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Responses to Racism, Health, and Social Inclusion as a Dimension of Successful Societies[1]

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Objectives and Contributions

This chapter informs one aspect of what makes societies successful: social inclusion. My focus is social recognition and cultural citizenship – who fits in, who belongs, who is "us" and who is "them." Societies that are inclusive are societies that make room for the social recognition of a variety of groups. They are societies that sustain competing definitions of a worthy life and a worthy person, which empower low-status groups to contest stereotypes and measure their worth independently of dominant social matrices. They are also societies where people do not have to pay a heavy toll (symbolic or material) for crossing group boundaries – for intermarriage for instance.

I study one social process that leads to greater social inclusion: how ordinary members of stigmatized ethnic and racial groups respond to exclusion by challenging stereotypes that feed and justify discriminatory behavior and rebutting the notion of their inferiority.[2] This is what I call destigmatization

strategies.[3] This chapter explains and illustrates this notion and explores how such strategies may enhance social inclusion, and contribute to societal success.

This chapter also speaks to health inequality, another topic at the center of this collective volume. Considering destigmatization strategies can broaden our understanding of the effect of racism and discrimination on health. Research has clearly shown the impact of inequality and discrimination on physical and mental health.[4] However, social epidemiologists rarely consider how *responses* to inequality and discrimination can modulate this impact,[5] and those who consider them tend to have a thin understanding of the role of meaning and the cultural environment in shaping these responses.[6] My agenda is to illuminate the role of meaning and available cultural repertoires (or schemas) in the pathways leading to the production of the health gradient.[7]

It is reasonable to believe that how individuals interpret and deal with exclusion and stigmatization is a key intervening factor in how racism and discrimination affect their mental and physical health. Inequality and discrimination affect health behavior not only by influencing the frequency at which individuals experience negative life events and access to resources – to quality health care and decent housing – and not only by shaping lifestyles, but also by affecting feelings of worth and belonging, which in turn undermines

physical and mental health through a variety of stress-related biological pathways, including psychoneuroendocrinological and psychoneuroimmunological mechanisms.[8] Perceived discrimination can bring about emotions such as shame, anger, distancing, privatizing, and stereotyping, as well as envy, resentment, compassion, contempt, pride, deference, and condescension.[9] These emotions are intimately tied to the experience of inequality and misrecognition and they contribute to the health gradient.[10]

How members of subordinate groups respond to these emotions by internalizing their lower status and the stigma that comes with it or interpreting their situation so as to alter the status hierarchy or power dynamics must matter. Whether the social context broadly defined facilitates or hinders such a contestation (through its collective myths, cultural repertoires, institutions, and so forth) must matter as well, and can be regarded as an indicator of how successful a society is. In societies where no alternative valuation system is available, low-status groups are more likely to be resigned and passive, instead of resilient. The absence of readily available cultural options could affect their well-being, and a range of related health outcomes such as depression and suicide. The availability of empowering cultural repertoires sustains resilience.[11] It should be considered in explanations of cross-national differences in the health gradient to the same

extent as welfare regime or political ideology.[12] Repertoires (collective myths, imaginaries, and so on) matter because they can energize, motivate, create excitement, and optimism.[13]

Considering responses to discrimination is crucial because individuals cannot be presumed to be passive recipient of discrimination. They have agency and their responses mediates the effect of discrimination on their well-being, as well as how exclusion occurs. The range of potential responses is circumscribed by the repertoires that are made available to them. Thus, it really matters what these repertoires are and whether they facilitate or constrain greater inclusion.

Psychologists have given consideration to the intrapsychological mechanisms with which members of stigmatized groups cope with stigmas that they believe are associated with them, such as privileging in-group comparisons.[14] They examine what leads people to improve their self-esteem and subjective well-being, focusing on elements such as goal attainment.[15] However, they do not consider how cultural contexts – such as widely shared views on the moral character of low-income or immigrant populations – influence coping. Conversely, even though some have studied the effect of subjective social status on various health outcomes,[16] psychologists have not considered the variegated frameworks through which people define status, including through standards of

evaluation that are autonomous from socioeconomic status. This chapter complements their work by tackling these questions.[17]

Social epidemiologists have spent considerable energy elaborating various frameworks to account for the production of the health gradient, and inequality in health more generally. These frameworks typically take into consideration psychosocial and material factors, networks, neighborhood effects, life course, access to health care, and policies.[18] Considering the effect of meaning and destigmatization strategies on health adds an important dimension to these explanatory frameworks. Indeed, I believe that meaning (manifested in cultural scripts, collective myths, taken-for-granted meanings, and folk classification systems) mediate some of the psychosocial mechanisms emphasized by influential social epidemiologists such as Marmot and Wilkinson, who attribute the health gradient to lack of control, autonomy, participation, and relative status.[19] Even though the community of health scholars is becoming aware of the importance of broadening research on the cultural factors and mechanisms affecting health,[20] and some researchers are now introducing cultural elements into their analytical toolkits, their analyses often remain limited to cross-national or cross-cultural differences,[21] or to lifestyle and habitus.[22] This is not enough. We also need to explore how competing definitions of self-worth and status that

prevail in different segments of the population and in different societies. These are likely to mediate the relationship between psychosocial mechanisms and health and how they interact with the environment – with immigration and redistributive policies for instance – as constraints and conditions mediating this relationship.

We need a framework for reaching a more comprehensive and detailed understanding of how meaning-making contributes to the process by which the environment "gets under the skin" to create disparities in mental and physical health.[23] This chapter does some of the analytical groundwork needed for such an explanation.

