Result 21 of 166

Refine Search | Result List | Find More | Print | E-mail | Save [Go To Full Text] [Tips]

Title: Racism and Mental Health: the African American experience.

Subject(s): RACISM -- Health aspects -- United States; MENTAL health -- United States; STEREOTYPE (Psychology) -- United States

Source: Ethnicity & Health, Aug/Nov2000, Vol. 5 Issue 3, p243, 26p, 4 charts

Author(s): Williams, David R.; Williams-Morris, Ruth

Abstract: This paper provides an overview of United States-based research on the ways in which racism can affect mental health. It describes changes in racial attitudes over time, the persistence of negative racial stereotypes and the ways in which negative beliefs were incorporated into societal policies and institutions. It then reviews the available scientific evidence that suggests that racism can adversely affect mental health status in at least three ways. First, racism in societal institutions can lead to truncated socioeconomic mobility, differential access to desirable resources, and poor living conditions that can adversely affect mental health. Second, experiences of discrimination can induce physiological and psychological reactions that can lead to adverse changes in mental health status. Third, in race-conscious societies, the acceptance of negative cultural stereotypes can lead to unfavorable self-evaluations that have deleterious effects on psychological well-being. Research directions are outlined. [*ABSTRACT FROM AUTHOR*]

AN: 3976951

ISSN: 1355-7858

Full Text Word Count: 14954

Database: Academic Search Elite

Print: Click here to mark for print.

View Item: Full Page Image

View Links: Search for this Journal in the Library Catalog

[Go To Citation]

Select Language Translate

RACISM AND MENTAL HEALTH: THE AFRICAN AMERICAN EXPERIENCE

ABSTRACT

This paper provides an overview of United States-based research on the ways in which racism can affect mental health. It describes changes in racial attitudes over time, the persistence of negative racial stereotypes and the ways in which negative beliefs were incorporated into societal policies and institutions. It then reviews the available scientific evidence that suggests that racism can adversely affect mental health status in at least three ways. First, racism in societal institutions can lead to truncated socioeconomic mobility, differential access to desirable resources, and poor living conditions that can adversely affect mental health. Second, experiences of discrimination can induce physiological and psychological reactions that can lead to adverse changes in mental health status. Third, in race-conscious societies, the acceptance of negative cultural stereotypes can lead to unfavorable self-evaluations that have deleterious effects on psychological well-being. Research directions are outlined.

Keywords: race, racism, stress, discrimination, mental health, ethnicity.

INTRODUCTION

A growing number of researchers has argued that racism is a pervasive, adverse influence on the health of racial and ethnic minority populations in the United States.[1-8] This paper reviews the extant literature on direct and indirect influences of racism on the mental health of African Americans or blacks. It first reviews evidence for the complex nature of racial attitudes including the persistence of negative images of blacks by many whites. Second, it outlines the multiple pathways by which racism can affect mental health. Three primary mechanisms are identified. First, institutional discrimination can restrict socioeconomic mobility. This has led to racial differences in socioeconomic status (SES) and exposure to poor living conditions that can adversely affect mental health. Second, experiences of discrimination are a source of stress that can adversely affect mental health. Finally, the acceptance of the stigma of inferiority on the part of some minority group members can lead to impaired psychological functioning.

THE COMPLEXITY OF RACIAL ATTITUDES IN THE UNITED STATES

We use the term racism to refer to an organized system that leads to the subjugation of some human population groups relative to others. Fundamental to the development of such a system is an ideology of inferiority in which human population groups are categorized and ranked with some being inferior to others. This often leads to the development of negative attitudes and beliefs towards racial outgroups (prejudice), and differential treatment of members of these groups by both individuals and societal institutions (discrimination). This definition of racism locates it primarily within organized institutional structures and not in individual attitudes or behavior.[9] Racial prejudice and discrimination measured at the individual level can often be important indicators of the presence of racism, but it is possible for racism to exist in the absence of racial discrimination and prejudice at the individual level.[10]

Trends in Racial Attitudes Over Time

The extent to which racism persists in the United States is a contested issue. Much of the debate surrounds the interpretation of data on trends in racial attitudes over time. Some argue that the levels of racism in the United States have declined dramatically in the last 40 years. Table 1 provides data on changes in racial attitudes in the United States from the 1940s to the present arising from six questions selected from a comprehensive review of available data on this topic composed by Schuman et al. (1997).[11] These six items capture multiple aspects of racial prejudice and illustrate the complexity of racial attitudes. These questions were all asked in national probability samples of the white population in the United States. Appendix 1 contains the actual wording for each of the racial attitude questions.

The first two questions addressed the endorsement of principles of equality. The first item captures support for racial integration in education. In 1942, only 32% of white Americans believed that blacks and whites should attend the same schools. The level of support for this view doubled by the early 1960s and by 1995, an overwhelming 96% of white Americans supported integrated schooling. Similarly, while only 37% of white Americans said they would vote for a qualified black person for president of the United States in 1958, the percentage had risen to 95% in 1997.

Steady progress over time is also evident for the next two items that capture support for reducing social distance between the races. A key characteristic of racial prejudice has been an explicit desire to maintain social distance from stigmatized groups.[12] The first question, number of black students, was asked of white respondents with children in school. It ascertained their comfort level with sending their children to schools with varying proportions of black children. In 1958, three out of four white parents indicated that they would have no objection to sending their children to a school where a few of the children were black. That number increased to 99% in 1990. However, the level of support for having their children in an integrated school declines as the

number of blacks in that setting increases. The decline was more pronounced in 1958 than in more recent years, but the tendency for lower support for integration in settings where the majority of students are black persists. Fifty percent of white parents in 1958 said that they would not object to sending their children to a school where half the children were black. That support increased to 90% by 1990. In 1958 one in three white parents said they would have no objection to sending their children to a school where more than half of the children were black. That number has slowly but steadily increased over time with 66% of white parents reporting no objection in 1990.

A similar pattern is evident on the interracial marriage question. In 1958 only 4% of whites said that they would approve of marriage between whites and non-whites. At this time, interracial marriage was illegal in many states. However, even by the early 1980s only 39% of whites approved of interracial marriage. The level of support for interracial marriage has increased to a historic high of 67% in 1997. Thus, there has been a dramatic increase in attitudes favorable to blacks over time. This pattern is pronounced for both the endorsement of the principles of equality, as well as a decline in a desire to maintain social distance among the races. Particularly impressive on these questions is the progressive increase in favorable attitudes towards blacks in the 1980s and 1990s. At the same time, on the questions that capture social distance, one in every three whites express a preference for maintaining some social distance from blacks.

In spite of this impressive commitment to equality documented on the first four questions in Table 1, the final two items indicate that there is decidedly less support for policies that would implement equality. The job discrimination question ascertained the level of approval from whites for government intervention to ensure that blacks received fair treatment in obtaining jobs. In 1964, 38% of whites indicated that they would support intervention on the part of the federal government to ensure that blacks received fair treatment in employment. Thirteen percent expressed no interest in this issue. By 1996, the percentage of whites supporting such intervention had declined (28%) while the number expressing no interest in the issue had dramatically increased (36%). The second question captures white support for a law that would prohibit discrimination in the sale of housing. In 1973, the first year that this question was asked, only 34% of whites said that they would support a law that would prevent owners from discriminating against blacks in the sale of real estate. By 1996, the percentage of whites had increased to 67%. The data in Table 1 tell a complex story. Overwhelming support of egalitarian attitudes coexists with a desire to maintain at least some social distance from blacks and a less than resounding commitment to policies to eradicate entrenched inequalities.

The Persistence of Negative Stereotypes

Moreover, data on stereotypes reveal that African Americans and other minorities are viewed negatively by many whites. Table 2 presents whites' endorsement of stereotypes of blacks and other groups in the 1990 General Social Survey (GSS), a highly respected social indicators survey in the United States.[13] The first column reveals that 29% of whites viewed most blacks as unintelligent, 44% believed that most blacks are lazy, 56% endorsed the view that most blacks prefer to live off welfare and 51% indicate that most blacks are prone to violence. Similarly, only relatively small percentages of whites were willing to endorse positive stereotypes of blacks. Only 20% of whites believed that most blacks are intelligent, 17% that most blacks are hard working, 13% that most blacks prefer to be self-supporting, and 15% that most blacks are not prone to violence. Substantial numbers of whites opted for the 'neither' category on these questions and about 5% volunteered that they did not know or had no answer to the stereotype question. The contribution of social desirability concerns to these responses is not known.

To place the stereotypes of blacks into a comparative context, Table 2 also indicates how whites view themselves and other major racial/ethnic groups. A comparison of the first with the second column reveals that blacks are viewed much more negatively than whites. That is, compared to how whites view most whites, they are five times more likely to view most blacks as unintelligent, nine times more likely to view most blacks as lazy, 15 times more likely to view most blacks as preferring to live off welfare, and three times more likely to be prone to violence. Hispanics and Asians are viewed more negatively than whites but a clear hierarchy of preference is evident. African Americans are viewed more negatively than any other group and Hispanics are

viewed at least twice as negatively as Asians. On the other hand, Jews tend to be viewed more positively than whites in general. The persistence of pervasive negative stereotypes of African Americans suggests that there may be considerable cultural support for racist societal institutions and policies.

