



Linked fate and mental health among African Americans

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ABSTRACT

Linked fate, the feeling that what happens to one's group may indelibly shape one's own life, is variously conceptualized as an aspect of ethnoracial identity, expression of political solidarity, and/or sense of ethnoracial consciousness. In this study, I contend that, within the context of stigmatization, linked fate may also be compellingly conceptualized as an expression of collective threat and vulnerability with potential relevance for the mental health of African Americans, in particular. Nevertheless, existing research on race and mental health has remained silent on this issue, as linked fate has received little scholarly attention from researchers interested in mental health. Building on prior research on ethnoracial identity, stigmatization, and mental health among African Americans, I introduce linked fate as a neglected, yet important phenomenon among stigmatized minorities, which is deeply associated with ethnoracial identification and should also be considered when examining the consequences of ethnoracial identification on the mental health of African Americans. Using nationally-representative data and logistic regression, I find that linked fate not only fails to be health-protective but is significantly associated with poorer mental health among African Americans in the form of increased suffering from major depression, bipolar I, and anxiety disorders.

1. Introduction

Social scientists have carefully documented that African Americans suffer from profound inequalities across a multitude of different realms: lower educational attainment, lower household incomes, higher rates of unemployment, lower occupational prestige, worse physical health, and higher rates of arrest and incarceration (see, for example, Wilson, 1987; Massey and Denton, 1994; Wacquant, 2009). Nevertheless, despite significant material and symbolic disadvantages the prevailing view in the academic literature is that African Americans' mental health is relatively robust. Riolo et al. (2005) observe, drawing on nationally-representative data, that the prevalence of major depressive disorder, the most common mental health disorder suffered by adults in the United States (see Kessler et al., 2005), is the highest among Whites and Whites have significantly earlier onset of major depressive disorder than African Americans.

According to the existing literature, one of the most compelling reasons for the surprisingly robust mental health of African Americans is the strength of their ethnoracial identity (Branscombe et al., 1999; Sellers et al., 2003; Phinney and Ong, 2007; Smith and Lynda, 2011; Williams et al., 2012a,2012b). Ethnoracial identity is indeed a potentially critical factor to consider insofar as mental health is concerned, given that most African Americans (here and throughout this study I am

referring to native born African Americans), regardless of their socioeconomic status, strongly identify with their ethnoracial category (Broman et al., 1988; Dawson, 1994). As Phinney (2000: 256) explains, ethnoracial identity "is a central defining characteristic of many individuals, particularly those who are members of minority groups" (see also Portes and Rumbaut, 2001). Based on relatively small-scale studies, some researchers posit and often claim to find that ethnoracial identification, typically operationalized as feelings of closeness to group members and/or ingroup attitudes and affect, following social identity theory (Tajfel and Turner, 1986; Haslam et al., 2009), is mental health-protective, especially when it comes to mitigating social stress linked to perceived discrimination (Mossakowski, 2003; Sellers et al., 2003; Lee, 2003; Yip et al., 2008; Williams et al., 2012a,2012b; Seaton et al., 2014; Hughes et al., 2015). It is important to note, however, that a meta-analysis by Pascoe and Richman (2009) finds that only 18% of studies found that ethnoracial identity buffered negative mental health effects and 12% of studies found that ethnoracial identity exacerbated mental health. Some 71% of studies found no relationship between ethnoracial identity and mental health at all.

Operating against the grain of nearly exclusive focus on ethnoracial identification as a buffer for mental health, a number of studies consider instead, whether ethnoracial identification and its consequences may, in fact, be a *double-edged sword* (see Yip et al., 2008 and Yip, 2018); also see

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Noh et al., 1999; Woo et al., 2019; Mossakowski et al., 2019). Indeed, one reading of the current literature is that it often stops short of considering the potential costs of ethnoracial identification. That is, what are the consequences of identifying with a stigmatized social category whose members experience, on average, profound inequalities and deprivation across such a wide array of important indicators of life chances and outcomes? After all, one not only identifies with a particular category, often, one also recognizes their group's position in society (see Blumer, 1958; Bobo, 1999; Veenstra, 2009; Brondolo et al., 2009). Thus, it stands to reason that measures of ethnoracial identification that tap into this recognition of group position and its personal relevance may not only fail to be mental health protective but may actually be bad for mental health.

This study builds on the growing number of studies eschewing widespread contentions that ethnoracial identification is universally positive for mental health by, instead, aiming to consider ethnoracial identification as a *double-edged sword* (Yip et al., 2008; also see Yip, 2018; Noh et al., 1999; Woo et al., 2019; Mossakowski et al., 2019). Specifically, I argue that commonly used measures of ethnoracial identification, which tend to focus on ingroup attitudes, affect, and feelings of closeness to other category members are unlikely to capture feelings of vulnerability that may also be associated with identifying with a stigmatized social category (see Lamont et al., 2016); and, in order to capture these feelings of vulnerability associated with ethnoracial identification, I propose introducing *linked fate* (see Dawson, 1994; Lee, 2008; McClain et al., 2009), one of the most common measures of ethnoracial identification across the social sciences, to the study of ethnoracial identification and mental health.

Using nationally-representative data (N = 3268), the present study considers the consequences of ethnoracial identification for mental health by examining how linked fate relates to suffering from the most common mental health disorders in the U.S. – anxiety (generalized anxiety, panic attacks, etc.) and mood disorders (e.g. major depression and bipolar I). Linked fate is feeling as if one's own fate is affected by what happens to other category members and/or the group as a whole (Dawson, 1994). Linked fate has been variously conceptualized as an important aspect of ethnoracial identification, an expression of political solidarity, and ethnoracial consciousness. It is often theorized to be the 'glue' that holds African Americans together – a broad recognition of the consequences of collectively shared oppression as relevant for one's own personal fate (see Shelby, 2005).

In contrast to much of the prior theorizing and conceptualization across the social sciences (especially political science), however, I contend that linked fate is *not* a measure of ethnoracial identification *per se*, but rather, it is a potential collateral consequence of ethnoracial identification with compelling consequences for mental health. After all, linked fate requires, in advance, that one identifies with a particular category, has a sense of detrimental social and political forces that, in this case, may feel beyond one's own personal capabilities to reckon with, and feel that these forces may personally impact them. As such, it exceeds identification, but is, nevertheless, associated with identification. It is, then, I contend, a recognition of collective threat or vulnerability that one sees as personally relevant and consequential, which is inextricably linked to one's ethnoracial identification. In short, I argue that linked fate may capture, at least in part, the feeling that, when seeing or hearing about acts of racial terrorism and violence, 'that could have been me' or 'that could have been my mother, my father, my daughter, my son, etc.'

