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THE IMPACT OF EDUCATIONAL HABITUS ON SUBJECTIVE HEALTH AND SUBSTANCE USE AND THE MODERATING EFFECT OF GENDER: FINDINGS FROM A NATIONALLY REPRESENTATIVE STUDY OF SLOVENIAN YOUTH

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ABSTRACT

The main purpose of our research was to examine the relationship among various indicators of educational habitus, subjective health and substance use and the moderating role of gender. The results indicated that 1) over one third of bivariate correlation coefficients between habitus and health outcome measures were statistically significant; 2) the most consistent correlate of subjective health was satisfaction with the Slovenian educational system, while school adjustment most consistently correlated with substance use; 3) when controlling for several socioeconomic and parenting confounders in multivariate analyses, only in two out of twelve examined cases did habitus predictors remain significant (only for substance use); 4) gender moderated the impact of two indicators of educational habitus on overall substance use, but not on overall subjective health.

Keywords: educational habitus, inequalities in health, school perceptions, gender, cultural capital

L'INFLUENZA DELL'HABITUS EDUCATIVO SULLA SALUTE SOGGETTIVA E L'USO DELLE SOSTANZE ED IL RUOLO DI MODERAZIONE DEL GENERE: ANALISI DI INDAGINE RAPPRESENTATIVA DELLA GIOVENTÙ SLOVENA

SINTESI

Lo scopo della nostra ricerca era esaminare la relazione tra diversi indicatori di habitus educativo, salute soggettiva e uso di sostanze, esaminando anche il ruolo di moderazione del genere. I risultati hanno mostrato che un buon terzo dei coefficienti di correlazione bivariata tra indicatori di habitus e indicatori di salute era statisticamente significativo; che la soddisfazione per il sistema educativo è stata collegata in modo più coerente agli indicatori sanitari soggettivi, al consumo di droghe e all'adattabilità scolastica; che nelle analisi multivariate, comprese le variabili di controllo in due casi dell'indicatore di habitus, rimane una previsione statisticamente significativa; e che il genere ha moderato la relazione di due indicatori dell'habitat educativo con uso di sostanze.

Parole chiave: habitus educativo, disuguaglianze nella salute, percezioni dell'ambiente scolastico, genere, capitale culturale

INTRODUCTION[1]

School is a crucial social environment for young people (Crosnoe & Muller, 2004; Jamal et al., 2013; Lovenjak & Peklaj, 2016; OECD, 2015). School is where young people spend a large part of their days, form relationships with their schoolmates and teachers, and have their competencies publicly assessed (Hughes, 2012; Juvonen, 2018; Košir & Tement, 2014; Mikuš Kos, 1993; Ryan et al., 1994). Consequently, the school environment has a significant influence on numerous aspects of young people's health, wellbeing and personal development (Inchley et al., 2016; Jamal et al., 2013; Kuperminc et al., 1997; Langford et al., 2014; Pilkauskaite-Valickiene & Gabrialaviciute, 2015; Riekie et al., 2017; Ruus et al., 2007; Sweeting & Hunt, 2014). In this article, we examine the impact of young people's perceptions of the school environment and their attitudes towards education (*educational habitus*) on their subjective health and substance use. We test these effects on a subsample of school-enrolled youth from a nationally representative survey sample of young people from the Slovenian Youth 2013 Study (Flere et al., 2014).

CULTURAL CAPITAL, EDUCATIONAL HABITUS AND HEALTH

The resources individuals have at their disposal can also be termed "capital", which French sociologist Pierre Bourdieu defined as "*accumulated labor (in its materialised form or its 'incorporated' embodied form)*" (Bourdieu, 1986, 46). Bourdieu differentiated between three forms of capital: economic, social and cultural. In the present study, we focus on the latter. Cultural capital refers to the skills, habits, styles, behaviour and aesthetic preferences (tastes) one acquires through the socialization process and is related to one's position in the social structure (Bourdieu, 1984; also see Swartz, 1997). In particularly, *embodied* cultural capital refers to lasting dispositions that guide one's actions and tastes (Bourdieu, 1984; 1986). Habitus has previously been operationalized in a variety of ways by Bourdieu and his contemporaries (e.g., Edgerton & Roberts, 2014; Lahire, 2003; Reay, 2004). Bourdieu sees the habitus as durable "*schemata or structures of perception, conception and action*" (Bourdieu, 2005, 43), and Edgerton and Roberts (2014, 195) conceptualize habitus as a "*learned set of preferences or dispositions by which a person orients to the social world*" (also see Swartz, 1997). As Dumais (2002, 45) succinctly puts it, habitus is "*one's view of the world and one's place in it*". Habitus not only refers to mental attitudes and perceptions but is also expressed through permanent ways "*of standing, speaking, walking, and thereby of feeling and thinking*" (Bourdieu, 1990, 70).

