Racial Discrimination and Blood Pressure: Perceptions, Emotions, and Behaviors of Black American Adults

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Racial Discrimination and Blood Pressure: Perceptions, Emotions, and Behaviors of Black American Adults

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This study examined racial discrimination and blood pressure (BP) in 211 Black Americans. Racial discrimination is a chronic stressor for many Black Americans and hypertension prevalence is high in this population. Secondary analyses of data from the study, “Everyday Life for Black American Adults,” were conducted to examine relationships among perceived racial discrimination, emotional and behavioral responses to racism, and BP. Although racial discrimination was not correlated with BP, sadness and frustration were significantly but negatively correlated with BP. Speaking out and prayer were frequent behavioral responses to racism. Findings should sensitize healthcare providers to the effects of racial discrimination on the health of Black Americans.

Racial discrimination and blood pressure are independently well-researched topics, although their relationship to each other is not clearly understood. Many generations of Black Americans report experiencing the devastating effects of overt and/or covert racial discrimination. Black Americans also have the highest prevalence of high blood pressure in the United States, with hypertension rates that are much higher than those of White Americans (American Heart Association [AHA], 2007; Centers for Disease Control and Prevention, 2004). Although several studies have investigated the effects of racial discrimination on Black Americans’ health, in general, and blood pressure, in particular (e.g., Peters 2004; Sweet, McAdoo, Kiefe, & Liu, 2007; Williams, Neighbors, & Jackson, 2003), clearly more research is needed to determine its impact and to assist in the development of strategies to reduce both racial discrimination and blood pressure.

Hypertension or chronically elevated blood pressure is a major health problem for Black Americans in particular because this group has the highest rate of hypertension (HTN) in the world (AHA, 2007). In 90–95% of cases, the causes of HTN are unknown (AHA, 2007). When compared to White Americans, HTN develops at a younger age for Black Americans (Chobanian et al., 2003). According to death rates adjusted to the year 2000 population, Black Americans are more likely to have had elevated blood pressure for a longer time prior to diagnosis and treatment, which results in more target organ damage (AHA, 2007; Chobanian et al., 2003). Black American males have the highest hypertension death rates (51.8 per 100,000 population) followed by Black American females (40.4 per 100,000). White American male and female HTN death rates per 100,000 population are 13.8 and 12.9, respectively.

Racial discrimination and its effect on health and health care are evident in institutionalized social structures, personal mediated relationships, and individual human responses (Jones, 2000). Sociologic generalizations with no logical basis create stereotypes and prejudice based on skin color and other physical characteristics. Disparities in institutionalized structures such as living conditions, health access, economics, and education help to perpetuate stereotypes for Blacks especially when they are compared to White Americans. In today’s society, personally mediated racial discrimination might present as overt acts such as direct verbal slurs, innuendos, or physical action, or as less obvious covert acts such as being perceived as less capable, worthy or deserving of success, opportunities, or rewards.

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RACIAL DISCRIMINATION, STRESS AND BLOOD PRESSURE

Stress from racial discrimination is the result of actions, behaviors, or practices of White American society toward Black Americans that are perceived as unfair and hinder or prevent Blacks’ activities or that imply inferiority due to physical characteristics such as skin color, hair texture, or the size of one’s lips or nose (Clark, Anderson, Clark, & Williams, 1999). Discrimination against Black Americans is pervasive, though often subtle, in today’s American society. However, the relationship between racial discrimination and BP has produced inconsistent finding across studies. For example, Williams and colleagues (2003) examined community studies focusing on the relationship between perceptions of discrimination and blood pressure. Among 11 studies of perceived discrimination and BP, three reported positive associations. Five reported conditional associations when factors such as coping style, sex or social class, and ethnicity were examined, and three studies found no associations with hypertension. In the following sections, other conflicting studies will be examined.

