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Stigmatized Identities, Psychological Distress, and Physical Health: Intersections of Homelessness and Race

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This study of a racially and ethnically diverse group of homeless adults examined the relationship between perceived homelessness stigma and psychological distress, physical health, and avoidance of services. We also explored independent and interactive effects of perceived racial stigma and homelessness stigma on these outcomes for members of racially stigmatized groups. Women (n = 73) and men (n = 65) experiencing homelessness (81 Persons of Color, 57 White) completed survey questions about stigma, mental and physical health, service avoidance, and background characteristics. Homelessness stigma predicted greater psychological distress, poorer physical health, and increased avoidance of services after controlling for gender, race, age, chronic mental illness status, and time homeless. For Persons of Color, perceived racial and homelessness stigma interacted in predicting outcomes: among those reporting low and moderate levels of racial stigma, homelessness stigma predicted psychological distress and poor health, whereas for those reporting high levels of racial stigma, psychological and physical health was poor regardless of the level of homelessness stigma. Additionally, perceived racial stigma from service providers predicted higher levels of service avoidance. Persons of Color also reported higher levels of racial stigma than did White respondents. Glaring racial disparities in homelessness make understanding and addressing the burdens of racism for individuals experiencing homelessness a social justice imperative. Our findings suggest that social stigma and the intersections among stigmatized identities are important for understanding health and health-related behaviors in this vulnerable population.

Keywords: homelessness, stigma, race, racism, health

Homelessness is a deeply stigmatized identity (Belcher & Deforge, 2012; Fiske, Cuddy, Glick, & Xu, 2002). Despite a rich research literature linking stigmatization to negative health outcomes (e.g., Pascoe & Smart Richman, 2009; Schmitt, Branscombe, Postmes, & Garcia, 2014), very little empirical research has been directed toward understanding the health consequences associated with the stigma of homelessness. Moreover, being homeless is associated with other vulnerabilities that make people the targets of stigma, including mental illness, addiction, criminal history, unemployment, and race (McNiel, Binder, & Robinson, 2005; Skosireva et al., 2014; Tsai, Kasprow, & Rosenheck, 2014). While homeless individuals may be attuned to these multiple sources of stigma (Zerger et al., 2014), little is known about the independent and interactive effects of multiple stigmata on health outcomes of homeless individuals.

In this cross-sectional survey study, we recruited a racially diverse sample of people without homes to examine whether perceived homelessness stigma and perceived racial stigma
predict psychological distress, poor physical health, and service avoidance. Understanding health-related effects of stigma for people who are homeless is important from a practical perspective because poor health may negatively impact individuals, families, and communities; create challenges that prolong homelessness; and contribute to racial disparities in health and homelessness. Additionally, by testing the independent and interactive effects of homelessness stigma and racial stigma, we add to a growing literature on intersectional identities and health (e.g., Grollman, 2014; Williams et al., 2012).

Stigma is a broad concept encompassing negative stereotypes, labeling, antipathy, avoidance, discrimination, dehumanization, exploitation, and harm directed toward persons based on devalued personal or social characteristics (Goffman, 1963; Link & Phelan, 2001; Major & O’Brien, 2005; Smart Richman & Hatzenbuehler, 2014). Our research focuses on perceived stigma that we operationalize as a target person’s beliefs and concerns about being viewed or treated negatively based on a socially devalued characteristic or identity, and which includes both perceptions of discrimination in the past and anticipation of stigmatization in the future (Quinn & Earnshaw, 2011). For all participants, we measured perceived stigma associated with being homeless. Negative effects of perceived homeless stigma may be severe for homeless individuals because of the extremity of stereotypes and prejudice associated with homelessness. Research on social perceivers shows that homelessness triggers social distancing (Phelan, Link, Moore, & Stueve, 1997), negative stereotypes and emotions (Fiske et al., 2002), dehumanization (Harris & Fiske, 2006), and even violence (Levin, 2015). Homeless people may have experienced these various forms of stigma and may also worry about future mistreatment based on their homeless status.

For participants from racial/ethnic minority groups, we also examined the effects of two types of racial stigma on health outcomes: general perceptions of racial stigma (operationalized in a similar manner to homelessness stigma), and perceived racial stigma in the form of negative stereotypes and treatment from service providers. We included this second measure because of the compelling literature linking racial bias among service providers to health outcomes and racial disparities in health (e.g., Dovidio & Fiske, 2012; Major, Mendes, & Dovidio, 2013). Including both measures also allowed us to examine the independent effects of general versus specific perceptions of racial stigma on avoidance of services.

