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Ethnic-Racial Stigma and Health Disparities: From Psychological Theory and Evidence to Public Policy Solutions

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The presence of diverse ethnic-racial groups in the United States today is a source of national pride. However, this cultural sentiment is overshadowed by the reality that stigmatized ethnic-racial groups carry a disproportionate burden of negative physical health outcomes. These systematic differences are referred to as health disparities. Although this phenomenon is fairly well documented, relatively little is understood about the social contexts and the psychological processes they activate that contribute to poor health. Equally important, to demonstrate the processes underlying health disparities does not single-handedly address the issue of social injustice in the health of disadvantaged people. Scientists must assume the burden of facilitating the translation of their laboratory and community-based research to public policy recommendations. This volume of the Journal of Social Issues brings together social, developmental, cognitive, and clinical psychological research on the physical health of ethnic-racial stigmatized individuals in the United States. Each contribution explicitly discusses the implications of research for public health policy.

The presence of diverse ethnic-racial groups in the United States today is one of the country's greatest assets and a source of national pride. However, the social benefits of this heterogeneous society are overshadowed by the reality that *stigmatized* ethnic-racial groups in the United States carry a disproportionate burden of negative physical health outcomes. For example, Hispanic and African-American individuals are more likely than White non-Hispanic

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individuals to be obese (Flegal, Carroll, Kit, & Ogden, 2012; Ogden, Carroll, Kit, & Flegal, 2012), which is a risk factor for a variety of chronic physical conditions including heart disease and diabetes (Beers, 2006; Malnick & Knobler, 2006; National Institutes of Health, 1998). Furthermore, Hispanic, African-American, and Native American individuals suffer disproportionately from higher rates of hypertension, sexually transmitted diseases, and some cancers (Clark et al., 1999; Cooper & David, 1986; Davalos, Hlaing, Kim, & de la Rosa, 2010; Dressler et al., 2005; CDC, 2014; Satcher, 2007). Altogether, these detrimental physical health conditions are predictors of poor mental health, low psychological well-being, and short life expectancy.

Differences in the burden of chronic physical health conditions experienced by socially disadvantaged groups are referred to as *health disparities* (Braveman et al., 2011). The issue of health disparities draws the attention of medical doctors and scientific researchers alike because they are not simply generic health differences, but systematic health inequities targeting groups that are afforded a relative low position in the United States social status hierarchy. This low status is a function of the historic and/or present unequal distribution of social, economic, and environmental resources. Poverty, inadequate health care, less education, greater residential segregation, and lack of access to healthy foods are among a host of resource-based variables that leave individuals vulnerable to poor physical health (Brondolo, Libretti, Rivera, & Walsemann, 2012; Chen, Cohen, & Miller, 2010; Dressler et al., 2005). One factor that is common among all of these resources is that they tend to be linked to an individual's ethnic-racial identity. Individuals who identify as African-Americans, Hispanic-Americans, and Native-Americans are less likely than White-Americans to possess these tangible resources that are necessary for good health.

Over the past decade in particular, a literature has emerged to suggest that intangible *psychological* factors can determine an individual's physical health, above and beyond the social, economic, and environmental resources listed above. Notwithstanding the contribution of this research, many unanswered theoretical and empirical questions remain about the particular role of psychology in the physical health of historically stigmatized ethnic-racial groups. What are the psychological processes by which one's ethnic-racial identity translates into poor physical health? How are these processes related to ethnic-racial biases and stigma? Do they operate at multiple stages, namely at the intraindividual, interpersonal, and intergroup levels? Moreover, how do these different levels interact with structural-based resources that are available (or not) to ethnic-racial stigmatized individuals? Finally, how do these phenomena maintain or broaden health disparities?

These questions are addressed in the present special volume of the *Journal of Social Issues (JSI)*. This *JSI* includes social, developmental, cognitive, and clinical psychological research that examines the physical health of ethnic-racial stigmatized individuals in the United States. It contributes to the literature by

testing new hypotheses that link contexts, and the processes they activate, with physical health outcomes. We focus on physical health because ill physical health conditions are predictors of poor mental health, low psychological well-being, and short life expectancy.

The issue of health disparities is about social justice because every person should have the right to enjoy optimal health regardless of their ethnic-racial group membership (Braveman et al., 2011). To empirically demonstrate the existence of health disparities and their underlying psychological processes does not single-handedly address the social justice issue of health disparities. The burden of translating laboratory and community-setting research to public policy recommendations lies on the shoulders of scientists. Therefore, and consistent with *JSI*'s mission as the flagship journal of the *Society for the Psychological Study of Social Issues*, the second goal of the present special issue is to discuss how the present health disparities research can inform public health policies.

