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The effects of perceived discrimination on Samoan health

Shail Singh

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THE EFFECTS OF PERCEIVED DISCRIMINATION
ON SAMOAN HEALTH

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Shail Singh
December 2007
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ON SAMOAN HEALTH

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ABSTRACT

The purpose of this study was to examine the effect of perceived discrimination on Samoan health. This study employed purposive data collection and was conducted quantitatively using a questionnaire format, which measured everyday perceived discrimination, depression, and physical health. The sample was composed of 36 Samoan respondents. Questionnaires were distributed at the Samoan Assembly of God church in Ontario, California, in March, 2007. Results indicate that a significant relationship exists between depression and perceived discrimination. And respondents who reported encounters of institutional discrimination also were likely to report everyday perceived discrimination.
ACKNOWLEDGMENTS

I would like to give thanks to Dr. Rosemary McCaslin for her support as supervisor on this project and Dr. Tom Davis for being such an inspiration when it came to research.

I would also like to thank Zenobia Hooper for her kind words and encouragement when it came to my education. Additionally, I would like to thank Cynthia Phillip for taking good care of me, and Nancy Stapleton for putting up with me as I stayed awake many nights finishing up my papers.

Last but not least I would like to thank Vasa Mailo for linking me with Reverend Ma’anaima and Tina Aloalii. I am also thankful to all the church members who so graciously took the time to participate in the survey. Thank you. You have made this study possible!
DEDICATION

I would like to dedicate this to Ms. Roberta Omonaka who has nurtured and supported my educational endeavors for the last eight years.
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CHAPTER ONE

INTRODUCTION

Racial discrimination contributes to health discrepancies in minorities via multiple inter-related pathways. First, institutional discrimination can constrict socioeconomic mobility, foster unequal access to desirable resources, and perpetuate inadequate living conditions, which negatively affect mental and physical health. Second, encounters with discrimination activate stress responses, which can produce physiological and psychological changes adversely affecting health. Third, negative racial stereotypes can lead to acceptance of an inferior sense of self, which has detrimental effects on psychological and physiological functioning (Williams & Williams-Morris, 2000). This study specifically examined the effects of perceived discrimination on Samoan physical and mental health.

Problem Statement

Many studies have documented the ill effects of racism on the physical and mental health of African Americans (Gibbons, Gerrard, Cleveland, Wills, & Brody, 2004; Kessler, Mickelson, & Williams, 1999; Krieger &
Sidney, 1996; Landrine & Klonoff, 1996; Peters, 2004; Read & Emerson, 2005; Sellers, Caldwell, & Schmeelk-Cone, 2003; Schulz, Gravelee, Williams, Israel, Mentz, & Rowe, 2006). However, African Americans are not the only racial group to be adversely affected by racism. A growing body of literature examined racism and its effect on other minorities including Mexicans, Japanese, Filipinos, and Native Americans (Araujo & Borrell, 2006; Gee, 2002; Karlsen & Nazroo, 2002; Mossakowski, 2003; Noh, Beiser, Kaspar, Hou, & Rummens, 1999; Noh & Kasper, 2003; Stuber, Galea, Ahern, Blaney, & Fuller, 2003; Wu, Noh, Kaspar, & Schimmele, 2003). However, there is no such literature examining Samoan mental and physical well being in relation to racial discrimination.

Three-fourths of the Samoan population arriving in the United States migrates from the U.S. Territory of American Samoa. The U.S. Territory is made up of the eastern Samoan archipelago, which was relinquished to the U.S. government by the Samoan chiefs in early years of the 20th Century. Samoans born in American Samoa are U.S. nationals with full citizenship rights and have no restrictions on travel between American Samoa and the United States. The Samoan migration to the United States
began in the 1950s with the termination of naval operations in American Samoa (Janes, 1990).

Samoans represent the second largest Pacific Islander group in the United States. They represent 23 percent of the Pacific Islander population compared to Native Hawaiians who make up 37 percent of that population (Census, 2000). Samoans along with Native Hawaiians are also California's largest Pacific Islander group (The Diverse Face, 2005).

Until the 1997 revision by the Office of Management and Budget (OMB) of Statistical Policy Directive No. 15, Race and Ethnic Standards for Federal and Administrative Reporting, Samoans were categorized in the Census and other data as Asian or Pacific Islander. The 1997 Directive separated the Asian or Pacific Islander categories into two categories of Asian and Native Hawaiian or other Pacific Islander. This disaggregating of data has revealed that Samoans do not fit the mold of the model minority. The model minority myth assumes that all Asians share similar cultural traits and beliefs, which promote successful assimilation into American academic and professional institutions. Disaggregated data has revealed that Samoans live in poverty, lack
heath insurance and have low educational attainment (Diverse Face, 2005).

