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Abstract

Quantitative studies have drawn attention to the patterning of health inequalities in relation to subjective social status (SSS). There is currently little insight into the complexities of the social and biographical aspects that lie behind these findings. Narrative accounts were gathered in a mixed-methods study involving a population of people with coronary heart disease (CHD) and/or diabetes in a region of the United Kingdom with above average levels of socio-economic deprivation. The aim of this secondary qualitative analysis was to examine the accounts of interviewees with low socio-economic status (SES) who ranked themselves either low or high in terms of SSS. The results highlight the multiplicity of adverse circumstances leading to subjective assessments of low SSS. Loss of employment status contributed more to a feeling of being “at the bottom of the ladder” than the symptoms of chronic illness did, perhaps because having somewhere to go is central to the accrual of social, economic, and cultural capital. The narratives of those who ranked themselves highly (in spite of low SES) appeared to have more family and community connections. The findings contribute to theories of socio-economic biographies or trajectories, subjective social status, and engagement with the self-management aspects of chronic illness.

Keywords

subjective social status, chronic illness, qualitative study, UK

Introduction

Although previous quantitative studies have pointed to the possible role of subjective social status (SSS) in inequalities in health (e.g., Demakakos, Nazroo, Breeze, & Marmot, 2008), little is known about the mechanisms by which people choose to rank themselves notionally above or below others in society. We draw on several broad social scientific research strands from within the sociology of health and illness including inequalities in health, the sociology of chronic illness (Bury, 1982), and recent work concerning an expansion of the framework used to classify socio-economic position (Savage et al., 2013). In doing so, we adopt primarily a narrative approach that incorporates notions of biographical disruption (Bury, 1982) and a concern with how structural dimensions and forms of “capital” emerge in accounts of managing, or coping with, a chronic illness (after Townsend, 2012). The latter dimension is typically associated with a theoretical approach that derives from the work of Pierre Bourdieu, applied to the sociological study of class, health, and lifestyle (Williams, 1995). Key here is Bourdieu’s (1999) concept of “habitus,” an “embodied history, internalised as second nature and so forgotten” (p. 111) referring to routinized cultural practices, which structure and maintain class divisions in the social world: “routine knowledge of social

structures and conditions produces enduring orientations toward action that are more or less routine, and when these orientations are acted upon they tend to reproduce the structures from which they are derived” (Cockerham, Rütten, & Abel, 1997).

The data used in this article derived from interviews conducted with 68 people with diabetes or coronary heart disease (CHD) recruited in primary care settings. These interviews were conducted as part of a broader program of mixed-methods research concerned primarily with investigating the role of social networks and social assets or resources in long-term condition self-management in 300 survey participants (Vassilev et al., 2013). In the context of this article, we are mostly concerned with the notion of the various resources that are available to people with a long-term condition and the extent to which different

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“capitals” (whether economic, cultural, social, or symbolic; Townsend, 2011) influence people’s self-assessments of their subjective status. Through this analysis, we highlight the reflexivity evident in interviewees’ self-assessments of status (or class) consciousness and the role of chronic illness in disrupting biographical or status trajectories.

Method

Data were collected as part of a wider program of study concerned with developing and implementing methods of self-care support in long-term condition management focused on resources based in social networks (Rogers et al., 2011).

The program involved a number of studies that incorporated a mixed-methods social networks survey, and previously published articles have reported on the statistical findings of the main survey data (Vassilev et al., 2013), the development of a telephone and web-based toolkit to link people with chronic illness to local community resources and activities (Blickem et al., 2013), and qualitative analyses focused on the importance of pets (Brooks et al., 2012) and “weak tie” social network members in supporting condition self-management (Rogers et al., 2014). The social networks survey used in the various studies included structured questionnaire schedules alongside semi-structured interviews. This allowed fieldworkers and interviewers to incorporate “think aloud” techniques, such as exploring why people had given specific responses to structured questions. As part of the questionnaire, the MacArthur Scale of SSS was used, which consists of a 10-rung ladder on which respondents are asked to place themselves in relation to everyone else in society (Adler & Stewart, 2007). The study team consisted of long-standing experts in medical sociology, chronic illness, and mental health and the interviews were undertaken by experienced qualitative health researchers with backgrounds in health services research, sociology, psychology, nursing, and anthropology.

The aim of the analysis was to illuminate narrative experiences of survey participants with diabetes or CHD who reported themselves as being of low socio-economic status (SES). We wanted to describe the personal stories of these participants who also rated themselves at the extremes (low or high) of SSS. To do this, we conducted a focused secondary analysis of data from participants who were part of the wider survey (Rogers et al., 2011).

The total sample size for the main survey was 300. Respondents were mainly older people in the Greater Manchester area recruited from participating primary care practices, and results from the main survey have been reported elsewhere (Rogers et al., 2011).

