The Cost of Color: Skin Color, Discrimination, and Health among African-Americans[1]

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In this study, the author uses a nationally representative survey to examine the relationship(s) between skin tone, discrimination, and health among African-Americans. He finds that skin tone is a significant predictor of multiple forms of perceived discrimination (including perceived skin color discrimination from whites and blacks) and, in turn, these forms of perceived discrimination are significant predictors of key health outcomes, such as depression and self-rated mental and physical health. Intraracial health differences related to skin tone (and discrimination) often rival or even exceed disparities between blacks and whites as a whole. The author also finds that self-reported skin tone, conceptualized as a form of embodied social status, is a stronger predictor of perceived discrimination than interviewer-rated skin tone. He discusses the implications of these findings for the study of ethnoracial health disparities and highlights the utility of cognitive and multidimensional approaches to ethnoracial and social inequality.

INTRODUCTION

Ethnoracial health disparities have been documented for at least the past 100 years in the United States (Williams 2012, p. 279). African-Americans tend to suffer from "higher rates of mortality, earlier onset of disease, greater

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severity and progression of disease, and higher levels of comorbidity and impairment" than whites (Williams and Mohammed 2013, p. 1153). These disparities are not trivial. McCord and Freeman (1990) estimated that in 1980, black male youths in Harlem, New York City, were less likely to survive to age 65 than male youths in Bangladesh. In fact, it was not until 1990 that African-Americans achieved the life expectancy that whites had in 1950 (Williams 2012, p. 282). While life expectancy has been increasing for all ethnoracial populations, the disparities between blacks and whites have been persistent. As of 2007, for example, African-Americans' overall death rate was 30% higher than whites, and blacks had higher death rates than whites for 10 of the 15 leading causes of death (Williams 2012, p. 280).

The examination of ethnoracial disparities in health has garnered a steadily increasing amount of attention in the past two decades. Perhaps as a testament to his perspicaciousness, ethnoracial health disparities were one of the early concerns of W. E. B. Du Bois, a foundational figure in the history of sociology, in his magnum opus *The Philadelphia Negro* ([1899] 1995). As Williams and Sternthal (2010, p. S1) point out, Du Bois argued that the relatively poorer health of African-Americans was a critically important indicator of ethnoracial inequality in the United States in general. While work in the 19th and early 20th centuries attributed ethnoracial disparities in health to innate biological differences, Du Bois stressed the role of socioeconomic inequality, such as unfit housing, unsanitary living conditions, and poor food quality. That is, Du Bois emphasized the importance of examining *social determinants of health*, which is today a defining feature of research in public health and epidemiology.[2]

Much of the existing research on the social determinants of health focuses on comparisons between categories, notably, between African-Americans and whites. Researchers find that ethnoracial inequality in socioeconomic status (SES), which has been documented by social scientists for decades, is a key predictor of ethnoracial disparities in health (Williams and Collins 1995; Hayward et al. 2000; Williams et al. 2010). This research suggests that closing socioeconomic gaps between African-Americans and whites would help mitigate health disparities. While this may be true, studies are now reporting that even after adjusting for SES (and health behaviors), African-Americans tend to suffer from an increased risk of hypertension, inflammation, and various forms of metabolic issues (e.g., total cholesterol, HDL cholesterol, BMI, and glycated hemoglobin; Williams and Sternthal 2010; Das 2013).

[2] There is, however, still considerable debate regarding the explanatory weight of social determinants and genetic and biological factors regarding ethnoracial health disparities (see Chae et al. 2011).

These residuals have prompted researchers to look beyond SES alone and consider the social context of ethnoracial inequality, especially the role of discrimination, in shaping health outcomes among African-Americans. Discrimination is a key aspect of stigma (a broader concept that also includes labeling, stereotyping, social exclusion, and status loss), which is widely held to be a "fundamental cause" of health (i.e., the cause of multiple health outcomes through a variety of mechanisms; Phelan, Link, and Tehranifar 2010). Discrimination is held to be a stressor, which may lead to pernicious physiological responses that cause or exacerbate a variety of physical and mental health outcomes (Clark et al. 1999; Kessler, Mickelson, and Williams 1999; Dressler, Oths, and Gravlee 2005; Lewis et al. 2009).

Accordingly, many studies report that perceived discrimination (usually ethnoracial discrimination) is often significantly associated with the incidence or severity of a variety of mental and physical health outcomes such as depression, psychological distress, anxiety, hypertension, self-reported health, and even breast cancer (for a review, see Paradies 2006; Pascoe and Richman 2009; Williams and Mohammed 2009). African-Americans report higher amounts of perceived discrimination and tend to have worse physical health outcomes than non-Hispanic whites (Williams 1997; Keyes 2009).[3] In fact, some studies show that even the mere anticipation of discrimination may have negative consequences for the health of African-Americans (Sawyer et al. 2012).

Despite how promising discrimination seems to be as a key factor explaining health disparities, researchers caution that there is still much to be learned about the relationship between discrimination and the health of African-Americans (Williams 2012). Two important questions are what predicts exposure to discrimination among African-Americans and how does this exposure relate to differences in health outcomes within the black population? Addressing this is important not only in terms of within-category differences in health but also to help explain health disparities between categories (i.e., between African-Americans and whites). Consequently, examining this matter will undoubtedly make an important contribution to our understanding of ethnoracial health differences and disparities and possibly help inform new interventions to reduce said differences and disparities (Williams and Mohammed 2013).

[3] Some research suggests, however, that African-Americans report lower rates of lifetime major depressive disorder and better overall mental health than non-Hispanic whites (i.e., the "mental health paradox"; Williams et al. 2007). Nevertheless, there are substantial differences among African-Americans with respect to depression, which SES and other factors do not explain (Hudson et al. 2012). This suggests the need to uncover other predictors of heterogeneity in health within the black population.

It is also important to consider that research shows that there are often as many or even more health differences within ethnoracial categories than there are between ethnoracial categories (Williams and Sternthal 2010). Analyses that focus solely on differences between "groups," however, are largely unable to address the heterogeneity that exists within ethnoracial "groups." As Schwartz and Meyer (2010, p. 1114) explain, between-"group" analyses give us insight on the experiences of the "average" member of an ethnoracial "group" in comparison to the average member of another ethnoracial "group." Such analyses, while valuable, are not necessarily designed to help explain within-category heterogeneity.

Nevertheless, while studies have drawn researchers' attention to these intraracial differences in health, existing research often stops short of directly examining how or why these substantial intraracial differences exist. Fortunately, there is a leading candidate to answer this question, which according to some evidence not only predicts socioeconomic inequality among African-Americans (Hughes and Hertel 1990; Keith and Herring 1991; Monk 2014) but has also been hypothesized to predict African-Americans' exposure to discrimination. This factor is skin tone (Williams and Collins 1995; Krieger, Sidney, and Coakley 1998).

Still, skin tone has received "inadequate research scrutiny as a potential risk factor for the health of African Americans" (Borrell et al. 2006, p. 1416). Indeed, while most research on ethnoracial disparities in health focuses primarily on the role of differences in SES and perceived ethnoracial discrimination, there are very few studies that have investigated the relationship between skin tone and perceived discrimination among black Americans, let alone skin tone, discrimination, and mental or physical health. Furthermore, the few studies that have investigated the relationship between skin tone and perceived discrimination report mixed findings.

A few studies, for example, find that skin tone is associated with hypertension, although the mechanisms linking skin tone to hypertension remain elusive (Harburg et al. 1978; Krieger et al. 1998). With respect to perceived discrimination, one study finds that darker-skinned black Americans are much more likely to report being discriminated against (Klonoff and Landrine 2000), and another study finds that lighter-skinned African-Americans were only slightly less likely to report being discriminated against than darker-skinned African-Americans (Hersch 2011). Other studies report no association between skin tone and the frequency of perceived discrimination or skin tone and self-reported mental or physical health (Borrell et al. 2006; Keith et al. 2010). Consequently, it is unclear whether or how skin tone may be associated with perceived discrimination or health status among African-Americans, despite compelling arguments and theories, which strongly suggest that such relationships should exist.

In this study, I use a nationally representative survey of African-Americans to investigate this constellation of interrelated quandaries in our literature on discrimination and health among African-Americans, focusing primarily on the role gradations of skin color may play in shaping health outcomes through their association with the frequency of multiple forms of perceived discrimination among African-Americans and, secondarily, on skin tone's possibly direct association with health outcomes even after controlling for discrimination, SES, and a range of sociodemographic controls.

My approach emphasizes the importance of making and using analytical distinctions between different measures of discrimination, health, and even skin tone (see "Meanings and Measures" below). I argue that the study of ethnoracial health disparities must include a richer theoretical understanding of what the various measures we use (or tend not to) in our research mean and that leveraging multiple measures is essential to not only having a deeper understanding of ethnoracial health disparities but also uncovering aspects of social inequality in health that may have been previously overlooked (see Telles and Lim [1998], Saperstein [2012], and Bailey, Loveman, and Muniz [2013] for discussions of "race" as a multidimensional concept).

A key contribution of the current study is the use of multiple measures of perceived discrimination. As was discussed above, the vast majority of current research examines the role of ethnoracial discrimination in shaping health outcomes among African-Americans. I extend this research by considering the role of "everyday discrimination" (i.e., everyday experiences of unfair treatment or harassment) as a predictor of health differences among African-Americans. Research suggests that chronic exposure to discrimination in general, rather than particularly traumatic episodes of "racial discrimination," may be more important for explaining health outcomes anyway (Williams and Mohammed 2009, p. 29). Chronic stressors are often stronger predictors of the onset and course of diseases than acute life events (Cohen et al. 1995), and everyday discrimination measures have been found to be associated with subclinical cardiovascular disease and elevated C-reactive protein levels (Lewis et al. 2009, 2010).

I also employ two separate measures of perceived skin color discrimination. One measure is the frequency of perceived skin color discrimination from whites, and the other is a measure of the frequency of perceived skin color discrimination from blacks. In so doing, I not only further consider the role skin color may play in shaping health outcomes, but I also consider the multidimensionality of discrimination. To the extent that African-Americans are indeed segregated (see Sharkey 2013), then a substantial portion of their everyday interactions with others will be with other African-Americans. Given the social salience and consequences of

color among African-Americans (Frazier 1940, 1957; Drake and Cayton [1945] 1993; Hunter 2005), it stands to reason that tensions over color may be an important factor of stress within the black population (e.g., within families, among friends) and, thus, also help shape health outcomes within the black population. Analyses that only focus on intercategorical comparisons and ethnoracial discrimination, however, are unable to tap into this potentially critical dimension of African-Americans' social experience.

By employing a multidimensional approach, I am able to determine not only whether these dimensions of discrimination significantly affect health outcomes but also which dimensions matter more or less and when. Such analyses constitute an important and novel contribution to our understanding of not only how discrimination affects health but also how skin color affects health outcomes along multiple dimensions. My main goal in this study is to take skin tone seriously as a critical factor of heterogeneity within the black population (specifically in terms of social disadvantage and health), which is so often seen as homogenous (Du Bois 1995). In the following section, I provide a brief overview of research on skin tone stratification to explain how and why skin tone is a critical factor of inequality for African-Americans, although it is often overlooked in conventional research on ethnoracial inequality.