In so doing, this study extends prior research by expanding our vision of ethnoracial identification beyond feelings of ingroup closeness and affect to its consequences: feelings of group solidarity, collective threat, and vulnerability; and this study considers the possibility that some elements of ethnoracial identification, given the sociopolitical context faced by some minority groups, may not only fail to be protective of mental health, but may be detrimental (see Noh et al., 1999; Yip et al., 2008; Veenstra, 2009; Yip et al., 2008; Yip, 2018; Woo et al., 2019;

Mossakowski et al., 2019). Thus, African Americans, may find themselves facing a profound dilemma – their feelings of solidarity with one another, which invariably serves as the glue that holds them together as a group and fuels collective political action towards justice and freedom, may come at the cost of their mental health.

Nevertheless, following the lead of many researchers interested in ethnoracial identification for its potentially positive buffering effects on mental health, it is also possible that this rarely considered collateral consequence of ethnoracial identification may actually be health-protective. Accordingly, this study examines the extent to which linked fate is directly beneficial, harmful, or inconsequential for mental health among African Americans by considering whether linked fate and the strength of the expression of linked fate is significantly associated, positively or negatively, with suffering from anxiety and/or mood disorders (see Mossakowski et al., 2019: 446). In what follows, I provide more background on ethnoracial identity and mental health, in addition to further developing the argument that linked fate should be considered as an important aspect of ethnoracial identification, broadly construed, with relevance for mental health.

1.1. Ethnoracial identification and mental health: Patterns and lacunae

Racial identity has long been linked to the psychological health and well-being of African Americans (see Horowitz, 1939). As explained above, for the past few decades researchers have debated the relationship between ethnoracial identification and mental health; and despite strong contentions, there is still much to be learned about the relationship between ethnoracial identification and mental health. In particular, existing research has paid little attention to the collateral consequences of ethnoracial identification – phenomena that are associated with ethnoracial identification. That is, one not only identifies with a particular category, one also recognizes their group's position in society (see Blumer, 1958; Bobo, 1999; Brondolo et al., 2009).

The recognition of one's status in society as an ethnoracial minority, as an African American, specifically, is what W.E.B. Du Bois wrote so eloquently about in 'Of Our Spiritual Strivings,' which was the first chapter in his landmark *The Souls of Black Folk* where he posed a still pressing question for many African Americans – "How does it feel to be a problem?" He continues,

"And yet, being a problem is a strange experience – peculiar even for one who has never been anything else, save perhaps in babyhood and in Europe. It is in the early days of rollicking boyhood that the revelation first bursts upon one, all in a day, as it were. I remember well when the shadow swept across me. I was a little thing, away up in the hills of New England, where the dark Housatonic winds between Hoosac and Taghkanic to the sea. In a wee wooden schoolhouse, something put it into the boys' and girls' heads to buy gorgeous visiting-cards—ten cents a package—and exchange. The exchange was merry, till one girl, a tall newcomer, refused my card, –refused it peremptorily, with a glance. Then it dawned upon me with a certain suddenness that I was different from the others; or like, mayhap, in heart and life and longing, but shut out from their world by a vast veil" (Du Bois, 1903: 1) [Emphasis added].

The recognition of being shut out by dominant members of society, as if by a vast veil is powerful imagery with which Du Bois tragically renders the situation in which many ethnoracial minorities find themselves – with little choice but to identify with a subordinate and stigmatized social category. This potential ambivalence with ethnoracial identification (see, for example, Du Bois, 1903 and Fanon, 1952 [2008]), I argue, is often lost in standard approaches to ethnoracial identification, which tend to emphasize the health-buffering potential of ingroup affect and feelings of closeness over feelings of collective vulnerability and threat that may accompany ethnoracial identification. In other words, whether ethnoracial identification and its consequences

are health-protective or detrimental for mental health is contingent up on our conceptualization of ethnoracial identification and its consequences (Yip et al., 2019).

Thus far, however, most existing research operationalizes ethnoracial identity as closeness to other blacks (a concept that assesses an individual's levels of feelings of understanding and intimacy with other blacks) and black group evaluation (an overall appraisal, ranging from negative to positive views of blacks as a group) (Ida and Christie-Mizell, 2012: 42; Broman et al., 1988; Shelton, 2008). These measures trace their conceptualizations of ethnoracial identity back to the key tenets of social identity theory (Tajfel and Turner, 1986) and Erik Erikson's (1959: 101) model of ego identity development, which highlight that one's personal identity includes "a persistent sharing of some kind of essential character with others" (Smith and Lynda, 1952: 42). This is best exemplified by the work of Phinney (1992) (see also, Phinney and Ong, 2007), whose Multigroup Ethnic Identity Measure (MEIM) is nearly ubiquitous in research on ethnoracial identity and health (a recent meta-analysis of over 180 studies of ethnoracial identity and health finds that over 70% of all studies used this measure, Smith and Lynda, 1952).

Undergirding the MEIM and other measures of ethnoracial identity like it, is the notion that closeness to, pride in, and affect towards other group members is the foundation of ethnoracial identity (see Harris, 1995). Indeed, Max Weber's [1918] 1978 canonical definition of an ethnic group (though, he explicitly refuses to make a sharp distinction between 'racial' and 'ethnic' groups) also emphasizes the importance of both *shared subjective belief in commonality* with others coupled and shared sense of *ethnic honor* (e.g. pride, self-esteem associated with group membership, etc.).

In contrast to the tendency to focus solely on feelings of closeness and ingroup attitudes, Sellers et al., (2003) constructed a comprehensive measure of ethnoracial identification including what they call racial centrality, regard (public and private), and ideology as part of their *Multidimensional Inventory of Black Identity* (MIBI). These three core components represent how significant 'being black' is to their own selfhood (centrality), positive feelings and/or affect toward African Americans as a group (private regard), how they feel other groups view African Americans (public regard), and how similar they feel African Americans are to other groups, the 'mainstream,' and political attitudes with respect to these feelings (ideology) (Sellers and Nicole Shelton, 2003). Studies using this measure report that, on the one hand, racial centrality is associated with reporting higher frequencies of perceived discrimination (Sellers and Nicole Shelton, 2003; Sellers et al., 2003; see also Operario and Fiske, 2001). Given that perceived discrimination is negative for mental health, this suggests that there are indeed *negative* consequences of ethnoracial identification (a point rarely raised, as Umana-Taylor et al., (2004) correctly notes). Yet, on the other hand, for individuals who expressed high racial centrality, discrimination did not predict stress in contrast to low and medium racial centrality individuals. Thus, according to this study, ethnoracial identification's relationship with mental health is complex, but ultimately ethnoracial identification, once again, serves as a buffer against poor mental health (e.g. stress as a consequence of discrimination) (Sellers et al., 2003: 311). Accordingly, in other related research the authors do acknowledge that future research needs to uncover if the buffering effects of ethnoracial identity hold for other outcomes that they have not examined (Sellers et al., 2003: 1090).

