

CHAPTER III

CONCEPTS OF RANK AND POWER

One concise way to define rank is: Rank conceptualizes the stratification and distribution of power and privileges within a community (Lukes 1986). In this sense rank or power are the “determinants of privilege” (Lenski 1966) in the struggle between individuals and groups for culturally recognized advantages in a context of relative scarcity and competing claims. Differences in rank and power presuppose some sort of competition or conflict over the distribution of the surplus generated by society with some gaining more right and privileges over it than others.

Existing rank and power hierarchies, domination, and class inequalities can be traced back to the formation of value opposites, the process of establishing and justifying “dual tiers of life” (Chittister 1998, 23). What assumptions led to the establishment of social structures of intrinsic inequality? The worldview that some deserve more authority and right over others has its roots in theological and philosophical thoughts that take biological and other differences to form hierarchical power structures – e.g. that humans come in two sexes or many races, with one sex or race fundamentally lesser and therefore also weaker than the other. Institutionalized patriarchy or sexism, racism, and other structural inequalities originate in dualistic and value laden thinking, that thinks in terms of either/or and that attaches, for example, greater value to the mind than to the body, to

reason and rationality than to emotionality, to whiteness than to blackness. These institutions then use these value preferences to justify and perpetuate uneven distribution of power and privileges and the domination of a few over others. Minnich (1990) calls it a kind of “hierarchically invidious monism:”

...a system in which one category is taken to be not literally all there is, but the highest, most significant, most valuable, and, critically, most real category — which sets up all others to be defined and judged solely with reference to that hegemonic category. Eventually, that one category/kind comes to function almost as if it were the only kind, because it occupies the defining center of power, either casting all others outside the circle of the ‘real’ or holding them on the margins, penned into subcategories. (53)

In this meaning system, differences are not mere distinctions but characteristics that justify privileging some over others. Woman turns into not the equal opposite of man but a failed version of him and men’s qualities set the norm for universal human qualities. Sex/gender, class, and race distinctions get generalized into hierarchical divisions. White heterosexual men get reinforced as the kind of humans who ought to be dominant. In the resulting belief systems, men are supposed to be superior to women, heterosexual men and women superior to homosexual men and women, well-educated and financially-privileged men and women superior to socio-economically underprivileged men and women, white people superior to colored people. Race, class, and sex/gender categories are used to define Otherness and not just descriptive categories of difference. They are used as normative categories and to perpetuate hegemonic systems of power and privilege.

In the Hebrew-Christian tradition, hierarchy and power structures are also rooted in the generalization of God's 'Commandments' and the simple relation of a higher power commanding and requiring obedience. In more recent times, biological and social sciences, with their controversial discoveries of an inborn instinct of domination and an innate aggressiveness in the human animal, were used to justify power relations. Others, still under the influence of past experiences of totalitarianism, also referred to a psychological instinct of submission which they described as an ardent desire to obey and be ruled by some strong man (Arendt 1970).

The eighteenth-century revolutions and the creation of republics were motivated by the aspiration to put an end to the rule of "man over man," the simple power relationship of someone commanding and someone else obeying, and replace it by the rule of law, resting on the power of the people. Obedience would ideally be substituted by an always disputable support of the laws to which a majority had given its consent.

One of the most cited definitions of power comes from Max Weber (1978). He defined power as the possibility of imposing one's own will on the behavior of others even against opposition. His definition stresses the coercive aspect of power. Hannah Arendt (1970), on the other hand, differentiates between an individual and a collective dimension of power and transcends the one-sided coercive reference of power. For the individual dimension of power she reserves the term 'strength.' For her power is intrinsically an attribute related to the collective.

Power corresponds to the human ability not just to act but to act in concert. Power is never the property of an individual; it belongs to a group and remains in existence only so long as the group keeps together. When we say of somebody that he is in 'in power' we actually refer to his being empowered by a certain number of people to act in their name. (59)

Power is not the enactment of someone's will, but the creation of a common will in a communication directed to reaching agreement. This can but must not include the use of external means of coercion and violence. She often refers to democratic institutions in which the legitimacy of the power of the majority and its executors is recognized by both sides, the one who commands and the one who obeys.

Talcott Parsons (1986) similarly gives power a systemic dimension. He understands power to mean the general capacity of a social system to get things done in the interest of collective goals: "I have defined power as the capacity of a social system to mobilize resources to attain collective goals" (p.95).

For Hannah Arendt society or in her words "the social" is an emergent sphere, collectively created both external and objective and inner and psychic. It is a bureaucratically organized economical system and an aggregation of generalized norms that its members create and conform to. Social norms and categories are a collective projection, a myth, constructed out of each individual's outwardly projected Otherness – something that everybody receives, feels subdued to but does not create. It is a collective refusal to think about what they are doing. Social norms are monstrous abstractions nobody identifies with (Pitkin 1998). For Mindell (2001) social categorizations are an expression of externalized inner xenophobia. They are a collective projection of

characteristics that we fear and therefore marginalize in ourselves. Projections serve to relieve energy. It is a relief to see distinctive features of others as characteristics of someone else and not to attribute them to marginalized aspects of oneself. Obedience to norms and conformity to conventions are useful to structure everyday reality and help us pursue our lives. But this also sustains conflict. The lack of awareness of our own inner diversity co-shapes a world of hierarchical divisions.

Society or each individual through his or her belief systems, norms, and conventions conveys power which can be used to discriminate or innovate. Hannah Arendt believed in a public realm of unimpaired intersubjectivity, a sphere of collective relationships that would transcend the blob of social abstractions and faulty generalizations. In this public space the collective power relies on the interest of a group of people to come to an agreement that is not primarily geared towards individual success. Consensus is formed through organized solidarity towards a higher collective goal. Hannah Arendt's idealized concept of power is based on an anthropology of communicative action. She envisioned collectively created structures and institutions whose authority were recognized by all and through which an intersubjectively shared life-world is formed. In her view the totalitarian regimes of the first half of the twentieth century historically arose from a depoliticized mass that was administered by bureaucratic organizations and that was composed of humans who had lost their human agency. In contrast she finds models of ideal democratic institutions in the American town meetings around 1776, in the "*sociétés populaires* " in Paris between 1789 and 1793, in the sections of the Paris Commune of 1871, in the Russian soviets in 1903 and 1917, and in the

“*Rätedemokratie*” in Germany in 1918. From the historical example of the Athenian city-state she draws the ideal of people disinterested in individual power that collectively co-create the public life of the community where everybody is equal.

No concept of power, even an idealized one that believes in democratic institutions, has solved the problem of potential coercion. In democracies coercion manifests through the overpowering of a minority position by the consensus of a majority. The power of normative values and regulative structures will always be felt as coercive by opposing minorities, even when they are reached through a consensual process. Pluralism and diversity are difficult to integrate with notions of power. Mindell (2001) suggests a culture and practice of taking one’s projections back to relieve others from the burden of our misplaced judgments and generalizations. To move into the other’s side seeing the world from her perspective and to notice the effect we have on others will help us stop propagating the hierarchical paradigm of winning and losing.

Domination in the most general sense is one of the most important elements of social action. Of course not every form of social action reveals a structure of dominancy. But in most of the varieties of social action domination plays a considerable role, even where it is not obvious at first sight. (Weber 1978, 941)

What Weber calls domination Mindell (1995) calls rank. Rank confers the notion of being in a more dominant position that entails more privileges or socio-culturally assigned power in Arendt’s sense. Rank refers not only to the actual individual power (strength) of somebody to get what she actually wants (e.g. even against resistance in Weber’s sense) but to the likelihood that she would get, no matter what she might happen

to want. It alludes to the possibility of someone to make choices and to the probability that she will be successful in achieving her goals. Collectively it mirrors the properties and characteristics of one's social groups and the powers that come with them. Lenski (1966) describes it as the 'power of position' or the power which belongs to the holder of any social role possessing authority or influence. Rank or power of position refers to the strength and power that comes with the social position one inherits and achieves in the categories of socio-cultural influence (e.g. sex/gender, class, race, and socio-economic status).

Today concepts of pluralism and diversity challenge the idea of innate power hierarchies and noninclusive concepts that propagate a kind of hierarchically invidious monism (Minnich 1998), be it based on gender, class, and/or race. False universals have led to mystified concepts which marginalize and discredit some modes of thought (e.g. irrationality) to maintain other modes of expression (e.g. rationality) at the center of the dominant tradition. Undoing them, we make it possible to cease turning difference into deviance. In particularizing what has been made universal and dominant, in confronting our personal fears of the Other in us we learn to live with more complexity and diversity. We recognize key concepts, belief systems, standards and values in their historical and cultural contexts and how they have been used to justify and reinforce domination and rank. Pluralism and diversity, the recognition that we are all unique, opens us up to our gender-, race-, and class-blindness. It helps us deconstruct the very powerful meanings and systems of thought that confuse 'human' with 'man,' and 'man' with a particular group of white heterosexual males.

Also in recent academic writing there has been considerable discussion about the concept of marginality and the relationship between margin and center (Jones 2000). The study of these socio-cultural dynamics of power and empowerment enabled the construct of a differentiated concept of rank. Social standing, the way we position and perceive ourselves in society, the sense of ease we feel in our environment, reflects one feature of rank. Feelings of security and being cared for in one's community, self-knowledge, self-esteem and a capacity to interrelate with others are further non-materially based dimensions of rank. And again another facet describes "a sense of having justice on one's side, or of connection with a divine or transcendent entity which enables the person to remain calm and untroubled in the face of difficulties and upsets" (Jones, 2000, 116).

