

# Colorism and Physical Health: Evidence from a National Survey

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## Abstract

This study uses nationally representative data to extend a steadily growing body of research on the health consequences of skin color by comparatively examining the consequences of perceived ingroup and outgroup skin color discrimination (perceived colorism) for physical health among African Americans. Using a comprehensive set of measures of physical health, I find that perceived ingroup colorism is significantly associated with worse physical health outcomes among African Americans. Notably, the magnitude of ingroup colorism's associations with most of these outcomes rivals or even exceeds that of major lifetime discrimination, everyday discrimination, and perceived outgroup colorism. These findings compellingly suggest the inclusion of perceived colorism measures in future survey data collection efforts.

## Keywords

African Americans, colorism, perceived discrimination, physical health, skin color

A well-developed literature, across the social sciences, has systematically detailed myriad ways in which individuals' ethnoracial backgrounds are associated with a whole host of inequalities. With respect to nearly every outcome one could imagine, studies detail how, for example, Black people fare worse than whites—from the labor market to the criminal justice system to education and more. Undoubtedly, a key part of this literature is research that details how individuals' ethnoracial backgrounds are associated with their health. Building on the legacy of W. E. B. Du Bois ([1899] 1995), who pioneered analyzing *social* determinants of health against a backdrop of research arguing that Black people were biologically inferior, this large and steadily growing body of research shows how a whole range of factors—from the role of socioeconomic inequalities associated with ethnoracial background to the social stress of perceiving chronic, patterned experiences of unfair treatment and discrimination—connect ethnoracial backgrounds to health (Bastos et al. 2010; Harnois et al. 2019; McFarland et al. 2018; Paradies 2006; Pascoe and Richman 2009; Williams and Collins 1995; Boen 2020).

Yet running in parallel to research highlighting the consequences of belonging to stigmatized ethnoracial categories, a relatively smaller but growing collection of studies demonstrate that Black people's life chances and outcomes are significantly associated not only with their ethnoracial category membership but also, crucially, gradational differences in their skin tone—a phenomenon typically referred to as *colorism* or *skin tone stratification* (Hunter 2005). This research signals that discrimination not only occurs with respect to one's membership in a broad ethnoracial category but also along a continuous spectrum of phenotypic difference within these broad and considerably heterogeneous ethnoracial categories. Indeed, from education to the labor market to the criminal justice system, evidence strongly suggests that Black people are

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significantly stratified by their skin tone (Monk 2014, 2019). Some studies even find that within-race inequality associated with skin tone among Blacks rivals or exceeds what obtains between Blacks and whites as a whole (Keith and Herring 1991; Monk 2015).

Still, studies explicitly linking colorism to health are relatively rare in comparison to the large and growing number of studies on race, perceived discrimination, and health. This study uses nationally representative data with direct measures of perceived skin color discrimination to assess the extent to which colorism (from whites and from Blacks) is associated with a comprehensive set of measures of physical health even after adjusting for everyday and major lifetime discrimination. In so doing, this study extends prior research (see Monk 2015) by considering the relative consequences of ingroup and outgroup colorism, respectively, for physical health above and beyond the most widely used measures of perceived discrimination (e.g., everyday and major lifetime discrimination).

These commonly used measures (e.g., everyday and major lifetime discrimination) were largely inspired by consistent findings that ethnoracial health disparities often persist even after adjusting for differences in socioeconomic status (SES) and health behaviors. This suggested a need to more comprehensively and accurately measure social positions and the social experiences linked to these positions that are likely to shape health outcomes (Harnois, Bastos, and Shariff-Marco 2020; Williams et al. 1997). Accordingly, research on race-ethnicity, perceived discrimination, and health has grown substantially in the past two decades (Paradies 2006; Pascoe and Richman 2009). The most widely used measure of perceived discrimination in the literature is the Everyday Discrimination Scale, which was directly inspired by Essed's (1991) theory of everyday racism, derived from the experiences of Black women in the United States and the Netherlands, which contended that structural racism is produced and reproduced in routine, chronic interpersonal interactions, many of which appear "trivial" or even "normal" (Williams et al. 1997).

Although the Everyday Discrimination Scale is framed generically and potentially could be used across ethnoracial categories, the items on the scale are primarily based on qualitative data from interviews with Black women in the United States and the Netherlands and are thought to capture the social stress of living one's life as a member of a stigmatized ethnoracial category. Similarly, the items of the Major Lifetime Discrimination Scale

are framed generically yet are conceptualized to capture acute events of unfair treatment that are likely to be disproportionately experienced by ethnoracial minorities, especially Blacks (Williams and Mohammed 2009). Thus, taken together, these commonly used measures are thought to capture the effects of racism on health by capturing important dimensions of social stress linked to one's position in society as an ethnoracial minority.

Although certainly important, the central contention of the present study is that these measures may not capture the effects of colorism on health. Specifically, commonly used measures of perceived discrimination may not tap into *ingroup* colorism—everyday and major lifetime discrimination are typically conceptualized as measures of *outgroup* discrimination and are thought to tap into perceptions of discrimination on the basis of one's ethnoracial category, not gradational differences in skin tone among members *within* an ethnoracial category. Finding that perceived skin color discrimination is not only theoretically but also *empirically* distinct from the most commonly used measures of perceived discrimination and that the magnitude of perceived skin color discrimination's association with health may be similar to or even larger than the most commonly used measures of perceived discrimination would be quite positive evidence for further investigation into the health consequences of colorism as a unique and important dimension of social experience that other measures of perceived discrimination do not totally capture. Certainly, this would help make the case, at the very least, for adapting these measures in surveys for future research. Alas, this is an open question, which the present study seeks to answer.

