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Discrimination and Health Outcomes

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Race and ethnicity are social constructs that have been used to divide people categorically into superior and inferior groups. Historically in the United States, racial groups categorized as inferior have experienced multiple forms of discrimination. This column explores issues related to the effects of racial discrimination on health disparities and outcomes. Within the US, racial discrimination as a source of health disparities is multileveled and complex and has both historical and contemporary roots. Racial issues influencing health outcomes have been identified on an individual level as feelings of subordination, depression, anger and hostility, aggressiveness, and as being manifested in internalized racism. Racial issues and conditions also play a role in health on a societal level. In 1998, Jonathan Mann spoke of the societal context to the taxonomy of health. He said that lack of resources and power, discrimination, and violation of human rights were primary pathogenic forces in creating health disparities (Mann, 1998). Illustrating the complexity of the influence of race on health outcomes are the possible underlying genetic and environmental causes for health disparities. Historically, racism has had a major effect on health outcomes and elements of that effect remain in current times.

HISTORIC AND CONTEMPORARY RACISM

Jones (2000) offers three perspectives for understanding discrimination and racism. These perspectives are institutionalized racism, personally mediated racism, and internalized racism (Jones, 2000). Institutionalized racism in the United States originally manifested itself in historical events, but persists today because of contemporary structural factors that perpetuate historical and social injustices (Jones, 2000).

The Tuskegee Syphilis Study exemplifies an historic event that severely affected the health of poor black men and continues to influence health behavior in contemporary times. In 1932 the US Public Health Service working with the Tuskegee Institute began a study of the natural history of syphilis in black men—399 with syphilis and 201 who did not have the disease (Centers for Disease Control [CDC], 2011). The study was conducted without the benefit of patients' informed consent. Although originally projected to last six months, the study actually went on for 40 years. In July, 1972, an Associated Press story about the Tuskegee Study caused a public outcry that led the Assistant Secretary for Health and Scientific Affairs to appoint an Ad Hoc Advisory Panel to review the study (CDC, 2011). The panel found that the men had agreed freely to be examined and treated. However, there was no evidence that the researchers had informed them of the study or its real purpose. The men were never given adequate treatment for their disease, even when penicillin became the

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drug of choice for syphilis in 1947, nor were they ever given the choice of quitting the study, even when this new, highly effective treatment became widely used. The advisory panel concluded that the Tuskegee Study was “ethically unjustified,” that it encouraged intentional, unethical medical treatment of American black males and advised stopping the study at once (Brandt, 1978; CDC, 2011). The Tuskegee Syphilis Experiment created distrust in the health care system among African Americans that continues today, contributing to a reluctance to participate in biomedical research and a suspicion of the American medical system.

Personally mediated racism occurs on an interpersonal level but is common throughout contemporary American society. It is reflected in behavior as a lack of respect toward Blacks (poor or no service; failure to communicate options, even in health care choices), suspicion (shopkeepers’ vigilance; everyday avoidance, including street crossing, purse clutching, and standing when there are empty seats on public transportation), devaluation (surprise at competence, stifling of aspirations), scape-goating, and dehumanization (police brutality, non-consented sterilization, abuse, and hate crimes) (Jones, 2000).

Finally, internalized racism is both historic and contemporary and occurs when members of a group who are stigmatized by racism believe the negative messages about themselves and accept a low value of their own intrinsic worth (Jones, 2000). It occurs, for example, when a black patient prefers a white physician over a black one. It is characterized not only by an inability to believe in oneself, but also by the inability to believe in others who look like us. Internalized racism involves limiting the potential of one’s own humanity. It serves as a major impetus for extreme efforts at physical, mental, and even emotional assimilation into the dominant culture. For some, this sentiment leads to hopelessness and social resignation, such as dropping out of school, failing to vote, participating in criminal activity, or engaging in risky health practices (Jones, 2000). The most insidious manifestation of internalized racism occurs when stigmatized persons, who hold negative beliefs, deny that racial discrimination exists and are completely unaware that it has an effect on their own well-being.