Social Marginality and Rank

Interpretations and perceptions of the meaning of marginality differ among social scientists and no clear consensus has emerged (Cullen & Pretes 2000). In a socio-political context it is understood as the designation of a person or a group as peripheral to the main group or groups of society. Social marginality refers to a state of being excluded from social activity as an "outsider" and being placed at the margins of social norms and conventions (Macionis 2000). Different categories (e.g. race, gender, class, sexual orientation, health) are used in our society to marginalize individuals and groups to varying degrees. The concept is influenced by *social constructionist* perspectives and a Foucauldian view of language as an instrument of power. Social constructionism's worldview is that social realities are constructed by the members of a culture as they interact with one another. The lenses through which individuals experience themselves

and interpret the world around them are continuously co-created through language and maintained in narrative. Social constructionism is also based on the belief that we have no direct access to knowledge about “objective” reality. Bateson (1972) used the metaphor of “maps,” saying that all our knowledge of the world is carried in the form of various mental maps of “external” or “objective” reality, and that different maps lead to different interpretations of “reality.” “No map includes every detail of the territory that it represents, and events that don’t make it onto a map don’t exist in that map’s world of meaning” (Freedman & Combs 1996, 64).

Constructivism focuses on the biology of perception and cognition through the operations of the nervous system. It argues that since sensory data go through several transformations as they are received and processed, it is impossible to know what external reality is “really like” (Maturana & Varela, 1980). Social constructionists take this notion further and stress the social interpretation and the intersubjective influence of language and culture. They move from an experiential epistemology, from focusing on how an individual person constructs a model of reality from her individual experience, to a social epistemology that focuses on how people interact with one another to construct, modify, and maintain what their society holds to be true, real, and meaningful (Gergen 1985). For them realities are socially constructed, they arise through social interaction over time, they are brought forth through the language we use, and are kept alive in the stories we live and tell. To Foucault (1971) power in a given society is in direct relation to the domineering discourses¹, with some people’s voices dominating the discussion and some issues being privileged over others. As King (1992) observes: “The history of

¹ Foucault uses the term discourse to refer to the ongoing historical conversations within a society.

human discourse has been a dialogue between the center and the margin over the character and quality of modern life...a cycle of emerging, dominant, dying and muted voices carrying on the long struggle over whose voice should prevail and whose rule will be honored” (xii).

The dominant narratives in our society disempower large numbers of people by excluding them from a significant voice. Thus marginalization is the process by which individuals and groups get silenced and rendered invisible (Tucker 1990). It also refers to the process by which certain people are excluded from the decision making process that a given society employs to distribute privileges (Trimiew 1995).

Center margin dynamics operate at both socio-cultural and intrapsychic levels. Foucault (1971) writes that we internalize the dominant narratives of our culture, believing that they speak the truth. Marginal and central groups alike adopt the normative assumptions of mainstream² culture. Mainstream norms are implied standards, routinely taken for granted by most, and therefore often intangible. Thus the power of the center derives significantly, as Jones (2000) remarks: “from its invisibility, and its denial or unconsciousness of its distinguishing characteristics, abilities and privileges. As the dominant and all-encompassing norm, the center is not overtly and specifically acknowledged and is generally forgotten, while exerting enormous influence on the culture” (103).

² Mainstream describes the norms, conventions and values held by the majority or dominant groups living in a particular cultural setting (Herbst 1994).

This intangible and pervasive nature of mainstream social norms and conventions is equivalent to Hannah Arendt's notion of 'the social' as something that people experience as an overwhelming, external force whose powers seem always to belong to someone else.

Dominant narratives are pervasive and concealed. They get internalized by central and marginal individuals and groups alike, and shape our views of reality. They are often significantly contradicted by important aspects of the individuals' or groups' lived experiences. For example, in an American culture that legitimates income differences, those who are marginalized by virtue of their economic standing may feel and behave as if they deserved it and support the mainstream, while disregarding their own inner sense of self worth. In a study of patients with chronic fatigue syndrome, Ware (1999) describes a social course in chronic illness along a continuum of marginality that depends on the process of internalized cultural expectations. Culturally shaped normative assumptions for social life and personal conduct triggered microsocial processes of marginalization (e.g. role constriction, impoverishment, and social isolation). The illness course was related to the ill individuals ability to resist to the marginalizing processes.

Minority and marginalized groups are not only powerless. They often contain the seeds of social change and creativity. Many scientific progresses evolve from a fruitful debate with a marginal or minority concept. Aspects of minority cultures (e.g. youth culture, feminist culture, and Black culture) have powerful influence on the normative mainstream. Some musical sub-cultures strongly influenced political movements. Jazz for

example was intimately related to the civil rights and student movements of the sixties. Minority influence theory (Moscovici, Mucchi-Faina & Maass 1994) studies how dissents, difference and diversity initiate social innovation. It further stresses that divergent ideas that are brought forward by minority groups are often used by the mainstream to discriminate against them. And members of marginalized groups also feel put down if they get associated or identified with singular “favorable” clichés that mainstream assigns to their group (for example, the stereotype of having rhythm that some people associate with being black). Nevertheless, as Jones (2000) comments, “despite the denial, and also because of the conflict it engenders, marginal standpoints have an impact on the belief systems and behavior patterns of the mainstream” (111).

Another feature of minority power is its potential to interrogate the morals of the majority. This property of “moral superiority” comes with oppression and discrimination. “Because of their oppression, marginalized people are not on the margins of moral reasoning and ethical living, but rather at their center” (Trimiew 1995, xviii).

Let me exemplify this critical point from a health perspective. Kay Toombs (1995) writes of giving a speech about her illness experience with multiple sclerosis and being asked by audience members “to state explicitly those things that I find ‘good’ about my situation. Is it ‘enabling’ rather than ‘disabling’? Has the experience caused me to ‘grow’ in certain ways?” To these questions Toombs answers, “Harsh tough the reality may be, there is nothing intrinsically good about chronic, progressive multiple sclerosis. Nothing” (19-20).

Yet Toombs also writes of what she has gained through illness – empathy for others’ suffering, friendships, and “a clearer view of what is really important in my life” (20). There is nothing “good” about illness and no one living in even moderately good health wants to imagine ceasing to be the person they enjoy being. In like manner there is nothing “good” about being oppressed and discriminated against. Nevertheless there are some moral qualities and personal powers that some members of oppressed groups might gain from living through marginalization.

This viewpoint sees sociocultural power as only one dimension of power within many. A. Mindell (1995) describes various ways in which power may be experienced. He defines power in terms of “rank” as “a conscious or unconscious, social or personal ability or power arising from culture, community support, personal psychology and / or spiritual power” (p 42).

Mindell differentiates between distinct dimensions of personal power and rank: social, psychological, relational, transpersonal or spiritual, and contextual rank. Social rank depends on one’s position in regard to mainstream values in the areas of socio-cultural influence like gender, age, disability, religion, ethnic identity etc. Psychological rank includes positive qualities, skills and abilities, self-love, self-confidence and self-knowledge. Relational rank stresses good relationship skills, high ingroup status, and a loving support network. Transpersonal rank reflects one’s sense of connectedness with something spiritual and divine or with something greater than yourself (e.g. Nature). It also reflects a sense of inner strength from surviving hardship, suffering or oppression, as

well as one's sense of leadership, care and responsibility for the well-being of the wider community (Jones, 2000). Contextual rank derives from one's momentary roles in a given situation. A teaching position, or one's role as a therapist provides us with additional rank that is more or less³ limited to the situation. He argues that some people have a lot of psychological power while having few social privileges. Some people from marginalized groups who survive social abuse may acquire a different power. Through their daily confrontation with marginalization and discrimination, they may succeed in gaining awareness of and pride in their individual roots.

Jones (2000) showed that one's subjective experience of one's social standing can strongly differ from the outside perception of a third person. Individuals whom one would place in a low social rank perceived themselves with more rank. For example, as a physician immigrating to a new country (the U. S.), unable to work in my original profession and forced to start a new career, I still keep a sense of social rank that is greater than how I experience people seeing me in my new professional environment. In my daily interactions I constantly sense this discrepancy. Some times I experience overt xenophobia as, for example, when in my duty as a witness the opposing attorney discredits my former education of my country of origin. But more often my experience is one of a silent and intangible categorization that puts me down. Others with a different sense of themselves might rank their social standing as lower than what others would grant them. The actually felt externalized social rank competes with an internal sense of strength and power that one has in the various areas of socio-cultural comparison. There

³ Some roles come with high social status that extend the sense of rank beyond the momentary context (e.g. physician).

is a projected outer process of categorization on a continuum of center and margin and an inner stratification of one's social standing. Life experiences, personal strength, feelings of belonging to a specific social group, lineage or family, community support, and spiritual beliefs influence one's inner sense of social rank. Crocker (1999) showed that behaviors that could be assigned to outer socio-cultural dynamics (e.g. racism) had a protective effect on some people's sense of self worth. Characteristics (e.g. overweight) that were seen to rely more on one's own personal control were more influential in decreasing the subject's sense of self.

