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ADDRESSING OCCUPATIONAL STRESS AMONG AFRICAN AMERICANS

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According to the World Health Organization (WHO), stress is one of the top 10 social determinants of health disparities, with substantial research suggesting that greater stress is associated with increased risk for impairments in mental and physical health across populations (Baum, 2002, Chen & Miller, 2013) African Americans, who comprise roughly 12% of the workforce (Bureau of Labor Statistics [BLS], 2011), face job- and workplace-related circumstances that increase their risk of occupational stress per se African Americans' overexposure to stressful aspects of work and the link between job stress and the stress-related illnesses that disproportionately impact them (e g , hypertension) suggest that interventions designed to prevent or reduce occupational stress among Black Americans are needed Although churches are often in unique positions of influence in Black communities

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(Poussaint & Alexander, 2000), experts have not typically worked with them to design and deliver customized occupational safety and health interventions Consequently, this chapter explores the question of whether an occupational stress intervention developed in partnership with churches might positively influence African Americans' awareness of risks to health and well-being posed by job stress and help them build skills and a sense of efficacy with respect to preventing or managing it

AN INTRODUCTION TO OCCUPATIONAL STRESS

Stress is defined as "the adverse reaction people have to excessive pressures or other types of demand placed on them" (Health and Safety Executive, 2007, p 7) It is the process that arises when work demands or work stressors of various types and combinations exceed the resources a person has available to him or her (Balducci, Schaufeli, & Fraccaroli, 2011) Stress is an internationally recognized health and safety risk factor (Jordan et al , 2003, National Institute for Occupational Safety and Health [NIOSH], 1999) According to the American Psychological Association (2011), more than one third (36%) of workers said that they typically feel tense or stressed out during their workday, and 20% reported that their average daily level of stress from work is an 8, 9, or 10 on a 10-point scale In addition, about one fourth viewed their jobs as the top stressor in their lives (NIOSH, 1999) Further, up to 44% of women and 37% of men have been found to want to quit their jobs because of occupational stress (Marlin Company, 2003)

Stress has become increasingly visible in the field of occupational disease (Bellarosa & Chen, 1997) The basic rationale underpinning the concept of job stress is that the work situation has certain demands and that difficulties in meeting these demands can lead to illness, injury, and psychological distress (Edwards & Burnard, 2003, Health and Safety Executive, 2001, Jordan et al , 2003) An impressive body of empirical research supports the link between occupational stress and problems in health and safety Researchers have found that mood and sleep disturbances, upset stomach, headaches, and disrupted familial relationships are common early manifestations of job stress (NIOSH, 1999) Studies have also found that stress at work plays an important role in high blood pressure and cholesterol levels (Goodspeed & DeLucia, 1990), cardiovascular disease (CVD, Sauter, Hurrell, & Cooper, 1999), infectious and autoimmune diseases (e g , Brunner, 2000), anxiety and depression (e g , Landsbergis, Schnall, Deitz, Friedman, & Pickering, 1992), and accidents and injuries (e g , Schnall, Belkic, & Pickering, 2000) Researchers have reported that exposure to job stress may even amplify the impact of a given toxicant, producing a variety of health-damaging effects (Gee & Payne-Sturges, 2004)

Occupational stress has far-reaching consequences, not only for the health and safety of workers but also for employers It contributes to a number of outcomes that threaten organizational success, including physical injuries at work, absenteeism, labor turnover, decreased work productivity, diminished job satisfaction (Alves, 2005), low morale, and burnout (e g , Sutherland & Cooper, 1990) Some estimate that between 50% and 60% of lost workdays each year can be attributed to stress and that the average cost of absenteeism in a large company is more than $3 6 million per year (American Institute of Stress, 2012, Matteson & Ivancevich, 1987, Maxon, 1999) The American Institute of Stress (2012) estimated that 40% of job turnover is due to stress and that replacing an average employee costs 120% to 200% of the salary of the position affected In general, stress-related health and safety problems result in considerable losses to industry, costing employers a total of up to $60 billion per year (Benton, 2000)

The U S economy at large also incurs considerable costs related to occupational stress Econometric analyses show that, over the years, health care expenditures have increased nearly 50% for workers who perceive their jobs as stressful and nearly 200% for those reporting high levels of job stress and depression (Alves, 2005) Health care expenditures tend to be almost 50% greater for workers who report high levels of stress According to national estimates, the total cost of job stress to the U S economy ranges from $250 to $300 billion annually in lowered productivity, turnover, and direct medical, legal, and insurance fees (American Institute of Stress, 2012, D L Jones, Tanigawa, & Weiss, 2003)

