CHAPTER I

INTRODUCTION

"The major problem facing the modern world is that the Judeo-Christian ethic justifies domination" Lynn White (1967)

Context of the Discourse About Health and Rank

The concept of health is, as Hannah Arendt (1971) said: "something like a frozen thought which thinking must unfreeze" (431). In common language, we take the meaning of the word health for granted. When we speak about health we assume a tacit understanding and consensus about the notion of health, for instance, the good and muscular shape of a healthy body or that smoking is in general bad for your health. On second thought, however, the hidden difficulties of defining the concept of health become manifest.

The meaning of health is difficult to grasp and scientific inquiry has approached it from many angles. Throughout history health has been perceived in manifold ways. Religions and philosophies have touched upon it and its fragility has motivated many people to find metaphysical answers. For some it is a core value of life and closely related to their general sense of well-being; for others health is less central. Many times we can only define it by its negative counterpart "ill-health", when we become deprived of our privilege of good health.

Obviously, most peoples' preferred approach towards illness after getting sick and suffering is to get treatment and through treatment to restore their health. This approach towards restitution is encouraged by most scientific medical practice. Disease becomes an enemy and cure is a version of conquering that enemy. The notion of talking about illness as meaningful experience is seen as superfluous – even vaguely subversive – to biomedicine. Kleinman (1988) speaks of an "iron cage" of reductive concerns with mechanically viewed bodily processes and a too technically narrow and therefore dehumanizing vision of treatment. For him, the particular significances of a person's illness, the stories in which patients reveal the meanings they attach to their suffering is a way to break out of the current limitations of medicine.

Furthermore, culture has an immense influence on our conceptions of health and there is a complex mutual relation between the body and culture. Illness and suffering are a social experience. Cultural values and collective modes of experience shape individual perceptions and expressions and these culturally shaped patterns of how to bear with illness and disease are taught and learned via our socialization. Then social interactions influence sick peoples' illness experience (for example the grievance of a group for their friend with supposedly terminal cancer may limit the diseased to the terminal cancer patient role). Thus, both aspects of social experience – its collective mode and intersubjective processes – are formed by the characteristic cultural meanings of time and place. These cultural representations and moral values interfere with the sick person's subjective experience and her ability to recreate a renewed sense of self and coherent view of her challenged life process.

Cultural values of autonomy or interdependence and the weight one assigns to personal merits or collective achievements infringe upon people's handling of health and illness. In addition health has an individual and a collective aspect and societal structures and policies impregnate many dimensions of individual health. Relationships, intimacy and sexuality affect people's health as well as many other behaviors and emotions. Feeling healthy is very subjective. Each person will define it in their own unique terms; on the other hand, it relies on definite objective elements. Health also has many irrational appearances, and encompasses people's search for meaning and purpose. Art, poetry, philosophy, and science have many valuable thoughts and insights to contribute to the discourse about health. I can't possibly cover all these issues and won't. My research will concentrate on one distinct aspect of health, namely its association with one's sense of being empowered in social space, and its relationship to processes of social comparison and marginalization. I will call this dimension "rank" as it has been defined and applied by Arnold Mindell (1995).

Again there are so many intertwined and interrelated dimensions to the discourse about the influence of rank on health and well-being. It touches issues of power distribution and national and international politics (e.g. the current debate about the appropriate price for AIDS medication in Africa). Collective values and norms (e.g. society's view on hierarchy and diversity) play an important role. The quality of relationships in communities and families (e.g. how we deal with deviance, competition and conflict) and the treatment of our environment are affected by our conception of rank. Individual constitutions and the individual's psychological perception of his or her rank influence

coping abilities from cumulative adversity over a life span. The rank concept includes interconnected interpersonal dynamics of marginalization and oppression and intrapersonal processes of handling inner diversity, self-love and self-esteem. Because the complexity of the issue makes it difficult to write about it in a linear way, I chose to incorporate a circular style of discourse that touches upon the various themes – the social dimension of health, the relationship of health and rank, the struggle between health's subjective and objective dimension – at many moments as they naturally appear. This choice implies some redundancy which I will try to limit to a minimum.

The Social Dimensions of Health and Illness

The social dimensions of health and illness have been extensively studied from a materialistic angle (e.g. material conditions like diet, housing, exercise, environmental pollutants or access to health care) (Anderson & Armstead, 1995). Many studies have shown a correlation between life expectancy and various measures of social status (Wilkinson 1992). Marmot's (1986) Whitehall Study of British civil servants uncovered an obvious gradient in mortality and morbidity from top to bottom of social hierarchy. This gradient could not be explained solely by the common materialistic interpretation of the correlation between socio-economic status and health. He concluded that something correlated with hierarchy per se, which powerfully influences health. The Whitehall study suggested stress or the ability to cope with stress as the biological pathways through which the rank or hierarchy factors influence health. Other researchers like Hertzman (1999) and the authors Singer and Ryff (1999) explain this health gradient as an emergent property of the interaction between the developmental status of people and the material

and psychosocial conditions they encounter over their life course. They conceptualize health outcome as a product of cumulative adversity and advantage over a life span.

