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CHAPTER FIVE

THE INTERSECTION OF RACE, GENDER, AND SES

Health Paradoxes

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Race/ethnicity, gender, and socioeconomic position are social status categories that predict the differential distribution of disease, disability, and death in society (Krieger and others, 1993). Prior research has attended to variations in health by each of these categories, considered separately, or by two of them in combination. But health researchers seldom consider how health is distributed when these three social status categories are considered simultaneously. In this chapter, we focus on social disparities in health and underscore the complex interactions among these social categories. We begin by briefly documenting that race, gender, and socioeconomic status (SES) each matters in predicting variations in health. We then consider the complex patterns that emerge when we consider race/ethnicity, SES, and gender together. In highlighting some of the paradoxes in the health literature, we draw particular attention to members of the black middle class. We conclude with directions for future research, describing the ways in which intersectionality theory (Mullings and Wali, 2001; Weber

and Parra-Medina, 2003) can be used to further our understanding of persistent health inequalities.

RACIAL DIFFERENCES IN HEALTH

The United States routinely reports health statistics by race. However, members of the major racial/ethnic groups are divided over preferred terminology. For example, a large national study found that 62 percent of whites prefer "white" (17 percent prefer "Caucasian"), 58 percent of Hispanics prefer "Hispanic" (12 percent prefer "Latino"), 44 percent of blacks prefer "black" (28 percent prefer "African American"), and 50 percent of American Indians prefer "American Indian" (37 percent prefer "Native American") (Tucker and others, 1996). In an effort to recognize individual dignity, we use the preferred terms for each group interchangeably.

Table 5.1 illustrates the magnitude and pervasiveness of racial disparities in health across different diseases by considering the top fifteen causes of death in the United States (Hoyert and others, 2001). These data are officially reported only for blacks and whites. The first column shows the age-adjusted rates for white men and women, and the second presents the black-white ratios for each condition for men and women. (The last two columns focus on gender differences that we will return to shortly.) A ratio greater than 1.0 means that blacks have a higher mortality rate compared to whites. If the ratio is less than 1.0, then the mortality rate is higher for whites.

As shown in Table 5.1, heart disease, cancer, and stroke are the three leading causes of death in America. Compared to whites, black men and women have mortality rates that are at least 20 percent higher for each of these outcomes. A similar pattern can be seen for almost all diseases. Black men have higher death rates than whites for eleven of the fifteen leading causes of death, and black women have higher rates than their white counterparts for twelve of the fifteen leading killers. Compared to their white counterparts, the rates for black men and women are at least twice as high for five causes of death (diabetes, nephritis, septicemia, hypertension, and homicide). Black men and women have lower rates than their white peers for pulmonary disease, suicide, and Alzheimer's disease.

TABLE 5.1. AGE-ADJUSTED DEATH RATES FOR WHITE MEN AND WOMEN FOR THE FIFTEEN LEADING CAUSES OF DEATH AND THE RACIAL AND GENDER DIFFERENCES IN THE UNITED STATES, 1999

	Whites		Racial Differences, Black/White Ratios		Gender Differences, Male/Female Ratios	
Cause of Death	*Men*	*Women*	*Men*	*Women*	*Blacks*	*Whites*
1. Heart disease	324.7	215.5	1.23	1.35	1.37	1.51
2. Cancer	246.5	168.6	1.38	1.19	1.70	1.46
3. Cerebrovascular disease (stroke)	60.0	58.7	1.46	1.33	1.12	1.02
4. Pulmonary disease	59.6	40.2	0.84	0.59	2.10	1.48
5. Accidents	50.0	22.7	1.24	1.04	2.62	2.20
6. Diabetes mellitus	25.8	20.5	1.88	2.46	0.96	1.26
7. Pneumonia and influenza	27.7	20.8	1.17	1.02	1.52	1.33
8. Alzheimer's disease	14.7	18.4	0.66	0.66	0.80	0.80
9. Nephritis	14.8	9.7	2.22	2.68	1.27	1.53
10. Septicemia	11.0	9.4	2.56	2.39	1.25	1.17
11. Suicide	19.4	4.4	0.54	0.36	6.50	4.41
12. Liver disease and cirrhosis	13.7	6.1	1.10	1.05	2.36	2.25
13. Hypertension	5.1	5.3	3.31	2.91	1.10	0.96
14. Homicide	5.5	2.2	6.35	3.41	4.65	2.50
15. Aortic aneurysm and dissection	9.0	3.8	0.70	1.05	1.58	2.37

Source: National Vital Statistics Reports (2001), per 100,000 population.

MAKING SENSE OF RACIAL DISPARITIES IN HEALTH

The first U.S. Census, conducted in 1790, enumerated whites, blacks (as three-fifths of a person), and civilized Indians (those who paid taxes). This was done to comply with Article One of the U.S. Constitution. Over time, racial categories have been added and altered to keep track of new immigrants. The U.S. racial groupings do not capture race in a biological sense but are socially constructed (American Association of Physical Anthropology, 1996; Williams, 1997). Historically and currently, these social categories have reflected differential access to power and resources in society.

There are large racial differences in SES. For example, compared to whites, African Americans, Hispanics, American Indians, and some Asian groups have higher rates of poverty and unemployment and lower levels of median family income, educational attainment, and wealth (Williams, forthcoming). Adjusting racial differences for indicators of SES typically reduces the size of these differences substantially but does not completely eliminate them. That is, there appears to be an additional effect of racial/ethnic status even after SES is controlled. There is growing recognition among health researchers that there may be other factors shaping racial differences in health in addition to SES (LaVeist, 2002).

GENDER DIFFERENCES IN HEALTH

Like race/ethnicity, gender is a highly visible characteristic. Similar to race/ethnicity, SES is patterned by gender, with men having higher levels of SES than women (Andes, 1992; Grodsky and Pager, 2001; Tienda and Lii, 1987). Accordingly, we might have expected that women, an economically disadvantaged group compared to men, would fare worse than men in terms of health. The last two columns of Table 5.1 show, surprisingly, that across a broad range of disease conditions, men have higher death rates than women. Ratios greater than 1.0 reflect higher mortality rates for men compared to women, while ratios less than 1.0 mean that women have higher death rates than men. For both African Americans and whites, the two racial groups for which these data are available,

men show higher death rates than women for thirteen of the fifteen leading causes of death. Moreover, men have death rates that are at least twice as high as those of women for accidents, suicide, cirrhosis of the liver, and homicide.

Making these gender comparisons in health is in no way intended to deny or minimize the historic and ongoing systems of exploitation that have adversely affected women in general, and women of color in particular, in the United States (Krieger and others, 1993; Sanchez-Hucles, 1997) or the pressing need to reduce health and other inequalities for women. Women continue to be disadvantaged on multiple social dimensions, and women of color continue to experience disparities for many indicators of health (Lillie-Blanton, Martinez, Taylor, and Robinson, 1993; Williams, 2002). Nonetheless, gender disparities in health dramatically illustrate that factors other than economic status can powerfully shape the distribution of health.

MAKING SENSE OF GENDER DIFFERENCES IN HEALTH

In most Western societies, men claim more power, prestige, and property than women. In general, these resources are linked to positive health outcomes (Reynolds and Ross, 1998). However, gender as a socially constructed category often produces unexpected health risks due to social roles and expectations that can be linked to gender role occupancy. For example, deeply held cultural views about maleness and masculinity can shape men's beliefs in ways that can lead to increased health risks for some men. Research indicates that beliefs about masculinity and manhood that are deeply rooted in culture and supported by social institutions play a role in shaping the behavioral patterns of men in ways that have adverse consequences for health (Williams, 2003). Compared to women, for example, men are more likely to smoke cigarettes and twice as likely to consume five or more drinks of alcohol in a single day (Eberhardt and others, 2001). Importantly, engaging in high-risk behaviors, refraining from engaging in health-promoting activities, and claiming that risky behaviors such as alcohol drinking will not negatively affect performance (for example, driving) are often demonstrations of the norms of masculinity in the larger culture and

strategies that men use to construct and reinforce their masculinity (Courtenay, 2000).

