



Examining the influences of gender, race, ethnicity, and social capital on the subjective health of adolescents

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Abstract

We investigate the factors that influence adolescent self-assessed health, based upon surveys conducted between 2000 and 2004 of high-school seniors in Washington State ($N = 6853$). A large proportion of the sample (30%) was first and second generation immigrants from Asia, Latin America, and Eastern Europe. Findings include a robust negative effect of female gender on self-reported health that is largely unmodified by demographic, developmental, social capital, and parental support variables, gender differences in the covariates of self-reported health, and the tendency of male adolescents of Cambodian and Vietnamese origin to report lower levels of self-reported health despite controls for other health-related individual characteristics. Social capital dimensions such as positive school affiliation, social network cohesion, and a safe learning environment were found to covary with the self-reported health of adolescent females.

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Introduction and theoretical background

A common and enduring feature of post-demographic transition societies is the linear relationship between individual socio-economic status (SES) and various measures of morbidity and mortality risk. Although some of this relationship can be explained through individual health behaviors and health-care access associated with SES, there is a significant component of individual health that is mediated by the social environment in complex ways that are independent of individual characteristics (Yen & Syme, 1999). For a variety of reasons, the period of adolescence affords an important glimpse of the complex interplay between individual and contextual influences on health throughout the life course (Goodman, 1999). In addition to being a particularly high-risk period for the initiation of lifelong tobacco use, unprotected sex, substance abuse, and violent death, transition through adolescence brings with it the foundations for future educational attainment. It is also during adolescence that the acquisition of social skills essential to the lifelong task of establishing and sustaining supportive social networks takes place. Such interpersonal networks are argued to mediate between various forms of social stress and health (Wilkinson, Kawachi, & Kennedy, 1998). Finally, unlike adulthood, adolescence offers the chance to observe the SES–health relationship with minimal influence of the “social drift” phenomenon; namely, the circumstance in which poor health is the determinant of social class via reduced earning power and educational attainment (Starfield, Riley, Witt, & Robertson, 2002). For all of these reasons, investigators from a wide array of disciplines and theoretical orientations have turned to adolescent health as a point of leverage for disentangling the SES–health gradient.

In this paper, we seek to provide two important contributions to the literature on adolescent health. First, we investigate the magnitude of differences in self-reported health by gender, race, ethnicity, and immigrant background. Of particular interest is the extent to which the “gender gap” in adolescent health is common and of similar magnitude across all racial and ethnic groups represented in our diverse sample. Second, we identify a general model of adolescent health that considers the role of social capital. Our investigation is based upon the self-reported health of a pooled sample of four waves of high-school senior classes from 12 high schools in Washington State surveyed over the 2000–2004 period ($N = 6853$). Aside from the high response rate (71% of the sampling frame) and a rich array of survey items that reflect both known and plausible correlates of adolescent health, nearly one-third ($N = 2086$) of participants were from immigrant family households.

The interpretation of self-reported health in adolescence

The measure of health employed is the self-reported health of participants on a five-point scale. Self-reported health is a widely utilized measure of subjective health in public health and the social sciences. Self-reported health is highly correlated with more objective measures of health (Andresen, Catlin, Wyrwich, & Jackson-Thompson, 2003; Idler & Benyamini, 1997). Moreover, self-reported health has predictive effects on longevity independent of objective health status (Idler & Benyamini, 1997). Among adolescents, self-reported health also has a broader interpretation, extending to a more general sense of social competence, coherence, and well-being (Mechanic & Hansell, 1987). These psychological traits are highly correlated with subjective health complaints that are common to adolescents and associated with socio-economic inequalities (Goodman, 1999; Leveque, Humblet, Wilmet-Dramaix, & Lagasse, 2002; Mechanic

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