



HAL
open science

Role of socialization in explaining social inequalities in health.

Archana Singh-Manoux, Michael Marmot

► **To cite this version:**

Archana Singh-Manoux, Michael Marmot. Role of socialization in explaining social inequalities in health.. Social Science and Medicine, 2005, 60 (9), pp.2129-33. inserm-01155222

HAL Id: inserm-01155222

<https://inserm.hal.science/inserm-01155222v1>

Submitted on 26 May 2015

HAL is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L'archive ouverte pluridisciplinaire **HAL**, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d'enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.

Soc Sci Med

The role of socialization in explaining social inequalities in health.

Running title: Socialization and Epidemiology

Archana Singh-Manoux*

Michael Marmot

International Centre for Health and Society

Department of Epidemiology and Public Health

University College London

1-19 Torrington Place

London WC1E 6BT, U. K.

*Corresponding author

Tel.: 44 (0)20 7679 1692

Fax: 44 (0)20 7813 0242

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

Acknowledgments

AS-M is supported by grants to the Whitehall II study from National Institute on Aging (AG13196), US NIH and the John D and Catherine T MacArthur Foundation Research

Networks on Successful Midlife Development and Socioeconomic Status and Health. MM is supported by an MRC Research Professorship.

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 intra-generational 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 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.

Abstract word count: 98

Main text word count: 2000

Key Words: health inequalities, habitus, socialization, socioeconomic position, lifecourse

Reports on socioeconomic inequalities in nineteenth century Europe (Chadwick, 1842; Villermé, 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 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 lifecourse, 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 intra-generational 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 lifecourse 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 (throughout the lifecourse) 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 pre-disposed ways of thinking, feeling, and acting. Bourdieu's work emphasizes the reproduction of social hierarchies through the concept of habitus.

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 suggests that behaviour or 'practice' is not entirely consciously organized. Socio-economic circumstances determine habitus and that 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 lifecourse 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 Mheen, Looman & Mackenbach, 1997), poor diet (Martikainen, Brunner & Marmot, 2003; Pryer, Nichols, Elliott, Thakrar, Brunner & Marmot, 2001), and lack of physical exercise (Ford, Merritt, Heath, Powell, Washburn, Kriska & Haile, 1991; Parks, Housemann & Brownson 2003) - are socially patterned and found to contribute to the social gradient in death and disease. Attempts to unravel the origins of health-related behaviours suggest that there is a learnt component to both health-enhancing and health-impairing behaviours. Parents as socialization agents have been found to influence many health behaviours – smoking (Clark, Scarisbrick-Hauser, Gautam & Wirk, 1999), healthy eating (Hays, Power & Olvera, 2001; Lees & Tinsley, 1998), alcohol consumption and physical exercise (Lau, Quadrel & Hartman, 1990). Health behaviours, when viewed as

the property of individuals, lead health education messages to be targeted at a specific behaviour, usually successfully only among the already healthy. The socialization perspective stresses the importance of the interrelation between social structure and behaviour and the assessment of global rather than individual health behaviours.

2. Psychological vulnerability: Psychological characteristics such as depression, cynical hostility, control, anxiety, insecurity are more prevalent in the disadvantaged social classes; and have been proposed as possible explanations for the social gradient (Adler, Boyce, Chesney, Cohen, Folkman, Kahn & Syme, 1994; Bosma, Gallo & Mathews, 2003; .Van de Mheen & Mackenbach, 1999; Kaplan, 1995; Kessler, 1982; Marmot & Wilkinson, 2001; Ulbrich, Warheit & Zimmerman, 1989). Differential exposure to stressful life events may explain some of this association, but differential psychosocial vulnerability as an explanation has also been put forward (McLeod & Kessler, 1990; Pearlin & Schooler, 1978). In other words, individuals at the bottom of the social strata have fewer psychosocial resources to cope with life events. Resilient personality characteristics may be less accessible, by not being available in the repertoire of learnt behaviours, to the socio-economically deprived, thus increasing their vulnerability to life events. The socialization hypothesis has proved useful to examine development of attitudes (Glass et al., 1986; McLanahan & Bumpass, 1988), and is likely to provide insight into psychosocial vulnerability.
3. Social participation: Social networks, social support and the wider concept of social capital has been extensively linked to health in recent years (Berkman, Glass, Brissette & Seeman, 2000; House, Landis & Umberson, 1988; Putnam, 2000). The central premise here is that good social bonds provide specific benefits that flow from the trust, reciprocity, information, and cooperation associated with social networks. There is extensive research on the benefits of structural vs. functional aspects of social support

