

RECENT SOCIOLOGY TITLES FROM W. W. NORTON

Code of the Streets by Elijah Anderson
The Cosmopolitan Canopy by Elijah Anderson
Social Problems, 2nd Edition by Joel Best
You May Ask Yourself: An Introduction to Thinking Like a Sociologist,
3rd Edition by Dalton Conley
The Real World: An Introduction to Sociology,
3rd Edition by Kerry Ferris and Jill Stein
Introduction to Sociology, 8th Edition by Anthony Giddens,
Mitchell Duneier, Richard P. Appelbaum, and Deborah Carr
Mix It Up: Popular Culture, Mass Media, and Society by David Grazian
The Contexts Reader, 2nd Edition
edited by Douglas Hartmann and Christopher Uggen
When Sex Goes to School by Kristin Luker
Inequality and Society by Jeff Manza and Michael Sauder
Doing Race by Hazel Rose Markus and Paula M. L. Moya
Readings for Sociology, 7th Edition edited by Garth Massey
Families as They Really Are edited by Barbara J. Risman
Sociology of Globalization by Saskia Sassen
The Sociology of News, 2nd Edition by Michael Schudson
The Social Construction of Sexuality, 2nd Edition by Steven Seidman
The Corrosion of Character by Richard Sennett
Biography and the Sociological Imagination
by Michael J. Shanahan and Ross Macmillan
A Primer on Social Movements by David Snow and Sarah Soule
Six Degrees by Duncan J. Watts
More than Just Race by William Julius Wilson
American Society: How It Really Works by Erik Olin Wright and Joel Rogers

**For more information on our publications in sociology, please visit
www.norton.com/soc**

CULTURAL SOCIOLOGY

AN INTRODUCTORY READER

EDITED BY

MATT WRAY

TEMPLE UNIVERSITY

FOREWORD BY

MICHÈLE LAMONT

HARVARD UNIVERSITY



W. W. NORTON & COMPANY

New York • London

34

CULTURE AND HEALTH

PETER A. HALL AND MICHÈLE LAMONT

In 2006, a team of health researchers painstakingly compared the health status of older residents in England and the United States by analyzing datasets that collected comparable measures of health, income, and education levels from representative samples of individuals in both countries. Given that the United States spends considerably more money on health care than England, the findings were striking: Americans were sicker than their English counterparts for a wide range of illnesses, including cancer, heart and lung diseases, stroke, and diabetes. These differences were not due to health issues among American blacks or Latinos, as these populations were excluded from the analysis. Nor were results explained by differences in health behaviors between Americans and the English, as the study controlled for smoking, overweight, obesity, and alcohol use. It remains a puzzling fact: Americans spend so much money to be healthy, but end up being sicker. What gives?

Peter Hall and Michèle Lamont argue that the answer can be found by comparing how culture shapes the “wear and tear of daily life” from one society to the next. Some societies, they contend, are more successful than others in equipping members with abilities to manage the many challenges life throws in their paths. In cultural contexts where life challenges exceed a person’s ability to cope with them, normal wear and tear turns into toxic stress: depression, anxiety, and anger take a toll on the health and happiness of citizens,

resulting in higher levels of illness and early death. Central to their argument is the notion that successful societies breed cultures that feature shared moral orders and symbolic boundaries that are broadly inclusive rather than exclusive. Successful societies also find ways to minimize the distance between high- and low-status members, and, moreover, they provide meaningful ways for minorities to see themselves as full participants in citizenship and national belonging. Without these characteristics, Hall and Lamont note, societies fail to protect the well-being of all of their inhabitants.

FROM SUCCESSFUL SOCIETIES: HOW
INSTITUTIONS AND CULTURE AFFECT HEALTH

Across time and space, the social fabric is woven differently. How do differences among societies affect the well-being of those who live in them? Are some types of societies more successful than others at promoting individual lives and the collective development of the community? How might the character of a society have such effects, and how are such societies built? These are large questions of classic interest to the social theorists of modernity, such as Comte, Tocqueville, Durkheim, Weber, and Marx, with a pedigree that stretches back to the utopian writings of Bacon, More, and Saint-Simon.

In recent years, however, social science has been more reluctant to tackle such questions. There are good reasons for caution. Post-Enlightenment thought observes that the success of a society is difficult to define independently of complex normative issues, not least because trade-offs must often be struck between goals or groups. Assessing the multifaceted web of social relations connecting members of society also poses major empirical challenges. Even the most promising studies in contemporary social science usually fasten onto one or two dimensions of it to the exclusion of others. Their formulations reflect a balkanization among disciplines that has seen some scholars focus on strategic interaction, while others concentrate on symbolic representations or psychosocial processes, each construing institutions and human motivation in different terms.

