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"We Just Haven't Put Our Minds to It": An Interview With David Williams Describing the Trajectory of His Career Studying Racism

David R. Williams, PhD, MPH, with Derek M. Griffith, PhD

Derek Griffith interviewed David Williams by phone on April 27, 2018 to gain insight into the key factors that shaped Williams's career studying racism and developing measures of racism.

CHOOSING A CAREER IN PUBLIC HEALTH AND A DOCTORAL DEGREE IN SOCIOLOGY, AND LIMITATIONS OF PUBLIC HEALTH TRAINING

GRIFFITH: Thank you again for your willingness to participate in this interview as part of the book [*Racism: Science and Tools for the Public Health Professional*]. The lead editor is Dr. Ford. This is Derek Griffith. Also part of the editorial team are Drs. Marino Bruce and Keon Gilbert. So, Dr. Williams, again, thank you for your support and willingness to participate in this interview. Let me start by asking you just the general question: what led you to a career in public health?

WILLIAMS: What led me to a career in public health? I think I was very interested in working to make a difference at the level of the community, of doing something that would really impact populations and help individuals. And I thought of health as one of those areas. My undergraduate degree was in religion, in theology, and I thought of public health as one avenue where one could really improve the quality of life. And so I moved from the study of theology to study of public health.

My MPH was in health education because I was interested in working at the level of the community to help improve conditions. And I did work briefly, just about two years, in public health as a hospital-based public health educator where I was responsible for community health education as well as employee health education. And in my work as a public health educator, it was clear to me that my public health training had not adequately provided me [with the skills] to address all of the challenges that poor communities, particularly poor African American communities, faced. I had knowledge. I had information. I had theories of behavioral change. But none of them seemed to adequately capture the social context and the social barriers that also existed.

Williams D.R. with Griffith, D.M. "We Just Haven't Put Our Minds to It": An Interview With David Williams Describing the Trajectory of His Career Studying Racism." In Chandra L. Ford, Derek M. Griffith, Marino A. Bruce, and Keon L. Gilbert (Eds.) 2019. Racism: Science & Tools for the Public Health Professional. Washington, D.C.: APHA Press, Pp. 73-95.

And so I went from working as a public health educator to doing a doctorate in sociology because I sensed the need to better understand and address the social context—the social and cultural factors—the contextual and structural barriers that communities faced and that had to be addressed if we were going to be successful in really improving health in disadvantaged communities.

WILLIAMS'S FIRST EXPLICIT MENTION OF "RACISM" IN A PUBLICATION

GRIFFITH: That actually answered a couple of questions. So you earned your PhD in 1986, and then you published your first paper that actually included "racism" in the title a decade later in a special issue that you guest edited on racism and health in *Ethnicity & Disease*. So what prompted that, or how did that come about, that particular special issue and your interest, specifically, in racism?

WILLIAMS: It's a good question. My 1996 introductory essay to a special issue of *Ethnicity & Disease* on racism and health may be the first paper of mine that had "racism" in the title, but it's not my first paper that addressed racism.

DISSERTATION RESEARCH TOPIC

WILLIAMS: So, there're a number of events. Let's begin with my dissertation—I was interested in issues of race, but my dissertation actually was not about race; it was about socioeconomic inequalities in health. I was very interested in the social context. And as I worked with my advisor, looking at various possibilities for a doctoral dissertation, one of the possibilities was the Tecumseh Community Health Study. It had exquisite longitudinal data on health outcomes for a community in Michigan called Tecumseh. Back in 1959, researchers from the University of Michigan had gone into that community and enrolled every man, woman, boy, or girl who lived there into a major epidemiological study. The community had about 10,000 residents and over 90% enrolled in the study. There had been three major waves of data collection and there was long-term mortality follow-up and morbidity follow-up. So it was one of the multiple data sets we considered. I was trying to get out of graduate school and not collect my own data.

HOW WILLIAMS'S INTEREST IN RACISM BEGAN

WILLIAMS: So I was looking for good preexisting data. I was absolutely interested in race/ethnicity and health, but it did not reflect my only interest. I was also interested in socioeconomic status [SES] and health. One of the downsides of Tecumseh was that it was a lily-white community. There might've been a couple Black families in the community, but too few for analysis. But the Tecumseh Study was a great public health data set, and I used it for

my dissertation. As my work continued, I conducted research looking at race and socioeconomic status. I remember a 1992 paper where I looked at what happens when we examine the distribution of psychiatric disorders, considering race and SES together, focusing on African Americans and Whites and using the ECA study [the Epidemiologic Catchment Area study], which was the best data on mental health that existed back then. But I would say that my interest in racism specifically clearly crystallized in the early 1990s.

GRIFFITH: Okay.

Noteworthy Publication: *Review of Health Issues in the Black Community* (Editors: Ronald L. Braithwaite and Sandra E. Taylor)

WILLIAMS: I'll mention a couple events that I think were pivotal for me. One of them was reading a recently published book (in 1992) called *Health Issues in the Black Community* edited by Ronald Braithwaite and Sandra Taylor.[1] I was asked to review the book, and it was an excellent book. I read it. I enjoyed it because it covered so many domains of African American life.

But if you read my review that was published in 1993, the last paragraph of the review says that "the most disappointing failure of the volume was not addressing systematically the role of racism and racial discrimination in health." And I go on to say that almost every chapter says that racism, racial bias, or racial discrimination is an important determinant of the health of the Black population. But little direct evidence was provided. "Everyone talked about racism and said that it mattered, but they just asserted that racism was a factor. The authors were not making a conceptual case or talking about the mechanisms and pathways" by which racism might affect health. "And I just thought that that was unsatisfactory, and that we, as a group of scholars who were studying race and health needed to do better." I will actually quote from the review right now: "Arguably, one of the most important issues in future research on the relationship between race and health is the development of theoretically informed measures of racism and discrimination and empirical assessment of the effects on health."[2] And I began to focus more attention on racism. If you look at a 1994 paper on "The Concept of Race and Health Status in America," there is a specific section in that paper discussing racism and its relationship to health.[3]

INFLUENCES ON WILLIAMS'S EARLY WORK ON MEASURING DISCRIMINATION

A Key Panel: Final Panel of a Meeting at the National Center for Health Statistics

