

Social positions and young people's health: A Bourdieu'ian critique of dominant conceptualisations of social capital

Kristian Larsen & Virginia Morrow

Abstract: The concept of social capital is used in many sociological studies in general, and has recently been applied in studies about children and health, and often with reference to Coleman and Putnam. Bourdieu's concept of social capital is also utilized, and is frequently seen as closely related to Coleman and Putnam. In this theoretical article, we will unpack Bourdieu's use of social capital, and will suggest that his general sociology has different questions, concepts and perspectives to the questions addressed in the work of Coleman and Putnam. Social capital in the work of Bourdieu needs to be related to his overall reflections on reproduction in society, his construction of the 'scientific object' and his concepts of capital in general. Based on epistemological reflections, we suggest, following Bourdieu, sociology needs to be based on theoretical and not everyday constructions, and as such needs to elaborate political constructions of the object. Our starting point for this paper arises from our experiences of empirical social research with young people in Denmark and England that attempted to explore 'social capital' in relation to health.

Key words: Bourdieu, Children, Coleman, Health, Putnam, Social capital, Social inequality

Introduction

Social inequality in children's state of health has been documented in a number of Western studies, even during the 1980s and 1990s when prosperity has increased (Lundberg et al, 2001; Marmot & Wilkinson, 1999/2003; Swann and Morgan, 2002; Machenbach et al., 1997; Marmot & Smith, 1996; Illsley et al., 1990; Townsend et al., 1988). In many countries, considerable social inequality in health has been shown, for instance, by using indicators such as birth weight and infant mortality (Bremberg, 1998); and health problems that seem to disappear around school age reappear later in life (Lynch, 2000; West, 1997; Lynch & Kaplan, 1997). Studies that measure health by other indicators (such as self-rated health and the occurrence of

physical and psychosocial symptoms) also show considerable inequalities in health amongst adults (Lynch et al., 1997).

Besides uncertainty about the scope of health inequality, it is also unclear what exactly social inequality is, the extent to which it has specific forms in differing parts of the world, countries or regions, and how it has developed over the last two to three decades. This can be linked to differences in, and confusion about, definitions, and the isolation of mechanisms behind social inequality (Macinko & Starfield, 2001; Portes, 1998; Schambler & Higgs, 1999). A number of studies define inequality on the basis of family socioeconomic background and social status, whereas only a few studies attempt to shed light upon mechanisms and processes that create and reproduce social inequality. In public health research, studies that link social relations (often seen as social inequality) and the health of children (often on a range of indicators of health behaviours) tend to dominate, but few studies include theoretical explanations that make connections between the two. In other words, few studies question the mediating link(s) between statistical objective 'facts' of unequal health distribution, nor explore what causes children from subordinated social groups to have poorer health, poorer self-experienced health, and riskier health-related behaviour, than children from higher social groups. What is distributed from one generation to the next, and how, also remains under-researched. How do high/low positioned agents transfer their high/low position and related health privileges (or lack of privileges) to their children? The aim of this paper is to discuss some dominant theoretical traditions.

In the research literature there are differing types of studies and explanations. The first type of explanation that is offered focuses on the individual and cognitive level in terms of (choice of) lifestyles. This position tends to be presented by epidemiologists who have either no, or insufficient explanation of, the relationship between behaviour and social position (Bertsson et al., 2001; Case et al., 2002; Fergusson et al., 1990; Gilmann et al., 2003; Hemmingsson et al., 1999). Epidemiology is the dominant discipline in this research area, and by using hypothesis and relating variables and statistical calculations, the "modern" or "post-modern" reader unconsciously 'reads in' a "rational choice" theory of practice. As an example, the "lifestyle hypothesis" assumes that people with poor education or low social position are at higher risk of conducting risky behaviour, because of their 'choice of' life style. Their health is damaged because of smoking, unhealthy eating habits, and inactivity in their spare time. Furthermore, they are less focused on protecting themselves against injuries, for example, by using bicycle helmets or safety harnesses. The choice that manifests itself in healthy or unhealthy lifestyle seems to apply to parents as well as their children.

The second type of explanation focuses on the relations between biology and genes (Martin, 1999) and biological programming (Kuh et al., 2003; Barker, 1997; Marmot & Wilkinson, 1999). This position is slowly taking hold in the research area. It focuses on how the social body and mind are shaped and formed by social and

environmental conditions, including housing conditions (Saegert & Evans, 2003). This could also include explanations for health. The differing distributions of health possibilities correspond to differing social positions. Poor health produces lower social positioning, that is to say that persons with poor health end up in the lowest social stratum. There are many dialectical variations of this hypothesis. Marmot et al. (1999) suggest that some individuals from lower social classes develop vulnerability during the embryonic stage – a vulnerability that increases the risk of attaining a number of illnesses during one's lifetime.

The third type of explanation focuses on social structure, or on the political level (the macro-level). A sociological perspective views societal structures and policies as the underlying reason for inequalities, that directly influence people's physical space, actions, choices and habits related to health behaviour (Marmot & Wilkinson, 1999; Lindblad & Lyttkens, 2002, 2003). Having privileged social conditions provides for better access to healthy conditions of life compared to living under socially strained conditions, such as impoverishment. This may explain why people in higher social positions appear to be likely to be more capable of healthier practice than people who experience stressful conditions regarding housing, economy and education. It is, of course, easier to make healthy choices if economic possibilities are available, combined with experiences from family practices and later experiences about what constitutes a 'health-promoting lifestyle'.

