

Original article

Neighborhood quality and somatic complaints among American youth

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Abstract

Purpose: This study examines the relationship between the social context of neighborhood and somatic complaints in a national probability sample of adolescents.

Methods: Structural equation modeling is used to estimate paths of influence between neighborhood quality and somatic complaints. An analysis of variance highlights the relationship between demographic characteristics and neighborhood quality.

Results: Neighborhood quality appears to play an indirect role in producing somatic complaints in adolescents. Linkages between correlates of somatic complaints, such as stressful life events, family environment, psychological distress, and measures of neighborhood quality are discussed.

Conclusions: These findings emphasize the need to conceptualize adolescent somatization as contextually dependent and to use an ecological perspective when intervening with somaticizing teens. © 2005 Society for Adolescent Medicine. All rights reserved.

Keywords: Somatic complaints; Adolescence; Neighborhood; Context

Physical complaints without medical origin have haunted medical and mental health practitioners for centuries. Frequently referred to as somatic complaints, such distress is thought to be a physical expression of an emotional disturbance. Somatization is believed to start in childhood or adolescence and continue into adult life; it is estimated that 10% to 15% of all youngsters report “somatic” or “psychogenic” complaints [1]. A smaller percentage is thought to meet psychiatric criteria for somatization disorder [2]. Unfortunately, true prevalence rates are not known because inconsistent criteria are used to define words such as somatic and psychogenic. Research findings have shown that approximately one-fifth of services provided to children by local health maintenance organizations were for somatic complaints and that children who had recurrent pain without medical origin often go on to have problems such as migraine headaches as adults [1]. In addition, both adults and teens seeking psychiatric treatment often present first with

somatic symptoms [3,4]. Although somatic complaints are related to psychological distress, the mental health community generally regards somatization as distinct from other difficulties such as anxiety or depressive disorders [5]. Although somatic complaints are assumed to mask emotional distress, they are only one potential expression of a negative emotional state of which the client may or may not be aware [3]. Potential consequences of such findings include decreased work and school productivity and increased use of health care dollars [6]. With the current national focus on containing health care costs, understanding the basis for somatic complaints in adolescence becomes increasingly important.

Somatization has been linked to individual experiences, psychological distress, family patterns, and life events [1,4,7]. However, social workers have long recognized that family dynamics and specific life events do not occur in a vacuum [8]. The social contexts in which individuals and families live influence family interactions, individual beliefs, psychological states, and the likelihood of experiencing difficult life events [8,9]. Neighborhood is a particularly salient social context for adolescents. A safe and supportive neighborhood can provide teens with positive role models,

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reinforce parental expectations for behavior, and allow teens to safely test their growing independence. Conversely, the absence of these characteristics has been linked historically to a variety of negative outcomes [9]. To date, research on somatic complaints in adolescence has not addressed larger contextual influences such as neighborhood.

Understanding somatic complaints

Theoretical perspectives

Three theoretical approaches have dominated the research in understanding somatic complaints: stressful life events, social learning theory, and integrated approaches that include the role of family dynamics. Empirical support has been found for the idea that life events perceived as stressful have the potential to produce somatic symptoms. Both ethnographic and empirical methods have been used to advance this view [10,11]. Children with recurrent abdominal pain reported stressful life events more frequently than children in the control group [11]. Similarly, adolescents visiting a university teen clinic for somatic complaints or behavior problems had experienced more negative life events than those in other diagnostic categories [12]. Finally, Kowal and Pritchard [13] found that children with headaches exhibited other somatic symptoms and that anxiety measures, perfectionist behavior, and stressful life events predicted pain severity.

Both adult women and girls appear to experience somatic complaints at higher rates than males [5]. Bandura's social learning theory [14] has been most useful in understanding these gender differences. Walker and Zeman [15] examined the influence of parent and child gender, child's age, and the type of illness the child was experiencing on parental encouragement of child illness behavior. The findings suggested significant gender effects, with girls receiving more encouragement for illness behavior than boys, and mothers encouraging illness behavior more than fathers [15].

