Habitus and Heart Health:
Using Bourdieu to Interpret Socioeconomic and Racial Disparities in Physical Activity Participation

A Thesis

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Abstract

Health deteriorating behaviors such as tobacco use, consuming an unhealthy diet and leading a sedentary lifestyle have been found to account for half of all mortality (Mokdad et al 2004; McGinnis and Foege 1993). Although some of these behaviors vary by socioeconomic status and race, the role of these proximal determinants in creating racial and socioeconomic disparities have recently been eschewed in favor of more distal, “fundamental” causes of disease. Being physically active is one such health behavior that varies both by race and socioeconomic status and has been documented to prevent and improve a myriad of morbidities and premature mortality (CDC 2008). Blacks and those of low socioeconomic status have been found to participate in significantly less physical activity than whites and those of higher socioeconomic status (CDC 2008) and bear a disproportionate burden of morbidities and untimely mortality that could be improved with physical activity (Adler and Rehkopf 2008; Heron et al 2006). Despite this evidence, we know very little about the process through which this health behavior becomes socially distributed. Investigating this process allows for a clearer understanding of how fundamental causes such as socioeconomic status, race and gender affect proximal determinants such as health behaviors to produce health disparities. To examine this process, I analyze physical activity behaviors of twenty young adults from various socioeconomic statuses whom self-identify as black or white. Through focusing on these interviews, it is evident that differential access to economic capital, rather than
differences in physical activity knowledge, beliefs, body image, and social norms are essential in shaping physical activity behaviors.
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Abstract........................................................................................................................................ ii
Acknowledgements.................................................................................................................. iv
List of Tables .............................................................................................................................. vii

Introduction............................................................................................................................... 1

Conceptual Framework............................................................................................................ 7
The Fundamental Cause Framework....................................................................................... 7
Bourdieu’s Theory of Cultural Reproduction ........................................................................ 11
Extending the Fundamental Cause Framework .................................................................... 14

Methods.................................................................................................................................... 29

Results....................................................................................................................................... 39
Motivations................................................................................................................................. 48
Body Size Preferences and Body Satisfaction ........................................................................ 51
Access to Economic Capital...................................................................................................... 57

Conclusion ................................................................................................................................. 70

References................................................................................................................................. 75
List of Tables

Table 1: Semi-Structures Guiding Questions .................................................. 34
Table 2: Sample Characteristics ................................................................. 39
Introduction

Chronic morbidities such as cancer, stroke and cardiovascular disease have emerged as the primary causes of mortality in the U.S. accounting for 70% of all deaths among Americans (National Center for Chronic Disease Prevention and Health Promotion 2008). Since the specific biological agents that cause these chronic diseases are largely unknown, contemporary disease prevention efforts have focused on the modification of proximal individual-level health behaviors such as tobacco and alcohol use, physical activity and diet. However, several scholars have expressed their dissatisfaction with such efforts since these approaches do not adequately address how populations become more or less susceptible to morbidity and mortality (Sretzer 2003; McMichael 1999; Krieger 1994). As a result, recent research has been dominated by a focus on social conditions such as race, socioeconomic status, gender and social relationships deemed the “fundamental” causes of disease (Link and Phelan 1995) leaving health behaviors such as diet, exercise and alcohol and tobacco use under-contextualized (Glass and McAtee 2006). I argue that the analysis of health behaviors continues to be of value as long as it is linked to processes that generate social inequality. By only focusing on social conditions themselves, and not on the processes that generate these social conditions, we are overlooking the importance of the social stratification
process in creating physical activity disparities. Physical activity is a crucial health behavior that prevents and improves a myriad of morbidities including stroke, cardiovascular disease, hypertension, diabetes, osteoporosis, cancer and depression (Physical Activity Guidelines Advisory Committee 2008; Warburton, Whitney and Bredin 2006; USDHHS 1996) and has been linked to over half of the top ten causes of death for blacks and whites in the U.S. (Heron et al 2009). Despite these benefits, over half (51%) of Americans do not regularly participate in enough physical activity to obtain these health improvements (CDC 2008). There are also marked socioeconomic and racial disparities in physical activity participation. Those with lower levels of educational attainment and some racial and ethnic minorities are less physically active than whites and those with high educational attainment. Over half (54%) of Americans with a college degree participate in the recommended level\(^1\) of physical activity while only 38.4% of those with less than a high school diploma are physically active at this level (CDC 2008). In addition, lower income groups are three times more likely to participate in physically inactive leisure activities (USDHHS 1996). With regard to racial disparities, over half (51.7%) of whites while only 40.4% of blacks participating in the recommended level of physical activity (CDC 2008). Although there are disparities in health outcomes between a variety of racial and ethnic groups, this research will focus on

\(^1\) Recommended level of Physical activity is defined as completing 150 minutes of moderate intensity aerobic activity, 75 minutes of vigorous intensity aerobic activity OR an adequate mix of moderate and vigorous intensity activities per week AND two or more days of muscle training that works all major muscle groups per week (Centers for Disease Control and Prevention 2009).
disparities between non-Hispanic blacks and non-Hispanic whites (hereafter referred to as blacks and whites) since 1) health outcomes between these groups are more divergent than those between many other racial and ethnic groups and 2) these health disparities are the product of unique race relations in America that warrant further investigation.

Blacks have poorer health indicators than whites for a variety of health outcomes. Blacks have a 30% higher risk of death from all causes and are expected to live five years shorter than whites at comparable ages (Adler and Rehkopf 2008; Heron et al 2006). One of the largest disparities in the leading causes of mortality between whites and blacks is diabetes related-deaths with the risk of dying from diabetes among the black population being more than double than that for the white population (Heron et al 2006). Diabetes increases the likelihood of heart disease, stroke, high blood pressure, nervous system damage, amputation, dental diseases and complications in pregnancy (Harris et al 1995). An individual’s risk of the development of diabetes increases dramatically as the degree of overweight increases. Modifications in diet and physical activity behaviors are two well-known ways in which diabetes, and obesity, a common predecessor of diabetes, can be prevented. It is estimated that an individual’s risk for type 2 diabetes can be prevented or delayed by losing 5-10% of one’s body weight (Smith 2007; Tuomilehto et al 2001).

Furthermore, epidemiological research has established that physical activity participation decreases throughout the lifecourse with a significant drop in activity occurring during the transition to adulthood (Centers for Disease Control and Prevention 2008). Nonetheless, this transition marks the peak of physical activity for American adults with the likelihood of being physically active decreasing throughout the lifecourse (Cockerham 2010; Centers for Disease Control and Prevention 2008). This transition is
also characterized by a decrease in institutional influence on physical activity behaviors. Thus it is imperative to examine the process that triggers this downward trend in physical activity throughout adulthood.

Variation in physical activity by race and socioeconomic status has been known for some time; however, the mechanisms that cause this variation have not been adequately theoretically explored and tested. Research that has gone beyond the conventional barriers and facilitators of physical activity such as “lack of time” or “inclement weather” have postulated that structural determinants such as access to recreational facilities (Powell et al 2006; Ball et al 2001; Booth et al 2000) and safe and walkable neighborhoods (Chang 2006; Davison and Lawson 2006; Burton et al 2003) can lead to racial and socioeconomic disparities in physical activity. Racial residential segregation is hypothesized to play an important role in differential access to safe neighborhoods with accessible and quality recreational facilities since whites generally live in safer residential contexts than blacks such that the worst possible urban residential environment that whites live in is superior to the average environment that blacks reside in (Sampson & Wilson 1995).

Other nonmaterial determinants of socioeconomic and racial physical activity disparities include physical activity-related knowledge (Young et al 1996), motivations (Lindbladh et al 1997), sporting and physical activity preferences (Wilson 2002; Bourdieu 1978) and body size ideals (Chang and Christakis 2003; Anderson et al 2002). Body satisfaction and body size preferences vary considerably by race and socioeconomic status with blacks favoring larger bodies and expressing more body satisfaction than whites, even when they are heavier than the white participants in the
study (Anderson et al 2002; Mossavar-Rahmani et al 1996; Akan and Grilo 1995; Abrams et al 1993; Rucker and Cash 1992). Those in the lower socioeconomic strata have also been found to have higher levels of body satisfaction and to be less likely to classify themselves as overweight than those in higher socioeconomic positions (Chang and Christakis 2003; Anderson et al 2002). This is especially noteworthy since low body satisfaction has been found to be a key predictor in physical activity participation (Anderson et al 2002). These differences are hypothesized to emerge from the propensity of individuals to use those of similar races and socioeconomic statuses, rather than those of different races and socioeconomic statuses, as reference groups, which is particularly problematic since blacks and those of low socioeconomic status have significantly higher rates of obesity (CDC 2007). Research has also hypothesized that those of higher socioeconomic status have a propensity to adopt “healthier behaviors and lifestyles”, which ultimately creates socioeconomic disparities in physical activity participation yet fail to provide a theoretical explanation for why or how this occurs (Winkleby 1992; Ross and Wu 1995).

This paper contributes to our understanding of how racial and socioeconomic disparities in physical activity are produced and provides an example of how proximal determinants of health outcomes continue to be of use given that they are carefully contextualized. Furthermore, this paper locates previous theoretical work under Bourdieu’s theory of cultural reproduction to highlight the process of social stratification in the creation of physical activity behaviors with emphasis on the utilization and transformation of capital. I will begin with a brief discussion of the fundamental cause framework and Bourdieu’s theory of cultural reproduction followed by a discussion of
how these theories can be united to provide a useful analysis of socioeconomic and racial disparities in health. Afterwards I will provide an in-depth theoretical account of how differential access to economic and cultural capital can create disparities in physical activity behaviors.
Conceptual Framework

*The Fundamental Cause Framework*

As aforementioned, a focus on more proximate determinants of health such as health behaviors has recently been eschewed in much social epidemiology literature since this approach is deemed to divert attention from what Link and Phelan describe as the “fundamental cause of disease”. In response to the proliferation of psychosocial and behavioral models of epidemiology that focus on health behaviors that put *individuals* at risk of morbidities, Link and Phelan argue that research should concentrate on what puts populations “at risk of risks” (Link and Phelan 1995). In other words, a focus on underlying or “upstream” determinants of health is needed to understand the process through which *populations* become at risk for morbidity and mortality. Link and Phelan argue that *social conditions* that affect access to knowledge, power and resources are the underlying causes of morbidities that put individuals at risk of more proximate determinants of health. Social conditions are defined as “factors that involve a person’s relationships to other people” (Link and Phelan 1995: 81). Thus, interpersonal relationships, stressful events, social support, and one’s position within the social and economic sphere, among other factors, are considered social conditions. Furthermore, some social conditions such as socioeconomic status, social networks, race/ethnicity, and gender are deemed *fundamental causes*. These social conditions can be identified as fundamental causes since they: 1) affect multiple health outcomes and diseases through
multiple risk factors; 2) are associated with mortality historically through the substitution of intervening mechanisms; 3) allow individuals to have access to and utilize resources that prevent risk factors for morbidities and/or mitigate any negative effects that may result once the morbidity has occurred (Phelan et al 2004).

The nature of morbidities and mortalities in modern society is quite dynamic. As new medical information is disseminated, known risk factors and etiologies of disease change, and research suggests that some populations are better able to act on this information than others (Phelan et al 2004; Link 2008; Mirowsky and Ross 2003). However, it is unclear what factors lead some individuals to act upon medical information while others do not (Link 2008; Phelan and Link 2005). Link uses the history of tobacco use as an example to bolster this point (2008).

When smoking was first introduced, those in the higher social strata quickly took up the behavior while those in the lower strata lagged behind. However, when evidence of the health deteriorating effects of smoking were discovered in the 1950s, the proportion of smokers with over sixteen years of education dropped dramatically by the late 1960s and early 1970s from 45.5% to 34.4% while these percentages remained relatively unchanged for those with less than sixteen years of education (Link 2008). In addition, there was a clear educational gradient in the belief the smoking was a cause of lung cancer with nearly two-thirds (62.8%) of those with less than a high school education believing that smoking was a cause of lung cancer while 84.7% of those with at least a four year college degree believed this. By the 1990s this gap narrowed greatly. Nearly all individuals (96.8%) with a four year college degree believed smoking is a cause of lung cancer while 86.6% of those without a high school diploma believed this.
However the educational gradient in the proportion of current smokers actually increased. Furthermore, while the mortality rate of lung cancer was higher for those of high socioeconomic status than for those of low socioeconomic status in the 1950s, by the 1970s this trend was completely reversed with lung cancer mortality rates being lower among those in the middle and lower socioeconomic strata.

