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Stigma, status, and population health

Jo C. Phelan [a,*], Jeffrey W. Lucas [b], Cecilia L. Ridgeway [c], Catherine J. Taylor [d]

[a] Department of Sociomedical Sciences, Mailman School of Public Health, Columbia University, 722 W. 168th Street, 16th floor, New York, NY 10032, USA
[b] Department of Sociology, University of Maryland Energy Research Center (UMERC), College Park, MD 20742, USA
[c] Stanford University, Sociology Department, MC 2047, Main Quad – 450 Serra Mall, Building 120, Room 160, Stanford, CA 94305-2047, USA
[d] Department of Sociology, Ballantine Hall 744, 1020 Kirkwood Ave, Bloomington, IN 47405, USA

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ABSTRACT

Stigma and status are the major concepts in two important sociological traditions that describe related processes but that have developed in isolation. Although both approaches have great promise for understanding and improving population health, this promise has not been realized. In this paper, we consider the applicability of status characteristics theory (SCT) to the problem of stigma with the goal of better understanding social systemic aspects of stigma and their health consequences. To this end, we identify common and divergent features of status and stigma processes. In both, labels that are differentially valued produce unequal outcomes in resources via culturally shared expectations associated with the labels; macro-level inequalities are enacted in micro-level interactions, which in turn reinforce macro-level inequalities; and status is a key variable. Status and stigma processes also differ: Higher- and lower-status states (e.g., male and female) are both considered normal, whereas stigmatized characteristics (e.g., mental illness) are not; interactions between status groups are guided by "social ordering schemas" that provide mutually agreed-upon hierarchies and interaction patterns (e.g., men assert themselves while women defer), whereas interactions between "normals" and stigmatized individuals are not so guided and consequently involve uncertainty and strain; and social rejection is key to stigma but not status processes. Our juxtaposition of status and stigma processes reveals close parallels between stigmatization and status processes that contribute to systematic stratification by major social groupings, such as race, gender, and SES. These parallels make salient that stigma is not only an interpersonal or intrapersonal process but also a macro-level process and raise the possibility of considering stigma as a dimension of social stratification. As such, stigma's impact on health should be scrutinized with the same intensity as that of other more status-based bases of stratification such as SES, race and gender, whose health impacts have been firmly established.

Introduction

One goal of this special issue is to consider novel conceptualizations of stigma that help us understand systemic aspects of stigma and their relationship to health. In this paper, we pursue that goal by considering the applicability of status characteristics theory (SCT) (Berger, Fisek, Norman, & Zelditch, 1977) to the problem of stigma and health. SCT represents a useful perspective from which to consider stigma and health for several reasons. First, SCT focuses on macro-level bases of social stratification such as those based on race, socioeconomic status (SES), and gender and on how those inequalities are created and reproduced at the micro level of interpersonal interactions. In contrast, conceptualizations of stigma typically do not fully explore the systemic or structural level aspects of stigma (but see Corrigan, Markowitz, & Watson, 2004; Link & Phelan, 2001). Consequently, to the extent that we find parallels between stigma and SCT, our ability to conceptualize and investigate stigma as a macro-level phenomenon will be enhanced. Second, the axes of stratification upon which SCT focuses have been shown in large empirical literatures to be strongly connected to health outcomes (Berkman & Kawachi, 2000; Link & Phelan, 1995; Read & Gorman, 2010). There is also a large literature addressing the impact of social status *per se* on health inequalities (Marmot, 2004). Although SCT has not been connected to these literatures, doing so may elucidate some pathways through which status-related characteristics influence health, and this in turn may help us understand stigma's impact on health. Third, SCT is a rigorous theory supported by a large and systematic empirical

* Corresponding author.
E-mail addresses: jcp13@columbia.edu (J.C. Phelan), jlucas2@umd.edu (J.W. Lucas), ridgeway@leland.stanford.edu (C.L. Ridgeway), cattaylo@indiana.edu (C.J. Taylor).

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literature that describes processes very similar to those involved in stigma. Translating the well developed theory to stigma may provide new insights and systematic propositions to test. Empirical results from SCT research may also be applicable to the problem of stigma. Finally, SCT has generated interventions to alter existing status hierarchies, and these approaches may be useful in developing stigma-reduction interventions.

Although stigma and status involve similar processes, they have until recently (Link & Phelan, 2001; Lucas & Phelan, 2012) been conceptualized and studied independently of one another. We first describe the two traditions, then review what appear to be common and divergent features of the social processes at work in each. Finally, we assess what is gained by bringing the two literatures in contact with one another for understanding the social processes involved and their implications for health.

Status characteristics theory

Research on status characteristics has shown how status hierarchies based on characteristics such as gender, race, or education are maintained through social interactions, as well as how those hierarchies can be created (Ridgeway & Erickson, 2000) and altered (Berger et al., 1977; Ridgeway, Johnson, & Diekema, 1994). *Status characteristics theory* (Berger et al., 1977; Berger, Rosenholtz, & Zelditch, 1980) relates characteristics of an individual to that person's rank in a status hierarchy based on the esteem in which the person is held by self and others. The theory proposes that members of a group form expectations about each other's competence to contribute to group goals based on their status characteristics. Individuals expected to make greater contributions are more highly valued by the group (Berger et al., 1977).