By lumping all Pacific Islanders in the same category, data has failed to capture the true realities of Samoans. According to the 2000 Census, 20.2 percent of the Samoan population lived below the poverty level compared to 12.4 percent of the U.S. general population. Only ten percent of the Samoan population has a college degree compared to 24 percent of the U.S. population. It is well documented that Samoans suffer from high rates of obesity, hypertension, and diabetes, resulting in Samoans having higher mortality risks than other Asians.

Frisbie, Cho, and Hummer, 2001, analyzed the 1992-1995 National Health Interview Survey, to study the effects of immigration on the health of Asian and Pacific Islander adults. They found that Pacific Islander self-reported health was worse than other Asians. Pacific Islanders were more likely to report activity limitations and more bed-ridden days due to illness, compared to other Asians. Pacific Islander immigrant health was found to be better than their U.S counterparts but their health consistently declined with duration of residence.
This leads to speculation on whether discrimination plays a role in the unsuccessful assimilation of Samoans into American society. Does American society have structural constructs which allow some minority groups to successfully assimilate and others not? Is unsuccessful assimilation a result of discrimination? Does discrimination then harm health? Understanding whether Samoans are a vulnerable population and whether or not they are subjected to discrimination is important to social work practice because it would allow social work practitioners to gain an understanding of the hardships Samoans face. With such an understanding, social workers can also influence policy on behalf of the Samoan population on health and social justice issues.

Purpose of the Study

The purpose of this study was to understand the impact of discrimination on Samoan physical and mental health. Samoans suffer from high rates of poverty and disease. Samoans are a unique population with unique issues that are left unaddressed when they are lumped in the same category as other Asians. Substantial literature
is lacking in regards to discrimination and its effects on health in the Samoan population.

This study employed purposive data collection. It was conducted quantitatively using a questionnaire format, which measured everyday perceived discrimination, depression, and physical health. The questionnaire also asked for demographic information such as age, gender, income, marital status, educational level, nativity status, and education. The questionnaires were administered to parishioners of a Samoan church in Ontario, California.

Significance of the Project for Social Work

This study is important to social work because it sought to unearth some of the unique challenges faced by Samoans. It informs the assessment stage of the generalist model. This study assesses whether there is a link between discrimination and Samoan health in the United States and if further research is warranted. Its findings can offer insight to social work practitioners so that they can offer culturally sensitive care to Samoans. This study also adds to the existing literature on health and discrimination. It is further beneficial to
Social work practice because the results can guide future large-scale studies. Large-scale studies can have a significant impact on policy by offering suggestions on community-based interventions for improving health in minority populations.
CHAPTER TWO
LITERATURE REVIEW

Introduction

This chapter examines the existing literature on perceived institutional discrimination and perceived everyday discrimination and its effect on physical and mental health in U.S. minority populations. Differences between perceived institutional discrimination and perceived everyday discrimination are identified. Theories guiding this research and past research are identified.

Discrimination and Health

There is no existing literature specifically examining the role of perceived discrimination in Samoan physical and mental health. Existing literature focuses on other minorities and the effects of perceived discrimination on their mental and physical health. The bulk of the literature currently available has explored the link between perceived discrimination and health among the African American population. There are a few emerging studies of other minorities such as Native Americans (Whitbeck, Mcmorris, Hoyt, Stubben, &
Lafromboise, 2002), Filipinos (Mossakowski, 2003), and Mexicans (Finch et al., 2001; Finch, Kolody, & Vega, 2000). Most research focuses on perceived discrimination and depression. Perceived discrimination has been shown to be a strong indicator of depression. A few studies take into account the moderating effects of ethnic identity as a way of dealing with the effects of discrimination.

Theories Guiding Conceptualization

The theory that has guided past research is the psychosocial stress model. To explain health disparities, the psychosocial stress model takes into account the stresses associated with perceived institutional discrimination and perceived interpersonal discrimination. Discrimination is treated as a psychosocial stressor affecting health.

This research study also employed the psychosocial stress model to examine the role of perceived discrimination on Samoan health. It examined the role of perceived institutional discrimination and perceived interpersonal discrimination on Samoan physical and mental health. This study differed from the other studies
because there was not an instrument to measure ethnic identity and, thus, the moderating effects of identity were not taken into account. Also, unlike the majority of the studies, this study was not limited to perceived discrimination and depression. It also used instruments to measure institutional discrimination, perceived discrimination, depression and physical health.

