EDITORIAL

Seeing social position: visualizing class in life and death

Mary Shaw,1 Helena Tunstall2 and George Davey Smith1

There is a ‘magician’ Derren Brown who has recently been featuring on British television (www.derrnbrown.co.uk). One of his tricks is to stop a passer-by in the street and then, by using his apparently ‘psychic powers’, to guess their occupation. This produces an amusingly amazed reaction from the member of the public, but what Brown does is really a more extreme version of what we do many times a day—gauging social position from visual cues. When we look at an individual we quickly process visual information that denotes where they fit in the social world, and we do this predominantly without conscious thought.

Visual indicators of class and wealth have played an important part in the historical development of the understanding of the relationship between class and health. Accounts of poverty and ill health in the 19th century frequently included descriptions of the physical effects of poverty upon the body. Death rates in British cities increased during the first half of the 19th century1 and to contemporary commentators it was clear that the burden of ill health was concentrated on the poorest urban residents and that this was evidenced by their abject physical condition.2–4 In Frederick Engels’ The Condition of the Working Class in England in 1844 a Dr Hawkins is quoted as saying that visitors to Manchester were struck by ‘the lowness of stature, the leanness and the paleness which presents itself so commonly to the eye’ and in London Engels had seen ‘pale, lank, narrow chested, hollow eyed ghosts’ with ‘languid, flabby faces, incapable of the slightest energetic expression’.2

The physical effects of the living conditions of the poor had their effects from early life: contemporary commentators pointed out that; the female factory operatives worked when pregnant until the hour of delivery (because otherwise they lost their wages) and their offspring were feeble. The appearance of these children showed their circumstances and neglect, which left them, like obesity—we continue to ‘see’ class. A second possible explanation is that approaches to social class differences in health which emphasize the physical characteristics of the poor have become associated with hereditarian thinking and with eugenics. An example of this type of hereditarian research is the work by Lee Ellis which postulates a fundamental genetic determination of socioeconomic differences in height, birthweight, and brain size, in addition to intelligence, parental investment, work motivation, drug use, altruism, and thus health.13 Thirdly, a major concern of recent work on health inequalities has been the assertion that socioeconomic differentials in major causes of death, such as coronary heart disease, are not simplistically explicable in terms of differences in behavioural patterns, such as smoking, drinking, and exercise.14 Emphasis upon visual manifestations of class differences may appear to support arguments which focus upon cultural differences in class-related behaviour, class ‘lifestyles’, and the moral criticism of the disadvantaged.

1 Department of Social Medicine, University of Bristol, Canynge Hall, Whiteladies Road, Bristol BS8 2PR, UK.
2 School of Geographical Sciences, University of Bristol, Bristol, UK.

During the economic depression of the 1930s there was a resurgence of popular and academic interest in the effects of poverty on health. Again a particular focus was on the physical condition of the poor. In their well-known book Poverty and Public Health M’Gonigle and Kirby detailed shorter stature, lower weight, greater dental decay, greater prevalence of rickets and other bone diseases, worse posture, and greater prevalence of squint among the inadequately nourished children from poor households.7,8 The social medicine movement of the period was concerned with social physiology; as John Ryle stated: The comparison of social class with social class in respect of height, weight, the routine clinical examination of systems, radiographic appearances, the common disabilities, and of mental and physical function tests ... should have much to teach us.9

It is clear therefore that discussions of poverty and health over the 19th century and the first half of the 20th century were much concerned with the effects of social disadvantage on the physique and constitution of the poor. However, the explosion of research into inequalities which followed the 1980 publication of the Black Report has largely been disinterested in the procession of squint among the inadequately nourished children from poor households.7,8 The social medicine movement of the period was concerned with social physiology; as John Ryle stated: The comparison of social class with social class in respect of height, weight, the routine clinical examination of systems, radiographic appearances, the common disabilities, and of mental and physical function tests ... should have much to teach us.9

Why has the recent inequalities in health literature paid so little attention to the visual evidence of the relationship between social position and health?

One possible explanation is that as material conditions of living have improved in an absolute sense the direct effects of living conditions upon the body have become less clearly apparent. However, as some class-associated forms of ill health have disappeared, for example rickets, others have replaced them, like obesity—we continue to ‘see’ class. A second possible explanation is that approaches to social class differences in health which emphasize the physical characteristics of the poor have become associated with hereditarian thinking and with eugenics. An example of this type of hereditarian research is the work by Lee Ellis which postulates a fundamental genetic determination of socioeconomic differences in height, birthweight, and brain size, in addition to intelligence, parental investment, work motivation, drug use, altruism, and thus health.13

10,12 The resultant poor constitution increased susceptibility to disease and death. While there were some improvements in social conditions and standards of living from the mid 19th century onwards,6 during the economic depression of the 1930s there was a resurgence of popular and academic interest in the effects of poverty on health. Again a particular focus was on the physical condition of the poor. In their well-known book Poverty and Public Health M’Gonigle and Kirby detailed shorter stature, lower weight, greater dental decay, greater prevalence of rickets and other bone diseases, worse posture, and greater prevalence of squint among the inadequately nourished children from poor households.7,8 The social medicine movement of the period was concerned with social physiology; as John Ryle stated: The comparison of social class with social class in respect of height, weight, the routine clinical examination of systems, radiographic appearances, the common disabilities, and of mental and physical function tests ... should have much to teach us.9
The decline of interest in the visual manifestations of class differences in epidemiological investigations of socioeconomic variations in health coincided with an increasing interest in these visual signifiers in academic sociology and cultural studies. Much of this work has concentrated on the aesthetics of consumption. During the 1980s the classic work of the French social theorist Pierre Bourdieu described how the system of social class is manifested through consumption, aesthetics, and education, via a system of ‘distinction’. Bourdieu argued that this struggle for social distinction was a fundamental element of all social life.

