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"If your shoes are raggedy you get talked about": Symbolic and material dimensions of adolescent social status and health☆

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ABSTRACT

This paper examines the interaction of symbolic and material dimensions of social status for African American adolescents and its relationship with blood pressure. Mixed ethnographic methods were used to develop cultural models of social status for urban African American teens in a predominantly African American lower-income community west of Chicago. Resting blood pressure and covariate data were collected, as well as standardized measures of perceived stress and social standing. Findings show that, adjusting for covariates, adolescents' consumption of symbolic status goods is significantly associated with their blood pressure, dependent upon parental economic resources. The political economy of status consumption, the underlying contexts of racial and economic inequality, and the implications of these findings for health disparities are discussed.

Introduction and background

Health inequality has become a central public health concern in the United States, and is the focus of research spanning biomedical and social science fields. Across multiple indicators of health, and with respect to both race/ethnicity and socioeconomic class, disadvantaged groups in the US have poorer health outcomes and higher mortality rates than those more advantaged. African Americans, for instance, have higher mortality due to heart disease, cancer, and stroke than any other racial/ethnic group (AHA, 2005; CDC, 2007; Mensah, Brown, Croft & Greenlund, 2005); those with lower economic status have higher mortality than those higher on the economic ladder (Adler, Boyce, Chesney, Cohen, Folkman & Kahn 1994; Adler & Ostrove, 1999); and areas with higher relative economic inequality have lower average life expectancy than those with more equitable income distributions (Kawachi & Kennedy, 2002; Marmot, 2001; Wilkinson, 1992). These patterns overwhelmingly point to social determinants as primary underlying causes of health inequalities; in particular, the harsh realities of social, economic, and racial inequality in US society and the complex ways in which those inequalities overlap and intersect.

Chronic stress is posited as one likely pathway linking social inequities with disparities in disease and mortality (Marmot & Wilkinson, 2001; Siegrist & Marmot, 2004). The association of stress with health is thought to be mediated through both physiological changes (McEwen, 2001) and psychological distress (and associated negative health behaviors, such as alcohol and tobacco use) (Everson-Rose & Lewis, 2005; Rozanski, Blumenthal, Davidson, Saab & Kubzansky, 2005; Rugulies, 2002). Increasingly, this chronic stress pathway is being considered in a life-course perspective, recognizing that stress during critical periods early in life can prime stress responsivity and influence emotional, behavioral, and physical health outcomes later in life (Barker, 1990; Kuzawa & Sweet, 2009; Pollitt, Rose, & Kaufman, 2005; Romeo & McEwen, 2006).

The specific ways in which social and economic inequality result in stress, however, are still under investigation. Relative deprivation, in which social comparisons with individuals of higher economic standing result in negative emotional states (Runciman, 1966), is one hypothesized mechanism. In research on relative deprivation, and in much health inequalities literature in general, income is the most commonly used measure of economic status. However, income measures, while useful, ignore the more Weberian notion of status, or symbolic presentation of social position (Weber, 1978 [1922]), which may play an important role in status-based social comparisons. This notion of social status, or

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'symbolic capital' (Bourdieu, 1984), includes the consumption and display of both lifestyle behaviors and material goods. Exploring this domain necessarily includes a consideration of culture and the extent to which status symbols are woven into the cultural fabric of particular communities as a shared understanding of their meaning. Anthropological research has demonstrated associations between material lifestyle and health (Dressler, 1988, 1990; Dressler & Bindon, 2000), suggesting the potential utility of this area for understanding health inequities.

This paper explores the role of symbolic capital in health inequality by examining its intersection with conventional measures of economic status in relation to health. Based in a life-course understanding of health, the study examines how symbolic and material dimensions of status relate to blood pressure for African American adolescents. By utilizing a mixed methods approach to operationalize culturally salient markers of symbolic status, this study explores another dimension along which stressful social comparisons can be made.