Discrimination

Discrimination is defined as the practices and actions carried out by dominant ethnic groups that have adverse impact on subordinate race-ethnic groups (Feagin & Eckberg, as cited in Finch et.al, 2001). Discrimination exists in three distinct forms. Discrimination can be institutionalized, personally mediated, or internalized. Institutional discrimination is structural and infused in societal institutions of custom, practice, and law. Personally mediated discrimination can be defined as actions which take place on a personal level, such as harboring assumptions about ability, motives, and intentions of others simply based on race. Internalized discrimination is the acceptance of negative stereotypes by the subordinate group about their capabilities and
innate sense of worth (Jones, 2000). This study focused on institutional discrimination and personally mediated discrimination also known as interpersonal discrimination.

Perceived discrimination is the appraisal of discriminatory acts both in institutional settings and interpersonal interactions. Perceived discrimination is the subjective response of the person experiencing discrimination.

Everyday Discrimination

The concept, everyday racism was first studied by Essed (1991). Essed (1991) conducted qualitative interviews of African American women in the United States and Surinamese women in the Netherlands. Her exploratory study specifically examined, "how racism is experienced in everyday situations, how blacks recognize covert expressions of racism, what knowledge of racism blacks have, and how this knowledge is acquired" (Essed, 1991, p. 7). She defines everyday discrimination as a "process in which (a) socialized racist notions are integrated into meanings that make practices immediately definable and manageable, (b) practices with racist implications become
in themselves familiar and repetitive, and (c) underlying racial and ethnic relations are actualized and reinforced through these routine or familiar practices in everyday situations" (Essed, 1991, p. 52). Essed’s study shed light on how discrimination is viewed by the person being discriminated against. The study formulated an interdisciplinary theory that looked at racism as a process conceptualized at the micro level such as everyday racism rather than just at the macro level such as institutional discrimination.

Discrimination and Depression

Kessler and colleagues (1999) measured perceived institutional discrimination and perceived everyday discrimination among the general population and found that perceived discrimination was experienced by 60.9 percent of the study population. They found perceived discrimination to be highly prevalent with strong associations with mental well-being.

In a study of Southeast Asian refugees in Canada, Noh and colleagues (1999) reported a strong correlation between discrimination and depression among refugees who had experienced racial discrimination compared to their
counterparts who had not. The researchers also found that a strong ethnic identity and passive approach to the discrimination served as a moderator.

Mossakowski (2003) conducted an empirical study using quantitative research to study Filipino Americans, perceived discrimination, its effect on their mental health (depressive symptoms), and the impact of ethnic identity on their mental health. Mossakowski (2003) found that perceived discrimination had negative effects on mental health and a strong ethnic identity protected against mental illness in Filipinos.

Landrine and Klonoff (1996) administered a questionnaire, which measured everyday racist events and found a strong relationship between experiencing racism and expression of psychiatric symptoms in African Americans.

Discrimination and Physical Health

Krieger and Sydney (1996) found associations between hypertension and self reported responses to unfair treatment and experience of racial discrimination. On the other hand, Peters (2004) found that perceived discrimination was not associated with higher levels of
hypertension when moderated by age. Peters (2004), found higher levels of hypertension in adults forty years and older who had reported high rates of perceived discrimination. Also, among older adults who reported the lowest levels of discrimination, she found higher levels of hypertension. The author concluded that higher levels of hypertension could be a result of internalized discrimination among elderly African Americans.

In a study of Mexican-origin adults, Finch and colleagues (2001) found a significant negative effect of perceived discrimination on self-rated health. The study found that people who had been discriminated against reported chronic health problems along with depressive symptoms.

Summary

This chapter examined literature available on perceived discrimination and its effects on minority health. This chapter outlined and examined the theories that have been used to study the social problem of discrimination and its effects on health. This chapter also clarified institutional discrimination and everyday discrimination.
CHAPTER THREE

METHODS

Introduction

This chapter outlines the instruments used to study the effects of discrimination on Samoan health. Sampling procedures and data collection guidelines also are outlined. The components of the questionnaire are described in detail, along with the procedures undertaken to protect the study participants. Finally, independent and dependent variables are identified and data analysis techniques are discussed.

Study Design

The specific purpose of the study was to explore the possible effects of perceived discrimination on Samoan health. A quantitative questionnaire was administered that asked respondents if they had ever been exposed to institutional discrimination and perceived everyday discrimination. The questionnaire also inquired about depressive symptoms and physical health.

A quantitative method was the best approach to study the effects of discrimination on Samoan health because it can quickly capture an accurate picture of a large
population. A limitation of this study was that the sample was collected from one Samoan church and as a consequence, findings are not representative of the larger Samoan population.

Sampling

Respondents were Samoans who attended the Samoan Assembly of God church in Ontario, California. The selection criteria was that all respondents be eighteen years of age or older and Samoan. The questionnaires were administered on two consecutive Sunday's, March 18 and March 25, 2007. The total number of participants needed to meet the requirements of the project was 30.

Data Collection and Instruments

Data that were collected on the quantitative questionnaire included independent variables such as demographics, perceived everyday discrimination, and perceived life-time institutional discrimination. The dependent variables captured were depression, self-rated health and self-reported chronic conditions (see Appendix A).