A mixed-methods paper focused on an analysis of the statistical variables associated with SSS and how respondents interpreted the “ladder” question, to discuss the worth of using SSS as a predictor of health, has previously been published (Vassilev et al., 2014). In this article, we move beyond

the discussion focused on completion of the SSS (“ladder”) question to analyze key themes in the total narrative accounts for those who had low SES and also scored low for SSS (by placing themselves on one of the bottom three rungs of the ladder). We contrast these accounts with those classed as having low SES who scored high for SSS (by placing themselves on one of the top three rungs of the ladder).

The qualitative data for analysis came from audio recordings of face-to-face interviews conducted to complete the social networks survey. Although this interview comprised of key structured questions, to map out social networks and the work involved in managing long-term conditions, the interviews were conducted in such a way as to allow respondents to talk in-depth about their experiences of living with and managing their health problems. Interviews ranged from 1 to 2 hr and as respondents identified key people in their network, they talked at length, for example, about the nature and history of their relationships, people who had come in and out of their lives at crucial times, the environments in which they lived now and in the past, and so on. As such, the recordings of these interviews contained an interweaving of short responses to a structured questionnaire, combined with pockets of rich narrative. For this reason, the interviews were not transcribed in full. Rather, interviews in the sample were divided between members of the research team who read the interviewer’s field notes before listening in depth to the whole recording in each case, while making detailed notes to summarize narratives and identify key themes. During this process, researchers selectively transcribed elements of these rich narratives to illustrate the key themes found. These themes were discussed and refined in multiple team meetings and by having multiple researchers listen to a proportion of the interviews. One member of the team (C.S.) then synthesized all of the summary documents within the key themes identified by the group, providing one overarching descriptive account. The findings reported here move beyond a thematic interpretation and instead reflect the biographical stories of peoples’ lives in relation to SSS. The manner in which the data were collected and analyzed means that the results draw as much on researchers’ summaries of the whole life story contained in each account (the biography) as on specific quotations taken from the more conversational (or “depth”) elements of the mixed-methods interviews.

Results

Sample

There were a total of 51 respondents in the category low SES and low SSS, and 17 in the low SES and high SSS groups. The bulk of findings were derived from the former group, who had an average age of 62 years (range = 20–93, median = 63) and were mostly males (37/50, 74%). Roughly half of the sample were married or in a civil partnership (23/49, 47%), with the remainder widowed (5/49, 10%), divorced or

separated (15/49, 30.6%), or else had never married or formed a civil partnership (6/49, 12%). Ten participants placed themselves on the lowest rung of the ladder, 16 on the second rung from the bottom, and 25 on the third rung. It was noteworthy that only 5/26 (19%) of the people who placed themselves on Rungs 1 or 2 were married or in a civil partnership, compared with 18/25 (72%) of those who positioned themselves on Rung 3.

The Enduring Nature of Social Background and Adverse Life Events on Personhood and Habitus

Biographical and temporal aspects appeared as key features of the narratives. The accounts of people who placed themselves at the bottom of the socio-economic ladder were primarily characterized by tales of social adversity and a “hard life” as lived. These particular tales commonly involved domestic violence, alcohol abuse, relationship breakdown, and deaths in the family. Such events were sometimes used as an explanation for having an illness in the first place. One man reported being so severely beaten around the head by his father as a child that he was deaf in one ear. This violence was also used to explain a lifelong history of problems with obesity and depression, as well as having caused the family to fracture, with some family members no longer speaking to each other (ID69). In another account, a woman outlined her own history of being brought up in deprived conditions by her grandmother, following being abandoned by her own parents. This was presented in a matter-of-fact way, as was the stress of living in an area where a next door neighbor was murdered in the house. She reported that her husband had died of a heart attack, but that this event was expected or “deserved,” as he had been violent, abusive, and “an alcoholic.” She had divorced him before he died, and brought the children up herself, who were now said to have their own “issues,” with one being described as “alcoholic” and another “epileptic”:

He died of a heart attack [husband], but I think he gave it to himself for being so violent. He shouldn't have been violent all his life. That was a sign, he was a drinker. But he worked away most of the time, so that was good for me, and he only came back like say . . . and every time he came back I was pregnant by the time he went, so that was no good . . . I know what it's like to be battered and battered all my life, by the ex-husband. (ID51)

