

“I Think About Oprah”: Social Class Differences in Sources of Health Information

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Abstract

Health information influences an individual's health outcomes. Indeed, researchers have found that communication inequalities contribute to health inequalities. We do not have a clear understanding of why and how the communication disparities exist, however, particularly the social forces behind such differences. The qualitative nature of this article reveals the nuances of health information seeking using the case of infertility. Through 58 in-depth interviews, I demonstrate how differences in social and cultural capital between women of low and high socioeconomic status (SES) result in different ways of learning about health. Women of high SES have access to support groups, physicians, and the Internet, whereas women of low SES do not discuss their health problems with their peers, and lack access to and distrust physicians. I explore how these differences in health information shape the illness experience. I conclude with policy implications.

Keywords

communication; fertility / infertility; health information seeking; social equality / inequality; women's health

I haven't [thought about medical treatments for infertility]. . . . I see it on TV and you hear about it, and it's like, wow, that sounds interesting. Let's see. Was it—I think it was Angela Bassett was the last thing I seen and she got twins, but they took her egg out of her and put it in another woman and used her husband's sperm and I'm thinking, “Wow, that is quite a bit.” So that was kind of amazing to me. . . . Yeah, but I haven't really looked like, for myself. (Woman of low socioeconomic status [LSES])

I remember going to the library and looking on books on infertility. . . . And so I think I just went looking for—I think I found information in the pregnancy section like, “How do you process?” I remember looking in—it seemed like every time I went to a bookstore, I was drawn to that section for some reason. And so I would look there. And then [pause] I think I asked different people or if I heard a conversation, maybe at church or in—at the school if teachers were talking, I would—I was really quick to tune in like, “Oh, they had that struggle?” I didn't always want to talk about it. But I wanted to listen so I would pay attention to those kinds of things. (Woman of high SES [HSES])

As the above quotes demonstrate, women of high and low socioeconomic status (SES) learned about health, in this case their reproductive health, in very different ways. Understanding why there are differences in health communication¹ between social classes² is important because it has significant implications for health care and its

outcomes (Brodie, Kjellson, Hoff, & Parker, 1999; Kontos, Bennett, & Viswanath, 2007; Viswanath, 2008). Communication, including interpersonal, Internet, and other media sources of information, not only facilitates the dissemination of new information but also influences how individuals approach health; what treatment, if any, they select; and their attitudes about a particular health issue, ultimately shaping the experience of health and illness. As the participants' quotes demonstrate, however, there are inequalities in health communication among socioeconomic groups.

There is a plethora of research demonstrating such communication inequalities (e.g., Blake, Flynt-Wallington, & Viswanath, 2010; Kontos, Emmons, Puleo, & Viswanath, 2011; Rooks, Wiltshire, Elder, BeLue, & Gary, 2012; Wathen & Harris, 2007). As Blake and colleagues (2010) summarized, communication inequalities encompass “differences among social classes in the generation, manipulation, and distribution of information at the societal level, and differences in access to and ability to take advantage of information at the

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individual level” (p. 2). Women of low SES tend to rely on television, or forms of health “scanning” in which they receive information passively, whereas women of high SES “seek” health information using multiple forms of communication, typically the Internet and health care providers (Rooks et al., 2012). Disparities exist across all forms of communication. The infamous “digital divide” persists with increased Internet access and understanding among high-SES individuals compared to their low-SES counterparts (Jensen, King, Davis, & Guntzville, 2010). Similarly, higher-income individuals are more likely to have access to and use wide interpersonal networks of communication, including enhanced communication with physicians (Lee, 2009).

Ultimately, these communication inequalities result in health inequalities. Communication acts as a mediator between social class and health, and thus can be used to explain class disparities in health (Ackerson & Viswanath, 2009; Kivits, 2009). For example, Kontos and colleagues (2007) found that higher morbidity and mortality rates among low-SES groups compared to high-SES groups could at least partly be attributed to communication differences. Despite its prevalence and significant implications, we still know little about how and why communication inequalities exist. Although researchers have exposed the inequalities inherent in health information, they have failed to examine the social factors behind such disparities (Rooks et al., 2012). We must move beyond individual demographic characteristics to explain communication inequalities and examine the contextual, everyday experiences of seeking, retrieving, and scanning for health information (Blake et al., 2010; Kivits; Lambert & Loiselle, 2007). Doing so will not only expose what is driving the disparities but also reveal how they might be prevented.