The independent demographic variables were gender, age, marital status, nativity, level of education,
employment status and annual household income. The variable gender was measured at the nominal level. The variable age was measured at the interval level; respondents were asked to fill in their age. Marital and employment status were measured at the nominal level. Annual household income was measured at the ordinal level, respondents were asked to check the income category that corresponded to them. Education was measured at the ordinal level; the sample was asked to check the highest educational level completed. Nativity status was measured at the nominal level and respondents were asked their birth place. The categories were born in American Samoa, born in U.S., or born in Western Samoa. And length of residence, measured at the ordinal level; respondents were asked to report the number of years they had resided in the United States. The response categories were less than 5 years, 6 to 10 years, 11 to 15 years, or more than 15 years.

The focal independent variables, perceived institutional discrimination and perceived everyday discrimination, were measured using the ratio level of measurement. Perceived institutional discrimination was measured with an instrument previously used by Kessler
and colleagues (1999). Respondents were asked, “Have you ever been discriminated against in each of the following ways because of your race?” The question was followed by a series of yes-no items: not hired for a job, not given a promotion, denied or received inferior service, discouraged by a teacher from seeking higher education, denied a bank loan, hassled by police, fired from a job, prevented from renting or buying a home, denied a scholarship, denied or received inferior medical care, and forced to leave a neighborhood. These items responses were added, resulting in an interval score ranging from eleven to twenty-two.

Perceived everyday discrimination was also measured with an instrument previously used by Kessler and colleagues (1999). The respondents were asked, “How often on a day-to-day basis do you experience each of the following types of discrimination?” This question was followed with a series of nine items: you are treated with less courtesy than others; you are treated with less respect than others; you receive poor service at restaurants or stores; people act as if they are afraid of you; people act as if you are dishonest; people act as if you are inferior; you are called names or insulted;
you are threatened or harassed; and people act as if you are not smart. The response categories for the questions were never, hardly ever, not too often, fairly often, and very often, coded one through five. These item scores were added, resulting in an interval score ranging from five to forty-five.

The self-rated chronic health conditions were those previously asked about by Finch and colleagues in a study of discrimination and health among Mexican-origin adults in California (2001). Finch and colleagues (2001) noted that self-reported chronic conditions are an excellent predictor of mortality. The dependent variable, self-reported chronic health conditions, was constructed asking the question, "Have you ever experienced any of these health problems?" (a) hypertension/high blood pressure, (b) diabetes/high blood sugar (c) ulcer, and (d) heart attack/serious heart trouble. The respondents were asked to check all the chronic health conditions that applied to them. These items were added resulting, in an interval score ranging from zero to four.

The second dependent variable, depression, was measured using the depressive symptom scale from the Symptom-Check-90-Revised (Derogatis, 1994). The scale
consisted of a total of twelve questions. Respondents were asked, "Do you ever feel low in energy or slowed down, lonely, blue, worthless, hopeless about the future, everything is an effort, trapped or caught, no interest in things, worrying too much, having thoughts of ending your life, blaming yourself for things and crying easily." The response categories for the questions were not at all, a little, moderately, quite a bit, and extremely. These items were added, resulting in an interval score ranging from twelve to sixty.

This scale was evaluated for effectiveness by Takeuchi and colleagues (1989) on Asian Americans and Native Hawaiians, specifically Filipinos, Japanese, and Native Hawaiians. The Symptom Checklist was evaluated for reliability using Cronbach’s alpha and yielded .80 to .90 alpha coefficients across all the ethnic groups. Although, the Symptom-Checklist-90 was not tested on Samoans, it has shown a strong reliability when tested on other Asian Americans. For the purpose of this study this scale was adequate to measure depressive symptoms among Samoans.
Procedures

The data were gathered at The Samoan Assembly of God church in Ontario, California. Participation was solicited through the church pastor, who informed the parishioners of the study one month prior to data collection. Flyers were distributed to parishioners at the same time (see Appendix B). The flyers gave the date and time of the study and incentives offered for participation in the study. It also had the researcher's contact information if participants desired more information. The pastor also stressed that participation in the study was voluntary.

A five-dollar Target gift card and chance to win a D.V.D player were incentives offered to procure participation in the study and as a form of reimbursement for the participants' time. The questionnaires were administered after the church sermon at 1 p.m. on two consecutive Sundays in March, 2007. The researcher spoke to the parishioners of the church prior to administering the questionnaires (refer to Appendix C). She informed the participants of the purpose of the study and also stressed that participation in the study was voluntary.
and confidential. The researcher handed out and collected all questionnaires at the time of administration.