Meanings and cultural structures factor into our analysis at several levels. I consider: (1) personal and group identity and the transformation of the boundaries that define them; (2) frames and schemas concerning injustice and what is possible and how they shape strategies of collective action; (3) taken-for-granted views of the relationship between superordinate and subordinate groups; (4) available cultural models (scripts, repertoires) of how to lead one's life and of what defines a good life; (5) conceptions of status, recognition, moral order, and imaginaries that affect resilience and the capacity to respond to challenges; (6) broader cultural repertoires that define cultural citizenship, what makes one part of the collectivity, and how the characteristics of one's group measure up to such

standards – particularly what is unquestioned and what is contentious about each of these cultural constructs.

Even though, in the absence of data, it is too early to reach conclusion about what responses to racism lead to the best health outcome, related literatures suggest a number of hypotheses. The first section describes theoretical tools and defines and illustrates destigmatization strategies by drawing on my earlier work on various groups of African Americans and on North -African immigrants living in France. The second section provides hypotheses on the relationship between destigmatization strategies and health. The third section discusses the broader agenda for the study of the health gradient and of successful societies.

Destigmatization Strategies

The empirical focus is the everyday narratives of ordinary people who are members of stigmatized groups – as opposed to intellectuals or social movement leaders or members – concerning how they understand similarities and differences between their group and dominant groups, and what they do in the course of daily life to transform the negative meanings associated with their collective identity, to challenge stereotypes about their group and to create, enact, or demand new forms of personal interaction.[24] Ordinary people face discrimination on a daily basis, and negotiate relationships, including the meaning of their ethnoracial identity, in the course of daily life.[25] In this context, they produce changes at the interactional

level that are fed by the rhetoric and the efforts of broader social movements.[26] The sum of these microchanges can be considerable and contribute to greater social inclusion.

Borrowing from Jenkins, I use the term "social identity" to refer to a twin process of group identification and social categorization. Individuals differentiate themselves from others by drawing on criteria of commonality and a sense of shared belonging within their subgroup, as well as on a shared perception that members of other groups also have commonalities.[27] This is what Jenkins calls "group identification." This internal identification process must be recognized by outsiders for a collective identity to emerge. This is what he calls "social categorization" – the meaning given to a group by outsiders.

These two processes are at the center of my analysis. I study how individuals draw group boundaries – who is "in" and "out" – and define the meaning they give to their group – who is "us" and "them." This requires considering how they construct similarity and difference between themselves and others, as well as the types of evidence they give of equality or equivalence between group ("we are the same or as good because…"; "we are better because…").[28] I also analyze the meaning of one's group to oneself – what it means for African Americans, for instance, to belong to their group (what defines

their distinctiveness, their authenticity). Instead of focusing exclusively on direct responses to discrimination or racism, I study folk classification systems and everyday narratives about group boundaries and what makes people worthy.[29]

Responses to racism can range from efforts to assimilate to the dominant group and downplaying one's low-status identity, to affirming and celebrating differences. For their part, destigmatization strategies may include demonstrating that one does not present the negative characteristics associated with one's group, that negative views of this group are unfounded, and that the group has a great many strengths. Moreover, individuals may appeal to a wide range of evidence to demonstrate equality between groups, including shared morality or religion, similar earning or consumption capabilities, common physical characteristics ("we all have ten fingers"), citizenship ("we all have the same rights"), or the universality of human nature. Others also want to demonstrate the superiority of their group on spiritual, moral, or economic grounds. Although developing an encompassing inventory of destigmatization strategies is beyond the scope of this chapter, I identify several possible axes of comparison next.

1. We can differentiate strategies by their effect on the actors, that is, by the extent to which they produce self-empowerment, increased autonomy in self-definition, gains in recognition, maximization of self-actualization, and an increase in resilience or the capability to cope with change. Strategies can also result in improving the character of interactions with others, facilitating collective

action, and enhancing security. Negative effects of destigmatization strategies can include low self-esteem, depression, passivity, and the absence of self-acceptance. I expect those to be present when individuals reject their group of origin and important aspects of their self-concept.

2. We can compare the extent to which strategies require strong group identification or maximizing the autonomy and distance of the individual from the group. Strategies that require strong and exclusive identification of the individual to the group may produce a rigidification of group boundaries, as opposed to greater social inclusion.

3. We can compare the degree to which strategies mobilize universalistic or particularistic rhetorics. Some strategies are based on universalistic criteria or supraindividual principles of similarity that are available to all, such as an affirmation of basic human rights. Others are particularistic and imply the inferiority of out-groups instead of appealing to shared supraindividual principles – it is the case for nationalist strategies. This axis speaks to the normative and political implications of strategies for communal life.

