



Article

Race-Based Social Rejection and Mental Health: The Role of Racial Identity

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Abstract: Background and Introduction: Race-based social rejection has been found to predict post-traumatic stress and depression symptoms, consistent with previous studies that have shown the negative mental health effects of racism, as well as social rejection in general. While racial identity has been noted as a protective factor among African Americans, the role it plays in the context of race-based social rejection is less clear. Methods: This study examines the relationships among self-reported race-based social rejection, hypothesized protective factors, and negative psychological outcomes among a sample of 230 low-income, urban African American men and women. Results: Multiple regression analyses revealed that racial identity did not moderate the race-based social rejection–depression relationship. However, it exacerbated post-traumatic stress symptoms in the face of race-based social rejection. Discussion: These results suggest that when one perceives such rejection, identifying strongly with one’s group may amplify post-traumatic stress by triggering collective instances of racial trauma. Conclusions: The role of racial identity highlights the unique nature of racial trauma, involving the interplay of individual and social facets, particularly among those who highly identify with their racial group, and call for collective and creative solutions.



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1. Introduction

Racial/ethnic discrimination, defined as a “behavioral manifestation of a negative attitude, judgment, or unfair treatment” [1], (p. 553) toward members of a particular racial group based on their group membership has long been associated with poorer mental health, including depression, PTSD, and other anxiety and psychological distress [2–7]. Findings of the deleterious effects of racial or ethnic discrimination are not only robust, but consistent across diverse samples of African Americans, Latinos, and Asian Americans [8–10]. Moreover, discrimination as part of daily life has been consistently reported by members of racial/ethnic minority groups [11,12]. The outpouring of anger and grief in the aftermath of the killings of unarmed Black citizens in the past several years, including George Floyd, Breonna Taylor, Ahmaud Arberry, and Jacob Blake, among many others, speaks to the widespread and rippling effect of racial trauma.

Theories on the psychological impact of race-based trauma have their roots in historical trauma frameworks, which focus upon the adversity experienced by ancestors that is transmitted intergenerationally, resulting in psychosocial harms to the descendants [13]. These frameworks emphasize the importance of socio-historical contexts of trauma [14] in understanding its sources, outcomes, and mediators, leading to more contemporary theories that take into account the possible multiple dimensions of race-based trauma.

This complexity has been advanced in the work of Cenat [15], which aligns racial trauma with complex trauma, as racial trauma affects the target's life course, as well as nearly every sphere of an individual's functioning. Moreover, experiences of race-based incidents appear to add significantly to the extent of PTSD symptoms experienced. For example, in a recent study of Black Canadians [15], it was found that traumatic events, racial microaggressions, everyday discrimination, and internalized racism accounted for 51.8% of the variance in PTSD symptoms, significantly higher than traumatic events themselves, with 25.9% of the variance accounted for, suggesting that what might be considered mundane, everyday experiences, such as social rejection, may have pernicious mental health effects.

The process by which deleterious psychological outcomes occur is also consistent with the popular utilitarian framework from the sociological literature that recognizes it as comprising of various elements, such as sources, outcomes, and mediators [16–18]. Conceptualizing race-based trauma as a type of environmental stressor invites the investigation of the role of this stressor in the hypothetical outcomes of depression and post-traumatic stress symptoms.

Because racial discrimination appears to be multifaceted, including the dimensions of social rejection, discrimination at school or work, stereotyping, direct threat or attack, and police mistreatment [2,19], previous studies have hypothesized that different dimensions may affect psychological health differently. For example, a recent study found that in a sample of African American and Latine individuals, social rejection, above and beyond other dimensions, served as a unique and significant predictor of post-traumatic stress symptoms among men and of depression among both men and women [2]. Social rejection and other forms of social pain have been found to be harmful, perhaps due to humans' evolutionarily based need to belong [20]. Race-based social rejection may have the additional stress-inducing element of ambiguity; that is, when one is socially rejected, one may be uncertain whether the rejection is attributable to one's race, rendering it more stressful than stereotyping or direct attacks in which racist intent is evident.