INSTITUTIONAL DIMENSIONS OF RACISM

Negative attitudes and beliefs about minority racial populations are not without consequence. Historically, beliefs about the inferiority of blacks have been actively translated into policies that restricted the access of African Americans to educational, employment, and residential opportunities. Arguably, the most dramatic example of this is the development and maintenance of racial residential segregation in the United States. Residential segregation was driven by beliefs of black inferiority and an explicit desire to avoid social contact with this outgroup.[14] Residential segregation in the United States also illustrates the institutional aspects of racism. The physical separation of the races was possible only because of the cooperative efforts of major societal institutions, including the real estate industry, banking institutions and housing policies of the federal government.[15] These institutional policies combined with the efforts of vigilant neighbor-hood organizations and individual discrimination ensured that blacks were restricted in housing choices to the least desirable residential areas. In both northern and southern cities, levels of black-white segregation increased dramatically between 1860 and 1940 and have remained relatively stable since then.[16] Analyses of the 1990 census data revealed that there has been only minimal decline in segregation in recent decades especially in the large industrial cities of the northeast and Midwest.[17] Although other racial minority populations and white ethnic groups have experienced some degree of residential segregation in the United States, the high level of segregation of the black population has been distinctive.[17] Moreover, although the Civil Rights Act of 1968 made discrimination in the sale or rental of housing units illegal in the United States, studies reveal that explicit discrimination in housing persists.[18,19] Indeed, in more subtle ways blacks are still discouraged from residing in white residential ways, and whites continue to move out of communities when the black population increases.[20,21]

Residential segregation has been a central mechanism by which racial inequality has been created and reinforced in the United States. Segregation has determined access to education and employment opportunities that have importantly led to truncated socioeconomic mobility for blacks.[15,16] In addition, segregation affects the quality of life of the community where African Americans reside. First, residential segregation has led to racial differences in the quality of elementary and high school education. In the United States, residence determines which public school students can attend and the funding of public education is under the control of local government. Thus, community resources importantly determine the quality of the neighborhood school. There is a very strong relationship between residential segregation and the concentration of poverty. In metropolitan Chicago, for example, the correlation between minority percentage and low-income percentage for elementary schools was 0.90.[22] Although there are millions of poor whites in the United States, poor white families tend to be dispersed throughout the community with many residing in desirable residential areas.[23] Accordingly, in 96% of predominantly white schools, the majority of students come from middle-class back-grounds.[22] In contrast, public schools with a high proportion of blacks and Hispanics are dominated by poor children. Forty years after a unanimous Supreme Court ruled in Brown versus Board of Education that intentional segregation in schools was inherently unequal and unconstitutional, elementary and high school education in the United States is highly segregated and decidedly unequal.[24]

The concentration of poverty and not racial composition per se, is the critical determinant of the challenges facing segregated schools.[22] These problems include lower test scores, fewer students in advanced placement courses, more limited curricula, fewer qualified teachers, little serious academic counseling, fewer connections with colleges and employers, more deteriorated buildings, higher levels of teen pregnancy and higher dropout rates. These conditions often give rise to peer pressure against academic achievement and in support of crime and substance use. Moreover, levels of segregation for black students are currently on the increase.[22] The end result is that African American students are concentrated in urban schools that have different and inferior courses and lower levels of achievement than the schools attended by white students in adjacent suburban school districts.[22] Even in integrated schools, black students are disproportionately allocated or 'tracked' into

low ability and non-college preparatory classes that are characterized by a less demanding curriculum and lower teacher expectations.[15] Thus, the likelihood of high school graduation, the skills and knowledge that a student has upon completion of high school, and the probability of going to college varies by race.

Research also reveals that segregation has limited the employment opportunities and adversely impacted income levels for African Americans. In the last several decades there has been a mass movement of low-skilled high-pay jobs from many of the urban areas where blacks are concentrated to the suburbs.[23,25] This has resulted in both a 'spatial mismatch' and a 'skills mismatch' of jobs for African Americans. That is, African Americans live in areas where they lack proximity to the entry-level high-paying jobs, and the available jobs in urban areas where African Americans reside require a level of skill and training that many African Americans do not have. Lack of access to jobs produces high rates of male unemployment and underemployment which in turn underlies the high rates of out-of-wedlock births, female-headed households, and the 'feminization of poverty' in many black communities.[26,27]

Negative racial stereotypes of African Americans also play an important role in under girding systematic discrimination against blacks in the labor market. For example, a study of white employers in a major metropolitan area revealed that they use negative racial stereotypes to systematically deny jobs to black applicants.[28,29] Audit studies conducted by the Urban Institute also found discrimination that favored white over black applicants in one in every five audits.[19] In these studies, when trained black and white job applicants with identical qualifications applied for jobs, there were racial differences in being allowed to submit an application, in offers for an interview, and in being offered a job. Although there were instances when black job applicants received favorable treatment relative to that of whites, on average, differential treatment was three times more likely to favor white job applicants than their black counterparts.

Racial residential segregation has also led to unequal access for most blacks to a broad range of services provided by municipal authorities. Compared to more affluent areas, political leaders have been more likely to cut spending and services in poor neighbor-hoods, in general, and African American neighborhoods, in particular.[20,30,31] Because poor and minority persons are less active politically, elected officials are less likely to encounter vigorous opposition when services are reduced in these areas. This disinvestment of economic resources in these neighborhoods has led to a decline in the quality of life in those communities.[32] The selective out-migration of many whites and some middle-class blacks from cities to the suburbs has also reduced the urban tax base and the ability of cities to provide a broad range of supportive social services to economically deprived residential areas. Research also indicates that residential segregation leads to smaller returns on the investment in real estate for African Americans compared to whites. That is, the growth in housing equity over time, a major source of wealth for most American families, is smaller for blacks in highly segregated areas than for comparable homes in other areas.[33] All of the above-mentioned factors combine to reduce the neighborhood and housing quality of highly segregated residential areas.

A final way in which segregation can affect socioeconomic status is by isolating blacks in segregated communities from both role models of stable employment and social networks that could provide leads about employment opportunities.[23] The social isolation created by these structural conditions in segregated residential environments can then induce cultural responses that weaken the commitment to norms and values that may be critical for economic mobility. For example, long-term exposure to conditions of concentrated poverty can undermine a strong work ethic, devalue academic success, and remove the social stigma of imprisonment, as well as, of educational and economic failure.[20]

The Consequences of Institutional Racism: Racial Differences in SES

The processes of institutional discrimination just described have led to dramatic racial differences in socioeconomic circumstances. Table 3 presents selected socioeconomic characteristics for blacks and whites in the United States. The median family income for white households in 1996 ($38,787) was almost 1.7 times higher than that of African Americans ($23,482). Compared to whites, blacks are three times more likely to be poor. If we combine persons in poverty with persons who are near poor (incomes above poverty but less than

twice the poverty level), then one-quarter of white households but more than half of African American households are in this economically vulnerable category. Rates of poverty are especially high among children. In 1996, 40% of black children under the age of 18, compared to 11% of their white peers, were growing up poor. Moreover, almost one-third of white children and two-thirds of black ones were either poor or near poor. The average level of education was relatively high in the United States in 1996 but racial differences in educational attainment were also evident. Among persons aged 25-64, nine out of ten whites and eight out of every ten African Americans had a high school diploma or more. Whites are also twice as likely as blacks to have graduated from college (29% versus 15%).

The unemployment rate for blacks is more than twice that of whites. Racial differences in educational attainment account for part of this disparity. However, large racial differences in unemployment persist even at equivalent levels of education.[34] There is also an overrepresentation of African American workers in the lowest paying sectors of the economy which accounts in part for the racial differences in income. White-collar occupations (executive, professional, managerial, administrative, technical, clerical and sales) have higher average compensation than blue-collar and service jobs. Among male civilian workers in the United States, blacks are one and a half times less likely than whites to be employed in white-collar positions and one and a half times more likely to hold blue-collar and service jobs. Similarly, compared to white women, African American females are 1.3 times less likely to be white-collar workers but almost twice as likely to be employed in service and blue-collar occupations.

Moreover, because of ongoing discrimination, many socioeconomic indicators are not equivalent across race.[35,36] As noted earlier, a given level of education may not reflect an equivalent level of educational preparation and skills across race. There are also racial differences in the income returns for a given level of education. National data reveal that among persons working full-time in the labor force, blacks and Hispanics earn less income than whites at comparable levels of education.[37] These racial differences are more marked for males than for females. In addition, irrespective of race, American women earn less than their similarly educated male counterparts. This gender difference in earnings combined with racial differences in household structure (black households are more likely than white ones to be headed by a female) means that racial differences in individual earnings at equivalent levels of education, understate racial differences in household income. Table 3 shows, that in 1996, an African American male college graduate had a median annual household income of $54,500 compared to $67,952 for his white counterpart.[38] That is, black households with a college-educated male earned 80 cents for every dollar earned by a comparable white household. Such racial differences in the returns to education are evident at all levels of educational preparation but are more marked for women than for men. For every dollar earned by a household with a similarly educated white female, households with black women who completed high school earned 64 cents and those with a college degree earned 74 cents.

There are also racial differences in the purchasing power of a given level of income. Many commercial enterprises withdraw from marginalized urban areas with a high concentration of blacks. Thus the available services in highly segregated black areas tend to be poorer in quality but higher in price. On average blacks pay higher costs than whites for housing, food, groceries, insurance, and other services.[36] Some evidence also suggests that African Americans encounter systematic discrimination in the purchase of goods and services in society that also leads to higher costs. For example, in a carefully executed study, Ayres (1991) examined racial differences in the price of new cars.[39] This study sent black and white testers to automobile dealers to negotiate the price of a new car. Although all of the testers followed the same script, there were dramatic racial and gender differences in the final price offered for the new car. White males were offered the lowest prices. Compared to the final offer to white males, the average dealer profit for the best price offered to others was 40% higher for white women, twice as high for black men, and three times as high for black women.

The largest racial difference evident in Table 3 is for wealth. The median net worth of whites is almost ten times that of blacks. This illustrates the extent to which racial differences in income understate racial differences in economic status and resources. At every level of income, blacks have considerably less wealth than whites.[40] For example, the net worth at the lowest quintile of income is $10,257 for white households compared to $1 for

African American households. At the highest quintile of income white households have a net worth of $129,394 compared to $54,449 for their black counterparts. Racial differences in wealth also link the current situation of blacks to historic discrimination. For most American families, housing equity is a major source of wealth. Thus, today's racial differences in wealth are, in large part, a direct result of the institutional discrimination in housing practiced in the past.[33]

Institutional Racism and Mental Health

These differences in SES have important mental health consequences. Socioeconomic status is a strong predictor of variations in physical and mental health.[36,41,42] The Epidemiologic Catchment Area Study (ECA), the largest population-based US study of specific psychiatric disorders in persons in treatment and not in treatment, found that adults in the lowest quartile of SES (based on a composite measure of income, education and occupation) were almost three times more likely to have a psychiatric disorder than those in the highest quartile.[43] This strong inverse relationship between SES and psychiatric illness in the ECA was evident for both blacks and whites.[44] More recently, the National Comorbidity Study (NCS), the first study to use a national probability sample to assess psychiatric disorders in the United States, also found a strong graded relationship between SES and psychiatric illness.[45] Persons in the lowest categories of both income and education were twice as likely compared to those at the highest levels to meet criteria for one of the major psychiatric disorders assessed.

It is also likely that residence in the highly segregated, economically impoverished neighborhoods created by institutional racism can adversely affect mental health. Research reveals that several characteristics prevalent in these neighborhoods such as high levels of population turnover, crime, violence, fear of crime, noise and crowding can have a negative effect on the psychological functioning of adults and children.[46] These studies have generally found that neighborhood characteristics are related to health independent of individual indicators of SES.[47] More of these studies have focused on physical health outcomes than on mental health status and many have not explicitly contrasted the levels of pathogenic characteristics in highly segregated versus less segregated communities. However, this body of research suggests that the impact of residence in segregated neighborhoods on mental health is deserving of close empirical scrutiny.