Health care institutions and practitioners also respond differently to men and women. For example, in the emergency room, men with depressive symptoms (inconsistent with gender norms) are more likely to be hospitalized than women with the same symptoms, and women with antisocial behavior or substance use problems are more likely to be hospitalized than men with those presenting symptoms (Rosenfield, 1999). There are also large gender differences in the typical medical encounter. Compared to women, health care providers spend less time with men; provide them with fewer services, less health information, and less advice; and are less likely to talk about the need to change behaviors to improve health (Courtenay, 2000). Men also tend to have lower levels of adherence to medical regimens than women (Rose, Kim, Dennison, and Hill, 2000).

INTERSECTIONS OF RACE/ETHNICITY, SES, AND GENDER

Socioeconomic status is a term conventionally used to refer to an individual's or group's location in the structure of society, which determines differential access to power, privilege, and desirable resources. It is typically assessed by education, income, or occupational status. SES is one of the strongest known determinants of variations in health (Adler and others, 1993; Williams and Collins, 1995). Table 5.2 illustrates the power of SES by presenting the percentage of persons reporting fair or poor health by income for black, white, and Hispanic men and women in the United States. These data reveal that there are large differences in health by income for blacks, whites, and Hispanics. Moreover, while the largest effects of SES are at the lowest categories of income, there is a stepwise progression of risk in the relationship between SES and health status, with each higher level of income associated with better health status for both men and women in each racial group. At the same time, some racial/ethnic and gender differences remain evident when groups are compared at similar levels of SES.

Clearly, the associations among race/ethnicity, gender, SES, and health are complex. National data reveal that the patterns

TABLE 5.2. PERCENTAGE OF MEN AND WOMEN REPORTING FAIR OR POOR HEALTH BY RACE AND INCOME, 1995

	Men			Women		
Income	*White*	*Black*	*Hispanic*	*White*	*Black*	*Hispanic*
Poor	30.5	37.4	26.9	30.2	38.2	30.4
Near poor	21.3	22.6	19.2	17.9	26.1	24.3
Middle income	9.3	13.1	11.9	9.2	14.6	13.5
High income	4.2	4.8	5.8	9.2	7.0	

Note: Poor = below federal poverty level; near poor = less than twice the poverty level; middle income = more than twice poverty level but less than $50,000; high income = $50,000 or more.

Source: Pamuk and others (1998).

appear to vary depending on the specific group and specific indicator of health status under consideration (Pamuk and others, 1998). For example, it is frequently observed, for multiple indicators of health status, that differences between socioeconomic categories within each racial group are larger than differences between races (Navarro, 1989; Williams, 1999). Moreover, numerous paradoxes are evident when race, ethnicity, gender, and SES are simultaneously considered. Observed patterns of association among race/ethnicity, gender, and SES may reflect complex interactions among these social factors and the long-term effects of exposure to social and economic adversity during childhood, cultural practices and beliefs, nativity differences, migration history, acculturation processes, individual and institutional discrimination, and the noncomparability of SES indicators across race/ethnic populations (Kaufman, Cooper, and McGee, 1997; Williams, 1997).

Elucidating all of these processes is beyond the scope of this chapter. We illustrate the kind of research that is needed by focusing in detail on a largely unrecognized and high-risk pattern in the minority health literature. While the "epidemiological paradox" surrounding the health achievements of some Latino and Asian groups (in the light of their socioeconomic, migration, or discriminatory histories) has been given much attention (Franzini, Ribble, and Keddie, 2001), another is also evident. We refer to this paradox as the

intersectionality paradox because it captures the recurring dilemma of certain health problems faced at the intersection of race, SES, and gender by members of the black middle class. In some instances, African American women are at risk, and in other instances their male counterparts seem to be particularly vulnerable. We now turn our attention to this oft-ignored segment of the population.

THE INTERSECTIONALITY PARADOX: THE BLACK MIDDLE CLASS

The definition and composition of the black middle class has changed over time. DuBois (1996) initially characterized it as consisting of married households where the husband engaged in a professional job and the unemployed wife maintained the home. Frazier (1997), however, identified the black middle class only in terms of personal occupation, including professional and technical workers; managers, officials, and proprietors; clerical and sales workers; artisans; and supervisors. More recently, Wilson (1987) defined the black middle class as those who occupy white-collar jobs (professional, managerial, and clerical workers). Oliver and Shapiro (1995) augmented Wilson's definition, identifying the black middle class along the dimensions of education (college educated), occupation (white-collar workers), household income (ranging between $25,000 and $50,000), and wealth (for example, home ownership). And still others focus specifically on white-collar workers who work in or live in predominantly white settings (Hochschild, 1993). In many communities, prestige is afforded to those who have symbolic power beyond objective characteristics such as income. Political, religious, and military officials such as civil servants or clergy, for example, are included in this category (Cayton and Mitchell, 1970). These individuals have played a long-standing role in serving the psychological needs of the black community, primarily through affirmation of black identity.

The black middle class emerged during the pre-Reconstruction era (Cayton and Mitchell, 1970). Although this group was relatively small, there is some evidence that following Reconstruction, many cities had an active black professional class (Gatewood, 2000). The amount of political power afforded this group was very restricted, but they furnished the growing black working class with professional

and business services. During the industrial era, the black middle class developed further. Descendants of the older bourgeoisie were soon joined by the new industrial class, who took advantage of the educational and employment opportunities afforded them during the early decades of the twentieth century (Gatewood, 2000). The mass migration from southern farms to northern cities between 1910 and 1950 and the increase in the number of black businesses during that time helped solidify the existence of the black middle class (Franklin, 1974). It was during this era that the black middle class expanded to include church, civic, political, and labor group leaders (Cayton and Mitchell, 1970; Gatewood, 2000).

The 1960s and 1970s witnessed a growing number of African Americans entering a wide range of occupations. Blacks became more visible as chief executives of many cities, especially as city mayors in the late 1960s (Biles, 1992). Following government intervention policies, minority representation in state and bureaucratic jobs increased substantially (Collins, 1993). Some minorities were able to take full advantage of affirmative action efforts that helped to increase black representation in professional and managerial positions (Allen and Farley, 1986), resulting in increasing class differentiation (Wilson, 1987).

A constant feature of black life in America that has transcended the changing occupational opportunity structure is residential segregation (Alba, Logan, and Stults, 2000; Massey and Denton, 1993). The hypersegregation of middle-class African Americans significantly reduces the returns typically associated with home ownership, limits educational opportunities for African American children, and is related to racial disparities in health (Williams and Collins, 2001). Research further indicates that successful blacks receive fewer returns on their education and possess much less wealth than their white counterparts (Oliver and Shapiro, 1995). These statistics shed light on the racialized structure underlying American meritocracy and the tenuous position of the black middle class. Furthermore, they allude to a set of race-related stressors that all black Americans experience.

In the following section, we argue that at the intersection of race, class, and gender, new experiences emerge that undermine the benefits of being a member of the black middle class. In fact, Willie (1979) forewarns of this dilemma when he describes how

the black middle class "who, because of school desegregation and affirmative action and other integration programs, are coming into direct contact with whites for the first time for extended interaction" (p. 157). Operating within the context of the historical legacy of racial discrimination, African Americans must combat a range of negative stereotypes that infiltrate their social interactions (Benjamin, 1991; Cose, 1993; Greenhaus, Parasuraman, and Wormley, 1990; Williams, Neighbors, and Jackson, 2003). The "race work" that has to be done is even more extensive among those who reside in predominantly white neighborhoods, which helps explain why many middle-class African Americans return to predominantly black neighborhoods (Taylor, 2002). Even this strategy, however, may have negative repercussions, as we discuss later.