Still, as important as this research is, measures of internalized racism or racial centrality, again, do not quite capture feelings of vulnerability or collective threat that may be associated with viewing oneself as a member of a stigmatized group (Lamont et al., 2016). Internalized racism, for example, is really a measure of ingroup affect, collective self-esteem, or shared ethnic dishonor to offer a variation on Weber [1918] 1978. Perhaps, unsurprisingly, then, as Sellers and Shelton (2003: 1083) explain, their measures of racial centrality and regard (public and private) are conceptually most similar to Luhtanen and Crocker's, (1992) scales of collective self-esteem and measures of public

and private collective self-esteem. Thus, it remains to be seen whether measures that come closer to capturing the duality of feelings of political solidarity and collective vulnerability, such as linked fate, shape health positively or negatively. Indeed, Sellers et al. (2003: 306) report that an item very similar to linked fate – "My future is tied to the future of other blacks" – had poor internal consistency (as measured by Cronbach's alpha) with their racial centrality scale and perhaps even more important, it lacked 'face validity' and "conceptual consistency" with their racial centrality construct (the authors ultimately dropped it from their measure of racial centrality). This leaves open the possibility that linked fate, a potential collateral consequence of ethnoracial identification that has received little scholarly attention with respect to health, may be significantly linked to mental health.

1.2. *Linked fate and mental health*

Linked fate, is neither a measure of 'racial centrality' (see above) or feelings of "closeness to other African Americans," nor, even another measure of perceived discrimination. After all, we must consider that if one did not belong to a *stigmatized* social category, linked fate may not be associated with feelings of vulnerability, but feelings of inviolability *or even superiority*. Or, at the very least, a general sense that the world is not "full of injunctions and prohibitions," but rather, full of "posts to be occupied, courses to be taken, markets to be won, etc." (Bourdieu [1998] 2001: 225). Moreover, one may feel close to other group members and have intense feelings of pride associated with viewing oneself as a member of a group *without* believing that what happens to other group members necessarily affects one's own fate.

Accordingly, following a long line of theorists of linked fate, I contend that linked fate is a cognitive heuristic, which goes beyond mere in-group identification by capturing an explicit acknowledgment and awareness of sharing a similar status with other group members in a context of profound deprivation and stigmatization (McClain et al.: 477; see also Shelby, 2005). For instance, given heightened mortality rates for blacks, in addition to a host of socioeconomic inequalities, blacks are disproportionately exposed to the death of loved ones (Umberson, 2017). A substantial portion of these deaths are violent – homicide is the leading cause of death for black males ages 15 to 24 and accounts for half of all deaths for this group, compared with 8% of deaths among white males ages 15 to 24 (Umberson, 2017: 406). Indeed, "the highly visible premature deaths of young black Americans, as underscored in the Black Lives Matter movement, surely further contribute to a sense of collective threat and personal vulnerability" (Umberson, 2017: 407; Ross and Catherine, 2011; McFarland et al., 2018). Indeed, as Ross (2011: 287) eloquently explains channeling Pearlman's seminal work on stress, "socially structured, persistent, durable everyday life experiences shaped by social stratification, inequality, and disadvantage influence psychological distress (Pearlin, 1989; Pearlman et al., 1981)." For African Americans, this form of stress, linked to violent, premature deaths at the hands of the State and others has persisted across centuries. A situation that may be reasonably considered the source of intergenerational cultural trauma.

Crucially, then, it is this sense of linked fate, which I argue may not only fail to be health-protective but may be associated with worse mental health outcomes. Indeed, the central contention of this study is that within a context of sociopolitical deprivation and profound inequality, expressing linked fate is expressing a sense of personally-felt, collective vulnerability with potentially negative consequences of mental health. This, however, is an open question given the dearth of research on linked fate and mental health. One must also consider the possibility that linked fate, as an expression of group solidarity, in addition to potential collective vulnerability (see Dawson, 1994) may be mental health-protective as so many researchers of ethnoracial identification claim (see above). Extending the relatively small body of research on ethnoracial identification as a double-edged sword (see Yip, 2018), I use nationally-representative data to examine whether linked

fate is significantly associated, negatively or positively, with suffering from common mental health disorders such as anxiety and mood disorders among African Americans, even after taking the most common measures of ethnoracial identification (e.g. feelings of closeness and ingroup attitudes and evaluation) into account.

2. Methods

2.1. Data

This study uses data from the National Survey of American Life (NSAL). 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. The NSAL sample has a national multi-stage probability design which consists of 64 primary sampling units (PSU's). Fifty-six of these primary areas overlap 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 African Americans in the proportion in which they are distributed nationally. The data collection was conducted from February 2001 to June 2003. The interviews were administered face-to-face and conducted within respondents' homes; respondents were compensated for their time (Jackson et al., 2004).

A total of 6,082 face-to-face interviews were conducted with persons aged 18 or older, including 3,570 African Americans, 891 non-Hispanic Whites, and 1,621 Blacks of Caribbean descent. The overall response rate of 72.3% is excellent given that African Americans (especially lower income African Americans) are more likely to reside in major urban areas which are more difficult and expensive with respect to survey fieldwork and data collection. The African American sample is nationally representative of African American households in the 48 coterminous states with one adult aged 18 and over. With respect to sample selection, I focus here on African Americans born and raised in the United States. Research shows that racial identification is understood and operates differently in meaningful ways among those of West Indian and Caribbean descent (Waters, 1999). Moreover, evidence suggests that ethnoracial identification may be more salient among the native born than immigrants (see Yip et al., 2008). Given the relative lack of missing cases, I use list-wise deletion, resulting in an analytic sample of $N = 3,268$.

The National Survey of American Life (NSAL) (Jackson et al., 2004) is uniquely suited to address these important gaps in the current literature. Notably, it is one of the largest, nationally-representative samples of African Americans available that includes, in addition to its wide range of measures of mental health and well-being, myriad measures of ethnoracial identity such as feelings of closeness and ingroup attitudes and linked fate.