WILLIAMS: I think another pivotal moment for me came in 1993. I was at a National Center for Health Statistics conference that addressed disparities in health, and I was on the final panel. And we were to reflect on research priorities. Among other things, I said

that one of the biggest priorities for research, echoing the point I had made in the review, was to really understand and document the ways in which racism can affect health. And a well-intentioned researcher stood up after I had said that and he said that he agreed with me. Racism was important and it affected African American health. But he also said that what I was asking researchers to do was impossible because racism could not be measured. And I recall saying to him, "If you were to ask me, 'Do we have valid, reliable measures of racism that we can use in a study today?' I would say, 'No.'" But I said, "I see no reason why we couldn't develop such measures of racism if we put our minds to it." And I remember ending my comments to him by saying, "We measure self-esteem. Why can't we measure racism? We just haven't put our minds to it." And those two things in quick succession actually drove me to say, "I want to work on developing measures." And my initial goal was of capturing measures of interpersonal discrimination.

Key Collaborator and Mentor: James Jackson, University of Michigan, Director of the Program for Research on Black Americans

WILLIAMS: So I left that conference and read the work of sociologist Joe Feagin, who had done a lot of qualitative research on discrimination among African Americans. And I also read the work of Philomena Essed, who had written two books—one of them, *Everyday Racism*,[4] and the other, *Understanding Everyday Racism*,[5] both of them focusing on the same populations. She studied Black immigrants from Surinam in the Netherlands as well as African American women in California. And both of these scholars provided rich qualitative descriptions of the experiences of discrimination. And from reading Feagin's and Essed's work, I began to take notes and think of how questions about discrimination might be worded, what dimensions need to captured, and how can we advance the field.

And then I spoke to one of my senior colleagues at the University of Michigan. That's Professor James S. Jackson. He headed the Program for Research on Black Americans and had directed the National Study of Black Americans. And James became my cheerleader. I was still early in my career. I was an early stage associate professor. So it was affirming to have James's support that this was an important idea. He was all gung ho with me that we should do this.

DEVELOPMENT AND TESTING OF FIRST DISCRIMINATION SCALES WITH JAMES JACKSON IN THE 1995 DETROIT AREA STUDY

WILLIAMS: The University of Michigan had a mechanism called the Detroit Area Study, which was an annual survey done in the Detroit Metropolitan Area that was a practicum in survey research. A faculty investigator would pick a particular topic and participate in

teaching a three-course sequence. And as part of this practicum, students could get experience in every phase of a survey research project, from the conceptual issues, to actually developing questions, to pretesting the survey, helping to select the household sample, and actually being a part of the interview team that conducted the survey in the Detroit Metropolitan Area. And then in the final semester students would write a paper based on some aspect of the study. And I thought that the Detroit Area Study would be a mechanism that I could use.

So, back in 1994, I applied to do the Detroit Area Study in 1995, and it was a joint application because, again, James Jackson was a wonderful supporter and collaborator, and he was willing to co-teach the course with me. The topic of measuring discrimination was a key component of the course. And James Jackson also led the charge to raise research money so that we could increase the sample size of the Detroit Area Study and have a much larger study than was typical. We oversampled African Americans and ended up with a sample that was approximately 1,000 people, with half of the sample being African Americans and the other half being White.

And that 1995 Detroit Area Study is where the instruments developed—the Everyday Discrimination Scale and the Major Experiences of Discrimination Scale were fielded for the first time. The first paper using them was published in 1997. I had also developed the Heightened Vigilance Scale, which seeks to capture how people prepare for experiences of discrimination.

So those were some of the key moments. I was motivated, but I also give a lot of credit to the support that I received from James Jackson, who joined me in this quest to utilize the mechanisms at Michigan that would help us to collect the data. He's a co-author of that first paper, of course.

OTHER KEY PUBLICATIONS, COLLABORATORS, AND DEVELOPMENTS IN THE EARLY 1990s

WILLIAMS: But I would say that, throughout the early 1990s, in my written work, such as a 1994 paper with Risa Lavizzo-Mourey and Reuben Warren, "The Concept of Race and Health Status in America,"[3] we talk about the challenges of African American health and the research priorities for the future. And a better understanding of racism and its consequences for health was a clear theme in my work. And, in 1995, we collected data that allowed us to begin, empirically, to assess the association between discrimination and health.

I want to talk about another significant development—my collaboration with one of my doctoral students, Dr. Chiquita Collins. Chiquita was a graduate student in demography at the University of Michigan. She was interested in doing a dissertation that would focus on residential segregation and its effects on mortality. She asked me to serve as the chair of her committee. And we worked together on the issue of segregation. A number

of papers came out of our collaboration. One of them was an empirical analysis examining the association between segregation and mortality.[6] We also wrote a 2001 conceptual paper that argued that residential segregation was a fundamental cause of racial disparities in health.[7] But I think that working with Chiquita Collins and her interest in segregation and her devotion to doing the necessary empirical work was another stimulus that expanded my work on racism from interpersonal aspects of discrimination to upstream structural factors like segregation. I am also illustrating that my own work on discrimination was a product of teamwork. First, I spoke about the influence and support of a senior faculty member and then about the impact of one of my students that helped to shape and advance this area of work.

Key Publication: Special Issue of *Ethnicity & Disease*—Racism and Health: A Research Agenda (Guest Editor: David R. Williams)

WILLIAMS: *Ethnicity & Disease* was an important journal published by the International Society for Hypertension in Blacks. It was an organization primarily of Black cardiologists and others who studied cardiovascular disease in African Americans. Richard Cooper from Loyola Medical School was the editor of the journal. I should note that Richard is someone who had a profound influence on my thinking and understanding of race. When I was in graduate school and early in my career, Richard Cooper's papers on race, and what race is, and how race wasn't what most people and most researchers thought it was, were seminal. And, although he was a physician, many of his papers read as if he were a sociologist.

I still remember an influential 1981 paper that he wrote on the impact of the Civil Rights Movement on the health of the African American population.[8] He showed that the economic benefits that the Civil Rights Movement provided to the African American community led to improved health for African Americans between 1968 and 1978. And he showed that during that period of time, the health of African Americans improved more rapidly than the health of Whites, and we had a narrowing of the Black–White gap in health. So Richard was a trailblazer and one of my heroes because of his insightful research and writing on race and health.

