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Gilbert C. Gee
Kathryn J. Lively
Larissa Larsen
Jennifer Keith
Jana Stone
Kara MacLeod

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Hungry for Respect: Discrimination Among Adults Using Emergency Food Services

Gilbert C. Gee, Ph.D., University of California, Los Angeles
Kathryn J. Lively, Ph.D., Dartmouth College
Larissa Larsen, Ph.D., University of Michigan
Jennifer Keith, MPH, Philadelphia Health Management Corporation
Jana Stone, MPH, California Department of Health Services
Kara MacLeod, MPH, University of California, Berkeley

Abstract

Objectives: We examined how adults using emergency food services report discrimination and how these reports may be associated with well-being. Methods: Data come from a survey (n=318) and from five focus groups of adults using emergency food services, conducted between 2003-2004. The survey included measures derived from the Everyday Discrimination Scale and the Centers for Epidemiologic Studies Depression Scale (CES-D). Focus groups were analyzed with content analysis. Results: The survey data suggest that everyday discrimination was associated with the CES-D, conditional on covariates. Focus group data are consistent with the survey results and suggest several avenues for future research, including how some individuals may forgo access to food and medications in order to protect their dignity in the face of discrimination. Conclusions: Qualitative and quantitative data converge into a similar theme - discrimination may be an important factor associated with well-being.

Key Words: Discrimination, disparities, hunger, race, mixed-methods

"I get food stamps every month, but I refuse to use any other kind of government agency because… they treat you like an animal just because you need a little help…I don't know anyone who likes getting welfare because of the [garbage] you have to deal with in the welfare office." Quoted in Edin & Lein, 1997. p.138(Edin & Lein, 1997)

Introduction

Systematic negative treatment by individuals and institutions may contribute to illness. Self-reports of discrimination refer to the recanting of experiences one finds to be systematic, unjust, and associated with disadvantaged group membership. In accord with these observations, the present study has two major goals. First, we examine the association between discrimination and depression among individuals who use emergency food services. Second, we explore some previously undocumented pathways whereby discrimination may contribute to depression and diminished well-being.

A growing literature suggests that self-reports of discrimination are associated with depression and a variety of other health problems (Krieger, 1999; Mays, Cochran, & Barnes, 2007; Williams, Neighbors, & Jackson, 2003). For example, Kessler and colleagues (1999) found that discrimination experienced "day-to-day" was associated with a nearly twofold greater odds of depression among a general population sample. Similar findings have been reported a variety of other groups (Finch, Kolody, & Vega, 2000; Noh, Beiser, Kaspar, Hou, & Rummens, 1999; Schulz et al., 2006; Gee, Spencer, Chen, Yip, & Takeuchi, 7 A.D.). A recent study of female welfare recipients in Michigan found that discrimination was associated with increased risk of depression after three years of followup (Heflin, Siefert, & Williams, 2005).

Discrimination is often viewed as a stressor that may trigger physiological and psychological reactivity (Clark, Anderson, Clark, & Williams, 1999). Discrimination may contribute to depression by reducing one's sense of control, threatening one's ego identity, and lead to the internalization of negative stereotypes (Harrell, 2000; Williams & Willams-Morris, 2000). Further, the ambiguity stemming from the covert and symbolic nature of modern discrimination may lead to rumination, itself a risk factor for discrimination (National Research Council, 2004; Sears & Henry, 2003; Harrell, 2000; Nolen-Hoeksema, Larson, & Grayson, 1999). In addition, discrimination may lead to socioeconomic disadvantage and subsequent depression(Williams & Willams-Morris, 2000).

Finally, discrimination may prompt behavioral responses. Some of these responses, such as the enlisting of social support and engaging in community activism, may be health protective (Gee et al., 2006a; McNeilly et al., 1995; Noh & Kaspar, 2003). However, some responses may be harmful, such as when individuals use tobacco, alcohol and other substances to cope with discrimination (Bennett, Wolin, Robinson, Fowler, & Edwards, 2005; Whitbeck, Hoyt, McMorris, Chen, & Stubben, 2001; Yen, Ragland, Greiner, & Fisher, 1999a).

