Chapter 12
Social Stratification and Inequality

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Abbreviation

AFDC Aid to Families with Dependent Children

Social stratification refers to the unequal distribution of valued resources across social groups. The resources that underlie stratification systems are both tangible and intangible: economic, political, social, civil, but also cultural and honorific (Grusky, 1994; Weber, 1922/1958). In the USA, the most widely recognized stratification systems are based on social class,[1] race/ethnicity, and gender. Systems of stratification are maintained through institutional and interpersonal processes by which dominant groups assert and maintain control over valued social resources. These processes—variously referred to as social closure, exploitation, opportunity hoarding, othering, and boundary maintenance (Roscigno, Garcia, & Bobbitt-Zeher, 2007; Schwalbe et al., 2000; Tilly, 1998; Tomaskovic-Devey, 1993)—produce and reproduce social advantages for dominant groups and social disadvantages for their subordinates.

Research on stratification and mental health aims to understand how experiences of advantage and disadvantage affect individual well-being.[2] In Pearlin's (1999) words, "(s)ociological interest in mental health and disorder is rooted in its mission to identify elements of social life that have dysfunctional consequences" (p. 410). Early research in this area was motivated by the straightforward, and seemingly reasonable, assumption that social disadvantages create mental health disadvantages. Recent empirical research challenges that assumption. For example, although women are socially disadvantaged relative to men, they differ from men in the types, rather than the level, of mental health problems they experience (see Chap. 14). Similarly, although Blacks are socially disadvantaged

[1] The terms "social class," "socioeconomic status," and "socioeconomic position" are defined and used in various ways by mental health researchers. I use the term social class here to emphasize that the resources that vary according to traditional indicators of socioeconomic status are more than socioeconomic in nature. Social classes differ in terms of lifestyles and prestige as well as in terms of tangible resources, both of which are relevant to understanding mental health differentials.

[2] Because this chapter covers many specific areas of research, citations are necessarily selective.

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relative to Whites, Blacks do not consistently report higher levels of distress and do not have higher rates of most mental disorders (Brown, Sellers, Brown, & Jackson, 1999; Kessler et al., 2005). Even the association of social class with mental health problems does not hold for all indicators of social class or at all ages (Harper et al., 2002; Kessler et al., 2005; Miech, Eaton, & Brennan, 2005). In short, the straightforward assumption that social disadvantages create mental health disadvantages is met with a more complex empirical reality.

This complex empirical reality is the consequence, in part, of the multifaceted meanings associated with indicators of social advantage and disadvantage. For individuals, social class, race/ethnicity, and gender represent positions in systems of stratification that signal differential access to valued social resources. Yet, they also represent social categories whose subjective meanings are fluid and negotiable, meanings that can be used to resist the distressing effects of social disadvantage. A key goal for sociologists interested in stratification and mental health is determining whether and how these subjective meanings modify the effects of objective disadvantage (see also Conger, Conger, & Martin, 2010).

In this chapter, I review our collective progress toward that goal. I examine two general processes through which stratification is thought to affect mental health and that correspond roughly to my previous distinction between tangible and intangible resources: the distribution of life conditions and social evaluation. The first process corresponds most closely to the traditional concerns of stratification researchers in its emphasis on objective life experiences as explanations for mental health disparities. The second process corresponds most closely to the concerns of social psychologists in its emphasis on subjective evaluations of life experiences and status distinctions. The two processes overlap: social evaluations are influenced by objective life conditions and the effects of objective life conditions depend on how those conditions are perceived. Yet the two processes also are conceptually distinct and merit separate consideration. For each process, I highlight contributions from life course research and research on emotions—areas of increasing influence.

The Distribution of Life Conditions

By definition, stratification involves the unequal distribution of life conditions: "the panoply of circumstances that define the quality and character of our social lives" (Weeden & Grusky, 2005, p. 143). Early sociological research on stratification and mental health conceptualized life conditions with reference to components of the stress process model, specifically as stressors and coping resources (Aneshensel, 1992). The stress process model posits that the higher risk of mental health problems among people in socially disadvantaged positions can be explained by their greater exposure to stressors and lesser access to coping resources (intrapsychic, interpersonal, and material). As noted, evidence is mixed as to whether people in socially disadvantaged positions have relatively high levels of mental health problems. To the extent they do, evidence also is mixed as to the role stress plays (Schwartz & Meyer, 2010).

Early research that relied on measures of life-events exposure found that differences in exposure did not account for mental health disparities (Dohrenwend & Dohrenwend, 1969; Langner & Michael, 1963; see Hatch & Dohrenwend, 2007 for a review). Later research that incorporated more comprehensive measures of stressors found stronger evidence for the mediating role of stress exposure for social class and race/ethnicity but not for gender (McDonough & Walters, 2001; Sternthal, Slopen, & Williams, 2011; Turner, Wheaton, & Lloyd, 1995; see Thoits, 2010 for a review), although stress exposure still was not a sufficient explanation. Studies of coping resources generally find that people in socially disadvantaged positions have fewer social and personal resources to cope with stressors, although there are exceptions to this pattern (e.g., the higher self-esteem reported by Blacks as compared to Whites).

Most studies of differential exposure and vulnerability rely on global measures of stressors—sums of life events, chronic stressors, and lifetime traumatic experiences. Although useful for establishing the relevance of stress processes to explaining mental health disparities, global measures are blunt instruments that tell us little about the specific types of stressors associated with social disadvantage or about the specific processes through which stratification affects mental health. The overwhelming reliance of prior research on depression as an outcome also leaves open the possibility that different patterns would be observed for other outcomes (Aneshensel, Rutter, & Lachenbruch, 1991).

Research on the "stress of higher status" illustrates the benefits of measuring specific stressors in stratification research (Schieman, Whitestone, & Van Gundy, 2006). This hypothesis posits that certain role-related strains are more common among people in socially advantaged positions. Consistent with that hypothesis, higher-status jobs are associated with greater work-to-family conflict (Schieman et al., 2006). The types of stressors that are common in higher-status groups appear to be as or more strongly associated with substance use and anger as they are with depression (Martin & Roman, 1996; Schieman & Reid, 2009), supporting an expansion of outcomes.

The limitations of studies that rely on global measures of stressors highlight the utility of studies that focus on specific proximate experiences. The latter complement the former by moving beyond broad descriptive patterns to analyze the processes through which stratification affects mental health.