Besides the objective determinants of health, the subjective elements of one's health and quality of life[1] have also attracted a large research focus. These studies have shown that good physical health is only one aspect of quality of life and psychological well-being. "What Doesn't Kill You Makes You Stronger" (Stewart, Wong, Duff, Melancon & Cheung, 2001) is the title of a Canadian study of ovarian cancer survivors. Many survivors proved to be very resilient and appeared to have put other life difficulties into perspective, altered their priorities, and felt enriched by the experience. Another study of persons with cleft palate and other debilitating craniofacial conditions showed that many individuals have rich and satisfying lives despite the various challenges experienced (Strauss, 2001). Bad health does not mean unequivocally low quality of life and good health does not equal a strong sense of well-being (Sek & Pasikowski, 1998).

The subjective experience of one's social standing (e.g. one's perception of social class, gender, ethnicity) and its consequences on health have only recently been studied in medical literature (Adler, Epel, Castellazzo & Ickovics, 2000). Arnold Mindell's (1995) work suggests that this subjective perception influences most of our relationships and social interactions, and I suppose that it has more impact on health than the objective constituents of our daily life.

[1] I use the terms quality of life and well-being as synonyms. They stand for one's subjective experience of life for which health is only one aspect.

Antonovsky (1979, 1987) explored the origins of health and its response to non-materially based dimensions of power. Coming from the field of sociology, he developed the Sense of Coherence construct, a general measure of a person's world view, with which he explained why some people are less likely to be adversely affected by stressful environments and life events than others. Antonovsky's view on health and disease called "Salutogenesis" – the generation and maintenance of health – focuses on the patient's coping resources. His Sense of Coherence concept describes a condensation of one's general resistance resources against the ubiquitous pathogens or stressors. Antonovsky stresses the importance of meaningfulness in life and one's perceived control over life circumstances. He views the social context as part of one's resistance resources or deficits.

At present psychosomatic medicine studies the intrapsychic mediation between psychosocial and physiological processes. Kleinman (1986) adds a "sociosomatic" dimension to disease, connecting the body-self with the social world.

Concepts of Medicine, Health and Illness

The nature and limits of the medical discourse have been the subject of major controversy. The "nature-nurture" issue is one example with advances in understanding the biomedical nature of many diseases, leading some to believe that we are determined by genes and biochemistry, that medicine has no other basis than biology. Representatives of this view exclude psychological, social, and cultural aspects from their definition of medicine. One such narrow description reads: "...medicine is a very narrow

discipline. Its goals may be defined as the relief of pain, the prevention of disability, and the postponement of death by the application of the theoretical knowledge incorporated in medical science to individual patients" (Seldin 1997, 251).

Dr. Seldin continues to clarify and delimit the boundaries of medicine by confining its theoretical framework to the basic biomedical sciences such as biochemistry, physiology, and cell biology. He sees cultural and social issues as well as biomedical ethics as not being part of medicine. Biological and cultural phenomena, he states, are separate entities. They form separate areas of knowledge, and the latter should be excluded form physicians' activities. To explain disease this conception of medicine relies exclusively on a scientistic model, that excludes social sciences from its framework. Following Michael Lerner (2000) I define scientism as the ideology that claims there is only one approach to reality, namely only through empirical and replicable methods. Whereas science is an openness to evidence, scientism adds two corollaries: first, that the scientific method is the most reliable method of getting at truth; and second, that the material entities science deals with are the most fundamental things that exist. I chose to make this distinction to avoid discrediting science as a whole which, I believe, is a valid form of knowledge and a way of approaching reality. From a scientistic view diseases are natural phenomena that follow clear cut scientific laws of causation which are best assessed by quantitative measurement and empirical experimentation. This strictly biomedical view of medicine uses a disease concept called "Disease Realism/Empiricism." Disease is defined as "abnormalities in the structure and/or function of organs and organ systems; pathological states whether or not they are culturally recognized" (Young, 1982, 261).

Diseases can be observed; they are universal and have a real, substantial existence regardless of social norms and values, and exist independent of whether they are discovered, named, recognized, classified, or diagnosed. Diseases are a deviation from a biomedical norm; they have causal roots, the elimination of which is curative. Continual ongoing refinement and perfection of our understanding of the biological roots of diseases will improve physicians' abilities to cure what until now was incurable or had irreversible damage. Treatment is primarily aimed at the molecular cause of the disease process which secondarily alleviates the symptoms of the disease. This definition assumes that 'disease' is somehow objective and culture-free.