Positive Associations between Racial Discrimination and Blood Pressure

In support of the connection between racial discrimination and BP, in a sample of 101 Black and White women, Krieger (1990) found that among Black women, the age-adjusted risk for high blood pressure among those who expressed no experience with racial or gender discrimination was 2.6 times greater than those reporting at least one incident. Among the White respondents, there was no association between race or gender bias and BP. In the Coronary Artery Risk Development in Young Adults (CARDIA) study, Krieger and Sidney (1996) examined self-reported experiences of racial discrimination and incidences of high blood pressure among young adults over a 7-year period. The sample included 831 Black men, 1143 Black women, 1006 White men, and 1106 White women between the ages of 25–37. Working-class Black adults who challenged racism had systolic blood pressures (SBP) that were 7 mmHg lower on average than those who did not challenge racism. Professional Black adults who typically challenged unfair treatment or had not experienced discrimination had on average a 9–10 mmHg lower SBP (Krieger & Sidney, 1996). Therefore, based on these two studies, blood pressure was lower in those who reported little or no experience with racial discrimination and in those who challenged racism when it occurred.

Several other researchers have found a connection between racial discrimination and blood pressure. For example, Din-Dzietham and colleagues (2004) examined perceived stress and racially based discrimination on the job in a sample of 356 African Americans 21 years of age and older in the Metro Atlanta Heart Disease Study. They found that African Americans who reported stress from racism at work were more likely to also report having a diagnosis of hypertension. Using 24-hour ambulatory BP monitoring, Steffen, McNeilly, Anderson, and Sherwood (2003) examined the effect of perceived racism on blood pressure in 69 African American men and women with normal to mildly high BP. Similarly, they found a correlation between perceived racism and awake BP (controlling for demographic variables) and to both awake BP and asleep BP if there were no controls. More recently, Ryan and colleagues (2006) found an association between perceived racial discrimination and SBP in African Americans, Black immigrants, and Latino immigrants living in New Hampshire. However, they found no significant association between racial discrimination and diastolic blood pressure (DBP). These three studies add further support for the connection between racial discrimination and elevated blood pressure.

Interestingly, Sweet and colleagues (2007) using data from the CARDIA Study (n = 1893) found that differences in skin tone among Black Americans are associated with variations in the severity of BP. Those with lighter skin tones tend to have lower blood pressure. They postulate that this relation is associated with different levels of chronic stress and that those with darker skin have more chronic stress and experience more racial discrimination than those with lighter skin. In an earlier study, Ernst et al. (1997) also found a statistically positive association between darker skin and SBP. As Maddox (2004) concluded in his discussion of perspectives on racial phenotype bias, there is still much to be learned through both discussion and research about the consequences, complexities, and role of skin tone in social perceptions and its effects on health.

Racial Discrimination Not Associated with Blood Pressure

On the other hand, Peters (2004, 2006) found no association between perceived racism and blood pressure in her sample of 162 African Americans aged 18–80. Similarly, using data from the Metro Atlanta Heart Disease Study, Davis and colleagues (2005), concluded that although racial discrimination is a prevalent stressor for African Americans, exposure to incidents of racial discrimination was not significantly associated with prevalence of hypertension. However, the degree of stress caused by the incidents was critically important. Those who reported a moderate or high level of stress from racist incidents were twice as likely to have hypertension. They advocated for more research to study the complex relationship between stress from racism and its association with blood pressure.

Clearly more research is needed to enhance our understanding of how individuals are stressed due to perceived racial discrimination and how blood pressure reacts to perceived overt and covert racial discrimination (Harrell, Hall, & Taliaferro, 2003). This study adds to the current body of literature by increasing our understanding of how racism affects blood pressure in Black American adults.
PURPOSE
The purpose of this study was to examine the relationship between blood pressure and Black Americans’ perceptions of racial discrimination. Further, their emotional responses to perceived racial discrimination and its relationships to blood pressure also were examined. Lastly, behavioral responses to perceived racial discrimination were explored.

The research questions were:
1. Does perceived racial discrimination correlate with systolic (SBP) or diastolic blood pressure (DBP)?
2. Do emotional responses to perceived racial discrimination correlate with SBP or DBP?
3. What behavioral responses to perceived racial discrimination do Black Americans report most frequently?