AFRICAN AMERICAN HEALTH STATUS

Given the adverse impact of occupational stress on individuals, organizations, and society, it is clear that there are enormous potential benefits to taking steps to reduce it One population for which the development of interventions to reduce stress may be particularly crucial is African Americans Approximately 13% of the U S population, or about 39 million persons, identify themselves as non-Hispanic Black or African American (U S Census Bureau, 2011), and as a group, they appear to be worse off than the general population on several dimensions of health For example, rates of hypertension or high blood pressure have been inordinately high among Blacks (Fields et al , 2004) According to the Centers for Disease Control and Prevention (CDC), the age-adjusted prevalence of hypertension is 40 5% among non-Hispanic Blacks compared with 27 4% among non-Hispanic Whites (CDC, 2005) The racial/ethnic disparity in hypertension begins after puberty and persists into adulthood By the ages of 40 to 59, roughly

50% of Black Americans are hypertensive, compared with 30% of White Americans By age 65, 75% of Black women are hypertensive, compared with 50% of White women in the same age group (CDC, 2005)

Hypertension is a major risk factor for CVD, coronary heart disease (CHD), stroke, and other adverse health outcomes The CVD prevalence rates for African American males and females are about 46% for each group, compared with 38% and 33% for non-Hispanic White males and females, respectively African Americans also have an earlier onset and a higher risk of first myocardial infarction or heart attack at all ages than do their White counterparts (Clark, 2006), as well as the highest overall out-of-hospital CHD death rates of any U S ethnic group—particularly at younger ages (Clark & Anderson, 2001)

The prevalence rate for stroke for African American males and females is about 4% for each group, compared with about 2% and 3% for non-Hispanic males and females, respectively (Klag et al , 1996, McGruder, Malarcher, Antoine, Greenlund, & Croft, 2004) There are racial differences in the subtypes of stroke, and these racial disparities in subtype are greatest at younger ages Young African Americans have a 2- to 3-fold greater risk of ischemic stroke than their White counterparts and are more likely to die as a result of stroke (CDC, 2001) African Americans also possess a disproportionate burden of the risk factors for stroke mortality They have the highest age-adjusted death rate due to stroke at 65 2 per 100,000 persons, compared with 46 6 per 100,000 persons for all other races combined (CDC, 2005)

In general, National Center for Health Statistics (2007) data indicate that Blacks have the highest all-cause, age-adjusted death rate at an alarming 1016 5 per 100,000 persons This exceeds the age-adjusted death rate of 798 8 per 100,000 persons for all races combined The average life expectancy of African Americans is about 6 years shorter than that of White Americans, and CVD, CHD, and stroke account for a significant portion of these years CVD accounts for 2 2 years of this reduced life expectancy, with CHD accounting for 1 7 of those years and stroke for 0 5 of those years (CDC, 2001, Astone, Ensminger, & Juon, 2002)

STRESS AND HEALTH DISPARITIES

The root causes of these health disparities are not well understood, but a variety of factors are thought to contribute to them These include but are not limited to socioeconomic factors, geography, behavioral risk factors, lifestyle choices (e g , smoking, physical inactivity, excess weight), and health care provider behavior Further, many scholars believe that the disparities

that affect African Americans and other minority groups ultimately reflect inequalities in many aspects of life, including in access to health care, social and economic status, educational opportunity, and environmental conditions (Diez-Roux, 2000, Diez-Roux et al , 1997)

Researchers have begun viewing stress as an important contributor to racial and ethnic health disparities (Williams, Neighbors, & Jackson, 2003) in light of the fact that stress has been long identified as an important factor in chronic disease development, maintenance, and/exacerbation and in increased susceptibility to infectious and other diseases (Cohen, Tyrrell, & Smith, 1991) Scholars have proposed that differential exposure and vulnerability to environmental, sociocultural, and psychosocial stressors of various types is at the core of health disparities For instance, Gee and Payne-Sturges (2004) asserted that stress is a key component of differential susceptibility to illness and further explained that stressors, especially when not ameliorated by resources, may lead directly to health disparities among racial/ethnic groups