Furthermore this theory of medicine and disease is contingent upon dualistic thinking that divides the "physical" from the "mental" and explains the latter in terms of a secondary epiphenomenal process of the former. Causality is rigorously reduced to the smallest level of biological operation with the newest development being the expansion of medicine into the realm of molecular nanotechnology (Freitas 1999). It limits its competence to the areas encompassed by the explanatory theories of biomedical science and excludes all social, political, economic or cultural causes for suffering from its goal. It opposes medicalization of human suffering that originates from social and cultural processes. It doesn't deny social suffering but it limits its scope to the fields of biomedicine.

Other concepts of medicine have emphasized the role of sociocultural contexts in disease causation. Influenced by social sciences they developed a different theory of disease

called “Disease Relativism/Constructivism.” This definition stresses that health and diseases are a social construction, that they are cultural categories which get identified or labeled in accordance with explicit or implicit social norms and values at a particular time. Spokespeople of this view of disease understand biomedical science in the context of social and cultural issues. Based on social theory, they see disease integrated in social interaction and the emergence of biomedicine at the end of the eighteenth century as a social process that involves mechanisms of power and control (Foucault 1963).

Engel (1977) combined the classical biomedical model with the new researches of social scientists into a biopsychosocial model of disease. Engel’s model attempts to link social theorizing with biomedicine. One definition of medicine that is based upon Engel’s biopsychosocial model reads as follows:

> Medicine is a broad discipline, a helping profession, which has a constantly growing body of knowledge to call upon. Of the component parts of medicine’s knowledge, biomedical science is the most powerful and best developed portion yet known, but biomedical science is but the centerpiece of an amalgam of concepts useful to the care of patients. It (medicine) deals with biomedical, social and cultural function. It is in the strength of its inclusive character that medicine can prevent disability, relieve pain, cure disease, care for illness and promote life, even for those in the process of dying. (Perkoff 1997, 262)

There are many more types of disease concepts that are employed in clinical reasoning and practice (Albert, Munson, & Resnik 1988). Another example is “Disease Nominalism” which defines disease as whatever a physician says. Kleinman and Seeman (2000) describe it as “the practitioner’s construction of patients complaints in the technical terminology of a particular healing system” (231).

In the dispute about the role of culture and society in medicine Romanucci-Ross and Moerman (1997) make the distinction that disease is natural, while, in general, healing is cultural. They argue that the clinical categories of disease that arise from doctors' observations of symptoms are not socially constructed and do not significantly change over time. What changes is the way the symptoms get interpreted. Lester King (1982) suggested a distinction between a clinical entity and a disease entity. The clinical entity is a configuration of patterns and symptoms that are observed by a health professional in interaction with a patient. This clinical description of a specific condition remains relatively constant and stable over time. The disease entity is, in contrast, the momentary valid theory explaining the symptoms. The theories and conceptions of disease change radically over time because of new discoveries and changing social circumstances, not the clinical signs. Thus, the fundamental concepts of science are more a product of general social values than the clinical entities. However, clinical entities are also socially produced by the fact that they are mediated through the perception of individuals who exercise their skills within a specific and local medical culture. The choice to regard certain signs of symptoms as more important than others is a cultural process that undergoes changes over time and varies from one culture to another.

Campbell, Scadding, and Roberts (1979) showed in an opinion survey that different groups of people had differing answers when read a list of common diagnostic terms and then asked if they would rate the condition as a disease. A trend was to attribute to certain conditions the term "disease" when doctors had important contributions to the diagnosis (nominalism) and when the illness was due to some microorganisms (infectious agency).

These results reflect the prevailing values of the seventies and early eighties where the doctor's image still outshone nearly every other profession and where the medical model was still largely influenced by the great successes in treating infectious diseases. Today a similar survey might uncover divergent results. I assume that today the public would regard immunological and environmental factors as important causes for disease.

Let us now explore the concept of health. The words "heal" and "health" go back to the root word "*heilag*" or "whole." Healing and health are related to the concept of wholeness physically, mentally and psychologically. Implicitly, as health practitioners, we are supposed to work towards a state of wholeness and help our patients attain it. The philosopher Ian Hacking (1990) postulates that the idea of normal currently contains both the meaning of an existing average and a state of perfection towards which individuals or societies can strive. Normal now comprises not only the concept of an objective average but also the notion of good health. Diseases have become part of a moral dispute about the boundaries between normal and abnormal and their social significance. Individual health, wellness, the avoidance of disease and illness are part of a new health morality and have become ends in themselves rather than means to some other objectives. The resulting virtue of health improvement strongly contrasts with the fact that we are never completely whole, despite our desperate urges toward wholeness, which we hope to achieve by healthy life styles and diets, by exercising, and by going to therapies of all kinds. Physical and emotional symptoms are always part of our lives. Wholeness, unimpaired health, is an illusion; symptoms are a basic aspect of our lives.

