Mental Health

5.2.1.1 *Psychological Distress* was assessed in the NSAL with a 7-item (α=0.85) scale (Jackson 1991). They asked respondents "In the past 30 days, about how often did you feel…?", with items indicating emotional states such as "nervous", "hopeless", and "worthless". The responses ranged from 1=all to 5=none. All items were reverse-coded and summed, such that higher scores indicated higher levels of psychological distress. Given that there was an overdispersion of zeroes for the distribution of this variable across the sample, psychological distress remained a count variable in the analysis.

5.2.1.2 *Self-Rated Mental Health* was assessed using a single item in the NSAL. Participants were asked how they would "rate their mental health in general". The response options ranged from 1=poor to 5=excellent. Based upon previous literature (Manor, Matthews, and Power 2000; Assari, Lankarani, and Burgard 2016), responses were dichotomized: (0) Very Good/Good/Excellent SRMH (reference category), and (1) Fair/Poor SRMH.

5.2.1.3 *Depressive symptoms* were assessed using the Center for Epidemiological Studies-Depression (CES-D) 12-item scale (Radloff 1977; Roberts and Sobhan 1992). This scale includes items that assess depressive symptoms in the past 30 days among respondents (α=0.79). A sample item is, "I've had trouble enjoying life". Respondents were asked to respond on a scale from 0 "rarely" to 3 "most of the time". Items were summed for a total score such that a higher score indicates higher depressive symptoms.

To account for the non-normal distribution of this variable, in addition to capturing subsequent risk for clinical depression (Radloff 1977), depressive symptoms were then dichotomized. The scores were dichotomized based on previously established cutoff scores (i.e., 16 or greater) (Lewinsohn et al. 1997). The categories were: (0) low-risk depressive symptoms (reference category), and (1) high-risk depressive symptoms.

5.2.1.4 *Past-Year Major Depressive Disorder* was assessed in the NSAL using the World Mental Health version of the WHO Composite International Diagnostic Interview (WHO-CIDI) (Jackson et al. 2004; WHO World Mental Health Organization Consortium 2004). The WHO-CIDI is a structured interview that was utilized to measure the prevalence of Diagnostic Statistical Manual-IV (DSM-IV) psychiatric disorders (Jones et al. 2020). Although the WHO-CIDI assessed the prevalence of multiple psychiatric disorders, this dissertation focused on major depressive disorder. This is especially relevant for the current study because major depressive disorder is a chronic disorder for Black populations (Williams et al. 2007). Moreover, Black women face a higher risk for major depressive disorder compared to White women (Erving et al. 2019), and scholars have demonstrated a significant and positive relationship between depression and mortality (Wuslin, Vaillant, and Wells 1999). Past-year measures of major depressive disorder were examined. The recoded categories were: (0) no past-year major depressive disorder (reference category), and (1) past-year major depressive disorder.

5.2.2 Physical Health

5.2.2.1 *Self-Rated Health (SRH)* was assessed using a single item in the NSAL. Participants were asked how they would rate their health in general. The response options for this

item were on a Likert scale ranging from 1=poor to 5=excellent. Consistent with previous research (Manor, Matthews, and Power 2000; Assari, Lankarani, and Burgard 2016), the self-rated health answer choices were dichotomized: (0) Very Good/Good/Excellent SRH (reference category), and (1) Fair/Poor SRH.

5.2.2.2 *Chronic Health Conditions* was assessed with a series of 20 items asking NSAL participants (yes/no) whether a doctor or health professional had diagnosed them with a particular health condition. Examples of conditions considered included arthritis, diabetes, and asthma. Prior research demonstrates that Black women experience disproportionate rates of chronic health conditions (Woods-Giscombé 2010), and number of chronic health conditions is associated with mortality, (Nunes et al. 2016; Rosbach and Andersen 2017). Therefore, to identify the physical health burden that African American and Caribbean Black women experience, chronic health conditions were assessed using a count variable to capture overall physical health risk in this dissertation.

5.2.3 John Henryism

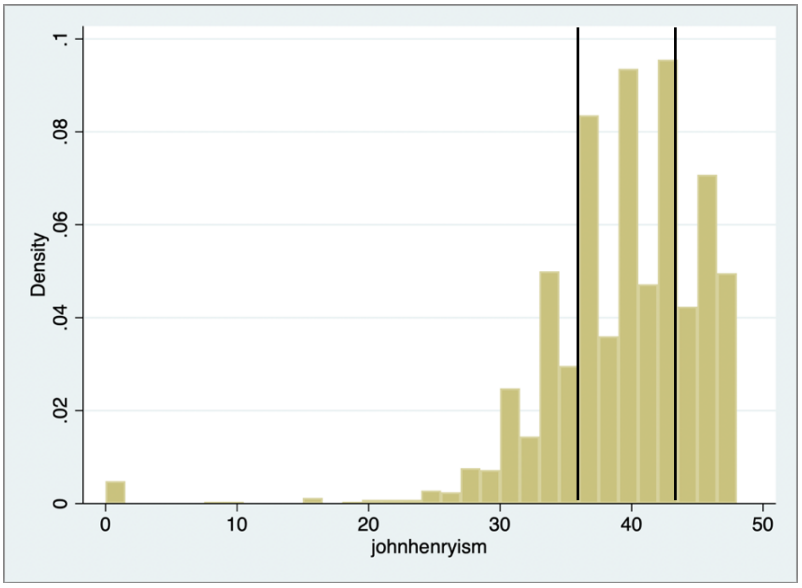


Figure 7: Raw distribution of John Henryism among Black women in the NSAL (2001-2003). Note: Items were reverse-coded and summed, such that higher scores indicate increased levels of John Henryism.

5.2.3.1 *John Henryism* was assessed in the NSAL using the validated John Henryism Active Coping Scale (JHAC-12). This 12-item, validated scale (α=0.82) was developed by Dr. Sherman James (James et al. 1983), and it asks respondents to identify how true each item or statement was for them. A sample item is "I've always felt that I could make of my life pretty much what I wanted." (James et al. 1983). Response options ranged from 1 "completely true" to 5 "completely false". Items were reverse-coded and summed, such that higher scores indicated increased levels of John Henryism. Given the central focus of the John Henryism construct in this dissertation, individuals who were missing on any of the 12 items were excluded from the analysis. To account for potential threshold effects (Kiecolt et al. 2009; Robinson and Thomas Tobin 2021), and the non-normal distribution of this variable (see Figure 7), John Henryism scores were categorized based on the 25th and 75th percentiles, resulting in the following coding: (1) low John Henryism (reference category), (2) moderate John Henryism, and (3) high John Henryism.

For Aim 4's exploratory analysis of Caribbean Black women, a John Henryism variable specific to this group was created based on findings from the confirmatory factor analysis, which indicated that two items on the scale did not capture the construct of John Henryism among Caribbean Black women: Items #1 ("I've always felt that I could make of my life pretty much what I wanted to make of it") and #7 ("I feel that I am the kind of individual who stands up for what he believes in, regardless of the consequences"). These two items were removed and the responses from the remaining items were summed for each participant, such that higher scores indicated increased levels of John Henryism

(α=0.80). The Caribbean Black women's John Henryism variable was also categorized based on the 25th and 75th percentiles. The three categories were: (1) low John Henryism (reference category), (2) moderate John Henryism, and (3) high John Henryism.

5.2.4 *Ethnicity* was assessed in the NSAL through a series of questions regarding race and ethnicity. Interviewers indicated whether the respondent was White, Black, or Caribbean based on their sample group. If the respondent was White or Black, they were asked to indicate, "In addition to being American, what do you think of as your ethnic background or origins?". Those who indicated they were White or Black and did not provide a response to the question for ethnic background were asked to indicate what best describes their racial background as well as their mother's and father's. If the respondent was Caribbean, they were asked, "Can you please tell me what your ancestry or country of origin is?". Of note, the main countries that Caribbean participants were from included: the Spanish Caribbean, Haiti, Jamaica, and Trinidad and Tobago. If Caribbean respondents provided more than one country, they were asked this question a second time. All Caribbean respondents were then asked, "which would you say is more important to you—being Black or being from [country they provided] or are both equally important to you?". For this question, Caribbean respondents who previously responded only one country were asked about that one country. Caribbean respondents who previously responded with more than one country were asked about the country they provided when the question was asked a second time. From these responses, two categories were created: (0) African American, (1) Caribbean Black.

5.2.5 Stress Exposure

5.2.5.1 *Chronic Stress* was assessed in the NSAL using a 10-item checklist with a prompt of, "Over the past month or so, have you…", with items including 'had health problems?", "had family or marriage problems?", and "had problems with the police?". Response options were "yes" or "no". For each respondent, answers endorsing the items were summed, such that higher scores indicated increased exposure to chronic stress.

5.2.5.2 *Everyday Discrimination* was assessed in the NSAL using the Everyday Discrimination Scale developed by Williams and colleagues (1997). This scale includes 10-items (α=0.88) that assess different experiences of perceived discrimination. The overall prompt was for respondents to identify how frequent each of the ten items had occurred for them in their daily lives over the past year. A sample item is, "People behave as if they think you are not honest" (Williams et al. 1997). Respondents were asked to provide answers on a Likert scale of 1 "never" to 6 "almost daily" (Williams et al. 1997). Items were summed such that higher scores indicated a higher frequency of discriminatory events.

5.2.5.3 *Goal-striving stress* was assessed in the NSAL using four items that were designed to measure the discrepancy between an individual's aspirations for a goal, and their achievement, weighted by the chances of achieving that goal, and the level of disappointment that would occur if an individual were to not achieve the goal (Sellers et al. 2012). Respondents were first asked to think of a ladder with ten rungs, where rung 10 is the respondent's best way of life and rung 1 being the worst. Aspirations were measured by asking the respondent to indicate the rung number they desire to be in a few years. Achievement was measured by asking the respondent to indicate the rung number of where they currently were at the time. Chance was measured by asking

respondents to indicate their chances for reaching this goal, from 1=highly likely to 4=highly unlikely. Importance was measured by asking the respondent to indicate what their level of disappointment would be if they could never reach their goal from what they listed in aspirations, with 1=very disappointed to 4=not at all disappointed. The equation for goal-striving stress is the following: (Aspirations-Achievement) * (Chances*Importance). From this equation, a continuous measure was created such that higher scores indicated higher goal-striving stress. Individuals who indicated that they did not have any aspirations were given a goal-striving stress score of zero. To account for the non-normal distribution of this variable, it was categorized based on the 25th and 75th percentiles. The categories were: (1) low goal-striving stress (reference category), (2) moderate goal-striving stress, and (3) high goal-striving stress. Given that the distribution of goal-striving stress was distinct for Caribbean Black women, goal-striving stress remained continuous for Aim 4's exploratory analysis of this subgroup.

5.2.6 Sociodemographic Characteristics

5.2.6.1 *Age* was assessed in the NSAL through asking respondents to provide their age in years at the time of the study (Jackson et al. 2004) and was measured continuously in this dissertation.

5.2.6.2 *Socioeconomic Status (SES)* was assessed in the NSAL from respondents via multiple indicator variables, including educational attainment and household income. Educational attainment was assessed continuously with respondents indicating the highest number of years of education they had achieved. While most values were numeric, the lowest and highest response options were categorized as "4 or less" and "17 or more". Household Income was measured continuously in the NSAL, with

respondents providing their household income in a dollar amount (Jackson et al. 2004; Erving 2011). An SES score was generated for each participant. To create this, values for educational attainment and household income were first standardized and then the scores for these two dimensions (educational attainment and household income) were summed for each participant. This process created a composite or index of SES that represents the number of standard deviations higher or lower each participant's SES level is relative to the sample's mean SES (Erving and Thomas 2018). Higher scores indicated higher SES. By weighting educational attainment and household income equally, this approach provided a more complete evaluation of SES (R.L. Brown 2014). Additionally, this measurement of SES may more effectively depict an individual's placement in a socially stratified society, which is based on their concurrent positions in various social locations (Erving and Thomas 2018).

5.2.7 Analytic Strategy

This dissertation included analysis from 1,209 African American women and 371 Caribbean Black women. Analyses of "Black women" refer to the collective sample, which included both "African American" and "Caribbean Black"-identified women. The methods used to assess each research aim are described below.

Descriptive Characteristics (Black Women):

Weighted proportions for all categorical variables were estimated for the full sample. Weighted means, standard deviations, and variable ranges for continuous variables for the full sample are also presented (Tables 1A-1B). Significant differences for categorical variables were assessed with chi-squared tests for categorical variables and with t-tests for continuous variables.

Aim #1: Assess the social distribution of John Henryism among Black women.

1.1 Examine the frequency of John Henryism dimensions among Black women.

For each item of the John Henryism scale, a tabulation with column percentages was calculated to assess the percentage of Black women who endorsed certain responses (i.e., "completely true", "somewhat true", "somewhat false", "completely false") for each item.

1.2 Identify underlying factors in the John Henryism construct for Black women.

A confirmatory factor analysis was conducted to identify underlying factors in the John Henryism construct for Black women (Hoyle 2000; Harrington 2009). First, the factor analysis was run to obtain eigenvalues for each item of the scale. Next, factor loadings for each item of the scale were calculated in correspondence to the two factors found, with correlations of uniqueness. Then, these factor loadings were rotated using the varimax method to clarify the uniqueness of items that corresponded to each factor. Items with factor loadings (i.e., correlations) above 0.50 were attributed to that factor. Following this, the correlations between the two factors were calculated. These approaches were used because they allowed for the assessment of underlying factors in the construct of John Henryism for Black women to identify which themes are present for this group.

1.3 Assess the sociodemographic and stress-related correlates of John Henryism.

Multinomial logistic regression was used to examine (a) sociodemographic differences in John Henryism and (b) the associations between social stressors and John Henryism, given that John Henryism had three levels. Multinomial logistic regression was used to estimate relative risk ratios and 95% confidence intervals. The full model included John Henryism regressed on age, SES, ethnicity, chronic

stress, everyday discrimination, and goal-striving stress. Multinomial logistic regression, rather than ordinal logistic regression, was used because it allowed for the assessment of relative risk of endorsing moderate vs. low John Henryism categories, and high vs. low John Henryism categories rather than assuming a linear patterning across the categories.

<u>Aim #2:</u> Examine the role of John Henryism in shaping mental health outcomes (i.e., psychological distress, self-rated mental health, depressive symptoms, major depressive disorder) among Black women.

The stress process model, one of the theoretical perspectives guiding this dissertation, motivated the multivariate modeling strategies in this analysis. A key tenet of Social Stress Theory is that differences in social characteristics shape health (Pearlin et al. 1981). Since Social Stress Theory also emphasizes the focal relationship between stress, sociodemographic characteristics, and mental health, the baseline model examined the association between stressors (i.e., chronic stress, everyday discrimination, goal-striving stress), sociodemographic characteristics (i.e., age and SES) and each mental health outcome (Model 1).

2.1 Examine the direct association between John Henryism and mental health.

Since John Henryism was the key variable of interest in this dissertation, it was important to first assess the direct association between John Henryism and mental health to clarify the nature of this relationship before including other variables in the model. This was done for all mental health outcomes and it is reflected in Table 3. Logistic regression was used to estimate odds ratios and 95% confidence intervals for the dichotomous mental health measures (i.e., depressive symptoms, past-year

major depressive disorder, and self-rated mental health). Separate models were run for each mental health outcome. Negative binomial regression was used to estimate incidence rate ratios and 95% confidence intervals for psychological distress, because this variable was a count with an overdispersion of zeroes. These approaches were used because they allowed for the assessment of how John Henryism directly shapes the development of mental health outcomes.

2.2 Assess the association between John Henryism and mental health, accounting for sociodemographic factors, and stressors.

Because John Henryism was the key variable of interest, and Social Stress Theory posits that it is important to account for sociodemographic characteristics and stress exposure when assessing the association between coping and mental health (Pearlin et al. 1981), Model 2 considered the association between John Henryism and each mental health outcome, accounting for sociodemographic characteristics and stressors. Logistic regression and negative binomial regression were used. Logistic regression was used to estimate odds ratios and 95% confidence intervals for the association between John Henryism and dichotomous mental health measures (i.e., depressive symptoms, past-year major depressive disorder, and self-rated mental health), accounting for sociodemographic characteristics and stressors. Since psychological distress was a count with an overdispersion of zeroes, negative binomial regression was used to estimate incidence rate ratios and 95% confidence intervals for the association between John Henryism and psychological distress, accounting for sociodemographic characteristics and stressors. For each mental health outcome, the following modeling strategy was used. Model 1 included the

mental health outcome regressed on age, SES, ethnicity, chronic stress, everyday discrimination, and goal-striving stress. Model 2 included the mental health outcome regressed on John Henryism, age, SES, ethnicity, chronic stress, everyday discrimination, and goal-striving stress. These approaches were used because they allowed for the assessment of the extent to which John Henryism may or may not shape mental health after accounting for sociodemographic characteristics, and stressors.

2.3 Test the John Henryism Hypothesis by evaluating whether the John Henryism-mental health association is moderated by SES.

The John Henryism Hypothesis (*JHH)* suggests that SES conditions the impact of John Henryism on health. More specifically, it proposes that low SES individuals who engage in high-effort coping consistently experience an increased risk of developing poor health (James et al. 1983). To this end, Model 3 evaluated the John Henryism Hypothesis (*JHH*). To assess the John Henryism Hypothesis for mental health outcomes, logistic regression and negative binomial regression were used. Logistic regression was used to estimate odds ratios and 95% confidence intervals for the association between John Henryism and dichotomous mental health measures (i.e., depressive symptoms, past-year major depressive disorder, and self-rated mental health), with SES as a moderator. Since psychological distress was a count with an overdispersion of zeroes, negative binomial regression was used to estimate incidence rate ratios and 95% confidence intervals for the association between John Henryism and psychological distress, with SES as a moderator. For each mental health outcome, the following modeling strategy was used. Model 3

tested an interaction term between John Henryism and SES. This approach was used because it allowed for the assessment of the extent to which SES moderates (i.e., conditions) the association between John Henryism and mental health outcomes.

2.4 Assess the interactive associations between stressors and John Henryism on mental health among Black women.

Another key assumption of Social Stress Theory is that coping tools have the capacity to buffer or offset the harmful impact of stress on health (Pearlin et al. 1981). To empirically assess this, Models 4-6 for each mental health outcome tested this assumption via interactions between John Henryism and each stressor (i.e., chronic stress, everyday discrimination, and goal-striving stress). To assess the interactive associations between stressors and John Henryism on mental health among Black women, logistic regression and negative binomial regression was used. Logistic regression was used to examine the association between each stressor and dichotomous mental health measures (i.e., depressive symptoms, past-year major depressive disorder, and self-rated mental health), with John Henryism as a moderator. Since psychological distress was a count with an overdispersion of zeroes, negative binomial regression was used to evaluate the association between each stressor and psychological distress, with John Henryism as the moderator. For each mental health outcome, the following model strategy was used. Model 4 tested an interaction between John Henryism and chronic stress. Model 5 tested an interaction between John Henryism and everyday discrimination. Model 6 tested an interaction between John Henryism and goal stiving stress. All models included age, SES, ethnicity, chronic stress, everyday discrimination, and goal-striving stress

as covariates. These methods provided information identifying how the interaction of John Henryism and stressors shaped risk for the various mental health outcomes of interest. In other words, it assisted in specifying under which conditions John Henryism may buffer or mitigate the adverse effects of stress on mental health, and for whom.

<u>Aim #3:</u> Examine the role of John Henryism in shaping physical health (i.e., self-rated health and chronic health conditions) among Black women.

Considering that this dissertation is heavily guided by the stress process model, Social Stress Theory guided modeling strategies. A key component of Social Stress Theory is that differences in social characteristics shape health (Pearlin et al. 1981). Since the focal relationships for Social Stress Theory focus on the direct link between stress, sociodemographic characteristics, and physical health, the baseline model examined the association between stressors (i.e., chronic stress, everyday discrimination, goal-striving stress), sociodemographic characteristics (i.e., age and SES) and each physical health outcome (Model 1).

3.1 Examine the direct association between John Henryism and physical health.

As John Henryism was the key variable of interest in this dissertation, it was important to assess the direct association between John Henryism and physical health to clarify this relationship before including other variables in the model. This was done for all physical health outcomes (Table 8). To examine the direct association between John Henryism and physical health, logistic and negative binomial regression were used. Logistic regression was used to estimate odds ratios and 95% confidence intervals for the association between John Henryism and the

dichotomous physical health outcome (i.e., self-rated health). Given that chronic health conditions was a count variable with an overdispersion of zeroes, negative binomial regression was used to estimate incidence rate ratios and 95% confidence intervals for the association between John Henryism and chronic health conditions. Separate models were run for each physical health outcome. These approaches were used because they allowed for the assessment of how John Henryism directly shapes the development of physical health outcomes.

3.2 Assess the association between John Henryism and physical health, accounting for sociodemographic characteristics, and stressors.

Because John Henryism was the key variable of interest, and Social Stress Theory posits that it is important to account for sociodemographic characteristics and stress exposure when assessing the association between coping and physical health (Pearlin et al. 1981), Model 2 looked at the association between John Henryism and each mental health outcome, accounting for sociodemographic characteristics and stressors. To assess the association between John Henryism and physical health, accounting for sociodemographic characteristics, and stressors, logistic and negative binomial regression were used. Logistic regression was used given that one physical health outcome (i.e., self-rated health) was dichotomized. Logistic regression was used to estimate odds ratios and 95% confidence intervals for the association between John Henryism and the dichotomous physical health outcome (i.e., self-rated health), accounting for sociodemographic characteristics and stressors. Given that chronic health conditions was a count, with an overdispersion of zeroes, negative binomial regression was used to estimate incidence rate ratios

and 95% confidence intervals for the association between John Henryism and chronic health conditions, accounting for sociodemographic characteristics and stressors. For each physical health outcome, the following modeling strategy was used. Model 1 included the physical health outcome regressed on age, SES, ethnicity, chronic stress, everyday discrimination, and goal-striving stress. Model 2 included the physical health outcome regressed on John Henryism, age, SES, ethnicity, chronic stress, everyday discrimination, and goal-striving stress. These approaches were used because they allowed for the assessment of the extent to which John Henryism may or may not shape physical health after accounting for sociodemographic characteristics, and stressors.

3.3 Test the John Henryism Hypothesis by evaluating whether the John Henryism-physical health association is moderated by SES.

The John Henryism Hypothesis (*JHH)* suggests that SES conditions the impact of John Henryism on health. Specifically, the *JHH* proposes that low SES individuals who engage in high-effort coping consistently experience an increased risk of developing poor health (James et al. 1983). As such, Model 3 investigated the JHH for each physical health outcome. To assess the John Henryism Hypothesis for physical health outcomes, logistic regression and negative binomial regression were used. Logistic regression was used to estimate odds ratios and 95% confidence intervals for the association between John Henryism and the dichotomous physical health measure (i.e., self-rated health), with SES as a moderator. As chronic health conditions were a count and had an overdispersion of zeroes, negative binomial regression was used to estimate incidence rate ratios and 95% confidence intervals

for the association between John Henryism and chronic health conditions, with SES as the moderator. For each physical health outcome, the following modeling strategy was used. Model 3 tested an interaction term between John Henryism and SES. This approach was used because it allowed for the assessment of the extent to which SES moderates (i.e., conditions) the association between John Henryism and physical health outcomes.

3.4 Assess the interactive associations between stressors and John Henryism on physical health among Black women.

Another component of Social Stress Theory is that coping tools have the capacity to buffer or offset the harmful impact of stress on health (Pearlin et al. 1981). To empirically test this, Models 4-6 for each physical health outcome tested this assumption via interactions between John Henryism and each stressor (i.e., chronic stress, everyday discrimination, and goal-striving stress). To assess the interactive associations between stressors and John Henryism on physical health among Black women, logistic and negative binomial regression were used. Logistic regression was used given to estimate odds ratios and 95% confidence intervals for the association between each stressor and the dichotomous physical health measure (i.e, self-rated health), with John Henryism as a moderator. Chronic health conditions was a count variable with an overdispersion of zeroes. As such, negative binomial regression was used to estimate incidence rate ratios and 95% confidence intervals for the association between each stressor and chronic health conditions, with John Henryism as a moderator. For each physical health outcome, the following modeling strategy will be used. Model 4 tested an interaction between John

Henryism and chronic stress. Model 5 tested an interaction between John Henryism and everyday discrimination. Model 6 tested an interaction between John Henryism and goal stiving stress. All models included age, SES, ethnicity, chronic stress, everyday discrimination, and goal-striving stress as covariates. These methods provided information identifying how the interaction of John Henryism and stressors shaped risk for the physical health outcomes of interest. In other words, it assisted in specifying under which conditions John Henryism may buffer or mitigate the adverse effects of stress on physical health, and for whom.

<u>Aim #4:</u> Explore the significance of John Henryism for the health of Caribbean Black women.

For Aim 4, the same modeling strategy from Aims 2 and 3 was employed. Since the focal relationships for Social Stress Theory focus on the direct links between sociodemographic characteristics, stress, and health (Pearlin et al. 1981), my baseline model evaluated the direct association between sociodemographic characteristics (i.e., age and SES), stressors (i.e., chronic stress, everyday discrimination, goal-striving stress), and each mental and physical health outcome for this subgroup analysis (Model 1).

<u>Descriptive Characteristics (Caribbean Black Women):</u>

Weighted proportions for all categorical variables were estimated for the full sample. Weighted means, standard deviations, and variable ranges for continuous variables for the full sample have also been presented. Significant differences for categorical variables were assessed through chi-squared tests. Significant differences for continuous variables were assessed through t-tests.

4.1 Examine the frequency of John Henryism dimensions among Caribbean Black

women.