In the current study, we focus on the reporting of discrimination by individuals using emergency food services. Individuals using these services are diverse, ranging from persons in chronic poverty to those who encountering a temporary emergency (Alaimo, Olson, Frongillo, & Briefel, 2001; Algert, Reibel, & Renvall, 2006). In 2004, 11.9% of the American population was food insecure, representing 13.5 million households; a majority of these households used some form of food assistance (Nord, Andrews, & Carlson, 2005). In 2000, food pantries alone distributed 239 million pounds of food per month (Ohls, Saleem-Ismail, Cohen, & Cox, 2002). Despite the prevalence of emergency food service use, the well-being of individuals who use these services are understudied. Greater knowledge will help inform the provision of services. As suggested in the opening quote, in order to maintain their dignity in the face of discrimination, individuals may disengage from the very services that are designed to help them (Edin & Lein, 1997).

We use quantitative analyses from a survey to examine the association between discrimination and depression. Because prior research suggests food insecurity is associated with depression and other health outcomes (Alaimo, Olson, & Frongillo, 2002), we control for reports of food insecurity and the use of emergency food services as well as a variety of demographic characteristics (e.g. education, age, gender). Secondarily, we explore the factors that are associated with the reporting of discrimination. Of particular interest is whether standard general indicators of socioeconomic status (e.g. employment) and indicators of specific deprivation (e.g. emergency food use) are associated with increased reporting of discrimination. Prior studies often find that unemployment and similar measures are associated with increased reports of discrimination,(Kessler, Michelson, & Williams, 1999; Sigelman & Welch, 1991) but it is unknown whether more specific indicators of deprivation are also associated with discrimination.

In addition, we use qualitative analyses from focus groups to better understand the sources of and potential responses to discrimination. Use of mixed methods will help us to triangulate findings and address some of the limitations of each method used singularly. The survey has a major strength in use of a standard measure of discrimination, permitting a formal test of the association between discrimination and depression and allowing for comparison with other populations, but a disadvantage is that the instrument has less detail about the ways discrimination is expressed in this particular population. The focus groups provide rich data to better understand the particular manifestations of discrimination and permit the generation of previously unexplored hypotheses about discrimination.

Methods

Data come from a pilot study of adults using emergency food services. We first describe the survey, then the focus groups.

Survey:

Using in-person interviews, we surveyed 412 adults at 12 emergency food distribution centers in Arkansas. Arkansas was chosen as a study site because of the state's high rates of poverty and food insecurity (Nord et al., 2005). Between 1999-2000, 16.4% of Arkansas residents lived below the federal poverty threshold, compared to 11.5% nationally, ranking the state the 3rd highest in the nation (Dalaker, 2001). However, there is a paucity of research on disadvantaged persons in this area.

A non-random sample was obtained because of the nature of emergency food need (i.e., clients are often transient, homeless, use food services on a one-time or sporadic basis) and service provision (i.e., many food services do not keep identified lists of their clients). Data were collected during the summer to minimize biases due to seasonality in emergency food use. Adult clients at a provider site were approached by trained interviewers, informed about the study, and surveyed after obtaining informed consent. The response rate was 87%. Participants were paid $5. In this analysis, we omit 94 persons indicating a race other than black or white. Supplemental analyses (not shown) including these respondents are consistent with those reported here.

Measures:

Depression was measured with the shortened Centers for Epidemiologic Studies Depression Scale (CES-D; Turvey, Wallace, & Herzog, 1999; Andersen, Malmgren, Carter, & Patrick, 1994). Participants were asked to describe how frequently (1=rarely to 4=most/all of the time) in the past seven days they were: "bothered by things that didn't usually bother me," "had trouble keeping my mind on what I was doing," "felt depressed," "felt that everything I did was an effort," "felt hopeful about the future," "felt fearful," "sleep was restless," "was happy," and "could not get going." The interitem correlation (Cronbach's alpha) was 0.74. Scores greater than or equal to 10 indicate probable depression; respondents meeting this threshold were coded 1 for depressed, 0 otherwise.

Perceived discrimination was adapted from the Everyday Discrimination scale measuring frequency of routine experiences of unfair treatment (Williams, Yu, Jackson, & Anderson, 1997). This scale has predicted depressive symptoms, chronic health conditions, self-rated health, and substance use in

prior studies (Gee et al., 2006a; Gee, Delva, & Takeuchi, 2006b; Schulz et al., 2000; Taylor, Kamarck, & Shiffman, 2004; Williams et al., 1997). Respondents indicated how often (never to almost every day) they experienced the following: encountering prejudice and discrimination from others; being treated with less courtesy than other people; being treated with less respect; receiving poorer service at restaurants or stores; people acting as if they are afraid of you; acting as if you are dishonest; acting as if they are better than you are; being called names or insulted; being threatened or harassed. These items are averaged and higher scores (range 1-6) on the scale indicated greater frequency of everyday discrimination. Interitem correlation was 0.84. Consistent with prior studies,(Kessler et al., 1999; Krieger, Smith, Naishadham, Hartman, & Barbeau, 2005) an exploratory factor analysis found a one-factor structure (eigenvalue 3.17; factor loadings from 0.48-0.72) with this scale.