RACE AND ETHNICITY AS SOCIETAL DETERMINANTS OF HEALTH DISPARITIES

A lack of theoretical and analytic creativity prevented an early recognition of the role of discrimination and racism in the development of health inequalities (Karlsen & Nazroo, 2002). Fortunately there has been emerging interest in the potential consequences of racial discrimination on physical health. Link and Phelan developed the fundamental cause theory in 1996 to explain the formation or exacerbation of health inequalities as outcomes associated with socioeconomic status (SES). Persons with lower SES experience higher morbidity and mortality than those with higher SES. As discussed in a previous column, race and ethnicity are often used as a proxy for SES with minority status as a stand-in for low SES to demonstrate the relationship to higher mortality rates. However, it is important to note that racial minorities are more likely to have higher mortality rates than their majority counterparts not because of race or ethnicity, per se, but because racial/ethnic minorities experience low SES (Flaskerud & DeLilly, 2012).

Why would this be so? According to Jonathan Mann (1998), discrimination against racial/ethnic minorities is at the root of their low social and economic status. Furthermore, he said that discrimination, violation of human rights, and lack of resources are primary pathogenic forces in creating health disparities (Mann, 1998). Karlsen and Nazroo (2002) explored the relationship between indicators of racism, such as social class, and health among racial/ethnic minorities in England and Wales. They concluded that the different ways in which

racism manifests itself upon vulnerable populations, such as through interpersonal violence, institutional discrimination, or socioeconomic disadvantage, all have independent detrimental effects on health.

RACE AND THE COMPLEXITY OF INTERPRETING HEALTH DATA

The underlying causes for health disparities and differentials remain one of the most perplexing biological questions in disease epidemiology. Considerable research seeking genetic causes or environmental factors has had inconsistent outcomes and limited answers. Karlsen and Nazroo (2002) point out that on the whole, genetic or environmental factors are considered only after other potential confounders have been accounted for, rather than being the focus of explicit investigation. Assumptions of genetic explanations for racial/ethnic disparities in health persist despite many years of research evidence exposing limitations and inconsistencies (Karlsen & Nazroo, 2002). Nazroo (1998) suggests that three research questions in the current structural context are unaccounted for: (1) the effects of the accumulation of disadvantage over the life course; (2) the role of the concentration of ethnic/racial minorities in deprived residential areas, and (3) the effects of living in a racist society.

Adding to the complexity of interpreting health data, there remain several unresolved methodological issues on the effects of race, ethnicity, and discrimination on health outcomes. Two such issues are particularly relevant to the discussion here: (1) measuring perceived discrimination and (2) the effects of John Henryism. Measuring perceived discrimination can be difficult as instruments may be insensitive or inadequate to capture individual perceptions. Further complicating the measurement of perceived discrimination and the effects on health is that discrimination may be a chronic stressor affecting health outcomes in the long term (Taylor et al., 2007). It is difficult to determine the effects of chronic stressors because individuals experiencing them may have become so accustomed to these occurrences that they perceive them as normal; people may not recognize their experiences as discrimination but may still manifest the physical and emotional health effects.

An assessment of the effects of discrimination on health outcomes can be complicated by a cultural value placed on individual determination, an attitude that individuals can master their environment if they are just determined enough or work hard enough, sometimes referred to as John Henryism (Waitzman & Smith, 1994). John Henryism is a strategy for coping with prolonged exposure to stresses such as social discrimination by expending high levels of effort; this can result in accumulating physiological costs. Psychologists have formally recognized John Henryism as a style of strong coping behaviors used by many African Americans to deal with psychosocial and environmental stressors such as career issues, health problems, and even racism. Use of these coping behaviors has been shown to result in adverse health outcomes (Duke Medicine News & Communication, 2006).

