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How group processes influence, maintain, and overcome health disparities

Jeff Stone¹ and Virginia S. Y. Kwan²

¹University of Arizona, USA

²Arizona State University, USA

Abstract

This special issue of *Group Processes and Intergroup Relations* presents new theory and research on how group processes influence, maintain, and overcome health disparities. We present eight papers that document the causes and consequences of health disparities from the perspective of stigmatized and disadvantaged groups, health care providers, and during the course of interaction between patients and providers. Several papers describe interventions and other factors that have the potential to reduce differences in health and well-being. We hope the research in this collection inspires more investigators to consider how their work on group processes and intergroup relations can address, and help to eliminate, disparities in health outcomes for the disadvantaged.

Keywords

disadvantaged groups; health disparities; patients and providers; stigmatized groups

Recent years have witnessed a rapidly growing interest from psychological research on the topic of health disparities. In *Healthy People 2020*, the U.S. Department of Health and Human Services (2010) defines a *health disparity* as “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.” As of January 2016, there were 3,644 articles in peer-reviewed journals with “health disparity” as keyword in their PsycINFO database entries. A vast majority of these articles (3,617) has been published since year 2000 and 1,419 articles were published in the last 3 years. Together, these publications address a diverse range of groups in terms of race or ethnicity; socioeconomic status; gender; age; mental health; physical disability; sexual orientation or gender identity; and geographic location (U.S. Department of Health and Human Services, 2010).

The breadth of disparities in health outcomes is vast; just taking the disparities for cancer outcomes in the US as an example, data from the National Cancer Institute shows that people with lower socioeconomic status (SES) have disproportionately higher cancer death rates than those with higher SES, in part because low SES is associated with higher

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Corresponding author: Jeff Stone, Department of Psychology, University of Arizona, Tucson, AZ 85721, USA.
jeffs@email.arizona.edu.

behavioral risk factors such as tobacco smoking, physical inactivity, obesity, excessive alcohol intake, and failure to follow cancer screening recommendations. With respect to racial and ethnic cancer disparities, compared to Whites, African Americans have higher rates of colorectal and lung cancer, Asian American, Pacific Islanders have higher rates of liver and stomach cancer, and while Hispanics are less likely to die from cancer than Whites, they are more likely to receive their diagnosis at a later stage of the disease. Wide ranges of similar disparities appear for other diseases in the US and in other countries around the world (see Penner, Albrecht, Orom, Coleman, & Underwood, 2010).

Overview of This Special Issue of *Group Processes and Intergroup Relations*

Several factors or determinants play a causal role in health disparities, including biology, genetics, the physical environment, literacy levels, and legislative policies (Penner et al., 2013). The focus of the current special issue is on the role that group processes and intergroup relations play in health disparities, and specifically, on *how groups influence, maintain, and overcome health disparities*. To this end, we aim to gain a better understanding of three processes. The first is to understand the role that group processes play in health disparities, including small group dynamics, large scale social categories (e.g., ethnic groups), and relations between groups and social categories as they are located in society (e.g., power, status, resource differences, social/educational disadvantage). The second is to understand how interaction processes that occur between and within groups contribute to health disparities. For example, influence processes in groups can play a role in health disparities through prejudice and discrimination, social influence and persuasion, prescriptive/descriptive norms, leadership, conformity, role modeling, or communication. Group processes can also maintain disparate outcomes through identity, stigma, culture, SES, health literacy, stereotyping and stereotype threat. The third aim is to understand the group processes that overcome health disparities, such as when health care providers make changes that reduce the disparate treatment of racial and ethnic minority groups, or when a group's cultural processes provide a buffer against certain diseases or illness.

The eight papers in this special issue of *Group Processes & Intergroup Relations* highlight several theoretical, methodological and empirical advances that researchers are making toward the aims identified before. The research documents the causes and consequences of health disparities from the perspective of stigmatized and disadvantaged groups, from the perspective of health care providers, and in the course of interaction between and within groups of patients and providers. Importantly, several papers describe and test interventions and other factors that show promise for reducing health disparities. Across this array of topics, the papers fall into two broad categories: Those that address the role that group identity and cultural processes play in health disparities, and those that investigate how intergroup bias contributes to health disparities.

Four papers examine how group identity and cultural processes influence minority individuals' health behavior. The research by Smart-Richman, Blodorn, and Major (2016) examines the possibility that the motivation to validate in-group identity, and a sense of

belonging, can cause African Americans to engage in in-group-prototypical behaviors that are unhealthy. The work by Prati, Crisp, Pratto, and Rubini (2016) tests whether the interplay between social identity complexity and multiple categorization processes can increase support for immigrants' health. Molina and James (2016) present research testing the relationship among Caribbean Blacks between internalized racism, perceptions of discrimination, and past-year major depressive disorder (MDD). Ruiz, Hamann, Mehl, and O'Connor (2016) review evidence for the so-called "Hispanic paradox"—data showing the health benefits that Hispanics have over Whites and other minority groups—and discuss potential sociocultural resilience factors that may contribute to the positive health outcomes for the fastest growing minority group in the United States.

Four papers examine how the presence and communication of intergroup biases serve to influence, maintain, and overcome health disparities for a variety of groups. Frost and Fingerhut (2016) investigate the impact that exposure to same-sex marriage campaign messages (e.g., commercials, billboards, yard signs) has on the psychological and relational well-being of couples living in states that had same-sex marriage voter initiatives in the 2012 general election. Hoffman and Trawalter (2016) examine how perceptions of hardship shape perceptions of pain and contribute to racial bias in pain perception. They also present research examining if challenging lay beliefs about the relationship between hardship and pain can reduce racial bias in pain perception.

Two papers in the special issue focus on the relationship between health care provider bias and minority patient health outcomes. Hagiwara, Dovidio, Eggly, and Penner (2016) present a secondary analysis of video-recorded medical interactions between non-Black physicians and Black patients to further investigate the relationship between provider implicit and explicit bias and patient engagement with their medical care. The paper by Zestcott, Blair, and Stone (2016) reviews the overall evidence that provider implicit bias contributes to health disparities, and examines the available data on whether training in implicit bias can effectively reduce the biases that providers exhibit.

We deeply appreciate the efforts of the authors in this special issue to share their work on how groups influence, maintain, and overcome health disparities. We also extend our heartfelt thanks to the reviewers for their helpful comments on the research and scholarship in this special issue. Our hope is that the research in this collection inspires more investigators to consider how their work on group processes and intergroup relations relates to health disparities. Social psychology has much to offer toward understanding and eradicating disparities in health outcomes for the disadvantaged.

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