

Linköping University Post Print

Status incongruence revisited: associations with shame and mental wellbeing

Johanna Lundberg, Margareta Kristenson and Bengt Starrin

N.B.: When citing this work, cite the original article.

This is the author version of the following article:

Johanna Lundberg, Margareta Kristenson and Bengt Starrin, Status incongruence revisited: associations with shame and mental wellbeing, 2009, SOCIOLOGY OF HEALTH and ILLNESS, (31), 4, 478-493.

which has been published in final form at:

<http://dx.doi.org/10.1111/j.1467-9566.2008.01148.x>

Copyright: Blackwell Publishing Ltd

<http://www.blackwellpublishing.com/>

Postprint available at: Linköping University Electronic Press

<http://urn.kb.se/resolve?urn=urn:nbn:se:liu:diva-18261>

Status incongruence revisited - associations with shame and mental well-being (GHQ)

Johanna Lundberg*, Margareta Kristenson*, Bengt Starrin**

** Department of Medical and Health Sciences, Linköping University, Sweden*

*** Department of Social Sciences, Karlstad University, Sweden*

Introduction

Discrepancy in the status positions held by an individual has been referred to as status incongruence or status inconsistency (Vernon & Buffler, 1988). Status incongruence and status inconsistency are both derivative concepts based on combinations of various status positions within an individual. Both of these concepts describe the state of an individual who simultaneously holds positions of unequal rank, such as having a high education but a low-status job, or a low education but a high income. Initial research on status incongruence revolved around methodological issues about accurate measurement of this concept and mapping of political preferences, but research has also been driven by an interest in health effects. The relationship between status incongruence and health has been discussed mainly by sociological researchers, with some epidemiological contributions. Status incongruence is generally described as psychologically stressful for the individual and has been shown to be related to health problems (both clinical and self-assessed outcomes) and all-cause mortality, but it has also been found to have associations with lack of social trust and undermined confidence in economical and political institutions (Blalock, 1966; Faresjo et al., 1997; Horan & Gray, 1974; Horan & Gray, 1976; House & Harkins, 1975; Hyman, 1966; Jackson, 1962; Meile & Haese, 1969; Syme et al., 1965; Zhang, 2008). Several studies on CHD were carried out mainly in the 1960's with discrepant results, most likely because of a lacking consistent theoretical framework and methodology (Vernon & Buffler, 1988).

The research on status incongruence more or less disappeared from the scene in the 1970's, and only a handful studies can be found in the past decade (Faresjo et al., 1997; Macleod et al., 2005; Zhang, 2008). However, status incongruence could be a growing public health problem due to recent changes in the labour market in Sweden and many other Western societies during later decades, which have encouraged a large share of younger generations to attend university studies while equivalent job opportunities have been scarce (Bergmark & Fritzell, 2007). If health effects do arise from experiences of incongruent positions in society, this study could contribute to a better understanding of the role that individual (incongruent) social status play for the experience of negative emotion, such as shaming experiences, and poor mental well-being.

The psychology and aetiology of status incongruence

Jackson (Jackson, 1962) and House and Harkins (House & Harkins, 1975) both emphasise sociological theories on role conflict and distributive injustice as central to hypothesising on why occupational and educational inconsistencies should be stressful for the individual. As for health consequences deriving from role conflict, different constructs of “psychological distress” have been put forward as the major pathway. Jackson (1962) suggests that the social uncertainty experienced by the individual with discrepant positions will reduce the stability of his or her self-image, and conflicting expectations will result in frustration and uncertainty which in turn will increase psychological stress. Health consequences of status incongruity have also been suggested as deriving from feelings of distributive injustice and perceived relative deprivation, where the incongruent individual may feel like she has “missed out” on what life had promised (for instance, expectations of prestige or financial security built on educational attainment) and may experience a lived discrepancy between investment (education) and reward (occupation) (Wegener, 1991).

According to relative deprivation theory, social comparisons are made in relation to a specific reference group. Following from this hypothesis, the internalised norms from these reference groups are assumed lay the ground for the individual's discontent with his situation. In short, the individual will live a discrepancy between "what is" and "what ought to be". However, this theory has been criticised for relying on “psychological speculations” with regard to the choice of reference groups (Wegener, 1991). An alternative approach to assessing one's position, based not on psychological perceptions but rather on objective conditions, has been presented by Wegener (1991) who studied social mobility in terms of job change. Here, opportunities (such as education) and restrictions (such as a scarce job market) are two central conditions for the steering of perceptions of individuals. Wegener dichotomised these conditions into “many” and “few” and ended up with a matrix of four different mobility types, whose characteristics are summed up as described below:

		Restrictions	
		Many	Few
Opportunities	Many	Type 1 (-)	Type 3 (+)
	Few	Type 2 (+)	Type 4 (++)

1. Individuals of type 1 begin with many opportunities and will invest in competition because of high promotion probabilities. When they find they have not been compensated for their investments, they will experience frustration and discontent (-).
2. Members of type 2 begin with few opportunities and will therefore not invest. They will not feel especially deprived, because there are no investments for them to lose. These individuals will be in a state of ‘content resignation’. (+)

3. Type 3 members have invested and reached their goals. These people will not experience any discontent, but will feel justly rewarded (+).