A similar pattern has occurred throughout history with physical activity behaviors. In the early 1900s, coronary heart disease was considered an affliction of the upper social classes. The link between physical activity and coronary heart disease was developed by comparing the coronary mortality between men of differing occupational statuses (MacAuley 1994). Those in the professional and business classes were found to have double the coronary heart disease mortality as unskilled workers whose occupations required great physical exertion. However, like smoking behaviors, this trend was reversed with those in the lower socioeconomic strata now experiencing a larger burden of coronary heart disease and being less likely to be physically active. Although it can be suggested that those in higher status white collar positions utilized their resources to prevent this morbidity, this trend was also undoubtedly impacted by a recent decrease in physically rigorous positions that often characterize blue-collar positions. The percentage of high activity occupations has decreased since 1970 from 30% to 22.6% while low activity positions have increased to 41% remaining relatively stable for 30 years (Brownson, Boehmer and Luke 2005). Furthermore, unlike the tobacco use situation, it is questionable as to whether significant variations in physical activity knowledge or beliefs exists.
These trends in the diffusion of health information and health behaviors suggest that social conditions, namely socioeconomic status, are the fundamental cause of disease since disparities in smoking persist even when such disparities do not exist in knowledge and beliefs surrounding tobacco use. However Phelan and colleagues set out to empirically test the fundamental cause theory by using the National Longitudinal Mortality Study to determine whether the relative risk of mortality from highly preventable and less preventable causes varied by socioeconomic status (2004). The results of this study found that socioeconomic status was increasingly related to survival only when the cause of death was highly preventable. This finding implies that access to and utilization of material and nonmaterial resources are central to the reproduction of socioeconomic disparities in health outcomes since socioeconomic differentials are the greatest in health outcomes that can be prevented or reduced through known behavioral or medical interventions. This relationship held across racial/ethnic and gender groups. However, stating that those with more knowledge, power and resources actively use their assets to prevent morbidity and mortality is far different from describing how this process occurs. We still do not have a firm understanding of how health behaviors are socially distributed (Link 2008).

Given this gap in the literature, Link and Phelan argue for the contextualization, not the abandonment, of proximal determinants by focusing on how upstream processes affect more downstream determinants. Instead of delineating individual risks for morbidities and premature mortality, Link and Phelan advocate the explanation of how populations become more or less susceptible to these more proximal risks of morbidity and mortality.
However, the fundamental cause framework does not provide a useful framework to contextualize these factors. In order to make such contextualization, it seems necessary to find a way to theoretically link individual behaviors to a larger collective to explain population trends in physical activity behaviors. Furthermore, a dynamic theoretical approach is needed to understand the processes through which social conditions gain meaning and power to influence health outcomes. It is this process, not the resulting social strata that is in need of explication to understand how health disparities are created and reproduced. Bourdieu’s theory of cultural reproduction can aid in this endeavor with the concept of *habitus* that links individual behaviors to a larger collective through structural gain and disadvantage and multiple classifications of *capital* that assist in discussing how the social hierarchy is established, legitimized and maintained.

* Bourdieu’s Theory of Cultural Reproduction

Bourdieu attempts to explain how stratified social systems of hierarchy, created by an unequal distribution of various forms of capital, persist and *reproduce* intergenerationally with little resistance to the status quo (Schwartz 1997). Like Link and Phelan, Bourdieu argues that access to a wide range of resources including money, power, knowledge, and social relationships determine a person’s status in the social hierarchy. For Bourdieu, these various types of resources are conceptualized as forms of capital. A person’s position in the social hierarchy is then determined by access to and utilization of capital. Those with similar access to these resources who experience long
term occupation in these positions generate collective perceptions of the world that have a significant influence on how people live and perceive the world (Singh-Manou & Marmot 2005).

As mentioned above, Bourdieu’s multiple conceptualizations of capital are of great use in the contextualization of physical activity behaviors. All forms of capital (cultural, social, symbolic and economic) are linked to a larger social structure, which Bourdieu calls the field. Fields are a central concept of Bourdieu’s sociology and represent an “arena of struggle” in which actors engage in conflict to gain legitimation, or more precisely, the right to monopolize the exercise of symbolic violence (Schwartz 1997). In a highly stratified society, people will search for ways in which they can maintain or improve their status in the hierarchy. In order to achieve this, actors must convince others through the usage of their multiple forms of capital that their position in the social hierarchy is legitimate. Bourdieu did not conceptualize the field as a physical location with geographical parameters but instead conceptualized fields as contexts in which people interact and refer to both physical and social spaces (Lynam et al 2007, Ritzer & Goodman 2004). Fields can be arenas of production, circulation, appropriation of goods, services, knowledge and status.

Field struggle centers on particular forms of capital. Bourdieu describes four general forms of capital: economic (accumulated wealth), cultural (educational credentials, aesthetic tastes), social (networks), and symbolic (honor, legitimation) (Schwartz 1997; Jenkins 2002). The amount and sources of capital individuals and groups have dictates their location in the social hierarchy and their position in the field. Those who share common positions in the field develop a collective conscious that
generates collective perceptions of the world and strategies to move within it. These unconscious and persistent dispositions and actions are defined as *habitus*.

Habitus provides individuals with predetermined ways of perceiving, experiencing, and behaving (Singh-Mantoux & Marmot 2005). More specifically, habitus is defined as a “collective social construction of the world (Schwartz 1997: 89).” Bourdieu argues that the relationship between objectivity and subjectivity is dialectical and that *practice*, action completed by the individual, is the product of this relationship. These practices are influenced by a *habitus*, which represents the internalization of structures that arise from the long-term occupation of a social position in a culture (Calhoun et al 1993; Lindbladh et al 1997). Habitus is viewed as a product of both early childhood socialization and adjustment to current material and nonmaterial conditions (Jenkins 2002).

A key aspect of habitus is that it provides a script for people’s daily lives; replacing the need to regularly reinvent actions or deliberate the benefits and costs of engaging in every behavior. Habitus provides a set of predilections, choices, knowledge and perceptions that don’t need to be recreated every day. Bourdieu spent a great deal of his scholarly energy exploring the origins of various health-oriented practices. According to Bourdieu, “the way of treating [the body], caring for it, feeding it, maintaining it reveals the deepest disposition of the habitus” (1984: 190). His research, and the work of many other scholars, has shown in both qualitative and quantitative terms that orientations to the body and conceptualizations of health vary considerably by social class (Bourdieu 1984; D’Houtad and Field 1984; Crawford 1984). Therefore, using Bourdieu’s framework, individual physical activity behaviors (practices) result from a
shared social construction of the world (habitus) that is developed from long-term occupation in a position within the social structure that is determined by access to capital.

*Extending the Fundamental Cause Framework*

The fundamental cause framework and Bourdieu’s theory of cultural reproduction both draw attention to how material and nonmaterial circumstances create and reproduce socially patterned health outcomes. However, these theoretical orientations differ in their treatment of what Link and Phelan term “fundamental causes”. As aforementioned, social conditions are the fundamental cause of disease since they affect multiple health outcomes, are associated with mortality through the substitution of intervening mechanisms throughout history and allow access to and utilization of resources. Yet this framework does not theorize how these fundamental causes are fashioned and replicated. The fundamental cause framework views socioeconomic status, social networks, and ascribed statuses such as sex, race and ethnicity as fundamental causes, the most distal determinants of disparities in health outcomes; however these determinants are not the most upstream and are not appropriate starting points for understanding health disparities since social conditions do not arise out of nowhere. Certain processes precede these conditions to give these categories meaning in the context of various health determinants.

Firstly, the fundamental cause framework somewhat falls victim to what the theoretical orientation was, in part, created to critique. This framework criticized researchers’ limited concentration on proximal factors such as health behaviors and biomarkers, and argued that such attentiveness to these factors neglected the role of the
social structure as the fundamental cause of disease. However, while identifying the
social structure as the fundamental cause of morbidity and mortality is useful, it is only
an initial step in a research agenda geared towards understanding how social determinants
of health are created and is equally limited in scope. Just as it was identified that the
social structure is the antecedent to proximal factors of health, we must also recognize
that the processes that generate and reproduce these structures are the antecedent to the
structure. Stating that social conditions such as education, income and gender are
fundamental causes does not capture the dynamic and complex processes of social
stratification. It is this process of social stratification, not the outcome, that is need of
exploration to understand how social conditions work to create inequalities in health.
Thus the sorting process itself, not the product, can be thought of as the fundamental
cause of disease. Ignoring this process leads one at a disadvantage of explaining how
fundamental causes affect health outcomes. For example, it will be difficult to
understand how and why class works in creating health disparities if the processes
through which social and economic classes are formed are not understood or incorporated
into research.

Secondly, the fundamental cause framework can lead to the belief that social
conditions such as race, class, gender and social networks are separate social
determinants of health outcomes since they are not clearly theoretically linked in this
framework. However, it is well recognized that these aspects of social life collide in
meaningful ways that allocate persons and groups within the social hierarchy. The
separation of such dimensions of social conditions has led to an often non-productive
dialogue surrounding the relative importance of one aspect of social conditions over another.

While the fundamental cause framework adequately pushes the field beyond risk factor epidemiology by drawing attention to how social conditions are the fundamental causes of morbidity and mortality, Bourdieu’s theory of cultural reproduction can be applied to understand why these social conditions, namely class, matter. The theory of cultural reproduction addresses the shortcomings of the fundamental cause framework by (1) presenting a framework for understanding the processes through which people become sorted into statuses within the social hierarchy that assist in contextualizing downstream determinants of morbidity and mortality and (2) contributing the concept of multiple forms of “capital” that are theoretically distinct, yet are discussed relationally to explain the generation and reproduction of the social structure. Although Bourdieu defines three elements of capital that are mediated by symbolic capital to create distinct social classes, this paper will only focus on cultural and economic capital. Social capital is not discussed in this paper since the data did not pick up on social capital networks that may influence physical activity. Furthermore social capital can never exist independently of cultural and economic capital since monetary and cultural resources are needed to participate in and benefit from social networks. Due to this interdependency, an in-depth account of cultural and economic capital continues to be of use in contextualizing physical activity behaviors and may inform future research on social capital and physical activity.
Economic Capital

Bourdieu conceptualizes economic capital as access to monetary resources such as personal and household income and shares (Jenkins 2002). Economic capital is one of the most tangible and well-known dimension of class and is considered a significant component of socioeconomic status. Its relationship to class is quite intuitive. Generally speaking, those with more access to economic capital are able to attain higher positions in the social hierarchy since the possession of money is legitimized through the mediation of symbolic capital via consumption of material goods. Economic capital, often measured as personal and household income, has a persistent positive relationship with favorable health outcomes and health-promoting behaviors including physical activity.

Research has consistently found a positive relationship between income and physical activity participation throughout the life course (Gordon-Larsen, et al 2000; Steenland 1992; Stephens et al 1985). The likelihood of participating in moderate and vigorous physical activity increases as individual and household income increases. Although this relationship has been extensively documented, explanations as of why this relationship exists are few. One pathway through which monetary resources affect physical activity behaviors is through the consumption of equipment for physical activities and the purchase of memberships to recreational facilities. Research has found that having access to home equipment is associated with an increase in moderate and vigorous physical activity and strength training (Jakicic et al 1997; Sallis et al 1997). Another potential pathway economic capital affects physical activity behaviors is through the consumption of housing. Those with more access to economic resources can
purchase housing in neighborhoods rich with amenities that promote physical activity such as recreational facilities, safe public trails and parks, and areas amenable to walking (Powell et al 2006; Ball et al 2001; Booth et al; Ross 2000).

Occupation, another important indicator of socioeconomic status, is a source of economic capital since it is a primary source of income. Occupation is hypothesized to influence health through its effect on prestige, obligations, physical activity and environmental exposure in employment settings (Winkleby 1992; Brownson et al 1991). Steenland et al estimate that occupational mortality is the eighth leading cause in the U.S. after diabetes and is greater than deaths attributable to motor vehicle accidents (2003).

Significant variations in physical activity have been found among occupations with those in blue collar positions reporting lower levels of physical activity than those in white collar and professional positions (Olridge 1992; Niknian et al 1991). These differences in physical activity participation among blue collar and white collar workers have been hypothesized to result from differences in time availability, activity levels at work and reporting of physical activity participation.