Health Disparities as a Social Justice Issue

The United States has played a historical role in addressing social justice issues. *Brown vs. Board of Education*, the Civil Rights Act, and the American with Disabilities Act are examples in which social issues drove the United States to reject (or protect its citizens from) institutional forms of prejudice and discrimination. The present social issue is health disparities, and like the issues that came before it, this issue is about justice (Braveman et al., 2011). This is consistent with the values held by many contemporary societies including the United States. Such principles are driven by the belief that all human beings regardless of their demographic background should be afforded basic, equal, and fair rights (Jones, Hatch, & Troutman, 2009). One such right should be the opportunity to live a healthy life because it enables citizens to work, to participate in government and political activities, and to enjoy their personal lives including their close relationships. Physical health disparities are an injustice because it limits the ability of certain social groups—in this case, those that are the target of ethnic-racial stigma—to function in society. It is unfair that stigmatized individuals who suffer poor health should be further disadvantaged by their inability to enjoy a host of social benefits and privileges.

As scientific researchers who are driven by social justice issues, we present this *JSI* volume on ethnic-racial health disparities in the United States. This contribution is consistent with the current trends of public health research establishments in the United States (Woolf, Johnson, Fryer, Rust, & Satcher, 2004). For example, according to the *Healthy People 2010* program, the National Institutes of Health announced that a public health goal is to reduce health disparities. From epidemiology to clinical medicine, nearly every field of public health has attempted to examine and explain this phenomenon. In spite of these efforts, past research has

been unable to comprehensively account for the ethnic-racial differences in health outcomes (Dressler et al., 2005; Hummer, 1996; Kaufman et al., 1997). In a review of multiple theoretical models to explain the health disparities, Dressler and colleagues (Dressler et al., 2005) concluded that psychological (and sociological) theories offer the greatest promise to explain the gap.

The Current *Journal of Social Issues* Volume

The main hypothesis that drives the research in the current *JSI* issue is that ethnic-racial groups associated with stigma are the targets of physical health disparities. These group members are exposed to multiple sources of stereotypes, prejudice, and discrimination, which in turn trigger or maintain a host of social psychological processes that can increase their risk for detrimental health. The current *JSI* issue brings together psychologists, sociologists, and public health and public policy experts to address this hypothesis. They present new directions for answering pervasive and timely research questions that are at the intersection of stigma and health disparities. The present contributions use multiple methodologies—qualitative observational, correlational, experimental, and longitudinal designs—that are carried out in the laboratory and the field with diverse ethnic-racial groups. The present issue is organized into three sections that represent distinct sources (or levels) of stigma. It is proposed that exposure to stigma-based sources—intrapersonal, interpersonal/intergroup, and structural—all trigger related social psychological processes that can ultimately affect health.

Intrapersonal Factors

Part 1 of the special issue highlights intrapersonal factors as a source of physical health disparities. By intrapersonal factors, we mean the self and identity-based psychological processes that are mentally represented in memory. Given the pervasiveness of cultural stereotypes and prejudice, these attitudes can impact the development of the self-concept and identity of individuals. To the extent that individuals absorb ethnic-racial stigma into the self-concept and identity over time, this can have implications for health.

Oyserman, Smith, and Elmore begin this section with a review of their identity-based motivation theory and its application to health. They argue that social determinants operate at the micro-level to influence whether or not a health-based behavior or choice feels congruent with important identities and how such identity-congruence, in turn, influences which strategies are chosen and how difficulty is interpreted. Lack of choice and control make an interpretation of difficulty as meaning that effort is pointless and “not for people like me” (rather than important) more likely, reducing belief that one’s action and effort matter. These processes can ultimately affect the physical health of individuals.

Next, Rivera and Paredes draw upon social, personality, and health psychology to propose and test a self-stereotyping and psychological resource model of overweight and obesity. The model contends that self-stereotyping depletes psychological resources, namely self-esteem, that help to prevent overweight and obesity. They test their model with a sample of adult American Hispanics (and Whites). By empirically linking self-stereotyping and self-esteem (a psychological resource) with a strong physiological risk factor for morbidity and short life expectancy in stigmatized individuals, their research contributes to understanding ethnic-racial health disparities in the United States and beyond.

In the final contribution of this section, LaVeist, Thorpe, Pierre, Mance, and Williams argue that a vigilant coping style is an explanation for the observed inequalities in depression. Using a community-based adult sample, they demonstrate that while high rates of depression among Whites compared with Blacks are well documented, the degree of the differences appears to be greater than previously reported once vigilance is accounted for. Their findings suggest that were it not for the high prevalence of vigilant coping in Blacks, the well-documented Black advantage regarding depression compared to Whites would likely be an even greater advantage. They discuss how and why depression is important to understanding physical health disparities.