4. Type 4 individuals are the “lucky” ones who have not invested in competition but who have still gained positive mobility. (++)

Social status and shame

While Wegener regarded the typology above as a guide for distinguishing between different groups of careers in order to make predictions about their respective justice responses, this model should also be appropriate as a model for different types of status incongruence, where people of type 1 are negatively incongruent individuals, type 2 are low-status congruents and type 3 are high-status congruents, while type 4 comprises the positively incongruent individuals. Further, one could very well imagine pessimism or anxiety as potential outcomes instead of the originally proposed measures of relative injustice. The social uncertainty and role conflict that is assumed to spring from the discrepancy between individuals' different forms of capital (Bourdieu, 1986) or ascribed status, and their achieved social status position, should open also for emotionally related outcomes, such as shame. Jackson (1962) writes on negative incongruence: “A person whose achievement ranks are inferior to his ascribed rank is likely to view his situation as one of personal failure [that] tend to stimulate feelings of personal deficiency and self-blame, thus increasing the likelihood of an intra-punitive response such as symptomisation.”

The self-blame mentioned by Jackson in the quote above is closely related to the concept of shame. Perceiving oneself as inferior to others has been suggested as a form of status-bound sense of shame in modern society (Neckel, 1991). Shame may be said to be a feeling of inferiority arising from a sense of personal failure. It is a result of seeing oneself negatively in

the eyes of the other, such as feeling rejected, unworthy or inadequate (Charlesworth et al., 2004; Scheff, 1990; Starrin et al., 2003). In short, shame results when perceptions of negative *social* evaluation are transformed into negative *self*-evaluation (Dickerson et al., 2004a). Scheff (Scheff, 1990) emphasises that the social order is not static: “status honour requires continuous affirmation”. This might help explain the mechanisms underlying social status evaluation and its connections to shaming experiences: when your social status (either ascribed or achieved) and the honour that comes with it is threatened to be taken away from you, the emotional reaction will be one of shame (for instance expressed as a feeling of being looked down on, or of being ignored). In short: a sensation of not being regarded and respected in the way one thinks one deserves to be.

Several studies have shown that being subjected to shaming in the form of humiliation, ridicule and other forms of insult, relates to ill health. For example, studies show that shaming co-varies with mental ill health among social benefit recipients (Starrin et al., 2003) and the unemployed (Starrin, 2006). Eales (Eales, 1989) found that the experience of shame was associated with depression and anxiety. Studies also show that shame and humiliation such as being rejected by someone close, publicly snubbed, personal failure, and similar things which all are shame indicators can cause depression (Brown et al., 1995). Dickerson et al (Dickerson et al., 2004a; Dickerson & Kemeny, 2004; Dickerson et al., 2004b) suggest that conditions characterised by social evaluation or rejection will elicit a specific or coordinated psychobiological response. This was also supported by their findings of increased pro-inflammatory cytokine activity in association with feelings of shame. It is plausible that the social processes of shame and shaming could accompany the hypothesised experiences of role conflict and social uncertainty, as described by previous sociological studies, and studying the role of shame in relation to social status is therefore one of our aims with this study.

Aim

Our aim is to study whether there are any differences in the risk for shaming experiences, pessimism, anxiety, depressive feelings, and poor mental well-being (GHQ) in four different status categories: negatively and positively incongruent individuals, and low-status and high-status congruent individuals. A special focus will be assigned shame and its associations with the four status categories and GHQ.

Material and methods

Data

Our data are from a regional sample of 33 834 individuals drawn from a health-related survey which was distributed in mid-Sweden in the year 2000 to randomly selected men and women, 18-79 years old (Molarius, 2000). After the coding of the four status categories central to our analyses, 14 854 individuals remained in our dataset¹. Questions in the survey encompassed various aspects of health, lifestyle, finances, living conditions, social trust, and mental and emotional well-being.

Measurements

Occupation was measured according to the Swedish SEI-coding system (StatisticsSweden, 2008) and comprised the following categories: unqualified manual, qualified manual, unqualified non-manual, qualified non-manual, qualified non-manual including managerial, self-employed and farmers.

Education was measured on seven levels: less than primary, primary, vocational, secondary, university <3 years, university >=3 years, and PhD level.

¹ Coding of the four status categories meant exclusion of individuals that did not meet with certain educational and occupational criteria, see “Status incongruence” under Measurements for details.

Status incongruence was measured as a combined measure of education and occupation, where **negative incongruents** were coded as university education in combination with manual worker occupational status or unqualified non-manual occupational status, while **positive incongruents** were coded as primary or vocational education in combination with qualified non-manual status. A university education and qualified non-manual occupational status were coded as **high-status congruents**, while primary or vocational education with worker occupational status was coded as **low-status congruents**. Secondary level education (which is theoretical, as compared to the more practically oriented vocational education), the self-employed and farmers were not included in the coding of incongruents or congruents due to difficulties in determining the appropriate occupational and educational requirements for these categories.

GHQ: The General Health Questionnaire (GHQ) is a state measure of current mental health which concentrates on broader components of psychiatric morbidity but does not make clinical diagnoses (Goldberg et al., 1998). The questionnaire was originally developed as a 60-item instrument but several shortened versions of the questionnaire are available.

In this study, the GHQ-12 is used. The scale asks whether the respondent has experienced a particular symptom or behavior recently. Each item is rated on a four-point scale (0-3) and will result in a maximum score of 36 for the GHQ-12, with a cut-off at 19 points.