Generic Resources and Proximate Life Conditions

The life conditions that define stratification hierarchies are experienced within proximate environments. Proximate environments can be characterized by their geographic boundaries (e.g., states, cities, neighborhoods), functions (e.g., workplace, family), structure (e.g., role sets, networks), and quality (e.g., job conditions, marital satisfaction). Life conditions defined by virtually all possible combinations of these characteristics have been examined as explanations for stratification's effects on mental health. Instead of reviewing these many specific experiences, I review research on four generic resources that shape the nature and quality of proximate life conditions: economic resources, social capital, power and authority, and civil rights (Grusky, 1994). By using the term "generic," I intend that these resources can be analyzed across geographic, functional, and structural contexts, although they may take context-specific forms. These resources align with fundamental components of stratification systems that have long intellectual histories in sociology, and they are associated with identifiable lines of research related to mental health. Thus, they link research on stratification and mental health to the sociological mainstream.

Economic Resources

In *The Condition of the Working Class in England in 1844*, Engels (1892/2008) attributed the high rate of alcoholism in the working classes to material deprivation.

> The working-man comes from his work tired, exhausted, finds his home comfortless, damp, dirty, repulsive; he has urgent need of recreation, he *must* have something to make work worth his trouble, to make the prospect of the next day endurable. His unnerved, uncomfortable, hypochondriac state of mind and body arising from his unhealthy condition, and especially from indigestion, is aggravated beyond endurance by the general conditions of his life, the uncertainty of his existence, his dependence upon all possible accidents and chances, and his inability to do anything towards gaining an assured position. (pp. 102–103)

Engels' work presaged the central importance of economic resources to contemporary research on stratification (Weeden & Grusky, 2005). Low income is part of what defines people with low

education and occupational prestige, members of racial and ethnic minority groups, and women as socially disadvantaged groups (DeNavas-Walt, Proctor, & Smith, 2010). Poverty, economic deprivation, and financial strain also are common indicators of social class in mental health research, and variation in economic resources is a common explanation for mental health disparities. Although most studies find that economic resources are not a sufficient explanation for mental health disparities based on gender or race/ethnicity (Williams & Collins, 1995), the processes through which economic resources affect mental health are central to the study of stratification.

A primary mechanism by which economic resources affect mental health is through their association with stress exposures. People with limited economic resources experience many specific stressors that increase the risk of mental health problems, including food insecurity, problems paying bills, family conflict, and ill health (Bickel, Carlson, & Nord, 1999; Broussard, 2010; McLeod & Kessler, 1990; Pearlin & Lieberman, 1979). People with limited economic resources also are more likely to live in disadvantaged neighborhoods (Jargowsky, 1996), which exposes them to ambient stressors that further increase their risk of mental health problems (see Chap. 23 for a review).

Life course studies have enriched research on economic resources, stress, and mental health by investigating variation in effects based on the duration and timing of exposure. Exposures of longer duration have more profound effects on mental health. For example, children's mental health declines as poverty persists (McLeod & Shanahan, 1996) and improves with increases in income (Strohschein, 2005). Early deprivations also have effects that persist over time. For example, receiving welfare in young adulthood increases women's levels of distress in later adulthood even when prior distress and current poverty status are controlled (Ensminger & Juon, 2001). Childhood neighborhood economic deprivation also has a significant association with adult mental health independent of adult neighborhood characteristics (Wheaton & Clarke, 2003).

To fully understand these patterns, future research must attend to life course variation in the specific processes that account for the effects of economic resources. Research on adults has focused primarily on perceived financial strain, chronic stressors, ambient stressors, and social support as mediators of the association of economic resources with mental health (Heflin & Iceland, 2009; Schulz et al., 2006). In contrast, research on children has focused on family process variables, such as parental psychological distress, parenting behaviors, and parental investments (Conger & Donnellan, 2007; McLoyd, 2011), with some interest in school and classroom characteristics (Milkie & Warner, 2011). Broadening these foci would encourage a more complete conceptualization of life course variation in the proximate experiences that account for the effects of economic deprivation.

More generally, basic questions about the role of economic resources in mental health disparities across the life course have not yet been asked and/or answered (George, 2005). Developmental researchers have investigated whether there are "sensitive" periods for academic outcomes (Duncan, Yeung, Brooks-Gunn, & Smith, 1998) and how developmental risks and mental health outcomes might interact to produce negative developmental "cascades" (Masten et al., 2005). These ideas are only rarely incorporated into sociological research on stratification and mental health (see Martin et al., 2010 and Wickrama, Conger, & Abraham, 2005 for exceptions). Mental health researchers also have not taken full advantage of the conceptual models of cumulative advantage and cumulative disadvantage that have been offered to explain social class disparities in physical health (see Hatch, 2005 for a review). These models integrate insights from multiple disciplines to understand the complex, reciprocal connections among persistent vulnerabilities, age-specific risks, and social disadvantage in the production of health disparities. They are a useful starting point for the development of comparable models tailored to mental health outcomes.

Social Capital

Resources people can access through their social connections are a second fundamental determinant of life conditions. For purposes of this chapter, I use the concept of social capital to represent these resources. As defined by Parcel, Dufur, and Cornell Zito (2010) (who borrowed from Coleman's [1988] original definition), social capital refers to "resources that inhere in the relationships between and among actors that facilitate a range of social outcomes" (p. 830). This broad definition encompasses the concepts of social integration and social support that have long histories in mental health research (see Chap. 17). Although some specificity is sacrificed by glossing over distinctions among these concepts (Hartwell & Benson, 2007), doing so allows me to focus on the general properties of social connections that link stratification to mental health.

Social capital can be conceptualized within different domains of social interaction. In the context of the family, social capital refers to the bonds between parents and children that promote child socialization, including parental involvement, parental support, and parental monitoring of child behavior (Parcel et al., 2010). In the context of schools, social capital refers to relationships with teachers and school-based community connections. Although less often discussed, social capital at work could be conceptualized analogously as relationships with supervisors and employment-based social relationships. Social capital also may reside in neighborhood connections, as represented in concepts such as collective efficacy and community integration (Sampson & Graif, 2009). Some forms of social capital strengthen bonds within social institutions ("bonding" social capital; e.g., parent–child relations) whereas others bridge social institutions ("bridging" social capital; e.g., parent-teacher relations). Social capital allows for the sharing of material resources, as well as the sharing of information, the development of relationships involving obligation and reciprocation, and the cultivation of effective norms and sanctions (Coleman, 1988).

Research clearly demonstrates the mental health benefits of social capital as well as the potential of social resources in one interactional domain to compensate for the absence of social resources in another (Call & Mortimer, 2001). For instance, Parcel and Dufur (2001) report that family and school social capital both influence children's mental health, and that the negative effects of low school social capital can be offset by high parental monitoring. Among adults, social integration and the perception of social support enhance mental health and, in the case of the latter, buffer the effects of stressors (see Chap. 17).

There are good reasons to believe that social disadvantage is associated with the nature and quality of social connections. People's social networks tend to be populated by similar others (McPherson, Smith-Lovin, & Cook, 2001), which implies that people who are socially disadvantaged are members of resource-poor collectivities. Social disadvantage also is associated with community characteristics, such as social disorder, that impede the construction of mutually supportive social networks (Massey & Denton, 1993; Wilson, 1991; although see Kim, 2010). Within families, social disadvantage diminishes the quality of intimate relations and heightens tensions (Conger et al., 2010).