Guggenbühl-Craig (1999) speaks of a basic phenomenon of life that defies all healing efforts. He calls it the “archetype of the invalid.” Deficiencies, functional impairments and symptoms are always part of ourselves. He regards health and invalidity as complementary archetypal fantasies and reproves the fact that wholeness has been identified one-sidedly with health. He argues that the prevailing idea that health is wholeness in mind and body ignores the archetypal invalid within each of us. Splitting health from invalidity leads to a health and wholeness moralism and to negative stereotyping of people with symptoms. Illich (1992) further suggested that well-being as virtue is being transformed into a dangerous fetish, while little is done about the social determinants of ill health, in particular about discrimination and poverty. The body becomes a symbolic field for the reproduction of dominant values and conceptions. In Guggenbühl-Craig’s opinion it may also be a site for resistance to and transformation of those systems of meanings. Sickness may be an unconscious expression of a struggle to resist and defend ourselves from the moralistic call for good total health. The strive to heal everyone and everything forces a counteraction that resists the expectations of wholeness and good health.

Susser (1974), in his analysis of value systems in the definition of health, differentiates between three levels of health: the organic, the functional, and the social level. All three levels involve conceptions of normality. Pathology sees disease as either present or absent on the organic level, statistics define normality for a specified condition from its modal distribution in a population, and society defines normality by its values. Antonovsky (1979) argues that a pathogenic orientation with a dichotomous classification

of normality (e.g. a person being diseased or healthy, functional or not functional) is inadequate for solving the problems of the origins of health. It cannot explain why a given individual does not break down under the ubiquity of pathogens or why a given group has such a relatively low proportion of people who have broken down. He therefore postulates a breakdown continuum between a health pole and an illness pole and a conception of normality that is conceived along a continuum model. He views the final outcome of one's location on the health ease/dis-ease continuum dependent on a long chain of phenomena that affect the individual's ability to resist ubiquitous stressors and challenges. Similar to Seldin he excludes from his definition of health other realms of well-being. He sees health in a broad context that goes far beyond the physiological level and is interconnected with other areas of well-being (family relations, social relations and material resources etc.). These other dimensions of well-being influence the individual's general ability to resist or cope with the stressors immanent in life but are distinct from his conception of health.

In contrast the definition of health developed by the World Health Organization (WHO 1986) explicitly includes all areas of well-being: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Through this definition, WHO has helped to move health thinking beyond a limited, biomedical and pathology-based perspective to the more positive domain of "well-being." By including the mental and social dimensions of well-being, WHO expanded the scope of health to embrace the broader societal dimensions and context of individuals and

populations. Further, this expanded view of health integrates the concepts of curative medicine (absence of disease) with public health (absence of excessive mortality, morbidity, and risk factors for disease), and social psychology (social capital, social support, collective self-esteem). It opens the way to understand health and disease not simply as a function of "free" individual behavioral choices, but rather as a result of lives constrained by social forces such as poverty and discrimination. It enables a view that includes the notion that individuals also define themselves through, and take meaning from, their relationships with others. It recognizes the extent to which "we come into being in a social context that is literally constitutive of us" (Nedelsky 1989, 33).

The critics of this broad definition of health, that includes everything that people feel about their state of well-being, fear the danger of over-medicalization of areas of social and cultural well-being. Antonovsky (1979), for example, speaks of physical well-being as being shaped by or as interacting with social well-being, but he rejects the assumption that everything in life falls within the jurisdiction of health care.

Dubos (1968) takes a different, less idealistic approach, in his definition of health: "Health is not to be considered an ideal state of well-being achieved through the complete elimination of diseases, but as a modus vivendi enabling imperfect men to achieve a rewarding and not too painful existence while they cope with an imperfect world" (67).

This definition stresses the fact that complete health is an illusion and that the endeavor to conquer "diseases," be they related to social factors or not, solves only one part of the

problem, the eradication of the causes of disease. It omits looking at how people cope with their imperfect health. He therefore raises the question of our capacities for adaptation and draws our attention to the socio-cultural and economic contexts in which this adaptation occurs. Clearly Antonovsky's thinking has been strongly influenced by Dubo's work. It is at the heart of his salutogenic orientation and his and my research question: how do some people resist the permanent attacks of disease and stay healthy?