Shaming experiences (Starrin et al., 2008) was measured by the five following questions: “During the past three months, have you experienced... (I) that anyone has treated you in a condescending way? (II) that anyone has ridiculed you in front of others? (III) that anyone has insulted you? (IV) that anyone talked disparaging about you? (V) that anyone around you ignored you?”. Response alternatives were coded as a dichotomous variable where a positive answer on 1 or more questions was coded as 1. Cronbach’s alpha for the items in this study was 0.80.

A measure of **civil status** was derived from the question “Do you currently live with another adult?” where a negative answer was coded as 1.

Foreign born was coded as a dichotomous variable where those who were born outside of Europe and Northern America were coded as 1.

A measure of **longstanding illness** was derived from the question: ”Do you suffer from any longstanding illnesses (longer than 6 months) caused by accidents, or any other impediments or longstanding health issues?” where a positive answer was coded as 1.

Financial difficulty was coded as 1 in case of a positive response to the question: “During the past three months, have you experienced any financial difficulties in relation to paying rent(s), mortgages or other necessary household expenses?”

A measure of **pessimism** was derived from a 5-item Likert scale following the question “What do you think the future will hold for you?” where the bottom two (negative) items were coded as 1.

Questions regarding **anxiety** and **feeling low** were formulated as “During the past three months, have you experienced feeling of anxiety / feeling low?” where a positive response were coded as 1.

Methods

Descriptive data was presented as crude frequencies and as a correlation matrix of partial correlations with control for sex and age (Tables 1-3). A chi-square test (Kruskal-Wallis) for the categorical variables and a one-way ANOVA for the continuous variables was used to test if the prevalence of each characteristic presented in Tables 2-3 differed in the four exposure groups. Logistic regression was then used to explore the relative risk, presented as odds ratios (OR) for five outcomes: poor mental well-being (GHQ), shaming experiences, anxiety, having a pessimistic outlook, and feeling low, in relation to the different status positions.

Adjustment was made in two steps: for age and sex in a first step, and for age, sex, financial difficulty and longstanding illness in a second step (Table 4). Further, as we had a special focus on shaming in our study, potential effects from shaming experiences within the various status positions on GHQ were tested by coding a matrix that combined the four status categories with two frequency levels of shaming experiences (0 and 1-5). Frequencies of poor mental well-being (GHQ) within each category were calculated and all categories were then included in a logistic regression model with control for age, sex, financial difficulty and longstanding illness in two steps, with GHQ as outcome. In all regression models (Tables 4 and 5) we used positive incongruent individuals as our reference group, partly because early analyses showed that they de facto ran the lowest risk of adverse outcomes among all groups, but also because the choice of regarding positive incongruent individuals as those “best off” have found theoretical support in the literature (see Wegener’s model above). For Table 5, we used positive incongruents without shaming experiences as the reference category. For all analyses, a p-value of <0.05 was considered significant.

Table 1. Partial correlations of variables included in the regression models², with control for sex and age.

	longstanding illness	financial difficulty	anxiety	feeling low	shame	GHQ	pessimist	occupation	education
longstanding illness	1.0								
financial difficulty	.12**	1.0							
anxiety	.16**	.17**	1.0						
feeling low	.17**	.15**	.60**	1.0					
shame	.09**	.13**	.20**	.19**	1.0				
GHQ	.12**	.14**	.39**	.43**	.15**	1.0			
pessimist	.13**	.12**	.27**	.31**	.12**	.30**	1.0		
occupation	-.06**	-.08**	-.01*	-.01*	.04**	.01	-.03**	1.0	
education	-.07**	-.07**	-.02*	-.01	.07**	.02*	-.03**	.46**	1.0

*p<0.01 **p<0.001

² occupation and education was included to study their exclusive associations with the outcomes before coding the incongruent and congruent status categories.

Table 2. Descriptive data of the study population. For categorical data, frequencies are presented as crude percentages (%) within each category, followed by (n). SEM is presented for continuous data. P-values are presented per variable indicating significant differences in frequencies between the four categories.

Category	share of total population % (n)	age mean (SEM)	men / women % (n)	cohabiting with adult % (n)	foreign born % (n)	longstanding illness % (n)	financial difficulty % (n)
Positive incongruent	27 (3966)	46.6 (0.19)	60/40 (2378/1588)	85 (3270)	1.5 (56)	29 (1132)	19 (727)
Negative incongruent	2 (302)	45.5 (0.60)	46/54 (140/162)	79 (233)	2.7 (37)	33 (96)	24 (72)
High-status congruent	21 (3112)	46.3 (0.19)	41/59 (1274/1838)	81 (2479)	2.3 (70)	28 (849)	15 (460)
Low-status congruent	50 (7474)	44.2 (0.15)	44/56 (3281/4193)	78 (5763)	1.9 (141)	35 (2548)	28 (2077)
Chi-square (p-value)	p<0.001	p<0.001	p<0.001	p<0.001	p<0.001	p<0.001	p<0.001

Table 3. Descriptive data of the emotional outcomes: feeling low, anxiety, pessimistic outlook, shaming experiences and GHQ. For categorical data, frequencies are presented as crude percentages (%) within each category, followed by (n). P-values are presented per variable indicating significant differences in frequencies between the four categories.