## BACKGROUND

### *Colorism as a Social Determinant of Health*

The terms race and color are often used interchangeably. Nevertheless, "though race and color are indeed related concepts, they are not synonymous. While racism may affect an individual regardless of the person's color, two individuals belonging to the same ethnoracial category may face differential treatment due to their varying skin tones" (Jones 2009:223). Furthermore, whereas ethnoracial stratification is rooted, in part, by biases and discrimination against Blacks as a group (i.e., their mere membership in a broad, aggregate ethnoracial category) by members of various outgroups, by

contrast, colorism as a system of inequality entails the differential treatment of Blacks based on gradational differences in the lightness or darkness of their skin by members of various outgroups *and* the members of the ingroup.

The matter of colorism makes it to the very first page of E. Franklin Frazier's 1931 *Social Forces* article, "Certain Aspects of Conflict in the Negro Family." Drake and Cayton's ([1945] 1993:497) *Black Metropolis* refers to colorism several times, and they detail, for instance, the existence of "negro social clubs" with "unspoken" rules regarding how light skinned someone must be to join them. The historical record shows that even churches were not free of colorism; many Black churches operated within a "color caste system," both during and after slavery, with certain denominations known for only allowing Blacks of the fairest complexions to worship there (Frazier 1963:31). For example, some churches used brown paper bag tests where those with skin darker than the brown paper bag were refused entry. Some churches even painted their doors a light shade of brown, and anyone darker than the door was told to worship elsewhere. Even at the height of the "Black Is Beautiful" movement, evidence demonstrates the persistence of colorism among Blacks (Anderson and Cromwell 1977).

Evidence shows that skin tone's importance originated during slavery (see Reece 2018), where, as Keith and Herring (1991:2) point out, lighter-skinned Blacks were privileged by whites and thought to be more aesthetically appealing and intellectually superior to darker-skinned Blacks—thinking that typically rested on a foundation of "race science" that held that lighter-skinned Blacks (i.e., those who had kinship ties with whites, hence the lightness of these individuals' skin tones) were less African and more European and thus superior to other Blacks (Reuter 1918). The adoption of such thinking by whites afforded lighter-skinned Blacks advantages in obtaining education, property, and even their freedom (i.e., manumission). Blacks of lighter complexions were more likely to be skilled workers and professionals and even own their own farms (Bodenhorn 2015; Gatewood 2000). Thus, whereas initially kinship ties to whites played a major role in these dynamics, over time, this colored status hierarchy was not only unmoored from direct kinship ties to whites but also became entrenched among Blacks themselves. Contemporary research shows that these cognitive biases persist to the present day (Maddox 2004), which helps explain, at least in part, the persistence of skin tone stratification from slavery to the present.

Whereas much of the discussion of colorism is dominated by the disadvantages suffered by darker-skinned individuals, the reality is much more complicated, as Drake and Cayton ([1945] 1993) pointed out many decades ago. Strong evidence suggests that lighter-skinned Blacks are often targets for colorism from other Blacks, too (Hunter 2005; Monk 2015; Uzogara et al. 2014). The policing of ethnoraacial boundaries often means that lighter-skinned and/or "mixed-race" Blacks face the stigma of having their racial bona fides and self-identifications questioned, which can be quite stressful (see Khanna 2010). Whereas, on the other hand, Blacks of medium skin tone, who are ostensibly unambiguously "Black" perceive significantly less intraracial skin tone discrimination (Uzogara et al. 2014). Thus, although many highlight the advantages and disadvantages of being light-skinned versus being dark-skinned, there is evidence that when it comes to skin tone attitudes among Blacks, there may be a strong preference for "medium" skin tone, which is neither "too light" (e.g., ambiguously Black) or "too dark" (e.g., overly prototypical; see Monk 2015). Dalmage (2000:114) carefully documents these complications:

Light-skinned multiracial people often desire darker skin so that they will not be mistaken for White. *Although such a mistake can provide a social and economic boost in a racist society, it can also lead to loneliness* [emphasis added]. Several multiracial women prayed that their unborn children would have dark skin so that they wouldn't always have to proclaim their Blackness. Kimberly, who has light skin and racially ambiguous features, shared her dreams for the future: "I have to say I hope I end up marrying a Black man, so my daughter has darker skin than me and she knows she's Black, so she has the appearance and a background."

The complicated morass of anxiety over fair skin and ethnoraacial ambiguity alongside strivings for racial pride and intraracial respect has persisted among Blacks for quite some time. Du Bois ([1940] 2007:51) writes,

"[W]hen I came to Harvard the theory of race separation was quite in my blood.... There was not the slightest idea of the permanent subordination or inequality of my world. Nor again was there any idea of racial amalgamation. I resented the assumption that we desired it. I frankly refused the possibility while in Germany

and even in America gave up courtship with one "colored" girl because she looked quite White, and I should resent the inference on the street that I had married outside my race [emphasis added].

As Du Bois and Fanon ([1952] 2008) both pointed out, albeit in different ways (e.g., the theory of double consciousness and exegetical treatises on the psychodynamics of colonialism, color, and desire), the sine qua non of racial domination is its negative work on the psyches of the dominated, that is, how the dominated come to view themselves and other members of their stigmatized group in the crucible of their domination and how the dominated themselves are coerced and recruited to reproduce their own domination even as they attempt to resist being dominated. This is what Bourdieu ([1998] 2001:34–35) referred to as *symbolic violence*: an "adherence that the dominated cannot fail to grant to the dominant" when "the schemes [they] apply in order to perceive and appreciate [themselves], or to perceive and appreciate the dominant (high/low, male/female, White/Black, etc.) are the product of the embodiment of the—thereby naturalized—classifications of which her social being is the product." A key strength of extending the study of perceived discrimination and health to the domain of colorism is that it forces one to confront these dynamics—the *insides of racial domination*.

