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INTRODUCTION

Introduction to Special Section on Health Disparities

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In this special section, we highlight the diverse ways in which behavioral medicine can contribute to the study of racial/ethnic health disparities. Health disparities are often described as differences in the incidence, prevalence, mortality, burden of disease, and other adverse health conditions or outcomes between minority and majority population groups [1]. Although this special section focuses on racial/ethnic health disparities, disparities have also been observed in gender, age, socioeconomic status (SES), geography, sexual orientation, disability, and special health care needs. Disparities occur among groups who have persistently experienced historical trauma, social disadvantage or discrimination, and systematically experience worse health or greater health risks than more advantaged social groups.

In February 1998, President Clinton made a commitment on behalf of the U.S. government to work toward the elimination of health disparities in racial and ethnic minority populations by the year 2010. Although we have advanced our knowledge and approaches to reducing disparities, they still persist. One of the most striking demographic characteristics in health statistics continues to be mortality differences between African Americans and Whites. The age- and gender-adjusted death rate from all causes is significantly higher in African Americans than in Whites [2]. There are some limited positive signs for the health of minorities, however. For example, McWilliams et al. found differences between Black or Latino and White adults did not significantly change from 1999 to 2006 on four measures of disease control (age- and sex-adjusted rates of blood pressure control, mean systolic blood pressure, glycemic control, and mean hemoglobin A1c levels), although differences in rates of glycemic control between Latino and White adults broadened over that time period [3].

The goal of this special section is to contribute to our understanding of current health problems experienced by America's major races/ethnicities and economic groups. The papers fall into three general areas: testing of potential explanations and risk factors for disparities, identification of potential resilience factors that might narrow disparities, and interventions to improve health outcomes in populations affected by health disparities. They span a range of health conditions, risks, perceptions, and behaviors (e.g., asthma, obesity, hypertension control, coronary artery disease, self-rated mental and physical health, mortality, smoking) across the life span (from children to middle age to older adults), and investigate health disparities among Black and subpopulations of Latino men and women, including Mexican Americans and Puerto Ricans.

Three papers investigated risk factors for worse health outcomes and behaviors, such as low SES, discrimination, and illness representations [4–6]. In a sample of Black and White older adults, Thorpe et al. found that more than half (60%) of racial/ethnic differences in all-cause mortality

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were accounted for by differences in SES [6]. Hickson and colleagues found that higher perceived everyday discrimination was associated with greater subcutaneous adipose tissue, and passive coping in response to discrimination was associated with higher visceral adipose tissue among Black men (but not Black women) [4]. Sidora-Arcoleo et al.'s study suggests that racial/ethnic differences in parental understandings and representations of illness contribute to pediatric healthcare utilization for acute asthma [5].

Papers on resilience factors by Janssen et al. [7] and Rios et al. [8] suggest the power of social supports such as neighborhood social cohesion [8] and perceived social role rewards [7] in protecting Black and Latinos from poor health outcomes. Rios and colleagues found that neighborhood social cohesion significantly contributed to the relationship between neighborhood context (including higher neighborhood SES) and better physical and mental health among Latino and non-Latino residents [8]. Janssen et al.'s work showed that Black women who perceive greater social role rewards (from parenting, employment, intimate partnerships, and/or family member caregiving) had lower progression of coronary artery calcium; the corresponding results for White women were not significant [7].

Three intervention studies are included in the special section: a culturally tailored intensive telephone intervention aimed to improve blood pressure control among Black [9], a cognitive behavioral smoking cessation therapy group intervention for Black [10], and a culturally tailored obesity prevention promotoras intervention targeting Latino elementary school children through communities, schools, and families [11]. Migneault's intervention had significant effects on overall diet quality and energy expenditure, but did not affect blood pressure [9]. Webb Hooper found that less-acculturated African Americans (e.g., those who hold more culturally relevant superstitions) were less likely to be abstinent following a smoking cessation intervention [10]. Although children's BMI was not affected, Crespo et al.'s intervention led to changes in children's self-reported behaviors (e.g., fruit and vegetable consumption) and achieved real-world community-level change, including improvements in local playgrounds and parks, and restaurant menus [11].

Several of these articles highlight challenges to implementing behavioral health disparities interventions and potential avenues for strengthening existing interventions. As demonstrated by Migneault's [9] and Crespo's [11] research, retaining participants into intensive multi-session interventions over a large span of time can be difficult, even if the intervention is culturally tailored and designed with input from members of the target population. Webb Hooper and colleagues' results indicate that certain culturally relevant characteristics such as acculturation may have implications for the strength of the intervention effect, and thus must be attended to in intervention design [10]. The studies on resilience factors [7, 8] suggest that community-level interventions may be needed to harness the strength of social support within individuals' families, social networks, and neighborhoods.

Despite the impressive breadth of research topics and methodologies covered, several absences from this special section are notable: Similar to most research in this area to date, the papers in the special section do not include minority populations other than Blacks and Latinos, such as Native Americans and different subpopulations of Asians. Further, little research in general has examined racial/ethnic disparities in the context of other types of cross-cutting disparities (e.g., by sexual orientation), although several papers in this section examine gender subgroups [6, 7]. Additional research is needed to understand whether and how different racial/ethnic and social categories combine to affect health.

Special sections of journals are a necessary starting point for developing areas of research that have been ignored or understudied. The papers presented here address the starting points suggested by Whitfield and Hayward [12] to provide information on the processes by which health disparities arise, increase the specificity of information on health problems, evaluate the potential for current data collection efforts to provide appropriate samples that reflect the socioeconomic distribution of minority groups, and address health disparities in a lifecycle context. Future multi-method studies could be invaluable in uncovering why certain variables are associated with health disparities, as well as providing a basis for intervention development. This special section of the *Annals of Behavioral Medicine* provides an important contribution to attempting to improve our knowledge of risk and protective behaviors that may be responsible for disparities.

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