EXPERIENCES OF DISCRIMINATION AND MENTAL HEALTH

Racism may also adversely affect mental health status through the subjective experience of discrimination. Recent qualitative studies,[48,49] and journalistic accounts[50] reveal that blacks experience discrimination in a broad range of contexts in society and that these incidents can induce considerable distress. Some studies have found that exposure to discrimination in the laboratory setting leads to cardiovascular and psychological reactivity among blacks.[51-55] Similarly, some epidemiologic studies have found that exposure to racial discrimination was positively related to elevated levels of blood pressure in blacks[56-58] although this association has not always been found.[59] Other laboratory studies reveal that the experimental manipulation of discrimination leads to elevated levels of psychological distress for a broad range of groups.[60-62]

Table 4 lists studies using community samples that have examined the association between self-reports of discrimination and mental health. Reports of discrimination based on sexual orientation have been related to mental health status. A New York City study of gay men found that antigay discrimination and/or violence was positively related to psychological distress.[63] Similarly, a Toronto study of a convenience sample of gay male and lesbian adults also found that subjective reports of discrimination were inversely related to levels of life satisfaction and personal control.[64] Studies of diverse racial and ethnic groups also revealed that perceptions of racial/ethnic discrimination are adversely related to mental health. Two studies of Hispanic women found a positive association between reports of discrimination and psychological distress.[65,66] A study of Chinese immigrants in Toronto found that discrimination was positively related to psychological distress.[67] A more recent study of Southeast Asian refugees in Canada also found a positive association between racial discrimination and depressive symptoms.[68] Rumbaut (1994) also found a positive association between reports of discrimination and depressive symptoms in a large sample of over 5,000 children of immigrants in southern

Florida and San Diego.[69] This study of eighth and ninth grade students included the major immigrant groups in the United States. Similarly, in a national probability sample of blacks, whites, Hispanics and Asians, Williams (2000) found that reports of discrimination due to race or cultural background were positively related to psychological distress.[70]

Several studies have focused on the experiences of African Americans. In the first wave of the National Study of Black Americans (NSBA), Williams and Chung (in press)[71] documented that perceptions of racial discrimination were related to higher levels of psychological distress and lower levels of life satisfaction and happiness, as well as with poorer physical health. Prospective analyses of the NSBA data revealed that discrimination was inversely associated with life satisfaction but unrelated to happiness and psychological distress.[72] In spite of the value of longitudinal data in this study, the measurement of discrimination (experiences of discrimination in the month prior to the interview at each data collection point) makes it difficult to draw firm conclusions about the association between racial bias and health.

Some of these studies have focused attention on the limited conceptualization and measurement of discrimination in health research. All of the studies reviewed so far used a single-item global measure of discrimination. Such global measures underestimate the true prevalence of major experiences of discrimination.[73] Scales that capture discrimination in multiple domains of life exist[74] and several recent studies have provided more comprehensive assessments of discrimination. Landrine and Klonoff (1996) developed an 18-item scale of racist events, and found that this measure of discrimination was positively related to psychological distress.[75] Thompson (1996) found that a multiple item measure of exposure to discrimination was predictive of higher levels of psychological distress in a probability sample of African Americans in St. Louis, Missouri.[76] Ren et al. (1999)[77] used a scale developed by Krieger (1990)[57] that assessed exposure to discrimination in seven different situations: at school, getting a job, at work, getting medical care, getting housing, from the police or in the courts, and on the street or in a public setting. Using a nationally representative sample, they found that blacks were five times more likely than whites to report at least one experience of discrimination. In this study, experiences of discrimination were positively related to depressive symptoms and psychological distress.

Williams and colleagues[78,79] have argued in line with theories of distributive justice and equity[80,81] that the generic perception of unfair treatment can lead to negative emotional reactions and the induction of psychological distress. Accordingly, the generic experience of unfair treatment can adversely impact health for all persons who have such experiences, but because of their stigmatized social status, racial minority populations will experience higher levels of unfair treatment. Their discrimination measure does not ask about racial bias but about experiences of unfair treatment. When a respondent reports an experience of unfair treatment, a follow-up question ascertained the main reason for the experience. Respondents were allowed to select from a list that included ethnicity, gender, race, age, religion, physical appearance, sexual orientation, and income level/social class. This approach allows for the comprehensive assessment of discrimination experiences and facilitates the evaluation of experiences of discrimination based on race compared to those linked to other social statuses.

In addition, Williams et al. (1997) developed a scale to capture minor but recurrent experiences of discrimination.[78] Essed (1991) has argued persuasively that the traditional assessment of discrimination neglects the routine and subtle forms of discrimination that are embedded in everyday life.[48] This measure of chronic discrimination termed everyday discrimination assesses the frequency of experiences such as being treated with less courtesy than others, less respect than others, and receiving poorer service than others in restaurants or stores. In a study of a major metropolitan area in the United States, these researchers documented that blacks experience higher levels of discrimination than whites, experiences of chronic and acute discrimination that were adversely related to life satisfaction and psychological distress for both blacks and whites. Importantly, everyday discrimination was significantly related to both measures of mental health status, independent of traditional measures of life events, chronic stress, and financial stress. Similarly, using a national probability sample, Kessler et al. (1999) found that acute discrimination was associated with psychological distress and major depression while everyday discrimination was positively related to generalized anxiety, as

well as distress and depression, for both blacks and whites.[82]

THE STIGMA OF INFERIORITY AND MENTAL HEALTH

Another significant psychological effect of racism is its attack on the ego identity of its victims. Negative images of blacks are pervasive in American culture. Moore (1988), for example, documents the widespread use of blatant and subtle racist stereotypes, images and symbols in the English language.[83] Categorical beliefs about the biological and/or cultural inferiority of some racial groups can attack the self-worth of at least some members of stigmatized racial groups and undermine the importance of their very existence. The age-old proverb that 'sticks and stones may break my bones but words can never hurt me' does not ring true for the effect that believing hurtful words and negative cultural images can have on an individual's health. This idea of 'believing the words' is addressed in the concept of internalized racism. Internalized racism refers to the acceptance, by marginalized racial populations, of the negative societal beliefs and stereotypes about themselves. It is premised on the assumption that in a color-conscious racially stratified society, one response of populations defined as inferior would be to accept as true the dominant society's ideology of their inferiority.[84-86] For some African Americans, the normative cultural characterization of the superiority of whiteness and the devaluing of blackness, combined with the economic marginality of blacks, can lead to the perception of self as worthless and powerless.

Several lines of evidence suggest that the internalization of cultural stereotypes by stigmatized groups can create expectations, anxieties and reactions that can adversely affect social and psychological functioning. Fischer and colleagues' (1996) review of research from several countries indicates that groups that are socially regarded as inferior have poorer academic performance than their more highly regarded peers (such as Koreans versus Japanese in Japan, Scots versus the English in the United Kingdom, and Eastern European origin versus Western European origin Jews in Israel).[87] Research in the United States reveals that when a stigma of inferiority is activated under experimental conditions, performance on an examination was adversely affected.[88] African Americans who were told in advance that blacks perform more poorly on exams than whites, women who were told that they perform more poorly than men, and white men who were told that they usually do worse than Asians, all had lower scores on an examination than control groups who were not confronted with a stigma of inferiority.[87,88] Similarly, studies of mental patients revealed that the expectation of negative stigmatization adversely affected social networks, job performance and self-esteem.[89,90]

Research by Jerome Taylor and his colleagues at the University of Pittsburgh has systematically addressed the mental health consequences of internalized racism. These researchers utilized a 30-item instrument called the Nadanolitization Scale[91] that captures the extent to which blacks believe in the innate inferiority of blacks and feel uncomfortable around other blacks. In a study of 289 African American women, Taylor and Jackson (1990) found a positive association between internalized racism and alcohol consumption.[92] Internalized racism was also positively related to psychological distress.[93,94] These associations remained significant after adjustment for stress, social support, religious orientation, SES, marital status, and physical health. Other studies with the Nadanolitization Scale have produced similar results. McCorkle (1991) found that internalized racism was related to lower self-esteem, less ego identity, and had a negative effect on the socio-emotional development of children whose mothers had high scores on internalized racism.[95] Similarly, a study of low SES black mothers found a positive relationship between internalized racism and symptoms of depression.[96]

Other support for the adverse health consequences of internalized racism comes from analyses of the NSBA.[71] In this study, blacks were asked the extent to which they regarded seven negative stereotypes and seven positive stereotypes as true of most black people. The endorsement of negative stereotypes was positively related to chronic health problems and psychological distress. The rejection of positive stereotypes as true was inversely related to happiness and life satisfaction. These associations were significant net of controls for socio-demographic factors (age, education and gender) and discrimination. Much is yet to be learned about the determinants and consequences of internalized racism. Hughes and Demo (1989) found an inverse association between internalized racism (measured in terms of the endorsement of stereotypes) and self-esteem among blacks, but we do not currently understand the causal dynamics underlying this association.[97]

The stigma of racial inferiority may also adversely affect the treatment of black patients in the mental health system. Black clinicians have long argued that popular misconceptions, inaccuracies, and stereotypes of the psychology of African Americans could lead to the misdiagnosis of black patients.[98] The over-diagnosis of paranoid schizophrenia and the under-diagnosis of affective disorders are the most frequent types of misdiagnoses for blacks.[99,100] The differential interpretation of similar symptoms due to conscious or unconscious acceptance of negative stereotypes of blacks may be a contributing factor to misdiagnosis.[101] Some evidence suggests that the misdiagnosis of black patients persists even when formal diagnostic criteria are utilized.[102]

DIRECTIONS FOR FUTURE RESEARCH

The evidence reviewed suggests that there is a need for more systematic research attention to the construct of racism and critical evaluation of its impact on health.[4,103] This must begin with a clear understanding of the nature and structure of racism, especially in terms of its multiple dimensions and components. Our society is racially stratified with groups defined as 'races' differing in power, status and access to societal rewards. Racism is not the only social factor that affects health and it is not independent of other social influences. In societies stratified by race, racism transforms and structures other societal institutions so that the entire social system is racialized.[9] A symbiotic relationship has existed between racism and the political, legal, economic and cultural institutions with racism being shaped by and reshaping these institutions. Different combinations of these forces have been salient during varying historical periods, but there has been a racial dimension to every institution, policy and practice in the United States.[104] The expression of racism changes over time but the fundamental inequalities between groups persist.