2.2. Measures

2.2.1. Dependent variables: mental health

This study focuses on the incidence of suffering from the most common classes of mental health disorders – anxiety disorders and mood disorders (Kessler et al., 2005). Specifically, I use 12 month and lifetime measures of suffering from one of the six most common anxiety disorders (e.g. generalized anxiety disorder, panic disorder, etc.), 12 month and lifetime measures of suffering from major depression, and 12 month and lifetime measures of suffering from bipolar I. Taken together, these measures cover the range of the most common mental health disorders suffered by adults in the U.S., including African Americans (see Riolo et al., 2005). Each variable is coded as a dummy variable (0 = No, 1 = Yes). The measures are based on a modified form of the DSM-IV World Mental Health Composite, International Diagnostic Interview (WMH-CIDI), which is a fully structured diagnostic interview conducted by trained survey interviewers designed to assess the probability that

respondents may suffer from DSM-IV disorders (e.g. mood and anxiety disorders). They were developed for the World Mental Health Project initiated in 2000 (World Health Organization, 2004) and the instrument used in the National Comorbidity Survey-Replication (NCS-R).

2.3. Controls

Given their well-established link to mental health outcomes, I use a variety of sociodemographic control variables such as age, sex (female), income, education, employment status, rurality, and region (south). Age is a continuous variable. *Female* is coded as a dummy variable where 0 = Male and 1 = Female. *Poverty index* is a categorical variable ranging from 0 to 17 which represents the degree to which respondents are above, below, or at the poverty line ($Poverty\ index = \frac{Household\ income}{Poverty\ Threshold}$). *Educational attainment* is a continuous variable capturing the number of years of completed education, ranging from 0 to 17. *South (Region)* is a dummy variable where 0 = Non-South and 1 = South. *Rural* is a dummy variable where 0 = Non-Rural and 1 = Rural. *Marital status* is a binary variable where 0 = Not Married and 1 = Married/Cohabiting.

Employment Status is a binary variable where 0 = Unemployed or Out of the Labor Force and 1 = Employed. While it may be true that being unemployed and out of the labor force may seem to be distinct states (perhaps for women with children in particular), studies by economists demonstrate that being unemployed and out of the labor force are experienced in psychologically *non-distinct* ways and that these two states are also empirically indistinguishable for the vast majority of the labor force (Goldsmith et al., 1995).

In order to examine whether the relationship between linked fate and mental health holds when considering common measures of ethnoracial identification, I employ two measures. These measures capture represent feelings of closeness and commonality as well as ingroup affect and pride. First, there is feelings of closeness to Blacks where respondents were asked "How close do you feel in your ideas and feelings about things to black people?" Response choices range along a 4-point scale from "Not Close at All" to "Very Close."

Next, I also use a measure of "internalized racism," (Cross, 1971), which is a scale reflecting respondents beliefs about negative and positive stereotypes regarding African Americans. They were asked: "How true do you think it is that most black people are: hardworking; intelligent; proud of themselves; lazy; give up easily; violent?" Response categories ranged from 0 to 3 and the scale was coded such that higher scores represent more positive evaluations of African Americans as a group (i.e. Positive Ingroup Attitudes).

2.4. Independent variables

2.4.1. Linked fate

The wording of the linked fate item in the NSAL (and many of the other surveys using this item) is: "Do you think what happens generally to Black people in this country will have something to do with what happens in your life?" (0 = No, 1 = Yes). Similar to previous research, I find that not all African Americans express a sense of linked fate (i.e. there is variation). In fact, nearly 40% of the sample states that what happens to other blacks does not affect their own life at all (see Table 1) – a figure in line with previous findings going back to the mid-1980s (see Dawson, 1994).

There is also a 'strength of linked fate' item where respondents are asked how much what happens generally to Black people affects their life. The strength measure I construct ranges from 0 to 3, where 0 = "None" (those who answered 'No' to the linked fate item above) and 3 = "A lot." I use this measure to examine the possibility that the stronger one's fate is perceived to be linked to a stigmatized ethnoracial category, the worse one's mental health may be. Using this measure enables consideration of the relationship between linked fate and mental health in a more granular way than a simple dichotomy between endorsing or

Table 1
Descriptive statistics of variables in analysis.

Variable	Mean (Std. Dev)	Min.-Max.	N
Age	42.6 (16.04)	18–93	3268
Years of Education	12.38 (2.46)	4–17	3268
Employed	0.66 (0.47)	0–1	3268
Poverty Index	2.48 (2.29)	0–17	3268
Marital Status	0.35 (0.48)	0–1	3268
Region (South)	0.66 (0.47)	0–1	3268
Rural	0.20 (0.40)	0–1	3268
Closeness to Blacks	3.45 (0.69)	1–4	3268
Positive Ingroup Attitudes	3.18 (0.49)	1–4	3268
Linked Fate	0.62 (0.48)	0–1	3268
Strength of Linked Fate Scale	1.33 (1.16)	0–3	3268
Strength of Linked Fate (0)	0.38 (0.48)	0–1	3268
Strength of Linked Fate (1)	0.10 (0.30)	0–1	3268
Strength of Linked Fate (2)	0.34 (0.48)	0–1	3268
Strength of Linked Fate (3)	0.18 (0.38)	0–1	3268
Major Depression (12 month)	0.07 (0.25)	0–1	3268
Major Depression (Lifetime)	0.12 (0.33)	0–1	3268
Bipolar I (12 month)	0.012 (0.11)	0–1	3268
Bipolar I (Lifetime)	0.012 (0.11)	0–1	3268
Anxiety Disorder (12 month)	0.20 (0.40)	0–1	3268
Anxiety Disorder (Lifetime)	0.20 (0.40)	0–1	3268

not endorsing linked fate.

2.4.2. Analytic plan

To examine the direct relationship between linked fate and mental health, I use logistic regression models. Please note that by using the STATA ‘svy’ procedures, all of the analyses adjust for the effects of clustering and the effects of weighting. For more information on this survey’s sample design see [Heeringa et al., \(2004\)](#). In each analysis the first model uses a dichotomous measure of linked fate, while the second model uses a scale measure of the strength of linked fate. I report odds ratios with 95% CI in the Tables corresponding to the analyses. Given linked fate’s known connection to education and social class, I also run a series of unadjusted models – the results I report in the text remain the same even in these unadjusted models (results available by request).

3. Results

3.1. Major depression

Table 2 presents the results of logistic regression models of major depression among African Americans even after controlling for a host of relevant sociodemographic factors and common measures of ethnoracial identification (e.g. closeness and ingroup attitudes). I find that while linked fate and the strength of linked fate are not significant predictors of suffering from major depression in the past 12 months, they are both significant predictors of suffering from major depression in one’s lifetime. Expressing a sense of linked fate (OR = 1.356) and expressing two highest levels of the strength of linked fate are significantly associated with suffering from major depression (lifetime) even after taking ethnoracial identification and relevant sociodemographic factors into account. Further models show that these results hold when adding perceived discrimination as another potentially relevant covariate (results available by request).