After responding to the scale, participants were then asked, "What do you think was the main reason for this/these experiences?" to gauge their attribution of discrimination. Responses were grouped as: race/ethnicity/skin color/national origins, sexual orientation, age, weight, sex/gender, income/education, and physical appearance and other. These responses were coded to indicate a "yes" or "no" to each grouping. These responses are mutually exclusive.

Food security was measured with a three-item scale adapted from prior research on food insecurity (Blumbert, Bialostosky, Hamilton, & Briefel, 1999). Respondents indicated how frequently (often, sometimes, never) within the past 12 months they "worried whether my/our food would run out before I/we got money to buy more;" "food I/we bought just didn't last and didn't have money to get more," "couldn't afford to eat balanced meals." Higher scores indicated greater food insecurity. Interitem correlation was 0.77

Emergency food use was one item asking respondents how many times within the past 30 days they visited an emergency food provider.

Other covariates included age, marital status, gender, race, current employment and education.

Survey Analyses:

Analyses are stratified by race because prior research suggests that blacks and whites may differ from one another in their reports of discrimination. We began the analysis by first exploring the predictors of discrimination.

Logistic regression was then used to examine the association between perceived discrimination and depression, controlling for food security, emergency food use and other covariates. These analyses, conducted with Stata 9.0 software(StataCorp, 2005), used robust standard errors to correct for clustering within food service providers.

Focus Groups:

Five focus groups, consisting of about 10 persons each, were conducted with adults currently using emergency food services in New Hampshire, Michigan and Arkansas. The focus groups were disproportionately female, although there was a fairly even participation by blacks and whites. While the groups in Michigan and New Hampshire were virtually all black and all white, respectively, the Arkansas group was fairly integrated. Focus group participants ranged in age from 21 to 79 and reported a variety of physical ailments (e.g. emphysema, cancer, diabetes, rheumatoid arthritis); many participants noted multiple physical maladies and a small number reported mental conditions (e.g., schizophrenia, depression). The majority were unemployed.

Focus group participants were recruited through word of mouth and compensated with $50 worth of grocery supplies or money orders. Each focus group was conducted with two trained moderators. Sessions were audiotaped and transcribed.

A semi-structured guide was used to organize questions around six themes: homelessness, poverty, making ends meet, transportation, health, and personal strengths/assets. Although we did not plan to discuss discrimination in these groups a priori, participants mentioned experiences of discrimination during the discussion. Following a grounded theory approach (Glaser & Strauss, 1967), we reviewed these emergent themes and used them to help interpret the survey findings.

Focus groups were analyzed with Atlas.ti (4.2), a qualitative data analysis program that facilitates conceptual coding and the sorting of data by both similarities and differences (Muhr, 1997).

Results

Survey

Table 1 summarizes characteristics of the survey respondents, stratified by race. Over 62% of respondents met the threshold for depression; most reported low levels of discrimination and a moderate level of food insecurity. Respondents used emergency food services an average of 1.8 times in the last 30 days. About one-third of the respondents had less than a high school education, but notably, 21% had at least some college education. Forty percent of the sample was married or living with a partner.

Compared to whites, blacks were older and less likely to be depressed or married. Blacks and whites did not differ in the level of perceived discrimination, but did differ in their attributions. Blacks were more likely to attribute discrimination to their race/ethnicity and to "other," whereas whites were more

Table 1. Select characteristics of the study sample, by race. Users of emergency food services in Arkansas.