Numerous studies have shown that habitus impacts educational outcomes (e.g., Dumais, 2002; Edgerton & Roberts, 2014; Flere et al., 2010; Nash, 2002). Less is known, however, about whether habitus impacts non-school related outcomes, including young people's subjective health. In recent years, more and more studies have indicated that perceptions of and attitudes towards the school environment and education may act as important resources young people possess that impact their health outcomes (Lazzeri et al., 2014; Ravens-Sieberer et al., 2009; Shek & Li, 2016; Sonmark & Modin, 2017; Suldo et al., 2006). It remains less clear which school and education-related perceptions and behaviours have the most substantial impact on young people's health, relative to one another. Most studies examine only a small number of school-related perceptions simultaneously, e.g., perceived school climate (including social support from classmates and teachers), satisfaction with school, perceptions of school stress, academic grade, or some combination of these. In our study, we examine the impact of six indicators of habitus on health.

Within the cultural capital framework, we argue it may be fruitful to examine the health-related impact of a specific type of habitus: "educational habitus". The term has recently been used when referring to internal dispositions and schemes of perceptions which orient young people in the educational process and guide their behaviours, as well as to behaviours in the educational process. Building on Nash (2002) and his use of the term "educated habitus", Edgerton and colleagues (2014, 190) use the term "school-related habitus" to refer to "***positive response*** *to the purposes, priorities, and processes of school, including positive perceptions of teachers*" (my emphasis). In their research, Edgerton and colleagues (2013; 2014) operationalize habitus as students' expected level of educational attainment, perceptions of teachers, perceptions of the desirability of post-secondary education and self- assessment of their potential as post-secondary students. Educated habitus is positively linked to "academic practices", i.e. practices which are particularly conducive to educational achievement (e.g. assignment completion and task perseverance). Edgerton and colleagues (2013; 2014) also found that educational habitus had a positive impact on academic achievement. Positive school achievement, in

1 The study was supported by a scientific programme group at the Department of History, Faculty of Arts, University of Maribor (P6-0138 (A): *The history of North-East Slovenia between Central Europe and the European Southeast*), and by project No. V5-1726 (*Cultural Participation of Young people in Slovenia and Europe: Analysis of Trends, Determinants, Consequences and a Proposal of Solutions*) at the Department of Sociology, University of Maribor, financed by the Slovenian Research Agency (ARRS) and the Ministry of Culture of Republic of Slovenia.

turn, may lead to better health. Ravens-Sieberer and colleagues (2009), for example, found that perceived school climate and demands have a positive impact on positive school adjustment, which then favourably affects life satisfaction and health.

Other studies have also found that positive perceptions of the school environment – such as perceived low school demands and stressfulness, a perceived high-quality school climate (e.g., peer and teacher support), perceived enjoyment of school, satisfaction with school and academic achievement – are related to better self-reported health, higher levels of life satisfaction and fewer health complaints (Lazzeri et al., 2014; Ravens-Sieberer et al., 2004; 2009; Shek & Li, 2016; Suldo & Huebner, 2006; Suldo et al., 2006). A study of Croatian adolescents even found that the school environment was a "*more consistent and stronger predictor*" of health outcomes than family affluence and peer groups (Simetin et al., 2011, 122).

Among perceived school environment indicators, in particular, stress related to schoolwork and school demands was found to be associated with lower subjective health and more health complaints, more so for girls than boys (Aanesen et al. 2017; Eriksson & Sellström, 2010; Låftman & Modin, 2012; Ravens-Sieberer et al., 2009; Wiklund et al., 2012). For example, students with higher rates of school-related stress report having more headaches, backaches, and psychosomatic problems, such as tiredness and sadness (Torsheim & Wold, 2001; Wiklund et al., 2012). In addition, students' perceptions of their school performance were also found to be associated with health outcomes, including with higher life satisfaction (Suldo et al., 2006), better self-rated health and fewer health complaints (Ravens-Sieberer et al., 2004). Some studies also found positive associations between students' actual school performance (school grades) and their health perceptions (Piko, 2007) and health outcomes (Ravens-Sieberer et al., 2004). In addition, in a longitudinal study, Herd (2010) found that school performance was linked to health outcomes in later life, as well.

Perceptions of the school environment were previously found to be related not only to young people's general health outcomes but also to their mental health. In a study of early adolescents, perceptions of school belonging and within-school relationships were associated with fewer mental health problems (Gaete et al., 2016). Similarly, school functioning (fewer school problems) was found associated with fewer symptoms of anxiety and depression, more so for boys than girls (Derdikman-Eiron et al., 2011). Some research also found negative correlations between students' perceived or actual school performance and depression (Cole et al., 2001; Fröjd et al., 2008; Huang, 2015; Ranđelović et al., 2015; Undheim & Sund, 2005).

The evidence, therefore, shows that students' school perceptions and their links with health outcomes are dependent on gender. In several studies, stress related to school was particularly associated with various symptoms of mental health problems, such as depression, aggression, and anxiety. Substantial variability was found regarding the strength of these links between genders (see, for example, Little & Garber, 2004; Moksnes et al., 2013). While in some cases stronger associations between school-related stress and depression (Sund et al., 2003) and aggression (Little & Garber, 2004) were found among boys, in other studies stronger associations were found among girls for depression (Khanehkeshi & Basavarajappa, 2011; Little & Garber, 2004), aggression (Khanehkeshi & Basavarajappa, 2011) and anxiety (Wiklund et al., 2012). As argued by Moksnes and colleagues (2013), the gender-dependent impact of school stress might be related to the type of stress members of each gender are experiencing at school. The authors found positive associations between general school stress and depression among girls, while stress related to school performance was positively associated with depression and anxiety among boys (Moksnes et al., 2013).