CONCEPTUAL FRAMEWORK
The conceptual framework for this study is a biopsychosocial model, a synthesis between sociological, psychological, and biological traditions. It is based on Brown’s (2002) sociopsychophysiological model that explains the relationship among everyday stress, emotions, and cardiovascular responses experienced by Black Americans and Jones’ conceptualization of the levels of racial discrimination (Jones, 2000). Figure 1 illustrates the multi-directional nature of these hypothesized relationships. Individual biological and psychosocial stressors will influence blood pressure over time.

CONCEPTUALIZING BLACK AMERICANS
In this study, the term Black Americans is used to describe people that have shared experiences due to the social and political construction of a “Black” race (Brown, 2004). This social construction is based primarily upon physical traits such as skin tone, hair texture, and facial features. Their shared experiences constitute a shared culture. The term “Black American” is generally more inclusive than the often used term “African American” because individuals or groups may consider themselves Black in America but not African American. Some of these Black, but not necessarily African American, citizens include people originating from Puerto Rico, Cuba, Haiti, Jamaica, and other Caribbean and African countries. Current research shows that Blacks in America share similar social positions and therefore, similar disease risk. Neither of the terms “African American” nor “Black” should presuppose a homogeneous group in all aspects. We prefer to use the more inclusive term because most studies do not specify whether participants were totally “African American” descendents of slaves or include people from some of the other Black groups, whose only choice on a demographic questionnaire is to check the “politically correct” term of African American.

In a recent study comparing foreign-born Afro-Caribbeans, U.S.-born Afro-Caribbean Americans, and African Americans, Davis and Huffman (2007) found no differences in blood pressure. The major differences in blood pressure in Blacks are seen between those living in the U.S. and those living in other
countries, although that gap is closing. So being African American is not the issue, but being Black in America is.

METHODS

Research Design

This descriptive correlational study was a secondary analysis of data from the study, “Everyday Life for Black American Adults: Stress, Emotional, and Cardiovascular Responses” (Brown, 2002). All statistical analyses were performed with SPSS software version 11.0. The University of North Carolina, Chapel Hill, Nursing IRB approved this secondary analysis of the existing data set.

Sample and Setting

The convenience sample was composed of 64 Black American men and 147 Black American women from the Midwest. In the original study, sample size was determined by power analysis and based upon Cohen’s power tables for a medium effect with a power of .80 at \( p < .05 \) with 17 parameters, a minimum total sample size of 143 was required (Cohen, 1992). Age ranged from 25 to 79 years (\( M = 44.09 \)) with 85.8% of the sample (\( n = 180 \)) between the ages of 25 and 60 years and 14.7% (\( n = 31 \)) between 61 and 79 years (Brown, 2002). The mean family per capita income was $18,990, although the mean family income was $43,339 and individual income ranged from 0 to $200,000. Family per capita income represents the total family income divided by the number of people in the family. Therefore, the family per capita income was quite high with an average of almost $19,000 to care for each family member. About 45% (\( n = 95 \)) of the sample reported having a college degree, Forty-five percent (\( n = 95 \)) of the sample were married, 27% (\( n = 57 \)) never married, and 28% (\( n = 59 \)) were widowed, divorced, or separated. Just over half (52%) of the participants reported having no children younger than 18 years of age in the household. Only those who reported no diagnoses of hypertension and who were not taking medications for hypertension qualified for participation in the study. For the overall sample, the mean SBP was 126.3 mmHg (\( SD = 21.1 \)) and the mean DBP was 82.9 (\( SD = 12.56 \)). A detailed description of the sample is found in Brown (2004).

