
THE RELATIONSHIP BETWEEN RACIAL DISCRIMINATION AND HEALTH FOR BLACK AMERICANS: MEASUREMENT CHALLENGES AND THE REALITIES OF COPING

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Introduction

Racial and ethnic differences in health status are well documented (Lillie-Blanton, Parsons, Gayle, & Dievler, 1996; Williams, Yu, Jackson, & Anderson, 1997). In 1999 Black Americans developed AIDS at a rate of 84.2 per 100,000 population, compared to Asian/Pacific Islander Americans who developed the same disease at a much lower rate of 4.3 per 100,000 population (Centers for Disease Control and Prevention [CDC], 2003). Black Americans are also disproportionately affected by coronary heart disease, the leading cause of death in the United States. In 1998, Black Americans were 2.5 times more likely to die from heart disease than Asian/Pacific Islander Americans (CDC, 2003). These health disparities may result from differences in exposure to structural elements that influence the health of population groups (Williams, Lavizzo-Mourey, & Warren, 1994). For example, Black Americans are subjected to inferior education, inadequate housing, less employment and lower income, all of which lead to a poorer quality of life compared to other racial/ethnic groups. The relative disadvantage experienced by Black Americans may result in harsh environmental conditions, thus exposing them to higher levels of stress over the life course than is experienced by other race/ethnic groups (Geronimus, 2001). This additional stress may lead to unhealthy coping behaviors, elevated blood pressure, and ultimately to disparities in health relative to other US racial/ethnic groups (Williams, 2000).

Exposure to racial discrimination is a specific example of a stressor that can lead to racial group differences in health. Racial discrimination is defined as “those decisions and policies based on considerations of race for the purpose of subordinating and maintaining control over a racial group” (Neighbors, Jackson, Broman, & Thompson, 1996, p. 168). In essence, Black Americans may experience unfair policies (institutional discrimination) and practices (interpersonal discrimination) that may contribute to poor health outcomes (Nazroo, 1998). Institutional discrimination (e.g.,

ideologies, policies, and structural arrangements that support racial discrimination) may equate to policies that prevent Black Americans from joining specific organizations or residing in certain neighborhoods, while interpersonal discrimination may take the form of racial slurs or insults. Thus, the fundamental issue that must be addressed by researchers in clarifying the role of discrimination in racial health disparities is to determine exact pathways through which racial discrimination operates to affect health. However, before this can happen, a number of conceptual and methodological issues must be resolved.

The main purpose of this paper is to raise important and challenging questions about the nature of research on discrimination and health. The first section of this paper discusses how best to measure coping and racial discrimination. Second, we locate the concept of racial discrimination within a stress-and-coping paradigm. Specifically, we conceptualize research on discrimination and health through a stress-coping perspective (Cohen, 1987; Pearlin, Menaghan, Lieberman, & Mullan, 1981). From this perspective, discrimination is viewed as a unique and significant stressor (or set of stressors) to which Black Americans are disproportionately exposed. As such, we argue that discrimination has the potential to clarify racial disparities in health. We also note, however, that the empirical research on discrimination and health suffers from both conceptual and methodological shortcomings which make definitive statements difficult at this time (Williams, Neighbors, & Jackson, 2003; Hill, Njai, Neighbors, Williams, & Jackson, 2003). We describe both exposures and responses to discrimination in order to better understand how discrimination affects the health of Black Americans. Finally, because stress may ultimately affect health through disrupting physiological processes, we provide a description of the possible mechanisms that can damage the health of Black Americans.

Measurement Issues

The study of stress has led to a focus on coping behavior, which has routinely been assessed as either a disposition or episodic indicator (Cohen, 1987). Drawing from the work of Cohen, “dispositions” refers to assessing whether Black Americans use only one specific type of coping strategy when experiencing racial discrimination. Because there are different types of discrimination (e.g. institutional and interpersonal) that may warrant use of multiple coping strategies, it may not be the most effective strategy for Black Americans to use only one coping strategy to deal with the effects of racial discrimination. Episodic assessments measure the particular strategies that individuals employ when coping with a particular stressor (Cohen, 1987). Just as a single coping strategy may not be the most effective strategy with different types of racial discrimination, it is also unlikely that Black Americans will use the same coping strategies in dealing with all aspects of a discriminatory experience.

