How Prejudice Can Harm Your Health

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Before the Rev. Dr. Martin Luther King declared health inequity the most shocking and inhumane form of injustice, W.E.B. Du Bois wrote that “the Negro death rate and sickness are largely matters of condition and not due to racial traits and tendencies.” Before Du Bois made his case, James McCune Smith — the nation’s first black doctor — carefully detailed the health consequences of freedom and oppression.

Dr. James McCune Smith, physician and abolitionist.
W.E.B. Du Bois wrote that “the Negro death rate and sickness are largely matters of condition and not due to racial traits and tendencies.” Credit The New York Public Library

These men grasped an insight that modern researchers and policy makers often fail to make explicit: Discrimination, especially when chronic, harms the body and the mind. How we treat one another, and how our institutions treat us, affects how long and how well we live.

We tend to think of discrimination as a moral or legal issue, and perhaps, in the case of immigration, an economic one. But it’s also a medical issue with important public health consequences. A growing body of evidence suggests that racial and sexual discrimination is toxic to the cells, organs and minds of those who experience it.
Research suggests that discrimination is internalized over a lifetime, and linked to a variety of poor health markers and outcomes: more inflammation and worse sleep; smaller babies and higher infant death rates; a greater risk of cancer, depression and substance use. The cumulative burden of discrimination is linked to higher rates of hypertension and more severe narrowing of important arteries in the heart and neck. Even the telomeres at the end of our chromosomes, which act as a sort of timer for aging cells, can shorten.

In one study, researchers asked black women to complete questionnaires on how often they experienced minor “everyday” discrimination, as well as major instances of unfair treatment in housing, employment or with the police. They then followed the women for six years, and found that those who had reported more frequent discrimination were more likely to develop breast cancer. The more pervasive the reported discrimination, the higher their risk.

This remained true even after adjusting for more than a dozen other factors like family history, education level, physical activity and use of hormonal supplements or oral contraceptives. Similar work has found that discrimination is a strong predictor of lower back pain in black patients — but not in white patients, who were less likely to report discrimination and for whom discrimination was unrelated to pain.

Those who endure chronic discrimination not only experience more stress, but may also process it differently. To test this theory, researchers used surveys to assess the extent of lifetime discrimination that black and white patients had experienced. They then injected patients with phenylephrine (a chemical similar to adrenaline) and found that black patients had a larger temporary increase in blood pressure than white patients. Those who had experienced more discrimination had the largest rise of all.

There may also be something particularly sinister about racial stress: People have a bigger spike in blood pressure when talking about racial stressors (being accused of shoplifting) compared with nonracial stressors (experiencing delays at the airport).

These effects start early. By fifth grade, black and Hispanic children are already more than twice as likely as white students to say they’ve experienced discrimination at school. (About 7 percent of white children also reported discrimination, and online bullying is a growing problem for students of all backgrounds.)

Children who experience discrimination have higher rates of depression, A.D.H.D. and other behavioral problems. And teenagers who endure more discrimination — racial slurs, physical threats, disrespectful behavior, false accusations — are more likely to have disrupted cortisol levels, elevated blood pressure and higher body mass index years later.

Most important, even for students who experience similar levels of discrimination, there is considerable variability in whether or not they go on to develop health problems. Many negative health effects seem to be mitigated — and in some cases eliminated — for those who have robust emotional support from family and friends. And some research even suggests that low levels of adversity can promote resilience.

Most studies have focused on the health effects of what researchers call interpersonal discrimination, including harassment, “micro-aggressions” or even just the anticipation of prejudice. But an emerging literature is also exploring the role of structural discrimination — the social and economic policies that systematically put certain groups at a disadvantage.
Researchers have tried to calculate structural bias by using racial differences in four domains — political participation, educational achievement, employment and incarceration. Blacks, for example, are 12 times more likely to be imprisoned than whites in Wisconsin, but only twice as likely in Hawaii. In Arkansas, the unemployment rate for blacks is 3.6 times higher than for whites; in Delaware, they’re employed at similar rates.

These unequal social conditions foster unequal health outcomes. Blacks in states high in structural discrimination are more likely to have heart attacks than blacks in low-discrimination states, and black women are more likely to give birth to babies too small for their gestational age. (Data is mixed on whether whites in these states do better or worse.)

In a revealing study of historical data, researchers found that before the abolition of Jim Crow laws, the black infant death rate was nearly 20 percent higher in Jim Crow states versus non-Jim Crow states. This disparity declined sharply after the Civil Rights Act of 1964, such that the gap had essentially closed a decade later. Still, the caustic effects of segregation persist: Blacks in segregated neighborhoods remain at higher risk for hypertension, chronic disease, violence and exposure to environmental pollutants.

Research is also identifying harmful inequities for white Americans along geographic and socioeconomic lines. Whites living in rural areas, compared with those in metropolitan centers, now contend with many of the same structural challenges that worsen health: less education, lower incomes, higher unemployment rates and poorer access to medical care. They increasingly feel that they, too, face significant discrimination. In some counties in the Midwest and South, the death rate for white women in their 40s has doubled since 2000.

Other work has found that gays and bisexuals living in states that institute policies restricting their rights — like same-sex marriage bans or lack of workplace protections — are more likely to develop depression, anxiety and substance use disorders. And a recent study suggests that the Deferred Action for Childhood Arrivals program, or DACA, conferred large mental health benefits to eligible Hispanic adults, who were nearly 50 percent less likely to report symptoms of major depression compared with non-eligible people at risk of being deported.

As important as specific policies may be, the general social and political climate probably has broader and longer-lasting effects. Even if they haven’t experienced bias themselves, members of minority groups may develop a hyperawareness for cues of mistreatment, and this sustained vigilance can lead to chronic stress, mood problems and poorer health outcomes. For example, amid a sharp rise in anti-Arab sentiment after the Sept. 11 attacks, women with Arabic names — but not other women — had an increased risk of preterm birth and low-birth weight babies.

If Dr. King’s moral arc does in fact bend toward justice, it still has a long way to go. When people are marginalized, even unintentionally, it inflicts a toll. Discrimination raises many moral concerns — but also, it seems, many medical ones.

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