Although insufficient time is often considered as an excuse rather than a legitimate barrier to physical activity, some hypothesize that there may be real differences in time availability between blue and white collar workers. Those in blue collar positions who earn less income may have to live in farther away, affordable housing and may rely on public transportation which may take time away from being physical active. In addition, blue collar workers often have less control over work hours leading to inconvenient time opportunities to participate in physical activity (Burton and Turrell 2000). Employees in blue collar occupation may also have more active jobs and
thus feel as if further activity is not needed or may not consider moderate activities such as walking as a physical activity due to high levels of activity at work (Brownson et al 2000; Garrison et al 1993). Lastly, those in higher status groups such as those in professional or white collar occupations may report higher levels of physical activity since their peers may place more emphasis on a healthy lifestyle than lower SES groups (Doomers et al 1998).

However, economic capital, like all forms of capital, can be converted into other forms of capital. For example, economic capital can be converted into cultural capital via investing financial resources into higher education. In this case, financial resources (economic capital) can be converted to educational credentials (an institutionalized form of cultural capital). Furthermore, this investment in cultural capital can lead to both higher returns for economic and social capital. An individual who invests economic capital to gain educational credentials will often do so with hopes that these credentials will lead to a better employment situation with higher economic compensation. Furthermore, this single financial investment also reaps social capital benefits. Social networks will also be altered as the may improve in quality and quantity as these networks become saturated with groups who are also in pursuit, or have already attained, educational credentials and steady employment. In relation to physical activity behaviors, economic capital that is converted to cultural capital in the form of higher education can lead to increased access to indoor and outdoor physical fitness facilities, fitness classes and other physical activity-related educational programming, and access to a qualitatively different social network that may influence physical activity behaviors.
These same mechanisms also contribute to racial disparities in health since there are strong and unique racial disparities in access to economic capital. Blacks are more likely to live in poverty and have substantially fewer assets than whites (Kiester 2000; Conley 1999). Furthermore, blacks are disproportionately located in undesirable and low-paying occupations. Even at high levels of educational attainment, marked differences in compensation exist with blacks receiving less pay for similar jobs (Grodsky and Pager 2001). It has been suggested that these racial disparities in socioeconomic status are driven by racial residential segregation (Williams and Collins 2001). Blacks are more likely to live in racially segregated areas with concentrated poverty that are riddled with a myriad of structural constraints to participating in physical activity. Residents of areas with high crime are more likely to constrain their outdoor physical activities due to a fear of victimization (Chang 2006; Burton et al 2003). Furthermore, businesses may avoid investing in urban areas characterized by high levels of segregation which leads to fewer accessible, satisfactory recreational facilities (Williams & Collins 2001). In addition, these neighborhoods often have a low tax base which produces a lack of public land devoted to accessible and safe outdoor facilities for exercise. Chang hypothesized that this intense residential segregation, characterized by restrictions of economic and cultural resources such as educational, income and employment opportunities, create a divergence between mainstream expectations and tangible opportunities that facilitate the development of subcultures in which widely held cultural values are opposed (2006). Thus, embodied cultural capital expressed as normative emphasis on health enhancing behaviors such as consuming a nutritious diet and being physically active may be rejected.
Cultural Capital

Bourdieu identifies three different “states” of cultural capital; the embodied state, the objectified state and the institutionalized state (Bourdieu 1986). The embodied state of cultural capital consists of long lasting dispositions of the mind and body that are transmitted through socialization. Cultural goods such as books and art are objectified states of cultural capital that, unlike economic capital, can be transmitted via gift or bequest; however the appropriate embodied cultural capital is needed to use an appreciate these goods appropriately. Finally, the institutionalized state of cultural capital includes educational qualifications and credentials that are most easily converted into economic capital. I will focus on institutionalized and embodied forms of cultural capital since they are more relevant to the discussion of physical activity behaviors.

Research has focused on the institutionalized form of cultural capital since over time, educational attainment is the most commonly used measure of socioeconomic status (Winkleby 1992). The positive impact of educational attainment on health outcomes has received a considerable amount of attention and has been documented as the strongest predictor of health outcomes among other SES indicators (Winkleby 1992). An article by Ross and Wu provides a useful theoretical account of the mechanisms through which education influences these outcomes, yet some pathways remain unclear (1995). Although Ross and Wu did not make reference to capital in their article that identifies labor, social support and healthy lifestyle as potential mechanisms through which education affects morbidity and mortality, these mechanisms highlight the process through which educational credentials, an institutionalized form of cultural capital, is
transformed into social, cultural, and economic capital. I will now briefly discuss these pathways.

Perhaps the most familiar conversion process is the use of educational credentials to legitimately gain access to economic capital through better paying full-time employment, which can be used to purchase health-enhancing resources and gain entry into desirable housing conditions. In addition, those with higher levels of education are less likely to work in health compromising employment settings and are more likely to evaluate their work positively which may lead to favorable mental health outcomes. In its institutionalized form, education can also increase access to social capital. Those with higher levels of education are less likely to experience unemployment which results in a lack of social support, which has been found to prevent morbidity and premature mortality. Increased marital conflict is also a common result of unemployment which further diminishes social support.

However, in addition to its role as a mere “credential”, educational institutions also serve as important socializing agents. The socialization that occurs in these settings can have “long lasting dispositions of the mind and body” and are therefore important sources of embodied cultural capital. Ross and Wu argue that educational attainment affects health outcomes through the institution’s ability to develop problem solving skills through gathering and analyzing information (1995). These skills are also believed to be useful in increasing one’s control over outcomes. Ross and Wu also state that education affects health outcomes through the adoption of health enhancing behaviors such as consuming a healthy diet, obtaining preventive care, drinking moderately and abstaining or quitting tobacco use resulting in an overall healthier lifestyle. However, the pathway
through which education leads to the adoption of a healthy lifestyle is not well-articulated; the rationale for why those with more education lead healthier lifestyles is not explicit. I will now focus attention on this matter to provide other theoretical accounts through which educational attainment leads to the adoption of physical activity, one such health-enhancing behavior that is the focus of this paper.

Ross and Wu have already indicated that education can aid in the development of personal control skills that may aid in attaining better health outcomes. However, education may also impart resources that may have a more direct impact on physical activity participation such as physical activity related knowledge. Although some argue that the accumulation of knowledge alone often does not stimulate behavior change (Rudd 1990), research has shown that knowledge about exercise and physical activity has a positive association with physical activity participation in children (DiLorenzo et al 1998), overweight patients in clinical settings (Galuska 1999), and other populations (Martin et al 2000). Young et al also found that in a community sample of adults, those with higher levels of educational attainment were more knowledgeable of physical activity and were more physically active (1996).

However, the process though which those with higher educational attainment gain more physical activity knowledge is unknown. Those with more education may have been exposed to more health-enhancing messages over time or enrolled in qualitatively superior educational institutions that include more or better health-enhancing messages in their curricula. On the other hand, knowledge can also be transmitted through familial and other social relationships. Thus, the findings that more educated people have more knowledge of physical activity may be a result of socialization outside of school; those
with higher educational attainment may have been surrounded by other high SES groups who provide them with physical activity related information. However, Link’s examination of knowledge and behaviors surrounding tobacco use indicate that while knowledge was initially a significant determinant of smoking, the ability to act on this knowledge emerged as a determinant as the health-damaging effects of smoking became widespread (2008). Thus, depending on the universality of the acceptance of physical activity’s role in improving health across people of varying socioeconomic statuses and racial and ethnic groups, knowledge may or may not serve as a determinant of physical activity behaviors.

Another way to explain the propensity of those with higher educational attainment to be more physically active is to think of the uptake of health behavior as an adoption of an innovation. Applying the theory of diffusion of innovation to health behaviors is not a novel effort; however, this theory has often been used to predict patterns of the uptake of health information and behaviors rather than to explain the socioeconomic gradient in health outcomes. Those attempting to do the latter argue that rather than acting on informational cues, there is a “socially hierarchical process of change” whereby those in the lower socioeconomic strata imitate trends set by those in the higher socioeconomic strata with some time lag in between (Lindbladh et al 1997).

Following Bourdieu, those in the upper echelons of society are constantly using their abundance of resources to reinforce objective distinctions between “high brow” culture from the remainder of society, thus laying the template for the desirable lifestyle. As a result, commodities and behaviors that are consumed and performed by the upper classes signify high status and are thus sought after by those in the middle and lower
classes. When such commodities and knowledge become readily available to the general public via shifts in the market, the upper class must find new ways to legitimately differentiate themselves to maintain their position in the social hierarchy.

Nevertheless, this imitation process does not fully explain some mechanisms in the creation and reproduction of racial and socioeconomic disparities in physical activity behaviors such as body satisfaction and body size preferences. Body size preferences and body satisfaction are two components of embodied cultural capital that have important implications for socioeconomic and racial disparities in physical activity since 1) body satisfaction is influenced by body size preferences 2) body satisfaction has been found to be a significant predictor of being physically active and 3) both of these concepts have been found to vary by race and socioeconomic status.

Body satisfaction, an attitudinal aspect of body image that reflects how an individual experiences and perceives his or her body, has been found to be influenced by body size preferences and affect physical activity participation. Several studies have found that black women find heavier bodies attractive (Stevens, Kumanyika and Kiel 1994; Thomas 1988) and are less likely to perceive themselves as overweight even when their BMI classifies them as such when compared to white women (Chang and Christakis 2003; Anderson et al 2002) indicating that black women are more accepting of larger bodies. Furthermore, Chang and Christakis found a gradational relationship between socioeconomic status and body size preferences with those in the higher strata being more likely to aspire to thinner bodies than those in the lower strata (2003).

These variations in body size preferences reflect racial and socioeconomic variations in body satisfaction. Consistent with findings that black women prefer larger
bodies and are less likely to classify themselves as overweight, research has consistently shown that black women have higher levels of body satisfaction than white women, even when they are heavier than the white women in the study (Anderson et al 2002; Akan and Girlo 1995; Abrams et al 1993; Rucker and Cash 1992). A negative gradational relationship was also found between education and body satisfaction with those with higher levels of education being more likely to report lower levels of body satisfaction (Anderson et al 2002). Consistent with this finding, Allen et al also found that higher SES black women had body satisfaction levels similar to white women and were more likely to favor thinner bodies indicating that socioeconomic status may be exerting an influence above racial preferences (1993).

Nonetheless, this discussion on body satisfaction and body image would be fruitless if body satisfaction did not influence physical activity participation and if a primary motivation to be physically active was not to lose weight. This, however, is not the case. Body satisfaction has been shown to affect physical activity participation in both blacks and whites. In a study of over 1,500 overweight and obese adult women, body satisfaction was the strongest predictor of trying to lose weight with those who were unsatisfied with their bodies being over nine times more likely to be currently trying to lose weight than those who were satisfied with their bodies (Anderson et al 2002). Furthermore, weight loss and maintenance has also been found to be a primary objective of physical activity for black and white men and women of varying socioeconomic statuses (Lowry et al 2000; Nies, Vollman and Cook 1999).

These findings have important consequences for the study of socioeconomic and racial disparities in physical activity since racial and socioeconomic variation in body
satisfaction and body preferences mirror variations in physical activity patterns. For example, Lowry et al found that blacks were twice as likely to be overweight or obese as whites but were significantly less likely to be trying to lose weight or use physical activity as a weight management practice (2000). This could indicate that individuals are more likely to evaluate their weight status in reference to the weight distribution of peers in their group rather than to those in the upper socioeconomic strata has which seems to provide evidence for a more localized “social hierarchical process of change” (Dawson 1998). Additionally, these findings seem to contradict any notions of imitation since those of lower socioeconomic status seem to reject mainstream body preferences.

Another important, yet often overlooked, factor shaping the socioeconomic gradient in physical activity participation is sport participation. Although participation in sports is just one mode of physical activity, it has important implications for understanding the socioeconomic gradient since 1) sports preferences are highly associated with social class and 2) sports participation is a primary source of physical activity for children and young adults.

According to Bourdieu, sports consumption as a form of cultural consumption requires the appropriate preferences, skills and knowledge which are gained through socialization. Sports that are consistent with the preferences of the upper class are those that are pursued as an end in themselves rather than an means to a mean much like art, music or “pure” academics (Wilson 2002). Sports that treat the body as an instrument rather than an “object of cultivation” that emphasize physical contact and toughness are reserved for lower status groups. These sports are often inexpensive, while sports such as
golf and tennis, which are favored by the upper class, are more costly and require a great deal of early childhood socialization (Wilson 2002).