**Stigma and Health Outcomes**

An extensive amount of empirical research has demonstrated a negative relationship between stigma and psychological and physical well-being (for reviews, see Dolezsar, McGrath, Herzig, & Miller, 2014; Major et al., 2013; Pascoe & Smart Richman, 2009; Schmitt et al., 2014), although very little has focused on the stigma of homelessness. Much of the work focuses on perceived discrimination as a predictor. Kessler, Mickelson, and Williams (1999), for example, found associations between many forms of perceived life-time and day-to-day forms of discrimination and poor mental health. One study of homeless youth found that perceived homeless stigma predicted negative outcomes including loneliness, suicidal ideation, and low self-esteem (Kidd, 2007). Other studies have demonstrated links between poor mental and/or physical health and perceived discrimination because of race or ethnicity (Broudy et al., 2007; Lightsey & Barnes, 2007; Sellers, Caldwell, Schmeelk-Cone, & Zimmerman, 2003; Torres & Vallejo, 2015; Williams, Neighbors, & Jackson, 2003), mental illness (Corrigan, Watson, & Barr, 2006; Markowitz, 1998; Quinn et al., 2014), substance abuse (Ahern, Stuber, & Galea, 2007; Link, Struening, Rahav, Phelan, & Nuttbrock, 1997), and sexual orientation (Ramirez-Valles, Fergus, Reisen, Poppen, & Zea, 2005).

Perceived stigma can impair health and well-being through a number of processes including stress (e.g., Clark, Anderson, Clark, & Williams, 1999), social isolation (Pachankis, 2007), and unhealthy coping behaviors such as smoking, drinking, and substance abuse (Gibbons et al., 2014; Hatzenbuehler, Phelan, & Link, 2013; Paradies, 2006). Perceived and anticipated stigma can also deter people from seeking health care (Burgess, Ding, Hargreaves, van Ryn, & Phelan, 2008; Corrigan, Druss, & Perlick, 2014; Clement et al., 2015; Earnshaw & Quinn, 2012) and adhering to medical treatment (Boarts, Bogart, Tabak, Armelie, & Delahanty,
Multiple Stigmatized Identities and Health Outcomes

Taking the lead of feminist and critical race scholars (Beale, 1970; Combahee River Collective, 1977/1995; Crenshaw, 1989/1993; McCall, 2005), psychologists have begun to attend to intersectionality, which refers to “analytic approaches that consider the meaning and consequences of multiple categories of social group membership” (Cole, 2009, p. 170).

A number of studies focus on the impact of multiple devalued identities in predicting health outcomes. Studies of youth (Grollman, 2012) and adults (Gayman & Barragan, 2013; Thompson, Noel, & Campbell, 2004) show that people who report discrimination associated with a higher number of disadvantaged identities report worse mental and physical health, as well as discrimination that is more frequent and stressful (Grollman, 2014). Not surprisingly, members of racial minority groups generally report experiencing discrimination based on more identities than do White people (e.g., Thompson et al., 2004).

Some studies look specifically at the ways that race or perceived racial discrimination interact with other identities such as gender, sexual minority status, or socioeconomic status to predict health outcomes (e.g., Bratter & Gorman, 2011; Earnshaw, Bogart, Dovidio, & Williams, 2013; Williams et al., 2012). Although some of these researchers theorize that experiences related to one devalued identity may sensitize individuals to stigma associated with other identities, few if any examine the interactive effects of perceived stigma measured for two different devalued identities. Our study may be the first to take this approach.

Race, Homelessness, and Health

In the United States, the Department of Housing and Urban Development (HUD) has documented a large and persistent overrepresentation of racial minorities, particularly African Americans and Native Americans, among people who are homeless. For example, of about 1.5 million people in the United States who used shelters or transitional housing over the course of a year, 41.4% were African American (compared with about 13% of the total U.S. population) and 2.7% were American Indian or Alaska Native (compared with 1.2% of the U.S. population; US Census Bureau, 2015; HUD, 2015). Additionally, a national point-in-time count found that among 549,928 people identified as homeless on a single night in 2016, 39.1% were African American, 2.8% were Native American, and another 7.2% identified as multiracial (HUD, 2016). Hispanic people (of any race) made up 22.1% of this count, a sizable proportion of individuals experiencing homelessness although not an overrepresentation of the general population.