There are several facets that can be drawn out of this account. First, the interviewee suggests an explanation for illness in her husband in his immorality (heavy drinking, domestic violence), which points to a locus of illness etiology that lies in individual or inter-personal behavior. It is common these days for media and political commentators to speak of the “deserved” or “undeserved” poor (in relation to access to welfare benefits) but here we see what looks like an extension of such currents into the “deserved” or “undeserved” unwell. At root, these notions seem to hark back to

religious ideas of the real or potential consequences of bad or intemperate behavior. The above account also speaks to another popular narrative that concerns male agency and female suffering, which is picked up again later. Thus, accounts such as these point toward a lay perspective of chronic illness simultaneously tied to biological, genetic, environmental, and social explanations (Williams, 1998) on one hand, and in the context of deprivation, relationships to broader environments, and social connectedness, on the other. This alerts us to the possibility that illness is merely one further misfortune that people might have to contend with as part of a parcel or sequence of unpleasant experiences (Davison, Frankel, & Davey-Smith, 1992). In one extreme case in the sample, these had included “bad relationships,” a son born “following rape,” a violent husband who had stalked and kidnapped the interviewee, and the death of a child. These events formed the kernel of an explanation for subsequent alcohol problems, a heart attack, and mental illnesses including paranoia and suicidal ideation, which the interviewee described as going “a bit doolally” (ID359). The researcher who analyzed this interview reported that the respondent “scores herself on the bottom of the ladder but doesn't really talk about it.”

These tales of a hard life, death, and misfortune appeared gendered, such that women usually spoke about their own misfortunes at the hands of violent men (e.g., ID368), whereas men usually spoke about misfortunes suffered by their wives or partners, such as miscarriages, still births (e.g., ID291), or having a terminal illness (ID100). In that sense, the accounts underlined dominant notions of men as the perpetrators of violence or misfortune and women as the powerless victims of it. However, as noted above, one man also reported being severely beaten by his father as a child:

My father was a very cruel man and he used to . . . punch, you know, abuse us a lot. I wake up with the “black dog” [a lay term for depression] every day of my life . . . and I go to bed stroking the black dog and it's been the bane of my life. I can be as happy as a pig in a poke but it still comes, and I'm not blaming no one. I mean I'm not blaming no one, what happened to me when I was a kid happened to thousands and perhaps they coped with it. I mean I am physically, mentally, emotionally, I've not been able to cope with it. I've hid it, I've put it to one side, but the black dog has always been there. He will always come out and no matter what medication I take, it will always raise its ugly muzzle. (ID69)

If we contrast this account with one presented earlier by a woman (ID51), it is noteworthy that although ID69 partly presents himself as a victim of social wrongdoing, it appears as though his gender identity means that it is not appropriate for him to present himself as an “agency-less” “victim,” and thus he qualifies his story by reporting that what happened to him “happened to thousands” and he does not “blame” his father for his subsequent ill health following the beatings. However, although he does not attach agency to “blame,” he does attach it to condition self-management and freely admits

that he has “not been able to cope.” This man placed himself on the bottom rung of the ladder and the above narrative asserts how formative life experiences could have a potentially dominant impact on ill health, life chances, and access to social and economic capital. In one account of a woman who had lived with a violent partner, she reported the experience had “opened her eyes” and she “gradually built up her strength” and left him. In this case, although she placed herself at the bottom of the socio-economic ladder, this was explained purely in terms of monetary resources (ID368). The focus on finances in relation to the question on SSS in light of the above account also points to the potential role of a self-perception of “agency” in, or control over, one’s own life (i.e., developing the courage to leave a violent partner and start a new life) as a factor in SSS. However, because these issues were not discussed by the interviewee, and her largely unspoken reasons for responding the way she did were not sufficiently unpacked, it is difficult to expand further.

SSS in Relation to Work: Past, Present, and Future

Commonly, chronic illness is articulated as both a reason for low SES and a consequence of it. Because of the inter-linking of illness and life circumstances in respondents’ accounts, subjective status emerged as a concept that is fluid through time. In particular, illness had the capacity to lead to declining social status, largely when it also led to extended sickness leave or medical retirement from work. In the particular habitus of chronic illness, however, “mobility” in this context most often seemed to reflect a downward spiral (after Robinson, 1990). In terms of SSS, one interviewee reported that as a result of losing work due to illness, he felt kept “at the bottom”:

ID212: I’ve no job. I can’t see me having prospects of a job due to my illness. Obviously, with no job, there’s no money. I’m just on benefits so that keeps you at a certain level, anyway it keeps you at the bottom.

Interviewer: Yeah, catch 22.

ID212: You can’t go up on benefits.

Interviewer: Yeah I know.

ID212: So that’s the easiest way to do it, you’re at the bottom.

Interviewer: Big problem.

ID212: Don’t get me wrong, I’ve been past half way up.

Interviewer: No, I know, yeah.

ID212: I’ve been there, but it makes no difference.