A status characteristic is defined as a characteristic of an actor that has two or more states that are differentially evaluated in terms of honor, esteem, or desirability, each of which is associated with distinct performance expectations. For example, gender is a status characteristic in U.S. society with higher (male) and lower (female) states (Pugh & Wahrman, 1983). Status characteristics theory distinguishes two types of status characteristics: specific vs. diffuse. Specific status characteristics produce expectations for competence in limited settings, while diffuse status characteristics create expectations that are unbounded in range. That is, a *specific* status characteristic involves two or more states that are differentially evaluated, and each state is associated with a distinct and specific expectation state. For example, high musical ability is evaluated more positively, and we expect people with high musical ability to perform better on musical tasks. *Diffuse* status characteristics involve two or more states that are differentially valued. Associated with each state are distinct sets of specific expectation states, each itself evaluated, and a similarly evaluated general expectation state. Gender is an example: (1) Males are more highly evaluated; (2) being male is associated with more highly valued specific status characteristics such as mathematical, managerial and problem-solving abilities; and (3) men are assumed to be more competent than women in general (Pugh & Wahrman, 1983).

Two scope conditions limit the domain of status characteristics theory—task orientation and collective orientation (Berger et al., 1977). Task orientation means that the group is formed for the purpose of solving some problem. Collective orientation means that group members consider it necessary to take into account the input of every group member in solving the task. For all groups that meet its scope conditions, the theory makes predictions about the process through which observable status characteristics lead to behavioral inequalities.

In status characteristics theory, status characteristics produce rank in a status hierarchy through a chain of four logically connected assumptions. First, the theory assumes that any characteristic will become salient to group members if it is know or believed to be related to the task or if it differentiates among group members. Second, the burden-of-proof assumption states that all salient characteristics (e.g., gender) will be treated as relevant by group members unless they are specifically disassociated from the task. Third, the aggregated expectation states assumption holds that when group members are confronted with more than one relevant characteristic, they act as if they combine together the expectations associated with each characteristic. In the theory, members do so according to the principle of organized subsets, that is, individuals act as though they aggregate positive and negative expectations for group members and combine them to form overall performance expectations for self and others. The fourth assumption is the basic expectation assumption, according to which a member's rank in the group's status hierarchy will be a direct function of the group's expectations for that member's performance. With this assumption, the status order of the group will be determined by the aggregated expectation states that each group member has for herself and for other group members.

Research in the SCT tradition has consistently demonstrated that members of collectively goal-oriented groups use status characteristics to form expectations about each other's competence to contribute to group goals. Individuals with higher status are expected to contribute more. Those who are expected to make greater contributions are more highly valued by the group, are held in higher esteem, have more opportunities to perform, have more influence in the group, and have their performances evaluated more highly than individuals with positions lower in the status order. For example, those with higher status tend to speak more, have their ideas accepted by others, and be elected group leader (Berger et al., 1980). This is true even if the diffuse status characteristics by which their positions are determined have no relevance to the task at hand.

These differently evaluated states of status characteristics and their associated differential performance expectations are part of a society's culture, learned and thus shared by most societal members, so both high and low status interactants expect lower status group members (e.g., women or non-whites) to have lower competence, and all parties act in ways to make that expectation more likely to come true. Importantly, these processes often take place outside of the conscious awareness of group members (Berger et al., 1980).

Research in status characteristics theory is primarily carried out in a standard experimental setting (for a review, see Kalkhoff & Thye, 2006). The setting involves participants at computer terminals being told information about partners on computers in different rooms. The partners in these studies are typically fictitious, and characteristics of partners are controlled by the researcher. The participants and "partners" complete a task together in which the partner has opportunities to influence the participant. Most commonly, the task is a "contrast sensitivity" exercise in which participants determine whether the black or white shaded areas of rectangles are larger. Participants make initial guesses, see their partners' initial guesses (again, typically controlled by the researcher), and then make final decisions, which are not shared with the partner. Partner influence is treated as an indicator of the consequences of status. If, for example, participants with male partners were influenced more than participants with female partners, it would provide evidence that gender acts as a status characteristic that advantages men. This prototype has been employed by many studies that have reliably found status effects for gender, age, race, ethnicity, occupation, and physical attractiveness (Berger et al., 1980; Webster & Foschi, 1988).

Stigma

Whereas SCT is precisely described and consensually agreed upon, the same cannot be said for stigma. Stigma is not unified by a single theoretical approach to the same extent as SCT (Link & Phelan, 2001); moreover, there is no single agreed-on definition of stigma, and several important conceptualizations have been put forward (Goffman, 1963; Jones et al., 1984; Link & Phelan, 2001). In this paper, we draw on Goffman's (1963) classic work *Stigma: Notes on the Management of Spoiled Identity,* Link and Phelan's (2001) more systematic and comprehensive conceptualization of stigma, and modified labeling theory (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989), which has strong parallels to SCT.

