ADDRESSING RACIAL DISPARITIES IN HEALTH USING LIFE COURSE PERSPECTIVES

Toward a Constructive Criticism[1]

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Abstract

In the United States, African Americans face stark inequalities in health. The life course perspective offers a unique viewpoint through which racial disparities in morbidity and mortality may be understood as the result of repeated exposures to risk factors during both childhood and adulthood. However, the utility of this approach is limited by its failure to investigate the degree to which racial/ethnic minorities are able to translate gains in socioeconomic status into favorable health outcomes, both for themselves and for their children. In order to adequately reflect the realities of marginalized groups, life course models must explore the interactive nature of linkages across lifecourse stages, pay particular attention to the unique processes that create and maintain health disparities over time, and consider the specific contexts in which these processes occur. To this end, I examine the ways in which exclusionary forces and discriminatory conditions are likely to prevent African American women and their children from reaping the health benefits typically associated with upward socioeconomic mobility.

Keywords: Race, Health, Socioeconomic Mobility, Discrimination, Life Course

INTRODUCTION

Racial disparities in health have been well documented across a wide variety of outcomes and disparate settings. In the United States, stark inequalities persist despite medical advancements, public health campaigns, and policy initiatives. In 2006, life expectancy at birth for White men and women reached seventy-six and eighty-one years, respectively. However, Black men and women could only expect to survive until their seventieth and seventy-seventh birthdays, respectively (Heron et al., 2009).

Racial disparities in health cannot be attributed to differential distributions of socioeconomic resources across minority and majority populations. While African Americans are overrepresented among the poor, Black/White inequalities in well-being remain apparent after accounting for socioeconomic position (SEP) (Braveman et al., 2010). Moreover, racial differentials in health tend to be *more* pronounced

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among high-SEP individuals (Williams and Sternthal, 2010). In 2007, African Americans whose incomes fell below the poverty threshold were 8% more likely than Whites within the same income category to report fair or poor health, while African Americans with incomes above 200% of poverty were 59% more likely than similarly situated Whites to rank their health as fair or poor (National Center for Health Statistics (NCHS) 2010).

Efforts to understand, and thus eliminate, racial inequalities in health can be enhanced by theoretical perspectives that accurately capture complicated, longitudinal progressions instead of relying on overly reductive, time-insensitive explanations. To this end, social scientists have turned toward the life course approach as a conceptual lens through which adult disease risk may be understood with greater insight. A rapidly accumulating body of research highlights the importance of childhood and adult factors in the production of health (Davey Smith 2003; Kuh and Ben-Shlomo, 1997). Life course models simultaneously emphasize the importance of past and current exposures, underscore cumulative progressions within individuals and across populations, and provide an ideal framework within which to examine intergenerational outcomes due to a focus on sequential events. However, the extent to which existing life course perspectives consider experiences unique to racial/ethnic minorities remains highly circumscribed.

While it has become evident that conditions in childhood contribute to the development of health in later life, the specific pathways by which social, economic, and political forces interact over time to produce an exclusionary environment toxic to the health of African Americans remain largely uncharted. We cannot simply assume that current life course frameworks will be useful in explaining Black/White disparities in well-being. In order to fully appreciate the dynamic processes and recursive complexities that characterize the ways by which SEP, race, and gender coalesce to (re)produce racial inequalities in health over time, it is necessary to expand our theoretical focus.

The purpose of this paper is twofold. First, following a review of existing life course models, I will delineate the shortcomings of current frameworks that limit their ability to accurately reflect experiences common to many racial/ethnic subpopulations. Second, I will illustrate how exclusionary forces, along the fault lines of race, class, and gender, work in tandem *over time* to erode health and hasten disease progression among minority populations. Doing so will require a shift in focus from static to dynamic interpretations of stratification processes. To this end, I will be asking whether changes in SEP over the life course (i.e. socioeconomic mobility) are likely to differentially impact the health of African Americans compared to their White counterparts.