This account underlines three things: the importance of employment in subjective assessment, an articulated awareness that the function of a hierarchy is to keep some people down, and the lived experience that previous status is no guarantee of current position. Many informants explained

their subjective status at the bottom of the ladder by pointing out their status relative to others: They were a pensioner, they had retired, or they were currently unable to work because of illness. In the case of some men, it was clear that work was the essence of their existential selves and their accounts were more about the consequences of losing work than they were about the consequences of having an illness. Thus, for these men (and some women), the main consequence of illness was that it prevented the possibilities for social and material production. The following extract from an interview with a 65-year-old man with CHD is particularly illustrative in this regard:

Because up until then . . . I’d never been off work in my life . . . I used to work 60 and 70 hours a week . . . and all of a sudden from working seven days a week to working no day a week, not even one hour. Sitting here in the house looking out the window, I thought I would go mental. You know I just couldn’t wait to get back to work. But I kept going down to the doctor asking him to sign me off and he said he wouldn’t sign me off because he said, “You’re not fit to go back to work.” So anyways when I said I’d found a job that makes it easier—because I said I’ll be in charge, I’ll be a foreman and I said I don’t have to do the physical work—I said I’ve been responsible for 20 men, I said supervising workers I said I can do that. So anyways he wouldn’t sign me off . . . he said, “Get the idea out of your head completely.” He said that, “You’re going to go back to work?” And he said, “Don’t come back to me again,” . . . he said, asking for me to sign off because he said, “I won’t.” So I got it into my head eventually that it wasn’t going to happen so I [inaudible 00:24:51] trying anymore. I said that’s it. But basically that’s . . . [starts crying]. (ID381)

This man lived alone and had never married. Although it might be tempting to suggest that, in a social networks context, work provides more important economic (and social) capital for men than women, men were not the only ones who missed paid employment, as in the case of a 60-year-old divorced woman with diabetes who placed herself on the bottom rung of the ladder:

[From the overview of the interview] [She] spoke quite a lot about work. She really misses it and felt much better when working. She says she can’t do it anymore because of her legs. Her previous doctor told her that she was a very expensive patient. She says that she gets a hundred and odd quid a week “which is crap.” The only thing that keeps her going is smoking. She is limited with what she can do because of lack of income. Once a month she can have a ride out in the car, otherwise she can’t afford petrol. (ID163)

In both of the above accounts, absence of work is linked to both a lack of money and the inability to “go anywhere.” To have work is to have “somewhere to go to” (Scheid & Anderson, 1995) although from our perspective, we are as interested in the opportunities for people to “go somewhere”

in their local communities that need not necessarily involve spending money for travelling long distances (Blickem et al., 2013). These accounts illuminate the “locked in” syndrome that can accompany both unemployment and the manifestations of illnesses or medical conditions. However, for the purposes of the analysis presented here, we are more minded to note that “having somewhere to go” affords opportunities for the acquisition or exchange of social or cultural, as well as economic capital (but cf. Skeggs [2004]) and see discussion, below).

A 65-year-old female with CHD and diabetes reported having to balance the utility of working short hours for low wages with her need to care for her children. Again, medical conditions made her job (typing) difficult. Following re-training, she returned to part-time work but then had to balance the demands of work with advancing age and symptom severity. However, she told the interviewer that she is anxious that she “wouldn’t leave the house” if she did not have a job (ID368). That is why work was so important to her, that is, it prevented entrapment. In light of these findings, we suggest that the ability to go out of the house is likely to have potentially as important a role in subjective social status as employment.

Within social relations, work is not only important to individuals (or rather part of the habitus of being working class), it is also a central part of expectations around productive roles. One 49-year-old divorced male with CHD and diabetes expressed anxiety at being classed as a “type 1” diabetic, the effect of which would be to jeopardize his job as a lorry driver. He informed his medical staff of this, and they were endeavoring to keep him on oral medication as opposed to injectable, so that he may stay in work. However, his fear of being switched to insulin and losing his job meant that he avoided medical appointments and ignored that his blood sugar was high at the time of the interview (ID221).

Notwithstanding the helpfulness of the medical staff in this case, clinicians would likely be concerned that the patient in question was failing to enact self-care strategies, such as self-monitoring and attending for medical appointments. However, and following from accounts previously presented, the main consequence of a medical diagnosis such as diabetes appears to be its potential to lock people out of the social world and into a domestic environment at once seemingly removed from wage earning, self-esteem, and access to social and cultural capital. Medical accounts repeatedly emphasize the importance of screening activities and early diagnosis as the key to effective management and better outcomes. However, the Parsonian (Parsons, 1951) notion of illness identity that runs through these accounts suggests that depriving people of their productive capacity and opportunities for “normal” social involvement potentially carries more serious consequences for people that possibly go beyond issues related to symptoms and medicine taking (see discussion).