Goffman defines stigma as "an attribute that is deeply discrediting" (Goffman, 1963, p. 3) and emphasizes two major consequences of stigma: status loss and social rejection. Regarding status loss, Goffman states that the stigmatized person is "reduced in our minds from a whole and usual person to a tainted and discounted one" (Goffman, 1963, p. 3). Regarding social rejection, stigma is "the situation of the individual who is disqualified from full social acceptance" (Goffman, 1963; preface). Although Goffman acknowledges that the stigma process is not confined to face-to-face interactions (for example, reading a negative newspaper account of a person with mental illness is part of the stigma process), *Stigma* is concerned with what he calls "mixed contacts" between what he calls "normals" and stigmatized people. A key feature of such contacts according to Goffman is interaction strain, which we elaborate in a later section of the paper. More recently, Link and Phelan (2001) characterized the stigma process as follows:

> Stigma exists when the following interrelated components converge. In the first component, people distinguish and label human differences. In the second, dominant cultural beliefs link labeled persons to undesirable characteristics – to negative stereotypes. In the third, labeled persons are placed in distinct categories so as to accomplish some degree of separation of 'us' from 'them.' In the fourth, labeled persons experience status loss and discrimination that lead to unequal outcomes. Stigmatization is entirely contingent on access to social, economic and political power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories and the full execution of disapproval, rejection, exclusion and discrimination
>
> Link and Phelan (2001, p. 367).

As in Goffman (1963), status loss and social rejection are prominent.

Modified labeling theory (Link et al., 1989) offers the closest parallel to SCT in the area of stigma. Modified labeling theory begins with the idea that there are shared cultural beliefs (analogous to status beliefs in SCT) that mentally ill people are devalued and rejected that are learned by members of a culture as part of their socialization. If a person at some point becomes mentally ill, those beliefs become personally relevant, and the person is likely to expect devaluation and social rejection from others, which in turn may affect their psychological state as well as coping behaviors such as secrecy and social withdrawal. As in Goffman (1963) and Link and Phelan (2001), modified labeling theory focuses on status loss and social rejection as the core negative outcomes that a person with mental illness can be expected to experience. While modified labeling theory explicitly focuses on consequences of shared cultural beliefs for the stigmatized and not for normals, these consequences will affect interactions with normals in that stigmatized individuals will approach those interactions with the expectation of being rejected and of being treated as having lower status, and this alone should produce some of the self-fulfilling prophecy effects seen in SCT. Although not part of the theory, it can also be expected (analogous to SCT) that normals approach these interactions with the expectation that they have higher status and that it is reasonable for them to impose social distance.

Because the stigma literature is not as unified as that surrounding SCT, we cannot identify a prototypical study of stigma processes. However, here we describe an experiment by Sibicky and Dovidio (1986) that shares SCT's and Goffman's focus on interactions between individuals and illustrates many aspects of the stigma process. Introductory undergraduate psychology students participated in a mixed-sex dyadic interaction. Subjects were randomly assigned to be a "perceiver" or a "target." They were also randomly assigned to one of the following conditions: the perceiver was led to believe that the target was recruited from the psychological therapy clinic at the college or from an introductory psychology class. In fact, the target was always recruited from a psychology class. Both targets and perceivers were led to believe that the study was focusing on the acquaintance process in social interaction. All subjects completed a brief inventory of their courses, hobbies, and interests. The experimenter then exchanged the inventories and provided the perceiver with the labeling information (student or therapy client). Subsequently, the two engaged in a tape-recorded conversation that was later reliably evaluated by two raters who were blind to the experimental conditions. Perceivers rated the therapy targets less favorably even before meeting them. Moreover, blind ratings revealed that in their interactions with therapy targets, perceivers were less positive (e.g., less open and sincere). Finally, the behavior of the targets was affected as well, with therapy targets behaving in a less socially desirable manner than the non-client targets, even though they had no knowledge that they had been negatively labeled.

Common features of stigma and status processes

Both literatures describe basic social processes that emerge in interpersonal interactions. They are basic processes in that the characteristics that produce them vary by time and place, but the processes themselves exist as fundamental organizing features of social groups. There are many commonalities in the processes described in the two literatures.

1. Labels are differentially valued and produce unequal outcomes in valued resources

The most basic commonality is that both literatures attend to characteristics, or labels, that differentiate members of social groups—with some categories viewed more positively and some more negatively than others (Lucas & Phelan, 2012). This differentiation produces unequal outcomes, including differences in influence and esteem, social and occupational opportunities, access to civil rights, and health (Berger & Webster, 2006; Corrigan et al., 2004; Hatzenbuehler, Link, & Phelan, 2013; Link & Phelan, 2001).

2. Differently valued labels are linked to differential outcomes by shared expectations associated with the labels

In SCT, expectations of low competence lead to low levels of influence and performance evaluation. In stigma, a variety of expectations lead to negative outcomes. Based on Goffman's (1963) and Link and Phelan's (2001) emphasis on the status-diminishing effects of stigma, we should see that stigmatized individuals are expected to be less competent and to have lower levels of influence and performance evaluation, just as in SCT. In addition, from Link

and Phelan's (2001) conceptualization, we can say that stigmatized individuals are expected to be different from normals, which should lead to social distance from them. There are also specific expectations (stereotypes) associated with individual stigmatized characteristics (e.g., mentally ill people are dangerous; obese people are lazy) which may have a variety of negative consequences. The expectation of danger in the case of mental illness is a strong predictor of social distance (Link, Cullen, Frank, & Wozniak, 1987).