I highlight the ways in which exclusionary forces are likely to constrain health returns typically associated with upward mobility for African American women. This type of narrow analytic approach allows me to disentangle complex ways in which race, class, and gender shape the production of health and illness over time while placing the experiences of an often overlooked population at the forefront of an important debate. However, many of the issues raised here are of significance to African American men as well as women and to individuals descending the socioeconomic hierarchy as well as ascending it. It should be noted that by providing this type of critique, I am not suggesting that upward mobility, in and of itself, is harmful to the well-being of Black women. Rather, I am hoping to illuminate how stratification processes curtail the subsequent benefits that African American women can obtain by improving their level of SEP across the life course.

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EXISTING LIFE COURSE FRAMEWORKS

Critical Periods (Latency) Model

Previous research suggests three mechanisms through which early life conditions may influence subsequent health. First, the critical periods model proposes that excessive rates of adult disease are strongly and independently influenced by exposure to risk factors during specific periods of biological growth. For example, the fetal origins hypothesis predicts that individuals who are exposed to unfavorable intrauterine environments, primarily as a result of inadequate maternal nutrition, during certain stages of fetal development face an increased probability of experiencing adverse health conditions in adulthood (Barker 1998).

This approach often emphasizes the importance of early life factors while ignoring the ways in which intrauterine exposures, childhood conditions, and resources in adulthood *interact* to influence health during later life. This is especially problematic since the empirical evidence points to the importance of examining linkages across life course stages. The negative effect of restricted intrauterine development on adult health appears to be most pronounced among individuals who have experienced a period of catch-up growth during childhood (Barker et al., 2005). This suggests an interactive, as opposed to cumulative, relationship between conditions at different stages of development, where the true effects of early life exposures on adult health are dependent on subsequent experiences.

Accumulation-of-Risk Model

The accumulation-of-risk approach hypothesizes that chronically poor individuals will experience the highest rates of morbidity and mortality, while their consistently nonpoor counterparts will have the lowest rates of disease and death. To the extent that investigators have considered the impact of social mobility on adult health, individuals experiencing upward or downward mobility are expected to fall somewhere in between. Thus, a simple model where upward mobility is unambiguously beneficial to physical well-being has been proposed. Because this type of framework reinforces deeply held American ideals concerning individuality, personal responsibility, and achievement, it is often thought to be axiomatic.

Limited empirical support for the accumulation-of-risk hypothesis exists (Davey Smith and Hart, 2002; Lawlor et al., 2005). However, studies that typify the implementation of this perspective often simply count the number of times an individual (or one's father) occupies the lower rungs of the socioeconomic hierarchy at three time points: childhood, labor market entry, and adulthood. This approach neglects to take into account the length of time an individual spends in poverty, thus ignoring characteristics vital to the examination of longitudinal progressions such as duration, temporality, and causal ordering. In so doing, an interactive process is distilled to discrete occurrences and the dynamic interchange between conditions at different time points is overlooked. Similarly, measures of lifetime SEP are often based on occupational categories, such as manual versus nonmanual, rather than continuous gradations of educational attainment, occupational prestige, or income. Such blunt measurement tools may mask the impact of subtle shifts in upward or downward mobility on subsequent well-being.

Pathways Model

The pathways model highlights probabilistic linkages between exposure to risk factors during childhood and repeated insults to health encountered throughout the life

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course (Case et al., 2005; Duncan et al., 1998). This model often characterizes individual physical well-being as heavily influenced by socioeconomic trajectories, which are envisioned as a series of discrete circumstances that unfold in a successive manner with each event affecting the likelihood that the next will occur. For example, individuals with limited socioeconomic resources during early life tend to exhibit lower rates of educational preparedness which may, in turn, negatively influence the probability of high school completion, occupational success, income trajectories, wealth accumulation, socioeconomic stability, and thus physical well-being during adulthood. In contrast to the accumulation of risk model, the pathways model emphasizes the processes that lead an individual from one social status to the next and how this sequence of events, taken as a whole, impacts adult health. This is typically the most underdeveloped and least frequently tested life course model; however, its central argument remains compelling.