Consequently, it is important to emphasize that colorism, as a form of perceived discrimination, is especially unique. As has been the case for centuries, the preponderance of the evidence suggests that both Blacks and nonblacks treat Blacks differently based on gradations of skin color along a continuum from the fairest to the darkest skinned. To the extent that nonblacks, especially whites, are more likely to serve as gatekeepers across a number of important domains (e.g., education, criminal justice, policing, banking, health, etc.), then given whites' preference for lighter-skinned Blacks, lighter skin will remain deeply associated with advantages among Blacks. Still, as colorism is experienced along multiple dimensions (e.g., ingroup and outgroup) and perceiving oneself to be the target of discrimination by other members of the same stigmatized social category, within the context of ingroup loyalty and solidarity that typically binds lower status groups together (Brewer 2007), ingroup colorism is quite likely to be a particularly damaging form of social stress (Bernstein et al. 2010; O'Brien, Major, and Simon 2012).

Indeed, given all that is known about ethnoracial segregation, ethnoracially inflected marital patterns, and ethnoracially clustered social networks, this is a form of discrimination that may be perceived as coming from family members, lovers, or close friends (Burton et al. 2010; Drake and Cayton [1945] 1993; Frazier 1931; Wilder 2015). Thus, perceived ingroup skin color discrimination may be especially bad for health even though it has received relatively little scholarly attention in quantitative research on discrimination and health (for an exception, see Monk 2015). Perceived discrimination is multidimensional (see Grollman 2012, 2014; Harnois et al. 2020; Vargas et al. 2019), and failing to assess stress comprehensively, by neglecting to measure key aspects of social experience that may produce social stress, leads to an underestimation of the effects of stress on health (Williams and Mohammed 2009:29).

As Goosby, Straley, and Cheadle (2017:700) ably explain, perceived discrimination (a key example of social stress) leads to wear and tear on bodily systems through frequently activating human response systems to stress that are harmful when continually activated (i.e., "fight or flight"). Precisely, in response to perceived threats and stressors, the brain activates the sympathetic nervous system and the hypothalamic-pituitary-adrenal axis, which triggers the release of glucose and fats as well as the stress hormone cortisol (leading to further increases in glucose and the inhibition of insulin production; Wassink et al. 2017:7). As some scholars put it, "racism is a fundamental cause of inequalities in health" (Phelan and Link 2015) that "gets under the skin" via physiological processes such as inflammation and weathering (Cobb et al. 2016; Das 2013; Green and Darity 2010; Lewis, Cogburn, and Williams 2015).

Perceived colorism (ingroup and/or outgroup), it stands to reason, is just as likely as racism to be a fundamental cause of inequality in health, but this possibility has received relatively less attention from researchers. The present study, then, not only builds on existing research on the consequences of colorism for health but also is positioned to make novel contributions to the understanding of perceived discrimination and health more broadly. As researchers have noted, most existing studies on perceived discrimination and health focus on mental health (Paradies 2006; Williams and Mohammed 2009). This means that there is still much to be learned about how perceived discrimination shapes physical health. Some studies report little to no relationship between perceived discrimination and

physical health (Chae et al. 2010), but, again, these studies are limited relative to the number of studies on perceived discrimination and mental health.

Moreover, like many studies on health disparities, these studies tend to use a very limited number of measures of health. While perhaps practical, the usage of just one or two measures of health in studies runs the risk of misclassifying respondents who do not suffer from those particular ailments as “well” even though they may indeed suffer from the vast range of other conditions that the study neglected to examine (Aneshensel 2005). Indeed, the issue of misclassification may even lead to the overinterpretation of results. Finding that perceived discrimination is not significantly associated with hypertension, for instance, only means that perceived discrimination was not significantly associated with hypertension, not that perceived discrimination is not significantly associated with physical health in general. Coming to that conclusion would necessitate, at the very least, the usage of a comprehensive set of measures of physical health, not just one or two (Aneshensel 2005).

Similarly, many studies rely on a single measure of perceived discrimination (e.g., everyday discrimination) to test the consequences of perceived discrimination on health even though “measures like the Everyday Discrimination Scale capture an important, [to be sure], but limited aspect of the phenomenon of self-reported discrimination” (Williams and Mohammed 2009:29). The tendency to use a restricted number of measures of perceived discrimination means, then, that the consequences of perceived discrimination on health may be underestimated. After all, some dimensions of perceived discrimination that are often overlooked by researchers may matter for health—hence, this study’s focus on perceived skin color discrimination. Taken together, then, the use of a limited number of measures of health and perceived discrimination means that researchers are not well positioned to consider the relative consequences of perceived discrimination on health. Not only may particular measures of perceived discrimination vary in their consequences for health, this variance may itself be contingent on the measure of health being examined (see Aneshensel 2005).

This study’s use of multiple dimensions of perceived discrimination and a comprehensive set of measures of physical health positions it to contribute to our understanding of the relative consequences of different dimensions of perceived discrimination for physical health. Specifically, I build on existing research by examining whether

and to what extent perceived skin tone discrimination (colorism), from ingroup and outgroup members, shapes physical health outcomes among Blacks. I use a comprehensive set of measures of physical health, which represent, according to the Centers for Disease Control and Prevention, some of the most common conditions and ailments suffered by adults, especially as they age: cardiovascular and cardio-metabolic health (e.g., hypertension, diabetes, and heart trouble), sensory dysfunction (i.e., loss of vision and hearing, which is often conceived of as measure of biological aging), pain conditions, and suffering from illnesses (morbidity) net of everyday and major lifetime discrimination. By using multiple measures of perceived discrimination in the same model, I directly consider the relative costs of colorism for health across a comprehensive set of measures of physical health.