However, these class differences in sports consumption not only function to assist in the legitimization the current social hierarchy but also have important implications for the socioeconomic gradient in physical activity. Since sports favored by the lower classes are often game-like in nature and seem less appropriate to participate in as one ages (Bourdieu 1978). Furthermore, these sports often require physical toughness and contact that does not allow for lifelong participation. Early participation may also reduce subsequent involvement due to the high prevalence of injury in these sports. This is in contrast to sports preferred by the social elite that make an artful use of the body do not share the same “play-like” character of sports favored by the lower classes. Thus, involvement in such activities declines less precipitously than physical activities popularized among the lower and middle classes.
Methods

The various ways in which habitus, a shared world perspective, informs physical activity practices via access to capital have been discussed. The literature has hypothesized that several resources including educational credentials, recreational facilities, involvement in community activities, safe neighborhoods among other capital affect physical activity behaviors by way of influencing a groups’ collective consciousness. The goal of this research is to provide glimpses into moments of young adults’ lives in which capital is used and transformed to reproduce a habitus that creates patterns of physical activity among socioeconomic and racial lines. This habitus is a collective conscious that is believed to be developed in response to long term occupation in a position within the social hierarchy. As such, interpreting and understanding these collective consciousnesses requires revealing subjective life experiences, motivations, expectations, beliefs and knowledge. Such information does not lend itself well to quantitative exploration since many of these aspects of collective consciousness may be deeply embedded and/or reified in daily interactions that require extensive probing to reveal complex and nuanced data.

Participants

Involved in this investigation were twenty young men and women between the ages of 18 and 24 who self identify as black (African American) or white. As previously mentioned, this age group is of significant importance in analyzing physical activity since
this period in the life course (1) marks the most active time in adulthood followed by a continuous decline and (2) represents a transition to adulthood marked by increased autonomy and decreased parental and institutional control over physical activity behaviors. Thus, studying the physical activity behaviors of this population will allow for the contextualization of physical activity behaviors during a time that significantly influences health throughout the remainder of adulthood. Furthermore, the sample was restricted to those who self-identify as black or white since the aim of this study is to uncover potential explanations for the sizeable disparity in physical activity participation between blacks and whites. The race of all respondents was obtained through self-report rather than being determined by the interviewer since this research is concerned with understanding how respondents’ embodiment as a racialized being affects physical activity behaviors.

Since another aim of this study is to understand differences in physical activity behaviors by educational attainment and income, participants represent a variety of socioeconomic backgrounds. Since most of the participants are just beginning their occupational careers and have not yet completed their educational careers, and because this research seeks to understand the intergenerational reproduction of collective conscious and physical activity habitus, each respondent’s parents’ or legal guardians’ educational attainment, income, and occupation in addition to the respondents’ same attributes were used as indicators of socioeconomic status.

The respondents’ household income was categorized according to the 2008 Health and Human Service Poverty Threshold Guidelines. Although respondents often resided with persons outside of their family, household income for these individuals did not
include the income of other roommates. Only personal income was collected from these respondents since it is assumed that these individuals did not share economic resources. However, household income was calculated for cohabiting and married couples and those who resided with their family.

Furthermore, it was also necessary to obtain a sample with variation in physical activity participation in order to elucidate potential explanations for disparities in physical activity behaviors. These behaviors were collected twice; respondents provided a brief description of physical activity during the screening process, and a more in-depth description was provided during the interview.

Procedure

The participants for this study were chosen using purposive sampling in order to obtain a sample that is racially, socioeconomically, and behaviorally diverse. More specifically, purposive sampling was utilized to obtain an ideal sample in which there were a similar number of blacks and whites in all socioeconomic strata and a fair amount of variability in the frequency, duration and intensity of physical activities. This sampling method was used to allow for comparisons both between and within socioeconomic status and race. For example, the experiences of white lower class respondents could be contrasted with black lower class individuals and with whites in the upper and middle classes. Such comparisons allow for the exploration of the independent and interactional effects of both race and socioeconomic status.

In order to obtain such a sample, all potential respondents were screened by responding to a brief demographic interview to assess age, race, socioeconomic status,
and physical activity. Individuals who self-identified as a race other than black or white
and/or were not currently between the ages of 18 and 24 were automatically excluded
from participation. Those that did fall within the aforementioned guidelines were then
admitted on a case-by-case basis until the quota for each category was filled (i.e. black,
middle-SES participants). Ideally, the sample would include approximately three black
low-SES, three white low-SES, three black middle-SES, three middle-SES, three black
upper-middle to high-SES, and three white upper-middle to high-SES respondents.

Respondents were categorized as “low-SES” if at least one of their parents’
highest educational attainment was a high school degree, the respondent was not
currently pursuing higher education, and the parents’ household income was at 200%
poverty or below. “Middle-SES” respondents had completed some college, had at least
one parent who completed some college, and either the respondent or his or her parents
earned an income above 200% of poverty, but less than 400% of poverty. Finally, those
in the “high-SES” group are those respondents who have either completed a four year
degree or higher or are currently enrolled in a degree program granting a four year
degree, had one or more parent that earned a graduate or professional degree, and earned
201% of poverty or more.

Participants were recruited through a variety of sites to obtain socioeconomic and
racial diversity in Columbus, OH throughout the months of November, December and
January. Advertisements were created in which the research was described as concerned
with studying the physical activity behaviors of young adults between the ages of 18 and
24. Respondents were informed that people both physically active and inactive adults
were needed. The ad also indicated that participants who were selected for the study
would be interviewed and would receive a $25 gift certificate to a grocer of their choice. Respondents were informed that the interview would involve a discussion of their past and present experiences with exercise and physical activity.

Both on-line and paper advertisements were used to recruit respondents for the study. Paper ads were posted in four apartment complexes that were identified as having a high number of young adult residents. These flyers were placed in common areas throughout the apartment complex such as laundry rooms, recreational facilities (i.e. exercise rooms, pool table and dart game areas, indoor pools) and on-site cafes. Additionally, such ads were placed at the African American and African Studies Extension Center (AAASEC) to obtain more black respondents. On-line ads were also posted on-line under local classified “miscellaneous” ads through Craig’s List.

Five individuals responded to the apartment complex ads, but two were not invited to participate because they were over the age of 24. The remaining two respondents were interviewed. Six individuals were recruited from the African American and African Studies Extension Center through the advertisements and word of mouth, yet one participant was not interviewed due to scheduling conflicts, and another was excluded because the individual did not fulfill the need for a specific race-socioeconomic group. Ten individuals responded to the on-line advertisement. Three individuals were not accepted into the study due to age restrictions and another three respondents were excluded since the particular race-socioeconomic status group they represented was already saturated.

In addition to the aforementioned recruitment tactics, individuals were recruited face-to-face at the Columbus Metropolitan Library, a local Wal-Mart and on a local bus.
route to increase socioeconomic diversity. Similar to the on-line ad, individuals were informed of the general aim of research (to study physical activity behaviors of young adults) and were invited to complete a brief screening questionnaire to determine eligibility. Five individuals were approached at the library while they were looking for reading materials, using the computers, and standing outside of the library entrance. I approached nine individuals who looked as if they were in the appropriate age range, were white or black, and appeared to be not too occupied with their current activities and thus, may be more open to interruption. Two respondents stated that they were not interested in participating, one individual was too young to participate, and one individual took a flyer about the research yet did not contact the interviewer at a later date. The five remaining respondents participated in the research. Three respondents were recruited through a local Wal-Mart. One of the respondents was a customer service representative at the store that was recruited while I was purchasing gift cards for the study. This respondent also referred me to another respondent who worked at a different Wal-Mart store whom I contacted through the phone. Another respondent was recruited while waiting in line at Wal-Mart. Finally, one respondent was recruited through causal conversation on a local bus route.

Once participants were identified as fulfilling the needs for a specific race-socioeconomic category, they were invited to participate in a semi-structured interview. Semi-structured interviews were chosen as the method of data collection since they allow for an open framework and focused yet open communication. This method also permits the collection of both detailed qualitative and quantitative information. Unlike structured
interviews, the flexibility of semi-structured interviews allows respondents to not only give answers, but also to provide the reasons behind these answers.

Semi-structured interviews typically start with a few predetermined open-ended questions that are used to guide future queries (Silverman, 2000). Guided questions were designed to provide participants the opportunity to reflect on past and present social relationships, physical activity experiences, neighborhood environments, and evaluations of personal body image and the meaning of these experiences and ideas in relation to their current physical activity behaviors, knowledge and beliefs. Table 1 provides the guiding questions utilized in this study.

<table>
<thead>
<tr>
<th>1. Past and Present Social Relationships, Obligations, Neighborhood Environments, and Physical Activity Experiences:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Can you walk me through a typical weekday in your life from when you wake up to when you go to sleep?</td>
</tr>
<tr>
<td>b. Describe your family life growing up.</td>
</tr>
<tr>
<td>c. Where did you meet your friends? What do you do together? What did you do with your friends in the past?</td>
</tr>
<tr>
<td>d. Can you tell me about the neighborhoods you have lived in?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Current Physical Activity Knowledge, Attitudes, Behaviors and Beliefs</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. How would you define physical activity? What benefits does it provide? How much do you need to do to receive these benefits?</td>
</tr>
<tr>
<td>b. What types of physical activity do you, your family and friends typically do?</td>
</tr>
<tr>
<td>c. What physical activities do you enjoy the most? The least? Why?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. How would you describe your ideal body size?</td>
</tr>
<tr>
<td>b. How do you think you compare to this ideal?</td>
</tr>
</tbody>
</table>

Table 1: Semi-Structured Guiding Questions
Nineteen of the twenty semi-structured interviews were conducted face-to-face in a location of the respondents’ choosing. Nine of these interviews were conducted in the respondents’ home, five were conducted at the interviewers’ university office during an academic break, three were conducted at local restaurants and cafes, and two interviews took place at the AAASEC. One interview was conducted over the phone. Each interview lasted between 45 to 85 minutes with the average interview lasting one hour. All interviews were conducted by the investigator. Before the interview began, all participants gave their written and oral consent to participate, to have the interview audi-taped, and to have the interviews transcribed at a later date. After the respondents gave their consent, the interviewer gave them their $25 gift certificate. A small audio-recorder was placed between the respondent and the interviewer during all interviews. The audio-recorder did not appear to distract the respondents or cause any discomfort.

Respondents were also assured of their confidentiality orally and in writing, and were given a copy of the informed consent form. Only the interviewer had access to audiotapes, transcripts and consent forms. Furthermore, pseudonyms and/or participant identification numbers, and not participant names, were used on all transcripts and audio-recordings. All respondents were given an opportunity to withdraw from the study at any time during the interview; however none of the respondents withdrew.

Data Analysis

Although the investigator was operating from a somewhat deductive approach given that Bourdieu’s theory of cultural reproduction and the fundamental cause framework were anticipated prior to analysis; the goal of data analysis and of the
investigator was to keep an open mind to the perspectives of the subjects to investigate whether these theories were appropriate for the emerging data.

Data analysis was an ongoing process that began with the first interview. The interviewer took brief notes during each interview and expanded upon these notes immediately following each interview. These notes discussed general ideas and topics and paid special attention to how the interview went (i.e. Did the respondent seem comfortable? Was rapport established?), and elaborated on any unique or memorable verbal and nonverbal communication. Notes on respondent’s body size were also taken to provide additional context for questions concerning body image. Furthermore, the interview included any comments on noted similarities and differences among respondents and ideas on how to improve future interviews.

After all interviews were conducted, each interview was transcribed verbatim by the interviewer. Notes of any important nonverbal communication were also included on these transcripts, including comments on mood or tone, possible reasons for laughter and pauses, and non verbal cues such as fiddling with objects or hands.