Serious constraints limit the ability of existing life course models to accurately depict the dynamic interplay of race, class, and gender in the (re)production of health disparities among African American women. First, both accumulation and pathways models assume that upward mobility will result in significant improvements to physical well-being. This is thought to occur through a number of different mechanisms, such as increased access to health-care services, reduced environmental stressors, and the adoption of protective health behaviors. Due to a convergence of social, economic, and political factors, upward mobility is not likely to provide similar health returns to Black as to White women. Successful attempts at socioeconomic ascendancy in the face of protracted discriminatory forces may come at a cost to well-being.

Second, most empirical studies designed to test existing life course frameworks have been conducted using data from Western European countries. Because of differences in the structure of national welfare policies, accessibility of health-care services, and historical patterns of immigration, it is unclear how relevant these results will be to the experiences of minority populations in the United States, especially those facing prolonged discrimination and disadvantage. Third, the degree to which the association between lifetime SEP and adult health varies by race/ethnicity is rarely assessed. The few studies that have included African Americans in their samples have produced mixed results and require replication before definitive conclusions can be drawn (Farmer and Ferraro, 2005; McDonough et al., 1997; Preston et al., 1998; Walsemann et al., 2008).

Fourth, extant life course models do not critically consider the ways in which gender is likely to influence the production of health over time. An important aspect of this failing concerns using one's father's and/or husband's social class status to capture female mobility trajectories. Compared to White women, African American women have historically exhibited a greater attachment to the labor force. Although this gap has narrowed in recent years (England et al., 2004), Black families rely heavily on the earnings of their female members, who are more likely than White women to be household heads (Bianchi and Casper, 2000). Thus, SEP measures based on male workforce participation are more likely to reflect the economic resources available to White rather than African American families.

Finally, research examining the impact of life course processes on physical well-being has largely neglected maternal and infant outcomes. A limited number of existing studies specifically address these linkages (Collins et al., 2009; Love et al., 2010). Colen et al. (2006a) report that among women who were poor as children, increases in adult family income across the life course were associated with a 50% decrease in low birth weight (LBW) for Whites but not Blacks. Not only are perinatal indicators central to the lives of women, but they often serve as an early

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signal of a lifetime of suboptimal health status. Racial disparities in perinatal health remain an epidemiologic puzzle that is proving difficult to solve. African American infants remain at risk of being born preterm or LBW even after controlling for risk factors such as prenatal care, maternal health behaviors, and insurance coverage.

These critiques call into question the universality of life course frameworks that assume a monotonic, linear relationship between lifetime SEP and health. For some individuals, especially those who face discrimination and/or disadvantage along multiple social fault lines, health returns to upward mobility are likely to be significantly muted. This suggests the need for conceptualizations flexible enough to capture the impact of interactions, both over time and across social statuses, on long-term health outcomes. While the fetal origins hypothesis recognizes that early life factors may act to constrain the association between adult resources and physical well-being, its narrow focus on the intrauterine environment prevents it from being a satisfying explanation for why racial inequalities in health are (re)produced over time even among populations who have successfully ascended the socioeconomic hierarchy.

In the following sections, I will discuss the distinct mechanisms through which upward mobility may not confer similar health benefits to Black and White women. I will argue that the processes involved in ascending the socioeconomic hierarchy *qualitatively* differ for African American women compared to White women due to three overarching factors: the extent to which structural level racial inequalities restrict African Americans' access to social and economic resources; an increased exposure to interpersonal psychosocial stressors; and their greater reliance upon intrapersonal strategies that may inadvertently harm their health. Figure 1 presents a conceptual framework designed to elucidate these mechanisms.

STRUCTURAL FACTORS

Employment-Based Discrimination

While Black women have historically worked outside the home, they typically have not been able to gain access to high-paying professions offering opportunities for advancement and job security. Instead, they are often segregated within the lower primary or secondary labor market (Reid and Rubin, 2003). Hughes and Dodge (1997) find that African American women occupying positions in the lower primary report significantly more incidences of institutional discrimination than African-American women in the secondary sector. It is precisely in the lower primary segment that we would expect upwardly mobile Black women to be clustered. Chronically poor women are more likely to hold jobs in the secondary sector, while women from middle-class backgrounds have a greater chance to occupy positions in the upper primary sector. Occupational discrimination may restrict health returns to upward mobility directly by triggering negative physical reactions or indirectly by hindering promotional advancement and subsequent income trajectories.