For each item of the John Henryism scale, a tabulation with column percentages was calculated to assess the percentage of Caribbean Black women who endorsed certain responses (i.e., "completely true", "somewhat true", "somewhat false", "completely false") for each item.

4.2 Identify underlying factors in the John Henryism construct for Caribbean Black women.

A confirmatory factor analysis was conducted to identify underlying factors in the John Henryism construct for Caribbean Black women. First, the factor analysis was run to obtain eigenvalues for each item of the scale. Next, factor loadings for each item of the scale were calculated in correspondence to the two factors found, with correlations of uniqueness. Then, these factor loadings were rotated using the varimax method to clarify the uniqueness of items that corresponded to each factor. Items with factor loadings (i.e., correlations) above 0.50 were attributed to that factor. Following this, the correlations between the two factors were calculated. These approaches were used because they allowed for the assessment of underlying factors in the construct of John Henryism for Caribbean Black women to identify which themes are present for this group.

4.3 Assess the sociodemographic and stress-related correlates of John Henryism among Caribbean Black women.

Multinomial logistic regression was used to examine sociodemographic differences in John Henryism and the associations between social stressors and John Henryism among Caribbean Black women, given that John Henryism had three levels. Multinomial

logistic regression was used to estimate relative risk ratios and 95% confidence intervals. The full model included John Henryism regressed on age, SES, chronic stress, everyday discrimination, and goal-striving stress. Multinomial logistic regression was used because this approach allowed for the assessment of relative risk for being in the moderate vs. low John Henryism categories, and high vs. low John Henryism categories. This provided an understanding of which social stressors may be associated with relative risk for membership in moderate vs. low John Henryism categories, and high vs. low John Henryism categories.

4.4 Examine the direct association between John Henryism and health among Caribbean Black women.

4.4.1 Mental Health

4.4.1.1 It was important to clarify the direct association between John Henryism and each mental health outcome before including other variables in the model. This was done for all mental health outcomes (Table 13). Logistic regression was used to estimate odds ratios and 95% confidence intervals for the direct association between John Henryism and dichotomous mental health measures (i.e., depressive symptoms, past-year major depressive disorder, and self-rated mental health). Separate models were run for each mental health outcome. Negative binomial regression was used to estimate incidence rate ratios and 95% confidence intervals for the association between John Henryism and psychological distress, taken that psychological distress was a count and had an overdispersion of zeroes. These approaches were used because they allowed for the assessment of

how John Henryism directly shapes the development of mental health outcomes among Caribbean Black women.

4.4.2 Physical Health

4.4.2.1 Since John Henryism was the key variable of interest in this dissertation, it was important to assess the direct association between John Henryism and physical health to understand the nature of this relationship before including other variables in the model. This was done for all physical health outcomes (Table 18). To examine the direct association between John Henryism and physical health among Caribbean Black women, logistic and negative binomial regression were used. Logistic regression was used for the dichotomous physical health outcome (i.e., self-rated health) to estimate odds ratios and 95% confidence intervals for the association between John Henryism and self-rated health, accounting for sociodemographic characteristics and stressors. Since chronic health conditions was a count with an overdispersion of zeroes, negative binomial regression was used to estimate incidence rate ratios and 95% confidence intervals for the association between John Henryism and chronic health conditions, accounting for sociodemographic characteristics and stressors, Separate models were run for each physical health outcome. These approaches were used because they allowed for the assessment of how John Henryism directly shapes the development of physical health outcomes among Caribbean Black women.

4.5 Assess the association between John Henryism and health, accounting for

sociodemographic characteristics, and stressors among Caribbean Black women.

4.5.1 Mental Health

4.5.1.1 Because John Henryism was the key variable of interest, and Social Stress Theory posits that it is important to account for sociodemographic characteristics and stress exposure when assessing the association between coping and mental health (Pearlin et al. 1981), Model 2 examined the association between John Henryism and each mental health outcome, accounting for sociodemographic characteristics and stressors. Logistic regression and negative binomial regression were used. Logistic regression was used to estimate odds ratios and 95% confidence intervals for the association between John Henryism and dichotomous mental health measures (i.e., depressive symptoms, past-year major depressive disorder, and self-rated mental health), accounting for sociodemographic characteristics and stressors. Considering that psychological distress was a count with an overdispersion of zeroes, negative binomial regression was used to estimate incidence rate ratios and 95% confidence intervals for the association between John Henryism and psychological distress, accounting for sociodemographic characteristics and stressors. For each mental health outcome, the following modeling strategy was used. Model 1 included the mental health outcome regressed on age, SES, chronic stress, everyday discrimination, and goal-striving stress. Model 2 included the mental health outcome regressed on John Henryism, age, SES, chronic stress, everyday discrimination, and goal-striving stress. These approaches were used

because they allowed for the assessment of the extent to which John Henryism may or may not shape mental health after accounting for sociodemographic characteristics, and stressors among Caribbean Black women.

4.5.2 Physical Health

4.5.2.1 Given that Social Stress Theory posits that it is important to account for sociodemographic characteristics and stress exposure when assessing the association between coping and physical health (Pearlin et al. 1981), Model 2 examined the association between John Henryism and each physical health outcome, accounting for sociodemographic characteristics and stressors. To assess the association between John Henryism and physical health, accounting for sociodemographic characteristics, and stressors, logistic and negative binomial regression were used. Logistic regression was used to estimate odds ratios and 95% confidence intervals for the association between John Henryism and the dichotomous physical health measure (i.e., self-rated health), accounting for sociodemographic characteristics and stressors. As chronic health conditions were a count with an overdispersion of zeroes, negative binomial regression was used to estimate incidence rate ratios and 95% confidence intervals for the association between John Henryism and chronic health conditions, accounting for sociodemographic characteristics and stressors. For each physical health outcome, the following modeling strategy was used. Model 1 included the physical health outcome regressed on age, SES, chronic stress, everyday discrimination,

and goal-striving stress. Model 2 included the physical health outcome regressed on John Henryism, age, SES, chronic stress, everyday discrimination, and goal-striving stress. These approaches were used because they allowed for the assessment of the extent to which John Henryism may or may not shape physical health after accounting for sociodemographic characteristics, and stressors among Caribbean Black women.

4.6 Test the John Henryism Hypothesis by evaluating whether the John Henryism-health association is moderated by SES.

4.6.1 Mental Health

4.6.1.1 Model 3 for each mental health outcome assessed the John Henryism Hypothesis (*JHH*), which posits that SES moderates the association between John Henryism and health (James et al. 1983). To assess the John Henryism Hypothesis for mental health outcomes among Caribbean Black women, logistic regression and negative binomial regression were used. Logistic regression was used to estimate odds ratios and 95% confidence intervals for the association between John Henryism and dichotomous mental health measures (i.e., depressive symptoms, past-year major depressive disorder, and self-rated mental health), with SES as a moderator. Taken that psychological distress was a count with an overdispersion of zeroes, negative binomial regression was used to estimate incidence rate ratios and 95% confidence intervals for the association between John Henryism and psychological distress, with SES as a moderator. For each mental health

outcome, the following modeling strategy was used. Model 3 tested an interaction term between John Henryism and SES. This approach was used because it allowed for the assessment of the extent to which SES moderates (i.e., conditions) the association between John Henryism and mental health outcomes.

4.6.2 Physical Health

4.6.2.1 For each physical health outcome, the John Henryism Hypothesis (*JHH*) was evaluated (Model 3). The *JHH* suggests that SES moderates the association between John Henryism and health (James et al. 1983). To assess the John Henryism Hypothesis for physical health outcomes among Caribbean Black women, logistic regression and negative binomial regression were used. Logistic regression was used to estimate odds ratios and 95% confidence intervals for the association between John Henryism and the dichotomous physical health measure (i.e., self-rated health), with SES as a moderator. Because chronic health conditions was a count with an overdispersion of zeroes, negative binomial regression was used to estimate incidence rate ratios and 95% confidence intervals for the association between John Henryism and chronic health condition, with SES as the moderator. For each physical health outcome, the following modeling strategy was used. Model 3 tested an interaction term between John Henryism and SES. This approach was used because it allowed for the assessment of the extent to which SES moderates (i.e., conditions) the association between John Henryism and physical health outcomes.

4.7 Assess the interactive association between stressors and John Henryism (i.e., does John Henryism buffer the impact of stress) on health.

4.7.1 Mental Health

4.7.1.1 Given that Social Stress Theory emphasizes the role of coping in mitigating the impact of stress on health (Pearlin et al. 1981), Models 4-6 for each mental health outcome tested this assumption via interactions between John Henryism and stress (i.e., chronic stress, everyday discrimination, goal-striving stress). To assess the interactive associations between stressors and John Henryism on mental health among Caribbean Black women, logistic regression and negative binomial regression were used. Logistic regression was used to estimate odds ratios and 95% confidence intervals for the association between each stressor and the dichotomous mental health measures (i.e., depressive symptoms, major depression, and self-rated mental health), with John Henryism as a moderator. Considering that psychological distress was a count with an overdispersion of zeroes, negative binomial regression was used to estimate incidence rate ratios and 95% confidence intervals for the association between each stressor and psychological distress, with John Henryism as a moderator. For each mental health outcome, the following model strategy was used. Model 4 tested an interaction between John Henryism and chronic stress. Model 5 tested an interaction between John Henryism and everyday discrimination. Model 6 tested an interaction between John Henryism and goal stiving stress. All models included age, SES, chronic stress, everyday discrimination, and

goal-striving stress as covariates. These methods provided information identifying how the interaction of John Henryism and stressors shaped risk for the various mental health outcomes of interest. In other words, it assisted in specifying under which conditions John Henryism may buffer or mitigate the adverse effects of stress on mental health, and for whom.

4.7.2 Physical Health

4.7.2.1 Another component of Social Stress Theory is that coping tools have the capacity to buffer or offset the harmful impact of stress on health (Pearlin et al. 1981). To assess this, Models 4-6 for each physical health outcome tested this assumption via interactions between John Henryism and each stressor (i.e., chronic stress, everyday discrimination, and goal-striving stress). To assess the interactive associations between stressors and John Henryism on physical health among Caribbean Black women, logistic and negative binomial regression were used. Logistic regression was used to estimate odds ratios and 95% confidence intervals for the association between each stressor and the dichotomous physical health measure (i.e., self-rated health), with John Henryism as a moderator. Given that chronic health conditions was a count with an overdispersion of zeroes, negative binomial regression was used to estimate incidence rate ratios and 95% confidence intervals for the association between each stressor and chronic health conditions, with John Henryism as the moderator. For each physical health outcome, the following modeling strategy will be used. Model 4 tested an interaction between John Henryism and chronic stress. Model 5 tested an

interaction between John Henryism and everyday discrimination. Model 6 tested an interaction between John Henryism and goal stiving stress. All models included age, SES, chronic stress, everyday discrimination, and goal-striving stress as covariates. These methods provided information identifying how the interaction of John Henryism and stressors shaped risk for the physical health outcomes of interest. In other words, it assisted in specifying under which conditions John Henryism may buffer or mitigate the adverse effects of stress on physical health, and for whom.

Statistical analyses were conducted using Stata 17.0. To account for the complex sampling design of the NSAL, to ensure that variances were accurate, and estimates can be generalized to the population level, appropriate survey weights were used.

CHAPTER SIX: RESULTS

6.1 *Characteristics among Black Women in the National Survey of American Life*

6.1.1 *Distribution of Mental and Physical Health Outcomes*

Table 1A: Health Outcomes among Black Women, National Survey of American Life (2001-2003)

	All (N=1,580)	
	Mean or %	*SD*
Mental Health Outcomes		
Psychological Distress [0-28][b]	4.02	6.14
Self-Rated Mental Health (SRMH)		
Very Good/Excellent SRMH (Ref.)	86.90	
Fair/Poor SRMH	13.10	
Depressive Symptoms		
Low-Risk (Ref.)	88.99	
High-Risk	11.01	
Past-Year Major Depressive Disorder (MDD)		
No Past-Year MDD (Ref.)	92.39	
Past-Year MDD	7.61	
Physical Health Outcomes		
Self-Rated Health (SRH)		
Very Good/Excellent SRH (Ref.)	77.57	
Fair/Poor SRH	22.43	
Chronic Health Conditions [0-13][b]	1.86	2.44

Note: Ref= reference category; weighted means and percentages reported.

To better understand the distribution of mental and physical health outcomes among Black women, weighted means and proportions were calculated. Table 1A shows the distribution of mental and physical health outcomes among the sample. Overall, Black women reported generally good mental health. Psychological distress scores ranged from 0 to 28, and the average score was 4.02 (standard deviation, SD=6.14), which indicates that psychological distress scores for Black women were relatively low. In addition, almost 87% of the sample reported "very good/excellent" self-rated mental health, while approximately 13% reported "fair/poor" self-rated mental health. Nearly 89% of the sample reported low-risk for clinically significant depressive symptom scores,

while approximately 11% reported high-risk scores. About 92.39% of the sample reported no past-year major depressive disorder, while 7.61% reported past-year major depressive disorder.

A similar pattern emerged with physical health outcomes. Approximately 78% percent of the sample reported very good/excellent self-rated health, while 22% reported fair/poor self-rated health, which indicates that most Black women rated their physical health as very good/excellent. While the number of chronic health condition ranged from 0 to 13, most women reported only about two chronic health conditions, on average (m=1.86; SD=2.44), which shows that most women had very few chronic health conditions. However, given that having two chronic health conditions is indicative of comorbidity, these findings demonstrate that Black women do experience physical health burden. Nevertheless, Black women reported fairly good mental and physical health overall.

6.1.2 Distribution of Stressors and Sociodemographic Characteristics among Black Women

Table 1B: Sample Characteristics of Black Women, National Survey of American Life (2001-2003)

	All (N=1,580)	
	Mean or %	*SD*
John Henryism (JH)		
Low JH (Ref.)	20.13	
Moderate JH	47.42	
High JH	32.45	
Social Stressors		
Chronic Stress [0-8][b]	1.86	1.93
Everyday Discrimination [0-50][b]	10.93	10.92
Goal Striving Stress (GSS)		
Low GSS (Ref.)	30.71	
Moderate GSS	36.27	
High GSS	33.01	
Sociodemographic Characteristics		
Age [18-93][b]	42.29	20.06
Socioeconomic Status[a] [-4.45-6.93][b]	-0.08	1.96

Note: Ref= reference category; weighted means and percentages reported.

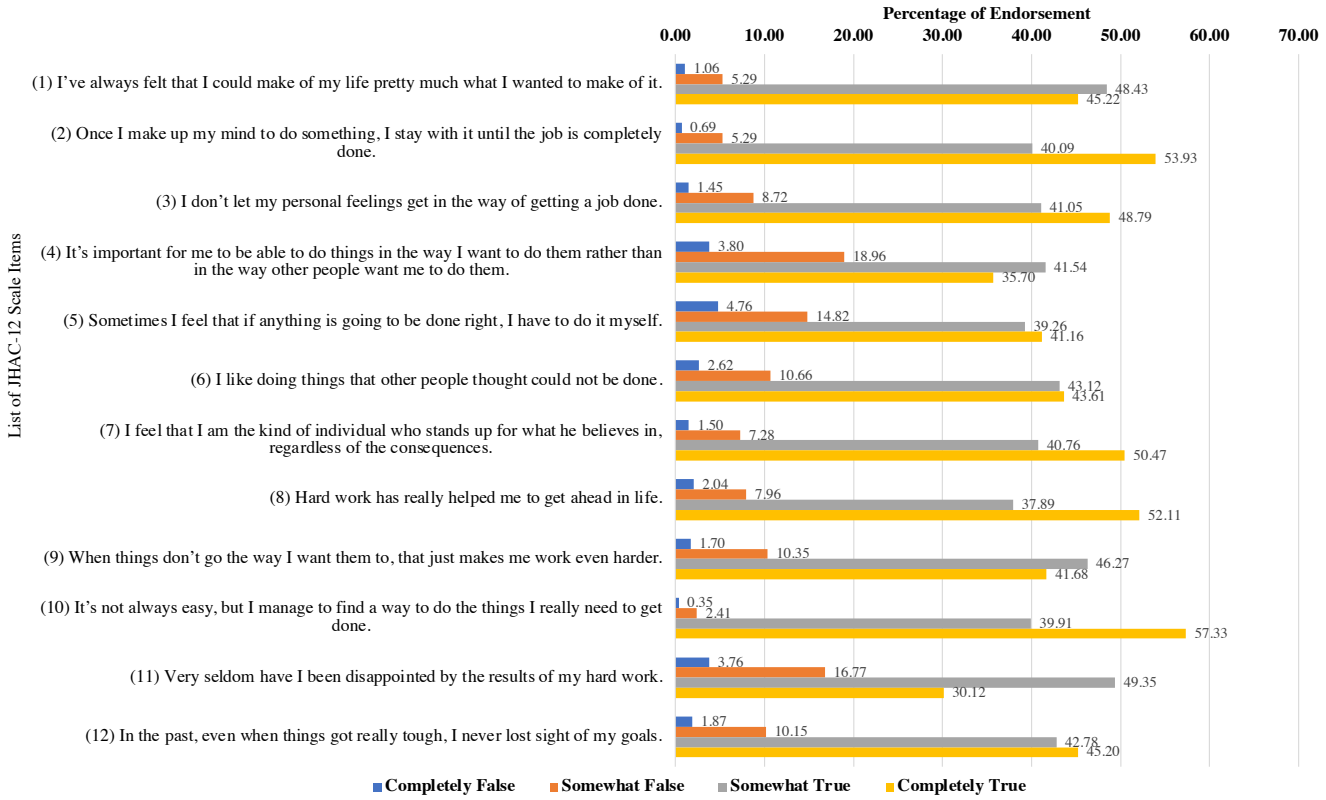
Weighted means and proportions were also calculated to better understand the distribution of John Henryism, social stressors, and sociodemographic characteristics among Black women. Table 1B shows the distribution of these sample characteristics. While not a majority, a large portion of the sample (47.42%) reported moderate John Henryism, while 20.13% reported low John Henryism, and 32.45% reported high John Henryism. While the range for chronic stress was 0 to 8, most women reported about two chronic stressors (m=1.86; SD=1.93). The range for everyday discrimination was 0 to 50, most women reported an average score of almost 11 (m=10.93; SD=10.92). Most of the sample (36.27%) reported moderate goal-striving stress, while 30.71% reported low goal-striving stress, and 33.01% reported high goal-striving stress. These findings demonstrate that most women reported relatively low stress exposure. Although the range for age was 18 to 93, most women were about 42 years of age (m=42.29; SD=20.06), which illustrates that women were about middle-aged. While the range for SES was -4.45 to 6.93, most women reported an SES score of -0.08 (m=-0.08; SD=1.96), which indicates that most women were of lower SES.

Overall, Black women engaged in moderate levels of high-effort coping, reported fairly low levels of stress exposure, with the exception of goal-striving stress, were middle-aged, and of lower SES.

6.2 *Meaning of John Henryism*

6.2.1 Frequencies of John Henryism Items

FIGURE 8: Distribution of John Henryism Active Coping Scale (JHAC-12) Items Among Black Women, National Survey of American Life (NSAL 2001-2003), N=1,580



To better understand the frequency of John Henryism item endorsement among Black women (Aim 1.1), and to capture which components of John Henryism Black women are more apt to identify with, the distribution of John Henryism items was examined. Figure 8 shows the distribution of John Henryism item endorsement among Black women. For the following items, most Black women reported that they were "completely true" for them: (2) Once I make up my mind to do something, I stay with it until the job is completely done; (3) I don't let my personal feelings get in the way of getting a job done; (5) Sometimes I feel that if anything is going to be done right, I have to do it myself; (6) I like doing things that other people thought could not be done; (7) I feel that I am the kind of individual who stands up for what he believes in, regardless of the consequences; (8) Hard work has really helped me to get ahead in life; (10) It's not always easy, but I manage to find a way to do the things I really need to get done; (12) In the past, even

when things got really tough, I never lost sight of my goals. However, trends were different for the following items, such that most Black women reported these items as "somewhat true" for them: (1) I've always felt that I could make of my life pretty much what I wanted to make of it; (4) It's important for me to be able to do things in the way I want to do them rather than in the way other people want me to do them; (9) When things don't go the way I want them to, that just makes me work even harder; (11) Very seldom have I been disappointed by the results of my hard work. Overall, most Black women endorsed the John Henryism Active Coping Scale (JHAC-12) items as "completely true" or "somewhat true".

6.2.2 Underlying Factors in John Henryism Construct for Black Women

As previously noted, the construct of John Henryism was developed based on the experiences of Black men (James et al. 1983; James 1994) and recent scholarship has indicated that some items on the scale may be less relevant for the life experiences of Black women (Adkins-Jackson and Levine 2020). As such, a confirmatory factor analysis was conducted to clarify what factors are present in the John Henryism Active Coping Scale, in addition to identifying items that may be linked to each factor, for Black women (Aim 1.2). Figure 9 shows results from the confirmatory factor analysis of John Henryism items among Black women. For the varimax rotation, items with factor loadings (i.e., correlations) above 0.50 were attributed to that factor. In previous work, Dr. Sherman James indicated that each of the items of the JHAC-12 scale to different degrees captured the following three themes: (1) efficacious mental and physical vigor, (2) a strong commitment to hard work, and (3) a single-minded determination to succeed (James 1994). However, the confirmatory factor analysis of the present study indicated that there were only two distinct John Henryism factors among Black women. There was a 0.56 correlation between these two factors.

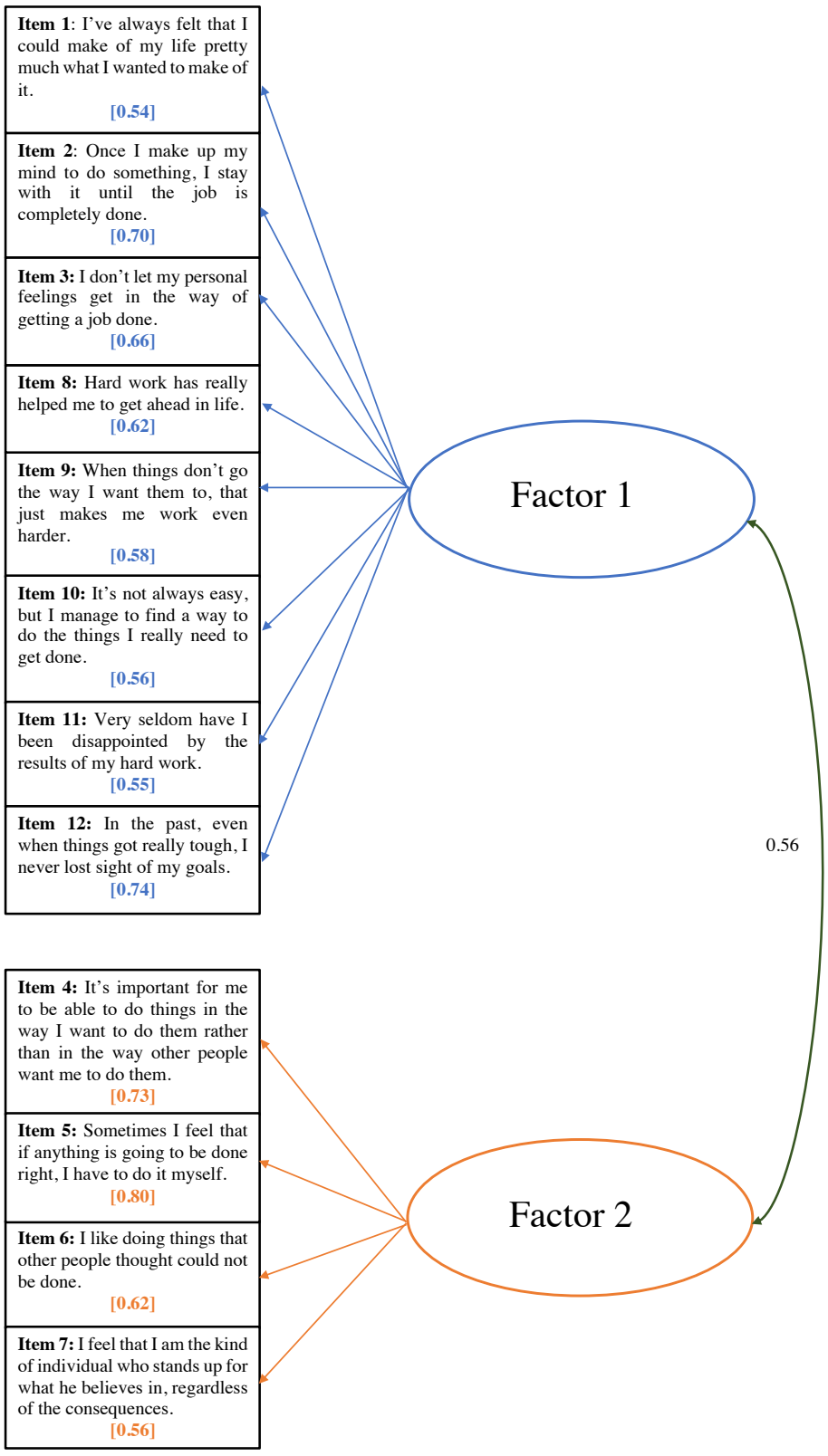


FIGURE 9: Confirmatory Factor Analysis of John Henryism Items among Black Women, National Survey of American Life (NSAL 2001-2003), N=1,580

Factor 1 included the following items:

(1) I've always felt that I could make of my life pretty much what I wanted to make of it.

(2) Once I make up my mind to do something, I stay with it until the job is completely done.

(3) I don't let my personal feelings get in the way of getting a job done.

(8) Hard work has really helped me to get ahead in life.

(9) When things don't go the way I want them to, that just makes me work even harder.