The interviewer then read and reread these transcripts and notes several times. Each interview was first read in its entirety from start to finish until the interviewer became familiar with each respondent’s story. Once familiarity was established, the interviews were divided into sections reflecting the guided questions presented in Table 1. Thus, the interviews were divided into sections concerning social relationships, neighborhood environments, physical activity knowledge, attitudes, beliefs and behaviors and body image assessments and analyzed separately; keeping in mind the respondents’ race, socioeconomic status, physical activity level and overall story. This data analysis
progressed by making notes on these excerpts and highlighting key passages and keywords to identify patterns emerging from the data. Finally, these data categories were drawn out on pieces of paper. This step provided a visual representation of the connections among these categories which lead to the identification of themes. These themes were then categorized according to the three forms of capital (economic, social and capital).
Results

Nine (45%) of the respondents self-identified as black and eleven (55%) self-identified as white. No respondents self-identified as multi-racial. Over half (55%) of the respondents were female. A large portion (70%) of respondents was either currently enrolled in a post-secondary educational institution or had completed a vocational or bachelor’s degree. Although many respondents were pursuing higher education, there was great variation in experiences with and positions within the post secondary education system. Some respondents were beginning their postsecondary education public and private colleges and institutions of various sizes while other respondents had completed degree programs and were looking for employment or continuing on to graduate and professional school. Furthermore, some respondents were first generation college students while others had one or more parent that had completed some college or attained a college degree. None of the respondents had completed high a graduate or professional degree. Five respondents (25%) had not completed any schooling beyond high school, and only one respondent had not completed high school. Parents of these respondents were also highly educated with 75% of mothers and fathers having some college.

Utilizing the CDC recommended levels of physical activity\(^2\); I interviewed seven

\(^2\) Recommended level of physical activity is defined as completing 150 minutes of moderate intensity aerobic activity, 75 minutes of vigorous intensity aerobic activity OR an mix of moderate and vigorous intensity activities per week AND two or more days of muscle training that works all major muscle groups per week. “Inactive” is defined as participating in fewer than 10 minutes of moderate or vigorous physical activity per week. “Insufficiently active” is defines as participating in less than the recommended yet more than the inactive level of activity (Centers for Disease Control and Prevention 2009).
respondents who participate in a “recommended” level of physical activity and twelve “insufficiently active” respondents. Four of these seven active participants were in the middle and high-SES groups, four were women, and two were black. Only one of the respondents, a black low SES female, was “inactive”. The small number of individuals in this group may be due to social desirability; the respondents may have over-reported their physical activity behaviors to appease the interviewer.

<table>
<thead>
<tr>
<th>Respondent Characteristics</th>
<th>n (%)</th>
<th>Parental Characteristics</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>11 (55%)</td>
<td>Mother’s Educational Attainment</td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>9 (45%)</td>
<td>Less Than High School</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>Highest Level of Education Completed</td>
<td></td>
<td>High School</td>
<td>6 (30%)</td>
</tr>
<tr>
<td>Less than High School</td>
<td>1 (5%)</td>
<td>Some College or 2-year Degree</td>
<td>3 (15%)</td>
</tr>
<tr>
<td>High School</td>
<td>5 (25%)</td>
<td>Four-Year Degree</td>
<td>5 (30%)</td>
</tr>
<tr>
<td>Some College or 2-Year Degree</td>
<td>6 (30%)</td>
<td>Graduate/Professional Degree</td>
<td>4 (20%)</td>
</tr>
<tr>
<td>Four-Year Degree</td>
<td>8 (40%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Graduate/Professional Degree</td>
<td>0 (0%)</td>
<td>Less Than High School</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Percent Currently Enrolled</td>
<td>6 (30%)</td>
<td>High School</td>
<td>4 (20%)</td>
</tr>
<tr>
<td>Median Income</td>
<td></td>
<td>Some College or 2-year Degree</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>$10,000 - $20,000</td>
<td></td>
<td>Four-Year Degree</td>
<td>8 (40%)</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td>Graduate/Professional Degree</td>
<td>5 (25%)</td>
</tr>
<tr>
<td>Single</td>
<td>15 (75%)</td>
<td>Parental Income</td>
<td></td>
</tr>
<tr>
<td>Cohabitng</td>
<td>3 (15%)</td>
<td>Below Poverty</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>Married</td>
<td>2 (10%)</td>
<td>200% Poverty</td>
<td>7 (35%)</td>
</tr>
<tr>
<td>Divorced/Separated</td>
<td>0 (0%)</td>
<td>201% to 400% Poverty</td>
<td>8 (40%)</td>
</tr>
<tr>
<td>Physical Activity Level</td>
<td></td>
<td>Above 400% Poverty</td>
<td>3 (15%)</td>
</tr>
<tr>
<td>Recommended</td>
<td>7 (35%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insufficient</td>
<td>12 (60%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inactive</td>
<td>1 (5%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>9 (45%)</td>
<td>White</td>
<td>11 (55%)</td>
</tr>
<tr>
<td>Low-SES</td>
<td>3 (15%)</td>
<td>Low-SES</td>
<td>3 (15%)</td>
</tr>
<tr>
<td>Middle-SES</td>
<td>5 (25%)</td>
<td>Middle-SES</td>
<td>5 (35%)</td>
</tr>
<tr>
<td>High-SES</td>
<td>1 (5%)</td>
<td>High-SES</td>
<td>3 (15%)</td>
</tr>
</tbody>
</table>

Table 2. Sample Characteristics
These findings will explore racial and socioeconomic variation in access to cultural capital including physical activity related knowledge and beliefs, motivations, and body size preferences and economic capital including neighborhood and occupational environments. Results indicate that while respondents share similar knowledge believes, motivations and body sized preferences, marked differentiation in economic capital may influence socioeconomic and racial variation in physical activity behaviors found in this sample.

*Physical Activity-Related Knowledge and Beliefs*

Education, an important indicator of socioeconomic status and source of cultural capital, has been hypothesized to influence health outcomes through personal control, the perceived ability to manipulate life outcomes (Ross & Wu 1995). This sense of control is believed to be developed through problem solving skills obtained through formal education that helps one gather, organize and apply information to a given situation. Therefore, those with more exposure to educational institutions may be better equipped with the skills necessary to gather physical activity-related information.

Research has found that those with higher educational attainment have more physical activity-related knowledge (Young et al 1996) and such knowledge has been found to increase physical activity participation in some populations (Galuska 1999; DiLorenzo et al 1998; Martin et al 2000). To assess physical activity knowledge in this sample, respondents were asked 1) how they define physical activity b) what kind of benefits can be obtained from being physically active and c) how much physical activity
is recommended to receive those benefits. Respondents’ responses were then compared to information provided by the National Library of Medicine (NLM), National Institutes of Health (NIH), and the Centers for Disease Control and Prevention (CDC) to test whether respondents were knowledgeable of current government suggestions.

Results from this sample of young adults indicate that there are not socioeconomic or racial differences in physical activity knowledge. Since there is racial and socioeconomic variation in physical activity participation but no variation in physical activity knowledge, it can be implied that in this sample, education, a significant stratifying aspect of social life, does not seem to influence physical activity knowledge through the educational institution’s ability to develop information gathering skills to obtain physical activity knowledge.

The NLM and NIH define physical activity as “…any activity that causes your body to work harder than normal. It describes activities beyond your daily routine of sitting, standing, and walking up stairs” (“Physical Activity: MedlinePlus Medical Encyclopedia”). Respondents’ definitions ranged from very simple, “…any movement that increases your heart rate” to more complex:

Uh, anything that your…as long as your…up moving around outside of your normal…like…I wouldn’t qualify walking, because I wouldn’t see walking…but something more than just like the typical having to lift or running or something that’s pushing your body to where you are getting a work out, you know to where you are building up, you know…your conditioning and things like that. But, so anything basically past your regular walking around and stuff like that.

-Mark, white, middle SES, physically active

Nonetheless, respondents generally seemed to recognize that being physically active requires both engaging in activities that occur outside of their normal regimen and make their bodies “work harder than normal”. Respondents who did not identify these two
components directly when asked this question often did so indirectly through their distinction between “physical activity” and “exercise”. For those making this distinction, being physically active was perceived as participating in activities that were a part of one’s normal routine such as walking or using the stairs and/or “fun” recreational activities that take place outside of one’s normal routine such as riding bikes or rollerblading for leisure. On the other hand, exercise was defined as an activity that was performed with the intention of weight maintenance or physical conditioning that needs to be added to one’s daily routine:

“Physical activity sounds fun where exercise sounds, I don't want to say forced, but I don’t know...you have to make yourself go do exercise, but physical activity could be anything.”
-Lisa, female, white, middle SES, insufficiently active

“You need to be physically active every day of the week I think. You don't have to necessarily exercise, but as long as you’re not sitting on your couch watching tv and you're up and doing things like running errands or going on a walk or something.”
-Sarah, female, black, low SES, physically active

These respondents’ definitions of “exercise” appear to approximate the NIH and NLM definition of physical activity in that they referred to both activities that occur outside of one’s regular routine and makes the body work harder than normal.

Responses regarding benefits that can be gained from being physically active differed greatly from information provided by the NIH and NLM; however respondents’ answers did not vary from each other in any significant way. The NLM and NIH list the following benefits of physical activity: 1) burn calories and reduce body fat 2) control and maintain current weight 3) improve medical conditions such as diabetes, high blood pressure and heart disease 4) improve fitness and ability to perform daily activities 5)
prevent diseases such as osteoporosis and depression 6) reduce appetite. These benefits seem to fall into two categories: the prevention and improvement of morbidities and the maintenance of weight.

Most respondents did not provide such an exhaustive list of health benefits of physical activity, even when probed further. Instead, the responses were global in nature in that they did not provide any specific health/weight maintenance benefits. Respondents indicated that physical activity, “increases your health”, “increases your life span”, “is good for every part of your body”, and “helps you live a healthier lifestyle”. Furthermore, only one respondent mentioned the weight maintenance benefits of physical activity:

“You get to lose weight if you want to lose weight or maintain your weight.”
- Trista, female, white, upper SES, physically active

Lastly, respondents were asked how much physical activity they thought was necessary to attain the previously mentioned health benefits. The CDC currently recommends all adults to complete two and a half hours of moderate aerobic activity such as brisk walking or 75 minutes of vigorous activity such as jogging or running or an adequate mix of these activities each week. In addition, adults are advised to include strength training that works all major muscle groups twice a week (2009).

Respondents were largely aware of time recommendations and generally believed that approximately two and a half hours of physical activity a week, usually expressed as “30 minutes at least five times a week”, or more is necessary to receive these health benefits. However, none of the respondents made a distinction between “moderate” and “vigorous” physical activities, and only one respondent, a 19-year-old black, upper SES
female included strength training as a component of physical activity. Although other men and women in the sample regularly weight trained, she was the only respondent to mention this activity as a necessary component of physical activity. Once again, these responses did not significantly vary by socioeconomic status or race.

While gathering physical activity related information has been found to increase physical activity participation, some argue that informational cues are not enough to precipitate behavior change (Rudd 1990). In Link’s tobacco use example, there appeared to be a relationship between the belief that smoking is a cause of lung cancer and quitting smoking (2008). Nonetheless, this belief was socially stratified with highly educated persons being more likely to believe that smoking is a cause of cancer and were more likely to quit smoking. The role of education in creating this stratification is unclear, yet this finding indicates that the extent to which respondents believe that serious medical conditions can be prevented or improved by engaging in a health practice may be a proximate determinant of racial and socioeconomic disparities in physical activity.

Respondents expressed the belief that physical activity can prevent or improve morbidities and mortality by either by expressing they 1) were at risk for such morbidities because they were not physically active or 2) were not at risk for such morbidities because they were physically active. Both stances indicate that respondents not only know what constitutes being “physically active” and what benefits can be gained, but that they believe that these benefits have real health consequences in their lives.

There was no significant variation by race or socioeconomic status in the belief that physical activity can prevent or reduce the risk of adverse health outcomes. However, those of low socioeconomic status reported more morbidities that could be
prevented or mitigated through physical activity in their families. This, coupled with the increased propensity of low SES respondents to be physically inactive in this sample led those of low socioeconomic status to believe that they were at risk for morbidities and mortality because they were physically inactive while those of higher socioeconomic statuses reported not being at risk due to their levels of physical activity participation.

Mike, a black, low SES respondent cites physical activity as one behavior modification (in addition to dietary changes) he should make to improve and prevent medical conditions he currently experiences or is at risk for:

I: Ok. Have you ever been told by a doctor that you have any health conditions?
R: High blood pressure and uh, sleep apnea
I: Ok. And um, do you suspect that you have any health condition that you haven’t gone to the doctor for that you may need to go for?
R: Um….I don’t think so.
I: And you already said that high blood pressure runs in your family, does diabetes, heart disease or cancer…
R: Diabetes.
I: Ok, do you know if it’s type one or type two?
R: Type II
I: Type II. And how about heart disease and cancer?
R: Uh, there have been a couple cases of cancer, but it’s nothing big in our family. And my grandpa had a bad heart, but that’s about it. But…like diabetes and high blood pressure are the two biggest things in my family, like big things. And I know, because I have been tested for diabetes recently and I don’t have it, but I know like I don’t want to have it. So I may have to start doing something soon. So yeah. So high blood pressure and diabetes are the biggest things.
I: So uh do you think you are at risk for high blood pressure and diabetes?