There are other issues related to the effective measurement of coping with racial discrimination. The mere assessment of coping behavior, outside of the other thoughts and behaviors that people employ to maintain equilibrium, serves as a key methodological concern in this area (Gottlieb, 1997). Because some Black Americans may not fully recall or acknowledge coping techniques used to deter discriminatory experiences, it may be more effective for researchers to develop measures that assess racial discrimination coping behaviors as they are implemented. Examples of these types of measures include interval-contingent recording (reporting of thoughts and behaviors at pre-determined times), signal contingent recording (completion of a questionnaire or checklist whenever the respondent receives a message from the investigator), and event contingent coding (completion of a report whenever a pre-determined event occurs) (Gottlieb, 1997). Experiences of racial discrimination may change over time, thus altering the ways in which coping should be measured. Knowing this, researchers should routinely assess the context of racial discrimination for Black Americans and determine changes influenced by the environment (e.g., political and economic climate, demographic profiles).

There are additional fundamental issues in the measurement of racial discrimination that must be addressed. First, many current measures focus only on discrimination to self. However, racial discrimination experienced by loved ones such as family members may also have deleterious consequences. Hence, measures should be expanded to consider significant others. Second, investigators may need to determine how people decide they have been discriminated against specifically because of their race. For instance, if an older Black American woman is denied an apartment, is it due to race, age or gender discrimination? The person who is discriminating is certainly not going to tell her. So how does she decide which it is? Or is it a combination of various types of conscious exclusion and discrimination? What role does individual personality and perception play? In this case researchers may be dealing with something broader than race per se. There is a psychosocial process here that needs to be elaborated in substantiating the role of discrimination based on race. An additional question is whether Black Americans are *exposed* to more discrimination than other race/ethnic groups or whether Black Americans are more *responsive*, that is, more affected by exposure to racial discrimination than other groups (Neighbors, Hill, Brown, & Williams, 2003). If research on discrimination expects to contribute to our understanding of health disparities, it must address group differences in exposure and response to quantifiable acts of discrimination in *all* racial/ethnic groups.

While some in the research community fully accept the idea that racial discrimination decreases the health of Black Americans, because the empirical research on racial discrimination and health is in its methodological infancy, there are reasons to be skeptical. One problem involves maintaining measurement validity, which aims to fully measure the concept of racial discrimination (Hill et al., 2003; Williams et al., 2003). Measurement validity involves ensuring a proper interface between an

operational definition and the concept it is purported to measure (Singleton & Straits, 1999). As such, measures of racial discrimination have not, for the most part, encompassed all of the dimensions that comprise the construct. Racial discrimination can be differentiated by experiences that are chronic, acute, subtle (ambiguous), and traumatic (Hill et al., 2003). For example, Hill, Njai, Neighbors, Williams, and Jackson (2003) found that none of the studies that examined this relationship for Black Americans accounted for subtle or traumatic experiences of racial discrimination, which raises concerns about the sensitivity and comprehensiveness of discrimination measures. Moreover, the omission of traumatic experiences of racial discrimination from some measures also indicates a failure to fully represent the various components of discrimination, thus compromising construct validity (Singleton & Straits, 1999).

Most studies that have examined the relationship between racial discrimination and health also suffer from poor research designs, decreasing the likelihood that findings are valid, reliable, or generalizable (Williams et al., 2003). For example, the majority of these studies failed to employ prospective designs, while only a few studies used instruments for measuring racial discrimination that have undergone appropriate psychometric testing (Hill et al., 2003; Williams et al., 2003).

Racial Discrimination and Coping

While a study of racial discrimination maintains several limitations, this approach may prove to be useful for understanding the health of Black Americans within a stress-coping paradigm. Within this paradigm, health is a function of exposure and response to stress. Coping is defined as “efforts, both action-oriented and intraphysic, to manage environmental and internal demands, and conflicts among them, which tax or exceed a person’s resources” (Cohen & Lazarus, 1979, p. 219). Coping also serves one of two distinct functions for individuals exposed to stressors such as acts of racial discrimination (Cohen, 1987). First, coping assists in *problem solving functions* that help individuals deal with identifying and responding to an external or environmental threat. This includes acknowledging and responding to being referred to by a racial slur, or reporting ongoing racial discrimination in the workplace to the appropriate authority.