For some people, social rank and privilege is a form of outside empathic feedback from culture or society and improves their self-esteem. Centrality, fitting into mainstream values, gives them ongoing positive feedback. They feel accepted by the majority and don't have to be afraid of being marginalized or persecuted because of their skin color or sexual orientation or their values and beliefs. On the other hand internalized mainstream social values may contribute to a sense of inner oppression for people with high social rank. The constant pressure of having to live up to these values and the fact that we never really fully succeed to achieve these elitist standards can lead to a feeling of inferiority and self hate. Therefore, if one's self-worth relies only upon social rank it may have a weak foundation, and it may be equally important for a mainstream person to overcome the mainstream oppressive values to establish a positive sense of self. Others, often members of minority groups, develop, through their struggle with mainstream oppression, a high sense of pride and self-esteem. Again others with low rank succeed through personal insight and awareness to counterbalance the lack of social rank. Their

faculty to engage in the different challenges of life and to perceive them as a chance for personal growth gives them psychological rank. Nevertheless they start with fewer resources than people with more privileges. The sum of inner and outer oppression is much ampler when you have i.e. a black skin, a female body, a different sexual orientation, come from a lower class, are differently physically abled, or belong to a marginalized age group etc.

The relation between the various dimensions of rank in one's subjective experience may work like the following. Let's say I am a woman and therefore marginal in regard to gender. If I have a low sense of overall rank, my subjective experience of my gender will be one of extra low value or lack of empowerment by my gender. But if I happen to have rank in other areas, like the psychological or relational, it will affect my subjective experience of my gender in a positive way. I believe, therefore, that in one's subjective experience of the various areas of social rank there are implicit additional influences from the other dimensions of rank. Measures of perceived social rank will implicitly contain and express other areas of personal rank.

Arnold Mindell compares social rank to potential energy or more potential to do things (Mindell, 2000). He writes, "whether or not you use this rank or are even conscious of it, rank means you have the potential to do things in the world that others with less rank cannot do" (416).

Within a social context, some people have higher rank and more power than others. This rank imbalance and the polarization that ensues evokes tension and a tendency in a low ranked individual to attempt to equalize power distribution. More tension builds up when these basic social inequalities are denied and high ranked people insist that there is no disparity. As Minnich (1998) alleges: “There is no more powerful position than that which dominates while appearing not to, no more influential position than that which sets standards for and informs cultural meanings and their expression as knowledge” (161).

Understated and unrecognized rank, the fact that most standards and norms are taken for granted and most of the times generalized from a dominant perspective, creates tension and conflict. Mindell (1995) further showed that rank, whether inherited or earned, organizes much of our communication behavior and that when we are unaware of rank, communication becomes confused and chronic relationship problems develop. The differences around race, gender, age, religion, sexual orientation, health, social power, spiritual power and wealth are predicaments that influence our communication and relationship in general. The more aware we are of how our rank participates in marginalizing the issues of those with lower social status, the more we contribute to reducing tension and improving health and quality of life of everybody in our environment.

I also think that unconsciousness of rank, on part of the health care professional is the cause of most therapy dropouts and a cause of negative compliance. It might also explain the information block about self-health care efforts mentioned above. Besides its own

value and rightfulness, the use of alternative medicine might also be seen as an act of empowerment of the health care receiver, and a reaction against unawareness of rank on the part of the biomedical field.

Last, the discrepancy between one's personal ranking of one's position in the areas of social comparison and one's perception of how others rank us forms an additional strain. An open question remains if an individual's higher subjective ranking or positive sense of self has a protective function against outer perceived marginalization. One might think that high pride, an inner sense of self-worth, a high subjective social rank should constitute a resource against outer low status. On the other hand, the felt discrepancy might in itself cause stress, independently from personal strength. The feelings of unfair treatment can result in tension. When, for example, I call someone on the phone in my function as a counselor I often feel doubly put down – first, as a foreigner and immigrant with an accent, and second, by not being recognized in my rank as a well educated and highly qualified professional.

Thus, there are many contingent factors that influence our sense of self and rank. Examples are individual competencies, experience of power or control over others, a sense of self-reliance, love from family and friends, physical attractiveness as defined by cultural norms, having virtue and higher goals, an experience of God's love, and one's experience of social identity (Crocker & Lawrence 1999). People also differ in the degree to which they base their self-esteem on external approval and regard or on how others view them. The vulnerability to stigma or devaluation of one's group memberships

furthermore varies depending on cultural differences of self concepts and representations. Therefore the status or social rank of individuals is not completely dependent on the status and powers of the groups to which they belong. An individual's relative station in life is a combination of the result of his or her own effort, talent, intelligence, behavior or virtue and the function of his or her membership in a socially constructed group such as race, gender, age group, religion, clan, tribe, lineage or social class. The consequences of stigma for the self-regard of those who are devalued is complex and not the same for all devalued individuals and groups. There are both group differences and individual differences in the contingencies on which self-worth is based. Mindell's (1995) differentiated rank model takes these contingencies into consideration. His expanded concept of personal strength, "comprehensive power and rank" combines an individual mental level (personal rank or strength), a microcultural level of interpersonal roles and interactions (relational and social rank), and a macrocultural level of ecological, historical, and political conditions (umbrella concept⁴). How people individually and collectively perceive and respond to health problems is shaped by the dynamics of the many intertwined levels or parallel worlds⁵. These forces resonate and reverberate in people's bodies, and, in so doing, co-create the worlds of experiences and body symptoms. Kiecolt-Glaser demonstrated (1995) that mental, social, and spiritual factors have distinctive but similar effects on health mediated through psychoneuroendocrine pathways. Thus newer developments in the fields of neuroimmunology and

⁴ The umbrella is a metaphor that A. Mindell used in one of his classes to describe his view that underneath any particular social issue there are many related problems that need to be considered. Sexism, for example, cant be addressed separately from related issues like racism, classism, centrism with America and Europe etc....

⁵ Parallel world is a concept from quantum physics that was developed by Bryce DeWitt and Hugh Everett (1973) to understand the mathematics of quantum mechanics. I use the term here as an analogy for coexisting levels of experience.

neuroendocrinology as well as stress research will help us to understand the mechanisms that link our subjective experience to bodily processes. But the exact translation of thoughts and feelings into biochemical impulses remains a mystery. Rank or power differentials, income inequalities, or social disparities in general are powerful factors influencing the mortality and morbidity of people. Social cohesion and social trust (Wilkinson 1996) are important in preventing health disparities on a cultural level. A sense of coherence (Antonovsky 1979), the ability to attribute meaning and purpose to one's life, and an inner sense of being connected to something bigger, contribute to what Mindell (1995) defines as spiritual or psychological rank. This individual characteristic might constitute an immense resource that protects us from the adverse effects of social dynamics.

The Social Construction of Medicine and the Body

Let me deepen the notion of the social construction of ideas, knowledge, and the individual's experience and perception of her body in terms of health and sickness. One central argument of this chapter is that health and illness and the accompanying treatment modalities of health care may all be viewed as products of culture and the social sphere. As we have seen there are varying opinions on the importance of the sociocultural context that animate the nature versus nurture debate. Some think that the ways we think about, treat, and live in our bodies are always and ultimately socially and culturally shaped. This contrasts, on the other extreme, with a scientific⁶ view of others who see disease as an objective physiological condition located in the body and independent of one's contexts.

⁶ See page 7.

Contemporary sociological analysis of medical systems and beliefs that favor a constructivist approach are strongly influenced by Michel Foucault's (1971, 1977) work on the handling of madness and mental health by the dominant ideology of psychiatry. His writings on power, knowledge, and discourse center on the importance of language in establishing notions of reality, including the experience of having and being a body. His concept of discourse incorporates the understanding that language, visual imagery and power relations are implicated in co-creating our experience. They direct the way we talk, think, write about and make sense of phenomena of consensual⁷ reality such as the human body, sexuality, health, illness, and medical practices. The social discourse (the way some ideas, values, and knowledge are viewed as more central or valid by the group we belong to) structures our experience of normality, what we perceive as functional or dysfunctional, normal or deviant, healthy or unhealthy. It influences the way we feel about certain groups of people (e.g. the elderly) and various types of bodies (e.g. the thin and the obese body, the ill or diseased body). The doctrines that arise from the discourse are subjected to power struggles within competing social groups and interests with some dominating others and defining what counts as 'truth'. These perceptions and values are constantly challenged and have a long history as I have tried to demonstrate by delineating the broader historical context in which the discourse of science is embedded in medicine (see chapter II).

Thus concepts of health and illness evolve out of a social discourse and stand at the core of the social values of human society. Kleinman (1995) states that: "Medicine, like religion, ethnicity, and other key social institutions, is a medium through which the

⁷ See footnote 2 page 45.

pluralities of social life are expressed and recreated” (24). He concludes that there is no essential medicine, no medicine that is independent of historical and social context. Therefore, differences in concepts of health reflect fundamental religious and moral views as well as power relations in society.

As I have illustrated before there is a large diversity of opinion and little consensus about what constitutes ‘health’ and ‘illness’. This is reflected in the many explanatory models (Kleinman, Eisenberg, & Good, 1978) – the ways in which an illness is interpreted and understood by patients and medical practitioners – that coexist today. They may be shared or contested and they include notions of etiology, expected course and predicted outcome, and ideas about appropriate treatment. Patients’ and professionals’ explanations alike comprise religious ideas, cultural understandings of bodily processes, and moral perceptions of what constitutes acceptable behavior to achieve or regain health. They mirror one’s attempt to create meaning in an insecure environment and moment of life. In an increasingly pluralistic society they are drawn from different healing traditions and religious cosmologies. They are an expression of dynamic social, personal, and moral processes.