A BRIEF HISTORY OF "COLORISM"

The elevated SES of lighter-skinned blacks finds its roots in slavery. Lighter-skinned slaves (i.e., typically those with direct kinship ties to whites) were favored by slave owners and were predominantly given work as house slaves as opposed to field slaves (Russell, Wilson, and Hall 1992). Working in the house as opposed to the fields dramatically increased the chance that lighter-skinned blacks would be literate and trained in a trade. Manumission was also "color-coded," which meant that the vast majority of the free black population was composed of lighter-skinned blacks and mulattos. Furthermore, nearly all blacks regarded as prominent by whites were lighter skinned or mulatto (Reuter 1917; Davis 1991). Even after slavery, the substantial social, educational, and economic advantages of lighter-skinned blacks undoubtedly gave these blacks, who often practiced homogamy and other forms of social closure, an undeniably immense head start in relation to all other blacks (Bodenhorn and Ruebeck 2007).

The association of gradations of skin color with SES among blacks persisted well into the first half of the 20th century (Frazier 1940; Edwards 1959). Hughes and Hertel (1990) find substantial evidence that the impact of skin tone on the educational attainment and socioeconomic and marital status of blacks remained virtually unchanged from 1950 to 1980. In fact, this research found that gaps in SES among African-Americans related to

gradations of color were comparable to or even larger than gaps in SES between African-Americans and whites as a whole (Hughes and Hertel 1990, p. 1114). A more recent study finds that the association between skin tone and SES among African-Americans persists into the early 21st century (Monk 2014). In fact, using data drawn from nationally representative surveys, I find that inequality in educational attainment among African-Americans along the color continuum (from the lightest to the darkest skinned) is larger than what obtains between African-Americans and whites as a whole.[4] Nevertheless, as most conventional research on ethnoracial inequality compares ethnoracial populations to one another using census categories, this substantial heterogeneity in skin tone and, thus, life chances is obscured.

Gradations of skin color also pattern interpersonal relationships among African-Americans. Scholars often find that darker-skinned females pay a heavy penalty when it comes to mate selection, as darker-skinned black women are consistently passed over for marriage by middle-to-high-status black males in favor of lighter-skinned partners (Hunter 2005; Hamilton, Goldsmith, and Darity 2009). One study even finds that the spouses of the darkest-skinned black females have a full year less education than the spouses of the lightest-skinned black females—even after taking the educational attainment of the respondent and other sociodemographic factors into account (Monk 2014). Such findings are consistent with accounts of black marital patterns going back to the antebellum South (Johnson 1934; Drake and Cayton 1993; Bodenhorn 2006).

The significance of skin tone among black Americans, however, is not simply a matter of these intracategorical dynamics; skin tone also affects how black Americans are treated by nonblacks, as has been the historical pattern in the United States (see above). While white Americans may not make as fine-tuned phenotypic distinctions of black Americans as black Americans draw among themselves (Hill 2002), there is still compelling evidence that black Americans of different skin tones are treated differently by whites. For example, studies find that blacks with darker skin tone were sentenced to an average of eight additional months of prison time compared to blacks with lighter skin tone, even after taking their prior criminal records into account, and darker-skinned, more 'Afrocentric'-appearing black Americans are significantly more likely to face the death

[4] According to data drawn from the National Health Interview Survey (2005), which is a large-scale nationally representative survey conducted by the Centers for Disease Control ($N > 1$ million), white Americans between age 25 and 44 have 10.2 months more education on average than black Americans. By contrast, according to data drawn from the National Survey of American Life (2001–3), the gap in educational attainment (weighted mean) between the lightest- and darkest-skinned black Americans between ages 25 and 44 is 15.4 months.

penalty than lighter-skinned African-Americans (Blair, Judd, and Chapleau 2004; Eberhardt et al. 2004, 2006; Gyimah-Brempong and Price 2006; Viglione, Hannon, and DeFina 2011). Moreover, audit studies of housing find that lighter-skinned blacks are treated better by whites in real estate transactions, experimental studies of hiring practices report that white subjects preferred lighter-skinned blacks to darker-skinned blacks when making hiring decisions, and lighter skin has even been found to protect African-American politicians from being the target of negative ethnoracial stereotypes (Weaver 2012).

While the vast majority of research on social inequality consists of making comparisons between aggregates of individuals who self-classify into (or are classified by others into) various highly visible social categories—typically those used by the state in the form of censuses and various bureaucratic procedures[5]—we must keep in mind that "the categories used by ordinary people in everyday interaction often differ substantially from official categories. The categorized are themselves chronic categorizers; the categories they deploy to make sense of themselves and others need not match those employed by states, no matter how powerful" (Brubaker, Loveman, and Stamatov 2004, p. 35). In fact, "a common thread in studies of everyday classification is the recognition that ordinary actors usually have considerable room to maneuver in the ways in which they use even highly institutionalized and powerfully sanctioned categories. They may adhere nominally to official classificatory schemes while infusing official categories with alternative, unofficial meanings" (p. 35).

Furthermore, research on social psychology and cognition clearly signals that the social world is far more complex than what most research on social inequality and public discourse regarding inequality often suggests. This research on how individuals deploy categories in everyday life demonstrates that our ability to see differences exceeds that of the broad (dichotomous) categories used in most research. On the one hand, studies demonstrate that we classify individuals into the superordinate categories of sex and race extremely quickly (i.e., in under 150 milliseconds; see Ito and Urland 2003) and often automatically, outside of our conscious awareness (Bargh et al. 2012). These superordinate categories often trigger various stereotypes that shape and constrain social interactions in ways that produce and reproduce social inequalities (Fiske 2000; Macrae and Bodenhausen 2001). Yet, on the other hand, these superordinate categories are often so broad that they are not very informative with respect to the for-

[5] As Bourdieu explains, "Using a variation around Max Weber's famous formula, the state successfully claims the monopoly of the legitimate use of physical and *symbolic* violence. . . . It incarnates itself simultaneously in objectivity, in the form of specific organizational structures and mechanisms, and in subjectivity, in the form of mental structures and categories of perception and thought" (1998, pp. 40, 54).

mation of social judgments that guide the decision-making processes that may be critical in producing and reproducing social inequalities across a wide array of key institutions (e.g., the education system, the labor market, the criminal justice system; Devine and Baker 1991; Twuyver and Knippenberg 1998; Irmen 2006; Pattyn et al. 2015).

On this view, the social categories most research examines (i.e., superordinate categories) are important because they act as anchoring points, which often set the stage for social interactions. Research shows, however, that these initial classifications are often modulated by subcategorical distinctions (see above). This is especially true regarding subcategories linked to variation in physical appearance. Evidence strongly suggests that physical appearance trumps information about traits and behavior when forming social judgments (Deaux and Lewis 1984; Macrae and Bodenhausen 2001). In fact, some even contend that "physical qualities can serve as a basis for social impressions in the absence of explicit categorization processes, and that variations in physical qualities should lead to within-category variations in social impressions" (Zebrowitz 1996, p. 109, cited in Maddox 2004, p. 387). Moreover, unlike stereotypes at the superordinate level, phenotype-related, subcategorical stereotypes prove extremely difficult to suppress, even when individuals are explicitly warned about such biases in advance (Dasgupta, Banaji, and Abelson 1999; Blair et al. 2002).

What is important to consider regarding the importance of subcategories is that research on social cognition shows that we not only perceive whether an individual fits a certain category but also, and this is crucial, how much they fit a certain category (Maddox 2004). This means that one may be classified as fitting the category "black" but still be seen as more or less black along a continuum, depending on, for example, one's ethnoracially coded phenotypic appearance (see Maddox 2004; Wade, Romano, and Blue 2004). Therefore while it is certainly likely that all blacks face discrimination, the frequency and kind they face may vary substantially within the category, along a continuum of color. This continuum of color, researchers argue, is marked by various color-related subcategories of African-Americans that are commonly recognized by blacks and nonblacks alike (Maddox 2004).

There is considerable compelling evidence not only that individuals use these subcategories to organize information about the social world but that categorization at the level of subcategories may actually be preferred to categorization at the superordinate level because subcategories are more informative than superordinate categories while remaining cognitively efficient. Furthermore, much like superordinate categories, subcategories also trigger stereotypes (often automatically) and play a decisive role in the formation of social judgments (Maddox 2004; Irmen 2006). Moreover, research also demonstrates that knowledge of both superordinate and sub-

categories with respect to key social categories such as age, gender, and race is often widely shared by "in-group" and "out-group" members, which links macrolevel structure to microlevel action through intersubjectively shared cognition (e.g., categories and schemata; see DiMaggio 1997; Brubaker et al. 2004).

Accordingly, there are well-documented stereotypes of darker-skinned blacks, shared by both blacks and whites, which describe darker-skinned blacks as unintelligent, unattractive, impoverished, criminal, and lazy; by contrast, both blacks and whites often stereotype lighter-skinned blacks as motivated, educated, and attractive (Anderson and Cromwell 1977; Maddox and Gray 2002). There is even the well-documented use of color labels among African-Americans (Parrish 1946; Wilder 2010), such as "high yellow" and "blue-black," which have been in consistent use for well over a century and roughly correspond to these socially salient, color-related subcategories (e.g., "light skinned" and "dark skinned," respectively). These color labels are very similar (although not precisely equivalent) to the myriad color labels that Brazilians use in everyday life (Harris 1970; Telles 2004; Bailey 2009).

Regarded more broadly, however, such dynamics may obtain with respect to social categories in general. Consider the case of gender. Research suggests that gender (and stereotypes linked to gender) is perceived in terms of not simply a dichotomy between male and female but instead continua of masculinity and femininity (Green, Ashmore, and Manzi 2005). These continua of perceived masculinity and femininity are probabilistic and overlapping with respect to the various characteristics, traits, and stereotypes that define them, and these continua are also marked by a variety of socially salient and consequential subcategories (Deaux and Lewis 1984; Green et al. 2005). Again, perceptions of physical appearance play a primary role in these processes of social classification. The key insight also remains the same: we not only perceive whether individuals fit a particular category but also the degree to which they fit a particular category, and perceptions of typicality often correspond with socially salient and consequential subcategories nested within broader superordinate categories. Dualistic categories are often continua in practice.

Consequently, to the extent that stigmatization and discrimination are held to be key explanations for various social inequalities, these inequalities, which most research only examines at the level of a broad demographic category (i.e., the average across an entire superordinate category), may actually be produced and reproduced by much more complex, relational, and fine-tuned processes of social categorization and classification along multiple, possibly conflicting, dimensions. Thus, I endorse not only a reconsideration of "the social categories of disadvantage" (Schwartz and Meyer 2010, p. 1117) but also a redefinition of our approach to the study

of social inequality (e.g., ethnoracial inequality) and social categories that moves beyond analyses focused almost exclusively on superordinate, dichotomous categories such as black, white, Latino, and so on.

Moreover, I depart from the orthodox "social stress model," as described by Schwartz and Meyer (2010), with its firm rooting in a view of the social world that presupposes the existence of "groups" and focuses almost exclusively on differences between them (i.e., comparing the "average" individual of one "group" to that of another "group"). Such a view of the social world not only reifies survey instruments but also falls into the trap of *groupism* (see Brubaker 2004). Such approaches bracket out the complexity of social interaction in practice—as is demonstrated by research on social cognition—which is neither necessarily nor strictly dichotomous, as much as it is gradational and nested (i.e., subcategorical).

I propose that instead of focusing solely on the consequences of belonging to this or that social category, researchers should also consider the social salience and consequentiality of the degree to which individuals are perceived to fit a particular category. This will often also involve an examination of the various subcategories nested within the superordinate category under investigation that individuals may be perceived to belong to (or, also the subcategories one perceives oneself as belonging to). One way of doing this is by identifying key markers that not only signify categorical membership but also help determine the degree to which individuals are perceived to fit a particular category (or their perceived membership in subcategories nested within a superordinate category). Researchers, then, may investigate how variation in these markers of a particular social category are implicated in the production and reproduction of social inequalities. These markers (or cues) of categories may even be orthogonal to the category under consideration.[6] Studying color-related inequality among African-Americans is an apposite example of this approach.