Evidence for the mediating role of social capital is weak, especially in adult populations. Turner and Marino (1994) reported that perceived social support was unable to explain the association of socioeconomic status with depression; findings from studies that have used more comprehensive measures of bonding social capital are similar (Ensminger & Juon, 2001; Ettner & Grzywacz, 2003). Observed patterns of social support by gender and race also do not conform to patterns of social disadvantage. Women report receiving more rather than less social support than men (Turner & Marino, 1994) and ethnic minority groups maintain stronger and more supportive family and friendship ties than Whites (Burton et al., 1995). These studies suggest that the types of bonding social capital that are most often investigated in studies of mental health do not vary in predictable ways with social disadvantage.

In contrast, studies of children frequently find that family and school social capital importantly contribute to explaining social class disparities in mental health (Vandewater & Lansford, 2005). The apparent greater relevance of social capital for explaining children's mental health may reflect the different types of measures used in studies of children and adults. Studies of children typically include measures of bridging as well as bonding forms of social capital—for example, parental engagement in children's schools, parental monitoring. Although less often studied, bridging capital may affect mental health through its association with the structure and content of the institutional environments (e.g., workplace, school) to which people have access. Moreover, bridging forms of social capital may be more closely tied to social disadvantage than are bonding forms of social capital—especially for children, whose access to bridging capital depends more on parental investments than on their own actions. (See Conger et al., 2010 for a review.)

Research has not yet investigated systematically how the costs and benefits of bridging and bonding social capital vary with social disadvantage (Umberson & Montez, 2010). Evidence that social support buffers the association of stressors with mental health (see Chap. 17) would lead us to expect bonding forms of social capital to buffer the association of social disadvantage. However, the social relationships that generate social capital may be perceived as stressful rather than as supportive by members of disadvantaged groups because they carry expectations for reciprocity that are difficult to meet (Henley, Danziger, & Offer, 2005). Race differences in the effects of bridging forms of social capital on academic achievement differ across indicators (Kao & Rutherford, 2007) suggesting highly specific patterns of association.

Because of these complexities, social capital may prove more useful for explaining variation within disadvantaged groups than between advantaged and disadvantaged groups (Scheffler, Brown, & Rice, 2007). For example, Cairney, Boyle, Offord, and Racine (2003) found that lesser access to social support explained why single mothers had worse mental health than married mothers. More generally, supportive relations seem to be especially important to understanding variation in the mental health of low-income women (Broussard, 2010). These studies reinforce the idea that the role of social capital in the association of stratification with mental health is highly contingent, varying with the dimension of stratification and the type of social capital.

Power and Authority

People who occupy lower positions in stratification hierarchies have fewer economic and social resources, in large part, because they have less power to control the conditions of their daily lives and to influence the actions of others. Objective conditions of power and powerlessness shape subjective beliefs about one's efficacy in the social world. Powerlessness is a major component of alienation (Seeman, 1959), a concept with roots in Marx's (1844/1964) writings on alienated labor. It is demoralizing in and of itself, and it diminishes the will and ability to cope effectively with life challenges (Mirowsky & Ross, 1986; Wheaton, 1983).

Whether operationalized as mastery, locus of control, learned helplessness, or self-efficacy, personal control is positively associated with mental health (Kiecolt, Hughes, & Keith, 2009; Pearlin, Menaghan, Lieberman, & Mullan, 1981; Wheaton, 1980; see Chap. 19). In addition, people who occupy higher positions in stratification hierarchies have higher average levels of perceived control (Pearlin et al., 1981; Ross & Mirowsky, 1992) and perceived control contributes to explaining differences in mental health by social class, gender, and race/ethnicity (Turner, Lloyd, & Roszell, 1999; Turner, Taylor, & Van Gundy, 2004). Thus, perceived control is an important explanation for mental health disparities.

Perceived control is rooted in objective conditions of powerlessness and dependency that vary across stratification hierarchies. As stress research attests, people who are in socially disadvantaged positions are exposed to adversities that diminish control. High status also carries opportunities and positive life experiences that enhance sense of control through "social conditioning" (Weeden & Grusky, 2005) and learning generalization (Kohn & Schooler, 1983). For example, education nurtures control by exposing youth to progressively more challenging tasks that can be mastered (Mirowsky & Ross, 2007). People with higher levels of education also tend to hold jobs that involve schedule control, interesting work, and high pay, all of which contribute to perceived control (Schieman & Plickert, 2008).

The general association between social disadvantage and perceived control takes specific form in research on job conditions and mental health (see Chap. 21). In their classic study of work and personality, Kohn and Schooler (1983) proposed that occupational conditions connect broad patterns of occupational stratification to individual attitudes and well-being. Specifically, they argued that low prestige occupations offer fewer opportunities for self-directed activities which, in turn, increase distress and alienation. Subsequent studies confirmed the importance of control, authority, and autonomy in the workplace for the health, well-being, and self-esteem of workers (Karasek & Theorell, 1990; Link, Lennon, & Dohrenwend, 1993) and for the mental health of their children (Rogers, Parcel, & Menaghan, 1991).

These results notwithstanding, the power and authority that come with prestigious jobs do not have uniformly positive associations with mental health (Marchand, Demers, & Durand, 2005). Jobs that involve authority bring higher earnings, more autonomy, and less routine work, but they also involve more interpersonal conflict and work-to-home conflict (Schieman & Reid, 2009; Schieman et al., 2006). These forms of conflict may be especially distressing to women, who experience more tension between their roles as workers and as parents and spouses than do men (Simon, 1995). The complex meanings of work may explain why, despite strong evidence that women have less power and authority in the workplace than men (Elliott & Smith, 2004), job conditions do not account for gender differences in the prevalence of distress (Roxburgh, 1996).

Recent research on gender has shifted from using women's lesser power and authority to explain their higher levels of distress (Gove & Tudor, 1973) to using these concepts to explain gender differences in the manifestations of distress. Simon and Nath (2004) draw on Kemper's (1978) theory of emotion to hypothesize that men's high status and power are associated with positive emotions and women's low status and power are associated with negative emotions. Consistent with that hypothesis, they found that men reported more positive emotions (e.g., calm, excited) than women whereas women reported more negative emotions (e.g., sad, anxious) than men. Moreover, although men and women reported equal frequencies of experiencing anger, women's anger was more intense.