In employment settings, African American women may be faced with the difficult decision to express concerns in terms of their gender or their race but seldom get the opportunity to do both. Black women who work in settings with few racial minorities are likely to encounter difficulties stemming from their token status. Jackson et al. (1995) report that African Americans outnumbered by Whites in occupational settings are more likely to suffer from token stress—defined as loss of Black identity, multiple demands of being Black, having to demonstrate more competence, and a sense of isolation—and become depressed. Similarly, African American women whose work environment is dominated by men are more likely to

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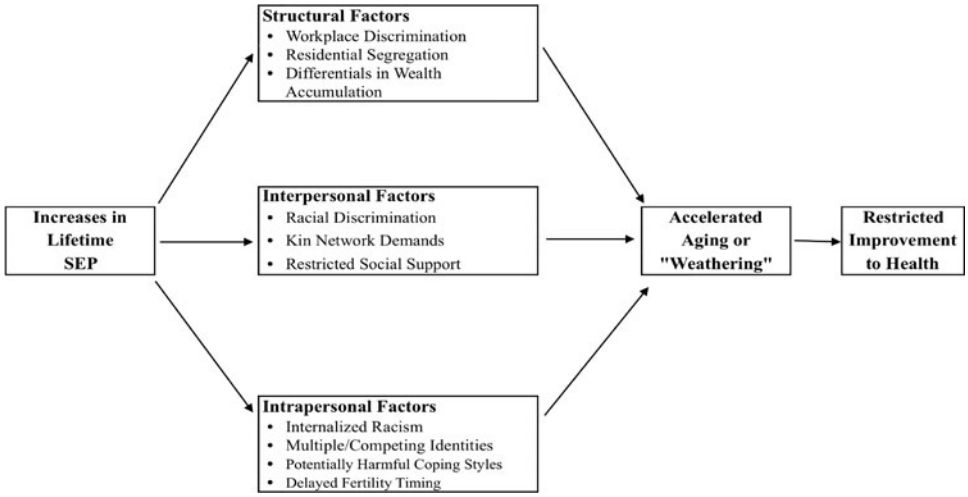


Fig. 1. Mechanisms likely to restrict health returns to upward mobility for African American women

experience role overload—defined as too many time demands, juggling private and work life, and too many responsibilities—and become anxious.

Residential Segregation

Racial residential segregation contributes to increased concentrations of neighborhood poverty, substandard schools, persistent unemployment, as well as increased crime and social disorder (Charles 2003; Massey and Denton, 1998). Although upwardly mobile African American women may have access to increased monetary resources, residential segregation limits their ability to move into neighborhoods with less crime, better schools, and fewer environmental hazards (Pattillo 2005). Blacks remain substantially less likely than Whites with similar sociodemographic characteristics to move from poor to nonpoor census tracts (Crowder and South, 2005). Moreover, the extent to which Blacks are residentially segregated from other racial/ethnic groups appears to increase as income rises (Massey and Fischer, 1999). Pattillo-McCoy (1999) finds that upwardly mobile African American residents of Chicago remain within the confines of traditionally Black neighborhoods, often serving as a buffer between poor Black and White areas. It should be noted, however, that some middle-class African Americans may choose to live in predominantly Black neighborhoods in order to strengthen social ties with supportive neighbors, maintain connections to religious institutions and community organizations, and enable their children to form lasting relationships with same-race friends (Lacy 2007).

The negative effects of residential segregation are hard felt and far-reaching. For African Americans, segregation is positively associated with all-cause mortality (LaVeist 2003), self-rated health (Subramanian et al., 2005), cardiovascular disease, (Cooper et al., 2001), tuberculosis (Acevedo-Garcia 2001), and infant mortality (Grady 2006). Jackson et al. (2000) illustrate that African American men and women living in census tracts with the highest proportion of Black residents are 2.8 and 2.7 times more likely to die, respectively, than African American men and women living in census tracts with the lowest proportion of Black residents. Osypuk and Acevedo-Garcia (2008) report that Black/White disparities in preterm birth are significantly

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greater in hypersegregated as opposed to nonhypersegregated metropolitan areas. Moreover, the effect of segregation on preterm birth appears to intensify as maternal age increases.