If race-based social rejection is strongly associated with post-traumatic stress and depression symptoms after a perceived discriminatory incident, might its effects be attenuated if one holds a deep sense of belonging to one's racial group, thus counteracting its effects? Racial or ethnic identity is an aspect of one's self-concept, derived from a sense of belonging and commitment to a particular racial or ethnic group, and includes self-identification, pride and positive valuation of the group, and taking part in the group's traditions, practices, and values [21,22]. It has been posited as a protective factor [21,23], associated with fewer depressive symptoms [24], lower stress [25], and higher self-esteem [26], perhaps because individuals with a strong racial identity would attribute discrimination directed at them not to their personal characteristics but to systemic social injustice [10]. However, a strong racial identity might also lead one to perceive more discriminatory behavior and to interpret ambiguous incidents as discriminatory [27], as has been found in a meta-analysis, which concluded that for Black Americans, a greater sense of racial belonging was associated with more perceived discrimination, indirectly affecting psychological distress [10]. Other research suggests a more complex relationship, depending on race and ethnicity. For example, one study found that moderate levels of racial/ethnic identity attenuated

associations between discrimination and psychological disorders for African Americans and Asians, whereas high levels of racial/ethnic identity intensified links between discrimination and negative mental health outcomes in other racial/ethnic groups [28]. Research aimed at better understanding how racial/ethnic identity intersects with other marginalized identities and the processes that increase risks for or protect against adverse mental health outcomes is needed [29,30].

In addition to racial identity, spirituality has been posited as an important strategy to cope with racism among African Americans and other ethnic minorities [31,32]. Studies on the role of spiritual-based coping have yielded mixed results; some have found a dampening effect in the relationship between racial stress and negative mental health outcomes [32,33], others have found no significant role [34], and yet another found that it amplified negative outcomes in face of institutional racism [35]. Therefore, to date, it remains unclear whether spiritual-based coping serves as a protective factor against the negative mental health effects of racial discrimination.

As racial trauma is ubiquitous and insidious in the lives of racially minoritized citizens [36], researchers and mental health professionals should delineate the complex processes by which psychological harm results. To that end, the present study examines the relationships among race-based social rejection, hypothesized protective factors (racial identity, spiritual coping), and negative psychological outcomes (depression, post-traumatic stress symptoms).

2. Methods

2.1. Participants and Procedures

Based on a larger dataset from a parent study, a sample of 230 African American participants (167 men and 63 women) were included in the present study, which investigated race-based social rejection and related outcomes. All study procedures and methods were approved by the Institutional Internal Review Board (IRB) of the university at which the study was conducted. From community clinics and community-based organizations in South Los Angeles, participants were recruited by flyers and word-of-mouth by clinic and organization staff. South Los Angeles is an area within Los Angeles County with 25.6% of people living below the poverty line, which represents twice below the median income level in California [37], and is considered an impoverished area. Potential participants were screened and assessed by members of an experienced multiethnic and multicultural research team. Detailed descriptions of study procedures have been previously published [30,38].

A core battery of psychosocial measures was administered to participants in one-to-one sessions on laptop computers, on which with the Audio Computer-Assisted Self-Interview (ACASI) system was loaded. Respondents were assessed on the ACASI in sessions lasting 2 to 2.5 h. All participants received cash compensation of \$35–\$100, which varied depending on how much time was spent in the sessions. After each session, participants were provided information and referrals to mental health, social, and other services.

2.2. Measures

Self-reported demographic characteristics included age, race/ethnicity, household income, years of education, employment (full/part-time, not employed), and marital/relationship status. Household income was categorized as above or below \$1249/month, the federal poverty level for a family of four. For California, the poverty level for a family of four is \$2075/month to account for the higher cost of living.

Perceived race-based social rejection was assessed with the Social Rejection subscale of the Brief Perceived Ethnic Discrimination Questionnaire—Community Version (BPEDQ-

CV) [2,39], a widely used measure of perceived discrimination with demonstrated validity and reliability among diverse samples [19,39]. The six-item Social Rejection subscale measured the degree to which respondents felt they were rejected socially due to their race or ethnicity, for example, “because of your race or ethnicity, have others made you feel like an outsider who doesn’t fit in because of your dress, speech, or other characteristics related to your ethnicity?” Items were scored on a five-point Likert scale ranging from 1 (never) to 5 (very often), which, in the current sample, had good internal consistency reliability (Cronbach’s $\alpha = 0.86$). A higher score on this scale indicates higher perceived race-based rejection.

2.3. Outcomes

Post-traumatic stress (PTS) symptoms were assessed with the 17-item Post-traumatic Diagnostic Scale (PDS) [40]. Respondents answered each item on a four-point Likert scale ranging from 0 (not at all) to 3 (almost always). Scores of 0–27 suggest no PTSD and scores 28 and above suggest a probable PTSD diagnosis [41].