The effect of stigma on psychological distress and physical health may be one of many factors that contributes to racial disparities in homelessness. These negative effects of stigma may compound difficulties People of Color face navigating racist systems that are stacked against them as they try to achieve self-sufficiency and housing stability. Our focus on perceived stigma sits within a larger context of multiple forms of institutional and systemic racism—in incarceration, housing, banking, transportation, health care, education, and employment—that increase people’s vulnerability to both homelessness and poor health (Carter, 2011; Jones, 2016). Additionally, members of racially stigmatized groups who are homeless may carry the double burden of worrying about stigma linked to both race and homelessness, and this may increase negative health outcomes relative to their White counterparts who are homeless.

Concerns about racial stigma may also negatively affect health by influencing people’s motivation to engage with services where they may encounter racism. Research suggests that Black individuals generally trust health care systems and service providers less than White persons do (Boulware, Cooper, Ratner, LaVeist, & Powe, 2003) and that members of racial minority groups who perceive more discrimination from service providers are less likely to access care or adhere to treatment (Lee, Ayers, & Kronenfeld, 2009; Penner et al., 2009; Zestcott, Blair, & Stone, 2016). The overrepresentation of White providers in organizations that deliver health care and other social services may further exacerbate homeless clients’ concerns.
about racial stigma and decrease their motivation to use these services (Dovidio et al., 2008).

Although racial disparities in homelessness have been documented by HUD for a decade (HUD, 2007), there is very little research or policy addressing the relationship between race and homelessness (Jones, 2016). A recent review of social science literature identified only 29 quantitative studies and 5 qualitative studies on race and homelessness, and very few of these studies examined the dynamics of stigma (Jones, 2016). A small number of studies have looked at the relationship between perceived racial stigma and health-related outcomes in homeless populations. One study of homeless youth found that perceived racial stigma predicted higher levels of psychological distress (Milburn et al., 2010). Another study found that both homelessness stigma and racial stigma independently predicted depression symptoms in a sample of Black homeless youth (Gattis & Larson, 2016).

A study of homeless adults (Skosireva et al., 2014) looked at perceived discrimination from health care providers and found that higher levels of perceived discrimination because of race/ethnicity, homelessness/poverty, and mental illness/substance were each linked to more mental health symptoms, substance use, and emergency room visits. The study also found that being White (vs. Black) increased odds of reporting stigma because of homelessness, and being a Person of Color (vs. White) increased the odds of reporting stigma because of race/ethnicity. This study did not, however, look at independent or interacting effects of homelessness stigma and racial stigma on health outcomes.

Study Hypotheses

We surveyed adults who were homeless about their perceptions of discrimination experienced and anticipated because of homelessness and race/ethnicity. We hypothesized that in the full sample, homelessness stigma would predict worse physical health, higher psychological distress, and more service avoidance after controlling for the effects of age, race, gender, time spent homelessness, and mental illness status. In an exploratory fashion we also tested whether homelessness stigma interacted with race in predicting these outcomes.

Although we did not expect race differences in levels of homelessness stigma, we predicted that participants who were Persons of Color would report higher levels of racial stigma than participants who identified as White, and that among participants who were Persons of Color, perceived racial stigma would predict poor health outcomes independent of homelessness stigma. We also tested for interactive effects of racial stigma and homelessness stigma for Persons of Color. It could be that a history of and/or sensitivity to racial stigma intensifies the negative effects of homelessness stigma, and as a result the relationship between homelessness stigma and negative outcomes should be stronger at higher levels of racial stigma. Alternatively, for individuals who experience high levels of racial discrimination, homelessness stigma may be less salient than racial stigma and, therefore, have fewer negative effects. The relationship between homelessness stigma and poor health outcomes might, therefore, have less negative effects. The relationship between homelessness stigma and poor health outcomes might, therefore, be stronger for individuals reporting low rather than high racial stigma. Given these alternative predictions and the lack of previous research on the topic, interactional analyses were exploratory.

Our final set of predictions concerned perceived racial stigma from service providers. We predicted that for People of Color, this measure would be a strong predictor of service avoidance, and to a lesser extent of psychological distress and poor physical health.