(10) It's not always easy, but I manage to find a way to do the things I really need to get done.

(11) Very seldom have I been disappointed by the results of my hard work.

(12) In the past, even when things got really tough, I never lost sight of my goals.

Collectively, these items captured two themes simultaneously: (1) efficacious mental and physical vigor and (2) a strong commitment to hard work.

Factor 2 included the following items:

(4) It's important for me to be able to do things in the way I want to do them rather than in the way other people want me to do them.

(5) Sometimes I feel that if anything is going to be done right, I have to do it myself.

(6) I like doing things that other people thought could not be done.

(7) I feel that I am the kind of individual who stands up for what he believes in, regardless of the consequences.

Collectively, these items captured the theme of "a single-minded determination to succeed".

To summarize, Factor 1 items capture the themes of unrelenting mental and physical stamina and a dedication to hard work. Factor 2 items capture the theme of a steadfast resolve to achieve. The confirmatory factor analysis demonstrated that the 12 items in some way capture the three themes originally conceptualized by Dr. James. However, given that only two factors were found, there may not be a clear delineation in terms of items and factors that capture distinct themes for John Henryism among Black women. In other words, John Henryism may have a unique meaning for Black women.

6.3 *Correlates of John Henryism*

6.3.1 Sociodemographic and Stress-Related Correlates of John Henryism

TABLE 2: Multinomial Logistic Regression Estimating the Association Between Sociodemographic Characteristics, Stressors, and John Henryism among Black Women, National Survey of American Life (2001-2003), N=1,580

	Moderate JH			High JH		
	RRR	95% CI	p-value	RRR	95% CI	p-value
Chronic Stress	1.08	0.96-1.22	p=0.21	1.01	0.89-1.15	p=0.82
Everyday Discrimination	1.00	0.98-1.02	p=0.89	1.00	0.98-1.03	p=0.66
Goal Striving Stress (GSS)						
Low GSS (Ref.)						
Moderate GSS	0.91	0.60-1.39	p=0.66	0.93	0.64-1.35	p=0.69
High GSS	0.98	0.61-1.56	p=0.92	1.20	0.74-1.96	p=0.45
Age	1.00	0.99-1.01	p=0.61	0.99	0.98-1.00	p=0.20
Socioeconomic Status	0.93	0.84-1.04	p=0.19	0.93	0.82-1.04	p=0.21
Ethnicity						
African American (Ref.)						
Caribbean Black	1.00	0.57-1.76	p=0.99	0.97	0.57-1.66	p=0.92
Intercept	2.46	1.18-5.15	p<0.05	1.97	0.86-4.53	p=0.11

Note: Ref.=reference category; Low John Henryism is the reference category for analysis; RRR= relative risk ratio

Table 2 shows results for evaluating the association between sociodemographic characteristics, stressors, and John Henryism (Aim 1.3). Results indicate that none of these factors were significantly associated with differences in John Henryism among Black women.

Taken together, Aim 1 findings indicate that most Black women in the NSAL (2001-2003) report good mental and physical health, lower SES, and are middle-aged. Results also demonstrate

that John Henryism holds significance for most Black women and that among this group, the John Henryism construct taps into two themes as opposed to three. Furthermore, sociodemographic characteristics and stressors did not contribute to differences in levels of John Henryism (i.e., low, moderate, high) among Black women in this sample.

6.4 *John Henryism and Mental Health*

6.4.1 Direct association between John Henryism and mental health among Black women.

TABLE 3: Direct Association Between John Henryism and Mental Health among Black Women, National Survey of American Life (2001-2003), N=1,580

	Psychological Distress	*SRMH*	*Depressive Symptoms*	*Past-Year MDD*
John Henryism (JH)				
Low JH (Ref.)				
Moderate JH	1.10	1.09	1.94*	1.48
	[0.90-1.33]	[0.70-1.69]	[1.05-3.58]	[0.68-3.21]
High JH	1.05	1.16	2.45**	1.94*
	[0.83-1.32]	[0.70-1.92]	[1.28-4.71]	[1.08-3.51]
Intercept	3.79***	0.14***	0.07***	0.05***
	[3.18-4.52]	[0.09-0.22]	[0.04-0.11]	[0.03-0.10]
F-Statistic	0.48	0.18	3.81*	2.87
df	(2, 56)	(2, 56)	(2, 56)	(2, 56)

Note: Incidence Rate Ratios (IRR), Odds Ratios (OR) Reported. *p<0.05; **p<0.01; ***p<0.001 (two-tailed tests); SRMH=Self-Rated Mental Health; MDD= Major Depressive Disorder; Logistic regression used for SRMH, Depressive Symptoms, and Past-Year MDD; Negative binomial regression used for psychological distress; F-Statistic=Adjusted Wald Test (joint-test) df= degrees of freedom

To assess the direct association between John Henryism and mental health among Black women, regression analyses were conducted to clarify the direct association between John Henryism and each mental health outcome (Aim 2.1). Table 3 shows the direct associations between John Henryism and mental health outcomes among Black women. Overall, John Henryism was directly associated with one of the mental health outcomes, while only certain levels of John Henryism were directly associated with another mental health outcome. More specifically, while there was not a direct association between John Henryism and psychological distress or self-rated mental health, John Henryism was directly associated with depressive symptoms (F (2,

56)=3.81; p<0.05). Compared to those engaged in low John Henryism, those engaged in moderate John Henryism reported greater odds of high depressive symptoms (OR=1.94; 95% CI=1.05-3.58; p<0.05). Compared to those engaged in low John Henryism, those engaged in high John Henryism reported higher odds of high depressive symptoms (OR=2.45; 95% CI= 1.28-4.71; p<0.01). In other words, moderate and high levels of John Henryism were associated with higher odds of high-risk depressive symptoms. While John Henryism was not overall directly associated with past-year major depressive disorder (F(2, 56)= 2.87; p>0.05), a specific level of John Henryism was. Relative to those engaged in low John Henryism, those engaged in high John Henryism reported higher odds of past-year major depressive disorder (OR=1.94; 95% CI: 1.08-3.51; p<0.05). To put it another way, high John Henryism was associated with higher odds of past-year major depressive disorder. Collectively, these findings demonstrate that higher levels of John Henryism were associated with higher odds of high-risk depressive symptoms and past-year major depressive disorder among Black women.

6.4.2 John Henryism and Mental Health Association Mechanisms

To further assess the potential mechanisms through which John Henryism may shape mental health among Black women, a series of analyses were conducted for each mental health outcome. The association between John Henryism and mental health, accounting for sociodemographic characteristics was examined (Aim 2.2; Model 2). The association between John Henryism and mental health was assessed, with SES as a potential moderating variable (Aim 2.3; Model 3). The association between stress and mental health was assessed, with John Henryism as a potential moderating variable (Aim 2.4; Models 4-6). For clarity, the results for these analyses will be presented for each mental health outcome in consecutive order.

6.4.2.1 Psychological Distress

Table 4 shows the association between John Henryism and psychological distress among Black women. After accounting for sociodemographic characteristics and stressors (Model 2), John Henryism remained unassociated with psychological distress. SES did not moderate the association between John Henryism and psychological distress (Model 3), nor did John Henryism moderate the association between any of the stressors and psychological distress (Models 4-6). Overall, John Henryism was not significantly associated with psychological distress among Black women through the mechanisms assessed.

6.4.2.2 Self-Rated Mental Health

Table 5 shows the association between John Henryism and self-rated mental health among Black women. After accounting for sociodemographic characteristics and stressors (Model 2), John Henryism remained unassociated with self-rated mental health. SES did not moderate the association between John Henryism and self-rated mental health (Model 3), nor did John Henryism moderate the association between any of the stressors and self-rated mental health (Models 4-6). Overall, John Henryism was not significantly associated with self-rated mental health among Black women through the mechanisms assessed.

6.4.2.3 Depressive Symptoms

Table 6 shows the association between John Henryism and depressive symptoms among Black women. After accounting for sociodemographic characteristics and stressors (Model 2), John Henryism was no longer associated with self-rated mental health. SES did not moderate the association between John Henryism and depressive symptoms (Model 3).

TABLE 4: Negative Binomial Regression Examining the Association Between John Henryism and Psychological Distress among Black Women, National Survey of American Life (2001-2003), N=1,580

	Model 1	*Model 2*	*Model 3*	*Model 4*	*Model 5*	*Model 6*
John Henryism (JH)						
Low JH (Ref.)						
Moderate JH		0.94	0.93	1.00	0.82	0.96
		[0.77-1.15]	[0.76-1.14]	[0.68-1.46]	[0.57-1.17]	[0.66-1.38]
High JH		0.84	0.84	0.94	0.75	0.86
		[0.67-1.05]	[0.68-1.05]	[0.59-1.49]	[0.51-1.11]	[0.57-1.29]
Stressors						
Chronic Stress	1.32***	1.31***	1.31***	1.36***	1.32***	1.31***
	[1.25-1.39]	[1.25-1.38]	[1.25-1.38]	[1.21-1.54]	[1.25-1.39]	[1.25-1.38]
Everyday Discrimination	1.03***	1.03***	1.03***	1.03***	1.02	1.03***
	[1.02-1.04]	[1.02-1.04]	[1.02-1.04]	[1.02-1.04]	[1.00-1.04]	[1.02-1.04]
Goal Striving Stress (GSS)						
Low GSS (Ref.)						
Moderate GSS	0.97	0.97	0.97	0.97	0.97	0.95
	[0.81-1.15]	[0.81-1.15]	[0.81-1.16]	[0.81-1.16]	[0.81-1.16]	[0.67-1.35]
High GSS	1.06	1.06	1.06	1.06	1.05	1.14
	[0.87-1.28]	[0.88-1.28]	[0.87-1.29]	[0.88-1.29]	[0.87-1.28]	[0.71-1.82]
Sociodemographic Characteristics						
Age	0.99*	0.99*	0.99*	0.99*	0.99*	0.99*
	[0.99-1.00]	[0.99-1.00]	[0.99-1.00]	[0.99-1.00]	[0.99-1.00]	[0.99-1.00]
SES	0.85***	0.85***	0.89*	0.85***	0.85***	0.85***
	[0.81-0.89]	[0.81-0.89]	[0.80-0.99]	[0.81-0.89]	[0.81-0.89]	[0.81-0.89]
Ethnicity						
African American (Ref.)						
Caribbean Black	1.13	1.12	1.13	1.12	1.12	1.13
	[0.87-1.47]	[0.87-1.46]	[0.86-1.49]	[0.86-1.46]	[0.86-1.45]	[0.87-1.45]
John Henryism x SES						
Low JH x SES (Ref.)						
Moderate JH x SES			0.90			
			[0.78-1.05]			
High JH x SES			0.98			
			[0.84-1.14]			
John Henryism x Chronic Stress						
Low JH x Chronic Stress (Ref.)						
Moderate JH x Chronic Stress				0.97		
				[0.84-1.11]		
High JH x Chronic Stress				0.94		
				[0.80-1.10]		
John Henrysim x Everyday Discrimination						
Low JH x Everyday Discrimination (Ref.)						
Moderate JH x Everyday Discrimination					1.01	
					[0.99-1.04]	
High JH x Everyday Discrimination					1.01	
					[0.99-1.03]	
John Henryism x Goal Striving Stress						
Low JH x Low GSS (Ref.)						
Moderate JH x Moderate GSS						1.02
						[0.61-1.71]
Moderate JH x High GSS						0.93
						[0.51-1.71]
High JH x Moderate GSS						1.03
						[0.63-1.66]
High JH x High GSS						0.90
						[0.44-1.81]
Intercept	1.78***	1.96***	1.98***	1.82**	2.18***	1.93**
	[1.39-2.27]	[1.49-2.57]	[1.50-2.60]	[1.18-2.80]	[1.49-3.20]	[1.30-2.87]
F-Statistic		1.58	1.05	0.31	0.59	0.06
df		(2, 56)	(2, 56)	(2, 56)	(2, 56)	(4, 54)

Note: Incidence Rate Ratios (IRR) Reported. *p<0.05; **p<0.01; ***p<0.001 (two-tailed tests); F-Statistic=Adjusted Wald Test (joint-test); df=degrees of freedom

TABLE 5: Logistic Regression Examining the Association Between John Henryism and Self-Rated Mental Health among Black Women, National Survey of American Life (2001-2003), N=1,580

	Model 1	*Model 2*	*Model 3*	*Model 4*	*Model 5*	*Model 6*
John Henryism (JH)						
Low JH (Ref.)						
Moderate JH		0.90	0.77	1.48	0.78	0.78
		[0.52-1.56]	[0.42-1.39]	[0.51-4.29]	[0.30-2.03]	[0.27-2.28]
High JH		0.89	0.86	0.85	0.44	0.42
		[0.50-1.56]	[0.44-1.68]	[0.34-2.11]	[0.17-1.14]	[0.11-1.66]
Stressors						
Chronic Stress	1.49***	1.50***	1.50***	1.65**	1.49***	1.50***
	[1.36-1.64]	[1.36-1.65]	[1.36-1.65]	[1.22-2.23]	[1.35-1.64]	[1.36-1.65]
Everyday Discrimination	1.04***	1.04***	1.04***	1.04***	1.02	1.04***
	[1.02-1.07]	[1.02-1.07]	[1.02-1.07]	[1.02-1.07]	[0.96-1.07]	[1.02-1.07]
Goal Striving Stress (GSS)						
Low GSS (Ref.)						
Moderate GSS	1.81	1.80	1.79	1.81*	1.86*	1.33
	[0.99-3.29]	[0.99-3.28]	[0.98-3.26]	[1.01-3.27]	[1.00-3.44]	[0.57-3.11]
High GSS	2.52**	2.53**	2.54**	2.53**	2.57**	1.80
	[1.50-4.26]	[1.51-4.23]	[1.51-4.26]	[1.50-4.28]	[1.54-4.29]	[0.57-5.69]
Sociodemographic Characteristics						
Age	1.02**	1.02**	1.02**	1.02*	1.02*	1.02*
	[1.01-1.03]	[1.01-1.03]	[1.01-1.03]	[1.00-1.04]	[1.00-1.03]	[1.00-1.04]
SES	0.66***	0.65***	0.74*	0.65***	0.66***	0.65***
	[0.56-0.77]	[0.56-0.77]	[0.57-0.95]	[0.55-0.77]	[0.56-0.77]	[0.55-0.77]
Ethnicity						
African American (Ref.)						
Caribbean Black	0.55	0.56	0.56	0.54	0.55	0.57
	[0.27-1.12]	[0.28-1.12]	[0.28-1.11]	[0.26-1.09]	[0.27-1.13]	[0.28-1.17]
John Henryism x SES						
Low JH x SES (Ref.)						
Moderate JH x SES			0.79			
			[0.59-1.07]			
High JH x SES			0.93			
			[0.60-1.45]			
John Henryism x Chronic Stress						
Low JH x Chronic Stress (Ref.)						
Moderate JH x Chronic Stress				0.82		
				[0.57-1.18]		
High JH x Chronic Stress				1.00		
				[0.72-1.40]		
John Henrysim x Everyday Discrimination						
Low JH x Everyday Discrimination (Ref.)						
Moderate JH x Everyday Discrimination					1.01	
					[0.95-1.08]	
High JH x Everyday Discrimination					1.05	
					[0.98-1.13]	
John Henryism x Goal Striving Stress						
Low JH x Low GSS (Ref.)						
Moderate JH x Moderate GSS						1.13
						[0.30-4.18]
Moderate JH x High GSS						1.25
						[0.28-5.63]
High JH x Moderate GSS						2.55
						[0.58-11.18]
High JH x High GSS						2.42
						[0.43-13.50]
Intercept	0.01***	0.01***	0.01***	0.01***	0.01***	0.01***
	[0.00-0.02]	[0.00-0.02]	[0.00-0.03]	[0.00-0.03]	0.00-0.04]	[0.00-0.03]
F-Statistic		0.10	1.20	0.97	2.00	0.44
df		(2, 56)	(2, 56)	(2, 56)	(2, 56)	(4, 54)

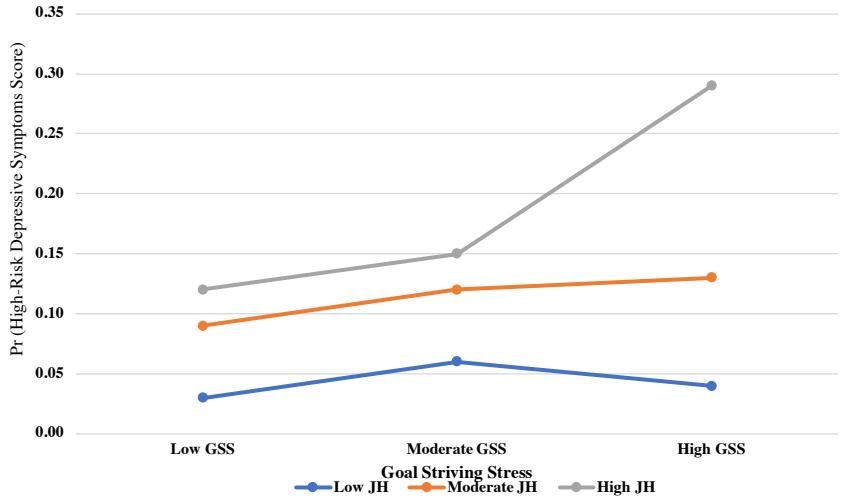
Note: Odds Ratios (OR) Reported. *p<0.05; **p<0.01; ***p<0.001 (two-tailed tests); F-Statistic=Adjusted Wald Test (joint test); df=degrees of freedom

TABLE 6: Logistic Regression Examining the Association Between John Henryism and Depressive Symptoms among Black Women, National Survey of American Life (2001-2003), N=1,580

	Model 1	*Model 2*	*Model 3*	*Model 4*	*Model 5*	*Model 6*
John Henryism (JH)						
Low JH (Ref.)						
Moderate JH		1.63	1.44	2.08	1.34	2.25
		[0.85-3.14]	[0.74-2.81]	[0.58-7.40]	[0.37-4.86]	[0.52-9.72]
High JH		1.80	1.87	3.18	1.36	1.22
		[0.85-3.83]	[0.78-4.48]	[0.76-13.34]	[0.45-4.17]	[0.23-6.45]
Stressors						
Chronic Stress	1.52***	1.51***	1.51***	1.72***	1.51***	1.52***
	[1.34-1.72]	[1.33-1.72]	[1.33-1.72]	[1.29-2.29]	[1.31-1.74]	[1.33-1.73]
Everyday Discrimination	1.06***	1.06***	1.06***	1.06***	1.05	1.06***
	[1.04-1.08]	[1.04-1.08]	[1.04-1.08]	[1.04-1.09]	[0.99-1.11]	[1.04-1.08]
Goal Striving Stress (GSS)						
Low GSS (Ref.)						
Moderate GSS	1.13	1.15	1.14	1.14	1.16	2.15
	[0.57-2.23]	[0.59-2.25]	[0.58-2.22]	[0.58-2.25]	[0.59-2.29]	[0.41-11.25]
High GSS	2.52**	2.49**	2.52**	2.50**	2.50**	1.59
	[1.28-4.95]	[1.28-4.88]	[1.29-4.93]	[1.27-4.90]	[1.27-4.90]	[0.35-7.29]
Sociodemographic Characteristics						
Age	1.00	1.00	1.00	1.00	1.00	1.00
	[0.98-1.02]	[0.98-1.02]	[0.98-1.02]	[0.98-1.02]	[0.98-1.02]	[0.98-1.02]
SES	0.64***	0.65***	0.68*	0.65***	0.65***	0.66***
	[0.57-0.73]	[0.57-0.74]	[0.50-0.92]	[0.57-0.74]	[0.57-0.74]	[0.58-0.74]
Ethnicity						
African American (Ref.)						
Caribbean Black	0.36**	0.34**	0.34**	0.36**	0.34**	0.35**
	[0.20-0.65]	[0.19-0.64]	[0.18-0.64]	[0.20-0.64]	[0.18-0.64]	[0.19-0.64]
John Henryism x SES						
Low JH x SES (Ref.)						
Moderate JH x SES			0.86			
			[0.60-1.22]			
High JH x SES			1.05			
			[0.65-1.69]			
John Henryism x Chronic Stress						
Low JH x Chronic Stress (Ref.)						
Moderate JH x Chronic Stress				0.91		
				[0.63-1.33]		
High JH x Chronic Stress				0.81		
				[0.55-1.20]		
John Henrysim x Everyday Discrimination						
Low JH x Everyday Discrimination (Ref.)						
Moderate JH x Everyday Discrimination					1.01	
					[0.94-1.10]	
High JH x Everyday Discrimination					1.02	
					[0.95-1.09]	
John Henryism x Goal Striving Stress						
Low JH x Low GSS (Ref.)						
Moderate JH x Moderate GSS						0.46
						[0.08-2.72]
Moderate JH x High GSS						1.02
						[0.17-6.07]
High JH x Moderate GSS						0.48
						[0.06-3.60]
High JH x High GSS						3.53
						[0.49-25.38]
Intercept	0.01***	0.01***	0.01***	0.01***	0.01***	0.01***
	[0.00-0.03]	[0.00-0.02]	[0.00-0.02]	[0.00-0.01]	[0.00-0.02]	[0.00-0.03]
F-Statistic		1.36	0.64	0.57	0.16	3.58*
df		(2, 56)	(2, 56)	(2, 56)	(2, 56)	(4, 54)

Note: Odds Ratios (OR) Reported. *p<0.05; **p<0.01; ***p<0.001 (two-tailed tests ; F-Statistic=Adjusted Wald Test (joint-test); df=degrees of freedom

FIGURE 10: John Henryism Moderates the Association Between Goal-Striving Stress and Depressive Symptoms among Black Women (NSAL 2001-2003), N=1,580



Note: F (4, 54) = 3.58; p<0.05; GSS= Goal-Striving Stress

After examining whether John Henryism may buffer or mitigate the negative impact of stress on depressive symptoms, results from a significant interaction between John Henryism and goal-striving stress indicate that John Henryism moderated the association between goal-striving stress and depressive symptoms among Black women, as evidenced by the adjusted wald test ($F(4, 54)=3.58$; $p<0.05$). Figure 10 shows these results (see Table 6; Model 6). There was not a significant association between goal-striving stress and depressive symptoms for women who engaged in low or moderate John Henryism. However, the expected association was found among women who endorsed high John Henryism, such that high goal-striving stress was linked to significantly higher depressive symptoms for this group. Overall, John Henryism conditioned the impact of goal-striving stress on depressive symptoms. More specifically, high levels of John Henryism were particularly impactful. Rather than mitigating the negative impact of goal-striving stress on depressive symptoms, this association was significantly worse for Black women who endorsed high John Henryism.

TABLE 7: Logistic Regression Examining the Association Between John Henryism and Past-Year Major Depressive Disorder among Black National Survey of American Life (2001-2003), N=1,580

	Model 1	*Model 2*	*Model 3*	*Model 4*	*Model 5*	*Model 6*
John Henryism (JH)						
Low JH (Ref.)						
Moderate JH		1.27	1.27	2.15	0.71	1.95
		[0.57-2.85]	[0.55-2.95]	[0.57-8.17]	[0.20-2.55]	[0.30-12.63]
High JH		1.46	1.69	0.87	0.56	2.55
		[0.79-2.72]	[0.92-3.11]	[0.25-2.99]	[0.18-1.73]	[0.44-14.68]
Stressors						
Chronic Stress	1.49***	1.48***	1.49***	1.53*	1.48***	1.49***
	[1.29-1.73]	[1.28-1.72]	[1.29-1.72]	[1.10-2.12]	[1.28-1.72]	[1.29-1.71]
Everyday Discrimination	1.04**	1.04**	1.04**	1.04**	0.99	1.04**
	[1.02-1.07]	[1.02-1.07]	[1.02-1.07]	[1.01-1.06]	[0.94-1.04]	[1.01-1.06]
Goal Striving Stress (GSS)						
Low GSS (Ref.)						
Moderate GSS	1.44	1.45	1.44	1.45	1.52	2.72
	[0.73-2.82]	[0.74-2.82]	[0.74-2.81]	[0.74-2.86]	[0.77-3.00]	[0.48-15.42]
High GSS	1.72	1.70	1.75	1.70	1.71	2.42
	[0.89-3.33]	[0.87-3.33]	[0.88-3.49]	[0.86-3.37]	[0.87-3.36]	[0.45-13.00]
Sociodemographic Characteristics						
Age	0.99	0.99	0.99	0.99	0.99	0.99
	[0.97-1.01]	[0.97-1.01]	[0.97-1.01]	[0.97-1.01]	[0.97-1.01]	[0.97-1.01]
SES	0.85	0.86	0.71*	0.86	0.86	0.87
	[0.70-1.04]	[0.71-1.05]	[0.51-0.99]	[0.70-1.05]	[0.71-1.05]	[0.71-1.06]
Ethnicity						
African American (Ref.)						
Caribbean Black	0.92	0.91	0.92	0.84	0.90	0.88
	[0.53-1.61]	[0.52-1.59]	[0.54-1.59]	[0.47-1.52]	[0.52-1.57]	[0.51-1.52]
John Henryism x SES						
Low JH x SES (Ref.)						
Moderate JH x SES			1.08			
			[0.69-1.67]			
High JH x SES			1.47			
			[0.97-2.22]			
John Henryism x Chronic Stress						
Low JH x Chronic Stress (Ref.)						
Moderate JH x Chronic Stress				0.82		
				[0.59-1.14]		
High JH x Chronic Stress				1.18		
				[0.79-1.75]		
John Henrysim x Everyday Discrimination						
Low JH x Everyday Discrimination (Ref.)						
Moderate JH x Everyday Discrimination					1.05	
					[0.98-1.12]	
High JH x Everyday Discrimination					1.07*	
					[1.01-1.14]	
John Henryism x Goal Striving Stress						
Low JH x Low GSS (Ref.)						
Moderate JH x Moderate GSS						0.60
						[0.09-4.04]
Moderate JH x High GSS						0.62
						[0.08-4.86]
High JH x Moderate GSS						0.34
						[0.04-2.70]
High JH x High GSS						0.71
						[0.11-4.58]
Intercept	0.02***	0.02***	0.02***	0.02***	0.03***	0.01***
	[0.01-0.05]	[0.01-0.04]	[0.01-0.04]	[0.00-0.06]	[0.01-0.11]	[0.00-0.05]
F-Statistic		0.87	2.03	2.41	3.19*	0.36
df		(2, 56)	(2, 56)	(2, 56)	(2, 56)	(4, 54)

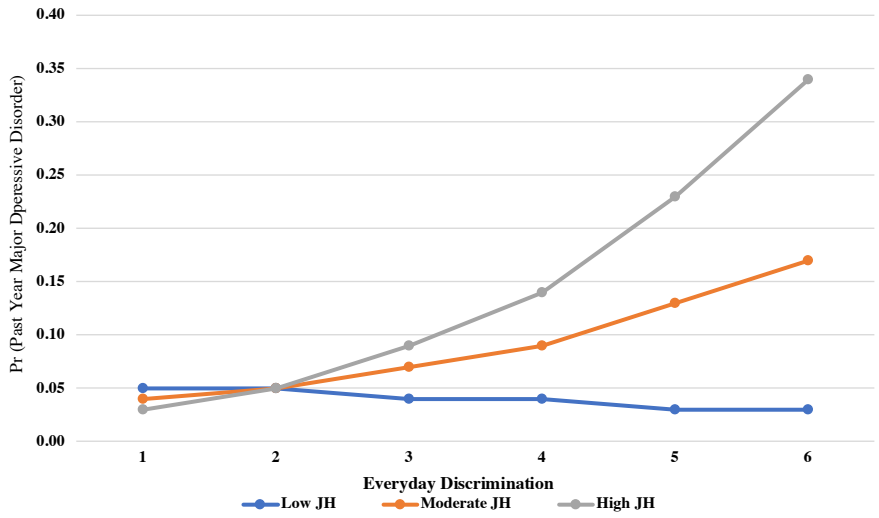
Note: Odds Ratios (OR) Reported. *p<0.05; **p<0.01; ***p<0.001 (two-tailed tests ; F-Statistic=Adjusted Wald Test (joint test); df=degrees of freedom

6.4.2.4 Past-Year Major Depressive Disorder

Table 7 shows the association between John Henryism and past-year major depressive disorder among Black women. After accounting for sociodemographic characteristics and

stressors (Model 2), John Henryism was no longer associated with past-year major depressive disorder. SES did not moderate the association between John Henryism and depressive symptoms (Model 3).