There is something becoming in the modesty of contemporary social science. It has made focused empirical inquiry more practicable. But something has also been lost. There are good reasons for believing that well-being is conditioned by many dimensions of social relations, but we do not know enough about how those dimensions interact with one another, whether some are substitutes or complements for others, and by what standards some societies can be said to be more successful than others.

This book steps into that breach. We define societies as patterns of social relations structured by institutional practices and cultural repertoires. We are especially interested in understanding how institutions and cultural structures combine to advance (or limit) collective well-being. If this scope connects us to a classic literature, for conceptual tools we draw on contemporary arguments about social networks, identity, social hierarchies, collective action, boundaries, and social capital. Our objective is not to supersede such perspectives but to build on them. We are especially interested in understanding the effects of institutions, organizations, and available cultural repertoires and how they interact with one another.

Our premise is that some societies are more successful than others but, unlike some of the modernization theories of the 1960s, we do not claim there is a single path to success, and, precisely because institutions interact with local cultures, we are skeptical about proposals to identify "best practices" that can readily be transferred from one society to another. There may well be more than one way to solve similar problems. Nevertheless, the contributions the structures of society make to social welfare should be investigated.

A wide range of outcomes can be associated with successful societies, including nonviolent intergroup relations, open access to education, civic participation, cultural tolerance, and social inclusion. We see each as desiderata. However, the priority each should be assigned is open to debate, and engaging in that debate could easily absorb much of this volume, leaving little room to consider the issues that most concern us, namely, how institutional and cultural structures feed into such outcomes. Therefore, the empirical outcomes on which we have decided to focus the book are those of population health, taken as a proxy for social well-being. We concentrate on the health status of those living in a particular

country, region, or community and what we sometimes describe as "health plus."¹

This is an appropriate choice. On the one hand, a focus on population health fits well with our understanding of successful societies. A successful society is one that enhances the capabilities of people to pursue the goals important to their own lives, whether through individual or collective action, and, as we will argue later, population health can be seen as an indicator of such capabilities.² On the other hand, health is a relatively uncontroversial measure of well-being—longer life expectancies and lower rates of mortality can reasonably be associated with the success of a society—and it provides measurable outcomes to explain.

In these outcomes are many sets of puzzles for social scientists. Consider three examples. When the communist regimes of Eastern Europe fell after 1989—in a set of developments some described as the "end of history"—one might have expected life to improve for those people who had been given new freedoms, and for some it did. After dipping amidst the transition, male life expectancy in the Czech Republic, for instance, began to improve more rapidly than under the previous regime, to reach 72 years by 2001. But male life expectancy in Russia dropped sharply during the transition and remained so low that it was barely 59 years in 2001. Why did a historic development improve collective well-being in one nation and erode it in another?

Recent gaps in the trend lines for life expectancy in the United States and Canada are equally puzzling. In the two decades after World War II, Canadians and Americans gained years of life at about the same pace. However, life expectancy has been increasing more slowly in the United States since the 1970s, such that the average Canadian now lives two years longer than his American neighbor. Moreover, women, who live longer than men, are losing their relative advantage at a faster pace in the United States than in Canada. These gaps translate into millions of years of productive life. Why are they occurring?

1. We owe this term to James Dunn who uses it to indicate that good health is usually accompanied by higher levels of self-esteem and associated with many other valued social outcomes, including fruitful employment and a satisfying family life.

2. For an influential argument that associates development with the promotion of capabilities, see Sen (1999), although the meanings we associate with "capabilities" are more specific than his.

Some of these puzzles have policy implications. As sub-Saharan Africa copes with a devastating AIDS epidemic, some governments have had much more success than others. Uganda brought its rate of HIV infection down from about 20 percent of adults in 1992 to less than 8 percent a decade later, while Botswana has seen the rate of infection climb toward 38 percent. By most conventional measures, however, Botswana is much better governed than Uganda. How can one explain these differences in the success of AIDS prevention strategies? These are the types of puzzles this book tackles. For answers, we look to new ways of understanding the relationship between institutional frameworks, cultural repertoires, and population health.

