
Social Structure and the Health Behaviors of Blacks

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Health behaviors appear to be central determinants of health status. The U.S. Surgeon General, for example, has indicated that almost half of U.S. mortality is attributable to unhealthy behavior or lifestyle (U.S. Department of Health, Education and Welfare, 1979). In comparison, 20% is due to environmental factors, 20% to genetic factors, and 10% to inadequate medical care. It has been estimated that the health status improvements possible through increases in healthy behaviors exceed those that would be achieved if an overnight cure were found for heart disease or cancer (Olishansky, 1985). Moreover, health behaviors are primary determinants of the heavy burden of disease in the Black population. The recent report on Black and Minority Health identified six causes of death that are responsible for 80% of the 60,000 annual excess deaths in the Black (or African-American) population (U.S. Department of Health and Human Services, 1985). Table 1 indicates that cigarette smoking and/or alcohol abuse is a risk factor for five of the six causes of death. Dr. James' insightful and informative chapter highlights the need for more systematic efforts to understand the factors responsible for the social distribution of health behaviors.

The chapter by James et al. also provides unique glimpses into the heterogeneity of the Black population. Much of the research on the health status of African-Americans has utilized a race-comparison paradigm in which the health status of Blacks is compared to that of Whites. Although this research strategy has yielded important information, much research on Blacks continues to compare them to Whites in a routine, mechanical, and ahistorical manner (Gary & Howard, 1979). This comparative approach masks the heterogeneity of the African-American population and fails to identify subgroups that may be especially disadvantaged.

TABLE 1
The Leading Causes of Death for Blacks
and Their Associated Risk Factors

| Causes of Death | Risk Factors |
|---|---|
| Cardiovascular disease | Smoking, high blood pressure, elevated serum cholesterol, obesity, diabetes, lack of exercise. |
| Cancers | Smoking, alcohol, solar radiation, worksite hazards, environmental contaminants, diet, infectious agents. |
| Homicide, suicide, and unintentional injuries | Alcohol or drug misuse, stress, handgun availability. |
| Diabetes | Obesity. |
| Infant mortality | Low birth weight, maternal smoking, nutrition, stress, trimester of first care, age, marital status. |
| Cirrhosis of liver | Alcohol. |

Source: DHHS (1985).

A central finding of James et al.'s research is that, for both Blacks and Whites, the prevalence of unhealthy behavior is higher among the less educated than among their peers of higher social status. This pattern of results is consistent with national data. Cigarette smoking, for example, is becoming increasingly concentrated among the socioeconomically disadvantaged (Pierce, Fiore, Novotny, Hazizandrea, & Davis, 1989). People with more education are both more likely to quit and less likely to start than their peers with less education. Between 1974 and 1985, for example, the prevalence of smoking declined five times faster among college graduates than among persons with less than a high school education (Pierce et al., 1989). Not surprisingly, smoking rates among Blacks (especially Black males) are higher than among Whites.

This represents a dramatic historic shift in the social distribution of health behaviors. In the 1930s lung cancer death rates for Blacks were half that of Whites, and up through the 1950s smoking rates for Blacks were lower than for Whites (Cooper & Simmons, 1985). Similarly, if we use death rates for cirrhosis of the liver as an indicator of alcohol use, higher levels of alcohol abuse among Blacks than among Whites are also a relatively recent phenomenon. Up through 1955 age-adjusted mortality rates for cirrhosis of the liver were higher for Whites than for Blacks (DHHS, 1985). Accordingly, efforts to understand and address the health problems of the Black population must come to grips with the social structures and processes that facilitate the initiation and maintenance of particular health behaviors.

The mass migration of Blacks from the rural South to the urban North may have played an important role in health behavior changes in the Black population (Cooper & Simmons, 1985). It is likely that several other factors were involved and research that seeks to delineate them would enhance our understanding of the social production of ill health. The critical point is that the behavior of social groups is embedded in their particular social circumstances.

Social structures create stressful living conditions and working environments and shape the adaptive response of social groups. Health behaviors that may have long-term adverse consequences for health status, do provide immediate physiological, psychological, and social benefits that may be necessary for daily survival.

Cigarettes, for example, are widely used as an aid to cope with stress. As Mausner (1973) noted, they "make it possible to get up and face the world, to calm down when tension becomes too great to bear. They take the edge off boring, repetitive tasks like driving, typing and tending machines" (p. 124). A study by the American Cancer Society found that one third of Blacks smoke in order to relieve tension; half of the Black smokers said that smoking was very enjoyable, with an additional one third indicating that it was fairly enjoyable (DHHS, 1985). Moreover, Blacks were more interested in giving up smoking than Whites and were more likely that Whites to believe that quitting would not be difficult. In reality, however, Blacks are less likely than Whites to quit smoking (cf. Fiore et al., 1989). This discrepancy probably reflects both the addictive power of nicotine (Garner, 1986), and the extent to which personal choice is constrained by one's position in social structure.