3. Expectations are sufficient to produce differences in outcomes

In both SCT and stigma models, expectations are sufficient to produce unequal outcomes. In a standard SCT study, there are no correct answers to the problems being solved by "dyads; " moreover, the partner is fictitious and so differential competence of the partner cannot account for differences in the partner's influence or performance evaluation. The only factor that can account for differences in influence and performance evaluation are the labels (e.g., male vs. female) and expectations associated with them. Further, tests of status construction theory (Ridgeway & Erickson, 2000) show that differential expectations and evaluations can be created for initially arbitrary labels (e.g., Type S2 vs. Type Q2) by treating Type S2 and Type Q2 persons with different degrees of deference. Similarly, in the Sibicky and Dovidio (1986) stigma experiment, research participants were randomly assigned to be labeled as psychotherapy clients, so as in SCT studies, there is no reason to expect anything other than the psychotherapy label to have produced the conversational differences observed in the different labeling conditions.

Demonstrating the sufficiency of labels to produce unequal outcomes between racial, socioeconomic and gender groups is a critical contribution of SCT to understanding the bases of social stratification. Few would deny large inequalities between these groups in the real world. However, a perennially debated question is why those inequalities develop. Is it because the groups with superior outcomes are more capable and effective? Or is it something else? SCT research does not show that the processes it investigates are the only way in which prestige and influence differences are created and perpetuated, but it does show unambiguously that these processes are one way that inequalities are created and that differences in ability are not necessary to produce differences in esteem, influence and power. Expectations based on labels are fully sufficient. As Sibicky and Dovidio (1986) demonstrate, the same power of expectations to produce unequal outcomes can be demonstrated for stigma.

4. Macro-level inequalities are enacted in micro-level interactions, which in turn reinforce macro-level inequalities

SCT takes as its starting point inequalities that are strongly socially patterned – men have more power and money than women, whites more than blacks, etc. These macro-level inequalities are apparent in the differential distribution of resources by status characteristics in a population such as that of the U.S. (Leicht, 2008; Link & Phelan, 1995; Risman, 1998). While stratification theories typically suggest that macro-level beliefs shape behavior and opportunities, a distinctive strength of SCT is that it offers a specific and detailed account of how one such link occurs, that between macro-level status beliefs and micro-level interactions: Expectations shared in the general culture (macro-level) associated with status labels are imported into goal-oriented cooperative interpersonal interactions (micro-level). The culturally based expectations affect outcomes of influence and performance evaluation in these social interactions which in turn reinforce the culturally shared expectations (those with lower states of status labels are believed to have been less competent in the interaction, and in fact they were less influential, from which participants may infer that they were less competent).

Inequalities between stigmatized and non-stigmatized groups are also strongly socially patterned. Stigmatized groups are systematically excluded and have poorer life chances (Herek, 1999; Hinshaw & Cicchetti, 2000; Puhl & Heuer, 2009; Smeets, van Lierop, Vanhoutvin, Aldenkamp, & Nijhuis, 2007). As in SCT, culturally shared expectations are brought into micro-level interactions which in turn reinforce cultural expectations. We again call on Sibicky and Dovidio (1986) to illustrate. In their study, culturally shared expectations about people with mental illness (i.e., that they are less competent and attractive) affected social interactions (in which people who were labelled with mental illness behaved less competently and attractively than people not so labelled), which in turn reinforced culturally shared expectations. Notably, however, these macro-micro links are not as salient in the stigma literature as in the SCT literature, where these links are an integral part of the theory. In this paper we bring to the forefront the macro-level, systemic properties of stigma in order to theorize links between these properties and structural-level health inequalities.

5. Centrality of status

In SCT, status is the central variable. In stigma, it is one of the central variables. For Goffman (1963), status loss and social rejection are the two major consequences of stigma. For Link and Phelan (2001), status loss is one of the interrelated processes considered key to stigma (along with identifying and labeling human differences deemed socially significant, stereotyping, defining "us and them" categories, and discrimination).

Divergent features of stigma and status processes

Although we have argued that status and stigma processes share important features, they also have notable differences (Lucas & Phelan, 2012).

1. The role of normality

Status characteristics such as education and gender have higher and lower levels, but we believe both are considered standard or "normal," both in the sense of having normal human competencies and appearance and in the sense of adhering to major social norms. By contrast, reflecting Link and Phelan's (2001) emphasis on sharp distinctions drawn between the kind of people "we" are and the kind of people a stigmatized "they" are, stigma implies the comparison of a standard and a non-standard, deviant or "abnormal" characteristic. Put starkly by Goffman, "we believe the person with a stigma is not quite human" (Goffman, 1963, p.5). A low status individual can be seen as below a high status one, but it seems more apt to describe a stigmatized individual as below and apart from a non-stigmatized one.