Cronbach’s α was very high (0.92), indicating high internal consistency. The PDS has demonstrated strong cross-cultural reliability, including among African American samples, and shown high validity among primarily African American samples [42,43], as well as Latine women and White men and women [44,45].

Depression symptoms were assessed with the Center for Epidemiological Studies–Depression Scale (CES–D) [46], which consists of 20 items asking respondents whether they had experienced specific depression symptoms in the last two weeks. Responses were measured on a four-point Likert scale ranging from 0 (not at all) to 3 (every day or almost every day). The sum score of this scale has demonstrated high internal consistency in this sample. ($\alpha = 0.91$). Higher scores represent higher risk for depression, with a sum score of 16 representing the cutoff between no risk for depression to mild or moderate symptoms and a risk for depression [46]. Although some research has questioned its cultural responsiveness [47], the CES-D has demonstrated adequate validity and reliability in the general population and primary care settings. In addition, it has shown adequate reliability and validity with ethnic minority samples [48,49], including African American and Latine populations [44].

2.4. Moderators

Racial/ethnic identity was assessed with three items taken from the Multigroup Ethnic Identity Measure [26], which measures the degree of identification and belonging with respect to one’s racial or ethnic group. This measure has been widely used, evidencing good reliability and validity with diverse samples [50]. Responses were scored on a five-point Likert-type scale ranging from “not at all” to “very much.” In our sample, the items demonstrated excellent reliability (Cronbach’s $\alpha = 0.87$). A higher score on this scale represents a stronger identification with one’s racial/ethnic identity.

Spiritual coping was measured with the Spiritual Coping subscale of the Spiritual Coping Strategies (SCS) Scale [51]. While many religiosity measures apply only to religious respondents, this scale is relevant to both religious and non-religious participants. This Likert-type subscale consists of 11 items, which taps into respondents’ reliance on spirituality to cope with stress; for example, “When facing life’s challenges, I rely on God (or a higher being) to see me through,” and “My relationship with God (or a higher being) contributes to my sense of well-being.” The subscale has demonstrated good validity and reliability with multiple samples [52], and internal consistency (Cronbach’s α) in this sample was 0.89. Higher scores indicate a greater use of spiritual coping.

3. Results

As shown in Table 1, participants reported an average age of 41.7 years, with a range of 18 to 67 years. A great majority, 86.3%, reported a household income of less than \$1249/month, reflective of low income. About one-quarter (25.3%) had less than high school education. In terms of psychological distress, the sample evidenced a mean of 17.9 on the CESD, which is above the clinical cutoff of 16 for experiencing depression symptoms [46]. Participants reported a mean of 12.3 on the PDS scale, indicating a mild to moderate level of post-traumatic stress [40] and below the threshold of 28 for a probable PTSD diagnosis. Scores of social rejection based on race were high, with a mean of 15.4. A mean of 12.1 was found for racial/ethnic identity, indicating a strong level of racial/ethnic identification (maximum score is 15). Spiritual coping was also high, with a mean of 55 (maximum score is 66).

Table 1. Demographic characteristics of sample.

	Mean or N (S.D. or %)
Age	m = 41.7 (10.2)
Gender	
men	167 (72.61%)
women	63 (27.39%)
Income ^a	
≤1249/m	157 (86.26%)
>1249/m	25 (13.74%)
Education ^b	
less than high school	58 (25.33%)
high school+	171 (74.67%)
Spiritual Coping	55 (11.3)
Race-Based Social Rejection	15.4 (5.9)
Racial/ethnic Identity	12.1 (3.1)
PTS Symptoms	12.3 (11.6)
Depression Symptoms	17.9 (12.5)

^a: 48 of the sample didn't report income; ^b: 1 of the sample didn't report education level.

Bivariate correlations between predictor and outcome variables were performed (see Table 2). Age was negatively correlated with PTSD ($r = -0.18, p < 0.01$) and CESD ($r = -0.14, p < 0.05$). Lower education was significantly related to higher levels of PTSD ($r = -0.13, p < 0.05$). Compared to men, women reported higher levels of social rejection based on race ($r = -0.16, p < 0.05$), PTSD ($r = -0.26, p < 0.0001$), and CESD ($r = -0.20, p < 0.01$). Religious well-being was positively correlated with racial/ethnic identity ($r = 0.31, p < 0.0001$) and negatively correlated with CESD ($r = -0.14, p < 0.05$). Racial/ethnic identification was negatively correlated with CESD ($r = -0.23, p < 0.001$) and positively correlated with PTSD ($r = 0.70, p < 0.0001$). Race-based social rejection was significantly related to higher scores in PTSD ($r = 0.44, p < 0.0001$) and CESD ($r = 0.46, p < 0.0001$).