This article is a first step to achieving such aims. Using a qualitative comparison of health communication differences between women of high and low SES, I provide an in-depth examination of the social factors driving communication inequalities. I do so through the study of women’s infertility, which presents an ideal case for three reasons. First, infertility is a media-laden “health”³ issue. Stories of celebrities using assisted reproductive technologies (ARTs) are common in the press, as are reality shows that celebrate infertility “successes” through the birth of multiples. Second, infertility is a consumer-driven health problem (Conrad & Leiter, 2004). Most insurance companies do not cover infertility treatment, so it is up to individuals to seek care, and thus the information about such care. Health communication is therefore all the more pertinent to women’s experiences of infertility. Finally, infertility itself is rife with inequalities (Bell, 2010; Sandelowski, 1993). In 2002, nearly 20% of women with a college degree received medical care for

their infertility compared to less than 10% of women without a college education (Chandra, Martinez, Mosher, Abma, & Jones, 2005). Financial reasons are typically cited for this disparity, but class differences in health information could also be to blame.

I suggest that differences in social and cultural capital among women result in communication disparities and ultimately health disparities. In simplified terms, capital⁴ refers to resources that allow (or prevent) social mobility or advancement (Bourdieu, 1977, 1979/1987). Such resources, however, must be activated or used to become a form of capital. For example, Lareau (1987) employed the concept of capital in her analysis of social class and schools. She found that middle-class parents had more productive relationships with schools than working-class parents because their resources (e.g., education and income) and parenting behaviors were more closely aligned with school requirements. Middle-class families were able to use this capital to gain increased access to school resources and teachers and to network with other parents, ultimately enhancing their children’s educational experience.

Similarly, differences in social and cultural capital can result in class disparities in health information. For instance, Emmison and Frow (1998) noted that socioeconomic differences in cultural capital result in the unequal uptake of information technology. Moreover, like communication, social and cultural capital are also related to health. Researchers have found that social capital reduces stress and risky behaviors (Viswanath, Steele, & Finnegan, 2006). It is also related to reduced mortality and improved self-rated health (Ackerson & Viswanath, 2009; Kawachi, Kennedy, & Glass, 1999). Taken together, then, in the findings that follow, I explore the relationships between capital, communication, and health: How do social and cultural capital influence health communication mechanisms, and in turn, to what extent and how does that impact the health and illness experience, ultimately maintaining health inequalities?

Methods

Qualitatively comparing how women of high and low SES engage with communication allows for a nuanced analysis of the relationship between communication and health, particularly how it is situated in a social context. To this end, I conducted 58 in-depth, semistructured interviews with women of diverse socioeconomic backgrounds. These interviews were part of a larger study exploring differences in infertility experiences between women of high and low SES. Women could participate in the study if they had ever been involuntarily childless for at least 1 year because of the inability to become pregnant or carry a child to term (medical definition for infertility),

and were between the ages of 18 and 44 years. Given the findings from prior research (e.g., Greil, 1991) that revealed the salience of infertility for women more than men, recruitment for this study was limited to women. On receiving institutional review board approval, I recruited participants in southeastern Michigan through flyers and advertisements posted at public venues (e.g., grocery stores and libraries) and organizations affiliated with low-income populations (e.g., food banks and shelters).

Rather than the term *class*, I chose to use the phrase *socioeconomic status* when referring to the participants for a variety of reasons. First, SES encompasses the numerous economic and social facets of class position that were present in the women's everyday lives, such as occupation, education, family background, and income. It also represents the hierarchical ranking and relationships among socioeconomic strata in society. Second, I wanted to avoid using the pejorative phrase *lower-class* and felt that *low socioeconomic status* better encompassed and represented the women in the group.

To determine the participants' SES group, I looked at several variables. Before being interviewed, participants completed a demographic questionnaire in which I inquired about a variety of factors, many of which were to ascertain a woman's class status. These factors included the woman's occupation and education along with her partner's, her parents' education, household income, household size, and a subjective question inquiring about income adequacy. As a starting point, I began grouping women according to their household income. Not only is income one of the three primary variables encompassed within the concept of socioeconomic status (in addition to occupation and education), but it is also the variable on which women are explicitly excluded from infertility treatments because of the cost of medical treatment and its connection to insurance. However, income is a highly sensitive topic, which participants might not fully disclose. Therefore, I used the other indicators of SES, including the occupation and educational attainment of the participants and their households, to verify the income categorization and determine the final groupings of participants.

In the majority of cases, these variables, taken together, corresponded to income. For those that did not group succinctly, primarily because of a disjuncture between education and income (e.g., a teacher), I based the socioeconomic category on a variety of factors. Despite a few outliers, grouping women according to income typically resulted in consistency across income, education, and occupation. Defining socioeconomic status in this way and based on the inductive division of the findings resulted in two overarching SES groups: low SES, which, in terms of class, included both poor and working-class women, and high SES, which included both middle-class and upper-middle-class women.