	Black (n=161)	White (n=157)	Total (n=318)
	Est	Est	Est
Depressed, %*	0.55	0.68	0.62
Female, %	0.68	0.73	0.70
Age, mean***	48.34	41.46	44.95
Employed, %	0.28	0.21	0.25
Education, %			
Less than High School	0.35	0.34	0.35
High School Diploma	0.43	0.44	0.44
College	0.21	0.22	0.21
Food insecurity, mean	2.05	2.08	2.07
Emergency food use, mean	1.79	1.80	1.79
Spouse/partner,%***	47.58	27.33	39.56
Perceived discrimination	2.40	2.24	2.32
Attribution of discrimination			
Other,%*	48.73	37.66	43.07
Physical appearance	4.43	15.54	9.75
Income/education	6.96	9.09	8.42
Race/ethnicity/color/origin*	8.23	1.95	5.69
Age	3.16	3.25	3.22
Gender/Sex	0.63	3.90	2.72
Weight*	0.63	6.49	2.72
Sexual orientation	0	0.65	0.5
Don't know/refused	27.85	27.92	26.73

Tests of significance are between blacks and whites: *p<=0.05, ** p<=0.01; *** p<=0.001

likely to attribute discrimination to weight/appearance. Within the "other" category, many respondents externalized these attributions to focus on characteristics of the perpetrators (e.g. "people aren't considerate," "thought they were better," "ignorance."), rather than of their own characteristics.

We next examined the correlates of self-reported discrimination, stratified by race (Table 2). We first summarize the bivariate analyses. Among blacks, reporting of discrimination was higher among those who were younger, male, and who reported more food insecurity. Among whites, discrimination was greater among those who were younger, those who reported high school graduation compared to those with less than high school education, and among reporting more food insecurity. The multivariate analyses were consistent with those in the bivariates except that age and education were no longer associated with discrimination among whites. Thus, the data indicate that acute deprivation, as measured by food insecurity, was associated with reports of discrimination, whereas more general measures of socioeconomic status were not.

Is discrimination associated with depression as hypothesized? Table 3 displays the logistic regression models predicting depression. Turning first to blacks, self-reported discrimination is associated with increased unadjusted odds of depression for blacks (OR=1.59; 95% CI: 1.16-2.19). In addition, the odds of depression are increased for those who experience unemployment, food security, and emergency food use. Although initial evidence suggests that discrimination is associated with depression, this relationship might be confounded with other factors associated with both discrimination and depression (in particular, food insecurity). However, reports of discrimination are still associated with increased odds of depression (OR=1.52; 95%CI: 1.11-2.07) even after controlling for food security, emergency food use, employment, age, gender and marital status. In addition, odds of depression were higher among women, the unemployed, those who were married, those using emergency food services and reporting food insecurity in multivariate models.

The findings for blacks are also seen for whites. In both bivariate (OR=1.66; 95% CI: 1.16-2.38) and multivariate models (OR=1.58; 95%CI: 1.14-2.21), self-reported discrimination is associated with increased odds of depression. In addition, in multivariate models, unemployment, food insecurity and emergency food use were associated with increased odds of depression. However, unlike for blacks, female gender and marital status did not predict depression for whites in multivariate models.

Table 2. Predictors of Self-Reported Discrimination, by Race

	Black (n=154)						White (n=157)					
	Bivariate			Multivariate			Bivariate			Multivariate		
	b	SE		b	SE		b	SE		b	SE	
Age	-0.019	(0.007)	*	-0.019	(0.007)	*	-0.009	(0.003)	*	-0.006	(0.003)	
Gender												
Male	Ref.			Ref.			Ref.			Ref.		
Female	-0.644	(0.158)	**	-0.431	(0.160)	*	-0.348	(0.215)		-0.341	(0.167)	
Employment												
Unemployed	Ref.			Ref.			Ref.			Ref.		
Employed	-0.170	(0.115)		-0.243	(0.125)		0.258	(0.193)		0.130	(0.232)	
Education												
< high school	Ref.			Ref.			Ref.			Ref.		
High school	0.006	(0.221)		-0.038	(0.194)		0.435	(0.159)	*	0.159	(0.192)	
College	-0.599	(0.270)		-0.375	(0.182)		0.268	(0.200)		0.042	(0.241)	
Food insecurity	0.748	(0.118)	***	0.599	(0.154)	**	0.715	(0.140)	***	0.690	(0.151)	***
Emergency food use	-0.006	(0.009)		-0.018	(0.009)		0.019	(0.086)		0.022	(0.086)	
Marital status												
Married/with partner	0.026	(0.203)		0.071	(0.158)		-0.065	(0.161)		-0.047	(0.122)	
Other	Ref.			Ref.			Ref.			Ref.		
Intercept				2.562	(0.622)	**				1.181	(0.293)	**

b's are unstandardized regression coefficients from ordinary least squares regression.
SE=Robust Standard Error Ref = reference category for dummy variables.* p<=0.05; ** p<=0.01; *** p<= 0.001

Table 3. Association between Perceived Discrimination and Depression among Clients of Emergency Food Services, Arkansas, by Race. Odds Ratios from Multivariate Logistic Regression.