The fourth type of explanation involves the concept of social capital as a "new" factor that may play a role in relation to people's health (Field, 2003; Blaxter & Poland, 2002; Baron et al., 2000; Wilkinson, 1999a; Wilkinson 1999b; Putnam, 1993; Portes, 1998; in relation to children's health and well-being, see Ferguson, 2006 and Waterston et al., 2004). This concept is discussed from differing approaches and is linked to new understandings of the relationship between health and inequality. Studies exploring social capital have increased exponentially, and social capital has to some extent taken over the position of the former concept of socioeconomic background (economic capital) as the most predominant paradigm in this area of research. The concept of social capital is also an object of scientific discussion, and the relation between social capital and health seems to be at a crossroad (Vimpani, 2000; Keating, 2000; Lynch & Kaplan; 1997; Marmot & Wilkinson, 1999). In this paper, we will discuss whether this has brought forward a more precise concept as a tool for empirical research.

The lack of conceptual coherence generates considerable problems, not only within health research. Political inventions and strategies for health promotion that attempt to reduce health inequalities amongst children still lack good sociological studies to be based on (Hawe & Shiell, 2000; Gepken & Gunnin-Schepers, 1996; Gillis, 1998).

In summary, firstly, a large corpus of knowledge documents the existence of social inequality in children's health. Secondly, the relations between social inequality and children's health remain unclear. Thirdly, it is necessary to apply new

concepts, and one of these is social capital in relation to health. Fourthly, the concept of social capital is too unclear to be used convincingly and unambiguously in such a way to create coherent findings. Furthermore, a review of the theoretical positions within the field shows that these fall into two positions: an economically-based approach that is based on a rational choice thinking (evident in the work of Coleman and Putnam) and a more sociological approach that views human behaviour from a theoretical perspective that emphasizes power relations, emphasizing behaviour as governed by other factors than rational choices (based on the work of Bourdieu). The two positions will be presented and discussed in order to develop a more rigid and stringent theoretical framework for future empirical studies in relation to children and young people.

Our interest in this has been to ground theorizing in empirical studies. KL has contributed to a development of a theoretical framework for studying social position and health among young people in Denmark. 16 young people aged 15-17 years have been interviewed at two Danish Secondary School using semi-structured interviews (Jensen et al., 2007). Even in a welfare country like Denmark, young people are very differently positioned and they can draw upon differing amounts of, and distributions of, capital. The study found that when young people are highly positioned in social space, based on economic and cultural capital, they also draw upon highly positioned agents (dentists/medical doctors) in the social and health care system (social capital related to health), whereas those who are lower positioned draw on low positioned agents (nurse assistants and auxiliaries). High amounts of social capital provide assistance of high level (access to specialists/hospital, translation of journals/prescriptions), whereas low amount of this capital only provides for low level help, such as lay advice in relation to health. Further, social capital can to some degree supplement or compensate for poor economic and cultural capital among young people. So for example, when a father of a poor family invests his social capital and activates friends or connections to help his son to obtain an apprenticeship (cultural capital), this cultural capital can later be converted to a job and income (economic capital) (Jensen et al., 2007).

Virginia Morrow undertook research that explored the relevance and meaning of the concept of social capital for children's well-being in empirical research with approximately 100 English children aged 12-16, conducted in the late 1990s. She used qualitative methods to elicit 12-15 year olds' subjective experiences of their neighbourhoods, their quality of life, the nature of their social networks, and their participation in their communities. The research was carried out in two schools in relatively deprived wards in a town in SE England. She found that while 'social capital' may be a useful tool with which to explore social context and social processes, it has serious limitations because it is often assumed to be a community-level (as in geographically define community) attribute that can be measured empirically. She argued that this is in marked contrast to ideas about social capital found in Bourdieu's work (Morrow, 1999a, 1999b, 2001 and 2002).

The remainder of this article focuses on the theories of Coleman/Putnam and of Bourdieu, with a focus on social capital, health and children. These theoretical reflections are epistemological, inspired by the work of Pierre Bourdieu, and involve a presentation of his concepts of social field, positions, capital (including social capital), theory of practice and habitus. This conceptual framework will be used to critique of parts of Coleman and Putnam's work. This will be unfolded on the following levels:

- The social, political and research conditions that utilise social capital
- The genesis of the concept of social capital
- Contemporary use of social capital (Coleman, Putnam and Bourdieu will briefly be presented, including similarities and differences between the positions)
- A Bourdieu'ian inspired discussion of Coleman and Putnam's concept of social capital with special attention to:
 - Unnoticed processes of reproduction in culture and society
 - The differing construction of the object
 - Capital in relation to health

We will conclude with a discussion and explore briefly some research implications of the sociology of Bourdieu.

Theory, methods and materials. Epistemology

From an epistemological perspective this paper is not produced outside but inside the research field. And as there is no privileged position for the production of knowledge, the researchers, as part of being positioned in the field of research, have certain and specific social dispositions including preferences, abilities and blindness for describing and explaining social relations and health. This ambition to reflect on the conditions of production of knowledge is important. As Bourdieu and Waquant (1992: 236) put it: 'A scientific practice that fails to question itself, does not, properly speaking, know what it does'. We have found the meta-theoretical, theoretical and empirical work of Bourdieu attractive as a tool for developing research in this field of health research.