This is an important contribution because most of the existing research on colorism and health, although important and innovative, tends to focus on estimating *direct* relationships between skin tone and a fairly restricted range of health outcomes such as blood pressure, hypertension, and self-rated health. Cobb et al. (2016) find that disparities in allostatic load were largest between the darkest-skinned Blacks and whites compared to what obtains between the lightest-skinned Blacks and whites. Hargrove (2018b) also considers intragroup heterogeneity in health along the skin color gradient but includes a focus on the intersection of skin tone and gender. She reports significant associations between machine-rated skin tone and cumulative biological risk as well as between machine-rated skin tone and self-rated health among Black women. In each case, darker-skinned Black women suffered from worse health than their lighter-skinned counterparts. Similarly, Hargrove (2018a) finds significant associations between machine-rated skin tone and BMI trajectories among Black women such that darker-skinned Black women experienced higher BMIs across the life course.

These studies add to prior research, which has also identified significant direct associations between skin tone (machine or interviewer-rated), systolic blood pressure, hypertension, and cardio-metabolic health (Krieger, Sidney, and Coakley 1998; Wassink et al. 2017). In fact, a recent study found links between skin tone and prenatal care (Slaughter-Acey et al. 2019). Another recent study found significant associations between skin tone and hypertension between siblings using a family fixed-effects approach that even considered genetic pleiotropy—strong evidence of a

robust relationship between being darker skinned and increased risk of hypertension among Blacks (Laidley et al. 2019). Taken together these studies compellingly suggest that skin tone is an important factor in health inequalities among Blacks.

Nevertheless, questions remain over potential mechanisms to explain direct associations between skin tone and physical health among Blacks. Most studies explicitly suggest links between skin tone, perceived discrimination, and physical health outcomes. This pathway does have some evidence in its favor, with some studies connecting skin tone to increased incidence of perceiving discrimination (Keith et al. 2017; Monk 2015; Uzogara and Jackson 2016). Yet the focus on direct associations between skin tone and various aspects of physical health means the link between perceived skin color discrimination and health is mostly inferred (an exception is Monk 2015). Extending previous studies, I consider whether perceived skin tone discrimination (colorism) is independently and significantly associated with physical health outcomes after taking the most common measures of perceived discrimination into account (e.g., everyday and major lifetime discrimination) and whether perceived ingroup colorism and perceived outgroup colorism have differential physical health consequences among Blacks. The latter possibility is especially compelling given that there is good reason to believe that ingroup discrimination may be particularly pernicious for health. As some studies have shown, being rejected by ingroup members is associated with cardiovascular reactivity associated with threat states and poor performance (Basáñez et al. 2014; Córdova and Cervantes 2010). In sum, this study's (a) use of multiple measures of perceived discrimination to investigate their relative consequences for health, (b) use of a comprehensive set of measures of physical health, and (c) focus on colorism position it to make a number of compelling contributions to existing research on the health of ethnoracial minorities.

## DATA AND METHODS

This study used the National Survey of American Life (NSAL; 2001–2003). The field work for this study was completed by the University of Michigan's Institute for Social Research's Survey Research Center in cooperation with the Program for Research on Black Americans between 2001 and 2003. The NSAL sample has a national multi-stage probability design which consists of 64 primary sampling units.<sup>2</sup> Fifty-six of these primary areas overlapped substantially with existing

Survey Research Center National Sample primary areas. The remaining eight primary areas were chosen from the South in order for the sample to represent Blacks in the proportion in which they are distributed nationally. The interviews were administered face-to-face and conducted within respondents' homes; respondents were compensated for their time (Jackson et al. 2004). I used these data because even though they are becoming aged, this survey is the only one of its kind with respect to the measures of health, perceived skin tone discrimination, and its large, nationally representative sample of Blacks.

A total of 6,082 face-to-face interviews were conducted with persons aged 18 or older, including 3,570 Blacks, 891 non-Hispanic whites, and 1,621 Blacks of Caribbean descent. The overall response rate of 72.3% is excellent given that Blacks (especially lower-income Blacks) are more likely to reside in major urban areas, which are more difficult and expensive with respect to survey fieldwork and data collection. The Black sample is nationally representative of Black households in the 48 coterminous states with one adult aged 18 and over. The analyses were restricted to native-born U.S. Blacks<sup>3</sup> with no missing data on the measures of interest (i.e., listwise deletion), yielding an analytic sample of 3,415 (a very low rate of attrition of roughly 4%).

### Perceived Discrimination

The study used multiple measures of perceived discrimination to examine the relative consequences of each dimension of perceived discrimination. The first measure of discrimination was a measure of chronic, daily perceived discrimination, which is often referred to as *everyday discrimination* (see Williams and Sternthal 2010). It was a Likert-scale variable ranging from 1 to 5, where 1 = never and 5 = very often, which referred to a construct composed of 10 different types of unfair treatment, such as the frequency that one feels like they are treated with less courtesy or respect than others, the frequency the respondent feels like people act like they are not smart, the frequency that people act afraid of them or call them names and insult them, or how often they feel threatened, harassed, or followed in stores. Everyday discrimination scores for respondents corresponded to the average level of the severity of perceived discriminatory treatment across the items in the scale. Major lifetime discrimination, by contrast, referred to the sum of relatively rare but deeply consequential discrete events such as whether the respondent was ever "unfairly fired,"

“unfairly denied a loan,” “unfairly treated or abused,” and more (where 1 = yes and 0 = no).

The centerpiece of this study, however, were two separate measures of perceived discrimination due to skin color (colorism) where respondents were asked how often “they perceived discrimination due to their skin color” from whites (outgroup) and from Blacks (ingroup), respectively. The measures were frequency scales that ranged from 1 to 5, where 1 = never and 5 = almost everyday. Importantly, these measures of perceived discrimination were only modestly collinear—perceived ingroup skin color discrimination, for instance, only had a correlation of .27 with everyday discrimination and .17 with major lifetime discrimination. The regression analyses that follow, however, provide more exacting evidence of the potential empirical distinctiveness of these measures of perceived discrimination with respect to physical health.