It is important to note that the normal-abnormal distinction may not be sharply demarcated. Although women occupy a lower status than men, we would argue that they are in no way considered abnormal. At the other extreme, dwarves or people with psychosis would clearly be considered abnormal. Racial minority status may occupy a middle ground in terms of the degree to which they are viewed as "normal" human beings by racial majority group members. Similarly, the distinction between status and stigmatized characteristic may not be unambiguous. Race has traditionally been described as a status rather than a stigmatized characteristic (Phelan et al. 2008), but all the components of a stigmatized

characteristic described by Link and Phelan (2001) appear to apply to minority racial status.

2. Social ordering schemas

Ridgeway (2006) argues that status-based interactions draw on a "modular" or "social ordering schema" that guides and smooths interactions between different status groups. The shared status beliefs that associate status and competence differences with people who differ on given social characteristics effectively provide people from different status groups with a common knowledge schema for anticipating one another's behavior and coordinating their interaction accordingly. For example, there is a culturally shared belief that men are more esteemed and competent than women (Fiske, Cuddy, Glick, & Xu, 2002); these shared status beliefs tell people how they should behave in interactions with one another (men more assertively; women more deferentially); and people act out their roles accordingly. Interestingly, although there are also shared cultural beliefs that stigmatized persons are less esteemed and competent than "normals" (Link et al., 1989), interactions between stigmatized and normals are not smooth. In fact, a key aspect of stigma as described by Goffman (1963) (also see Blascovich, Mendes, Hunter, Lickel, & Kowai-Bell, 2001; Jones et al., 1984) is that the presence of the stigmatized characteristic (such as a facial scar or mention of a psychiatric hospitalization) disrupts interactions, causing discomfort and awkwardness, particularly for the non-stigmatized, because they are less practiced at "mixed contacts" and don't know what to expect from or how to behave with the stigmatized person, and also for the stigmatized person, who may have difficulty dealing with the non-stigmatized person's discomfort. This "not knowing what to do" problem is very different from what is observed in interactions between status groups. We do not have a firm answer as to why this is the case, but we propose the following possibilities for future exploration.

First, it may be that by casting the stigmatized outside the circle of the normal, we exclude them from participation in consensual processes that guide social interaction. Because these consensually shared road maps are necessary for smooth interactions, such interactions are not possible in mixed contacts. Note that this makes the stigmatized individual appear more unpredictable and consequently more anxiety provoking.

Second, it may be that the interaction strain seen in mixed contacts surrounds aspects of the interaction that don't have to do with status. That is, if we could separate out behavior relating to who is dominant, who defers and who asserts, the status-related aspect of the interaction might go smoothly enough. But mixed contacts also involve the "abnormal" dimension of stigma, and this dimension may be what causes the interaction strain. Though status-related behavior may be well prescribed, there is still the unsettling issue, for example, of where to look if the stigmatized interaction partner has a prominent burn on his or her face.

The unsettled reaction may reflect an element of fear or anxiety, which might sometimes be manifested as disgust, at being confronted with some attribute that is culturally defined as outside the consensual bounds of "normal." This abnormality dimension may also lead to strain through the normal's fear of "courtesy stigma" (Goffman, 1963). That is, the normal may fear being identified with and tainted by association with the stigmatized person in a way that would not be expected for status-related interactions, for example between women and men or blacks and whites, which are common and probably not expected to transfer lower status to the higher status individual.

Third, it may be that there are conflicting sets of consensual beliefs, operating at different levels, about the relative esteem and abilities of stigmatized and non-stigmatized groups. Either of these sets of beliefs, operating alone, could generate well orchestrated interactions between stigmatized and normals, but operating simultaneously, the interactional scripts they suggest conflict with one another. As described in Gaertner and Dovidio's (1986) theory of aversive racism, there may be one longstanding and well-rooted consensual belief that stigmatized people are less esteemed and capable than normals, and a second, historically more recent set of consensual beliefs that are considered more socially acceptable or "politically correct," superimposed on the first set. This second set of consensual beliefs may indicate that stigmatized people are no different from normals and should be treated no differently. This kind of conflict causes interaction strain for "aversive racists," whose long-held and implicit negative attitudes about blacks are at odds with their more recently acquired explicit positive attitudes, which are the beliefs they feel they should have and believe they do have. This phenomenon may apply to other situations in which long-held negative stereotypes (e.g., of mentally ill people or sexual minority groups) are confronted by prominent anti-stigma or anti-discrimination campaigns that suggest the long-held negative stereotypes are immoral or unacceptable. SCT recognizes that consensual status beliefs have historical origins and change but doesn't address the issue of transitional periods when multiple conflicting consensual beliefs may be broadly held in the population. In fact, conflicting consensual beliefs may not characterize most social status categories dealt with in the SCT literature. Although beliefs in the injustice of socioeconomic or gender inequalities do have currency in U.S. culture, at the same time, these inequalities are broadly legitimated by system-justification beliefs (Jost & Banaji, 1994) and various dimensions of sexism (Glick & Fiske, 1996). Racial differences have also traditionally been legitimated by beliefs in the inferiority of racial minority groups (Feagin, 2001), but in the current context, especially for middle-class liberals, these justifications are strenuously challenged (Gaertner & Dovidio, 1986). Likewise, this explanation would not apply to stigmatized characteristics (such as obesity) that are consensually considered worthy of disdain at both implicit and explicit levels.