In Slovenia, a few previous studies on perceptions of the school environment have given mixed results. On the one hand, the school was found to be the most important stressor for young people (Koštal, 2000; Lovenjak & Peklaj, 2016). On the other hand, more recent cross-national studies have indicated that Slovenian students spend a relatively small amount of their time occupied with school activities. For example, analysing Slovenian Youth 2013 data, Tavčar Krajnc and colleagues (2014) found that Slovenian youth spend the least amount of their time studying, as compared to other youth in the region. The most substantial proportion of Slovenian youth (38%) reported studying up to one hour per day, while in Kosovo, the largest proportion (31%) of youth reported studying 2-3 hours daily. In addition, 19% of Slovenian youth said that everyday life in their school/university was "*(very) difficult and stressful*", compared to 28% in Croatia and 30% in Kosovo.

Several mechanisms that might play a role in the positive impact of habitus on health deserve mentioning. Ravens-Sieberer and colleagues (2009), for example, found that school climate, demands and adjustment impact satisfaction with life, which then improves health. Educational habitus, including academic achievement, might play a role in the formation of positive self-concepts such as self-esteem and internal locus of control (Bodovski, 2015), which may in turn increase general wellbeing (Ravens-Sieberer et al., 2009). An unfavourable school environment, on the other hand, may have a detrimental impact on health behaviours, increasing the odds of smoking,

alcohol use and other unhealthy behaviours (Lazzeri et al., 2014; McLellan et al., 1999). For example, Jamal and colleagues (2013, 5) emphasize that "*where young people feel educationally marginalised and/or unsafe* […]" the "*process of identity construction based on aggression and substance use appears to be an important source of bonding, social support and security*". Higher perceived social support in school, on the other hand, might be positively related to health and wellbeing (Sonmark & Modin, 2017), for example, via better coping with school-related and other stressors (Rosvall, 2019), which could also be efficiently promoted through school-based mental health promotion programmes (Fenwick-Smith et al., 2018).

STUDY AIM

Despite previous studies on the importance of the school environment for European and Slovenian youth, there has not yet been a comprehensive analysis of the health impact of young people's perceptions of the school and educational environment (educational habitus) using various measures of health and health behaviours, as well as different measures of educational habitus. The present research aimed to fill this gap and to examine whether educational habitus is related to subjective health outcomes and health behaviours among Slovenian youth, and to investigate differences in the associations according to respondents' gender. We frame our analysis within Bourdieu's perspective on the importance of cultural capital for one's success in life and youth outcomes, and on the importance of (educational) habitus. We examine the relationship among various indicators of adolescent educational habitus and subjective health and substance use, using a subsample of school-enrolled youth from a nationally representative survey sample of young people from the Slovenian Youth 2013 Study (Flere et al., 2014).

METHODOLOGY

Sample

The Cepyus-FES Slovenian Youth 2013 Study consisted of a stratified quota sample. The target population surveyed were Slovenian youth residing in the Republic of Slovenia and who were on May 28th, 2013, aged between 16 and 27 years. The sample consisted of 907 respondents (N = 907; M(age) = 21.90; SD = 3.25; 48.3% women). The survey was conducted between May 29th and July 20th in the form of a face-to-face interview within respondents' households (for details on sampling and data collection, see Flere & Divjak, 2014). We carried out our analysis on a subsample of school-enrolled young people (n = 608; M_{age} = 20.9 years).

Measures

Health outcomes

We examined four single-item indicators of subjective health and four measures of substance use. Single item measures have become "*the norm for measuring overall health in population studies published in the international literature*" (Rohrer et al., 2005, 438). First, we employed the most frequently used indicator of *self-rated health*: "In general, how would you rate your health? Would you say it is?" (1 = poor; 5 = excellent). *Self-perceived stress* was measured with the following question: "How often would you say you experience stress? 'Stress' refers to a situation in which a person feels tense, restless, nervous or anxious and is out focus." The responses in our questionnaire were recorded on a 5-point Likert scale: 1 = "Never or a few times per year"; 5 = "Most days per week". *Self-reported depression* was measured with the following question: "How much did the following statement apply to you over the past week? In the past week, I felt sad and depressed" (1 = did not apply to me at all; 4 = applied to me very much). We also used a single-item measure of *self-rated mental health*: "In general, would you say your mental health is…?" (1 = poor; 5 = excellent). Finally, we also measured satisfaction with life (1 = completely unsatisfied; 10 = completely satisfied). We analysed five items separately, and we also carried out exploratory factor analysis, where one factor emerged. We standardized all five measures and created a summation scale of a five-item overall subjective health (Cronbach's α = 0.67), which was also analysed as the outcome variable in bivariate and multivariate analyses. To carry out ordinal regression analysis, we ranked respondents into quartiles (1 = lowest subjective health; 4 = highest subjective health).