From a meta-perspective, the research domain is seen as a social field (Bourdieu, 1984) of research including positions (institutions and agents) that are competing to define health, including the way to study health. In the social field of health there is a *doxa*, which is the 'taken for granted', natural and un-discussed assumptions of the field (Bourdieu, 1977a). In the field of health research, there is a *basic* assumption that research is for health for everybody. The positions in the field of research have differing and opposite backgrounds and interests and they are related to each other (a relational perspective) and cannot be understood as islands (substance). The position of Kristian Larsen's research is situated in a mainly state financed Danish University

of Education in Copenhagen. Virginia Morrow's research was also funded by a government body, the then health promotion arm of the English government Department of Health (since disbanded, became Health Development Agency, then NICE, National Institute for Clinical Excellence). The position could be seen as state-oriented or dominated to the extent that it takes as given a rather strong welfare state (in the case of Denmark), including a large degree of its concepts and classifications (for example, definitions of health/illness). An objectification of our positions in the relational field would rather argue that as we are not positioned in the National Board of Health or in a Medical research institution, we have to distance ourselves from those positions and their related paradigms, by "choosing" to address theoretical issues.

The social, political and research conditions that receive social capital

As noted, it is clear that the concept of social capital has grown exponentially (Forsman, 2003). Social capital is related to other disciplines like social theory, economic science, schooling/education, communities and health. Further, social capital has reached the two-sided and conflicting status of being put on the website of the World Bank (www.worldbank.org) and the United Nations (www.un.org). A quick search confirms the growth by listing millions of links related to social capital. There has, so to speak, been a shift in social research from "can you afford it" to "have you got friends". The change, from "economics" and structures, to "social" and individuals in research question is happening at the same time as western countries have been said to develop from industrial societies to 'knowledge societies' (Bindé 2005). This increase in studies using social capital could serve as a documentation of radical and fundamental changes in Western societies, suggested by studies inspired by social philosophers like Giddens (1991, 1992), Beck (1996) and Ziehe & Stubenrauch (1982). From their work with on "modernity" and the "risk society", they construct individuals as free-floating entrepreneurs, with the self as a reflexive project. Economic structures and social classes are no longer active and present as either determining or supporting the project of shaping the (in this case) healthy lifestyle. Also in general, we have seen, in the last decade, the dominant and general policy change to a focus on the individual (lifestyle) and a disappearance of focus on societal structures. Polemically speaking, environmental factors have now turned to (unquestionably important) concerns oriented towards pollution and climate change.

In contrast to the philosophy of Giddens and Beck, the growth of social capital will be explained as a response to two dynamics. First the economic and capitalist based market is getting stronger and the (welfare) state is getting weaker, and this provides for and supports a structural need for focusing on social aspects in order to 'avoid looking' at the concrete material and economic resources that function as basis for everyday life of people, and most importantly, how these resources are unequally distributed in society. In other words, the accentuation of social capital, not only in policy, but also in social science (and the repression or, rather, *mis-recogni-*

tion of other capitals and social positioning) serves, from a sociological perspective, social functions. This is not a Durkheim'ian (1956, 1995) functionalist statement, but a sociological analysis that reveals how the field of social research is dominated by the field of economic power and the field of policy. At the very least, it shows the limited autonomy of the research field.

The genesis of the concept of social capital

The interest in the phenomenon that later included social capital can be traced back to assumptions made by Marx, Durkheim and Weber who all, from differing philosophical and political standpoints, studied the "glue" that keeps society together. The concept of social capital was first used by L. J. Hanifan (Hanifan, 1916, 1920) who was concerned with the cultivation of good will, fellowship and social intercourse among those that make up a social unit. Later the concept was used by Jacobs (1961) in relation to urban life and neighbourliness. According to Putnam (2000) the concept of social capital was re-invented six times during the course of the twentieth century.

The current studies of social capital are primarily inspired by Coleman and Putnam, described briefly below, and have focused on social capital as a resource, or a privilege that some have and others don't have, or possess in less quantity. In other words, the concept is constructed on a quantitative basis and the resources are unequally distributed among individuals and social groups, and this gives fundamentally differing possibilities and limits for living in a society. In this paper, we are interested in children's health.

In summary, social capital has been used in research to minimize at least five limitations within conventional research on health. Firstly, that the individual is seen as an island, and is the sole object of research. Secondly, the capacity for good health/resistance to illness draws only on economic position and individual ability; thirdly, the practice is generated and learned by cognitive and reflexive processes, fourthly, health behaviour is an object of research in itself, and fifthly, quantitative paradigms and methods are fundamental principles for the study of this topic.