4. We can compare whether individuals privilege one type of strategy, or combine several types (for example, by simultaneously claiming common citizenship and common belonging to the human race as bases for equality). We can also compare whether they always favor more confrontational strategies, or switch between more confrontational and more conciliatory ones. Individuals may want to challenge stereotypes and affirm the value of their group under some circumstances, while conforming to dominant culture in others. They may want to "exit" when boundaries are strongly policed and "voice" when they are contestable (to borrow Albert Hirschman's categories).[30]

I provide a few examples of destigmatization strategies, including strategies for establishing equality and for contesting stereotypes, before proposing hypotheses concerning the impact of various types of destigmatization strategies on health. These examples are drawn from interview-based studies I have conducted. Destigmatization strategies often consist in redefining symbolic boundaries between groups – who is us and them. I use the interview setting as an experimental context in which I ask respondents to describe to me the taken-for-granted classification system in which they locate themselves. Although this approach does not capture boundary work in natural settings, it is an adequate approach for comparing the broad contours of boundary work of a number of individuals across a range of settings.[31]

Antiracism among Black Working-Class Men

In a previous study, I analyzed the destigmatization strategies of thirty randomly sampled African American blue-collar workers and low-status white-collar workers living in the New York area.[32] This study explored inductively how workers concretely define the boundaries between us and them and draw the lines between the worthy and the less worthy. It is in this context that African American workers were interviewed concerning what they believe made them equal to whites and what made them equal to "people above," that is, to middle- and upper-class people. The study revealed that workers emphasize various moral

values as standards of worth (having a strong work ethic, having high moral standards, and being responsible and dependable as providers), and readily use religion as a proxy for moral character.[33] For instance, Abe Lind, a plumber on Long Island, chooses his friends on the basis of whether they "believe in God, to a large extent, [because] that's who they answer to, and they treat people fairly." John Lamb, a recycling technician from Georgia who recently moved to the North, describes his friends in the following terms: "We basically have the same background…Baptists who have a lot of respect for people, believe in just doing the right thing." By privileging morality and religion as criteria for worth, these workers refuse to measure themselves solely by a socioeconomic yardstick that would put them at the bottom of the racial and class hierarchy. At the same time, they refute the view of their inferiority, at least in their own eyes. Their emotional and cognitive commitment to this alternative yardstick should have repercussions on their well-being, sustain their resilience, and lessen the subjective impact of their relatively low social status.

The African American workers were compared with forty-five white American workers. I contrasted the kinds of evidence both groups used to discuss equality between whites and blacks. I found that blacks used a much wider range of evidence of equality or similarity than whites, perhaps because racism and discrimination forces them to confront the question of their relative equality on a

more regular basis than is the case for whites. White workers believed that blacks who make as much money as they do are equal ("if you can buy a house and I can buy I house, we are the same"). They also emphasized the universality of human nature as evidence of equality between racial groups, and argued that there are good and bad people in all races. In the words of Billy Taylor, a white foreman employed in a cosmetic company, "I could have a problem with you as a black but I could have the same problem if you were white, or green, or yellow, or whatever. People are people. There's good cops, there's bad cops. There's good whites, there's bad whites."[34] Blacks also point to the universality of human nature and the market as an arbitrator of worth to ground racial equality. However, they also point to their status as American citizens, their ability to consume, and their competence at work to demonstrate their equality with whites. A black recycling plant worker for instance says:

> Basically it comes down to, once you prove yourself that you're just as good as [your white coworkers]…that you can do anything they do just as well as them, and you carry yourself with that weight, then people respect you, they kinda back away from you. I'm kind of quiet, I just go there, I don't miss a day on the job, I do what I gotta do, and I'm one of the best throughout the whole plant at what I do.

Black workers also rebut racism by referring to the fact that we are all children of God, have similar human needs (food, sleep), and a common physiology ("we all spend nine months in our mother's womb"). These are universalistic evidence of equality – available to all, independent of level of education, income, or civil status.

Workers' antiracist rhetoric draws on everyday experience – such as the common-sensical view that human nature is universal. It is in stark contrast with that produced in academia, popularized by school curriculum debates, and shared by a number of professionals, that multiculturalism or cultural diversity should be celebrated. This is an argument never used by the workers I interviewed. Perhaps the latter appeal less to workers than to professionals due to their desire to keep the world in moral order and to distinguish clearly the boundaries between what is permissible and normal and what is not.

The African American Elite

Another study concerned the destigmatization strategies of the African American elite.[35] It drew on interviews with ten individuals identified by other elite members as belonging to this highly select group in the mid 1980s.[36] These individuals included the poet Nikki Giovani, the Congresswoman Eleanor Holmes Norton, the civil rights lawyer Julius Chambers, the former U.S. Ambassador to

South Africa James Joseph, and Thirman Milner from Hartford, Connecticut, who was the first black mayor of a New England town.[37]

Unlike their working-class counterparts, members of the African American elite do not draw on religion to cope with racism – as one of them puts it, he doesn't believe in "praying my way out of discrimination." Instead, elite African Americans emphasize using one's intelligence, competence, and education as the most effective destigmatization strategies. They frequently identify these qualities as their ticket out of social exclusion. This common theme animates the responses of both Congresswoman Norton, who coped with racism by showing that "you can out-do them, you can outlearn them, you can be smarter than them" and of James Joseph, an ambassador, who took to heart his mother's warning that "you have to be twice as smart to get half as good a job." Betty Lou Dodson suggests a similar strategy of competency, saying: "make sure that you know what you're doing… Knowledge is power… So you try to learn as much as you can about whatever it is you're doing." Thus, African American workers and elite members use different concepts of equality and have different views concerning how to achieve it.

Black Marketing Executives

A third case concerns African American marketing executives specialized in the African American market. Based on only eight interviews, this study shows that

these individuals offer cues and cultural models to blacks about how to achieve full social membership. They believe blacks should use consumption to signal social membership (as citizens, middle-class people, and people of color): through consumption, African-Americans transform the meanings attributed to the category “black,” enact a positive vision of their distinct cultural identity (for example, as fashionable or proud black people), and affirm their distinctiveness. These marketing experts equate mainstream society with elite society, perhaps because acquiring expensive goods makes social membership undeniable. In their eyes, buying power is a true mark of personal worth and racial equality, as well as a powerful rebuttal to racism. Like elite African Americans who emphasize expertise and knowledge as key to social membership, these marketing specialists provide to most blacks an ambiguous message: that this membership is out of reach for most of them. Their narratives about what grounds equality across ethno-racial groups made no reference to other traits available to all, such as common humanity, shared physiology and needs, shared citizenship, or religion and our shared status as children of god. They do not challenge the racial boundaries that define the American class structure. Instead, they reinforce the view that those who can consume are worthy, as they met the standards of cultural membership that prevail in American society. Thus they promote a particularist, instead of a universalist, definition of membership – one where membership is available to all.