Scholars have directly speculated that the high rates of hypertension and related illnesses that disproportionately affect African Americans are attributable to their differential exposure to psychosocial stress (Poussaint & Alexander, 2000), and there are data that support this theory Studies have demonstrated that Blacks as a group are exposed to more chronic and insidious stressors and report more distress, disease, and dysfunction than Whites (Orr et al , 1996) Further, some research investigations have found that Blacks often report a greater number of negative life events, report greater and more frequent exposure to generic life stressors (i e , stressors that are a usual part of modern life—financial, occupational, relationship, parental, etc), perceive these events as more stressful, and report greater psychological distress from these stressful life experiences than their White counterparts (Orr et al , 1996)

It is fairly well established that Blacks/African Americans and other minority groups are differentially exposed to race-related stressors (e g , racial and ethnic discrimination) These stressors appear to make an additional contribution to the level of experienced psychological distress beyond that accounted for by generic life stressors that all people experience In addition, African Americans and other minority groups may perceive greater stigma or pressures not to report episodes of discrimination, which may only increase stress levels Both generic and race-related stressors impact health For example, a study examining the effects of stress on self-reported physical and mental health of 520 White Americans and 586 African Americans in Detroit found that both race-related stressors and general life stiessors significantly account for racial differences in physical health status (Williams et al , 2003)

AFRICAN AMERICAN EXPOSURE TO OCCUPATIONAL STRESSORS

An extensive literature indicates that a variety of stressors that are associated with the way jobs are designed and other working conditions contribute to problems in health and safety For example, Karasek and Theorell (1990) proposed that workers that confront high psychological demands and low control or decision latitude in meeting those demands on the job appear to be at greater risk for cardiovascular disease than workers who are not subjected to such conditions (Johnson, Hall, & Theorell, 1989) Further, Whitehall II study researchers investigating the relationship between work-related factors and ill-health found that a variety of health outcomes were dependent on effort and reward, job demands, decision latitude, and job stability (e g , Stansfield, Head, & Marmot, 2000)

African Americans may confront a greater number of stressors in the workplace than other racial/ethnic groups, and this may contribute to their susceptibility to illness Some evidence lends support to this conjecture First, it appears that as a group, Blacks are overrepresented in lower status occupations and underrepresented in higher status occupations (Darity, 2003) For example, recent national surveys indicate that Whites are more likely to hold managerial positions, whereas Blacks are more likely to be employed in service and transportation jobs (Roberts, Swanson, & Murphy, 2004) It is noteworthy that managers and other white-collar professionals are more likely to have health benefits and access to additional financial and other resources to help them manage workplace stressors, whereas this is less likely to be the case for blue-collar workers

Blue-collar occupations have been linked to problems in health In a ranking of jobs based on the blood pressures of incumbents, Leigh, Markowitz, Fahs, Shin, and Landrigan (1997) determined that service and transportation positions were in the top 40% in terms of having an incumbent with high blood pressure, whereas a disproportionately low number of professional and managerial incumbents had higher than average blood pressure Leigh et al explained that managers and professionals may have high levels of psychological demands, but they also have considerable decision latitude, which protects them from developing strain reactions, whereas service and transportation workers are not afforded this protection

In addition to their potential overexposure to high demand/low control job conditions, Blacks must contend with an increased risk of stress due to job insecurity that involves threat of job loss and uncertainty regarding future employment This is because they tend to be overrepresented in work involving atypical employment contracts and low job tenure For example, Black females tend to be disproportionately employed in temporary work

arrangements They constitute 21% of the workforce provided by temporary help firms, which is almost twice their representation in the traditional workforce (DiNatale, 2001)

Another indication that African Americans are differentially exposed to job insecurity is high rates of joblessness Layoffs and discharges are higher for Black males than White males (Elvira & Zatzick, 2002, Holzer, 1998) Also, the unemployment rate for African Americans has historically been higher than the national average In 2010, the average unemployment rate for Blacks was 16%, compared with 8 7% for Whites (BLS, 2011) Further, 48 4% of all unemployed Blacks were unemployed 27 weeks or longer in 2010, compared with 41 9% of unemployed Whites (BLS, 2011) The unemployment rate for African Americans remained high in 2011 In mid-2011, their unemployment rate was 16 2%, only 0 3 percentage points down from its peak of 16 5% in 2010 (BLS, 2011)

Although the impact of job insecurity on African Americans has rarely been studied, empirical studies have suggested that precarious forms of employment are associated with poor health and high levels of stress-related tension and exhaustion (Vosko, Zukewich, & Cranford, 2003) Threat of job loss has also been associated with increases in self-reported morbidity, serum cholesterol, depression, anxiety (Ferrie, Shipley, Marmot, Stansfeld, & Davey Smith, 1998, Kivimaki, Vahtera, Pentti, & Ferrie, 2000), and accidents (Probst, Graso, Estrada, & Greer, 2013, Probst & Hagger, 2014)