The achievements of modern Biomedicine are also a product of our culture and our history. Medicine and our healing cultures mirror our societies. Biomedical reductionism, with its metaphor of the body as a machine, a mechanism that can be taken apart and put together again, has been very successful. The notion of single causal chains of effect has been very useful for the sick person and for health professionals alike. With clear

definitions and interpretations, definite and accurate actions and interventions are possible. An acute lobar pneumonia can be very successfully treated with a mechanistic and materialistic approach. Furthermore, this concept has the advantage of remaining modern. Biomedicine can adapt and refine its machine model of the human body according to technical progress without giving up its paradigm. On the other side, meaning has increasingly been excluded from how we perceive illness and disease. For many professionals, the sick person's subjective experience of suffering, as well as her narratives, have fallen into oblivion. For the chronically ill⁸, those who cannot be cured but must continue to live with illness, the preferential treatment of our biological bodies is moreover discriminating. When chest pain is reduced to chronic coronary artery disease and the accompanying symptoms, like the patient's fear, the family's frustration, the job conflict, and sexual impotence, remain unaddressed, the patient will experience this attitude as detrimental, because it is one-sided and biased, and a conflict might result.

We all share some responsibility for the power and authority of Biomedicine and its one-sidedness. We all profit from the clarity of the actual concepts. Confronted with the danger, threat and insecurity of the disease process, we are all relieved when we can delegate responsibility to a powerful medicine, which is able to act. In integrating and supporting the values and norms of our medical culture, and in devaluing our own inner pluralism, we participate in the maintenance of today's medical structures and their prejudicial values.

⁸ In North America the management of chronically ill patients increasingly dominates medical practice. Yet many studies show that patients often miss effective therapies and lack the support they need (Davis & Wagner, 1999).

On the other hand medical and technological knowledge is used by groups with more centrality and power to maintain and defend their privileges. Bodies, and in many cultures especially women's bodies, are subjected to political and ideological control and regulation. Medicine dictates which body is normal or deviant and how bodies have to look hygienically. Public health and preventative medicine tell us to take care of our bodies and health in a responsible way. With our health behaviors we are asked to keep ourselves in good shape and foster our health. Good health, we are told, is an achievement against ill-health. Taking the mind-body link into account, psychosomatic medicine is used to advise us to identify ill-health promoting psychological factors and to avoid behavioral or attitudinal patterns like negative thinking and lack of self-confidence. Psycho-hygiene becomes part of medically prescribed health prevention. We, as individuals, are one-sidedly regarded as responsible for our diseases and blamed if we don't adapt to culturally defined and accepted behaviors. Consequently bonuses for medical insurance are linked to specific health behavior patterns. Social and environmental factors disappear from their roles in causing disease while self-discipline and self-responsibility turn into central cultural values and attitudes towards life. The danger of this view is that people behaving differently get discriminated against, and the chronically ill get blamed for not having succeeded in staying healthy.

Concepts of illness and body image as they relate to health are constantly shifting, incorporating older ideas from rediscovered ancient health traditions and newer ideas often introduced by medical and scientific discoveries about the body. The germ theory strongly influenced notions of hygiene in protecting oneself from external invaders in the

1940s. Later the changing biomedical understanding about the role of the immune system shifted the focus from the outside to what was happening on the inside with a marked interest in nutrition, vitamins, and trace minerals as immune modulating factors and agents (Martin 1994). Only a few years ago in Switzerland, women with breast cancer explained their sickness in terms of an accident that took place several years before the occurrence of cancer: “Sometimes in the past I hit my breast” was often heard in the women’s narratives (personal observation). Today certain groups⁹ in Western societies often psychologize cancer and medical processes become connected with moral behaviors. For example, there is a strong professional and lay tendency to blame people for their illness. Cancer is often related to lack of self-assertion, to holding back negative emotions, to repressed anger and grief, to depression, and to environmental factors. In the center of illness beliefs and explanatory models of lay persons and professionals alike are life events and one’s own life style (e.g. diet and fitness). Illness and suffering are to a smaller degree seen as an essential natural part of our lives and our mortality that comes with our natural existence, but increasingly as being in the sphere of influence of our responsibly lived lives. Blameworthy ill-health and responsible health are the two poles of today’s discussions on health matters. On the other hand I also think that we don’t blame ourselves enough for how we treat our physical and social environment. We self-destructively continue to pollute our bodies, our natural environment, and our relationships. We all tend to project onto others that nobody else cares; we think that we are powerless and that our individual actions won’t make a difference.

⁹ Predominantly a counter-cultural group of younger middle class people with some interest and awareness about health issues.

In my work with chronically ill patients I often encounter this internalized guilt laden debate. Many times individuals will take responsibility for past ill-proned behaviors and self-abuse. But others suffer from judgmental inner figures that reflect the larger societal debate and express unrealistic expectations and discriminatory attitudes. In the media, unexpected recovery stories receive more attention than the more frequent stories of daily struggles for little improvement or just for some delay of aggravation. This cultural emphasis on success stories gives too much weight to personal achievements and too much centrality to health.

The juvenile and ‘good-looking’ body has become a symbol for a successful person. It is a metaphor for fitness and attractiveness and a standard for social acceptance and recognition. Slimness and a muscular body have evolved into central standard values and are linked to sexual appeal. The great concern in many Western cultures with faultless skin surface, deodorized, youthful bodies, fit and sexy body shapes is part of a commercialized system of symbolic meanings, which aligns us with the priorities and expectations of the majority. Non-conforming bodies are devalued. Impaired, overweight, or aging bodies are discriminated against. Old age has become a negative value and signs of aging get socially stigmatized. The body has turned into a commodity, which can be shaped and adjusted to social values. Ill, disabled, elderly, or dying people are the ‘other’, those from whom the healthy and young seek, often unconsciously, to differentiate themselves. This, in turn, leads to an increasing sense of isolation and being discriminated against for people with less health privileges.

From this perspective life style is not perceived as a product of socio-economic developments, but reduced to a cause of physiologic processes. Social processes get simplified to body events and are made treatable through discipline and control of the body. The socio-political level gets one-sidedly mingled with the level of the body's health. Through these embodied values social control is internalized and political ideology materialized as corporeal feelings and physiological needs. We fail to remember that if someone, for example, attains a state of calmness and improves her health through relaxation, her social status hasn't necessarily ameliorated.

Social Causation

By focusing on notions of social causation and rank, my research is situated at the intersection of social, psychological, and biological phenomena influencing human life. What causes disease? And if we assume a social dimension to illness causation, what do we mean by social causation of health and illness? Social constructionism, one theory of medical sociology that is used to explain a social basis for disease, relies on the following assumptions. First, the meanings of social reality are not fixed or intrinsic, but are the product of human interaction; they emerge out of the constant flux of social exchange. Second, these meanings are constantly reevaluated in everyday interactions and cannot be taken for granted. Human beings constantly intervene to discuss and change these meanings in a self-reflexive process (Levine 1992).

These social dynamics account also for the construction of illness experience and the assignment of meaning to suffering. Siegrist (2000) differentiated between three types of

possible answers to the question of the social origin of illness experience. Labeling theorists thought that illness, in particular mental illness, is produced by societal reactions to a person exhibiting deviant behavior. The social construct of normality gets validated by assigning a diagnosis to whatever is marginal or outside of consensual norms.

Labeling theorists stressed the danger of social control and the process of stigmatization inherent in valuing one state over another. Every sick person feels that stigma by not fitting the unrealistic norm of, for example, being pain free. Another consequence of this process of labeling and valuation is that many social privileges depend upon being in a condition of functionality and good health, which then automatically excludes sick people from them.

A second type of answers refers to processes of social heritage and biological embedding of early experiences. Transmitted life-style patterns and early health-related socialization and unfavorable circumstances influencing the mother's health during pregnancy are associated with excess risk of certain diseases. "Developmental priming mechanisms" and the socioeconomic and psychosocial environment of childhood are empirically linked to adult health status (Hertzman 1999).

A third paradigm of social causation stresses the amount of exposure to health detrimental risks in the social environment and its counterpart of acquired coping resources. Society determines the health of individuals by exposing them to material (poor housing, air pollution, inappropriate sanitation etc..) and psychosocial stresses. "Poverty not only increases the risk of being exposed to health-adverse conditions, but

also reduces the opportunity of having adequate coping resources at one's disposal" (Siegrist, 2000, 101).

The new "sociosomatic" model proposed by Kleinman (1986, 1995, 1998) strengthens, in comparison to a psychosomatic model¹⁰, more: a) the primacy of social events, conditions and relations; b) the role of social events in producing or alleviating disease states, and c) a view of the self in relation to the social world. Thus in conceiving illness and health as the embodiments of social events and conditions, it integrates the social into psychosomatic thinking. Physiologic states become a metaphor for social processes. Further, his concept of patients' explanatory models moves beyond the cognitive constraints of biomedicine and offers an alternative understanding of the nature of illness. In including lay theories he expands the scope of conceptualization about illness and weakens the monopoly of biomedicine on theories of illness.

Social constructionist analyses challenge the one-sided objectivist and empirical perspective on medicine and the body that dominates medical discourse. They help identifying social dynamics that shape our views and experiences and contribute to discriminating assumptions about social groups. They reflect how values and worldviews of the mainstream culture are translated into a political discourse of power and control over the body. The social constructionist perspective is a first step against values that foster social and health inequalities. In the next sections I will turn my attention towards structural, socio-economic, gender and racial factors that influence health and develop a

¹⁰ See page 57.

comprehensive theory of the social construction of health that incorporates cultural beliefs as well as structural injustices.