So I approached him in his role as the editor of *Ethnicity & Disease*. And I told him I would love to guest edit a special issue of *Ethnicity & Disease* on the topic of racism and health. I approached him because I thought that he was clearly someone who would be interested in the topic, and I was right. He said, "Absolutely. Do it. Let's do it."

And so Richard gave me that opportunity and we publicized and did a call for papers. I'm not sure if that was the first special issue on racism and health, but it was certainly one of the early special issues explicitly devoted to the topic of racism and health. Importantly, it reflected this growing interest that I had to raise the visibility of racism in all of its complexity and to stimulate more research in the field. And I think the paper

that you referred to where the term "racism" actually appears in the title of the paper was the introduction that I wrote to that special issue entitled, "Racism and Health: A Research Agenda." Because that's exactly what I was trying to create with the special issue. I reached out to people in this emerging field and people who were doing related work and tried to ensure that this special issue would reflect the state of the emerging evidence and would lay out a research agenda for where the field needed to go. So, again, I would say a big thank you to a visionary like Richard Cooper, who supported this fledgling young scholar who had this audacious idea to do a special issue on the topic. So I'm saying, all along the way, there were lots of other people who provided important support.

Other Key Scholars and Publications That Influenced Williams's Approach to Research on the Relationship Between Discrimination and Health

GRIFFITH: That's very helpful. Are there other people that you—I mean, I know you mentioned several—but are there other people whose work either appeared in that issue or in other ways were influential in how you thought about this?

WILLIAMS: I mean, clearly, one person whose work was influential as well, was Nancy Krieger. Nancy Krieger had written an early paper looking at discrimination and hypertension among African American women.[9] And that was an influential early paper. There was also another early paper, published in 1993 in the *American Journal of Preventive Medicine*, with Nancy, and Diane Rowley, Allen Herman, Byllye Avery, and Mona Phillips, and it was entitled, "Racism, Sexism, and Social Class: Implications for Studies of Health, Disease and Well-Being."[10] And that paper was one of the early conceptual pieces that reviewed the available conceptual and empirical evidence and clearly laid out an agenda of research on racism and health.

SIGNIFICANCE AND CONTENT OF *ETHNICITY & DISEASE*—RACISM AND HEALTH: A RESEARCH AGENDA

WILLIAMS: And that paper was influential in my thinking as well, especially because it did a good job of linking racism with sexism and social class, and it was one of the first systematic treatments of the topic. And if you look at the special issue of *Ethnicity & Disease*, you also see considerable depth in the conceptualization of the pathways by which racism can affect health.

Alan Herman, one of Nancy Krieger's co-authors, wrote a piece on the conceptualization of race in epidemiologic research and how we need to rethink how we think about race.[11] Tom LaVeist had a similar piece on why we need to continue to study race but do

a better job, and part of that better job is paying attention to racism.[12] Gary King wrote an article on institutional racism and how it affects the medical/health complex and access to care and the quality of care for minorities.[13] I mean, there were just many excellent pieces. Racism and children's health, there was an article on that.[14] There was a paper on target marketing showing how African Americans are disproportionately marketed alcohol and tobacco products.[15] There was a piece on segregation by Anthony Polednak who had written a book about segregation and health.[16] So it really brought together a lot of the leaders doing work. Jules Harrell and his group at Howard had done important work in the area. There was a piece by James Jackson, and Norman Anderson and his group at Duke had a paper on the measurement of racism as well.[17]

So I was very happy with that special issue because it brought together, for the first time, to my knowledge, not only a special issue on racism but a special issue that laid out the multiple pathways and dimensions by which racism operated. So it really laid out for the field, for scholars who wanted to do work in this area, and broadened the agenda of the multiple pathways by which racism operated.

RACISM IS MULTIDIMENSIONAL

GRIFFITH: Well, to that point, I want to connect a couple of dots.

WILLIAMS: Okay.

GRIFFITH: So you started with your work on interpersonal racism, the measures of everyday racism, and, those pieces, and then, with Chiquita Collins, you moved also then to talking about segregation. And so you had these kind of multilevel thoughts about—you were sort of—even in your own work, and as you bring some of these other pieces together—were looking at racism at multiple levels. Was that kind of the norm within the field, or how was that fitting with how this early work was being conceptualized?

WILLIAMS: I think it was the early days, and there weren't a lot of publications on the topic. But I think one of the things I was trying to do—if you look at the special issue in 1996—was to show that racism was multidimensional. There is a figure in my commentary in that special issue that showed how racism was one of the fundamental drivers of racial inequality in society. It showed that, with racism, there was discrimination at a societal level and the individual level. There was the racial ideology and the prejudice and discrimination in the culture. And I basically argued that racism shaped other social statuses in society, including socioeconomic status and race/ethnicity. They were all impacted by racism, and, as racism's mechanisms played out in society, they went back and reshaped the other macro social structures of society, such as the economic, political, and legal systems. In short, racism was an organized system within society and there were multiple pathways by which racism could affect health.

CHAPTER ON INTERNALIZED RACISM

WILLIAMS: I actually wrote, in the 1990s, a chapter on internalized racism that actually never got published [laughter].

GRIFFITH: Hmm.

WILLIAMS: It's funny because it was written for an edited book on Black health. With one of my students, I analyzed data from the National Study of Black Americans on internalized racism and health. And if you were to go to Google Scholar, the chapter is cited about 15 times because I had shared it with multiple colleagues. But it's always cited as "in press" because, for one reason or another, that book never got published. I still have it on my CV. It's been listed there as "in press" for at least 25 years.

GRIFFITH: That's funny.

WILLIAMS: Yes, and it reflected my interest in internalized racism. And I had analyzed the scale of racial stereotypes in the National Study of Black Americans. African Americans were asked in that study how much you agree with certain stereotypes of Blacks. Some were positive stereotypes, and some were negative stereotypes. And factor analysis showed that there were two clusters. There were two different dimensions. One was endorsing the negative stereotypes of African Americans, and the other was rejecting the positive stereotypes of African Americans. And we called both of them internalized racism. And we looked at their relationship to multiple indicators of mental health.