	Black (n=154)						White (n=157)					
	Bivariate			Multivariate			Bivariate			Multivariate		
	OR	95% CI		OR	95% CI		OR	95% CI		OR	95% CI	
Perceived discrimination	**1.59**	**1.16**	**2.19**	**1.52**	**(1.11-**	**2.07)**	**1.66**	**1.16**	**2.38**	**1.58**	**(1.14-**	**2.21)**
Age	0.99	0.97	1.00	0.99	(0.98-	1.01)	0.98	0.96	1.00	0.98	(0.95-	1.01)
Gender												
Male	1.00			1.00			1.00			1.00		
Female	1.54	0.92	2.57	**3.11**	**(1.40-**	**6.88)**	0.82	0.43	1.58	0.56	(0.20-	1.59)
Employment												
Unemployed	1.00			1.00						1.00		
Employed	**0.54**	**0.35**	**0.86**	**0.52**	**(0.29-**	**0.94)**	0.66	0.35	1.24	**0.27**	**(0.10-**	**0.69)**
Education												
Less than high school	1.00			1.00						1.00		
High school	1.05	0.44	2.49	0.99	(0.57-	1.73)	0.97	0.57	1.64	0.91	(0.20-	4.16)
College	0.98	0.43	2.26	0.64	(0.19-	2.14)	0.65	0.18	2.36	1.00	(0.24-	4.25)
Food insecurity	**2.14**	**1.25**	**3.68**	**1.94**	**(1.06-**	**3.54)**	**2.55**	**1.47**	**4.42**	**2.39**	**(1.46-**	**3.91)**
Emergency food use	**1.11**	**1.05**	**1.18**	**1.09**	**(1.03-**	**1.15)**	1.10	0.91	1.32	**1.26**	**(1.04-**	**1.54)**
Marital status												
Married/with partner	1.61	0.99	2.61	**2.24**	**(1.12-**	**4.49)**	1.12	0.74	1.69	1.34	(0.76-	2.36)
Other				1.00						1.00		

OR=Odds Ratio; CI = confidence interval. Analyses also control for age, gender and marital status, in addition to the factors listed above.

We also tested the interaction between discrimination and race, but it was not significant. Hence, the association between discrimination and depression was similar between blacks and whites. Additional analyses also examined the attribution of discrimination (to race, to gender, etc.), but consistent with prior studies, these attributions did not predict depression above and beyond that of discrimination.(Gee et al., 2006a; Kessler et al., 1999).

Focus Groups

We include qualitative data from the focus groups to add texture to our quantitative analyses. Although only a few quotations will be presented, the individual sentiments shown below were not dissimilar from those of the majority of focus group participants.

Respondents in four out of the five focus groups volunteered explicit connections between discrimination and their feelings. They suggested that being unfairly treated led to feelings of worthlessness and depression. Respondents also named the sources of their unfair treatment:

[a] "All of the welfare workers – city welfare workers, town welfare workers – they make you feel like it's [social assistance] coming out of their pockets and it's not. But they make you feel like that. They really do. You feel very uncomfortable when they, when they treat you like that. You feel like you're really not human or something, you know? You feel like – they make you feel like you're nothing but a piece of garbage."

[b] "We went to the Salvation Army and this woman made me feel like I was a drug addict and I was an alcoholic and that's why I had no money to buy clothes for my kids…I don't drink. I don't do drugs. There was just no money to buy clothes and, and, you know, she just made me feel like…a piece of trash there asking for help to get clothes for my children...even the Salvation Army is another place that treats you just like…the town welfares, the city welfares."

[c] "'I have five kids and two grandkids and I have it rough sometimes and I've cried coming out of there [city services]. They treat you badly.' 'I won't go there.'

'Yeah, they act like they're takin' it out of their pockets and giving it [social assistance] to you.'"