While the meaning attributed to visual signs of social distinction vary across time and place, in any setting there is symbolic meaning attached to visual codes, and these convey information about status and socioeconomic position. The visual codes of clothing and fashion mirror the social structure, allowing us to send messages to others as to how we expect to be received and providing useful clues as to where to place people in the social hierarchy. The Aztec civilization used headdresses made from the feathers of eagles to denote the status of brave and esteemed warriors. In contrast, in Britain in the 19th and early 20th centuries hats were an indispensable part of any man’s wardrobe, but the type of hat—be it top hot, bowler, or peaked cap—indicated his position in the social structure of industrial society; hats were used to claim and maintain traditional social class boundaries. If examined, these markers of social position would have been strongly associated with health outcomes, as GB Shaw eloquently remarked:

‘... it is easy to prove that the wearing of tall hats and the carrying of umbrellas enlarges the chest, prolongs life, and confers comparative immunity from disease; for the statistics show that the classes which use these articles are bigger, healthier, and live longer than the class which never dreams of possessing such things.’

Instead, hats and other symbols of social status were indicators of the material factors which really did have an influence on health outcomes—working and living conditions. As material living standards have risen in all socioeconomic groups (albeit more in some than in others) markers of social class may appear far less obvious and more complex. It has been argued since the 1930s that the visible signs of class in British society have lessened, but with hindsight these markers remained clearly apparent and they continue today. The visual markers of class have not declined, rather, it is more the case that we have different, proliferated, and more rapidly changing markers of social position (such as the precise make and style of trainers deemed desirable by one cultural group or the shade and fabric of a pashmina for others). It is still the case that subtle signs of appearance are read as markers of social position.

Physical characteristics, such as obesity, are also current ‘aesthetic’ markers of social class. In western contexts obesity now indicates low social status and is commonly seen as a sign of self-indulgence, lack of control, and lack of concern for health. Children as young as three have been found to have negative attitudes towards overweight people. There is even evidence that the stigma of fat is so insidious that it also transfers to those associated, even by mere observed proximity, to overweight people. The medical profession have also been found to share with the wider public an ‘anti-fat’ bias, as demonstrated by negative moral stereotypes, even among those who specialize in treating obesity. In other contexts, however, and others times, excessive body fat has denoted high social status and beauty. The aesthetic of the muscular body, on the other hand, has recently shifted in most post-industrial nations as manual labour and the association of muscularity with low social status has declined; even the physique of male action toys has become more muscular in the last 30 years.

Height too continues as a physical marker associated with social position and social mobility, with taller height being associated with higher social position, and the upwardly mobile being on average taller than their less socially successful counterparts. Epidemiologically, the extent to which adult height results from social position and better conditions in early life as opposed to height contributing to a more advantaged adulthood
social position (through social mobility) is debated. However, there is certainly evidence that height continues to affect the way we respond to people; one psychological study has found that tall people are perceived as of higher professional status, tall men are seen as more socially attractive, and tall women as more physically attractive than their shorter counterparts.27

Health-related behaviours are part and parcel of the system of codes used to indicate social distinctions.28 Many foods hold connotations of class; peasant stew has been superseded by certain types of fast food as an indicator of low social status in developed countries.29,30 Smoking too has become a marker of low socioeconomic position in many of these countries, and in some cases a badge of honour of working class identity in contexts where there is a palpable normative pressure to smoke.31 Discussion of the relationship between visual signifiers of class and healthy and unhealthy ‘lifestyles’ may be uncomfortable for those researchers who have focused on repudiating behavioural explanations of socioeconomic inequalities in health. There has, however, been some recent interest in researching the relationship between health and visual signifiers of socioeconomic position found in housing and living environments.

One such visual indicator that has recently entered health-related research is the ‘broken windows index’, which has been used as an alternative or supplementary measure of socioeconomic circumstances within residential areas or localities. The ‘broken windows’ theory, originated by Wilson and Kelling,32,33 suggests that if the first broken window of a building is not repaired then people will presume that no-one cares about the building and more windows will be broken. The sense of decay in the neighbourhood will increase and social disorder will flourish. A number of studies have taken up this idea in an epidemiological setting. For example, Galobardes and Morabia have developed an indicator of the ‘social standing of the habitat’ which assesses descriptors of the wider neighbourhood as well as immediate streets and surroundings, and the external and internal aspects of a building.34 In this project digital photography was used and buildings were classified as of high, medium, or low social standing. Intriguingly, the authors found an association with hypertension, and that this highly visual measure appeared to capture aspects of the socioeconomic environment that were not revealed by the education or occupation of the residents alone. Our visual culture thus not only relates to how we see and classify individuals, but how we interpret the appearance, and standing, of places as well.

Bringing together people and places, in death too visual cues can communicate information about social position. An example of this is the positive correlation between height of commemorative obelisks and the social standing of the deceased (and their length of life), as exemplified in Glasgow graveyards of the 19th century.35

Moreover, these more affluent people also chose to (and could afford to) continue to visually convey their social status in death through taller memorials—every metre in height of the obelisk translated to 1.42 years later age at death for men and 2.19 years for women.35

Life and death are still marked by visual cues of social position. Social position, social processes, and inequalities become embodied and our life chances continue to be related to our accumulated social (dis)advantage. We do not need to be magicians to see it, but epidemiologists do need to hone their perception to the continued pervasiveness of socioeconomic position on health. Many of the papers in this volume of the IJE contribute to that understanding.36–47

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References