North African Immigrants in France

A fourth case concerns North African immigrants living in Paris and shows that they mobilize cultural repertoires made available to them by the Muslim tradition in their responses to racism and discrimination. I conducted and analyzed interviews with thirty randomly sampled North African immigrants living in the Paris suburbs.[38] Lamont, Morning, and Mooney analyzed these interviews to understand more finely the destigmatization strategies used by North African immigrants.[39] We found that respondents rebut racism by drawing on their daily experience and on a *particular universalism*, a moral universalism informed by Islam. Even though French political ideology equates Republican universalism with antiracism, North African immigrants refute the notion of their inferiority by culling evidence of universal equality from their daily lives. Like African American workers, they point to traits shared by all human beings, such as common morality, human needs, biology, and destiny. Second, they refer to explicitly particularist and differentialist arguments and to conceptions of moral universalism informed by the Koran to disprove their inferiority in the eyes of the French: they stress that they follow specific forms of moral conduct including tranquility, following a straight path, altruism toward the poor and the elderly, and rejecting an excess of freedom. They explicitly link these virtues to the five pillars of Islam and to the Koran more generally. This moral universalism is central to what defines a good Muslim and what makes some claim superiority over the

French. Grounded in Islam, this moral universalism is in fact particularlist because it is not available to all.

Interviews do not refer to the principles of the Enlightenment and Republicanism, or to the right to difference. These themes are central in elite and popular antiracist rhetoric in France.[40] French civic culture does not appear to have penetrated the immigrant population significantly, as they seem not to have deeply internalized Republican and Enlightenment principles pertaining to the rule of law, human rights, and equality.[41] Undoubtedly, the high rate of illiteracy, the uneasy relationship that immigrants have with the educational system, and strong ethnic enclaves influence which cultural tools immigrants use to rebut racism. Considering which cultural toolkits are made most readily accessible to low-status population is an important complement to the work of psychologists who emphasize in-group comparison and neglect the broader cultural context in which concepts of self-worth are developed.

The Impact of Destigmatization Strategies on Mental Health

With these examples in mind, we can review the existing research on well-being, self-esteem, school success, personal efficacy, and health to generate hypotheses about the kinds of destigmatization strategies that are most likely to mitigate the effect of discrimination and racism on health. I am concerned with their impact on mental and physical health; nevertheless, most of the following examples concern

primarily mental health and its correlates – self-esteem, resilience, and efficacy. I discuss the added value of considering meaning and cultural repertoires to the framing of the relevant questions.

But first, a note on measurement: The impact of different destigmatization strategies on mental health can be ascertained by comparing the health status (measured by a depression scale, the clinical global index, or others) of individuals who use various strategies. One could also use scales measuring mastery and self-efficacy – psychosocial coping/buffering factors that have been extensively linked to health and well-being (particularly depression). Or else, one could consider how the mental health status of one individual changes as she adopts different strategies or collect narrative accounts of how individuals perceive the relationship between their response to racism and their health. A more experimental approach could consist in monitoring cardiovascular and other reactions occurring while members of stigmatized groups are reading description of various racist incidents and antiracist strategies.[42]

Negative health outcomes are correlated with numerous factors other than exposure to discrimination (for example, access to health care) and these factors work against establishing a clear causal relationship between destigmatization strategies and improved health. Moreover, the impact of daily hassles that are associated with discrimination may be profound, as these stressors tend to be

persistent, chronic, and linked to life-long exposure. Their effect can be spread over the life course, which raises additional challenges.[43] The impact of destigmatization strategies may not be easily reflected in their short-term effect on mental health – especially given that health self-report is also affected by who the reference group is. These challenges should be kept in mind as we consider the relevant social psychological literature and future research agendas. Perhaps what we have learned concerning how to measure parsimoniously the impact of discrimination on health (in the work of Nancy Krieger for instance) can be of help in conceptualizing how to measure the effects of destigmatization strategies.[44] Analytical descriptions may also be particularly useful to capture the effects of cultural repertoires and meaning on resilience and capabilities, and related aspects of mental health.

Social psychologists have produced a variety of findings about what types of racial identification sustain better correlates of mental health and well-being such as self-esteem, personal efficacy, and school success. Studies all suggest that how one relates to one's racial group influences various aspects of well-being. Strong racial identification predicts positive psychosocial and physical health. The more central race is to the self-concept of African Americans, the more positive is their mental health.[45] Thinking positively about one's group also has desirable outcomes: adolescents who are culturally connected to their racial group and think

highly of it report the highest level of adjustment.[46] Similarly, Canadian First Nation tribes with the lowest suicide rate are tribes those that keep alive and celebrate their traditional culture; Gerard Bouchard (Chapter 7, in this volume) also suggests this association.[47] Such findings lead us to predict that greater awareness and pride in collective identity and traditions is correlated with better mental health outcomes for a variety of racial and ethnic groups. This pride would act as a buffer when experiencing racism and discrimination and would foster resilience and strengthen capacities to meet life's challenges. To illustrate with the case of North African immigrants living in France: individuals having access to positive collective myths and cultural repertoires celebrating the moral virtues of the group (perhaps through their commitment to Islam) would show greater resilience when experiencing discrimination. Although neglected by social psychologists, there is an added value to considering the cultural toolkits on which destigmatization strategies hinge and that are mobilized by individuals to make sense of the exclusion they face and to respond to it.