Method

Participants

Participants were 175 volunteers attending a 1-day homelessness service fair in Tacoma, WA, in October 2009 (95 women) and October of 2010 (80 men). Members of the research team approached guests at the event individually and invited them to complete a confidential survey. Efforts were made to recruit similar numbers of White individuals and Persons of Color. Because measures were the same for both samples, we combined the data from women and men to increase statistical power. Data were excluded from 5 participants who had been homeless less than one month and 32 participants whose responses were incomplete or unclear. The remaining 138 participants (73 women, 65 men) self-identified as White (57),
Participants each sat at a private table with an interviewer who administered informed consent. The interviewer next asked a series of questions about demographics and housing history and recorded answers. Participants were then given the option of either having the interviewer continue to ask the questions or filling out the survey themselves. Interviewers recorded any problems participants displayed attending to instructions and questions. The survey included a range of open- and closed-ended questions, and took between 40 and 60 min for most participants to complete. Questions on stigma asked about homelessness, race/ethnicity, gender, mental illness, addiction, criminal history, and domestic violence. Our report here focuses only on stigma related to homelessness and race/ethnicity. Other measures not discussed in this report pertained to alcohol and drug use, time perspective, and other personal attitudes and experiences. At the end of the survey, participants were thanked and given a $15 grocery gift card and referral information if requested. The study was conducted in compliance with the Institutional Review Board at the University of Puget Sound.

Measures

**Perceived homelessness stigma and perceived racial stigma.** We developed a brief set of items for this study that could be used to measure anticipated and experienced dimensions of stigma. Participants were asked to “think about how you have felt in general over the last month (not counting today).” Two items measured anticipated stigma associated with each identity: I worry about being treated badly because I am homeless (because of my race/ethnicity); and I worry about how people will view me because I am homeless (because of my race/ethnicity); and a third item measured experienced stigma: I have experienced negative treatment from other people in the last month because I am homeless (because of my race/ethnicity). Participants rated agreement with these statements on a 4-point scale (1 = not at all true, 4 = very true). A fourth item measuring experienced stigma asked participants to think about discrimination or mistreatment they may have received because of their personal or social characteristics at any time in their adult life, and then to respond to the question: To what extent have you experienced discrimination or mistreatment due to being homeless (to your race/ethnicity)? (1 = not at all, 4 = an extreme amount).

We had intended to create separate measures for anticipated and experienced components of stigma, but the items were highly correlated, so we created a single index of homelessness stigma by averaging responses to the four items related to homelessness stigma (α = .84). Similarly, the race stigma items were highly correlated and averaged to form a single index of racial stigma (α = .89 for Persons of Color). Although all participants responded to items about racial stigma, the responses by White individuals were difficult to interpret and highly skewed (70% had an index score of zero, compared with 38% for Persons of Color). Therefore, regression analyses regarding racial stigma were conducted only with Persons of Color.

**Racial service stigma and service avoidance.** Participants were asked to think about their feelings and experiences regarding services and service providers (including health, mental health, case workers, DSHS, housing, education, and others), and to rate their agreement with a set of statements (1 = not at all true, 4 = very true). Concerns about racial stigma from service providers was measured with three items: I worry that service providers may hold stereotypes about me because of my race; Some service providers treat me badly because of my race; and When interacting with a service provider of a different race than myself, I think about stereotypes they may have about me (α = .77 for Persons of Color). As with the general racial stigma index, the index of racial service stigma was difficult to interpret and highly skewed for White participants (65% had an index score of zero, compared to 40% of Persons of Color) and, therefore, only used in regression analyses for Persons of Color. Avoid-
ancence of service use was measured with three items: I put off making appointments for services; I avoid using services even if they may be helpful to me; and I have difficulty getting to service appointments ($\alpha = .66$).

**Psychological distress.** Psychological distress was measured with two scales. We used a short version of the Center for Epidemiological Studies Depression (CES-D) Scale (Radloff, 1977) that was designed for general population surveys and correlates strongly with the full CES-D (Ross & Mirowsky, 1984). Participants indicated how many days in the past week they experienced seven symptoms of depression (e.g., felt sad; felt that everything was an effort; had trouble getting to sleep or staying asleep). Responses were averaged to form a depression index ($\alpha = .88$). Participants also rated how often in the last month they had experienced various moods (1 = never, 5 = very frequently), and responses to 12 items were averaged after reverse scoring the positive items: happy, sad, interested, annoyed, energetic, content, irritated, depressed, hopeful, angry, lonely, and cheerful ($\alpha = .88$). Because these two indexes were highly correlated, $r = .75$, $p < .001$, we standardized the scores and averaged them into a single measure of psychological distress.

**Physical health.** We measured physical health in four ways. Participants indicated whether or not they experienced 10 physical health symptoms in the last month: back pain; headaches; heart problems; high blood pressure; ulcers; indigestion; trouble sleeping; heart pounding; dizziness; and tiredness or fatigue. These items were adapted from Moos, Cronkite, Finney, and Billings (1986) and Quinn and Staines (1979). A different checklist asked participants to indicate whether they suffered from chronic medical conditions. We created a variable that was the sum of 10 conditions that more than 5% of participants endorsed: stomach problems, breathing problems, heart problems or heart disease, cancer, diabetes, hepatitis, skin problems, chronic pain, high cholesterol, and high blood pressure. Participants also provided a self-report rating of their physical health on a single item (1 = very poor, 3 = fair, 5 = very good) and indicated how many days out of the last 30 they felt physically sick. The four health indices were all correlated ($rs$ ranged from .35 to .66) and were standardized and averaged to form a single index of poor physical health ($\alpha = .79$).