From the Material to the Social in Population Health

What accounts for variation across countries and communities in the health of the population? Although they loom large in popular conceptions, variations in the quality and availability of medical care do not fully explain such differences. New vaccines, diagnostic procedures, and treatments have reduced the incidence and effects of many diseases, but comparisons over time and countries show that this type of innovation explains only a small portion of the variance in population health.³ Much more can be attributed to the economic prosperity of a country or community and corresponding improvements in sanitation, housing or basic utilities.⁴ But material factors alone do not provide complete explanations. Among the developed countries with annual per capita incomes greater than about US\$11,000, there remain wide variations in population health that bear no relationship to national income. The United States has the world's highest income per capita, for instance, and spends more on health care per person than any other country in the world, but it ranks only forty-first in terms of average life expectancy. Population health is clearly conditioned by factors that go well beyond the medical or material.

Much the same can be said about the distribution of health inside each society. . . . In all countries, people of lower socioeconomic status tend to

3. For a classic statement, see McKeown (1965) and the controversy published in the *American Journal of Public Health* (2002). Compare Cutler, Deaton, and Lleras-Muney (2006).

4. Pritchett and Summers (1996).

have worse health than those in higher socio-economic positions—a relationship so pervasive that some describe social inequality as the “fundamental cause” behind disparities in population health.⁵ But how is this gradient to be explained? Some of it turns on the distribution of material resources: people with higher incomes are likely to be able to purchase the housing, health care, and opportunities for relaxation that contribute to better health. Nothing in our analysis disputes this basic point. However, there is more to one's position in a social structure than the material resources associated with it, and some of these other dimensions are likely to be consequential for health. Even studies of baboons show that position within a social hierarchy engenders physiological effects that impinge on health.⁶ One of the objectives of this book is to explore how such dimensions of social relations can affect the distribution of health across the population. We are looking for the social sources of the health gradient.

Of course, this is a problem central to social epidemiology, a field on whose findings we build. One of our objectives is to integrate work in social epidemiology with the concerns of a wider range of social sciences, and to that task we bring a distinctive perspective, which emphasizes the impact on health of institutional structures and cultural repertoires. Many social epidemiologists share these concerns, but they tend to focus on a limited range of social relations and to conceptualize explanations based on them in terms of relatively undifferentiated categories, such as the “psychosocial.” We look at the impact of a broader range of institutional structures and cultural repertoires with special emphasis on how they relate to one another.⁷ This perspective allows us to identify a number of dimensions of social relations consequential for population health that deserve more

5. Link and Phelan (1995; 2000). For overviews of the large literature on this topic, see Adler and Newman (2002); Lynch et al. (2004); Wilkinson (2005); Leigh and Jencks (2006).

6. Sapolsky, Alberts, and Altmann (1997).

7. Social relations broadly construed are the day-to-day interactions, informal (left to the subject's agency) or formalized (into structures, institutions, traditions), between individuals and groups, along with their various correlates: symbolic, material and social *stricto sensu* (hierarchies, networks, solidarities, and so on). Our analysis focuses on cultural structures and institutions rather than other dimensions of social relations. Cultural structures are representations (identities, scripts, frames, myths, narratives, collective imaginaries) that feed into behaviors and social boundaries. Institutions are defined as a set of regularized practices, whether formal or informal, with a rule-like quality in the sense that the actors expect those practices to be observed.

attention than they have received and to deepen our understanding of the ways in which the effects of institutional structures can operate through the cultural frameworks they sustain. Although grounded in ongoing research projects, all the chapters in this book are exploratory. Our objective is to widen the lens through which issues of population health can be seen.

Pathways from Institutions and Culture to Health

... Some consider the challenges to health posed by contemporary developments. Others address problems associated with policies to improve health. Some focus on the impact of collective representations or symbolic boundaries. However, all are concerned with the roles played in such processes by institutional and cultural structures, which affect health through many routes.

Among these routes, this book accords special importance to the health effects that follow from what is sometimes called the "wear and tear of daily life." Although less dramatic than a virus that decimates the population, the toll taken by the stresses of everyday life may be just as great, given the number of people they affect. Many studies show that the emotional and physiological responses generated by the challenges people encounter in daily life condition not only their risk behaviors but also their susceptibility to many of the chronic illnesses that have become the dominant causes of mortality in the developed world, including stroke and heart disease.

Biological pathways link the anger, anxiety, or depression generated in daily life to a person's health. Chronic exposure to high levels of stress has been associated with cumulative developments in the neuroendocrine system that inspire hypertension and poor health. Negative emotions such as depression, resentment, and anxiety appear to raise all-cause mortality, as well as the risk of coronary heart disease, through their effects on the sympathetic-adrenal-medullary (SAM) system, hypothalamic-pituitary-adrenocortical (HPA) system, and immune system. In many cases, these effects seem to operate, much as aging does, to induce progressive increases in the physiological costs of meeting new challenges from the social environment, thereby reducing resilience to health threats over time. Moreover, there can be interaction along these pathways. The development of reflective consciousness, widely associated with the growth of the prefrontal

cortex during adolescence, for instance, can condition the levels of stress experienced later in life.