Family systems approaches have become part of the somatic complaints literature by way of inquiries using integrated theoretical perspectives [16]. Studies have found that family dysfunction, in combination with other factors such as behavioral reinforcement and modeling, were linked to somatic complaints [17–19].

Neglect of contextual effects

Largely neglected in the study of somatic complaints is the influence of neighborhood effects, although there is accumulating evidence that contextual factors, such as neighborhood quality, can affect the well-being of adolescents and families in both urban and rural settings [20–22]. For example, youth growing up in difficult neighborhood contexts are more likely to be exposed to violence and other negative life events that challenge their ability to pursue productive life trajectories [23,24]. Frequently, opportuni-

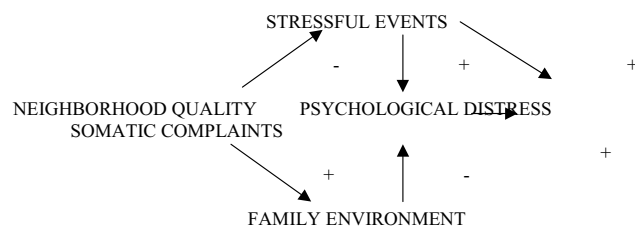


Fig. 1. Conceptual model for understanding somatic complaints in adolescents.

ties for developing supportive relationships with adults and positive peer role models are constrained. Such experiences may be associated with a variety of negative outcomes including psychological distress [25,26].

Some studies have found indirect associations between neighborhood conditions and particular outcomes, such as ineffective parenting, drug use, grade point average, delinquency, and physical health [21,27–30]. Others have found that the presence of more affluent neighbors predicted higher IQ scores, lower teen birth rates, and lower school drop-out rates, regardless of variation in individual family income [31].

Hypotheses

Ecological theory provides a larger contextual lens for understanding somatic complaints [20,32]. In ecological theory, a reciprocal interaction between person and environment is assumed; however, structural issues outside of the individual's or family's control are postulated to exert powerful influences over choices and behavior.

Figure 1 presents a series of hypothesized paths of influence between neighborhood quality and somatic complaints that are consistent with an ecological perspective. The model contains known links to somatic complaints: life events, psychological distress, and family environment as mediating variables and incorporates neighborhood quality as the exogenous variable. Plus and minus signs denote the direction of the hypothesized relationships. A set of six hypotheses is depicted in the model: (a) Neighborhood quality is negatively related to the likelihood of experiencing stressful life events such as the death of a friend or relative. (b) Neighborhood quality is positively related to the availability of a nurturing family environment. (c) Stressful life events are positively related to the level of psychological distress. (d) A nurturing family environment is negatively associated with psychological distress. (e) Psychological distress is positively related to the presence of somatic complaints. (f) Stressful life events are positively related to higher levels of somatic distress.

Methods

The data for this cross-sectional study come from a two-stage, stratified probability sample of 2099 6th through

Table 1
Descriptive information on study measures

	Range	Mean	Standard deviation	Skewness	Kurtosis	Alpha
Neighborhood safety ^a	8–16	14.90	1.67	–1.96	3.84	.77
Neighborhood support ^a	7–14	11.49	1.75	–.46	–.51	.66
Neighborhood peer culture	4–8	6.58	1.48	–.56	.07	.81
Life events	11–22	12.11	1.33	2.00	6.99	N/A ^b
Alienation	3–6	3.97	1.06	.66	–.91	.67
Depressed mood	5–15	8.47	2.67	.61	–.27	.79
Poor self-worth ^a	4–12	5.90	2.23	1.16	.48	.82
Somatic complaints	6–18	9.50	2.76	.81	.43	N/A ^b
Parent support	20–60	49.80	10.37	–1.01	.18	.92
Family harmony ^a	4–12	9.50	1.82	–.71	.07	.63
Family integration	7–21	17.20	4.00	–.91	–.18	.86

^a Indicates that response formats were re-coded.

^b Indicates an index versus a scale.