In the following section I will focus on the category "illness," the lived experience of the disease process. 'Illness', as an analytically distinctive entity, refers to what the patient feels is wrong; disease refers to what medicine says is wrong. Illness has been described as an experience-near category with culturally patterned social and personal elements. Allan Young (1982) wrote: "illness refers to a person's perceptions and experiences of certain socially disvalued states, including, but not limited to, disease" (265). It is the lived experience of culturally constructed categories. It is also important to denote that the social course of illness and the personal experience of illness are intertwined. And then, what do I mean by experience? To define experience in a useful way is difficult. Experience refers to something directly observable by the individual and observable by others indirectly in his expression. It is an always present, underlying phenomenon of inwardly sentient living; it is shaped by the ongoing stream of feeling that we have every moment. Gendlin (1997) has shown that our subjective experiences are not just inner reactions; they are also the foundation for our interactions in life and constitute immediate interactional meanings. Thus experience represents the felt flow of events that is constituted in a social space. It is intrinsically intersubjective. Illness experience

combines the social world with the subjective world of the sufferer as well as her psychophysiological processes.

This link between culturally patterned and personally contingent elements of experience is mirrored in the story of a 60-year-old Caucasian woman of German origin who suffers from chronic bone problems and who told her story in a seminar that was held on the Oregon coast in September 2000. In her narrative she relates her symptoms to growing up in Germany during World War II and suffering from malnutrition. She still remembers hearing the sounds of the bombing resonating in her bones. She complains that she has suffered from debilitating chronic symptoms all her life and that her existence is dominated by fatigue and dizziness. She is so frustrated and fed-up with being a victim that she wants to jump out of her body and leave it all behind.

The therapist, who counsels her, expresses his compassion for the amount of pain and agony rooted in her historical background. Knowing his Jewish heritage, she is deeply moved by his compassion. She states that she knows their stories could divide them and that she longs for a way to reconcile. The therapist recounts waking up singing the song of a man on his way to a concentration camp thinking: “Who says I have to be a calf on the way to slaughter, why can’t I be a swallow flying free?” He helps her to disidentify with the tragedy and to stay in touch with her incarnated sentient essence. He encourages her to leave the bone carcass and free herself from history. A calf that knows itself also as a swallow lives outside the finiteness of history.

In her ongoing account she recounts how in the U.S. she lives among a community of many Jews, and how she is constantly exposed to overt and covert conflicts regarding Germany's role in anti-Semitism and the Holocaust. This forces her to keep the story of her own immense suffering as a young child in post-war Germany buried inside and she feels further victimized by the collective processes she endures in her community. Besides the physical pain, she experiences deep emotional and spiritual torment related to her biographical roots. The cause of her bone disease now includes emotional and cultural suffering. Her personal and collective history are intricate parts of her symptom origins and actual experiences. To focus on them implies that she continues to identify with her cultural context and feelings of being a victim. With the help of the therapist she understands that her process is instead to leave the "old continent," her origins, and roots behind, and to "immigrate" to the new world. This would psychologically involve detaching from her identity as a German woman and from the sufferings she relates to that particular identity.

"Illness experience connects the social and cultural context and the biography of a person – not any person, but a highly specific one – to the disease process" (Kleinman & Seeman 2000, 235). The way people individually and collectively perceive and respond to health problems is shaped by the dynamics of many intertwined levels. These forces resonate and reverberate in people's bodies and thus co-create the worlds of experience and body symptoms. Illness experiences take place in the interpersonal spaces of social life and express the diversity of possible or actual ways of being in the world. They

materialize under the reciprocal influence of cultural patterns of meaning, collective events and social processes, and subjective experiences.

Among the core elements of serious illness are existential hardship, a threat of mind-body integrity and of personal indestructibility, a loss of connectedness and social status, and also a loss of the power of rational reasoning and of a sense of control. The shock of a sudden accident, and the panic accompanying strong pains chase these faculties away. The experience of suffering overwhelms the patient's feelings and undermines her rational judgment. Plus the patient is not only anxious, but by definition dependent. The power relationship, then, is inherently asymmetrical. This rank difference is also expressed in what Metcalfe (1998) describes as arousal gap. The encounter with the clinician might bear for the patient a major life crisis and consequently puts her in a state of arousal, in which she observes every detail of the interaction. The clinicians and therapists are doing their ordinary job, most of the time unconscious of their minor comments and mannerisms. Moreover the clinicians' responsibility is to be aware of all these possible consequences of illness and of the invariably hierarchic character of the therapeutic relationship. The tendency to reduce medical action to the biomedical sphere disregards the psychic needs of the patient, which are, in the patient's view, legitimate medical problems. The clinician-patient relationship mirrors social and contextual power gradients and only when the clinician sees and relates to the patient within this sociocultural context can the results of the interaction be effective for both sides. Consequently the clinician cannot limit himself or herself to the responsibility for curing the biomedical cause of the disease. The sick person not only needs a knowledgeable

expert but also a compassionate partner who assists her in all her healing needs. This includes coming out of social isolation and regaining control, bearing her existential fears, supporting the experience of her illness, and fashioning a meaningful interpretation of what is happening to her.