Rosenfield and colleagues provide an alternative account of how gender differences in power and authority produce gender differences in the manifestations of distress. Drawing on symbolic interactionist theories of the self, they attribute the gender difference in mental health to gendered life experiences that encourage boys and girls to develop different assumptions about the relative importance of self and others (Rosenfield, Vertefuille, & McAlpine, 2000). Specifically, girls' experiences of powerlessness together with gendered expectations for autonomy, worth, and confidence promote low self-salience—an emphasis on the collective over the individual—which leads to internalizing problems. In contrast, boys' experiences of greater power promote high self-salience—a world view that privileges the self over others—which is associated with externalizing problems. Consistent with their expectations, Rosenfield and her colleagues found that gendered expectations are associated with self-salience, adolescent girls report lower self-salience than boys, and self-salience importantly contributes to explaining gender differences in internalizing and externalizing problems (Rosenfield, Lennon, & White, 2005). With Simon's research, Rosenfield's studies demonstrate that power can influence the manifestations, as well as the likelihood, of distress.

Civil Rights

In general terms, civil rights refer to legal rights that ensure equal citizenship (Altman, 2009). In liberal democracies, and in mental health research, civil rights are conceptualized with respect to discrimination. Although the term discrimination has various definitions, most refer to unfair treatment of members of disadvantaged groups that is intended to maintain the advantages of dominant groups (Krieger, 2000). Discrimination can be conceptualized at multiple levels of analysis—with reference to institutionalized practices of discrimination, personal experiences of discrimination, and internalized racism (Williams & Williams-Morris, 2000). In its diverse forms, discrimination produces a hierarchy of social disadvantage by constraining opportunity structures and excluding members of subordinate groups from full societal benefits.

The effects of institutionalized discrimination on mental health are usually represented by group differences in economic deprivation, residential segregation, job conditions, and the like. Because I cover those components of stratification in other sections, here I emphasize research on personal experiences of discrimination.

Personal experiences of discrimination can be acute (e.g., losing one's job because of one's race) or chronic (e.g., repeatedly being treated less courteously by others). Their effects may cumulate over the life course, and may vary depending on the specific social context in which discrimination is experienced (Williams, Neighbors, & Jackson, 2003). Regardless of how they are measured, experiences of race and gender discrimination produce variation in mental health among members of racial/ethnic minority groups (Finch, Kolody, & Vega, 2000; Gee, Spencer, Chen, Yip, & Takeuchi, 2007; Keith, Lincoln, Taylor, & Jackson, 2010; see Williams et al., 2003 for a review). Discrimination also has been linked to differences in mental health between lesbian, gay, and bisexual populations as compared to heterosexuals, and to variation in mental health problems among sexual minorities (Meyer, 2003). The effect of discrimination appears to be attributable, at least in part, to its association with diminished personal control (Keith et al., 2010).

Whereas the concept of discrimination usually is reserved for unfair treatment directed toward women, persons of color, and sexual minorities, the concept of stigma is invoked to understand the experiences of other groups that are viewed as having socially undesirable traits (Stuber, Meyer, & Link, 2008; see Chap. 25). In stratification research, stigma applies most directly to welfare recipients (Stuber & Schlesinger, 2006) and has been shown to have adverse psychological consequences (Belle, 1990). For example, women who receive Aid to Families with Dependent Children (AFDC) view receiving public assistance as unpleasant and embarrassing (Goodban, 1985). They also report feeling ashamed and depressed by their interactions with social services organizations (Popkin, 1990).[3]

Despite the consistency of evidence for the negative effects of discrimination and stigma on mental health, these experiences do not appear to explain mental health disparities based on race/ethnicity, gender, or social class (Kessler, Mickelson, & Williams, 1999; Williams, Yu, Jackson, & Anderson, 1997). In part, this result occurs because racial/ethnic minorities and women do not always report more mental health problems and more experiences of discrimination than Whites and men (Kessler et al., 1999). Yet, even when they do, controlling for discrimination does not explain mental health disparities (Williams et al., 1997). This failure is inconsistent with evidence of the pervasive discrimination that members of socially disadvantaged groups experience (Benokraitis & Feagin, 1986; Feagin, 1991). It is possible that extant measures of discrimination do not capture the most relevant aspects of discrimination. Racial minorities and women may experience subtle but persistent forms of

[3] In mental health research, stigma also is used to understand the social disadvantages associated with having received mental health treatment and the implications for recovery and relapse (see Chap. 25).

social exclusion that are not easily captured by survey items. Also, standard measures typically do not collect information about the frequency or duration of discriminatory experiences (Williams & Mohammed, 2008) or about stigma associated with receiving means-tested forms of public assistance (Stuber & Schlesinger, 2006).

More generally, perceived discrimination may be only loosely related to objective discrimination. Targets of discrimination may not recognize unfair treatment as such, and people who were not discriminated against may believe they were unfairly treated (Major et al., 2002; Stangor et al., 2003). Experimental studies, for example, find that members of lower status groups are less likely to perceive discrimination when they accept an ideology that legitimates the status quo (for instance, an ideology that attributes success to individual effort; Major et al., 2002). Perceptions of discrimination also are influenced by racial beliefs and racial identity. African Americans who believe that other groups hold negative attitudes toward African Americans and whose racial identities are central to their sense of self report higher levels of perceived discrimination than other African Americans (Sellers, Caldwell, Schmeelk-Cone, & Zimmerman, 2003; Sellers, Copeland-Linder, Martin, & Lewis, 2006).

The negative effects of discrimination on mental health are buffered by these same factors. The effects of discrimination on mental health are dampened by the belief that the public holds one's group in low regard (Sellers et al., 2006) and by having a strong racial identity (Mossakowski, 2003; Sellers et al., 2003; although see Yip, Gee, & Takeuchi, 2008). Culturally normative coping strategies, such as forbearance, also diminish the negative effects of discrimination, although their effectiveness varies across social contexts (Noh, Beiser, Kaspar, Hou, & Rummens, 1999; Noh & Kaspar, 2003). Thus, discrimination and stigma may affect mental health only in specific subgroups of disadvantaged populations (Meyer, Schwartz, & Frost, 2008).

In addition, a more appropriate outcome than occurrence of disorder may be its course (Smedley, Stith, & Nelson, 2002) given studies that have not found higher prevalence among racial/ethnic minorities, but rather more persistent, severe, and disabling mental health problems (Williams et al., 2007). With regard to course, diagnostic practices that rely on stereotypes of those in disadvantaged statuses may be associated with the persistence of mental health problems in these groups. For example, women are more likely to be diagnosed with depression, and men with adjustment disorder (Loring & Powell, 1988), whereas Blacks are over-diagnosed with schizophrenia and under-diagnosed with affective disorders relative to Whites, even when standardized diagnostic criteria are applied (Neighbors, Trierweiler, Ford, & Muroff, 2003). Cultural barriers, especially as reflected in language, also contribute to lower rates of mental health care utilization by Hispanic Americans (Fiscella, Franks, Doescher, & Saver, 2002; for a review, see Brach & Fraserirector, 2000). To the extent that appropriate treatment aids recovery and prevents relapse and recurrence, these factors may contribute to a protracted or recurrent course, a possibility that is not captured in studies that examine only the occurrence of disorder.