R: Oh yeah

I: And um, what are you doing to lessen that risk?

R: I’m really not doing anything right now…at all

I: What do you think you should do?

R: Start getting on an exercise regimen…[sigh] dieting.

-Mike, black, low SES, physically inactive

While Mike is not currently physically active, he is aware and believes that physical activity can mitigate and prevent morbidities that he is at risk for. In contrast, Leslie, a white, middle SES female with a family history of heart disease and cancer did not feel susceptible since she felt being physically active sufficiently protected her from these health risks, despite her habitual alcohol and tobacco use:

I: How would you rate your health?

R: Good…It would be excellent if I didn't drink.

I: Have you been diagnosed with any serious health conditions?

R: No

I: Does anyone in your immediate family have diabetes, heart disease or cancer?

R: My grandmom had cancer…and both of my granddads had heart attacks, so I am guessing they had some type of heart disease. But my parents are both okay for now.

I: Do you think you are at risk for any of these health conditions?

R: I hope not. I mean, I exercise and stuff every weekday so I don’t think that I am at risk for any of those things. I try to eat healthy too.
Leslie, a white, middle SES, physically active

Like Mike, Leslie also believes that being physically active can decrease the risk for morbidities that are present in her family. However, this belief also leads her to think that being physically active counteracts other health-diminishing behaviors she practices in such as alcohol and tobacco use.

In this sample, it is evident that within this sample of young adults, there are no meaningful racial or socioeconomic variations in physical activity knowledge or beliefs. Respondents were generally aware of what physical activity is, what the benefits of being physically active are, and how much physical activity is needed to achieve such benefits. Furthermore, respondents seemed collectively unaware of the various components of physical activity (moderate, vigorous, and strength training) and often cited global health-enhancing benefits of physical activity rather than the aesthetic enhancing and weight maintaining benefits.

Motivations

One way to interpret the propensity of those with higher educational attainment to be more physically active is to view this health-enhancing behavior as the adaption of an innovation. In this case, those with more educational attainment would be described as “early adapters” of the behavior. This trend in which those with high level of educational attainment are more likely to adopt health-enhancing behaviors faster than those with lower levels of educational attainment can be explained in part by Bourdieu’s habitus theory.
Habitus, the theoretical link between individual behaviors and social conditions determined by access to economic, social and cultural capital, generates collective perceptions of the world and strategies to move within it. These shared strategies are then transformed into subjective motivations (Lindbladh et al 1997). Motivations are often discussed in public health literature, but such research often does not address the issue of, if motivations are a key determinant of physical activity, how and why these motives are socially stratified. In a theory advanced by Lindbladh and colleagues, motivations that may drive those of higher socioeconomic status to uptake health-enhancing behaviors earlier than those in lower socioeconomic strata may include: (1) those in higher socioeconomic positions are further removed from necessity and the “stylization of life” leading this group to use their resources to adopt innovations to keep up with new trends and/or those that will enhance aesthetics (2) those in higher socioeconomic positions are more likely to delay gratification as a response to having a larger range of opportunities and thus will adopt innovations that will aid in some long term goal (Lindbladh et al 1997). This leads to two somewhat competing motivations for being physically active; those with more resources are more physically active to attain an attractive, thin body or to prolong life and prevent morbidity.

To assess whether such variation in motivations existed in this sample, respondents were asked, out of 100%, what percentage of motivation for being physically active is for looking good versus being healthier. Interestingly, although respondents did not regularly cite the weight loss benefits of physical activity when prompted to discuss why they are currently active, or wish to be more physically active, all but one
respondent claim that increased attractiveness was a larger motivator than health-enhancing benefits to be physically active.

I: So when you do play football and when you do try to convince yourself to do some type of exercise, how much of that is for looking good versus being healthy?

R: It’s more so looking good than being healthy. Like I know, because I have high blood pressure, so I know I need to lose weight to help with that or whatever. But you gotta, I look at, you know, like looking good about it, like every time I think about going to the gym or something… I imagine what I’d look like 100 pounds lighter or whatever or stuff like that. Yeah, so it’s pretty much more so… like I still know the health benefits and I still know I need to do it for health, but its... I think the not being fat part about it is what I look at the most.

I: So if you think were 100 pounds lighter, would you go to the gym more often?

R: I think I would if I was 100 pounds lighter because I exercise it off. If I was naturally 100 pounds lighter, probably not.

-Sam, black, middle SES, insufficiently active

This excerpt provides evidence that the health-enhancing benefits of physical activity are hardly a factor, if at all, in Sam’s decision to be physically active. However, most respondents indicated that health-enhancing benefits still motivated them to be physically active, but these benefits did not outweigh aesthetic-enhancing benefits. Matt, a white middle-class male was motivated by the physique-enhancing benefits of physical activity over the health benefits when he was in college, but after he got out of college, his motivations were dominated by the health-enhancing effects of physical activity (but is still motivated by those physique-enhancing benefits):

I: So, if you had to um, be like 100% like a piece of pie, and you had to… I always have a hard time phrasing this question. How much of when you do
exercise, how much of is it for vanity or good looks versus how much if it is for being healthier or…

R: I would probably say, I mean, as in the last few years, maybe I would say it’s maybe 70/30 for 70 being health, but I mean in college it was probably flip-flopped if not more, it was more of a vanity type of thing definitely. And definitely 30 or 40% vanity now I know. Definitely getting out of the shower and making sure I still look fit, so yeah, it’s still there for sure.
-Matt, white, middle SES, physically active

While there was not great socioeconomic or racial variation in the motivations cited for physical activity, these findings indicate that, although respondents in this sample reported that aesthetics or physique-enhancing benefits motivated them to be physically active more than health-enhancing benefits, both were relevant stimuli to be physically active. This may indicate that Lindbladh’s hypothesis regarding differential motivations that are created in response to objective life circumstances may be limited in scope in that persons can be motivated by multiple incentives. Furthermore, the extent to which higher SES groups are actually motivated by health-enhancing benefits or are simply citing this benefit because it matches the interests of others in the higher social strata is questionable.

*Body Size Preferences and Body Satisfaction*

Since most respondents claim that the aesthetic benefit of being physically active is the most salient motivation to be physically active, it is constructive to assess whether there are significant socioeconomic and racial variations in body size preferences and body image. As indicated above, research has suggested that body size preferences and body satisfaction have important implications for socioeconomic and racial disparities in
physical activity behaviors since body size preferences influence body satisfaction, body size preferences vary by socioeconomic status and race, and body satisfaction influences physical activity participation. Bourdieu’s theory of class imitation maintains that those in the middle and lower strata of the social hierarchy attempt to emulate those in the higher strata (Gartman 2002). Thus, applied to body size preferences, those in the middle and lower classes should prefer the same body sizes as those in the upper strata; however, research has consistently challenged this assumption. Blacks (Anderson et al 2002; Akan and Girlo 1995; Abrams et al 1993; Rucker and Cash 1992) and those of low socioeconomic status (Chang & Christakis 2003; Anderson et al 2002) have been found to have higher levels of body satisfaction and to prefer larger body sizes than whites and those in the higher strata of the social hierarchy. These findings indicate that, rather than imitating the preferences of those in the upper strata of the social hierarchy, persons may evaluate their bodies in reference to their socioeconomic and racial peers.

To assess body satisfaction and body size preferences in this sample, respondents were asked to describe what they believed is the idealized body in American culture, and how their own preferences correspond to this definition. In addition, respondents were also asked to compare their bodies to their own characterization of the ideal body to gauge their degree of body satisfaction.

Respondents generally had a shared idea of how American society characterizes a desirable male or female body. Both men and women included height and weight in their descriptions and included references to specific body parts. Women described the aesthetically appealing female as, "Really thin, tall girl with big boobs.", "Tall, skinny, long legs, like hourglass kind of shape…long hair", and “Like a small size, like Barbie
but on a person!” Males often described a desirable male body to be tall, fit and muscular.

Additionally, both men and women engaged in a nuanced description of the attractive body. Desirable female bodies were “…curvy, but only in the right spots” while males discussed a balance between being thin, and having the right amount of musculature “…an average skinny guy, not too muscular”, “tall, toned guy, but not too skinny”. Matt provided a detailed description of the nuanced male body:

“…tall as in around 6 foot, more or less a few inches. Um...I guess there is not necessarily an hour glass shaped guy that they have said. But you know broad shoulders .I guess like an athletic fit, you know not necessarily a cover model, not necessarily that defined, that muscular but uh, just you know someone that you could tell you know could get up and walk around and [was physically active] that isn’t obese or anything. I guess that would be handsome…what guys strive to look like.”

-Matt, male, white, middle SES, physically active

Although all respondents were aware of what features make an aesthetically pleasing male or female in America, when they were asked to compare this ideal to their own, many rejected this definition and adopted a less stringent characterization of attractiveness. Often times, this definition had nothing to do with body size at all. Women often cited that confidence was a more decisive factor in attractiveness rather than a particular body weight or size:

“There shouldn't be one set standard. I think people are fine the way they are. I feel like if you are happy with who you are and you're confident, then that's fine.”

-Nina, female, white, middle SES, insufficiently active

“I think anyone that is confident in themselves [is attractive]. You can be chunky and still be beautiful. I’ve seen a lot of pretty chunky girls. As long as you’re confident and you hold yourself high and you know what you want in life.”
However, when respondents were asked to compare themselves to their own ideals of a desirable body size to assess their body satisfaction, it appeared as if they truly accepted and internalized mainstream definitions of an attractive body although they had initially claimed to reject them. For example, Nina and Lauren, who had previously indicated that they believed that confidence rather than body weight made a person attractive made the following comments later on in the interview.

I: If you could change one thing about your appearance, what would it be?

R: I would definitely be skinnier, which totally goes against…goes against what I just said…
-Nina, female, white, middle SES, insufficiently active

I: Where do you think you would be if you had not met the dietician when you were told you were a borderline diabetic as a child?

R: Big, sad…and lonely. Well, maybe not lonely, there are some guys out there who like big girls.
-Lauren, female, white, low SES, insufficiently active

Some black respondents (three women and one man) made a clear distinction between what “mainstream” media defines as an attractive body size, and what “black” media and African American culture in general deems favorable. Respondents indicated that Black women are preferred to be “thicker” than white females while black males were expected to be more muscular than white males. Furthermore, the black women that made such distinctions asserted that they were happy that they are not held to the same stringent beauty standards as white women:
“I’m glad [black women] are not expected to look that skinny. It’s gross…I mean models look sick to me.”
-Sarah, female, black, low SES, insufficiently active

“…being black, a lot of things work against us, but even though the media doesn't portray black women in the media well at all, at least they're not saying we have to look like twigs. It's okay to have an ass and have some thighs. You know, we can't help that, that's what we have. So, like I think it works out in a way because we know that black men or people don't want us to be sticks anyway. It's okay to be a little more thick if you're a black woman. So, that is a positive I think.”
-Renee, female, black, middle SES, insufficiently active

However, when these respondents were asked about how they compare to their own race-specific ideals of beauty, they reported falling short of this definition just as white respondents did, or were unsure about how they compared to this ideal.