The long-standing body of social science research on racial stereotypes has shown that whites' attitudes toward African Americans have changed over the past four decades (Schuman, Steeh, and Bobo, 1985). Other work indicates the emergence of a subtler form of racism, with many whites believing that African Americans do not embrace the American values of hard work, self-reliance, and self-discipline (Kinder and Sears, 1981). These stereotypes are also gendered. For example, black women are often depicted as sexually promiscuous, single mothers, and welfare recipients (Collins, 1990; Guy-Sheftall, 1990; Marshall, 1996; Mullings, 1994). Black men are perceived as dishonest, dangerous, lazy, and involved with drugs (Hacker, 1995; Majors and Billson, 1992). These stereotypes confront African Americans every day regardless of their social class standing and have significant implications for many health outcomes. We focus on the case of infant mortality rates among women and homicide rates among men. These indicators of premature death reflect a paradox at the intersection of race, class, and gender that draws our attention to the unique status of the black middle class.

MIDDLE-CLASS BLACK WOMEN

Affirmative action programs have provided many opportunities for qualified women to gain access to professional fields they would otherwise have been denied. For example, IBM's affirmative action program resulted in an increase in the proportion of female executives from 1.8 percent in 1980 to 13.3 percent in 1994 (Pathways and Progress, 1996). Similarly, the total number of African American women on public Fortune 1000 corporate boards increased from 223 in 1992 to 342 by 1996 (Norment, 2002). Nonetheless, many professional occupations remain male-dominated fields. In 2002, for example, women were only 10.8 percent of all engineers, 30.7 percent of all doctors, and 29.2 percent of all lawyers (U.S. Department of Labor, 2003).

Among middle-class black women who are employed in managerial and professional occupations, the majority work in industries dominated by government and nonprofit employment: health, social services, and education (Council of Economic Advisers, 1998). Black women are the most underrepresented subgroup in private-sector professional jobs. As such, African American women are likely to be a minority in professional workplace settings.

Work groups have been characterized as uniform (that is, homogeneous), skewed, tilted, or balanced in proportional representation (Kanter, 1977). Tokens—minority group members who work in skewed work settings—are identified by ascribed characteristics (gender, race, ethnicity), attached to which are sets of assumptions about the culture, competence, and behavior of the status occupant. Kanter (1977) argues that women who occupy token positions in their organizational settings experience performance pressures (added pressure to perform well), boundary heightening (feeling socially isolated), and role entrapment (typecasting by dominants). Thus, black women must not only contend with the cultural stereotypes of "black" and "female" but must also combat stereotypes of "black women" as matriarch. Some argue that "once in the labor market . . . all women are treated as mothers—former, actual, or potential" (Sokoloff, 1980, p. 216; Kennelly, 1999), but black women are also accused of spending "too much time away from home" working (Collins, 1990, p. 72).

Other evidence suggests that African American women face additional hostility in corporate workplaces from African American men, with whom they are often competing (Bell and Nkomo, 2001). One of the ways in which workers confront work problems is by seeking social support (Loscocco and Spitze, 1990). In a sample of black professionals, however, Jackson and Saunders (forthcoming) find that 71 percent of men but only 59 percent of

women turn to family members or colleagues for advice about dealing with work problems. These professional black women are much more likely than their male peers to try to handle work problems on their own. Furthermore, Bailey, Wolfe, and Wolfe (1996) report that the support of supervisors and coworkers does not reduce levels of depression among the black professional women in their study. Thus, professional African American women may actually be disadvantaged in regard to the important resource of social support (Gray and Keith, 2003).

While it is useful to examine the relationship between individual social characteristics and health outcomes, we also believe that differences in social class intersect with race and gender to account for the paradox facing some African American women (Martin, 1994). African American middle-class women are disadvantaged on a variety of health outcomes. In national data, the highest SES group of African American women has equivalent or higher rates of infant mortality, low birth weight, hypertension, and excess weight than the lowest SES group of white women (Pamuk and others, 1998). Of these health outcomes, we discuss infant mortality, an often-used indicator of the general well-being of a population. African American women are more than twice as likely to suffer the loss of an infant than their non-Hispanic white counterparts. Moreover, the black-white differential in infant mortality becomes larger as maternal education increases.

As shown in Table 5.3, infant mortality rates are strongly patterned by educational level for both black and white women, with increasing years of education predicting lower levels of infant mortality. Among whites, women who did not complete high school have an infant mortality rate that is 2.4 times the rate of women who graduated from college. Similarly, among African Americans, women with less than twelve years of education have an infant mortality rate that is 1.5 times as high as that of college graduates.

Racial differences at every level of education are striking. Infants born to black women in the lowest education category are 1.7 times as likely to die before their first birthday as are infants born to similarly educated white females. At every other level of education, the black-white ratio is greater than two. In fact, there is an even greater gap between the infant mortality rates of non-Hispanic white and African American mothers who have sixteen

TABLE 5.3. INFANT MORTALITY RATES, MOTHERS AGED TWENTY YEARS AND OLDER, 1995

Maternal Education	*White*	*Black*	*Black-to-White Ratio*
Less than 12 years	9.9	17.3	1.74
12 years	6.5	14.8	2.28
13–15 years	5.1	12.3	2.41
16 years or more	4.2	11.4	2.71

Source: Pamuk and others (1998).

or more years of schooling than between those with less than twelve years of education (Pamuk and others, 1998).

The black-white difference in infant mortality has been linked to a complex web of biological (for example, genetic heritage), socioeconomic (for example, access to neonatal technology), and behavioral factors (for example, diet). A more recent emphasis has been placed on the role played by psychosocial stressors (James, 1993; McLean, Hatfield-Timajchy, Wingo, and Floyd, 1993; Mullings and Wali, 2001; Rini, Wadhwa, and Sandman, 1999) and a lack of support systems available to middle-class African American women (Hogan and others, 2000). These concerns are crystallized when we consider how race/ethnicity, gender, and SES converge to create the paradox facing those interested in the alarming rate of black infant mortality: highly educated African American women have a higher infant mortality rate than less educated non-Hispanic white women.

Intersectionality theory provides a useful lens through which such health disparities may be more clearly viewed because of the attention paid to resources that are available to actors as a result of the amount of power afforded to a group (Weber and Parra-Medina, 2003). In terms of infant mortality, we highlight the fact that African American professional women must navigate within the confines of organizations that are structured by both racial and gender divisions. Patterns of dominance and deference also intersect with these master status characteristics. More specifically, we argue that middle-class status is experienced in a less profound and beneficial way for these women than for any other group because

they are not in a position to mobilize all of the resources that should be at their disposal given their social class standing.

First, African American women earn lower wages at each education level and realize less of a payoff for additional education than otherwise similar nonblack women and especially men (Bradbury, 2002). Income provides the means to pay the bills, feed the children, and obtain shelter and medical care for members of the household. It is the most soluble dimension of social class position. When it is scarce, people become vulnerable to negative events and psychological distress (Thoits, 1995).

The figures in Table 5.4 represent the median family incomes reported in 1996. The data clearly indicate that median family income rises with each higher level of education regardless of gender and race/ethnicity. Several patterns are noteworthy. First, at all levels of education, black and Hispanic men and women tend to reside in households with lower levels of income than their white counterparts. Other data reveal that individual earnings at every level of education are markedly greater for whites compared to their black and Hispanic peers, but only for men (Williams and Collins, 1995). However, at the level of household economic resources, both black and Hispanic men and women are disadvantaged. The lower levels of household income for black than for Hispanic women reflect the reality that African American women are more likely than their Latino peers to be the primary wage earner in the household. At every level of education, Asian households report the highest levels of income. However, whites have higher per capita income than Asians, and the higher median income for Asian households reflects the fact that they are more likely than white households to have multiple wage earners (DeNavas-Walt and Cleveland, 2002).