Finally, interaction patterns suggested by consensual status beliefs are only "roadmaps." Interaction patterns are actually worked out in real interactions and reinforce themselves across many interactions over time (Ridgeway, 2006). Whether because particular stigmatized groups may be small in number (e.g., sexual minorities are only about 3.5% of the general population, Gates, 2011) or because of social distance and segregation, interactions between stigmatized people and "normals" may not be as frequent as between status groups, and this may hamper the development of ordering schemas and the interaction patterns that flow from them.

3. Normality, ordering schemas and social distance

The differences we have noted between stigma and status processes are likely to produce differences in social distance as well, with social distance arising in the case of stigma but not in the case of status differences. Viewing another person as abnormal and very different from oneself would be expected to increase social distance. Likewise, uncertainty as to how to behave in interactions and resulting interaction strain also would be expected to increase social distance. Thus these processes may help explain the distinction in the way status and stigma processes have been characterized in their respective literatures with respect to social distance.

Overview of relationship between status and stigma processes

Status processes clearly differentiate people along a vertical hierarchical status dimension as illustrated in Fig. 1. Major treatments of stigma suggest that stigmatization also results in

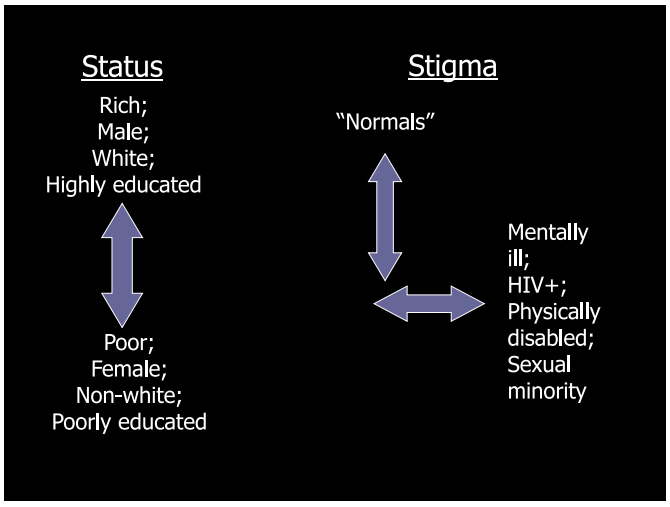

Fig. 1. Conceptual models for status (left) and stigma (right) processes.

differentiation along such a dimension. However the cognitive, social and physical separation that is described as a central component of stigma do not have a place in SCT. Fig. 1 illustrates our conceptualization of stigma, which entails a vertical status dimension, like status, but also a horizontal dimension of separation. In short, recalling the two major consequences for stigma according to Goffman (1963), we conceptualize stigma as involving status loss and social rejection. Partial support for this conceptualization was provided by Lucas and Phelan (2012), who used a standard SCT setting in which "partners" labeled with varying status characteristics were fictitious, and their input on a problem-solving task was pre-programmed and delivered to research participants by computer. Consistent with our conceptualization, labels of low educational attainment and mental illness reduced influence. Also consistent with our conceptualization, mental illness and physical disability labels, but not education labels, increased social distance. Inconsistent with the model presented here was the finding that a physical disability label did not reduce influence. This finding points to a complexity that needs to be addressed in further work. Stigmatized characteristics are quite heterogeneous, with a broad range of stereotypes associated with specific stigmatized statuses, and the model we propose may apply to specific stigmatized characteristics to a greater or lesser degree.

What do We gain by comparing status and stigma processes?

Theoretical development

Our understanding of interpersonal processes that lead to unequal outcomes is refined by examining similarities and distinctions between the social processes described in these two literatures. We provisionally conclude that there are two similar sets of processes leading to status differentiation, one of which includes social distance and one of which does not. Alternatively, it may be that status and stigma are not two distinct processes but that different social labels activate status, interaction strain, and social distance to different degrees.

Shared empirical literatures and research paradigms

In addition, we see that the empirical literatures and research paradigms in SCT and stigma have relevance for each other. For example, SCT provides experimental paradigms that will allow researchers to examine status loss for any stigmatized characteristic and to compare the results to dozens of existing studies of a variety of status characteristics.

A macro-social perspective on stigma

Most important for our purpose of understanding the social systemic aspects of stigma, we have seen close parallels between processes characterizing stigmatization and the status processes that contribute to systematic stratification by major social groups, such as race, gender and SES. We have seen that status and stigma link macro and micro social processes in similar fashion. Like status processes, stigma is rooted in shared cultural expectations that play out and become reinforced in interpersonal situations. This parallel underscores our contention that stigma is not only an interpersonal or intrapersonal process but also a macro-level process and raises the possibility of considering stigma as a dimension of social stratification.