In addition to their overexposure to the stressors mentioned previously, Blacks might be more likely than other groups to contend with racial/ethnic discrimination in the workplace *Discrimination* is defined as an adverse distinction made with regard to a person or group (Krieger, 1999) These distinctions are manifested in judgment and/or action and result in structured opportunity and assignment of value that unfairly disadvantage some groups while unfairly advantaging others (Krieger & Sidney, 1996) Discrimination can appear at the interpersonal and institutional levels Interpersonal discrimination may have its roots in stereotypes and pigeonholing attitudes and assumptions, making ethnic slurs or ethnic jokes At the institutional level, discrimination can block opportunities for certain groups and limit their access to resources (Krieger & Sidney, 1996) It is important to note that racial harassment is a form of discrimination that involves creation of a hostile work environment on the basis of race It includes verbal abuse such as name-calling, slurs, epithets, threats, derogatory comments, and other unwelcome remarks

Evidence indicates that Blacks encounter racial/ethnic discrimination and harassment in the workplace The General Social Survey found that of all employed adults 18 years and older, 19 4% of Blacks, compared with only 2 1% of Whites, responded affirmatively when asked if they felt "in any way"

discriminated against on their job because of race or ethnic origin (Roberts et al , 2004) In one study of racial bias in the workplace, researchers found that 60% of African American respondents reported that they hear racial and ethnic jokes in the workplace, which indicates a very real presence or perception of negative racial overtones in the workplace Additionally, studies have shown that African American women encounter both sexual and racial harassment and tend to leave workplace cultures that they perceive to be negative and oppressive

Exposure to racial/ethnic discrimination and harassment impacts individuals in a variety of ways that in turn affects health, safety, and well-being Those who are exposed may respond with anger, rage, hostility, resentment, bitterness, and aggression (Keashly, 1998) Some may displace their feelings of frustration onto others and may have problems in their family and personal lives Feelings resulting from psychological and emotional abuse in the workplace include confusion, depression, feelings of helplessness, hopelessness, and despair, and an attitude of distrust and paranoia toward the hostile environment Research has suggested that workplace environment characterized by hostility based on race/ethnicity contributes to poor mental health of employees Studies have previously reported that stress engendered by racial discrimination in general is associated with high blood pressure (Krieger & Sidney, 1996), mental health problems (Gee, 2002, Kessler, Mickelson, & Williams, 1999), and alcohol consumption (Yen & Syme, 1999)

LIMITATIONS OF EMPLOYER-SPONSORED STRESS INTERVENTIONS

African Americans' overexposure to stressful aspects of work and the linkage between job stress and illnesses that undermine their overall health and safety status suggest that customized interventions designed to prevent or reduce job stress among Blacks are needed Stress management programs (SMPs) are one type of intervention Evidence has suggested that these programs can result in reduction of physiological arousal level and stress indicator variables such as anxiety, as well as in increased emotional stability and fewer somatic complaints (e g , Bunce, 1997, van der Klink, Blonk, Schene, & van Dijk, 2001) SMPs typically consist of three core components psychoeducation, skill-building in stress arousal reduction, and employee support and active problem solving (Girdano, 1986, Lamontagne, Keegel, Louie, Ostry, & Landsbergis, 2007, Murphy, 1984, 1985, Raeburn, Atkinson, Dubignon, McPherson, & Elkind, 1993)

Psychoeducation is an evidenced-based practice shown to be effective in addressing a variety of health problems (U S Department of Health and

Human Services, 2002), and it involves providing instruction about a given problem It may include providing education about occupational stress and its health consequences using one or more stress models as a teaching tool Further, interactive exercises may be used to foster (stress) symptom recognition and recognition of occupational stress triggers In addition, education about the role that nutrition, physical fitness, and other key lifestyle factors that can build resistance to stress may be provided Finally, participants may be made aware of accessible occupational safety and health resources that may be drawn on for assistance in addressing various occupational safety and health problems in the workplace

The second core component of an SMP may involve helping participants build skills to reduce stress arousal Health psychologists are in agreement that stress is lessened in situations where there is a sense of personal control and efficacy (Bandura, 1977, Roddenberry & Renk, 2010) Breathing and relaxation techniques foster this sense because they enable individuals to actively reduce body arousal under or in anticipation of stressful conditions In an SMP, participants may be taught the mechanics of relaxation, and multiple practice sessions may be provided to build relaxation skills

