UNDERSERVED AND SOCIALLY DISADVANTAGED GROUPS AND LINKAGES WITH HEALTH AND HEALTH CARE DIFFERENTIALS

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JENNIE JACOBS KRONENFELD
Arizona State University, USA

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ABOUT THE CONTRIBUTORS

Zinobia C. Bennefield is an Assistant Professor of Sociology at the University of North Carolina, Charlotte. Her research interests include childhood and adolescent mental health, structural inequality and health, and the application of intersectionality theory in health research.

Jennifer M. Brailsford is an Instructor in the Care, Health, and Society program at The University of Arizona. As a medical sociologist, her research focuses on the impacts of social and physical environments on human health. Her research interests include neighborhood contexts, environmental hazards, and the stress process.

Amy M. Burdette is Professor of Sociology and an associate in the Pepper Institute on Aging and Public Policy at Florida State University. Amy M. Burdette is Professor of Sociology and an associate in the Pepper Institute on Aging and Public Policy at Florida State University. Amy M. Burdette's research investigates connections between religious involvement, neighborhood context, and health. Her research has examined social variations in health and health behaviors at virtually every stage of the life course from birth (e.g., low-birth weight), to adolescence (e.g., HPV vaccination, substance use), to young adulthood (e.g., BMI, sexual activity), to adulthood (e.g., breastfeeding, obesity, psychological distress, prescription drug misuse), and old age (e.g., cognitive functioning, mobility). Much of her research has paid special attention to disadvantaged populations, including low-income urban mothers.

Claudia Chaufan is Associate Professor of Health Policy and Global Health at York University in Toronto. She practiced medicine in her native Argentina, before shifting to an academic career. Her background spans medicine, sociology, comparative political economy, and philosophy. Her research and intellectual interests include the politics of health and global health in the context of capitalist globalization, medicalization and social control, language/power/discourse, and the scholarship of teaching and learning. She teaches about, and has published on, these topics in *Social Science & Medicine*, the *International Journal of Health Services*, and *Critical Public Health*. She is Editorial Board Member and Reviewer of academic journals, and a long-time supporter of organizations opposing Western intervention in the Global South.

Jessica Eckhardt is Assistant Professor of Sociology and Social Justice at Northland College, an environmental liberal arts school on the south shore of Lake Superior. As an environmental health sociologist, she uses frameworks and methodologies from medical sociology, environmental justice, social epidemiology, and public health to explore differential exposures to environmental hazards and how those hazards impact human health.

Terrence D. Hill is Associate Professor in the School of Sociology and a Scientific Member of the Arizona Center on Aging at the University of Arizona. His research examines the social distribution of health and health-relevant behaviors. To date, he has published over 100 peer-reviewed journal articles and book chapters. According to Google Scholar, his published work has been cited across a range of disciplines nearly 4,000 times.

Charley Henderson received MA in Sociology from Texas State University in 2018. She has been working on several research projects with Atsuko Kawakami, PhD, at Tarleton State University since 2015. While conducting research with Dr Kawakami, Ms Henderson completed her MA and published an article, “Hepatitis C and the Social Hierarchy: How Stigma Is Built in Rural Communities,” as her research interests include medical sociology, rural sociology, stigma, and viral infections.

Andrew K. Jorgenson is Professor and Chair in the Department of Sociology and Professor of Environmental Studies at Boston College. The primary area of his research is the human dimensions of global environmental change, with a focus on the drivers of greenhouse gas emissions, energy consumption, industrial pollution, and land cover change. He also conducts research on the political-economic and environmental conditions that shape population health outcomes, uneven development, income inequality, and environmental concern.

Karen E. Joseph-Kent is an Assistant Professor at DeSales University and is Director of the MBA program. She has taught health services administration for over 20 years at Xavier University and Penn State and has an extensive background in health administration leadership as an Administrator for Johns Hopkins Medicine. She received her PhD from Miami University of Ohio in Social Gerontology. She dedicates this study to Ian Kent and the myriad of caring professionals who improve the lives of people with ASD.

Atsuko Kawakami is Associate Professor of Sociology at Tarleton State University. She received PhD in sociology from Arizona State University and MA in sociology from Doshisha University, Kyoto, Japan. Her research interests include, but are not limited to, the following areas: support systems among various groups, living arrangement and health service utilization among the elderly population, and transnational identity of immigrants.

Jennie Jacobs Kronenfeld is Professor Emerita in the Sociology Program, Sanford School of Social/Family Dynamics, Arizona State University. Her research areas are medical sociology and aging with special focus on health policy, health care utilization, and health behavior. She is Coeditor of *Health* and Associate Editor-In-Chief for *American Journal of Health Promotion*. She is a past Chair of Medical Sociology Section, American Sociological Association and past President of Sociologists for Women in Society.