Protection of Human Subjects

Protection of human subjects was ensured because the questionnaire administered did not ask for the respondents' names. Storing of the data in a locked briefcase protected other identifying information such as age, gender, marital status, education attainment, and income, which were asked on the questionnaire. The completed surveys were turned into the researcher in a sealed envelope, which the researcher numbered and placed in the locked briefcase. The locked briefcase was stored in the researcher's office at home. After completing the surveys the respondents were given a debriefing statement (see Appendix D) along with a five-dollar Target gift card and were asked to put their names in an envelope for the D.V.D player drawing.

Data Analysis

The data retrieved were analyzed using the Statistical Package for the Social Sciences (SPSS). Included in the statistical analyses were frequencies, correlations, and t-tests. Inferential statistics were
utilized to determine whether there was a relationship between the variables discrimination and health in the Samoan population.

Summary

In summary, this chapter covered the methods, procedures, and variables that were utilized to determine the effects of discrimination on Samoan health. This chapter detailed study procedures and the protocol that was established to ensure protection of human subjects. This chapter outlined in detail the variables that were measured to analyze the relationship between discrimination and health in the Samoan population.
CHAPTER FOUR

RESULTS

Introduction

This chapter examines the results of the survey conducted on discrimination and its effect on health in the Samoan population. Descriptive statistics were used to analyze demographic data such as age, gender, marital status, employment status, annual household income, education, and nativity status. Correlations were used to analyze relationships between variables such as institutional discrimination, perceived discrimination, depression, and chronic health conditions.

Presentation of the Findings

The exact figures for the demographic variables may be found in Appendix E. The total number of participants in the sample surveyed was 36. Their ages ranged from age 18 to 69 years old. The mean age of the entire sample was 37.35 with a standard deviation of 15.25. There were slightly more females than males in the study population. Out of the total sample, 47.2 percent were male and 53.8 percent were female. The majority of respondents were married and a small percentage was widowed. On employment
status, 56.6 percent were employed while 44.4 percent were unemployed. The majority of the sample (39.4%) earned an income between $25,000 and $49,999, and a small percentage (6.1%) earned more than $100,000. On highest level of education completed, 50 percent of the sample reported having some college education; the rest had high school or equivalent; Bachelor’s degree; post-graduate education; or vocational or technical training. On nativity status, a slightly higher number of participants were born in American Samoa (42.9%) compared to Western Samoa (25.7%) and a third of the sample were born in the United States. On the residency question of number of years resided in the U.S., 23.3 percent had been in the states less than five years; 13.3 percent had resided here between six and ten years; 3.3 percent had resided here from eleven to fifteen years; 30 percent had lived in the states more than fifteen years; and 30 percent were born in the states.

The depression scale had scores ranging from 12 to 41, with a standard deviation of 7.99. The everyday discrimination scale had scores ranging from 9 to 31, with a standard deviation of 5.95. The health scale had scores ranging from 0 to 4, with a standard deviation of
1.12. The institutional discrimination scale had scores ranging from 0 to 4, with a standard deviation of 1.36.

Table 1. Correlation Matrix of Effects of Discrimination on Samoan Health

<table>
<thead>
<tr>
<th></th>
<th>Depression</th>
<th>Everyday Racism</th>
<th>Institutional Racism</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pearson Correlation</td>
<td>1</td>
<td>455**</td>
<td>0.233</td>
<td>0.186</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td></td>
<td>0.009</td>
<td>0.028</td>
<td>0.030</td>
</tr>
<tr>
<td>N</td>
<td>33</td>
<td>32</td>
<td>31</td>
<td>33</td>
</tr>
<tr>
<td>Everyday Racism</td>
<td>455*</td>
<td>1</td>
<td>0.422</td>
<td>0.062</td>
</tr>
<tr>
<td>Pearson Correlation</td>
<td></td>
<td></td>
<td>0.046</td>
<td>0.729</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td></td>
<td></td>
<td>0.016</td>
<td>0.32</td>
</tr>
<tr>
<td>N</td>
<td>33</td>
<td>34</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>Institutional Racism</td>
<td>455*</td>
<td>0.422</td>
<td>1</td>
<td>-0.042</td>
</tr>
<tr>
<td>Pearson Correlation</td>
<td></td>
<td></td>
<td>0.818</td>
<td></td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td></td>
<td></td>
<td>0.818</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>33</td>
<td></td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>Health</td>
<td>455*</td>
<td>0.422</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Pearson Correlation</td>
<td></td>
<td></td>
<td>0.818</td>
<td></td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td></td>
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<td>0.818</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>33</td>
<td></td>
<td>33</td>
<td></td>
</tr>
</tbody>
</table>

* Correlation is significant at the 0.05 level (2-tailed)
** Correlation is significant at the 0.01 level (2-tailed)

A Pearson correlation was used to explore the relationships between depression, health, institutional discrimination and everyday discrimination. The results indicated a significant positive correlation of .455 (P = .009) between the variables depression and perceived everyday discrimination indicating that a relationship
exists between discrimination and depression. A significant positive correlation of \( r = .422 \) (\( P = .016 \)) also was found between perceived institutional discrimination and perceived everyday discrimination indicating that study participants perceiving discrimination were likely to report both forms of discrimination.