12th grade students enrolled in public schools throughout the United States. Louis Harris and Associates, Inc., a national polling firm, collected the data between October 1996 and February 1997. Harris has developed a sampling process and survey methodology for surveying students consistent with the National Center for Education Statistics. Parental consent is not required when using this methodology because no identifying information is used [33]. When the survey is used with identifying information, active parental consent is required. This data collection was part of a larger project that was approved by the Academic Affairs Institutional Review Board at the University of North Carolina at Chapel Hill.

Student participants completed the School Success Profile [34], a self-administered survey created for Communities In Schools, a national stay-in-school network. Grounded in ecological theory, the 11-page survey helps practitioners understand student perceptions of four primary social environments: school, family, friends, and neighborhood. In addition, students answer questions about their general well-being, health, and psychological adjustment.

Sample profile

The final sample contained 1413 cases. Approximately two-fifths of respondents were male and two-thirds were Caucasian. Respondents had a median age of approximately 14 years, and three-quarters lived in two-parent households. Approximately one-quarter of respondents lived in households below 180% of the federal poverty level, as indicated by their answering yes to a survey item asking whether or not they received a free or reduced price lunch at school. Chronic illness affected the lives of almost a quarter of the sample. These figures reflect similar trends documented elsewhere [35].

Measures

Eleven measures were created to test the research hypotheses. Two indices, somatic complaints and life

events, were used to understand how often certain experiences or events occurred in students' lives. Nine scales: depressed mood, poor self-worth, alienation, family harmony, parent support, family integration, neighborhood safety, neighborhood support, and neighborhood peer culture were used as indicators of three latent constructs: psychological distress, family environment, and neighborhood quality. The scales used in this analysis demonstrate acceptable alpha reliability (.63 or higher). The neighborhood, parent support, family integration, and psychological distress measures demonstrate strong face and construct validity [36]. Other measures used were created for this analysis. Table 1 provides complete information on each measure.

Measure definitions

In this analysis, three multi-dimensional latent constructs are used: neighborhood quality, psychological distress, and family environment. The other constructs are observed variables that are less subjective in nature, such as experiences or symptoms that one has had or not. To define neighborhood quality, many investigators choose particular aggregate measures that describe economic and structural conditions of a particular location and use these to predict outcomes for children and families [21,37,38]. This is a contextual effects approach that examines how structural conditions influence individual behavior over and above individual perceptions [39]. Criteria such as the number of vacant lots, abandoned homes, or child abuse rates may be used. In this analysis, neighborhood quality has been defined through the eyes of individual adolescents. This analysis will focus on attributes that may be important to teens and families regardless of their socioeconomic status. Neighborhood quality is thus defined as the degree to which a neighborhood provides safety, support, and a nonthreatening peer culture to the youth who live there. This latent construct was measured using three indicator scales: neighborhood safety, neigh-

borhood support, and neighborhood peer culture. Neighborhood safety, adapted with permission from Small [40], was measured by summing eight items that asked students about threatening events that may have happened in their neighborhood in the past 30 days. Students answered “no” (1) or “yes” (2) to questions about events like muggings, gang fights, and hearing gun shots.

Neighborhood support was measured by summing seven items about the level of agreement with statements about the neighborhood environment. Examples include statements regarding adult interest in youth activities, such as communication between neighbors and the student’s parents, being able to ask neighbors for assistance, feeling safe in the neighborhood, and general happiness with the neighborhood. Response options were “agree” (1) or “disagree” (2). Finally, Neighborhood Peer Culture was measured by summed responses to four items concerned with negative peer activities. Students were asked whether peers in their neighborhood were “likely” (1) or “unlikely” (2) to get in trouble with the police, use drugs, join a gang, or drink alcoholic beverages.