Methods

This study was conducted in Maywood, Illinois, a predominately African American, lower-income community west of Chicago. Like many communities in the Chicago area, the population of Maywood was heavily shaped by rapid demographic shifts after World War II, with dramatic white flight following an influx of southern African American migrants. While there were no black residents in Maywood at the turn of the 20th century, the African American population grew to 84% by 1990 (Guarino, 2004). Throughout much of this shift, the American Can Company and other small manufacturing industries in the community sustained relatively stable working- and middle-class employment opportunities. But in the latter half of the 20th century Maywood saw a significant economic downturn, with most of the major retailers and manufacturing employers leaving by the 1970s (Guarino, 2004). Today, this community of approximately 27,000 has a median family income of $46,000 and median individual income of approximately $17,000. Sixteen percent of youth in Maywood live below the poverty line and 23% of the school district is classified as 'low income' (US Census Bureau, 2009).

Cultural models of status

To understand how symbolic aspects of status influence adolescent health in Maywood, I conducted a multi-part study using the cultural consensus (Romney, Weller, & Batchelder, 1986) and consonance approaches (Dressler, 1996). These biocultural anthropological approaches combine qualitative and quantitative methods to define models of beliefs that are widely shared in a particular community. The approaches are innovative in that they allow cultural domains to be operationalized quantitatively, and explored statistically in relation to health measures, while still drawing on ethnographic insights.

I employed the consensus and consonance approaches across three phases of data collection and analysis: 1) an elicitation phase, in which individual models of social status were described in semi-structured ethnographic interviews, 2) a survey phase in which cultural consensus was tested, and 3) a consonance phase, in which cultural consonance, biomarkers, and covariates were measured. For all phases of research, high school adolescents, aged 14–18 years, were recruited from either an after-school arts program in Maywood or one of the two local high schools. The Office for the Protection of Research Subjects at Northwestern University approved all phases of research, and both parental consent and adolescent assent were acquired from all participants. All data collection occurred between February and October 2006.

Phase 1: elicitation

Consistent with recommended sample sizes for eliciting cultural domains and establishing consensus (Weller & Romney, 1988), 20 students participated in the first phase of the study. All interviews were conducted privately in an empty classroom and recorded digitally. Interview participants were asked to think about peers at the their high school and to respond to questions, such as "describe the kids at your school that have high status" and "what are the things that make someone have high status, or be popular, at your school?" Individual free-lists of status indicators were extracted from each transcribed interview. These individual lists were then pooled into large composite lists, consisting of every item listed by every participant.

Phase 2: consensus

In the second phase of research, the extent to which individual models of status were shared among adolescents in the community was formally tested using a general application of cultural consensus analysis (Handwerker, 2002). Forty-eight participants completed a survey in which they rated on a three-point scale ("1 – not important", "2 – somewhat important", or "3 – very important") the importance of items elicited in phase one interviews as indicators of social status for youth in their community. Consensus analysis was then performed by factor analyzing the survey data using STATA Statistical Software (StataCorp, 2003), with individuals treated as variables in order to assess inter-respondent agreement. A focus group with 15 teens was conducted at the conclusion of the consensus phase to confirm that the results seemed appropriate and to facilitate the interpretation of results.

Phase 3: consonance

109 adolescents participated in the third phase of research. In this phase cultural consonance, or the extent to which individuals were consistent in their own behavior with the agreed upon cultural model of status, was measured. To measure consonance in social status, participants were asked to report (yes/no) whether they participated in activities and behaviors or whether they owned material consumer items that were determined to be culturally salient indicators of social status. Consonance scores were computed as a sum of each individual's survey responses, weighted by each item's average consensus score from Phase 2. In addition to this composite measure, subscales of consonance were formed by factor analyzing items in the cultural model to determine if there were constellations of material goods and behaviors that tended to co-occur in adolescents' reported ownership and activity.

Covariates and biomarkers

Parents of study subjects completed demographic questionnaires that were returned with informed consent materials. Parental socioeconomic status was assessed from self-reported occupation and, when that data was missing, adolescents' reports of their parents' occupations. Parents' occupation was used as the measure of SES in this study for two reasons: 1) While the parental demographic survey asked for self-reported income, many respondents opted not to report this sensitive information; 2) While income and educational attainment capture only single dimensions of economic standing, occupation data can be transformed into a more general measure of SES using the Nam–Powers–Boyd (NPB) Occupational Status Scale (Nam & Boyd, 2004). The NPB scale computes a score for every census-listed occupation in the United States based on