T-test's were run between gender and everyday discrimination and also between gender and institutional discrimination but no significant relationship was evident. T-tests were also run between gender and depression and gender and health but no significant relationship existed. Additionally, t-tests were run between depression and institutional discrimination but no significance was found.

Summary

This chapter summarized the significant findings yielded by SPSS. Demographic information was presented using descriptive statistics. This chapter presented relationships between the variables health and discrimination with correlations.
CHAPTER FIVE

DISCUSSION

Introduction

This chapter discusses conclusions gleaned as a result of completing the project. Additionally, limitations encountered by the researcher are discussed. Recommendations for the field of social work are presented along with a summary, of the project’s findings.

Discussion

The purpose of the study was to explore the effects of institutional discrimination and everyday discrimination on Samoan health. The study’s focal variables examined the link between perceived institutional discrimination, everyday discrimination, depression and physical health. Significant findings suggest that there is a relationship between perceived discrimination and depression. Significant findings also suggest that a relationship exists between encounters with perceived everyday discrimination and perceived institutional discrimination.
There were no significant relationships present between chronic health, depression and perceived everyday discrimination. Demographic variables such as age, employment, nativity status, income level, health did not yield significant relationships with discrimination and effects on health. It was expected that a respondent's nativity status, such as number of years residing in the U.S. would effect whether or not they had significant encounters with discrimination which, would then result in poorer self-reported health and nativity status having a strong correlation with the variable depression.

Culture, language, and ethnic identity could have contributed to the lack of significant relationships present between the focal variables and demographic variables. The Samoan people live in a largely a communal society. The small Samoan villages are often headed by a chief (matai) and "consist of people born or adopted into his household and, beyond them, of their descendents outside the village of the household, which extension is usually limited to one or two generations. Most of the land occupied and cultivated by the matai's household is subject use and control inherited by the members of his descent groups" (Gilson, 1970, p. 29).
This leads to the discussion on the word discrimination in the Samoan language. This researcher was first told by Tina Aloalii, the church pastor’s wife, that the word discrimination did not exist in the Samoan language (Tina Aloalii, personal communication, March 4, 2007). Prior to this study being approved she had a meeting with the church members to explain the nature of the study. She mentioned that she had to explain to the group the meaning of the word discrimination and used examples of nepotism to explain the study. According to this informant, the closest word to discrimination in the Samoan language is nepotism. This information makes sense given that the position of matai is often passed down through lineage. Nepotism is probably more prevalent in Samoan social structure than discrimination. After consulting two Samoan-English dictionaries, I found no translation for the word discrimination or racism (Neffgen, 1978; Milner, 1993). Therefore, respondents in this study may not have had a clear understanding of the concept of discrimination, which may have affected the outcomes of this study.

Additionally, a strong ethnic identity can act as a buffer from the ill effects of discrimination. The study
sample illustrated this ethnic solidarity by maintaining many communal traditions. For example, they prayed in the Samoan language, many dressed in formal Samoan attire, and after church service they shared traditional Samoan food. Almost a hundred percent of the church members attending the church were Samoan thereby minimizing encounters of discrimination at least in the church setting.

Another factor affecting this study’s results could be denial of discrimination. In this instance denial is seen as a coping mechanism against discrimination. For example, denial has shown positive outcomes in the elderly facing deterioration that accompanies the aging process. “In a ten-year study by Bultena and Powers (1978), one-third of a sample aged 70 and above defined themselves as middle-aged, rather than elderly or old. Those who saw themselves as old were more likely to die during the study period” (McCaslin, 1987, p. 161). This concept can be applied to acceptance of discrimination and health outcomes of minorities. It could be that minorities who do not allow themselves to focus on discrimination have better health outcomes than those who are more perceptive about discrimination and acknowledge
discrimination. The denial of racism then would not activate the stress mechanism that is activated when a person acknowledges discrimination and reacts to it. Not reacting to the stressor then would not have a negative impact on health.

Limitations

A major limitation of this study was its sample size. The sample consisted of a total of 36 church parishioners. Another limitation of this study was that the sample was drawn from one specific location rather than having a random sample.