Stratification, Life Conditions, and Mental Health

In summary, the positions that people occupy in stratification hierarchies are strongly associated with the nature and quality of proximate life conditions. In this section, I conceptualized these experiences with reference to four generic resources that represent major components of stratification systems: economic resources, social capital, power and authority, and civil rights. Given the strong associations of those resources with mental health, they are likely candidates to explain mental health disparities. It is somewhat disconcerting, then, that empirical results are so mixed. Results are strongest for social class as an index of stratification, and for economic resources and job conditions as mediators—the characteristics that conform most closely to the traditional concerns of stratification researchers. Results are weaker for race/ethnicity and gender as dimensions of stratification, and for social capital

and discrimination as explanations. The patterns for race/ethnicity and gender may reflect that, in addition to defining positions in stratification hierarchies, these characteristics define membership in social categories that have consequential meanings. In the next section, I consider these meanings in the context of social evaluation processes.

Social Evaluation Processes

Social stratification involves the differential distribution of status and prestige—honorific resources that confer esteem and worth. Social evaluation theories share an interest in the bases for and outcomes of these resources. They advance two general claims: (1) that people learn about themselves by comparing themselves to others, and (2) that social comparisons lead to positive, neutral, or negative self-evaluations relative to the standards employed for comparison (Pettigrew, 1967). Social comparisons can be evaluative or normative (Kelley, 1952).[4] Evaluative social comparisons provide information about relative standing and equity. Normative social comparisons provide information about the appropriateness of one's emotions, attitudes, and behaviors.

Most research on mental health focuses on evaluative social comparisons. Three main classes of theories offer insight into the determinants and consequences of these comparisons: theories of social comparisons and reference groups, equity theory, and status inconsistency theory. Although the theories often arrive at similar predictions regarding which individuals or groups will experience negative mental health outcomes, each offers unique insight into the processes through which social comparisons influence well-being and each has generated a distinct line of research. Research based on these theories challenges the simple assumption that people who are socially disadvantaged evaluate themselves and their life conditions unfavorably.

Social Comparisons and Reference Groups

The concepts of social comparisons and reference groups are most often associated with Hyman (1942), Festinger (1954), and Merton (1957). Festinger (1954) asserted that, when objective standards are unavailable, people use social comparisons with similar others to evaluate their abilities, opinions, and emotions. Hyman (1942) and Merton (1957) introduced the concept of a reference group to define these comparative others. Because of the deprivations and discrimination they encounter, we might reasonably expect people in socially disadvantaged positions to perceive themselves as disadvantaged relative to others. However, people are flexible and motivated in their choices of comparative standards so as to preserve a positive self-evaluation (Festinger, 1954; Kruglanski & Mayseless, 1990; although see Taylor, Buunk, & Aspinwall, 1990). Moreover, when upward comparisons cannot be avoided, people cope in ways that severely attenuate the link between negative comparisons and psychological distress (Diener & Fujita, 1997).

The claim that negative social comparisons do not uniformly produce distress takes a more specific form in research on self-esteem, relative deprivation, and subjective social status. Each line of research provides evidence of the contingent nature of the associations between social disadvantage and negative social comparisons, and between negative social comparisons and mental health.

[4] Kelley used the terms "comparative" and "normative" to distinguish the two functions of reference groups. I opt for "evaluative" to avoid confusion in multiple uses of the terms "comparative" and "comparison."

Social Comparisons and Self-Esteem

Rosenberg and Pearlin (1978) offered a cogent statement of the relevance of social comparisons for self-esteem. They argued that social disadvantage becomes relevant for self-esteem to the extent that members of disadvantaged groups internalize the negative appraisals of advantaged groups (reflected appraisals), see themselves as having been less successful than those groups (negative social comparisons), and attribute their lack of success to their own actions (self-attribution) (see also Rosenberg, 1981).

Consistent with the focus of Rosenberg and Pearlin's (1978) work, most empirical studies of social comparisons and mental health have used self-esteem as the outcome. In their own study, social class, as measured by occupational prestige, was unrelated to self-esteem for young children (ages 8–11), was only weakly related to self-esteem for older adolescents, and was strongly related to self-esteem for adults. The greater relevance of social class to the self-esteem of adults has been confirmed in other studies, with more recent studies finding that the association between social class and self-esteem begins to decline after age 60 (Twenge & Campbell, 2002). This association has increased in recent birth cohorts for women and is stronger for Asians than for Whites and Blacks, and weakest for Hispanics. These patterns are consistent with the idea that social class matters most to self-esteem when it is a salient indicator of success (Twenge & Campbell, 2002).

In contrast to social class, race/ethnic differences in self-esteem are not consistent with the hypothesis that disadvantaged groups experience lower self-esteem. In fact, African Americans report higher self-esteem than Whites who, in turn, report higher self-esteem than Latinos and Asian Americans (Gray-Little & Hafdahl, 2000; Twenge & Crocker, 2002). Several explanations have been proposed for the relatively high self-esteem observed among African Americans: that members of disadvantaged groups tend to compare themselves to similarly disadvantaged others (Singer, 1981), that they attribute failures or rejection to prejudice (Ogbu, 1986), that they devalue domains in which their group shows relatively poor achievement (McCarthy & Yancey, 1971; Rosenberg & Simmons, 1971), and that they hold positive group identities that protect self-esteem (see Twenge & Crocker, 2002 for a review). However, Latinos and Asian Americans report low self-esteem relative to Whites and Blacks, despite presumably having access to the same cognitive coping strategies (Pearlin & Schooler, 1978). Twenge and Crocker (2002) explain this pattern with reference to cultural values. When individualism is prized (such as in White and Black cultures), the self is seen as independent of relationships and people are motivated to enhance self-esteem by standing out from others. In contrast, when collectivism is valued (such as in Latino and Asian cultures), the self is seen as interdependent and people are encouraged to practice self-criticism as a means of maintaining harmony in relationships. If their explanation withstands empirical scrutiny, it suggests that the association between social disadvantage and negative self-evaluations depends on cultural values, as well as on the reference groups people choose and the attributions they make for their disadvantage.

Relative Deprivation

Research on relative deprivation provides further evidence for the contingent nature of social evaluation processes. Relative deprivation refers to a perceived discrepancy between what one anticipates and what one attains (Stouffer, 1949). In essence, it is the outcome of a social comparison that leads to the conclusion that the person is not receiving valued goods to which she or he feels entitled. The comparisons that prompt feelings of relative deprivation can be personal or group based; we can feel deprived relative to other specific people or we can feel that the groups to which we belong are deprived relative to other groups. Group-based relative deprivation has been linked to collective action

(Grant & Brown, 1995), whereas personal relative deprivation has been linked to poor mental health (Crosby, 1976). In particular, relative deprivation is thought to produce negative emotions such as anger, frustration, hostility, and fear.