Jennifer McDonald's research interests include women's health and international health policy. She has presented research at the American Sociological Association Conference, has spoken at the Canadian Coalition for Global Health Research University Conference, and has been a delegate at the World Health Assembly. Jennifer enjoys traveling and plans to attend medical school in the next two years.

Kristine M. Molina, PhD, is Associate Professor of Psychology at the University of California-Irvine. She earned a joint PhD in Psychology (Personality & Social Contexts) and Women's Studies from the University of Michigan. Her research focuses on how different dimensions of inequality, often resulting from racism, become embodied at multiple levels to affect health across the life course among racialized groups.

Ethel Nicdao, PhD, is Professor and Chair of Sociology at California State University, San Bernardino. Trained as a medical sociologist, her work centers on health disparities among minority populations. Her current research applies a community-based participatory research and intersectionality approach to examine the mental health and well-being of adults in San Joaquin and San Bernardino counties. She completed her doctoral training at the University of New Mexico and postdoctoral fellowship at the University of Washington.

Ignatius Uche Nwankwo, PhD, is Associate Professor of Medical Sociology at the Department of Sociology/Anthropology, Nnamdi Azikiwe University, Awka, Anambra State, Nigeria. He has taught sociology for more than a decade and served as Head of Department from 2012 to 2014. Currently, he is the Sub-Dean for Postgraduate Studies in the Faculty of Social Sciences. His research interests cut across health policy and finance, gender and health, sociocultural determinants of health services access, evaluation of health programs and the administration of public health law, etc.

Kim Price-Glynn, PhD, is Associate Professor of Sociology at the University of Connecticut. She was the inaugural recipient of the University of Connecticut College of Liberal Arts and Sciences Faculty Achievement Award for Excellence in Teaching. Her research examines gender, labor, health and caregiving in diverse organizational settings, from nursing homes to strip clubs. She is the author of *Strip Club: Gender, Power and Sex Work*, New York University Press (2010). She has also published in *Gender & Society; Sociology of Health & Illness; Research in the Sociology of Health Care;* and *Work, Employment & Society*, as well as other journals and the edited volume, *Caring on the Clock*.

Valentina Raffa, PhD, is a Researcher of Sociology in the Department of Cognitive Science, Educational and Cultural Studies (CSECS), University of Messina. Her research focuses on social exclusion, social marginality, social movements, new political identities, postcolonial studies, urban art, sociology of development, and sociology of health. She worked on several national and international projects.

Carter Rakovski, PhD, is Professor of Sociology at California State University Fullerton. She studies gender and work. She also applies statistical methods in her interdisciplinary work. Her research has been published in a range of journals including the *Sociology of Health and Illness*, *Work, Employment and Society*, *Disability and Rehabilitation*, and the *Journal of Accounting Research.*

Fernando I. Rivera is Professor of Sociology and Director of the Puerto Rico Research Hub at the University of Central Florida. His research interests and activities are in the sociology of health/medical sociology, disasters, and race and ethnicity. He earned his MA and PhD in Sociology from the University of Nebraska-Lincoln. He also completed a postdoctoral fellowship at Rutgers University.

Anne Scheer is Assistant Professor at the Department of Population Science and Policy at Southern Illinois University School of Medicine. She holds a master's degree in Anthropology and a PhD in Sociology – both from Freie Universität Berlin, Germany. Her research interests include obesity and nutritional health in rural communities, school discipline in US public education, and the ways in which childhood trauma/toxic stress relate to children's health and their experiences with school discipline. As a qualitative childhood sociologist, she has conducted extensive research with elementary school-aged children, using participant observation and interviews, including research about punitive disciplinary policies in a large Midwestern school district, and her current study about rural children's perspectives on health, well-being, and nutrition.

Juyeon Son is Associate Professor in Sociology at University of Wisconsin Oshkosh. She received her MA in Women's Studies from Rutgers University in 1998 and her PhD in Sociology from the University of Oregon in 2007. Dr Son is a medical sociologist and has published articles that examine issues such as health service utilization and immigrant incorporation, postpartum care, health disparities, transnationalism, and technology. Her current research is on end-of-life and palliative care.

Jessica Valles is a Doctoral Student in the Department of Sociology, and a Research Fellow for the Office of Diversity, Equity and Inclusion at the University of Alabama at Birmingham. She received her MA in Sociology from the University of North Florida in 2014. Her research focuses on mental health for immigrant and aging populations, as well as racial and ethnic disparities in caregiving and familial support.