Advancing our understanding of the role of racism in health will require careful theoretical and empirical work that seeks to (1) characterize the multiple dimensions of racism; (2) comprehensively assess potential health consequences; and (3) identify the proximal mechanisms by which racism may lead to changes in health status. Such efforts must recognize that the association between racism and health is likely to be dynamic, and must include the comprehensive characterization of the living conditions created by racism and the systematic assessment of their health consequences. This approach can facilitate the identification of the conditions under which various components of racism are more or less consequential in predicting specific health outcomes. We will illustrate the kinds of questions that need to be addressed by focusing on the criminal justice system in the USA.

Multiple Dimensions of Racism

African Americans are over-represented on almost every criminal justice statistic. Blacks are much more likely than whites to be victims of all types of crime, with the racial disparity being largest for violent crime.[34] Among the 15 leading causes of death in the United States, the largest racial disparity is for homicide. In 1995, the homicide rate for blacks was six times higher than the rate for whites.38 Rates of involvement with the criminal justice system are also high for blacks. Although African Americans are only 13% of the US population, they were almost half of all persons admitted to prison in 1995. 34 Between 1970 and 1995, incarceration rates for whites tripled while black admissions into prisons increased by more than five times. In 1995, 9% of blacks compared to 2% of whites were on probation, on parole, or in jail or prison. Among men aged 20-29, 26% of blacks were under the supervision of the criminal justice system, compared to 7% of whites.[34]

These stark racial differences are often viewed as being due to differences in underlying values and beliefs or even possible differences in biology. However, considerable evidence suggests that racism plays some role in these differences. First, residential segregation creates and exacerbates conditions that lead to high rates of violent crime. Research indicates that the combination of high rates of concentrated poverty, male joblessness, and residential instability lead to high rates of single-parent households. The combination of these factors completely accounts for the elevated levels of violent crime in the black population.[105] Moreover, the

association between these factors and crime for whites was virtually identical in magnitude with the association for blacks. These researchers concluded that 'the sources of violent crime appear to be remarkably invariant across race and rooted instead in the structural differences among communities, cities, and states in economic and family organization' (Sampson and Wilson 1995, p 41).[105]

Second, institutional discrimination in the administration of justice also plays a role. Some evidence indicates that there are racial differences in the punishment for at least some crimes. Before the Civil War, laws in the United States explicitly provided more severe punishments for blacks than for whites who were guilty of the same crime.[106] Such legal statutes no longer exist, but the administration of justice is still especially harsh to blacks when the victim is white. Reflecting a well-documented sexual dimension to racism,[107] during the first half of this century, twice as many blacks as whites convicted of rape were sentenced to life in prison;[106] and between 1930 and 1973, black men were nine times more likely than whites to receive capital punishment for rape.[34] In contemporary America, a defendant who killed a white person is more than four times more likely to receive a death sentence than a defendant who killed a black person.[106] However, given that most crimes occur within race the relative number of blacks affected is small.

Other evidence suggests that the administration of criminal justice has a bias against blacks. In 1994, for example, African Americans were 43% of arrests, 54% of convictions, and 59% of prison admissions for violent crimes.34 This indicates that compared with whites, blacks are more likely to be arrested, arrested blacks are more likely to be convicted, and convicted blacks are more likely to be imprisoned. Judges also discriminate against blacks in the setting of bail. One recent study found, for example, that even after adjusting for 11 variables related to the severity of the charged offense, the bail amounts set for black male defendants were 35% higher than those of their white peers.[108] Moreover, blacks were no more likely to flee than whites.

Negative stereotypes of African Americans as criminals and violent has led to the widespread use of race in the creation of law enforcement profiles of likely criminals. Accordingly, to be black, especially to be a young black male makes one a suspect. Police officers maintain greater surveillance of blacks, and blacks are more likely to be stopped, questioned and searched than whites.[106] A study of a major metropolitan area found that African Americans were almost three times more likely than whites (37% versus 13%) to report that they had been unfairly stopped, searched, questioned, physically threatened or abused by the police.79 Recently, the American Civil Liberties Union (ACLU) completed a careful statistical study of drivers on the major highway (Interstate 95) in the state of Maryland.[109] This study found that although blacks were 17% of all motorists and 18% of the drivers violating traffic laws, 73% of all drivers detained and searched by the police were black and 20% were white.

The criminal justice system's response to drug use provides other examples of institutional racism. African Americans are more likely than whites to be arrested for possession of drugs, selling drugs, or using drugs. What is surprising about these data is that national studies consistently find that there are either no racial differences in drug use or that black adults and adolescents use drugs at lower rates than whites.30,45,49 There are laws that, even if not racist in intent, have a racist impact on blacks. Legally mandated reporting of the drug use of pregnant women is an example. A study in one Florida county found that there was differential reporting of drug offenses by race.[110] Although toxicological screening revealed similar levels of drug use among black and white pregnant women, black women were reported to the authorities at ten times the rate of white women. Poor women were also more likely to be reported than their wealthier peers.

Legally mandated differential responses to types of drug offenses illustrates another institutional mechanism that discriminates against blacks regardless of the intent of the original statute. Increasing admissions for drug offenses explains a large part of the increased incarceration rates in the last 20 years. In addition to differential surveillance, racial differences in sentencing for race-patterned drug crimes have played a critical role in placing blacks behind bars. In 1986, a federal law required a mandatory sentence of no less than ten years in prison for anyone convicted of possession with intent to distribute 50 grams or more of crack cocaine. In striking contrast, it takes 100 times as much (5,000 grams) powder cocaine to be subject to the same mandatory sentence. There is a racial dimension to this disparity. Crack cocaine is commonly used and sold by African Americans and

powder cocaine is commonly used by whites. In 1992, 93% of the defendants convicted of crack cocaine offenses were black and only 5% were white; 45% of defendants sentenced for powder cocaine offenses were white and only 21% were black.[106]

Health Consequences

Once the multiple dimensions have been identified in a particular domain of society, attention must focus on comprehensively characterizing the ways in which racism might affect health. The high level of police surveillance may be an important but neglected source of stress in the lives of many African Americans. The threat of a humiliating encounter with law enforcement officers may lead to a high level of psychological arousal. Qualitative research and journalistic accounts suggest that many African Americans engage in a broad range of anticipatory coping strategies to avoid or minimize exposure to discriminatory experiences, including encounters with the po-lice.[48,50,111] The psychological costs, if any, of this heightened vigilance have not been systematically addressed.

There is also clearly a need to fully trace and assess the mental health consequences of the black population's high level of involvement with the criminal justice system. The high rates of exposure to violent crime, homicide, police harassment, and incarceration are all fraught with mental health consequences that are not yet well understood. The high levels of criminal victimization of African Americans suggests that large segments of the black community cope with personal victimization and its aftermath, as well as the victimization of relatives and friends. It is estimated that for every homicide there are 100 incidents of assault and violence.[112] Problems such as suicidal ideation and attempts, psychosomatic symptoms, depression, drug and alcohol abuse have all been reported to stem from non-lethal assaults.[113] In addition to direct victimization, exposure to scenes of violence can also have adverse mental health effects. Levels of exposure to violence are high. In many large cities at least 25% of inner city children and youth have seen someone shot or stabbed.[114,115]

Crime affects not only the victims and offenders but can have mental health consequences for families and communities. High levels of homicide suggest that many households experience grief over the loss of loved ones. Given that a disproportionate share of homicides represents the loss of young adult males, each homicide also represents the loss of economic and social support to the family and the surrounding community. Research suggests that children who experience the loss of a significant loved one early in life may have long-term adverse mental health consequences.[116]

Research reveals that 10-15% of prisoners have severe mental illness[117] and mentally ill community residents are at an elevated risk of arrest and incarceration.[118] In addition, the incarceration experience may also have adverse mental health consequences for the prison inmate and his/her family. The offender has to cope with the conditions of incarceration and its attendant negative stigma. The mental health consequences of these aspects of incarceration for ex-offenders are not well understood. These issues may be especially acute for children. More than half of all male prisoners in the United States have children under the age of 18. 34 While imprisoned, offenders are unable to provide needed social and economic support to their families. The strain of separation can lead to depression in prison inmates[119] and to emotional, behavioral, and academic problems in their children.[120] With the rising rates of incarceration in the United States much needs to be done to address the therapeutic needs of children whose parents are incarcerated[120] and to make the policies of the correctional and child welfare system more supportive of the psychological well-being of incarcerated parents and their families.[121] Incarceration can also adversely affect the socioeconomic and psychological well-being of the families of ex-offenders.

A criminal record may also negatively impact an individual's objective SES and subjective sense of well-being. Many employers are wary of hiring someone with a criminal past so that it is difficult for an ex-offender to obtain desirable jobs. A criminal record also leads to the disempowerment of an individual. In many states, persons convicted of a felony are temporarily or permanently prohibited from voting.

Intermediary Mechanisms and Processes

Large-scale societal factors affect health through proximal mechanisms. There is a pressing need to identify the intervening processes and structures that link both racialized social structures and personal experiences with racism to health. This will require a clearer understanding of the linkages between physical and mental health. We do not now understand an important paradox in the literature on African American health. Compared to whites, African Americans are disadvantaged on most measures of physical health, with the racial disparity widening over time for several of these indicators.[122] At the same time, in spite of exposure to a broad range of risk factors and pathogenic characteristics, African American mental health is considerably better than would be predicted on at least some dimensions of mental health.

African Americans are disadvantaged on most subjective indicators of the quality of life. Blacks report lower levels of life satisfaction, happiness, marital happiness, and higher levels of anomia and mistrust than whites.[123] Moreover, between 1972 and 1996 there has been no change in the black disadvantage on these quality of life indicators.[123] In addition, these racial disparities in the quality of life did not vary by and were not explained by SES. However, on other indicators of mental health status, blacks fare as well or do better than whites. Research on self-esteem indicates that there are no black-white differences in self-esteem.[124,125] Similarly, elevated rates of psychological distress among African Americans compared to whites are not consistently found. Some studies find higher rates of psychological distress for blacks than whites, other studies find the opposite and some studies find no racial differences.[42,126-128] Compared to whites, blacks also tend to have equivalent or lower current and lifetime rates of specific psychiatric disorders 43,45 and lower rates of suicide.38 Some have hypothesized that this pattern may reflect the presence of coping strategies within the black population that can mitigate some of the psychological consequences of exposure to racism but are less able to overcome the cumulative physiological impact of exposure to high levels of adversity. 78 This hypothesis awaits empirical evaluation.