RESEARCH ON RACE AND ETHNICITY AS CORRELATES TO HEALTH STATUS

To demonstrate the relationship of racial discrimination to health outcomes among African Americans, three studies are discussed and analyzed (Chae, Lincoln, Adler, & Syme, 2010; Roberts, Vines, Kaufman, & James, 2008; Taylor et al., 2007). Particularly germane to these studies are concepts described above from the research and theoretical literature, especially internalized racism, perceived discrimination, and John Henryism. The three studies reviewed here used different criteria to operationalize discrimination. All studies used validated instruments.

Racial Discrimination and Cardiovascular Disease

In their 2010 study, Chae and colleagues (2010) asked the question: Do experiences of racial discrimination predict cardiovascular disease among African American men? They were especially interested in African Americans with cardiovascular diseases who reported no discrimination. A potential explanation of this association is that hypertension and other cardiovascular problems are fostered by internalization and denial of racial discrimination. To explore this hypothesis, the investigators examined the role of internalized negative racial group attitudes (internalized racism) in linking experiences of racial discrimination and history of cardiovascular disease among African American men. Racial discrimination was measured as a participant's reported experiences of perceived discrimination. Negative racial group attitudes were measured using three items assessing whether the respondent agreed with negative statements about Blacks, specifically, whether Blacks are lazy, give up easily, and are violent. Agreement with each item was measured on a 4-point scale (1 = not at all true, 4 = very true). Scores ranged from 3 to 12, with higher scores representing more negative racial group attitudes (alpha 0.70). History of cardiovascular disease also was assessed.

The study (Chae et al., 2010) involved 1216 African American men and was carried out from 2001–2003. Weighted logistic regression analyses were conducted, first examining the main effect of the experience of racial discrimination on history of cardiovascular health. The researchers then added racial group attitudes (internalized racism) to the model. In addition, whether the influence of racial discrimination on these outcomes was moderated by racial group attitudes was examined. In their final model, they controlled for body mass index and smoking status. No main effect of racial discrimination in predicting history of cardiovascular disease was found. However, agreeing with negative beliefs about Blacks was positively associated with cardiovascular disease history, and also moderated the effect of racial discrimination. Reporting racial discrimination was associated with higher risk of cardiovascular disease among African American men who disagreed with negative beliefs about Blacks. But the most interesting results were found in those who reported no experiences of discrimination and held negative racial group attitudes. Their risk of cardiovascular disease was the highest and their cardiovascular health was the poorest (Chae et al., 2010). The authors concluded that racial discrimination and the internalization of negative racial group attitudes are both risk factors for cardiovascular disease among African American men. Furthermore, the combination of internalizing negative beliefs about Blacks and the absence of reported racial discrimination appear to be associated with particularly poor cardiovascular health (Chae et al., 2010).

Racial Discrimination and Hypertension

Roberts and colleagues (2008) examined the impact of the frequency of discrimination on hypertension risk. The investigators assessed the cross-sectional associations between frequency of perceived racial and nonracial discrimination and hypertension (HTN) among 1110 middle-aged African-American men ($n = 393$) and women ($n = 717$) participating in the 2001 follow-up of the Pitt County Study in North Carolina. Three research questions were examined: (1) Compared with persons who report never perceiving racial discrimination, does perceiving racial or nonracial discrimination increase the odds of HTN? (2) Does the frequency of perceived racial or nonracial discrimination modify the observed associations in a dose-response manner? and (3) Do the associations differ by gender?

Measurement instruments included the Everyday Discriminations Scale; blood pressure measurements; covariates, such as weight and body mass index; and psychosocial well-being, which was measured using instrumental and social support scales. Also measured was John Henryism using the John Henryism Scale for Active Coping. Education and occupation

were used as proxies for SES. Odds ratios were estimated using gender-specific unconditional weighted logistic regression with adjustment for relevant confounders and the frequency of discrimination.