Interpersonal and Intergroup Factors

Part 2 of the special issue will present research on interpersonal and intergroup factors as a source of physical health disparities. We define interpersonal and intergroup factors as the perception of stigma in the daily or long-term interactions of ethnic-racial individuals with other individuals or groups. Here, the interaction context is paramount given that situational factors are powerful determinants of perceptions of the self and others. Page-Gould, Mendoza-Denton, and Mendes begin this section by examining the interplay of psychosocial risk and protective factors in daily experiences of health. Two empirical studies suggest that the experiences of intergroup stress can spill over into everyday life in the absence of positive contact, but cross-race friendships may be a resource that mitigates the expression of interracial stress. The implications of this work for physical health are important given that stress is an antecedent to ill health.

Next, Sanders-Phillips and her colleagues posit that racial discrimination and social inequality are related to higher levels of psychological distress that may contribute to health disparities among youth, including problems with substance use. Consistent with this notion, their data with a sample of African American youth show that greater perceived racial discrimination is linked to more depressive symptoms, which, in turn, are associated with greater past month alcohol and marijuana use. They discuss the implications of these findings for future research on racial discrimination, drug use, and psychological functioning in African

American youth. Moreover, they emphasize the need for prevention and intervention programs for African-American youth that acknowledge and address the potential effects of perceptions of racial discrimination on physical health.

Following on the heels of Sanders-Phillip et al., Beatty, Matthews, Bromberger, and Brown end this section with a discussion on everyday discrimination and how it has emerged as a negative predictor of psychological and physical health outcomes among racial minorities and recently among nonminority racial groups. Then, they present a 7-year longitudinal study with a racially diverse sample of adult American women that examines the relation of everyday discrimination to C-reactive protein, a marker of inflammation and risk factor for future cardiovascular disease. Their results demonstrate that greater perceived discrimination increases inflammation over time in racial minority and nonracial minority women. Their findings have important implications for the interpersonal sources of social stress for long-term physical health via their impact on intermediary biological pathways, specifically inflammation. They argue that a greater emphasis on such linkages is warranted as researchers work toward ameliorating health disparities exacerbated by individual-level factors.

Structural Factors

The final section of this special issue turns to research on structural factors that can serve as a source for physical health disparities. By structural factors, we refer to the social institutions, communities, and neighborhoods in which stigmatized ethnic-racial individuals live. Elements of stigma are reflected in these structural factors, and thus can shape the psychology and health of individuals. In line with this idea, Brady, Winston, and Gockley start this section with a comprehensive review of the literature on externalizing behavior among disadvantaged African-American youth and how it may be a response to structurally embedded stressors and inequities within the home, school, and community. They argue that inadequate resources may lead professionals to focus solely on children's behavior, without also addressing underlying affective symptoms, such as depression, and related attitudes, such as low academic investment. Youth assets and resources for resilience fostered by parents, teachers, and community members may protect youth from negative outcomes. They review the relevant empirical literature in support of this conceptual model, present qualitative data from their formative work, and outline policies and practices that could be implemented by health professionals, schools, and the juvenile justice system to better address health among disadvantaged youth.

Next, Haile, Rowell-Cunsolo, Parker, Meyer, Padilla, and Hansen argue that the research on sexual stigma management techniques expected to decrease HIV risk among Black men who have sex with men (MSM) have yielded some counterintuitive findings. Moreover, they contend that some of this research tends to

assume that Black and White MSM experience the gay community in identical ways. Borrowing from key tenets of intersectionality theory, they examine whether there are substantive differences in the ways in which Black and White MSM experience the gay community. Their findings suggest that Black MSM may routinely encounter racism, and may experience their engagement with the gay community as less positive than their White counterparts. These data contextualize existing research, and suggest that racism may shape the extent to which affiliation with the gay community serves as a protective factor against HIV for Black MSM.

Finally, Rooks, Xu, and Williams examine the relationship between neighborhood environment and obesity. Using rigorous statistical methods, they demonstrate that a host of neighborhood factors (e.g., disliking neighborhood, social participation) are linked to obesity. Moreover, qualitative results partially corroborate their quantitative results that low socioeconomic status neighborhood adults are more likely to experience neighborhood disorders and safety issues. Their findings highlight the importance of examining objective and subjective neighborhood environments related to central obesity, and their underlying psychological processes. They end their contribution with suggesting specific health targets for community prevention programs.

Conclusion

Smedley and Myers provide a brief review of the original research in this special issue and argue that a comprehensive model of the lived experience of race is needed that considers the cumulative, interactive effects of the different forms of racism and related risk factors on health as they operate over the lifespan. They posit that such a model must facilitate an intersectional analysis to better understand the interaction of race with gender, socioeconomic status, sexual orientation, geography, and other factors, and should also consider the negative consequences of racism for Whites. They end their discussion with an analysis of how the present health disparities research may contribute to building public health policy.

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