Research on the impact of racism on health must pay attention to the ways in which victims respond to and attempt to manage these negative experiences.[103,129] More generally, future research must identify the health-enhancing resources that provide protection from at least some of the pathogenic risk factors faced by African Americans. At least some victims of discrimination are active agents who attempt to manage and control exposure to negative experiences and the impact that these experiences may have on them. The distinction between an active versus a passive response is one of the key themes that cuts across major typologies of behavioral responses to experiences of injustice.[130] Some limited research suggests that this distinction predicts variations in the impact of reported discrimination.57,58 Anger is another theoretically important response pattern that has not received systematic empirical examination in the literature.[131] John Henryism (a predisposition to cope actively with stress) is another psychosocial factor that deserves further study.[132]

Attention should also be given to identifying the cultural strengths and psychosocial resources that may be mobilized by individuals to cope with pathogenic circumstances. Much prior research on minority populations has focused only on pathology and deficits and has not adequately taken health-promoting resources into consideration. All models of the stress process recognize that a variety of social and psychological moderators can affect the impact of stress on health. Experiences of racism may be viewed as a significant stressor. The impact of the stressor will be dependent on the presence of both constitutional and other vulnerability factors that predispose to health problems and psychosocial resources and/or resilience factors that can insulate the individual from stress or provide coping mechanisms to reduce the negative effects of stress on health. In addition to well-established psychosocial resources, such as supportive social ties, perceptions of mastery or control and self-esteem, health-enhancing factors that may be unique to or more prevalent in minority populations can also affect the association between racism and health.

The extent to which resources such as religious beliefs and behavior and group identity and consciousness are mobilized to respond and deal with stressful circum-stances should be attended to in future research. African Americans are arguably the most religious population subgroup in the industrialized world, and it has been suggested that both personal religious involvement and tangible support provided by religious organizations may shield this population from some of the adverse consequences of stress.7 The strength of group identity

may be another important psychosocial resource for minority group members. One recent study found that racial identity clearly buffered the adverse effects of acute and chronic discrimination on health problems for African Americans.[133]

The full range of coping strategies utilized in dealing with racism needs to be identified and their effects on health systematically assessed. Research is needed to identify how vulnerability factors and psychosocial resources are associated with race-related and other stressors and combine in additive and interactive ways to affect health. Importantly, an enhanced understanding of health-enhancing resources and resilience factors can facilitate the development of interventions to increase their role in the lives of vulnerable members of minority groups.

Such research must take a life course perspective and identify how these processes unfold over time. In the case of internalized racism, for example, following children over time may shed light on how processes of internalization and self-hatred because of skin color develop and express themselves in adulthood. A recent study by Delgado (1998) suggests that the process may begin early.[134] This study of African American 4-year-olds found that 75% of these pre-school children preferred white friends over African American peers to play with and over 50% of this group already felt inferior to their white counterparts! At the same time, we do not know what factors determine the acceptance or rejection of negative cultural messages. Exposure to racism is unlikely to affect every African American child in the same way. Williams-Morris (1996) outlines several ways in which racism in the larger culture can adversely affect the psychological development of minority children.[135] She indicates that a potential role of racist cultural messages is implicit in most of the major theoretical models in developmental psychology and proposes a research agenda in that area. Research must also attend to how children from majority ethnic groups learn from a young age to associate dark skin with a variety of adjectives that have negative meanings.

The Distinctiveness of Each Racial Minority Population

Research must also give attention to the uniqueness of each major racial/ethnic group. This paper has focused on the African American experience. Many of the issues discussed apply with varying degrees to other stigmatized groups. At the same time, there is no generic minority health model that can be indiscriminately applied to the distinctive racial and ethnic groups that make up the American mosaic.[136]

The challenges for the African American population are likely to be unique and greater than those of other minority groups. African Americans are darker in skin color than any other racial group. There is a fairly universal negative perception of the color black.[137] Moreover, studies of African Americans,[138] Mexican Americans[139] and Jews in multiple settings[140-142] reveal that darker skin color predicts higher levels of discrimination. American Indians and most immigrant groups to the United States have experienced, and many continue to experience prejudice and discrimination, but blacks have always been at the bottom of the racial hierarchy, and this is unlikely to change in the foreseeable future. The stereotype data reviewed earlier indicate that perceptions of D. R. WILLIAMS & R. WILLIAMS-MORRIS 262 blacks are more negative than those of any of the other groups. Moreover, the blurring of the current racial categories in the future due to high rates of interracial marriage will have a smaller impact on blacks than on other racial groups. Of Hispanics 25-45% marry non-Hispanics, and 25-50% of Asians marry persons of other races.[69] Although rates of black-white intermarriage have increased in recent years (from 2% in 1970 to 6% in 1990) they are considerably lower than those of other minority populations. Thus, the polarization of black versus others is likely to persist.

Similarly, while other groups have experienced residential segregation, no other racial or ethnic population in the United States has ever lived under the high levels of segregation that currently characterize the experience of African Americans.16 The high level of segregation of the black population is not self-imposed because blacks reflect the highest support for residence in integrated neighborhoods.[143] Moreover, greater ethnic diversity does not appear to lead to greater acceptance of blacks as neighbors. A study in Southern California found that Hispanics were as hostile as whites to black neighbors, and Asians were more hostile than whites.[143] The high levels of segregation combined with discrimination in the labor market have ensured that blacks have had

the greatest difficulties with socioeconomic mobility.[144] This is unlikely to change soon and the consequent challenges for health are likely to continue.

CONCLUSION

W.E.B. DuBois stated that 'the problem of the twentieth century is the problem of the color-line' (DuBois, 1961[1953], p 23).[145] The evidence reviewed here suggests that the problems attendant to race persist and are likely to continue undiminished into the twenty-first century. This paper reviewed research suggesting that racism may have important costs for society in terms of health. Our understanding of these mental health consequences is still limited but this review identifies many promising directions for future research. The evidence reviewed suggests that there is the need of greater acknowledgment of the presence of racism and a new commitment to investing the resources needed to document and alleviate its pathogenic consequences. Even more challenging is the need to dismantle both the ideological foundations of racism and the societal structures and policies created by them.

ACKNOWLEDGEMENTS

An earlier version of this paper was presented at the Mental Health Beyond the TRC Conference, Cape Town, South Africa, 7-8 October 1998. Preparation of this paper was supported by grants 1 RO1 MH59575 and 1 RO1 MH57425 from the National Institute of Mental Health and the John D. and Catherine T. MacArthur Foundation Research Network on Socioeconomic Status and Health.

TABLE 1. Racial attitudes of whites in the United States

Legend for Chart:

A - Question
B - Year of survey: 42
C - Year of survey: 58
D - Year of survey: 63
E - Year of survey: 64
F - Year of survey: 71
G - Year of survey: 72
H - Year of survey: 73
I - Year of survey: 80
J - Year of survey: 83
K - Year of survey: 90
L - Year of survey: 95
M - Year of survey: 96
N - Year of survey: 97

A	B	C	D
	E	F	G
	H	I	J
	K	L	M
			N
Principle Items			
1. Approve Same Schools (%)	32	--	65
	63	--	86
	--	88	--
	--	96	--
			--
2. Vote for Black Presidential Candidate (%)	--	37	45
	--	71	--
	--	--	81
	--	--	--
			95

Social Distance			
3. Number of Black Students			
a. No objection to few (%)	--	75	77
	--	--	--
	92	95	--
	99	--	--
			--
b. No objection to half (%)	--	50	52
	--	--	--
	69	76	--
	90	--	--
			--
c. No objection to majority (%)	--	33	29
	--	--	--
	37	42	--
	66	--	--
			--
4. Approve Intermarriage (%)	--	4	--
	--	--	27
	--	--	39
	--	--	--
			67
Implementation Items			
5. Job Discrimination			
a. Government should ensure no discrimination (%)	--	--	--
	38	--	40
	--	--	--
	--	--	28
			--
b. No interest (%)	--	--	--
	13	--	18
	--	--	--
	--	--	36
			--
6. Housing Discrimination			
a. Owner cannot discriminate	--	--	--
	--	--	--
	34	40	46
	54	--	67
			--

Source: Schuman et al. (1997). 11

TABLE 2. White Americans' stereotypes. Percentage agreeing that most group members ...

Legend for Chart:

A - Blacks
B - Whites
C - Hispanics
D - Asians
E - Jews

	A	B	C	D	E

Are Unintelligent					
Unintelligent	28.8	6.1	29.1	13.2	7.0
Neither	45.0	33.3	42.6	38.0	25.9
Intelligent	320.0	55.4	18.4	37.3	58.8
DK/NA[*]	6.2	5.2	9.8	11.5	8.3
Are Lazy					
Lazy	44.3	4.9	33.5	15.0	4.7
Neither	34.0	36.4	33.7	27.7	21.9
Hard-working	16.8	54.5	23.9	47.2	65.5
DK/NA	4.9	4.2	9.0	10.1	7.9
Prefer to Live Off Welfare					
Prefer Welfare	56.1	3.7	41.6	16.3	2.4
Neither	26.5	21.5	30.5	31.6	14.6
Prefer Self-support	12.7	70.5	18.3	40.6	75.7
DK/NA	4.7	4.3	9.7	11.5	7.3
Are Prone to Violence					
Violence Prone	50.5	15.7	38.3	17.2	10.1
Neither	28.3	42.3	34.0	41.1	33.3
Not Violence Prone	15.2	36.6	17.8	29.6	46.6
DK/NA	5.9	5.5	9.8	12.1	10.0

* DK/NA: Don't Know or No Answer.

