

The Perceived Discrimination–Psychological Distress Relationship in Adults: Published Evidence and the Potential Roles of Identity Distress and Resilience

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ABSTRACT

Everyday unfair treatment can unsettle belonging and accompany psychological distress, but evidence of an association does not establish the mechanism behind it. This study explores existing aggregate data and constructs a model where identity distress is a potential mediator of the relationship between identity stress and a moderator for resilience. Focused synthesis consists of an existing published analysis of the 2023 US National Health Interview Survey and basic psychological and methodological studies. Six adjusted exposure contrasts are identified, described, and used to construct hypothetical multinomial probability scenarios. High levels of discrimination have strong relationships with poor screening outcomes. Contrasts between calculated high and low exposure contrasts on the relative odds scale are in the range 2.45–3.40. Translation of these relative odds to probabilities requires knowledge of the entire distribution of outcomes in the reference case. Identity distress and resilience do not co-occur in the data that has been analyzed. Therefore, mediation and moderation are not tested. This is a testable interpretation of the existing results and a carefully designed study of a proposed mechanism.

Keywords: Everyday Discrimination, Psychological Distress, Identity Distress, Resilience, Secondary Analysis, Moderated Mediation

Introduction

This is because being discredited, distrusted, or being served in a poor manner may complicate simple interactions. This is crucial because it not only concerns the treatment of the individual but also his/her status in a specific social setting. Therefore, for adults who have to move around between their work, studying, home, and society, discrimination can be a repeated experience rather than an isolated incident.

The work of Williams et al. has done much to establish the everyday discrimination as an operational measure of the social stress [1]. This research explores the relationships among socioeconomic conditions, discrimination, and health without combining the different experiences into one variable. It is critical because the survey question about the disrespectful behavior is the individual's experience and does not prove automatically the intent of the other person, his/her wrongdoing, or institutional context of the experience.

Other evidences point towards the significance of the association under consideration. According to Schmitt et al. synthesis of

328 effect sizes from correlational researches including 144,246 participants revealed the association of $r = -.23$ between discrimination and well-being. Longitudinal studies adjusted by the previous well-being also confirmed the negative association [2]. This data provides a significant context for further research, although it does not provide a psychological explanation and does not prove the application of the average value to a Vietnamese community.

A distress in identity could be another possible mechanism for explaining why similar situations mean something different for different people. The individual can interpret the event as an instance of being disrespected, or he may interpret the pattern of these kinds of events as evidence that some specific ideas and personal identity simply cannot coexist. It can resilience that will dictate the ability to recover from such an event. However, while a mechanism may make theoretical sense, it is not necessarily an empirical finding and therefore should be tested.

There are three major questions posed in this research. What can be seen from existing estimates related to discrimination and mental health screening in the case of adults? How will interpretation change if we use odds ratios instead of hypothetical probabilities? What data should be collected to examine the impact of identity distress and resilience on the same model?

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The research is based on existing estimates and not on new subjects who need to be recruited.

This difference also decides the target audience. People who are curious about the well-being of adults can use the numbers provided to determine the magnitude and boundaries of the relationship between variables. Scientists can use the proposed approach in order to design future measurements and comparative analyses based on time. Teachers and community centers can think about practical applications without thinking that this paper has tested any treatment.

Identity distress and resilience as possible mechanisms

The theory of minority stress by Meyer differentiates between external stressors and processes that involve expectations, concealment, and internalized stigma [3]. As a model originally developed for lesbians, gays, and bisexuals, it provides an explanation of how social circumstances turn into psychological ones. Its application to the general adult population means finding out what the appropriate stigmatized status and environment are. Everyday discrimination, identity concerns, and internalized stigma are similar concepts but are not identical measurements.

Hatzenbuehler similarly describes psychological processes that may connect stigma-related stress with psychopathology [4]. It facilitates asking how cognitive, emotional, and interpersonal mechanisms function as mediators between an encounter and subsequent distress. It does not suggest that identity distress is invariably the mediator. Rumination, anticipation of rejection, economic deprivation, and lack of access to resources may be alternative accounts of the mechanism that need further investigation in the future.