Nevertheless, science-oriented Western medicine continues to favor the clinician's role of an expert, disease nominalism and realism, and a narrow understanding of pathology as defining concepts of disease and health. The tenacious biomedical understanding and definition of health is negatively and dichotomously framed as "the absence of disease." The distinction between disease and illness, the dichotomy between a materialistic process and a lived experience, is in itself not problematic. Problematic is the imbalance of values and power that comes with it.

Reductionism of contemporary biomedicine sanctions instrumental rationality and economic efficiency. The choice of locating the essence of disease not in the interpersonal context of social life, nor within the life trajectories, but in cellular and molecular processes, is a powerful political inclination. Reductionist accounts when focusing on pathologies of individual choice and risk behavior miss, for instance, the relationship between poverty, gender, and sexually transmitted disease. The special risk of poor women in many societies for sexually transmitted disease doesn't reflect their pathological inability to make appropriate behavioral choices, but existing structures of power and economic inequality that render them incapable of refusing the sexual demands of male partners (Farmer 1996).

Furthermore a cure and disease-oriented approach to medicine focuses on the eradication of the single cause of a disease and disavows the fact that, for example, most chronic diseases have multiple causes. Although cure is unquestionably an appropriate goal, the limited effort to treat the origins of pathologies prevents us from pursuing other important goals: restoring functional capacity; relieving suffering and other palliative measures; preventing illness, injury, and untimely death as well as health disparities; promoting health; and caring for those who cannot be cured. Not including the domain of illness experience can lead to a serious dehumanization of medical care. A health care provider who does not attend to the demoralizing effects of life with chronic pain, for example, doesn't take the sufferer seriously and won't be able to adequately respond to her needs. The inclusion of an experiential dimension of illness, in contrast, opens the door to a more diverse non-dualist conception.

The curative model is highly invested in a biomedical perspective that values scientifically-based data over other information and accepts evidence-based approaches to treatment over those less rigorously derived. Cure-oriented medicine reveres the 'hard' medical sciences, and it ignores behavioral phenomena that are not entirely explained by biological science. Effective cure is presumed to be contingent on diagnosis gained from knowledge of disordered function. Treatment is supposed to be derived from empirical research on clinical outcomes. In fact, on careful analysis, a significant component of medical practice is neither knowledge based nor supported by evidence, and that is the relationship with the patient. As Dr. Bernhard Lown (1999), a renowned cardiologist,

states: “even the most sophisticated technological procedures won’t elude the complex chemistry of human relationship” (xi).

The materialistic or objectivistic worldview, which relies only on empirical data, has brought many beneficial advances in modern sciences and has contributed to the record of biomedical discovery and progress from which we all benefit. The detrimental side of this predominant attitude towards disease is that the subjective experiences are reduced to the behavior of mechanistic processes. The inner experience of an illness, including its cultural meaning and context, and the interpersonal relationships experienced by the patient, are not considered. In addition, the concept of a single self in a single body demonstrates the powerful orientation of today’s Western society to individual experience, and the singular attention of today’s biomedicine on the solitary body of the individual. That disease shares some of its origins in society; that it infiltrates and deeply affects social relations is not recognized. This fact denies the experiential and social phenomenology of suffering of many cultures and their community based healing efforts.

This narrowly bounded view of health is pervasive in Western biomedical models and is influenced by liberal theory. Modern liberalism, the prevailing social theory in developed countries, has brought immense progress in actual social conditions, including economic, material, health, and political freedom, as well as the spread of democracy as a political structure. One pillar of this progress is individualism, which focuses on material and economic measures. Liberal individualism views people abstractly, as self-made, self-contained, separate individuals, isolated from others, set in opposition to the collective,

and pursuing their economic self-interest without reliance on the state. Biomedical approaches to health that incorporate liberal theory and individualism are therefore biased, especially when focusing on individual behavior as the source of and solution to all social ills.

> The biomedical model is also premised on the ideology of individualism. Adopting the notion of the abstract individual from liberal political and economic theory, it considers individuals "free" to "chose" health behaviors. It treats people as consumers who make free choices in the marketplace of products and behaviors, and it generally ignores the role of industry, agribusiness and government in structuring the array of risk factors that individuals are supposed to avoid. There is little place for understanding how behaviors are related to social conditions and constraints or how communities shape individuals' lives. (Fee & Krieger 1993, 1481)

Further, illness "is removed from the sphere of the unpredictable, the supernatural, and the divine, and is placed squarely, in EuroAmerica at least, at the feet of responsible individuals" (Lock 2000, 272).