Contemporary use of social capital

In the beginning of the 1980s, the concept of social capital was specified and developed by Bourdieu (1980) and the term was later developed by Coleman (1988) and Putnam (1993). The positions have differing historic, epistemological and scientific origins, which give rise to differing and to some degree opposing theory, methods, and empirical findings related to health and health-related practice among children. The concept of social capital has also been developed and criticized at many levels, for example in Swann and Morgan (2002); Veenstra (2002); Morrow (1999, 2002); Baron et al. (2000); Woolcock (1998); Field (2003); Machinko and Starfield (2001); Williams (1998); Portes (1998). It can be argued that social capital could be seen as 'the ability to secure benefits through membership in networks and

other social structure' (Portes, 1998). Ferguson (2006) and Waterston et al. (2004) attempt to integrate social capital in studies of children and young people's health and wellbeing. Based on a literature review, Ferguson shows how Bourdieu, Coleman and Putnam are the central figures as theoretical inspiration of studies about social capital and children. Ferlander (2007) focuses on differing forms of social capital in relation to health. She suggests that more research is needed on the impact of different forms of capital on health including more theoretical discussion. Carpiano (2007) goes further as he develops an interesting empirical test of a Bourdieu-based model with a focus on a conceptual model of neighbourhood conditions and social capital. Both Ferguson (2006), Ferlander (2007) and explicitly Carpiano (2007) draw upon Bourdieu, especially "The Forms of Capital" (Bourdieu, 1986) in striving to improve tools in the study of health. However, in all these examples, social capital, or forms of social capital, are isolated and found, but they are not related to other forms of capital. These authors fail to capture relational thinking (social space and distributions of position) and the amount and distribution (economic, cultural and social) of capitals in general. Carpiano's (2007) study in particular is theoretically and methodologically constructed as a Putnam-esque study. It is also common that the studies focus on the outcome side of social capital, and not on capital as investment in a market. Capital in these studies is a resource in so far as it is seen as such, and this is obvious when differing contexts (social fields) provide for differing and sometime opposed ideals of what are seen as resources. The four dimensions of social capital (Carpiano, 2007) are interesting, but social capital is not a 'theory' (it does not explain anything, it merely describes), and the whole theory of Bourdieu is not integrated. Here, Bourdieu's arguments in *Distinction* (1986) would be very useful to incorporate, as the differing kinds of capital and social distinctions are fully presented in large-scale study.

J. Coleman: Social capital and youth

Coleman (1988, 1990a, 1990b) worked within a framework of functionalist sociology inspired by economic theory with particular attention to the social context of education. In this field he carried out several empirical quantitative studies. His focus was on how social structures and social control are created and maintained within social networks, and also how norms and systems of sanctions work.

Social structures can be built up in differing ways. Coleman discusses how differing social relations have differing potentials. In his theory, people will cooperate if personal advantages are bigger than the personal disadvantages. If not, social relations will collapse. According to Coleman, strong networks provide social support, and the clearer the norms are, the greater the individual motivation. Coleman used the example, 'it is for this the reason, that a performing athlete, musician or actor may experience far greater motivation than will a book author, who cannot see the reactions of his audience' (Coleman, 1990a: 182).

Rational choice theory has many inventors, such as Gary S. Becker (2000) and others. However, Coleman is seen as a re-inventor, or a proponent, of the theory in the field of social science. He follows the lead of economic theorists when he developed social choice mechanisms. According to Coleman, individuals will always choose and act based on calculations that optimise their situation. The process of decision-making is based on an ongoing ranking and elimination, until only one alternative remains. For Coleman, there are close and determinable relations between the structure, the agent, the decision and practice. He focuses on the conditions for individual choice and (after he 'invented' social capital) also on the unintended consequences of these choices in the constitution of the social environment.

In empirical studies, Coleman acknowledged that individuals did not always act as the rational choice theory would predict. People did not always follow their own best interest (Field, 2003), they (even) did things that could not, in the long-term, be explained as strategies to optimise their own or their families interests. People often cooperate, even when their immediate interests seem best served by competition (Field, 2003). Coleman developed social capital as a post hoc explanation to what is almost an irrational phenomenon. Social capital is seen as the 'invisible', 'hidden' hand (Smith, 1776), and it serves as a corrective to the theory. Social capital is a by-product to his rational choice model. As many others have noted (Portes, 1998; Baron et al., 2000), Coleman's definition of social capital is vague. Social capital is defined by its function. Human capital is defined as resources of the individual as a kind of outcome of taking part in social relations, whereas social capital is a by-product and connects individuals. These types of capital are not connected in the work of Coleman, but supplement each other in a functionalist way. They are resources that can be applied to get access to something else.

R. Putnam: Declining social capital

The work of Putnam (1993, 2000) and his formulation of social capital has derived partly from the theoretical ideas developed by Coleman. From a political science viewpoint, he is interested in social changes in Italy (1993) and the United States (2000). Taking the US case, based on quantitative studies involving indicators of social capital, public health, mortality and happiness (2000) he argues that there has been a reduction of social capital since 1940, and that social capital helps people stay healthy. His paradigm shares many similarities with the paradigm of Coleman and his definition of social capital. Putnam is more normative in his fundamental thinking. His research is based on a postulated and studied decrease of social cohesion and coherence in United States. He argues that individually and collectively, the US is paying a heavy price for the loss of social capital, which is the product of communal activity and community sharing (2000). According to Putnam, North Americans 'care less' for each other. His interest seems to be measuring and documenting the decline of social capital, rather than developing a theoretical discussion of the status of the concept. He presents social capital in the following way:

Whereas physical capital refers to physical objects and human capital refers to properties of individual, social capital refers to conventions among individuals – social networks and the norms of reciprocity and trustworthiness that arise from them. In that sense social capital is closely related to what some have called ‘civic virtue’ (Putnam, 2000: 19).

While Coleman is more descriptive and sociological in his work with social capital, the normative perspective of Putnam is explicit as he states how people *ought* to do things for each other without expecting immediate pay back (specific reciprocity) but rather later on (generalized reciprocity). Social capital is almost seen as a cure of societal and individual illness.