Earlier research efforts, conducted primarily with aggregate data, provided overwhelming substantiation that segregation is linked to poor health for populations of African descent. However, there is mounting evidence that specific characteristics of segregated environments are detrimental to the health of African Americans while others might actually be protective. For example, Bell et al. (2006) demonstrate higher racial *isolation* to be predictive of LBW, preterm birth, and fetal growth restriction, while higher racial *clustering* is associated with significant reductions in the odds of LBW and preterm birth. Subramanian et al. (2005) similarly find that high Black isolation, but not White/Black dissimilarity, predicts poor self-rated health across U.S. metropolitan areas.

Differential Wealth Accumulation

African Americans at every level of the socioeconomic hierarchy accumulate less wealth than their White counterparts (Conley 1999; Oliver and Shapiro, 1995). Within the lowest income quintile, Black and White households report a median net worth of $2,400 and $17,066, respectively. Within the highest income quintile, the median net worth of Black and White households is $43,806 and $133,607, respectively. These stark differences in wealth accumulation are evident when examining racial disparities across other dimensions of SEP (Shapiro 2004). For upwardly mobile Black women, these unquestionable discrepancies in wealth accrual translate into a precarious middle-class status that can be eliminated easily by economic downturns or financial crises.

A substantial proportion of net worth is attributable to home equity. The greater tendency for African Americans to be segregated within poorer neighborhoods, encounter restricted access to mortgage loans, and witness limited appreciation or devaluation of home values contributes to the enormous difference in assets when comparing middle-class Blacks to similarly situated Whites (Shapiro 2004). The precarious nature of home ownership and equity among African Americans has been painfully apparent during the recent mortgage crisis as foreclosures among Blacks substantially outpace those among Whites (Rugh and Massey, 2010). For men and women occupying a wide range of ages, measures of wealth have been found to be significant predictors of morbidity and mortality above and beyond traditional indicators of SEP (Bond-Huie et al., 2003; Robert and House, 1996). Moreover, because of continued responsibilities to extended kinship networks as well as the clustering of concentrated poverty within these networks, upwardly mobile Black women are more likely than Whites to feel a sense of indebtedness to families of origin and share newly acquired wealth with poorer network members (Higginbotham and Weber, 1992).

INTERPERSONAL FACTORS

Racial Discrimination

Although upwardly mobile Black women have access to greater socioeconomic resources, they remain at risk of encountering racial discrimination. In fact, there is mounting evidence to suggest that individuals occupying the upper tiers of the socioeconomic hierarchy are *more* likely to experience racial discrimination than

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their low-SEP counterparts (Forman 2003; Ren et al., 1999; Schulz et al., 2000; Williams et al., 1997). Ren et al. (1999) find that among African Americans, 71% of respondents with some college, 53% of high school graduates, but only 45% of high school dropouts are subjected to discriminatory acts related to one's race. A similar trend is nonexistent among Whites (3.1%, 2.5%, and 2.1%, respectively). It remains unclear, however, whether this is due to differential reporting or discrepancies in exposure.

Racial discrimination does not have to result in a life-altering event to negatively impact health. Williams et al. (1997) find that everyday discrimination, rather than major experiences of discrimination, is associated with self-reported ill health and physical incapacitation. Middle-class African Americans report having a difficult time moving past incidents involving interpersonal racism because they cause a significant amount of psychological pain (Cose 1993) and "haunt the mind for months and years" (Feagin and Sikes, 1994, p. 64). Middle-class Blacks face a serious dilemma. According to accepted American ideals, hard work and educational attainment are supposed to result in socioeconomic achievement curtailed only by one's abilities. However, upwardly mobile African Americans encounter a reality in which the color of their skin limits the extent to which they will be able to benefit from accomplishments and ensure intergenerational transmission of newly acquired SEP.