To understand how institutional practices and cultural frames impinge on health, we develop a particular conception of how the wear and tear of daily life is generated. We suggest that wear and tear depends crucially on the balance between the magnitude of the *life challenges* facing a person and his or her *capabilities* for responding to such challenges. We use the term "life challenges" to refer to the tasks a person regards as most important to life, ranging from basic efforts to secure a livelihood and raise a family to others whose importance will vary across individuals—such as securing material goods, companionship, or social prestige in specific arenas of activity.

We conceptualize "capabilities" in terms that borrow from psychology as well as sociology. To some extent, these are constituted by basic attributes of personality associated with reflective consciousness and emotional resilience, which are conditioned by the experiences of childhood and refined in the contexts of adulthood. But a person's capabilities depend on much more than personality. They include the ability to secure cooperation from others, which invokes a person's capacities for meaning-making and self-representation and the recognition he receives from the community, as well as the institutional frameworks that allow for recognition and effective cooperation. Ultimately, they depend on access to the range of resources that can be used to resolve life's problems. The import of this equation should be apparent. As the life challenges facing a person loom larger relative to his or her capabilities for coping with them, we expect that person to experience higher levels of wear and tear in daily life, feeding into feelings of stress, anger, anxiety, and depression that take a toll on health.

The impact of material circumstances on health is readily captured by this model. In general, people with higher incomes face fewer—and generally different—challenges than those with low incomes. Even more important, however, is the contribution economic resources make to a person's capabilities. In most societies, income is a multipurpose instrument that can be deployed to meet many kinds of challenges, ranging from securing housing to finding a partner. In short, the balance between life challenges and capabilities is a function of material resources. We acknowledge the important impact economic inequality has on the distribution of health across populations and nations.

However, the advantage of our model is that it also illuminates the role played by institutional practices and cultural frameworks in the determination of population health. The core point is that a person's capabilities can be augmented (or attenuated) not only by his access to material resources but also by his access to social (including symbolic) resources. A number of scholars have suggested that the correlates of social class constitute such resources.⁸ However, existing attempts to enumerate them remain limited. Our analysis can be read as an effort to specify in more detail how resources are constituted and how they work their way into health. We focus on the ways in which institutional structures and cultural frames are constitutive of such resources, and we explore the ways in which those resources affect peoples' health by conditioning their capabilities for coping with life challenges.

The results are informative for comparisons across communities. Some societies seem to have more symbolic and social resources than others. However, the analysis also illuminates the familiar relationship between socioeconomic status and health, revealing pathways through which social inequalities impinge on health. Moreover, instead of assuming that the distribution of resources corresponds exactly to the distribution of economic resources, we look into that relationship, allowing for the possibility that social and symbolic resources may not be as tightly coupled to income inequality as some studies imply.⁹

Bringing Culture Back In

Social epidemiologists have shown, in repeated studies, that social relations matter to people's health. Broadly speaking, the field has emphasized three types of relationships. The first is the set of social networks to which people belong. There is substantial evidence that people with close ties to others, through marriage, friendship, or social networks, tend to enjoy better health and to recover more effectively from illness than those who have relatively few such ties. Research shows that the level and intensity of contacts with

8. Giddens (1975); Pearlin and Schooler (1978); Weber (1978); Bourdieu (1984); Link and Phelan (1995, 2000); Kristenson (2006); among others.

9. For a theoretical model spelling out the determinant role of semiotic practices in relation to material resources, see Sewell (2005).

others affect all-cause mortality, self-rated health, and rates of recovery from illnesses such as myocardial infarction. Membership in networks offers resilience against depression, illness, and addiction.¹⁰

A second body of work emphasizes the secondary associations and trust in others they are said to promote, arguing that such associations provide a community with multipurpose "social capital" that can be used to mobilize collective action, especially to press governments to address the needs of the community. Studies show relatively strong correlations between the density of membership in secondary associations and average levels of health across communities. Those who belong to such associations also appear to be healthier, even when factors such as age, income, and social class are controlled.¹¹

If the concept of social capital highlights symmetrical relations among people, a third set of studies stresses the asymmetrical relationships found in hierarchies. Pioneering studies of British civil servants, for instance, have found differences in their health, corresponding to their rank within the employment hierarchy, and others find a relationship between the level of autonomy people enjoy in their job and their health.¹² Others suggest that society-wide status hierarchies may have health effects based, in particular, on the feelings of relative deprivation that high levels of income inequality may engender.¹³

[We are] inspired by these lines of research. They blaze important paths. However, we think those paths are still too narrow, notably in the range of social relationships they consider and how they construe the causal linkages to population health. One of the objectives of this book is to broaden prevailing conceptions of how social relations impinge on health, and we think one of the principal ways to do so is to bring the cultural dimensions of such relationships into fuller focus. Doing so reveals new causal logics and enriches understanding of the pathways to which social epidemiology has pointed.