3.2. Bipolar I

Table 3 presents the results of logistic regression models of bipolar I among African Americans even after controlling for a host of relevant sociodemographic factors and common measures of ethnoracial identification (e.g. closeness and ingroup attitudes). Bipolar I is one of the most common mood disorders suffered by adults in the U.S., second only to major depression. I find that linked fate is significantly associated with suffering from Bipolar I in the past 12 months (OR = 5.091) and

Table 2
Results of logistic regression, major depression.

	Major Depression (12 months)	Major Depression (12 months)	Major Depression (Lifetime)	Major Depression (Lifetime)
Age	0.980*** [0.97–0.99]	0.980*** [0.97–0.99]	0.988** [0.98–1.00]	0.988** [0.98–1.00]
Female	1.789** [1.26–2.53]	1.834** [1.28–2.63]	1.795*** [1.33–2.43]	1.793*** [1.32–2.44]
Educational Attainment	0.956 [0.87–1.05]	0.954 [0.87–1.05]	1.022 [0.94–1.12]	1.016 [0.93–1.11]
Employed	0.811 [0.53–1.23]	0.796 [0.52–1.21]	0.860 [0.61–1.20]	0.839 [0.60–1.17]
Poverty Index	1.021 [0.93–1.12]	1.022 [0.93–1.12]	1.026 [0.96–1.09]	1.027 [0.97–1.09]
Married	0.596* [0.37–0.97]	0.606* [0.37–0.98]	0.698* [0.51–0.96]	0.710* [0.51–0.99]
South	0.553*** [0.42–0.74]	0.550*** [0.41–0.73]	0.583*** [0.46–0.73]	0.582*** [0.46–0.73]
Rural	0.731 [0.46–1.17]	0.748 [0.47–1.19]	0.772 [0.53–1.11]	0.781 [0.54–1.13]
Closeness to Blacks	0.791 [0.60–1.04]	0.787 [0.60–1.04]	0.792* [0.63–1.00]	0.783* [0.62–0.99]
Positive Ingroup Attitudes	0.750 [0.50–1.12]	0.738 [0.50–1.10]	0.737 [0.54–1.01]	0.726* [0.53–1.00]
Linked Fate	1.025 [0.73–1.44]		1.365** [1.09–1.71]	
Strength of Linked Fate (0)		1 [1.00–1.00]		1 [1.00–1.00]
Strength of Linked Fate (1)		0.616 [0.27–1.41]		0.748 [0.47–1.18]
Strength of Linked Fate (2)		0.967 [0.67–1.39]		1.439* [1.08–1.91]
Strength of Linked Fate (3)		1.445 [0.90–2.33]		1.655** [1.20–2.28]
N	3268	3268	3268	3268

Notes. Exponentiated coefficients (odds ratios); 95% confidence intervals in brackets. All analyses account for the survey’s complex design (e.g. clustering and stratification).

p* < 0.05, *p* < 0.01, ****p* < 0.001 (Two-Tailed Tests).

during one’s lifetime (OR = 6.515). Furthermore, as the strength of expressing linked fate increases, so does the probability of suffering from Bipolar I in the past 12 months and during one’s lifetime. Similar to what obtained with respect to major depression, this is relationship is particularly strong among those expressing the 2 highest levels of strength of linked fate. And, once again, further models reveal that these relationships hold even after introducing perceived discrimination as a covariate (results available by request).

3.3. Anxiety disorders

Finally, **Table 4** presents the results of logistic regression models of suffering from a range of anxiety disorders. Mirroring the findings with respect to suffering from Bipolar I, I find that linked fate is a significant predictor of suffering from anxiety disorders in the past 12 months (OR = 1.991) and during one’s lifetime (OR = 1.979). Similarly, as the strength of one’s expression of linked fate increases so does the probability of suffering from an anxiety disorder – the two highest levels of the strength of linked fate are significantly associated with suffering from anxiety disorders in the past 12 months and during one’s lifetime. Again, this is after taking sociodemographic factors and the most common measures of ethnoracial identification (e.g. feelings of closeness and ingroup attitudes) into account. Furthermore, models also show that these relationships hold when adjusting for perceived discrimination as well (results available by request).

Table 3
Results of logistic regression, bipolar I.

	Bipolar I (12 Months)	Bipolar I (12 Months)	Bipolar I (Lifetime)	Bipolar I (Lifetime)
Age	0.973 [0.94–1.01]	0.973 [0.94–1.01]	0.977 [0.95–1.00]	0.977 [0.95–1.00]
Female	0.702 [0.24–2.06]	0.706 [0.24–2.08]	0.653 [0.31–1.38]	0.676 [0.31–1.48]
Educational Attainment	0.839 [0.62–1.13]	0.840 [0.63–1.13]	0.919 [0.74–1.14]	0.921 [0.74–1.15]
Employed	1.589 [0.45–5.59]	1.594 [0.42–6.02]	1.245 [0.50–3.07]	1.212 [0.47–3.10]
Poverty Index	0.864 [0.71–1.05]	0.863 [0.70–1.06]	0.792* [0.65–0.97]	0.790* [0.64–0.97]
Married	0.649 [0.26–1.65]	0.647 [0.27–1.57]	0.806 [0.36–1.82]	0.832 [0.38–1.84]
South	0.256** [0.11–0.61]	0.256** [0.11–0.62]	0.299** [0.15–0.61]	0.302** [0.15–0.62]
Rural	1.102 [0.32–3.83]	1.116 [0.32–3.93]	0.904 [0.29–2.78]	0.918 [0.30–2.80]
Closeness to Blacks	0.733 [0.36–1.48]	0.734 [0.37–1.47]	0.857 [0.49–1.50]	0.860 [0.50–1.47]
Positive Ingroup Attitudes	0.756 [0.35–1.63]	0.758 [0.36–1.58]	0.877 [0.47–1.64]	0.851 [0.47–1.53]
Linked Fate	5.091* [1.08–23.89]		6.515** [1.73–24.57]	
Strength of Linked Fate (0)		1 [1.00–1.00]		1 [1.00–1.00]
Strength of Linked Fate (1)		5.312 [0.49–57.33]		4.358 [0.46–41.09]
Strength of Linked Fate (2)		4.984* [1.24–20.11]		6.044** [1.77–20.60]
Strength of Linked Fate (3)		5.178 [0.92–29.25]		8.820** [2.20–35.44]
N	3268	3268	3268	3268

Notes. Exponentiated coefficients (odds ratios); 95% confidence intervals in brackets. All analyses account for the survey’s complex design (e.g. clustering and stratification).

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$ (Two-Tailed Tests).