FIGURE 11: John Henryism Moderates the Association Between Everyday Discrimination and Past-Year Major Depressive Disorder among Black Women (NSAL 2001-2003), N=1,580



Note: F (2, 56) = 3.19; p<0.05

After examining whether John Henryism may buffer or mitigate the negative impact of stress on depressive symptoms, results from a significant interaction between John Henryism and everyday discrimination show that John Henryism moderated the association between everyday discrimination and past-year major depressive disorder among Black women ($F(2, 56)=3.19$; $p<0.05$). Figure 11 shows these results (see Table 7; Model 5). Compared to women engaged in low John Henryism, there was not a significant association between everyday discrimination and past-year major depressive disorder among Black women who endorsed moderate John Henryism. However, the expected association was found among Black women who engaged in high John Henryism, such that higher levels of everyday discrimination were linked to higher endorsement of past-year major depressive disorder for this group. Overall, John Henryism conditioned the impact of everyday discrimination on depressive symptoms. High levels of John Henryism were

particularly influential. Instead of buffering the adverse effects of everyday discrimination on past-year major depressive disorder, for women who engaged in high John Henryism, it was exacerbated.

6.4.3 Summary of Mental Health Findings among Black Women

No association was found between John Henryism and psychological distress or self-rated mental health through any of the mechanisms tested. However, different patterns emerged for depressive symptoms and past-year major depressive disorder. A direct association was found between John Henryism and depressive symptoms and John Henryism and past-year major depressive disorder, such that higher John Henryism was associated with greater odds of these mental health outcomes. Once sociodemographic characteristics and stressors were accounted for, these associations were no longer observed. Although SES did not moderate the association between John Henryism and depressive symptoms and past-year major depressive disorder, other evidence of buffering was found. For instance, while high John Henryism moderated the impact of goal-striving stress on depressive symptoms, it also moderated the impact of everyday discrimination on past-year major depressive disorder. In other words, among Black women engaged in high John Henryism, the association between goal-striving stress and depressive symptoms was heightened, and the same was found for the link between everyday discrimination and past-year major depressive disorder. In summation, John Henryism significantly shaped depressive symptoms and past-year major depressive disorder but not psychological distress or self-rated mental health among Black women.

6.5 *John Henryism and Physical Health*

6.5.1 Direct association between John Henryism and physical health among Black women.

TABLE 8: Direct Association Between John Henryism and Physical Health among Black Women, National Survey of American Life (2001-2003), N=1,580

	SRH	*Chronic Health Conditions*
John Henryism (JH)		
Low JH (Ref.)		
Moderate JH	0.86	1.10
	[0.60-1.23]	[0.91-1.33]
High JH	0.66	1.03
	[0.42-1.05]	[0.87-1.22]
Intercept	0.35***	1.76***
	[0.25-0.50]	[1.49-2.08]
F-Statistic	1.64	0.59
df	(2, 56)	(2, 56)

Note: Incidence Rate Ratios (IRR), Odds Ratios (OR) Reported. SRH=Self-Rated Health; *p<0.05; **p<0.01 ***p<0.001 (two-tailed tests); Logistic regression used for SRH; Negative binomial regression used for chronic health conditions; F-Statistic=Adjusted Wald Test (joint-test); df=degrees of freedom

To assess the direct association between John Henryism and physical health among Black women, regression analyses were conducted to clarify the direct association between John Henryism and each mental health outcome (Aim 3.1). Table 8 shows the direct association between John Henryism and physical health among Black women. There was no direct association between John Henryism and self-rated health or John Henryism and chronic health conditions among Black women. among the sample.

6.5.2 John Henryism and Physical Health Association Mechanisms

To further assess the potential mechanisms through which John Henryism may shape physical health among Black women, a series of analyses were conducted for each physical health outcome. The association between John Henryism and physical health, accounting for sociodemographic characteristics was examined (Aim 3.2; Model 2). The association between John Henryism and physical health was assessed, with SES as a potential moderating variable (Aim 3.3; Model 3). The association between stress and physical health was assessed, with John Henryism as a potential moderating variable (Aim 3.4; Models 4-6). For clarity, the results for these analyses will be presented for each physical health outcome in consecutive order.

TABLE 9: Logistic Regression Examining the Association Between John Henryism and Self-Rated Health among Black Women, National Survey of American Life (2001-2003), N=1,580

	Model 1	*Model 2*	*Model 3*	*Model 4*	*Model 5*	*Model 6*
John Henryism (JH)						
Low JH (Ref.)						
Moderate JH		0.71	0.75	0.87	0.71	0.86
		[0.43-1.18]	[0.44-1.28]	[0.41-1.83]	[0.33-1.52]	[0.34-2.21]
High JH		0.53*	0.54	0.46	0.47	0.64
		[0.31-0.91]	[0.29-1.01]	[0.21-1.01]	[0.20-1.08]	[0.22-1.89]
Stressors						
Chronic Stress	1.43***	1.44***	1.45***	1.48**	1.44***	1.45***
	[1.30-1.59]	[1.31-1.60]	[1.31-1.60]	[1.15-1.91]	[1.31-1.58]	[1.31-1.60]
Everyday Discrimination	1.01	1.01	1.01	1.01	1.01	1.01
	[0.99-1.03]	[0.99-1.03]	[0.99-1.03]	[0.99-1.03]	[0.96-1.06]	[0.99-1.03]
Goal Striving Stress (GSS)						
Low GSS (Ref.)						
Moderate GSS	1.50	1.50	1.50	1.50*	1.51	1.85
	[1.00-2.27]	[1.00-2.26]	[1.00-2.25]	[1.00-2.25]	[1.00-2.28]	[0.67-5.12]
High GSS	2.06**	2.11**	2.11**	2.11**	2.11**	2.53*
	[1.29-3.28]	[1.33-3.33]	[1.33-3.33]	[1.33-3.35]	[1.36-3.33]	[1.04-6.13]
Sociodemographic Characteristics						
Age	1.03***	1.03***	1.03***	1.03***	1.03***	1.03***
	[1.02-1.04]	[1.02-1.04]	[1.02-1.04]	[1.02-1.04]	[1.02-1.04]	[1.02-1.04]
SES	0.67***	0.67***	0.63**	0.67***	0.67***	0.67***
	[0.58-0.78]	[0.58-0.77]	[0.46-0.86]	[0.58-0.77]	[0.58-0.77]	[0.58-0.77]
Ethnicity						
African American (Ref.)						
Caribbean Black	0.59	0.60	0.60	0.59*	0.60	0.60
	[0.34-1.00]	[0.36-1.01]	[0.36-1.01]	[0.35-0.99]	[0.36-1.00]	[0.36-1.01]
John Henryism x SES						
Low JH x SES (Ref.)						
Moderate JH x SES			1.10			
			[0.74-1.62]			
High JH x SES			1.05			
			[0.72-1.52]			
John Henryism x Chronic Stress						
Low JH x Chronic Stress (Ref.)						
Moderate JH x Chronic Stress				0.92		
				[0.66-1.28]		
High JH x Chronic Stress				1.06		
				[0.78-1.43]		
John Henrysim x Everyday Discrimination						
Low JH x Everyday Discrimination (Ref.)						
Moderate JH x Everyday Discrimination					1.00	
					[0.94-1.07]	
High JH x Everyday Discrimination					1.01	
					[0.95-1.07]	
John Henryism x Goal Striving Stress						
Low JH x Low GSS (Ref.)						
Moderate JH x Moderate GSS						0.76
						[0.21-2.75]
Moderate JH x High GSS						0.79
						[0.27-2.33]
High JH x Moderate GSS						0.76
						[0.20-2.89]
High JH x High GSS						0.79
						[0.23-2.75]
Intercept	0.02***	0.03***	0.03***	0.03***	0.03***	0.03***
	[0.01-0.05]	[0.01-0.07]	[0.01-0.08]	[0.01-0.08]	[0.01-0.08]	[0.01-0.08]
F-Statistic		2.86	0.12	0.86	0.09	0.06
df		(2, 56)	(2, 56)	(2, 56)	(2, 56)	(4, 54)

Note: Odds Ratios (OR) Reported. *p<0.05; **p<0.01; ***p<0.001 (two-tailed tests ; F-Statistic=Adjusted Wald Test (joint-test); df=degrees of freedom

6.5.2.1 Self-Rated Health

Table 9 shows the association between John Henryism and self-rated health among Black women. After accounting for sociodemographic characteristics and stressors (Model 2), though John Henryism overall was not associated with self-rated health ($F(2,56)=2.86$; $p>0.05$), a specific level of John Henryism was. Compared to those engaged in low John Henryism, Black women engaged in high John Henryism reported a 47% decrease in their odds of reporting fair/poor self-rated health, all else equal (OR=0.53; 95% CI=0.31-0.91; $p<0.05$). SES did not moderate the association between John Henryism and psychological distress (Model 3); nor did John Henryism moderate the association between any of the stressors and self-rated health (Models 4-6).

While John Henryism overall was not significantly associated with self-rated health, high John Henryism in particular lowered the odds of fair/poor self-rated health among Black women after accounting for sociodemographic characteristics and stressors.

6.5.2.2 Chronic Health Conditions

Table 10 shows the association between John Henryism and chronic health conditions among Black women. After accounting for sociodemographic characteristics and stressors (Model 2), John Henryism remained unassociated with chronic health conditions among the sample. SES did not moderate the association between John Henryism and chronic health conditions (Model 3), nor did John Henryism did moderate the association between any of the stressors and chronic health conditions (Models 4-6). Overall, John Henryism was not significantly associated with chronic health conditions among Black women through the mechanisms assessed.

TABLE 10: Negative Binomial Regression Examining the Association Between John Henryism and Chronic Health Conditions among Black Women, National Survey of American Life (2001-2003), N=1,580

	Model 1	*Model 2*	*Model 3*	*Model 4*	*Model 5*	*Model 6*
John Henryism (JH)						
Low JH (Ref.)						
Moderate JH		1.08	1.10	1.07	1.06	1.05
		[0.90-1.30]	[0.91-1.32]	[0.80-1.44]	[0.79-1.40]	[0.81-1.36]
High JH		1.06	1.06	0.99	1.06	1.16
		[0.91-1.23]	[0.91-1.23]	[0.77-1.28]	[0.78-1.45]	[0.82-1.63]
Stressors						
Chronic Stress	1.21***	1.21***	1.21***	1.19***	1.21***	1.21***
	[1.16-1.26]	[1.16-1.26]	[1.16-1.26]	[1.09-1.30]	[1.16-1.26]	[1.16-1.26]
Everyday Discrimination	1.00	1.00	1.00	1.00	1.00	1.00
	[1.00-1.01]	[1.00-1.01]	[1.00-1.01]	[1.00-1.01]	[0.99-1.02]	[1.00-1.01]
Goal Striving Stress (GSS)						
Low GSS (Ref.)						
Moderate GSS	1.05	1.05	1.05	1.05	1.05	1.03
	[0.90-1.22]	[0.90-1.22]	[0.90-1.22]	[0.90-1.22]	[0.90-1.22]	[0.71-1.49]
High GSS	1.10	1.10	1.10	1.10	1.10	1.16
	[0.98-1.23]	[0.98-1.24]	[0.98-1.24]	[0.98-1.24]	[0.98-1.23]	[0.84-1.60]
Sociodemographic Characteristics						
Age	1.03***	1.03***	1.03***	1.03***	1.03***	1.03***
	[1.03-1.04]	[1.03-1.04]	[1.03-1.04]	[1.03-1.04]	[1.03-1.04]	[1.03-1.04]
SES	0.99	0.99	0.96	0.99	0.99	0.99
	[0.96-1.02]	[0.96-1.02]	[0.88-1.05]	[0.96-1.03]	[0.96-1.02]	[0.96-1.02]
Ethnicity						
African American (Ref.)						
Caribbean Black	1.11	1.11	1.11	1.11	1.11	1.10
	[0.91-1.35]	[0.91-1.35]	[0.91-1.35]	[0.91-1.34]	[0.91-1.35]	[0.91-1.34]
John Henryism x SES						
Low JH x SES (Ref.)						
Moderate JH x SES			1.07			
			[0.97-1.18]			
High JH x SES			1.01			
			[0.91-1.12]			
John Henryism x Chronic Stress						
Low JH x Chronic Stress (Ref.)						
Moderate JH x Chronic Stress				1.01		
				[0.91-1.11]		
High JH x Chronic Stress				1.03		
				[0.93-1.14]		
John Henrysim x Everyday Discrimination						
Low JH x Everyday Discrimination (Ref.)						
Moderate JH x Everyday Discrimination					1.00	
					[0.99-1.02]	
High JH x Everyday Discrimination					1.00	
					[0.98-1.02]	
John Henryism x Goal Striving Stress						
Low JH x Low GSS (Ref.)						
Moderate JH x Moderate GSS						1.11
						[0.77-1.61]
Moderate JH x High GSS						0.98
						[0.71-1.35]
High JH x Moderate GSS						0.88
						[0.55-1.39]
High JH x High GSS						0.88
						[0.57-1.34]
Intercept	0.25***	0.23***	0.23***	0.24***	0.24***	0.23***
	[0.20-0.31]	0.18-0.30]	[0.18-0.29]	[0.18-0.32]	[0.18-0.31]	[0.17-0.32]
F-Statistic		0.38	1.98	0.32	0.10	0.74
df		(2, 56)	(2, 56)	(2, 56)	(2, 56)	(4, 54)

Note: Incidence Rate Ratios (IRR) Reported. *p<0.05; **p<0.01; ***p<0.001 (two-tailed tests); ; F-Statistic=Adjusted Wald Test (joint-test); df=degrees of freedom

6.5.3 Summary of Physical Health Findings among Black Women

Overall, an association between John Henryism and chronic conditions was not found through the mechanisms assessed. A similar pattern emerged for self-rated health, but with one exception. Once sociodemographic characteristics and stressors were accounted for, high John Henryism resulted in decreased odds of fair/poor self-rated health. In summation, findings indicate that of the mechanisms tested, while John Henryism overall did not shape chronic health conditions or self-rated health among Black women, after accounting for sociodemographic characteristics and stressors, high John Henryism decreased the odds of fair/poor self-rated health.

6.6 *Characteristics among Caribbean Black Women in the National Survey of American Life*

The following sections report findings from an exploratory analysis among Caribbean Black women only.

6.6.1 Distribution of Mental and Physical Health Outcomes among Caribbean Black Women

TABLE 11A: Health Outcomes among Caribbean Black Black Women, National Survey of American Life (2001-2003)

	All (N=371)	
	Mean or %	*SD*
Mental Health Outcomes		
Psychological Distress [0-28][b]	3.86	9.38
Self-Rated Mental Health (SRMH)		
Very Good/Excellent SRMH (Ref.)	92.24	
Fair/Poor SRMH	7.76	
Depressive Symptoms		
Low-Risk (Ref.)	95.17	
High-Risk	4.83	
Past-Year Major Depressive Disorder (MDD)		
No Past-Year MDD (Ref.)	92.78	
Past-Year MDD	7.22	
Physical Health Outcomes		
Self-Rated Health (SRH)		
Very Good/Excellent SRH (Ref.)	85.84	
Fair/Poor SRH	14.16	
Chronic Health Conditions [0-12][b]	2.01	4.70

Note: Ref= reference category; weighted means and percentages reported.

To better understand the distribution of mental and physical health outcomes among Caribbean Black women, weighted means and proportions were calculated. Table 11A shows the distribution of mental and physical health outcomes among Caribbean Black women. Table 11A shows the distribution of mental and physical health outcomes among Caribbean Black women. Overall, Caribbean Black women reported very good mental health. Psychological distress scores ranged from 0 to 28, and the average score was 3.86 (standard deviation, SD=9.38), which indicates that psychological distress scores for Caribbean Black women were relatively low. Approximately 92% of Caribbean Black women reported very good/excellent self-rated mental health, while almost 8% reported fair/poor self-rated mental health. About 95% of Caribbean Black women reported low-risk for clinically significant depressive symptom scores, while about 5% reported high-risk scores. Almost 93% of Caribbean Black women reported no past-year major depressive disorder, while approximately 7% reported past-year major depressive disorder.

Similar trends were present for physical health. Roughly 86% of Caribbean Black women reported very good/excellent self-rated health, while about 14% reported fair/poor self-rated health. While the number of chronic health condition ranged from 0 to 12, most Caribbean Black women reported about two chronic health conditions, on average (m=2.01; SD=4.70), which indicates that most Caribbean Black women had very few chronic health conditions. Yet, because two chronic health conditions are significative of comorbidity, these findings show that Caribbean Black women do experience physical health challenges. Nonetheless, Caribbean Black women reported fairly good mental and physical health.

6.6.2 Distribution of Stressors and Sociodemographic Characteristics among Caribbean Black Women

TABLE 11B: Sample Characteristics of Caribbean Black Women, National Survey of American Life (2001-2003)

	All (N=371)	
	Mean or %	*SD*
John Henryism (JH)		
Low JH (Ref.)	18.21	
Moderate JH	52.40	
High JH	29.39	
Social Stressors		
Chronic Stress [0-8][b]	1.87	3.85
Everyday Discrimination [0-50][b]	12.08	19.95
Goal Striving Stress (GSS) [0-84][b]	6.84	17.40
Sociodemographic Characteristics		
Age [18-92][b]	42.65	33.08
Socioeconomic Status[a] [-4.45-6.93][b]	0.29	3.79

Note: Ref= reference category; weighted means and percentages reported.

To better understand the distribution of John Henryism, social stressors, and sociodemographic characteristics among Caribbean Black women, weighted means and proportions were calculated. Table 11B shows the distribution of these sample characteristics. Overall, a large proportion of Caribbean Black women (52.40%) reported moderate John Henryism, while 18.21% reported low John Henryism, and 29.39% reported high John Henryism, which indicates that most Caribbean Black women engaged in moderate levels of high-effort coping. Overall, most Caribbean Black women reported relatively low stress exposure. While the range for chronic stress was 0 to 8, most women reported about two (m=1.87; SD=3.85), which indicates that most Caribbean Black women reported low exposure to chronic stress. While the range for everyday discrimination was 0 to 50, most Caribbean Black women reported an average score of 12 on the everyday discrimination scale (m=12.08; SD=19.95), which indicates that most Caribbean Black women reported low exposure to everyday discrimination. While the range for goal-striving stress was 0 to 84, most Caribbean Black women reported about 7 (m=6.84; SD=17.04), which indicates that most Caribbean Black women reported low exposure to goal-striving stress. While the range for age was 18 to 92, most Caribbean Black women were about 43

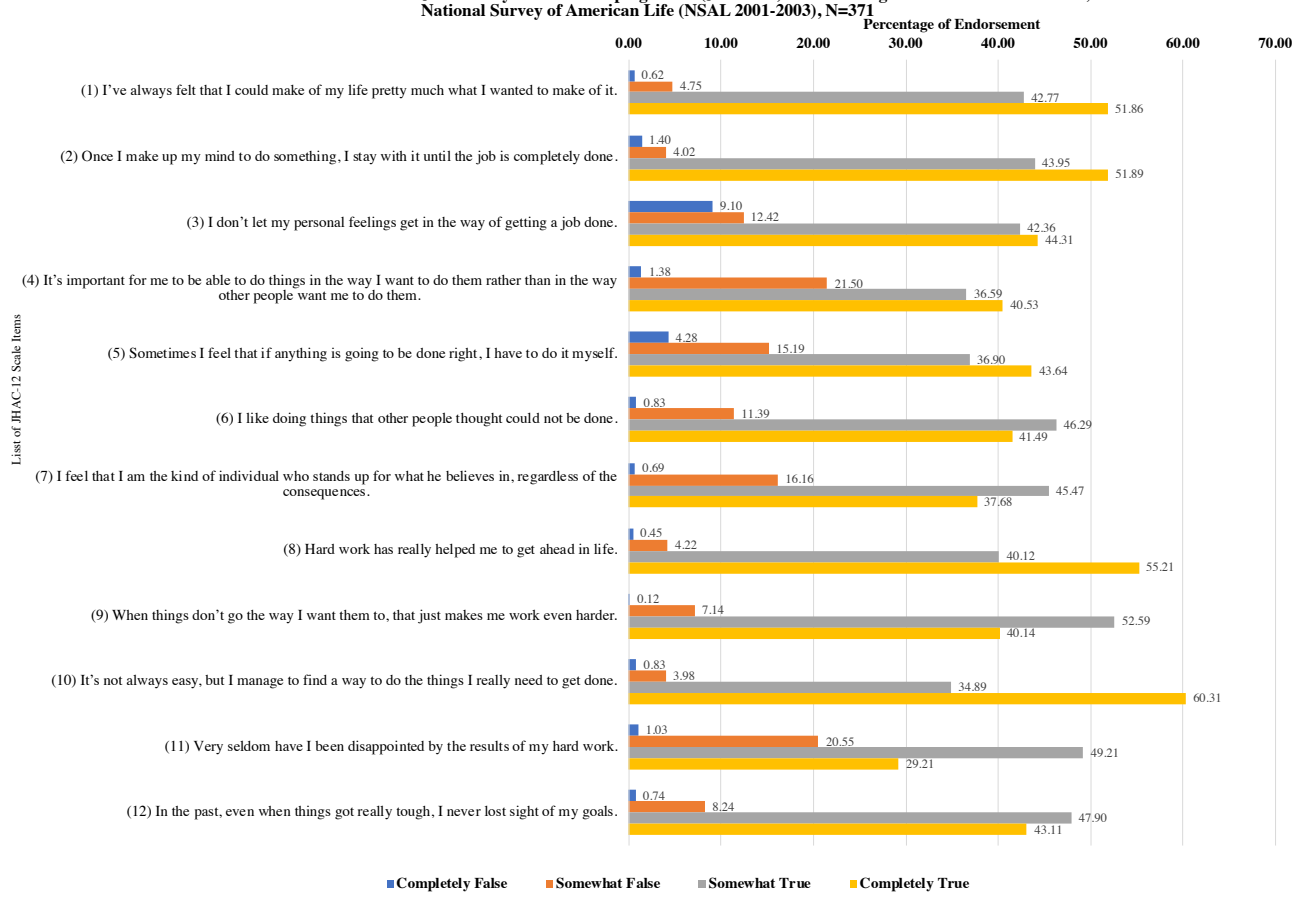
years of age (m=42.65; SD=33.08), which indicates that most Caribbean Black women were about middle-aged. While the range for SES was -4.45 to 6.93, most Caribbean Black women reported an SES score of 0.29 (standard deviation, SD=3.79), which indicates that most Caribbean Black women were of higher SES.

Overall, Caribbean Black women engaged in moderate levels of high-effort coping, reported fairly low levels of stress exposure, were middle-aged, and of higher SES.