Intervention

SCT researchers have developed effective interventions to alter status hierarchies. These interventions start with the assumption that expectations about performance ability associated with different statuses are widely shared in our society, that people will generally hold those expectations going into an interaction situation, and that unequal outcomes will ensue and further reinforce stereotypes, unless something is done to alter this sequence. Status hierarchies have been manipulated by demonstrating and making salient to all group members the competence of disadvantaged group members (Cohen & Roper, 1972; Lucas & Phelan, 2012), by identifying a disadvantaged-group member as a legitimate candidate for a high-status position (Lovaglia, Lucas, Houser, Thye, & Markovsky, 1998; Lucas, 2003) and by allowing people to observe a person in a disadvantaged group being treated deferentially by another person (Ridgeway & Erickson, 2000). Interventions have not only been demonstrated in analog experimental situations. They have also been applied effectively in settings such as schools and organizations (Cohen & Lotan, 1995; Lovaglia & Lucas, 2006).

Each of these approaches can potentially be applied to stigmatized statuses. Lucas and Phelan (2012) recently conducted what we believe is the first application of an SCT-based intervention approach to the problem of stigma. For fictitious partners labeled as having mental illness or physical disability, identifying the partner as also having high task ability mitigated against status loss and social distance. We suggest two general ways in which stigma-reduction efforts may be enhanced by attention to SCT processes: (1) programs that promote contact between stigmatized and other members of the public and (2) altering how stigmatized persons are portrayed in the media.

Contact

A large empirical literature on intergroup contact (Pettigrew & Tropp, 2006) suggests that contact between racial groups and other in- and out-groups, including persons with mental illness and with HIV/AIDS, generally reduces prejudice toward the out-group, even in the absence of the optimal conditions for prejudice-reduction (equal status, intergroup cooperation, common goals, and institutional support) proposed by Allport (1954), although such outcomes are not found consistently and do not always persist (Brown, Macintyre, & Trujillo, 2003). Research suggests that anxiety and uncertainty reduction may be important mechanisms in the contact-liking relationship (Blascovich et al., 2001; Stephan & Stephan, 1985). As discussed above, because of an absence of social ordering schemas for interaction between normals and many stigmatized groups, we expect anxiety and uncertainty to be prominent in stigma-based interactions (but not in status-based interactions), and thus contact may reduce prejudice toward stigmatized groups in a broad range of contact circumstances as suggested by the literature on inter-group contact.

A different perspective on contact is brought to bear by SCT. SCT addresses intergroup contact that, for the most part, occurs regularly and does not engender anxiety or uncertainty. SCT research shows that this contact normally serves to reinforce inequalities rather than reduce them. The different pictures presented by the inter-group contact and SCT literatures may be due to the difference in frequency of contact and the presence of anxiety and uncertainty, or it may be due to the different outcomes considered in the two literatures. Whereas the contact literature typically looks at the impact of contact on liking and prejudice, SCT looks at outcomes of influence and performance evaluation. Notably, race has been the most common focus of intergroup contact research, where contact increases liking (Brown & Hewstone, 2005). However, race has also been studied in SCT research (Webster & Driskell, 1978), where contact results in lower influence and performance evaluation for blacks than for whites. This suggests the possibility that many forms of contact that do not explicitly attempt to alter performance expectations may affect comfort and liking but not status. Therefore, we believe that contact-based stigma intervention programs should follow the model of SCT-based interventions by attending to the conditions under which contact occurs, so that contact increases the status of the stigmatized person.

Stigma and the media

SCT is based on processes that occur in interactions between people. However, many people do not have regular interactions with stigmatized individuals. For many members of the public, "interactions" with mentally ill people are not first-hand but are observed, for example, on television and in movies. Moreover, the mass media is an important source of stigmatizing messages about mental illness (Wahl, 1995). Ridgeway and Erickson (2000) showed that an initially arbitrary, value-neutral status characteristic could be taught to third-party observers by having an experimental confederate treat the person with the characteristic with either a high or low degree of deference. Although, to our knowledge, this phenomenon has not been demonstrated in the stigma literature, it is consistent with Link's modified labeling theory (Link et al., 1989). Link and colleagues argue that conceptions of how mentally ill people are viewed and treated by "most people" derive from messages in the culture, which we can assume includes observations of interactions between mentally ill and other people in real life and in mass media. If Ridgeway and Erikson's (2000) findings do apply to the case of mental illness and other stigmatized characteristics, this finding has implications for fighting stigma in the entertainment media. It suggests that, in addition to the more obvious problem that characters with mental illness are portrayed as having negative qualities such as being incompetent or dangerous, the way other characters relate to the mentally ill character may be equally as important (Wahl, Wood, Zaveri, Drapalski, & Mann, 2003). Stigma will be reduced by having other characters relate to the mentally ill character in a respectful manner. This will involve subtle cues such as listening, nodding, giving credence to statements made by the character with mental illness, and following suggestions made by the mentally ill character.