We measured substance use with four items. *Alcohol use* was measured with a question: "Do you drink alcohol?" (1 = yes, regularly (every day); 2 = yes, several time a week; 3 = on weekends; 4 = rarely; 5 = never), while *tobacco use* was tapped with the question "Do you smoke tobacco/cigarettes" (1 = yes, regularly (every day); 2 = occasionally; 3 = non-smoker). In addition, illegal substance use was tapped with questions about the *frequency of soft drugs* (marijuana, hashish) and *hard drugs* use (cocaine, heroin, 'speed', LSD, ecstasy) (1 = never; 2 = once; 3 = 2-5 times; 4 = more than five times). As with subjective health variables, we standardized all four measures and created a summation scale of a four-item substance use scale (Cronbach's α = 0.63), which was also analysed as the outcome variable in bivariate and multivariate analyses. When performing ordinal regression analyses, we ranked respondents into quartiles. For ease of interpretation, those

respondents who reported the worst health behaviour were ranked in the lowest quartile (1 = highest substance use; 4 = lowest substance use).

Educational habitus

The concept of habitus has previously been operationalized in a variety of ways. We aimed to examine young people's habitus in the educational (school) field, i.e. educational habitus. We included six indicators of habitus, which refer to one's (educational) dispositions, behaviours and outcomes. First, *perceived school stressfulness* was measured with the following question: "What is your opinion about studying at the school/faculty you are enrolled in?" (1 = Very difficult and very stressful; 5 = Very easy and without stress).

Second, *satisfaction with the educational system* in Slovenia was tapped with the question: "In general, how satisfied are you with the quality of education in Slovenia?" (1 = Very dissatisfied; 5 = Very satisfied). Third, satisfaction with attending one's school (*school adjustment*) was measured with the question: "Would you say that you go to the school/faculty you are enrolled in ...?" (1 = Very reluctantly; 5 = Very eagerly).

We also measured young people's expectations of getting a job. We asked whether respondents believed they would get a job after finishing school. While not all jobs are alike, in a social climate with increasing youth unemployment, caused by structural and labour market changes in recent decades, expectations regarding acquiring a job may reveal one's habitus. The question for measuring *job prospects* was: "Do you think that after finishing undergraduate/postgraduate study, it will be possible for you to find a job?" (1 = No, I do not believe that I will find a job quickly; 2 = Yes, I will find a job after some time; 3 = Yes, I will find a job immediately after).

Finally, we also tapped *average school grade* in the previous year with a 4-point scale (1 = Between 1-2 /unsatisfactory-satisfactory (students: between 5-6); 4 = Between 4-5/very good-excellent (students: between 8-10) and the *average amount of studying daily* (in hours). Both were included not only as important indicators relating to school outcomes but also since these were examined in previous studies on the link between school perceptions and youth wellbeing.

Control variables

Several control variables were included in our regression models. *Age* (from 16 to 27 years), *gender* (1 = male; 2 = female), *paternal* and *maternal education* (1 = primary school or less; 2 = completed high school; 3 = higher education), *self-assessed family economic/material status* (1 = highly below average; 10 = highly above average) and *size of the residential settlement* (1 = less than 2,000 inhabitants; 4 = more than 100,000 inhabitants) were included as standard sociodemographic controls.

To eliminate the confounding effect of parenting on the habitus-health link, we included *parenting styles* as controls, since parenting has previously been found as a consistent link to both youth educational and health outcomes. We measured *parenting style* with nine items on a 5-point Likert scale (1 = "very uncharacteristic of me"; 5 = "very characteristic of me"), which were adapted from a study on parenting by Robinson and colleagues (1995). Respondents were asked how they were treated by their parents when they were elementary school pupils. The three *authoritative parenting style* items measured were: "My parents were aware of my problems or concerns about school."; "My parents gave me reasons why rules should be obeyed." and "My parents allowed me to give input into family rules." A summation scale of authoritative parenting was created, with Cronbach's alpha reaching 0.67. The three *permissive parenting* style items were: "If I caused a commotion about something, my parents usually gave in to my wish", "I was given rewards (toys, candies etc.) in order to behave well", "My parents threatened punishments that were never implemented in practice" (Cronbach's $\alpha = 0.65$). Finally, *authoritarian parenting* items were "My parents yelled or shouted at me if I misbehaved", "If I did not meet my parents' expectations, I was scolded and criticized" and "I was slapped if I misbehaved" (Cronbach's $\alpha = 0.72$).

Plan of analysis

In the Results section, we first examine bivariate associations (Spearman's rho) between educational habitus indicators and subjective health and substance use and control variables at the total sample level. We then perform ordinal regression analyses with habitus indicators as predictors variables due to the ordinal health and substance use indicators. We also include interaction variables in our models to examine whether gender moderates the associations between perceived habitus and overall subjective health and substance use. Habitus indicators were dichotomized in multivariate analyses.

RESULTS

Table 1 shows the determinants of educational habitus as indicated by bivariate analysis. We investigated 66 associations between subjective health outcomes and substance use and educational habitus indicators. Twenty-five (38%) of these coefficients were statistically significant, indicating the impor-

Table 1: Determinants of educational habitus (bivariate analysis) (Flere et al., 2014).
Tabela 1: Dejavniki izobraževalnega habitusa (bivariatna analiza) (Flere et al., 2014).