Francesca Alice Vianello, PhD, is Lecturer in Sociology of Work at the University of Padua (Italy). Her main areas of research are migration, gender, and labor. She leads the research project "Migration and Occupational Health: Understanding the Risks for Eastern European Migrant Women" funded by the University of Padua under the STARS Grants program. She is one of the regional representatives for Europe of the RC 32 "Women in Society" of the International Sociological Association.

PART I
INTRODUCTION TO VOLUME

UNDERSERVED AND SOCIALLY DISADVANTAGED GROUPS AND LINKAGES WITH HEALTH AND HEALTH CARE DIFFERENTIALS

Jennie Jacobs Kronenfeld

ABSTRACT

Purpose – *This chapter provides an introduction to the volume along with a very brief review of literature on underserved and socially disadvantaged groups and health and health care differentials.*

Methodology/Approach – *This chapter uses the approach of a literature review.*

Findings – *The chapter argues for the importance of greater examination of underserved and socially disadvantaged groups in consideration of health and health care differentials.*

Originality/Value of Paper – *The author reviews the issues of underserved and socially disadvantaged groups in consideration of health and health care differentials and previews this book.*

Keywords: Income; education; underserved; socially disadvantaged; health care differentials; health differentials

This chapter provides an introduction to Volume 37 in the *Research in the Sociology of Health Care* series, "Underserved and Socially Disadvantaged Groups and Linkages with Health and Health Care Differentials." The beginning of this chapter will briefly review some of the more important material

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Underserved and Socially Disadvantaged Groups and Linkages with Health and Health Care Differentials
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about underserved and socially disadvantaged groups in consideration of health and health care differentials. The second part of this chapter will review the overall contents of the volume and the structure of the volume.

UNDERSERVED AND SOCIALLY DISADVANTAGED GROUPS AND OTHER SOCIAL FACTORS AS LINKED TO HEALTH DISPARITIES AND HEALTH CARE DISPARITIES

When one uses the terms underserved and socially disadvantaged groups, it could mean many different things. In this volume, it mostly means people of color including Asian Americans and Latinx Americans, as well as rural Americans, and aging populations. In addition, it means issues related to women and gender both as recipients of care and providers of care. Also, a few chapters look at issues of underserved groups outside of the American context. In addition, many of the chapters relate to a variety of other social factors, including but not limited to components of socioeconomic status (SES) such as income, education and occupation, demographic social factors such as age and gender and factors linked to the family such as marriage or divorce and factors linked to employment such as job stress or unemployment. The literatures covering these different groups and factors are huge, and the literature on health inequalities and health care inequalities is also quite large. This chapter will not cover any of this in a comprehensive manner but will focus in a brief section on what we mean by health and health care inequalities. There is also a brief section on the linkage of a few major social factors such as income, education and race and ethnicity with health and health care inequalities.

HEALTH INEQUALITIES, HEALTH CARE INEQUALITIES, AND HEALTH DISPARITIES

One area of growing interest within medical sociology in the past 20 years has been research in health disparities and this is also true within public health and medicine as well as medical sociology more specifically. The interest in health care disparities has expanded beyond researchers to also become an area of high interest to providers of care and policymakers, especially within the United States. The definition of health disparities or differences in health care is important to review. The Institute of Medicine (IOM) defines health care disparities as differences in treatment or access between population groups that cannot be justified by different preferences for services or differences in health (McGuire, Alegria, Cook, Wells, & Zaslavsky, 2006). Within the United States, much of the focus on health care disparities has turned to differences in access and quality across racial and ethnic groups, although these are not the only social characteristics that are of interest either sociologically or from a policy perspective. Differences based on SES and its components including education and income are of both research and policy interest. Beyond research and thinking about policy implications, health care disparities matter even more if they result in health disparities, defined as differences in health outcomes across population groups (Schnittker & McLeod, 2005).

One interesting study that demonstrates the growth in research about social differences in health and health disparities was summarized well by the Adler and Rehkopf (2008) review of US disparities in health by examining literature for the term "health disparities" and finding that while this was a key word in only one article in 1980, and fewer than 30 in the 1990s, it went up to over 400 articles from 2000 to 2004. If the term "health inequalities" was used instead, the pattern of increase was similar.