So far, we have refrained from ascribing interviewees to one social class or another, although for the purposes of the

material presented so far, all of the cases referred to ranked themselves as being on one of the bottom three rungs of the social ladder. In the first two sections of “Results,” we have laid out the narratives of these interviewees, which underline the experience of chronic illness as rooted in a life characterized and experienced biographically as a series of hardships or misfortunes. Employment formed an important identity construct in interviewees’ accounts. In the account of a 47-year-old man with diabetes, these issues were conjoined with stoicism, the importance of self-reliance, and humor as a way of dealing with unpleasant life events. From the summary notes by the researcher:

Doesn’t like to be dependent on anyone else. Work is very important for him and helps him relax. He does not like to discuss his problems. Has suffered from depression in the past. He was depressed when diagnosed with cataracts and he lost his job. He also talked about significant life events when his partner had miscarriages and a stillbirth. He laughs quite a lot when talking about upsetting problems. This seems to be a way of managing the discomfort. Rates himself as rung 3 from the bottom on the ladder. He says he would have been higher when he was working; not just because of increased affluence but also due to greater “self respect.” (ID291)

Thus, most of those interviewed placed themselves lower down the socio-economic ladder as compared with when they were in work. When interviewees were asked to rank other members of their social networks on the socio-economic ladder, they also used employment, education or qualifications, and monetary resources to make their assessments. In one case, a social network member who was a student was ranked highly because of his putative future earning capacity:

ID123: Well with him being a student he’s not high up on the financial. He’s not getting the money yet. But just above half way I would think. Just above half way.

Interviewer: Yes, okay.

ID123: And if you come back in another year, he might have gone up a bit, passed his exams and all the rest of it.

In this case, a personal downward socio-economic trajectory is contrasted with a younger person in higher education who is perceived to have an “upward” social trajectory. However, a further demarcation linked to contemporary social status trajectories was the comparison made of one’s own state of having a chronic illness with others in a personal network who did not. The question about SSS caused problems for some interviewees who had previously had good jobs, but were now out of work. For one 37-year-old married man with CHD and diabetes, work had provided a “thrill” and a social life, as well as an income. When asked to complete the ladder question, he struggled to place himself as he was unclear whether to incorporate his previous employment status into his self-assessment. A further part of the

confusion seemed to be that although work was viewed as thrilling and rewarding, the stresses of the job were also offered as an explanation for being ill in the first place (ID 273).

Depression and Isolation, Fatalism, and Hierarchy

It was common for interviewees to relate concepts such as stoicism, self-reliance, and an unwillingness to express a need for help from others. However, the bulk of respondents *did* have family members, neighbors, or friends who could be drawn on if and when help was needed. For others, there was nobody to call on for help or support. These concerns seemed to be exaggerated in people who placed themselves at the bottom of the ladder.

As with the results concerned with adverse life events, accounts of depression and loneliness were (unsurprisingly) more frequently encountered in people who were divorced, separated, or single. However, one 56-year-old married man with a 15-year history of depression, diabetes, and CHD also described himself as a “loner” (ID209). In general, it was not always clear whether people had ended up lonely and isolated by dint of circumstances or whether they perhaps preferred things that way. Certainly a distinction needs to be made on the basis of the meaning that individuals gave to their relatively isolated position. Nonetheless, in this context, it is worth re-iterating that work provided a primary means of interaction for many people, and thus the nexus of loneliness and depression is likely to involve an integration of exacerbatory and complementary factors. An underlying theme in the accounts suggested strong social expectations of individualism, self-reliance, and privacy, as well as a preference for weak tie relationships because of the opportunity for reciprocity rather than dependence (see also Brooks et al., 2012; Rogers et al., 2014). Thus, network interactions need to be considered against this background. These issues are summarized in the words of a 65-year-old single man with CHD who described how he had previously been friendly with his neighbors, “but friendly at a distance” (ID381). In an extreme example, a man who could think of nobody to name in his social network also expressed fatalism in relation to the hierarchy of social class, as in the following summary notes of the interview:

Didn't want to place anyone in the network. He said nobody helps him. He said, “I am on my own.” Had fatalistic view of inequality. When it comes to scoring the ladder he says that it doesn't matter what you do, you'll never get to move up as the people at the top of the ladder won't let you move up. (ID338)

Three people who placed themselves higher up the socio-economic ladder despite their own objectively low status (i.e., according to income and occupation as recorded in survey data) reported large and dense social networks and two of them said that they had family members who were wealthy.

It is not clear from the accounts whether some of this wealth was perhaps transferred or available to interviewees (e.g., in a crisis or emergency) or whether the status of other family members had partly “rubbed off” on them as part of their self-assessments.