	Perceived school stressfulness	Average academic grade	Hours of studying daily	Satisfaction with the educational system in Slovenia	School adjustment	Job expectations
SRH				0.15**		0.12*
STRESS	0.18***		-0.12**	0.16***		
DEP.						
SRMH				0.14***		
LS		0.10*		0.22***	0.18***	0.16**
Subjective health				0.22**	0.12*	0.13*
Alcohol use	-0.13**		0.09*			
Tobacco use	-0.10*	0.15***	0.11**	0.09*		
Soft drugs					0.09*	
Hard drugs					0.11**	
Total substance use	-0.10*	0.10*	0.13**		0.13**	
Gender (male)	-0.10*	0.18***	0.22***		0.19***	-0.14*
Age		0.13**	0.13**	-0.09*	0.09*	-0.11*
Father's education						
Mother's education						
Family economic status				0.14***		0.13*
Size of residential settlement						
Authoritative parenting		0.15***	0.14***		0.17***	
Permissive parenting			-0.09*		-0.08*	
Authoritarian parenting		-0.09*	-0.11*			

Note: * < 0.05; ** < 0.01; *** < 0.001. Only significant correlations are shown (p < 0.05). Higher scores on health variables indicate more favourable health outcomes. Higher scores on school variables indicate higher values on educational habitus.

tance of educational habitus for the health outcomes and health-risk behaviours of Slovenian youth. Satisfaction with the educational system in Slovenia was the most consistent habitus correlate of subjective health outcomes, as it proved associated with four out of five subjective health measures and with the overall subjective health scale. More satisfied youngsters reported higher satisfaction with life (rho = 0.22; p < 0.001), lower stress levels (rho = 0.16; p < 0.001), better self-rated health (rho = 0.15; p < 0.01) and mental health (rho = 0.14; p < 0.001), and better overall subjective health (rho = 0.22; p < 0.01). There were also several other significant habitus correlates of subjective health (see Table 1). School adjustment and job expectation were also significant correlates of overall subjective health.

Table 2: The impact of control variables on subjective health and substance use (bivariate analysis) (Flere et al., 2014).
Tabela 2: Odnos med kontrolnimi spremenljivkami in subjektivnim zdravjem ter uporabo substanc (bivariatna analiza) (Flere et al., 2014).

	SRH	STRESS	DEP.	SRMH	LS	Subjective health	Alcohol use	Tobacco use	Soft drugs	Hard drugs	Total substance use
Gender (female)	-0.19***	-0.18***	-0.22***	-0.14***	-0.08***	-0.25***	0.18***		0.09*		0.10*
Age							-0.09*	-0.10*	-0.18***	-0.15***	-0.19***
Father's education	0.13**					0.10*	-0.13**	-0.13**	-0.16***		-0.17***
Mother's education							-0.12**		-0.18***		-0.16***
Family economic status	0.16*	0.14***	0.11**	0.19***	0.39***	0.29***	-0.09*				
Size of residential settlement											
Authoritative parenting				0.16***	0.27***	.018***		0.11**	0.09*	0.10*	0.13***
Permissive parenting	0.08*								-0.13***	-0.17***	-0.15***
Authoritarian parenting			-0.15***		-0.14***	-0.13***	-0.10*		-0.10**	-0.18***	-0.16***

Notes: * < 0.05; ** < 0.01; *** < 0.001. Only significant correlations (p < 0.05) are shown. Higher scores on health variables indicate more favourable health outcomes. Higher scores on school variables indicate higher values on educational habitus.

Habitus measures were found to be even more consistently linked with substance use than with subjective health. School adjustment was the most consistent habitus correlate of substance use, with four out of five coefficients being significant. Total substance use correlated with four out of six habitus measures, three of them being positive, indicating a favourable impact of habitus on lowering the frequency of substance use. Table 1 also shows that out of 25 significant coefficients, only four were negative, while 21 were positive, indicating an overall favourable impact of educational habitus on better subjective health and lower substance use. Finally, Table 1 also shows that several control variables were linked with habitus, mostly in the anticipated direction, with few exceptions (e.g., residential settlement proved non-significant). Authoritative parenting had a significant positive impact on habitus, while both permissive and authoritarian parenting had a negative impact, confirming the need for these to be controlled for in our multivariate models.

Before turning to the multivariate analyses, Table 2 shows that control and cofounding variables also impact subjective health and substance use: gender, age, parental education, family economic status and parenting styles have an impact on subjective health and substance use. Since size of residential settlement again proved to be non-significant, we did not include it in our multivariate analyses. As with the results of habitus correlates in Table 1, Table 2 indicates that authoritative parenting has a favourable impact on better subjective health and lower substance use, while both permissive and authoritarian parenting styles show a deleterious effect on youth. This again confirms the

Table 3: Ordinal regression analysis (parameter estimates) for predicting overall subjective health among Slovenian youth (Flere et al., 2014).
Tabela 3: Ordinalna regresijska analiza (ocena parametrov) napovedovanja subjektivnega zdravja slovenske mladine (Flere et al., 2014).