I, in contrast, believe that the concepts of health and illness stand at the core of the social values of human society and are defining elements of how individuals view themselves and their bodies. These concepts are not merely neutral products that scientists derive from laboratory findings. They emerge from social processes, from a sociocultural discourse. As we have seen, biomedicine sees diseases as preprogrammed entities whose course is independent of the sick person's biography and her social context. Biological reductionism presupposes a value free science and scientific objectivity with an indisputable, "scientifically correct" understanding of disease causation. I believe that the body's physiologic response to distress is defined by our genes and biological

constitution and also shaped by social dynamics of norms, morals, and power relations. Not only do symptoms and signs that denote suffering vary culturally, but the incidence and course of disease vary from one society to another and within nations from priviledged to underserved communities (Kawachi 1997). “Communities affect the one who is ill just as the one who is ill affects community” (Estroff 1993, 258). The politics of human interactions and structures constitute a virulent causal agent of ill-health. The unequal enjoyment of health within and between nations, between genders, age-groups, and people from differing sexual orientations and skin colors represents a big challenge to today’s health sciences and societies as a whole. Freedman (1999) stressed:

> “that even an individual’s physical health – not to mention her mental and emotional health – is inextricably tied to the wider conditions of her life. Thus physical health cannot be detached from political and social concerns, posited as an objective state of biological being, and then treated as though the choices we make in pursuit of it are apolitical and compelled by some internal logic that derives solely from health itself.” (233)

The experience of illness and health must be studied on several analytical levels. The level of analysis cannot be solely individual, but needs to comprise contextual factors that are important in accounting for variation in illness expression and experience. The notions of health and illness therefore have to include an individual (personal identity; biogenetic/ontogenetic traits), a microcultural (interpersonal roles and interactions, family and group traditions), and a macrocultural (cultural and transcultural systems) level. Illness experience cuts across all three levels communicating through “idioms of distress,” culturally distinctive ways of symbolizing and imaging illness and symptoms.

The concept of “illness narratives” and “explanatory models” (Kleinman & Seeman 2000) expresses the fundamentally semantic character of illness realities on an individual level. Parson’s concept of “sick role” (1948, 1951) denotes how illness transforms the psychosocial microcultural realm of relationships. The sick role sanctions an unspoken pact between the ill person and community and helps negotiate the terms of interpersonal illness experience in a local world. Symbolic interactionism theory of the self (Cooley 1902) stresses the importance of external perceptions and interpretations for one’s sense of self and explains the power of negative stereotypes and moral value orientations in stigmatizing and discrediting sick people. Social units – families, peers, and communities – carry the cultural meanings of the illness and co-define the individual illness experience. Consequently research on health and illness at the micro- and macrocultural level contextualizes health problems as part of family and large global and regional systems. Family, group and socio-cultural dynamics are crucial elements in the experience of illness. In addition they define the discourse in which the illness experience is embedded. They are most critical in ethical decision making around chronic and terminal illness, coma and end of life decisions, the allocation of medical interventions in the elderly (e.g. the discussion of rationing health expenditures), and in the perception of health problems of marginalized groups (e.g. the medical view on menopause, HIV, hypertension in Blacks).

Definitions of health are inherently subjective and reflect our basic assumptions about the meaning of life and death. They further represent a political choice. Criteria of health usually include interdependent components such as the ability to work and fulfill

expected roles , the ability to procure enough resources to live without undue hardship, and a sense of life that is coherent and meaningful (McElroy & Jezewski 2000). These determinants of health and well being comprise some objective elements (e.g. socioeconomic status, location, gender, age...) and a central phenomenological[2] dimension. The phenomenology of illness focuses on the person's subjective experience, her meaning attributions, values, and norms. It is intrinsically intertwined with the sense of self and others across time, and has, thus, a collective scope. The response of others and the community we live in influence our experience and therefore illness is not only an individual experience but a social and community experience. "The experience of illness is not bounded by the bodies or consciousness of those who are ill" (Kleinman & Seeman 2000, 231). I see them as individual as well as collective processes, which include our subjective and interpersonal experiences.

Consequently, I believe that the complexity of health and the relationship between social factors and health demands an integrated multilevel and interdisciplinary approach. The various levels of analysis in health research include: the social/environmental, behavioral/psychological, organ systems, cellular, and molecular (Anderson 1998). Each of these levels contains a large number of variables that I summarize in Table 1.

[2] Phenomenological refers to perspectives that are subjective. It also accounts for the transformation of consciousness and self-identity that can occur in illness or disability.