Women of all racial/ethnic groups earn considerably less income at every educational level compared to men. A striking pattern in Table 5.4 is the female disadvantage in household economic resources for many U.S. women at every level of education. This pattern is largest and most pronounced for African American women and persists for them at every level of education.

Second, the benefits of receiving social support may not outweigh the costs of providing social support. Social support is generally given or received, but upwardly mobile African American

TABLE 5.4. MEDIAN FAMILY INCOME AMONG ADULTS TWENTY-FIVE YEARS OF AGE AND OVER, 1996

Sex, Race, and Hispanic Origin	Education			
	Less Than 12 Years	*12 Years*	*13–15 Years*	*16 or More Years*
Men				
White, non-Hispanic	$25,274	$41,200	$49,000	$67,952
Asian or Pacific Islander	$34,146	$44,612	$55,392	$68,327
Black, non-Hispanic	$19,957	$36,020	$42,500	$54,500
Hispanic	$24,000	$35,000	$43,734	$58,079
Women				
White, non-Hispanic	$18,471	$37,000	$45,510	$64,007
Asian or Pacific Islander	$37,420	$42,658	$57,300	$65,675
Black, non-Hispanic	$13,100	$23,556	$33,162	$47,100
Hispanic	$19,310	$32,000	$38,000	$56,765

Source: Pamuk and others (1998).

women are twice as likely as their white counterparts to give support resources to family and friends than they are to receive support from these sources (Higganbotham and Weber, 1992). As a result, African American women may feel overwhelmed by support requests. Perceived social support is associated with high depressive symptoms among black middle-class women (Warren, 1997).

Marriage is an important venue for social support and predictor of health across racial groups in the United States. On average, married persons live longer and enjoy better health than those who are nonmarried, especially the formerly married. Differential rates of marriage across race may also be a contributor to the elevated health risks of African American women. Blacks have lower rates of marriage and higher rates of marital dissolution than whites (Tucker, 2000). These differences appear to be driven not by cultural preferences but by the social and economic conditions that African Americans face. For both blacks and whites in the United States, rates of marriage are positively related to average

male earnings and inversely to male unemployment rates (Bishop, 1980). Thus, African American women face real challenges finding mates given the high rates of unemployment, underemployment, and incarceration among black men.

National data reveal that men have higher levels of college completion than women. This pattern does not hold true for the black population. Accordingly, many professional African American women marry mates who are lower in educational and occupational status than themselves. Thus, on average, white women receive larger economic benefits from marriage than black women. Research needs to systematically assess the extent to which the actual costs and benefits of marriage may vary across race, class, and gender. Given their hypersegregation and low marriage rates, black professional women may lack the network ties that would enable them to compensate for the support resources they give to others. This added burden may very well be linked to poor health habits, less attention to personal health and well-being, and subsequent physical health problems, including those linked to birth outcomes.

MIDDLE-CLASS BLACK MEN

Middle-class African American men may be an understudied group of vulnerable men. Middle-class status does not provide African American men with the normally expected reductions for at least some health risks. For both African Americans and whites, rates of suicide are much higher for males than females. Over the past two decades, the suicide rate has remained relatively stable for white men but has increased for young black men (McLoyd and Lozoff, 2001). Several studies have found that while SES is inversely related to the suicide rate for whites, it is positively related to the suicide rate for African American males (Williams, 2003).

Three factors may contribute to higher level of stress and subsequent adverse consequences on middle-class African American men. First, the personal experience of discrimination based on race is an added burden that all African Americans face but may seem especially egregious to the black middle class because they feel that their socioeconomic success has earned them the right not to have to deal with such indignities. Again, a growing body of

research reveals that these perceptions of discrimination are stressors that can adversely affect physical and mental health (Jackson, Thoits, and Taylor, 1995; Krieger, 1999; Williams, Neighbors, and Jackson, 2003). There is a positive association between perceptions of discrimination and education among African Americans, and African American men report higher levels of chronic and acute discrimination than African American women (Forman, Williams, and Jackson, 1997).

Second, middle-class status is often recent, tenuous, and marginal for African Americans (Collins, 1993, 1997). College-educated African Americans are more likely than whites to experience unemployment (Wilhelm, 1987; Council of Economic Advisers 1998). Middle-class African Americans have markedly lower levels of wealth than whites of similar income (Davern and Fisher, 1995). They are also less likely than whites of similar income to translate their higher economic status into desirable housing and neighborhood conditions (Alba, Logan, and Stults, 2000).

Third, unfulfilled expectations because black men's investment in education has not provided comparable gains in income may be a unique and additional source of stress and alienation for African American men (Anderson, 1999). Educational attainment is an important indicator of lifetime economic opportunities, with higher levels of education being associated with higher wages, higher family income, and lower unemployment (Council of Economic Advisers, 1998). Over the past several decades, the gap has narrowed between African American males and other Americans in the number of years of formal education. Although racial disparities in education still exist, there is only a narrow gap in educational attainment between African American and white men aged twenty-five to twenty-nine (Council of Economic Advisers, 1998). However, for African American men, higher education has not translated into additional income. At every level of education, minority men earn lower levels of income than whites, and differences in pay between whites on the one hand and African Americans and Hispanics on the other are larger for men than for women (Council of Economic Advisers, 1998). One of the ways in which these problems may become manifest is in homicide rates.

Table 5.5 presents the homicide rates for men and women stratified by race and education. Regardless of racial status, the homicide rate varies markedly by SES. Among adults aged twenty-five to forty-four, homicide rates are strongly patterned by education levels for both blacks and whites, males and females (Pamuk and others, 1998). The homicide rate for black males who have not completed high school is more than five times that of black males with some college education or more. Similarly, there is a ninefold difference for black females and a sixfold difference for white females by level of education. At the same time, elevated rates of homicide for African Americans compared with whites exist at all levels of individual SES, with striking racial differences in homicide even when blacks and whites are compared at similar levels of education. For example, the homicide death rate for African American men with some college education is eleven times that of their similarly educated white peers. Strikingly, the homicide rate of black males in the highest education category exceeds that of white males in the lowest education group!

Residential segregation plays a major role in racial differences in homicide. Sampson's empirical research (1987) has traced the pathways that lead from residential segregation to elevated homicide risk for African American males. Segregation creates restricted educational and employment opportunities for many poor black communities. These conditions produce a diminished pool of employable or stably employed males.

TABLE 5.5. HOMICIDE RATES AMONG ADULTS TWENTY-FIVE TO FORTY-FOUR YEARS OF AGE, BY EDUCATIONAL ATTAINMENT, SEX, AND RACE, 1994–1995

	Males		Females	
Education (in years)	*White*	*Black*	*White*	*Black*
All (data for 1995)	11.0	77.9	3.3	17.4
Less than 12 years	25.0	163.3	10.2	38.2
12 years	10.6	110.7	4.7	22.0
13 or more years	2.9	32.4	1.6	9.4

Source: Pamuk and others (1998).

Lack of access to jobs creates high rates of male unemployment and underemployment, which in turn generates the high rates of out-of-wedlock births, female-headed households, the "feminization of poverty," and the extreme concentration of poverty in many black communities (Testa, Astone, Krogh, and Neckerman, 1993; Wilson, 1996). For both blacks and whites, male employment and earnings are positively related to entry into marriage, and economic instability is positively related to marital dissolution (Bishop, 1980; Wilson, 1996). Single-parent households are associated with lower levels of social control and supervision of young males, which lead to elevated rates of violent behavior among males (Sampson, 1987). Research documents that the neighborhood characteristics associated with residential segregation and household characteristics that result from the concentration of poverty account for racial differences in violent behavior and homicide (Sampson and Wilson, 1995).