It is important to note that in exchange [c], the respondent said she would not return to the welfare office because of how she was treated. This suggests that respondents were not passive recipients, but also purposively responded to their experiences with discrimination. This theme is illustrated further below:

[d] "I was in a car accident … needed prescriptions filled for –three different prescriptions for pain medication that were first prescribed by the doctor at the emergency room…. And when I went yesterday morning to see my regular doctor for a follow up visit, she refilled those prescriptions… I dropped over to the city welfare and this woman treated me like I was scamming something from her. And I'm also on depression medication and I said, "Well, look, forget about the painkillers if this is how you're going to be. Just give me my depression medication. Yeah, it would be great to have it, because I'm in pain – that's why it was prescribed to me. But if you're going to make a big ordeal about it, then see ya'."

[e] "Being on disability you are entitled to food stamps, but it's just these welfare people, you know, are so high and mighty, you know, they make you feel like you're there begging them for the food stamps and so you'd rather either go hungry or –if you don't have kids you would rather go hungry than to go begging for it."

Additionally, respondents often nodded to one another and made affirming gestures. Some used the sessions to take the "moral high ground" against those they viewed as their oppressors, as seen in the following exchange:

[f] "'I wonder if they'd ever stop and look back at themselves and say, 'you know, I really treated some of them people nasty, you know?' But I don't think any of them ever will or would.' 'They don't realize that if it wasn't for people who have problems, like ourselves, they wouldn't even have a job.' (nodding, hoots and laughter)."

Respondents' affirmations of statements made by fellow participants suggests that these experiences were not unique or infrequent, but shared by many participants.

Discussion

Using a mixed-methods approach, we find that adults using emergency food services report discrimination and that these reports are associated with their well-being. Our survey suggests that adults using emergency food services who report discrimination appear to be at higher risk of depression, controlling for age, gender, education, race, food security, frequency of emergency food use, and marital status. These findings join a growing literature that has demonstrated associations between discrimination and mental health problems (Bhui et al., 2005; Caughy, O'Campo, & Muntaner, 2004; Finch et al., 2000; Fischer, Shaw, & Christina, 1999; Klonoff & Landrine, 1999; Landrine & Klonoff, 1996; Noh & Kaspar, 2003).

In our study, discrimination was associated with depression for both blacks and whites. Extant literature suggests mixed results, with some studies showing racial differences and others reporting no differences (Kessler et al., 1999; Barnes et al., 2004; Roberts, Swanson, & Murphy, 2004). The similarity between racial groups found here might be related to our sampling of materially disadvantaged persons. That is, by selecting respondents who represent the lower socioeconomic strata, the indicator of unfair treatment may be skewed towards economic rather than racialized experiences. These findings do not necessarily discount the importance of race/ethnicity, but do reinforce the idea that discrimination is related to socioeconomic disadvantage (Krieger, Rowley, Herman, Avery, & Phillips, 1993; Bird & Bogart, 2001; Ren, Amick, & Williams, 1999; Nazroo, 2003; Williams, 1999).

The importance of socioeconomic disadvantage is further suggested by analyses showing that food insecurity is associated with reports of discrimination. Being acutely deprived of basic necessities (i.e. food) may force individuals into situations where they may be more likely to encounter discrimination. Although all individuals in our study were in need of emergency food supplies, those who had greater needs reported more discrimination. Interestingly, discrimination was not associated with employment or education. Previous studies show mixed findings between standard socioeconomic measures and discrimination. For example, some studies find a positive association between perceived discrimination and education (Forman, Williams, & Jackson, 1997) whereas other studies find no such relationship (Kessler et al., 1999). Perhaps including more sensitive measures of material deprivation, such as food insecurity, may show more consistent findings in future research.

Our survey results are reinforced by the focus group findings. Respondents are quite clear about how unfair treatment makes them feel: dehumanized and like "trash." These events occurred on an everyday basis, as respondents undertook mundane, yet necessary, activities such as purchasing clothing or filling prescriptions. As noted in other work, discrimination may occur on a routine basis and often consists not of blatant acts, but of subtle "microaggressions."(Essed, 1991; Walters, Simoni, & Evans-Campbell, 2002) The daily accumulation of discrimination and similar stressors may contribute to the "weathering" of disadvantaged groups over the life course.(Geronimus, 1992; Geronimus, Hicken, Keene, & Bound, 2006)

Moreover, participants identified specific institutions (or more precisely, representatives from these institutions) among the sources of unfair treatment. These findings suggest that discrimination is not merely an abstraction "out there" but may be rooted in public and private institutions. Of course, the actions of some individuals working in organizations themselves do not

constitute institutional behavior. Further, while respondents in our sample did point out several institutions as sources of discrimination, they generally had high praise for their emergency food providers.