APPROACH TO CONCEPTUALIZING RACISM IN THE MID-1990s AND KEY INFLUENCES

WILLIAMS: So I'm making the point that even from back in the mid-1990s, my thinking of racism and its pathways were comprehensive and multidimensional. Even though I thought that, for the standard epidemiologic study, measuring discrimination as one type of stressful life experience was one thing that could easily be done, it was not that I was uninterested in the institutional dimensions, which my work with Chiquita on segregation revealed, but I thought that really capturing fully all of the institutional dimensions was more challenging. And I thought that the interpersonal dimension was a place where we could at least enhance the assessment of stressful life experiences that were relevant to race.

I should back up and say that one of my interests from my days in graduate school was the impact of stress on health. While I was in graduate school, I worked with James House and Ronald Kessler, two eminent medical sociologists at the University of Michigan. And I worked with them on a study of unemployment and health, and looking at unemployment as a stressful life experience. And my thinking about discrimination

from reading the qualitative work of Joe Feagin and Philomena Essed was that discrimination was one type of stressful life experience that traditional batteries of stress had failed to measure, so my work and that of others measuring self-reports of discrimination was filling that void.

And I would say there were critiques of the stress literature back then. One was that the measurement of stress was heavily driven by the stressors that characterized middle-class White males, and that many of the stressors that might have been unique to women, or that were unique to poorer populations, as well as to racial/ethnic minority populations, had not been fully captured in the traditional assessment of stress. So I also saw that my work on discrimination was contributing to filling this void that had been identified by people like Peggy Thoits and other sociologists who study stress.

RESISTANCE TO RESEARCH ON RACISM AND DISCRIMINATION

Peer-Review of an Article in Which the Reviewer Said, "The Term *Racism* Does Not Belong in a Scientific Paper."

GRIFFITH: I want to go back again to—just because you mentioned it before in the previous conversation. I don't want to lose that. When you—the paper that you submitted to [a major social science journal].

WILLIAMS: Yes.

GRIFFITH: And it was a similar sort of comment to, to what you were saying with the National Health—

WILLIAMS: Yes.

GRIFFITH: —the '93, '94. Can you sort of talk about that too, because I remember you mentioned that as also particularly important in an earlier point?

WILLIAMS: Right. So, I'm doing research and writing papers, talking about the role of racism and discrimination and health. And I remember this article submitted to a major social science journal . . . And one of the reviewers said, "*The term racism does not belong in a scientific paper.*" He or she went on to explain, "*Racism is an ideological concept that cannot be measured.*" And, thankfully for me, the editor told me, "Disregard [laughter] that comment by reviewer A," or whatever the number was "and respond to the other points raised." But I'm just illustrating just how contested these issues were back then and how much pushback there was from audiences, even a social-science audience, in terms of doing research on the topic. I'll give you another example of the pushback.

GRIFFITH: Well, before you leave that, do you remember what year that was—approximately?

WILLIAMS: I literally do not remember what year it was, but I think that it was back in the 1990s. But off the top of my head, I don't remember which year it was.

GRIFFITH: That's fine. Do you think it was before the special issue that you were talking about—the *Ethnicity & Disease* special issue—or after?

WILLIAMS: My sense is it is somewhere within that same time frame.

CRITIQUE OF MEASURES OF DISCRIMINATION BEING BASED ON SELF-REPORT

WILLIAMS: I want to give you another example of the pushback from my days in graduate school. I was working with researchers, and we were studying the association between stress and health. And I had given talks about stress and health. One of the intriguing things I discovered, in the mid-1990s as we got data from the Detroit Area Study and I began to do analyses looking at discrimination and health, that *in almost every single talk I would give, one of the first questions I would get, or comment I would get to my presentation is, "You have used the word 'discrimination.' You should not be using the word 'discrimination.' You should be using the words 'perceived discrimination' because all you have is the reports of individuals. You don't have an objective assessment of discrimination."*

And the point that was being made was correct that, yes, my measure of discrimination was based on self-report. *For me, what was intriguing, and I would oftentimes say it to the audience, is that when I talk about stress and health, no one has ever told me, "You need to say 'perceived stress' because your measure of stress is based on self-report."* So what I'm talking about is a double-standard that existed, where individuals were just uncomfortable with the topic, and their scientific critique came out more strongly on the topic of discrimination than it did on the topic of stress more generally. No one has ever said to me, "You can't say 'stress.' You need to say 'perceived stress,'" although in both cases, I was dealing with a stressful life experience that was based on self-report.

I want to give you another example of this. And this one—I don't remember the year, but it was in the late 1990s. It was with Detroit Area Study data, and it was at a top journal in sociology, the *American Sociological Review*. I wrote a paper with findings from the Detroit Area Study that I sent to the *American Sociological Review* and I got feedback from three reviewers. Two reviewers were absolutely positive. They had some minor issues, but they were very positive. One of them says things like, "This is going to be a widely cited paper." And the third reviewer says this is the best paper he has seen on the topic, but the paper has two fatal flaws that preclude it from ever being published in that journal.

GRIFFITH: Wow.

WILLIAMS: And that's fine. So what are the two fatal flaws? The two fatal flaws were that the measure of discrimination, the exposure, was based on self-report and, number two,

that the data were cross-sectional. Both of those points were absolutely correct. In fact, both of those factors were discussed explicitly as limitations of the study in the discussion section of the paper. Importantly though, if you look back, as I did, at that journal, you would discover that it routinely published studies of stress and other phenomena based on self-report that utilized cross-sectional data. So again, *a higher standard was being applied to research on discrimination, because the editor obviously agreed with the third reviewer.* He had two very positive reviews, and one that said, "This is a critical, fatal flaw." And the editor sided with the third reviewer and rejected the paper.

And it just so happened that I served on a committee with the editor at the time, and the editor found it necessary to write me a one-page personal note encouraging me and telling me not to be discouraged by the rejection. He said that this work was important, and I should continue to do it. And I thought this was so intriguing. Why did he feel the need to write me this long note? I mean, you reject the paper. You're the editor. You can do that. But somehow, he felt the need to write, and encourage me, and say all this stuff even while he was rejecting the paper. He was obviously going along with the views of one reviewer who was very negative and who was raising a standard for my work that was not a standard routinely applied to what the journal published. So I'm saying that's the kind of contested space within which we worked at the time.