**Demographics and control variables.** Participants answered questions about demographics (e.g., age, gender, and race/ethnicity), housing history, and other characteristics using a variety of open- and closed-ended formats. They were asked whether they had ever been diagnosed with a mental illness and to describe the type of disorder. Responses coded for use as covariates in regression analyses included age (years), gender (female = 0, male = 1), race/ethnicity (White-non-Hispanic = 0, Person of Color = 1), self-reported mental illness (0 = no, 1 = yes), and total time homeless (1 = less than a year, 2 = 1–2 years, 3 = over 2 years).

**Results**

**Descriptive Statistics and Correlations**

Table 1 shows means and SDs for all participants broken down by race and gender. Two-way (Race × Gender) analysis of variences (ANOVAs) were conducted for each measure. As expected, Persons of Color reported more racial stigma, $p = .006$, and racial stigma from service providers, $p = .04$, than White participants, and there were no race effects for homelessness stigma. White participants were younger on average than Persons of Color, $p = .002$. Compared with men, women reported more homelessness stigma, $p = .045$, worse physical health, $p < .001$, and more psychological distress, $p = .009$, and chronic mental illness, $\chi^2(N = 138) = 12.38, p < .001$. Mental illness did not differ by race, $\chi^2(N = 138) = .10, p = .75$, and there were no gender or race effects for service avoidance or time homeless, and no significant race by gender interactions for any measure.

Table 2 shows the matrix of Pearson correlations among continuous measures with results for Persons of Color above the diagonal and those for White individuals below the diagonal. The three stigma measures (homeless stigma, racial stigma, and racial service stigma) were positively correlated for both groups. Positive correlations also appeared among the health outcome measures (psychological distress, poor physical health, and service avoidance) with the strongest correlations between psychological distress and poor physical health. As expected, homelessness stigma was associated with worse outcomes. Correlations between homelessness stigma and the three out-
come measures were moderate in size and similar for both groups. The correlations were similar for male and female participants (and are not shown in the table). For Persons of Color, both racial stigma and racial service stigma predicted worse health outcomes, with the strongest correlation between racial service stigma and service avoidance. These patterns were similar for men and women except that correlations were stronger for men than women ($r_s = .56$ vs. $.18$) and racial stigma and service avoidance ($r_s = .48$ vs. $.09$). For White participants, in contrast, only the correlation between racial service stigma and psychological distress reached significance.

Regression Analyses Predicting Outcomes in the Full Sample

To examine the effects of perceived homelessness stigma, we conducted linear regression analyses for each outcome measure. In step one, we entered age, gender, race/ethnicity, mental illness, and time homeless as covariates. In the second step we entered homelessness stigma. The third step included interaction terms for race-by-homelessness stigma and gender-by-homelessness stigma.

As can be seen in Table 3, having a chronic mental illness was a strong predictor of psychological distress, and time homeless was a weaker predictor. The control variables as a