Taking this step not only will allow researchers to add depth and complexity to our understanding of the key mechanisms that produce and reproduce social inequalities but may also allow us to uncover new mechanisms and processes. Alas, a fuller discussion of these important issues is beyond the scope of the current study, which focuses centrally on the role of skin tone as a factor leading to disparate intraracial health outcomes. Researchers propose that gradations of skin color pattern exposure to discrimination among African-Americans, which may not only help explain health outcomes among African-Americans (and between blacks and non-

[6] Evidence suggests that differences in skin color, nativity, names, and linguistic ability (e.g., English language adoption and accent) significantly stratify educational attainment and earnings among Latinos, in addition to shaping their ethnoracial self-identifications (Mason 2004; Golash-Boza and Darity 2008).

blacks) but also help explain why SES is stratified along a color continuum among African-Americans (Keith and Herring 1991). Nevertheless, as I explained above, research has fallen short of directly linking skin tone to variation in the frequency of discrimination African-Americans perceive. Consequently, addressing this quandary directly, using a nationally representative sample of African-Americans, will not only contribute to our understanding of health differences among African-Americans but also lend evidence for the existence of a key mechanism (i.e., differential exposure to various forms of discrimination), which may produce and reproduce socioeconomic differences within the black population.

MEANINGS AND MEASURES: THEORIZING THE ROLE OF SKIN COLOR AND DISCRIMINATION IN SOCIAL INEQUALITY

In this study I employ a multidimensional approach to examining social inequality, which analytically distinguishes between and deploys multiple measures of discrimination, health, and even skin tone. In so doing, I demonstrate the utility of examining multiple dimensions of discrimination and leveraging intracategorical heterogeneity (in physical appearance) to help explain both intra- and interracial inequalities in health, thus illuminating aspects of social inequality that may go unnoticed in conventional research. A central contention of the current study is that how we measure discrimination and even skin tone is somewhat responsible for the mixed findings currently reported in the literature. As Keith and her colleagues point out, in anticipation of this argument, "Inconsistent findings [in the literature] may reflect differences in sample compositions as well as *the measures of skin tone and discrimination employed* [in existing research]" (2010, p. 3). In the following sections, I make the case that researchers should use multiple measures of discrimination and skin tone in order to more comprehensively examine inequalities in health.

Discrimination: More than Just "Race"

While most studies of discrimination and health only concern themselves with ethnoracial discrimination, some scholars astutely point out, given the emotional gravity of ethnoracial discrimination for respondents and subsequent matters of unreliable recall and other cognitive biases, that it is important to ask questions about discrimination in general. "Building attribution into the question is likely to underestimate discriminatory encounters for which the attribution is uncertain" (Williams and Mohammed 2009, p. 31). This suggests the need to use measures of the perceptions of discrimination, regardless of their specific attribution, such as the everyday discrimination scale that I use in the current study.

Many studies also ask respondents whether they have ever experienced ethnoracial discrimination. Such measures pose a serious problem for studies attempting to link perceived discrimination among black Americans to health outcomes because nearly all black Americans report experiencing ethnoracial discrimination. For example, Borrell et al. (2006, p. 1422) report that 75% of their respondents claimed that they faced "racial discrimination." This leaves very little variation for gradations of skin color (or anything else) to predict. This suggests the need for a measure of the frequency of perceived discrimination respondents report. Accordingly, I use measures of the frequency of perceived discrimination respondents report in the current study.

In addition to using a measure of the frequency of perceived discrimination in everyday life, I also use two separate measures of skin color–related discrimination. One captures perceptions of skin color discrimination from whites, and the other captures perceptions of skin color discrimination from other African-Americans. Using both measures of skin color discrimination is important because they pick up analytically distinct forms of differential treatment. On the one hand, as some studies have shown, whites distinguish between African-Americans on the basis of variation in skin tone, which helps produce inequalities in the labor market, the criminal justice system, housing, and more (Eberhardt et al. 2004). On the other hand, African-Americans also distinguish between themselves on the basis of variation in skin tone, which may also produce and reproduce intracategorical inequalities. Using both measures is important given the evidence that suggests that skin color discrimination may be patterned differently between African-Americans and whites (i.e., interracially) than it is among African-Americans (i.e., intraracially).

Drake and Cayton (1993), for example, noted a preference for being medium skin tone among African-Americans in their landmark study *Black Metropolis*. Recent research also highlights that being on either extreme of the color continuum (i.e., very light or very dark skinned) is stigmatized among African-Americans (Hunter 2005). Such dynamics are very different from what is hypothesized to occur between African-Americans and whites (or other nonblacks), where research demonstrates that being darker skinned is stigmatized and being lighter skinned is advantageous (Maddox and Gray 2002; Blair et al. 2004).

Skin Tone: Beyond "Objectivity"

In addition to using multiple measures of discrimination, I also exploit a unique feature of the nationally representative survey I analyze—its two measures of skin tone. Many previous studies have sought to use "objective" measures of skin tone. Yet, it remains unclear whether these "ob-

jective" measures of skin tone are actually a fair gauge of what observers see or focus on in their interactions with respondents in the context of discrimination (i.e., the putative goal of "objective" measures). Many studies use spectrophotometers to "objectively" measure respondents' skin tone (see, e.g., Krieger et al. 1998; Borrell et al. 2006). In these studies, researchers typically measure the skin reflectance of respondents' inner arms. Spectrophotometers are often used to measure levels of melanin in individuals' skin for cancer research (Dwyer et al. 1998). As research demonstrates, however, social classification (broadly construed) and ethnoracial discrimination related to skin tone, in particular, are both related to the perception of the lightness or darkness of faces, not inner arms (which, due to differential exposure to the sun, among other factors, may not even be the same shade as individuals' faces see; Blair et al. 2002; Maddox 2004).[7]

Furthermore, it is unclear whether "objectivity" alone should be desired with respect to measuring skin color. As Villarreal (2012, p. 501) astutely points out, "Adherence to a notion of objectivity in the measurement of skin color is incongruent with much of what we have learned about race and ethnicity over the past several decades. *Like perceptions of race, perceptions of individuals' skin color are necessarily subjective*. The fact that they are subjective *does not, of course, mean that they do not have social consequences*. On the contrary, people's behavior toward others is affected by how they perceive them, including, in many instances, by how they perceive the color of their skin. This *perception may not correspond precisely with an exact measurement of their skin pigmentation. . . . [Thus], a better measure of skin color to examine potential discrimination is how individuals are perceived rather than an 'objective' measure of their skin pigmentation*" (emphasis added). Accordingly, this study uses an interviewer-rated skin color measure.

Still, using only interviewer-rated skin tone may be somewhat shortsighted as well. It is possible that how we perceive ourselves is also a predictor of our health. There is (indirect) evidence that self-reported skin tone may also be important in understanding discrimination and inequality. Examining self-reported "race" data, for example, has been a mainstay of the literature on ethnoracial classification and inequality in Brazil for quite some time (Telles and Lim 1998; Telles 2004; Schwartzman 2007;

[7] While skin tone is not the only phenotypic trait that marks ethnoracial categories, it is the primary marker of ethnoracial difference. Furthermore, gradations of skin color are highly correlated with gradations of hair type and "Afrocentric" facial features among African-Americans (Blair et al. 2002; Maddox 2004). Moreover, skin tone activates subcategorical, phenotype-based stereotypes of African-Americans among both blacks and whites independent of, more consistently than, and more strongly than variation in African-Americans' ethnoracially coded facial features (Maddox and Gray Chase 2004; Hagiwara, Kashy, and Cesario 2012; Stepanova and Strube 2012, p. 867).

Bailey et al. 2013). This work highlights how, in Brazil, individuals may "whiten" or even "darken" their self-classifications in accordance with their SES (e.g., individuals with higher SES may self-identify as white instead of brown or brown instead of black regardless of their skin color). Recent work is beginning to consider such Brazilian-esque possibilities in the United States (Saperstein and Penner 2012), where ethnoracial classification is thought to be much more rigid (Davis 1991).[8]

In addition to this indirect evidence, however, there is direct evidence. Consider that one of the only studies ever to find that skin tone was associated with the frequency of perceived discrimination among African-Americans used self-reported skin tone data and not interviewer-rated skin tone data (Klonoff and Landrine 2000). Unfortunately, the authors do not consider the potential importance of self-reported skin color; instead, they write, "this study is *limited* by the use of self-reported (instead of measured) skin color. . . . These self-reports of skin color [are] *inferior to direct measurement* . . . [although they] nonetheless may be a valid procedure for assessing skin color among Blacks" (Klonoff and Landrine 2000, p. 336; emphasis added).

Recent research on the United States and long-standing findings on Brazil, however, suggest that it may be possible that how light or dark skinned individuals think they are may be a significant predictor of how much discrimination they perceive in their everyday lives. This possibility is presaged by recent theorizing on the "multiple dimensions" of ethnoracial identification in the United States and Brazil. Scholars highlight several important dimensions such as internal (subjective self-identification), expressed (the "race" you say you are to others), observed (the "race" others actually assume you to be), and reflected (the "race" you believe others assume you to be; Roth 2010, p. 1294). Of particular importance in this study is the "reflected" dimension. Given the importance of skin tone among black Americans, in encounters with other blacks but also nonblacks (especially whites), it is possible that experiences of unfair treatment and discrimination are "internalized" by black Americans such that their own appraisal of how

[8] Indeed, comparatively there are extremely significant differences between the United States and Brazil in terms of the consistency of ethnoracial classification: findings from the National Longitudinal Study of Adolescent Health (Harris and Sim 2002) reveal that 99.8% of self-classified "blacks" were also classified as "black" by interviewers, compared to only 51% of self-classified "blacks" (*pretos*) being classified as "black" by interviewers in Brazil, according to findings from the nationally representative Pesquisa Social Brasileira, 2002 (Bailey 2009, p. 50). Unsurprisingly, the estimates of "racial fluidity" a recent study reports (Saperstein and Penner 2012) are substantially lower than what obtains in Brazil (Telles 2004; Bailey 2009)—in fact, what may be considered "fluidity" from a U.S.-centered viewpoint may actually be rigidity once one extricates oneself from a U.S.-centered viewpoint.

light or dark their skin is is a good predictor of how much discrimination they perceive.[9]

Consider, for example, the case of ethnoracial self-identification among "biracials." Khanna (2010) argues that many individuals explain that they identify as black only, despite being "bi- or multiracial," because other blacks and whites see them as black only. Khanna (2010) proposes that these "reflected appraisals" of one's ethnoracial self-identification, that is, the negotiated internalization of observers' ascriptions of their race, are a key mechanism by which the "one-drop rule" persists. Thus, similar to the case of ethnoracial self-classification in Brazil,[10] there may be a tight, inextricably interwoven relationship between perceptions of discrimination and self-perceptions of skin color, which may have the consequence that self-reports may be stronger predictors of perceptions of discrimination than interviewer-rated skin tone data.

Nevertheless, it is important to note that self-reported skin color is not simply another measure of discrimination. Measures of discrimination focus on either negative experiences or the lack of negative experiences with respect to a single analytic dimension (i.e., interracial contact in a variety of social contexts). What self-reported skin color may capture is not only negative experiences or the lack of said experiences along a single analytic dimension (i.e., interracial or intraracial contact) but instead negative and positive experiences along multiple possibly conflicting dimensions (i.e., interracial and intraracial social experiences). Not only this, but it may provide of measure of social experience over the entire life course of the respondent, instead of only the past year or less (most discrimination measures are worded with clear temporal bounds).