HAS THE RESISTANCE TO RESEARCH ON RACISM AND DISCRIMINATION DECREASED OVER TIME?

GRIFFITH: Do you feel like that's changed?

WILLIAMS: I think things are better. If I just look at the proliferation of research, the volume is impressive. In the early days of research on discrimination and health, I suspect that I was asked to review every paper because there weren't that many people who had done work in the area. I can't even keep up with the publications now. There is just so much work in so many journals. That's the first thing that changed. The second is that now there is work from all around the world looking at discrimination and health. So there's certainly been an explosion of research interest in racism that is important and significant. There are probably still a few researchers who are skeptical of this work, but I think that the weight of the evidence is quite strong.

There have also been some significant developments since those very early days. In the early days, some of the critics of the science were correct. We were using a self-report measure of discrimination with self-reported measures of health—typically, self-reported measures of *mental health*, where the association was strongest. And, at one level, that makes sense. One of the ways discrimination works is that it leads to negative emotions, so finding that a measure of stress was leading to negative emotions and high levels of psychological distress makes sense. From a scientific point of view, though, you

have, cross-sectionally, measures of mental health symptoms and a measure of discrimination. And so you should worry about which way is the causal arrow. Could it be that there are some depressed people, that because they are depressed, are perceiving discrimination that doesn't even exist and reporting it, and you are documenting that the two things are related? So which came first, and how do you tease those apart?

And one of the important early papers that a group of us at Michigan did—Tony Brown, James Jackson, and others—was where we used data from the National Study of Black Americans and utilized baseline levels of mental health, both a measure of clinical depression and a measure of depressive symptoms, and we looked, longitudinally, to see if mental health predicted subsequent reports of discrimination.[18] And we documented that there was no relationship between baseline mental health status and subsequent reports of discrimination. And I think that that paper was important in really showing that reports of discrimination were independent of underlying mental health.

And, over time, we've had a growing number of papers, using prospective data, that have showed that exposure to discrimination predicts changes in health over time. We have also had a number of studies that have adjusted for some of the psychological factors that people thought might be driving the association between discrimination and health. And these studies find that even after you have statistically adjusted for psychological factors such as social desirability, negative affect, or neuroticism, discrimination still matters for health. And the other body of work that I think was really important in this developing field was the emergence of studies that assessed health status independent of self-report. And we found that the associations between discrimination and health were still robust when we use a broad range of subclinical indicators of health status and measures of disease states. These studies have certainly given more scientific credence to the fact that self-reports of discrimination are real, bona-fide risk factors that matter for health.

ADVANCES IN THE MEASUREMENT OF RACISM AND DISCRIMINATION: THE IMPORTANCE OF HAVING A GLOBAL PERSPECTIVE

GRIFFITH: Are there other strengths that you've seen—I guess I'm asking you to kind of look backwards and look forwards. So, other strengths that you've seen the field advance since that special issue? I keep going back to that '96 special issue; it seems like it's a really seminal piece, and what you brought together. But are there other ways that you've seen the field advance in this area of scholarship?

WILLIAMS: Yes. I think the international dimension is also striking. In the early days, the research on discrimination was heavily focused on the experiences of African Americans and, to a lesser extent, Latinos, in the United States. And then there were

studies looking at Native Americans, Asian Americans. And then studies began emerging from other countries. There was important work by Yin Paradies and his colleagues from Australia, and work of Ricci Harris and colleagues from New Zealand, and work of James Nazroo and his collaborators from the UK, as well as research on discrimination from multiple other Western European countries, typically looking at immigrant populations. I should also include the early work of Kenneth Dion, Sam Noh, and others in Canada that documented that there was discrimination against immigrants there. So we now had international research that was documenting that discrimination was a universal phenomenon and predictive of health outcomes. And coupled with the improvements in the methodological quality of the work, research on discrimination and health was offering new credence to the many doubters that discrimination was, in fact, a robust determinant of health that should not be ignored.

GRIFFITH: Are there areas that you still feel like—what's the next area, or what's the thing that you feel like is still a limitation in how we conceptualize and measure these issues?

UNRESOLVED MEASUREMENT CHALLENGES

WILLIAMS: I still think there are some unresolved measurement issues in the field. One, I would say that what I am in the middle of has to do with, How do we best capture discrimination? So if you look at the measures of discrimination I developed, I explicitly and deliberately, in collaboration with James Jackson, framed the questions very carefully. We recognized that the questions around race discrimination are somewhat sensitive, and there's empirical data showing that. So the question is how do we best capture it? So we wanted to get as objective a measure as possible.

We didn't want to use racial terminologies, like saying, "Did this happen because of racism?" or "Was this discrimination?" Instead, we tried to get a clean description of the incident. "You were treated with less courtesy and respect than others." Or, "Have you ever been unfairly," with the word "unfairly" underlined, "stopped, physically threatened, or abused by the police?" So we were just trying to get a clean, neutral description of an experience. And then after the individual had reported it, we would say, "What do you think was the main reason for that experience?" So this approach allowed us to capture all kinds of experiences of unfair treatment, or discrimination, or bias that individuals had encountered, as well as get their subjective sense of what was the source of this experience.

There are some scholars who argue that using this two-stage approach may not be the best way to capture racial discrimination, and we should ask people directly, "Has this happened because of your race?" The jury is still out on this issue, to be honest with you. What we know is that both types of measures predict health. There are studies that have tried to look at both of them, and the levels of reported discrimination vary depending on how the question is worded.

Another big unresolved question in the field is whether the experience of discrimination by a minority, or some other stigmatized population, is the same as when a White person reports an experience of unfair treatment. And is the experience of discrimination by persons for whom discrimination is a routine part of their existence and a constant challenge to their sense of self-worth and belonging in society—is that the same as discrimination for someone for whom it is an occasional experience?