Category	feeling low % (n)	anxiety % (n)	pessimistic outlook % (n)	shaming experiences % (n)	GHQ poor health % (n)
Positive incongruent	14 (531)	18 (687)	4.5 (180)	54 (2027)	6.5 (226)
Negative incongruent	22 (62)	26 (74)	8.0 (24)	69 (192)	10.0 (27)
High-status congruent	16 (495)	20 (607)	5.0 (156)	61 (1785)	8.0 (216)
Low-status congruent	17 (1207)	21(1548)	6.5 (474)	55 (3776)	7.0 (480)
Chi-square (p-value)	p<0.001	p<0.001	p<0.001	p<0.001	0.019

Table 4. Risk for having experienced shaming, anxiety, feeling low, pessimistic outlook or poor mental well-being in status congruent vs. status incongruent categories, expressed as odds ratios with p-values (a p-value <0.05 is considered significant) and 95% CI. Adjustments are made in two steps: for age and sex, and for financial difficulties and longstanding illness, with positive incongruence as the reference category.

Unadjusted and fully adjusted OR:s are presented in the table.

Category	feeling low		anxiety		pessimistic outlook		shaming experiences		GHQ poor health	
	unadj.	adj. ^a	unadj.	adj. ^a	unadj.	adj. ^a	unadj.	adj. ^a	unadj.	adj. ^a
Negative incongruent	1.7** (1.3-2.3)	1.6* (1.2-2.2)	1.6* (1.2-2.1)	1.5* (1.1-1.9)	1.8* (1.2-2.8)	1.7* (1.0-2.7)	1.9** (1.4-2.4)	1.8** (1.3-2.3)	1.6* (1.1-2.5)	1.5 (0.9-2.3)
High-status congruent	1.2* (1.1-1.4)	1.2* (1.0-1.3)	1.1* (1.0-1.3)	1.1 (0.9-1.2)	1.1 (0.9-1.4)	1.2 (1.0-1.6)	1.3** (1.2-1.5)	1.3** (1.2-1.4)	1.3* (1.1-1.6)	1.3* (1.0-1.5)
Low-status congruent	1.2** (1.1-1.4)	1.0 (0.9-1.1)	1.2** (1.1-1.4)	0.9 (0.8-1.1)	1.4** (1.2-1.7)	1.2* (1.0-1.5)	1.0 (0.9-1.1)	0.8** (0.8-0.9)	1.1 (0.9-1.3)	0.8* (0.7-1.0)

* p<0.05

** p<0.001

^a control for sex, age, financial difficulty and longstanding illness

Table 5. Frequencies (%) of poor health (GHQ) per status category and risk for poor health (GHQ) in status congruent vs. status incongruent categories with and without shaming experiences, expressed as odds ratios with p-values (a p-value of <0.05 is considered significant) and 95% CI. Positive incongruence without shaming experiences is the reference group.

	Frequency poor health (%) and (n) of total (N) per category	Model 1 (unadjusted)	Model 2 (adj. for sex and age)	Model 3 (adj. for sex, age, longstanding illness and financial difficulty)
(Positive incongruence no shaming experiences)	2.1 (33/1584)	1.0	1.0	1.0
Negative incongruence no shaming experiences	6.0 (5/83)	3.0* (1.1-7.9)	2.8* (1.1-7.4)	2.7* (1.0-7.3)
High-status congruence no shaming experiences	2.7 (27/999)	1.3 (0.8-2.2)	1.2 (0.7-1.9)	1.2 (0.7-2.1)
Low-status congruence no shaming experiences	2.1 (63/2950)	1.0 (0.7-1.6)	0.9 (0.6-1.4)	0.8 (0.5-1.2)
Positive incongruence with shaming experiences	10.1 (185/1837)	5.3** (3.6-7.7)	4.8** (3.3-7.0)	3.9** (2.7-5.8)
Negative incongruence with shaming experiences	11.6 (20/173)	6.1** (3.4-11.0)	5.3** (2.9-9.5)	4.2** (2.3-7.7)
High-status congruent with shaming experiences	11.3 (179/1591)	5.9** (4.1-8.7)	4.9** (3.4-7.2)	4.5** (3.1-6.7)
Low-status congruent with shaming experiences	11.2 (397/3539)	5.9** (4.1-8.5)	4.9** (3.4-7.0)	3.5** (2.4-5.0)

* p<0.05 ** p<0.001

Results

Descriptive data

Partial correlations (Table 1) showed that GHQ and shame, following from our cut-off points, were only remotely correlated. The largest correlation coefficients were found for “feeling low” and anxiety (0.60; $p < 0.001$); for GHQ and “feeling low” (0.43; $p < 0.001$), and for GHQ and anxiety (0.39; $p < 0.001$). This result was expected since the GHQ includes items screening for these emotions, however despite some overlap this shows that the measures included in the study as emotional outcomes were not exclusively correlated. Also, GHQ and pessimism were correlated (0.30; $p < 0.001$) while pessimism and “feeling low” had a coefficient of 0.31 ($p < 0.001$). The smallest coefficients, although significant, were found for occupation and education in relation to all outcomes.

As for the descriptive data of the population per status category (Table 2) differences in mean age and the proportion of men and women were small between the groups (although significant). The low-status congruent category were less likely to be cohabiting with another adult (78%) and had the largest proportion of respondents with a longstanding illness (35%) or financial difficulty (28%), however frequencies were similar to the negative incongruent category for these variables. For the emotional outcomes (Table 3) the negative incongruent category was ranked first on all outcomes, that is, the negative incongruent category showed the highest frequencies of negative emotions, whereas the positive incongruent category showed the lowest frequencies.