Scholars who look at the impact of social networks on health have been the most expansive in their formulations. They argue that networks provide logistical support for important tasks, such as rearing children, securing

10. See the pioneering work of Berkman and Syme (1979); Berkman (1995); Berkman et al. (2000); Smith and Christakis (2008).

11. Kawachi, Kennedy, and Wilkinson (1999: Chapters 22 and 23).

12. Marmot (2004).

13. There is controversy about some of these points. See Wilkinson (1996; 2005) and Kawachi (2000).

employment, and managing illness; information about how to approach these tasks; and social influence useful for securing the cooperation of others. Close contacts provide the emotional support that wards off feelings of isolation or depression.¹⁴ This is congruent with our model. In each of these ways, membership in social networks can improve a person's health by enhancing her capabilities for meeting life challenges.

However, these formulations stop short of capturing the full meanings people give to their relations with others. What is missing is a sense of the moral valence people attach to people around them. Long ago, sociologist Max Weber made the point that there is no action and social relationship without meaning. Building on this insight, recent network analysts have observed that the social connectedness of a society is not specified simply by the structural properties of networks, such as their density or even the instrumental functions they serve, but by the meanings those networks produce and convey. For those who belong to a network, membership is often associated, not only with arrangements of mutual convenience, but with value-laden judgments about the self and others, defined at its limits by a sense of who belongs, who should be defended and respected, and who is only at the margins. People use these meanings to derive purposes for their actions as well as a sense of what they can reasonably expect in moral terms from each other. Those meanings constitute social resources. The research of Sampson and his colleagues underlines this point. They find that variations in the level of violence present across Chicago neighborhoods are best explained, not by the presence of social networks per se but by whether people in each neighborhood believe it appropriate for them to admonish their neighbors' children.¹⁵

Studies of the relationship between health and social capital take an even more restricted view of social relations and how they condition behavior. By and large, they emphasize relationships built on a logic of mutual exchange, whereby face-to-face encounters in associations or networks create generalized trust and a diffused reciprocity that can be mobilized for collective action.¹⁶ There is evidence that relations of this sort can improve the ability of communities to press governments to address local problems. But this perspective misses many of the contributions that organizations make to a

community's capacities for collective mobilization through the cultural frames they promote.¹⁷

Social organizations do not simply foster a diffuse sense of reciprocity. In many cases, they contribute important moral visions, identities, symbols, and historical narratives to the collective representations of a community, thereby influencing how individuals or groups see themselves and their relationship to the community as a whole. They convey information about the relative status of groups within the community. They communicate boundaries, defining inclusion or exclusion, and visions of what it means to belong to the community as a whole, which can promote specific models for action. These visions can be more crucial to mobilization, whether individual or collective, than the diffuse reciprocity engendered by associational life. . . .

The literature linking health to social status is especially important for its attentiveness to the distributional implications of social structure. However, there is no consensus in this literature about how social position affects health. Much of it relies on a vague concept of status or links status to health through a concept of relative deprivation that implies status derives mainly from income. In some instances, of course, status inequalities can give rise to a sense of deprivation, which affects a person's health by inspiring feelings of anger and resentment.

However, we think there is room for more multifaceted approaches to the relationship between status and health. On the one hand, differences in status may be grounded in a variety of sources. People may secure status in their local community and in their own eyes, not only from their material possessions but also from their commitment to collective solidarity or from their role in raising a family.

On the other hand, the effects of status may not operate entirely through feelings of relative deprivation. Hall and Taylor argue that social status conditions the toll daily life takes on people's health by affecting their capacities to secure the cooperation of others. Social status can condition a person's self-image in ways that increase the anxiety or stress he feels—what Giddens calls “ontological security”—without necessarily engaging feelings of relative deprivation.¹⁸ Psychologists have noted that the stereotypes embedded in status systems can influence the self-confidence

14. See, for instance, the nice formulations in Berkman et al. (2000).

15. Sampson, Raudenbush, and Earls (1997).

16. Putnam (1993).

17. For an illustration of this point, see Small (2004). For relevant critiques, see Hall (1999) and Offe (1999).

18. Giddens (1991).

and competence people bring to particular tasks, even if they are not conscious of it doing so.¹⁹ Recognition influences self-efficacy independently of access to material resources. Being defined as able to achieve or as a valuable member of the community has to be a component of how inequality penetrates under the skin. In short, we need a more expansive conception of the mechanisms through which status works its way into health, notably by affecting the capabilities people bring to life challenges.