Table 2
Correlations Among Study Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Homeless stigma</td>
<td></td>
<td>.49**</td>
<td>.57**</td>
<td>.57**</td>
<td>.39**</td>
<td>.45**</td>
<td>−.24*</td>
<td>.20</td>
<td>.26*</td>
</tr>
<tr>
<td>2. Racial stigma</td>
<td>.42**</td>
<td></td>
<td>.59**</td>
<td>.28*</td>
<td>.27*</td>
<td>.29**</td>
<td>−.06</td>
<td>.12</td>
<td>.16</td>
</tr>
<tr>
<td>3. Racial service stigma</td>
<td>.34**</td>
<td>.73**</td>
<td></td>
<td>.33*</td>
<td>.42**</td>
<td>.51**</td>
<td>−.05</td>
<td>.28</td>
<td>.17</td>
</tr>
<tr>
<td>4. Psychological distress</td>
<td>.50**</td>
<td>.23</td>
<td>.29*</td>
<td></td>
<td>.65**</td>
<td>.37**</td>
<td>−.10</td>
<td>.17</td>
<td>.42**</td>
</tr>
<tr>
<td>5. Poor health</td>
<td>.54**</td>
<td>.19</td>
<td>.21</td>
<td>.65**</td>
<td></td>
<td>.47**</td>
<td>−.15</td>
<td>.23</td>
<td>.39**</td>
</tr>
<tr>
<td>6. Service avoidance</td>
<td>.41**</td>
<td>.17</td>
<td>.24</td>
<td>.28*</td>
<td>.33*</td>
<td></td>
<td>−.08</td>
<td>.13</td>
<td>.12</td>
</tr>
<tr>
<td>7. Age</td>
<td>.36**</td>
<td>.13</td>
<td>.00</td>
<td>.29*</td>
<td>.30*</td>
<td>.14</td>
<td></td>
<td>.10</td>
<td>.00</td>
</tr>
<tr>
<td>8. Time homeless</td>
<td>.24</td>
<td>.15</td>
<td>.14</td>
<td>.27*</td>
<td>.24</td>
<td>.25</td>
<td>.23</td>
<td></td>
<td>.13</td>
</tr>
<tr>
<td>9. Mental illness</td>
<td>.36**</td>
<td>.03</td>
<td>.11</td>
<td>.56**</td>
<td>.44**</td>
<td>−.03</td>
<td>−.01</td>
<td>.00</td>
<td></td>
</tr>
</tbody>
</table>

Note. Numbers above the diagonal are for racial/ethnic minority participants ($n = 81$) and those below the diagonal are for White participants ($n = 57$).

* $p < .05$, two-tailed.  ** $p < .01$, two-tailed.
Table 3

Predicting Outcomes From Homelessness Stigma (N = 138)

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Psychological distress</th>
<th>Poor health</th>
<th>Service avoidance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Step 1 β</td>
<td>Step 2 β</td>
<td>Step 3 β</td>
</tr>
<tr>
<td>Gender</td>
<td>-12</td>
<td>-08</td>
<td>-08</td>
</tr>
<tr>
<td>Race</td>
<td>-13</td>
<td>-16*</td>
<td>-36</td>
</tr>
<tr>
<td>Age</td>
<td>.03</td>
<td>.05</td>
<td>.07</td>
</tr>
<tr>
<td>Time homeless</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental illness</td>
<td>.18*</td>
<td>.10</td>
<td>.10</td>
</tr>
<tr>
<td>Homelessness stigma</td>
<td>.42***</td>
<td>.32***</td>
<td>.32***</td>
</tr>
<tr>
<td>Racial stigma</td>
<td>.24</td>
<td>.24</td>
<td>.24</td>
</tr>
<tr>
<td>Gender × Race</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender × Homelessness stigma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted R²</td>
<td>.26***</td>
<td>.41***</td>
<td>.40***</td>
</tr>
<tr>
<td>ΔR²</td>
<td>.14***</td>
<td>.01</td>
<td>.01</td>
</tr>
</tbody>
</table>

*p < .05, **p < .01, ***p < .001.

In the next series of linear regressions, we examined the effects of both perceived racial stigma and perceived homelessness stigma on several outcomes. For each of the three outcomes, we entered control variables in the first step, racial stigma in the second step, and the interaction of racial stigma and homelessness stigma in the last step. Stigma variables were centered before creating the interaction term. For all outcomes, gender and age were significant predictors. Mental illness was a significant predictor and accounted for an additional 15% of the variance. For the model predicting physical health, the only significant predictor was mental illness, which accounted for an additional 8% of the variance. Homelessness stigma was a significant predictor of psychological distress, accounting for 16% of the variance. For avoidance of social services, the only significant predictor was time homeless, which accounted for 14% of the variance. Again, there were no significant interactions involving race or gender.
### Table 4
**Predicting Outcomes From Racial and Homelessness Stigma for Persons of Color (n = 81)**

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Psychological distress</th>
<th>Poor health</th>
<th>Service avoidance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Step 1 β</td>
<td>Step 2 β</td>
<td>Step 3 β</td>
</tr>
<tr>
<td>Age</td>
<td>-12</td>
<td>-10</td>
<td>-01</td>
</tr>
<tr>
<td>Time homeless</td>
<td>.14</td>
<td>.12</td>
<td>.05</td>
</tr>
<tr>
<td>Mental illness</td>
<td>.37**</td>
<td>.32**</td>
<td>.26**</td>
</tr>
<tr>
<td>Racial stigma</td>
<td>.24*</td>
<td>.03</td>
<td>.15</td>
</tr>
<tr>
<td>Homelessness stigma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Racial Stigma x Homelessness stigma</td>
<td>.48***</td>
<td>.46***</td>
<td></td>
</tr>
<tr>
<td>Adjusted R²</td>
<td>.18**</td>
<td>.23***</td>
<td>.38***</td>
</tr>
<tr>
<td>ΔR²</td>
<td>.06*</td>
<td>.15***</td>
<td>.03*</td>
</tr>
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* p < .05. ** p < .01. *** p < .001.