Psychological distress is defined in many ways throughout the adolescent literature. Some authors use behavior as both an indicator of distress and an outcome in need of attention [41,42]. Symptom counts used to diagnose conditions such as depression and anxiety are often used to indicate the presence of distress [43]. Concerns about mood, connection to others, and poor self-worth have also been used to mark emotional difficulty [42,44]. For this analysis, psychological distress is defined by three components: affective disturbance, relationship isolation, and self-deprecation. Accordingly, measures of depressed mood, alienation, and poor self-worth are used. Depressed mood consisted of five summed items that asked students how often they experienced feelings of loneliness, fear, confusion, sadness, or wanting to cry. Responses ranged from “never” (1) to “often” (3). Poor self-worth was measured using a four-item scale adapted from Rosenberg’s [45] self-esteem scale. Students were asked whether statements indicating feelings of

failure, not having much to be proud of, feeling no good, and feeling useless were “a lot like me” (1) to “not like me” (3). Responses were summed. The alienation measure examined students’ levels of disengagement from others. Three items asked whether, in the past 30 days, students had believed that no one cared about them, thought seriously about running away from home, or felt lost and confused. The dichotomous responses, “no” (1) or “yes” (2), were summed.

Family environment is defined in terms of what needed functions the family is providing to adolescents. These functions were measured by using three indicator variables: parent support, family integration, and family harmony. Parent support was measured using a 20-item scale ranging from “never” (1) to “often” (3) that asked students how often in the last 30 days their parents had engaged in both instrumental and expressive supportive behaviors. Family integration was measured using a 7-item scale ranging from “not like us” (1) to “a lot like us” (3). The scale was adapted from Bowen [46] asking students how much the component statements resemble their family situation. Items included whether “people in my home support one another during difficult times, give each other plenty of time and attention, and work to solve problems together.” Family harmony consisted of four questions that focused on how members of a household get along with each other. Students were asked about how adults living in the home get along with each other, how often things go well between students and adults in their homes, how often students feel able to share their feelings with adults in their home, and how often students disagree with adults in their home about the adults’ behavior. Responses ranged from “never” (1) to “almost always” (3).

Somatic complaints were defined as bodily symptoms that are unaccounted for by a known physical illness or condition [4]. The somatic complaints index, an observed variable, was created by summing six items asking students how often in the last 7 days they had experienced any of the following symptoms: loss of appetite, trouble

Table 2
Correlation matrix for study constructs (n = 1413)

	2	3	4	5	6	7	8	9	10	11
1. Neighborhood safety	.280*	.443*	-.550*	-.200*	-.100*	-.156*	-.200*	.201*	.235*	.190*
2. Neighborhood support	—	.387*	-.240*	-.239*	-.213*	-.216*	-.223*	.316*	.306*	.347*
3. Neighborhood peer culture	—	—	-.248*	-.182*	-.155*	-.132*	-.170*	.223*	.238*	.214*
4. Life events	—	—	—	.230*	.141*	.277*	.219*	-.216*	-.273*	-.203*
5. Alienation	—	—	—	—	.535*	.477*	.343*	-.331*	-.420*	-.336*
6. Depressed mood	—	—	—	—	—	.448*	.396*	-.228*	-.306*	-.233*
7. Poor self-worth	—	—	—	—	—	—	.350*	-.340*	-.369*	-.300*
8. Somatic complaints	—	—	—	—	—	—	—	-.234*	-.300*	-.193*
9. Parent support	—	—	—	—	—	—	—	—	.626*	.740*
10. Family harmony	—	—	—	—	—	—	—	—	—	.667*
11. Family integration	—	—	—	—	—	—	—	—	—	—

* $p \leq .01$.

going to sleep, upset stomach, headaches, other aches and pains, or trouble with nerves. Response choices ranging from “never” (1) to “three or more days” (3) were summed to create the somatic complaints index variable. This variable was regressed on two control questions regarding menstrual pain and chronic illness to remove variance associated with these variables. The standardized residual for the somatic complaints index was then used as the dependent measure. This procedure provides some assurance that the dependent variable represents physical complaints that are not explained by pain associated with chronic illness or menstrual pain.

Life events were conceptualized as events that combine both change and trauma. Accordingly, a life events index was formed to determine how many of 11 stressful life events a student had recently experienced: whether the student had moved in the past year, witnessed violence, experienced the death of a friend or loved one, been suspended or expelled from school, or received failing grades on a recent report card. Time frames for having experienced a particular event varied from within the last year to the last 30 days. Responses were dichotomous; students either experienced an event or did not. Summing the responses across the 11 events created the index.