Social psychologists also show that higher academic self-concept and achievement among African American adolescents is found among those who have a racial-ethnic self-schema that emphasizes that one is a member of both an in-group and the larger society, or a member of an in-group that must fight to overcome obstacles to attain larger societal resources.[48] Students who succeed the

least do not have racial-ethnic self-schemas. Alternatively, they only have in-group self-schemas and the latter do not connect to the larger society.[49] Comparable conclusions can be drawn from Prudence Carter's research that compares low-income African American and Latino students in a multiracial high school. She finds that those who succeed best are cultural "straddlers" who master the cultural capital most valued by teachers, as well as the forms of nondominant cultural capital valued by the students.[50] Their biculturalism allows them to do well in two competing status hierarchies. Applied to the case of African American workers, these results suggest that individuals who have a strong sense of group identity *and* are well-integrated in American mainstream culture are most resilient and most empowered to claim social membership. Individuals who are less aware of and proud of their collective identity may be less in touch with common cultural repertoires of resistance on which they could draw to make claims. And indeed, Mario Small's study of community participation across various generations of residents of public housing project serving a Latino population in Boston supports these conclusions.[51] This study shows the importance of intergenerational exposure to collective frames for explaining differences in degree of collective involvement – the very type of collective meanings that are beyond the disciplinary toolkit mobilized by social psychologists

Complementary results concern more exclusively the impact of awareness of racism and discrimination on mental health. Both denial of racism and acceptance of the notion of white superiority are inversely related to health.[52] Students who are aware of the existence of racial discrimination are better protected against its effects.[53] Children who are made aware of racial barriers and socialized to be proactive toward blocked opportunities have a greater sense of personal efficacy than those who are not – and we know that self-mastery has been extensively linked to well-being (particularly depression).[54] If being aware of racism and of discrimination has a positive impact on health income, it is likely that being familiar with the historical struggle of one's group against exclusion also contributes to resilience. Exposure to such narratives may have an effect that goes beyond the simple awareness of discrimination that is of concern to social psychologists."[55]

In another direction, the work of Jennifer Crocker and colleagues shows that people whose self-worth is contingent on God's love have better well-being outcomes than those whose self-worth is contingent on other criteria such as appearance and academic achievement.[56] This research suggests the importance of looking closely at the effect of various destigmatization strategies on mental health, and at whether these strategies are universally available.

Another example of the role of cultural repertoires in sustaining group identification and destigmatization strategies comes from my previous work, which showed that compared with middle class people, working-class people mobilized criteria based on moral character and solidarity rather than money and education in their evaluation of what defines a worthy person, so as to value more highly their own positions.[57] This is more the case among French workers than among American workers, in part because Catholicism, Republicanism, and socialism make repertoires of social solidarity more readily available to workers in France than in the Untied States.[58] Such cultural repertoires facilitate, or are conditions for, lower-status groups to develop feelings of self-worth despite being lower in a status hierarchy. I hypothesize that this ability to develop a sense of self-worth somewhat autonomously from the dominant matrixes plays an important role in sustaining resilience, individual self-efficacy, and the ability to react collectively to challenges, which in turn would affect mental health.

All societies do not make the cultural tools necessary to sustain alternative matrixes equally available. The nationalist movements in Québec, Brittany, and Scotland provided well-defined repertoires for collective affirmations. In contrast, the ubiquitous celebration of economic success in American society may facilitate individualistic destigmatization strategies for better endowed individuals but may lead to passivity and withdrawal for those who are less well-endowed. The former

may respond to the stigmatization of their identity not by attempting to change the meaning associated with their group, but by trying to improve their own position within a given hierarchy, perhaps while drawing on narratives of upward mobility, passing, forgiveness, and reconciliation. It is notable that American workers have a greater sense of personal distress than their counterparts in countries such as Japan and Poland; however, professionals have higher self-esteem in the United States.[59] Considering the relative availability of different cultural schemas concerning empowerment could help us make sense of the health gradient, but also of the fact that among the advanced industrial societies, the association between GNP, well-being and health is nonlinear. Societies that allow for the coexistence of various matrices for defining worthy or meaningful lives could very well be the most successful if success is defined in terms of health outcomes.

The Future Agenda

Social epidemiologists have been studying the effect of various ecological elements on the health/inequality nexus. They have given particular attention to range of mechanisms and factors such as social cohesion and integration, networks, residential segregation, and income inequality. They have also spent considerable energy exploring how relative status, as opposed to absolute status, affects psychosocial orientations and their impact on health.[60] But contexts have

material, social structural, and sociopsychological components, as well as cultural components.[61]

The task at hand has been to add specificity and parsimoniousness to our understanding of how cultural templates influence the health gradient, and to explore how various cultural and noncultural (for example, psychosocial) factors interact with one another. Earlier treatment of cultural explanations of health outcomes concentrated on cross-cultural or cross-national differences, rather than analyzing the supply side of ideas and how they vary across national contexts.[62] This literature presumes that to each nation correspond cultural differences that can explain cross-national differences. This essentialist approach, akin to the old national character argument, has been widely criticized and rejected in favor of an approach that considers the relationship between space and cultural similarities an empirical issue, as opposed to simply describing certain countries as more materialistic or solidaristic.[63]