Social Gradient in Health

One important new finding is that “there is a social gradient in health and [that] that gradient applies to people who are not poor” (Marmot 1999, 1). Researchers have come up with two alternative explanations for this basic association of social conditions and health. One is that social circumstances influence health (social causation). The other is that adverse health contributes to the shaping of our social lives (social drift or selection) (Adler & Ostrove 1999). Some chronic diseases with early onset (e.g. schizophrenia or juvenile arthritis) have profound effects on the life course of patients and their chances for social achievements. However, these conditions are rare, and cannot account for much of the association between social conditions and health in general populations.

Consequently there is some consensus to endorse the role of the social environment in causing inequalities in health. But what is this social environment? The spectrum of multiple intertwined factors and levels makes it difficult to come up with a coherent definition and useful suggestions for interventions. The factors that have been found to account for the social gradient are many and include individual socioeconomic status across the life cycle, economic policies at the level of communities, trust and social cohesion within communities, equity of income distribution within states or countries, segregation and discrimination of individuals and groups, the subjective experience of one’s social standing, and some particular emotions (e.g. chronic hostility, pessimism, fear). One explanation views the cumulative effect of extensive chronic stressors (e.g.

socioeconomic disadvantages) and the lack of buffering health relevant behaviors (e.g. diet and exercise) to overload one's physiologic coping mechanisms and lead to ill-health (Antonovsky 1979, McEwen & Seeman 1999). Furthermore social capital and cohesion, psychological interpretations of rank differences, and the communities way in dealing with hierarchies and dominance have been shown to influence the level of social anxiety individual experience and the health of the community.

Socioeconomic Factors and Health

Thus, health is a social process, and poverty is only one of the major risk factor for ill-health and early death. Many findings support the idea that the factors that define our social group also directly impact our chances of suffering illness or early death (Henderson et al.,1997). In other words, health is closely related to cultural and social categories like socioeconomic status, gender, race, sexual orientation and age.

For a long time it seemed somehow to be taken for granted that people in poverty had worse health than better off people. Researchers for many years assumed a poverty line below which increasing income would contribute to improved health and above which increasing income would have no further beneficial influence. Only in the mid 1980s did the notion arise that the impact of socioeconomic factors on health was broader and more pervasive than the poverty threshold model suggested. So-called diseases of the affluent (e.g. coronary heart disease) were found to be more frequent among those in lower socioeconomic groups as well. It was not difficult to reason why people suffering from poverty had a greater likelihood of succumbing to diseases associated with unsanitary

conditions, malnutrition, and lack of access to medical care. It was, however, less obvious and more challenging to understand why people in deprivation should have higher rates of coronary heart disease, stroke and many cancers. A second challenge was the finding mentioned earlier, that there is a social gradient in health not limited to the poor but across the whole range of social status. It seemed unlikely that the explanations applied to the health disadvantages of those below the poverty line would explain the health outcome disparities for people in other ranges of social standing. Other psychosocial factors had to be drawn into consideration for describing the links in the chain from social position to ill health. Newer findings from the fields of psychophysiology and animal research led to an expanded conceptualization of stress that incorporated social disadvantages as stressors causing the health outcome gradient.

Socioeconomic Status and Health

A relationship between socioeconomic status (SES) and health has apparently existed for some time. Measuring the height of graveyard obelisks in Glasgow, Davey and colleagues (1992) showed, that between 1800 and 1920, the age at death was significantly older for individuals with taller (more expensive) grave markers. In the last century infant mortality dropped and life expectancy increased to an unprecedented degree. Although all segments of the population have improved health status and life expectancy, in developed countries individuals of lower socioeconomic status have faced higher mortality rates than individuals of higher status (Kitagawa & Hauser, 1973; Anderson & Armstead, 1995; Marmot 1999). These researchers uncovered the fact that as one moves up the SES ladder, morbidity and mortality rates generally decrease. Others

demonstrated that there is at least some evidence that such inequalities in health outcomes have not diminished over time, and may have even increased in recent decades (Townsend, 1988; Drever, Whitehead & Roden 1996). British Census data on mortality rates by social class over the time period 1970 to 1993, for example, show that the magnitude of the social gradient increased for heart disease and suicide.

The SES-health gradient is now seen in mortality rates, life expectancies and a wide range of health problems including heart disease, some cancers, stroke, diabetes, hypertension, infant mortality, arthritis, back ailments, mental illness, kidney diseases and many others (Anderson & Armstead, 1995). This relationship between SES and health begins at the earliest stages of life and has been found in children with the following health problems: lead poisoning, vision problems, otitis media and hearing loss, cytomegalic inclusion disease, iron deficiency anemia, mental retardation, learning disorders, and emotional and behavioral problems.

As I stated above there is evidence that the association of SES and health occurs at every level of social hierarchy, not only for those in poverty. The most striking results linking social status and health come from the Whitehall Study (Marmot, 1986; Marmot, Kogevinas, & Elston, 1987). This population-based longitudinal study followed more than ten thousand British civil servants for nearly two decades. Over a ten-year period, Marmot found that the age-standardized mortality among males aged forty to sixty-four was about three and a half times as high for those in the clerical and manual grades as in the senior administrative grades (Table 1).

Table 1. Age-Adjusted Relative Mortality in Ten Years by Civil Services Grade and Cause of Death (Calculated from logistic equation adjusting for age) (Marmot 1986)

Cause of death	Administrators	Professional & Executive	Clerk	Other
Lung cancer	0.5	1.0	2.2	3.6
Other cancer	0.8	1.0	1.4	1.4
Coronary heart disease	0.5	1.0	1.4	1.7
Cerebrovascular disease	0.3	1.0	1.4	1.7
Chronic bronchitis	0.0	1.0	6.0	7.3
Other respiratory disease	1.1	1.0	2.6	3.1
Gastrointestinal disease	0.0	1.0	1.6	2.8
Genitourinary disease	1.3	1.0	0.7	3.1
Accidents and homicide	0.0	1.0	1.4	1.5
Suicide	0.7	1.0	1.0	1.9
Nonsmoking related causes				
Cancer	0.8	1.0	1.3	1.4
Non-cancer	0.6	1.0	1.5	2.0
All causes	0.6	1.0	1.6	2.1

Grade of employment showed a clear inverse relation with mortality: the lower the grade the higher the risk. Striking was the smooth nature of the relationship. Not only were the men at the bottom at increased risk; but each grade of employment was associated with higher risk than the one above it. And in none of the observed groups were people impoverished or deprived. All were employed, most in office jobs, with low risk from the physical environment. Thus, the usual interpretations of factors associated with low SES (lack of the material conditions of good health and risky health behaviors) could not explain differences in the upper levels of social position. While some of the gradients in mortality were clearly correlated with smoking (high-ranking people rarely smoke, while low-ranking people often do) gradients were also observed in other causes of death

unrelated to smoking. Moreover, the few high-ranking people who did smoke were much less likely to die from smoking related causes. Other 'individual' risk factors also failed to explain the gradient.

Marmot's later studies (Marmot et al. 1991; North et al.1993) similarly showed a gradient in morbidity, as measured by rates of sickness absence, which were at least as steep as the mortality gradient.

The researchers' conclusion was that something correlated with hierarchy per se influenced health. They argued that this factor was operating on all of us, not only on some underprivileged minority, and that its effects were large. Levels of self-actualization and self-esteem, which varied greatly from the top to the bottom of the ranking scale, were discussed as causal factors.

Further controversial explanations are many and cover resource dependent characteristics like wealth, income, and education, access to health care services, and behavioral characteristics like eating or smoking habits, subsumed in health damaging or promoting behaviors.

Another interesting relationship between SES and health is for persons lower in SES to experience more stressful life events and more subjective distress than their higher SES counterparts. Their higher subjective burden is viewed as due to the greater emotional impact of stressors, suggesting that they have greater vulnerability to stress. In Marmot's

study (Marmot & Theorell, 1988) people in all ranks had similarly elevated blood pressure when at work. But the blood pressure of senior administrators dropped much more when they went home. They seemed to be better able to turn off the stress response. This suggested that rank correlated inversely with stress, or with the ability to cope with stress. Knowing that immune status is compromised by stressful events we may infer that this represents a biological pathway through which social status can have generalized health effects.

Other researchers (Karasek & Theorell, 1990) focused on the nature of the work environment and job characteristics. They found a connection between job demand (effort-reward imbalance) and mortality and morbidity. They showed that people in jobs with this specific characteristic and no opportunity for personal growth tend to have higher rates of heart disease and death. In Marmot's Whitehall study, lower-ranked workers more frequently reported that their work was dull and their abilities were underutilized. Such findings suggest, plausibly, that it may be among other things the quality of the social and physical microenvironment that is critical to health.

It is frequently assumed that differences in access to health care, be they geographical or economical, account for SES health gradients. A more equitable distribution of health care coverage is indeed important and a valuable goal, but according to Anderson and Armstead (1995), it will probably not level out the problem. He claims that first, other countries with better coverage have similar disparities; second, the differences are also found in the upper range of the SES hierarchy, where health insurance coverage is more

likely to be the same; and third, SES differences appear in diseases that are treatable and in those that are not. Furthermore, I think there are also subjective reasons why marginalized people tend to avoid primary health care facilities. Underprivileged people might experience the lack of awareness about rank and social factors contributing to health problems as subtle racism. Many may choose, most probably unconsciously, to avoid a renewed traumatic experience, being already in a weak and fearful position because of their illness. A visit to a local 'lay' healer might be more comforting than the confrontation with a hostilely-experienced medical environment, not necessarily an openly hostile institution, but hostile through lack of awareness – like the fact that the majority of primary health care providers are white men. And, as I will show with the results of Antonovsky's research, lack of social status represents in itself a deficit in coping resources.