Source: Davis and Smith (1990).13

TABLE 3. Selected socioeconomic indicators for blacks and whites in the United States, 1996

Legend for Chart:

A - White (W)
B - Black (B)
C - B/W Ratio

	A	B C
A. Income		
1. Median income	$38,787	$23,482 0.61
B. Poverty		
2. Percentage poor	8.60	28.4 3.30
3. Percentage poor and near poor	25.6	55.1 2.15
4. Children under 18, poor (%)	11.1	39.9 3.59
5. Children under 18, poor and near poor (%)	30.8	68.0 2.21
C. Educational Attainment, age 25-64		

6. High school graduate or higher (%)	90.5	79.8 0.88
7. College graduate or higher (%)	28.8	14.8 0.51
D. Unemployment[*]		
8. Percentage unemployed	4.70	10.5 2.23
E. Current Occupation, age 25-64		
9. White collar, males (%)	52.6	33.5 0.64
10. Blue collar/service, males (%)	44.1	54.5 1.24
11. White collar, females (%)	77.6	59.3 0.76
12. Blue collar/service, females (%)	21.3	40.5 1.90
F. Household Income by Education, age 25 & over		
13. Median inc., h. s. graduate, male	$47,200	$36,020 0.76
14. Median inc., coll. graduate, male	$67,952	$54,500 0.80
15. Median inc., h. s. graduate, female	$37,000	$23,556 0.64
16. Median inc., coll. graduate, female	$64,007	$47,100 0.74
G. Wealth		
17. Median net worth	$44,408	$4,604 0.10
Lowest Income Quartile	$10,257	$1 0.00
Highest Income Quartile	$129,394	$54,449 0.42

Source: NCHS (1998).[38]

* Source: US Bureau of the Census (1998). Statistical Abstract of the United States: 1998. Washington, D.C.: US Government Printing Office.

a Data are for 1990. Source: Eller (1994). 40

TABLE 4. Discrimination and mental health in community samples

Legend for Chart:

A - Study
B - Sample
C - Measure of Discrimination

D - Measure of Mental Health
E - Findings

A	B	C	D	E
1. Meyer (1995)	741 New York City gay men randomly selected from gay organizations and via snowballing techniques	Any past-year experience of anti-gay violence and/or discrimination	Psychological distress (PERI)	Positive association
2. Birt & Dion (1987)[64]	Convenience sample of 74 gay men and women in Toronto	--	Life satisfaction	Inversely related
3. Amaro et al. (1987)[65]	303 Hispanic women professionals; mail survey	Ever experienced any discrimination	Psychological distress Life satisfaction	Positive association for married women only Inverse association
4. Salgado de Snyder (1987)[66]	140 immigrant Mexican women in Southern California	Experienced discrimination because of being Mexican	Psychological distress	Positive association
5. Dion et al. (1992)[67]	184 adults with Chinese surname in Toronto telephone directory	Incidents of discrimination experienced by respondent or family since arriving in Canada	Psychological distress	Positive association

6. Noh et al. (1999)[68]

647 Southeast Asian refugees in Canada

Ever experienced discrimination

Depressive symptoms

Positive association

7. Rumbaut (1994)[69]

5,264 8th and 9th grade children of immigrants in San Diego and Miami

Ever experienced discrimination

Psychological distress (four items from the CES-D)

Positive association

8. Williams (2000)[70]

National probability telephone sample of 1,114 whites, 1,048 blacks, 1,001 Hispanics, and 632 Asians

Treated badly because of race or cultural background in past year

Psychological distress

Positive association

9. Williams & Chung (in press)[71]

2,107 adults in the National Survey of Black Americans

Respondent or family treated badly because of race in the past month

Psychological distress life satisfaction Happiness

Positive association
Inverse association
Inverse association

10. Jackson et al (1996)[72]

623 adults who participated in all four waves of the NSBA

Treated badly due to race in past month

Psychological distress
Life satisfaction
Happiness

No association
Inverse association
No association

11. Landrine & Klonoff (1996)[75]

Convenience sample of 153 African Americans

	Frequency of having ever experienced 18 racist events	
	Psychological distress (Hopkins Symptom Checklist)	
		Positive association
12. Thompson (1996)[76]		
	200 African American, St. Louis	
	Any experience of unfavorable, unfair, or insulting event or action in the last 6 months	
	Symptoms of intrusion	
		Positive association
13. Ren et al. (1999)[77]		
	1,819 adult respondents from a national probability sample	
	Scale that sums experiences of racial discrimination in seven domains	
	Psychological distress: (a) Seven items from CES-D (b) Distress subscale of SF-36	
		Positive association Positive association
14. Williams et al. (1997)[78]		
	586 blacks and 520 whites in a probability sample of the Detroit Metro area	
	1. Acute experiences of discrimination 2. Chronic, everyday discrimination	
	1. Psychological distress 2. Life satisfaction	
	1. Psychological distress 2. Life satisfaction	
		No association Inverse association
		Positive association Inverse association
15. Kessler et al. (1999)[82]		
	3,032 adults from a national telephone-mail survey	
	1. Acute experiences of discrimination 2. Chronic everyday discrimination	
	1. Psychological distress 2. Major depression 3. Generalized anxiety	

1. Psychological distress
2. Major depression
3. Generalized anxiety

Positive association
Positive association
No association

REFERENCES

1. Cooper RS, Steinhauer M, Miller W, David R & Schatzkin A. Racism, society, and disease: an exploration of the social and biological mechanisms of differential mortality. International Journal of Health Services. 1981; 11 (3): 389-414.

2. Hummer RA. Black-white differences in health and mortality: a review and conceptual model. Sociological Quarterly. 1996; 37 (1): 105-25.

3. Krieger N, Rowley DL, Herman AA, Avery B & Phillips MT. Racism, sexism, and social class: implications for studies of health, disease, and well-being. American Journal of Preventive Medicine. 1993; 9 (6): 82-122.

4. Krieger N. Embodying inequality: a review of concepts, measures, and methods for studying health consequences of discrimination. International Journal of Health Services. 1999; 29 (2): 295-352.

5. LaVeist TA. Why we should continue to study race ... but do a better job: an essay on race, racism and health. Ethnicity and Disease. 1996; 6 (1-2): 21-29.

6. Williams DR. Racism and health: a research agenda. Ethnicity and Disease. 1996; 6 (1-2): 1-6.

7. Williams DR. Race and health: basic questions, emerging directions. Annals of Epidemiology. 1997; 7 (5): 322-33.

8. King G & Williams DR. Race and health: a multi-dimensional approach to African American health. In: Amick BC, Levine S, Walsh DC & Tarlov AR, Eds. Society and Health. New York: Oxford University Press, 1995: 93-130.

9. Bonilla-Silva E. Rethinking racism: toward a structural interpretation. American Sociological Review. 1996; 62: 465-80.

10. Jackman MR. The Velvet Glove: Paternalism and Conflict in Gender, Class, and Race Relations. Los Angeles: University of California Press, 1994.

11. Schuman H, Steeh C, Bobo L & Krysan M. Racial Attitudes in America: Trends and Interpretations (revised edition). Cambridge, MA: Harvard University Press, 1997.

12. Pettigrew TF & Meertens RW. Subtle and blatant prejudice in Western Europe. European Journal of Social Psychology. 1995; 25: 57-75.

13. Davis JA & Smith TW. General Social Surveys, 1972-1990. Chicago: National Opinion Research Center, 1990.

14. Cell J. The Highest Stage of White Supremacy: The Origin of Segregation in South Africa and the American South. New York: Cambridge University Press, 1982.

15. Jaynes GD & Williams RM. A Common Destiny: Blacks and American Society. Washington, DC: National Academy Press, 1987.

16. Massey DS & Denton NA. American Apartheid: Segregation and the Making of the Underclass. Cambridge, MA: Harvard University Press, 1993.

17. Farley R & Frey WH. Changes in the segregation of whites from blacks during the 1980s: small steps toward a more integrated society. American Sociological Review. 1994; 59: 23-45.

18. Clark WAV. Residential preferences and residential choices in a multiethnic context. Demography. 1992; 29: 451-66.

19. Fix M & Struyk RJ. Clear and Convincing Evidence: Measurement of Discrimination in America. Washington, DC: Urban Institute Press, 1993.

20. Shihadeh ES & Flynn N. Segregation and crime: the effect of black social isolation on the rates of black urban violence. Social Forces. 1996; 74 (4): 1325-52.

21. Turner MA. Limits on neighborhood choice: evidence of racial and ethnic steering in urban housing markets. In: Fix M & Struyk RJ, Eds. Clear and Convincing Evidence: Measurement of Discrimination in America. Washington, DC: The Urban Institute Press, 1993: 117-52.

22. Orfield G. The growth of segregation: African Americans, Latinos, and unequal education. In: Orfield G & Eaton SE, Eds. Dismantling Desegregation: The Quiet Reversal of Brown v. Board of Education. New York: The New Press, 1996: 53-71.

23. Wilson WJ. The Truly Disadvantaged. Chicago: University of Chicago Press, 1987.

24. Orfield G & Eaton SE. Dismantling Desegregation: The Quiet Reversal of Brown v. Board of Education. New York: The New Press, 1996.

25. Kassarda JD. Urban industrial transition and the underclass. Annals of the American Academy of Political and Social Science. 1989; 501: 26-47.

26. Testa M, Astone NM, Krogh M & Neckerman KM. Employment and marriage among inner-city fathers. In: Wilson WJ, Ed. The Ghetto Underclass. Newbury Park, CA: Sage, 1993: 96-108.

27. Wilson W & Neckerman KM. Poverty and family structure: the widening gap between evidence and public policy issues. In: Danziger SH & Weinberg DH, Eds. Fighting Poverty. Cambridge, MA: Harvard University Press, 1986: 232-59.

28. Kirschenman J & Neckerman KM. 'We'd love to hire them, but ... ': the meaning of race for employers. In: Jencks C & Peterson PE, Eds. The Urban Underclass. Washington, DC: The Brookings Institution, 1991: 203-32.

29. Neckerman KM & Kirschenman J. Hiring strategies, racial bias, and inner-city workers. Social Problems. 1991; 38: 433-47.

30. Wallace R. Urban desertification, public health and public order: 'planned shrinkage,' violent death, substance abuse, and AIDS in the Bronx. Social Science and Medicine. 1990; 31: 801-13.

31. Wallace R. Expanding coupled shock fronts of urban decay and criminal behavior: how U.S. cities are becoming hollowed out. Journal of Quantitative Criminology. 1991; 7: 333-356.

32. Alba RD & Logan JR. Minority proximity to whites in suburbs: an individual-level analysis of segregation.

American Journal of Sociology. 1993; 98 (6): 1388-1427.

33. Oliver ML & Shapiro TM. Black Wealth/White Wealth: A New Perspective on Racial Inequality. New York: Routledge, 1997.

34. Council of Economic Advisers for the President' s Initiative on Race. Changing America: Indicators of Social and Economic Well-being by Race and Hispanic Origin. Washington, DC: US Government Printing Office, 1998.

35. Kaufman JS, Cooper RS & McGee DL. Socioeconomic status and health in blacks and whites: the problem of residual confounding and the resiliency of race. Epidemiology. 1997; 8: 621-28.