Direct evidence for the association of relative deprivation with negative emotions and mental health is scarce. Experimental studies have successfully produced negative emotions in response to manipulated levels of relative deprivation (Bernstein & Crosby, 1980). However, the observed effects are highly contingent on whether people blame themselves or others for their deprived state, how much they value the outcomes under consideration, and how entitled they feel—contingencies that parallel those found in research on social comparisons and self-esteem (see Major & Schmader, 2001). Moreover, the transient emotions that are observed in experimental settings are not necessarily analogous to the outcomes of interest in mental health research.

Indirect evidence is more plentiful but also more mixed. This evidence derives from comparisons of the association of individual-level social disadvantage with mental health across countries that differ with respect to inequality. In an early influential study, Easterlin (1974) found that income was positively associated with happiness within countries, but that average happiness levels were not higher in wealthier countries as compared to poorer countries and did not increase within countries during periods of economic growth. He concluded that relative income rather than absolute income is a stronger determinant of happiness. A more recent line of research shifts focus to the association of income inequality with mental health. Wilkinson and Pickett (2007) reported a significant positive correlation between income inequality and the prevalence of mental illness in 12 countries, but found no such correlation for the 50 US states (see also Pickett, James, & Wilkinson, 2006). Because their country-level analysis did not control for potential confounders, however, their conclusion about the effect of relative deprivation on mental health remains tentative. Ladin, Daniels, and Kawachi (2009) extended this strategy in a multilevel analysis of the associations of individual- and country-level social class with late-life depression. Consistent with relative deprivation, they found that country-level income inequality was significantly associated with country-level rates of depression in bivariate analyses, and that low education was more strongly associated with the individual risk of depression in less egalitarian countries. In an apparently contradictory pattern, Hopcroft and Burr (2007) observed that women's relative disadvantage with respect to depression was higher in countries with high levels of gender equity (see also Culbertson, 1997). They posited that women in countries with high levels of gender equity experience a greater discrepancy between perceived societal opportunities and their personal circumstances.

Hopcroft and Burr's (2007) study highlights a key limitation in large-scale studies of relative deprivation: they do not provide direct evidence that people in different social contexts perceive themselves as deprived relative to others and that these perceptions are responsible for the observed patterns of mental health. Future progress will require more direct measurement of these perceptions. In addition, inasmuch as theories of relative deprivation predict specific emotional responses (i.e., anger, frustration, hostility, fear), studies that differentiate among mental health outcomes will prove especially valuable.

Subjective Social Status

Research on subjective social status extends research on relative deprivation by investigating the association between objective and subjective social statuses. This research follows on Centers' (1949) early investigation into the determinants of subjective social class which revealed that objective and subjective social statuses do not necessarily correspond. People who are socially disadvantaged do not always think of themselves as disadvantaged and people who are socially advantaged do not always

think of themselves as advantaged. Indeed, most Americans rank themselves as "middle class" or "working class" despite a much more differentiated objective class distribution (Hout, 2008). It is reasonable to expect, then, that subjective and objective social statuses have independent associations with mental health.

Most studies measure subjective social status by asking respondents whether they are better off or worse off than a given comparative standard ("others in American society," "your neighbors"; Wolff, Subramanian, Acevedo-Garcia, Weber, & Kawachi, 2010) or by asking respondents to place themselves on a ladder to indicate their position relative to others (Adler, Epel, Castellazzo, & Ickovics, 2000). Regardless of measurement approach, subjective social status is consistently associated with psychological distress and depressive symptoms independent of objective status indicators (Demakakos, Nazroo, Breeze, & Marmot, 2008; Franzini & Fernandez-Esquer, 2006). Importantly, this finding does not appear to be a function of the influence of psychological characteristics on subjective status ratings (Singh-Manoux, Adler, & Marmot, 2003).

Although research is limited, it suggests that subjective social status is a product of social comparison processes and a determinant of relative deprivation. Subjective social status is a function of people's beliefs about their current and future prospects and their experiences of discrimination and victimization as well as their current socioeconomic position (Singh-Manoux et al., 2003; see Franzini & Fernandez-Esquer, 2006 for a review). Moreover, the determinants of subjective social status vary by race/ethnicity and acculturation status. Objective and subjective social status correspond less closely for African Americans than for Whites and Latinos, and education contributes less to subjective social status for Latinos (Ostrove, Adler, Kuppermann, & Washington, 2000). The choice of reference groups also differs depending on levels of acculturation (Franzini & Fernandez-Esquer, 2006). For instance, foreign-born, Spanish-speaking Mexicans were most likely to choose Mexicans in the USA as their reference group, whereas US born, English-speaking Mexicans were more likely to choose people in the USA (including Anglos). In short, subjective social status is a social product that depends on the choice of reference group and attributions for disadvantage as well as perceived life chances.

The association of subjective social status with mental health usually is explained with reference to the concepts of relative deprivation and/or hierarchy stress. These explanations emphasize negative affect and stress responses as mediators of the association, respectively. Empirical evidence for both explanations is supportive, if limited. Subjective social status is associated with negative affect (Operario, Adler, & Williams, 2004) and with stress-related indicators of physiological functioning (Adler et al., 2000). Assuming that these findings withstand further scrutiny, subjective social status holds promise as a link between evaluative social comparison processes and experiences of relative deprivation.

Taken together, research on social comparisons, relative deprivation, and subjective social status highlight the importance of discrepancies between objective life conditions and perceptions of those conditions. People's judgments of their relative social standing and worth are shaped by self-enhancement motives, their attributions for their own circumstances, and the degree to which they perceive inequalities as legitimate. Much of the evidence derives from psychological experimental research, which privileges the role of cognition and tells us little about the social contexts that influence motives, attributions, and perceptions of legitimacy. Sociologists are uniquely positioned to contribute to future research on these topics and, thereby, to complete the links between stratification hierarchies, social comparison processes, subjective social status, and relative deprivation—and their mental health effects.

Equity and Justice

Theories of equity and justice emphasize the psychological outcomes of comparing one's own inputs and outcomes to those of others. In a departure from other social evaluation theories, equity theory predicts that people will experience distress upon perceiving an inequity to themselves *or* others, that is, from either under-benefitting or over-benefitting (Homans, 1961/1974; Walster, Walster, &

Berscheid, 1978). According to equity theory, under-benefitting produces anger or resentment while over-benefitting produces guilt (Homans, 1961/1974; Stets, 2003). Experimental studies generally support these predictions, although evidence is stronger for the effects of under-benefitting than over-benefitting (Austin & Walster, 1974; Hegtvedt, 1990).