### Physical Health

This study, following most survey research on health, used indicators of physical health where respondents were asked whether a medical professional had informed them that they suffered from particular illnesses or conditions (see Turner et al. 2017). I used a broad and comprehensive set of measures of physical health to examine whether perceived discrimination skin color has nonspecific and negative effects on physical health and whether the relationship between perceived skin color discrimination and health varies contingent on the measure employed. Moreover, following Aneshensel (2005), using a broad and comprehensive set of measures of physical health enabled me to avoid misclassifying respondents who may suffer from some but not all of the measures of health I used.

The measures I used in this study covered a range of the most common illnesses and disorders suffered by adults in the United States, especially as they grow older, according to CDC statistics (e.g., National Health Interview Survey and National Hospital Discharge Survey). First, there was the measure of *cardiovascular and cardio-metabolic health*. This was the sum of how many of the following maladies the respondent suffers from: high blood pressure (hypertension), heart trouble, diabetes, stroke, and blood circulation problems. Next, there was a measure of how many *pain-related conditions* the respondent suffered from. This included ulcers, arthritis, bad headaches, and back pain. Additionally, there was a measure of *sensory dysfunction*, which measured the degree of the respondent’s sensory

impairment (e.g., having hearing and/or seeing problems in the past 12 months)—often considered a sign of biological aging (see Crimmins et al. 2008). Finally, I used a measure of *morbidity* composed of the sum of the total number of conditions and illnesses the respondent suffered from. It included the following conditions: cancer, liver problems, kidney problems, and glaucoma.

### Analytic Plan

I used negative binomial regression (for zero-inflated outcomes and overdispersion) to examine the measures of overall morbidity and cardiovascular and cardiometabolic health, and I used ordered logistic regression models to examine the relationship between perceived skin tone discrimination (colorism), the seriousness of suffering from pain conditions, and the degree of sensory dysfunction. Multiple dimensions of perceived discrimination were included in the same models to examine the relative consequences and empirical distinctiveness of each dimension of perceived discrimination, respectively. Note that while the tables present coefficients, I discuss the results using odds ratios (OR) and incidence rate ratios.

### Controls

Following standard practice in research on health disparities, this study used a variety of sociodemographic control variables such as age, sex, and more that are common potential confounders with respect to physical health disparities. *Age* was a continuous variable. *Female* was coded as a dummy variable where 0 = male and 1 = female. *Poverty index* was an ordinal variable ranging from 0 to 17 which represented the degree to which respondents were above, below, or at the poverty line (*Poverty index = Household Income / Poverty Threshold*). This has been used in previous analyses of the NSAL (see Monk 2015). Note, however, that the results were robust to the use of household income instead of poverty index (available by request). *Educational attainment* was an ordinal variable capturing the number of years of completed education, ranging from 0 to Xmax. *South (region)* was a dummy variable where 0 = non-South and 1 = South. *Rural* was a dummy variable where 0 = nonrural and 1 = rural. *Marital status* was a binary variable where 0 = not married and 1 = married/cohabitating. *Employment status* was a categorical variable, which measured whether the respondent was employed, unemployed, or out of

**Table 1.** Descriptive Statistics (Weighted Means) with Data from National Survey of American Life (2001–2003).

Variable	Mean (SD)	Minimum–Maximum	N
Age	43.05 (16.23)	18–93	3,415
Female	.65 (.48)	0–1	3,415
Years of education	12.29 (2.49)	4–17	3,415
Employed	.65 (.48)	0–1	3,415
Poverty index	2.46 (2.28)	0–17	3,415
Marital status	.34 (.47)	0–1	3,415
Region (South)	.66 (.48)	0–1	3,415
Rural	.21 (.41)	0–1	3,415
Major lifetime discrimination	1.12 (1.27)	1–5	3,415
Everyday discrimination	2.63 (.96)	1–5	3,415
Skin color discrimination (whites)	2.65 (1.23)	1–5	3,415
Skin color discrimination (Blacks)	2.21 (1.17)	1–5	3,415
Cardiovascular and cardio-metabolic disorders	.49 (.77)	0–4	3,415
Pain-related conditions	.70 (.88)	0–3	3,415
Sensory dysfunction	.16 (.41)	0–2	3,415
Morbidity	.16 (.44)	0–3	3,415

the labor force where 0 = unemployed or out of the labor force and 1 = employed.

## RESULTS

### *Descriptive Statistics*

Descriptive statistics for all variables are included in Table 1. Insofar as perceived discrimination is concerned, the rarest form experienced by respondents is major lifetime discrimination, whereas everyday and skin tone discrimination from whites appear to occur at similar frequencies in the sample and skin tone discrimination from other Blacks is slightly less frequent than skin tone discrimination from whites.

### *Cardiovascular and Cardio-Metabolic Disorders*

Table 2 presents the results of a negative binomial regression model examining the relationship between multiple dimensions of perceived discrimination and the incidence of cardiovascular and cardio-metabolic disorders among Blacks. I find that even after considering important sociodemographic factors, some dimensions of perceived discrimination are significantly associated with worse cardiovascular and cardiometabolic health, contrary to findings in prior research (see e.g., Chae et al. 2010). While everyday discrimination and perceived skin tone discrimination from whites are not significantly associated with suffering from cardiovascular and cardio-metabolic

**Table 2.** Results of Negative Binomial Regression, Cardiovascular and Cardio-Metabolic Disorders with Data from National Survey of American Life (2001–2003).