We should also acknowledge that the status order is a cultural construct whose shape varies across societies. Status is not determined exclusively by material affluence or position within formal hierarchies. The extent to which status corresponds to income will depend on the available cultural frames. Michèle Lamont's comparison of the French and the American upper-middle class, for instance, shows how much these two societies vary with respect to the value or prestige attached to money, culture, and morality. In another study, she finds that French and American workers employ quite different matrices for assessing the value of various groups, such as blacks, immigrants or the poor, which means that blacks and the poor are regarded in more inclusive terms in the French than American context.²⁰ Because the status or social recognition accorded such groups varies across national contexts, the social opportunities available to them do so as well, with important implications for their health.

The study of population health can be enriched by taking into account the meaning-laden dimensions that permeate all social relations, even when the latter might seem solely interest-based. Those who belong to a society are tied together by ideas of who they are and what they can do that are as evaluative as they are factual. These ideas underpin the judgments we make about others and ourselves. They provide resources for our imagination and specify its limits. In some respects, these "webs of meaning" constitute moral orders. They are organized around group boundaries that have negative (exclusive) aspects as well as positive (identity-bearing) aspects and embodied in hierarchies that assign status or prestige. They find voice in collective narratives grounded in tales about the historic struggles of the tribe or nation, redolent with implications about what a member can or should do—providing definitions of "possible selves" for individuals and aspirations for the collectivity.

19. Shih, Pittinsky, and Ambady (2002).

20. Lamont (1992; 2000; 2006).

For the purposes of this book, we put special stress on three dimensions of culture, which are often embodied in institutional forms. The first is the set of *symbolic boundaries* that define who is at the center of the community and who is at its margins.²¹ Boundaries of this sort construct ethnicity and the other social categories that structure the transactions of daily social life. They may be more or less permeable. Closely associated with them are sets of evaluative criteria, which attach more or less opprobrium to one side of a boundary and give rise to the stereotypes that influence views of ourselves as well as others.²²

The second dimension consists in the *status hierarchies* of a society, understood as implicit sets of principles for distinguishing among social positions and a distribution that assigns varying amounts of social prestige to those positions. We are concerned with the steepness of the relevant status hierarchies, namely, the distance in status between positions at the top and bottom, and in the multidimensionality of status distribution. As Max Weber argued, where status can be secured in several different ways, the social disadvantages experienced by those who lack status on one hierarchy may be offset by the status they gain through alternative means. Relevant to such processes are the terms on which a society assigns status, whether on the basis of citizenship, learning, income, or some other criteria.

Finally, we are attentive to the *collective imaginaries* that portray a society and its members in particular ways. If nations are "imagined communities," as Benedict Anderson has suggested, it matters how they imagine themselves. Collective imaginaries are sets of representations composed of symbols, myths, and narratives that people use to portray their community or nation and their own relationship as well as that of others to it. By virtue of their contributions to collective identity, these imaginaries condition the boundaries and status hierarchies to which we have just referred. In addition, by presenting a community's past in a particular way, collective narratives influence the expectations of its members about the future, suggesting paths of collective development available to the community and "strategies of action" feasible for individuals within it. The moral valence of such representations lends them influence, but they have cognitive and emotional impact as well, conjuring up templates for action from the past.

21. On the literature on boundaries, see Lamont and Molnár (2002).

22. See Steele (1988); Steele and Crocker (1998); Krieger (2000); Son Hing et al. (2002).

These cultural frameworks condition the health of individuals and its distribution across the population in multiple ways. As noted later, they provide blocks on which effective policies to promote healthy behaviors can be built and underpin the collective mobilization central to securing more healthy living conditions in many societies. However, we want to emphasize the ways in which cultural frameworks affect health by conditioning peoples' capabilities for coping with life challenges and, hence, the amount of daily wear and tear they experience.