Reflecting the demographics of the region in which recruitment occurred, the majority (76%) of high-SES women had a college degree, whereas only 5% of low-SES women had a college education. Women of high SES reported an average annual household income of \$90,000 compared to \$20,000 reported by women of low SES. On average, the women were in their early 30s (low SES: 31 years; high SES: 35 years). All women of high SES were married compared to approximately 40% of women of low SES. I found no differences in health communication by relationship status. All of the women of high SES were White, whereas 51% of the low-SES participants were Black and 49% were White.⁵

I conducted the interviews between 2008 and 2010 in public libraries. These one-on-one interviews covered a range of topics, including how women learned about infertility, their social support networks, and interaction with medicine. Interviews lasted an average of 90 minutes, and participants received a \$10 gift card as compensation. All interviews were transcribed verbatim. Using HyperResearch (Kinder, 2008), I developed a coding schema to inductively develop research reports for analysis. Given the initial research questions prior to data collection and analysis, I formulated some codes (e.g., "research") prior to reading the interviews; however, I generated the majority of the analysis from the data and created codes inductively as I read the transcripts, similar to a grounded theory approach (Charmaz, 2006).

Once all of the codes were created and verified, I refined those codes into hierarchical coding schemes. I then formed a more formal, detailed, and thematic analytical approach, ultimately identifying patterns and variations in responses. For the purposes of this article, I analyzed the class basis of health communication using the themes and codes about information and research. In particular, I focused on the structural and cultural contexts in which the participants lived and how such environments shaped the women's narratives about health communication.

Results

As demonstrated through the following stories, and reflected in previous research findings, there are communication disparities between classes: Women of low SES use the media, primarily entertainment television, as their primary source of information on infertility, whereas women of high SES use a variety sources, including friends, family, physicians, books, the Internet, and other media. In the following sections, I explore why those discrepancies exist and how they impact health experiences.

Health Communication Inequalities: The Role of Capital

Social and cultural capital are typically divided along economic lines; low-SES individuals have less capital compared to their high-SES counterparts (Bourdieu, 1979/1987). Exploring how these differences impact health information begins to reveal the social, cultural, and contextual basis for communication disparities. Social capital, in particular, might be especially salient in health information given the importance of interpersonal mechanisms of communication. Many researchers have found, however, that women of low SES are less likely to use interpersonal sources for health information because of their limited social networks compared to more economically advantaged women (Jensen et al., 2010; Lee, 2009). Kontos and colleagues (2011) found that when low-income individuals do engage in interpersonal communication, they typically rely on lay sources, such as friends and family. In the case of infertility, however, even reaching out to friends and family might be difficult for women of low SES given the stereotypes surrounding the ailment, as well as the silencing of such issues within the demographic.

Infertility is typically thought of as a White, wealthy woman's issue. In contrast, poor women and women of color are stereotyped as having too many children; in other words, they are portrayed as "hyperfertile" (Bell, 2009; McCormack, 2005). Despite the inaccuracy of these stereotypes—as both classes have an equally high prevalence of infertility—the women internalized such norms, which influenced their interpersonal communication about their reproductive problems. For instance, reflecting the internalization of the stereotype of infertility as a White, wealthy woman's issue, women of low SES did not know many others with infertility (Bell, 2012). In turn, the women learned about infertility from entertainment television, which further distanced them from the issue. For example, when I asked if she knew anyone who was infertile, a woman of low SES told me:

No. Only what I've seen on television. . . . You know, when I do think about it, I do, yeah, about Oprah she did. . . . I don't think it's easily accessible—you know, to find out, okay, what is it that women at these certain age, demographics or whatever can't have kids?

This participant did not know others with infertility. Instead, she, like other women of low SES, knew about infertility through television, which typically provided sensationalized images of celebrities or multiples. Thus, women of low SES had no one to relate to and, perhaps more significantly, no one to talk to about their difficulties. Another participant illustrated this lack of social support with her response: "I wouldn't say [I know] a lot [of

people with infertility] because they're—I— . . . It's not something you just readily talk about with people."