(Melchior, Berkman, Niedhammer, Chea & Goldberg, 2003), on the mechanisms by which social support works – main effects vs. the stress buffering hypothesis (Cohen & Wills, 1985). We believe that the skill to build social ties is learnt, some social connections are likely to be inherited, and social participation is facilitated by social advantage (Marmot, 2004), making social ties one mechanism by which social structure relates to health.

4. Future time perspective: Future time perspective (FTP) is a disposition to ascribe high value to goals in the future and to anticipate in the present, the long-term consequences of a potential action (Shell & Husman, 2001). Individuals with high FTP would be able to project themselves farther into the future than people with low FTP, and work out the consequences of imagined future scenarios (Shell & Husman, 2001; Zimbardo, Keough & Boyd, 1997). FTP is akin to a cognitive style of information processing based on a learned, preferred focus on the future (Zimbardo et al., 1997). FTP has been found to play a role in educational achievement (Peetsma, 2000; Shell & Husman, 2001), risky behaviour (Rothspan & Read, 1996; Zimbardo et al., 1997), and has been extensively linked to substance abuse (Keough, Zimbardo & Boyd, 1999; Wills, Sandy & Yaeger, 2001). It is likely that advantaged adult environments, the work place in particular, influence the development of cognitive styles that are high on future time perspective.

We contend that norms on healthy behaviour, psychosocial resilience, social skills and future time perspective are key skills that are conditioned by the socioeconomic context, beginning early in childhood and then continuing throughout the lifecourse. The importance of the social environment lies in the kinds of behaviours, attitudes and beliefs that are sampled in a particular environment. The processes of observation, imitation and internalization ensure a certain uniformity within a particular socioeconomic context in individual level variables linked to health. Furthermore, the macro-structural processes of socialization lead to

intergenerational similarity in social status, implying continuities in life events, daily hassles, and work conditions experienced by members of a family across generations. Children learn to respond to life events and difficulties from their parents and when faced with similar adversity in adulthood they react in comparable ways. This hypothesis does not negate the importance of actual material circumstances of an individual. It attempts to tie in the social, psychological, behavioural and material explanations in order to explain the monotonic relationship between socioeconomic position and health.

Conclusions

The Black Report favoured the material explanation; however the interpretation of this category in that report covers a wide range of phenomena: nutrition, housing, self-fulfilment, job satisfaction, physical or mental strain, deprivation in education or the upbringing of children (Townsend & Davidson, 1982). This paper argues that the social selection, material and behavioural explanations are interrelated, and socialization is the mechanism through which societies shape patterns of behaviour and being that then affect health outcomes. The importance of socialization lies in explaining group rather than individual behaviour, explaining the more common rather than the unexpected trajectories.

References

- Adler, N. E., Boyce, T., Chesney, M. A., Cohen, S., Folkman, S., Kahn, R. L., & Syme, S.L. (1994). Socioeconomic status and health. The challenge of the gradient. *American Psychologist*, 49, 15-24.
- Berkman, L. F., Glass, T., Brissette, I., & Seeman, T. (2000). From social integration of health: Durkheim in the new millennium. *Social Science & Medicine*, 51, 843-857.
- Bosma, H., Van de Mheen, H., & Mackenbach, J. P. (1999). Social class in childhood and general health in adulthood: questionnaire study of contribution of psychological attributes. *British Medical Journal*, 318, 18-22.
- Bourdieu, P. (1984). *Distinction: A social critique of the judgment of taste*. London: Routledge.
- Bourdieu, P. (1993). *The field of cultural production*. New York: Columbia University Press.
- Bourdieu, P., & de Saint Martin, M. (1982). La saint famille. L'épiscopat français dans le champs de pouvoir. *Actes de la Recherche en Sciences Sociales*, 44/45, 2-53.
- Brook, J. S., Whiteman, M., & Zheng, L. (2002). Intergenerational transmission of risks for problem behavior. *Journal of Abnormal Child Psychology*, 30, 65-76.
- Chadwick, E. (1842). *Report of an enquiry into the sanitary conditions of the laboring population of Great Britain*. London: Poor Law Commission.
- Clark, P. I., Scarisbrick-Hauser, A., Gautam, S. P., & Wirk, S. J. (1999). Anti-tobacco socialization in homes of African-American and white parents, and smoking and nonsmoking parents. *Journal of Adolescent Health*, 24, 329-339.
- Cohen, S., & Willis, T. (1985). Stress and Social Support and the Buffering Hypothesis. *Psychological Bulletin*, 98, 310-357.