Importantly, these family and neighborhood factors that predict increased risk of violent crime and homicide are identical for blacks and whites (Sampson, 1987). However, because of residential segregation, blacks are more likely to be exposed to these conditions than members of other racial groups. For example, in not even one of the 171 largest cities in the United States do whites live in comparable conditions to blacks in terms of poverty rates or rates of single-parent households. Sampson and Wilson (1995, p. 41) concluded that "the sources of violent crime appear to be remarkably invariant across race and rooted instead in the structural differences among communities, cities, and states in economic and family organization." Thus, the elevated rates of violent crime and homicide for African Americans are determined by their greater exposure to poverty and lack of jobs created by segregation and by the family structures and processes that result from these economic conditions.

This leaves unanswered why middle-class black males have such an elevated risk of homicide. Again, segregation appears to provide the answer. African Americans in general, and middle-class African Americans in particular, are unique in the United States in terms of the experience of high levels of segregation (Massey, 2004). All other racial/ethnic minority groups in the United States have markedly lower levels of segregation than African Americans (Massey, 2004). Moreover, while the level of residential segregation

varies by income for Latinos and Asians, the segregation of African Americans is high at all levels of income. In fact, the most affluent African Americans (annual income over $50,000) experience higher levels of residential segregation than the poorest Latinos and Asians (income under $15,000) (Massey, 2004).

These data also highlight that middle-class blacks are less able than their white counterparts to translate their higher economic status into desirable residential conditions. Research reveals that middle-class suburban African Americans reside in neighborhoods that are less segregated than those of poor central city blacks (Alba, Logan, and Stults, 2000). However, compared to their white counterparts, middle-class blacks live in poorer-quality neighborhoods, with white neighbors who are less affluent than they are. An analysis of 1990 census data revealed that suburban residence does not buy better housing conditions for blacks, with the suburban locations where African Americans reside being equivalent or inferior to those of blacks in central cities (Harris, 1999). Segregation is thus a neglected but powerful example of institutional racism in the United States that continues to have pervasive adverse consequences on SES and health.

Instructively, the high levels of segregation of blacks do not reflect their residential preferences. Of all the major racial/ethnic groups, blacks reveal the highest preference for residing in integrated areas (Massey, 2004). Thus, regardless of individual or household SES, black and white neighborhoods differ dramatically in the availability of jobs, family structure, opportunities for marriage, and exposure to conventional role models (Sampson and Wilson, 1995). This highlights the importance of future research that pays attention to social and economic characteristics of areas that may capture important aspects of the social context over and above individual or household characteristics.

Intersectionality theory paints an even more complex picture of the lives of socially mobile African American men. Leadership "schemas" in the United States include "male" as a critical attribute (Nye and Simonetta, 1996), thereby reducing the extent to which black men have to evoke justifications for their high-status job positions. Black professional men must overcome the cultural stereotypes that challenge their abilities. Based on personal interviews with a sample of African American professional workers, Cose (1993)

finds that blacks often face a "dozen demons" that haunt them as they interact with colleagues within their organization. Some of these demons include under- or overidentifying with other African Americans and feeling that they constantly have to prove they are worthy of respect. Even here, being male does not guarantee that one will be afforded the symbolic resources of deference and respect. Rather, the cumulative effect of everyday racism (Essed, 1991) and structural discrimination reduces the life chances of African American men.

In particular, residential segregation may contribute to many professional black men finding themselves in a no-win situation. Those who reside in predominantly white neighborhoods must confront racial stereotypes at work and at home. For many, home is no longer a refuge from the racist world. They have to ruminate on unfriendly neighbors and the extent to which they are simply unfriendly people or pose a potential danger to self and family (Green, Strolovitch, and Wong, 1998). They may even have to worry that any need for assistance could be met with indifference. Consequently, some find themselves returning to predominantly black neighborhoods even though their social class position could buy them more elaborate housing in a predominantly white suburb (Taylor, 2002). Those who elect to live in the city, then, increase their probability of being the victim of a crime (Sampson, 1987). Even those who live in low-stress, low-crime areas (predominantly black suburbs, for example) expose themselves to other neighborhood conditions when visiting with family members. Blacks have larger families than whites (Jackson, 2000), and many middle-class blacks have large family networks, many residing in high-stress, low-SES contexts. Research reveals that the costs of caring for a large extended social network can adversely affect an individual's health (Kessler, Price, and Wortman, 1985). We contend that there is a similar fatal cost associated with caring for and about those who live in unstable neighborhoods.

CONCLUSION

Despite the gains made in the past decade toward improved health outcomes across America's racial/ethnic groups, there are still large disparities in health. This chapter emphasized the unique status and vulnerabilities faced by members of the black middle class. We

believe more systematic research is needed on the unique problems of these African American professionals (Jackson and Stewart, 2003). In particular, more attention should be paid to the tokenism processes that African Americans in high-ranking positions experience (Yoder, 1994). Perhaps there exists an intricate interplay among such factors as visibility (that is, feeling that your work is always being noticed and scrutinized), colleagueship (encouragement, feeling accepted as a colleague), and social atmosphere (sharing social time) rather than any single issue that characterizes work lives. These may be exacerbated by other aspects of work and non-work-related stress.

Work-family research provides some insight into these issues (Lundberg and Frankenhaeuser, 1999). For example, African American women are more likely than white women to be simultaneously employed and caring for young children (Seltzer, 1994), thus resulting in greater work-family strain. There is also some evidence that African American husbands report lower levels of marital well-being when their wives describe themselves as career women rather than wage earners or housewives (Orbuch and Custer, 1995). Thus, professional blacks (specifically those who are married) may experience family-work conflict that often goes unnoticed in most research studies.

Future research applying the intersectionality paradigm to African American health should attend to how context affects family relationships. There are intriguing research findings on the ways in which the social and economic circumstances of one spouse affect the economic and health status of the other. For example, U.S. data reveal that a woman's employment outside the home benefits her mental health but adversely affects the psychological well-being of her spouse (Rosenfield, 1992). Similarly, national mortality data reveal that while a woman's earnings are positively related to her longevity, they are inversely related to that of her husband (McDonough, Williams, House, and Duncan, 1999). In addition, at least five major epidemiological studies in the United States, including the Framingham Heart Study, have found an adverse effect of being married to well-educated women on men's heart disease risk (Matthews, 2002).

At the same time, other research documents the positive effects of women's employment on men and the family. Ono's work

(1998) indicates that in households with working wives, men's difficulties as providers have become less devastating for marital instability. Similarly, increasing economic resources for women in countries like the United States and Sweden, where dual-earning couples have become the norm, strengthen the institution of marriage, while the opposite occurs in more strongly gendered societies like Japan (Ono, 2003). Importantly, all of these findings come from studies of white populations or studies in which racial differences were not tested. We do not understand how the economic situations of socially advantaged men and women affect each other's health and the extent to which these patterns vary by race. African American women have been working outside the household in large numbers much longer than white women (Jackson, 2000), and this could lead to variations in some of these processes. What is needed is research that seeks to identify under what conditions a spouse's social circumstances can have positive or negative effects on health (see Orbuch and Custer, 1995). More generally, the available evidence clearly indicates that the impact of social structure and context on black husbands' and wives' social circumstances and health should be estimated jointly.