	Estimate	Std. Error	Wald	df	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
Gender (female)	-2.5	1.74	2.14	1	0.144	-5.96	0.87
Age	0.07	0.06	1.41	1	0.235	-0.04	0.18
Father's education (low group)	-0.53	0.50	1.12	1	0.290	-1.52	0.46
Father's education (middle group)1	-0.37	0.29	1.58	1	0.208	-0.93	0.20
Mother's education (low group)	0.36	0.46	0.61	1	0.435	-0.54	1.26
Mother's education (middle group)2	0.17	0.29	0.34	1	0.558	-0.40	0.74
Family economic status	0.34	0.09	14.56	1	0.010	0.16	0.51
Authoritative parenting	0.45	0.14	10.46	1	0.001	0.18	0.73
Permissive parenting	1.12	0.15	0.66	1	0.417	-0.17	0.41
Authoritarian parenting	-0.45	0.15	8.58	1	0.003	-0.748	-0.15
Average grade	0.18	0.83	0.05	1	0.824	-1.44	1.81
Hours studying	0.30	0.83	0.13	1	0.722	-1.33	1.92
Satisfaction with educational system	0.36	0.79	0.21	1	0.646	-1.19	1.91
School adjustment	0.72	0.83	0.74	1	0.388	-0.91	2.34
Perceived school stressfulness	-1.35	0.86	2.38	1	0.123	-3.06	0.37
Job expectations	-1.24	0.85	2.11	1	0.146	-2.91	0.43
Average grade x Gender	-0.02	0.51	0.01	1	0.973	-1.01	0.97
Hours studying x Gender	-0.34	0.52	0.44	1	0.507	-1.36	0.67
Satisfaction with educational system x Gender	0.11	0.48	0.05	1	0.819	-0.84	1.06
School adjustment x Gender	-0.39	0.50	0.63	1	0.427	-1.37	0.58
Perceived school stressfulness x Gender	0.66	0.51	1.63	1	0.201	-0.35	1.67
Job expectations x Gender	0.92	0.51	3.26	1	0.071	-0.08	1.93

Note: 1 = reference group is father's high-education group. 2 = reference group is the mother's high-education group.

Table 4: Ordinal regression analysis (parameter estimates) for predicting overall substance use among Slovenian youth (Flere et al., 2014).
Tabela 4: Ordinalna regresijska analiza (ocena parametrov) napovedovanja uporabe substanc slovenske mladine (Flere et al., 2014).

	Estimate	Std. Error	Wald	df	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
Gender (female)	-2.36	1.75	1.83	1	0.176	-5.79	1.06
Age	-0.04	0.06	0.52	1	0.470	-0.15	0.07
Father's education (low group)	1.09	0.52	4.30	1	0.038	0.06	2.11
Father's education (middle group)1	0.04	0.29	0.02	1	0.880	-0.52	0.61
Mother's education (low group)	0.65	0.46	1.94	1	0.163	-0.26	1.56
Mother's education (middle group)2	0.53	0.29	3.42	1	0.064	-0.03	1.10
Family economic status	-0.06	0.09	0.48	1	0.487	-0.23	0.11
Authoritative parenting	0.06	0.14	0.21	1	0.647	-0.21	0.33
Permissive parenting	-0.38	0.15	6.72	1	0.010	-0.70	-0.09
Authoritarian parenting	-0.25	0.15	2.75	1	0.097	-0.54	0.05
Average grade	-0.35	0.83	0.18	1	0.673	-1.98	1.28
Hours studying	-1.69	0.83	4.16	1	0.041	-3.32	-0.07
Satisfaction with educational system	-0.55	0.79	0.49	1	0.484	-2.10	0.10
School adjustment	2.20	0.84	6.86	1	0.009	0.56	3.85
Perceived school stressfulness	-0.53	0.87	0.37	1	0.541	-2.23	1.17
Job expectations	-0.25	0.85	0.09	1	0.766	-1.91	1.41
Average grade x Gender	0.30	0.51	0.36	1	0.548	-0.69	1.30
Hours studying x Gender	1.19	0.52	5.29	1	0.022	0.18	2.21
Satisfaction with educational system x Gender	0.48	0.49	0.98	1	0.321	-0.47	1.43
School adjustment x Gender	-0.10	0.50	3.97	1	0.046	-1.98	-0.02
Perceived school stressfulness x Gender	0.15	0.51	0.09	1	0.768	-0.85	1.15
Job expectations x Gender	0.18	0.51	0.13	1	0.724	-0.82	1.18

Note: 1 = reference group is father's high-education group. 2 = reference group is mother's high-education group.

need for parenting styles to be controlled for in multivariate analysis, to provide a more thorough test of the health-impact of educational habitus.

In Table 3 and Table 4 we present the results of two ordinal regression analyses as a more stringent test of the impact of educational habitus on subjective health and substance use, with sociodemographic, socioeconomic and parenting control variables included in regression models. In addition, we included six interaction terms between gender and habitus indicators in each regression model to test whether gender moderates the impact of habitus on overall subjective health and substance use.

Table 3 shows the regression model predicting overall subjective health. The full model was significant ($p < 0.001$) and explained 24.9% of the variance (Nagelkerke) in overall subjective health. Among demographic and socioeconomic control variables, only family economic status proved a significant predictor of better subjective health (see estimated coefficients in Table 3). Two additional controls proved significant: authoritative parenting improved subjective health, while authoritarian parenting decreased it. Taking into account the control variables, neither the six habitus indicators nor the interaction terms proved significant predictors of subjective health.