	(1)
Age	.034** (.002)
Sex	.146* (.066)
Educational attainment	-.016 (.015)
Employed	-.212** (.073)
Poverty index	-.035* (.016)
Married	.124+ (.063)
South	-.027 (.067)
Rural	.085 (.080)
Major lifetime discrimination	.073*** (.018)
Everyday discrimination	.014 (.031)
Skin tone discrimination (whites)	.008 (.032)
Skin tone discrimination (Blacks)	.069** (.024)
Constant	-2.392*** (.262)
Observations	3,415

Note: Standard errors in parentheses. All analyses are weighted to account for the survey's complex design (e.g., clustering and stratification).

+ $p < .10$ , \* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$  (two-tailed tests).

disorders, both major lifetime discrimination and perceived skin tone discrimination from Blacks are significantly associated with a higher incidence and severity of cardiovascular and cardio-metabolic disorder.

Notably, the magnitude of the relationship between these two dimensions of perceived discrimination, respectively, and this health outcome are virtually the same (incidence risk ratio = 1.07,  $p < .01$ ). Colorism (perceived), a heretofore seldom examined social determinant of health, is actually on par with major lifetime discrimination insofar as its negative consequences for cardiovascular and cardio-metabolic health among Blacks.

## Pain

Next, I turn to pain-related disorders (Table 3). These results resemble what was found with respect to cardiovascular and cardio-metabolic health. The magnitude of the association between major lifetime discrimination, ingroup colorism, and pain disorders is extremely similar as reflected in their odds ratios (OR = 1.16 and OR = 1.13). Similar to the findings with respect to cardiovascular and cardio-metabolic disorders, perceived skin tone discrimination from whites (outgroup colorism) is not a statistically significant predictor of this measure of physical health. By contrast, everyday discrimination is a significant predictor of pain (OR = 1.12). Taken together, these findings suggest that ingroup colorism appears to be more consequential for physical health than outgroup colorism, and ingroup colorism is just as important for this physical health outcome as major lifetime and everyday discrimination. Moreover, that each of these dimensions is statistically significant when included in the same model speaks to their analytic and empirical distinctiveness.

## Sensory Dysfunction

Table 4 reports the results of analyses of the relationship between multiple dimensions of perceived discrimination and sensory dysfunction. Age, major lifetime discrimination, everyday discrimination, and ingroup colorism are all significant predictors of increased impairment from sensory dysfunction—a proxy for biological aging. Furthermore, the magnitude of the association between perceived discrimination and sensory dysfunction is the highest for everyday discrimination and ingroup colorism (OR = 1.24 and OR = 1.23, respectively).

Skin tone discrimination from whites (i.e., outgroup colorism), however, is only statistically significant at  $p < .10$ , and its association is actually negative. In other words, while it is outside of the range of classical statistical significance, skin tone discrimination from whites is associated with *lower* sensory dysfunction among Blacks. In line with the hypothesis that the different dimensions of perceived discrimination are both analytically and empirically distinct, it is worth noting that nearly all of the dimensions of perceived discrimination are statistically significant.

## Morbidity

Finally, I examine the relationship between the multiple dimensions of perceived discrimination and

**Table 3.** Results of Ordered Logistic Regression, Pain Disorders with Data from National Survey of American Life (2001–2003).

	(I)
Age	.015*** (.00210)
Sex	.857*** (.075)
Educational attainment	-.093*** (.020)
Employed	-.583*** (.097)
Poverty index	-.041* (.017)
Married	.166+ (.086)
South	-.0570 (.110)
Rural	-.0781 (0.132)
Major lifetime discrimination	.146*** (.027)
Everyday discrimination	.113* (.045)
Skin tone discrimination (whites)	-.012 (.046)
Skin tone discrimination (Blacks)	.125*** (.044)
Constant	.467 (.293)
Observations	3,415

Note: Standard errors in parentheses. All analyses are weighted to account for the survey's complex design (e.g., clustering and stratification).

+ $p < .10$ , \* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$  (two-tailed tests).

the degree of overall morbidity using negative binomial regression. Table 5 reports that only major lifetime discrimination and perceived skin tone discrimination from Blacks are significantly associated overall morbidity among Blacks. Once again, the magnitude of the association with overall morbidity for major lifetime discrimination and skin tone discrimination from Blacks is quite similar (OR = 1.14 and OR = 1.10, respectively). By contrast, everyday discrimination and outgroup colorism are not statistically significant predictors of morbidity among Blacks. Overall, the preponderance of the evidence suggests that perceived ingroup skin tone discrimination is an independent and consequential risk factor for physical health among Blacks.

**Table 4.** Results of Ordered Logistic Regression, Sensory Dysfunction with Data from National Survey of American Life (2001–2003).

	(I)
Age	.020*** (.005)
Sex	.396** (.129)
Educational attainment	-.100*** (.022)
Employed	-.833*** (.106)
Poverty index	-.058 (.041)
Married	.026 (.140)
South	.053 (.107)
Rural	-.059 (.164)
Major lifetime discrimination	.136** (.044)
Everyday discrimination	.211*** (.054)
Skin tone discrimination (whites)	-.118+ (.062)
Skin tone discrimination (Blacks)	.207*** (.057)
Constant	2.114*** (.436)
Observations	3,415

Note: Standard errors in parentheses. All analyses are weighted in order to account for the survey's complex design (e.g., clustering and stratification).

+ $p < .10$ , \*\* $p < .01$ , \*\*\* $p < .001$  (two-tailed tests).

### Ancillary Analyses

To delve deeper into the relationship between perceived discrimination and physical health, I ran a series of additional analyses where each dimension of perceived discrimination was entered independently in models predicting each measure of physical health; and then, to supplement the models I present in this article, I ran a series of step-wise models that added each measure of perceived discrimination, one at a time, along with the others to examine their relative statistical independence and contributions to physical health (results available by request).