The work of Putnam has become globally renowned as it not only touches some historic and actual problems within political science, economics and sociology, but also as it has close relations to the field of politics and social policy, and to ‘common sense’ or ‘lay’ understandings.

P. Bourdieu: Related forms of capital

The sociology of Pierre Bourdieu (1980, 1986) builds on a creative conceptual unification of Karl Marx (1984), Max Weber (1978) and Emile Durkheim (1956, 1995). He also has a foundation in so-called historical epistemology (Broady 1990, 1996), such as Bachelard (1968), Koyre (1957) and Canguilhem (1988), and in terms of the relational perspective his work is also inspired by Cassirer (1911, 1950). The sociology of Bourdieu and the theory of practice is developed from studies in many social fields (1977a, 1984, 1996, 1996b, 1999, 2000), in pre- and also post modern societies (1977b) and over the course of 30 years. Bourdieu’s work is rooted in anthropology and sociology. His contribution to sociology in general is the ambition to challenge old dichotomies like macro and micro, society and individual, quantitative and qualitative, structure and agency and in doing so, he developed new concepts – those of field, habitus, positions and dispositions and differing forms of capital.

In the effort to understand the practice of the agents (a theory of practice in a specific position in the field), Bourdieu has introduced field, positions and habitus, but also the concepts of economic, cultural, symbolic and social capital. But in his many publications, he did not develop the concept of social capital to the same extent as he did with cultural capital. This could indicate both that social capital is present in its absence, as it is implicit in sociology. It could also indicate, as suggested by Savage¹ that the concept was not particularly elaborated upon for Bourdieu, who was more concerned to explain how dominant positions reproduce their position. This could explain why economic capital and cultural capital are more developed in Bourdieu’s work. We argue that social exchange is central for Bourdieu, and this

¹ Whither social capital? Past, present and Future. Conference, London South Bank University, 7 April 2005.

makes social capital an important concept in its interaction with the other capitals. It is a 'credit' that the agents can (usually unconsciously) bring to bear when necessary, or that can be applied by converting one capital to another. Social capital in terms of Bourdieu should not and cannot be isolated from other forms of capital, as it is often done in fragmentary use of Bourdieu. Bourdieu suggests that capital

can present itself in three fundamental guises: as economic capital, which is immediately and directly convertible into money and may be institutionalised in the form of property rights, as cultural capital which is convertible on certain conditions into economic capital and may be institutionalised in the form of educational qualifications, and as social capital made up of social obligations (connections), which is convertible in certain conditions into economic capital and may be institutionalised in the form of a title of nobility (ibid.: 242).

Bourdieu's most developed concept is cultural capital, which exists in three forms: in the embodied state, in other words, long-lasting dispositions of the mind and body; in the objectified state, in the form of cultural goods (pictures, books, dictionaries, instruments) and in the institutionalised state, a form of objectification, in the case of educational qualifications (1986, *The forms of capital* ibid.: 243). Here, Bourdieu defines social capital as actual and potential resources that are linked to the possession of durable networks. The volume of the social capital possessed by a given agent thus depends on the size of the network of connections he can effectively mobilize and on the volume of capital (economic, cultural and symbolic) possessed in his own right by each of those to whom he is connected' The profits which accrue from membership in a group are the basis of the solidarity which make them possible' (1986 p. 248). Bourdieu emphasises the genesis and the structure of the social. He suggests that the existence of a network of connections

is not a natural given or even a social given, constituted once and for all by an initial act of institution. It is the product of an endless effort at institution, of which institutions rites mark the essential moments and which is necessary in order to produce and reproduce lasting useful relationships that can secure material and symbolic profits. (ibid.: 250).

Bourdieu's interest is the logic of the social, with special attention to social reproduction in society, inspired by classical sociologists like Durkheim, Weber and Marx. His theory is an elaborated theory of class and social reproduction, and the associated concepts are to a large degree determined to explain how social fields, institutions and agents structurally reproduce themselves. A central 'device' in this reproduction is how social mechanisms are seen and experienced as 'natural' mechanisms. Social capital is a small but important brick in this general and wide-ranging sociology.

Unnoticed processes of reproduction in culture and society

Opposed to theories that focus on the constant changing of society that produce ever changing and changeable agents, such as theories of modernity inspired by Giddens (1991, 1992), Beck (1996) and Ziehe & Stubenrauch (1982), Bourdieu's attention is focused on the constant, persistent and continuous processes of reproduction (1977a, 1977b). These processes of reproduction, from a sociological perspective, (have to) pass unnoticed as everybody needs to feel that they are constantly inventing their lives. As modern individuals, we need to refute the fact that we are socialised, we inherit, and are products of the investments of former generations. In an informal, distorted and complex way, the amount and composition of capital is handed over from one generation to the next (Bourdieu, 1999). Here the educational system plays a major role (1977b, 1984). Access to cultural, educational, informational, economic and social resources are not invented by each child. Dispositions for basic social ability related to health are, from this theoretical perspective, on a bodily level, transferred between generations and continued in generations, without being recognised or experienced as such. In other words, some children *possess* low levels of capital while others can immediately profit from what was produced before them. According to Bourdieu, agents are also creative and reflective, within limits, and some social mobility can be observed. But the unnoticed processes of reproduction in society are the main objects of enquiry for Bourdieu.