Not only is self-reported skin color theoretically and analytically distinct from discrimination, but it is also empirically distinct from each of the measures of discrimination I use in this study. The correlation of self-reported skin color and perceived discrimination (in general) is only .03, and the correlation between self-reported skin color and skin color discrimination from other blacks is (surprisingly) even lower, .01. Consequently, while I do argue that self-reported skin color may be a crucial predictor of multiple forms of perceived discrimination, self-reported skin color is not coterminous with or empirically intercorrelated with these forms of discrimination.

[9] For a discussion of what is meant by "internalization" in this study, please see Bourdieu's more elaborate and refined conceptualization of *habitus* and implicit knowledge in *Pascalian Meditations* (Bourdieu 2000).

[10] Ironically, research on ethnoracial inequality in Brazil, a country renown for the centrality of skin color, has moved toward a dichotomous, U.S.-style model (i.e., black [*negro*] and white) of estimating ethnoracial inequality, which also obscures the consequentiality of the skin color continuum for individuals' life chances.

Self-reported color is important because it likely reflects the local-level experiences of individuals over their life course in a wide array of social contexts and fields with respect to their treatment by a wide array of individuals of various social and national backgrounds. Also, it likely reflects individuals' anticipation of differential treatment by others (e.g., vigilance), and as such it may be implicated in such processes as stereotype threat (see Steele and Aronson 1995). Moreover, and this is critical, self-reported color is an assessment of individuals' skin tone relative to their peers. Consequently, it potentially represents much more than the assessment of a single interviewer on a single occasion—it is an assessment of individuals' sense of place, more precisely, the reflected appraisal (e.g., Mead 1934) of their place within myriad social hierarchies with respect to the wide array of social contexts and situations wherein they live out their lives. Consequently, while interviewer-rated skin color data may be a reasonable measure of how much discrimination black Americans may face from others or perceive that they encounter in their daily lives, self-reported skin color data (i.e., "reflected appraisals" of skin tone)[11] may tap into the accumulated experiences of differential treatment black Americans have faced over their life course along multiple possibly conflicting dimensions and, thus, prove an even stronger predictor of perceptions of discrimination than interviewer-rated skin color.

Therefore, I argue that self-reported skin color is a form of *subjective social status* among African-Americans. As Davis (1956, p. 54) puts it, subjective social status is fundamentally "a person's belief about his or her location in a status order." While subjective social status is often thought of as a "cognitive averaging of standard markers of socioeconomic position [in relation to others]" (Singh-Manoux, Adler, and Marmot 2003, p. 1331), I argue that self-rated skin color may be thought of as a cognitive averaging of one's *embodied social status*, which is strongly associated with one's experiences of treatment by alters (both positive and negative treatment by both blacks and nonblacks) over their life course and, importantly, is thoroughly relational and dynamic (i.e., it may shift over the life course).

What is so compelling about conceptualizing self-reported skin color as subjective social status is that it is "likely to reflect not only current social circumstances, but also incorporate an assessment of the individual's past, along with their future prospects. . . . [Moreover], the process of assigning oneself social status is likely to involve processes of social comparison and reflected appraisals (self-perception is based on the way we see others

[11] "Reflected appraisals" draws from Charles H. Cooley's (1983) concept the "looking-glass self" and was explicitly formulated by Mead (1934). For more information on the looking-glass self, see Yeung and Martin (2003), and on symbolic interactionism, more generally, see Blumer (1969).

perceiving us)" (Singh-Manoux et al. 2003, p. 1322).[12] Research suggests that subjective social status is significantly correlated with a host of key health outcomes such as self-rated health, depression, mortality, and even biological risk factors such as increased heart rate, greater abdominal fat deposition, greater morning rise in cortisol, and greater susceptibility to infection (Adler et al. 2000, cited in Singh-Manoux et al. 2003; Operario, Adler, and Williams 2004). In fact, some studies show that subjective social status is an even stronger predictor of health outcomes than objective measures of SES and position (see Adler et al. 2000; Singh-Manoux, Marmot, and Adler 2005).

Furthermore, there is compelling evidence that relative disadvantage, operating through the perception of one's own relative standing in a social hierarchy, may be a crucial link between socioeconomic position and health outcomes (Singh-Manoux et al. 2003, p. 1322). Evidence from animal studies strongly suggests that individuals' position in social hierarchies is intimately linked to their health; being socially subordinate is significantly associated with poorer health (Kaplan and Manuck 1999). As a variant of subjective social status, self-rated skin color may be an important predictor of not only perceived discrimination (in its multiple forms) but also the health outcomes that the vast majority of public health and epidemiological research tends to examine (e.g., self-rated mental and physical health, depression, and hypertension). That is, self-reported skin color, much like subjective social status, may have a director independent effect on health outcomes (even after controlling for various forms of discrimination).

Thus, in this study, I examine not only the significance of multiple dimensions of discrimination but also the significance of multiple dimensions of skin color with respect to health outcomes among African-Americans. The first dimension refers to interviewer-rated skin tone, which captures skin tone as perceived from an outsider. This dimension likely captures where African-Americans are perceived to belong on a continuum of categorical membership (i.e., a continuum of blackness). The other dimension, which has received very little serious attention, is self-reported skin tone. This dimension likely captures individuals' own perception of where they belong on a continuum of categorical membership and as such operates as a form of subjective social status. I use each dimension of skin tone to investigate the skin tone–discrimination–health pathway that previous research has often hypothesized yet fallen short of substantiating. I use these measures alone (i.e., directly), as well as in the same models, to test which form of skin tone may be a better predictor of the various

[12] For more on the role of social status and social comparisons in the production and reproduction of social inequality, please see Fiske (2011) and Ridgeway (2014).

outcomes at hand, thus extending recent work on "multidimensionality" in ethnoracial inequality in the United States and Brazil (Telles and Lim 1998; Saperstein 2012; Bailey et al. 2013) and the multiple dimensions of ethnoracial identification (Khanna 2010; Roth 2010).

Additionally, these simultaneous models test whether discrepancies between the two measures, although correlated, may also help predict certain health outcomes. Certainly, one could imagine that individuals who rate themselves as darker than interviewers rate them may also be more likely to report higher incidences of being depressed or being in poorer mental or physical health. Such discrepancies would be reflected by instances in which each measure of skin color is significant, but in opposite directions. Consider that there is some evidence that conflicts between self- and outsider ascriptions of "race" may cause psychological conflict and lead to poorer mental health outcomes (see Campbell and Troyer 2007). While testing such possibilities with respect to skin tone is certainly not the central focus of this study, examining these possibilities, for the first time in our literature, is indeed yet another contribution of the current study.

DATA AND METHODS

In this study I use the National Survey of American Life (NSAL, 2001–3). The fieldwork 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 multistage probability design that consists of 64 primary sampling units.[13] 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 age 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 that are more

[13] Please note that all analyses are weighted to take into account the complex design of the survey. For more information on this survey's sample design, please see Heeringa et al. (2004).

difficult and expensive with respect to survey fieldwork and data collection. The African-American sample is nationally representative of black households in the 48 coterminous states with one adult age 18 and over. The analyses presented here are restricted to native-born U.S. blacks.[14]

Principal Outcomes

The first measure of discrimination I examine is perceived discrimination in general, which is often referred to as everyday discrimination (see Williams and Sternthal 2010). It is a categorical variable ranging from 1 to 5, where 1 = never and 5 = very often, which refers to a scale composed of 10 different types of unfair treatment, such as the frequency the respondents report feeling like they are treated with less courtesy than others, or less respect than others; and the frequency the respondents feel people act like they are not smart or act afraid of them, call them names, or insult them; or even how frequently the respondents feel that they are threatened, harassed, or followed in stores.

Additionally, I use two separate measures of perceived discrimination due to skin color, which quantify how much discrimination respondents perceived due to their skin color, from whites and blacks respectively. I do so following the proposition that skin tone may be a factor of differential exposure to discrimination among African-Americans, but the relationship between skin color and discrimination may be context dependent. As Keith et al. (2010, p. 56) point out, "discrimination on the basis of race alone and in combination with complexion may be operating to varying degrees depending on the racial composition of settings where discrimination is experienced." Accordingly, I argue that skin color, which I conceptualize as a form of *bodily capital* (e.g., Wacquant 1995), is a relational property akin to stigma (e.g., Goffman [1963] 1986).[15] Therefore, its salience and consequentiality depends on the particular demographic composition of the vari-

[14] All respondents in this study are self-identified African-Americans born in the United States, as was the case in Keith and Herring's (1991) analysis of the NSBA (National Survey of Black Americans), 1979–80. I separate African-Americans from Caribbean Americans in these analyses, given that the salience and consequentiality of skin tone may be patterned differently among the latter compared to the former. Moreover, differences of nationality and selection bias may also yield baseline differences in health between Caribbeans and African-Americans, in addition to different relationships between skin tone, perceived discrimination, and health outcomes.

[15] As Goffman (1986, p. 3) explains, "Stigma [is an] attribute that is deeply discrediting, but it should be seen that a language of relationships, not attributes is really needed. An attribute that stigmatizes one type of possessor can confirm the usualness of another, and therefore is neither creditable nor discreditable as a thing in itself." For example, while dark skin may be negatively valued and even an impediment in a majority white setting

ous fields or settings individuals find themselves in and the outcomes under investigation.[16]

Using each measure separately allows me to discern whether color discrimination is patterned differently intraracially (within the black population) as opposed to interracially (between blacks and whites), as some literature on African-Americans has long suggested (see Drake and Cayton 1993), and to test which forms of discrimination matter more or less and when. The measures of perceived discrimination due to skin color are frequency scales that range from 1 to 6, where 1 = never and 6 = almost every day. The alpha coefficient for the reliability of these scales is 0.89.

Finally, I examine the relationship between skin tone, discrimination, and four key health outcomes. The physical health measures I use are self-reported physical health and hypertension, both of which feature prominently in research on health disparities. The measure of self-reported physical health used in this study is a scale ranging from 1 to 5, where 1 = poor, 2 = fair, 3 = good, 4 = very good, and 5 = excellent. This measure has been used in a multitude of previous studies (for a recent review, see Pascoe and Richman 2009). A variety of studies in the United States, as well as large samples of people all over the world, demonstrate that this measure of self-rated health is a very strong predictor of morbidity and mortality (see, e.g., Mossey and Shapiro 1982; Idler and Benyamini 1997; DeSalvo et al. 2006). In fact, some studies find that self-reported health remains an independent predictor of mortality and other illnesses, even after controlling for objective measures of health (Jylhä, Volpato, and Guralnik 2006; van der Linde et al. 2013). Furthermore, self-reported physical health has a strong association with various biomarkers for disease (Jylhä et al. 2006) and in some cases is an even stronger predictor of mortality than "objective health status" (Mossey and Shapiro 1982). The clear message here is that respondents' self-perceptions are associated with clear and sometimes dire consequences (see Jylhä 2009).

(e.g., a predominantly white private school or a boardroom at a Fortune 500 company) or even a majority black setting (e.g., a Jack n' Jill cotillion or a meeting of the Tennessee Blue Vein Society; Russell et al. 1992, p. 52), dark skin may also be advantageous in certain settings (and light skin, negatively valued and a potential impediment) such as a Garveyite UNIA rally or in the case of black men in the marital market, with some findings suggesting a correlation between dark skin and the perception of heightened racial "authenticity," loyalty, and physical strength (Johnson 1934; Hunter 2005). These "fluctuations" in the value of certain skin tones are missed by the vast majority of researchers of "colorism" who focus, almost exclusively, on how being lighter skinned is "better" than being darker skinned (see, e.g., Bond and Cash 1992; Russell et al. 1992). Considerations of the relational value of lighter and darker skin tone are rare in the literature on colorism in the United States (an exception is Hunter 2005).

[16] For more on fields, see Bourdieu and Wacquant (1992, esp. pp. 94–115).