Compounding the lack of others to talk with about their reproductive troubles was the fact that many women of low SES did not talk about such personal issues within their communities. Not talking about their experiences furthers the stereotype that infertility is a White, wealthy woman's issue and maintains the feelings of isolation and loneliness among marginalized groups. One reason women of low SES did not discuss their childbearing difficulties was that to do so, these women had to admit that they desired a pregnancy and were "trying" to conceive. This was problematic for some women of low SES because of the ideology that they should not be mothers in the first place, given their economic status and other demographic factors (McCormack, 2005; Roberts, 1997). Despite the earlier childbearing norms within low-SES settings, many of the participants reported being criticized for being too young to attempt to have children. For instance, a woman of low SES stated,

[I don't want to tell my mom] because she's—I don't know—she's going to say, "[You're] too young. Why are you trying? You this. You that. You don't have a job right now. I'm too young to be a grandmother." And that's the first thing she's going to say. And I'm looking at her like, "You're almost fifty." It's, "I don't have any grey hair." "So?" I'm like, "I don't care, Mom." I'm like, "When I'm ready, I'm going to be ready."

Another woman of low SES had a similar experience:

Well, I wanted to talk to my mom about it but I never did. . . . And she asks but, you know, I—sometimes I lie to her and like, "No, we're using protection," you know, or whatever but, you know, I really—she thinks I should be further in my career to start having children but I think I've been working there a year and a half now and like, I think I'm in there good enough.

These participants were criticized by their mothers for going against the norm of "good" motherhood. They desired the role of mother despite their young ages and lack of an established career. The women negotiated with those stereotypes through avoidance or "information management" (Remennick, 2000); they did not tell their mothers, or chose to "lie" to them, about their childbearing difficulties so as to not be criticized for their mothering desires. Women of high SES did not face such conflict because of their embeddedness within norms of "good" motherhood.

Unlike the lack of conversation around infertility in the low-SES discourse, many women of high SES had the social capital necessary to disclose their fertility troubles and did so as a way to cope with them. For instance, a woman of high SES stated,

So yeah, I guess about two weeks ago [my husband] was like, “I don’t know. I think you need to go talk to somebody.” And I say, “But I talk to everybody. This is my—that’s my therapy,” you know, I talk to all of my friends and . . . it’s like—I don’t know. . . . I don’t know. Because I feel like—I guess I feel like I talk enough to people: to my friends and this friend at work and—I don’t know.

Disclosing her childbearing difficulties was this participant’s “therapy.” She had maintained friendships and had supportive family members who were there to listen to her stories even if they could not fully understand her experience. Another woman of high SES also talked with others to deal with her fertility struggles:

And I think that’s almost my—my outlet, you know. I really like to communicate with people and really pick their brains like, “Oh, this happened to you? Well, what happened? You—or what did you do? You had another baby. Well, what worked for you?” You know? So really talking to other people about what worked and what didn’t, and just kind of hearing through the grapevine.

For this participant of high SES, speaking with others about her struggles provided her not only with emotional support but also with a way to gain knowledge and resources about how to resolve her issues, perpetuating the knowledge and resource gap between classes.

Beyond talking with informal sources about infertility, there are also differences in how women of low and high SES discussed their reproductive difficulties with more professional sources of information, such as physicians. Women of low SES were less likely to use such sources of information for a variety of reasons. One reason was that women of low SES were not socialized to ask physicians for information. For instance, Lareau (2003) showed that families of high SES are more likely to socialize their children to approach authority figures with a sense of entitlement, whereas families of low SES are more likely to behave in a passive manner with professionals. Likewise, Fisher (1986) argued that women, particularly marginalized women, have been socialized to accept the authority of others. A participant of low SES demonstrated this type of submission when she stated that she “just let [the doctor] do her job and felt like it was going to be right.”

Such compliance caused many of the poor and working-class women not to mention their childbearing difficulties because they assumed the doctor would identify them. For example, a woman of low SES relayed,

Yeah, but still if they tell me everything normal, then that kind of ease for me instead of me telling them like, “Oh, I can’t have a baby. Could you tell me”—I’m thinking if they check me up and then they’ll let me know if they find something wrong. So that’s my way of thinking of it.

This participant was reassured that “everything [was] normal” when the doctor did not indicate otherwise. She waited for the physician to identify or probe about an issue rather than acting on it herself.

Beyond social capital, numerous researchers have demonstrated that doctor–patient communication is hindered for women of low SES because of unconscious discriminatory practices by physicians who give more information and prescribe more treatment to high-SES individuals (Roter & Hall, 1992; Smedley, Stith, & Nelson, 2003). In addition to class, physicians also engage in racial discrimination, causing Black women to not seek medicine as frequently as White women. In terms of health information, this is the one instance in which race differences arose among participants. There is a historical mistrust of medicine among the Black population, given past instances of grave medical mismanagement among their demographic, including negligence in the treatment of sickle cell disease and the failure to treat syphilis in the infamous Tuskegee studies (Hill, 1994). Such mistrust precludes medical help seeking and, thus, getting information from a physician. For example, a Black woman of low SES told me that “doctors try to talk you out of getting pregnant,” so she could not imagine going to them for assistance in becoming pregnant.