Social recognition can feed directly into capabilities.²³ As we have noted, it can affect a person's capacities for securing cooperation from others. Those who belong to low-status groups or occupy positions with low social respect may find it more difficult to secure such cooperation. Research on racial discrimination indicates that social recognition is also likely to affect self-confidence and the effectiveness with which tasks are performed.²⁴ Here, there are important life course effects: the recognition one achieves in childhood has durable importance for the self-concept and health. Even with the most auspicious upbringing, however, in the absence of cultural templates that sustain a sense of social recognition, adults can rarely sustain the self-esteem that feeds directly into health.²⁵

The predominant models of cultural citizenship, social boundaries, and status hierarchies of a society will influence whether social recognition is available and who will receive it. Where the status hierarchy is relatively flat or there are diverse paths toward status, those in the lower rungs of the social ladder should be healthier on average than their counterparts facing steeper or dominant hierarchies. Much may depend on whether status is driven by income.

Bibliography

- Adler, Nancy E. and Katherine Newman. 2002. "Socioeconomic Disparities in Health: Pathways and Policies." *Health Affairs* 21 (2): 60–76.
- Berkman, Lisa F. 1995. "The Role of Social Relations in Health Promotion." *Psychosomatic Medicine* 57 (3): 245–54.

23. On social recognition, see Taylor (1993) and Lamont and Bail (2005).

24. Steele (1999). Also Steele and Aronson (1998).

25. Steele (1988); Pyszczynski et al. (2004).

- Berkman, Lisa F. and S. Leonard Syme. 1979. "Social Networks, Host Resistance, and Mortality: A Nine-year Follow-up of Alameda County Residents." *American Journal of Epidemiology* 109 (2): 186–204.
- Berkman, Lisa F., Thomas Glass, Ian Brissette, and Teresa E. Seeman. 2000. "From Social Integration to Health: Durkheim in the New Millennium." *Social Science and Medicine* 51: 843–57.
- Bourdieu, Pierre. 1984. *Distinction: A Social Critique of the Judgement of Taste*, translated by R. Nice. London: Routledge.
- Cutler, David M., Deaton, Angus S., and Lleras-Muney, Adriana. 2006. "The Determinants of Mortality." National Bureau of Economic Research working paper no. W11963.
- Giddens, Anthony. 1975. *Class Structure of the Advanced Societies*. New York: Harper and Row.
- . 1991. *Modernity and Self-Identity: Self and Society in the Late Modern Age*. Stanford, CA: Stanford University Press.
- Hall, Peter A. 1999. "Social Capital in Britain." *British Journal of Political Science*. 29 (3): 417–61.
- Kawachi, Ichiro. 2000. "Income Inequality and Health." In *Social Epidemiology*, edited by Lisa Berkman and Ichiro Kawachi. New York: Oxford University Press.
- Kawachi, Ichiro, Bruce P. Kennedy, and Richard G. Wilkinson, eds. 1999. *The Society and Population Health Reader: Income Inequality and Health, Vol. I*. New York: The New Press.
- Krieger, Nancy. 2000. "Discrimination and Health." In *Social Epidemiology*, edited by Lisa F. Berkman and Ichiro Kawachi. New York: Oxford University Press.
- Kristenson, Margareta. 2006. "Socio-economic Position and Health: the Role of Coping." *Social Inequalities in Health*, edited by Johannes Siegrist and Michael Marmot. Oxford: Oxford University Press.
- Lamont, Michèle. 1992. *Money, Morals, Manners: The Culture of the French and American Upper-Middle Class*. Chicago: University of Chicago Press.
- . 2000. *The Dignity of Working Men: Morality and the Boundaries of Race, Class, and Immigration*. Cambridge, MA: Harvard University Press.
- . 2006. "How French and American Workers Define Cultural Membership." In *Inequalities of the World*, edited by Goran Therborn. London: Verso.
- Lamont, Michèle and Christopher Bail. 2005. "Sur les frontières de la reconnaissance. Les catégories internes et externes de l'identité collective." *Revue Européenne des Migrations Internationales* 21 (2): 61–90.
- Lamont, Michèle and Virág Molnár. 2002. "The Study of Boundaries Across the Social Sciences." *Annual Review of Sociology* 28: 167–95.

