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Social Or Status Incongruence

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Although many of us believe ourselves and our lives to be exemplary with respect to the consistency in our thoughts and behaviors, much of human social life and belief is fraught with inconsistencies, contradictions, and contested meanings. The effects of these inconsistencies on human health have been investigated for the past 50 years. In this contribution, research on both social or status incongruence (also referred to as status inconsistency) and cultural consonance (which measures cultural incongruities) will be reviewed and summarized.

Social or Status Incongruence

The hypothesis that discrepancies or inconsistencies in status might be related to health outcomes is derived from more general theories of socioeconomic differences and health. The general perspective on socioeconomic status implicit in most research derives from Max Weber's perspective on status. In this view, individuals in complex societies are ranked according to a number of criteria, including their relationship to the labor market (as assessed by occupation), their skills that can be marketed (as assessed by education), and the degree to which they are rewarded in the market for those skills (as assessed by income). Individuals can be ranked on these dimensions separately or according to some summary measure including all three. Generally speaking, the higher an individual's socioeconomic rank, the better his or her health status.

The question can be posed, however, regarding *nonvertical* dimensions of socioeconomic status. This question was first raised by Everett C. Hughes in 1944 in an article that examined how differences or discrepancies or inconsistencies in status for individuals might be problematic. Keeping in mind that he was writing before the modern civil rights movement, the ideal type that Hughes used for his analysis is instructive. He offered the case of an African American physician in the United States. On the one hand, physicians hold positions of both considerable esteem and considerable economic power. On the other hand, African Americans, as a result of systemic racism in this society, occupy a position with much lower status.

Hughes suggested that there would be considerable frustration and uncertainty in mundane social interaction for an African American physician, because at times he or she might receive the deference due the high status of physician while at others times being the object of racist interactions. This would lead to a lack of predictability in social interaction. At the same time, assuming that his or her sense of self would be**[p. 680 ↓]** significantly shaped by achievements in educational and occupational status, it would be a stressful and frustrating experience to offer one presentation of self in social interaction (i.e., the successful physician), only to have others respond in terms of a disvalued status (i.e., ethnicity).

This example summarizes the basic hypothesis regarding status incongruence. Researchers generalized Hughes's argument to include all differences along status dimensions. In other words, it was hypothesized that an individual whose occupational status was quite different from his or her educational status would experience the same uncertainties and frustrations that Hughes described. Within social epidemiological research in the 1950s and 1960s, especially in sociology but also in epidemiology, researchers examined closely the relationship between inconsistencies in status (along the traditional dimensions of socioeconomic status) and various health outcomes. These included studies of mental health, rheumatoid arthritis, overall mortality, and especially, coronary artery disease (see Vernon & Buffler, 1988).

Generally speaking, status incongruence was found to be associated with an increased risk of adverse health outcomes. Also during this time, the term *status inconsistency* was proposed to apply to intraindividual discrepancies in status (e.g., the PhD who sells shoes for a living), while the term *status incongruence* was proposed to apply to discrepancies in status within a family unit, especially between husbands and wives (e.g., the PhD married to an auto mechanic). A number of studies showed that these interindividual discrepancies in status between husbands and wives in the United States were associated with adverse health outcomes. Although this terminology was proposed and an understanding of the literature requires that the variety of uses of terms be understood, in this entry the term status incongruence will be used to refer to the intraindividual concept.

Despite the theoretical and empirical yield of the idea of status incongruence, research on the topic in sociology and social epidemiology slowed considerably in the late 1960s

and early 1970s, as a result of a series of papers by Hubert M. Blalock (summarized in Whitt, 1983). Status incongruence had typically been operationalized as some kind of difference term, indicating the degree of difference on a status dimension for an individual. Sometimes this was a directional term, that is, the degree to which one dimension exceeded another. At other times no direction was indicated, that is, the absolute difference between the status dimensions was calculated.

In either case, status incongruence would be used as a variable without reference to an individual's overall socioeconomic status. Blalock argued quite persuasively that examining the discrepancies in status made sense only after the vertical effects of status had been taken into account. In other words, since overall socioeconomic status was known to influence health, examining nonvertical effects made sense only after the vertical effects had been removed. What became apparent, however, was that there was no valid statistical procedure for separating vertical and nonvertical effects *in a single model*; that is, an effect of the vertical dimension and an effect of the nonvertical dimension could not be simultaneously estimated. In all existing research on status incongruence, the effect attributed to status incongruence could have been merely typical socioeconomic status effects masquerading as a discrepancy effect.

While Blalock's critique slowed research on status incongruence in some fields of study, the basic theoretical sense of the concept continued to guide research in other areas. In anthropology in the 1950s and 1960s, a great deal of research was taking place on acculturation (or the degree to which individuals in traditional societies adopted beliefs and behaviors introduced from other, usually more modernized, societies) and health. Mostly these were linear models suggesting that the greater the degree of acculturation, the greater the stress and risk of adverse health outcomes (see Dressler, 1999, for a review). There were several papers, however, that suggested a status incongruence effect. One of the major changes occurring in any community undergoing culture change is a shift in material lifestyles. Higher status comes to be associated with the ability to consume material goods associated with middle-class lifestyles in Europe and North America. Several authors suggested, although did not test directly, the idea that the attempt to satisfy these material aspirations could be stressful if individuals did not have resources (which might include access to paid employment or education qualifications) to make possible the acquisition of that lifestyle.