Ironically, the predominant use of one health information source—television—prevented women of low SES from accessing physicians as a second source of health information. Because women of low SES primarily learned about infertility from the television and its exaggerated media portrayals, they were fearful of medical treatments. For instance, a woman of low SES stated,

Like I have watched too many movies, and like when people be going through that and needles and—and then like when it don’t take and then when you do get pregnant, you end up pregnant with like six kids at once. I don’t—I don’t want that! That’s too much. I just want one at a time or twins. I can do that. But as far as six, seven, eight kids in your stomach at one time, I know that’s uncomfortable. . . . It was on like the Discovery channel, the Bio channel or whatever there. That’s just crazy.

Another woman of low SES had similar concerns:

Interviewer (I): So [pauses] you mentioned the fear of having multiples as a reason for not taking fertility drugs?

Participant (P): Mm-hm.

I: Where—where did that fear come from, do you think?

P: Because, you know, when I’d be watching the movies and stuff—it didn’t like—it seemed like every person that they were showing that had multiples was on the fertility pill. And like I like to watch that baby channel . . . and every person that was on there that had twins were on fertility pills.

For women of high SES, however, medicine was the answer to their childbearing difficulties. For them, the doctor–patient relationship was more of a partnership than one based in power differences. Similar demographic characteristics placed the women of high SES on a level footing with physicians. Additionally, the increased agency and control typical among women of high-SES settings also diminished the hierarchy of care that was so prominent within low-SES women’s experiences (Genuis, 2013).

The casual equality apparent within high-SES women’s relationships with their physicians is exemplified by one participant of high SES, who called her physician by his first name. She and her doctor were friends, peers, equals, working together to resolve her childbearing difficulties. Another woman of high SES also described her relative empowerment in relation to physicians. She said,

I could tell that I knew more than [the doctor] did. I mean because I—I tend to do research and read anyway, and I’m probably one of those patients who drive doctors crazy but it’s not like I’m going on like chat rooms or, you know, random Web forums. I’m really doing research and I still had access to the online medical library from when I was doing my MBA, so I would access medical trials and read and I just didn’t feel like she knew much. It wasn’t until I got to my RE [reproductive endocrinologist] that I felt like she could answer my questions. . . . I lied actually. I had only been trying for six months but I told her I had been trying a year because I had a feeling that it was going to be problematic and I didn’t want to waste any more time.

Rather than waiting for the doctor to identify a problem, this participant actually went to physicians with her own diagnoses, questions, and treatment ideas. Her access to resources and knowledge allowed the participant to believe that she “knew more” than the initial physician she visited. Additionally, as a woman of high SES she had the agency and ability to know how to work the system rather than be removed from it: she used the respect of her reproductive endocrinologist (RE) and her awareness of medicalized definitions to access infertility treatments early. Unlike the woman of low SES who “let the doctor do her job,” this more economically advantaged participant was in control of the medical interaction.

High-SES women’s agentic control over their medical care was further demonstrated by another woman of high SES, who told me,

I was like on the accelerated plan. I found out every single test I had to have, figured out where in my cycle it had to be done, and got everything done in like two months. . . . But I mean like that CDC [Centers for Disease Control and Prevention] Web site: I went through every single clinic and then made a spreadsheet for my age range. And then when I

would go into the doctor’s office, I had all of the tests and they were all color coded with little tabs and like a little notebook. I do, you know, looking back, like most people throw like a manila envelope at ’em [them], you know, with their tests in ’em and they’re like, “Did you want this back?” And I’m like, “No, that’s your copy.”

Rather than wait a full year to seek infertility treatment as indicated by the medical definition of infertility, this high-SES participant was “on the accelerated plan.” She had not only the ability to dictate her own timeline of care but also the knowledge to do so. Instead of depending on the physician to tell her if something was wrong like one low-SES participant, this more economically advantaged respondent took information to the doctors. She researched which fertility specialists were the most successful for her age group and, in her words, “interviewed them” for the best fit.

In addition to individual lay and professional sources for interpersonal communication, support groups also provide health information. Formal support groups for infertility abound, but are mainly composed of White women of high SES because of their marketing tactics, location, and focus on medical treatment. A woman of low SES described her lack of knowledge about such groups: “To not have no support is how this is crazy. I haven’t ever even heard of any groups out there, you know, for people like me.” In contrast, women of high SES knew about available support resources and utilized them to their full advantage. For example, a woman of high SES described attending RESOLVE, the largest national support organization for infertility:

And we were going to RESOLVE meetings. . . . They were great meetings for us. It was good to have other people to talk to who “got it.” Who got how it controlled your life. Who got how you could never make plans and how tiring it was to go to—for appointments, you know, driving to the university and parking in that God-awful structure to go in for a blood draw. You know, I mean they got it. And it was good for resources to talk about doctors and to talk about pharmacies. What’s the best pharmacy to get your drugs? Because, you know, certainly a rural pharmacy’s not going to have a full, you know, selection of Gonal-F and all of these other things you have to take. And so it was great from that standpoint, and it was great to hear what other people went through because it really gave us things to talk about. . . . But so, from that standpoint, you know, those meetings were great for us. And we, you know, I wouldn’t say we became friends with those people. We—it was very nice to be there and we would always go out afterwards, you know, for whatever.