4. Discussion

Most research on African Americans’ mental health contends that African Americans’ mental health is actually quite robust and one of the key explanations for this surprising constellation of findings is, according to many experts, the strength of African Americans’ ethnoracial identity (Branscombe et al., 1999; Sellers et al., 2003; Phinney and Ong, 2007; Williams et al., 2012a,2012b). In fact, national estimates show Whites have higher incidence and earlier onset of suffering from major depression than Blacks (Riolo et al., 2005). Yet, as I have argued throughout this study, this viewpoint is mostly rooted in a body of research that focuses on feelings of closeness to group members and ingroup attitudes and affect as the central ways of conceiving of and measuring ethnoracial identification and identifying the potentially positive benefits of ethnoracial identification.

What this approach sidesteps, however, are the collateral and potentially negative consequences of ethnoracial identification, particularly within a context of sociopolitical deprivation and domination (see Yip et al., 2008; Yip, 2018; Woo et al., 2019; Mossakowski et al., 2019). A sort of ambivalence with ethnoracial identification (see Fanon, 1952 [2008]), which I contend is rooted in the reality that for many people, one crucial aspect of identification with a collectively dishonored and stigmatized category is recognizing their own *personal* vulnerability as a member of that collective. That is, along with ethnoracial identification, for many minorities, is also a recognition of their place in a racialized social hierarchy (Bobo, 1999; Brondolo et al., 2009). This process of

Table 4
Results of logistic regression, anxiety disorders.

	Anxiety Disorders (12 Months)	Anxiety Disorders (12 Months)	Anxiety Disorders (Lifetime)	Anxiety Disorders (Lifetime)
Age	0.990* [0.98–1.00]	0.990* [0.98–1.00]	0.988*** [0.98–0.99]	0.988*** [0.98–0.99]
Female	2.038*** [1.55–2.69]	2.084*** [1.57–2.76]	1.949*** [1.52–2.50]	1.990*** [1.55–2.56]
Educational Attainment	0.962 [0.90–1.02]	0.958 [0.90–1.02]	0.964 [0.91–1.02]	0.961 [0.91–1.01]
Employed	0.714* [0.52–0.98]	0.712* [0.52–0.98]	0.909 [0.70–1.19]	0.903 [0.69–1.18]
Poverty Index	0.963 [0.84–1.10]	0.962 [0.84–1.10]	0.964 [0.88–1.05]	0.963 [0.88–1.05]
Married	0.797 [0.60–1.06]	0.809 [0.61–1.07]	0.770* [0.63–0.95]	0.781* [0.64–0.96]
South	0.792 [0.56–1.11]	0.785 [0.56–1.10]	0.668** [0.53–0.85]	0.660** [0.52–0.83]
Rural	0.877 [0.57–1.34]	0.895 [0.59–1.36]	1.080 [0.80–1.47]	1.109 [0.82–1.50]
Closeness to Blacks	0.783* [0.64–0.96]	0.782* [0.63–0.96]	0.921 [0.77–1.10]	0.915 [0.77–1.09]
Positive Ingroup Attitudes	0.542*** [0.41–0.72]	0.532*** [0.40–0.71]	0.660** [0.52–0.84]	0.644*** [0.51–0.82]
Linked Fate	1.991*** [1.45–2.73]		1.979*** [1.44–2.72]	
Strength of Linked Fate (0)		1 [1.00–1.00]		1 [1.00–1.00]
Strength of Linked Fate (1)		1.270 [0.71–2.27]		1.151 [0.76–1.75]
Strength of Linked Fate (2)		2.025*** [1.46–2.80]		2.001*** [1.44–2.77]
Strength of Linked Fate (3)		2.506*** [1.74–3.61]		2.640*** [1.79–3.89]
N	3268	3268	3268	3268

Notes. Exponentiated coefficients (odds ratios); 95% confidence intervals in brackets. All analyses account for the survey’s complex design (e.g. clustering and stratification).

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$ (Two-Tailed Tests).

recognition which, as Du Bois (1903) personally, among others, have eloquently explained, begins as early as childhood (also see the pioneering work of Clark and Clark, 1947).

Accordingly, using data drawn from a nationally-representative epidemiologically-focused survey of African Americans I introduce *linked fate*, a broad recognition of one’s common fate with other category members, to the study of ethnoracial identification and mental health. While linked fate is been widely used in studies of ethnoracial identification and political attitudes among political scientists, it has not gained much traction as a measure in research on mental health. This study bridges this gap across scholarly disciplines and sub-fields by considering the extent to which linked fate is associated with mental health among African Americans even after controlling for commonly used measures of ethnoracial identification such as closeness to blacks and ingroup attitudes.

Generally, I find that linked fate, is significantly associated with *poorer mental health* among African Americans. Furthermore, I found no evidence that linked fate moderated the relationship between everyday discrimination and mental health (results available by request). Thus, by expanding the conceptualization and measurement of ethnoracial identity beyond feelings of closeness and positive ingroup attitudes (or ethnic pride) to linked fate, this study reveals a more complicated vision of the relationship between ethnoracial identity, mental health, and well-being among African Americans than some research suggests. These findings, however, are actually more faithful to iconic, yet neglected theories of ethnoracial identification (at least among health

researchers) which emphasize the ambivalence and duality of ethnoracial identification (e.g. Du Bois's 'veil' and *double consciousness*); and highlights the importance of considering both sides of ethnoracial identification (Yip, 2019; Yip, 2018; Woo et al., 2019; Mossakowski et al., 2019).

Indeed, a key contention of research on stigma and identity (Link and Phelan et al., 2010; Pescosolido and Martin, 2015; Lamont et al., 2016) is that there may be *tradeoffs* between a stigmatized social identity serving as a resource and the negative psychological dynamics and consequences of strongly identifying with a stigmatized social category. Thus, African Americans find themselves facing a profound dilemma. For feelings of linked fate, in particular, are, arguably, the very glue that holds African Americans together (Dawson, 1994; Shelby, 2005). It is the fuel of solidarity and political struggles aimed at ameliorating the circumstances of material and symbolic deprivation faced by so many African Americans. Yet, the findings of this study reveal, as we are often reminded in life, nothing comes for free. The cost of strong ethnoracial identification and the sociopolitical solidarity it may afford (e.g. linked fate) appears to be paid in anxiety, depression, and diminished psychological well-being.

That African American mental health remains relatively robust may at least partially reflect the fact that nearly 40% of African Americans do not express a sense of linked fate. Doing so, the results of this study suggests, may be painful; and to the extent that linked fate is a vital ingredient in collective political action against ethnoracial domination, this pain may be an impediment to ethnoracial identification and collective political action. A pain that is itself, at its root, produced by the long history and contemporary manifestations of ethnoracial violence against members of their category and their political allies. Again, this is one crucial aspect of the dilemma confronting African Americans – their solidarity appears to come at the cost of their mental health. This suggests that *de-identification* with respect to linked fate appears to be protective of mental health.