#### Analyses Using Racial Service Stigma

In line with our hypothesis, after controlling for covariates and other stigma variables, racial service stigma uniquely accounted for 9% of the variance in psychological distress. A similar pattern was found for service avoidance except that the interaction term did not reach significance. The interaction term dropped to nonsignificance when homelessness stigma was entered. The stigma interaction term 4% of poor physical health, but did not account for additional variance in psychological distress.

Table 5 (unavailable in the image) shows the interaction effects for predicting service avoidance for Persons of Color and having service stigma was a significant predictor of service avoidance except that the interaction term did not reach significance. To explore the nature of the interactions for psychological distress and physical health, we used Hayes' (2013) process model to examine the interaction while controlling for psychological distress and physical health. As can be seen in Figure 1, the effect of homelessness stigma on psychological distress is moderated by level of racial stigma. At high levels of racial stigma, the effect of homelessness stigma on psychological distress is not significant at the 75th percentile, whereas participants with moderate levels of racial stigma, (r = .11). At low levels of racial stigma, the slope is more steep: the more participants with moderate levels of racial stigma, the greater their psychological distress. This relationship is significant at both the 50th and 25th percentiles of racial stigma, (r = .11).
Discussion

The primary goal of this research was to explore the relationship between the experience of stigma and psychological and physical health among individuals without homes, and we found evidence linking poor outcomes to stigma associated with both homelessness and race. The hypothesized link between homelessness stigma and
poor outcomes received strong support. Participants who experienced and anticipated more stigma as a function of being homeless reported more psychological distress, worse physical health, and a greater tendency to avoid using services, even after controlling for gender, race, age, time homeless, and having a chronic mental illness.

The broader literature on stigma and health suggests a variety of possible mechanisms underlying these relationships (e.g., Major et al., 2013; Pascoe & Smart Richman, 2009), and further research is needed to determine which mechanisms are associated with homelessness stigma in particular. Direct links may exist between homelessness stigma, psychological distress, and health. The association between stigma and poor health may also be mediated by chronic vigilance, stress, social isolation, service avoidance, internalized stigma (Quinn, Williams, & Weisz, 2015), or the effects of depleted self-control on health-related behaviors such as eating and substance abuse (Hatzenbuehler et al., 2013; Inzlicht & Kang, 2010). Additionally, perceived homelessness stigma may be a reflection of structural and interpersonal forms of discrimination that create an unhealthy environment (Gehlert et al., 2008). For example, individuals reporting high homelessness stigma may be those who are most often discriminated against by family members, employers, housing providers, or health care institutions, and therefore, experience the most structural barriers to good mental and physical health.

As predicted, comparisons of means show that racial stigma was on the minds of participants who were Persons of Color more than White participants, though the mean racial stigma scores were smaller in magnitude than homelessness stigma scores. Perceived homelessness stigma was similarly high for White participants and Persons of Color, and slightly higher for women than men. As in other studies with homeless adults (Skosirerva et al., 2014), individuals reporting stigma associated with homelessness were also more likely to report stigma associated with race/ethnicity. This finding might be because of a psychological construct such as stigma consciousness (Pinel, 1999) or could reflect structural factors that increase experiences of discrimination for individuals whose homeless status and racial identities are particularly salient to others.

Our regression analyses show that both homelessness stigma and racial stigma played a role in predicting outcomes for Persons of Color, and interacted in predicting psychological distress and physical health. For Persons of Color with moderate and lower levels of racial stigma, homelessness stigma strongly predicted more psychological distress and worse physical health; and at very high levels of racial stigma, participants who were Persons of Color reported high levels of psychological distress and poor health regardless of their experience of homelessness stigma. The pattern was similar for service avoidance, although the interaction effect did not reach significance. This pattern could represent a ceiling effect in measurement or in actual experiences of poor health among participants reporting the highest levels of racial and/or homelessness stigma. Even so, the

<table>
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<th>Predictor</th>
<th>Psychological distress</th>
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<th>Service avoidance</th>
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<tr>
<td></td>
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<td>-.14</td>
<td>-.41***</td>
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<td>.26**</td>
<td>.18*</td>
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<tr>
<td>Racial stigma</td>
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<td>$\Delta R^2$</td>
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*p < .05. **p < .01. ***p < .001.
findings suggest that both homelessness stigma and racial stigma are independently linked to poor outcomes for many Persons of Color (those not at the extreme on either stigma scale), and that high perceived stigma of either type, whether independent or not, is associated with very poor outcomes.