6.7 *Meaning of John Henryism for Caribbean Black Women*

6.7.1 Frequencies of John Henryism among Caribbean Black women

FIGURE 12: Distribution of John Henryism Active Coping Scale (JHAC-12) Items Among Caribbean Black Women, National Survey of American Life (NSAL 2001-2003), N=371



To better understand the frequency of John Henryism item endorsement among Caribbean Black women, and to capture the components of John Henryism with which Caribbean Black

women are more apt to identify, the distribution of John Henryism items was examined (Aim 4.1). Figure 12 shows the distribution of John Henryism item endorsement among Caribbean Black women. For the following items, most Caribbean Black women reported that they were "completely true" for them: (1) I've always felt that I could make of my life pretty much what I wanted to make of it; (2) Once I make up my mind to do something, I stay with it until the job is completely done; (3) I don't let my personal feelings get in the way of getting a job done; (4) It's important for me to be able to do things in the way I want to do them rather than in the way other people want me to do them; (5) Sometimes I feel that if anything is going to be done right, I have to do it myself; (8) Hard work has really helped me to get ahead in life; (10) It's not always easy, but I manage to find a way to do the things I really need to get done. However, trends were different for the following items, such that most Caribbean Black women reported these items as "somewhat true" for them: (6) I like doing things that other people thought could not be done; (7) I feel that I am the kind of individual who stands up for what he believes in, regardless of the consequences; (9) When things don't go the way I want them to, that just makes me work even harder; (11) Very seldom have I been disappointed by the results of my hard work; (12) In the past, even when things got really tough, I never lost sight of my goals. Overall, most Caribbean Black women endorsed the John Henryism Active Coping Scale (JHAC-12) items as "completely true" or "somewhat true".

6.7.2 Underlying Factors in John Henryism Construct for Caribbean Black Women

Ethnicity shapes the development of coping tools via socialization processes (Pearlin et al. 1981;Turner, Taylor, and Van Gundy 2004; Meyer, Schwartz, and Frost 2008) and may contribute to differences in the presentation and significance of particular coping resources. Considering this, a confirmatory factor analysis was conducted to clarify what factors are present in the John

Henryism Active Coping Scale, in addition to identifying items that may be linked to each factor for Caribbean Black women specifically (Aim 4.2). Figure 13 shows confirmatory factor analysis results of John Henryism items among Caribbean Black women. For the varimax rotation, items with factor loadings (i.e., correlations) above 0.50 were attributed to that factor. In previous work, Dr. Sherman James indicated that items of the JHAC-12 scale captured to the following three themes: (1) efficacious mental and physical vigor, (2) a strong commitment to hard work, and (3) a single-minded determination to succeed (James 1994).

The confirmatory factor analysis for Caribbean Black women indicated that there were two factors within the John Henryism scale, and that there was a 0.55 correlation between these two factors. Factor 1 included the following items:

(2) Once I make up my mind to do something, I stay with it until the job is completely done.

(3) I don't let my personal feelings get in the way of getting a job done.

(8) Hard work has really helped me to get ahead in life.

(9) When things don't go the way I want them to, that just makes me work even harder.

(10) It's not always easy, but I manage to find a way to do the things I really need to get done.

(11) Very seldom have I been disappointed by the results of my hard work.

(12) In the past, even when things got really tough, I never lost sight of my goals.

Collectively, these items captured two themes simultaneously: (1) efficacious mental and physical vigor and (2) a strong commitment to hard work. Factor 2 included the following items:

(4) It's important for me to be able to do things in the way I want to do them rather than in the way other people want me to do them.

(5) Sometimes I feel that if anything is going to be done right, I have to do it myself.

(6) I like doing things that other people thought could not be done.

Collectively, these items captured the theme of "a single-minded determination to succeed".

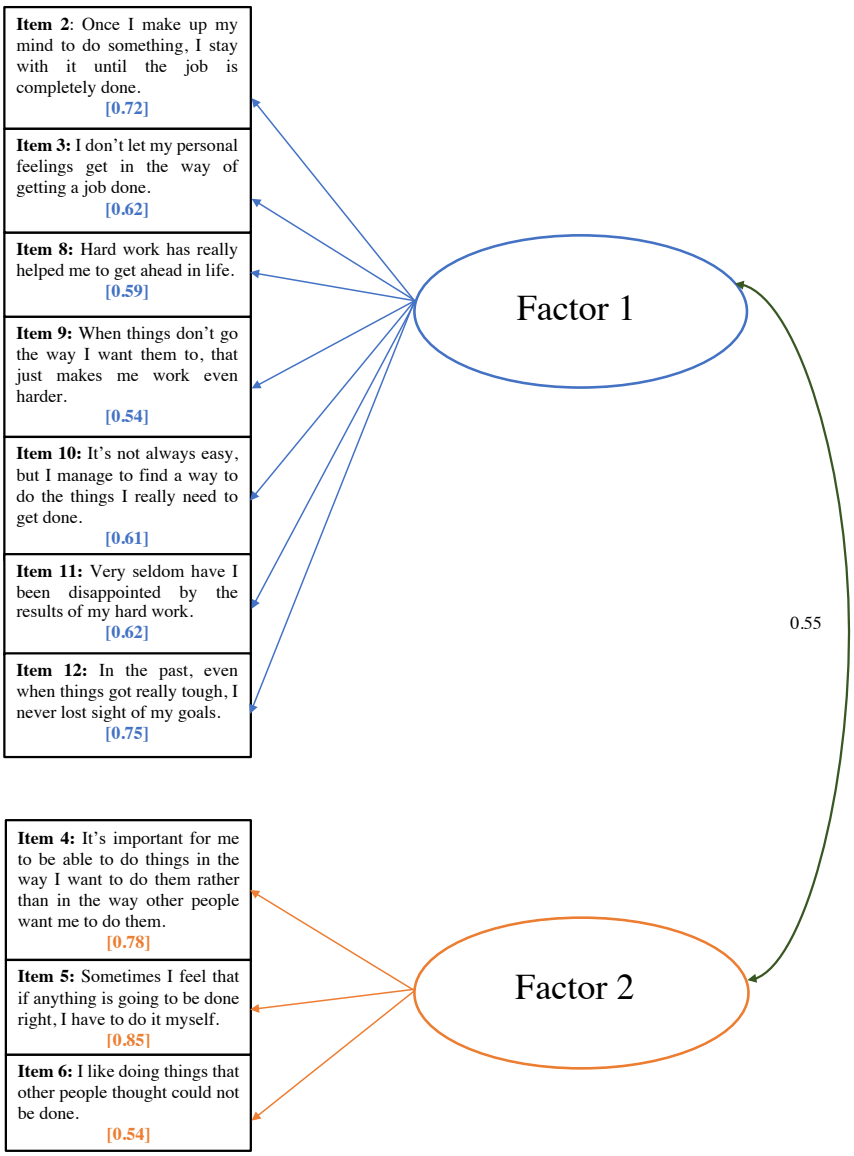


FIGURE 13: Confirmatory Factor Analysis of John Henryism Items among Caribbean Black Women, National Survey of American Life (NSAL 2001-2003), N=371

Interestingly, there were two items that notably did not correlate to factor 1 or factor 2 among Caribbean Black women. These two items were: (1) I've always felt that I could make of my life pretty much what I wanted to make of it; (7) I feel that I am the kind of individual who stands up for what he believes in, regardless of the consequences. These two items captured ideas of self-efficacy and defending one's beliefs despite constrained choices and potential consequences. This means that items 1 and 7 do not represent John Henryism for Caribbean Black women and instead allude to something else. Overall, these findings indicate that most of the items of the JHAC-12 scale capture the three themes of (1) efficacious mental and physical vigor, (2) a strong commitment to hard work, and (3) a single-minded determination to succeed (James 1994) among Caribbean Black women. However, these findings also indicate that two items of the JHAC-12 scale that conveyed the ideas of self-efficacy and standing up for one's beliefs despite constrained choices and potential consequences do not map onto the overall construct of John Henryism for Caribbean Black women.

6.7.3 Sociodemographic and Stress-Related Correlates of John Henryism among Caribbean Black women

TABLE 12: Multinomial Logistic Regression Examining the Association Between Sociodemographic Characteristics, Stressors, and John Henryism among Caribbean Black Women, National Survey of American Life (2001-2003), N=371

	Moderate JH			High JH		
	RRR	95% CI	p-value	RRR	95% CI	p-value
Chronic Stress	0.75	0.55-1.03	p=0.07	0.88	0.62-1.26	p=0.48
Everyday Discrimination	1.04	0.98-1.12	p=0.19	1.04	0.97-1.11	p=0.23
Goal Striving Stress (GSS)	1.06	0.99-1.14	p=0.07	1.02	0.91-1.14	p=0.69
Age	0.99	0.96-1.02	p=0.51	0.98	0.95-1.01	p=0.16
Socioeconomic Status	0.99	0.68-1.44	p=0.96	0.78	0.52-1.19	p=0.24
Intercept	3.02	0.53-17.08	p=0.20	3.20	0.40-25.87	p=0.26

Note: Ref.=reference category; Low John Henryism is the reference category for analysis; RRR= relative risk ratio

To evaluate factors that may shape the development of John Henryism among Caribbean Black women, the association between sociodemographic characteristics, stressors, and John Henryism was assessed (Aim 4.3). Table 12 shows results for this analysis. None of these factors were significantly associated with differences in John Henryism among Caribbean Black women.

Collectively, these findings indicate that most Caribbean Black women in the National Survey of American Life (2001-2003) report good mental and physical health, higher SES, and are middle-aged. Results also demonstrate that John Henryism holds significance for most Caribbean Black women; however, among this group, while the John Henryism construct taps into two themes as opposed to three, there are a couple of items that appear to not be as relevant for Caribbean Black women. Additionally, sociodemographic characteristics and stressors did not appear to influence the development of John Henryism among Caribbean Black women in this sample.

6.8 *John Henryism, Mental, and Physical Health among Caribbean Black Women*

6.8.1 Direct association between John Henryism and mental health among Caribbean Black women.

TABLE 13: Direct Association Between John Henryism and Mental Health among Caribbean Black Women, National Survey of American Life (2001-2003), N=371

	Psychological Distress	*SRMH*	*Depressive Symptoms*	*Past-Year MDD*
John Henryism (JH)				
Low JH (Ref.)				
Moderate JH	0.87	0.99	1.22	0.65
	[0.59-1.27]	[0.21-4.58]	[0.28-5.33]	[0.17-2.49]
High JH	0.67	0.74	1.81	4.38
	[0.39-1.16]	[0.28-2.00]	[0.46-7.18]	[0.89-21.50]
Intercept	4.64***	0.09***	0.04***	0.05***
	[3.73-5.76]	[0.03-0.27]	[0.01-0.13]	[0.01-0.18]
F-Statistic	1.18	0.30	0.59	4.59*
df	(2, 25)	(2, 25)	(2, 25)	(2, 25)

Note: Incidence Rate Ratios (IRR), Odds Ratios (OR) Reported. *p<0.05; **p<0.01; ***p<0.001 (two-tailed tests); SRMH=Self-Rated Mental Health; MDD= Major Depressive Disorder; Logistic Regression used for SRMH, Depressive Symptoms, and Past-Year MDD; Negative binomial regression used for psychological distress; F-Statistic=Adjusted Wald Test (joint-test); df=degrees of freedom

Table 13 shows the direct associations between John Henryism and mental health among Caribbean Black women (Aim 4.4). There was no direct association between John Henryism and any of the mental health outcomes among Caribbean Black women, except for past-year major depressive disorder ($F(2,25)=4.59$; $p<0.05$). Subsequent analyses indicated that while there was no significant difference between those with low or high John Henryism, there was a distinction between high and moderate John Henryism. Compared to Caribbean Black women who engaged in moderate John Henryism, those who endorsed high John Henryism reported 6.75 times the odds of past-year major depressive disorder ($p<0.01$).

6.8.2 John Henryism and Mental Health Association Mechanisms among Caribbean Black Women

To further assess the potential mechanisms through which John Henryism may shape mental health among Caribbean Black women, a series of analyses were conducted for each mental health outcome. The association between John Henryism and mental health, accounting for sociodemographic characteristics was examined (Aim 4.5; Model 2). The association between John Henryism and mental health was assessed, with SES as a potential moderating variable (Aim 4.6; Model 3). The association between stress and mental health was assessed, with John Henryism as a potential moderating variable (Aim 4.7; Models 4-6). For clarity, the results for these analyses will be presented for each mental health outcome in consecutive order.

6.8.2.1 Psychological Distress

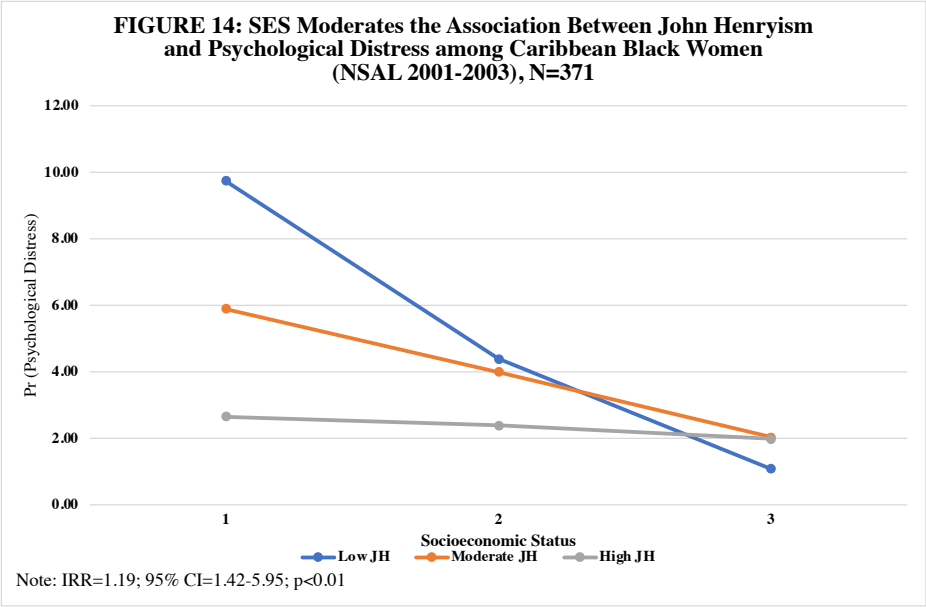
Table 14 shows the association between John Henryism and psychological distress among Caribbean Black women. After accounting for sociodemographic characteristics and stressors (Model 2), John Henryism overall shaped psychological distress ($F(2, 25)=5.10$; $p<0.05$). More specifically, compared to Caribbean Black women engaged in low John Henryism, those who

engaged in high John Henryism reported a rate for psychological distress 0.55 times lower, all else equal (IRR=0.55; 95% CI=0.36-0.82; p<0.01).

TABLE 14: Negative Binomial Regression Examining the Association Between John Henryism and Psychological Distress among Caribbean Black Women, National Survey of American Life (2001-2003), N=371

	Model 1	*Model 2*	*Model 3*	*Model 4*	*Model 5*	*Model 6*
John Henryism (JH)						
Low JH (Ref.)						
Moderate JH		0.93	0.91	0.72	0.93	0.94
		[0.59-1.45]	[0.60-1.38]	[0.36-1.48]	[0.42-2.03]	[0.52-1.71]
High JH		0.55**	0.54**	0.61	0.34**	0.51*
		[0.36-0.82]	[0.36-0.81]	[0.27-1.39]	[0.16-0.73]	[0.31-0.85]
Stressors						
Chronic Stress	1.28***	1.28***	1.29***	1.26	1.24***	1.28***
	[1.16-1.42]	[1.16-1.42]	[1.16-1.44]	[1.00-1.59]	[1.12-1.39]	[1.15-1.42]
Everyday Discrimination	1.01	1.01	1.01	1.02	1.00	1.01
	[0.98-1.04]	[0.99-1.04]	[0.98-1.04]	[0.99-1.05]	[0.97-1.03]	[0.99-1.04]
Goal Striving Stress (GSS)	0.99	0.99	0.99	0.99	0.99	0.99
	[0.98-1.01]	[0.98-1.01]	[0.98-1.01]	[0.97-1.01]	[0.98-1.01]	[0.96-1.02]
Sociodemographic Characteristics						
Age	1.00	1.00	1.00	1.00	0.99	1.00
	[0.99-1.01]	[0.98-1.01]	[0.98-1.01]	[0.98-1.01]	[0.98-1.00]	[0.98-1.01]
SES	0.91*	0.90	0.82**	0.91	0.90*	0.90
	[0.80-1.03]	[0.81-1.00]	[0.72-0.93]	[0.82-1.02]	[0.81-1.00]	[0.81-1.00]
John Henryism x SES						
Low JH x SES (Ref.)						
Moderate JH x SES			1.11			
			[0.85-1.44]			
High JH x SES			1.19**			
			[1.42-5.95]			
John Henryism x Chronic Stress						
Low JH x Chronic Stress (Ref.)						
Moderate JH x Chronic Stress				1.14		
				[0.86-1.52]		
High JH x Chronic Stress				0.95		
				[0.72-1.26]		
John Henrysim x Everyday Discrimination						
Low JH x Everyday Discrimination (Ref.)						
Moderate JH x Everyday Discrimination					1.00	
					[0.95-1.06]	
High JH x Everyday Discrimination					1.04	
					[0.99-1.09]	
John Henryism x Goal Striving Stress						
Low JH x GSS (Ref.)						
Moderate JH x GSS						1.00
						[0.95-1.05]
High JH x GSS						1.01
						[0.96-1.07]
Intercept	2.42**	2.93**	2.91**	2.90	3.71**	2.95*
	[1.29-4.56]	[1.44-5.96]	[1.42-5.95]	[0.93-9.04]	[1.80-7.67]	[1.28-6.77]
F-Statistic		5.10*	2.54	1.27	1.70	0.14
df		(2, 25)	(2, 25)	(2, 25)	(2, 25)	(2, 25)

Note: Incidence Rate Ratios (IRRs) Reported. *p<0.05; **p<0.01; ***p<0.001 (two-tailed tests); F-Statistic=Adjusted Wald Test (joint-test); df=degrees of freedom



After evaluating the John Henryism Hypothesis, although the interaction between John Henryism and SES was not significant overall (F(2,25)=2.54;p=0.10), findings indicate that a particular combination of John Henryism and SES shaped psychological distress among Caribbean Black women. Figure 14 shows these results (see Table 14; Model 3) . Compared to Caribbean Black women with low John Henryism, a significant association between SES and psychological distress was only found among those with high John Henryism. Among Caribbean Black women who engaged in high John Henryism, as SES levels increased, this group experienced a minimal increase in their levels of psychological distress. In other words, among high John Henryism Caribbean Black women, higher SES is not very protective against psychological distress. This is somewhat consistent with the John Henryism Hypothesis.

Overall, out of all mechanisms assessed, John Henryism was significantly associated with lower rates of psychological distress among Caribbean Black women after accounting for sociodemographic characteristics and stressors. Additionally, SES moderated the association between John Henryism and psychological distress, such that for Caribbean Black women who endorsed high John Henryism, higher SES was associated with higher psychological distress.

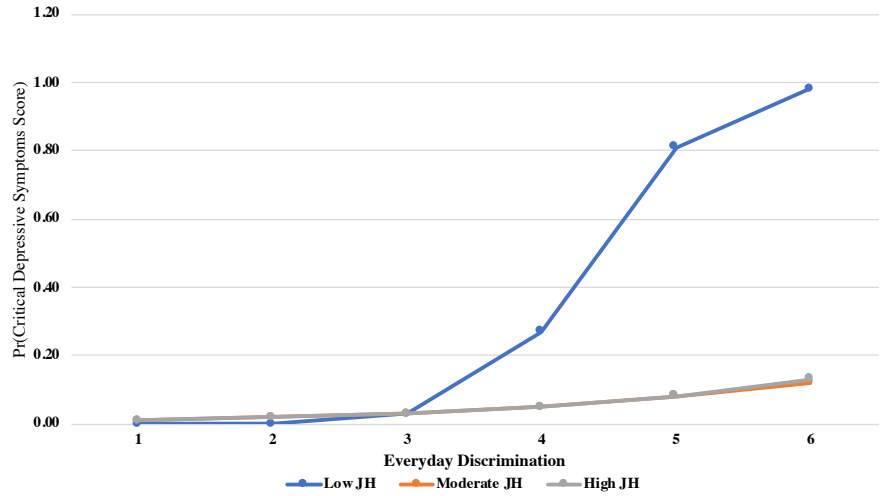
6.8.2.2 Self-Rated Mental Health

Table 15 shows the association between John Henryism and self-rated mental health among Caribbean Black women. After accounting for sociodemographic characteristics and stressors (Model 2), John Henryism remained unassociated with self-rated mental health among Caribbean Black women. SES did not moderate the association between John Henryism and self-rated mental health (Model 3), nor did John Henryism moderate the association between any of the stressors and self-rated mental health (Models 4-6). Overall, John Henryism was not significantly associated with self-rated mental health among Caribbean Black women through the mechanisms assessed.

6.8.2.3 Depressive Symptoms

Table 16 shows the association between John Henryism and depressive symptoms among Caribbean Black women. After accounting for sociodemographic characteristics and stressors (Model 2), John Henryism remained unassociated with depressive symptoms among Caribbean Black women. SES did not moderate the association between John Henryism and depressive symptoms (Model 3).

FIGURE 15: John Henryism Moderates the Association Between Everyday Discrimination and Depressive Symptoms among Caribbean Black Women (NSAL 2001-2003), N=371



Note: OR=0.83; 95% CI=0.69-0.99; p<0.05; OR=0.83; 95% CI=0.69-1.00; p<0.05

After examining whether John Henryism may buffer or mitigate the negative impact of stress on depressive symptoms, although the overall interaction between John Henryism and everyday discrimination was not significant ($F(2, 25)=2.37$; $p>0.05$), results indicate that specific combinations of John Henryism and everyday discrimination were impactful (OR=0.83; 95% CI=0.69-0.99; $p<0.05$; OR=0.83; 95% CI=0.69-1.00; $p<0.05$). Figure 15 shows these results (see Table 16; Model 5). Compared to Caribbean Black women engaged in low John Henryism, those who engaged in moderate or high John Henryism experienced fewer depressive symptoms as everyday discrimination increased. In other words, moderate and high levels of John Henryism seem to be protective against higher depressive symptoms among Caribbean Black women who experience everyday discrimination.

Out of all mechanisms assessed, though John Henryism overall was not significant, specific levels of John Henryism in combination with stressors shape depressive symptoms. For Caribbean Black women who endorsed moderate or high John Henryism, higher everyday discrimination was associated with fewer depressive symptoms.

6.8.2.4 Past-Year Major Depressive Disorder

Table 17 shows the association between John Henryism and past-year major depressive disorder among Caribbean Black women. After accounting for sociodemographic characteristics and stressors (Model 2), John Henryism was no longer associated with past-year major depressive disorder. SES did not moderate the association between John Henryism and past-year major depressive disorder (Model 3), nor did John Henryism moderate the association between any of the stressors and past-year major depressive disorder (Models 4-6). Overall, out of all mechanisms assessed, John Henryism was only directly significantly associated with past-year major depressive disorder among Caribbean Black women.