Bourdieu's concepts of 'mis-recognition' and 'symbolic violence' deal with the fact that all social classes live by and with (a social) neglect of certain aspects of social reality. The relations between the dominant/privileged and subordinated social agents are more or less supported by law (as an example, laws of private property or law of succession). But the strongest power that dominates *the dominated* is the internalisation of the arbitrary culture, as if it was the (only natural) universal culture. Culture, distributed in families and educational systems (Bourdieu, 1977b) is transmitted and perceived, by children not as one among other cultures, but as *the* culture.

Bourdieu argues, in discussion with the philosophy of Habermas and critical theory (Bourdieu, 1990b), that the mystery is not how external forces suppress or dominate the subordinated, so to speak, from the outside – but the suppression is held or supported by the fact that the subordinated positions suppress themselves. They accept their situation and arbitrary values as if they were universal and common, but unreflexively. An example that relates to children is the educational system and schools, particularly in the Nordic countries where a very strong rhetoric about "community school", "public school", is making efforts to provide (successfully) universal values. However, the content, the language, examinations, the ways of teaching are always distributed from a certain perspective, with certain choices that includes certain content and language, and while excluding others. The culture that is "taught" makes some children feel like 'fish in the sea', while other children may

feel excluded. Bourdieu calls this phenomenon misrecognition of the arbitrariness of the content, the language, the "ways", the culture, 'symbolic violence'. The subordinated dominate themselves by accepting an arbitrary culture/norm/value or practice as if it was "everybody's".

Habitus, or 'incorporated history', is a disposition which at the same time guarantees creative and stable practice. When children act as they do in daily practice (for example, in relation to preferences for food, friends, types of job, consumption of alcohol, drugs, smoking), they use principles that were handed over from one generation to the next. As opposed to dominant theories of modernity, reflexivity and rational choice, habitus (developed to avoid objectivism and subjectivism) provides knowledge not only of what to do, but also how to do it. Actions that seem irrational from outside can be very rational from the level of practice of a single agent (Larsen et al., 2002; Cox & Larsen, 2005).

There is not a direct link between the social position of agents and their health practice, but this theory gives some explanations of the complex relations between the two. In particular, it provides explanations of the tendency of stability in practice between two generations and the maintenance of positions between differently positioned social groups (the privileged stay privileged and the under-privileged stay under-privileged). In other words, this sociology helps us to understand that differences in health status among a large group of agents today are responding more to their social positions (including the structure and genesis of a field of health and the amount/composition of capitals) than to the reduced and simplified model of their individual and rational choices. In comparison to theories derived from Coleman and Putnam, this sociology offers a completely opposed theory of the dynamics of social reproduction and social mobility. The practice of agents is (of course) both creative and structured, improvised and predictable, and sometimes practices are experienced as an object or a result of rational choices. But practice is not and can never be a direct implementing of theory (Callewaert, 1999) or health instructions. The underlying principles that are applied in everyday practice of agents are not chosen or invented by the agent, but they are handed over. One of the most stable and stabilising principles here is the material structure of artefacts, such as structures of buildings, roads, houses, landscapes. These and other structures are what make social practice described more adequately in terms of stability than change.

The differing construction of the object

Bourdieu and Coleman/Putnam construct the object of research in very differing ways. This includes differing perspectives on a theory of practice. Construction of the object means how the object of research is thought about or conceptualised, and this is a key question in the sociology of Bourdieu (1991). In social research there is a tendency to think of social capital as the tool (and, unfortunately, in many studies, the *goal* and *process*) and often people of dominated agents seen as the object of study or intervention. From a Bourdieu'ian perspective, this is to convert a social

problem (often politically constructed) into a sociological problem. This is often born of humanistic and well-intentioned purposes (social researchers often see themselves as attempting to describe, understand and support people in subordinated positions) but the everyday constructed problems are not, or are very seldom, the sociological problem. The researcher needs to undertake intellectual effort to understand the “self constructed problem” often as part of a more complex and less self-evident problem. In other words, the researcher needs to convert the everyday problem into a sociological problem. This means to theoretically re-think, to break away from, everyday constructions, and by doing so, constructing a theoretical object. As an example, underprivileged or marginalised children are not (in themselves) the ‘objects’ of research. What might be the object is the complex and mostly unnoticed, seemingly “natural” processes of under-privileging, of marginalization, and how under-privileged and marginalised children take part in their own marginalisation. The relational perspective is fully developed in *Distinction* (1984).

In research inspired by Coleman and Putnam the object constructs itself. This spontaneous and positivist pre-construction of research is seen in the following elements:

- the definition of the “problem” of the research (such as obesity amongst children);
- the choice of informants (obese children/their parents);
- the theory of practice involved (practice seen as product of rational choices);
- the choice of methods (interviews with obese children/parents)
- and also in the normative implications of the research (guidance about how to eat more healthily).

In the work by Putnam, and especially Coleman, the theory of practice in general implies an agent that is meta-reflective, and action is seen as inspired by cognitive processes. The technical and rational theory of practice (“rational choice”), is often implicit, and thereby also integrated, is in terms of Bourdieu, constructed in all levels in research. The rational choice theory of practice has the strongest impact as it is taken for granted, and is a natural and an unquestioned principle. In much health literature this theory of practice is also hidden in concepts such as ‘decision-making’, ‘choice of lifestyle’, ‘free will’, ‘planning health’. The technical and rational theory of practice is a dominant and widespread self-perception among agents in modern Western societies. It is also an extensive, often implicit, theory of practice, in many theories about health practice in general, and (as mentioned earlier), especially those measuring ‘health behaviours’, inspired by epidemiology.