"I like how I am now, but if my arms were a little more toned and my stomach, I had some abs or something. I don't have a big gut, but it's not flat. Like now but more toned up. I don't really care how much you weigh, just how you look with the weight. Yeah I'm comfortable. You know a lot of people say, 'Oh, I weigh 100 and this and 100 that.' I'm like I weigh 140 lbs and I don't feel like anything is wrong with that because I look okay...I think...right?"
-Renee, female, black middle SES, insufficiently active

So while Renee claims that black women, herself included, are more comfortable with their body size and are more accepting of larger bodies, she seems unsure of whether her own body size is attractive. Additionally, some black respondents claimed distinct differences between white and black media in defining the desirable body, but when they were asked what these differences were, the divergences seemed minimal at best:

“A fit guy, not that much of a difference between black media and mainstream media. Maybe a little bit bigger. I mean muscularly I feel like the black male popular image would have them portrayed as little bit bigger whereas the white image might be a little bit smaller.”
-David, male, black, low SES, physically active

“White media favors thinner, like petite, not very curvaceous, cute face and long hair whereas the black [media] prefers thin, fit women but more curvaceous.”
-Jenna, female, black, middle SES, insufficiently active

In summary, although respondents seemed to initially reject widespread notions of physical attractiveness that they found too stringent, ultimately, they tended to compare their bodies to these ideals. This was reflected by respondents’ engagement in a “double talk” in which they both voiced their opposition of such narrow aesthetic preferences but later adhered to them. Furthermore, although some black respondents indicated that they were aware that larger body sizes are more acceptable in the African American community, it was difficult to definitively conclude whether these respondents compared themselves to these local standards or to mainstream body size preferences. It was also unclear whether these localized standards were just as limiting as mainstream body size preferences since black respondents in this sample seemed just as dissatisfied with their body as the white respondents in this sample once they were asked to compare themselves to their own culturally-specific body size preferences. Thus, although the collective perspective of viewing the black body as one that is differentiated from the white body was evident among the black respondents, the influence of this body habitus did not appear to close the gap between desired and actual body size and may not be powerful enough to overcome the mainstream collective body conscious that favors the nuanced thin, yet curvy and/or toned body.
Access to Economic Capital

Although there does not appear to be much meaningful socioeconomic or racial variation in physical-activity related knowledge and beliefs, motivations, and body size preferences and body satisfaction, other determinants of physical activity, namely access to economic capital varied by race and socioeconomic status. Whereas evidence of socioeconomic and racial variation in these determinants are not entirely novel findings, the strength of this analysis is its ability to use these young adults’ narratives to explain the processes through which forms of capital are generated and transformed to shape one’s position in the social hierarchy to produce physical activity behaviors that are patterned along socioeconomic and racial lines.

Utilizing economic capital to gain access to housing is one way in which economic capital has been found to impact physical activity behaviors. There was great differentiation in neighborhood environments across respondents in this sample. Those who lived in middle and upper SES neighborhoods reported feeling safer, having greater access to recreational facilities, and observing neighbors being physically active for recreational purposes. Respondents in low SES neighborhoods reported crime and fear of victimization and inadequate outdoor and indoor facilities. Mike, a low SES black male describes his neighborhood as a child:

I: How would you describe the appearance of your neighborhood, if you had to tell someone what it looks like?

R: [Silence]. It's like just uh, like a typical urban neighborhood. You have houses really close together, uh...kind of run down like fences are knocked over and spray paint on some signs. It's just you know, not too appealing, but it's not like. I don't want to make it sound so bad where it's like (laughs)...like ‘I will never go there’, but it's not...not something you go and brag about or nothing like
that but like you know the same kind of built houses that look typically look the same, have the same structure. But yeah, not to, not to fancy, not too bad, but kind of in between. You know…

I: If you said, oh I'm from {Westland}, what would somebody think if they heard that?

R: The first thing they think is like gangs or whatever. Like oh, that's where...you got bloods hanging out and stuff like that. That's the first thing they think about. And...it's usually the first think about is negative. Which I can't blame them because that's all you hear about it on tv and stuff, and that's pretty much all you hear about it, the biggest negative things that happen. But I know from experience that that's the first thing they think about…either gangs or the {Westland} high school. Something like that.

I: OK, and do you think that um, that's a fair opinion that people have of your neighborhood?

R: It is, but...and uh...even uh...because I live like on one street on {North}, and for some reason {North} Avenue, the street I live on is like that area like if you had like...like if you think about a tornado or something and there is like an eye and like {North} is like that area where like nothing really not too much happens...things happen, but it's not as bad as the neighborhoods that surround that area. So, if I hear somebody just thinking ya know that it's all bad and all this, it's really not. And I made it sound like that earlier because it's bad, it has bad to it, but it's not so bad where you can't go outside and walk around...or you can't come down there ya know. But, I mean, if I didn't live here, I'd probably say the same thing. So it is a fair opinion, but it might not be the most accurate opinion. -Mike, black, low SES, physically inactive

Furthermore, Mike felt that the amenities in his neighborhood were deficient and underutilized:

I: And what do you see as like...um...the main characteristics in your neighborhood. Is there a certain building or something that really defines your neighborhood?
R: Well like, ya know…there’s nothing . We have nothing around us.

I: Is there any like park or yard or shop?
R: There is a high school around the corner from us. Mary-Franklin Park and the rec center. Mary-Franklin rec center. There is not really a park around this. No I lied. {Greenview} Park I think it's called. There is {Greenview} Park. But no one really goes there anyway.

I: Why doesn't anybody go there?

R: I have no idea. I mean I won't even go there. I don't even know why. I never…it's just not a place that seems…they don’t have anything,

I: What’s there?

R: Just a whole bunch of grass, and there is a swimming pool that like summer camps would use, but besides that, you would hardly ever see anybody in that park. I don’t know why. It doesn't have a bad reputation or anything, it's just no one goes there.

-Mike, male, black, low SES, physically inactive

Since respondents were asked about their neighborhoods throughout the lifecourse, respondents were asked to compare past and current environments. Lauren, a white female from a socioeconomically disadvantaged family compares her current neighborhood to her childhood environment:

I: How would you compare your neighborhood [during childhood] to your neighborhood here?

R: “Ghetto. This is nice. People aren’t really out, and if they’re out they’re with their kids, walking their dog. There’s bad kids in the neighborhood that I grew up in you know? There is spray paint and toilet papering and breaking a lot of windows. Ghetto.”

-Lauren, white, low SES, insufficiently active

Later in the interview, Lauren also discusses feeling unsafe in her neighborhood during childhood and was afraid of being victimized:
“You never know when someone is going to rob you or play a prank, you never know. In the middle of the night, I would *never* walk down the street. In the daytime not so much, maybe it’s just the aspect of it being dark and not being able to see well.”

-Lauren, white, low SES, insufficiently active

Middle and upper SES respondents did not mention such fears about their childhood environments; *all* of these respondents reported that they never felt unsafe in their neighborhoods during childhood. Only one upper SES respondent claimed that she felt fearful in her current living conditions. In addition, these respondents described their neighborhoods as containing lakes or other bodies of water, bike and pedestrian paths, and gyms and other indoor recreational centers. However, some middle SES respondents lived in rural areas in which such amenities were not available. Nonetheless, these respondents had access to other resources such as private property to use for recreational purposes that low SES respondents did not have access to.

**I:** Ok, so did your neighborhood have a lot of outdoor recreation areas?

**R:** Not necessarily, but we did have a lot of open property. So we had like fields to play kickball and stuff like that. We did live probably maybe 4 miles away from the closest school which had basketball hoops and things like that. But fairly much, we just kinda stuck around the town and played sports.

-Matt, white, middle SES, physically active

These respondents also reported seeing neighbors using neighborhood spaces for recreational purposes such as biking and walking.

Upper and middle SES parents not only used economic capital to gain access to safer housing with more accessible and abundant recreational facilities, but also were able to use these resources to enroll their children into physical activities during early
childhood and continued to provide opportunities for their children throughout their lives. Middle and upper SES parents indicated that physical activity was an important component of their lives by having a history of physical activity participation themselves, modeling the behavior for their children, and ensuring that their children were also physically active by providing them with opportunities to participate in active extracurricular activities.

Scott, an upper SES white male remembers his parents being physically active as a child and describes how his parents encouraged him to participate in various sports throughout his childhood:

I: And when you were growing up how important was physical activity to your family?

R: Um… it was… I’d say they’re fairly strong about doing sports like I had to start doing piano lessons and some other musical things first. But um, yeah they enrolled me in baseball before I could remember. So yeah, they started enrolling me, they wanted me to get into sports. My dad was very active throughout high school and college in track and in football and things like that so. He played a lot of sports so I think it was not necessarily forced on me but definitely persuaded me to do it.

I: and, did you ever see your parents exercise regularly when you were a kid?

R: Yeah, my dad he would always play sports and football and stuff like that. He actually used to run, um… probably in his late 30s and early 40s he used to run maybe a mile or so every once in a while. He’d get up on the weekends and run so, I do remember him being pretty active, still running and stuff. My mom, she loves gardening outside and that’s kind of her physical activity. She loves doing landscaping and stuff so she still does that consistently. But as far as going for runs, I mean yeah, they started wearing a pedometer for checking their steps and everything. So that’s good that they are kind of getting into it more. But yeah I mean I wouldn’t say overly active, but still consistent.

-Scott, male, white, upper SES, physically active
A similar story was echoed by Sharon, an upper-class black female who is pursuing a bachelor’s degree while she is living with her parents.

R: I didn’t really want to join track at first, but my dad ran track a lot when he was in high school. He was really good and actually got a track scholarship for college. Um, so he kind of made me do it too. I mean, he didn’t make me do it…I just saw him running around all the time when I was a kid and I thought it looked like fun. (laughs) Well, that and he told me that I had to take up a sport to make myself a more, ya know, well-rounded person. So in high school I ran track too, but now I’m into weight lifting more…but I still run like three times a week on the treadmill or whatever.

I: So how did you get into weight lifting?

R: My dad took me to that, um, Arnold Classic and I just thought that those women looked amazing…I wanted to look like them. Well, maybe not that big, (laughs) but it was definitely something that I found, ya know, physically…um…appealing. So I started weight lifting. I mean, it’s easy for me to put on muscle anyway, so why try to fight what my body does naturally right? It makes no sense, I’ve been spending so much time trying to be skinny, but I don’t think my body was meant to be that way.

I: So when did you start weight lifting?

R: Not too long ago…maybe a couple of months? I told my daddy I wanted to start weight lifting after we saw the show, and he went and hired a personal trainer for me at the country club the next week so I could get started! I’ve loved it ever since. So yeah, my dad is really supportive…um, ya know he helps me make sure that I stay physically active.

- Sharon, female, black, upper SES, physically active

Both of these individuals come from upper-middle class families and were some of the most physically active respondents in the sample. Scott was raised in a neighborhood with “probably all two story houses, maybe one was a one story. Maybe an acre per land…per house per land.” He also described the neighborhoods residents as being “pretty religious-based” and “all whites”. Scott’s father works has a bachelor’s degree and works as a Human Resources Manager in manufacturing industry while his mother
went to work as a secretary after both him and his brother started high school. Sharon, on the other hand, could be described as coming from an upper social class, compared to other respondents in this sample. Both of her parents attained education beyond a four-year degree; her mother earned a Master’s degree in Real Estate and her father earned his J.D. Sharon’s parents make over $200,000 a year and live in a neighborhood she describes as “rich, but not too upper class”. Her family belongs to the local country club and generally “enjoys[s] nice things.” The parents of these respondents are not only utilizing economic capital to gain entry to safe housing with recreational amenities and to enroll their children into sports and other physical activity-related pursuits, but are also utilizing cultural capital by influencing preferences of physical activity behaviors and transmitting physical activity as a normative behavior/encouraging their children to value physical activity. Both of these cases provide evidence of the process through which parents influence their children’s physical activity through both modeling the behavior themselves and by actively enrolling their children in activities that promote physical activity.

John, a black male currently working as an administrative assistant raised in a low-SES family had a very different experience with physical activity in his family:

I: And when you were growing up, how important was physical activity? Did you ever see your parents exercise? Your sister?

R: Exercise really wasn’t that important. I don’t really remember seeing my parents do anything. But I always wanted to go outside and play or something. Because I could not stay inside the house and not do anything so...it was a big part, especially playing all those little league sports and things, doing stuff in school, without all that stuff I would have had no life whatsoever. So it was a big part of my younger life.
I: So what happened when you got older?

R: Like I said just moving out of high school, and then uh…I got a job and started getting kind of lazier and lazier, and then video games got better and better (laughs).

-John, black, low-SES, physically inactive

This excerpt draws attention to two aspects of that were often indicated by low SES respondents; parents were generally not physically active and did not encourage their children to be physically active, and the only opportunities to be physically active for these children was through school sports participation. Once these children aged out of a primary education system that possessed some institutional control over their physical activity behaviors, they became sedentary. In contrast, middle and upper SES respondents were accustomed to seeking out and participating in moderate and vigorous activities outside of educational settings and did not appear to experience such a rapid decline in physical activity. Furthermore, these respondents often attended postsecondary intuitions with accessible recreational facilities. Nonetheless, low SES participants in these same institutions often did not report using them.