Logistic regression analysis

Table 4 presents the risk for having experienced negative emotions per status category, with the positive incongruent category as reference group (following from the results in Table 3). For all outcomes, changes in odds ratios after full adjustment were small (around 0.1 in general). The results show that the negative incongruent category in general had a higher risk for negative emotional experiences than the other categories, with OR:s ranging between 1.5-1.9, while low-status congruents often presented OR:s below 1.0.

Following from the results in Table 4, indicating higher OR:s for shaming for negative incongruents, but also for high-status congruents, and because a particular aim with this paper was to further explore shaming experiences in relation to social status, we also wanted to study the potential effects of shaming in relation to GHQ per status category (Table 5). The first column of Table 5 shows that the frequencies of poor health were equally high in all status categories with shaming experiences. However for the categories without shaming, the negative incongruent category had a visibly higher frequency of poor mental well-being. As for the regression analysis, for all categories where shaming was included, OR:s increased for all groups to 3.5-4.5 ($p < 0.001$) while no significant differences were found between the categories without shaming as for the risk of poor mental well-being, except for the negative incongruent category where and OR of 2.7 remained after full adjustment ($p < 0.001$).

Discussion

Our aim was to study whether there are any differences in the risk for shaming experiences, pessimism, anxiety, depressive feelings, and poor mental well-being (GHQ) in four different status categories: negatively and positively incongruent individuals, and low-status and high-status congruent individuals. A special focus was assigned shaming and its associations with the four status categories and GHQ. Our results show that the negative incongruent category had a higher frequency of negative emotional outcomes and, hence, was the group most at risk for experiencing adverse levels of all of the five outcomes (Tables 3-4).

From Table 5 we learn that shaming experiences seems to be the primary producer of poor mental well-being, more than the social status position as such, since also the positive incongruent category with shaming experiences noted an increased risk for poor mental well-being. However, as for the categories without any shaming experiences, an increased risk for poor mental well-being (OR 2.7; $p < 0.05$) remained only for one category after full adjustment, and this was the group comprising the negative incongruent respondents.

Overall, the negative incongruent category persisted as the group most at risk for all adverse outcomes in all of our analyses. Although this observation could lead to conclusions of the state of negative incongruence as something that will produce an emotional stress effect above and beyond that of the objective status measures involved (education and occupation) there are many methodological issues related to the concept and measurement of status incongruence, of which some will be addressed in the sections below (for a review, see (Zhang, 2008). The research field around status inconsistency has suffered much critique for its complexity and lack of a consistent theoretical framework (Vernon & Buffler, 1988).

While it is not our aim here to propose one specific single theory as a complete explanatory

model for the state of status incongruence, on the pages to follow we will revisit some of the most frequently referred theories, and use these as a background for the interpretation of our results.

Negative or positive incongruence – addressing the substitution effect

As for the theoretical model by Wegener presented in the introduction (Wegener, 1991), our data corresponds quite well with this as our positive incongruents (type 4 members in the model) were the ones who in general had the lowest risk for any of the adverse outcomes. Although the group of high-status congruents (type 3 members in the model) were in general at higher risk than their low-status counterparts (see Table 2) Wegener's model does not grade the presumed happiness or contentment among the high-status versus low-status congruent groups. Wegener stated that "the deepest disturbance is likely to be experienced by the person who knows that he or she has invested in vain" (Wegener, 1991) and it is plausible that this theoretical model could help explain some of the discontent expressed by the various groups in our analysis.

Further, the increased health risks for the group of negative incongruents could possibly lend some support to theories of role conflict and of not being at ease in one's assigned cultural environment (as presented in the introduction of this paper). Referring back to Bourdieu (Bourdieu, 1986) status incongruity could be described as a forced change in the individual's social space, leading to a discrepancy in the agent's habitus, or a sense that one's various forms of capital have been devalued or disarmed. Perhaps it is comparable to the situation for the worker in a monotonous job who finds himself in a daily activity that "touches no part of him that is himself" (Marmot, 2004). However, previous studies have suggested that this discomfort might be the case no matter whether the person is moving up or down the ranking

scale. Reed et al (1984) (in: (Vernon & Buffler, 1988) open up for such an interpretation, as they use a conceptual model of status incongruence as a forced move from one socio-cultural context to another, which exposes the individual to a new setting in which behaviour, values and expectations differ from those of his original culture. This will result in lack of feedback on appropriateness of behaviour and will result in a state of chronic arousal. Though this seems like a possible scenario for the negative incongruent group in our study, according to these theories positive incongruents would feel equally “misplaced”. However our results do not support this hypothesis, as is clear from the analyses in Table 3 and Table 4.

A possible explanation for this reversed pattern might be provided by theories of so-called substitution effects of certain status positions. Zhang (Zhang, 2008) concludes from a review of the status discrepancy literature that discrepancy measurement necessarily will suffer from a substitution effect, that is, when the effect of a specific position decreases as other positions increase. He exemplifies by a college professor who is rich in cultural capital (education) but moderate in economic capital (income). Still, the professor’s cultural position will probably have a stronger effect on his social well-being than will his economic position, compared to a businessman with an equally moderate income (although the two men may have similar educational levels). From this perspective, it is plausible that the higher occupational status position achieved by those with a low educational level (those categorised as positive incongruents in this study) will provide the individual with a status shield (Hochschild, 1983) that will override the effects of their low education. In the case of the negative incongruents, their primary status shield will probably be their high educational level. But since this is not valued in their current occupational setting, they will become “socially disarmed” in the absence of their “righteous” status confirmation, hence experiencing shaming to a larger extent than other groups (this process will be described in further detail in the section below).