The same holds true in survey studies of marital equity. Husbands and wives who perceive their relationships as equitable experience fewer depressive symptoms than those who perceive themselves as under-benefitting or over-benefitting (DeMaris, Mahoney, & Pargament, 2010; Lennon & Rosenfield, 1994; Longmore & DeMaris, 1997; Mirowsky, 1985), although some studies report significant effects only for under-benefitting (Sprecher, 2001; Voydanoff & Donnelly, 1999). The association of marital equity with mental health varies with personal and social characteristics. It is stronger for women than for men (Glass & Fujimoto, 1994), for women who affirm more egalitarian gender ideologies (Mirowsky, 1985; Voydanoff & Donnelly, 1999), for people who believe that marriage is a sacrament (DeMaris et al., 2010), and for people with lower self-esteem (Longmore & DeMaris, 1997). The association also differs depending on the domain of life being considered with women being more sensitive to inequities in housework and men being more sensitive to inequities involving paid work (Glass & Fujimoto, 1994; Sprecher, 2001).

Previous survey studies of marital equity rely almost exclusively on depressive symptoms to measure distress, but equity theory implicates a much broader range of emotions (see also Hochschild, 1989). In a recent analysis, Lively, Steelman, and Powell (2010) extended research on marital equity and mental health to other outcomes by drawing on theories of emotions. Specifically, based on Kemper's (1978) work, Lively et al. (2010) predicted that spouses who over-benefit in the marriage will experience sadness and guilt whereas those who under-benefit will experience suspicion, anger, and fear. Moreover, based on affect control theory (Heise, 1979), they predicted that the effects of over-benefiting would be stronger for women whereas the effects of under-benefiting would be stronger for men as these states are inconsistent with women's and men's identities. The author's results were consistent with their predictions, and demonstrate the value of stronger integration between theories of emotions and of mental health (Simon, 2007).

Research on perceived marital equity and mental health treats equity as a starting point for the analysis. However, much like subjective social status, equity is the outcome of social comparison processes that have emotional consequences. Perceptions of marital equity are influenced by the comparative referents people use, their affective interpretations of contributions to household labor, and the justifications they give for the actual division of labor (Coltrane, 2000). Couples can also change their perceptions of equity by altering their identities (e.g., a husband defines himself as "co-provider" and "co-parent" rather than as "breadwinner") or the meanings of their activities (e.g., a husband defines his wife's in-home day care business as "being at home"; Kroska, 1997). The processes that produce perceptions of marital equity introduce potential contingencies that have received limited research attention (Kroska, 2009).

Status Inconsistency

Weber (1922/1958) argued that stratification is multidimensional—involving economic resources, power, and status—and, by implication, that people can hold inconsistent positions across those hierarchies. Although theory suggests that status inconsistency is consequential for mental health, there is only limited recent research on this topic. Parks (1928) theorized that people who hold inconsistent statuses, for example, economically successful African Americans, live in multiple worlds in all of which they are strangers. The moral and spiritual confusion that result generate restlessness, malaise, and intensified self-consciousness. Hughes (1945), Lenski (1954), and Jackson (1962) locate this "moral and spiritual confusion" in the conflicting behavioral expectations that inhere in

status inconsistency (a normative comparison argument), whereas House and Harkins (1975) argue that status inconsistency results in feelings of injustice that breed frustration (an evaluative comparison argument).

Although early empirical studies found significant effects of status inconsistency on mental health, the effects were neither as pervasive nor as straightforward as the theory would suggest (Hornung, 1977; House & Harkins, 1975). Methodological critiques of status inconsistency research fueled several studies that did not find any effects of status inconsistency on mental health (Horan & Gray, 1974; Jackson & Curtis, 1972). However, early research relied on a narrow definition of status inconsistency that may not capture the most important components of the concept.

In an influential study, Dressler (1988) expanded the concept in his analysis of the association of depression with three forms of status inconsistency—objective inconsistency (discrepancies between income and occupation), lifestyle incongruity (discrepancies between objective status and lifestyle choices, such as reading magazines and other "cosmopolitan" behaviors), and what he called goal-striving stress (discrepancies between education and occupation). Using data from a small southern Black community, he found that (independent of financial stress) only lifestyle incongruity was related to depression. Dressler speculated that lifestyle incongruity diminishes mental health because it leads to negative social comparisons and self-doubt, and because it creates uncertainty and stress in social interactions where status claims are important. His results imply that objective status inconsistency may be much less important for mental health than incongruity between one's actual status and status aspirations.

Research that engages Parker and Kleiner's (1966) definition of goal-striving stress extends status inconsistency research in an especially promising direction. They defined goal-striving stress as the distance between aspiration and achievement as weighted by the perceived likelihood of success and the anticipated level of disappointment in the case of failure. Using a measure consistent with this definition, Sellers and Neighbors (2008) found that goal-striving stress was significantly associated with lower levels of happiness, life satisfaction, and self-esteem, and with higher levels of psychological distress among Blacks surveyed in 1987–1988. Although levels of goal-striving stress were higher among poor as compared to nonpoor respondents, the associations of goal-striving stress with happiness and life satisfaction were stronger for nonpoor respondents. The authors suggest that goal-striving stress is more distressing the closer one is to achieving the goal.

Given the strong theoretical reasons for anticipating that status inconsistency is consequential for mental health, renewed empirical attention to this area is warranted.

Stratification, Social Evaluations, and Mental Health

Research on social evaluation processes adds depth to our understanding of the association between stratification and mental health by revealing the many contingencies that mediate between objective life conditions and subjective perceptions. While certain forms of resource deprivation cannot be managed cognitively, others can. People are motivated to protect and enhance their sense of self-worth, and they are motivated to see the world as a just and reasonable place (Major & Schmader, 2001). These basic motivations moderate the associations of objective deprivations with subjective deprivations and of subjective deprivations with mental health.[5]

[5] Social evaluation processes also may help explain why race has stronger and more consistent associations with physical health outcomes than with mental health outcomes. Socially disadvantaged racial groups do not consistently report worse mental health than socially advantaged racial groups but they do report worse physical health (Williams & Collins, 1995). The cognitive processes described by social evaluation theories may be more effective for preserving mental health than physical health inasmuch as preserving mental health can be considered a self-protective motive.

Summary and Future Recommendations

In the years since the first *Handbook of the Sociology of Mental Health* was published, literally hundreds of articles have been published that analyze some aspect of stratification as it relates to mental health. Evidence from life course studies has deepened and, in some cases, challenged our understanding of how social disadvantages produce mental health disadvantages. Evidence from research on emotions has encouraged a broadening in the definition of mental health along with greater attention to behavioral and emotional norms in the social distribution of mental health. These welcome developments provide a foundation for future research into life course patterns of cumulative advantage and disadvantage, and into the social distribution of emotional well-being.