Additionally, I examine the relationship between skin tone, perceived discrimination, and hypertension. Respondents were asked whether a medical professional has informed them that the respondent is suffering from high blood pressure. Again, I code this as a dummy variable, where 0 = no and 1 = yes. The mental health measures I use are self-reported mental health and depression, which also feature very prominently in the literature on health disparities. The measure of self-reported mental health used in this study is a scale ranging from 1 to 5, where 1 = poor, 2 = fair, 3 = good, 4 = very good, and 5 = excellent (again, similar measures have been used in a multitude of previous studies; see above). As a measure of depression, I use a survey item in which respondents were asked whether they have felt "sad/depressed/empty" for a several day period; I code this as a dummy variable, where 0 = no and 1 = yes.

Control Variables

I use a variety of sociodemographic control variables such as age and sex. *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 that represents the degree to which respondents are above, below, or at the poverty line (poverty index = household income/poverty threshold). *Educational attainment* is a continuous variable capturing the number of years of completed education, ranging from 0 to X_{max}. *South* (*region*) is a dummy variable, where 0 = non-South and 1 = South. *Rural* is a dummy variable, where 0 = nonrural 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 nondistinct ways and that these two states are also empirically indistinguishable for the vast majority of the labor force (Clark and Summers 1979; Goldsmith, Veum, and Darity 1995).[17]

Predictors

I use two measures of skin tone in this study. One measure of skin tone is interviewer-rated skin color, which is a scale ranging from 1 to 7, where

[17] Clark and Summers (1979, p. 31) contend that "many of those classified as not in the labor force are functionally indistinguishable from the unemployed." While the meaning of being "out of the labor force" may be shaped by gender, there were only slight differences in the averages of women reporting being "out of the labor force," as opposed to men.

1 = very light skin and 7 = very dark skin (Keith et al. 2010).[18] Please note that interviewers were matched for race with respondents (Jackson et al. 2004).[19] This is important because research shows that blacks make finer-tuned phenotypic distinctions within the black population than whites (Hill 2002).[20] The other measure of skin tone is self-reported skin tone, which is a scale ranging from 1 to 5, where 1 = very light skin and 5 = very dark skin. These two measures are, unsurprisingly, quite related, and their alpha coefficient of scale reliability is 0.80 with a correlation of .71. Nevertheless, I use both of these measures because each measure of skin tone corresponds to different analytic dimensions of social experience (see "Meanings and Measures" above) and may be empirically distinct. Descriptive statistics for the variables used in the analyses are available in table 1.

FINDINGS

Perceived Discrimination

As was explained earlier, while skin tone has long been hypothesized to be a significant predictor of perceived discrimination among African-Americans, current findings are inconclusive (see Borrell et al. 2006; Keith et al. 2010). In order to address this long-standing quandary, I use ordered logistic regression analysis to examine the relationship between respondents' skin color and how much discrimination they perceive they encounter in their everyday lives. The results presented in table 2 demonstrate that skin color is indeed significantly associated with how much discrimination African-Americans perceive in their everyday lives, net of a variety of sociodemographic controls. The darker skinned black respondents are, the more discrimination or unfair treatment they perceive that they encounter in their everyday lives. Converting to odds ratio for interpretation reveals that a one-level increase in the darkness of respondent's skin tone is associated with 13% higher odds of perceiving more discrimination than other respondents (exp[.122]). This finding provides evidence that skin tone is a significant predictor of differential exposure to discrimination. While these results do not necessarily speak to how much "racial" discrimination

[18] The distribution of respondent's skin tones is 2.7% very dark, 15.3% dark, 18.34% somewhat dark, 41.91% medium, 12.19% somewhat light, 7.05% light, and 2.51% very light.

[19] As information about interviewers was unavailable, I am unable to control for interviewer effects, but again, whether interviewers' ratings of respondents' skin colors are affected by the interviewers' own characteristics does not negate whether skin color is associated with individuals' perceptions of discrimination and health outcomes.

[20] Comparing white interviewers' ratings of skin color to black interviewers' ratings may be a potentially compelling analysis as well, but as whites were not used as interviewers for black respondents in the NSAL, I am unable to analyze any differences between white and black interviewers' perceptions of black respondents' skin color.

TABLE 1
DESCRIPTIVE STATISTICS OF VARIABLES IN ANALYSIS

Variable	Mean (SD)	Min–Max	*N*
Age	43.14 (16.34)	18–93	3,288
Years of education	12.27 (2.52)	4–17	3,288
Employed	.65 (.48)	0–1	3,288
Poverty index	2.44 (2.25)	0–17	3,288
Marital status	.34 (.47)	0–1	3,288
Region (south)	.66 (.48)	0–1	3,288
Rural	.21 (.41)	0–1	3,285
Self-rated physical health	2.61 (1.09)	1–5	3,033
Self-rated mental health	2.19 (1.04)	1–5	3,033
Hypertension	.34 (.47)	0–1	3,046
Depression	.41 (.49)	0–1	3,046
Skin color scale (interviewer rated; 1 = very dark skin to 7 = very light skin)	3.75 (1.26)	1–7	3,111
Skin color scale (self-rated; 1 = very dark skin to 5 = very light skin)	2.88 (.89)	1–5	3,275

TABLE 2
RESULTS OF ORDERED LOGISTIC REGRESSION (Weighted), PERCEIVED DISCRIMINATION

	(1)	(2)
Age	−.03*	−.03***
	(.00)	(.00)
Female	−.41***	−.41***
	(.09)	(.09)
Educational attainment	.02	.02
	(.01)	(.01)
Employed	.03	.03
	(.08)	(.08)
Poverty index	−.01	−.01
	(.02)	(.02)
Married	−.04	−.05
	(.09)	(.09)
South	−.40**	−.40**
	(.12)	(.12)
Rural	−.06	−.06
	(.10)	(.10)
Interviewer-rated skin color scale	.10+	
	(.03)	
Self-rated skin color scale		.12**
		(.04)
Constant	−3.83***	−3.76***
	(.26)	(.27)

NOTE.—Observations = 3,114. Numbers in parentheses are SEs. All analyses are weighted in order to account for the survey's complex design (e.g., clustering and stratification).

+ $P < .10$.

* $P < .05$.

** $P < .01$.

*** $P < .001$ (two-tailed tests).

respondents perceive, it is important to consider that studies show that "the generic experience of discrimination [causes] psychological distress . . . regardless of the attribution and characteristics of the target" (Williams et al. 2012, p. 977).

It is important to note, however, that it is the self-reported skin color scale that is significantly associated with perceived discrimination (table 2, model 2). The interviewer-rated skin color scale is only significant at the $P < .10$ level ($P = .06$). Nevertheless, those respondents judged to be in the dark skin color category by interviewers have 28% higher odds of perceiving more discrimination than other respondents ($P = .016$). Thus, in either form, there is evidence that skin tone is significantly associated with perceptions of everyday discrimination.

Perceived Skin Color Discrimination from Whites and Blacks

Tables 3 and 4 present the results of ordered logistic regression analyses of the relationship between skin color and perceived skin color discrimination from whites and other blacks, respectively. I find that a one-level increase in the darkness of respondents' (interviewer-rated) skin tone is associated with a 15% increase in the odds of reporting more skin color discrimination from whites (table 3, model 1; exp[.136]). Consequently, the darkest-skinned respondents have 126% higher odds of perceiving more skin color discrimination from whites than the lightest-skinned respondents (exp[.136]^6). Please note that self-rated skin color is also significantly associated with perceived skin color discrimination in the same direction (table 3, model 2).

Next, I test whether self-rated skin color or interviewer-rated skin color is a stronger predictor of how much color discrimination respondents perceive from whites and other blacks, respectively.[21] The results presented in table 3 reveal that the effect of interviewer-rated skin color on perceived color discrimination from whites disappears once self-rated skin color is taken into account (table 3, model 3). This suggests that self-rated skin color, which I argue is a form of subjective social status among African-Americans (see above), is an even stronger predictor of perceived skin color discrimination than interviewer-rated skin color.[22] Furthermore, these findings, which result from using both measures in the same model, strongly suggest that even though self-rated skin color and interviewer-rated skin

[21] I also test whether a discrepancy between these measures of skin tone predicts color discrimination (i.e., whether each measure of skin tone is significant, but in opposite directions).

[22] This contention is also supported by Bayesian information criterion comparisons, which provide "strong" evidence that the models using self-rated skin color yield a better fit than the interviewer-rated skin color models.

TABLE 3
RESULTS OF ORDERED LOGISTIC REGRESSION (Weighted), PERCEIVED DISCRIMINATION DUE TO SKIN COLOR (Whites)

	(1)	(2)	(3)
Age	.01*	.01*	.01*
	(.00)	(.00)	(.00)
Female	−.25**	−.26**	−.25**
	(.08)	(.08)	(.08)
Educational attainment	−.04*	−.05*	−.04*
	(.018)	(.017)	(.017)
Employed	.22*	.22*	.21*
	(.10)	(.10)	(.10)
Poverty index	−.04^{+}	−.04*	−.04*
	(.02)	(.02)	(.02)
Married	.05	.03	.04
	(.08)	(.08)	(.08)
South	−.22*	−.21*	−.21*
	(.09)	(.10)	(.10)
Rural	.03	.03	.03
	(.12)	(.12)	(.12)
Interviewer-rated skin color scale	.14**		.08
	(.04)		(.05)
Self-rated skin color scale		.19***	.11*
		(.04)	(.05)
Constant	−1.13**	−1.20**	−1.06*
	(.39)	(.36)	(.39)

NOTE.—Observations = 3,099. Numbers in parentheses are SEs. All analyses are weighted in order to account for the survey's complex design (e.g., clustering and stratification).

$^{+}P < .10$.

* $P < .05$.

** $P < .01$.

*** $P < .001$ (two-tailed tests).

color are relatively correlated, they are not equivalent (for similar "multidimensional" modeling, please see Telles and Lim [1998]). Rather, each measure is analytically and empirically distinct.

I also find that skin color is a significant predictor of how much skin color discrimination respondents perceive from other blacks (i.e., intraracial color discrimination). Intraracial color discrimination, however, is patterned differently from interracial color discrimination. Instead of the relationship being a linear continuum on which the lighter one's skin is, the less discrimination from blacks individuals perceive due to their skin color (as was the case with discrimination from whites), the relationship within the black population is more complicated. To model this complexity, I present results comparing how much discrimination from other blacks is due to skin color using three categories: the lightest-skinned, the darkest-skinned, and medium-tone blacks.

TABLE 4
RESULTS OF ORDERED LOGISTIC REGRESSION (WEIGHTED), PERCEIVED DISCRIMINATION DUE TO SKIN COLOR (Blacks)

	(1)	(2)	(3)	(4)	(5)
Age	.01***	. 01***	.02***	.01***	.01***
	(.00)	(.00)	(.00)	(.00)	(.00)
Female	.04	.05	.02	.04	.04
	(.08)	(.08)	(.08)	(.08)	(.08)
Educational attainment	.00	.00	−.00	.00	.00
	(.02)	(.02)	(.02)	(.02)	(.02)
Employed	.15	.15	.16	.16	.15
	(.11)	(.11)	(.11)	(.11)	(.11)
Poverty index	−.01	−.01	−.01	−.01	−.01
	(.02)	(.02)	(.02)	(.02)	(.02)
Married	.13	.13	.13	.13	.14
	(.09)	(.09)	(.09)	(.09)	(.09)
South	−.15	−.15	−.15	−.16^{+}	−.15
	(.09)	(.09)	(.09)	(.09)	(.09)
Rural	.07	.07	.08	.08	.07
	(.11)	(.11)	(.11)	(.12)	(.11)
Interviewer-rated skin color scale	.05				
	(.05)				
Self-rated skin color scale		.06^{+}			
		(.03)			
Self-rated very light skin			.37*		
			(.18)		
Self-rated medium skin				−.28**	
				(.10)	
Self-rated very dark skin					.48*
					(.19)
Constant	.17	.29	.02	−.10	.03
	(.32)	(.34)	(.26)	(.25)	(.26)

NOTE.—Observations = 3,104. Numbers in parentheses are SEs. All analyses are weighted in order to account for the survey's complex design (e.g., clustering and stratification).