One of these interviewees, a 77-year-old man who had lived with a diabetes diagnosis for 20 years initially said that he had nothing to do with his children; his siblings all lived abroad and he did not get involved with his neighbors. However, later during the interview, he explained that one of his daughters was living with him and his wife while her own house was being re-decorated. He was going to Church every Sunday and occasionally attending a social club that he had been going to for the past 45 years. He used to be a builder (ID202). Clearly, his account stood in contrast to the tales of misfortune and adversity described above. A woman with diabetes who had fostered children all her life and previously ran a children's home described how one of her foster daughters was a millionaire who lived abroad. She was still caring for one foster son at home and had grandchildren who were visiting for meals every day because their “mother is an alcoholic.” She had previously nursed her husband who had Alzheimer's disease and she was also cleaning someone else's home for them (ID337). In this case, however, difficult life events were part of the narrative and included a philandering (first) husband, regrets about not having children of her own, and being beaten by nuns as a child. Finally, one former Sergeant Major reported a rich and diverse social network including family members, neighbors, friends, and membership of a local community group. However, his account also included previous tales of adversity, including “yobbos” in the neighborhood, and daughters who fell out over financial matters. He was visiting family members in the United Kingdom and Australia several times a year (ID148).

Two of the three interviewees just referred to appeared to be members of local churches and two reported regularly visiting relatives abroad. Unlike those interviewees who placed themselves at the bottom of the ladder due to social isolation or the inability to “go somewhere,” those who self-assessed themselves as higher up the ladder reported more social activities and connections, lived with other people, and had opportunities to travel to visit relatives. Given that those who placed themselves at the bottom of the ladder suggested a sort of downtrodden fatalism, one hypothesis might be that people with wealthy social connections were not as fatalistic, perhaps because they had seen people who had been able to advance their own status up the socio-economic ladder.

Age, Physical Capacity, and Proximity to Impending Death

For one 55-year-old man with CHD and diabetes—and his partner, who also contributed to the interview—the most

important criterion used, in addition to lack of money, was physical capacity or capabilities. Thus, when asked to rank others in relation to himself, he said of his daughter's boyfriend, "A bit higher [than me] because he works and is more physical than I am" (ID69). Thus, the construction of physical capability was tied to the physicality of (manual?) labour and thus perhaps an extension of the major theme of not being in employment. In a similar manner, one interviewee described a neighbor as also being at the bottom of the ladder because he had "long term health issues" in the form of a severe spinal injury (ID212).

We previously saw how the financial aspects of retirement led some people to place themselves at the bottom of the ladder. Another used age more simply and explained their position at the bottom by virtue of the fact that they had "one foot in the grave" (ID264). One 45-year-old man with "very painful" arthritis in his spine, along with CHD and other health problems, expressed the opinion that he is "not even on the bleeding ladder" (ID074). This extreme case, among a sample of extreme cases, would suggest that issues of physical capacity are magnified for younger people within cultural expectations that people only become infirm and unable to work as they get older.

Discussion

In a study of cross-sectional data from the English Longitudinal Study of Aging, Demakakos et al. (2008) found that SSS was correlated with health in an elderly sample, "possibly because of its ability to epitomize life-time achievement and socioeconomic status." The effect of SSS on health, depression, illness, and disability was greater than that of occupation, wealth, marital status, and age (Demakakos et al., 2008, p. 7). Our findings taken from the qualitative aspects of mixed-methods interviews and focused on those who perceived themselves to be at the bottom of the socio-economic ladder illuminate and expand on these statistical findings. Thus, in our sample, rather than Demakakos et al.'s (2008) "accumulated successfulness in life," we rather witnessed a catalogue of hardships or adverse events, which could rather be termed an accumulation of failure or misfortune; "failure" in the case of social relationships, and misfortunes in relation to ill health and the premature death of children or other relatives. From the accounts presented herein, the loss of work was experienced as possibly the most serious consequence of a long-term illness or disability, rather than the symptoms. This emphasized the substantial reliance on employment as a source of money, social relations, and cultural identity. However, these findings seemingly contradict those from the quantitative analysis of our SSS survey data in the wider sample from which our qualitative findings were drawn, where employment was not in itself found to be an independent predictor of SSS (Vassilev et al., 2014). In the present analysis, we have focused on respondents with low SSS and (mostly) those also with low

SES. Our findings would seem to highlight the importance of work for those who do not have it and also assert the central role of employment status in self-constructions of SSS. Thus, our findings do not contradict the statistical data from the survey, but further underline the very limited circumstances under which SSS can be "rebuilt" outside the labour market in the context of life with chronic illness. Perhaps unsurprisingly, fewer respondents with low SES expressed higher SSS. Their accounts further underlined the importance of social relationships and social networks in contributing to a raised SSS. Thus, for interviewees of low SES who had people around them, who were involved in community groups, or who had relatives higher up the social ladder than themselves, some of the "positive" aspects in others appeared to somehow rub off on them. An important difference in the two groups seemed to involve whether people were able to get out of the house, or travel to different places, in a context where ill health had often closed down paid employment as the primary means of activity and social relations.