Lifestyle factors are also implicated in the epidemic of black infant mortality and homicide rates. For example, when compared to native black women, foreign-born blacks have a lower incidence of low-birth-weight babies (Hummer, Rogers, Nam, and LeClere, 1999), and certain health behaviors may play a role in these differences. Compared to foreign-born black women, native-born black women are four times more likely to smoke and nearly eight times as likely to use illegal drugs during pregnancy (Cabral and others, 1990). Researchers often view variations in health practices and beliefs as driven by individual differences in values and attitudes, but it is important to balance such views by attending to the ways in which health-related factors measured at the individual level are constrained by larger social structures and processes (Williams, 1998). For example, there are more retail outlets for the sale of alcohol in disadvantaged neighborhoods, and both the alcohol and tobacco industries heavily market their products to blacks and Hispanics.

Similarly, among men, certain lifestyle factors may be consequential for their health status. Men are socialized to project

strength, autonomy, dominance, stoicism, and physical aggression and to avoid any expression of emotion or vulnerability that could be construed as weakness (Courtenay, 2000; Davis, Matthews, and Twamley, 1999). These beliefs about masculinity and manhood can lead men to take actions that harm their health, as well as to avoid engaging in health-protective behaviors. A comprehensive review of research on gender differences in health practices shows that women are more likely to engage in a broad range of preventive and health-promoting behaviors than men, while men are more likely than women to engage in more than thirty behaviors that increase their risk of morbidity, injury, and mortality (Courtenay, 2000).

This chapter emphasized that while SES might afford adults the wherewithal to engage in preventive health care, not feeling accepted by society (or one's professional peers) or confronting multiple sources of strain can undermine the potential benefits of material resources (Jackson, 1997). The examples we used of the types of health problems that some members of the black middle class face highlight this complexity. The growing evidence of the emotional and physical health consequences of perceived discrimination among African Americans implies the need to address more systemic problems in society. The challenge is how to characterize multiple adversities and resources over the life course and understand their health consequences. In essence, a variety of situational constraints can very well undermine the benefits associated with one's socioeconomic status (Bailey, Wolfe, and Wolfe, 1996).

Intersectionality theory sensitizes us to the complexity of health disparities as well as some of the health paradoxes permeating the health literature (Mullings and Wali, 2001; Weber and Parra-Medina, 2003). Moving beyond a "double-jeopardy" or "triple-jeopardy" paradigm, this perspective suggests that new identities (and therefore new challenges or new sets of stressors) are formed when multiple minority statuses (linked to limited resources and a different set of relationships) converge. For example, problems faced by many black professional women are also faced by other ethnic minority women within workplace settings dominated by white men (Yoder, 1994). However, men who find themselves in token positions (working in female-dominated work settings) do not experience gender discrimination (Williams, 1992), suggesting that dominant

groups will use their power to maintain their privileged position (Reskin, 1988).

This chapter has focused heavily on the African American experience. Future research is needed to explore intersectionality paradoxes that might exist for other racial/ethnic populations. There is no generic minority health model that applies equally to all racial/ethnic groups. In fact, there is growing attention to the considerable diversity that exists within each of the broad racial/ethnic categories. The intersections of racial, gender, and socioeconomic factors as they influence health for each population group and subgroup need to be understood within their historical and social contexts.

References

Adler, N. E., and others. "Socioeconomic Inequalities in Health: No Easy Solution." *Journal of the American Medical Association,* 1993, *269,* 3140–3145.

Alba, R. D., Logan, J. R., and Stults, B. J. "How Segregated Are Middle-Class African Americans?" *Social Problems,* 2000, *47,* 543–558.

Allen, W. R., and Farley, R. "The Shifting Social and Economic Tides of Black America, 1950–1980." *Annual Review of Sociology,* 1986, *12,* 277–306.

American Association of Physical Anthropology. "AAPA Statement on Biological Aspects of Race." *American Journal of Physical Anthropology,* 1996, *101,* 569–570.

Anderson, E. "The Social Situation of the Black Executive: Black and White Identities in the Corporate World." In M. Lamont (ed.), *The Cultural Territories of Race: Black and White Boundaries.* Chicago: University of Chicago Press, 1999.

Andes, N. "Social Class and Gender: An Empirical Evaluation of Occupational Stratification." *Gender and Society,* 1992, *6,* 231–251.

Bailey, D., Wolfe, D., and Wolfe, C. R. "The Contextual Impact of Social Support Across Race and Gender: Implications for African American Women in the Workplace." *Journal of Black Studies,* 1996, *26,* 287–307.

Bell, E., and Nkomo, S. *Our Separate Ways.* Cambridge, Mass.: Harvard Business School Press, 2001.

Benjamin, L. *The Black Elite: Facing the Color Line in the Twilight of the Twentieth Century.* Chicago: Nelson-Hall, 1991.

Biles, R. "Black Mayors: A Historical Assessment." *Journal of Negro History,* 1992, *77,* 109–125.

Bishop, J. H. "Jobs, Cash Transfers, and Marital Instability: A Review of the Evidence." *Journal of Human Resources,* 1980, *15,* 301–334.

Bradbury, K. "Education and Wages in the 1980s and 1990s: Are All Groups Moving Up Together?" *New England Economic Journal,* Oct. 2002, pp. 19–46.

Cabral, H., and others. "Foreign-Born and U.S. Born Black Women: Differences in Health Behaviors and Birth Outcomes." *American Journal of Public Health,* 1990, *80*(1), 70–72.

Cayton, H. R., and Mitchell, G. S. *Black Workers and the New Unions.* Chapel Hill: University of North Carolina Press, 1970.

Collins, P. H. *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment.* New York: Routledge, 1990.

Collins, S. M. "Blacks on the Bubble: The Vulnerability of Black Executives in White Corporations." *Sociological Quarterly,* 1993, *34*(3), 429–447.

Collins, S. M. "Black Mobility in White Corporations: Up the Corporate Ladder But Out on a Limb." *Social Problems,* 1997, *44*(1), 55–67.

Cose, E. *The Rage of a Privileged Class.* New York: HarperCollins, 1993.

Council of Economic Advisers for the President's Initiative on Race. *Changing America: Indicators of Social and Economic Well-Being by Race and Hispanic Origin.* Washington, D.C.: U.S. Government Printing Office, 1998.

Courtenay, W. "Constructions of Masculinity and Their Influence on Men's Well-Being: A Theory of Gender and Health." *Social Science and Medicine,* 2000, *50,* 1385–1401.

Davern, M. E., and Fisher, P. J. *Household Net Worth and Asset Ownership: 1995.* Washington, D.C.: U.S. Government Printing Office, 1995.

Davis, M., Matthews, K., and Twamley, E. W. "Is Life More Difficult on Mars or Venus? A Meta-Analytic Review of Sex Differences in Major and Minor Life Events." *Annals of Behavioral Medicine,* 1999, *21,* 83–97.

DeNavas-Walt, C., and Cleveland, R. W. *Money Income in the United States: 2000.* Washington, D.C.: U.S. Government Printing Office, 2002.

DuBois, W.E.B. *The Philadelphia Negro.* Philadelphia: University of Pennsylvania Press, 1996. (Originally published 1899.)

Eberhardt, M. S., and others. *Health, United States, 2001: With Urban and Rural Health Chartbook.* Hyattsville, Md.: National Center for Health Statistics, 2001.

Essed, P. *Understanding Everyday Racism: An Interdisciplinary Theory.* Thousand Oaks, Calif.: Sage, 1991.

Forman, T. A., Williams, D. R., and Jackson, J. S. "Race, Place, and Discrimination." In C. Gardner (ed.), *Perspectives on Social Problems.* Greenwich, Conn.: JAI Press, 1997.

Franklin, J. H. *From Slavery to Freedom.* New York: Knopf, 1974.

Franzini, L., Ribble, J. C., and Keddie, A. M. "Understanding the Hispanic Paradox." *Ethnicity and Disease,* 2001, *11*(3), 496–518.

Frazier, E. F. *Black Bourgeoisie: The Rise of a New Middle Class.* New York: Free Press, 1997. (Originally published 1957.)