Coping is also used as *emotional regulation*, which involves modifying the actual distress, instead of the experience that caused it. This includes downplaying or even denying that a traumatic event was racially motivated, or ignoring routine slights that may be attributed to racial attitudes or stereotyping. Because experiences of racial discrimination are complex and multidimensional, this distinction may not be as easy to measure when considering the coping responses of Black Americans. For example, the actual context of racial discrimination for Black Americans may involve using both types of responses simultaneously. Thus, any attempt to measure coping empirically must acknowledge contextual factors that provide the foundation for percep-

tions of racial discrimination and ultimately the coping responses chosen to deal with them.

In an attempt to explain the functions of coping beyond a mere dichotomy of *problem solving* and *emotion regulation*, five additional coping strategies have been identified (Cohen, 1987; Cohen & Lazarus, 1979). *Inhibition of action* refers to refusing to do anything about an experience of racial discrimination. While certainly a possible coping option chosen by many Black Americans when experiencing racial discrimination, inhibition of action coping is not as straightforward as escape-avoidance behavior. The likelihood that Black Americans will cope with racial discrimination using an inhibition of action strategy may be increased due to the potential negative implications of responding to racial discrimination in more active, confrontational ways. For example, by acknowledging a racial slight, Black Americans may be at risk for greater or more chronic discrimination because of an attempt to identify and solve the problem. This risk may be affected by external realities such as the current political and social climate of the time. Thus, when determining that Black Americans employed an inhibition of action mode of coping with racial discrimination, it is imperative to assess the reasoning behind this decision. This may assist in distinguishing whether the decision was made (or not) because of personality type, external realities, past experiences with acts of discrimination, or a fear of retribution.

Direct action refers to implementing a direct behavioral act, confronting the perpetrator of the racial discriminatory act, removing one's self from the discriminatory environment, or contacting the appropriate authorities that deal with issues of racial discrimination (Cohen, 1987). However, this may not be as easily translated when assessing experiences of racial discrimination. For example, when measuring interpersonal forms of racial discrimination and appropriate coping, the source may be more readily identifiable, and action more easily directed. In contrast, experiences of institutional discrimination may not offer a clear source to confront or avoid. Thus, the prospect of using direct action to cope with institutional discrimination may lead to unrealistic, high effort coping that may be ineffective and ultimately unhealthy (James, LaCroix, Kleinbaum, & Strogatz, 1984).

Coping through *information-seeking* involves learning more about the experience of racial discrimination, in hopes of ultimately being able to deal with it (Cohen, 1987). This may involve learning more about a particular individual to assess whether an interpersonal offense was based on race or represented his/her normal interaction with others. In similar fashion, *intrapsychic processes* involve a reappraisal of the discriminatory experience to determine whether the experience should be considered a threat (Cohen, 1987). Key to this coping strategy is the use of various defense mechanisms that may downplay or deny that the experience was based on race. As

with the inhibition of action strategy, the possibility of retribution must be acknowledged when accounting for this coping response.

Those who experience racial discrimination may also *turn to others for social support*, which could enhance feelings of well being, and assist in dealing with the stressful experience. Social support is defined as social embeddedness (frequency of contact with others), perceived support (satisfaction of support), or received or enacted support (tangible support received from friends, family members) (Barrera, 1986). The response of drawing upon social support networks when coping with racial discrimination, however, may depend on cultural and historical factors. For instance, while conducting educational activities in Brazil, Paulo Freire realized the importance of cultural and historical factors in coping with oppression. Freire's (1970) observations suggest that members of oppressed groups may develop a sense of reality that does not identify experiences of prejudice and discrimination as resulting from their membership status, thus attributing unfair treatment to other characteristics such as individual attributes (Freire, 1970; Neighbors et al., 1996). Therefore, as one seeks to draw upon functional support from network members, the fact that family and friends may hold different views regarding racial discrimination may compromise the quality of the support received. In fact, it is likely that these network exchanges may become sources of stress. That is, disagreements among friends and family who differ in their racial ideologies about ambiguous or subtle forms of racial discrimination may result in arguments, or even worse, within-race insults (e.g., "Uncle Tom," "Oreo," "Angry Black man/woman," "Colonized Mind"). Hence, the beliefs and attitudes of network members toward racial discrimination may play a large role in determining whether summoning social support is an effective means of coping with this stress.