Amiot et al. explain how multiple social identities develop and become integrated within the self. Their theory brings relevance of identity consistency to adaptation without proposing that every conflict in roles is pathological [5]. The Identity Distress Scale was created by Berman et al. to measure distress that comes along with identity problems [6]. Thus, identity distress should be assessed independently and not through discrimination or symptom scales.

Resilience also needs a specific definition. Smith et al. developed the Brief Resilience Scale around recovery from stress [7]. According to Masten, there is no place for exceptional invulnerability in his theory; only adaptation and support matter [8]. This approach implies that both recovery capacity and resources should be considered. These theories do not imply that resilience can be used as an excuse for mistreatment.

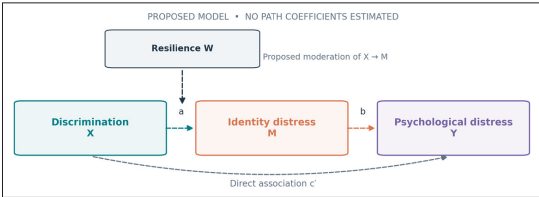


Figure 1: Proposed first-stage moderated mediation framework. Dashed arrows denote untested relationships; the diagram is a research specification, not an estimated model. Source: Author synthesis of the cited theories.

The first-stage model being proposed will predict that there is a connection between discrimination and increased identity distress, where the relationship becomes weaker with increased levels of resilience. Identity distress is then predicted to be connected to psychological distress in the future, even after controlling for previous symptoms. These are research predictions that are not hypotheses being tested using the exposure contrasts presented in the literature. The direct pathway has been left in the model because identity concerns do not have to mediate all associations.

Sources and measurement audit

This is a focused secondary analysis and does not represent a systematic review or a new survey. The sources were chosen for their transparency in adult exposure comparisons, definition of the construct, and information on mediation and observation. The searches and verification of sources took place on 16 October 2026, using publishers' websites, PubMed, and National Center for Health Statistics documentation. No attempt at a comprehensive search, registration, pooled effect size, or replication is implied. In some cases, foundational literature can be supported by the abstract and bibliographic data that have been available.

The numerical data comes from Wang & Narcisse and especially from the categorical exposure model in Table 3 [9]. The underlying NHIS data included 29,522 American adults, while the analyses performed used weights, strata, and sampling clusters for their consideration. The six numbers refer to estimates of anxiety-only, depression-only, and both-positive screening groups compared with negative results for both screenings. They have the same model description in the published work, while the total number of surveys cannot be considered item-complete or regression-complete.

Table 1: Source measurement and valid-response audit

Public variable	Item topic paraphrased	Valid n	Scoring and location
DISCRIM1_A	Respect / courtesy	28,585	EDS.0010; p. 437
DISCRIM2_A	Service quality	28,590	EDS.0020; p. 438
DISCRIM3_A	Assumed intelligence	28,520	EDS.0030; p. 439
DISCRIM4_A	Others showing fear	28,560	EDS.0040; p. 440
DISCRIM5_A	Threats / harassment	28,612	EDS.0050; p. 441
PHQ2SCREEN_A	Depressive symptoms	28,623	PHQ41/42; p. 433
GAD2SCREEN_A	Anxiety symptoms	28,622	PHQ43/44; p. 436

Source: NCHS printed pages; IDs abbreviated from EDS.00x0.00 [10].4. Valid n sums substantive unweighted categories, not a common model base. Raw EDS codes 1-5 range weekly → never; published scoring reversed to 4-0, sum 0-20 (none 0; low 1-10; high 11-20). Symptom items are coded 1-4 in frequency codes, scored 0-3, sum 0-6; ≥ 3 is positive. Codes 7/8/9 are

nonresponses; screener 8 is unascertained. Weight WTFA_A, strata PSTRA, cluster PPSU. No response level recoding was done here.

Table 1 does not combine the numbers of available responses with the usual complete-case sample which cannot be reconstructed based on individual item frequencies. Since the article does not offer an adequate model-specific valid count and missing data rule, this paper reproduces its estimates and intervals without re-computing the standard errors, assuming missing responses as zeroes, and without making any claims of reproducing the survey model.