Multiple regression analysis was used to examine the unique contribution of predictor variables to PTSD and CESD in the multivariate context. As shown in Table 3, the full model predicting CESD was significant ($F(7, 218) = 13.13; p < 0.0001$, R-squared = 0.30). Among the individual predictors, lower racial/ethnic identification was related to higher CESD scores ($t = -3.89, p < 0.0001$). Higher race-based social rejection also predicted higher CESD scores ($t = 7.80, p < 0.0001$). The interaction terms of gender with racial/ethnic

identity and social rejection were non-significant, and the interaction between racial/ethnic identity and social rejection was also non-significant. Interaction terms were excluded from the final model to preserve power.

Table 2. Correlations between predictor and outcome variables.

	Age	Gender	Income	Education	Spiritual Coping	Social Rejection	Racial Identity	PTSS
Age								
Gender	0.33							
	<0.0001							
Income	−0.1	0.03						
	0.1918	0.6696						
Education	0.09	0.01	0.05					
	0.1928	0.9196	0.4664					
Spiritual Coping	0.09	−0.06	−0.02	0.12				
	0.1776	0.3915	0.8131	0.082				
Social Rejection	−0.1	−0.17	0.07	−0.07	−0.02			
	0.1294	0.0116	0.3441	0.2882	0.7359			
Racial Identity	0.13	−0.003	−0.03	0.06	0.31	0.07		
	0.059	0.9655	0.7288	0.3623	<0.0001	0.2614		
PTS Symptoms	−0.18	−0.26	−0.1	−0.13	−0.07	0.44	−0.09	
	0.0056	<0.0001	0.1683	0.0453	0.2711	<0.0001	0.1945	
Depression Symptoms	−0.15	−0.2	−0.08	−0.13	−0.14	0.46	−0.23	0.7
	0.0275	0.0029	0.2758	0.055	0.0362	<0.0001	0.0006	<0.0001

Table 3. Multiple regression model of predictors on depression symptoms.

Parameter	Estimate	Standard Error	t Value	Pr > t
Age	−0.03590332	0.07593172	−0.47	0.6368
Gender (Men)	−3.13002031	1.72774789	−1.81	0.0714
Education (High School+)	−1.99247371	1.64876462	−1.21	0.2282
Spiritual Coping	−0.05192862	0.06721352	−0.77	0.4406
Racial Identity	−0.9572892	0.24640139	−3.89	0.0001
Social Rejection	0.96053349	0.1231848	7.8	<0.0001

In the prediction of PTS symptoms, the full model was also significant ($F(7, 217) = 12.30$, $p < 0.0001$; see Table 4). In terms of main effects, gender was significantly related to PTS symptoms, with women more likely to experience a higher level of symptoms ($F = 10.07$, $p < 0.01$). Stronger racial/ethnic identification was related to higher levels of PTS symptoms ($F = 9.11$, $p < 0.01$).

Investigation of the interactions between racial/ethnic identity and the other predictors revealed a moderating effect of racial/ethnic identity in the relationship between social rejection and PTS symptoms ($F = 6.35$, $p < 0.05$). To explore this effect, racial/ethnic identity was dichotomized using the mean score of 12 in this sample as the cutoff. The high group (13 and above) comprised 52% of the sample and the low group 48%. Among those with

high racial/ethnic identity, the relationship between race-based social rejection and PTS symptoms was significantly stronger than among those with lower racial/ethnic identity (see Figure 1). In other words, level of racial/ethnic identification determines whether PTS symptoms are related to race-based rejection. For those who identify strongly with their racial/ethnic group, an experience of race-based social rejection is more likely to result in PTS symptoms than for those who do not identify strongly.

Table 4. Multiple regression model of predictor variables on post-traumatic stress symptoms.

Parameter	Estimate	Standard Error	<i>t</i> Value	Pr > <i>t</i>
age	−0.05895285	0.07090537	−0.83	0.4066
gender (men)	−5.25647312	1.62886805	−3.23	0.0014
education (high school+)	−2.30046618	1.54147419	−1.49	0.1371
spiritual Coping	−0.03758428	0.06158164	−0.61	0.5423
racial identity (high)	−11.57913905	3.78853176	−3.06	0.0025
social rejection	0.43766055	0.18090015	2.42	0.0164
social rejection * racial identity (high)	0.59214587	0.23154384	2.56	0.0112

*: Denotes interaction.