In conclusion, SES or social status is, in general, a prevailing aspect of health functioning. In addition, the very existence of health inequalities violates many individuals' sense of equity and poses an important challenge to society as a whole. It further appears that equity is the key to the health of nations. Life expectancy tends to be highest in those developed countries where income is distributed most equally, rather than in those which are richest. The more egalitarian the distribution of income, the longer the average life expectancy appears to be among developed countries (Wilkinson 1990). Wilkinson concludes that:

The data seems to be telling us that, among the vast majority of people in the developed world, health is influenced less by the immediate physical effects of

our living conditions than by what those conditions mean in the broader social context.... It looks as if what matters about our physical circumstances is not what they are in themselves, but where they stand in the scale of things in our society....It seems increasingly that what matters now is the way we are led in modern societies to experience our circumstances and the social and behavioral repercussions which that socially constructed experience has. In short, it appears that health is now a psychosocially mediated function of the structure of inequality in society. (409)

If we follow Wilkinson it is inequality or rank disparity per se which is crucial in population health. To improve the health of our communities or the quality of life they offer, one focus of intervention should consequently be the quality of their social construct. Our attention should be directed towards the distribution of power within the community and towards improving the awareness of individual members of the community about rank and privilege.

The Added Effects of Racism

Certain sociodemographic factors amplify the association of SES with health. Racism and sexism directly affect the health of women and nonwhites (Ehrenreich 1986, Manton 1987, Reed 1986, Reddy, Fleming, & Adesso 1992). This section provides an overview of the ways in which race and SES combine to affect health status. It will also consider the ways in which economic discrimination, discrimination in medicine, perception of racial bias, and the stigma of inferiority have pathogenic consequences.

Table 2. Age-adjusted death rates (per 100,000 population) for whites and minority/white ratios for the 10 leading causes of death, United States 1996 (National Center for Health Statistics 1998)

Causes	White (W) (Rate)	Black/W Ratio	AmI/W Ratio	API/W Ratio	Hispanic/W Ratio
All causes	466.8	1.58	0.98	0.59	0.78
1. Heart disease	129.8	1.47	0.78	0.55	0.68
2. Cancer	125.2	1.34	0.68	0.61	0.62
3. Stroke	24.5	1.80	0.86	0.98	0.80
4. Pulmonary disease	21.5	0.83	0.59	0.40	0.41
5. Unintentional injuries	29.9	1.23	1.93	0.54	0.97
6. Flu and pneumonia	12.2	1.45	1.15	0.81	0.80
7. Diabetes	12.0	2.40	2.32	0.73	1.57
8. HIV/AIDS	7.2	5.75	0.58	0.31	2.26
9. Suicide	11.6	0.57	1.12	0.52	0.58
10. Liver cirrhosis	7.3	1.27	2.84	0.36	1.73

In the United States, race and ethnicity predict variations in health with racial classifications that have always had whites at the top, blacks at the bottom, and other groups in between. Because of the largest gap being between blacks and whites I will focus primarily on the differences between these two groups. African Americans have an overall death rate that is 1.6 times higher than that of the white population (Table 2).

Although the overall mortality rate has declined between 1950 and 1995, the above mentioned black/white ratio for all causes of mortality in 1995 is virtually identical to that of 1950. For some causes of death (cancer, diabetes, suicide, cirrhosis of the liver, and homicide) the death rates and the black/white mortality ratios (heart disease, cancer, diabetes, and cirrhosis of the liver) are higher in 1995 than in 1950 (Table 3).

Socioeconomic status accounts for much of the racial differences in health. But when

studying life expectancy, African Americans have lower levels of life expectancy than their white counterparts at every level of income and for both men and women.

Table 3. Mortality rates for blacks and black/white ratios (age-adjusted death rates per 100,000 for the leading causes of death in 1995. (National Center for Health Statistics 1998)

Causes of Death	1950		1995	
	Black Rate	B/W Ratio	Black Rate	B/W Ratio
All causes	1236.7	1.55	765.7	1.58
1. Heart disease	379.6	1.26	198.8	1.49
2. Cancer	129.1	1.04	171.6	1.35
3. Cerebro-vascular disease	150.9	1.81	45.0	1.82
4. Pulmonary disease	—	—	17.6	0.83
5. Unintentional injury	70.9	1.27	37.4	1.25
6. Flu and pneumonia	57.0	2.49	17.8	1.44
7. Diabetes	17.2	1.24	28.5	2.44
8. HIV/AIDS	—	—	51.8	4.67
9. Suicide	4.2	0.36	6.9	0.58
10. Cirrhosis	7.2	0.84	9.9	1.34
11. Homicide	30.5	11.73	33.4	6.07

Furthermore, an excess of black infant mortality, beyond that explained by lower socioeconomic status, shows a racial effect over and above the class effect. Blacks with the highest socioeconomic status (SES) have higher rates of infant mortality than the lowest SES whites. Poor non-Hispanic black children are at the greatest risk of having elevated blood lead levels. Twenty percent of them have high blood lead levels, compared with 8 percent of poor non-Hispanic white and 6 percent of poor Mexican-American children. Generally speaking, the morbidity and mortality rates are higher for

blacks than for whites at most levels of SES, differing most at the low end of SES hierarchy.

One needs, therefore, to look at racism¹¹ for explaining racial inequalities in health above the SES factor. There have been dramatic improvements in the racial climate in the United States in the last 50 years. Nevertheless there is a persistence of stereotypes and prejudices and, most of all, structural racial inequalities. Additionally, race is a determinant factor of SES, and racial differences in SES reflect discriminatory policies of which the single most influential is residential segregation. And the levels of segregation have pretty much remained unchanged in the last 20 years (Williams 1999). Clear relationships have been found between ethnicity, SES, and residential, social, and occupational environments. Demographic research has shown that blacks in larger cities experience an extreme level of residential isolation and segregation from other groups. This is associated with exclusion from amenities, opportunities and resources that affect social and economic well-being. Residential segregation correlates with the concentration of poverty, quality of elementary and high school education, unemployment, rates of marriage, single parent households, and levels of violent crime. Sampson and Wilson (1995) conclude: “The worst urban context in which whites reside is considerably better than the average context of black communities” (112). The Census Bureau’s Survey of 1990 (Bauman 1998) remarks that African Americans were more likely than whites to experience six of nine hardships examined: unable to meet essential expenses, unable to pay for rent or mortgage, unable to pay full utility bill, had utilities shut off, had

¹¹ By racism, I mean an ideology of marginalization that is used to justify unequal treatment (discrimination) of members of groups defined as inferior, by both individuals and societal institutions.

telephone service shut off, and were evicted from apartment or home. This urges me to conclude that structural discrimination against blacks explains much of the described health disparities in blacks and whites. Individual constitutional factors and learned competencies (e.g. genetic phenotype, personal resilience) as well as other environmental elements contribute to the health consequences of socio-economic determinants. An exact estimation of the weight of each component is impossible and constitutes grounds for a highly debated political and academic controversy.

Furthermore exposure to racism and discrimination can also more directly adversely affect health. The stigma of race appears to affect the way that minority group members are treated in the health care system. Two studies (Hannan et al. 1999; Ford, Newman & Deosaransingh 2000) demonstrated that African Americans were less likely than whites to receive bypass surgery when rigorous criteria demonstrated that the procedure was appropriate. Subjective experience of discrimination is also adversely related to both physical and mental health. Studies have found that internalized racism leads to psychological distress, depressive symptoms, substance abuse, and chronic physical health problems (Williams & Chung 1999).

Many concepts have been proposed to explain how ethnic differences are translated through social and somatic pathways into distinct health outcomes. The three most frequently proposed models are: (1) a racial-genetic model; (2) a health behavior/life-style model; and (3) a socioeconomic status model.

All three concepts are limited and fail rigorous scrutiny. First, “race” has been demonstrated to be a useless biological construct. There is too much biological variation in human populations for our racial categories to capture it. There is further more genetic variation within existing racial groups than between them. The diversity in genes within a specific racial group is broad, such that smaller groups than those based on skin color or race are necessary to understand the influence and role of genes (Dressler 1993, 1996, 1998). The American Association of Physical Anthropology (1996) recently stated that “pure races in the sense of genetically homogenous populations do not exist in the human species today, nor is there any evidence that they have ever existed in the past” (p.211).

Second, the behavioral model is also faulty. Studies that controlled for health behavior didn’t cause ethnic disparities to disappear. Controlling for obesity (a composite indicator of an unhealthy diet and low physical activity), for example, did little to reduce ethnic group differences (Heymsfield et al. 1977). The health behavior hypothesis, furthermore, infers that life-style and behavior are individual choices. It becomes the individual’s own fault that he or she chose to engage in that behavior. It ignores social aspects of behavior, their roots in culture, and their contingency with class and other measures of social status (Dressler & Oths, 1997).

Third, the socioeconomic status model implies that socioeconomic processes are equivalent for black Americans and white Americans. Studies of the association between lighter skin color and higher socioeconomic status within the black community demonstrate that it is the majority’s view on skin color and race that influences class

standing and that regarding the question of health disparities race is not confounded by other variables of socioeconomic status (e.g. higher occupational status, income etc.) (Dressler 1991).