More recently, epidemiologists have also drawn on broader sociological theory and on the work of Pierre Bourdieu in particular, to consider the effect of lifestyle and habitus on health. These approaches are more attuned to recent developments in cultural sociology, but they generally also ignore the role of cultural repertoires in empowering and constraining various types of responses to discrimination and racism. By using the analytical tools developed by recent

scholarship – concepts such as cultural structures, schemas, and repertoires, symbolic boundaries, and scripts of personhood – it is possible to analyze the relative availability of cultural schemas across environments.[64] Although much work remains to be done to fully develop the theoretical implications of this line of thinking, this chapter has outlined some of the analytical groundwork needed to elaborate an explanation that would include cultural repertoires, and consider their interactions with structural, psychosocial, institutional, and biological explanations of health outcomes.

Cultural structures – whether scripts, narratives, frames, repertoires, or identities – are intermediary between the social psychological processes and the health outcomes that have attracted the attention of social epidemiologists. Broader cultural templates having to do with injustice, definitions of a good life, and how status correlates with worth, are likely to influence the effect of discrimination on health. Whether stigmatized groups react to racism by fighting or exiting, and whether and how they identify with their group, is influence by the cultural repertoires they have access to. And various strategies will have different effect on actors – empowering them, buffering them from the wear and tear of everyday life, or else, weakening their resolve, their self-efficacy, and sense of entitlement. These are precisely the questions that are not considered by psychologists concerned with well-being.

This chapter has framed questions and provided analytical tools and means for answering them. The next stage will be to develop a more systematic empirical program to tackle these questions, building on some of the hypotheses developed here. We need to be more empirically specific concerning what kind of social context facilitates or hinders the contestation of dominant frameworks – through its imaginaries, boundaries, institutions, and so forth. Societies that allow for the coexistence of various matrices for measuring meaningful lives are those that are most inclusive, and thus, most successful.

More generally, it will be important to carry out a systematic comparison of the destigmatization strategies of groups located in various national contexts and to compare how strategies vary with the porosity of the boundaries that separate superordinate and subordinate groups across societies. In particular, one should consider how variations in the *range* and *salience* of evidence (or criteria such as race, class, status, or moral character) are used by stigmatized groups in different contexts to establish their value in relation to that of dominant majority groups. By "range, "I mean the number and diversity of such criteria. By "salience," I mean the extent to which individuals are using given criteria when comparing groups (whether they are present at all, and how much they are present compared to other criteria). Based on the comparisons of white and African American, and white and North African workers (described later), it appears that range and salience vary according to the strength of ethnoracial boundaries low-

status groups face: the more group members perceive discrimination, the more they are likely to draw on a wider range of evidence to demonstrate their equality and to combat the daily indignity of misrecognition.

It should be noted that not all destigmatization strategies lead to greater inclusion. Indeed, effective strategies may include affirming the cultural distinctiveness of a group, limiting intergroup interactions (for example, intermarriage), and defending the institutions that are essential for its survival – hospitals and schools that serve populations in their native language for instance, as in the case of Canadian francophones living outside Quebec. In such a case, the strengthening of group boundaries may lead to empowerment, but perhaps also to isolation and ghettoization if the group is not sufficiently engaged with mainstream culture – if it lacks in cosmopolitanism. Reaching a balance between self-affirmation and engagement with the out-group may be crucial to attenuating the impact of discrimination on health outcomes

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<<this note will be unnumbered footnote on chapter opener. The rest of the notes in the chapter will be renumbered.>>[1] <<AFN>>I wish to thank CIFAR and the Racliffe Institute for Advanced Studies for supporting this research. My gratitude also goes to colleagues who have commented on this chapter or discussed it with me: Peter Hall, Lisa Berkman, Christopher Bail, Gérard Bouchard, Rich Carpiano, Wendy Espeland, Katherine Frohlich, Mary Jo

Good, Christopher Jencks, Arthur Kleinman, Nancy Krieger, Mary Clare Lenon, Paul Lichterman, Bernice Pescosalido, Abigail Saguy, James Sidanius, Patrick Simon, Art Stinchcombe, David Williams, Andreas Wimmer, as well as the members of the Successful Societies Program for conversations around and/or feedback on this chapter. I also thank Joe Cook, Sabrina Pendergrass, and Seth Hannah for their assistance.

[2] I build on Goffman (1963) who shows how individuals with discredited or spoiled identities take on the responsibility of managing interaction to prevent discomfort in others. Much of the literature on responses to stigma concerns the management of mental illness and HIV-AIDS-based stigma, and with the health impact of reactions to such stressors. See Link and Phelan (2001) for a review. More recently researchers have developed an interest in the broader moral context of stigma (Yang et al. 2007) and in stigma and social exclusion (Reidpath et al. 2005). This literature can inform our study of responses to ethnoracial stigma.

[3] This notion is inspired by Essed's (1991) notion of "everyday racism." It also expands on Aptheker's (1992) definition of antiracism as rhetoric aimed at disproving racial inferiority.

[4] Williams (1997); Schnittker and McLeod (2003, 2005); Leigh and Jencks (2006). On income inequality, see Lynch et al. (2004). On discrimination, see Krieger (1999); Williams, Neighbors, and Jackson (2003).

[5] But Krieger et al. (1993) and Krieger (2001).

[6] For a critique of thin approaches to culture in the field of poverty, see Lamont and Small (2008).