Table 4 shows the ordinal regression model predicting youth substance use. The full model was significant ($p < 0.01$) and explained 17.1% of the variance (Nagelkerke) in overall substance use. Among control variables, lower paternal education proved a predictor of *lower* substance use. Additionally, among parenting controls, permissive parenting proved to have a deleterious impact on substance use, i.e. increasing substance use frequency. Taking into account the control variables, two of the six habitus indicators proved significant predictors of substance use at the total sample level. A lower number of hours studying and better school adjustment decreased substance use frequency, while the other four habitus predictors proved non-significant.

In addition, both significant habitus predictors of substance use also interacted with gender. Among men, fewer hours studying was linked with more frequent substance use, while among women, more hours studying was linked with lower substance use. The second significant interaction term was between school adjustment and gender. While better school adjustment was linked with less frequent substance use in both genders, the health beneficial effect of school adjustment was significantly higher among men than among women. Our results thus indicate that habitus indicators have no impact on overall subjective health and that gender plays no moderating role. On the other hand, the hours spent studying for school obligations and school adjustment predict substance use over and above several control variables. In addition, gender moderates their impact on substance use: hours studying is protective for women (but a risk for substance use among men), and school adjustment is more protective for men's substance use than women's.

DISCUSSION AND CONCLUSION

School contexts have a significant impact on the health and wellbeing of school-enrolled youth (Langford et al., 2014; Ravens-Sieberer et al., 2009; Suldo et al., 2006). In our study, several significant bivariate associations were found between educational habitus and health outcomes. On the other hand, multivariate analyses indicated that when controls and confounders were included in the model, habitus did not play as significant a role in Slovenian youth's subjective health. However, it did play a role in the young people's health behaviours.

Among the habitus indicators we analysed in the bivariate analysis, satisfaction with the educational system in Slovenia was positively associated with the largest number of subjective health indicators. At the total sample level, students who were more satisfied with the educational system also reported better self-rated health and mental health, less perceived stress, higher life satisfaction and better overall subjective health. It needs to be emphasized that satisfaction with the educational system might be a reflection (i.e. a consequence) of one's experiences with school and could then determine one's actions within the school field. In this sense, satisfaction with the educational system might function as habitus typically does: as a system of "*durable, transposable dispositions, structured structures predisposed to function as structuring structures*" (Bourdieu, 1990, 53). As Edgerton and Roberts (2014, 198) put it, "*As the circumstances of one's social origins – and associated life chances – tend to influence one's perceptual and behavioral dispositions, so too do one's consequent actions (practices) tend to contribute to the perpetuation or reinforcement of like circumstances and life chances*." Satisfaction with the educational system thus is reflected by it, while at the same time, it guides one's action within the educational field. More importantly, our multivariate models indicate that the educational satisfaction indicator might only be a proxy for some other determinant of health and substance use, e.g., family socioeconomic status or parenting styles, which shows the importance of including relevant controls when examining the health impact of habitus.

Contrary to some previous studies (e.g., Piko, 2007; Ravens-Sieberer et al., 2004), in our study, the academic grade was not a significant correlate of overall subjective health, nor substance use when

controlling for demographic and socioenomic variables and parenting confounders. Our results indicate that future studies of academic outcomes should increase the focus on outcomes other than academic achievement, since other educational and school variables might play as important a role as the academic grade, including on health-related outcomes and behaviours.

We also found that gender moderated the association between educational habitus and substance use, but not subjective health. This is not in line with some previous studies, where stronger associations of the perceived school environment with subjective health outcomes were detected among women (Aanesen et al., 2017; Eriksson & Sellström, 2010; Låftman & Modin, 2012; Ravens-Sieberer et al., 2009; Wiklund et al., 2012). Compared to Slovenia, in other countries school perceptions seem to play a more critical role in the health outcomes of women, which may partly be due to the higher expectations of parents and teachers regarding the importance of educational achievement for girls. In our study, gender did moderate the habitus' health impact on substance use. The results indicate that a higher number of hours studying is protective against women's substance use, but a risk factor for men. It may be that a higher number of hours spent studying among men is an indicator of having difficulties with school subjects or assignments, or a potential indicator of male students also having other types of school problems (e.g., school deviance), which could partly explain the association of the number of hours studying with more frequent substance use among men. Among women, on the other hand, the number of hours studying may be more a proxy for their diligence and higher school motivation (e.g., putting in additional studying time to get a maximum grade). Future studies should examine these gender differences in more detail.

Previous studies of the health of Slovenian youth have detected relatively low levels of socioeconomic inequality, with family and parental socioeconomic status proving to be a weak or insignificant predictor of young people's health (e.g. Kirbiš & Tavčar Krajnc, 2014; Kirbiš & Tement, 2014). In our study, we found that one's educational habitus also does not play a significant role in youngsters' subjective health but does play a role in their substance use. Future studies should investigate what determinants impact the health of Slovenian youth, including other indictors of habitus, e.g. cultural participation. In future studies on the health-impact of habitus, researchers should investigate the potential moderating role of age and type of schooling, since, at higher levels of education, specific school environment characteristics may become more pronounced concerning health (e.g., Klinger, 2015; Ravens-Sieberer et al., 2009).