Recommendations for Social Work Practice, Policy and Research

It is recommended that mental health professionals who treat minorities consider perceptions of racism as a stressor. Many mental health professionals are reluctant to consider the detrimental effects of racism and are socialized by the profession to be silent on the issue (Greene, as cited in Harris, 2000). Perceptions of racism should not be minimized by mental health professionals but be considered in the overall treatment plan of individuals who disclose perceptions of discrimination.
Furthermore, mental health practitioners should take the lead to empower their clients to find ways to “redistribute power and create social justice” (Shorter-Gooden, as cited in Harris, 2000, p. 54). Doing so would possibly alleviate depressive symptoms which result from perceptions of racism.

There is a need to reiterate Chestang’s (1976) recommendation for social welfare policy to increase equality and reduce racism for African Americans, which included program administration, personnel recruitment, and staff development. Similar policy adjustments are recommended here for Samoan Americans with an additional recommendation that public service workers have diversity training to build self awareness of how their actions may be perceived as discriminatory by other minorities. More importantly, the negative effects of these actions need to be highlighted. Current diversity training for staff lacks this indepth understanding of how discrimination affects minorities. It is further recommended that staff have open discussions among themselves about diversity and come up with guidelines to derail discriminatory practices. Doing so will build self awareness among staff
and would enable them to provide better service to clients.

This study further supports previous studies, which have shown significant relationships between symptoms of depression and perceived racism. It is recommended that this study be further expanded to include larger Samoan samples and other Pacific Islander populations in the United States. It is also recommended that a concise instrument be developed that can measure coping strategies such as denial and ethnic identity. Denial of discrimination and the effects of denial of discrimination need to be studied to further knowledge of mechanisms employed by minorities to cope with social stressors. It would also be beneficial to study outcomes if the participant’s primary language is taken into account when designing study questionnaires. Studies would ensure better results if language barriers are considered and questionnaires are tailored to participants’ primary language.

Conclusions

The results of this project indicated that a significant relationship does exist between perceived
discrimination and depression. And minorities who perceived institutional discrimination were more likely to perceive everyday discrimination as well. The study supported conclusions reached by similar studies that perceptions of racism have detrimental effects on health, specifically mental health. The future is not so grim; the fact that there continues to be emerging research studying the effects of racism on health is a positive step in the direction of treatment of the negative effects of racism and influencing policy to reduce racism in this country.
APPENDIX A

QUESTIONNAIRE
Thank you for taking the time to participate in this survey. This survey will take approximately twenty minutes to fill out. If at any time during the survey you feel uncomfortable answering the questions you have the option of not completing the survey.

Please indicate your:

Gender:  ______Male ______Female
Age: ______
Marital Status:  ______Married, ______Single, ______Widowed
Employment:  ______Currently employed  ______Unemployed
Annual Household Income:  ______less than $25,000
                        ______$25,000 – $49,999
                        ______$50,000 – $99,999
                        ______more than $100,000

Highest level of Education completed:
                        ______High School/ GED, ______some College, ______Bachelors Degree, ______Post Graduate, ______Vocational/Technical
Nativity Status: ______Born in American Samoa, ______Born in U.S., ______Western Samoa
If not born in the United States, how many years have you resided in the United States?
                        ______less than 5 years, ______6 to 10 years, ______11 to 15 years, ______more than 15 years.

How often do you feel the following symptoms?
1. Feeling low in energy or slowed down ______not at all, ______a little, ______moderately, ______quite a bit, ______extremely
2. Feeling lonely ______not at all, ______a little, ______moderately, ______quite a bit, ______extremely
3. Feeling blue ______not at all, ______a little, ______moderately, ______quite a bit, ______extremely
4. Feeling worthless
   ___ not at all, ___ a little, ___ moderately, ___ quite a bit, ___ extremely
5. Feeling hopeless about the future
   ___ not at all, ___ a little, ___ moderately, ___ quite a bit, ___ extremely
6. Feeling everything is an effort
   ___ not at all, ___ a little, ___ moderately, ___ quite a bit, ___ extremely
7. Feeling trapped or caught
   ___ not at all, ___ a little, ___ moderately, ___ quite a bit, ___ extremely
8. Having no interest in things
   ___ not at all, ___ a little, ___ moderately, ___ quite a bit, ___ extremely
9. Worrying too much
   ___ not at all, ___ a little, ___ moderately, ___ quite a bit, ___ extremely
10. Blaming yourself for things
    ___ not at all, ___ a little, ___ moderately, ___ quite a bit, ___ extremely
11. Having thoughts of ending your life
    ___ not at all, ___ a little, ___ moderately, ___ quite a bit, ___ extremely
12. Crying easily
    ___ not at all, ___ a little, ___ moderately, ___ quite a bit, ___ extremely

How often on a day-to-day basis do you experience each of the following types of discrimination?