Attending RESOLVE provided support to this participant on many levels. It provided her with others in her situation who could “relate” to her experiences, and they socialized

together. It also gave her resources, such as access to medical knowledge. Women of low SES already had restricted access to such opportunities, and their exclusion from groups like RESOLVE exacerbated this lack.

Women of low SES, however, not only lack social capital compared to women of high SES, but they also lack cultural capital, which further perpetuates the communication divide. Because of structural and contextual constraints, women of low SES have lower levels of knowledge, literacy, and research skills compared to women of high SES (Ackerson & Viswanath, 2009; Shieh, Broome, & Stump, 2010). Additionally, women of high SES are able to take a more active role in their health care, whereas women of low SES are many times restricted to more passive forms of engagement with their health given their limiting circumstances (Keeley, Wright, & Condit, 2009). As Rooks and colleagues (2012) pointed out, individuals of low SES are more likely to be health information “scanners” than health information “seekers.”

Such differences play out in health information and understanding, further driving health disparities between groups. For instance, a woman of low SES took a more fatalistic attitude about her infertility because of her contextual circumstances:

I: Did you ask the doctor about that?

P: No, I didn't. I just kind of figured like, okay, I just can't have kids. You know, maybe what I was supposed to output is pretty much about it. I mean, I don't know. I haven't really like, done more research on it, probably because of my time. So yeah. It's strange. It really is.

This woman of low SES lacked the time necessary to research her childbearing difficulties. Similarly, another woman of low SES “accept[ed]” her infertility because she did not recognize the utility of research in helping her overcome her childbearing difficulties:

I don't talk to nobody. And I can get on—on the computer all day and that's not going to help me. That's not going to do anything. Even if I told my mom, that's not going to do anything [laughs].

This participant did not recognize the usefulness of computers for health information, perhaps because she did not understand the information provided. As Zarcadoolas, Blanco, and Boyer (2002) reported, almost half of Americans read at or below the eighth-grade level, but most Web information is written at or above the tenth-grade level. This might contribute to the fact that 80% of adults with low literacy do not receive any health information from the Internet (Jensen et al., 2010). Women of low SES also might not recognize the utility of the information itself. Unable to access medicine, they do not see

how information alone is going to “help” them. In turn, women of high and low SES might place different value on health information based on their ability to act on that information.

In contrast, women of high SES have the means and knowledge to try to actively control their infertility. They are thus able to use the Internet more frequently and to greater effect than women of low SES. For example, a participant of high SES stated,

Also the thing is is even, you know, I wasn't working before, which I think was good. So my stress level wasn't that high but I honestly—it was sort of like my full-time job was researching this—this issue and how do I fix this and what do we need to do?

Another woman of high SES had similar research practices:

You know, and I started reading all of these things. . . . And s—so one of the things I usually—anytime I'm going to do something, I am asking a lot of questions or I am getting a book, you know, and now that there's the Internet I'm researching on the Internet.

In addition to the knowledge, means, and understanding necessary to conduct research, both of these participants of high SES had time to spend on research because they relied on their husbands' sufficient incomes and did not work. Researching on the Internet and in books became their “full-time job,” which was not possible for the women of low SES. Additionally, Lee (2009) found that use of the Internet for information was associated with using other forms of health communication, such as interpersonal sources, which would expand and build on the information gained. In turn, the digital divide might result in a knowledge gap between SES groups, widening health disparities (Albrecht et al., 2005).

Differences in social and cultural capital between classes resulted in different ways of using communication mechanisms. Women of low SES relied on the television for health information because they lacked the social capital of lay and professional sources of information as well as the cultural capital of the ability to actively seek information from the Internet and other sources. Exploring how communication is situated in a specific context reveals the nuanced social factors contributing to inequalities, such as the influence of ideologies of motherhood and the ability to control situations in life.