Instrumentation and Measures

**Responses to Perceived Racism Scale**

Perceived racism was measured using the Likert-type Responses to Perceived Racism Scale (PRS) developed by McNeilly et al. (1996). The PRS is a 51-item instrument that analyzes three dimensions of racism across four domains. The three dimensions are: (a) frequency of exposure to types of racist incidents over the past year and over one’s lifetime, (b) emotional responses to perceived racism, and (c) behavioral coping responses to perceived racism. The four domains included: (a) on the job, (b) academic setting, (c) public realm, and (d) responses to racist statements. Internal consistency reliability for the Perceived Racism Scale for this sample was .97. McNeilly et al. (1996) reported internal reliability with Cronbach’s Alpha of .96 for the frequency of exposure and .92 for the emotional and behavioral coping dimensions (items 44–51, pooled).

**Exposure to Types of Racist Incidents Subscale**

For the 43 questions related to perceived racial discrimination, participants responded to statements such as, “I am treated with less dignity and respect than I would be if I were White” or “People talk down to me because I am Black” by indicating their degree of agreement on a six point scale ranging from not applicable (0) to several times a day (5). The possible range of scores is 0 to 215 during the past year and over one’s lifetime.

**Emotional Responses to Perceived Racism Subscale**

For section II with emotions, participants responded to prompts such as, “When I experience racism on the job, I generally feel…” In each of the four domains, participants rated eight emotions (anger, hurt, frustrated, sad, powerless, hopeless, ashamed, strengthened) on a five-point Likert scale with 1 indicating “not at all” to 5 indicating “extremely”.

**Behavioral Coping Responses to Perceived Racism Subscale**

Lastly, participants were asked to indicate the behavior or behaviors that best describe how they deal with racism at work, in academic settings, in the public realm, and in response to racist statements. The ten behavioral responses included speak up, pray, try to change, prove wrong, ignore, avoid, forget, accept, keep to self, and react violently. Participants could indicate additional behavioral responses in the “other” category.

**Blood Pressure**

Mean systolic and mean diastolic blood pressures were used in our analysis. These measures were determined by an average of the two blood pressures found in the data set. The first BP measure was taken before questionnaires were administered. The second BP measure was taken after a 5-minute cool down period after the questionnaires were completed.

**Procedures**

In the primary study, an initial blood pressure was obtained after informed consent after a 5-minute settling period. The participants completed a series of questionnaires related to emotions, daily stress, financial stress, racial discrimination, and demographic factors. Five minutes after the questionnaires were completed, a second blood pressure was obtained. Blood pressure measurements followed the rigorous American Heart Association and Joint National Committee VI protocol (Brown, 2004).

Analysis

Descriptive statistics were used to describe the characteristics of the sample. Pearson’s product moment correlation coefficient
was used to determine correlations between perceived racial discrimination and blood pressure and the correlations between emotions and blood pressure. Frequencies were determined for each of the behavioral responses in each of the four domains.

RESULTS

Perceived Racial Discrimination and Blood Pressure

The possible range of scores on the exposures to racism scale was 0 to 215, however; the range in this convenience sample was 0 to 170 ($M = 54.91$, $SD = 30.76$) for lifetime exposure and 0 to 152 ($M = 35.23$, $SD = 30.36$) for past year exposure. Thus, these participants did not indicate high levels of perceived racial discrimination overall.

Pearson’s correlations were calculated for respondents’ score to (a) perceptions of lifetime exposure to racist acts, (b) past year exposure to racist acts, and (c) total exposure to racist acts and SBP and DBP. No correlation was found between perceived racial discrimination and SBP or DBP (see Table 1). For further clarification, perceived racial discrimination, SBP, and DBP were analyzed in only those with blood pressures in the pre-hypertensive or hypertensive range (Chobanian et al., 2003). Analysis of this subsample ($n = 150$) with blood pressure greater than 120 mmHg systolic or greater than 80 mmHg diastolic revealed no significant correlation between perceived racial discrimination and either SBP or DBP.

There was a strong negative correlation between past year exposure to perceived racial discrimination and age ($r = −.245$, $p < .001$). Further, total exposure to perceived racial discrimination was significantly and negatively correlated with age ($r = −.143$, $p = .037$). Older respondents perceived less racial discrimination.