[7] Following Sewell (2005: 131), I define cultural schemas as "society's fundamental tools of thought, but also the various recipes, scenarios, principles of action, and habits of speech and gesture built up with these fundamental tools,"

[8] See Keating (Chapter 2, in this volume). The development of the hypothalamus-pituitary-adrenal (HPA) axis, the body's stress-response system, is affected by levels of control, status, dominance, hierarchies, and threats. The level of serotonin production, which helps maintain positive emotionality and reduce depression, is affected by feelings of belonging, participation, and social connection. For its part, the functioning of the frontal cortex, which controls decision making and the integration of emotion, cognition, and judgment, is tied to feelings of worth and affection and to identity formation. See also Keating and Hertzman (1999b) ; Suomi (1999), McEwen (2003); Boyce and Keating (2004).

[9] Skeggs (1997); Sayer (2005b): 950 ; Todd (2006)

[10] Archer (2000); Nussbaum (2001) See Wilkinson (1999) on emotions and the health gradient.

[11] For an approach to health that emphasizes resilience and assets, see Bartley et al. (forthcoming).

[12] Coburn (2004); Chung and Muntaner (2006); Navarro et al. (2006).

[13] Here I expand from Gérard Bouchard (Chapter 2, in this volume) on collective imaginaries and myths. Also see Bouchard (2003b)

[14] Steele and Crocker (1998). Psychologists Oyserman and Swim (2001) propose an agenda for studying how members of stigmatized groups react to stigma. See also Steele (1998): Clark et al. (1999): Crocker, Major, and Pinel (1999), Brickson (2000).

[15] For a review, see Twenge and Crocker (2002). Also Oyserman et al. (2002). On subjective well-being, see Diener and Lucas (2000). On new approaches to self-esteem that are organized around definitions of worth, see Crocker and Knight (2005).

[16] On subjective social status, see the work of Nancy E. Adler and her collaborators (for example, Goodman et al. 2001).

[17] It particularly complements that of British social psychologists have made headways on such questions. Henry Tajfel (1981) advocated a return to the

content of stereotypes and "justificatory myths" of social inequalities. Condor (1996) applies qualitative methods to the examination of various aspects of racism and national identity in talk. See also Barrett (2005).

[18] Berkman and Syme (1979); Link and Phelan (1995); Kawachi (2000). For instance, for Krieger (2003), there are "5 key pathways through which racism can harm heath, by shaping exposure and vulnerability to the following: 1) economic and social deprivation; 2) toxic substances and hazardous conditions; 3) socially inflicted trauma (mental, physical, sexual, directly experienced or witnessed, from verbal threats to violent acts; 4) targeted marketing of commodities that can harm health, such as junk food and psychoactive substances (alcohol, tobacco, and other licit and illicit drugs); and 5) Inadequate or degrading medical care." Also Williams (1997); Adler and Ostrove (1999); Krieger (2001)Cockerham (2005) Link and Phelan (2005). Consensus has yet to emerge concerning the best model describing such mechanisms.

[19] Marmot (2004); Wilkinson (2005).

[20] See http://obssr.od.nih.gov/Documents/Conferences_And_Workshops/HigherLevels_Final.PDF.

[21] For instance, Corin (1994); for a critique of these assumptions, see Gupta and Ferguson (1992) and Lamont and Thévenot (2000). Wilkinson (2005: 219) distinguishes between national "cultures of inequality" in terms of how "macho" they are. For his part, Marmot (2004) suggests that cultural changes

affect societies as a whole, as if internal differences within the population did not matter.

[22] On lifestyle, see Dressler (1991); Trostle and Sommerfeld (1996); Frolich, Corin, and Potvin (2001); Nguyen and Peschard (2003); Cockerham (2005); Dressler, Ochs, and Gravlee (2005); Carpiano (2006).

On lifestyle and habitus, see Veenstra (2005). Karlsen and Nazroo (2002) compare the impact of "ethnicity as identity" versus "ethnicity as structure" (defined in terms of racialization and class experience) on the health of ethnic minority people in Britain.

[23] Similarly, Johnson-Hanks (2002) integrates culture in demographic explanation of fertility and contraception.

[24] On everyday narratives, see Berger and Miller (1999). This chapter complements the large literature on resistance – for instance, Scott (1990) . Mansbridge (1999); Silbey and Ewick (2003); Herzog (2004). I acknowledge that individuals may be victim of discrimination without being aware of it. These experiences may vary across social class, depending on the resources that individuals have at their disposal. This topic is beyond the scope of this chapter.

[25] Wimmer (2008).

[26] Mansbridge and Flaster (2007)

[27] Jenkins (1996). I thank Arthur Stinchcombe for pointing out to me the parallels between Jenkins's theory and Erik Erikson's classic essay, "The Problem of Ego Identity."

[28] My agenda is similar to that of Dressler, Oths, and Gravlee (2005) which draws on Bourdieu and focuses on "cognitive representations constructed out of an amalgam of socially shared understandings" (p. 214) – particularly racial folk self-categorization and self-identification – and their implications for health. These anthropologists are concerned with racial folk self-categorization and self-identification. My approach is inspired by developments in cultural sociology, cultural anthropology, and cultural psychology. See D'Andrade (1995); DiMaggio (1997); Schweder, Minow, and Markus (2002)

[29] See Boltanski and Thévenot (1991); Espeland and Stevens (1998); Lamont and Molnar (2002).

[30] Hirschman (1964).

[31] For more information on this approach, see Lamont (1992).

[32] Lamont (2000).