Gatewood, W. *Aristocrats of Color: The Black Elite, 1880–1920.* Fayetteville: University of Arkansas Press, 2000.

Gray, B., and Keith, V. "The Benefits and Costs of Social Support for African American Women." In D. Brown and V. Keith (eds.), *In and Out of Our Right Minds: The Mental Health of African American Women.* New York: Columbia University Press, 2003.

Green, D. P., Strolovitch, D. Z., and Wong, J. S. "Defended Neighborhoods, Integration, and Racially Motivated Crime." *American Journal of Sociology,* 1998, *104,* 372–403.

Greenhaus, J. H., Parasuraman, S., and Wormley, W. M. "Effects of Race on Organizational Experiences, Job Performance Evaluations, and Career Outcomes." *Academy of Management Journal,* 1990, *33,* 64–86.

Grodsky, E., and Pager, D. "The Structure of Disadvantage: Individual and Occupational Determinants of the Black-White Wage Gap." *American Sociological Review,* 2001, *66,* 542–567.

Guy-Sheftall, B. *Daughters of Sorrow: Attitudes Toward Black Women, 1880–1920.* Brooklyn, N.Y.: Carlson, 1990.

Hacker, A. *Two Nations: Black and White, Separate, Hostile, Unequal.* New York: Ballantine, 1995.

Harris, D. R. *All Suburbs Are Not Created Equal: A New Look at Racial Differences in Suburban Locations.* Ann Arbor: Population Studies Center, University of Michigan, 1999.

Higganbotham, E., and Weber, L. "Moving Up with Kin and Community: Upward Social Mobility for Black and White Women." *Gender and Society,* 1992, *6,* 416–440.

Hochschild, A. "Middle-Class Blacks and the Ambiguities of Success." In P. M. Sniderman, P. E. Tetlock, and E. G. Carmines (eds.), *Prejudice, Politics, and the American Dilemma.* Stanford, Calif.: Stanford University Press, 1993.

Hogan, V. K., and others. "A Public Health Framework for Addressing Black and White Disparities in Preterm Delivery." *Journal of the American Medical Women's Association,* 2000, *56,* 12–80.

Hoyert, D. L., and others. *Deaths: Final Data for 1999.* Hyattsville, Md.: National Center for Health Statistics, 2001.

Hummer, R. A., Rogers, R. G., Nam, C. B., and LeClere, F. B. "Race/Ethnicity, Nativity, and U.S. Adult Mortality." *Social Science Quarterly,* 1999, *80,* 136–153.

Jackson, J. S. (ed.). *New Directions: African Americans in a Diversifying Nation.* Washington, D.C.: National Policy Association, 2000.

Jackson, P. B. "Role Occupancy and Minority Mental Health." *Journal of Health and Social Behavior,* 1997, *38,* 237–255.

Jackson, P. B., and Saunders, T. "Work Stress, Coping Resources, and Mental Health: A Study of America's Black Elite." *Research in Occupational Stress and Well Being.* Greenwich, Conn.: JAI Press/Elsevier, forthcoming.

Jackson, P. B., and Stewart, Q. T. "A Research Agenda for the Black Middle Class: Work Stress, Survival Strategies, and Mental Health." *Journal of Health and Social Behavior,* 2003, *44*(3), 442–455.

Jackson, P. B., Thoits, P., and Taylor, H. "Composition of the Workplace and Psychological Well-Being: The Effects of Tokenism on America's Black Elite." *Social Forces,* 1995, *74,* 543–557.

James, S. A. "Racial and Ethnic Differences in Infant Mortality and Low Birth Weight: A Psychosocial Critique." *Annals of Epidemiology,* 1993, *3*(2), 131–136.

Kanter, R. M. *Men and Women of the Corporation.* New York: Basic Books, 1977.

Kaufman, J. S., Cooper, R. S., and McGee, D. L. "Socioeconomic Status and Health in Blacks and Whites: The Problem of Residual Confounding and the Resiliency of Race." *Epidemiology,* 1997, *8,* 621–628.

Kennelly, I. "That Single-Mother Element: How White Employers Typify Black Women." *Gender and Society,* 1999, *13*(2), 168–192.

Kessler, R. C., Price, R. H., and Wortman, C. B. "Social Factors in Psychopathology: Stress, Social Support, and Coping Processes." *Annual Review of Psychology,* 1985, *36,* 531–572.

Kinder, D., and Sears, D. "Symbolic Racism versus Racial Threats to the Good Life." *Journal of Personality and Social Psychology,* 1981, *46,* 414–431.

Krieger, N. "Embodying Inequality: A Review of Concepts, Measures, and Methods for Studying Health Consequences of Discrimination." *International Journal of Health Services,* 1999, *29*(2), 295–352.

Krieger, N., and others. "Racism, Sexism, and Social Class: Implications for Studies of Health, Disease, and Well-Being." *American Journal of Preventive Medicine,* 1993, *9*(6 suppl.), 82–122.

LaVeist, T. A. (ed.). *Race, Ethnicity, and Health.* San Francisco: Jossey-Bass, 2002.

Lillie-Blanton, M., Martinez, R. M., Taylor, A. K., and Robinson, B. G. "Latina and African American Women: Continuing Disparities in Health." *International Journal of Health Services,* 1993, *23,* 555–584.

Loscocco, K., and Spitze, G. "Working Conditions, Social Support, and the Well-Being of Female and Male Factory Workers." *Journal of Health and Social Behavior,* 1990, *31,* 313–327.

Lundberg, U., and Frankenhaeuser, M. "Stress and Workload of Men and Women in High-Ranking Positions." *Journal of Occupational and Health Psychology,* 1999, *4*(2), 142–151.

Majors, R., and Billson, J. M. *Cool Pose: The Dilemmas of Black Manhood in America.* New York: Touchstone, 1992.

Marshall, A. "From Sexual Denigration to Self-Respect: Resisting Images of Black Female Sexuality." In D. Jarrett-Macauley (ed.), *Reconstructing Womanhood, Reconstructing Feminism: Writings on Black Women.* London: Routledge, 1996.

Martin, S. "Outsider Within the Station House: The Impact of Race and Gender on Black Women Police." *Social Problems,* 1994, *41,* 383–400.

Massey, D. "Segregation and Stratification: A Biosocial Perspective." *DuBois Review,* 2004, *1,* 7–25.

Massey, D., and Denton, N. *American Apartheid: Segregation and the Making of the Underclass.* Cambridge, Mass.: Harvard University Press, 1993.

Matthews, K. A. "Commentary: Is an Educated Wife Hazardous to Her Husband's Heart? Never, Always, or Sometimes?" *International Journal of Epidemiology,* 2002, *31,* 806–807.

McDonough, P., Williams, D. R., House, J., and Duncan, G. J. "Gender and the Socioeconomic Gradient in Mortality." *Journal of Health and Social Behavior,* 1999, *40,* 17–31.

McLean, D., Hatfield-Timajchy, K., Wingo, I., and Floyd, R. "Psychosocial Measurements: Implications for the Study of Preterm Delivery in Black Women." *American Journal of Preventive Medicine,* 1993, *9,* 39–81.

McLoyd, V. C., and Lozoff, B. "Racial and Ethnic Trends in Children's and Adolescents' Behavior and Development." In N. J. Smelser, W. J. Wilson, and F. Mitchell (eds.), *America Becoming: Racial Trends and Their Consequences.* Washington, D.C.: National Academy Press, 2001.

Mullings, L. "Images, Ideology, and Women of Color." In M. B. Zinn and B. T. Dill (eds.), *Women of Color in U.S. Society.* Philadelphia: Temple University Press, 1994.

Mullings, L., and Wali, A. *Stress and Resilience: The Social Context of Reproduction in Central Harlem.* Norwell, Mass.: Kluwer, 2001.