In my view, striking racial differences in health and their persistence over time are an expression of ongoing structural and individual racism. Racism is responsible for the development of systems of social policies and practices, as well as individual behaviors, that create racial inequalities. These factors influence health through specific physiological pathways. One useful framework to explain these physiological mechanisms is the concept of allostatic load (see McEwen & Seeman 1999 and my section on rank, stress and coping).

The Added Effects of Sexism

For many decades, being female was considered a disease. Many physicians from the late nineteenth century to the early twentieth century held that woman's normal state was to be sick. Menstruation provided both the evidence and the explanation of this 'physiological' fact. The female reproductive organs, the uterus and the ovaries, were thought to direct the woman's entire personality and be a source of continuous ill-health. The history of the bygone psychiatric disorder hysteria may be one of the best examples of this patriarchal attitude. Freud, in 1896 was the first to recognize the connection between female survivor's mental health problems and their past histories of child sexual abuse, thus explaining the problem of hysteria. This led to his seduction theory. After much uproar by his male contemporaries Freud denounced the seduction theory and

replaced it with the oedipal theory, that viewed incestuous accounts by victims as repressed improper sexual desires. Their association with sexual abuse and trauma was rejected because of the sexist values and beliefs of the time (Masson 1984 & Russel 1986). Nevertheless the habit of aligning women with mentally induced, imagined disease still continues today. CFIDS (chronic fatigue immune dysfunction syndrome) is wrongly profiled to white middle class professional women and linked with some history of mental disturbance, making it the consequence of neurosis – another example of blaming gender for weakening the female body. Additionally it carries the prejudice against strong women and feminism.

Many modern medical textbooks still describe the female reproductive cycle in terms of failure, waste, and loss (Martin 1987). Consequently much of these reproductive processes – especially menstruation, childbirth, and menopause – have been medicalized. Once transformed into pathologies their treatment becomes an obligation authoritatively imposed by male physicians. This explains why some male gynecologists still perceive menopause as a disease, which has to be treated with hormones, regardless of the woman's point of view or debatable evidence for the value of hormone treatment.

In most areas of the world, and in most subgroups that have been studied, women report greater morbidity, illness symptoms, and health service utilization than men. However women have lower rates of mortality and live longer than men. How culture and male socialization impact men's survival is yet unresolved. It has been suggested that learning

to adopt the masculine gender role, which is in itself a product of sexism, is a source of psychosocial stress (Eisler, Skidmore, & Ward. 1988).

And when controlling for pregnancy and other reproductive based services, health care expenditure for men and women resulted in nearly equal levels (Mustard, Kaufert, Kozyrsky, & Mayer 1998). Further, if we consider that women outlive men by many years, equal levels of care receives new proportions; in fact it means that women cost society less health expenditures than men. A major portion of the non-reproductive causes of women's excess morbidity is thought to be emotional distress and depression (Liebenluft 1998)¹². Still many studies often omit mentioning domestic violence, sexual violence, and culturally shaped practices of female genital mutilation as major causes of women's morbidity, disability, and death worldwide.

Probably worldwide, there are striking gender differences in SES. Single mothers are often at the bottom of the SES scale. An epidemiological survey (Kitagawa & Hauser, 1973) showed that between 1960 and 1984 the mortality rate declined more rapidly for the more educated men compared with those who were less educated. In comparison, educational attainment didn't make a difference for women in the same period. Women didn't profit from the positive trend due to better education. Adler and Ostrove conclude that "additional years of education, particularly at the upper level of SES, appear to 'buy' more improvement in health for white men than for white women"¹³ (1999, 10). The

¹² Depression may be viewed as restrained personal power in the context of repressive and patriarchal social structures.

¹³ This difference has also been observed for African-American men and women (Adler, Singer, & Coriell 1999).

authors also state that there is still little understanding of this striking fact of sexism or in general of the interactions between SES and gender (and race/ethnicity).

Returning to the larger issue of the minorities' health situation we see that for instance when we look at cancer "ethnic minorities and the medically underserved have not shared equally in the nation's progress against cancer" (Lovell 1999, A8). A National Research Council report (Haynes & Smedley, 1999) shows that, for example, black men are more likely to develop prostate cancer, Asian Americans are more prone to stomach and liver cancer, and Hispanic and Vietnamese women are more likely to contract cervical cancer than their white counterparts.

Furthermore, although they are less prone to developing breast cancer, black women are more likely to die of the disease than white women. Native Americans are less likely to survive cancer than any other group in the U.S. Heredity accounts for about 5 percent of the higher cancer rate in minorities. But differences in environment, culture, diets and socioeconomic class between minorities and whites are likely responsible for the remaining 95 percent. Again, as we have seen with the results of the Whitehall Study, we might also consider the effect of rank per se.

In addition to the direct effects of racism and sexism, there are added burdens for nonwhite persons and women who go into a medical care system in which the majority of primary care givers are white men, and in which women and nonwhites are kept to the 'lower rungs' of the medical hierarchy (Weaver, 1978).

From the observations made until now we can conclude that the perpetuation of values that keep men central and maintain structures of patriarchal domination and racial violence on the micro and macro levels – in individual relationships and discriminatory policies – influence health status, social roles, culturally patterned behavior and access to health care. Gender combines with economic disadvantage and racism to increase health risks among some groups. Sexism is also affecting men. Socialization into hierarchical values, sexist beliefs and roles (e.g. that men are rational and therefore superior, that men have to be providers etc...) most probably also accounts for men's disadvantage in survival and early death.

Stress, Coping, and SES

Keys to understanding the biological pathways through which environmental and social factors have their effects may be found in the ways in which humans respond to stress. The body's reaction to stress is determined by the interplay of several physiological systems (immune, neural, and endocrine). Recent advances in these different fields have led to a clearer understanding of the connections among these systems, revealing possible mechanisms by which the host response to environmental and social stresses is mediated.

A resulting hypothesis is that SES may exert some of its effects by increasing the likelihood of exposure to stressors that are due to minority status, prejudice, racism, discrimination, unemployment, low income, and environments marked by residential segregation, and poorer living conditions. In other words, SES is correlated with

exposure to stressful environments and conditions that contribute to chronic stress, which in turn affects health.

The following studies furnish the rationale for the relationship between stress and disease and the physiology involved. Recent reports, for example, provide convincing evidence that chronic stress (1 month or longer) increases susceptibility to common cold (Cohen et al., 1998). Chronic stress generally refers to stress that lasts for a long time because it occurs repeatedly or continuously and to acute severe threats that one cannot easily adapt to or overcome and which effects persist beyond the initiating event. It also refers to ambient or background stress due to ongoing environmental stressors. Chronic social hardships and degrading experiences account from a social constructivist perspective for much of minority people's chronic stress burden.

Other studies show that traumatic experiences (abuse histories, lifetime traumas, turmoil in childhood family, and recent stressful life events) independently contribute to poor health outcome (Leserman, Li, Hu, & Drossman, 1998). There is evidence that prenatal and early child development – more specifically the psychosocial and socioeconomic environment of the unborn and young child – are linked to adult health status. Specific biological factors (e.g. low birth weight) and developmental opportunities have been shown to have lifelong impact on health and well-being regardless of subsequent life circumstances. History of sexual and physical abuse in childhood is a risk factor not only for posttraumatic stress disorder but also for hippocampal atrophy and cognitive impairment in adulthood (Bremner et al. 1997). It is also linked to substantial increases in

substance abuse, depression, and suicide, as well as sexual promiscuity and an increased incidence of heart disease, cancer, chronic lung disease, extreme obesity, skeletal fractures, and liver disease (Felliti et al 1998).

Life course factors interact with contemporary circumstances on a moment-by-moment basis and over time. The systematic differences in the quality of environment and life courses shape the sculpting and neurochemistry of the central nervous system. Animal studies have shown that one's immune system can be conditioned by outer events (Ader & Cohen, 1975). They convincingly demonstrate that how one feels about the world can directly influence the competence of one's immune system. Moreover, the observation that the immune system can be conditioned implies that these effects can endure beyond the precipitating event. The nervous system which interprets the environment influences the long term functions of the immune, hormone, and clotting systems.

The two main organ sites for this "biological embedding" (Hertzman 1999) of human experience are the autonomic nervous system and the hypothalamic-pituitary-adrenal axis (HPA). They mediate the adaptive response to stress by first initiating an increase in circulating catecholamines and glucocorticoids that alter the structure and function of a variety of cells and tissues. For each organ system of the body these stress mediators have both short term adaptive and protective and long term damaging effects if the stress response is overextended. Examples of adaptive reactions are: adjustment of heart rate and blood pressure, increased retention of memories of emotionally charged events, and the movement of immune cells to organs and tissues where they are needed to fight an

infection or another challenge. Examples of long term damaging reactions are: persistent high blood pressure and increased risk of atherosclerosis, increased risk of Type II diabetes, cognitive dysfunction, and increased risks of autoimmune and inflammatory disorders.

Two new terms have been used to describe these physiological stress responses: “allostasis” for the adaptive maintenance of stability through change and “allostatic load” for the wear and tear that the body experiences due to over stimulation of allostatic cycles (McEwen & Seeman 1999). Allostatic load represents the biological signature of cumulative psychosocial adversity. Various physiologic parameters (e.g. systolic and diastolic blood pressure, waist-hip-ratio, serum HDL and total cholesterol, overnight urinary cortisol excretion) have been investigated as measures of allostatic load. Sapolsky (1995) studied stress dynamics in a free-ranging baboon population by using one measure of allostatic load namely basal cortisol levels (with lower basal cortisol levels being healthier in terms of long term well-being). And, with a knowledge of the life circumstances of each baboon, he was able to define four factors that lead to variation of allostatic load in the wild.