[33] Along these lines, recent surveys find that blacks embrace religious commitments more than whites (Smith and Seltzer 1992): 30.

[34] See also Lamont and Aksartova (2002).

[35] Lamont and Fleming (2005).

[36] For details, see Jackson, Thoits, and Taylor (1995).

[37] These individuals authorized us to reveal their identity. Interviews were coded thematically by the first author. She systematically looked for counterevidence and used matrix displays (see Miles and Huberman 1994) to reveal patterns in the use of antiracist arguments. For details, see Lamont (2000: Appendix A).

[38] Lamont (2000).

[39] Lamont, Morning, and Mooney (2001).

[40] Lamont (2000).

[41] Note that my respondents are first-generation immigrants and have not undergone socialization in the French educational system. A study of the destigmatization strategies of second-generation blacks living in France reveals a greater centrality of Republicanism and of their French identity and citizenship in this group. See Bickerstaff (2008).

[42] As illustrated by the study by Bennett et al. (2004a) of the cardiovascular reactions of African American men to blatant and ambiguous racism.

[43] Hertzman and Power (2004)

[44] See also Yang and Collins (2004) on measuring mental illness stigma.

[45] Sellers et al. (2003) measure racial identity using a centrality scale and a public regard scale: “The revised centrality scale consists of three items assessing the extent to which race was an important part of how respondents defined

themselves. Sample items include, 'Being black is a major part of my identity,' and 'I feel close to other black people.' The revised public regard scale consists of two items assessing the individual's perceptions of how positively or negatively other groups view blacks. The items were, 'In general, other groups view blacks in a positive manner,' and 'Blacks are considered to be good by society.'" (pp. 306 and 311). Caldwell et al. (2002: 1325). On collective self-esteem scale, see Luhtanen and Crocker (1992) and Crocker et al. (1994). For their part, Williams and Harris-Reid (1999) find only relatively weak effects of ingroup identification with mental health.

[46] Chatman et al. (2001). Also, Sellers et al. (2003) show the impact of (positive) "private regard" for one's racial group on health outcomes. Feliciano (2005) also finds that children of immigrants who have not abandoned their immigrant ethnic culture have the greatest educational success, which is correlated with well-being.

[47] Chandler et al. (2003).

[48] Wong, Eccles, and Sameroff (2003); Shelton et al. 2006. See Noh et al. (1999) for contradictory results.

[49] Oysterman et al. (2003).

[50] Carter (2005).

[51] Small (2004).

[52] Jackson et al. (1996).

[53] Sellers et al. (2003).

[54] Bowman and Howard (1985): 139.

[55] Neighbors and Jackson (1996: Chapter 8). Neighbors et al. (1996). According to Schnittker and McLeod (2005), "Discrimination has stronger effects on physical health among persons with self-blaming rather than system-blaming attributional styles, and among those who accept discrimination rather than challenge it." Based on data from African American college-age men of high socioeconomic status, the literature on "John Henryism" also suggests that "a strong behavioral predisposition to directly confront barriers to upward mobility" is associated with positive health outcomes (see Bonham, Sellers, and Neighbors 2004).

[56] Sargent, Crocker, and Luhtanen (2006).

[57] Lamont (1992; 2000).

[58] Lamont and Thévenot (2000).

[59] Kohn (1987); Kohn et al (1990).

[60] House (2001); Marmot (2004).

[61] Epidemiologists often operationalize context as including the following: psychosocial factors (social capital), behavioral factors (for example, tobacco use, physical activity), public health (assessment, policy development, and

funding of programs), access to health care services, housing, environmental factors (for example, hazardous waste), political factors (for example, community political participation), education (related to socioeconomic status), and employment (including employment opportunities); see for instance Hillemeier et al. (2003). For Ashmore, Deaux, and McLaughlin-Volpe, contexts are "the general and continuing multilayered and interwoven set of material realities, social structures, patterns of social relations, and shared belief systems that surround any given situation" (2004: 103).

[62] See footnote **21** in this chapter. That the epidemiological literature so readily draws parallels between the behavior of rhesus monkey and that of humans raises issues concerning the rather minimalist causal role it gives to culture as an intervening dimension. The position of George Davey Smith (2003) is illustrative of broader trends in the field. He suggests that the impact of psychosocial factors is mediated by long-term exposure to domination over the life course, which leads to the embodiment of discrimination. A comprehensive view of the literature on inequality strongly suggests that structural/material domination goes hand in hand with cultural/semiotic subordination (in Bourdieu 1984, for instance). For a review, see Lamont and Small (2008) .

[63] For instance, Corin (1994); for a critique of these assumptions, see Gupta and Ferguson (1992) and Lamont and Thévenot (2000).

[64] For a review of conceptual tools for cultural analysis, see Lamont and Small (2008) Different national settings can present group boundary patterns that are organized around various dimensions, with religious, linguistic, or ethno-racial components being more or less salient in structuring conflict and political mobilization. The salience of these dimensions is sustained by structural factors as well as by the social representation of groups and by identificatory dynamics. Thus, in the United States, strong class boundaries separating the poor from others overlap with strong racial boundaries separating blacks from nonblacks (Gans 1999) which also translate into clear patterns of residential segregation across racial groups and into low rates of intermarriage (Kalmijn 1991; Lamont 2000; Pattillo 2005 . At the symbolic level, whites and blacks experience strong group identification and group categorization (McDermott and Samson 2005), have different patterns of religious affiliation (Emerson and Smith 2000). They also display differentiated patterns of cultural practices and tastes. See Lamont and Bail (2005).