Table 1. Some indices of various levels of analysis

Social/ environmental	Behavioral/ psychological	Organ systems	Cellular	Molecular
Stressful life events	Emotion	Blood pressure	Receptor number	DNA structure
Social support group, & family environment	Cognition	Heart rate	Electrical conductance	Proteins
Economic resources	Memory	Endocrine functions	Cell number	Oncogenes
Environmental hazards	Dietary practices, tobacco use, exercise	Immune functions	Synapse number	Transcription factors
Culture, rank and hierarchies	Stress coping styles	Brain functions		
Transcultural systems				

The majority of research in the health sciences occurs within a single level of analysis. Most studies don't explore factors from higher or lower levels that influence the problem under study. For solving the puzzle of the relationship between socio-cultural standing and health and for a more comprehensive understanding of health outcomes a multilevel cross-disciplinary research approach is needed.

Examples of multilevel approaches are: the research on the effects of early life stressors and cumulative adversity over a life course on the activity of neuroendocrine processes is a good example of sociobehavioral effects on organ systems (Coplan et al. 1996, Singer & Ryff 1999). Kaplan and associates' studies (1999) of monkeys in "stable" or "unstable" social groupings show an interaction of social environment and behavior on atherosclerosis (mediated by heightened sympathetic nervous system arousal). Klintsova and Greenough (1999) showed that a stimulating environment led to an increase in synaptic density and physical exercise induced an increase in brain capillaries in rodents.

Events at any levels of analysis can be influenced by events within the same level, from adjacent levels, and/or from higher or lower levels. The modes of interaction coexist and ask for an integrative approach that looks at cumulative effects.

I will demonstrate in chapter III that psychological, social, and personality factors can modulate or cause the stress response and affect health outcomes (Sapolsky 1999). The same psychological, social, and personality factors contribute to an individual's rank or personal power (Mindell 1995). My research centers on these intertwined social and psychological levels. I believe that rank is a mediating factor for the body's stress response and thus central for explaining divergent health outcomes. Optimally I would have liked to include some physiologic stress measures (e.g. measures of allostatic load[3]) but unfortunately I didn't have the structural support necessary for such a project. I therefore limited my scope to the study of rank and perceived health.

As I later will explore more in detail, socioeconomic status (SES) is linked to risk of disease and premature death (Adler, Marmot, McEwen, & Stewart, 1999). I will discuss the possible effect that health can have on SES and the stronger evidence that suggests an inverse relationship of SES on health (Fox, Goldblatt, & Jones, 1985; Haan, Kaplan, & Syme, 1989). I will also stress that the pathways by which SES exerts its influence on health are not well determined. Wilkinson's (1990, 1992, 1996, & 1999) research showed the health effects of income inequality and the evidence of a linear relationship of socioeconomic indicators with mortality and morbidity (Hinkle, Whiteney, Lehman & Dunn 1968; Antonovsky 1967; Kitagawa & Hauser 1973; Marmot, Adelstein, Robinson

[3] See chapter III, section on stress, coping and SES.

& Rose, 1978, Marmot et al. 1991) which strongly suggests that it is relative rather than absolute social deprivation that is important for health. It is not the absolute levels of SES that are important for health, but perceived inequality resulting from relative social standing. One's relative rank in comparison to others and perceived inequality resulting from one's lower social standing are strong predictors of health. Sapolsky's (1995, 2001) observations of free-ranging baboon populations support a similar conclusion, namely that the experience of rank hierarchies and lack of social stability are important factors in mediating the stress response and health. I therefore expect that a person's subjective experience of social status will show higher correlations with health than objective SES.

Today's prevailing medical theory based on pathology focuses on disease and disregards the individual's subjective experience. This paradigm contributes to isolating and marginalizing the sick from the world around them. Ware (1998) illustrates that chronic illness often leads to a marginalized position in social space. Most people try to resist as long as possible the role constriction (the inability to continue to fulfill valued and expected social functions) related to their chronic condition. The adversity experienced with deviation from mainstream values and norms, which one-sidedly overestimate the 'healthy self,' presents an additional burden for ill individuals. In psychosomatic medicine and other branches of medicine that deal with emotional and behavioral aspects of illness, different psychotherapeutic concepts from a variety of psychotherapeutic schools are used in treatment programs. However, few integrate the notions of rank and privilege or the social context at large in their methodology. A newer concept based on Antonovsky's 'Salutogenesis' and Mindell's rank construct (1995) can change our

attitude toward illness and deviance and promote a better integration of sick people. In choosing to study the role of social sciences in health and medicine I am not denying that health has biological dimensions but I want to contribute to our thinking of the ways in which ill-health is patterned by social factors, material and non-material.

In perceiving symptoms in their individual and collective dimension, my research aims at understanding the intercommunication between mind, body and society. My inquiry strives to conceptualize interventions concerned with the improvement of health in an integrative way, which sees the medical as inseparable from the political, the individual as inseparable from the collective. I combine in my study sociopolitical conceptions of marginality with other non-materially based dimensions of human experience of rank that are strongly related to health and well-being.