These ideas from anthropology were then integrated with the status incongruence hypothesis in a series of studies (Dressler, 1993). The association of higher status with the ability to attain a middle-class material lifestyle (which includes the acquisition of**[p. 681 ↓]** consumer goods such as manufactured furniture, appliances, and stereos as well as behaviors such as watching television, traveling, and reading books and magazines) appears to occur in virtually all societies undergoing modernization or culture change. Changing dimensions of status are not particularly problematic, except that these changes can occur much more rapidly than the economic expansion necessary to provide the access to the paid employment, which, in turn, makes possible the acquisition and maintenance of such a lifestyle. Therefore, virtually by definition, there will be individuals aspiring to such a lifestyle whose economic resources are not congruent with that lifestyle. This is an explicit directional hypothesis, in which the degree to which lifestyle aspirations exceed economic resources is thought to be stressful, but not the reverse.

At about the same time, a methodological solution to the dilemma posed by Blalock in the testing of discrepancy effects appeared in the literature. It was shown that if one assumed that the vertical dimension of status could be estimated using a sum of the separate status variables, then it was possible to estimate a discrepancy effect (Whitt, 1983). One could have, in essence, two variables: the sum of two status dimensions that operationalized the overall vertical effect, and a signed difference between two status dimensions estimating the discrepancy effect. Using this model, effects of what was referred to as “lifestyle incongruity” were found on arterial blood pressure in St. Lucia, Mexico, Brazil, and the African American community in the rural southern United States, as well as on depressive symptoms in the African American community and on disordered glucose metabolism among the Mississippi Choctaw.

Furthermore, the effect turned out not to be a simple matter of economic stresses, although that certainly would be a part of it. But where perceived economic stress was directly measured and controlled for, lifestyle incongruity continued to have an independent effect on health. Furthermore, the effect of lifestyle incongruity was moderated by the perceived availability of social support. This led to the argument that in fact the genesis of the stress associated with incongruities in status was probably in social interaction. Like Hughes's Black physician, an individual aspiring to a higher material lifestyle would be in essence projecting a sense of self into mundane social

interaction, a self perception involving one's belief in one's ability to participate in what is basically a middle-class lifestyle; however, others may respond in mundane social interaction less in terms of status defined by a mutable lifestyle, and more in terms of more fixed status characteristics like occupational or educational status. The person with high status incongruence, then, may fail to receive confirmation of his or her self perception in mundane social interaction, the result being frustration, stress, and ultimately, poorer health outcomes.

The lifestyle incongruity hypothesis has been replicated by a number of researchers in a variety of settings, including studies of blood pressure and mental health in adults, and of cell-mediated immune status in adolescents. These studies have also found that the effects of lifestyle incongruity can be moderated by a number of factors, including household structure, social support, and community characteristics.

One aspect of this research worth noting is that the anthropological studies have moved away from using the conventional status dimensions of survey sociology in favor of the measurement of status in terms more ethnographically authentic. That is, while the importance of the traditional dimensions of status is without question in influencing one's life chances, measures of status such as lifestyle capture the way that status is performed in mundane social interaction.

Cultural Consonance

Incongruence along other dimensions has been explored as well. Cassel, Patrick, and Jenkins (1960) some years ago offered what they called the “cultural incongruity” hypothesis. They were particularly interested in what happened to migrants from rural areas to urban areas, although the same reasoning can be applied to culture change occurring within any community. They offered the following hypothesis: The migrant to a novel setting carries with her a particular understanding of how the world works, in every sense (i.e., what it means to work, how marriages are constituted, how families treat themselves and their neighbors, how to worship—everything). She is confronted, however, with a system for which her understanding may not work. The novel and dominant culture of the new setting must be learned for everyone else's behavior to be understood, and indeed for her to behave in ways that are understandable to

others. She must, in other words, adapt to the new setting. Even if she is successful, such adaptation can be stressful and costly, and the **[p. 682 ↓]** cost of adaptation is written on the body in terms of what we call health. Cassel et al. argued that the less successfully the migrant culturally adapts to the new setting, the higher her risk of disease.

Unfortunately, Cassel and his associates had neither the theoretical nor the methodological tools to move this research forward. Recently, however, methods have been developed to make it possible to test these ideas directly. These studies employ the concept of “cultural consonance” to describe the discrepancy between an individual's behavior within some cultural domain, and the behaviors that are culturally valorized within that domain (Dressler & Bindon, 2000). The measurement of these factors has been made possible by the development of procedures that can be used to determine when in fact there are strongly shared (and hence cultural) models of appropriate beliefs and behaviors in some domain of culture. Then, the degree to which individuals deviate from that shared model can be measured using epidemiological survey techniques. In research both in the United States and in Brazil, it has been shown that there are indeed broadly shared cultural models both of valued lifestyles and of preferred patterns of access to social support. A higher degree of consonance or congruence with the culturally valued models for individuals is associated with lower levels of perceived stress, depressive symptoms, and arterial blood pressure. Furthermore, all of these associations are independent of conventional measures of socioeconomic status and social integration.

The cultural consonance hypothesis is again consistent with the basic ideas that Hughes proposed more than a half century ago. Conventional expectations regarding how life is to be lived are encoded in mental representations that we call cultural models. Many of these cultural models are widely shared, some are highly contested. Where they are widely shared, there are expectations, stemming both from the individual, regarding himself or herself, and from others in the social field, regarding the appropriate range of behaviors for any given individual. When, usually as a result of restricted access to economic resources, an individual is unable to act on these widely shared expectations regarding behavior, he or she is likely to experience frustration, uncertainty in social interaction, and a general sense that life lacks coherence. This can

be a profoundly stressful experience that, when continued over a long period of time, can lead to poor health.

Summary

The status incongruence hypothesis and the cultural congruity hypothesis have been extremely productive with respect to research in social epidemiology. Similarly, there is recent evidence that cultural consonance can be associated with health behaviors such as the decision to use health promotion/disease prevention services and level of participation in treatment support groups for chronic disease. Future studies should explore the broader health implications of these inconsistencies and uncertainties in the social and cultural dimensions of everyday life.

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See also

Further Reading

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