Notwithstanding our use of an analytical framework derived from Bourdieu (1999) and others, our findings also resonate with theoretical observations, which draw on the work of Talcott Parsons (1991), in relation to the role of human agency and motivational factors in illness when expectations around self-management are drawn into the equation. In *The Social System*, Parsons (pp. 289-290) noted the potential for illness to affect the "performance of social roles" while noting that "motivational factors" are involved in the causation of some illness, such as mental illness, where symptoms are seen as occurring "mainly on the behavioural level." Parsons's (1991) work is frequently drawn on in relation to his observation that the "sick role" exempts individuals from "normal social role responsibilities" and the commensurate normative expectation that "sick" people are obliged "to want to 'get well'" (p. 294). However, patients are also expected to "cooperate . . . in the process of trying to get well" (Parsons, 1991, p. 294).

Parsons (1951) wrote of "social role responsibilities," mainly focused on the importance of work in self-identity, which raises some interesting observations in relation to the treatment and management of long-term conditions where self-management aspects are currently seemingly highlighted over other issues, such as poverty or unemployment. Our findings lead to questions about the extent to which people can and expect to "get well" in the context of long-standing conditions where the etiology partly lies in material deprivation, social and economic "failure," and other biographies or trajectories characterized by a multiplicity of adversities. Brooks, Rogers, Sanders, and Pilgrim (2014) point to the preoccupation with managing the present because of a fatalism over not being able to recover from a long-term condition. This resonates and is extended by findings here. For example, the account of a man who had suffered lifelong partial deafness, obesity, and depression as a result of being repeatedly beaten around the head by his father as a child

suggests a man so “broken” that there is little motivation to “get well.” It also points to a weakness in Parsons’s (1951) theory in that it seemed to prioritize the behavior and attitudes of “the patient” “himself,” rather than the agency of other actors in the social system. However, the case alluded to above clearly points to an instance where the illness is “not his fault” and neither can he seemingly “extricate himself” from it “by his own effort” (Parsons, 1991, pp. 294-296). Thus, application of a Parsonian perspective in this manner actually shows up the potential weaknesses of a self-management approach to treatment, whereby the agency to “get well” is seemingly projected back onto the individual patients themselves and the delegation of “work” to them. Our findings also highlight the fundamental tension of employment as a source of wellness versus employment as a reason for sickness. Our data do bring to the fore the conflation of social status with the experience of the management of a long-term condition. *Habitus* implicates individuals in producing, reproducing, and embodying the habits, norms, practices, and representations associated with belonging to a particular social group (or groups). In relation to biographically based narratives of illness management and dispositions, “disposition” was routed in accounts of earlier life events—having a hard life and multiple adversities in earlier years. These were commensurate with references made to strategies of stoicism, self-reliance, and an unwillingness to express a need for help from others as a primary means of management in domestic settings. Although these notions are evident in accounts of illness management more generally, the degree to which these were expressed by those at the bottom of the ladder contrasts with the self-efficacy based on autonomy and success characteristics of accounts of more privileged “expert patients” (Protheroe, Brooks, Chew-Graham, Gardner, & Rogers, 2013). Moreover, this observation coalesces with evidence of the presence of a more proactive questioning and discussion of long-term condition management plans being the preserve of those in higher socio-economic groups, whereas those from a lower socio-economic situation have been found to be far less well disposed to the notion of participation following perceptions of the legitimacy based on prior formative experiences and norms (Rogers, Bury, & Kennedy, 2009).

Skeggs (2004) offers an overview of socio-cultural understandings of “the self” and demonstrates how formations such as Bourdieu’s *habitus* most usually rest “upon the accrual of property and value,” (pp. 75-77) often symbolic in nature (after Lash, 1990). However, within Bourdieu’s schema, the working class are viewed as “trapped by their habitus positions embodied as value-less dispositions” leading to a “resigned, adaptive” working class habitus (Skeggs, 2004, p. 87). Toward the end of her article, Skeggs (2004) highlights the distinction between a “future-blocked as opposed to a future that can be invested in”:

Bourdieu (1990) argues that emotion is a presenting of the impending future, but I’d argue that negative affects are past,

present and future—drawing on the history of inequality which is an accident of birth, the frustration that things are not fair and a knowledge that they are unlikely to change in the future. (Skeggs, 2004, p. 90)