Emotions, Racial Discrimination, and Blood Pressure

There was a great deal of consistency in the emotions reported by respondents across each of the four domains in that anger and frustration were the two dominant emotions on the job, in academic settings, and in response to racist statements. In three of the domains, feeling strengthened was also a strong emotion in response to racial discrimination. For example, in response to racism on the job the top three emotions reported were: feel angry ($M = 3.38$), feel frustrated ($M = 3.17$), and feel hurt ($M = 3.08$). In academic settings, the top three emotional responses to racism were: feel angry ($M = 3.35$), feel frustrated ($M = 3.07$), and feel strengthened ($M = 2.94$). Similarly, emotional responses in the public realm included: feel angry ($M = 3.65$), feel frustrated ($M = 3.06$), and feel strengthened ($M = 2.91$). Lastly, in response to racist statements, feel angry ($M = 3.62$) was followed by feel frustrated ($M = 3.08$), and feel strengthened ($M = 2.94$). Feeling ashamed ($M = 1.82–1.90$) and hopeless ($M = 2.03–2.21$) received the lowest ratings in each of the domains.

Total emotional response scores in all four domains of the Perceived Racism Scale were calculated. Pearson’s correlation was calculated for the eight emotional responses to perceived racial discrimination and SBP and DBP (see Table 2). Feeling frustrated or sad was significantly and negatively correlated with both SBP and DBP. None of the other emotions were correlated with either SBP or DBP.

Behavioral Responses to Perceived Racial Discrimination

Lastly, frequencies were calculated for behavioral responses to perceived racial discrimination: (a) on the job, (b) in academic settings, (c) in the public realm, and (d) reactions to racist statements (see Table 3). In all four domains, “speaking up” against racism had the highest response rate with 68.2–72.5% of the participants selecting this behavior. Prayer was the second most frequently reported behavioral response for racial discrimination in public, on the job, and in response to racist statements. In academic setting, “proving wrong” was the second most frequently reported behavioral response. “Try to Change” also received high response ratings with 22.7–32.7% of respondents selecting this option across all settings. In summary, “speak up,” “pray,” “try to change,” “prove wrong,” and “ignore” were the five most commonly selected options across settings. Equal numbers of participants chose “ignore” and “try

<table>
<thead>
<tr>
<th>Variable</th>
<th>SBP</th>
<th></th>
<th>DBP</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived lifetime exposure to racist acts</td>
<td>−.038</td>
<td>.586</td>
<td>−.077</td>
<td>.264</td>
</tr>
<tr>
<td>Past year exposure to racist acts</td>
<td>−.061</td>
<td>.380</td>
<td>−.077</td>
<td>.264</td>
</tr>
<tr>
<td>Total exposure to racist acts</td>
<td>−.052</td>
<td>.453</td>
<td>−.083</td>
<td>.233</td>
</tr>
</tbody>
</table>

TABLE 2

<table>
<thead>
<tr>
<th>Variables</th>
<th>SBP</th>
<th></th>
<th>DBP</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Anger</td>
<td>−.124</td>
<td>−</td>
<td>−.127</td>
<td>−</td>
</tr>
<tr>
<td>Hurt</td>
<td>−.104</td>
<td>−</td>
<td>−.118</td>
<td>−</td>
</tr>
<tr>
<td>Frustrated</td>
<td>−.161*</td>
<td>−</td>
<td>−.139</td>
<td>−</td>
</tr>
<tr>
<td>Sad</td>
<td>−.199**</td>
<td>−</td>
<td>−.187**</td>
<td>−</td>
</tr>
<tr>
<td>Powerless</td>
<td>−.104</td>
<td>−</td>
<td>−.056.</td>
<td>−</td>
</tr>
<tr>
<td>Hopeless</td>
<td>−.062</td>
<td>−</td>
<td>−.033</td>
<td>−</td>
</tr>
<tr>
<td>Ashamed</td>
<td>−.034</td>
<td>−</td>
<td>0.19</td>
<td>−</td>
</tr>
<tr>
<td>Strengthened</td>
<td>0.008</td>
<td>−</td>
<td>0.56</td>
<td>−</td>
</tr>
</tbody>
</table>

*p < .05, ** p < .001
to change” in the responses to racist statements domain. React violently was selected least frequently in the academic setting, in public, and on the job with only 2–5 respondents selecting this behavior.