The most relevant findings of those analyses are that (1) perceived ingroup colorism is, independently, significantly associated with poorer physical health across all of the measures of physical health I employ; (2) with

**Table 5.** Results of Negative Binomial Regression, Morbidity with Data from National Survey of American Life (2001–2003).

	(1)
Age	.035*** (.003)
Sex	.0836 (.123)
Educational attainment	.001 (.018)
Employed	-.553*** (.113)
Poverty index	-.059* (.029)
Married	.147 (.141)
South	.042 (.115)
Rural	.249 (.160)
Major lifetime discrimination	.128*** (.034)
Everyday discrimination	-.001 (.062)
Skin tone discrimination (whites)	-.070 (.048)
Skin tone discrimination (Blacks)	.092* (.042)
Constant	-1.277* (.524)
Observations	3,415

Note: Standard errors in parentheses. All analyses are weighted to account for the survey's complex design (e.g., clustering and stratification).

\* $p < .05$ , \*\*\* $p < .001$  (two-tailed tests).

respect to predicting physical health, perceived outgroup colorism is not empirically distinct from everyday or major lifetime discrimination; (3) the health consequences of perceived outgroup colorism appear to operate through everyday and major lifetime discrimination and (4) only in the cases of cardiovascular and cardio-metabolic disorders and pain. This may be because perceptions of outgroup discrimination on the basis of one's race category and one's skin color may overlap substantially from the vantage point of respondents, given the common practice of using the terms *race* and *color* interchangeably. After all, many Americans use the terms *race* and *color* interchangeably, and everyday discrimination and major lifetime discrimination are typically held to tap into perceptions of outgroup ethnoracial discrimination (e.g., Essed 1991).

## DISCUSSION

A steadily growing body of research documents how perceived discrimination negatively affects health among Blacks (Harnois et al. 2019; McFarland et al. 2018; Paradies 2006; Pascoe and Richman 2009; Williams et al. 1997). This research importantly sheds light on the significance of race-ethnicity for health beyond that of race-ethnicity's link with SES. Still, the vast majority of studies in this area focus on differences in health (usually mental health) between ethnoracial populations and measures of perceived discrimination that are conceptualized as general measures of interracial discrimination. A consequence of these dual tendencies is far less is known about the sources of intraracial inequality in health, which studies show is often similar or even larger in magnitude than interracial disparities in health, and our understanding of how perceived discrimination shapes health outcomes is somewhat narrowly rooted in unidimensional approaches that rely on a single measure of perceived discrimination (i.e., everyday discrimination; see Harnois et al. 2020).

Focusing its sights squarely on these gaps, this study uses nationally representative data to analyze the physical health consequences of a key source of intraracial heterogeneity in socioeconomic status among Blacks—skin tone. It does so by extending research on perceived discrimination and health to the domain of colorism (e.g., perceived skin tone discrimination from Blacks and whites, respectively). Put simply, the findings strongly suggest that colorism is an important risk factor for poorer physical health among Blacks. Specifically, perceived ingroup colorism is significantly associated with poorer physical health even after taking other more well-known and studied dimensions of perceived discrimination into account (e.g., everyday discrimination and major lifetime discrimination). In fact, the magnitude of ingroup colorism's association with this wide range of indicators of physical health is often similar or even slightly greater than that of major lifetime and the most commonly used measure of perceived discrimination—everyday discrimination.

The historical arc of research on colorism tends to show that the effects of colorism tend to be heavily gendered (Hill 2002; Hunter 2005). In fact, the very term *colorism* is commonly thought to have been coined by Alice Walker, whose work has long been noted as highlighting the unique experiences of Black women (see Collins 1996). Surprisingly, even though outside of the study of colorism and health there is evidence that Black women may suffer from worse physical health than Black men (Brown and

Hargrove 2013; Erving 2011), I do not find evidence that colorism contributes to these disparities. I find no significant gender differences in the consequences of perceived colorism (ingroup and outgroup) for physical health (results available by request), descriptive statistics reveal that men are significantly *more likely* to perceive outgroup colorism than women, and I find no significant gender difference in mean perceived ingroup colorism. With respect to perceived outgroup colorism, this may be a function of the salience of skin tone in policing and punishment among Black men (see Monk 2019). Still, a deeper look at the intersections between perceived colorism, gender, and health is an important topic worthy of future research attention.

This study's findings highlight the importance of not only expanding the understanding of how race-ethnicity shapes health outcomes beyond binary, census-style categories but also seriously considering other dimensions of perceived discrimination, especially what obtains *within* ethnoracial groups. Certainly, perceiving oneself to be a target of unfair treatment by members of a dominant outgroup may be distressing (as the findings pertaining to everyday and major lifetime discrimination suggest), but this study reveals how one important aspect of being an ethnoracial minority is that one contends with discrimination at the hands of not only the dominant group in society but also other members of the ingroup. This further emphasizes the importance of colorism as a risk factor for physical health for all Blacks despite the relative lack of attention it receives both inside and outside of the Academy.

After all, a central contention of this study is that there is good reason to believe that ingroup colorism is likely to be as significant or perhaps even more significant for health than everyday or major lifetime discrimination precisely because of its source—other group members (e.g., teachers, friends, family, etc.). Intra-racial skin color discrimination, as qualitative research has documented for decades, takes place in the most intimate of relationships and contexts—parents, brothers, sisters, spouses, and friends (Frazier 1931; Hunter 2005; Wilder 2015). In other words, it is a form of discrimination that may catch its victims with their “guard down” and lacks the usual social support for coping (e.g., other Blacks; O'Brien et al. 2012). Future research that considers the potential role of colorism in shaping health across the life course is certainly warranted.