$^{+}P < .10$.

* $P < .05$.

** $P < .01$.

*** $P < .001$ (two-tailed tests).

I find that medium-tone blacks actually perceive significantly less discrimination from other blacks due to their skin color than both the very lightest-skinned and very darkest-skinned blacks (both self-rated and interviewer-rated skin color measures produce this result, although I only present the self-rated skin color findings in table 4). Moreover, I find that both very light-skinned and very dark-skinned blacks report significant amounts of discrimination due to their skin shade within the black population (table 4, models 3 and 5). These results lend substantial quantitative validation (using a nationally representative survey) to the findings of qualitative research on "colorism" that has been conducted for several

decades regarding the politics of skin color among black Americans (Frazier 1940; Anderson and Cromwell 1977; Drake and Cayton 1993; Hunter 2005).[23]

Crucially, these findings highlight the importance of considering the relationality of skin color. Some research details that darker-skinned black women and men often feel stigmatized among other blacks as less attractive and less intelligent (Maddox 2004; Hunter 2005), while lighter-skinned blacks feel stigmatized among other blacks for allegedly being "racially inauthentic" (Hunter 2005, pp. 93–94). Interestingly, while women were more likely to perceive discrimination due to their skin color from whites, there were no significant gender differences in how much discrimination due to skin color from blacks respondents reported. This suggests that, even though most research emphasizes the importance of skin color for black women, skin color matters a great deal for black men as well.

Self-Rated Physical Health

Next, I examine the relationship between skin tone, perceived discrimination, and self-rated physical health. Self-reported physical health is consistently found to be a significant predictor of mortality, even after controlling for "objective" measures of health, and sometimes it is found to be an even stronger predictor of mortality than "objective health status" itself (Mossey and Shapiro 1982; Idler and Benyamini 1997; DeSalvo et al. 2006). The first of these analyses tests whether the frequency of perceived discrimination is significantly associated with respondents' self-reported physical health. I find that a one-level increase in the frequency of perceived discrimination reported by respondents is associated with 25% higher odds of respondents' reporting being in worse physical health (table 5, model 1; exp[.222]).

I also examine whether skin color discrimination from blacks or whites is significantly associated with respondents' self-reported physical health. I find that skin color discrimination from whites is not a significant predictor of respondents' self-reported physical health (table 5, model 2). Skin color discrimination from blacks, however, is a significant predictor of respondents' self-reported physical health (table 5, model 3). A one-level increase in the frequency of perceived skin color discrimination from blacks is associated with 18% higher odds in respondents' reporting being in worse physical health (exp[.162]). This means that those individuals who report the highest level of skin color discrimination from blacks have 91% higher odds of reporting being in worse physical health than those individuals

[23] Many blacks explicitly prefer a medium-brown skin tone, similar to the "Brazilian *moreno* ideal" (Drake and Cayton 1993, p. 504).

TABLE 5
Results of Ordered Logistic Regression (Weighted), Self-Rated Physical Health

	(1)	(2)	(3)	(4)	(5)	(6)
Age	.03***	.02***	.02***	.03***	.02***	.02***
	(.00)	(.00)	(.00)	(.00)	(.00)	(.00)
Female	.33***	.29**	.28**	.31***	.29**	.31***
	(.08)	(.08)	(.08)	(.08)	(.08)	(.08)
Educational attainment	−.05**	−.05**	−.05**	−.05**	−.05**	−.05**
	(.02)	(.02)	(.02)	(.02)	(.02)	(.02)
Employed	−.56***	−.56***	−.57***	−.56***	−.56***	−.57***
	(.10)	(.10)	(.10)	(.10)	(.10)	(.10)
Poverty index	−.06**	−.06**	−.06**	−.06**	−.06**	−.06**
	(.02)	(.02)	(.02)	(.02)	(.02)	(.02)
Married	.08	.07	.06	.08	.07	.07
	(.07)	(.07)	(.07)	(.07)	(.07)	(.06)
South	−.09	−.13*	−.13*	−.10^{+}	−.14*	−.10^{+}
	(.06)	(.06)	(.05)	(.05)	(.06)	(.05)
Rural	−.20*	−.20*	−.22*	−.22*	−.20*	−.22*
	(.09)	(.09)	(.09)	(.09)	(.09)	(.09)
Perceived discrimination	.22***			.20***		.20***
	(.04)			(.04)		(.04)
Skin color discrimination from whites		.05		−.08^{+}		−.08^{+}
		(.04)		(.04)		(.04)
Skin color discrimination from blacks			.162***	.162***		.163***
			(.03)	(.03)		(.03)
Self-rated skin color scale					.04	.07
					(.04)	(.06)
Interviewer-rated skin color scale						−.04
						(.04)
Constant	−1.20***	−1.73***	−1.60***	−1.20***	−1.78***	−1.17***
	(.24)	(.23)	(.21)	(.25)	(.23)	(.26)

Note.—Observations = 3,006. Numbers in parentheses are SEs. All analyses are weighted in order to account for the survey's complex design (e.g., clustering and stratification).

$^{+}P < .10$.

* $P < .05$.

** $P < .01$.

*** $P < .001$ (two-tailed tests).

who report the lowest level of skin color discrimination from blacks ($\exp[.162]^4$).[24]

[24] I also find that the association between perceived discrimination (in general) and perceived skin color discrimination from blacks remains significant even after controlling for depression (results not shown).

These findings demonstrate that the internal politics of skin color among African-Americans (i.e., colorism) are quite significant for African-Americans' health. Moreover, given that perceived discrimination remained a significant predictor of self-reported physical health along with intraracial skin color discrimination (even after controlling for the skin color of the respondent), it is likely that respondents who perceive higher frequencies of discrimination in general (i.e., regardless of its attribution) and higher frequencies of skin color discrimination from blacks may be subject to even worse health due to suffering from two analytically and empirically distinct yet overlapping dimensions of discrimination in their everyday lives.

Hypertension

I extend existing research by examining the association between skin tone, multiple forms of discrimination, and hypertension. I find that only self-rated skin color is a significant predictor of hypertension among African-Americans. A one-level increase in the darkness of respondents' self-rated skin color is associated with 18% higher odds of reporting hypertension (table 6, model 6; exp[.166]). Therefore, the darkest-skinned black Americans have 94% higher odds of suffering from hypertension than the lightest-skinned black Americans, net of sociodemographic controls (exp[.166]^4). The predicted probability of hypertension among African-Americans with respect to their skin color shifts from 25% among the lightest skinned to 39% among the darkest skinned, as one moves along the color continuum.[25]

While the lack of an effect for discrimination may seem surprising, Chae et al. (2010) also find that (racial) discrimination is not directly associated with cardiovascular disease among African-Americans. Unfortunately, a clear explanation for this null finding with respect to perceived discrimination remains elusive. Self-rated skin color (which is neither coterminous with nor correlated with discrimination), however, is directly associated with hypertension among African-Americans. Moreover, such results support my hypothesis that "reflected appraisals" of skin tone operate as a variant of subjective social status among African-Americans; research has found subjective social status to be a significant predictor of cardiovascular disease, morbidity, and mortality (Adler et al. 2000; Singh-Manoux et al. 2003). Nevertheless, it is clear that the link between skin color and hypertension is a compelling topic for future research.

[25] Further analyses reveal that the association between skin color and hypertension remains even after instituting a control for depression (results not shown).

TABLE 6
RESULTS OF LOGISTIC REGRESSION (Weighted), HYPERTENSION

	(1)	(2)	(3)	(4)	(5)	(6)
Age	.06***	.06***	.06***	.06***	.06***	.06***
	(.00)	(.00)	(.00)	(.00)	(.00)	(.00)
Female	.27*	.28*	.26*	.27*	.28*	.28*
	(.112)	(.113)	(.113)	(.111)	(.111)	(.110)
Educational attainment	−.04	−.04	−.04	−.04	−.04	−.04
	(.03)	(.03)	(.03)	(.03)	(.03)	(.03)
Employed	−.09	−.10	−.09	−.11	−.10	−.12
	(.12)	(.12)	(.12)	(.12)	(.12)	(.12)
Poverty index	−.06+	−.06+	−.06+	−.06+	−.06+	−.06+
	(.03)	(.03)	(.03)	(.03)	(.03)	(.03)
Married	.28*	.28*	.27*	.27*	.27*	.26*
	(.11)	(.11)	(.11)	(.11)	(.11)	(.11)
South	−.27*	−.27*	−.27*	−.27*	−.28*	−.28*
	(.12)	(.11)	(.11)	(.12)	(.11)	(.12)
Rural	.26	.25	.25	.25	.25	.25
	(.16)	(.16)	(.16)	(.16)	(.16)	(.16)
Perceived discrimination	.02			−.04		−.05
	(.07)			(.08)		(.08)
Skin color discrimination from whites		.09+		.09		.08
		(.05)		(.05)		(.06)
Skin color discrimination from blacks			.06	.02		.02
			(.04)	(.04)		(.04)
Self-rated skin color scale					.12*	.17*
					(.05)	(.07)
Interviewer-rated skin color scale						−.05
						(.05)
Constant	−2.78***	−3.02***	−2.85***	−2.94***	−3.11***	−3.17***
	(.59)	(.50)	(.49)	(.59)	(.52)	(.60)

NOTE.—Observations = 3,006. Numbers in parentheses are SEs. All analyses are weighted in order to account for the survey's complex design (e.g., clustering and stratification).

+ $P < .10$.

* $P < .05$.

** $P < .01$.

*** $P < .001$ (two-tailed tests).

Self-Rated Mental Health

Similar to self-reported physical health, I find that the frequency of perceived discrimination is also significantly associated with respondents' self-reported mental health. A one-level increase in the frequency of perceived discrimination is associated with 47% higher odds of respondents' reporting being in poorer mental health (table 7, model 1; exp[.382]). Skin color

TABLE 7
Results of Ordered Logistic Regression (Weighted), Self-Rated Mental Health

	(1)	(2)	(3)	(4)	(5)	(6)
Age	.02***	.01***	.01***	.02***	.02***	.02***
	(.00)	(.00)	(.00)	(.00)	(.00)	(.00)
Female	.388***	.341**	.295**	.376***	.308**	.377***
	(.10)	(.10)	(.10)	(.10)	(.10)	(.10)
Educational attainment	−.08***	−.07***	−.07***	−.07***	−.08***	−.08***
	(.02)	(.02)	(.02)	(.02)	(.02)	(.02)
Employed	−.36**	−.38***	−.38***	−.38***	−.36**	−.39***
	(.11)	(.11)	(.10)	(.10)	(.11)	(.10)
Poverty index	−.04^{+}	−.03^{+}	−.03*	−.03*	−.04^{+}	−.03^{+}
	(.02)	(.02)	(.02)	(.02)	(.02)	(.02)
Married	.02	.00	−.01	.01	−.00	.00
	(.07)	(.07)	(.06)	(.07)	(.07)	(.07)
South	−.07	−.12^{+}	−.14*	−.08	−.15*	−.08
	(.07)	(.06)	(.06)	(.06)	(.06)	(.06)
Rural	−.09	−.11	−.13	−.11	−.11	−.11
	(.08)	(.08)	(.08)	(.09)	(.08)	(.08)
Perceived discrimination	.38***			.30***		.30***
	(.04)			(.05)		(.05)
Skin color discrimination from whites		.19***		.02		.023
		(.03)		(.05)		(.05)
Skin color discrimination from blacks			.25***	.18***		.18***
			(.03)	(.04)		(.04)
Self-rated skin color scale					.08*	.11*
					(.03)	(.05)
Interviewer-rated skin color scale						−.06
						(.05)
Constant	−.25	−.86**	−.97***	−.09	−1.20***	−.04
	(.27)	(.28)	(.26)	(.28)	(.25)	(.30)

Note.—Observations = 3,006. Numbers in parentheses are SEs. All analyses are weighted in order to account for the survey's complex design (e.g., clustering and stratification).