Ford, E. S., Merritt, R. K., Heath, G. W., Powell, K. E., Washburn, R. A., Kriska, A., & Haile, G. (1991). Physical activity behaviors in lower and higher socioeconomic status populations. *American Journal of Epidemiology*, 133, 1246-1256.

Fox, A.J. (1989). *Health inequalities in European countries*. Aldershot: Gower Publishing Company Limited.

Gallo, L. C., & Mathews, K.A. (2003). Understanding the association between socioeconomic status and physical health: do negative emotions play a role? *Psychological Bulletin*, 129, 10-51.

Glass, J., Bengston, V. L., & Dunham, C. C. (1986). Attitude similarity in three-generation families: Socialization, status inheritance, or reciprocal influence. *American Sociological Review*, 51, 685-698.

Graham, H., & Hunt, K. (1998). Socioeconomic influences on women's smoking status in adulthood: insights from the west of Scotland twenty-07 study. *Health Bulletin*, 57, 757-765.

Grossman, M., & Joyce, T. (1989). Personal research perspective. In J. P. Bunker, D. S. Gomby, & B. H. Kehrer (Eds.), *Pathway to health: the role of social factors*. Menlo Park, California: The Henry Kaiser Family Foundation.

Hays, J., Power, T. G., & Olvera, N. (2001). Effects of maternal socialization strategies on children's nutrition knowledge and behavior. *Applied Developmental Psychology*, 2, 421-437.

House, J., Landis, K. R., & Umberson, D. (1988). Social relationships and health. *Science*, 41, 540-545.

Jonsson J, & Mills, C. (1993). Social class and educational attainment in historical perspective: A Swedish-English comparison, Part I. *British Journal of Sociology*, 44, 213-247.

Kaplan, G. A. (1995). Where do shared pathways lead? Some reflections on a research agenda? *Psychosomatic Medicine*, 57, 208-212.

Keough, K. A., Zimbardo, P. G., & Boyd, J. N. (1999). Who's smoking, drinking and using drugs? Time perspective as a predictor of substance use. *Basic and Applied Social Psychology*, 21, 149-164.

Kessler, R. C. (1982). A disaggregation of the relationship between socioeconomic status and psychological distress. *American Sociological Review*, 47, 752-764.

Korupp, S. E., Sanders, K., & Ganzeboom, H. (2002). The intergenerational transmission of occupational status and sex-typing at children's labour market entry. *European Journal of Women's Studies*, 9, 7-30.

Krieger, N., Williams, D. R., & Moss, N. E. (1997). Measuring social class in US public health research: concepts, methodologies, and guidelines. *Annual Review of Public Health*, 18, 341-378.

Lau, R. R., Quadrel, M. J., & Hartman, K. A. (1990). Development and change of young adults' preventive health beliefs and behavior: Influence from parents and peers. *Journal of Health and Social Behavior*, 31, 240-259.

Lees, N. B., & Tinsley, B. J. (1998). Patterns of parental socialization of the preventive health behavior of young Mexican origin children. *Journal of Applied Developmental Psychology*, 19, 503-525.

Marmot, M. (2004). *Status syndrome: how your social standing directly affects your health and life expectancy*. London: Bloomsbury.

Marmot, M. G., Rose, G., Shipley, M., & Hamilton, P. J. S. (1978). Employment grade and coronary heart disease in British civil servants. *Journal of Epidemiology and Community Health*, 32, 244-249.