It would be a mistake, however, to suggest that the answer to the riddle of mental health among African Americans is for them to simply choose to *identify* less with such a stigmatized social category. Moreover, it is not, of course, the case that for most African Americans, their ethnoracial identity is freely chosen, even if its strength varies (see again, Du Bois, 1903). This is the very essence of the dilemma imposed upon the stigmatized – the very thing that provides potential routes for their liberation, such as group solidarity, also comes at a severe psychological cost. After all, research shows that linked fate is also significantly associated with group mobilization and political participation (Dawson, 1994). While many initial studies found that whites had higher levels of political participation than African Americans, once controls for socio-economic status were introduced, African Americans actually had higher rates of political participation and their ethnoracial identity and linked fate was a leading explanation for this result (McClain et al., 2009: 478).

Thus, the "costs" of expressing a sense of linked fate also seem to "buy" political mobilization and political participation ostensibly aimed at combating the root causes of the feelings of vulnerability that may be associated with expressing linked fate in the first place – persistent, systemic, and systematic inequality and stratification. In other words, from a different point of view, the costs of linked fate (e.g. anxiety and affective disorders), may actually be the *fuel* of political action ostensibly orchestrated to considerably reduce the probability that expressing linked fate would be associated with feeling vulnerable as opposed to feeling safe and free from looming danger. Seen this way, the political mobilization and participation associated with linked fate may be conceptualized as a *response to stigmatization* (see Lamont and Mizrachi, 2012; Fleming et al., 2012; Lamont et al., 2016). Ethnoracial identity, then, may ultimately be protective, not on its own, but because of what it may impel people to do. Future research could help shed light on possible links between politics and mental health (e.g. political participation, political contexts, etc., see Patterson and Veenstra, 2016).

Likewise, future research should also explore whether linked fate is associated with anxiety and affective disorders for other ethnoracial groups – not only among other minorities, but also dominant ethnoracial groups within a given society. It stands to reason that for individuals who express a sense of linked fate with a non-stigmatized or even advantaged social category (e.g. ethnoracial, but also gender, class, sexuality, nationality, etc.) there may be psychological benefits: lower chances of suffering from mood and anxiety disorders. Or, perhaps, remaining 'color-blind' and not identifying with an ethnoracial group may also be associated with better mental health among members of dominant ethnoracial categories. Yet, with so much attention on the disadvantaged, our knowledge of such dynamics is profoundly limited. Dynamics, which emphasize, yet again, the complexity, contingency, and multidimensionality of how social identity relates to mental health.

References

- Blumer, Herbert, 1958. Race prejudice as a sense of group position. *Pac. Socio Rev.* 1, 3–7.
- Bobo, L.D., 1999. Prejudice as group position: microfoundations of a sociological approach to racism and race relations. *J. Soc. Issues* 55 (3), 445–472.
- Bourdieu Pierre, 1998. 2001. *Pascalian Meditations*. Stanford University Press, Stanford, CA.
- Branscombe, N.R., Schmitt, M.T., Harvey, R.D., 1999. Perceiving pervasive discrimination among African Americans: implications for group identification and well-being. *J. Pers. Soc. Psychol.* 77 (1), 135–149.
- Broman, C.L., Neighbors, H.W., Jackson, J.S., 1988. Racial group identification among Black adults. *Soc. Forces* 67 (1), 146–158.
- Clark, Kenneth B., Clark, Mamie P., 1947. Racial identification and preference in negro children. In: Newcomb, T.M., Hartley, E.L. (Eds.), *Readings in Social Psychology*. Holt, New York, 168–78.
- Cross Jr., William E., 1971. The negro to black conversion experience. *Black World* 20, 13–27.
- Dawson, Michael C., 1994. *Behind the Mule: Race and Class in African-American Politics*. Princeton University Press.
- Du Bois, W.E.B., 1903. *The Souls of Black Folk*. Free Press.
- Fanon, Frantz, 1952. [2008]. *Black Skin, White Masks*. Grove Press, New York.
- Fleming, C.M., Lamont, M., Welburn, J.S., 2012. "African Americans respond to stigmatization: the meanings and salience of confronting, deflecting conflict, educating the ignorant and 'managing the self'." *Ethn. Racial Stud.* 35 (3), 400–417.
- Harris, David, 1995. "Exploring the determinants of adult black identity: context and process." *Soc. Forces* 74, 227–241.
- Haslam, S. Alexander, Jetten, Jolanda, Postmes, Tom, Haslam, Catherine, 2009. Social identity, health, and well-being: an emerging agenda for applied psychology. *Appl. Psychol.* 58, 1–23.
- Heeringa, Steven G., Wagner, James, Torres, Myriam, Duan, Naihua, Adams, Terry, Berglund, Patricia, 2004. Sample designs and sampling methods for the collaborative epidemiology studies (CPES). *Int. J. Methods Psychiatr. Res.* 13 (4), 221–240.
- Hughes, M., Kiecolt, K.J., Keith, V.M., Demo, D.H., 2015. Racial identity and well-being among African Americans. *Soc. Psychol. Q.* 78 (1), 25–48.
- Ida, Aya Kimura, Andre' Christie-Mizell, C., 2012. Racial group identity, psychosocial resources, and depressive symptoms: exploring ethnic heterogeneity among black Americans. *Socio. Focus* 45, 41–62.
- Jackson, J.S., Torres, M., Caldwell, C.H., Neighbors, H.W., Nesse, R.M., Taylor, R.J., et al., 2004. *The National Survey of American Life: a study of racial, ethnic and cultural influences on mental disorders and mental health*. *Int. J. Methods Psychiatr. Res.* 13 (4), 196–207.
- Kessler, Ronald C., Chiu, Wai Tat, Demler, Olga, Ellen, E., Walters, 2005. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the national comorbidity survey replication. *Arch. Gen. Psychiatr.* 62 (6), 617–627.
- Lamont, M., Mizrachi, N., 2012. Ordinary people doing extraordinary things: responses to stigmatization in comparative perspective. *Ethn. Racial Stud.* 35 (3), 365–381.
- Lamont, Michèle, Graziella Moraes Silva, Welburn, Jessica, Guetzkow, Joshua, Mizrachi, Nissim, Hanna, Herzog, Reis, Elisa, 2016. *Getting Respect: Responding to Stigma and Discrimination in the United States, Brazil, and Israel*. Princeton University Press.
- Lee, R.M., 2003. Do ethnic identity and other-group orientation protect against discrimination for Asian Americans? *J. Counsel. Psychol.* 50 (2), 133–141.
- Lee, Taeku, 2008. Race, immigration, and the identity-to-politics link. *Annu. Rev. Polit. Sci.* 11, 457–478.
- Luhtanen, R., Crocker, J., 1992. "A collective self-esteem scale: self-evaluation of one's social identity." *Pers. Soc. Psychol. Bull.* 18, 302–318.
- McClain, Paula D., Johnson Carew, Jessica D., Walton Jr., Eugene, Watts, Candis S., 2009. Group membership, group identity, and group consciousness: measures of racial identity in American politics? *Annu. Rev. Polit. Sci.* 12, 471–485.
- McFarland, Michael J., Taylor, John, Cheryl, AS McFarland, Friedman, Katherine L., 2018. Perceived unfair treatment by police, race, and telomere length: a nashville community-based sample of black and white men. *J. Health Soc. Behav.* 59 (4), 585–600.
- Mossakowski, Krysia, 2003. Coping with perceived discrimination: does ethnic identity protect mental health? *J. Health Soc. Behav.* 44 (3), 318–331.