13. People act as if your are inferior
    ___ never, ___ hardly ever, ___ not too often, ___ fairly often, ___ very often
14. People act as if you are not smart
    ___ never, ___ hardly ever, ___ not too often, ___ fairly often, ___ very often
15. People act as if they are afraid of you
    ___ never, ___ hardly ever, ___ not too often, ___ fairly often, ___ very often
16. You are treated with less courtesy than others
    ___ never, ___ hardly ever, ___ not too often, ___ fairly often, ___ very often
17. You are treated with less respect than others
    ___ never, ___ hardly ever, ___ not too often, ___ fairly often, ___ very often
18. You receive poor service in stores/restaurants
    ___ never, ___ hardly ever, ___ not too often, ___ fairly often, ___ very often
19. People act as if you are dishonest
    ___ never, ___ hardly ever, ___ not too often, ___ fairly often, ___ very often
20. You are called names or insulted
    ___ never, ___ hardly ever, ___ not too often, ___ fairly often, ___ very often
21. You are threatened or harassed
    ___ never, ___ hardly ever, ___ not too often, ___ fairly often, ___ very often
22. Have you ever experienced any of these health problems, check all that apply?
___ Hypertension/high blood pressure
___ Diabetes/ high blood sugar
___ ulcer
___ heart attack or serious heart trouble

Have you ever been discriminated against in each of the following ways because of your race? Please check either Yes or No.

23. Not hired for a job: _____ Yes  _____ No
24. Not given a promotion: _____ Yes  _____ No
26. Denied/ or received inferior service by a plumber, mechanic, or others alike: _____ Yes  _____ No
27. Discouraged by a teacher from seeking higher education: _____ Yes  _____ No
28. Denied a bank loan: _____ Yes  _____ No
29. Hassled by police: _____ Yes  _____ No
30. Fired from a job: _____ Yes  _____ No
31. Prevented from renting or buying a home: _____ Yes  _____ No
32. Denied a scholarship: _____ Yes  _____ No
33. Denied or received inferior medical care: _____ Yes  _____ No
34. Forced to leave a neighborhood: _____ Yes  _____ No
APPENDIX B

FLYER
Interested in earning $5.00 Target Gift Certificate and a chance to be entered in a drawing for a free D.V.D player. Come participate in a study after church on Sunday, March 18th and Sunday March, 25th.

For more information please contact Shail Singh at singhs1@csusb.edu

Study approved by Department of Social Work Sub-Committee of the Institutional Review Board at California State University, San Bernardino
APPENDIX C

INFORMED CONSENT
The Effects of Perceived Discrimination on Samoan Health

Oral Consent Text

Good afternoon, thank you for being here today and agreeing to participate in this study. My name is Shail Singh and I am a graduate student in Social Work at California State University in San Bernardino. This study that you are about to participate in has been approved by the Department of Social Work Sub-Committee of the Institutional Review Board, at California State University, San Bernardino. This study is being conducted under my research supervisor Dr. Rosemary McCaslin.

A little about myself, I was born in the Fiji Islands and migrated here when I was ten years old. Most of you will agree that life is quite different here compared to life on the Islands. We get looked at differently here and face certain hardships that more often don’t get talked about. This study that you are about to participate in, is designed to investigate the hardships that we face as members living in American Society.

In this study you will be asked to complete a questionnaire, which asks, you respond to questions on your health and any experiences of discrimination. The questionnaire will take approximately twenty minutes to complete. It has about forty questions on it. You will not be asked to provide your names on the questionnaire. All other information that you fill out on the questionnaire will only be handled by my research supervisor, Dr. McCaslin and me.

Your participation in this study is totally voluntary. You are free not to answer any questions and withdraw at any time during this study without penalty. When you have completed the questionnaire you will be given a debriefing statement describing the study in more detail. To ensure validity of this study, I do ask that you not mention the contents of the study to anyone who has not yet had an opportunity to participate in the study. If you wish to discuss further the issues raised by the study please feel free to talk to Pastor Ma’anaima and Tina Aloalii. If you have questions or concerns about the study, please contact Professor Dr. Rosemary McCaslin at (909) 537-5507. A copy of this study will be provided to the church and will be available after September, 2007.
APPENDIX D

DEBRIEFING STATEMENT
The Effects of Perceived Discrimination on Samoan Health.

Debriefing Statement

The study that you have just completed was designed to study the possible effects of discrimination of Samoan Health.

To ensure validity of this study, I do ask that you not mention the contents of the study to anyone who has not yet had an opportunity to participate in the study. If you wish to discuss further the issues raised by the study questions please feel free to talk to Pastor Ma’anaima and Tina Aloalii.

If you have any questions or concerns about the study, please feel free to Professor Dr. Rosemary McCaslin at (909) 537-5507. A copy of this study will be provided to the church and will be available after September, 2007. Thank you for taking the time to participate in this study.
APPENDIX E

DEMOGRAPHIC VARIABLES
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