The descriptive theory of Bourdieu is based on empirical work, including observational studies (1977a). In the construction of the scientific object in the work of Bourdieu, in contrast, it is a basic assumption that agents are brought up and formed,

but also educated and qualified professionally by processes that are bodily. The social agent knows by bodily experience (habitus) how to act in the social field. This is possible because the body is brought up in similar social fields (Larsen, 2005). Bourdieu used the simile, 'like a fish in the sea'. Swimming, hunting, eating are not objects of reflection for the fish, the fish is just doing what it has to do. In social life, children are brought up in concrete and material conditions. Young children feel, smell, touch, see and hear, and thereby perceive and incorporate the social world, through the body. This includes the social and material conditions that provide for social specific practice in relation to health. As such, agents do reflect and they are creative, but not in the way suggested by rational choice theory. In this daily acting, "health", "food", "diet", "training" or "un-health", "fat-food" or "non-action" are not permanent and ever present objects. The agent simply acts in everyday life. The structure of the 'outer' world is familiar as it corresponds with, and is constructed, just like the 'inner' world. This is inspired by Maurice Merleau Ponty (1994). The cognitive structures that an agent implements when he or she understands the familiar world is a product of the structure of the known world (Bourdieu, 2000). Habitus strives to relate to similar agents, guided by sympathy and antipathy, affection and aversion, taste and dislikes, so he or she creates surroundings where the agent feels at home (Bourdieu, 2000: 150). In this context, habitus 'knows' what to do and how to do it, 24 hours a day, knowing how to move, eat, play, walk, bike or drive, as appropriate for that specific position in the social space (Bourdieu, 1984). Habitus guides and structures an agency that applies principles that are adequate for the position *in the social space*. There is a tendency for people to look for and create relationships with other people (friendships), places (urban/rural) and things (clothes, furniture) that are associated with, and similar to, what habitus "knows" from earlier experiences (Bourdieu, 1984).

To sum up, Coleman and Putnam do not construct the object in a theoretical way, and they do, to a large degree and explicitly, apply an everyday theory of practice. Their contribution focuses on free-floating individuals and their choices as the engines that drive practice forward. In relation to health, Bourdieu offers an opposite theory, one that focuses on relations between positions, stability of practice and the body, by use of concepts like social fields, positions, capitals and habitus. For researchers within studies of health, this contributes to an understanding that a) unhealthy social groups are not a theoretical object and b) health outcomes are not only products of free choices made of individuals. Studies of health *must* integrate social reproduction, include studies of the distribution of capital in a field as a whole, including economic, social and cultural capital. The dominant social groups and their privileges are also a study object in relational perspective, and the rational choice theory of practice need to be supplemented with one that involves the body.

Capitals in relation to health

Bourdieu did not work empirically with health and health studies, but his studies of similar social spaces and social fields can be applied to this field. From his sociology, it is obvious that agents differ, and are unequally positioned in social space. Capital is to a large degree passed from parents to their children. Using the concept of habitus, children or young people are active, creative and as such not passive recipients of capital from their parents (Morrow, 2002). The position in the field that also covers the possibility to act and re-act, in relation to health, is in Bourdieu's theory, a response to the amount and the composition of various capitals, and not an isolated product of single capacities (such as economic, cultural or social capital). The perspective on the genesis of practice is therefore: 'agents do as they have to do', in the field, with the positions and dispositions (habitus). Social conditions and possibilities exist on a structural and an individual level, and the practice of agents is seen as both structured and creative, within limits, that is within the social space. Activities which from one position seem as a healthy or an un-healthy job, a right or a wrong habit, a good or a bad grocery custom, a well informed or a stupid diet, is from this point of view, adequate with the position. Practice has its (social) reasons.

Capital in Bourdieu's terms is a disposition, that is, the possible capacity, both on a bodily level and also a cognitive level, to draw on differing types of 'credit' (economic, cultural, social) in the striving to maintain or improve a position in the social space. These forms of capital can to a certain extent be exchanged or converted. As an example; if a person becomes ill, and has a lot of money, he or she can buy better treatment. In that sense economic capital can be converted into "health capital", which in turn can be (re-)converted into economic capital if the person can return to work more quickly.

Coleman and Putnam share basic assumptions, paradigms and ask similar questions that are common among social scientists, economists, political scientists and epidemiologists, whereas the theory of Bourdieu originates from classical sociology. Bourdieu and Coleman co-organised a conference in 1989 in Chicago and they have also edited a book (Bourdieu and Coleman 1991). But they did not work together and their work did not refer to each other. The two concepts of social capital are developed in differing contexts and to a large degree from opposed theoretical standpoints. The work of Putnam could be categorised as a third strand to that of Coleman and Bourdieu (Field, 2003), but it seems obvious that his work is derived from Coleman's theory. In relation to social position, social capital and children's health, these two paradigms ask differing questions, construct the object differently, they have a differing epistemology and theory of practice and consistent with that, they also offer quite differing and thus opposed answers.