$^{+}P < .10$.

* $P < .05$.

** $P < .01$.

*** $P < .001$ (two-tailed tests).

discrimination from whites and other blacks is also significantly associated with self-rated mental health. Furthermore, the effect of skin color discrimination from blacks is larger than the effect of skin color discrimination from whites on African-Americans' self-rated mental health. Notably, a one-level increase in the frequency of perceived skin color discrimination from blacks is associated with 19% higher odds of respondents' reporting being in poorer mental health even after controlling for perceptions of skin color discrimination from whites and perceived discrimination in general.

In addition to discrimination, (self-rated) skin color is also directly associated with self-rated mental health. For a 1-degree increase in the darkness of respondents' skin tone, there is a 12% increase in the odds of respondents' reporting being in poorer mental health (table 7, model 6). Skin color remains a significant predictor of self-reported mental health, even after controlling for the various forms of discrimination and the same sociodemographic controls. These models suggest that prior work, which relied solely on interviewer-rated skin color data or spectrophotometer-measured skin color data, may have missed the link between skin color and mental health among black Americans due to not using self-reported skin color measures (see, e.g., Krieger et al. 1998; Borrell et al. 2006).

Examining intracategorical heterogeneity in health by considering the role of skin color and perceived discrimination may also help explain some long-standing quandaries regarding the relationship between ethnoracial background, social stress, and mental health. Contrary to what would be commonly expected, although African-Americans tend to have worse physical health than whites, many studies find that African-Americans may have relatively similar or even better mental health than whites—this is often referred to as the "race paradox in mental health" (Keyes 2009). This paradox, however, may be a function of aggregating blacks together and comparing them to whites without considering heterogeneity in mental health within the black population associated with skin tone.

Consider this: weighted mean self-rated mental health scores indicate that non-Hispanic whites in the NSAL ($n = 871$) have worse self-rated mental health than African-Americans overall, which corroborates the race paradox in mental health. The darkest-skinned African-Americans, however, have a weighted mean self-rated mental health score that is slightly worse than non-Hispanic whites. Furthermore, African-Americans who report perceiving a frequency of skin color discrimination from whites between levels 4 and 5 (e.g., fairly often and very often) also have weighted mean self-rated mental health scores that are worse than non-Hispanic whites, and African-Americans who report perceiving a frequency of intraracial color discrimination between levels 3 and 5 (e.g., not too often, fairly often, and very often) all have even worse weighted mean self-rated mental health scores than non-Hispanic whites and African-Americans overall (i.e., 40% of African-Americans in the NSAL).

Consequently, while the average self-rated mental health of African-Americans is better than that of whites overall, there is significant heterogeneity within the black category along the color continuum with respect to the frequency of perceived skin color discrimination. Averaging across the black population obscures that differences in self-rated mental health are actually larger within the black population along this color continuum

than they are between blacks and whites as a whole. Furthermore, averaging across the black population also obscures that both the lightest- and darkest-skinned African-Americans actually have worse self-rated mental health than the majority of African-Americans (i.e., those who are medium tone).

This is because there is a curvilinear distribution among African-Americans with respect to gradations of skin color and their perceptions of intraracial color discrimination. Both the lightest- and darkest-skinned African-Americans are significantly more likely to perceive higher frequencies of intraracial skin color discrimination than those in the medium-tone category, who perceive significantly lower frequencies of intraracial skin color discrimination than all other blacks (see table 4). At the same time, however, the lightest-skinned blacks perceive less everyday discrimination and skin color discrimination from whites than all other blacks, while the darkest-skinned blacks perceive significantly more everyday discrimination and skin color discrimination from both blacks and whites than do all other black Americans.[26]

Consequently, medium-tone blacks (i.e., the majority of African-Americans) are significantly less likely to suffer from intraracial skin color discrimination, while also being significantly less likely to suffer from everyday discrimination and interracial skin color discrimination than the darkest-skinned blacks. Thus, while it may be true that many African-Americans "flourish" in the face of interracial discrimination, which is the leading explanation for the "black-white paradox in health" (see Keyes 2009), the findings of this study suggest that taking into account intracategorical heterogeneity in exposure to multiple forms of discrimination may help dissolve the race paradox in mental health.

Depression

Finally, I use logistic regression analysis to examine whether skin tone is associated with the likelihood that respondents report being "sad/empty/depressed for a several day period." In agreement with previous studies on depression among black Americans, I also find that black women are much more likely to report feeling depressed (regardless of their skin tone; Krieger et al. 1998; Williams and Mohammed 2009; Harnois and Ifatunji 2011). Additionally, the relationship between depression and SES is mixed; the poverty index is not significantly associated with reported depression

[26] Uzogara et al. (2014) similarly find that among African-American men, the lightest skinned perceive significantly less "out-group" discrimination, while suffering from significantly more "in-group" discrimination than all other African-Americans.

and neither is educational attainment, which also corroborates previous research on depression among black Americans (Hudson et al. 2012).

I find that the darkest-skinned respondents (self-rated skin color) have 54% higher odds of reporting being depressed than the lightest-skinned respondents (exp[.108][4]). The results presented in table 8 (models 1–3) also demonstrate that each measure of discrimination is a significant predictor of depression among African-Americans. A one-level increase in perceived discrimination in general is associated with a 62% increase in the odds of

TABLE 8
Results of Logistic Regression (Weighted), Depression

	(1)	(2)	(3)	(4)	(5)	(6)
Age	−.01	−.01***	−.01***	−.01^{+}	−.01***	−.01*
	(.00)	(.00)	(.00)	(.00)	(.00)	(.00)
Female	.52***	.42**	.38**	.51***	.41**	.51***
	(.11)	(.12)	(.11)	(.12)	(.11)	(.12)
Educational attainment	−.00	.00	−.00	−.00	−.00	−.01
	(.02)	(.02)	(.02)	(.02)	(.02)	(.02)
Employed	−.03	−.05	−.05	−.04	−.04	−.04
	(.12)	(.12)	(.12)	(.12)	(.11)	(.12)
Poverty index	.01	.01	.01	.01	.01	.01
	(.03)	(.03)	(.03)	(.03)	(.03)	(.03)
Married	−.11	−.13	−.14	−.11	−.13	−.12
	(.09)	(.09)	(.09)	(.09)	(.09)	(.09)
South	−.38***	−.44***	−.44***	−.38***	−.46***	−.38***
	(.10)	(.11)	(.10)	(.10)	(.11)	(.10)
Rural	−.06	−.09	−.09	−.07	−.08	−.08
	(.11)	(.11)	(.11)	(.11)	(.10)	(.11)
Perceived discrimination	.48***			.46***		.45***
	(.06)			(.07)		(.06)
Skin color discrimination from whites		.15***		−.01		−.01
		(.04)		(.04)		(.04)
Skin color discrimination from blacks			.17***	.09*		.09*
			(.04)	(.04)		(.04)
Self-rated skin color scale					.11^{+}	.21**
					(.06)	(.08)
Interviewer-rated skin color scale						−.13*
						(.05)
Constant	−1.32***	−.22	−.10	−1.37***	−.09	−1.39***
	(.26)	(.27)	(.26)	(.28)	(.31)	(.36)

Note.—Observations = 3,005. Numbers in parentheses are SEs. All analyses are weighted in order to account for the survey's complex design (e.g., clustering and stratification).

$^{+}P < .10$.

* $P < .05$.

** $P < .01$.

*** $P < .001$ (two-tailed tests).

reporting being depressed (exp[.483]).[27] Skin color discrimination from other blacks is also a significant predictor of depression, and its association with depression is a slightly stronger than skin color discrimination from whites (table 8, models 3 and 4). Such a finding further suggests the importance of considering horizontal relations among black Americans as consequential for their health outcomes (see above). Considering these horizontal relations, unfortunately, is rare in conventional research on ethnoracial inequality and "racial disparities in health," which is dominated by between-"group" (i.e., interracial) comparisons solely using census or census-style categories (Wacquart 1997).

Furthermore, as was the case with respect to self-rated mental health, I find that while whites in the NSAL, on average, report higher incidence of depression than blacks, the average incidence of depression among the darkest-skinned African-Americans is virtually indistinguishable from whites. In fact, the disparity in the incidence of depression between blacks and whites as a whole is virtually indistinguishable from the disparity in the incidence of depression between the darkest-skinned and medium-tone blacks (self-rated skin color). Moreover, the weighted mean incidence of depression among the lightest-skinned African-Americans is also higher than that of medium-tone African-Americans. That African-Americans have lower reported incidence of depression than whites is driven by the relatively better mental health of medium-tone African-Americans. Taking intracategorical heterogeneity in skin color and the frequency of perceptions of various forms of discrimination (both inter- and intracategorical) into account, again, complicates the race paradox in mental health.

Surprisingly though, interviewer-rated skin color is not significant in any of the models presented in table 8, except when included along with self-rated skin color. I find that a discrepancy between self-rated and interviewer-rated skin color is a significant predictor of depression among African-Americans. While the analysis of these data alone is unable to substantiate definitive interpretations of such a novel finding, this finding does suggest that individuals who believe themselves to be darker skinned than interviewers did suffer from a higher probability of being depressed. This highlights, once again, the strong possibility that self-rated skin color is a neglected measure of skin color that gauges respondents' sense of place and stature among their peers (i.e., how they perceive their social status with respect to their physical appearance among their peers), not just the single

[27] I also tested whether a sense of mastery (i.e., control over one's fate) mediates the relationship between skin tone, discrimination, and depression. I find that mastery does somewhat mediate the incidence of depression among black Americans (see Keith et al. 2010). Still, perceived skin discrimination and skin color remain statistically significant predictors of depression among black Americans even after instituting this control (results not shown).

observation of a single interviewer. As a potential measure of subjective social status, future research should further examine the consequentiality of self-rated skin color for health outcomes.

DISCUSSION

The central goal of this study is to consider the role that gradations of skin tone play in shaping health outcomes among African-Americans (1) through their association with multiple dimensions of perceived discrimination and (2) through direct association with health outcomes even after controlling for discrimination, SES, and other relevant factors. In so doing, I leverage intracategorical heterogeneity in skin tone to rigorously assess health differences among African-Americans—a population that is so often seen as homogeneous (see Du Bois 1995). Using a nationally representative survey of African-Americans, I find that skin tone is a significant predictor of multiple forms of perceived discrimination and, in turn, that these forms of perceived discrimination are significant predictors of key health outcomes among African-Americans, net of a variety of relevant controls.

These findings alone make numerous contributions to a nexus of literature on black Americans, ethnoracial health disparities, and more. Principally, this study provided compelling evidence supporting the widely hypothesized skin tone–discrimination–health pathway among African-Americans, which few studies have tested and for which existing findings were inconclusive at best (Klonoff and Landrine 2000; Borrell et al. 2006; Keith et al. 2010). Pinning down the relationship between perceived discrimination and skin tone is important because many researchers find that discrimination is strongly associated with a variety of mental and physical health outcomes (Williams and Collins 1995; Krieger et al. 1998; Williams and Sternthal 2010).