- Leigh, Andrew and Christopher Jencks. July 2006. "Inequality and Mortality: Long-Run Evidence from a Panel of Countries." KSG working paper no. RWP06-032. Available at SSRN: <http://ssrn.com/abstract=902381>.
- Link, Bruce G. and Jo Phelan. 1995. "Social Conditions as Fundamental Causes of Disease." *Journal of Health and Social Behavior* 35: 80-94.
- Link, Bruce G. and Jo C. Phelan. 2000. "Evaluating the Fundamental Cause Explanation for Social Disparities in Health." In *Handbook of Medical Sociology*, edited by Chloe E. Bird, Peter Conrad, and Allen Fremont. Upper Saddle River, NJ: Prentice Hall.
- Lynch, John W., George D. Smith, Sam Harper, Marianne Hillemeier, Nancy Ross, George A. Kaplan, and Michael Wolfson. 2004. "Is Income Inequality a Determinant of Population Health? Part 1. A Systematic Review." *The Milbank Quarterly* 82: 1-77.
- Marmot, Michael G. 2004. *The Status Syndrome: How Social Standing Affects Our Health and Longevity*. New York: Times Books.
- McKeown, Thomas. 1965. *Medicine in Modern Society*. London: Allen & Unwin.
- Offe, Claus. 1999. "How Can We Trust Our Fellow Citizens?" In *Democracy and Trust*, edited by Mark E. Warren. New York: Cambridge University Press.
- Pearlin, L. I. and C. Schooler. 1978. "The Structure of Coping." *Journal of Health and Social Behavior* 19: 2-21.
- Pritchett, Lance and Lawrence H. Summers. 1996. "Wealthier Is Healthier." *Journal of Human Resources* 31 (4): 841-68.
- Putnam, Robert D. 1993. *Making Democracy Work: Civic Traditions in Modern Italy*, with Robert Leonardi, and Raffaella Y. Nanetti. Princeton, NJ: Princeton University Press.
- Pyszczynski, Tom, Jeff Greenberg, Sheldon Solomon, and Jamie Arndt. 2004. "Why Do People Need Self-Esteem? A Theoretical and Empirical Review." *Psychological Bulletin* 130 (3): 435-88.
- Sampson, Robert J., Stephen W. Raudenbush, and Felton Earls. 1997. "Neighborhoods and Violent Crime: A Multilevel Study of Collective Efficacy." *Science* 277 (5328): 918-24. doi: 10.1126/science.277.5328.918.
- Sapolsky, R. M., S. C. Alberts, and J. Altmann. 1997. "Hypocortisolism Associated with Social Subordination or Social Isolation among Wild Baboons." *Archives of General Psychiatry* 54 (12): 1137-43.
- Sen, Amartya. 1999. *Development as Freedom*. New York: Alfred A. Knopf.
- Sewell, William H., Jr. 2005. *Logics of History: Social Theory and Social Transformation*. Chicago: University of Chicago Press.
- Shih, Margaret, Todd Pittinsky, and Nalini Ambady. 2002. "Stereotype Susceptibility: Identity Salience and Shifts in Quantitative Performance." *Psychological Science* 10 (1): 80-3.

- Small, Mario. 2004. *Villa Victoria: The Transformation of Social Capital in a Boston Barrio*. Chicago: University of Chicago Press.
- Smith, Kristen P. and Nicholas A. Christakis. 2008. "Health and Social Networks." *Annual Review of Sociology* 24: 405-29.
- Son Hing, Leanne S., Winnie Li, and Mark P. Zanna. 2002. "Inducing Hypocrisy to Reduce Prejudicial Responses among Aversive Racists." *Journal of Experimental Social Psychology*, 38: 71-8.
- Steele, Claude M. 1988. "The Psychology of Self-Affirmation: Sustaining the Integrity of the Self." *Advances in Experimental Social Psychology*, Vol. 21: *Social Psychological Studies of the Self: Perspectives and Programs*. San Diego: Academic Press.
- . "Thin Ice: 'Stereotype Threat' and Black College Students." *The Atlantic Monthly* 284 (2): 44-7; 50-4.
- Steele, Claude M. and Joshua Aronson. 1998. "Stereotype Threat and the Test Performance of Academically Successful African Americans." In *The Black-White Test Score Gap*, edited by Christopher Jencks and Meredith Phillips. Washington, DC: The Brookings Institution Press.
- Steele, Claude and Jennifer Crocker. 1998. "Social Stigma." In *Handbook of Social Psychology*, edited by Daniel T. Gilbert, Susan. T. Fiske, and Gardner Lindzey. Boston: McGraw-Hill.
- Taylor, Charles. 1993. *Multiculturalism and the Politics of Recognition*. Princeton, NJ: Princeton University Press.
- Weber, Max. 1978. *Economy and Society*, Vols. 1 and 2. Berkeley: University of California Press.
- Wilkinson, Richard G. 1999. "Health Hierarchy and Social Anxiety." *Annals of the New York Academy of Sciences* 896 (1): 48-63.
- . *The Impact of Inequality: How to Make Sick Societies Healthier*. New York: Free Press.

STUDY QUESTIONS

1. How, according to the authors, is the "wear and tear of daily life" associated with inequality? How is it associated with health? And why is culture an important factor in these relationships?
2. What are *status orders* and *symbolic boundaries* and how are they related to health outcomes?