High status equals high sensibility to shaming?

It is interesting to note that also the high-status congruent category showed an elevated risk of experiencing shaming (Tables 3-4)³. A possible explanation for this higher risk and frequency of shaming experiences among the highly educated is, returning to Bourdieu, that their achieved cultural capital (represented by education) might contribute to feelings of shame, should these persons receive inadequate confirmation of their social status from others. Scheff (Scheff, 1992) refers to Goffman's theories on the ritual definition of the self among others, and the function of embarrassment: "Goffman's interactants are exquisitely sensitive to the exact nuance of their treatment by others, undergoing agonies of embarrassment or anticipated embarrassment when they receive inadequate deference." (Scheff, 1992).

Scheff also emphasises that the social order is not static, and that status honor requires continuous affirmation. This might help explain why higher-educated persons are more easily offended: it is because they actually have something to defend, something which is of value in the eyes of others. When their social status and honor is threatened to be taken away from them, the emotional reaction will be one of shame, of not being regarded and respected in the way one thinks one deserves to be. High-status people need to be on the tip of their toes more than low-status people, simply because the former group has a lot more socially desirable assets to defend from the threats of social devaluation. Following Wilkinson (Wilkinson, 2005) who states that shaming experiences are plausibly one of the most powerful and recurrent sources of the kind of stress that influence the association between social status and health in general, and between social status and psychiatric ill-health in particular, while considering our results that the negatively incongruent group was most at risk for both shaming and poor mental well-being, the health risks for this group could not be neglected.

³ However several studies have shown that the groups most exposed to shaming, overall, are the unemployed and those on long-term sick leave. N.B. these groups were not included in our study.

Social comparison – in reference to what?

The major part of all studies on status incongruity has used education and occupation as their construct of incongruity (Vernon & Buffler, 1988). Our categorisation builds on previous studies, but the reason for choosing occupation as the “measure of deviance” in relation to education is also supported by a study by Singh-Manoux et al. (Singh-Manoux et al., 2003) who found that education was a significant contributor to a measure of subjective status, although the tested population had a mean age of 55 years and therefore had finished school some 30 years ago. “For education to have remained in the prediction equation points to the pertinent role that education plays in the way in which individuals perceive themselves.”(p. 1331). The (relative status) discrepancy between “what is” and “what ought to be” is now measured by education and occupation in our study, but if we want to use the concept of relative deprivation in social status terms, and thereby accept the assumption that people do make comparisons that will result in feelings of satisfaction or dissatisfaction, we need to address the complex question of how to create correct reference groups at large, and what other influences that may contribute to a person’s social status identity.

Taylor and Lobel (Taylor & Lobel, 1989) found in their study that cancer patients preferably compared themselves to others of worse luck, but were strengthened when encountering healthier people. They conclude that while downward comparisons could make people feel fortunate in comparison with others and hereby raise self-esteem, upward comparison may serve other more practical needs by providing role models together with hope and inspiration. These two patterns (upward contacts and downward evaluations) may exist simultaneously in the same person.

Further, we could address two common directions within social psychology when discussing group formations: social groups and social categories. A social group is a collection of people with interdependent relations among them, for instance a family, a company, or a sports club. A social category is more loosely defined. Here, it is not the physical interdependence that is defining the group, but rather the individuals' perceptions of belonging to a certain group. Examples of social categories are the unemployed, men, women, retired and teenagers. However, while an individual could be a member of a certain group, say, her company, she might very well sympathize more with her social category, say, "female American right-wing Christians". This is probably the normative group she will use when comparing herself to others. But how can we *know* what normative social groups or categories people actually hold? Richard Lau (Lau, 1989) claims that the social psychology literature contains few or no analyses of what mechanisms contribute in making people feel like members of a group. Despite a foundation of several classical works on social identity during the 50's, there is still no consistent theory stating how or on what grounds people actually make their comparisons.

Gender differences

Research shows that traditional class measures do not produce similar gradients in health for women as for men, and that women's mortality risk instead is more strongly related to the prestige level of the most advantaged member of the household (Bartley, 2004). However, while this may be valid for the U.K. which only has 50 % of women working outside of the home, just as many Swedish women as Swedish men are currently included in the Swedish workforce – around 77 % of both sexes (StatisticsSweden, 2008) and it is not uncommon that the "most advantaged member of the household" today is a woman. There has also been discussions on women suffering from lower mental well-being because of the double burden of household work/children and a professional career, and there is literature

suggesting men to be more dependent on traditional status indicators (such as occupation) for their social status identity (Marmot, 2004). However, recent studies have shown that levels of psychosocial resources and mental well-being differ only slightly between the sexes according to occupational level in Sweden (Lundberg, 2008). When we stratified all analyses in the present study by sex, all outcomes followed a similar pattern, except for negative incongruent men who had a higher risk for pessimism and high GHQ scores than negative incongruent women. But overall, patterns remained the same for both sexes as they did in the non-stratified analysis.