TABLE 15: Logistic Regression Examining the Association Between John Henryism and Self-Rated Mental Health among Caribbean Black Women, National Survey of American Life (2001-2003), N=371

	Model 1	*Model 2*	*Model 3*	*Model 4*	*Model 5*	*Model 6*
John Henryism (JH)						
Low JH (Ref.)						
Moderate JH		1.02	0.94	1.22	4.79	0.98
		[0.25-4.16]	[0.21-4.26]	[0.10-14.86]	[0.33-70.23]	[0.19-5.02]
High JH		0.44	0.59	0.33	1.01	0.31
		[0.12-1.59]	[0.22-1.55]	[0.02-4.86]	[0.10-10.61]	[0.07-1.27]
Stressors						
Chronic Stress	1.41**	1.48**	1.44**	1.49	1.44**	1.49***
	[1.15-1.73]	[1.21-1.82]	[1.14-1.82]	[0.64-3.48]	[1.14-1.81]	[1.22-1.83]
Everyday Discrimination	0.99	0.99	0.99	0.90	1.08	0.99
	[0.92-1.06]	[0.92-1.07]	[0.92-1.07]	[0.92-1.07]	[0.95-1.22]	[0.92-1.07]
Goal Striving Stress (GSS)	1.04**	1.04*	1.04**	1.04**	1.04*	1.02
	[1.01-1.07]	[1.01-1.07]	[1.01-1.07]	[1.01-1.07]	[1.01-1.08]	[0.92-1.14]
Sociodemographic Characteristics						
Age	1.01	1.02	1.02	1.02	1.01	1.02
	[0.99-1.04]	[0.99-1.04]	[0.99-1.04]	[0.99-1.04]	[0.98-1.04]	[0.99-1.05]
SES	0.53***	0.51***	0.50*	0.49***	0.51***	0.51***
	[0.39-0.72]	[0.38-0.67]	[0.25-0.99]	[0.36-0.68]	[0.39-0.67]	[0.390.67]
John Henryism x SES						
Low JH x SES (Ref.)						
Moderate JH x SES			0.89			
			[0.35-2.24]			
High JH x SES			1.25			
			[0.50-3.09]			
John Henryism x Chronic Stress						
Low JH x Chronic Stress (Ref.)						
Moderate JH x Chronic Stress				0.93		
				[0.37-2.35]		
High JH x Chronic Stress				1.08		
				[0.45-2.58]		
John Henrysim x Everyday Discrimination						
Low JH x Everyday Discrimination (Ref.)						
Moderate JH x Everyday Discrimination					0.87	
					[0.72-1.06]	
High JH x Everyday Discrimination					0.93	
					[0.79-1.10]	
John Henryism x Goal Striving Stress						
Low JH x GSS (Ref.)						
Moderate JH x GSS						1.01
						[0.89-1.15]
High JH x GSS						1.04
						[0.90-1.21]
Intercept	0.01***	0.01***	0.01***	0.01**	0.01***	0.01***
	[0.00-0.08]	[0.00-0.10]	[0.00-0.11]	[0.00-0.14]	[0.00-0.08]	[0.00-0.09]
F-Statistic		1.25	0.77	0.32	0.96	0.23
df		(2, 25)	(2, 25)	(2, 25)	(2, 25)	(2, 25)

Note: Odds Ratios (OR) Reported. *p<0.05; **p<0.01; ***p<0.001 (two-tailed tests); F-Statistic=Adjusted Wald Test (joint-test); df=degrees of freedom

TABLE 16: Logistic Regression Examining the Association Between John Henryism and Depressive Symptoms among Caribbean Black Women, National Survey of American Life (2001-2003), N=371

	Model 1	*Model 2*	*Model 3*	*Model 4*	*Model 5*	*Model 6*
John Henryism (JH)						
Low JH (Ref.)						
Moderate JH		1.29	0.77	0.82	40.63	0.30
		[0.33-5.09]	[0.19-3.19]	[0.09-7.73]	[0.63-2604.97]	[0.06-1.66]
High JH		1.38	1.94	0.89	44.21	0.41
		[0.23-8.18]	[0.57-6.58]	[0.07-11.17]	[0.75-2600.91]	[0.06-2.97]
Stressors						
Chronic Stress	1.14	1.13	1.06	0.90	1.12	1.11
	[0.86-1.51]	[0.86-1.49]	[0.82-1.36]	[0.35-2.36]	[0.83-1.50]	[0.85-1.45]
Everyday Discrimination	1.07**	1.07**	1.08**	1.07**	1.27**	1.07**
	[1.02-1.12]	[1.02-1.12]	[1.03-1.13]	[1.02-1.12]	[1.07-1.52]	[1.02-1.11]
Goal Striving Stress (GSS)	1.05*	1.05*	1.06**	1.05*	1.05*	0.78
	[1.01-1.09]	[1.01-1.09]	[1.02-1.10]	[1.01-1.09]	[1.01-1.10]	[0.56-1.10]
Sociodemographic Characteristics						
Age	0.99	0.98	0.99	0.98	0.98	0.97
	[0.94-1.03]	[0.94-1.03]	[0.95-1.03]	[0.94-1.03]	[0.93-1.03]	[0.94-1.01]
SES	0.44***	0.43**	0.45*	0.44**	0.43**	0.42***
	[0.29-0.66]	[0.28-0.67]	[0.21-0.98]	[0.27-0.70]	[0.27-0.70]	[0.29-0.60]
John Henryism x SES						
Low JH x SES (Ref.)						
Moderate JH x SES			0.59			
			[0.25-1.41]			
High JH x SES			1.40			
			[0.50-3.90]			
John Henryism x Chronic Stress						
Low JH x Chronic Stress (Ref.)						
Moderate JH x Chronic Stress				1.26		
				[0.46-3.50]		
High JH x Chronic Stress				1.26		
				[0.47-3.36]		
John Henrysim x Everyday Discrimination						
Low JH x Everyday Discrimination (Ref.)						
Moderate JH x Everyday Discrimination					0.83*	
					[0.69-0.99]	
High JH x Everyday Discrimination					0.83*	
					[0.69-1.00]	
John Henryism x Goal Striving Stress						
Low JH x GSS (Ref.)						
Moderate JH x GSS						1.36
						[0.97-1.92]
High JH x GSS						1.34
						[0.91-1.97]
Intercept	0.01***	0.01***	0.01***	0.01**	0.00***	0.05**
	[0.00-0.08]	[0.00-0.06]	[0.00-0.06]	[0.00-0.18]	[0.00-0.02]	[0.01-0.39]
F-Statistic		0.08	3.26	0.12	2.37	1.90
df		(2, 25)	(2, 25)	(2, 25)	(2, 25)	(2, 25)

Note: Odds Ratios (OR) Reported. *p<0.05; **p<0.01; ***p<0.001 (two-tailed tests); F-Statistic=Adjusted Wald Test (joint-test); df=degrees of freedom

6.8.3 Summary of Mental Health Findings among Caribbean Black Women

No association was found between John Henryism and self-rated mental health among Caribbean Black women through any of the mechanisms tested. Overall, John Henryism was only directly associated with past-year major depressive disorder. None of the other mechanisms were

significant. However, different patterns emerged for psychological distress and depressive symptoms. There was no direct association found between John Henryism and psychological distress or depressive symptoms. This is where trends diverged. In terms of psychological distress, after accounting for sociodemographic characteristics and stressors, an association was found such that high John Henryism decreased the rate of psychological distress among Caribbean Black women. Additionally, some interesting empirical support for the John Henryism Hypothesis was found. SES moderated the link between John Henryism and psychological distress, such that among women who endorsed high John Henryism, increases in SES increased the rate of psychological distress. To put it simply, among Caribbean Black women who engaged in high John Henryism, higher SES was detrimental for their rates of psychological distress. Evidence of John Henryism moderation was found for the link between everyday discrimination and depressive symptoms, such that among Caribbean Black women who engaged in moderate or high John Henryism, higher everyday discrimination was associated with fewer depressive symptoms. In other words, for Black women who engaged in moderate or high John Henryism and experienced everyday discrimination, John Henryism was protective against depressive symptoms. In summation, findings indicate that of the mechanisms tested, John Henryism shaped psychological distress and depressive symptoms, but was not very influential for self-rated mental health or past-year major depressive disorder among Caribbean Black women.

TABLE 17: Logistic Regression Examining the Association Between John Henryism and Past-Year Major Depressive Disorder among Caribbean Black Women, National Survey of American Life (2001-2003), N=371

	Model 1	*Model 2*	*Model 3*	*Model 4*	*Model 5*	*Model 6*
John Henryism (JH)						
Low JH (Ref.)						
Moderate JH		0.50	0.45	0.12	0.59	0.55
		[0.10-2.43]	[0.10-2.06]	[0.01-1.07]	[0.05-6.64]	[0.09-3.22]
High JH		3.06	2.68	2.06	0.29	3.13
		[0.60-15.59]	[0.62-11.58]	[0.22-19.63]	[0.02-4.86]	[0.59-16.70]
Stressors						
Chronic Stress	1.75**	1.63**	1.63**	1.30	1.58**	1.64**
	[1.23-2.50]	[1.15-2.32]	[1.14-2.32]	[0.79-2.15]	[1.13-2.19]	[1.14-2.34]
Everyday Discrimination	1.06*	1.07*	1.06	1.07	0.99	1.07*
	[1.01-1.11]	[1.00-1.13]	[1.00-1.13]	[1.00-1.14]	[0.88-1.10]	[1.00-1.13]
Goal Striving Stress (GSS)	1.02	1.03	1.03	1.03	1.03	1.04
	[0.96-1.08]	[0.98-1.08]	[0.98-1.08]	[0.98-1.08]	[0.99-1.08]	[0.94-1.14]
Sociodemographic Characteristics						
Age	1.00	1.00	1.00	1.00	0.99	1.00
	[0.95-1.05]	[0.96-1.04]	[0.96-1.04]	[0.96-1.04]	[0.95-1.03]	[0.96-1.04]
SES	1.09	1.15	0.90	1.19	1.10	1.15
	[0.75-1.59]	[0.78-1.70]	[0.56-1.45]	[0.81-1.74]	[0.75-1.63]	[0.78-1.71]
John Henryism x SES						
Low JH x SES (Ref.)						
Moderate JH x SES			0.98			
			[0.38-2.49]			
High JH x SES			1.51			
			[0.84-2.73]			
John Henryism x Chronic Stress						
Low JH x Chronic Stress (Ref.)						
Moderate JH x Chronic Stress				1.62		
				[0.85-3.12]		
High JH x Chronic Stress				1.18		
				[0.62-2.26]		
John Henrysim x Everyday Discrimination						
Low JH x Everyday Discrimination (Ref.)						
Moderate JH x Everyday Discrimination					1.01	
					[0.89-1.15]	
High JH x Everyday Discrimination					1.18	
					[1.00-1.40]	
John Henryism x Goal Striving Stress						
Low JH x GSS (Ref.)						
Moderate JH x GSS						0.99
						[0.89-1.09]
High JH x GSS						1.00
						[0.90-1.10]
Intercept	0.01***	0.01***	0.01***	0.01**	0.02*	0.01***
	[0.00-0.06]	[0.00-0.06]	[0.00-0.06]	0.00-0.14]	[0.00-0.38]	[0.00-0.06]
F-Statistic		3.40	1.45	1.28	1.98	0.03
df		(2, 25)	(2, 25)	(2, 25)	(2, 25)	(2, 25)

Note: Odds Ratios (OR) Reported. *p<0.05; **p<0.01; ***p<0.001 (two-tailed tests); F-Statistic=Adjusted Wald Test; df=degrees of freedom

6.8.4 Direct association between John Henryism and physical health among Caribbean Black women.

Table 18 shows the direct association between John Henryism and physical health among Caribbean Black women (Aim 4.4). There was no direct association between John Henryism and self-rated health, or John Henryism and chronic health conditions among Caribbean Black women.

TABLE 18: Direct Association Between John Henryism and Physical Health among Caribbean Black Women, National Survey of American Life (2001-2003), (N=371)

	SRH	*Chronic Health Conditions*
John Henryism (JH)		
Low JH (Ref.)		
Moderate JH	0.51	1.05
	[0.14-1.89]	[0.64-1.72]
High JH	0.50	1.13
	[0.17-1.48]	[0.62-2.07]
Intercept	0.28**	1.89**
	[0.11-0.70]	[1.20-2.98]
F-Statistic	0.87	0.10
df	(2, 25)	(2, 25)

Note: Incidence Rate Ratios (IRR), Odds Ratios (OR) Reported. SRH=Self-Rated Health; *p<0.05 **p<0.01; ***p<0.001 (two-tailed tests); Logistic regression used for SRH; Negative binomial regression used for "chronic health conditions; F-Statistic=Adjusted Wald Test (joint-test); df=degrees of freedom

6.8.5 John Henryism and Physical Health Association Mechanisms among Caribbean Black Women

To further assess the potential mechanisms through which John Henryism may shape physical health among Caribbean Black women, a series of analyses were conducted for each physical health outcome. The association between John Henryism and physical health, accounting for sociodemographic characteristics was examined (Aim 4.5; Model 2). The association between John Henryism and physical health was assessed, with SES as a potential moderating variable (Aim 4.6; Model 3). The association between stress and physical health was assessed, with John Henryism as a potential moderating variable (Aim 4.7; Models 4-6). For clarity, the results for these analyses will be presented for each physical health outcome in consecutive order.

6.8.5.1 Self-Rated Health

Table 19 shows the association between John Henryism and self-rated health among Caribbean Black women. After accounting for sociodemographic characteristics and stressors (Model 2), although John Henryism overall was not associated with self-rated health ($F(2, 25)=2.47$; $p>0.05$) among Caribbean Black women, a particular level of John Henryism was. Compared to Caribbean Black women who engaged in low John Henryism, those who engaged in high John Henryism reported 65% lower odds of fair/poor self-rated health, all else equal

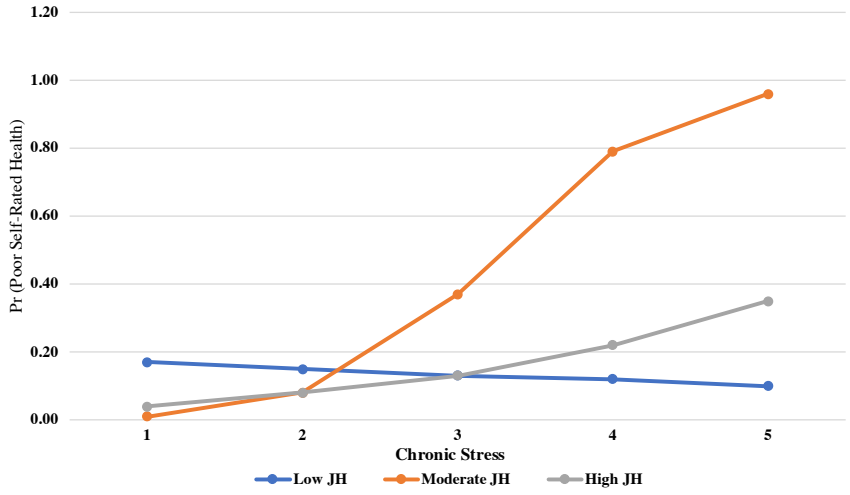
(OR=0.35; 95% CI=0.13-0.91; p<0.01). SES did not moderate the association between John Henryism and self-rated health (Model 3).

TABLE 19: Logistic Regression Examining the Association Between John Henryism and Self-Rated Health among Caribbean Black Women, National Survey of American Life (2001-2003), N=371

	Model 1	*Model 2*	*Model 3*	*Model 4*	*Model 5*	*Model 6*
John Henryism (JH)						
Low JH (Ref.)						
Moderate JH		0.53	0.36	0.06**	0.87	0.53
		[0.18-1.54]	[0.11-1.20]	[0.01-0.39]	[0.20-3.89]	[0.15-1.88]
High JH		0.35*	0.43	0.22	0.47	0.29
		[0.13-0.91]	[0.15-1.24]	[0.03-1.58]	[0.09-2.45]	[0.07-1.17]
Stressors						
Chronic Stress	1.52**	1.57**	1.47*	0.93	1.58*	1.58**
	[1.14-2.02]	[1.14-2.18]	[1.05-2.05]	[0.43-2.00]	[1.11-2.24]	[1.14-2.18]
Everyday Discrimination	0.96	0.96	0.97	0.96	0.99	0.96
	[0.91-1.01]	[0.91-1.01]	[0.91-1.02]	[0.90-1.01]	[0.90-1.09]	[0.91-1.01]
Goal Striving Stress (GSS)	1.04	1.04*	1.05*	1.03	1.04*	1.03
	[1.00-1.07]	[1.01-1.07]	[1.01-1.09]	[0.99-1.06]	[1.01-1.07]	[0.95-1.12]
Sociodemographic Characteristics						
Age	1.04**	1.04**	1.05**	1.05**	1.04**	1.04**
	[1.01-1.07]	[1.01-1.07]	[1.02-1.07]	[1.01-1.08]	[1.01-1.08]	[1.02-1.07]
SES	0.67*	0.64*	0.81	0.71*	0.65*	0.64*
	[0.47-0.95]	[0.45-0.91]	[0.42-1.58]	[0.52-0.98]	[0.46-0.92]	[0.45-0.92]
John Henryism x SES						
Low JH x SES (Ref.)						
Moderate JH x SES			0.46			
			[0.18-1.15]			
High JH x SES			1.00			
			[0.38-2.64]			
John Henryism x Chronic Stress						
Low JH x Chronic Stress (Ref.)						
Moderate JH x Chronic Stress				2.78*		
				[1.24-6.21]		
High JH x Chronic Stress				1.47		
				[0.65-3.32]		
John Henrysim x Everyday Discrimination						
Low JH x Everyday Discrimination (Ref.)						
Moderate JH x Everyday Discrimination					0.95	
					[0.84-1.06]	
High JH x Everyday Discrimination					0.97	
					[0.85-1.10]	
John Henryism x Goal Striving Stress						
Low JH x GSS (Ref.)						
Moderate JH x GSS						1.00
						[0.93-1.08]
High JH x GSS						1.02
						[0.93-1.13]
Intercept	0.01***	0.02**	0.02***	0.05*	0.01**	0.02**
	[0.00-0.08]	[0.00-0.14]	[0.00-0.12]	[0.00-0.88]	[0.00-0.15]	[0.00-0.15]
F-Statistic		2.47	2.40	8.04**	0.44	0.17
df		(2, 25)	(2, 25)	(2, 25)	(2, 25)	(2, 25)

Note: Odds Ratios (OR) Reported. *p<0.05; **p<0.01; ***p<0.001 (two-tailed tests); F-Statistic=Adjusted Wald Test; df=degrees of freedom

FIGURE 16: John Henryism Moderates the Association Between Chronic Stress and Self-Rated Health among Caribbean Black Women (NSAL 2001-2003), N=371



Note: F(2, 25)= 8.04; p<0.01

After examining whether John Henryism may buffer or mitigate the negative impact of stress on self-rated health among Caribbean Black women, results from a significant interaction between John Henryism and chronic stress indicate that John Henryism moderated the association between chronic stress and self-rated health among Caribbean Black women ($F(2,25)=8.04$; $p<0.01$). Figure 16 shows these results (see Table 19; Model 4). Compared to Caribbean Black women engaged in low John Henryism, there was not a significant association between chronic stress and self-rated health for women who endorsed high John Henryism, which was somewhat unexpected. However, among Caribbean Black women who engaged in moderate John Henryism, a significant association was found, such that higher levels of chronic stress were linked to increased odds of fair/poor self-rated health. In other words, the association between chronic stress and fair/poor self-rated health was exacerbated for Caribbean Black women who endorsed moderate John Henryism.

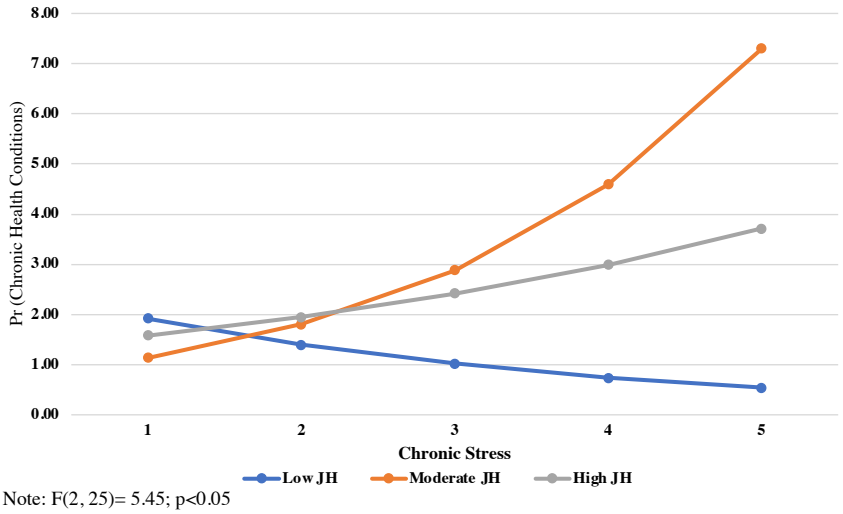
Overall, out of all mechanisms assessed, John Henryism was significantly associated with lower odds of fair/poor self-rated health among Caribbean Black women after accounting for sociodemographic characteristics and stressors. John Henryism was also found to be a moderator

of the association between chronic stress and self-rated health among Caribbean Black women who endorsed moderate John Henryism. More specifically, as opposed to buffering or mitigating the impact of chronic stress on fair/poor self-rated health, for Caribbean Black women engaged in moderate John Henryism, this association was worsened.

6.8.5.2 Chronic Health Conditions

Table 20 shows the association between John Henryism and chronic health conditions among Caribbean Black women. After accounting for sociodemographic characteristics and stressors (Model 2), John Henryism remained unassociated with chronic health conditions among Caribbean Black women. The association between John Henryism and chronic health conditions was not moderated by SES among Caribbean Black women, nor did SES moderate the association between John Henryism and self-rated health (Model 3).

FIGURE 17: John Henryism Moderates the Association Between Chronic Stress and Chronic Health Conditions among Caribbean Black Women (NSAL 2001-2003), N=371



Note: F(2, 25)= 5.45; p<0.05

TABLE 20: Negative Binomial Regression Examining the Association Between John Henryism and Chronic Health Conditions among Caribbean Black Women, National Survey of American Life (2001-2003), N=371

	Model 1	*Model 2*	*Model 3*	*Model 4*	*Model 5*	*Model 6*
John Henryism (JH)						
Low JH (Ref.)						
Moderate JH		1.15 [0.77-1.71]	1.12 [0.78-1.62]	0.59 [0.35-1.01]	1.21 [0.71-2.05]	1.15 [0.72-1.82]
High JH		1.24 [0.79-1.94]	1.23 [0.80-1.89]	0.82 [0.48-1.41]	1.56 [0.92-2.66]	1.28 [0.74-2.21]
Stressors						
Chronic Stress	1.13* [1.01-1.26]	1.13* [1.02-1.26]	1.14* [1.03-1.26]	0.85 [0.66-1.10]	1.15* [1.02-1.29]	1.13* [1.02-1.26]
Everyday Discrimination	1.01 [0.99-1.02]	1.01 [0.99-1.02]	1.01 [0.99-1.02]	1.01 [1.00-1.02]	1.02 [0.98-1.06]	1.01 [0.99-1.02]
Goal Striving Stress (GSS)	1.01 [1.00-1.02]	1.01 [1.00-1.02]	1.01 [1.00-1.02]	1.00 [0.99-1.01]	1.01 [1.00-1.02]	1.01 [0.99-1.03]
Sociodemographic Characteristics						
Age	1.04*** [1.02-1.05]	1.04*** [1.02-1.05]	1.04*** [1.02-1.05]	1.04*** [1.02-1.05]	1.04*** [1.02-1.05]	1.04*** [1.02-1.05]
SES	0.99 [0.91-1.08]	1.00 [0.92-1.09]	0.94 [0.71-1.24]	1.02 [0.95-1.09]	1.00 [0.93-1.09]	1.00 [0.92-1.09]
John Henryism x SES						
Low JH x SES (Ref.)						
Moderate JH x SES			1.10 [0.82-1.47]			
High JH x SES			1.06 [0.80-1.40]			
John Henryism x Chronic Stress						
Low JH x Chronic Stress (Ref.)						
Moderate JH x Chronic Stress				1.48** [1.15-1.91]		
High JH x Chronic Stress				1.31 [0.98-1.74]		
John Henrysim x Everyday Discrimination						
Low JH x Everyday Discrimination (Ref.)						
Moderate JH x Everyday Discrimination					0.99 [0.95-1.04]	
High JH x Everyday Discrimination					0.98 [0.94-1.02]	
John Henryism x Goal Striving Stress						
Low JH x GSS (Ref.)						
Moderate JH x GSS						1.00 [0.97-1.03]
High JH x GSS						1.00 [0.97-1.02]
Intercept	0.24** [0.09-0.65]	0.21** [0.08-0.55]	0.21** [0.08-0.57]	0.35* [0.14-0.91]	0.18** [0.06-0.52]	0.21** [0.07-0.58]
F-Statistic		0.48	0.28	5.45*	0.90	0.07
df		(2, 25)	(2, 25)	(2, 25)	(2, 25)	(2, 25)

Note: Incidence Rate Ratios (IRR) Reported. *p<0.05; **p<0.01; ***p<0.001 (two-tailed tests); F-Statistic=Adjusted Wald Test; df=degrees of freedom

After examining whether John Henryism may buffer or mitigate the negative impact of stress on chronic health conditions among Caribbean Black women, results from a significant interaction between John Henryism and chronic stress indicate that John Henryism moderated the association between chronic stress and chronic health conditions among Caribbean Black women ($F(2,25)=5.45$; $p<0.05$). Figure 17 shows these results (see Table 20; Model 4). Compared to Caribbean Black women who endorsed low John Henryism, there was no significant association found between chronic stress and chronic health conditions among women who endorsed high John Henryism. However, an association was found for women who endorsed moderate John

Henryism. Among Caribbean Black women who endorsed moderate John Henryism, as chronic stress levels increased, the number of chronic health conditions also increased. In other words, the link between chronic stress and chronic health conditions was heightened for Caribbean Black women who engaged in moderate John Henryism, which indicates that John Henryism did not mitigate this association for Caribbean Black women with moderate John Henryism.

Overall, out of all mechanisms assessed, John Henryism was found to be a moderator of the association between chronic stress and chronic health conditions among Caribbean Black women, such that for those engaged in moderate John Henryism, increases in chronic stress were associated with a higher number of chronic health conditions. To put it another way, John Henryism was not protective for the association between chronic stress and chronic health conditions among Caribbean Black women with moderate John Henryism.

6.8.6 Summary of Physical Health Findings Among Caribbean Black Women

There was no direct association between John Henryism and self-rated health or chronic health conditions among Caribbean Black women. After accounting for sociodemographic characteristics and stressors, however, high John Henryism was found to decrease odds of fair/poor self-rated health. Additionally, John Henryism moderated the association between chronic stress and self-rated health, such that among Caribbean Black women who engaged in moderate John Henryism, the association between chronic stress and fair/poor self-rated health worsened. In other words, John Henryism did not mitigate the association between chronic stress and fair/poor self-rated health for those with moderate John Henryism.

John Henryism also moderated the association between chronic stress and chronic health conditions. Among Caribbean Black women who engaged in moderate John Henryism, the association between chronic stress and chronic health conditions was heightened. In other words,

John Henryism did not diminish the adverse impact of chronic stress on chronic health conditions for those with moderate John Henryism. In summation, findings indicate that of the mechanisms tested, John Henryism shaped self-rated health and chronic health conditions in similar ways among Caribbean Black women.

CHAPTER SEVEN: DISCUSSION

7 Discussion of Key Findings

While coping resources may be especially useful for socially disadvantaged individuals (Pearlin et al. 1981; Turner and Roszell 1994; Meyer, Schwartz, and Frost 2008), these processes have not been widely explored among Black women. Additionally, although John Henryism is considered a form of culturally-relevant coping for Black Americans (James 1994; Robinson and Thomas Tobin 2021), this construct was developed based primarily on the experiences of Black men. Thus, the ways in which this coping style develops among Black women, and what it means for this group substantively, has been less clear. Moreover, scholars have increasingly emphasized the importance of examining within-group variability in terms of examining stress, coping, and health, while also underscoring the importance of ethnicity in shaping these processes (Brown et al. 2013). Therefore, this dissertation sought to address the aforementioned gaps in the literature by examining how John Henryism shapes mental and physical health among African American and Caribbean Black women.