In addition to relaxation, participants may be taught how to change responses to stressors from a cognitive perspective For example, cognitive rehearsal involves helping people respond adaptively to stressors by anticipating them before they happen and rehearsing ways to respond to them adaptively (Matteson & Ivancevich, 1987) This and similar techniques help reduce stress arousal, develop a capacity to effectively manage stressors, build resistance to stress-related situations, and increase well-being

The third core component of a generic SMP is support and active problem solving Stress appears to be buffered in situations where perceived social support is present (Baqutayan, 2011, Cohen & Wills, 1985, J Jones, 2003) Social support can extend individual resources by allowing reciprocal receiving and giving of emotional and tangible assistance Consequently, this portion of the intervention allows participants to discuss various stressors in the workplace, receive and give support, and problem solve around addressing the sources of stress Participants may be taught specific brainstorming and creativity techniques that may help them generate innovative ways of changing or responding to identified workplace stressors Following the brainstorming, participants may be coached to develop action plans detailing when, where, and how the ideas generated will be implemented The formulation of such plans typically makes it easier for people to follow through on their intended actions In addition to providing support and a stimulating, interactive environment for problem solving, this SMP component may provide an excellent opportunity for reinforcement of information and skills taught throughout the program

Although companies are increasingly offering these types of SMPs, they are generally not tailored to the demographic characteristics of workers (e g , Lambert, 2001, Tsui & Milkovich, 1987) Program customization appears to be needed, as variations in program and policy utilization according to certain characteristics exist For example, a study of the company Johnson & Johnson found that its employees from higher income households were more likely than employees from lower income households to have used virtually all family-responsive programs and policies offered by the company (Families and Work Institute, 1993) In a similar case study, Lambert (2001) found that a greater proportion of managers/supervisors (73 4%) used workplace programs and policies than operatives/laborers (30 7%)

This pattern of variability in program and policy utilization may emerge because limited income restricts workers' access to benefits in cases where workers must share cost Job status may also be related to benefit use because of differences in corresponding job conditions Higher status workers are likely to have more flexible jobs and to be better able to take advantage of programs operating at the worksite or off-site

COMMUNITY-BASED STRESS INTERVENTIONS AS AN ALTERNATIVE

As discussed, African Americans may be one of the least advantaged racial/ethnic groups in the workplace because of their overcrowding into lower status occupations, overrepresentation in temporary work arrangements, and so forth Consequently, this may significantly restrict their access to occupational SMPs that may be available through employers Another issue is that for African Americans and other groups, perceptions of programs and program utilization are likely to depend on cultural background, preferences, and beliefs (Cervantes, 1992, James, Pobee, Oxidine, Brown, & Joshi, 2012, Lettlow, 2008) Given these considerations, culturally appropriate occupational stress management and prevention programs designed for and clearly accessible to African Americans are needed

Prior to designing such interventions, researchers and practitioners should first develop a full understanding of the African American community's strengths There are a number of strengths in the African American community that have enabled families and communities to overcome the various challenges in the past and those that are present in today's society (Hill, 2003) that are relevant to the design of health interventions These strengths include, but are not limited to, a high achievement orientation, strong kinship (i e , strong relationships with immediate and extended

family and friends), social participation and volunteerism, strong work orientation, high levels of religious involvement, and strong religious values and family support (Walker, 2007) Designing effective interventions entails empowering and mobilizing Black communities to increase their knowledge of these and other strengths, natural supports, and resources It also requires increasing their capacity to promote, develop, and implement their own interventions for improving health in collaboration with community-based organizations that have a vested interest and sense of responsibility in improving the health, safety, and well-being of African Americans (Briscoe, 2009)

One such community-based organization is the Black church, which has been the most important social institution in the Black community (Williams, Neighbors, & Jackson, 2003) Historically, it has responded directly to the interests and needs of African Americans and has been a support system critical to Black survival (Poussaint & Alexander, 2000) Churches frequently offered the only respite from the continuous repression of slavery and afforded the only places where members would exercise leadership Not only have African American churches provided for spiritual and physical needs, they have also served as centers of political organization for the wider Black community The church has also been where many Blacks learn important aspects of socialization