Navarro, V. "Race or Class, or Race and Class." *International Journal of Health Services,* 1989, *19,* 311–314.

Norment, L. "Black Women on Corporate Boards." *Ebony,* Mar. 2002, pp. 42–48.

Nye, J. L., and Simonetta, L. G. "Followers' Perceptions of Group Leaders: The Impact of Recognition-Based and Inference-Based Processes." In J. L. Nye and A. M. Brower (eds.), *What's Social About Social Cognition.* Thousand Oaks, Calif.: Sage, 1996.

Oliver, M. L., and Shapiro, T. M. *Black Wealth/White Wealth: A New Perspective on Racial Inequality.* New York: Routledge, 1995.

Ono, H. "Husbands' and Wives' Resources and Marital Dissolution." *Journal of Marriage and the Family,* 1998, *60,* 674–689.

Ono, H. "Women's Economic Standing, Marriage Timing, and Cross-National Contexts of Gender." *Journal of Marriage and Family,* 2003, *65,* 275–286.

Orbuch, T. L., and Custer, L. "The Social Context of Married Women's Work and Its Impact on Black Husbands and White Husbands." *Journal of Marriage and the Family,* 1995, *57,* 333–345.

Pamuk, E., and others. *Socioeconomic Status and Health Chartbook. Health, United States, 1998.* Hyattsville, Md.: National Center for Health Statistics, 1998.

Pathways and Progress. *Corporate Best Practices to Shatter the Glass Ceiling.* Chicago: Chicago Area Partnerships, 1996.

Reskin, B. "Bringing Men Back in: Sex Differentiation and the Devaluation of Women's Work." *Gender and Society,* 1988, *2,* 58–81.

Reynolds, J. R., and Ross, C. E. "Social Stratification and Health: Education's Benefit Beyond Economic Status and Social Origins." *Social Problems,* 1998, *45,* 221–247.

Rini, C., Wadhwa, P., and Sandman, C. "Psychological Adaptation and Birth Outcomes: The Role of Personal Resources, Stress, and Sociocultural Context in Pregnancy." *Health Psychology,* 1999, *18,* 333–345.

Rose, L., Kim, M., Dennison, C., and Hill, M. "The Contexts of Adherence for African Americans with High Blood Pressure." *Journal of Advanced Nursing,* 2000, *32*(3), 587–594.

Rosenfield, S. "The Costs of Sharing: Wives' Employment and Husbands' Mental Health." *Journal of Health and Social Behavior,* 1992, *33*(3), 213–225.

Rosenfield, S. "Gender and Mental Health: Do Women Have More Psychopathology, Men More, or Both the Same (and Why)?" In A. Horowitz and T. Scheid (eds.), *A Handbook for the Study of Mental Health: Social Contexts, Theories, and Systems.* Cambridge: Cambridge University Press, 1999.

Sampson, R. J. "Urban Black Violence: The Effect of Male Joblessness and Family Disruption." *American Journal of Sociology,* 1987, *93,* 348–382.

Sampson, R. J., and Wilson, W. "Toward a Theory of Race, Crime, and Urban Inequality." In J. Hagan and R. D. Peterson (eds.), *Crime and Inequality.* Stanford, Calif.: Stanford University Press, 1995.

Sanchez-Hucles, J. "Jeopardy Not Bonus Status for African American Women in the Work Force: Why Does the Myth of Advantage Persist?" *American Journal of Community Psychology,* 1997, *25,* 565–580.

Schuman, H., Steeh, C., and Bobo, L. *Racial Attitudes in America.* Cambridge, Mass.: Harvard University Press, 1985.

Seltzer, J. A. "Consequences of Marital Dissolution for Children." *Annual Review of Sociology,* 1994, *20,* 235–266.

Sokoloff, N. J. *Between Money and Love: The Dialectics of Women's Home and Market Work.* New York: Praeger, 1980.

Taylor, M. *Harlem: Between Heaven and Hell.* Minneapolis: University of Minnesota Press, 2002.

Testa, M., Astone, N. M., Krogh, M., and Neckerman, K. M. "Employment and Marriage Among Inner-City Fathers." In W. J. Wilson (ed.), *The Ghetto Underclass.* Thousand Oaks, Calif.: Sage, 1993.

Thoits, P. A. "Stress, Coping, and Social Support Processes: Where Are We? What Next?" *Journal of Health and Social Behavior,* 1995, *45*(extra issue), 53–79.

Tienda, M., and Lii, D.-T. "Minority Concentration and Earnings Inequality: Blacks, Hispanics, and Asians Compared." *American Journal of Sociology,* 1987, *93,* 141–165.

Tucker, C., and others. "Testing Methods of Collecting Racial and Ethnic Information: Results of the Current Population Survey Supplement on Race and Ethnicity." *Bureau of Labor Statistical Notes,* 1996, *40,* 1–149.

Tucker, M. *Considerations in the Development of Family Policy for African Americans.* Washington, D.C.: National Policy Association, 2000.

U.S. Bureau of the Census. *Current Population Survey.*

U.S. Department of Labor, Bureau of Labor Statistics. *Employment and Earnings.* Washington, D.C.: U.S. Government Printing Office, Jan. 2003.

Warren, B. J. "Depression, Stressful Life Events, Social Support, and Self-Esteem in Middle Class African American Women." *Archives of Psychiatric Nursing,* 1997, *11*(3), 107–117.

Weber, L., and Parra-Medina, D. "Intersectionality and Women's Health: Charting a Path to Eliminating Health Disparities." *Advances in Gender Research,* 2003, *7,* 181–230.

Wilhelm, S. M. "Economic Demise of Blacks in America: A Prelude to Genocide?" *Journal of Black Studies,* 1987, *17,* 201–254.

Williams, C. "The Glass Escalator: Hidden Advantages for Men in the Female Professions." *Social Problems,* 1992, *39,* 253–267.

Williams, D. R. "Race and Health: Basic Questions, Emerging Directions." *Annals of Epidemiology,* 1997, *7*(5), 322–333.

Williams, D. R. "African-American Health: The Role of the Social Environment." *Journal of Urban Health,* 1998, *75*(2), 300–321.

Williams, D. R. "Race, SES, and Health: The Added Effects of Racism and Discrimination." *Annals of the New York Academy of Sciences,* 1999, *896,* 173–188.

Williams, D. R. "Racial/Ethnic Variations in Women's Health: The Social Embeddedness of Health." *American Journal of Public Health,* 2002, *92*(4), 588–597.

Williams, D. R. "The Health of Men: Structured Inequalities and Opportunities." *American Journal of Public Health,* 2003, *93*(5), 724–731.

Williams, D. R. "The Health of U.S. Racial and Ethnic Populations." *Journal of Gerontology: Social Sciences,* forthcoming.

Williams, D. R., and Collins, C. "U.S. Socioeconomic and Racial Differences in Health." *Annual Review of Sociology,* 1995, *21,* 349–386.

Williams, D. R., and Collins, C. "Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health." *Public Health Reports,* 2001, *116,* 404–415.

Williams, D. R., Neighbors, H. W., and Jackson, J. S. "Racial/Ethnic Discrimination and Health: Findings from Community Studies." *American Journal of Public Health,* 2003, *93*(2), 200–208.

Willie, C. V. *Caste and Class Controversy.* Bayside, N.Y.: General Hall, 1979.

Wilson, W. J. *The Truly Disadvantaged.* Chicago: University of Chicago Press, 1987.

Wilson, W. J. *When Work Disappears: The World of the New Urban Poor.* New York: Knopf, 1996.

Yoder, J. D. "Looking Beyond Numbers: The Effects of Gender Status, Job Prestige, and Occupational Gender-Typing on Tokenism Processes." *Social Psychology Quarterly,* 1994, *57,* 150–159.