Some low SES respondents also reported that their parents were ill and unable to participate in regular physical activity. Shaun, a white male from a low-SES family, indicated that his father, who was diagnosed with lung cancer, was too sick to exercise:

“…my mom and dad looked fit…well, my dad was sick on oxygen, but I don’t…you know, I don’t think I ever saw them exercise.”

-Shaun, white, low SES, physically inactive

This has socioeconomic implications since those of lower SES are more likely to experience morbidities and mortality at younger ages, and thus may be unable to model
physical activities for their children. None of the middle and upper SES respondents in this sample reported having parents that were too sick to participate, and generally described their parents as “healthy” and “doing well”.

Additionally, both the respondents’ and the respondents’ parents occupations had implications for physical activity participation as well. Parents who worked in blue collar positions that required more activity were often described as being “tired all the time” or “beaten down” and thus did not want to use their leisure time to participate in further activity. Shaun, the same respondent that indicated that his father was too sick to participate in physical activity discussed how his mother’s job influenced her propensity to be physically active:

“I mean, I don’t think my mom exercised because you know, she stayed fit because of her job. She worked construction and did a lot of other manly kind of jobs where she was always moving and lifting heavy stuff. She always came home really tired and sore. My mom she did a lot of work from construction work to working at a BP plant. Once I got older she wore herself out. She had to be put on social security because her body was just so wore out that she couldn’t work no more.”

- Shaun, white, low SES, physically inactive

Shaun himself, and other respondents working in positions in the service industry, also reported that constant standing and walking and a general inability to keep “normal” eight to five working hours made it difficult for them to be physically active:

“Work is too time consuming. It’s not like in school where you have a set schedule every day. Sometimes I work 11 to 8, and I could probably do something when I got home. But most of the time when I get home I’m so tired that I don’t want to do anything.”
In summary, these results highlight the importance of both material and nonmaterial resources and how the interplay between them can have implications for physical activity behaviors. It was hypothesized that variations in physical activity related knowledge would reflect differential quality and/or quantity of educational attainment. Educational attainment is an institutionalized form of cultural capital that can be obtained via access to economic capital and embodied cultural capital needed to gain entry into social networks and educational institutions. Those with more or better educational attainment were assumed to have gained skills that enable one to make well-informed decisions and adopt health-enhancing behaviors. Since blacks are disproportionately relegated to lower quality educational institutions and are less likely to attain high levels of educational attainment than whites, this proposed mechanism may have also had implications for racial disparities. However, this research did not find such socioeconomic or racial variations in physical activity knowledge. This finding may lead some to conclude that these are inconsequential determinants of physical activity behavior. However, I argue that since health information is dynamic, it may be that knowledge is only a determinant when new medical information is available. As seen with Link’s tobacco use example, educational disparities in health-related knowledge may only have an influence on new health information. As this information becomes common knowledge, this form of capital may no longer be of consequence in the formation of physical activity disparities. As a result, this study may have not picked up on any meaningful socioeconomic or racial variation in physical activity knowledge since this information may have been available long enough to be thoroughly disseminated throughout the population. While the lack of variation in knowledge has been used to
highlight the role of educational attainment as the most fundamental cause of disparities, this conclusion does not lead us to an understanding of why the educational stratification of health behavior persists and neglects the dynamic processes in the generation of health disparities.

Using Bourdieu’s terminology, motivations are shared strategies to move within the world that result from a habitus that is shaped by access to social, economic and cultural capital. Given that a group’s access to capital varies, and that motivations are created in response to these social conditions, it would seem that motivations to be physically active would be expected to vary by race and/or socioeconomic status. Nevertheless, this research was unable to corroborate hypotheses of marked motivational differences among racial or socioeconomic groups (Lindbladh et al 1997). This finding may be in part a result of the age group under examination. Research suggests that young adults are particularly body conscious (Rucker and Cash 1992) and thus, may be more motivated by the aesthetic benefits of physical activity. This desire for an appealing body size may supersede motivations generated by access to capital in this population.

Although Bourdieu does not make any specific reference to racial differences in tastes, previous research indicating racial differences in body tastes were suggested to be a critical component of embodied cultural capital in that these preferences are believed to reflect tastes that are symbolic of a particular position within the social hierarchy. While variations in body satisfaction and body size preferences were suggested as a key mechanism in generating racial disparities in physical activity, this study was unable to come to a definitive conclusion regarding such differences. While black respondents in this sample vocalized differential expectations of the black body, it was difficult to
determine if these differences have real consequences for physical activity behaviors. Previous research has repeatedly shown that black women prefer larger body sizes and have more body satisfaction than white women; however, findings that suggest dramatic differences in body satisfaction and body size preferences among various racial and socioeconomic groups are open to criticism due to the operationalization of such concepts. Body satisfaction is often measured with a single item such as “How do you feel about your body right now? (Anderson et al 2002)” or are assessed with the Body Shape Satisfaction Scale which measures contentment with various aspects and parts of the body. More in-depth analysis of body satisfaction is needed to understand these variations.

This research has indicated that individuals often engage in a double talk about their body size preferences in which they initially reject stringent mainstream definitions of desirable body size, yet ultimately accept these same definitions implying that respondents are internalizing these mainstream body preferences. Given this finding, racial variations may not have consequences for physical activity behaviors since black women may be socialized to outwardly reject mainstream body size preferences yet continue to internalize mainstream body size preferences. In addition, although black women have been more likely to favor heavier bodies than white women in previous research, in most cases black women preferred body sizes that are in a normal weight range (Rucker and Cash 1992). Thus, while black women favor heavier bodies, they do not prefer overweight bodies. Given that black women are not aspiring to overweight or obese bodies, it does not seem probable that discrepancies in the prevalence of overweight and obesity between black and white racial groups are due to differential
body size aspirations. Lastly, research has suggested that younger generations are more aware of health risks associated with being overweight and, as a result, may be less likely to aspire to larger body sizes (Flynn and Fitzgibbon 1998).

Economic capital was found to have a relationship with physical activity behaviors through access to safe neighborhoods with features conducive to physical activity and occupational tasks and work schedules. The utilization of economic resources also highlighted the intergenerational transmission of physical activity behaviors. This research has found that parents of respondents used economic capital attained from more prestigious and high-paying occupations and institutionalized capital in the form of educational credentials to (1) attain safe housing with amenities that facilitate physical activity participation and (2) enroll their children into extracurricular endeavors that emphasize physical activity. Furthermore, these parents had a form of embodied cultural capital that emphasized the importance of maintaining and cultivating the body through exercise and were physically active themselves while parents in the lower socioeconomic classes often did not model this behavior for their children. This finding may speak to previous scholars’ suggestions that those of higher socioeconomic status have an increased propensity to practice healthier lifestyles. The parents of respondents with higher educational attainment seemed to value physical activity as a component of leading a healthy lifestyle.
Conclusion

The present paper has contextualized physical activity, an important health behavior that has implications for racial and socioeconomic disparities in health outcomes, by focusing on the interplay between cultural and economic capital. Physical activity-related knowledge and beliefs, motivations for being physically active, sport and physical activity preferences and body size preferences and body satisfaction were identified as aspects of cultural capital that may have implications for physical activity behaviors. Access to safe neighborhoods with amenities conducive to physical activity participation and occupational duties and work schedules were aspects of economic capital that were hypothesized to influence physical activity behaviors. The finding that economic capital appeared to play an influential role in the socioeconomic and racial variation in this sample of young adults highlights the importance of social conditions while emphasizing the interplay between upstream and downstream processes. While economic capital was essential in the creation of socioeconomic and racial variations in physical activity by permitting respondents to gain access to neighborhoods with characteristics conducive to physical activity, these material resources may not have mattered without the more downstream, nonmaterial determinant in the form of parents and neighbors modeling and encouraging the behavior. As previous scholars have noted (Ross and Wu 1995; Winkleby 1992), there is something that leads those of higher socioeconomic status to engage in healthier behaviors.
Going back to Bourdieu’s theory of cultural reproduction, it could be suggested that this “something” is a *taste* for a lifestyle that is indicative of a desirable class position. Whether those in the upper echelons of the social hierarchy are more physically active in an effort to live longer, healthier lives, to attain a specific body size or to plainly adopt new innovations is debatable. However, Bourdieu reminds us that this group of individuals not only has the most access to cultural, social and economic capital, but that this capital is used to fulfill variable tastes that are used to create and legitimize class differences.

Upper class individuals share embodied cultural capital in the form of similar aesthetic preferences, which are often expressed as aversions to lifestyles unlike their own. The upper class may be intolerant of lifestyles led by the lower class that are characterized by sedentary leisure activities and of the heavier bodies that accompany this lifestyle, leading to the characterization of the lower class as a group of apathetic or lazy individuals. In attempt to reduce the social distance between upper and middle classes and increase the gap between the lower and middle classes, those in the middle class may employ resources and capital to lead a lifestyle that is similar to those in the upper class. However, those in the lower class have neither the tastes nor the capital to pursue this same lifestyle. This, in part, may explain the finding that virtually *all* respondents were motivated by the same purpose yet lower SES respondents cited that they were generally unmotivated to be physically active; perhaps lower SES individuals have and perceive more barriers to engaging in this activity due to their lack of capital, especially economic resources, making it more difficult act on these same goals.
By analyzing people’s physical activity behaviors in relation to their access to and utilization of economic and cultural capital, we are able to extend our focal lens in the study of health disparities. While the fundamental cause framework has been used, perhaps inadvertently, to close the door on understanding downstream determinants of health outcomes, this research has provided an example of how an analysis of material and nonmaterial social conditions can be used to understand proximal causes of health outcomes. This approach allows us to draw connections between structural determinants and health behavior by providing an account of how behaviors are constrained or facilitated by intergenerational access to economic and cultural capital. It is through these relationships between downstream and upstream processes that social conditions attain their meaning and have real consequences for health outcomes.

While contextualizing downstream determinants by highlighting downstream and upstream processes may prove complex, I believe that doing so will only strengthen our argument for the implications of social conditions in creating health disparities since we will be able to provide a fuller description of how persons come to embody inequality. This thick description will also provide us with multiple points in which to intervene to achieve Healthy People 2010’s goal to reduce, and eventually eliminate, health disparities. Much like an infectious disease epidemiologist must look for multiple pathways in which to intervene to limit or eradicate the host’s exposure to the agent, we too must find multiple points in which policies can be developed and implemented to decrease and eliminate health disparities.

It has been suggested that focusing on nonmaterial aspects of health disparities such as health behaviors will lead to lackluster policies that direct attention away from
the development of initiatives to address income inequality such as increasing minimum wage, access to early childhood education and access to adequate housing for low income and homeless populations (Link and Phelan 1995). However, I argue that providing a better account for how these inequalities affect downstream determinants will only bolster the need for such interventions in addition to providing possible alternative policies that may not involve a large scale redistribution of economic capital. Such policies may include initiatives to provide safe and accessible outdoor trails, parks, and walking paths in low income neighborhoods, incorporating and encouraging work-site physical activity in occupational settings in which low income persons are employed, and developing health education initiatives that clarify differences between moderate and vigorous physical activity and emphasize the usage of household items that can be used to improve physical fitness that don’t require any additional purchases.

This study may have been constrained by some methodological limitations. First, as mentioned above, these findings may be in part due to the age group analyzed. The extent to which these findings are a result of age, period or cohort effect remains unclear. The present study could also better analyze social determinants of socioeconomic and racial variations in physical activity by increasing the sample size and increasing variability in educational attainment among respondents and respondents’ parents. A larger sample size with more educational variability may have yielded more socioeconomic variation in physical activity-related knowledge, beliefs, motivations and body preferences. Furthermore, although a group of “high SES” respondents were examined in this sample, these respondents may be better categorized as upper-middle
class. Sharper variations may have been found had respondents been recruited from the upper echelons of society that Bourdieu refers to in his analysis.

An important next step in the contextualization of racial and socioeconomic disparities in physical activity behaviors is to determine whether these differences are indeed real. Since data collected from the Behavioral Risk Factor Surveillance Survey (BRFSS) is reliant on self-report data; it is questionable whether these differences reflect actual differences in behavior or reporting. Additionally, while the present paper did not examine social capital, future investigations that include this resource are needed to understand its unique role in creating health disparities. Lastly, further research is needed to understand the role of *tastes* in the creation of health disparities to better test the suggestion that these predilections may be that “something” that influences higher SES groups to adopt health-promoting behaviors.
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