In addition to issues relative to the accepted modes of coping, relatively few scales have been devised for measuring coping with racial discrimination. Most investigators think about coping with racial stress in terms of *acute* stress only. Clearly this is not appropriate for capturing responses to discrimination as a *chronic* stressor (Gotlieb, 1997). To cite one example, religion and church-based support may play a particularly crucial role in coping with chronic racial discrimination. Krause (in press) argues that the unique facets of Black religious experience are linked to common group experiences and that research should examine the interface between the two. Krause found that older Black Americans who received more church-related emotional support were more likely to report that their faith helps sustain them in the face of ongoing racial discrimination. This underscores the importance of making explicit distinctions between types of perceived racial discrimination (e.g. acute, chronic, institutional), while also acknowledging differences in the resources (e.g. intrapsychic, interpersonal, institutional) that are employed to cope.

Racial Discrimination and Health: Physiological Mechanisms

Research has documented that stressful experiences can trigger physiologic processes that can lead to poor health outcomes (Anderson, 1989; Anderson, McNeilly, & Myers, 1992). Because our society may be greatly stratified by race/ethnicity, perceptions of racial discrimination may be important stressors in the lives of Black Americans (Williams & Neighbors, 2001). In this sense, once these individuals are exposed to racial discrimination, the brain's hypothalamus sounds an alert to the adrenal glands indicating the need to respond to a potentially harmful external threat. The adrenal glands subsequently release adrenaline and the hypothalamus releases endorphins. The adrenal glands produce cortisol once they receive the message from the hypothalamus (McEwen & Stellar, 1993). The role of cortisol is to replenish bodily energy stores depleted by the initial adrenaline rush (McEwen, 2002). The entire process is monitored by the hypothalamic-pituitary-adrenal axis (HPA), which ultimately determines whether the experience of discrimination will be handled by a normal physiologic response or by an HPA overload (McEwen, 2002).

A normally functioning HPA systematically releases appropriate amounts of adrenaline and cortisol to address the threat of stress. In contrast, when the HPA has been overloaded by ongoing, durable experiences of racial discrimination, the intermittent release of adrenaline and cortisol can cause harm (McEwen, 2002). An excess of adrenaline may cause surges in blood pressure that, in turn, cause scars in arteries where plaque can build and hamper the flow of blood throughout the body, thus increasing the risk of heart attack, stroke, and/or heart disease (Anderson et al., 1992). In short, chronic exposure to racial discrimination may damage the HPA axis so severely that the secretion of cortisol and adrenaline are never again normal (McEwen, 2002).

Conclusion

We have reviewed important conceptual and methodological issues that are involved in research on discrimination and health. In advocating the relevance of the stress-coping paradigm, we conclude that increased attention must be placed on developing more comprehensive measures of discrimination, while researchers must also acknowledge contextual factors that influence how Black Americans use coping strategies to defend against the negative impact of racial discrimination.

It will be difficult for research on racial health disparities to progress without considering the impact of stress, namely racial discrimination, and the effects of various coping strategies and resources Black Americans employ to defend against this stress. The absence of realistic, effective coping options when dealing with racial discrimination has implications for a variety of poor coping behaviors, including substance abuse, inadequate dietary habits, and promiscuous sexual behavior. We recommend

that the impact of discrimination on health be studied in multiple racial/ethnic groups in order to clarify the relative importance and unique historical experiences of racial discrimination for Black Americans. This will involve assessing the contribution of distinct cultural factors that affect perceptions of racial discrimination by Black Americans in comparison to other racial/ethnic groups of color, as well as White Americans (Neighbors et al., 2003). Further, investigators will need to account for the diversity within the Black American population and its affect on the relationship between racial discrimination, coping and health status. For example, investigators may need to clarify how gender, country of origin and socioeconomic position differences among Black Americans affect relationships between racial discrimination and health. Similarly, researchers may also need to account for how varying beliefs and stereotypes of Black Americans by specific American ethnic (e.g. German, Caribbean, Italian, Jewish, Irish), socioeconomic position, and gender groups alter experiences of racial discrimination for this population. Thus, to fully assess the role of racial discrimination as a stressor that affects the health of Black Americans, investigators must consider all elements of the stress process, including cultural contextual factors, specific exposure route, and the variety of coping realities that promote and damage the health of Black Americans.

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