Extant research suggests that race-related stress is an important predictor of well-being among African Americans. While empirical evidence points to a more consistent negative association with mental health status (Williams et al., 2003), reports of racial discrimination have been linked to suboptimal physical functioning (Borrell et al., 2006), negative health behaviors (Borrell et al., 2010), and compromised perinatal outcomes (Collins et al., 2004). Mustillo et al. (2004) note that compared to women who report no racial discrimination, women reporting high levels of racial discrimination were almost five times as likely to give birth to a LBW baby net of the effects of SEP, negative health behaviors, and depressive symptoms.

Due to minimal attention to context-specific characteristics that may moderate the impact of racial discrimination on health, a paucity of standardized measures, and limited specificity regarding how racial injustice "gets under the skin," much about the relationship between discrimination and health remains unclear. It appears that the strength of this association is conditional on factors such as psychosocial strategies and coping styles, the accessibility and type of social support mechanisms, and demographic characteristics such as SEP and gender (Collins et al., 2004; Forman 2003; Krieger and Sidney, 1996; LaVeist et al., 2001). Relying on a unique study design, Lauderdale (2006) demonstrates that during the six-month period immediately following September 11, 2001, the risk of giving birth to a preterm or LBW baby significantly increased among California residents with recognizable Arabic names but not for any other racial/ethnic group. This finding suggests that racial/ethnic discrimination does, in fact, have the capacity to impact maternal and infant health status even among a subpopulation that does not typically experience poor perinatal outcomes.

Kin Network Demands

Of particular concern is the extent to which upwardly mobile African American women will be able to maintain ties to extended kinship networks as they move away from families of origin in order to ascend the socioeconomic hierarchy. This may be problematic in terms of frequency and quality of contact, receipt of social support, and increasing expectations to provide financial assistance. Upwardly mobile African

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Americans may find it increasingly difficult to socialize with families of origin, either due to rising responsibilities in their newfound social positions or mounting friction among network members stemming from diverging experiences. Networks that were once mobilized to maximize the likelihood that a particular member would achieve her educational or occupational potential may now expect to reap rewards associated with previous sacrifice. While upwardly mobile members of all racial/ethnic groups are likely to encounter similar pressures, the protective capacity of social networks is critically important for African American women who are likely to face unrelenting racial discrimination and gender bias in new educational, occupational, and neighborhood settings.

The importance of kin support, be it biologically or socially defined, in order to facilitate sharing of scant resources within high-poverty Black populations has been well documented (Sarkisian and Gerstel, 2004; Stack 1997). In particular, social networks provided a key source of support for African American women with regard to childbearing and rearing. What remains unclear is the extent to which *upwardly mobile* Black women rely on network members for such assistance, especially when they are likely to postpone childbearing. Given that African Americans encounter excessive rates of incarceration (Pettit and Western, 2004), disability (Geronimus et al., 2001), and mortality (Geronimus et al., 2010) with increasing frequency throughout the life course, nonpoor Black women from backgrounds of limited socioeconomic means may face particularly grim chances that family members would be able to provide similar support had they had children earlier. Moreover, upwardly mobile Black women may be expected to care for unhealthy or aging kin precisely at the time their careers are taking off and they are having children. Such conflicting needs among network members is likely to exacerbate existing problems and present new interpersonal challenges. Colen et al. (2006a) report that 47% of chronically poor Black women but only 18% of their upwardly mobile counterparts reside with their own mothers at the time of their child's birth. This often unforeseen consequence of combining intergenerational gains in SEP with delayed fertility timing may be especially detrimental to the health of African American infants given that the presence of a coresidential grandmother in the household at the time of birth has been found to be negatively associated with LBW (Colen et al., 2006a).

Internalized Racism

One of the most distressing outcomes stemming from experiences with racial discrimination involves the internalization of negative images and messages by members of the stigmatized group. This can happen on a conscious or subconscious basis; thus, individuals may not realize they rely on harmful characterizations to describe themselves or the groups to which they belong. Internalized racism stifles notions of self-worth, the capacity to accurately assess abilities, and, perhaps most importantly, the power to envision a different life for oneself. Jones (2000) likens discrimination that operates on an intrapersonal level to a form of self-hatred that not only erodes an individual's sense of worth but also prevents collective action from taking place.