The church continues to be important to Black life and Black communities The value of religion, reading religious materials, listening to religious programs, music, prayer, and other forms of nonorganized religious participation are part of the fabric in the life and culture of Blacks/African Americans in this country Further, according to the Pew Forum's U S Religious Landscape Survey, conducted in 2007 and released in 2008 (Pew Research Center, 2009), African Americans attend church more regularly than do Whites, and the typical African American church has average attendance that is about 50% greater than that of the typical White church Estimates of regular church attendance among African Americans range as high as 80% (Strawbridge, Cohen, Shema, & Kaplan, 1997) Church attendance appeared to have the greatest health benefit for the most vulnerable individuals Church attendance may provide social support that facilitates and reinforces positive health-seeking behaviors

With their long tradition of informing, organizing, and mobilizing, churches are in an ideal position to chart a new course of health, well-being, and safety for African Americans The nation's Black churches play primary roles as community employers, educators, and caregivers Particularly in rural communities or communities with few services, churches play a special role, often serving as the provider of various services Clergies deal

with marital and family problems, drug and alcohol problems, and financial problems—all of which directly affect the health of their parishioners Churches have steadily expanded their role in building a community-based infrastructure of supportive and health-related services for the African American community Black churches sometimes function as centers for health screening, promotion, and counseling Also, the church may serve as a site of heath care serve delivery and provide information on available services

It appears that the Black church can provide practical and pragmatic answers to health and other problems among African Americans (Poussaint & Alexander, 2000) Some agencies have recognized the church's potential and efforts in addressing health and safety in African American communities For example, the CDC has a rich history of working with churches and has been involved in funding participatory research that supports health promotion activities and examines health services and interventions provided by or through churches and other community-based organizations (CDC, 2005)

Given the church's potential for and efforts in addressing health and safety in the African American community, occupational safety and health professionals, regardless of race and religious affiliation, should also consider partnering with churches in responding to the health and safety needs of African Americans Although an important limitation to partnering with churches (vs employers) to address these needs is that workplace and job stressors cannot directly be addressed, this approach still has significant value By working with churches, occupational safety and health professionals can reach a significant proportion of the African American population through the large number of African Americans who hold church membership, as well as churches' community outreach with the unchurched In addition, this type of collaboration can ensure that messages are communicated in a culturally appropriate manner

If occupational stress interventions were designed and delivered in partnership with churches, the likelihood of the success of these interventions would be promising It appears that community-based health interventions that are delivered in partnership with churches in general are effective Duan, Fox, Derose, and Carson (2000) and Derose, Fox, Reigadas, and Hawes-Dawson (2000) conducted research on a Los Angeles–based population of Latinos and African Americans and found that a church-based telephone counseling intervention helped maintain mammography adherence among baseline-adherent participants and reduced the nonadherence rate from 23% to 16% Further, Johnson (2002) conducted an extensive literature review of community-based interventions and concluded that these interventions are associated with improved outcomes and are cost-effective and feasible to implement

CONCLUSION

The workplace is an important setting to include in dialogues that are relevant to understanding and eliminating health disparities Blacks/African Americans face a number of stress-related health challenges to which occupational stress may be a key contributor However, much of the knowledge that has been acquired about workplace conditions that are related to stress and adverse health and safety outcomes has been acquired from empirical investigations conducted with few large African American samples Thus, little to date is known about how and to what extent African Americans are exposed to, how they respond to, and how they are affected by generic stressors that all workers experience irrespective of race and ethnicity (e g , job demands and control) In addition, although some research efforts have attempted to study the impact of workplace racial and ethnic discrimination on African Americans and other minority groups, many of these efforts have focused on the impact of this particular race-related stressor on outcomes like job quality and job satisfaction rather than on more direct occupational safety and health outcomes Thus, additional studies of discrimination, as well as of other race-related stressors that are encountered by African Americans, are needed In summary, future studies should take a fuller approach to understanding how the workplace psychosocial environment influences the health and safety status of African American workers These research efforts should investigate protective and resilience factors

A combination of strength-based, community-based, and collaborative approaches can contribute to the development of occupational safety and health interventions that are culturally acceptable, relevant, and effective It is clear that there are numerous strengths within the Black/African American community that have historically enabled them to overcome many social and other difficulties Community-based organizations, including the Black church, have contributed to this resilience However, despite the potential advantages associated with partnering with churches to design and deliver health messages or interventions, occupational safety and health professionals appear to have rarely worked with them to design, deliver, and evaluate community-based occupational stress interventions Increased occupational safety and health efforts are needed in this area

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