Analysis

Structural equation modeling (SEM) procedures in Amos 3.6 [47] were used to analyze the conceptual model. SEM combines factor analysis and regression procedures, allowing for the simultaneous estimation of latent variable factor loadings and regression path coefficients among latent variables. Observed variables may be included in the models as independent or dependent variables. Regression path estimates involving latent variables have the advantage of being based only on the shared variance of latent variable indicators captured in the latent variable. These terms, therefore, are essentially free of error.

SEM parameter estimates are generated by a formula that seeks to minimize the difference between the matrix of actual covariances among all observed variables in the model and the corresponding matrix implied by the relationships posited in the model. In the current analysis, the goodness-of-fit index (GFI), the comparative fit index (CFI), and the root mean square error of approximation (RMSEA) were used to evaluate the model. In the current study, values of .90 or higher were sought for the GFI and CFI and a value of .08 or lower for the RMSEA [48].

Analysis of variance (ANOVA) examines within- and between-group variances to assess whether significant differences exist between group means. This technique will be used to examine whether students from different demographic groups experience different levels of neighborhood quality.

Results

Before conducting the SEM and ANOVA analyses, correlational and distributional characteristics of the data were examined. The 11 study variables shown in Table 2 were significantly correlated. Table 1 includes the means and standard deviations for each of the study variables. The variables evidenced generally good variation, as evidenced by the standard deviations. The mean scores on some constructs reflect the skewed distribution of the responses. As expected, particularly strong correlations were observed among variables used as indicators of common latent constructs. In addition, negative life events and neighborhood safety were strongly negatively correlated ($r = -.55$). The psychological distress variables and the somatic complaints variables correlated significantly in the positive direction ($r = .34$). All correlations between variables were significant at the .001 level and had associations in the expected directions.

Measurement model

Before simultaneously estimating latent factor parameters and regression paths among latent and observed variables, the measurement model was assessed. The measurement model contains the latent variables and their observed indicators and error terms [49]. All indicator scales loaded, when rounded, at .50 or better. Additionally, the fit indices were within the pre-established ranges, suggesting that the latent constructs were adequately measured.

Structural model

Analyses in the current study were first conducted using the default Maximum Likelihood (ML) procedure. Because of the non-normal distribution indicated by the skewness and kurtosis statistics in Table 1, the ML parameter estimates were compared with results using the bootstrap function present available in Amos [47]. Bootstrapped parameter estimates are the mean of the estimates calculated by drawing repeated samples with replacement from the raw data. They are therefore empirical estimates and independent from assumptions of normality. Bootstrapping revealed limited biases in the ML estimates and no significance levels were affected. Therefore only ML estimates are reported in Table 3. Standardized regression weights are shown on each hypothesized path. When the model was analyzed using the whole sample ($n = 1413$), a Chi-square of 438.59 ($df = 40$, $p < .001$) was obtained. The large and significant Chi-square is consistent with the large sample size used in this study. Analysis of fit indices showed a GFI of .95, CFI = .92, and RMSEA = .08. These values indicate that the proposed model has an adequate level of fit, according to the pre-established cutoffs.

As Table 3 and Figure 2 demonstrate, each hypothesis was supported. A decline in neighborhood quality was

Table 3
Beta weight and unstandardized weights for hypothesized paths

Hypothesized paths	Whole sample	
	Beta	Unstandardized
Neighborhood quality—life event	-.63*	-.66
Neighborhood quality—family environment	.42*	.47
Family environment—psychological distress	-.49*	-.64
Life events—psychological distress	.17*	.24
Psychological distress—somatic complaints	.49*	.27
Life events—somatic complaints	.07*	.05

* p ≤ .05.

associated with an increase in stressful life events ($\beta = -.63$). Neighborhood quality and family environment rose and fell together ($\beta = .42$). Family environment and psychological distress were negatively related; an improved family environment was associated with lower levels of psychological distress ($\beta = -.49$). Life events and psychological distress acted in concert; an increase in stressful life events was associated with an increase in psychological distress ($\beta = .17$). Increased psychological distress was associated with higher levels of somatic complaints ($\beta = .49$). Finally, increased numbers of stressful life events were associated with increased somatic complaints as supported in the previous literature ($\beta = .07$). Each of these were significant at the .05 level.