In addition, another warning issued by the NCHS is just as important: the discrimination questions may not have the same meaning for various demographic groups (NCHS, n.d.). Comparisons of scale answers between various demographic groups are discouraged. Consequently, this paper does not use the discrimination scores to compare race, ethnicity, sex, and age groups. The general associations are interpreted taking this measurement constraint into account.

Analytical approach and reproducibility

All computations are based solely on the basic operations of division, multiplication, and addition and the scientific calculator's logarithm. The published estimates and confidence intervals are merely copied rather than re-estimated. Let θ_{kL} and θ_{kH} denote the published relative odds for category k of the outcome variable under low and high discrimination, respectively. A descriptive contrast is:

$$C_k = \theta_{kH} / \theta_{kL}; \quad dk = \ln(C_k) \quad (1)$$

The contrast involves two exposure coefficients from the same outcome regression model. Its uncertainty depends on their covariance, which is not provided by the extracted table. The ratio of confidence interval endpoints will not result in a confidence interval for C_k . There is no additional significance test applied to the computed contrasts, nor is there any comparison of contrasts between different outcomes.

As the source model uses the multinomial distribution, the isolated binarization of the outcome variable would be incorrect. For the assumed reference distribution q_0, q_1, q_2, q_3 adding up to one, the probability of category k for exposure e will be equal to:

$$pk(e) = \theta_{ke} q_k / [q_0 + \sum_{j=1}^3 \theta_{je} q_j] \quad (2)$$

Here q_0 is negative for both screens, and category 1-3 represents anxiety only, depression only, and dual positives. In the case of no exposure, all θ s equal one. Distributions for scenarios are chosen by the author rather than baseline probabilities. Equation 2 uses point estimates from the literature assuming a common covariate structure; it does not have intercept terms and covariate specific information, hence cannot provide population-level predictions.

To make the proposed mechanism testable, let X represent discrimination, M identity distress, W centered resilience, Y a continuous distress measure, and Z prespecified covariates. A prospective first-stage moderation model can be written as:

$$M = a_0 + a_1X + a_2W + a_3XW + \gamma Z + \varepsilon M \quad (3)$$

$$Y = b_0 + c'X + bM + \delta W + \eta Z + \varepsilon Y \quad (4)$$

$$IE(w) = (a_1 + a_3w)b \quad (5)$$

$$\text{Index of moderated mediation} = a_3b \quad (6)$$

Eqs. 3-6 describe a future regression model; none of its coefficients are estimated here. After the approach of Hayes, the interval estimate of the index will allow checking whether the indirect effect depends on the moderator [11]. According to Maxwell & Cole, cross-sectional mediation may provide a distorted representation of longitudinal processes [12]. Thus, repeated measurements, a correct order of time points, and confounding assumptions would be necessary before causal interpretation of the model.

Published associations and calculated contrasts

Reference groups used in Table 2 are kept for both exposure and outcome variables. Confidence intervals provided in Figure 2 are the same estimates with their published uncertainties. Tables 2 and 3 are the representations of the analysis of one source, and thus, they cannot be considered as replications. Adjusted coefficients were corrected for covariates in the source population.

Table 2: Extracted adjusted estimates and descriptive high versus low contrasts

Screening outcome	Low OR [95% CI]	High OR [95% CI]	C _k
Anxiety only	1.97 [1.66, 2.33]	4.98 [3.59, 6.91]	2.53
Depression only	2.20 [1.77, 2.72]	5.39 [3.61, 8.04]	2.45
Dual positive	2.60 [2.13, 3.18]	8.84 [6.44, 12.14]	3.40

Source: Wang and Narcisse, Table 3; C_k calculated by Equation 1 [9]. Reference exposure: EDS score 0; low 1–10; high 11–20. Outcome reference: both screens negative. All six source contrasts $p < .001$. C_k has no calculated confidence interval.