We also measured particular concerns participants had about racial stereotyping and discrimination from service providers. We predicted and found that People of Color with high concerns about racial stigma from service providers were most likely to avoid using services, even after we controlled for other stigma variables. Perceived racial stigma from service providers was also uniquely associated with poor physical health, but not with psychological distress. These findings are consistent with research on stereotype threat that suggests that heightened awareness of negative stereotypes about one’s group can account for racial disparities in health by increasing anxiety, blood pressure, and avoidance of health care, and by impairing treatment adherence and communication between patients and health care providers (Aronson, Burgess, Phelan, & Juarez, 2013). These mechanisms associated with racial stigma from service providers may take a cumulative toll on physical health over time, but be less important in predicting psychological distress above and beyond other stressors experienced by homeless individuals, including effects of more general forms of stigma. Although we did not measure participants’ concerns about homelessness stigma from service providers, it is possible that the outcomes would be similar to those for racial stigma, and future research should explore this possibility.

Conducting field research with individuals experiencing homelessness is a challenging process, and our methods have several limitations. Our participants were recruited in one part of the United States and from women and men in different years, thus care should be taken when generalizing to other populations of homeless individuals. The size and characteristics of our samples prevent us from making fine-grained comparisons between racial and ethnic groups, and it is likely that some dynamics of stigma differ for individuals who are African American, Native American, Latinx/Hispanic, and so on. Some of our participants were excluded from the analyses because they did not complete the lengthy survey or follow instructions. Because we relied on self-reports and asked about sensitive topics, responses may reflect social desirability biases or have limited accuracy more generally. Additionally, because items measuring perceived stigma were highly correlated, we are unable to disentangle the effects of anticipated and experienced components of stigma. Finally, although we attempted to control for a number of important covariates, we used a cross-sectional design which limits our ability to make inferences about causality.

Despite these limitations, our research has important strengths. Given the challenges of collecting data from individuals facing many life challenges, we were successful in obtaining a large and rich set of information from most participants through in-depth one-on-one interviews. Our regression models yielded a robust set of links between perceived stigma, psychological distress, physical health, and service avoidance even after controlling for a broad range of potentially confounding covariates. Most of the participants were chronically homeless, and this is a critical group to understand because of the high toll of chronic homelessness on individuals and communities. Moreover, women are generally underrepresented in studies of homelessness, and our recruitment strategy yielded similar numbers of men and women allowing us to test for effects that generalize across gender. Our recruitment strategy also allowed us to obtain a large enough sample of Persons of Color to examine the independent and interactive effects of racial stigma and homelessness stigma.

Our research fills important gaps in the theoretical and applied literatures on stigma and health. There is a need for studies on the intersectionality of identity that go beyond the dimensions of gender and race, and that explore the additive and interacting effects of multiple stigmatized identities on health and well-being (Cole, 2009). Our study is among the first to empirically examine the interactive effects of anticipated and experienced stigmata of homelessness and race. More research is needed to better understand the pathways underlying these effects and examine effects of other stigmatized identities such as mental illness, addiction, and criminal history.

From a practical perspective, our findings have implications for understanding the role of stigma in creating racial disparities in health and housing. Increasingly, local, regional, and national audiences are paying attention to homelessness, including a focus on causes, costs, and
needed solutions. Homelessness is recognized as a crisis, a failure to meet a basic human need for shelter, and a public health and economic burden for communities. Markedly absent in the discourse about homelessness is a focus on systemic racism as a lens for examining the causes and disparate impact of homelessness for Persons of Color (Jones, 2016). Our findings suggest that racial stigma adds to the already heavy burden of homelessness experienced by Persons of Color and may play a role in compromising health and thereby prolonging homelessness.

A better understanding of the effects and complexities of stigma can also inform strategies for intervention. For instance, policies and practices that protect the confidentiality of people’s homeless status may avert stress and avoidance among people seeking employment, education, housing, health care, or other services. Efforts to signal equity and disrupt racism—such as diversifying organizational staff and leadership and ending housing discrimination—may decrease psychological threat associated with racial stigma. Steps such as these that reduce stigma and its negative consequences can improve the health and wellbeing of marginalized individuals and of communities where people with and without stable housing live.

References


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