



Perceived discrimination and poor health: Accounting for self-blame complicates a well-established relationship



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ABSTRACT

Past research has reliably demonstrated that both perceiving oneself as a target of discrimination and a tendency to blame negative events on oneself undermine psychological and physical health. These two literatures, however, have evolved largely independently of one another. The present research sought to develop a deeper understanding of the health effects of perceived discrimination by taking into account the relationship between perceived discrimination and self-blame. In two correlational studies, we examined perceived ethnic-based discrimination, self-blame, and psychological and physical health among White and ethnic minority adults residing in the United States. Contrary to the hypothesis that attributing negative events to discrimination leads to the discounting of self-blame, perceived discrimination and self-blame were positively related. Replicating past research, perceived discrimination was negatively related to health when examined as an independent predictor. When perceived discrimination and self-blame were examined as simultaneous predictors of health, however, the negative health effects of perceived discrimination were weakened. Furthermore, an alternative model revealed that perceived discrimination indirectly predicted decreased health through increased self-blame. The present findings highlight the importance of taking self-blame into account when assessing and interpreting the negative health effects of perceived discrimination.

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Perceived discrimination is an important public health issue. The perception that one has been a target of discrimination is reliably associated with poor psychological and physical health outcomes including increased depression, anxiety, hypertension, and mortality (e.g., Pascoe & Richman, 2009; Williams & Mohammed, 2009). Further, the negative relationship between perceived discrimination and health has been observed in both cross-sectional and prospective studies (Schmitt et al., 2014).

Because discrimination is often ambiguous and hard to document, most researchers interested in assessing the health effects of discrimination rely on self-report measures that assess participants' *subjective perceptions* that they have been targets of discrimination rather than objective measures of discrimination (Paradies, 2006). Research and theory on stress and coping illustrate that subjective appraisals of one's experiences are critical determinants of health and well-being (Lazarus & Folkman, 1984).

Given its well-documented negative health effects, it is important to critically examine perceptions of discrimination as predictors of health.

Many researchers assess general perceptions of discrimination with single-item or multi-item questionnaires that tap into the perceived frequency of exposure to discrimination using a "one-step" approach (e.g., Contrada et al., 2001; Gibbons et al., 2014; Krieger et al., 2005; Landrine & Klonoff, 1996). For example, participants are asked questions such as: "How many times have you been treated unfairly by teachers and professors because you are Black?" (Landrine & Klonoff, 1996). Responses to such items reflect both the *frequency* that an individual has experienced negative events (e.g., being treated unfairly) as well the *attribution* of those events to a social identity (e.g., because you are Black). This confound makes it difficult to determine whether the relationship observed between perceived discrimination and health is due to the fact that individuals have frequently experienced negative treatment or due to the fact that they attribute their negative treatment to discrimination (see Major et al., 2002 for a discussion of this issue).

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The Everyday Discrimination Scale (Williams et al., 1997), in contrast, measures perceived discrimination with a “two-step” approach (e.g., Kessler et al., 1999; Krieger et al., 2005; Sternthal et al., 2011). First, individuals are asked how frequently they have experienced various forms of negative treatment (e.g., “People act as if they think you are not smart”). Next, those who indicate they have experienced such treatment are asked to identify the main reason(s) for these experiences and are provided social identities such as race, gender, age, religion, and physical appearance as potential attributions. This scale separates the experience of negative treatment from attributions for that treatment and gives people the opportunity to make attributions to more than one social identity.

One limitation of the Everyday Discrimination Scale and other scales designed to measure general perceptions of discrimination, however, is that they do not assess the extent to which people might also make internal attributions for negative treatment. Internal attributions focus on the self-directed causes of outcomes (Kelley, 1973; Weiner, 1985). Victims of misfortune, such as rape and accident victims, often blame these negative events, at least in part, on themselves (e.g., Breitenbecher, 2006; Miller & Porter, 1983; Tennen et al., 1986). Furthermore, blaming negative outcomes on oneself predicts poor health (e.g., Beck, 1967; Else-Quest et al., 2009). Surprisingly, the literature examining the health effects of perceived discrimination and the health effects of self-blame have evolved relatively independently of one another.