7.1 What is the distribution and patterning of John Henryism among Black women?

The main purpose of Aim 1 was to assess the distribution and patterning of John Henryism among Black women. Findings indicate that John Henryism is relatively high among Black women and captured their experiences with mental and physical vigor, hard work, and a dedication to succeed; however, differences in John Henryism among Black women are shaped by other characteristics. These results were somewhat unexpected.

On the one hand, prior work has shown that Black women engage in elevated levels of John Henryism (Weinrich et al. 1988; Clark, Adams, and Clark 2001; Bronder et al. 2014; Robinson and Thomas Tobin 2021), which means that the present dissertation's results were in

alignment with prior work for this sub-finding. This is not surprising, given that Black women report increased exposure to trauma, financial strain, and chronic stress compared to other racial groups (Woods-Giscombé 2010; Woods-Giscombé et al. 2016; Amani et al. 2019), and often navigate interlocking systems of oppression (Collins 2001). These circumstances necessitate that Black woman engage in various methods of coping to offset the negative impact of these experiences, with John Henryism being one of those tools.

On the other hand, other sub-findings diverged from previous scholarship. Despite results demonstrating that John Henryism captured Black women's experiences with mental and physical vigor, hard work, and a dedication to succeed, the ways in which it occurs were somewhat unexpected. Dr. Sherman James (1994; 2019:174) has previously stated that John Henryism captures the three themes of: "tenacity, mental and physical vigor, and a commitment to hard work". However, findings from the confirmatory factor analysis within this dissertation indicates that there are only two factors within the JHAC-12, with most items of the scale clustering under one factor. For instance, Factor 1 consisted of items that reflected (1) "unrelenting mental and physical stamina" and (2) "a dedication to hard work simultaneously", while factor 2 captured (3) "a steadfast resolve to achieve". This is similar to what other scholars have found in their factor analyses conducted on the JHAC-12 (Weinrich et al. 1988; Fernander et al. 2003). However, the items found to be loaded on a certain factor for this dissertation were different from previous work. This discrepancy may be the case because prior studies were conducted on samples composed of Black and White middle-aged, late middle-aged, and older adults, and did not disaggregate the factor analysis findings by gender. Thus, the present dissertation contributes to the literature by identifying what themes John Henryism taps into for Black women specifically. Furthermore, in previous studies, items with factor loadings (i.e., correlations) above 0.30 were attributed to that

factor. In the present dissertation, the cut-off was 0.50, which is the typical methodological standard (Hoyle 2000; Harrington 2009). Supplemental analyses show that when a factor loading above 0.30 is used among Black women for the JHAC-12 factor analysis, there is a substantial amount of overlap in which multiple items from the scale are attributed to both factors. In other words, with such a low factor loading correlation cut-off for Black women, there is not a clear distinction among this group in terms of which items should be attributed to one factor or the other. Hence, using a factor loading above 0.50 when conducting a factor analysis of the JHAC-12 among Black women assists in clarifying what distinct features John Henryism captures among Black women.

Results also demonstrate that sociodemographic characteristics (i.e., age and SES) and stressors (chronic stress, everyday discrimination, goal-striving stress) were not associated with John Henryism among the sample. This finding was unexpected, given that previous studies have shown that SES and stress are correlated with John Henryism (James et al. 1983; James et al. 1987; James et al. 1992). The present dissertation findings may have differed since much of the prior work in this area has used different SES indicators (e.g., other indices, singular SES indicators), different measures of stress exposure (e.g., perceived stress), and very few disaggregated by gender. Therefore, present findings also suggest that John Henryism may be shaped by other characteristics among Black women. For example, characteristics such as marital status, parental status, and stressors such as caregiving strain, gendered racism, and colorism may be more influential than age, SES, chronic stress, everyday discrimination, and goal-striving stress in shaping the development of John Henryism among Black women (Woods-Giscombé 2010; Woods-Giscombé et al. 2016; Hall 2018; Thomas Tobin, Robinson, and Stanifer 2019; Quist et al. 2022); it is also possible that there was not much variation in these factors among the women. In

this case, future work examining correlates of John Henryism among Black women would benefit from exploring a wider range of stressors and sociodemographic characteristics.

7.2 How does John Henryism shape mental health among Black women?

Given the dearth of literature available examining the links between John Henryism and mental health among the general population and particularly among Black women, Aim 2 sought to examine the mechanisms through which John Henryism impacts mental health among Black women. This involved examining the direct association between John Henryism and mental health (i.e., psychological distress, self-rated mental health, depressive symptoms, and past-year major depressive disorder) among Black women. While some findings were expected, others were not.

For instance, John Henryism was not associated with psychological distress among Black women. This finding was somewhat unexpected, given that prior work has demonstrated that high-effort coping is protective against feelings of psychological distress among Black Americans (Kiecolt et al. 2009). One possible explanation for this unexpected finding is that most of the Black women in the sample reported low levels of psychological distress, which means that they may not have needed to engage in John Henryism to offset feelings of distress. Additionally, much of the previous work that has examined the role of John Henryism in shaping distress has not disaggregated by gender. Therefore, although John Henryism appears to be beneficial for psychological distress among Black populations in sum, this may in fact differ for subgroups, such as women.

Additionally, high-effort coping did not shape women's perceptions of their mental health, as no significant association was found between John Henryism and self-rated mental health among Black women. Since previous work has not examined the association between John Henryism and self-rated mental health, this finding was not immensely unexpected. While self-

rated mental health captures someone's personal rating of their mental health (Ahmad et al. 2014), John Henryism is technically strenuous and persistent coping (James et al. 1983). If someone engages in this type of coping, their perceptions of their mental health may not necessarily be impacted in a significant manner. It is more so how they feel their mental health is as opposed to more objective measures. Self-rated mental health is increasingly being used as a dimension of mental health to examine; nevertheless, less is known in terms of factors that may shape this domain of mental health.

Furthermore, engaging in high-effort coping was found to be harmful for depressive symptoms and past-year major depressive disorder. In particular, John Henryism was directly associated with higher depressive symptoms and higher odds of past-year major depressive disorder; however, after accounting for sociodemographic characteristics and stressors, these associations were no longer found. Depressive symptoms capture how often someone has had difficulty in enjoying their lives over the past month (Radloff 1977), while John Henryism is a form of high-effort active coping (James et al. 1983). Although John Henryism has been previously linked to fewer depressive symptoms (Bronder et al. 2014); it is possible that for Black women, engaging in high-effort coping poses significant risk for this group's mental health. Previous research has indicated that Black women may in fact have too many coping resources available, such that they cope even when they don't need to, which ultimately leads to compromises in this group's well-being (Erving et al. 2021). This may in fact be the case for Black women who engage in John Henryism, which leads to higher depressive symptoms among this group.

In terms of past-year major depressive disorder, this mental health domain captures whether someone has met the WHO-CIDI criteria for past-year major depressive disorder, while John Henryism is a form of high-effort active coping (Jackson et al. 2004; WHO World Mental

Health Organization Consortium 2004). Considering that previous work demonstrates that John Henryism can be beneficial for mental health among Black women (Bronder et al. 2014), prior work has also shown that high John Henryism is associated with higher odds of lifetime major depressive episodes among Black populations (Hudson et al. 2016). This may the case for Black women specifically for several reasons. Firstly, Black women report higher rates of major depression compared to Black and White men (Brody et al. 2018). While prior research has indicated that psychological distress shapes the development of psychiatric disorder, recent findings indicate this may not necessarily be so straightforward among Black women. Given the multitude of stressful experiences this group endures in attempts to navigate interlocking systems of oppression (Collins 2001), Black women likely draw upon different coping styles to offset the negative impacts of these circumstances. However, present findings show that all forms of coping may not be as beneficial for Black women in terms of major depression, such that engaging in high-effort coping over prolonged periods of time seems to hasten the advancement of past-year major depressive disorder among this group instead of preventing it. It could be that though John Henryism can be protective at first, overtime, engaging in this persistent form of tenacity begins to wear and tear on the psyche of Black women. Subsequently, this compromises their mental health in significant ways, which is likely a result of navigating various systems of reinforcing oppression, such that no matter what one does, there is still a mental health cost of sorts to contend with.

As evidenced by these results, John Henryism shapes various mental health outcomes in distinct ways among Black women. Whereas John Henryism was protective against psychological distress, it did not shape self-rated mental health, and was detrimental for depressive symptoms and past-year major depressive disorder among Black women. So, why might this be? Prior

research suggests that engaging in high-effort coping for short periods of time is fairly adaptive (James 1994). However, it is the process of engaging in high levels of high-effort coping for prolonged periods of time that may lead to differences in how John Henryism shapes individual mental health outcomes. Temporally, psychological distress is a more short-term mental health outcome that really points to recent feelings of nervousness and hopelessness (Kessler et al. 2003). Therefore, it is plausible that John Henryism would be helpful for psychological distress. In terms of self-rated mental health, this outcome captures someone's present assessment of their own mental health status, meaning that individuals do not have to think back to how they felt a month or even a week ago. With this in mind, it is possible that high-effort coping would not have a major impact on how someone rated their mental health at one point in time. Conversely, depressive symptoms and past-year major depressive disorder represent more chronic and severe mental health outcomes that are typically ongoing challenges in individuals' lives (Kessler et al. 2005; Woodward et al. 2012; Erving et al. 2019; Thomas Tobin 2021). So, it would stand to reason that women who engage in high levels of high-effort coping over prolonged periods of time would be more likely to experience heightened depressive symptoms and increased odds of major depression. Collectively, these dissertation findings demonstrate that John Henryism may not be the healthiest coping mechanism for Black women to engage in to maintain and enhance their mental health.

7.3 How Does John Henryism Shape Physical Health Among Black Women?

Although most work examining the association between John Henryism and health has focused on physical health, very few studies have assessed the ways in which John Henryism shapes physical health among Black women. To address this gap, the focus of Aim 3 was to examine the mechanisms through which John Henryism shapes physical health. This included

examining the direct association between John Henryism and physical health (i.e., self-rated health and chronic health conditions) among Black women.

Findings showed that John Henryism alone did not shape self-rated health or chronic health conditions. In other words, John Henryism was not directly associated with any physical health outcomes among Black women; nevertheless, after accounting for sociodemographic characteristics and stressors, high John Henryism was associated with lower odds of fair/poor self-rated health. This finding is in alignment with previous work showing that high John Henryism is protective for self-rated health, although many of these studies were conducted among Black men or did not assess gender differences (James et al. 1983; James et al. 1987; James et al. 1992; James 2019). In terms of chronic health conditions, the primary chronic health condition that John Henryism has been linked to previously among Black women is hypertension/cardiovascular disease, such that high John Henryism is associated with lower risk for hypertension (Dressler et al. 1998). Most previous work assessing the role of John Henryism in shaping health among Black women has primarily focused on mental health (Bronder et al 2014; Kramer, Johnson, Johnson 2015; Stevens-Watkins et al. 2016); therefore, less is known about the physical health implications of John Henryism among this group. The present dissertation findings suggest that John Henryism by itself may not be consequential for Black women's physical health, which may the case for a few reasons. For instance, two measures of physical health were assessed, one being an individual's perception of their health (Krause and Jay 1994), and another being doctor-diagnosed chronic conditions. Given that these are two distinct indicators of health status, and John Henryism did not shape either directly, it shows that there may be other factors worthy of consideration when assessing the link between John Henryism and health among Black women.

Social Stress Theory emphasizes the role of coping in shaping health among populations; however, this theory also underscores the necessity of accounting for sociodemographic characteristics and stress exposure to gain a better picture of how coping shapes health (Pearlin et al. 1981; Turner 2013), which is what was found for self-rated health among the sample. After accounting for sociodemographic factors and stressors, high John Henryism was, in fact, associated with lower odds of fair/poor self-rated health among Black women. In other words, once forms of social stratification and stress exposure are taken into consideration, we see that high John Henryism *is* protective or serves as a resource for Black women's self-perceptions of their physical health status. This may be the case because sociodemographic characteristics and stressors shape coping resources (Pearlin et al. 1981; Turner 2013), which ultimately influence physical health. Considering that high-effort coping provides individuals with the mental fortitude to push through challenges, and that self-rated health is essentially someone's mental perception of their physical health status, it is possible that John Henryism also taps into similar processes in terms of how Black women perceive their health. For example, if someone endorses high levels of high-effort coping, they are mentally pushing themselves to persevere through challenges, which likely provides them with endurance to navigate these circumstances. In turn, these individuals are probably less likely to perceive their physical health status as fair/poor because they feel good due to exerting a sense of control over difficulties. Collectively, these findings suggest that to clarify the physical significance of John Henryism among Black women, it is crucial to account for forms of social stratification and stress exposure. Failure to do so obscures the true influence of John Henryism on the physical health of Black women and stifles possibilities for effective interventions to promote population health among this group.

Collectively, these findings suggest that John Henryism does not directly shape physical health among Black women. Nonetheless, after consideration of stress exposure and sociodemographic characteristics, engaging in high levels of high-effort coping seems to be protective for self-rated health among Black women.

7.4 Does the John Henryism Hypothesis Extend to Black Women?

The John Henryism Hypothesis (*JHH)* suggests that SES conditions the impact of John Henryism on health, such that low SES individuals who consistently engage in this form of high-effort coping experience increased risk for poor health (James et al. 1983; James 1994; James 2019). To drive this point home further, it is the interaction of low financial resources and strenuous coping that leads to wear and tear on the body. From a Public Health perspective, it was important to examine the *JHH* because coping mechanisms and SES are both amenable to change; therefore, if we can understand how these two factors work together to shape health, this understanding will be beneficial in terms of developing interventions and policy for Black women. Yet, only a few studies have considered the *JHH* among this group. This work has largely yielded mixed findings, and none have examined the *JHH* for mental health among Black women.

Nevertheless, no evidence of the *JHH* was found among Black women in this dissertation. This finding was not unexpected, since prior work has demonstrated mixed findings for the *JHH* among Black women, with some finding support for the *JHH*, others finding the opposite of what the *JHH* proposes, or no association at all (Felix et al. 2019). While the *JHH* has primarily been tested for hypertension and other cardiovascular disease-related outcomes in terms of physical health among Black women (Felix et al. 2019), the *JHH* has not been assessed among this group for mental health outcomes. Therefore, it is quite possible that SES may not be as pertinent in shaping the association between John Henryism and health among Black women. Other factors

may serve as more impactful mechanisms (e.g., stress exposure), given that Black women typically report higher rates of stress exposure, and stress exposure is associated with poor mental and physical health outcomes. Or perhaps there are additional mental and physical health outcomes outside of the scope of this dissertation that the *JHH* may be more applicable to among Black women. Future work would be enhanced by examining the *JHH* among Black women with a more robust selection of mental and physical health indicators.

7.5 Does John Henryism Buffer the Impact of Stress on Health Among Black Women?

Social Stress Theory also suggests that John Henryism may be an important stress buffer but few studies have looked at this (Pearlin et al. 1981; Turner 2013). As opposed to buffering (i.e., mitigating) the impact of stress on health, findings show that high-effort coping exacerbated (i.e., worsened) the link between stress and mental health for Black women. Among Black women engaged in high John Henryism, the association between goal-striving stress and depressive symptoms was heightened, and the same was found for the link between everyday discrimination and past-year major depressive disorder. These findings were somewhat unexpected, particularly because coping is thought to diminish the adverse impacts of stress on health (Pearlin et al. 1981; Turner 2013), and John Henryism in particular has been shown to be protective for mental health among Black individuals (Bennett et al. 2004; Kiecolt et al. 2009; Bronder et al. 2014; Robinson and Thomas Tobin 2021). However, among Black women, this was not the case in terms of John Henryism and mental health. More specifically, high John Henryism actually exacerbated the negative effects of goal-striving stress on depressive symptoms, and the adverse impact of everyday discrimination on past-year major depressive disorder among Black women.

So, why might this be? A key distinguishing factor would be the type of stressor. Goal-striving stress is the difference between someone's aspirations for a goal and their achievement of

that goal, which is then weighed by how likely that individual believes they will succeed and the level of discontent they would experience if that goal was not achieved (Sellers et al. 2008). So, it would stand to reason that goal-striving stress may lead to higher depressive symptoms, particularly if a goal was not achieved. When you take someone who is experiencing goal-striving stress and they also begin to engage in high levels of high-effort coping, there is likely a synergy of sorts, in which high John Henryism may intensify goal-striving stress, especially if someone has a goal that they want to achieve but they are not sure that they will achieve it. This person would likely continue to engage in high levels of high-effort coping because it is an active way for them to elicit control over future circumstances (e.g., achieving a desired goal) (James et al. 1983; Lazarus and Folkman 1984; Lazarus and Folkman 1987). This, in turn, could hasten the development of higher depressive symptoms among someone is experiencing goal-striving stress and engaged in high John Henryism. This may be the case if it appears that despite all the effort being exerted, the goal might not be achieved, or in other words, one's efforts are perceived to have been in vain.

Another stressor, everyday discrimination, is a form of stress that taps into how frequent someone experiences discriminatory events that can be attributed to various sources (Williams et al. 1997). Thus, it is quite possible that experiencing persistent and frequent discriminatory events could eventually shape the development of psychiatric disorder, particularly past-year major depressive disorder among Black women. When someone experiences repeated daily "hits" of unfair treatment, it prompts feelings of confusion, frustration, sadness, and other emotions (Williams et al. 1997). These feelings and emotions likely compound over time, as the discrimination does not stop occurring. Rather, these incidences build upon one another to subsequently compromise mental health in a substantial way. In these circumstances, an individual

will likely attempt to draw upon available coping resources in attempts to offset the discomfort and harm being caused by everyday discrimination, with John Henryism being a possibility (Pearlin et al. 1981; Lazarus and Folkman 1987). Given that John Henryism is high-effort and active coping, people typically engage in this when they believe that their efforts can alter their reality, in this case, ameliorating what is causing them injury (James et al. 1983; Lazarus and Folkman 1984; Lazarus and Folkman 1987). When someone who is experiencing everyday discrimination starts to endorse high levels of high-effort coping, there is an interaction in which high John Henryism may even intensify the effects of everyday discrimination on past-year major depressive disorder, particularly if that individual is still experiencing discriminatory events every day. Their mind is not able to relax or calm down because they are likely anticipating the everyday discrimination and may pre-emptively engage in high John Henryism in efforts to prevent as much of a harmful impact on their well-being. This, in turn, may accelerate the development of past-year major depressive disorder among Black women who experience everyday discrimination and endorse high John Henryism. By contrast, there was no evidence of John Henryism stress buffering for physical health among Black women. In summation, John Henryism does not appear to lessen the impact of stress on health among Black women, which was unexpected. Taken that high John Henryism worsened the impact of stress on mental health specifically, forthcoming inquiries could elaborate on this work by investigating additional mechanisms that may be shaping these associations.

7.6 What is the Distribution and Patterning of John Henryism Among Caribbean Black Women?

A plethora of health research, including studies focused on John Henryism tend to not examine the role of ethnicity for Black women. This is challenging provided that scholars have underscored the role of ethnicity in shaping health processes (Brown et al. 2013). To this end, the

present study sought to address this gap by exploring John Henryism among Caribbean Black women specifically. As previously shown, John Henryism does not shape health in the expected ways among Black women. Among Caribbean Black women, additional nuances were also observed. With respect to the distribution and patterning of John Henryism among Caribbean Black women, similar trends as those for all Black women were found among this group, such that two factors were found in the confirmatory factor analysis for the JHAC-12 scale. A notable distinction was that among Caribbean Black women, while two factors were found, two items from the JHAC-12 scale were not correlated to either of these factors. These two items were: (1) "I've always felt that I could make of my life pretty much what I wanted to make of it"; and (7) "I feel that I am the kind of individual who stands up for what he believes in, regardless of the consequences." These two items captured ideas of self-efficacy and defending one's beliefs despite constrained choices and potential consequences and were correlated to factor 1 (item 1) and factor 2 (item 7) among all Black women. Given that findings also show Caribbean Black women endorsed items 1 and 7 as either "somewhat true" or "completely true", this does not mean that items 1 and 7 are not relevant for this group. Rather, it demonstrates that these two items do not capture the construct of John Henryism among Caribbean Black women, and capture something else.

It is possible that these two items might in fact be capturing a theme among Caribbean Black women that encompasses something different, even if slightly, from tenacity, hard work, and/or a determination to succeed. To reiterate, the two items were: (1) "I've always felt that I could make of my life pretty much what I wanted to make of it"; and (7) "I feel that I am the kind of individual who stands up for what he believes in, regardless of the consequences." These items are a little different from the other items on the JHAC-12 scale in that they are the only two items

that pose statements related to what participants have "always felt" or currently "feel", apart from one item that alludes to a temporal component (i.e., sometimes). The remaining items on the scale primarily focus on "actions", name specific emotions, or pose circumstances that involve overcoming a challenge.

To further unpack why items 1 and 7 do not map onto the John Henryism construct among Caribbean Black women, it is helpful to look at some of the other items on the scale, levels of endorsement, and the correlations between these items and factors. The item with the highest endorsement (60%) of "completely true" for Caribbean Black women was item 10: "It's not always easy but I manage to find a way to do things I really need to get done". Additionally, most Caribbean Black women indicated "completely true" or "somewhat true" for items that underscored not allowing one's personal feelings to prevent them from completing a job, sticking with a job until it is done, and never disregarding their goals even when faced with difficulty. This leads to a few possibilities: (1) Standing up for one's beliefs despite consequences poses a risk for getting a job done and/or accomplishing a goal for Caribbean Black women, and (2) Accomplishing goals and getting jobs done may supersede the importance of personal beliefs for Caribbean Black women, not because they have a desire to do this, but instead due to historical and contextual factors that constrain choices and options for this group.

Histories of colonialism in the Caribbean may have a substantial bearing on the aforementioned findings. Most Caribbean Black women in the sample had familial ties to Haiti or Jamaica, and both countries have very complicated histories with colonialism broadly, and to an extent, with the United States. Although Haiti, a former colony of France, fought for and won its independence in 1804, France did not formally recognize Haiti as an independent nation until 1825 (Obregón 2018). However, this would not occur without Haiti being required to pay France an

indemnity (i.e., protection against lost) amounting to 100 million francs ($21 billion dollars today) (Obregón 2018). It took over 100 years and loans from various sources to pay off the debt (Obregón 2018). Nevertheless, Haiti has yet to be compensated for the enslavement of its people, as a 2010 request for reimbursement of this debt to France was ignored (Choi 2021). Haiti also experienced imperialism at the hands of the United States, who occupied Haiti for almost twenty years through the use of military power (1915-1934) under the guise of a humanitarianism intervention to promote public health programs and sanitation (Lopez 2015). As we can see from historical events, Haiti has not recovered from this form of re-colonization and over 50% of Haitians live in poverty (Choi 2021). Unfortunately, these trends are still very much present in current day. For example, Haiti has experienced numerous natural disasters without sufficient support, and in July of 2021, the president of Haiti was assassinated, which has influenced political unrest and turmoil (Isacson 2022). As of February 2022, the Biden administration had deported 20,000 Haitian migrants from the United States (since January 2021), and this number is steadily climbing (Isacson 2022). On the other hand, Jamaica, a former colony of Britain, gained independence in 1962 (Choi 2021). As of 2021, Jamaica had prepared a petition to the British government requesting 7.6 billion pounds to go to individuals who had enslaved ancestors that worked on sugar plantations (Hassan 2021), given that the British government paid previous owners of enslaved people 20 million pounds (2 billion today) (Choi 2021). Consequently, though "officially" no longer in practice, these colonial processes and their effects are still very much applicable today and shape Caribbean Black women's lived experiences.

Colonialism shaped the life chances and lived experiences of Caribbean Black women in many ways. A primary mechanism was that of labor exploitation. One of the most profound articulations of this inequity came from Claudia Jones. Jones, a journalist, political activist,

Communist, and Black feminist, was born in Trinidad and Tobago and migrated to the United States as a young child (Boyce Davies 2007). Through her experiences, she developed a thesis of "super-exploitation" to describe the experiences of Black women (Boyce Davies 2007). To Jones, super-exploitation of Black women denoted (1) how the labor of Black women is presumed as a guarantee, and (2) the fact that Black women are often consigned to service work by all societal domains, oftentimes with the involvement of liberal and White women's and employment interests, with Black women being severely underpaid for the amount of labor they provide (Jones 1949; Boyce Davies 2007). The super-exploitation of Caribbean Black women was extremely evident in the colonial periods, such that there were policies in place to prevent women from securing employment outside of the service industry and displays of patriarchy in the workplace (Boyce Davies 2013). In terms of immigration experiences in the Caribbean, the uptick of immigration to the United States in the 1960s was driven by women who were seeking employment opportunities in efforts to achieve upward mobility and independence (Boyce Davies 2013). These circumstances were even more complex for Caribbean Black women, given that women were the ones who were tasked with securing employment, and settling their families in the United States and caring for them (Lorick-Wilmot 2010).

Thus, it is vital to consider the history of colonialism and imperialism experienced by the Caribbean, in conjunction with the super-exploitation of Caribbean Black women, and how these systems shaped immigration trajectories for these women. It is possible that these conditions inevitably shaped the worldview for Caribbean Black women who faced these circumstances, thereby prompting them to socialize their second-generation children in a manner that in some ways preserves this worldview and navigation of systems in terms of survival. More specifically, with this historical and political context in mind, it is less surprising that for Caribbean Black

women in the sample, items (1) "I've always felt that I could make of my life pretty much what I wanted to make of it"; and (7) "I feel that I am the kind of individual who stands up for what he believes in, regardless of the consequences" of the JHAC-12 scale represent concepts other than John Henryism for this group. These items speak to a semblance of self-efficacy and personal agency that in so many ways, Caribbean Black women and their second-generation children were systematically robbed of and may not have felt safe to exert.