Methods and measurement issues

A major critique delivered by some authors is that models proposing independent effects of status incongruity seem to think of these as above and beyond the effects of the component status positions, and that simply creating a group representing status inconsistency and comparing this group to a consistent group will blur the individual distinctions: “The fundamental problem in the analysis of the effects of mobility or status inconsistency on individual behaviour revolves around the issue of distinguishing between the effects of inconsistencies between two or more social positions and the effects of the social positions themselves.” (Horan & Gray, 1974) We have adjusted for financial difficulty to ensure that the effects of incongruence and congruence are not due to financial aspects of the position at hand, and while it is beyond the scope of this paper to try to contribute to the debate on how to best measure status incongruence, it has been our intention to construct as well-defined categories as possible, excluding secondary level education, the self-employed and farmers from the coding procedure due to difficulties in determining the appropriate occupational and educational parallels for these categories. Although this strict coding resulted in a rather small

group of negative incongruents, a broader definition would probably have lead us too far away from the theoretically supported constructs of incongruence.

We also count as a strength that our study is based on a healthy normal population with an even representation of age groups, sex and socioeconomic status, while including opportunities to control for longstanding illness and other factors that might influence the association between social status and the outcomes in our study. We are aware that our control variable reflecting a person's economic situation ("financial difficulty") is a rather narrow measure, targeting only those who experience actual financial crises and problems with paying for their basic household expenses each month. We chose this measure, primarily because we did not have access to income data for this population, but secondly because we believe that a more loosely defined self-assessed measure that would aim more at capturing feelings of dissatisfaction (with consumer options or consumption power, for instance) would probably blur the actual financial problems which are potentially inherent in a low-status position of any kind.

There has also been some discussion on appropriate cut-off points for the various constructs of the GHQ (Goldberg et al., 1997; Goldberg et al., 1998; Willmott et al., 2004). A general recommendation is to have the mean GHQ score for the whole population to provide a rough guide for the best threshold (of course the cut-off will differ whether it is a healthy population or a patient population under study). However, as is the case of many instruments designed to screen for depressive symptoms, our data were disproportionally distributed with a second score peak around 19, although the GHQ mean was 9.8 (SEM 0.03) for the total population. Hence, a cut-off point was set at 19, where 19-36 points indicated poor mental well-being. Though this might be seen as a rather "extreme" cut-off compared to previous studies,

we think this will provide us with a sharper measure of poor mental well-being which will ascertain that we include only those who really are at high risk. In light of this, our results for GHQ could probably be seen as underestimated, if anything.

Further, the cross-sectional nature of our data is of course a methodological issue in itself, as we can only check for prevalences at a specific point in time without any options of establishing causality between variables. The most recent longitudinal study carried out in the field was made by Faresjo et al. (1997) who found an increased risk of all-cause mortality for the negative incongruent category in their study, hereby indicating the need for further prospective studies in this area. We would also like to encourage future studies on social status using qualitative methods in combination with quantitative risk analyses of the present kind.

Conclusion

Of the four social status constellations studied here, being negatively status incongruent is associated with an increased risk of experiencing shaming, feeling low and anxious, having a pessimistic outlook and poor mental well-being, while belonging to the positively incongruent category means being at the lowest risk for these adverse emotional and health outcomes. Following from our results, the measure of shaming introduces a previously unappreciated but highly pervasive social-evaluative aspect of status incongruence that we hope will add to future studies within this field. While our results could be seen as being much in line with classic sociological theories on role conflict and emotional discomfort caused by status discrepancy, the patterns of status incongruence and congruence remain widely complex.

References

- Bartley, M.** (2004), *Health inequality - an introduction to theories, concepts and methods*, Cambridge, Polity Press.
- Bergmark, Å. and Fritzell, J.** (eds.) (2007), [*Välfärdens ansikte mot 2000-talet*], Socialvetenskaplig tidskrift.
- Blalock, H.M.** (1966), 'The identification problem and theory building: the case of status inconsistency', *American Sociological Review*, 31, 1, 52-61.
- Bourdieu, P.** (1986), 'The forms of capital', in Richardson, J.G. (ed.), *Handbook of Theory and Research for the Sociology of Education*, New York, Westport CT, London, Greenwood Press.
- Brown, G.W., Harris, T.O. and Hepworth, C.** (1995), 'Loss, humiliation and entrapment among women developing depression: a patient and non-patient comparison', *Psychol Med*, 25, 1, 7-21.
- Charlesworth, S.J., Gilfillan, P. and Wilkinson, R.** (2004), 'Living inferiority', *Br Med Bull*, 69, 49-60.
- Dickerson, S.S., Gruenewald, T.L. and Kemeny, M.E.** (2004a), 'When the social self is threatened: shame, physiology, and health', *J Pers*, 72, 6, 1191-216.
- Dickerson, S.S. and Kemeny, M.E.** (2004), 'Acute stressors and cortisol responses: a theoretical integration and synthesis of laboratory research', *Psychol Bull*, 130, 3, 355-91.
- Dickerson, S.S., Kemeny, M.E., Aziz, N., Kim, K.H. and Fahey, J.L.** (2004b), 'Immunological effects of induced shame and guilt', *Psychosom Med*, 66, 1, 124-31.
- Eales, M.J.** (1989), 'Shame among unemployed men', *Soc Sci Med*, 28, 8, 783-9.
- Faresjo, T., Svardsudd, K. and Tibblin, G.** (1997), 'The concept of status incongruence revisited: a 22-year follow-up of mortality for middle-aged men', *Scand J Soc Med*, 25, 1, 28-32.
- Goldberg, D.P., Gater, R., Sartorius, N., Ustun, T.B., Piccinelli, M., Gureje, O. and Rutter, C.** (1997), 'The validity of two versions of the GHQ in the WHO study of mental illness in general health care', *Psychological Medicine*, 27, 191-197.
- Goldberg, D.P., Oldehinkel, T. and Ormel, J.** (1998), 'Why GHQ threshold varies from one place to another', *Psychol Med*, 28, 4, 915-21.
- Hochschild, A.** (1983), *The Managed Heart: The Commercialization of Human Feeling*, Berkeley: The University of California Press. .
- Horan, P.M. and Gray, B.H.** (1974), 'Status inconsistency, mobility and coronary heart disease', *J Health Soc Behav*, 15, 4, 300-10.
- Horan, P.M. and Gray, B.H.** (1976), 'Status inconsistency, mobility and CHD re-visited', *J Health Soc Behav*, 17, 4, 404-5.
- House, J.S. and Harkins, E.B.** (1975), 'Why and when is status inconsistency stressful?' *The American Journal of Sociology*, 81, 2, 395-412.
- Hyman, M.D.** (1966), 'Determining the effects of status inconsistency', *The Public Opinion Quarterly*, 30, 1, 120-129.
- Jackson, E.F.** (1962), 'Status consistency and symptoms of stress', *American Sociological Review*, 27, 4, 469-480.
- Lau, R.** (1989), 'Individual and Contextual Influences on Group Identification', *Social Psychology Quarterly*, 52, 3, 220-231.
- Lundberg, J.** (2008), 'Social status - a state of mind? Objective and subjective measures of social status and associations with psychosocial factors and emotions', *Department of Health and Medical Sciences, Division of Community Medicine*, Linköping, Linköping University - forthcoming.