Analysis of variance

Analysis of variance (ANOVA) was used to examine the characteristics of teens who live in low-quality neighborhoods. Each indicator of neighborhood quality was considered separately. The following variables were used to examine demographic and “social address” differences: race (white and non-white), poverty status (receives

free or reduced price lunch or does not), family structure (two parent or single parent), and neighborhood transience levels (people frequently move in and out of the neighborhood a lot or not). It is not assumed that the profile characteristics are statistically independent. Findings by other scholars suggest high correlations between characteristics such as single parenthood, poverty, race/ethnicity, and neighborhood transience [38]. Table 4 lists the F - ratios, means, and η^2 statistics for each analysis.

Table 4 shows that the means for each pair of demographic groups were significantly different at the .05 level or above. On all measures of neighborhood quality, Whites had more positive scores than non-Whites. Those in poverty had poorer neighborhood quality than those not living in poverty. Single-parent families appeared to live in poorer neighborhood contexts than those in two-parent families. Neighborhood transience was associated with lower levels of neighborhood quality. Although each of the examined associations was statistically significant, the η^2 statistics indicated that the effect sizes were small, meaning that they have little predictive validity.

Discussion

Findings from this investigation add to the growing body of literature that links community level variables to the presence of specific behaviors and outcomes [21,30,31,37]. Results suggest that neighborhood variables may produce a ripple effect through other aspects of adolescents’ lives.

Specifically, these findings show a strong and positive relationship between neighborhood quality and family environment. This is a particularly salient finding. Families today find themselves in a rapidly changing and demanding situation. Workplace expectations and increased knowledge about the needs of children challenge the time and energy resources of parents. Accordingly, adolescents must look to the larger community for peer and adult role models. Confidence in the neighborhood in which they live can give parents solace and adolescents opportunities for growth [20]. As teens venture out of the home to socialize with friends, travel back and forth to school, and participate in

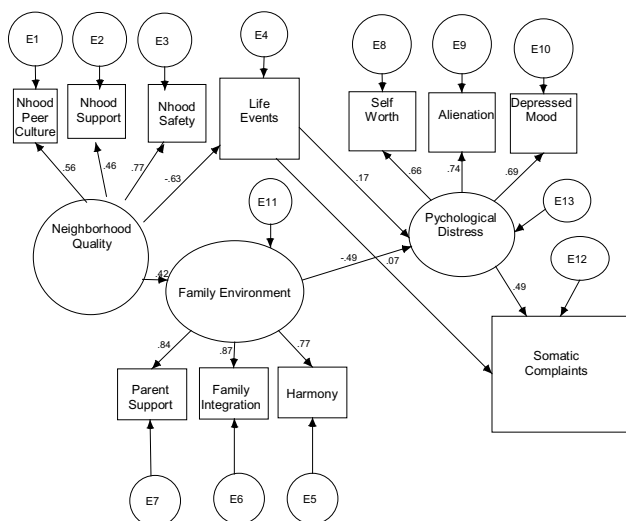


Fig. 2. Structural model with path coefficients.

Table 4
F-ratios, means, and η^2 for ANOVA

	Neighborhood safety (8–16)	Neighborhood support (7–14)	Neighborhood peer culture (4–8)
Race/ethnicity	56.33**	29.22**	23.25**
White	15.15	11.70	6.80
Non-white	14.47	11.15	6.25
η^2	.004	.020	.025
Poverty status	7.18**	10.10**	8.45*
Yes	14.73	11.27	6.45
No	15.00	11.61	6.63
η^2	.005	.007	.003
Family structure	16.65**	34.63**	23.25**
Single Parent	14.61	11.00	6.21
Two Parent	15.06	11.68	6.70
η^2	.001	.026	.017
Neighborhood Transience	36.97**	31.33**	15.11**
Yes	14.60	10.93	6.26
No	15.01	11.67	6.70
η^2	.008	.025	.012

* $p \leq .05$; ** $p \leq .01$.

employment, all family members are comforted if they know the environment is safe, other adults in the neighborhood are looking after the young people, and positive peer role models are present. When these qualities are missing in the neighborhood, families are put under increased strain, possibly contributing to more stressful family environments.