Although our study results point to some interesting results, the study implications are limited, owing to the use of several general educational indicators. For example, is satisfaction with the educational system perhaps a proxy for some more immediate determinant, such as teacher-student relationship (see, for example, Košir & Tement, 2014)? To investigate the role of the type of schooling, and in particular gender and parental education in these associations, future studies should include additional measures of subjective health, for example, specific mental health indicators (e.g., anxiety, aggression) and other health-behaviours, including fruit and vegetable consumption, junk food and meat consumption and frequency of physical activity. Moreover, since sources of school stress might vary at different stages of education and between genders (e.g., Klinger, 2015; Moksnes et al., 2013; Ravens-Sieberer et al., 2009), measuring different types of school stressfulness might also contribute to a more detailed analysis. Finally, the direction of the causality between the variables in our study remains unclear, owing to the cross-sectional nature of the Slovenian Youth 2013 Study data. It may be, for example, that substance use decreases students' wellbeing in school, their positive perceptions of the school environment, satisfaction with the educational system and their school adjustment. These are all possibilities that need to be examined in future research, preferably with panel data. Broadening the scope of examined health measures in future studies to include various dimensions of health – such as physical health, mental health, subjective wellbeing, but also health-behaviours such as substance use – is critical for successful future interventions for improving youth health outcomes. Substance use, in particular, is becoming more widespread and problematic among Slovenian youth and thus needs to be focused on; a recent cross-national HBSC study of 45 countries, for example, indicated that in 2018 Slovenian adolescents rank third in the frequency of marijuana use (Inchley et al., 2020).

Despite limitations, our study indicates that several examined indicators of educational habitus may have an impact on health-related outcomes of Slovenian youth. Improving the experience of attending a school (school adjustment), increasing satisfaction with the Slovenian educational system and decreasing the time needed to study (among men) might have a particularly positive impact on young people's health behaviours and outcomes. Of course, this should not be done by increasing specific non-productive and potentially deleterious socialization patterns in school. An example is the negative impact of permissive parenting detected in our study, which suggests that authoritative socialization – by parents and teachers – should be more widely implemented, i.e. by adults setting firm rules, but also providing support to students. Our

results also suggest that decision-makers and education professionals (e.g., school counsellors, teachers) should focus on policies and intervention health programmes that are tailored to specific subgroups of students. They should consider gender, as well as target specific dimensions of the school environment and experiences. This is crucial, since school and educational processes may impact not only students' educational and professional outcomes but also their health-related outcomes (e.g., Lazzeri et al., 2014; McLellan et al., 1999; Ravens-Sieberer et al., 2004; Shek & Li, 2016; Suldo & Huebner, 2006), although the impact seems less pronounced in Slovenia. Future studies should further investigate which cultural, social or economic resources play the most significant role in youth's wellbeing.

VPLIV IZOBRAŽEVALNEGA HABITUSA NA SUBJEKTIVNO ZDRAVJE IN UPORABO SUBSTANC TER MODERATORSKA VLOGA SPOLA: ANALIZA REPREZENTATIVNE RAZISKAVE SLOVENSKE MLADINE

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POVZETEK

Namen naše raziskave je bil preučiti odnos med različnimi kazalniki izobraževalnega habitusa, subjektivnega zdravja ter uporabe substanc, ob tem pa smo preučili tudi moderatorsko vlogo spola. Izvedli smo analizo podvzorca šolajočih se mladih, zajetih v anketnih podatkih nacionalnega reprezentativnega vzorca raziskave Slovenian youth 2013, v kateri so ciljno populacijo predstavljali prebivalci s stalnim prebivališčem v Republiki Sloveniji, stari od 16 let do 27 let (N = 608, $M_{starost}$ = 20,9 leta). Zdravstvene izide smo preučili s petimi kazalniki subjektivnega zdravja (samoocenjeno zdravje, duševno zdravje, pogostost doživljanja stresa, samoocenjena depresivnost in zadovoljstvo z življenjem) in štirimi kazalniki uporabe substanc (pogostost uživanja alkohola, kajenja ter uporabe mehkih in trdih drog). Izobraževalni habitus smo merili s samoocenjeno težavnostjo šolanja, šolskim uspehom, povprečnim dnevnim številom ur učenja/študiranja, zadovoljstvom z izobraževalnim sistemom v Sloveniji, (ne) pripravljenostjo obiskovanja šole in pričakovanji mladostnika glede težavnosti pridobitve zaposlitve po koncu šolanja. Rezultati so pokazali, da: 1) je bila statistično značilna dobra tretjina bivariatnih korelacijskih koeficientov med kazalniki habitusa in zdravstvenimi kazalniki; 2) je bilo zadovoljstvo z izobraževalnim sistemom v Sloveniji v bivariatnih analizah najbolj konsistentno povezano s kazalniki subjektivnega zdravja, z uporabo drog pa šolska prilagojenost; 3) sta v multivariatnih analizah ob vključitvi vrste socioekonomskih in starševskih kontrolnih spremenljivk le v dveh primerih kazalnika habitusa izmed dvanajstih ostala statistično značilna napovedovalca (zgolj uporabe substanc); 4) je spol moderiral odnos dveh kazalnikov izobraževalnega habitusa z uporabo substanc, ne pa tudi s subjektivnim zdravjem. Prispevek sklenemo z implikacijami rezultatov.

Ključne besede: izobraževalni habitus, neenakosti v zdravju, zaznave šolskega okolja, spol, kulturni kapital

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