The United States is not the only country with growing interest in this topic. Great Britain and more recently some European countries also have interest in the topic. Interest in the topic in Great Britain goes back to 1980, when the Black Report was one of the first in that country to apply the term inequality to an examination of health differences. In the United States in this same time period, studies did link together death and health information with information on SES from sources such as the Current Population Study, the US Census, and Social Security Administration records (Kitagawa & Hauser, 1978; Kliss & Scheuren, 1978).Within the US, some of these earlier studies and traditions in various fields including sociology of research into variation in health, health care utilization and health services issues by SES and race/ethnicity led to the now well-known efforts in the United States to examine and try to eliminate health disparities due to race/ethnicity and SES in the *Healthy People* series. From the federal government level, one of the pushes for more research on health care inequalities came from the passage of Public Law 106−129, the Health Care Research and Quality Act of 1999. A first National Health Care Disparities Report came out in 2005 and built on previous efforts in the federal government, especially Healthy People 2010 (U.S. Department of Health & Human Services, 2000) and the IOM Report, Unequal Treatment: Confronting Racial and Economic Disparities in Health Care (Smedley, Stith, & Nelson, 2003). Elimination of disparities in health was a goal of Healthy People, 2010. Unequal Treatment extensively documented health care disparities in the United States and focused on those related to race and ethnicity, but not on SES, a weakness of the report. The IOM report on Unequal Treatment also looked at factors related to providers of care and argued that providers' perceptions and, from that, their attitudes toward patients can be influenced by patient race or ethnicity (Smedley et al., 2003).

Federal government focus on these efforts has continued, and much of it is discussed in the Healthy People 2020 publications, much of which is now easily obtainable through United States government websites including access to data from the 2020 objectives (U.S. Department of Health & Human Services, 2019). For the 2020 effort, the report points out that in Healthy People 2000, the goal was to reduce health disparities among Americans, and in Healthy People 2010 the goal was to eliminate, not just reduce, health disparities. By Healthy People 2020, that goal was expanded even further: to achieve health equity, eliminate disparities, and improve the health of all groups. Healthy People 2020 defines health equity as attaining the highest level of health for all people. In addition, the Centers for Disease Control and Prevention (CDC) is another US federal agency that works on issues of health differences and health disparities in addition to many other concerns about diseases. In a special report they issued in 2011, the agency consolidated the most recent national data available on disparities in mortality, morbidity, behavioral risk factors, health care access, preventive health services, and social determinants of critical health problems in the United States by using selected indicators (Truman et al., 2011).

One of the newest federal government-related efforts to focus on health equity is an effort by the Centers for Medicare & Medicaid Services (CMS). They have collaborated with a wide variety of stakeholders to support work in all three areas of their path to equity: increasing the understanding and awareness of disparities and their causes, developing and disseminating solutions, and implementing sustainable actions. To increase understanding and awareness of disparities, CMS sponsored a special issue of Health Services Research (James, 2019) with a goal of contributing to the conversation on health disparities and emphasizing the value of continuing research in this area (Caro, 2019). This is an important new publication to consult related to these concerns.

Beyond the role of the federal government, private foundations such as the Commonwealth Foundation have programs that focus on health differences and health disparities (Commonwealth Fund, 2015). The goals of the Commonwealth Fund's Program on Health Care Disparities are to improve the overall quality of health care delivered to low-income and minority Americans, and to eliminate racial and ethnic health disparities. In addition to issues of health differences and health disparities as many of these reports have examined, another issue related to health disparities has to do with dissatisfaction with the health care system. Recent research that compares the United States with other countries reports that Americans often report low levels of satisfaction and it does not appear to be correlated with per capita health expenditures as it is in many other countries (Hero, Blendon, Zaslavzk, & Campbell, 2016). There is also variation in satisfaction by factors such as income, with greater income associated with greater satisfaction.

UNDERSERVED AND SOCIALLY DISADVANTAGED GROUPS

Many social factors are important in health and health care inequalities. Among the most important factors are aspects of SES such as education, income, and occupation, because these factors often create and shape patterns of disease, patterns of health care utilization, and patterns of inequalities. People who have greater advantages in SES live longer than those without such advantages (Kunst, Feikhe, Mackenbach, & the EU Working Group on Socioeconomic Inequalities in Health, 1998). This is true at the beginning of life in terms of differences in infant mortality as well as across the lifespan (Gortmaker & Wise, 1997). It has also been true across time and is true in many different countries, not just the United States.