As encouraging as these developments are, their potential impact has been constrained by over-reliance upon traditional conceptual models in research on stratification and mental health. Whereas research on stratification and physical health is now driven by an ever-expanding set of conceptual models (Anderson, 1998; Krieger, 2001), parallel research on mental health continues to draw on a circumscribed set of concepts contained within the stress process model. The stress process model is a rich and flexible conceptual tool that has motivated sociological research on mental health for decades and that resonates with the life course perspective (Pearlin, Schieman, Fazio, & Meersman, 2005). However, this model alone provides an incomplete understanding of the full spectrum of factors relevant to the association between stratification and mental health. Not all proximate environmental experiences are best conceptualized as stressors (e.g., job autonomy) and not all social evaluation processes are best conceptualized as coping strategies. Also needed are other conceptual tools for understanding how people ascribe meaning to the objective conditions of their lives—a critical link in the chain between social stratification and mental health. Although the range of social psychological theories that are represented in research on stratification and mental health has broadened in the past 15 years, these theories have not yet been integrated into a coherent framework.

More generally, research on stratification and mental health has not taken full advantage of theoretical advances in social epidemiology. The vibrant discussions about how best to conceptualize and operationalize social disadvantage (Krieger, Williams, & Moss, 1997; Muntaner, Eaton, & Diala, 2000) and about the role of material versus psychosocial resources in health disparities (Lynch, Smith, Kaplan, & House, 2000; Marmot & Wilkinson, 2001) are rarely, if ever, mentioned in mental health research. The models of cumulative advantage and disadvantage that drive much contemporary research on health disparities are virtually invisible (Thoits, 2010). It may not be possible for mental health researchers to apply these models directly—mental health and physical health are not necessarily produced through the same processes and cannot necessarily be understood with reference to the same concepts. However, those models could serve as the starting point for a potentially fruitful conversation about how mental health and physical health differ as outcomes that could, in turn, inform the development of analytic frameworks in both areas.

Any comprehensive conceptual framework for analyzing the association of stratification and mental health must meet several challenges. First, it must account for objective conditions of social disadvantage as well as the discrepancy between those conditions and how they are perceived. The differences in economic resources, social resources, power and authority, and civil rights that inhere in social stratification systems ensure that members of lower status groups will experience less favorable life conditions. The associations of these conditions with mental health, however, are contingent on how they are perceived. People's relative positions in social hierarchies involve interpretations of their own and others' life circumstances—interpretations that are shaped by the choice of reference group, ideologies, legitimacy beliefs, and social contexts.

Social evaluation theories offer one set of tools for understanding these contingencies, but there are other concepts from social psychology that may be equally or more useful, for example, identities, attributions, and values (Bierman, 2010). We can see the potential of these concepts in the scattered

studies that apply them, such as Simon's (1997) research on the gendered meanings of work and family identities and research by Sellers and colleagues (2003, 2006) on racial beliefs, racial identities, and perceptions of discrimination. As of yet, however, these concepts have not been incorporated into a comprehensive framework with broad applicability.

A comprehensive framework for the analysis of social stratification and mental health must account not only for group differences in mental health but also for heterogeneity within groups (Schwartz & Meyer, 2010). Studies of group differences evaluate the extent to which observed differences can be explained by statistical controls for potential explanatory variables (e.g., whether controls for job conditions explain gender differences in mental health). Studies of heterogeneity within groups evaluate variation in mental health based on experiences or characteristics that distinguish members of a single group (e.g., whether job conditions are associated with mental health for women). While one would hope for consistency in the results of between-group and within-group studies, my review identified several instances in which the results of between-group and within-group studies are inconsistent. For example, job conditions do not explain the gender difference in depression although they are strong predictors of mental health for men and women. Similarly, perceived discrimination does not explain racial/ethnic differences in mental health although it is a strong predictor of mental health within racial and ethnic minority groups.

One way to reconcile these inconsistencies is with reference to heterogeneity within disadvantaged groups. Women are disadvantaged relative to men in the aggregate but not all women are disadvantaged relative to all men. Similarly, African Americans, Latinos, Asian Americans, and members of other racial and ethnic minority groups are disadvantaged relative to Whites, but not all members of racial and ethnic minority groups are disadvantaged relative to all Whites. Studies that evaluate the predictors of mental health within disadvantaged groups identify nexuses of disadvantage—specific combinations of statuses and experiences—that place people at risk of mental health problems. Further research along these lines would bring mental health researchers into conversation with feminist theories of "intersectionality" (Choo & Ferree, 2010; Collins, 2000). Intersectionality theories assert that different dimensions of stratification, such as social class, race, and gender, must be studied in relation to one another, i.e., that the various combinations of status characteristics have unique associations with life experiences. Although some research on stratification and mental health has taken an intersectional approach (e.g., research on the unique mental health challenges of low-income, minority, women), most studies treat the different dimensions of stratification as separable.

A comprehensive framework for the study of social stratification and mental health must also account for the life course dynamics of mental disorders. Despite years of research on the associations of social class, race, and gender with mental health, we know little about whether social disadvantage is most strongly associated with age at onset, duration of illness, or relapse or about how disadvantages at different ages affect the risk of mental health problems. Miech et al. (2005) report that education does not predict new onsets of disorder among adults. Other studies have found that childhood social class is more strongly associated with the risk of adult disorder than adult social class (Gilman, Kawachi, Fitzmaurice, & Buka, 2002; Power, Hertzman, Matthews, & Manor, 1997). These studies suggest that much of the "action" in the association of social class with mental health happens in childhood, inconsistent with the dominant focus of sociological research on adult samples.

Finally, a comprehensive framework for the study of social stratification and mental health must account for how historical and social contexts shape proximate experiences of stratification and perceptions of those experiences. Studies conducted in times of social change may prove especially informative. For instance, research in South Africa indicates that childhood adversities are especially important to race differences in mental health in that country because childhood there is so fraught with peril (Slopen et al., 2010). Another study from the same project finds parallels between the changing circumstances of minority groups (i.e., Africans, Coloreds, and Indians), their levels of mental health problems, and the proximate life experiences that account for mental health differentials (Jackson et al., 2010). Perceptions of proximate environmental experiences may also depend on

the historical and social context. Divorce, a more common experience for children in lower-class families, has a different meaning now than it did 20 years ago, which may alter its association with mental health.

The construction of such a framework is a daunting challenge but a surmountable one. To succeed, mental health researchers will have to draw on the full set of conceptual tools that sociology has to offer regarding the conceptualization and operationalization of social stratification, as well as the full set of conceptual tools that social psychology has to offer regarding how people construct meaning in proximate environments. The potential rewards of success are great: stronger ties to mainstream sociology and to social psychology, and a better understanding of the conditions under which social disadvantages produce mental health disadvantages.

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