Discussion

The seventh re-invention of social capital has helped focus on the social glue and its importance in many areas, including health. It has also been said that social capital

bridges anthropologists, economics, political scientists and sociologists (Schuller et al., 2000; Woolcock, 2001; Foley & Edwards, 1999). There has been huge expansion of research using the concept of social capital, and range of policy inspired by social capital. Social capital derived from the work of Coleman and Putnam has contributed to a shift in research, from measuring the outcomes of individual health behaviour of young people to more focus on their everyday lives and social processes (Morrow, 2001: 47).

However, from a theoretical perspective, social capital, as it is conceptualised by Coleman and Putnam, remains an object for critique in general. It is dominated by liberal rational economic assumptions, and the overall body of knowledge about social capital can be viewed as confusing and ambiguous, rather than cohesive, and it runs the risk of producing a tautological account (Portes, 1998). Research based on the concept of social capital as used by Coleman and Putnam often fails to address relations of power and conflict, and tends not to incorporate the effects of broader social structures. Social capital is isolated from other forms of resources. As Fine (2001) suggests, the focus on social capital facilitates a neo-liberal withdrawal of the welfare state. The lack of a power and class perspective is also mentioned by Muntaner and Lynch (1999a, 1999b), who argue that social determinants and political changes are the most important features in the determination of health (see also Marmot & Wilkinson, 1999). However, the work of Bourdieu can be criticised for not leaving space for individual action, because it addresses structures, schemes and stability more than creativity, reflexivity and social mobility (Jenkins, 1992). Critics have also argued that Bourdieu's theory seems to have static consequences and refers to French society of the 1970s (Vester, 2005).

Research implications of the sociology of Bourdieu

First and foremost the marginalised and the unhealthy are not objects for scientific research. The object of scientific work must be constructed theoretically and not take as an object the pre-constructed object (the marginalised, the un-healthy). The scientific object of research is constructed as an epistemological "break", according to Bachelard (1968), against the 'self-evident' or 'natural' construction. Critical social science must challenge the taken for granted. This might be of particular importance within health studies that are dominated by paradigms (epidemiology, clinical experiments, exclusively quantitative studies, and so on) which take 'natural constructions' as scientific constructions. (The natural sciences that are working with natural objects (planets, cells, genes) have certain advantages, as their objects of study are not "speaking objects" as in social sciences).

The substance in the critique made explicit in this paper is that an alliance exists between (a) a dominant neo-liberal policy (support of the dynamics of capitalism and decreasing the role of the state), (b) modernity (a growing individualism, increase of focus on 'choice' of lifestyle) and (c) a social science with a specific use of the concept of social capital, that offers theoretical support to the first two. This is a risky

business. Critical studies of health suggest that the amount and distribution of resources (economic, cultural and social capital and other types of capital) must be studied as a whole. The main questions must be: who and what kind of social mechanisms organise and sustain the circulation of goods? In a relational perspective, 'unhealthy' and excluded agents can only be objects of research when they are understood in relation to those agents who are healthy and included.

Additionally health practice cannot be studied in isolation, and neither can social capacity or social capital. Health practices must be studied in relation to a broader analyses of social reproduction in society, including the often socially hidden principles that provide and legitimize differing social positions. Studies of differing distribution of health involve differing distribution of resources, credit or capital in society. This involves a conflict, descriptive and sociological perspective including relations of power -and not a consensus, normative and individual perspective as suggested by Coleman and Putnam.

Lastly, the general shift in research from a focus on economic to social capital, and an avoidance, more or less consciously, of other social credits, especially economic and cultural capital, in a complex but obvious way, takes part in reproducing (what humanistic oriented researchers rhetorically strive to avoid) the social conditions that include the included and exclude the excluded. The "contribution" is at first hand only symbolic, but under the "right conditions" it supplies what is needed. That is, to direct attention to the (politically stated and spontaneously constructed) marginalized as subjects/substance, and thus also directing the attention away from the unnoticed relations of power and silent processes of marginalisation and social mechanisms of exclusion. The spontaneous construction, which is a powerful construction as it is embodied in the marginalised themselves (symbolic violence), enables researchers to avoid analyzing the concrete material, spatial, economic, cultural conditions that give some children and young people the possibility to live long and healthy lives, and others are doubly disadvantaged as they bear the burden of bad living conditions, exclusion from workforce, poor education, 'bad habits', live shorter lives and with a lower quality of life, and even know that they are guilty of all this themselves. Bourdieu's theorising could help us to re-focus attention on these aspects of children's and young people's lives.

Kristian Larsen, Associate Professor, PhD, Danish School of Education, University of Aarhus

krla@dpu.dk

Virginia Morrow, Associate Professor, PhD, Reader in Childhood Studies, Dept. of Early Childhood and Primary Education, Institute of Education, University of London

v.morrow@ioe.ac.uk

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The World Bank

[http:// www.worldbank.org/poverty/scapital](http://www.worldbank.org/poverty/scapital)

A full and interesting site, including a very large library of relevant abstracts.

Saguaro Seminar

[http:// www.ksg.harvard.edu/saguaro/index/html](http://www.ksg.harvard.edu/saguaro/index/html)

This is Robert Putnam's site at Harvard for the Saguaro Seminars on Civic Engagement in America. Contains some papers and a few useful links.

Centre for the Study of Public Policy, Strathclyde University

<http://www.socialcapital.strath.ac.uk/>

Contains a few papers on building social capital in Russia and Africa.

National Public Health Partnership

[http:// www.hna.ffh.vic.gov.au/nphp](http://www.hna.ffh.vic.gov.au/nphp)