A notable aspect of internalized racism is its insidious nature. Often, minority group members do not recognize they have inadvertently adopted negative stereotypes or messages about themselves from the dominant culture. Moreover, they may hold conflicting explanations as to why racial inequalities persist regardless of the social, economic, and political inroads made. Bonilla-Silva (2001) notes that although a majority of African Americans reject dominant positions on race-related matters, notably those emerging from the "color-blind" perspective, these ideologies heavily

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shape the framing of the discourse on race in which both Blacks and Whites engage. For example, a nontrivial proportion of Black interviewees believed that while discriminatory forces curtail achievement among African Americans, their unequal position in society may be explained—at least in part—by their inability to obtain proper levels of education or employment.

To my knowledge, few studies specifically examine the linkages between internalized racism and health outcomes (Butler et al., 2002; Tull et al., 1999, 2005). These provide preliminary evidence to suggest a possible association between the internalization of negative racial stereotypes and abdominal obesity, glucose tolerance, and cortisol dysregulation among African Caribbeans. Given that upwardly mobile African Americans are likely to have more consistent contact with Whites, including those who have little experience functioning in an integrated environment, they may be bombarded with negative racialized messages on a more frequent basis than their chronically poor counterparts. Furthermore, Black women who have recently attained middle-class status may be less likely to seek out support from kin networks to reaffirm their racial identity if conflicts concerning socioeconomic divides already exist. Both frequency of occurrence and a reduced capacity to counteract the deleterious effects of internalized racism are likely to hamper upwardly mobile African American's capability of avoiding disease, disability, and death over the life course.

Multiple/Competing Identities

Due to differences between the social environment in which they were raised and the one they currently occupy, upwardly mobile Black women may need to adopt dual (or multiple) identities in order to successfully navigate sociocultural distances between their family of origin and their achieved SEP. Referring to the processes involved in developing separate identities as "biculturalism," Bell et al. (2001) note that from an early age Black women, but not their White counterparts, learn to negotiate vastly different social settings which are often organized around contradictory expectations. As African American women pursue middle-class status and encounter discrimination with greater frequency, a bicultural life structure allows them to maintain essential, affirming, and protective ties to the Black community.

The need to sustain dual/multiple identities is likely to trigger psychological or physiological manifestations of stress when one is forced to suppress key aspects of one's racial/ethnic identity—especially those that preserve connections to one's community of origin. While upwardly mobile individuals from a wide range of racial/ethnic backgrounds shift their sociocultural orientation depending on the subset of their social network with whom they are interacting, the need to cross class boundaries to preserve social ties is likely to be more common among African Americans due to the widespread effects of concentrated poverty and, more importantly, to the deleterious health effects of racial discrimination.

Similar to processes required to maintain dual identities, Jones and Shorter-Gooden (2003) find that a majority of Black women engage in "shifting" by frequently sublimating their true identities in order to project a self-image that is acceptable to either White colleagues or African American men. Shifting between divergent identities is thought to lead to increased psychosocial stress through three prevailing mechanisms: hyper-vigilance regarding the acceptability of one's own behavior or the possible presence of subtle discriminatory messages from others; pervasive stoicism which may be protective against racism but can also contribute to

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extreme emotional disengagement; and intense feelings of self-loathing or inadequacy that may lead to destructive behaviors.

Potentially Harmful Coping Styles

Coping styles employed by African Americans in order to function in a discriminatory and highly racialized environment may have unintended, harmful health consequences. Among Black women, sustained high-effort coping in the face of unyielding structural adversity (i.e., John Henryism) may attenuate the association between upward mobility and positive health outcomes such that the utility of simple linear, additive life course models must be questioned. The concept of John Henryism emphasizes an unwavering determination to succeed no matter what the physical costs (James 1994). Among high-status individuals, the empirical evidence linking John Henryism and negative health outcomes is mixed (Bonham et al., 2004; Fernander et al., 2004; Light et al., 1995; Markovic et al., 1998; McKetney and Ragland, 1996). Most relevant for examining racial disparities in health among nonpoor populations, Light et al. (1995) find that for Black women, high-effort coping in the presence of high, rather than low, status occupations is significantly associated with increased blood pressure.