**DISCUSSION**

**No Correlation between Perceived Racial Discrimination and Blood Pressure**

No correlation was found between lifetime exposure, past year exposure, or total exposure to perceived racial discrimination and mean SBP or mean DBP (Table 1). This finding is consistent with those of Davis et al. (2005) and Peters (2004, 2006). Since this study was conducted in the Midwest, it is possible that perception of racism might not be as high in this area as it might be in some other geographic regions of the United States. Further, this sample had a relatively high income, and much less is known about racial discrimination in middle class Black Americans. Nevertheless, perception of racism is dynamic and subjective, with each individual’s coping capacities and past experiences affecting their internal filters.

**Frustration and Sadness Related to Blood Pressure**

Significant negative correlations were found between feeling frustrated or sad and both SBP and DBP. Brown (2002) using the Positive and Negative Affect Scale (PANAS), found no correlation between positive emotions such as attentive, inspired, excited, and proud or negative emotions such as upset, hostile, afraid, and ashamed and BP. Brown, however, conceptualized emotions as two major dimensions rather than observing discrete emotions. Some evidence exists connecting repressed emotion (such as anger) and increased blood pressure; as one represses emotions, blood pressure increases (Krieger, 1990; Krieger & Sidney, 1996). Logically, increased frustration should lead to increased blood pressure; however, this assumption was not supported in this study.

The significant but negative correlations between blood pressure and emotions of sadness and frustration are interesting, yet unclear. Lambert, Khan, Lickel, and Fricke (1997) studied sadness and concluded that mood has an effect on judgment and motivation. They found that individuals exposed to stereotypes corrected their behavior in order to appear appropriate in social situations. This “correction” of behavior may affect BP as “sad” Black individuals increasingly try to correct their behavior in order to fit in with a White dominated society. In a study of anger, sadness, emotion, and attitude, DeSteno et al. (2004) argued that emotions affect cognition and the resulting adaptive changes to one’s environment influence physiologic responses. They further explained that prejudice helps simplify complex environmental stimuli, so that individuals can succeed or survive. For example, an emotional response, such as anger, will provoke a physiologic response so an individual can quickly adapt to an unfamiliar environment. The relationship of sadness to physiologic adaptation was less predictable. Clearly the interactions among perceived racial discrimination, emotional responses, and blood pressure is very complex.

**Speaking Up Against Racism May be Good for Blood Pressure**

Participants in this study were most likely to speak up to racism in all four domains. The action of speaking up allows emotions to be expressed, which may explain why this population did not show the expected relations among perceived racial discrimination, negative emotions, and blood pressure. Speaking up may be a form of confrontation that might indicate that these Black Americans were able to verbalize and communicate their frustration with racial discrimination, which prevented BP elevation to some extent. Perhaps speaking up against racism acted as a buffer or a protector from the effects of racism. Other research findings suggest that those who experience racism but challenge it are less likely to have elevated BP (Krieger, 1990; Krieger & Sidney, 1996; Peters, 2004). Furthermore, Krieger
Healthcare providers, especially professional nurses, are in an ideal position to influence the health of Black American adults. Nurses can link the art and science of nursing with social medicine and public health. Increasing knowledge through educational forums on the effects of perceived racial discrimination on the physical and emotional health of Black American adults will help nurses to examine their own practices and incorporate change. Understanding how racism and discrimination interact with psychological and physiological aspects of the individual will help nurses better implement holistic and comprehensive care for their patients as they work toward helping to eliminate disparities in blood pressure and cardiovascular disease in Black Americans. On the basis of these study findings, nurses could encourage speaking out and prayer as health-promoting responses of racism.

Declaration of Interest: The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

REFERENCES


