ELSEVIER

Social Science & Medicine 60 (2005) 2129–2133

SOCIAL SCIENCE & MEDICINE

www.elsevier.com/locate/socscimed

Role of socialization in explaining social inequalities in health

Archana Singh-Manoux*, Michael Marmot

Department of Epidemiology and Public Health, International Centre for Health and Society, University College London, 1-19 Torrington Place, London WC1E 6BT, UK

Available online 25 November 2004

Abstract

This paper argues that social selection, materialist/structural and cultural/behavioural explanations for social inequalities in health are related to each other through the mechanism of socialization, seen here as a process through which societies shape patterns of behaviour and being that then affect health. Socialization involves the inter- and intragenerational transfer of attitudes, beliefs and behaviours. Parallels between socialization theory and Bourdieu's concept of habitus are also drawn, and the implications for social epidemiology are discussed. Four key areas that would benefit from research within the socialization framework are identified: health behaviours, psychological vulnerability, social skills and future time perspective.

Keywords: Health inequalities; Habitus; Socialization; Socio-economic position; Life course

Introduction

Reports on socioeconomic inequalities in 19th-century Europe (Chadwick, 1842; Villerme, 1840) have been followed by research showing the existence of a socioeconomic gradient in health in developed countries (Fox, 1989; Krieger, Williams, & Moss, 1997; Marmot, Rose, Shipley, & Hamilton, 1978). The Black Report identified four theoretical explanations for social inequalities: artefactual, natural or social selection, materialist/structural and cultural/behavioural explanations (Townsend & Davidson, 1982). As social class differences are widely accepted as being real, i.e. not artefactual, further research efforts have been directed at the three other explanations. Although these have been set up in competing, mutually exclusive categories, the interrelation between them may be critically important for understanding social inequalities. This paper proposes that socialization is a process that links social selection (where early life environmental factors are seen to influence both adult health and social career), materialist/structural and cultural/behavioural explanations of health inequalities.

Socialization is defined as a process by which individuals become part of a group, involving processes that progressively confine their behavioural potentialities within an acceptable range and prepare them for the types of roles they will be expected to play later in life (Ryder, 1965). Socialization is a complex, interactive process that starts from birth and continues into adulthood, involving mechanisms like observation, imitation and internalization. Imitation of observed behaviour is reinforced by the social group, ensuring internalization of the behaviour in question. The idea that social class influences behaviour, emotion and cognition (Gallo & Mathews, 2003; Shaffer, 1994) is an emerging theme in the psychological literature. The

*Corresponding author. Tel.: +44 20 7679 1692; fax: +44 20 7813 0242.

E-mail address: a.singh-manoux@ucl.ac.uk (A. Singh-Manoux).

0277-9536/$ - see front matter © 2004 Elsevier Ltd. All rights reserved.
doi:10.1016/j.socscimed.2004.08.070

cult of 'individual differences' had kept the socializing influence of social class out of the psychological research agenda until recently.

This paper argues that social class, throughout the life course, has a powerful influence on behavioural, social and psychological variables. Health-related and psychosocial behaviours are never truly 'voluntary'; they are a product of, and embedded in structures of society. Therefore, the unit of analysis is not the individual but the socio-cultural context that shapes the individual. We argue that cultural, behavioural, structural and material explanations of social inequalities need to be integrated in order to understand the social determinants of health. Social advantage has been linked to maintenance and even increase in health advantage over the last century, despite changes in knowledge about risk factors. This suggests that there are collective strategies in acquiring education, new knowledge, health-promoting lifestyles, and regulating physical environments at home and work (Vagero & Illsley, 1995). We propose that the process by which these strategies are elaborated is socialization.

Socialization is broadly composed of distinct inter- and intragenerational processes. Both involve the harmonization of an individual's attitudes and behaviours with that of their socio-cultural milieu. The first is the more widely understood view of socialization, particularly in psychology: the learning view that sees parents, peers and teachers as principal agents of socialization in childhood. Socialization through childhood would lead to similarity in attitudes, beliefs and behaviours across generations. The second mechanism involves the socializing influence of an individual's own socioeconomic environment through the life course on attitudes, beliefs and behaviours. The socioeconomic position occupied by adults conditions the way in which they live and work, which in turn is critically linked to health (Marmot, 2004). Research suggests that both these pathways are in play in the intergenerational similarity of religious and political ideology (Glass, Bengston, & Dunham, 1986), personality and behavioural attributes (Brook, Whiteman, & Zheng, 2002), and occupational status (Korupp, Sanders, & Ganzeboom, 2002).

The two meanings inherent in the concept of socialization can be most meaningfully applied to social epidemiology by linking it to Bourdieu's work (Bourdieu & de Saint Martin, 1982; Bourdieu 1984, 1993). Bourdieu's basic thesis is that there is a correspondence between social structures (thoughout the life course) and mental structures. He advances the concept of 'habitus' to describe the homologous relations between social structure and practices in different domains—economic, political, social, cultural etc. of an individual's life. Habitus is thus a generative schema whereby social structures, through the processes of socialization, come to be embodied as schemes of perception that enable individuals to live their lives, leading societies to reproduce existing social structures (Bourdieu, 1984). It provides the individual with class-dependent and predisposed ways of thinking, feeling and acting.

The structure–disposition–practice (SDP) scheme can be used to understand Bourdieu's ideas better. Social structures give rise to characteristic dispositions that allow for competent performance of social practices (Nash, 2003). An individual's perception and strategies are connected to their place in the wider society. The individual, armed with a set of socialized dispositions, generates practice in keeping with structural principles. Social positions are seen to create socialized dispositions. In effect, dispositions are properties of individuals and refer to all learnt behaviour. Nevertheless, dispositions are highly influenced by social structure and result in practices which in turn reproduce the structures from which they are derived. The SDP scheme shows how social structures, and the associated dispositions and practices, are reproduced from one generation to the next.

Bourdieu's concept of habitus also suggests that behaviour or 'practice' is not entirely consciously organized. Socioeconomic circumstances determine habitus and this in turn determines behaviour. Individuals, socialized within a particular lifestyle, develop a preference or a taste for that lifestyle, leading to reproduction of that lifestyle. Bourdieu's work on the search for social distinction in the construction of lifestyles is also informative in this regard (Bourdieu, 1984). Different social groups attempt to define and appropriate as their own different behaviours that constitute a lifestyle, leading to what is popularly referred to as a middle-class or a working-class culture. Bourdieu also shows the manner in which dominant classes, due to their greater access to resources, bestow value on their own lifestyles as being prestigious. This suggests that different lifestyles are linked to different social identities, making it difficult for an individual to uncouple the two.

There need not be a direct and mechanical relation between social class and health. However, further research is required to determine the period of the life course most amenable to change in the social and behavioural trajectory; the role played by education in this context has received some attention (Grossman & Joyce, 1989; Jonsson & Mills, 1993; Mechanic, 1989).

Socialization: key areas for future research

Four key areas, linking social structure to health, are likely to benefit from research within the socialization framework.

(1) *Health behaviours*: Health-damaging behaviours—smoking (Graham & Hunt, 1998; Stronks, Van de