36. Williams DR & Collins C. U.S. socioeconomic and racial differences in health. Annual Review of Sociology. 1995; 21: 349-86.

37. US Bureau of the Census. Current Population Reports, Series P-60, No. 174, Money, Income of households, Families and Persons in the United States: 1990. Washington, DC: US Government Printing Office, 1991.

38. National Center for Health Statistics. Health, United States, Socioeconomic Status and Health Chartbook. Hyattsville, MD: USDHHS, 1998.

39. Ayres I. Fair driving: gender and race discrimination in retail car negotiations. Harvard Law Review. 1991; 104 (4): 817-72.

40. Eller TJ. Household Wealth and Asset Ownership: 1991. U.S. Bureau of the Census, Current Population Reports, P70-34. Washington, DC: US Government Printing Office, 1994.

41. Adler NE, Boyce T, Chesney MA, Folkman S & Syme SL. Socioeconomic inequalities in health: no easy solution. Journal of the American Medical Association. 1993; 269: 3140-45.

42. Dohrenwend BP & Dohrenwend BS. Social Status and Psychological Disorder: A Casual Inquiry. New York: Wiley, 1969.

43. Robins LN & Regier DA. Psychiatric Disorders in America: The Epidemiologic Catchment Area Study. New York: Free Press, 1991.

44. Williams DR, Takeuchi D & Adair R. Socioeconomic status and psychiatric disorder among blacks and whites. Social Forces. 1992; 71: 179-94.

45. Kessler RC, McGonagle KA, Zhao S, Nelson CB, Hughes M, Eshleman S, Wittchen H-U & Kendler KS. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Archives of General Psychiatry. 1994; 51: 8-19.

46. Wandersman A & Nation M. Urban neighborhoods and mental health: psychological contributions to understanding toxicity, resilience, and interventions. American Psychologist. 1998; 53 (6): 647-56.

47. Robert SA. Socioeconomic position and health: the independent contribution of community socioeconomic context. Annual Review of Sociology. 1999; 25: 489-516.

48. Essed P. Understanding Everyday Racism. Newbury Park, CA: Sage, 1991.

49. Feagin JR. The continuing significance of race: Anti-Black discrimination in public places. American Sociological Review. 1991; 56: 101-16.

50. Cose E. The Rage of a Privileged Class. New York: Harper Collins, 1993.

51. Anderson NB. Racial differences in stress-induced cardiovascular reactivity and hypertension: current status and substantive issues. Psychological Bulletin. 1989; 105: 89-105.

52. Armstead C, Lawler KA, Gordon G, Cross J & Gibbons J. Relationship of racial stressors to blood pressure responses and anger expression in black college students. Health Psychology. 1989; 8: 541-56.

53. Jones DR, Harrell JP, Morris-Prather CE, Thomas J & Omowale N. Affective and physiological responses to racism: the roles of afrocentrism and mode of presentation. Ethnicity and Disease. 1996; 6 (1-2): 109-22.

54. Morris-Prather CE, Harrell JP, Collins R, Leonard KL, Boss M & Lee JW. Gender differences in mood and cardiovascular responses to socially stressful stimuli. Ethnicity and Disease. 1996; 6 (1-2): 123-31.

55. Sutherland ME & Harrell JP. Individual differences in physiological responses to fearful, racially noxious, and neutral imagery. Imagination, Cognition, and Personality. 1986-1987; 6: 133-49.

56. James SA, LaCroix AZ, Kleinbaum DG & Strogatz DS. John Henryism and blood pressure differences among black men. II. The role of occupational stressors. Journal of Behavioral Medicine. 1984; 7: 259-75.

57. Krieger N. Racial and gender discrimination: risk factors for high blood pressure? Social Science and Medicine. 1990; 30 (12): 1273-81.

58. Krieger N & Sidney S. Racial discrimination and blood pressure: the CARDIA study of young black and white adults. American Journal of Public Health. 1996; 86: 1370-78.

59. Broman CL. The health consequences of racial discrimination: a study of African Americans. Ethnicity and Disease. 1996; 6 (1-2): 148-53.

60. Dion KL & Earn BM. The phenomenology of being a target of prejudice. Journal of Personality and Social Psychology. 1975; 32 (5): 944-50.

61. Pak AW-P, Dion KL & Dion KK. Social-psychological correlates of experienced discrimination: test of the double jeopardy hypothesis. International Journal of Intercultural Relations. 1991; 15: 243-54.

62. Dion KL. Women's reactions to discrimination from members of the same or opposite sex. Journal of Research in Personality. 1975; 9: 294-306.

63. Meyer IH. Minority stress and mental health in gay men. Journal of Health and Social Behavior. 1995; 36: 38-56.

64. Birt CM & Dion KL. Relative deprivation theory and responses to discrimination in a gay male and lesbian sample. British Journal of Social Psychology. 1987; 26: 139-45.

65. Amaro H, Russo NF & Johnson J. Family and work predictors of psychological well-being among Hispanic women professionals. Psychology of Women Quarterly. 1987; 11: 505-21.

66. Salgado de Snyder VN. Factors associated with acculturative stress and depressive symptomatology among married Mexican immigrant women. Psychology of Women Quarterly. 1987; 11: 475-88.

67. Dion KL, Dion KK & Pak AW-P. Personality-based hardiness as a buffer for discrimination-related stress in members of Toronto's Chinese community. Canadian Journal of Behavioral Science. 1992; 24 (4): 517-36.

68. Noh S, Beiser M, Kaspar V, Hou F & Rummens J. Discrimination and emotional well-being: perceived racial discrimination, depression, and coping: a study of Southeast Asian refugees in Canada. Journal of Health and Social Behavior. 1999; 40 (3): 193-207.

69. Rumbaut RG. The crucible within: ethnic identity, self-esteem, and segmented assimilation among children of immigrants. International Migration Review. 1994; 28: 748-94.

70. Williams DR. Race, stress, and mental health. In: Hogue C, Hargraves M & Scott-Collins K, Eds. Minority Health in America. Baltimore, MD: Johns Hopkins University Press, 2000: 209-43.

71. Williams DR & Chung A-M. Racism and health. In: Gibson R & Jackson JS, Eds. Health in Black America. Thousand Oaks, CA: Sage Publications, in press.

72. Jackson JS, Brown TN, Williams DR, Torres M, Sellers SL & Brown K. Racism and the physical and mental health status of African Americans: a thirteen year national panel study. Ethnicity and Disease. 1996; 6 (1-2): 132-47.

73. Sigelman L & Welch S. Black Americans' Views of Racial Inequality: The Dream Deferred. Cambridge, MA: Harvard University Press, 1991.

74. Utsey SO. Assessing the stressful effects of racism: a review of instrumentation. Journal of Black Psychology. 1998; 24 (3): 269-88.

75. Landrine H & Klonoff EA. The schedule of racist events: a measure of racial discrimination and a study of its negative physical and mental health consequences. Journal of Black Psychology. 1996; 22 (2): 144-68.

76. Thompson Vetta L. "Perceived experiences of racism as stressful life events". Community Mental Health. 1996; 32(3), 223-233.

77. Ren XS, Amick B & Williams DR. "Racial/ethnic disparities in health: The interplay between discrimination and socioeconomic status". ***Ethnicity & Health***. 1999; 9(2), 151-165.

78. Williams DR, Yu Y, Jackson J & Anderson N. Racial differences in physical and mental health: socioeconomic status, stress, and discrimination. Journal of Health Psychology. 1997; 2 (3): 335-51.

79. Forman TA, Williams DR & Jackson JS. Race, place, and discrimination. In: Gardner C, Ed. Perspectives on Social Problems. JAI Press, New York, 1997: Vol. 9, 231-61.

80. Adams JS. Inequity in social exchange. In: Berkowitz L, Ed. Advances in Experimental Social Psychology. New York: Academic Press, 1965: Vol. 2, 267-99.

81. Walster E, Walster GW & Berschied E. Equity: Theory and Research. Boston, MA: Allyn and Bacon, 1978.

82. Kessler RC, Mickelson KD & Williams DR. The prevalence, distribution, and mental health correlates of perceived discrimination in the United States. Journal of Health and Social Behavior. 1999; 40: 208-30.

83. Moore RB. Racism in the English language. In: Rothenberg PS, Ed. Race, Class, and Gender in the United States: An Integrated Study (4th edition). New York: St. Martin's Press, 1988: 465-75.

84. Pettigrew TF. Profile of the Negro American. Princeton, NJ: Van Nostrand, 1964.

85. Simpson GE & Yinger JM. Racial and Cultural Minorities: An Analysis of Prejudice and Discrimination

(5th edition). New York: Plenum, 1985.

86. McCarthy JD & Yancey WL. Uncle Tom and Mr. Charlie: metaphysical pathos in the study of racism and personal disorganization. American Journal of Sociology. 1971; 76: 648-72.

87. Fischer CS, Hout M, Jankowski MS, Lucas SR, Swidler A & Voss K. Inequality by Design: Cracking the Bell Curve Myth. Princeton, NJ: Princeton University Press, 1996.

88. Steele CM. A threat in the air: how stereotypes shape intellectual identity and performance. American Psychologist. 1997; 52 (6): 613-29.

89. Link BG. Understanding labeling effects in the area of mental disorders: an assessment of the effects of expectations of rejection. American Sociological Review. 1987; 52: 96-112.

90. Link BG, Struening E, Cullen FT, Shrout PE & Dohrenwend BP. A modified labeling theory approach to mental disorders: an empirical assessment. American Sociological Review. 1989; 54: 400-23.

91. Taylor J & Grundy C. Measuring black internalization of white stereotypes about blacks: the Nadanolitization Scale. Handbook of Tests and Measurements for Black Populations, 1988.

92. Taylor J & Jackson B. Factors affecting alcohol consumption in black women, Part II. The International Journal of Addictions. 1990; 25 (12): 1415-27.

93. Taylor J & Jackson BB. Evaluation of a holistic model of mental health symptoms in African American women. The Journal of Black Psychology. 1991; 18: 19-45.

94. Taylor J, Henderson D & Jackson BB. A holistic model for understanding and predicting depression in African American women. Journal of Community Psychology. 1991; 19: 306-20.

95. McCorkle KC. Effects of maternal internalized racism, socioeconomic status, depression and parenting quality upon child maladjustment. University of Pittsburgh: unpublished doctoral dissertation, 1991.

96. Tomes E, Brown A, Semenya K & Simpson J. Depression in black women of low socioeconomic status: psychological factors and nursing diagnosis. Journal of National Black Nurses Association. 1990; 4: 37-46.