Attention to ingroup colorism should not, of course, be taken as a means of avoiding and downplaying the importance of racial domination. If

anything, ingroup colorism should be understood as one of the means through which ethnoracial domination is maintained. As Ridgeway (2014:6) ably explains, higher-status and lower-status individuals both experience the effects of well-established status hierarchies, and status beliefs may cause tensions within lower-status groups who are often torn between “sticking with their own” or favoring higher-status individuals. All of which is to say that the existence of intraracial skin color discrimination need not be a matter of “self-hatred” (contra Kardiner and Ovesey 1951). In fact, direct evidence of “self-hatred” among Blacks is very limited because Blacks typically report high levels of ingroup affect and closeness and rarely ever endorse negative stereotypes about their own group (i.e., internalized racism; Hughes et al. 2015).

Rather, the notion of symbolic violence points us to consider the consequences of the brute fact that the stigmatized exist in the same world as the dominant and often share the same schemes of perception and appreciation (Bourdieu [1998] 2001) as the dominant even if their relationship to these cognitive schemata is fraught with tension and ambivalence. Put simply, a crucial way that white supremacy functions is through the provision, maintenance, and enforcement of social hierarchies that recruit ethnoracial minorities to take part in their own domination.

Thus, while “internalized racism” is typically explained as a psychological quirk that is the result of domination, symbolic violence highlights the deeply structural reality of living in a society as a member of a stigmatized group where there are material and symbolic incentives, in a world that is often a zero-sum competition for material and symbolic resources, for individually distinguishing oneself from other members of their stigmatized category. Thus, conflicts and discrimination arising among stigmatized individuals over the very markers that stigmatize them are to be expected in contexts where the stigmatized are treated slightly better or worse based on how prototypically they appear (Maddox 2004). That some qualitative and quantitative evidence suggests that both the lightest-skinned and darkest-skinned Blacks perceive more intraracial skin color discrimination than those in the middle of the color continuum speaks to the complicated internal politics of stigmatized groups (Monk 2015; Uzogara et al. 2014; Uzogara and Jackson 2016).

This study, however, is not without limitations. Principally, it must be noted that this is a cross-sectional observational study. Consequently, the significant associations between perceived skin tone

discrimination and multiple measures of physical health (e.g., cardiovascular and cardio-metabolic health, sensory dysfunction, and overall morbidity) cannot be interpreted as causal. Nevertheless, future research should continue to explore the link between colorism and health by expanding surveys to include measures of perceived skin tone discrimination in addition to canonical measures of everyday and major lifetime discrimination. Moreover, the study of skin tone and health may be profitably extended by branching out into the frontiers of bio-demography. While research in this area has focused on how membership in broad ethnoracial categories may relate to biomarkers of health, research on colorism and skin tone signal that there may be considerable intraracial heterogeneity in health that common approaches that lump all African Americans together regardless of their skin tone may miss. In particular, researchers should examine whether skin color may be associated with C-reactive protein, stress hormones (basal and reactive cortisol), glycosylated hemoglobin (A1C), various genetic and/or genomic markers of aging and illness (e.g., telomere length), and “weathering” in general (a recent example of this is Cobb et al. 2016; also see Stewart, Cobb, and Keith 2020).

It is worth noting, though, that given skin tone’s linear association with perceived outgroup colorism and nonlinear association with perceived ingroup colorism, detecting direct connections between skin tone and health may be difficult to the extent that colorism significantly affects health. As previous research has shown, while those in the middle of the color continuum are somewhat protected from ingroup colorism, those who are lighter or darker skinned are significantly more likely to perceive ingroup colorism, and darker-skinned Blacks perceive significantly higher frequencies of everyday discrimination (Monk 2015; Uzogara et al. 2014; Uzogara and Jackson 2016).

The findings of this study strongly suggest that everyday, major lifetime, and ingroup skin tone discrimination are analytically and empirically distinct dimensions of discrimination that have independent consequences for health. As any given health outcome is *overdetermined* by the many different significant dimensions of discrimination an individual perceives, skin tone’s *direct* relationship to any given health outcome is complicated by the variation in which it operates as a risk factor for exposure to different, albeit all significant, forms of perceived discrimination. This further emphasizes the importance of more deeply understanding how skin tone relates to different dimensions of perceived discrimination and how these different

dimensions of perceived discrimination relate to physical (and mental) health. Researchers should be careful not to hastily dismiss the role of skin tone in shaping health outcomes among African Americans or other ethnoracial minorities based solely on analyses of skin tone’s direct relationships to mental or physical health outcomes.

The findings of this study also suggest that researchers include measures of perceived colorism in future survey data collection efforts. This data collection should not be limited to Blacks, or to the United States, for there are compelling reasons to believe that the consequences of color for health may also exist for Latinx (Vargas et al. 2019; Wassink et al. 2017) given how skin color stratifies their life chances (see Golash-Boza and Darity 2008). Indeed, some evidence suggests that darker-skinned Latinx are substantially more likely to perceive discrimination from ingroup members (Basáñez et al. 2014), similar to what obtains among Blacks. Research on skin tone stratification around the world (Ezell et al. 2019; Glenn 2009), especially across Latin America (Monk 2016; Perreira and Telles 2014), suggests that colorism should affect health there, too. Ultimately, then, the understanding of how race-ethnicity relates to health will profit by taking colorism seriously as a risk factor. Although the subject is often taboo and painful to discuss, further popular discussion and scientific attention is precisely what is needed to craft countermeasures and policy to combat the manifold consequences of colorism.

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## NOTES

1. I use the term *ethnoracial* to denote the lack of a hard distinction between the terms *race* and *ethnicity*.
2. Note that all analyses account for the complex design of the survey (for more, see Heeringa et al. 2004).
3. All respondents in this study are self-identified U.S.-born African Americans. I separate Blacks from Caribbean Americans in these analyses given differences of nationality and selection bias that may yield baseline differences in health between Caribbean and Blacks.

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