These issues resonate with the findings of our own study where some people who placed themselves at the bottom of the ladder spoke of being kept or trapped there. This entrapment was largely associated with having an illness and being unable to work and was also linked to the kinds of “accidents of birth” that had resulted in biographies characterized by domestic violence, the consequences of heavy drinking, and other structural (or structurally located) adversities. Although others have noted that frailty and illness lead to an incapacity to enact class, gender, or other social roles (Angus, Kontos, Dyck, McKeever, & Poland, 2005), our own findings underline (as many before us) the socially situated nature of sickness, disability, or ill health. To put it simply, it is not clear from the accounts presented above whether illness is the nub of the problem, or whether the relationship failure and the loss of work are more important. Within a constellation of misfortune, illness is seen as both cause and effect, which also begs questions about the fetishization of “illness experience” by health and illness researchers, when other issues may hold more important consequences for individual trajectories, biographies, self-identity, and enactment of strategies to effectively manage long-term conditions. There was a seeming total absence of possibilities for social status or a positively emergent identity formation from being ill. The latter is cited as being evident in the emergence of a moral agency surrounding being “successfully ill” (Frank, 1997). The latter has been construed as identifiable in narratives of those overcoming illness or disability successfully through personal engagement with the healing process or illness experience. The narrative itself is seen as part of the process of empowerment through “telling ones story.” This formulation by Frank taken to its logical conclusions suggests the possibilities for the construction of a new status to emerge from managing illness successfully. The notion of being successfully ill has been most prominently located in those who prior to being ill held high social status jobs (the narratives of journalists, for example, suffering from cancer or stroke, come to mind). In the analysis presented above, there was little, if anything, to suggest the tangible emergence in narratives of a status based on being someone with or having a chronic condition. Rather, accounts emphasized the importance of the lost world of work for status identification and the futility or lack of belief that having a chronic illness could lead to new or positive social status identification. It seems that following the ethnographic fieldwork of Fabrega and Manning (1973), illness behaviors, symptoms, meanings, and interpretations involve wider (structurally and biographically situated) issues that go beyond illnesses and disease categories themselves.

Our findings also support those from Townsend’s (2012) application of Bourdieu’s theory of *habitus* to accounts of

people living with multimorbidity, where “diminished physical capacity shifted relational positions in fields” and “employment was expressed as a source of capitals; economic, social and symbolic” (p. 94). However, there appears to be a tension here between the centrality of employment to working class experience and identity and Skeggs’s (2004) assertion that working class identity formation “cannot be framed in the shape of a self that is in anyway interested in accruing exchange-value to itself” (p. 90). For Skeggs (2004), this “exchange-value” is largely understood to be symbolic in nature, following the theories of Bourdieu and others. In this regard, it was noteworthy that the three main aspects that determined whether people placed themselves near the top of the socio-economic ladder seemed to be mobility (and by extension, the ability to “go somewhere” and otherwise join in with consumer society), having larger family and friendship networks or being involved in churches or other community groups, and the existence of other family members who were rich in economic terms. If we combine these concerns with the primary importance of work as a source of “capitals,” we can begin to see the kinds of ways in which “accruing exchange-value” might indeed form a nexus in working class identity formation. Being involved in a reciprocal manner with groups and individuals that constitute weak ties leads to a re-valuing of a positive moral sense of agency, linked to the ability to direct one’s life in a way that is self-enhancing (Rogers et al., 2014). Although recent sociological models of class claim to have incorporated “the role of social and cultural processes in generating class divisions” (Savage et al., 2013), our findings would suggest that they might have not gone far enough.

Conclusion

Previous quantitative studies have identified a relationship between SSS and inequalities in health (Demakakos et al., 2008). In the secondary analysis of data collected for a social networks survey of peer support in condition self-management presented in this article, the reasons why this relationship might exist have been illuminated and linked to social theory. Our findings suggest that the primary factor that people use to rank themselves notionally above or below others is whether they are working or not. Illness is mainly important as it restricts productive capacity. Our results also highlight the interplay between social connectedness (versus isolation), perceptions of human agency or self-efficacy, and SSS. Most importantly, these narrative accounts underline forms of downward status trajectory. The accounts speak to a plethora of adverse life events and social circumstances where having a chronic illness is merely one small part of a wider orbit of misfortune. Importantly, chronic illness can be seen as either a reason for low SSS or as a consequence of it. The findings speak to Parsonian notions of motivational factors in illness (Parsons, 1951) and reflect that low SSS—as well as chronic illness—plays a role in debilitating social role responsibilities and threatening self-identity and biography (Bury, 1982). Viewed through the lens of Bourdieu’s

(1990, 1999) habitus framework, the findings underline challenges for those who have lived “a hard life” and faced multiple adversities in meeting institutional expectations around self-management, which are predicated on active, informed, engaged, and well-resourced human agents. Thus, a form of “resigned, adaptive” (after Skeggs, 2004) patient, with a self-perception of adversity and hardships, may be unable or unlikely to achieve a “successful” illness identity (after Frank, 1997).

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