97. Hughes M & Demo DH. Self-perceptions of black Americans: self-esteem and personal efficacy. American Journal of Sociology. 1989; 95: 132-59.

98. Carter JH. Racism's impact on mental health. Journal of the National Medical Association. 1994; 86: 543-47.

99. Adebimpe VR. Overview: white norms and psychiatric diagnoses of black patients. American Journal of Psychiatry. 1981; 138: 279-85.

100. Worthington C. An examination of factors influencing the diagnosis and treatment of black patients in the mental health system. Archives of Psychiatric Nursing. 1992; 6: 195-204.

101. Neighbors HW, Jackson JS, Campbell L & Williams D. The influence of racial factors on psychiatric diagnosis: a review and suggestions for research. Community Mental Health Journal. 1989; 25: 301-11.

102. Loring M & Powell B. Gender, race and DSM-III: a study of the objectivity of psychiatric diagnostic behavior. Journal of Health and Social Behavior. 1988; 29: 1-22.

103. Clark R, Anderson NB, Clark VR & Williams DR. Racism as a stressor for African Americans: a biopsychosocial model. American Psychologist. 1999; 54 (10): 805-16.

104. Omi M & Winant H. Racial Formation in the United States: From the 1960s to the 1980s. New York: Routledge, 1986.

105. Sampson RJ & Wilson WJ. Toward a theory of race, crime, and urban inequality. In: Hagan J & Peterson RD, Eds. Crime and Inequality. Stanford, CA: Stanford University Press, 1995: 37-54.

106. Kennedy R. Overview of racial trends in the administration of criminal justice. In: National Research Council, Ed. Racial Trends in the United States. Washington, DC: National Academy of Sciences, 1997.

107. Hernton CC. Sex and Racism in America. Garden City, NY: Doubleday, 1965.

108. Ayres I & Waldfogel J. A market test for race discrimination in bail setting. Stanford Law Review. 1994; 46 (5): 987-1047.

109. Lamberth J. In the courts. American Civil Liberties Union. Report of John Lamberth. http://www.aclu.org/court/lamberth.html, 1998.

110. Chasnoff IJ, Landress HJ & Barrett ME. The prevalence of illicit-drug or alcohol use during pregnancy and discrepancies in mandatory reporting in Pinellas County, Florida. New England Journal of Medicine. 1990; 322: 1202-06.

111. Feagin JR & Sikes MP. Living with Racism: The Black Middle-Class Experience. Boston, MA: Beacon Press, 1994.

112. Sampson RJ & Lauritsen J. In: Reiss Jr A & Roth J, Eds. Understanding and Preventing Violence: Social Influences. Washington, DC: National Academy Press, 1994: Vol. 3, 1-114.

113. Bell CC, Hildreth CJ, Jenkins EJ, Levi D & Carter C. The need for victimization screening in a poor outpatient medical population. Journal of the National Medical Association. 1988; 80: 853-60.

114. Groves B, Zuckerman B, Marans S & Cohen D. Silent victims: children who witness violence. Journal of the American Medical Association. 1993; 269: 262-64.

115. Osofsky J, Wewer S, Hann D & Fick A. Chronic community violence: What is happening to our children? Psychiatry. 1993; 56: 26-45.

116. Kessler RC, Gillis-Light J, Magee WJ, Kendler KS & Eaves LJ. Childhood adversity and adult psychopathology. In: Gotlib IH, Ed. Stress and Adversity over the Life Course: Trajectories and Turning Points. New York, NY: Cambridge University Press, 1997: 29-49.

117. Lamb HR & Weinberger LE. Persons with severe mental illness in jails and prisons: a review. Psychiatric Services. 1998; 49 (4): 483-92.

118. Schnapp WB, Nguyen T & Nguyen H. Offenders with mental illness: prevalence and responsibility. Administration and Policy in Mental Health. 1998; 25 (3): 333-35.

119. Lanier CS. Affective states of fathers in prison. Justice Quarterly. 1993; 10: 49-65.

120. Seymour C. Children with parents in prison: child welfare policy, program, and practice issues. Child Welfare. 1998; 75: 469-93.

121. Hairston CF. The forgotten parent: understanding the forces that influence incarcerated fathers' relationships with their children. Child Welfare. 1998; 75: 617-39.

122. Williams DR. Race, SES, and health: the added effects of racism and discrimination. Annals of the New York Academy of Sciences. 1999; 896: 173-88.

123. Hughes M & Thomas ME. The continuing significance of race revisited: a study of race, class, and quality of life in America, 1972 to 1996. American Sociological Review. 1998; 63: 785-95.

124. Porter JR & Washington RE. Minority identify and self-esteem. Annual Review of Sociology. 1993; 19: 139-61.

125. Jackson JS & Lassiter, in press.

126. Neighbors HW & Jackson JS. The use of informal and formal help: four patterns of illness behavior in the black community. American Journal of Community Psychology. 1984; 12 (6): 629-44.

127. Vega WA & Rumbaut RG. Ethnic minorities and mental health. Annual Review of Sociology. 1991; 17: 351-83.

128. Williams DR & Harris-Reid M. Race and mental health: emerging patterns and promising approaches. In: Horwitz AV & Scheid TL, Eds. A Handbook for the Study of Mental Health: Social Contexts, Theories, and Systems. New York: Cambridge University Press, 1999: 295-314.

129. McNeilly MD, Anderson NB, Armstead CA, Clark R, Corbett M, Robinson EL, Pieper CF & Lepisto EM. The perceived racism scale: a multidimensional assessment of the experience of white racism among African Americans. Ethnicity and Disease. 1996; 6 (1-2): 154-66.

130. Lalonde RN & Cameron JE. Behavioral responses to discrimination: a focus on action. In: Zanna MP & Olson JM, Eds. The Psychology of Prejudice: The Ontario Symposium. Hillsdale, NJ: Lawrence Erlbaum, 1994: Vol. 7, 257-88.

131. Grier WH & Cobbs PM. Black Rage. New York: Harper Collins, 1968.

132. James SA. John Henryism and the health of African Americans. Culture of Medicine and Psychiatry. 1994; 18: 163-82.

133. Williams DR, Spencer M & Jackson JS. Race, stress, and physical health: the role of group identity. In: Contrada RJ & Ashmore RD, Eds. Self, Social Identity, and Physical Health: Interdisciplinary Explorations. New York: Oxford University Press, 1999: 71-100.

134. Delgado R. Words that wound. The race and ethnic community. In: Adalberto A & Baker DV, Eds. Sources. Notable Selections in Race and Ethnicity. Guilford, CT: Dushkin/McGraw-Hill, 1998: 345-51.

135. Williams-Morris R. Racism and children' s health: issues in development. Ethnicity and Disease. 1996; 6 (1-2): 69-82.

136. Hayes-Bautista DE. Latino health indicators and the underclass model: from paradox to new policy models. In: Furino A, Ed. Health Policy and the Hispanic. Boulder, CO: Westview Press, 1992.

137. Franklin JH. Color and Race. Boston, MA: Houghton Miflin, 1968.

138. Keith VM & Herring C. Skin tone and stratification in the black community. American Journal of Sociology. 1991; 97 (3): 760-78.

139. Arce CH, Murguia E & Frisbie WP. Phenotype and life chances among Chicanos. Hispanic Journal of Behavioral Sciences. 1987; 9: 19-32.

140. Rosen S. Intermarriage and the 'blending of exiles' in Israel. Research in Race and Ethnic Relations. 1982; 3: 79-102.

141. Kraus V & Koresh Y. The course of residential segregation: ethnicity, socioeconomic status, and suburbanization in Israel. Sociological Quarterly. 1992; 33: 303-19.

142. Gale N. A case of double rejection: the immigration of Sephardim to Australia. New Community. 1994; 20: 269-86.

143. Bobo L & Zubrinsky CL. Attitudes on residential integration: perceived status differences, mere in-group preference, or racial prejudice? Social Forces. 1996; 74 (3): 883-909.

144. Lieberson S. A Piece of the Pie: Black and White Immigrants Since 1880. Berkeley, CA: University of California Press, 1980.

145. DuBois WEB. The Souls of Black Folk. New York: Fawcett Publications, 1961.

APPENDIX

Wording of Racial Attitude Questions in Table 1

1 Same Schools:

'Do you think white students and (Negro/black) students should go to the same schools or to separate schools?'

2 Vote for Black Presidential Candidate:

'There's always been much discussion about the qualifications of presidential candidates--their education, age, race, religion, and the like. If your party nominated a generally well qualified (man/person) for president and he happened to be a (Negro/black), would you vote for him?'

3 Number of Black Students (few):

'Would you, yourself, have any objection to sending your children to a school where a few of the children are black?'

Half (if no to few);

'Where half of the children are black?'

Majority (if no to half);

'Where more than half of the children are black?'

4 Intermarriage:

'Do you approve or disapprove of marriage between whites and nonwhites (between 1983-1997: between blacks

and whites)?'

5 Job Discrimination:

'Some people feel that if black people are not getting fair treatment in jobs, the government in Washington ought to see to it that they do. Others feel that this is not the federal government' s business. Have you had enough interest in this question to favor one side over the other? [If yes] How do you feel? Should the government in Washington see to it that black people get fair treatment in jobs or (1964, 1972: should the government in Washington leave these matters to the states and local communities) is this not the federal government's business?'

6 Housing Discrimination:

'Suppose there is a community-wide vote on the general housing issue. There are two possible laws to vote on. One law says that a homeowner can decide for himself who to sell his house to, even if he prefers to sell to (Negroes/Blacks/African Americans). The second law says that a homeowner cannot refuse to sell to someone because of their race or color. Which law would you vote for?'

~~~~~~~~

By David R. Williams, Department of Sociology, Institute for Social Research, University of Michigan, Ann Arbor, Michigan and Ruth Williams-Morris, Department of Psychology, University of St. Thomas, St. Paul, Minnesota, USA

Address for correspondence: David R. Williams, Department of Sociology, Survey Research Center, Institute for Social Research, University of Michigan, P.O. Box 1248, Ann Arbor, MI 48106-1248, USA. Tel.: (734) 936-0649; E-mail: wildavid@umich.edu

Source: Ethnicity & Health, Aug/Nov2000, Vol. 5 Issue 3, p243, 26p, 4 charts.
Item Number: 3976951

Result 21 of 166

Refine Search | Result List | Find More | Print | E-mail | Save [Go To Full Text] [Tips]
~~~~~~~~