Health implications

Large empirical literatures link diffuse status characteristics in SCT – in particular, gender, SES and race – to health outcomes (Berkman & Kawachi, 2000; Link & Phelan, 1995; Read & Gorman, 2010). A variety of explanations for these patterns have been proposed (Balsa & McGuire, 2001; Dohrenwend et al. 1992; House, Landau, & Umberson, 1988; Link & Phelan, 1995; Pearlin & Bierman, 2012; Williams & Collins, 2001). Of particular relevance to SCT are explanations that trace health inequalities to psychological and behavioral responses to status differences *per se* (Marmot, 2004). However, SCT itself does not address health outcomes, and health consequences of stigmatization have not been extensively investigated (but see Hatzenbuehler et al., 2013). In keeping with this issue's theme of systemic stigma and population health, we focus here on three ways in which our examination of SCT and its connection to stigma can help us understand the impact of status-related and stigmatized characteristics on health.

First, research linking placement in a status hierarchy with health has focused on stress responses as a mechanism. Being low status (Dickerson & Kemeny, 2004; Sapolsky, 2005; Taylor, 2014) causes biological stress responses in humans and other animals, and such responses are linked with negative health outcomes. As such, status dynamics may cause stress response to both members of groups with a low value of a status characteristic (e.g., women, people of color) and members of stigmatized groups. Consequently, members of social groups that are chronically treated as low status or stigmatized may be more likely to suffer the types of negative health outcomes linked to relatively low placement in a status hierarchy, such as cardiovascular disease, diabetes, fatigue and pain syndromes and mental health disorders (e.g., anxiety, depression and PTSD) (Dickerson & Kemeny, 2004; Gesquiere et al., 2011; Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010; Sapolsky, 2005; Stroud, Tanofsky-Kraff, Wilfley, & Salovey, 2000). And through the relationship between stress, social status and stigma, broad patterns of population health outcomes may partially be explained by the structural relationship between membership in a stigmatized or low-status group and lack of access to social status (Marmot, 2004). Although SCT and its research paradigms seem very fruitful for examining the stress consequences of status-based interactions, we believe Taylor (2014) is the first to make such an application.

The previous mechanism involves health impacts working through psychological or physiological responses in the low status or stigmatized individual. However, we argue that SCT-like processes can also affect the behavior of high-status individuals or "normals" in ways that harm the health of the low status or stigmatized. There is abundant evidence that racial minorities in the U.S. receive inferior health care (Institute of Medicine, 2003). Similarly, Druss, Bradford, Rosenheck, Radford, and Krumholz (2001), in a large study of Medicare patients, found that patients with any mental disorder had a 19% increased risk of death in the year following an acute myocardial infarction (MI) compared to those with no mental disorder, and this difference was largely mediated by differences in quality of care received after the MI. A study by Schulman et al. (1999) shows how at least some of these disparities in health care can be traced to processes described in the status and stigma literatures. Schulman et al., carried out an experiment in which they created videotapes of actors posing as cardiovascular patients. The behavior, dress and clinical information of the "patients" were identical; however, the patients differed in terms of race, gender and age. Cardiologists attending a national cardiology conference were randomly assigned to view one videotape, evaluate the case and provide treatment recommendations. Results showed that cardiologists were significantly less likely to recommend African American "patients" for cardiac catheterization, the treatment of choice for the symptoms described in the videotapes. As in SCT experiments and the experiment by Sibicky and Dovidio (1986), the identification (labeling) of the patient as African American and expectations associated with that label are the only plausible explanation for differences in treatment recommendations. We expect that, as illustrated in this study, negatively evaluated labels and the implicit, unspoken, expectations associated with them account for widespread inferior health care received by groups described in the status and stigma literatures.

Finally SCT helps elucidate the broad connection between stigma and more traditional bases of social stratification such as race, gender and SES. The connection between these statuses and health outcomes is well established. Researchers should likewise explore the value of thinking about the connection between stigmatized statuses and health in similar ways. For example, Link and Phelan (1995) proposed that SES is a fundamental cause of health inequalities. They observed that there is an obstinate association between SES and health that persists over time even when diseases, risk factors and treatments change radically. They proposed that the reason for this enduring association is that higher SES confers a set of flexible resources, such as money, power, prestige, knowledge and beneficial social connections – resources that can be used to benefit one's health regardless of the particular conditions one encounters. In fundamental-cause theory, prestige (a defining feature of status in SCT) is one of the core resources people draw on to improve their health, and thus the theory directly ties status to health outcomes. With the link between stigma and major forms of stratification that SCT has helped us appreciate, we might ask whether stigmatization is a fundamental cause of disease. Hatzenbuehler et al. (2013) argue that this is the case. Just as with low SES, a stigmatized person is likely to have poorer resources of money, power, prestige and beneficial social connections. These lower resources may in part entail a loss of SES or hampered ability to attain high SES that results from the stigmatized status, for example through job discrimination. They may also involve resources that are more independent of SES, such as a loss of beneficial social connections due to social rejection of the stigmatized person. According to fundamental-cause theory, these diminished resources would limit the stigmatized person's health. In sum, the application of status characteristics theory and research to the problem of stigma leads us to new and potentially fruitful avenues for establishing the existence and health consequences of systemic stigma.

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