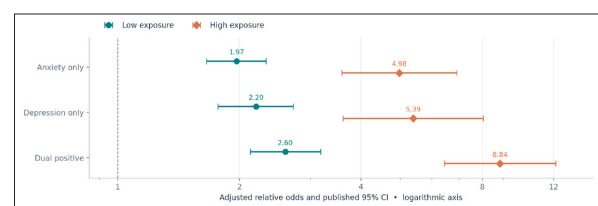


Figure 2: Published relative odds against no exposure; outcome reference is negative on both screens. Source: Wang and Narcisse, Table 3 [9]. Intervals are reproductions of source analysis; no model was refitted.

Using Equation 1 produces contrasts for high against low of 2.53 for anxiety only, 2.45 for depression only, and 3.40 for dual-positive screens; the natural logarithms are 0.927, 0.896, and 1.224, respectively. They are calculated statistics of six published coefficients. Their order is purely descriptive since the outcome contrasts are dependent and their covariance cannot be obtained.

The pattern fits a stronger correlation at the higher level of exposure, although two broad exposure categories do not create a smooth dose–response curve. Neither does the highest point estimate represent a unique mechanism for co-morbidity of symptoms. The screening categories are descriptions of the symptoms and not of clinical diagnosis, and there is no way to determine from the analysis whether discrimination preceded the symptom onset.

Why baseline composition changes interpretation

Figure 3 provides three deliberately hypothetical distributions for the non-exposed population of adults. In the order negative on both screens, anxiety only, depression only, and dual positive, the distributions are A = (94%, 2.5%, 1.5%, 2%), B = (88%, 5%, 3%, 4%), and C = (76%, 10%, 6%, 8%). These provide increasingly larger hypothetical symptom burdens. They are not distributions of the exposure-specific NHIS observations or predictions for Vietnam.

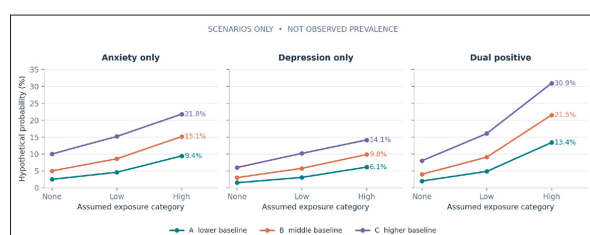


Figure 3: Hypothetical probabilities from Equation 2 under three stated reference distributions. Lines connect categorical scenarios, not a continuous dose-response curve. Source: Author calculations based on information from Table 2; no empirical probability estimates or confidence intervals included.

For the scenario B at high exposure levels, the denominator in Equation 2 becomes $0.88 + 4.98 \times 0.05 + 5.39 \times 0.03 + 8.84 \times 0.04 = 1.6443$. Hence, the probability of dual positivity will be $0.3536/1.6443 = 21.5\%$ compared to the assumed probability of 4%. In addition, the probabilities for scenarios A and C under high exposure levels become 13.4% and 30.9% respectively.

In this example, it becomes clear why the odds ratio measure is wrong because it defines the probability measure of an outcome. The denominator takes into account all competing events, and the probability is affected by an increase in the assumed base rate values of these events even if the coefficients for exposures are kept constant. The odds ratio thus does not influence the probability of being positive.

These scenarios help to interpret results rather than increase causal inference. The participants, independent estimates of effects, or evidence on identity-related difficulties and resilience are presented in these scenarios. Confidence intervals have not been included as the required covariance matrix is unknown. In the interest of clear communication, it is reasonable to start by presenting the outcome, the comparison group, the relative estimate, and the absolute probability if it is real, estimated, or hypothetical.

Discussion

What the secondary analysis contributes

The published exposure association and its mathematical representation respond to different queries. The estimated values

indicate an association in terms of a model adjusted for the survey. The mathematical representation demonstrates how the estimated values are to be interpreted and why no conclusions about the absolute value of such an estimate can be made without further data. This is a minor contribution, but one that avoids an important misinterpretation of a significant relative estimate.