The available evidence now suggests that the source of attribution for an experience of discrimination doesn't matter. That is, if someone reports an experience of being unfairly or badly treated, the effects on health are similar whether the incident is attributed to race or gender or religion. I think that there's still an unanswered question here. I think we need to do additional research to ensure that we are using the best measures to capture discrimination. I wouldn't claim that my measures are the best. I think we had good reasons for doing it the way we did, but I don't think it's the final word on the topic, and I do think that the whole question of measurement is an important one. There's another aspect of measurement that I think is really important.

Experience of Trauma and the Severity of the Experience of Discrimination or Trauma

WILLIAMS: There are a number of scholars, Robert Carter being one of them, who have talked about the importance of capturing traumatic experiences of discrimination. But that is a challenge even if you look at the measures I developed. One of my questions says, "Have you ever been unfairly stopped, searched, questioned, physically threatened, or abused by the police?" That could be a routine stop, and where the police said something rude to you. Or it could be a stop where the police literally beat you up. You cannot distinguish that from the question.

And one of the things we need is a better way to capture those experiences that are really traumatic or that are more severe than others. And that, to me, is another frontier in the work on discrimination and health, especially in terms of measurement, so that we are fully capturing all of the dimensions. And we also need to be vigilant in thinking about all of the domains of life in which discrimination operates. Brendesha Tynes is a University of Southern California psychologist who worked briefly with me as a postdoctoral fellow. She conducted the first study to look at the impact of online discrimination on the health of adolescents. And what we found in that very first paper—now there are several papers on the topic—was that the reports of discrimination in online contexts were adversely related to the mental health of adolescents, independent of off-line discrimination and a global measure of adolescent stress. So the stress of online discrimination was a unique contributor to the health of these African American teens. This illustrates the fact that we need to be thinking comprehensively of all the contexts and all the situations in which discrimination occurs so that we can fully capture and understand its impact on health.

Discrimination Is Not the Only Source of Stressful Life Experience That Should Be Measured

WILLIAMS: Another limitation for me, in terms of where the field is, is that there are a lot of researchers today who have now been persuaded that including a measure of discrimination is important, but it's the only type of stressful life experience they are measuring when studying disadvantaged racial/ethnic populations. And I think that's a mistake. Discrimination is a neglected measure of stressful life experiences, but it's certainly not the only type of stress that matters.

Racial minorities are experiencing higher rates of morbidity and mortality. That means that they have relatives who die prematurely, and who, while they were alive, were coping with illnesses. These are stressors. And we still have higher levels of unemployment, financial stress, work stress, exposure to crime, and being a victim of crime. So to fully capture the stressful life experiences of disadvantaged racial/ethnic populations, measuring only discrimination doesn't do it. It is very important for future research to situate discrimination within the context of all the other exposures that individuals are struggling with.

The final point I would mention on measurement is the work of Nancy Krieger. She has done some interesting work of trying to capture measures of discrimination that are not linked to self-report. She adapted the Implicit Association Test to try to capture experiences of discrimination that individuals are unable or unwilling to report. It's an important line of research, although I don't think the measures developed so far fully capture discrimination or are as predictive as we would like them to be. But I see this as an important area of exploration scientifically. We need to constantly think: are there ways that we can better capture discrimination? Not because I distrust the self-reports of individuals, but I think some scientists would be happy if we had measures that were more objectively assessed. At the same time, I think that, at some level, self-report measures have a profound role to play.

Intersectionality

GRIFFITH: One other question I want to follow up is as it relates to measurement. Then I kind of want to turn a little bit, in the last couple of minutes, to getting you to think about this in a more applied sense for practitioners. But the last measurement-related question I want to ask is about the concepts of things like intersectionality. And so how do you see measuring things like that? How do you see the intersection of race and gender, the intersection of all these different factors, and how that would shape how you think about measuring race and racism?

WILLIAMS: I've written several papers about intersectionality, not just in the context of discrimination but in the context of exposure to adversity and risk, as well as to sources of resilience and resources. I absolutely think that intersectionality is critical to all the

work that we do in this area, but in other areas as well. And I would say we made a mistake in our follow-up question in our measurement of both everyday experiences and major experiences of discrimination. The follow-up question was, "What do you think was *the main reason* for this experience?"

GRIFFITH: Right.

WILLIAMS: I was interested in the "main reason" because I really wanted to focus on racial discrimination. I wanted to capture that discrimination where race played a major role. I now think there's enormous value in asking people to check all the reasons that might apply and capture all of the domains of exposure. Some recent studies show that individuals who report discrimination in more than one domain of life (for example, bias based on age, race, gender, or sexual orientation) experience greater the negative impact of that discrimination on their health. And I think an approach that is much more focused on capturing all of the domains in which people perceive they have been treated unfairly or badly is a useful way to move forward and a way that facilitates the assessment of intersectionality, at least in the impact of discrimination on health.

GRIFFITH: Okay. Thank you. I don't want to take up too much more of your time because I think we're getting close to at least how much we'd told you we were going to take. But the last part I wanted to do is turn your attention to—kind of back to where you started in terms of being a practitioner. And a lot of the book—a lot of the work, in this area, at least—and I'll ask this more as a question has tended to focus more on, as you said, the measurement, the ability to kind of capture, from a self-report standpoint, these measures in self-reported racism, discrimination, those kinds of things. How would you think public health practitioners—whether it's your younger self as a health educator, whether it's folks doing other aspects of kind of frontline public health work—how should they start to apply this kind of—continue to apply—this kind of work on racism to their work as public health practitioners?

ADDITIONAL FACES OF RESISTANCE TO RESEARCH ON RACISM AND DISCRIMINATION

WILLIAMS: Thanks for the question. I think, to me, one of the things the question highlights is something I forgot to mention. And that is, in the early days of doing research on discrimination, there was so much criticism—we were pushing uphill, and there was so much resistance to this work—that our central efforts were focused on documenting that discrimination existed, that it could be measured, and that it had consequences. We were not heavily focused on interventions. But I think that to the extent that discrimination research and research on racism more broadly has matured, there is the need for redoubled efforts to systematically think of how we can dismantle institutional racism and reduce the

negative effects of other dimensions of racism and discrimination to improve health. And I think there's now research in the area of interpersonal discrimination that suggests that there are resources, the quality of social ties, some psychological resources, religious involvement, and spirituality that seem to buffer, at least some of the negative effects of experiences of discrimination on health. I think that this is information we need to provide to practitioners, so they are aware of resources that they can direct communities to.