Marmot, M., & Wilkinson, R. G. (2001). Psychosocial and material pathways in the relation between income and health: a response to Lynch et al. *British Medical Journal*, 322, 1233-1236.

Martikainen, P., Brunner, E., & Marmot, M. (2003). Socioeconomic differences in dietary patterns among middle aged men and women. *Social Science & Medicine*, 56, 1397-1410.

McLanahan, S., & Bumpass, L. (1988). Intergenerational consequences of family disruption. *American Journal of Sociology*, 94, 130-152.

McLeod, J. D., Kessler, R. C. (1990). Socioeconomic status differences in vulnerability to undesirable life events. *Journal of Health and Social Behavior*, 31, 162-172.

Mechanic, D. (1989). Socio-economic status and health: an examination of the underlying process. In J. P. Bunker, D. S. Gomby, & B. H. Kehrer (Eds.), *Pathway to health: the role of social factors*. Menlo Park, California: The Henry Kaiser Family Foundation.

Melchior, M., Berkman, L. F., Niedhammer, I., Chea, M., & Goldberg, M. (2003). Social relations and self-reported health: a prospective analysis of the French Gazel cohort. *Social Science & Medicine*, 56, 1817-1830.

Nash, R. (2003). Social explanations and socialization: on Bourdieu and the structure, disposition, practice scheme. *The Sociological Review*, 51, 43-62.

Parks, S. E., Housemann, R. A., & Brownson, R. C. (2003). Differential correlates of physical activity in urban and rural adults of various socioeconomic backgrounds in the United States. *Journal of Epidemiology and Community Health*, 57, 29-35.

Pearlin, L. I., & Schooler, C. (1978). The structure of coping. *Journal of Health and Social Behavior*, 19, 2-21.

Peetsma, T. T. D. (2000). Future time perspective as a predictor of school investment. *Scandinavian Journal of Educational Research*, 44, 177-192.

Pryer, J. A., Nichols, R., Elliott, P., Thakrar, B., Brunner, E., & Marmot, M. (2001). Dietary patterns among a national random sample of British adults. *Journal of Epidemiology and Community Health*, 5, 29-37.

Putnam, R. D. (2000). *Bowling Alone: The Collapse and Revival of American Community*. New York: Simon & Schuster.

Rothspan, S., Read, S. J. (1996). Present versus future time perspective and HIV risk among heterosexual college students. *Health Psychology*, 15, 131-134.

Ryder, N. B. (1965). The cohort as a concept in the study of social change. *American Sociological Review*, 30, 843-861.

Shaffer, D. R. (1994). *Social and personality development*. CA: Brooks/Cole.

Shell, D. F., & Husman, J. (2001). The multivariate dimensionality of personal control and future time reference perspective beliefs in achievement and self-regulation. *Contemporary Educational Psychology*, 26, 481-506.

Stronks, K., Van de Mheen, H. D., Looman, C. W. N., & Mackenbach, J. P. (1997). Cultural, material, and psychosocial correlates of the socioeconomic gradient in smoking behavior among adults. *Preventive Medicine*, 26, 754-766.

Townsend, P., & Davidson, N. (1982). *Inequalities in Health: The Black Report*. Harmondsworth: Penguin Books.

Ulbrich, P. M., Warheit, G. J., & Zimmerman, R. S. (1989). Race, Socioeconomic Status, and Psychological Distress: An Examination of Differential Vulnerability. *Journal of Health and Social Behavior*, 30, 131-146.

Vagero D, & Illsley R. Explaining health inequalities: beyond Black and Barker. *European Sociological Review* 1995; 11: 219-241.

Villerme, L. (1840). *Tableau d'état physique et moral des ouvriers employés dans les manufactures de coton, de laine et de soie*. Vol. 2. Paris: Renouard.

Wills, T. A., Sandy, J. M., & Yaeger, A. M. (2001). Time perspective and early onset substance use: A model based on stress-coping theory. *Psychology of Addictive Behavior*, 15, 118-125.

Zimbardo, P. G., Keough, K. A., Boyd, J. N. (1997). Present time perspective as a predictor of risky driving. *Personality Individual Differences*, 23, 1007-1023.