These findings suggest that future research should further investigate institutional sources of discrimination and more fully ascertain how potential actions of individuals may or may not represent the actions of the institutions from which they are a part. There is growing interest in potential discrimination within the health care system(Institute of Medicine, 2002), but it is important to continue examining potential discrimination other arenas. Indeed, extant research finds that discrimination occurs in shopping, home buying, and even walking on the street (Essed, 1991; Feagin, 1991; Feagin & McKinney, 2003; Massey & Lundy, 2001).

Moreover, respondents suggest that disadvantaged individuals may respond directly to perceived discrimination by avoiding the circumstances that they believe produce it. This deserves further investigation. On the one hand, respondents are showing their agency and resiliency. On the other hand, respondents may be choosing to forego food and medication. More generally, discrimination may lead to actions that have positive short term effects, but may lead to negative long term consequences.

Other studies support this idea. Van Houtven reports that perceived discrimination is associated with delayed filling of prescription medications(Van Houtven et al., 2005). Spencer and Chen (2004) suggest that discrimination makes Chinese Americans more likely to use traditional healing practices than biomedicine. Klassen and colleagues (2002) suggests that experiences with discrimination make African Americans more hesitant to try risky surgical procedures. Similarly, some studies find that discrimination is associated with tobacco(Bennett et al., 2005; Guthrie, Young, Williams, Boyd, & Kintner, 2002), alcohol and illicit drug use(Gee et al., 2006b; Yen, Ragland, Greiner, & Fisher, 1999b; Whitbeck et al., 2001). Taken together, these findings raise further questions of what other things people may forgo or do in order to protect their self-worth and resist discrimination.

Another important observation from our focus groups was the affirmation by respondents for their peer's experiences. Social support has been shown to moderate perceived discrimination (Gee et al., 2006a; Noh & Kaspar, 2003). Potential interventions might include fostering social ties among disadvantaged persons, with the aim of not only providing support to cope with their own experiences of discrimination, but of potentially organizing in order to (borrowing from Geronimus, 2000) "mitigate, resist and undo" potential sources of discrimination.

As with all research, our study has its limitations. First, focus groups and survey respondents were drawn from a convenience sample of individuals using emergency food services, and their views may not represent all who use such services. Although a random sample may have ameliorated some questions about sampling bias, these concerns were weighted against the practical issue of efficiently sampling a disadvantage population. There have been relatively few studies of persons using emergency food services and to our knowledge there are no studies that have specifically examined discrimination among this population. However, one recent study of welfare recipients found that reports of discrimination were marginally associated with depression after three years of followup (Heflin et al., 2005). Second, our data are cross sectional, so the associations should not be seen as causal. As noted previously, several longitudinal studies support the causal direction of discrimination to illness, (Schulz et al., 2006; Jackson et al., 1996; Pavalko, Mossakowski, & Hamilton, 2003) although more research is warranted. Third, we focused on respondents' perceptions, which may or may not represent their objective experiences. For example, we are unable to validate respondents' experiences with the welfare system or know their true usage of food services. However, these perceptions may be important barometers from which to gauge how individuals view themselves and their social circumstances. Despite these limitations, our study had several strengths, including the use of multiple methods to triangulate themes, and the investigation of an important understudied population.

In closing, our study finds that persons who experience material hardship also report discrimination. This discrimination is not only a source of inconvenience, but may have an effect on health. Further, the data suggest that perceptions of discrimination may force individuals to make choices that may influence their long-term well being, including the foregoing of medications and food. That is, individuals may not only hunger for respect, but may also be hungry and depressed from disrespect. Policies and interventions that prevent discrimination and poverty may help in improving the public health and reducing health disparities.

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Gilbert C. Gee, Ph.D.*, University of California Health Science

Kathryn J. Lively, Ph.D., Darthmouth College

Larissa Larsen, Ph.D., University of Michigan

Jennifer Keith, MPH, Philadelphia Health Management Corporation

Jana Stone, MPH, California Department of Health Services

Kara MacLeod, MPH, University of California, Berkeley

*Corresponding Author:

Gilbert C. Gee, Ph.D., Department of Community Health Sciences, Room 41-269A. 650 Charles E, Young Drive South, Los Angeles, CA 90095. (310) 825-8838 (voice). (310) 794-1805 (fax). gilgee@ucla.edu