Two, there's also research like that of Professor Patricia Devine at the University of Wisconsin, Madison. Her research is showing that it is possible to motivate the average person to increase their awareness of both implicit and explicit attitudes and behavior and they can implement a number of strategies to reduce discrimination and explicit and implicit prejudice. And we want to uplift those options and opportunities so that we can help people who are struggling with the negative effects of racism, but we also want to have redoubled efforts to test the strategies we can implement to reduce racism at its source, and to—

GRIFFITH: Yeah.

WILLIAMS: —dismantle some of the institutional mechanisms—in fact, all of them. But, to effectively dismantle the institutional mechanisms, there is the need for research that would guide us in the best strategies, especially for institutional racism. How do we build the political will? How do we tell the story of the disadvantaged so that we can develop a political movement that would work to dismantle the institutional discrimination that is so pervasive? There is, in our society today, enormous interest in cultural awareness and cultural competence. There needs to be an equal emphasis on creating structural competence so that people understand the ways in which racism has been embedded in the institutions, and the processes, and the laws of our society, and so that we can see the ways that the institutional and structural mechanisms work so that we can dismantle them. And I think of interventions broadly. At all levels of society, we need renewed effort to create the political will so that we can take action and identify the most effective ways to act that would achieve the results that we are looking for.

THE IMPORTANCE OF TERMINOLOGY AND FRAMING: LESSONS LEARNED

GRIFFITH: The only other question I wanted to ask was about—I know you had done some work a few years ago with the Commission for a Healthier America, the Robert Wood Johnson work—

WILLIAMS: Right.

GRIFFITH: —about framing conversations about this. Could you talk about that a little bit, just in relation to how—obviously, we know one of the challenges with, of course,

doing this work on the ground is when you raise the concept of race or racism, people just—or label something as racist—it tends to get, as you said, a very strong kind of reaction, to say it nicely. So the question is kind of, in this area of continued contested space, are there ways that you've identified to at least open the conversation with the ways of framing these kinds of topics?

WILLIAMS: That's a really important question. It actually reminds me of a couple of things that happened early on in my professional career. I recall the first proposal that I submitted to [National Institutes of Health] that was focused on examining the relationship between experiences of discrimination and health. When I first wrote the proposal, my title was "Racism and Health: A Study of Determinants." And one of the things that I wisely did, that I still recommend to my postdocs and students, is a good thing to do: *When you get a paper to where you like it, when you get a proposal to where you are happy with it, don't submit it. Get somebody to read it. Get a fresh pair of eyes to look at it.* So [I] sent it to one of my colleagues. And his comment back to me was, "David, do you want to get funded or what?" [laughter] He said, "If you want to get funded, you have to take the 'racism' out." And that's what I did. I did not change the substance of what I was going to do, but I changed the packaging. I changed the title of the proposal, and, instead of "Racism and Health," I called it "Race-Related Stress and Health." And in the first version of the proposal, the term "racism" may have appeared—I don't know—125 times.

GRIFFITH: Sure.

WILLIAMS: But in the final submitted version of the proposal, the term "racism" appeared, maybe five times. So it was still about racism, but racism was no longer salient. And some people might say I was selling out when I did that. But I think you have to realize the game you're in and what your goal is. My goal was to get funded so I could do research on the association between discrimination and health. And I got funded. And I did the research.

GRIFFITH: Sure.

WILLIAMS: And I think if I had kept racism so salient in those early days—this was the mid-1990s—I don't think I would have been successful in getting funding. So there is a certain sensitivity that we need to have. There are some audiences that I am asked to speak to, and I am going to talk about racism, that I don't put the word "racism" in the title. I want that audience to come and listen to my talk, and I don't want to put something in the title that will lead people who need to hear my message not to show up.

GRIFFITH: Right.

WILLIAMS: *I don't only want to preach to the choir.* I want to speak to individuals who are not part of the choir, and to really broaden the conversation and raise their awareness

levels. This reminds me of an experience I had just recently at a national meeting where I gave a talk about racism. A White gentleman spoke to me afterwards and said, "Thank you very much. For the first time in my life, I now understand white privilege." And he explained that he came from a very difficult background: very poor, worked hard, and he had always dismissed the idea of white privilege because he felt he had never experienced white privilege. But when I showed the multiple domains of life in which African Americans and other minorities experienced discrimination, he realized that he didn't have to worry about being discriminated against when he crossed the street. (I had described a high-quality study that shows that, compared with similarly dressed White pedestrians, Blacks wait longer to cross the street and multiple cars are twice as likely to pass a Black pedestrian waiting to cross the street). So what I am saying is that if you are going to be successful at fishing, you have to consider where the fish is coming from and think of the bait that the fish likes and not the bait that you like. So I think there are times I don't play up discrimination in the title of a talk because I want to encourage a broad audience to come so that I can educate them about discrimination.

One of the things we need to do as we talk about discrimination is to talk about it, as I try to do, in a way that is simply laying out the facts, step by step. First, I like to show that socioeconomic status predicts variations in health, but there is a residual effect of race, after we've taken income and education into account. And then we have to ask the question, what else is it about race, and what does race mean in contemporary society? And then I raise the idea of racism and try to systematically unpack racism for an audience so that they are following me. And I try to do it in as nonjudgmental a manner as possible. Just laying out the science that clearly shows this is a phenomenon that exists, and this is a phenomenon that has pervasive negative consequences. So I do think that in a society where research suggests that people are very stressed about race and that there are high levels of anxiety with interracial communication, we need to find creative ways to engage more people in these conversations. Let me come back to the Robert Wood Johnson Foundation's commission.

GRIFFITH: Yes.

WILLIAMS: For that commission, we did not explicitly do a lot of work on race, per se. We did communication research on the social determinants of health, more generally. The question was how should we—

GRIFFITH: Right.