- Mossakowski, Krysia, Wongkaren, Turro, Hill, Terrence, Johnson, Robert, 2019. Does ethnic identity buffer or intensify the stress of discrimination among the foreign born and U.S. Born? Evidence from the miami-dade health survey. *J. Community Psychol.* 47 (3), 445–461.
- Noh, S., Beiser, M., Kaspar, V., Hou, F., Rummens, J., 1999. Perceived racial discrimination, depression, and coping: a study of Southeast Asian refugees in Canada. *J. Health Soc. Behav.* 40, 193–207.
- Operario, D., Fiske, S., 2001. Ethnic identity moderates perceptions of prejudice: judgments of personal versus group discrimination and subtle versus blatant bias. *Pers. Soc. Psychol. Bull.* 27, 550–561.
- Pascoe, E.A., Richman, L., 2009. Perceived discrimination and health: a meta-analytic review. *Psychol. Bull.* 135 (4), 531–554.
- Patterson, A.C., Veenstra, Gerry, 2016. Politics and population health: testing the impact of electoral democracy. *Health Place* 40, 66–75.
- Pearlin, Leonard I., 1989. The sociological study of stress. *J. Health Soc. Behav.* 30, 241–256.
- Pearlin, Leonard I., Menaghan, Elizabeth G., Lieberman, Morton A., Mullan, Joseph T., 1981. The stress process. *J. Health Soc. Behav.* 22, 337–356.
- Pescosolido, B.A., Martin, J.K., 2015. The stigma complex. *Annu. Rev. Sociol.* 41, 87–116.
- Phelan, J.C., Link, B.G., Tehranifar, P., 2010. Social conditions as fundamental causes of health inequalities: theory, evidence, and policy implications. *J. Health Soc. Behav.* 51, S28–S40.
- Phinney, J.S., 1992. The Multigroup ethnic identity measure: a New scale for use with diverse groups. *J. Adolesc. Res.* 7, 156–176.
- Phinney, J., Ong, A.D., 2007. Conceptualization and measurement of ethnic identity: current status and future directions. *J. Counsel. Psychol.* 54, 271–281.
- Portes, Alejandro, Rumbaut, R.G., 2001. *Legacies: the Story of the Immigrant Second Generation*. University of California Press, Berkeley, CA.
- Riolo, S.A., Nguyen, T.A., Greden, J.F., King, C.A., 2005. Prevalence of depression by race/ethnicity: findings from the national health and nutrition examination survey III. *Am. J. Publ. Health* 95 (6), 998–1000.
- Ross, Catherine, E., 2011. Collective threat, trust, and the sense of personal control. *J. Health Soc. Behav.* 52 (3), 287–296.
- Sellers, Robert M., Nicole Shelton, J., 2003. The role of racial identity in perceived racial discrimination. *J. Pers. Soc. Psychol.* 84, 1079–1092.
- Sellers, Robert M., Caldwell, Cleopatra H., Schmeelk-Cone, Karen H., Zimmerman, Marc A., 2003. “Racial identity, racial discrimination, perceived stress, and psychological distress among african American young adults. *J. Health Soc. Behav.* 43, 302–317.
- Shelby, Tommie, 2005. *We who are dark: the philosophical foundations of black solidarity*. Harvard University Press.
- Smith, Timothy B., and Lynda Silva. "Ethnic identity and personal well-being of people of color: a meta-analysis." *J. Counsel. Psychol.* 58(1):
- Tajfel, H., Turner, J., 1986. The social identity theory of intergroup behavior. In: Worchel, S., Austin, W. (Eds.), *Psychology of Intergroup Relations*. Nelson-Hall, Chicago, pp. 7–24.
- Umana-Taylor, A., Yazedjian, A., Bamaca-Gomez, M., 2004. Developing the ethnic identity scale using eriksonian and social identity perspectives. *Identity: An International Journal of Theory and Research* 4, 9–38.
- Umberson, Debra, 2017. Black deaths matter: race, relationship loss, and effects on survivors. *J. Health Soc. Behav.* 58 (4), 405–420.
- Veenstra, Gerry, 2009. Racialized identity and health in Canada: results from a nationally representative survey. *Soc. Sci. Med.* 69 (4), 538–542.
- Weber, Max. [1918], 1978. *Ethnic groups*. In: *Economy and Society: an Outline of Interpretive Sociology*. Univ of California Press, Oakland, CA.
- Williams, David R., John, Dolly A., Oyserman, Daphna, Sonnega, John, Mohammed, Selina A., Jackson, James S., 2012a. Research on discrimination and health: an exploratory study of unresolved conceptual and measurement issues. *Am. J. Publ. Health* 102, 975–978.
- Williams, Monnica Terwilliger, Chapman, Lloyd Kevin, Wong, Judy, Turkheimer, Eric, 2012b. The role of ethnic identity in symptoms of anxiety and depression in African Americans. *Psychiatr. Res.* 199 (1), 31–36.
- Woo, Bongki, Fan, Wen, Tran, Thanh V., Takeuchi, David T., 2019. The Role of Racial/ethnic Identity in the Association between Racial Discrimination and Psychiatric Disorders: A Buffer or Exacerbator? *Social Science & Medicine: Population Health*.
- Yip, Tiffany, 2018. Ethnic/racial identity—a double-edged sword? Associations with discrimination and psychological outcomes. *Curr. Dir. Psychol. Sci.* 27 (3), 170–175.
- Yip, Tiffany, Gee, G.C., Takeuchi, D.T., 2008. Racial discrimination and psychological distress: the impact of ethnic identity and age among immigrant and United States-born Asian adults. *Dev. Psychol.* 44 (3), 787–800.
- Yip, Tiffany, Wang, Y., Mootoo, C., Mirpuri, S., 2019. Moderating the association between discrimination and adjustment: a meta-analysis of ethnic/racial identity. *Dev. Psychol.* 55 (6), 1274–1298.