Health Communication Inequalities: The (Re) Creation of Health Disparities

The type of communication source used for health information greatly influences the health and illness

experience. It shapes an individual's knowledge and understanding of the ailment and in doing so, serves to maintain and reproduce health disparities. Not talking with others about their reproductive struggles and not actively researching about infertility on the Internet leaves women of low SES with television as their primary source of information. This results in a knowledge gap between women of high and low SES (Blake et al., 2010; Viswanath, 2008). For instance, a woman of low SES said that she did not "know anything" about reproductive technologies, and another woman of low SES reported knowing only what she gleaned from the media:

P: Yeah, I know a little bit about [reproductive technology] because I watched like the baby channels and I watch—Kate—Jon and Kay Plus Eight [television program]?

I: Kate Plus Eight? Yeah, right.

P: And she have PCOS [polycystic ovary syndrome] and she had a—the IA—the IVF [in vitro fertilization]?

I: Okay.

P: Infertile. So yeah.

In contrast, a woman of high SES researched about infertility to purposefully and actively gain knowledge:

And I have—I have really only started doing more research recently that I have been getting into the—the reproductive endocrinology part of things. Okay, I finally have to admit to myself that maybe this isn't going to happen the way I thought it was going to happen. Maybe I'm going to need to go down a different path. So let's at least be knowledgeable about what the different paths are so that I either have intelligent questions if we get to that part and/or I am not shocked by the different testing and treatments that are going to be out there.

Conducting research through the Internet or books allowed this high-SES participant not only to increase her knowledge but also to enhance her interpersonal communication with her physician by asking "intelligent questions." It also reduced any fear she might have about medicine by making her aware of the existing treatments and what they entail.

Low-SES women's dependence on the media for health information limits not only the amount of information they are able to attain about a health issue but also the type of information they receive. For instance, Brodie and colleagues (1999) found that media coverage of health problems targets the needs of mainstream White audiences while ignoring those of racially and economically marginalized groups. This is especially problematic given that more individuals of low SES use media communication as their primary source of information. As a woman of low

SES demonstrated, television programming reinforces stereotypes of infertility and perpetuates the marginalization of low-SES women and women of color:

P: Mm, [pause] 'cuz [because] like pretty much brought up when I ever heard about someone not being able to have a child, they would always been White. I had never personally met or interacted with an African American woman that couldn't. . . . I said, "Why did I have that image in my head?" . . . I don't know. I really—I think just because as far as like TV or books or magazines, every time there was an issue, I always would see a White woman.

I: Mm-hm. Yeah. And do you know of any Black women who are having issues?

P: Personally, I don't. . . . Mm-mm, I don't know of any personally.

As a Black woman, this participant could not understand how she was experiencing infertility because she thought of it as a "White woman's" issue. This not only perpetuated communication inequalities by making it less likely that she would talk about her infertility with others, but it also reified health inequalities by reinforcing stereotypes of infertility.

Another woman of low SES further demonstrated the media's basis in dominant ideals:

You be seeing [White, affluent women] on TV—and I ain't trying to be funny but you will see them on TV and they study more. They—they find out at the drop of a hat what's going on with them. . . . And maybe that's because it—they can though—their husbands be having good jobs with all of that nice hot insurance that helps them out. . . . It seems to be so easy for them to get help. Like, "I just went and just did it and now we're having triplets." Dang. You was able just to go get a pill and do that? "Where you get it at?" "You know, well, my husband's private insurance paid for it." "Oh, all I've got is Medicaid. Do you think that'd help me? No." But yeah.

Because she relied on television for information about infertility, this low-SES participant confronted stereotypes of infertility—that it should be treated medically and that White, wealthy women are those receiving treatment. These images excluded her experience of infertility, and they also provided misinformation. The media's focus on infertility "successes" promulgates false hope in medicine even though only an average of 30% of ART cycles result in birth (Centers for Disease Control and Prevention, American Society for Reproductive Medicine, & Society for Assisted Reproductive Technology, 2011). This false hope caused this particular participant of low SES to feel isolated and hopeless. Moreover, she recognized the material disparities present in medical care for infertility. Perhaps it is because of

these disparities that women of high SES “study more.” Like other women of low SES, this participant might not have seen the utility in seeking health information because she would not be able to act on that information given that “all [she’s] got is Medicaid.”

In sum, communication inequalities among classes can explain, at least in part, disparities in infertility treatment between economic groups. Women of low SES are not only restricted financially from receiving medical care, but the information source they use to learn about infertility also serves to perpetuate their exclusion and prevent them from attaining the resources and understanding they need to access services.

Discussion

It is common knowledge that class-based communication inequalities exist. However, “forms of communication do not take place in a vacuum devoid of external influence, but rather are an organic part of a complex social system” (Ackerson & Viswanath, 2009, p. 5). As one of the first scholars to compare how women of various socioeconomic groups retrieve and use health information in their daily lives, I begin to reveal why communication inequalities exist, particularly exposing the ideological, social, and cultural bases of such disparities.