The practice of omitting self-blame when assessing perceived discrimination reflects, in part, widespread assumptions that respondents are certain of the cause of negative treatment and that they attribute their treatment to only one cause. In many cases, however, the true causes underlying negative treatment from others are unclear because others may disguise or misrepresent their true intentions (e.g., Kenny & DePaulo, 1993). Thus, people often experience uncertainty regarding the cause of others' behaviors (i.e., attributional ambiguity) in their social interactions (Crocker & Major, 1989). Furthermore, people are often aware that multiple causes can influence their outcomes (McClure, 1998). For example, perceiving that negative treatment is due to discrimination does not preclude an individual from recognizing that internal factors may also have played a role.

Theory and research on causal attribution indicate that the presence of an external cause for a negative event can lead individuals to discount internal causes (Kelley, 1973). A sizable body of experimental research has examined whether attributing discrete negative treatment to discrimination leads to the discounting of internal causes (e.g., Major, Kaiser, & McCoy, 2003a). This literature suggests that the relationship between discrimination attributions and self-blame attributions for a discrete event depends on context. Major, Quinton and Schmader (2003b) examined attributions among women who were rejected for a leadership position in the presence of blatant vs. subtle discrimination cues. When discrimination cues were blatant, the more women attributed their rejection to discrimination, the less they blamed themselves (discounting). When discrimination cues were subtle, however, the more women attributed their rejection to discrimination, the more they also blamed themselves (multiple-causes). This suggests that when the causes of negative treatment are ambiguous, discrimination and self-blame attributions can occur simultaneously (see also Schmitt et al., 2014).

No research has examined the relationship between perceived discrimination and self-blame outside of the domain of discrete negative treatment. For this reason, it is unclear whether a general perception that one experiences negative treatment due to discrimination is positively or negatively related to a general tendency to blame negative treatment on oneself. If individuals engage in discounting, we would expect general perceptions of

discrimination and self-blame to be *negatively* related. As described above, however, people often consider multiple causes for their outcomes (McClure, 1998) and self-blame and discrimination are positively related in response to discrete instances of ambiguously discriminatory treatment (Major et al., 2003a, 2003b). Because of strong social norms prohibiting the expression of blatant discrimination, discrimination encountered in contemporary society is likely to be covert, subtle, and ambiguous (Dovidio & Gaertner, 2004). Because measures assessing general perceptions of discrimination assess peoples' perceptions of their daily experiences, these measures likely assess perceptions of discrimination across circumstances where cues to discrimination are often ambiguous. Thus, general perceptions of discrimination and general tendencies to engage in self-blame may be *positively* related. Understanding the relationship between general perceptions of discrimination and self-blame has the potential to inform our understanding of the well-documented negative health effects of perceived discrimination. Since measures assessing general perceptions of discrimination have not simultaneously assessed general self-blame attributions, it is unclear whether the negative relationship between perceived of discrimination and health may be due, in part, to the negative health effects of self-blame.

1. Current research

In the present research we sought to develop a deeper understanding of the health effects of perceived discrimination. We had four primary goals. First, we sought to examine the relationship between individuals' general perceptions of discrimination and general tendencies to engage in self-blame. We explored two competing hypotheses. Perceived discrimination and self-blame may be *negatively* related, such that the more people report experiencing negative treatment due to discrimination the less they blame themselves for negative treatment. Alternatively, perceived discrimination and self-blame may be *positively* related, such that the more people generally report experiencing negative treatment due to discrimination the more they also generally blame themselves for negative treatment.

Second, we tested the effect of perceived discrimination on psychological health (i.e., self-esteem, anxiety symptoms, depressive symptoms) and physical health (i.e., physical symptoms, self-rated health) when self-blame is taken into account. Based on past research demonstrating the negative health effects of perceived discrimination, we predicted that perceived discrimination would predict poor health outcomes when examined as an independent predictor. In addition, given the well-documented relationship between self-blame and poor health, we predicted that both perceived discrimination and self-blame would be negatively related to health when examined as simultaneous predictors. Thus, we hypothesized that perceived discrimination would undermine health even when taking into account self-blame, although the relationship between perceived discrimination and health may weaken when the health effects of self-blame are accounted for.

Our third goal was to assess whether perceived discrimination and self-blame are similarly related to psychological and physical health among ethnic minorities, who generally have lower status, and Whites, who generally have higher status in the United States. Some scholars argue that because low status group members encounter more pervasive and severe forms of discrimination than high status group members, perceived discrimination is more detrimental to the health of low status group members (Schmitt et al., 2014). Others theorize that because discrimination poses a greater threat to status for high status group members than low status group members, perceived discrimination is more

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