Still, another innovation of the current study is that I employ a multidimensional approach to investigating health disparities. I use multiple measures of discrimination to estimate health differences among African-Americans. Instead of solely focusing on ethnoracial discrimination, I consider how perceptions of everyday discrimination and skin color discrimination shape the health of African-Americans. A major finding of the current study is that not only is everyday discrimination a key factor in African-Americans' health, but skin color discrimination within the black population is also a significant predictor of health outcomes among African-Americans.

Thus, in addition to discrimination from outsiders, processes of discrimination within one's own "group" cannot be ignored with respect to the relationship between social stress and health. Consider, for example, the potentially significant mental or physical health consequences of feeling

discriminated against within one's own family due to one's skin color (see Burton et al. 2010). This study demonstrates that such horizontal relations among African-Americans, which are typically obscured or foreclosed by comparisons between blacks and whites, are consequential for the health of African-Americans.

Some existing research finds that differences in health among African-Americans are larger than disparties between African-Americans and whites, largely due to the important role that differences in SES and gender play in shaping health outcomes (see Williams and Sternthal 2010). Extending this research, the present study finds that even after controlling for gender, SES, and other sociodemographic characteristics, the magnitude of differences in key health outcomes along a color continuum within the African-American population (i.e., from the lightest to the darkest skinned) are virtually indistinguishable from or even exceed the disparities between blacks and whites as a whole.[28]

Such substantial intracategorical heterogeneity related to gradations of skin color may help explain persistent puzzles in research on health disparities between blacks and nonblacks. Consider, for example, the race paradox in mental health in which African-Americans have been found to have similar or even better mental health than whites (Mouzon 2013). The leading explanation for the paradox is that, as counter-intuitive as it seems, African-Americans may actually flourish in the face of interracial discrimination (Keyes 2009). Considering the role of skin color and discrimination along multiple possibly conflicting dimensions, however, paints a more complicated picture of the race paradox in mental health. As was discussed earlier, I find that both the lightest- and darkest-skinned African-Americans have levels of depression or self-rated mental health ratings that are similar to or even worse than whites overall.

Averaging across the black category obscures how those in the medium-tone category actually have better mental health than all other blacks because they are (1) significantly less likely to perceive intraracial skin color discrimination than both the lightest- and darkest-skinned blacks and (2) significantly less likely than the darkest-skinned blacks to perceive discrimination of the forms I examine (e.g., everyday discrimination and skin color discrimination from blacks and whites). Consequently, given the

[28] In the NSAL, 33.8% of black Americans suffer from hypertension compared to 26.5% for whites (a difference of 7%). The darkest-skinned black Americans, however, have a 14% higher average incidence of hypertension than the lightest-skinned black Americans—double that of the disparity between blacks and whites as a whole. Furthermore, using the sample of non-Hispanic whites in the NSAL for comparison, I find that the magnitude of the association of "race" with hypertension, depression, and self-rated mental health is virtually indistinguishable from the magnitude of the association of the skin color continuum among African-Americans with these outcomes, net of controls.

significance of discrimination as a predictor of health among African-Americans, the findings I present here suggest that another compelling explanation for the race paradox in mental health (although not necessarily mutually exclusive with respect to the flourishing hypothesis) may be the relatively greater insulation against intraracial (color) discrimination enjoyed by medium-tone blacks and the fact that they perceive significantly less everyday discrimination than the darkest-skinned black Americans.

I also consider the multidimensionality of skin color. Exploiting a unique feature of the NSAL, its two measures of skin color, I examine the utility of self-rated skin color both as a predictor of discrimination and as a predictor of health outcomes even after controlling for various forms of discrimination and SES. While most existing research on the significance of skin color privileges ostensibly "objective" machine-scored or interviewer-rated skin color measures, I argue that self-rated skin color is not necessarily "inferior" to these "objective" measures as has been argued in previous research (see, e.g., Klonoff and Landrine 2000). Instead, I propose that self-rated skin color is simply another dimension through which skin color may be used to study social inequality among African-Americans. I argue that self-rated skin color is best thought of as a form of (embodied) subjective social status (e.g., Singh-Manoux et al. 2003; Operario, Adler, and Williams 2004). As a variant of subjective social status, self-rated skin color measures individuals' dynamic and relational sense of status in the social circles and contexts they live out their lives.

Consequently, I contend that self-rated skin color may not only be an important predictor of various forms of discrimination (although it is not statistically intercorrelated with the measures of discrimination I use in this study) but also, similar to what other studies of subjective social status find, have a direct association with health outcomes among African-Americans. Indeed, I find that self-reported skin color is often an even stronger predictor of perceived discrimination than interviewer-rated skin color, and self-rated skin color is, at times, directly associated with key health outcomes among African-Americans even after controlling for various forms of discrimination, SES, and more. I link this novel finding to a symbolic interactionist phenomenon known as "reflected appraisals" (e.g., Mead 1934), which scholars have recently theorized as a key mechanism that may help explain ethnoracial self-identification (Khanna 2010; Roth 2010).

Taking a step further, however, it is important to consider that the findings of this study suggest that "reflected appraisals" are not only a key mechanism of (ethnoracial) self-identification but an important mechanism of social inequality. That is, we must consider how dynamic and relational processes of self-identification are indelibly shaped by domina-

tion and, thus, exemplify symbolic violence.[29] The significance of skin color for life chances among African-Americans due to processes of differential treatment both between and within ethnoracial categories, especially self-rated skin color, highlights the utility of considering the role of symbolic violence in the production and reproduction of social inequalities. What others think of us is profoundly implicated in what we think about ourselves, and what we think about ourselves has consequences for social inequality, especially health inequality. Therefore our research will be enriched to the extent that we attempt to tap into this underappreciated dimension of social experience.

Still, I find that both interviewer-rated and self-rated skin color are significant predictors of the various forms of perceived discrimination I analyze in this study, which, in turn, are predictors of key health outcomes among African-Americans. Thus, returning to the core concern of this study, I demonstrate another way in which skin color shapes life chances among African-Americans—their health. Although interest in skin color is beginning to resurge with popular and academic discussions of putative shifts in the "U.S. racial order" being brought about by the rise of the "Latino" and "multiracial" populations (Bonilla-Silva and Dietrich 2009), it is important to remember that skin tone has always mattered for the life chances of black Americans, and thus skin color has always mattered in the United States.

Future research should continue to consider how skin color affects life chances in the United States. Certainly, skin tone stratifies life chances among not only African-Americans (Keith and Herring 1991; Monk 2014) but also Latinos and new immigrants to the United States (Murguia and Telles 1996; Mason 2004; Hersch 2008). Moreover, despite long-held as-

[29] Symbolic violence, following Bourdieu (2000, p. 170), "is the coercion which is set up only through the consent that the dominated cannot fail to give to the dominator (and therefore to the domination) when their understanding of the situation and relation can only use instruments of knowledge that they have in common with the dominator, which being merely the incorporated form of the structure of the relation of domination, make this relation appear as natural; or, in other words, when the schemes they implement in order to perceive and evaluate themselves or to perceive and evaluate the dominators (high/low, male/female, white/black, etc.) are the product of the incorporation of the (thus naturalized) classifications of which their social being is the product." Symbolic violence both refines and complicates notion(s) of "self-hatred" or "internalized racism" that are common in discussions of colorism. The power of the dominant is not only a matter of physical violence but also the symbolic power of imposing categories of perception and appreciation that are largely shared across society as a whole. "The most brutal relations of force are always simultaneously symbolic relations. And acts of submission and obedience are cognitive acts which as such involve cognitive structures, forms and categories of perception and appreciation, principles of vision and division" (Bourdieu 1998, p. 53).

sumptions that color may matter more in Latin America than in the United States, these compelling findings (in addition to existing research) suggest that the United States may also be a *pigmentocracy*, although this has been obscured to the extent that scholarship on ethnoracial inequality has predominantly relied on broad demographic categories (e.g., census categories), which obscure significant skin tone stratification within and across ethnoracial categories (Monk 2013, 2014).

As a general lesson, the findings of this study demonstrate the limits of census categories for the study of social inequality. Cognitive science demonstrates that our ability to see differences far exceeds that of the broad demographic categories that most researchers examine. Again, a key lesson of cognitive science is that we perceive not only whether individuals fit into a particular social category but also the degree to which they fit said categories. In other words, dualistic categories are often continua in practice. This holds true with respect to not only the perception of ethnoracial categories but also gender categories (e.g., continua of perceived blackness, masculinity, and femininity; see Maddox 2004; Green et al. 2005).

Research demonstrates that there are socially salient and consequential subcategories that mark key points along these continua of categorical membership (Maddox 2004; Irmen 2006). While superordinate categories are important, research on social cognition demonstrates that in a wide array of contexts, more nuanced, refined, and gradational intracategorical classifications, especially those related to differences in physical appearance, are crucial in triggering stereotypes and forming social judgments that indelibly shape social inequalities (Macrae and Bodenhausen 2001); in fact, research shows that classification at the level of subcategories may be preferable because it is more informative than classification at the superordinate level, while remaining cognitively efficient (Twuyver and Knippenberg 1998; Pattyn et al. 2015). Therefore estimations of inequality at the level of superordinate categories may actually be produced and reproduced by not only processes of stigmatization and differential treatment that are inextricably linked to the activation of stereotypes at the superordinate level but also more fine-tuned, contextual, and relational processes of stigmatization and differential treatment linked to the activation of stereotypes related to gradational variation in categorical typicality (i.e., continua of perceived categorical belongingness that are often marked by socially salient and consequential subcategories) nested within superordinate categories. Such processes, as the findings of this study suggest, may occur along multiple possibly conflicting dimensions.

Future research on social inequality should seriously engage with and examine such complexities. Integrating research on social cognition into the examination of social inequalities will be an important step (see Brubaker et al. 2004). This will also bring us that much closer to a sociology

of *the realization of categories*, that is, a sociology of "the concrete activities and operant mechanisms whereby evanescent mental constructs are turned into hard and enduring historical realities, in the twofold guise of institutions (systems of positions) and incarnate subjectivities (clumps of dispositions) that work in tandem to actualize symbolic divisions by inscribing them into materiality" (Wacquant 2013, p. 281). Such a focus was the epicenter of the oeuvre of Pierre Bourdieu, who reconsidered the relationship between domination and inequality by questioning the ontological status of groups (see, e.g., Brubaker 2004) and urged an analytic shift toward addressing the conundrum (and consequences) of "how [groups] come to be practically made and unmade in social life through the inculcation of shared schemata of perception and appreciation and their contested deployment to draw, patrol, or challenge social boundaries" (Wacquant 2013, p. 281).

The findings of this study also have implications for policy. Not only must we consider both interracial and intraracial processes of social inequality as I stated above, but this study also demonstrates that interventions to mitigate "racial" health disparities must look beyond "race" alone. This study shows how skin color, which has long been hypothesized to affect health among black Americans, operates as a factor of differential exposure to discrimination and is worthy of further attention in research on "racial" health disparities and possible interventions to lessen said disparities. At the very least, the findings here suggest that researchers may want to include self-rated measures of skin tone in their surveys as opposed to only spectrophotometer measurements or interviewer ratings.

Ultimately, this study provides compelling evidence of how inequality is indeed *embodied*, as Krieger (1999, p. 296) explains, "how we literally incorporate biologically—from conception to death—our social experiences and express this embodiment in population patterns of health, disease, and well-being." While long-standing research has demonstrated such a phenomenon in terms of "racial" disparities in health between blacks and whites as a whole, this study demonstrates how, even within the black population (which is so often held to be homogenous), inequality is not experienced or embodied equally.

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