Given that African Americans face employment discrimination, restricted returns to educational attainment, and vast disparities in wealth accumulation, being a member of the middle-class is not likely to confer a similar level of socioeconomic security for Black as opposed to White women. One way for upwardly mobile African Americans to maintain the impression that their newly established middle-class status offers comparable rewards is to engage in a coping style exemplified by lifestyle incongruity. This term, originally coined by Dressler (1988), refers to the extent to which individuals acquire more culturally valued items or behaviors than can be sustained by their current SEP. Lifestyle incongruity has been found to negatively influence depressive symptoms (Dressler 1988), blood pressure (Dressler 1990), and immune functioning (McDade 2001). However, empirical justification remains tentative as it is unclear how other important social characteristics, such as gender, age, and immigration status, affect the relationship between this coping style and subsequent well-being.

Fertility Timing and Accelerated Aging

Of particular relevance to the (re)production of racial disparities in well-being over the life course, the weathering hypothesis proposes that the health of African-Americans begins to decline in early adulthood and deteriorates at an accelerated pace over time as a manifestation of social, economic, and political exclusion (Geronimus 2001). Black women living on the South Side of Chicago are more than three times as likely as White women, nationwide, to die; only two-thirds can expect to be alive by their sixty-fifth birthday (Geronimus et al., 2010). By examining the age-related patterning of several biomarkers, including C-reactive protein, a potential biophysiological pathway through which weathering may occur has been established (Geronimus et al., 2006). Moreover, preliminary evidence suggests that telomere length, a biomeasure of aging especially responsive to stress, is significantly shorter among middle-aged Black as opposed to White women (Geronimus et al., 2010). Figure 1 illustrates that the concept of weathering provides a proximate pathway through which restricted returns to increased lifetime SEP is likely to constrain subsequent health gains.

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A key component of Geronimus's conceptualization suggests that impoverished African-American populations can mitigate the negative health impacts of circumscribed socioeconomic resources by adhering to accelerated fertility timing schedules (Geronimus 1996). The type of aging characterized by weathering has been shown to occur among nonpoor Black women, not just their poor counterparts (Geronimus 1996; Rauh et al., 2001). It is precisely this group, women who are trying to improve their SEP through educational attainment or occupational advancement, that is likely to delay childbearing. Colen et al. (2006b) find that during the unprecedented economic expansion of the 1990s, age-specific birth rates for young Black women significantly declined in response to increasing labor market opportunities. It is not uncommon for African-American women to suffer from life-threatening chronic conditions, such as diabetes and hypertension, by their early thirties to midthirties, ages at which they would still be having children if they chose to postpone childbearing. Women with these types of preexisting conditions face greater risks of experiencing pregnancy complications as well as detrimental perinatal outcomes.

CONCLUSION

The life course perspective has brought renewed interest in and conceptual clarity to the ways in which health is produced over time. However, the ability of extant models to explain the existence and intractability of racial disparities in well-being is severely restricted by their tendency to ignore linkages between multiple sources of stratification that run along the fault lines of race, class, and gender. In order to fully understand, and thus combat, long-standing inequalities in morbidity and mortality, it is necessary to delineate the ways in which socioeconomic deprivation, racial discrimination, and gender bias reinforce one another to erode the health of minority populations—men and women alike. It is not my intention to suggest that we should completely abandon the life course perspective as a theoretical approach. Rather, by gaining a deeper understanding of how the health of specific minority populations erodes over time, we can strengthen existing life course models and introduce new ones that reflect the unique realities of individuals from diverse racial/ethnic backgrounds. The propensity of extant frameworks to emphasize linear, cumulative pathways while ignoring critical interactions—both over time and across stratification processes—severely limits their ability to reveal the social processes necessary to maintain health disparities. By critically examining the ways in which health returns to upward mobility are likely to be muted for African American women, I hope this paper calls attention to the dynamic nature of the stratification processes that (re)produce racial disparities in well-being within and across generations—as well as provides a point of departure for a new generation of conceptual frameworks designed to explain, and thus eradicate, health inequalities.

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