- Macleod, J., Davey Smith, G., Metcalfe, C. and Hart, C.** (2005), 'Is subjective social status a more important determinant of health than objective social status? Evidence from a prospective observational study of Scottish men', *Soc Sci Med*, 61, 9, 1916-29.
- Marmot, M.** (2004), *The status syndrome - how social standing affects our health and longevity*, New York, Henry Holt and Company, LLC.
- Meile, R.L. and Haese, P.N.** (1969), 'Social status, status incongruence and symptoms of stress', *J Health Soc Behav*, 10, 3, 237-44.
- Molarius, A.** (2000), '[Folkhälsan i Värmland 2000 – resultat från enkätstudien Liv & Hälsa]', Department of Social Sciences - Public Health Sciences, Karlstad University.
- Neckel, S.** (1991), *Status und Scham: Zur symbolischen Reproduktion sozialer Ungleichheit*, Frankfurt, Campus.
- Scheff, T.J.** (1990), *Microsociology: discourse, emotion, and social structure*, Chicago, The University of Chicago Press.
- Scheff, T.J.** (1992), 'Emotion and illness: anger, bypassed shame and heart disease', *Perspectives on Social Problems*, 3, 117-134.
- Singh-Manoux, A., Adler, N.E. and Marmot, M.G.** (2003), 'Subjective social status: its determinants and its association with measures of ill-health in the Whitehall II study', *Soc Sci Med*, 56, 6, 1321-33.
- Starrin, B., Jönsson, L. R.** (2006), 'The finances - shame model and the relation between unemployment and health', in Kieselbach, T., Winefield, A.H., Boyd, C., Anderson, A. (ed.), *Unemployment and health*, Brisbane, Australian Academic Press.
- Starrin, B., Kalander-Blomkvist, M. and Janson, S.** (2003), 'Socialbidragstagande och statusbunden skamkänsla - en prövning av ekonomi-sociala bandmodellen', *Socialvetenskaplig tidskrift*, 10, 1, 24-47.
- Starrin, B., Åslund, C. and Nilsson, K.W.** (2008), 'Financial Stress, Shaming Experiences and Psychosocial Ill-Health: Studies into the Finances-Shame Model', *Social Indicators Research*, in press.
- StatisticsSweden** (2008), 'www.scb.se', Statistics Sweden.
- Syme, L.S., Hyman, M.M. and Enterline, P.E.** (1965), 'Cultural mobility and the occurrence of coronary heart disease', *Journal of Health and Human Behavior*, 6, 4, 178-189.
- Taylor, S.E. and Lobel, M.** (1989), 'Social comparison activity under threat: downward evaluation and upward contacts', *Psychol Rev*, 96, 4, 569-75.
- Wegener, B.** (1991), 'Relative deprivation and social mobility: structural constraints on distributive justice judgments', *European Sociological Review*, 7, 1, 3-18.
- Vernon, S.W. and Buffler, P.A.** (1988), 'The status of status inconsistency', *Epidemiol Rev*, 10, 65-86.
- Wilkinson, R.** (2005), *The impact of inequality - how to make sick societies healthier*, New York, The New Press.
- Willmott, S.A., Boardman, J.A.P., Henshaw, C.A. and Jones, P.W.** (2004), 'Understanding General Health Questionnaire (GHQ-28) score and its threshold', *Soc Psychiatry Psychiatr Epidemiol*, 39, 613-617.
- Zhang, X.** (2008), 'Status Inconsistency Revisited: An Improved Statistical Model', *European Sociological Review*, 24, 2, 155-168.