The strong connection between neighborhood quality and life events provides evidence that stressful events in the lives of young people may be determined to some extent by the neighborhood in which they live. However, longitudinal data are needed to confirm this. The study's findings extend knowledge about life events and psychological distress in producing somatic complaints. Past research has looked at these phenomena independently. By incorporating both life events and psychological distress into a structural model, the relationship between these two constructs can be seen. The direct path between life events and somatic complaints, although statistically significant, is one of the weakest in the model, a surprising finding given the past empirical literature [10–13]. This finding likely reflects limitations in the measure used to understand life events. In the future, researchers may want to use more established life events measures.

The findings of the ANOVA analyses are particularly telling. Members of racial and ethnic minorities, students living in single-parent families, and those living in poverty were more likely to have lower scores on neighborhood quality measures than other teens. These young people represent populations often forgotten in times of soaring stock prices and low unemployment. Their communities are forgotten as well, but not without a price. Somatic complaints represent one potentially costly outcome. There are many others, as previous investigators

have shown [21,30,31]. Delinquency, child abuse, and poor parenting practices are just a sampling of the outcomes linked to neighborhood circumstances. If society is seriously interested in effecting positive change in the lives of youth, these findings cannot be ignored.

Limitations

Finally, this study has several limitations that should be acknowledged. First, the model tested in the present analysis appears causal in nature because the variables have been ordered in a linear manner, with some variables sequenced before others. The decision to place some variables before others was based on theory and prior research. Because the data are cross-sectional, causality cannot be inferred. In addition, other models may represent the data equally well and may be valuable in understanding linkages not pursued in this analysis.

Second, perceptive and self-report measures of neighborhood quality were used in this analysis. It is possible that students who live in low-quality neighborhoods may not see their experience as unusual. Acclimation to their circumstances may cause them to report that they feel safe in neighborhoods that are clearly unsafe to an observer [27]. In future research, investigators may want to use aggregate measures, such as crime statistics or other census tract data, to examine how more objective measures correlate with perceptive measures of neighborhood quality. Similarly, other social contexts such as school or peer group may also influence the presence of somatic complaints in teens. Incorporating these contexts into the model may improve future research efforts.

Although somatic complaints are not experienced exclusively by one gender, females are often reported to somati-

cize more than males [5]. Further analysis is needed to ascertain whether the model presented here operates differently for boys and girls.

Finally, this analysis assumes that the dependent variable actually represents stress-related or somatic complaints. Although the variance for known illness and other organic physical distress was removed and health professionals attested to the face validity of the measure, no physical examination actually documented that some students in the sample were experiencing somatic complaints. Research replicating these findings with a sample of teens diagnosed as having somatic complaints would increase confidence in the validity of these findings.

Conclusions

This study adds to the rapidly expanding literature on the effects of social context, including the neighborhood in which a teen lives and the importance of considering context when attempting to intervene with somaticizing youth. Incorporating neighborhood influences into a practitioner's assessment may lead to systems level interventions, such as problem-solving for physical safety by creating linkages with neighbors, or simply allowing teens to acknowledge and process the impact of living in difficult environments.

In sum, the study affirms a professional focus on person–environment fit. In recent decades, many interventions have focused on the individual—both pharmacologically and psychologically. Clinicians have turned toward working with individuals to enhance functioning rather than focusing on helping people solve problems within the context of their communities [50]. However, treatment approaches that focus exclusively on individual or family dynamics may not be enough in the context of a highly disorganized community. Evaluations of interventions that target multiple areas of a young person's life are demonstrating success with complicated issues such as delinquency and suicide [51]. The findings presented here would suggest that such an approach may be useful when intervening in other types of dysfunction for which adolescents are referred to social workers, including internalizing behaviors such as somatic complaints.

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