WILLIAMS: —talk about the social determinants of health in a way that effectively communicates with nonacademic audiences? Research that I have found to be instructive on how to talk about race is work that has been done by the FrameWorks Institute. They have produced some issue briefs on the dominant frameworks that most Americans have about race. They explain why some of the ways in which individuals committed to racial

equity talk about race do not work because they fail to cut through the dominant framework that many Americans have. I don't believe that the work of the FrameWorks Institute is the final word on this topic. But I think that their work illustrates the kind of research that we need more of so that we can really better understand what are the ways in which we can talk about these sensitive topics in ways that would help them to have an open mind so that they could see and understand the nature and consequences of racism in American society. We need to recruit these well-intentioned but uninformed individuals to be part of the army for social justice. We all have to work together to dismantle racism in all of its manifestations in contemporary life.

GRIFFITH: And would you say that that would be a useful nugget, example, or tool for practitioners if they want to have these conversations within, say, a health department, or as they go into a community setting to talk about these kinds of issues?

WILLIAMS: I think that our society at large, including nonprofit organizations, community organizations, religious organizations, needs to work at trying to create safe places where Americans of different racial/ethnic backgrounds can come together and talk about race. Many, many Americans are afraid to have conversations about race across racial lines because they're scared they might say something that might offend someone, and, therefore, many people just avoid interracial conversations [about race]. For them, it is the safe thing to do to stay out of trouble. The attitude is to just not deal with the topic, because if you say something, somebody may jump on you or view you negatively. And I think, as a society, we need to create safe places where individuals can talk honestly about issues of race.

FINAL THOUGHTS

GRIFFITH: Any other thoughts, or anything else that this has kind of raised for you?

WILLIAMS: The one other thing that I would mention as an important priority for future research is that we need to better understand how racism in the larger culture (as measured by the amount of racial prejudice there is at the community level) can affect health. There are a number of recent studies that have found elevated levels of mortality for African Americans (and sometimes for Whites) who live in communities where more people are racially prejudiced. I think that we need to understand, first of all, what are the mechanisms and processes by which these negative effects occur?

Second, it highlights for us, that in this moment in American history, it is very important to work to reduce the racism that is so deeply embedded in our culture. We live in a time when a lot of people feel emboldened in the current political environment to use racial slurs and words of hatred and to be verbally and physically aggressive toward immigrants, racial/ethnic minorities, and stigmatized populations, more generally. There's

research that indicates that since the election of President Obama there has been an increase in hate websites and Facebook pages in the United States. And then the campaign of President Trump and the election of President Trump have further emboldened many.

And, for me, most distressing is the research from the Southern Poverty Law Center that indicates that the number-one site in which racial harassment occurs in the United States is in K-through-12 schools. So we have work to do to figure out how we can best take care of our vulnerable children in American society when teachers are reporting that many students in their classrooms feel emboldened to pick on others who differ from them based on race, or sexual orientation, or religion, or national background, or immigrant status. And the research documenting that this hostility, whether it's anti-immigrant sentiment, or anti-Muslim sentiment, or anti-LGBT sentiment, or antiracial sentiment really creates an environment that is literally harmful to health speaks to the urgency that we need to have.

We need to make this issue a national priority, and we need to work together to create a new culture of tolerance and of acceptance of others who are different from us. We need to broaden our definition of the determinants of health to include the hostility in the larger environments and commit ourselves to creating environments that are truly healthy for *all*.

REFERENCES

1. Braithwaite RL, Taylor SE, eds. *Health Issues in the Black Community*. San Francisco, CA: Jossey-Bass; 1992.

2. Williams DR. Review of *Health Issues in the Black Community* by R. L. Braithwaite and S. E. Tayler (eds.). *Contemp Sociol.* 1993;22(5):746–747.

3. Williams DR, Lavizzo-Mourey R, Warren RC. The concept of race and health status in America. *Public Health Rep.* 1994;109(1):26–41.

4. Essed P. *Everyday Racism: Reports From Women of Two Cultures.* Alameda, CA: Hunter House Publishers; 1990.

5. Essed P. *Understanding Everyday Racism: An Interdisciplinary Theory.* Vol. 2. Newbury Park, CA: Sage; 1991.

6. Collins CA, Williams DR. Segregation and mortality: the deadly effects of racism? *Sociol Forum.* 1999;14(3):495–523.

7. Williams DR, Collins C. Racial residential segregation: a fundamental cause of racial disparities in health. *Public Health Rep.* 2001;116(5):404–416.

8. Cooper R, Steinhauer M, Schatzkin A, Miller W. Improved mortality among US blacks, 1968–1978: the role of antiracist struggle. *Int J Health Serv.* 1981;11(4):511–522.

9. Krieger N. Racial and gender discrimination: risk factors for high blood pressure? *Soc Sci Med.* 1990;30(12):1273–1281.

10. Krieger N, Rowley DL, Herman AA, Avery B, Phillips MT. Racism, sexism, and social class: implications for studies of health, disease, and well-being. *Am J Prev Med.* 1993;9(suppl 6): 82–122.

11. Herman AA. Toward a conceptualization of race in epidemiologic research. *Ethn Dis.* 1996; 6(1-2):7–20.

12. LaVeist TA. Why we should continue to study race . . . but do a better job: an essay on race, racism and health. *Ethn Dis.* 1996;6(1-2):21–29.

13. King G. Institutional racism and the medical/health complex: a conceptual analysis. *Ethn Dis.* 1996;6(1-2):30–46.

14. Williams-Morris RS. Racism and children's health: issues in development. *Ethn Dis.* 1996; 6(1-2):69–82.

15. Moore DJ, Williams JD, Qualls WJ. Target marketing of tobacco and alcohol-related products to ethnic minority groups in the United States. *Ethn Dis.* 1996;6(1-2):83–98.

16. Polednak AP. Segregation, discrimination and mortality in US blacks. *Ethn Dis.* 1996;6(1-2): 99–108.

17. McNeilly MD, Anderson NB, Armstead CA, et al. The Perceived Racism Scale: a multidimensional assessment of the experience of white racism among African Americans. *Ethn Dis.* 1996;6(1-2):154–166.

18. Jackson JS, Brown TN, Williams DR, Torres M, Sellers SL, Brown K. Racism and the physical and mental health status of African Americans: a thirteen year national panel study. *Ethn Dis.* 1996;6(1-2):132–147.