Understanding the social forces that are linked to the distribution of health behaviors also requires systematic analysis of the targeting of vulnerable populations by large-scale economic interests. Several researchers have noted that women, teenagers, the poor, and members of minority groups are special targets of the tobacco and alcohol industries (Davis, 1987; Singer, 1986). One of the best illustrations of the targeting of a specific group is the detailed description by Hacker, Collins, and Jacobson (1987) of the promotion of alcoholic beverages in the African-American community. The alcohol industry has inextricably tied their products to Black culture. The promotion of alcohol is associated with the music, sports, and cultural events that are integral to the values and tastes of Blacks. Image advertisements in the Black media promote education, fatherhood, Black history, and Black culture. Black celebrities employed by the alcohol industry to promote their products to Blacks include Alex Haley, Will Chamberlain, and Lou Rawls. In addition to providing substantial support to Black History Month and the United Negro College Fund, the alcohol industry sponsors an extensive assortment of social, religious, educational, athletic, and business programs for Blacks.

Malt liquors (beer with higher alcohol content) are marketed almost exclusively to Blacks. And the saturation level of alcohol advertising in the Black community is higher than in the predominantly White market. This is evident both in the advertising in the major Black magazines and in the outdoor mediums targeted to Blacks. Cigarettes are the number one product advertised on the medium and alcohol is number two. Moreover, some alcohol producers link economic support of the Black community to increased sales of the com-

pany's products; and enlist the support of community leaders toward this end. For example, when the Adolph Coors Co. agreed to invest \$625 million over 5 years in Black and Hispanic areas, the NAACP, Operation PUSH, and the African Methodist Episcopal Church's Western District, among others, agreed to "take positive visible action to help eliminate the misconceptions of Coors" (Hacker et al., 1987, p. 34).

In addition to the ubiquitous presence of commercial enticement, alcoholic beverages are also more readily available to the poor and minorities. Retail outlets for alcohol are more prevalent in low income and minority neighborhoods than in more affluent communities (Rabow & Watt, 1982). And there is a strong positive relationship between the availability of alcohol and the amount of alcohol consumption (Singer, 1986).

I concur with James et al. that the high prevalence of cigarette smoking in the youngest age groups is especially disturbing. However, it is not surprising given the extent to which teenagers are currently being targeted by the tobacco industry (Davis, 1987, *Journal of the American Medical Association*, 1986). The tobacco interests are well aware that 95% of adult smokers started smoking between the ages of 12 and 21 (Arbogast, 1986). In fact, 85% of adolescents who smoke more than one cigarette will become long-term smokers (Gartner, 1986). And the tobacco industry's message that associates smoking with youth, health, romance, adventure, and success is frequently the only one that teenagers hear. The annual budget of the Office of Smoking and Health (OSH) is equivalent to the daily budget of the tobacco advertisers (Arbogast, 1986) and the annual spending on smoking deterrence activities of the OSH and the three major voluntary health organizations amounts to only 1% of the advertising expenditures of the tobacco industry (Gidlitiz, 1983).

The James et al. data also indicated that the prevalence of smoking was relatively low among Black females, clearly indicating that high rates of smoking are not uniform in disadvantaged populations. This finding also suggests that attempts to identify social structures that facilitate the initiation of unhealthy behaviors must include efforts to identify countervailing forces. Other data indicate that Black females also have high rates of abstinence from alcohol. It is likely that the high level of religious involvement in this population may be linked to the observed patterns of substance use. More systematic efforts to understand and facilitate the health-promoting efforts of the Black church are clearly warranted.

The high prevalence of obesity in middle-aged African-American females was also evident in the Edgecombe County data. Some of my own research, using data from the National Health and Nutrition Examination Survey, indicates that the higher prevalence of obesity in Black females, as compared to their White peers, can completely explain race differences in systolic and diastolic blood pressure (Williams & Bryant, 1989). These findings highlight the urgency of James et al.'s call for "detailed studies of environmental, be-

havioral and biologic risk factors for obesity in black women." It is likely that physical inactivity among Black females makes an important contribution to the high rate of obesity. Given that most exercise is obtained through leisure-time physical activity, research efforts must address the degree to which African-American females lack the opportunities and resources, economic and otherwise, to engage in regular physical exercise. Another promising direction for research is the exploration of the extent to which recurrent eating binges, associated with the use of food to gain comfort and relief from stress, contributes to obesity in Black females (Williams, *in press*).

Finally, taking seriously the role that large-scale social structures and processes have on the creation of the social distribution of health behavior, in particular, and a broad range of psychosocial factors more generally, has implications for the way we do research. Health enhancing and health damaging resources cannot be viewed as autonomous individual factors, unrelated to living and working conditions and independent of the broader social and political order. Renewed attention must be given to identifying why populations, as opposed to individuals, vary in their level of risk factors. Studies of the characteristics of populations can facilitate the specification of large-scale processes that affect the production of ill health.

Researchers must also give more explicit attention to the social, economic, and political forces that constrain the lives of participants in their research studies. Much research on health behaviors and risk factors focuses narrowly on selected aspects of people's lives without attending to ways in which both subjective reality and objective conditions of life are shaped by socioeconomic position. The collection of survey research data in a community study, for example, should be combined with an understanding of the social and economic structure of that community and the ways in which these conditions shape the values and behavior of social groups.

Nicholas Dorn's (1980) study of alcohol use among teenagers entering the job market is an excellent example of the kind of research that is needed. In addition to interviewing teenagers, Dorn (1980) also conducted interviews with guidance counselors and teachers, and studied the local labor market by researching documentary evidence, interviewing local employers, and visiting local workplaces. He was thus able to identify the ways in which socioeconomic position and occupational conditions shaped the daily realities and experiences of teenagers and gave rise to distinctive patterns of alcohol use. Research that fails to seriously address the social origins of illness, will serve to maintain the status quo and perpetuate the already widespread distortion of social reality.

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