Through the findings, I demonstrate that women of high and low SES retrieve health information differently. I also reveal why and how those disparities might occur. Because of stereotypes of infertility and ideologies of motherhood, women of low SES do not have friends or family members to talk with about their childbearing difficulties. Moreover, their more passive communication style and structural exclusion from medicine precludes conversing with physicians about their infertility. In other words, women of low SES lack the social capital necessary to foster strong interpersonal communication. They also lack the cultural capital necessary to effectively utilize the Internet. They are left with the passive communication medium of watching television to access health information. Doing so, however, serves to reinforce communication inequalities because television promulgates stereotypes of infertility that prevent women from discussing their reproductive troubles and limits women’s knowledge about infertility and their ability to address it.

The differences in health information I describe have significant implications for the health of populations. Not only does health information help define what an ailment is, but it also gives meaning to health in relation to everyday lives (Cotten & Gupta, 2004; Kivits, 2009). Communication enhances health through a variety of mechanisms. It disseminates information, improves knowledge, creates social supports, and can even be a mechanism for collective action (Viswanath, 2008). In

turn, communication is “critical to the advancement of public health,” so when such communication differs among socioeconomic groups, health disparities might ensue (Brodie et al., 1999, p. 148). Ironically, just as inequalities in health communication can contribute to health disparities, health disparities might also drive communication inequalities. As a woman of low SES lamented, “all I’ve got is Medicaid.” Recognizing the inaccessibility of medicine, women of low SES might not actively seek health information because they have limited options to act on such information.

Knowing why and how these disparities exist allows health intervention and education programs to develop (Kontos et al., 2007). For instance, health information relayed on the television should target people of all demographics. Doing so would help deconstruct stereotypes around health and illness, including those associated with infertility. By diminishing feelings of isolation and marginalization, expanded television programming might incite dialogue within low-SES communities about health and wellness. Recognizing the cultural basis of communication reveals the necessity to empower women of low SES to talk to their physicians and to educate women on the use of the Internet as an information source. This would broaden low-SES women’s communication base and thus enhance their health knowledge. Additionally, in the analysis, I demonstrate the need for support groups in low-income communities and suggest that health care providers should be educated in proper communication and health literacy for various populations.

Despite its contributions, this study also had its limitations. The results cannot be generalized to all health issues. The findings are specific to infertility, but the case of infertility was chosen because of its dependence on communication and its inherent inequalities. Additionally, the analysis is limited to class differences in communication, but I did so for two reasons. First, research has shown that communication inequalities are based in class rather than race (Brodie et al., 2000; Wilson et al., 2003). Second, my data support this in that I identified greater variation among socioeconomic groups than among racial groups. Future research should more fully explore gender and race differences in health information.

Understanding the context in which communication occurs is a first step to overcoming communication inequalities. Women of high and low SES learned about their health in different ways, and by understanding these differences, we can begin to overcome the health disparities they cause.

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Notes

1. Health communication encompasses many sources of information: formal sources (e.g., health care providers), informal sources (e.g., friends and family), and commercial and media sources (e.g., Internet and television; Kakai, Maskarinec, Shumay, Tatsumura, & Tasaki, 2003; Lambert & Loiselle, 2007; Worsley, 1989).
2. For the purposes of this article (as explicated more thoroughly in the Methods section), I define socioeconomic groups according to occupation, education, and income levels. Low socioeconomic status (SES) includes poor and working-class individuals, and high SES includes middle-class and upper-middle-class individuals.
3. In this article, I refer to infertility as a “health” issue because of its dominant medicalized construction. I do recognize, however, that infertility is a socially constructed process and not necessarily a medical entity (Franklin, 1990).
4. There are many ways to define capital and no consensus on how to do so (Lamont & Lareau, 1988). However, for the purposes of this article, capital is broadly defined as those assets that provide social mobility and advantage. Because I do not claim to measure capital, but instead use it as a framework for understanding communication disparities, having a broad sense of what capital means is sufficient.
5. As part of a larger study on infertility, this racial diversity was strategic in that it allowed for comparison of women marginalized (poor women and women of color) within infertility stereotypes to women enmeshed within such stereotypes (White and wealthy). As the findings reveal, and previous researchers have noted, class trumps race in driving communication inequalities (Brodie et al., 2000; Wilson, Wallin, & Reiser, 2003). Prior research revealed that the majority of racial differences in communication are because of income and education. Indeed, in this study there was more variation between classes than races; however, race differences are highlighted in the findings when they arose.

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