The meta-analytical framework provides additional information to that one survey. As Schmitt et al. state, negative effects were observed for a number of measures related to well-being along with variability by type of research design and measurement [2]. Their meta-analysis of experiments has separated global manipulations of discrimination from event-related attribution. Such differences imply that we should not assume that one incident, a chronic condition, and one question in a survey are all equivalent experiences. The current article maintains such difference instead of merging different effect estimates into one.

A useful role for identity and resilience

Identity-related distress is still an appropriate subject of study since discrimination can lead people to question their place within a group as well as the congruence between identities that people hold. Nevertheless, for any further research on the matter, it is important to differentiate distress related to commitments to one's identity from the feelings of sadness and/or anxiety in general. The scale by Berman et al. could be used as an initial basis for this purpose [6].

Resilience deserves equally close scrutiny. A negative effect would mean a reduced interaction between exposure and mediator in cases of greater resilience within the model. This does not mean that the training in resilience produced the improvement. Reduced symptoms could influence recovery potential through self-assessment, whereas supportive relationships and economic stability could influence both. In emphasizing ordinary adaptive systems, Masten draws attention to such resources. The question is which circumstances enable people to recover from adversity without further being discriminated against [8].

Implications for institutions and support

The response is one that balances considerations of the social context with avenues for assistance. For example, within an educational institution or work environment, this could include complaint processes, good communication, and avenues for assistance. The above are reasonable extensions of the model but not interventions that have been discussed in this paper, and their effectiveness can only be measured by their implementation and results, especially as far as those most at risk are concerned.

In research of Vietnam, initial interviews of participants might help understand how participants define issues of discrimination, identity, and recovery. Translations must aim at conveying meanings rather than replacing words. The NCHS cautioning about measurement reminds researchers that differences in answers to questionnaires can be due not only to different experiences but also different interpretations.

A design for testing the proposed mechanism

Longitudinal research would be a much better next step compared to building a more sophisticated cross-sectional analysis. At the beginning of the research, one can measure the levels of

discrimination, resilience, previous identity distress, symptoms, and other factors. Later waves would include measures of identity distress and symptoms change. The time between waves needs to be determined through the theoretical consideration of how these processes take place.

Table 3: Evidence needed for a prospective mechanism test

Construct	Timing and measurement priority	Interpretation check
Discrimination X	Baseline and follow-up; context and frequency	Establish exposure timing
Identity distress M	Baseline and later wave; adapted IDS	Separate identity concerns from symptoms
Resilience W	Baseline BRS plus support measures	Distinguish recovery from resources
Psychological distress Y	Baseline and final wave; validated scale	Adjust for prior symptoms
Confounders Z	Prespecify social and health conditions	Document causal assumptions

Source: Author design informed by Berman et al., Smith et al., Maxwell and Cole, and Hayes [6,7,11,12]. This table proposes future data collection; no listed measurement was newly administered.

The measures need to be tested out before recruiting participants, with coding scheme, reverse scoring, missing values, and outcome measures defined beforehand. Recruitment should focus on the interaction and mediation, rather than on the assumption that with a large enough sample, everything else is taken care of. The reporting process should include the dates of recruiting, criteria for eligibility, participant flow, valid observations for each model, exclusions, and uncertainties.

The main limitations of the current research are derived from the scope of the research. The selection of evidence was selective but not exhaustive; the use of aggregate coefficient is not helpful for the replication at the individual level; and the main numerical evidence used in the research is taken from only one survey conducted in the USA.

Conclusion

Findings from the existing literature suggest the link between experiences of discrimination and negative screening results in terms of mental wellbeing. The secondary analysis helps understand the structure of comparison and how the estimates become probability-based depending on the assumption about the structure of baseline groups. Identity distress and resilience are concepts that provide a good framework for future research, yet the exact functions of both constructs need to be studied

empirically. The next step would involve culturally-sensitive measurement, temporal data, and open reporting.

Data availability and ethics

All numerical inputs are found in the referenced tables and documentation; hypothesized distributions are described in Section 6. There was no access to participant data nor recruitment of participants. No claim is made here for any ethics approval, consent process, local survey, or independent estimate of mediation effects. This work may be replicated using a scientific calculator.

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