More than half of the men (57%) and women (55%) were hypertensive. The prevalence of perceived racial discrimination, nonracial discrimination, and no discrimination were 57%, 29%, and 13%, respectively, in men, and 42%, 43%, and 15%, respectively, in women. Although both sexes reported substantial levels of discrimination, men reported more racial discrimination, whereas women reported both racial and other forms of discrimination (sexism and/or ageism). Women who reported frequent nonracial discrimination versus those reporting no exposure to discrimination had the highest odds of hypertension. The psychosocial aspects of denial were observed in men and women who reported having never experienced discrimination. Their high score on the John Henryism scale suggested major efforts to cope with race-based stressors by minimizing them in the first place. Men who reported no exposure to racial or nonracial discrimination had higher rates of HTN in comparison with those who reported frequent exposure. The same was true of women who perceived no racial discrimination. These results indicate that the type and frequency of discrimination perceived by African-American men and women may differentially affect their risk of hypertension (Roberts et al., 2008).

Racial Discrimination and Breast Cancer

Breast cancer is an important health problem among young black women, particularly those forty years of age and younger (Taylor et al., 2007). Taylor and colleagues (2007) conducted a secondary analysis of prospective questionnaires completed between 1997 and 2003 on racial discrimination and breast cancer incidence in 49,161 black women using data from the US Black Women's Health Study. The aim of this study was to determine if perceived discrimination was associated with increased breast cancer incidence among black women. Perceived discrimination was measured in two domains: "everyday" discrimination and major experiences of unfair treatment due to race. Everyday discrimination was described as a frequency and variety of experiences such as poor service, people acting as if you are less intelligent, and so forth. Major discrimination was described as discrimination experienced on the job, in housing, and by police. Breast cancer identification was self-reported as a breast cancer diagnosis made between 1997 and 2003 or a death from breast cancer; 593 cases of breast cancer were ascertained, and among the confirmed cases, 88% were invasive cancers. Cox proportional hazards models were used to estimate incidence rate ratios, controlling for breast cancer risk factors. In the total sample, there were weak positive associations between cancer incidence and everyday and major discrimination. These associations were stronger among the younger women. Among women younger than 50 years of age, those who reported frequent everyday discrimination were at higher risk than were women who reported infrequent experiences. In addition, the incidence rate ratio was 1.32 for those who reported discrimination on the job and 1.48 for those who reported discrimination in all three situations—housing, job, and police—relative to those who reported none. These findings suggest that perceived experiences of racism are associated with increased incidence of breast cancer among US black women, particularly younger women (Taylor et al., 2007).

CLINICAL AND POLICY RECOMMENDATIONS

As public health practitioners or health care policy makers it is imperative that we recognize experiences of discrimination as potential determinants of health disparities and poor health outcomes. The studies reviewed here suggest that interventions aimed at reducing perceived discrimination in all social settings are warranted to confront poor health outcomes among vulnerable populations. Additionally, programs designed to promote positive racial group

identity among Blacks may aid in the improvement of health (Chae et al., 2010). Mann and Tarantola (1996) recommended a human rights approach to reducing vulnerability to poor health at three levels—individual, programrelated, and societal levels. At the individual level, this approach involves risk and vulnerability reduction—health promotion and disease prevention measures. At a program level, it involves the provision of health and social services to all people. At a societal level, a human rights approach would address three broad categories of contextual factors: political and governmental; sociocultural; and economic (Mann & Tarantola, 1996). Political and governmental factors that need to be addressed would include official or sanctioned discrimination against certain groups in employment, insurance, health care, and so forth. Sociocultural factors involve stigmatization and marginalization of different groups, including gender and racial groups. Economic factors include poverty and income disparity, lack of resources for prevention programs, and lack of work or job opportunities. The problems that Mann and Tarantola identified in 1996 are still with us and continue to be major determinants of health disparities.

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