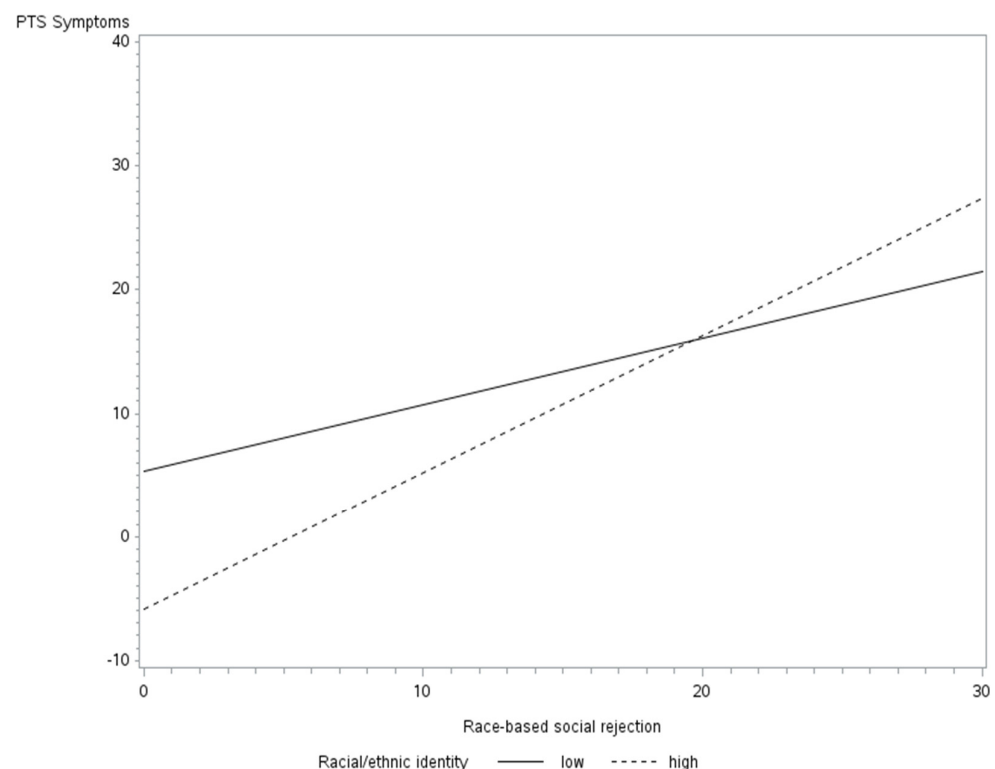


Figure 1. Race-based social rejection and PTS symptoms moderated by racial/ethnic identity.

4. Discussion

As expected, in this sample of low-income, urban African American adults, self-reported experiences of race-based social rejection were quite high. Post-traumatic stress symptoms were moderate and depression symptom scores exceeded the clinical cutoff, indicating mild to moderate levels. In terms of the hypothesized predictors, respondents reported high levels of spiritual coping and racial belonging, suggesting that this sample of African American participants possessed areas of strength and positive coping. Women were more likely to experience post-traumatic stress symptoms than were men, possibly a

reflection of higher levels of sexual harassment experienced by women [53,54]. Although a greater reliance on spiritual coping was associated with a higher degree of racial identity and with fewer depression symptoms, it did not uniquely contribute to the outcomes when other variables were accounted for, nor did it serve as a significant moderator in the social rejection–psychological distress relationships.

Consistent with previous research, greater race-based social rejection was uniquely related to higher levels of post-traumatic stress and depression symptoms. The need to belong has been posited as an intrinsically human need [20,55], and this result underscores the pain of being socially rejected. Social ostracism is a state that triggers the flight or fight response, leading to a host of physical and psychological maladies [20]. Perceived rejection based on one's race appears to trigger a similar response, leading to elevated depression and post-traumatic stress.