While items (1) "I've always felt that I could make of my life pretty much what I wanted to make of it"; and (7) "I feel that I am the kind of individual who stands up for what he believes in, regardless of the consequences" of the JHAC-12 scale do not represent John Henryism for Caribbean Black women, it is possible that these two items instead reflect elements of constrained choices within a matrix of domination. Constrained choices refer to how an individual's social location and governmental policies shape their daily options and choices, which ultimately shape their well-being and life chances (Bird and Rieker 2008). Matrix of domination, coined by Dr. Patricia Hill Collins, posits that there are four specific and interrelated domains (i.e., structural, disciplinary, hegemonic, and interpersonal) that structure power dynamics within society that maintain the subjugated social positions of Black women (Collins 2001). Navigating constrained choices within a matrix of domination does not preclude Caribbean Black women from agreeing that they have always felt that they were able to make of their lives what they wanted to, and/or that they stand up for their beliefs despite consequences. However, it is precisely their need to navigate these systems of interlocking oppression for survival as Black women, with ties to the Caribbean, within the United States setting which could in fact reflect why items 1 and 7 from the JHAC-12 scale convey a different concept than John Henryism for Caribbean Black women. Considering that John Henryism and the JHAC-12 scale were developed based on the United

States frame of reference, particularly in terms of enslavement processes and the need to develop an identity that signified American concepts of hard work and determination (James 1994), the distinct contexts and lived experiences of Caribbean Black women, their familial immigration histories, and remnants of colonialism and imperialism may in fact alter what items 1 and 7 represent for this population. Thus, findings from this dissertation indicate that John Henryism has a different meaning for Caribbean Black women. Prospective scholarship focusing on John Henryism among this group would be strengthened by further disentangling what John Henryism is and is not for Caribbean Black women, in addition to refining the measurement of this construct among Caribbean Black women.

7.7 How Does John Henryism Shape Mental and Physical Health Among Caribbean Black Women?

Trends for the association between John Henryism and mental health for Caribbean Black women were similar to those as all Black women, with a few distinctions. John Henryism was not directly associated with any mental health outcomes among Caribbean Black women except for past-year major depressive disorder, such that high John Henryism was associated with higher odds of past-year major depressive disorder. As previously mentioned, this finding was also present among all Black women. A key difference emerged in terms of psychological distress. While John Henryism was not directly associated with psychological distress among Caribbean Black women, high John Henryism was associated with lower psychological distress after accounting for sociodemographic characteristics and stressors among this group. This result suggests that if all Caribbean Black women shared the same age, SES, and exposure to chronic stress, everyday discrimination, and goal-striving stress, we would see this association between high John Henryism and lower levels of psychological distress among this population. In other words, differences in these factors might explain or account for this relationship among Caribbean

Black women. Given that this result was not found among all Black women, this suggests that sociodemographic factors and stress exposure matter for the link between John Henryism and psychological distress among Caribbean Black women in distinct ways.

According to Social Stress Theory, coping is supposed to protect against poor mental health (e.g., distress and psychiatric disorder) (Pearlin et al. 1981; Barnes and Bates 2017); however, findings from this dissertation suggest that the mechanisms put forth by Social Stress Theory may be nuanced across social groups. More specifically, based upon this school of thought, high John Henryism should be associated with lower psychological distress and lower odds of past-year major depressive disorder. However, this was not found. On the one hand, distress is a more manageable form of mental duress that still allots individuals the capability of utilizing coping tools to offset challenges. On the other hand, major depressive disorder is a more chronic and severe form of mental challenge that prevents individuals from drawing upon coping resources and/or the use of these coping tools is no longer adaptive for them and may prove more detrimental. Previous work has also posited that distress and disorder share the same correlates and are associated with one another (Payton 2009). Nevertheless, recent scholarship on this topic among Black women found that while stress exposure was associated with both distress and major depression, the association between distress and disorder varied by age and SES (Robinson, Erving, and Thomas Tobin 2022). Therefore, it is possible that John Henryism operates via similar mechanisms among Caribbean Black women, such that it differentially shapes certain mental health outcomes that are thought to share the same determinants.

Findings for the direct association between John Henryism and health among Caribbean Black women mirrored that of all Black women. While John Henryism was not directly associated with any physical health outcomes among Caribbean Black women, after accounting for

sociodemographic characteristics and stressors, high John Henryism was associated with lower odds of fair/poor self-rated health. Altogether, findings from this dissertation demonstrate that while John Henryism is somewhat harmful for the physical health of Caribbean Black women when the direct link is considered, it is protective for mental health. Future work would benefit from examining the direct association between John Henryism and health with a wider range of mental and physical health outcomes.

7.8 Does the John Henryism Hypothesis Extend to Caribbean Black Women?

While no support for the *JHH* was found among all Black women for mental or physical health, different trends emerged for Caribbean Black women. Findings show that among Caribbean Black women who engaged in high John Henryism, as SES levels increased, this group experienced a minimal increase in their levels of psychological distress. In other words, among high John Henryism Caribbean Black women, higher SES was not very protective against psychological distress. This is inconsistent with the *JHH*, which suggests that low SES individuals who engage in high levels of John Henryism will experience poor health outcomes. There are a few possible reasons as to why high endorsement of John Henryism while having high SES would lead to increased levels of psychological distress among Caribbean Black women. It is possible that second-generation Caribbean Black women may not be socialized by their parents to expect certain stressors (e.g., discrimination, gendered racism) within the U.S. context, or may not learn how to manage them once they have occurred. Thus, when these women experience particular stressors, it may be more shocking and impactful for them, given because they may have been taught that financial resources will protect them from such challenges or lessen the burden, or that upward mobility is the primary goal, which could lead to psychological distress. Therefore, when these women begin to engage in high levels of high-effort coping in attempts to offset these

challenges, it may be more maladaptive because they don't expect to have these issues to begin with, and high-effort coping may perhaps exacerbate feelings of psychological distress if the external challenges are still present despite coping.

Another potential explanation for this finding is that second-generation Caribbean Black women may not have access to a close-knit network of other Caribbean Black individuals for support to help insulate them from these stressors, given that prior work has emphasized the vital and beneficial role of close networks within immigrant communities (Bashi 2007; Lorick-Wilmot 2010; Hummer and Hamilton 2019). Thus, although they obtain higher levels of SES, they are still Black women within the context of the U.S., and to many, Black women are not supposed to have plentiful financial resources. Consequently, high SES Caribbean Black women might experience discrimination and stress that lead to heightened feelings of psychological distress. However, instead of offsetting these feelings of distress, engaging in high levels of persistent and active coping could actually do the opposite because women might realize that they are still unable to change their circumstances. Considering that second-generation Caribbean Black immigrants often report feelings of "in-betweenness" in terms of not always ascribing to their parent's worldviews and navigating a society that assumes they are African American (Waters 1999; Lorick-Wilmot 2014), it is also possible that Caribbean Black women do have networks to draw upon for support; however, the support provided by these networks may not be as beneficial for their lived experiences as U.S. born individuals (Waters 1999). For example, these women may be told to ignore the challenges they face and instead focus on obtaining economic resources, which could in turn elicit feelings of distress for these women because they do not know how to navigate these difficulties, in addition to handling feelings of being misunderstood by those who were born and socialized in their familial place of origin. In this case, perhaps engaging in high-effort coping

for Caribbean Black women though supposedly helpful, utilizes more mental energy than these women have to spare.

Transnationalism may also provide major insight into these trends. Transnationalism is defined as the processes by which immigrants build social contexts and ways of being that allow them to connect their place of origin to their destination (Schiller et al. 1992). Within this domain, immigrants who endorse transnationalism tend to create and preserve multi-dimensional (i.e., familial, social, political, and economic) relationships that transcend geographic location (Schiller et al. 1992). In the perspective of transnationalism, it is common for immigrants to send remittances (i.e., money or assets) back to their familial place of origin (Henke 2001), with women remitting more money and more frequently than men, despite earning less (Azam et al. 2020). Although most Caribbean Black women (80%) in the sample were born in the U.S., second-generation immigrants still maintain ties to their familial place of origin (Waters 1999). They might still financially support individuals from back home. Most Caribbean Black women in the sample were Haitian or Jamaican, and recent estimates indicate that in 2017, $1.8 million dollars were remitted from the United States to Jamaica, while $1.5 million dollars were remitted from the United States to Haiti (Pew Research Center 2019). This suggests that although Caribbean Black women may hold higher levels of SES, they might not necessarily keep all of that money for themselves. This in turn could produce feelings of psychological distress, particularly if these women may find it difficult to manage their financial situation after assisting back home. Consequently, if these women engage in high levels of John Henryism to cope with these circumstances, it can in fact worsen feelings of psychological distress, especially if external conditions are not shifting.

As a whole, these results show that high SES is not protective for psychological distress among Caribbean Black women who engage in high John Henryism. While this work challenges prior scholarship that suggests high SES is protective for health (Link and Phelan 1995), it aligns with other studies that have demonstrated diminishing health returns for SES among Black individuals (Farmer and Ferraro 2005; Assari 2018). Thus, subsequent research would be enhanced by further assessing the *JHH* among other ethnic subgroups of Black women, and understanding additional mechanisms that may be shaping these trends.

7.9 Does John Henryism Buffer the Impact of Stress on Health Among Caribbean Black Women?

Although results demonstrated similar trends among all Black women and Caribbean Black women for the direct associations between John Henryism and health, findings show that the mechanisms shaping these outcomes are quite distinct between all Black women and Caribbean Black women. For example, while high John Henryism unexpectedly exacerbated the links between stressors and poor mental health among all Black women, evidence for the anticipated stress buffering mechanism was found for stress and mental health among Caribbean Black women. Among Caribbean Black women engaged in moderate or high John Henryism, the association between everyday discrimination and depressive symptoms was buffered. In other words, among Caribbean Black women who endorsed moderate or high John Henryism, everyday discrimination was associated with fewer depressive symptoms.

There are a few possible explanations for this finding. Perhaps Caribbean Black women interpret everyday discrimination in a different way, such that this group might perceive it as a low-level stressor that does not impact them as severely. As mentioned earlier, many Caribbean Black individuals are socialized to achieve upward mobility to improve social standing (Waters

1999; Lorick-Wilmot 2014). What this means is that Caribbean Black women in the sample may have been very goal oriented in terms of their desire to obtain formal education and pursue financial stability. This would not be uncommon given that second-generation or higher Caribbean Black women during this particular time period were focused on educational pursuits and furthering their career prospects to ensure that their children and families were taken care of (Boyce Davies 2013). Additionally, it may just be that as opposed to moderate and high levels of high-effort coping, low levels may not be enough to offset the adverse mental health impact of frequent discriminatory events on Caribbean Black women's depressive symptoms. This finding also contrasts with recent scholarship examining the buffering role of John Henryism on the association between everyday discrimination and physical health among older Caribbean Black adults (Nguyen et al. 2022). In this study, the authors found that among older Caribbean Black adults who endorsed low John Henryism, discrimination was association with higher odds of hypertension, while among older Caribbean Black adults who endorsed moderate or high John Henryism, experiencing discrimination was not associated with hypertension (Nguyen et al. 2022), which is the opposite of what the present dissertation found for everyday discrimination and depressive symptoms among Caribbean Black women. Collectively, these findings further demonstrate that the ways in which John Henryism impacts the association between a particular stressor and mental health can be very different than how it shapes the link between that stressor and physical health, which underscores the need to examine both physical and mental health outcomes when clarifying the health implications of John Henryism.

Whereas empirical support for stress buffering was not found among all Black women for physical health, unanticipated results emerged for Caribbean Black women. Among Caribbean Black women who engaged in moderate John Henryism, the association between chronic stress

and both physical health outcomes (i.e., self-rated health and chronic health conditions) was worsened. To put it differently, among Caribbean Black women engaged in moderate John Henryism, chronic stress led to higher odds of fair/poor self-rated health, as well as more chronic health conditions. This may happen for a few reasons. As previously stated, chronic stress is a form of stress that severely undermines the health and well-being of Black women (Woods-Giscombé 2010; Woods-Giscombé et al. 2016). Research has shown that to a certain extent, by the second-generation, health patterns of those who migrate start to mirror that of the destination area (Carlisle 2012). Given that most Caribbean Black women in the sample were second-generation or higher, this is particularly relevant. It may be that chronic stress shapes self-rated health and chronic health conditions through similar mechanisms among Caribbean Black women, such that certain levels of John Henryism that may be protective among all Black women may be detrimental for this group. In other words, it could be that for physical health, Caribbean Black women's threshold by which John Henryism is no longer protective might be lower than expected. Relatedly, it could be that moderate John Henryism is just not enough to offset the adverse physical health implications of chronic stress among Caribbean Black women. Another possibility is that Caribbean Black women in the sample may be drawing upon other coping resources simultaneously, which could make it counterproductive for them to engage in high-effort coping if they have other supports. This possibility has been raised and supported in previous work among Black women which has shown that Black women may draw upon coping resources even when there isn't a need to do so, which consequently leads to poor health outcomes (Erving et al. 2021).

Nevertheless, among Caribbean Black women, we see that while higher levels of John Henryism were protective against poor mental health outcomes when women experience everyday discrimination, moderate levels of John Henryism were detrimental to physical health when

women experienced chronic stress. Taken together, these results emphasize the importance of examining a variety of stress exposures and mental and physical health indicators when assessing the utility of John Henryism as a potential stress buffer among Caribbean Black women. Future work assessing the role of John Henryism as a stress buffer for mental and physical health among Caribbean Black women could examine additional stressors that this group faces in efforts to understand whether the findings from this dissertation may be applicable to other mental and physical health outcomes. Doing so will assist in providing a more comprehensive understanding of John Henryism's stress-buffering potential among Caribbean Black women.

8 Limitations

Although this dissertation provides significant contributions to the literature, there are several limitations to consider. First, although the dataset used to conduct analyses is the most comprehensive assessment of mental health and psychiatric disorder among people of African descent, the dataset is 20 years old (NSAL 2001-2003). There are a number of implications for this. The social and political climate of that time, though similar, is also quite different than the one present today. Between 2001-2003, multiple events took place that shaped the United States societal context and worldviews in a major way. For example, the September 11, 2001 attack on the World Trade Center shifted public sentiments in the United States towards a variety of topics including: US involvement in world affairs, military presence, and attitudes towards immigration (Pew Research Center 2003). A 2003 Pew Research Center Political Landscape report found that following the attack, 90% of Americans believed it was important to be involved in world affairs, 62% of men and women agreed that the foremost way to guarantee peace was through military strength, and approximately 80% of Americans believed that "we should restrict and control people coming into our country to live more than we do now" (Pew Research Center 2003:27).

These sentiments were then intensified by the response of government leaders such as then-President George W. Bush. The system of immigration enforcement drastically changed during the Bush administration. For example, this administration institutionalized the term "illegal" in reference to undocumented immigrants, confounded immigration with crime and national security, and created the Department of Homeland Security in 2003. This organization ultimately led to the creation of Immigration and Customs Enforcement (ICE), and provided financial support to local law enforcement agencies for conducting immigration raids (Apollon 2013). The Bush administration's government sanctioned acts of dehumanization towards immigrants communicated to the general public that the aforementioned ideals were accepted and even rewarded in American society.

Furthermore, during this time period, the administration's response to addressing racial discrimination on a federal level was severely lacking with many cases being blatantly ignored, in addition to glaring disparities in health, such that although women of color comprised 33% of the U.S. population in 2003, this group made up over 50% of all uninsured women in the U.S. (Apollon 2013). Taken together, this social and political landscape was very important to consider, especially given that this dissertation focuses on the stress, coping, and health experiences of Black women, and a fair portion of this group identified as second-generation Caribbean Black women, meaning that they hold familial histories of immigration. In addition to being an older dataset, the data used was cross-sectional, which means that findings from this dissertation cannot be used to establish causality. Moreover, the dataset does not include African-identified women, thus the aims of the dissertation could not be assessed across the modern African diaspora. To address these limitations, future research assessing the association between John Henryism and health among

Black women and ethnic subgroups of this population would benefit from more up-to-date and longitudinal data, which would necessitate allocation of substantial funding for this endeavor.

The next set of limitations for this dissertation primarily focus on participant characteristics. This dissertation only included individuals who completed the re-interview mail to home survey because this is where key study variables were assessed (i.e., John Henryism and health measures). The implication for this limitation is that the number of participants available for analyses decreased, which may shape the interpretation of findings from this dissertation to the population-level. Next, there was non-response bias for a few health measures and John Henryism. The implication for this limitation is that it is unclear how these individuals fared in terms of high-effort coping and self-perceptions of mental and physical health, which potentially shaped the results and hence generalizability of these findings. Relatedly, there was a possibility of recall bias for health measures (i.e., chronic health conditions-doctor diagnosis and mental health indicators) and experiences of stress exposure (i.e., chronic stress and everyday discrimination), given that participants were asked to recall this information across varying time periods ranging from if something has ever happened, to 30 days prior, and even day-to-day experiences. In essence, this could have led to these participants being classified into a particular group or category when they should have been in another. Future work in this area could benefit from exploring the possibility of adjusting the ordering of survey items and/or inquiries for certain information (i.e., psychosocial resources and health) to lower the likelihood of attrition and non-responsiveness from participants.

An additional limitation is that most Black women in the full sample were of fairly good mental and physical health, reported lower SES, experienced fewer stressors, were middle-aged, and in the South, which poses implications in terms of the extent to which the present dissertation's findings can be used to provide sound inferences about Black women who did not share these

characteristics. A related limitation relates to the sample of Caribbean Black women for this study. Most Caribbean Black women shared the same characteristics as the full sample of Black women, except that Caribbean Black woman reported higher SES. This can in turn have implications for the extent to which findings for this sample of Caribbean Black women can be extended to those who did not share these characteristics, particularly in terms of immigrant generation (e.g., first-generation). Future work in this area that includes Black women and ethnic subgroups of this population would be greatly enhanced by accounting for proportions of the population who may not share typical sample characteristics in study designs to ensure generalizability. Another possibility would be to conduct this work among those populations alone to gain a deeper understanding of present trends, which can ultimately promote population level well-being for these groups as well. Given that health processes are severely understudied among Black women, and particularly ethnic subgroups of Black women, it is important to ensure that the experiences of under-represented individuals within these groups are also captured in research studies.

9 Contributions/Lessons Learned

9.1 *Theoretical Contributions*

Notwithstanding limitations, the present dissertation provides several contributions to John Henryism-focused health literature. One domain of contributions would be theoretical. This dissertation is one of, if not the first study to examine both the mental and physical health implications of John Henryism among Black women broadly, but also among Caribbean Black women specifically. This study broadens the theoretical landscape of John Henryism-focused health literature by demonstrating that John Henryism influences mental health outcomes other than depressive symptoms and psychological distress among Black women and can be expanded to include self-rated mental health and major depressive disorder. Another area of expansion

provided by this dissertation is that John Henryism shapes physical health outcomes other than hypertension and cardiovascular disease-related outcomes and can be extended to self-rated health and chronic health conditions among Black women and Caribbean Black women.

An additional theoretical contribution is that findings demonstrate that while the ways in which John Henryism shapes health directly among Black women and Caribbean Black women are similar, the mechanisms through which John Henryism shapes mental and physical health among these groups are distinct. Related to this contribution is that the extent to which John Henryism buffers (e.g., diminishes) the adverse impact of stress exposure on health depends on the type of stressor, whether it is physical or mental health being assessed, and the population(s) of interest. In terms of the John Henryism Hypothesis (*JHH*), this dissertation showed that the *JHH* extends to Caribbean Black women's mental health but also clarifies that it is a more nuanced process among this group. Moreover, this study provided more insight into the meaning and significance of John Henryism for Black women and Caribbean Black women. Although most Caribbean Black women in the sample were U.S. born, findings highlighted that the meaning of John Henryism differs for this group, such that two items on the scale allude to concepts and constructs other than John Henryism, which has implications for future research that aims to assess the health implications of this coping style among Caribbean Black women.

The research of this dissertation has also served to advance the various theories used as a foundation for this work. Results from this dissertation challenge assumptions of Social Stress Theory and the stress process model (i.e., visual representation of Social Stress Theory). While Social Stress Theory and the stress process model posit that coping buffers (e.g., mitigates/diminishes) the impact of stress exposure on health, this was not necessarily the case for Black women in terms of mental health and Caribbean Black women in terms of physical health.

Given these revelations, there is a need to further examine Social Stress Theory and the stress process model among Black women broadly, and Caribbean Black women specifically. An additional contribution is that this dissertation advances the Transactional Theory of Psychological Stress and Coping (TTPSC) by demonstrating that coping may not always be beneficial for health and lends support to this theory's proposed mechanisms through which coping (e.g., John Henryism) can ultimately do more harm than good for health and well-being depending on the circumstances. Black Feminist Thought and the modern African Diaspora provided cultural and historical context needed to address these key issues. This dissertation provided support for these frameworks such that in the United States, Black women and Caribbean Black women share experiences, but also face distinct challenges that they address in different ways. Future work centering Black women and Caribbean Black women would benefit from implementing these theoretical frameworks as opposed to relying primarily upon mainstream Eurocentric paradigms as a grounding for this work.

9.2 *Methodological Contributions*

An additional area of contributions provided by this dissertation includes methodological contributions. In the present dissertation study, a John Henryism variable (α=0.80) was created specifically for Caribbean Black women after a confirmatory factor analysis revealed that two items on the scale represent a construct other than John Henryism among this group. This approach ensured that the overall construct of John Henryism was being assessed among this group, as opposed to others. Additionally, for both Black women and Caribbean Black women, John Henryism was split into three separate categories (i.e., low, moderate, high) to capture potential threshold effects in terms of the extent to which different levels of John Henryism are either protective or harmful for health. Aside from assessing both mental and physical health implications

of John Henryism, this dissertation also used a variety of indicators for each domain of health. By doing so, this enhanced the ability to examine how John Henryism shapes various mental and physical health conditions. Instead of using a cumulative or total measure of stress, this dissertation evaluated multiple stressors to demonstrate that all stressors do not shape health outcomes in a uniform way. This method provided more specificity for identifying which stressors are particularly harmful for health and how John Henryism shapes these associations.

An additional methodological contribution of this dissertation is the testing of various mechanisms through which John Henryism shapes mental and physical health among Black women and Caribbean Black women. More specifically, the direct associations between John Henryism and each health outcome were examined, followed by an accounting of sociodemographic characteristics and stress exposure within these associations, then a testing of the *JHH* for each health outcome, and lastly an assessment of John Henryism as a stress buffer (e.g., mitigator) for each health outcome. This is one of the first studies to test this group of mechanisms for John Henryism both broadly, but also among Black women and Caribbean Black women specifically. Implementing this procedure provided a more comprehensive account of how John Henryism shapes health through various pathways.

9.3 *Practice/Policy Contributions*

Overall, this dissertation suggests that John Henryism is seemingly harmful for the mental health of Black women overall, but actually protective for Caribbean Black women. Although John Henryism is protective against psychological distress among Black women, it is also detrimental for depressive symptoms, past-year major depressive disorder, and worsens the impact of stress on mental health. Therefore, for clinicians and community-based interventions working to promote the mental health of Black women, based on this dissertation, the recommendation is to provide

Black women with alternative coping tools to better navigate the impacts of stress on mental health. Examples of these coping tools include mindfulness and meditation. An additional recommendation would be to encourage Black women to consider reconnecting with ancestral ways of knowing and being (e.g., communing with nature) that have been lost and forgotten through systems of oppression. More specifically, bell hooks (1993) noted in her book, *Sisters of the Yam: Black Women and Self-Recovery*, that detachment from nature and active separation of the body and mind has opened the possibility for Black communities to embody white-supremacist understandings of Black identity. Therefore, a key way to disrupt this process would be for Black individuals and Black women in particular to heal relationships with the Earth through walking in nature, gardening, farming, and other ways that allow space to deeply connect with the environment (hooks 1993). Policy recommendations would include actively addressing broader society ills that compromise Black women's mental well-being. Conversely, John Henryism is protective against psychological distress and diminishes the impact of stress on mental health for Caribbean Black women. A recommendation for clinicians and community-based interventions working with this population is to empower this group to exercise personal agency when they are faced with stressful experiences. When personal agency is exercised, individuals are more likely to believe that they can change their circumstances through their actions, which will probably lead these women to engage in John Henryism.

Overall, this dissertation suggests that John Henryism is largely neutral for the physical health of Black women overall but harmful for Caribbean Black women in particular. While John Henryism is protective against fair/poor self-rated health, it does not shape other physical health domains or change the impact of stress on physical health among Black women. Considering this, clinicians and community-based interventions that work to promote physical health among this

population would be recommended to neither dissuade nor urge Black women to engage in John Henryism. Although John Henryism is protective against fair/poor self-rated health, it intensifies the link between stress and physical health among Caribbean Black women. Henceforth, one recommendation for clinicians and community-based interventions would be to inquire with Caribbean Black women about other coping tools that they engage in and encourage them to draw upon the more adaptive resources. An additional recommendation would be to provide Caribbean Black women with alternative coping tools to better navigate the impacts of stress on physical health. Furthermore, given that chronic stress was the stressor leading to poor physical health outcomes, another suggestion would be to inquire with Caribbean Black women about the specific forms of chronic stress that they face and connect them with external resources for additional support in efforts to diminish the amount of chronic stress this group faces. A policy recommendation would be to thoughtfully and justly examine both the overt and covert anti-Black sentiments present within immigration legislation in the United States. The reinforcement of these sentiments within legislation and the challenges of navigating them contributes to the levels of stress experienced daily by Caribbean Black women that compromises their physical well-being.

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