More recent research in medical sociology has especially focused on some broader approaches to SES and other social factors, an approach now known as the fundamental cause approach (Link & Phelan, 1995; Link & Phelan, 1996). This is a sociologically based explanation for persistent associations between SES and disease. The argument is that the reason SES is so consistently associated with disease is that resources such as knowledge, money, power, and prestige, all factors embodied in the SES concept, can be used in many different ways and in many different situations to avoid risks for diseases and even death. More socioeconomically advantaged people can better avoid risks and also take up protective strategies to improve health and well-being and can modify these over time to take advantage of new knowledge and approaches in the medical arena. This makes the relationship a dynamic one. If new risk factors emerge, for example, such as lack of exercise or changes in nutritional information, those with the most resources are better able to avoid risks and take advantage of protective factors. The same is true for knowledge about new treatments; the most advantaged people not only often have better health insurance that allows people to use the treatments, but are more likely to learn about the treatments, seek out health providers who familiar with such treatments and be able to pay for the treatment with their own resources if the new treatments are not yet covered by standard health insurance.

Turning away from more theoretical discussions to actual data, the United States government reports have recently been working on ways to create some simpler indicators of such factors as health-related quality of life. They have developed the HALex score which provides one individual-level measure of health-related quality of life (HRQL) that can be used to monitor health status as well as examine inequalities in morbidity across time and groups (Truman et al., 2011). This measure provides a numerical based measure that combines information on self-rated health and activity limitation as reported in nationally representative surveys. The scores on HALex can theoretically range from 1.00 for persons who have no activity limitation and are in excellent health to 0.10 for persons who are limited in activities of daily living (ADL) and are in poor health. For example, a person in excellent health with ADL disabilities is considered as healthy, with an assigned HALex score of 0.47, as is a person in poor health with no disabilities. The average HALex and inequality for HALex among US adults for 1997–2007 is estimated to show a declining trend from 0.8766 in 1997 to 0.8662 in 2007. During the same period, health inequality among individual persons, as measured by the Gini index for HALex, fluctuated, varying from 0.084 to 0.093, and experienced an overall declining trend from 0.093 in 1997 to 0.087 in 2007.

As part of the same research efforts, agencies within the government have been examining the socioeconomic circumstances of persons and the places where they live and work because studies have indicated that these strongly influence their health. The risk for mortality, morbidity, unhealthy behaviors, limited access to health care, and poor quality of care increases with decreasing socioeconomic circumstances. The two most common indicators used are educational attainment and family or household income. To assess disparities in the prevalence of non-completion of high school and poverty, the CDC analyzed data from the 2005 to 2009 Integrated Public Use Microdata Series – Current Population Survey (IPUMS-CPS). This provides a cross-sectional monthly household survey of a representative sample of the civilian, non-institutionalized US household population and is conducted jointly by the US Census Bureau and the Bureau of Labor Statistics. Group disparities in age-standardized prevalence of non-completion of high school and poverty (poverty income ration (PIR) <100% of federal poverty level (FPL)) were assessed according to sex, race/ethnicity, age, education, PIR, and disability (Beckles & Truman, 2011). In the 2009 population, statistically significant disparities were identified in non-completion of high school for all characteristics studied. Except for non-Hispanic Asian/Pacific Islander males, the absolute differences between the age-standardized percentages of each non-white racial/ethnic group and non-Hispanic whites who had not completed high school were statistically significant. The degree of racial/ethnic relative disparity varied markedly among the non-white racial/ethnic groups, ranging from three to nine times greater for Hispanics than for other groups. During 2009, the group disparities in poverty observed were similar to those for non-completion of high school No statistically significant differences were identified between relative disparities in poverty observed for 2005 and 2009.

This section has presented only a small bit of the data linked to social factors and health and health care that is available from US government sources. Because this introduction to this material is in no way comprehensive, these paragraphs are illustrative of the types of information available on CDC and other US government websites such as the Healthy People reports. They are excellent sources for researchers interested in pursuing these topics in greater depth.

Also, previous volumes in this series have presented brief reviews of issues linked to gender and health and health care as well as to race and ethnicity (Kronenfeld, 2012; Kronenfeld, 2015; Kronenfeld, 2016). Consultation of the introductory essays to these volumes will also provide additional information as do the literature review sections of a number of the chapters in this volume.

REVIEW OF CONTENTS OF THE VOLUME

This volume is divided into five parts. The first part is the introduction to this volume and contains only this chapter. The second part is on mental health related issues and contains three chapters, all of which look partially at mental health issues as related to issues of race and ethnicity. The chapter by Bennefield explores mental health pathways for girls of color. The purpose of this study was to examine whether girls of color had more or less social support than their peers and whether that affected their likelihood of experiencing the symptoms of anxiety and depression. Using data from the National Comorbidity Survey, Adolescent Supplement, path analysis found that among adolescents with both low and high SES, girls of color had significantly less family support. Despite this fact, they were not more likely to experience symptoms of anxiety and