Stronger racial/ethnic identification was uniquely related to fewer depression and post-traumatic symptoms when all predictors were considered. This result was expected, as previous studies have found that a strong sense of kinship with one's group provides protection against psychological distress [56]. However, while racial identity did not affect the social rejection–depression symptoms relationship, racial identity moderated the relationship between discrimination and post-traumatic stress symptoms—among those who identified more strongly with being African American, a stronger association emerged between social rejection and post-traumatic symptoms. In the context of social cognitive theory, it makes sense that when one identifies more strongly with one's racial group, any perceived instance of social rejection may recall other personal and historical instances of discrimination, thereby amplifying its traumatic effects. In essence, the strong identification renders an individual more vulnerable to the collective trauma of the entire group. Indeed, a recent community-level study alludes to this as the spillover effect; in neighborhoods in which an unarmed Black American citizen was shot and killed by the police, Black residents evidenced poorer mental health in the two months following the shooting, compared to the months before the shooting, as well as compared to incidents in which the victim was armed [57]. Similarly, recent attacks on Asian Americans have increased mental and emotional distress among Asian Americans in general [58,59], even those who did not personally experience an attack [60]. Interestingly, victims were less likely to experience post-traumatic stress symptoms when they reported the attack compared to those who did not [61], an action which likely elicits community support and a sense of being seen.

The importance of racial identity is consistent with and supported by social identity theory [62], which emphasizes the salience of group identification as a basis for individual identity. Furthermore, the intersectionality theoretical framework adds to this understanding by recognizing the impact of multiple intersecting identities, historical oppression, and socio-structural context on health outcomes [13,63]. The complexity of this finding also lends credence to Cenat's work on race-based trauma as a complex, life-course trauma, as racial identification is an essential part of the ongoing process of identity formation and change over one's lifetime.

The finding that racial identification exacerbates post-traumatic stress symptoms in the context of perceived social rejection does not necessarily contradict its psychological benefits in general. In the absence of perceived discrimination, a strong sense of belonging satisfies a fundamental human need [55] and promotes greater self-esteem and self-evaluation [21]. However, being part of a collective also means bearing the pain and trauma of the entire group. When one perceives rejection based on one's race, this painful incident likely triggers the previous collective trauma suffered by one's group, amplifying the post-traumatic stress reaction. This finding implies that while racial socialization strategies benefit Black Americans and other ethnic minorities [64,65], they may not go far enough

to protect against acute traumatic incidents, and may in fact increase one's vulnerability. Culturally responsive interventions that address the intersection of racial identification and racial/ethnicity-related trauma experiences to promote and protect mental health are clearly needed [56].

Recent research has emphasized the importance of social belonging and human connection, and interventions that bolstered belonging have demonstrated positive outcomes [66,67]. However, the objectives of these programs are directed toward promoting belonging of marginalized groups into White majority settings [66]. In the face of race-based social rejection, programs that allow for a sense of belonging and connection among one's own racial group may be indicated. While large-scale social movements such as Black Lives Matter may fill this need, traumatized targets of racist incidents may distance themselves from their racial identity. More localized resources, including community groups, churches, schools, and mental health professionals that proactively promote social belonging may be critical in regaining one's sense of safety, particularly among those who highly identify with their race.

The limitations of this study include its cross-sectional design, which precludes conclusions about the temporal relationship among the variables. Although it makes sense that racial discrimination leads to psychological distress, as has been found in a plethora of previous studies, the reverse is also possible, that distress may heighten perceptions of discrimination and rejection. Another limitation of this study is the demographic characteristics of the sample, which may not allow generalizability of the findings to other groups. As this sample consists of low-income, inner-city Black Americans, future studies should investigate the relevance of these results to other ethnic minority groups, as well as in higher socioeconomic populations. Indeed, poverty has been found to be a major stressor, and its impact on mental health may intersect with or magnify the effects of race-based rejection [68,69]. In the present study, however, the skewness of the sample toward extremely low incomes places a limitation on exploring the influence of poverty. This is also true in terms of gender and education in this sample. Given the restricted range and skewness of these variables in this sample, it would behoove future studies to explore the nature of such an interaction, if any, using a sample of greater SES and gender diversity.

5. Conclusions

In conclusion, this study aimed to identify the role that racial identity plays in the context of race-based social rejection in a sample of 230 African American men and women. We examined the relationships among self-reported race-based social rejection, hypothesized protective factors, and negative psychological outcomes. Utilizing multiple regression analyses, we found that racial identity did not moderate the race-based social rejection–depression relationship; however, it exacerbated post-traumatic stress symptoms in the face of race-based social rejection, suggesting that when one perceives such rejection, identifying strongly with one's group may amplify post-traumatic stress by triggering collective instances of racial trauma. Clinicians treating those with PTS should explore cultural identity and address concerns related to racial trauma. These findings highlight the unique nature of racial trauma, involving the interplay of individual and social facets, particularly among those who highly identify with their racial group.

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