1. Rank – Higher rank means lower basal cortisol.
2. Social stability and its enforcement – When baboon societies are stable, those in dominant positions have lower basal cortisol levels than they do during periods of instability. When stability is imposed by high levels of violence and coercion, the non-

dominant baboons have higher cortisol levels than when it is maintained with low levels of violence and coercion.

3. The experience of rank, stability, and enforcement – In periods of social instability when dominant baboons fight for supremacy, some non-dominant baboons will experience decrease in basal cortisol levels if they are left alone. Other low-ranked baboons react with higher levels if they become victim of displaced aggression from the losers in the fight of dominance.
4. Personality and coping styles – Individual characteristics were shown to matter too. The ability to distinguish seriously threatening situations from ruses, to be able to develop friendships and alliances lead to decreased cortisol levels. These individual characteristics were related to supportive upbringing and mentorship.

Elaborate studies in captive *Cynomolgus* monkeys showed that relative social status of individuals was a major behavioral factor predicting susceptibility to atherosclerosis through activation of the HPA and sympathetic-adrenomedullary systems (Kaplan & Manuck 1999). Dominant male animals housed in reorganized (unstable) social groups developed about twice the coronary atherosclerosis seen among animals in stable environments. This effect was reversible in study males who received propranolol, a β -adrenoreceptor antagonist that blocks some of the sympathoadrenal activation.

Subordinate social status increased atherosclerosis in female monkeys through stress-induced ovarian dysfunction which was reversible when treated with an oral contraceptive.

Higher allostatic load scores in humans were also found to predict increased risks of cardiovascular disease as well as increased risks for decline in physical and cognitive functioning and for mortality (Seeman, Singer, Rowe, Horwitz, & McEwen 1997). Last a study of more than a thousand male Vietnam veterans 20 years after combat exposure suggests a strong link between severe stress exposures and a broad spectrum of human diseases (circulatory, digestive, musculoskeletal, endocrine-nutritional-metabolic, nervous system, respiratory, and nonsexually transmitted infectious diseases) (Boscarino, 1997).

Social ordering in human societies is, as we have seen, similarly associated with gradients of disease. Although the causes of these gradients of health are very complex, they reflect the cumulative burden of coping with limited resources and negative life events. They also mirror the allostatic load that these burdens place on the physiologic functions of the human body involved in coping and adaptation. As I have mentioned earlier, egalitarian communities, states, and countries with income differences that are small tend to be healthier (Wilkinson 1999). Characteristics of social cohesiveness, social trust, active community participation, or in general the quality of social relations correlate with income distribution and influence the overall health status of the community (Kawachi 1999). Social status disparities, and the way the communities deal with and respond to them – in the form of hierarchical power relations or some forms of egalitarian cooperation – have a huge impact on health. The way individuals, communities, states, and nations handle rank and hierarchy directly reflects the quality of their social relations and health (Williams, Feaganes, & Barefoot 1995; Putnam, Leonradi, & Nanetti 1993;

Kawachi, Kennedy, Lochner & Protherow-Smith 1997). Explanations draw on feelings of social anxiety and the accompanying state of physiological arousal – the stress response. The effects of relative poverty or low rank and the affronts to one's dignity it represents may result in violence. The feelings of shame and humiliation that ensue from it are believed to be psychological pathways that are subject to social anxiety and stress. In conclusion processes of harmful social comparisons and psychological perceptions triggered by relative deprivation explain the importance of social status in its effect on health (Kawachi, Kennedy, & Wilkinson 1999).

These findings suggest that the experience of hierarchy, social cohesion or lack of social solidarity, violence and conflict resolution have physiological consequences that over time can affect health and well being of communities. They demonstrate potential biological pathways through which nervous system sensations – such as an individual's response to the social environment – could influence the host defense system and the expression of a number of different diseases.

Other researchers were inspired by the fact that the consequences of inherent stressful situations were less adverse than they expected. An important question became why the emotional problems and physiological effects were not much greater. How can we know if a particular event or experience is in fact a strainful stress? Stress theories claim that the greater the cumulative adversity relative to advantage over the life course, the higher the probability of later-life chronic disease, disability, and mortality. In contrast, low cumulative adversity relative to advantage should be associated with high well-being and

low probability of chronic disease. The question that arises is of how persons at low levels in these hierarchies stay resilient in face of adversity and nevertheless have positive health outcomes? For many people life disadvantage and adversity need not lead to negative health outcomes. Many researchers reoriented their focus therefore on the coping mechanisms. Syme (1991) demonstrated that a perceived sense of control is positively related to better health outcomes. Studies focusing on health and resilience in children showed resilient children to adapt far better to chronic adversity and to recover more successfully from trauma (Masten, Best, & Garmezy, 1990). Resiliency was related to having a positive relationship with a competent adult, to being good learners and problem solvers, to being engaging with other people, and to having areas of competence and perceived efficacy valued by self and society. Another study from Vietnam veterans demonstrated the role of several post-trauma resilience factors (hardiness, postwar social support, and additional stressful life events) in moderating PTSD symptomatology (King, King, Fairbank, Keane & Adams, 1998). Components of cumulative advantage or coping resources may come in the form of, for example, positive life circumstances in childhood and over one's personal life course, personal capacities and abilities, the successful realization of expected life transitions (e.g. job transitions, marriage), or having positive evaluations of one's life.

Coping mechanisms, styles or strategies that influence the effect of stress vary among individuals. What is assumed to be a stress may in fact be much less stressful in some persons or situations than in others. The death of a spouse might be for one person a highly stressful life event. For an abused wife it might be a blessed relief from the stress

of the marriage. Even two people who lose spouses and experience it as a very distressing event might have very different resources for coping. There is, therefore, no independent measure for the external stress. What counts is only the subjective experience of the event and the strain response it triggers. This depends, as we will see later, on one's social position also. What these results unambiguously show is that sensory impressions processed through the nervous system (perceptions) have biological effects that can be significant for health or even survival. But the effects of these impressions may depend critically on the situation and the person involved. This may account for the observation that there is considerable variation in health outcomes at all levels of the SES ladder.

Studying the pathways of resilient persons – those who do well in the face of persistent adversity – led Aaron Antonovsky (1971, 1979, 1986, 1987, 1993), an Israeli sociologist, to formulate the theory of positive human health he called “Salutogenesis,” the generation and maintenance of health.

Writing a sociological study about menopause and its effect on health, he was drawn to a subgroup of women, who had survived the Holocaust and had resettled in Israel. From these women who had been subjected to severe trauma, 29% stated they were in relatively good physical and mental health. In comparison to the entire group their health status was as expected much more impaired. Nevertheless Antonovsky wondered how still one third of these women, in spite of the most difficult life circumstances, could see themselves in relatively good health. Given the ubiquity of pathogens – microbiological, chemical, physical, psychosocial, social, and cultural – it seemed to him self-evident that

everyone should succumb to this bombardment and constantly be dying. Henceforth, his research focus became: how do some people manage to stay reasonably healthy? He therefore oriented his research towards coping-strategies and factors, which helped people to be more resistant to illness. The handicaps of the more prevalent biomedical approach centered on pathology and disease causation he thought were: a) the reduction of a biological concept of disease, which disregards the subjective experience of the ill person; b) being bound to an etiologic thinking about disease; c) the ‘Magic bullet’ treatment approach which conceives one cure to one disease and resists the notion of multiple causation; and d) the dichotomous differentiation of disease from no disease which sees the individual as sick or well. In contrast, the advantages of a more salutogenic approach were: a) the notion of a multidimensional health-illness continuum between two poles; b) the valuation of everything of import about people who are ill; c) the openness to multiple causation; and d) the interest in generalized factors relevant to all diseases.

The conventional pathogenic approach relies, as we have seen, on different conceptions of normality. On an organic level disease is either present or absent; from a statistical point of view there is a modal distribution of disease in a given population; from a social sense normality is defined by values and by notions of how things have to be. In comparison, ‘Salutogenesis’ doesn’t support the idea of normality. Rather it looks at factors, which push us either towards the health-ease end of the continuum or towards the opposite end. It looks for particular patterns of life experiences that engender General Resistance Resources (GRR) or Deficits (GRD).

Antonovsky (1987) discussed in the context of his salutogenesis theory a global orientation and feeling of confidence that life's challenges are predictable, explicable, and meaningful; he called it "Sense of Coherence (SOC)." The ability to give one's life meaning in the sense of a motivating force seemed to be the most powerful component of a strong SOC and had the most beneficial effect on health matters. For Antonovsky (1979, 1986) healthier people not only care about the kind of world in which they live, but also feel that they can understand what is happening around them. Such people do not delude themselves that they live in a perfect world; they have maintained or promoted the desire to make sense of life. Sense of coherence is, in this sense, analogous to meaningfulness in life (Mirowsky & Ross 1989; Seeman 1959, 1991), and involves appraisals that society is discernible, sensible, and predictable. Antonovsky further expressively included a spiritual orientation and participation in a community in his SOC concept. He maintained that the sense of coherence is formed in early childhood and stays constant after the age of 10. He described it as a personality disposition (Antonovsky, Sagy, Adler, & Visel 1990; Sagy, Antonovsky, & Adler 1990) which, when once developed, was relatively resistant to change. Some more recent studies showed that there is no strong relationship between childhood conditions and SOC in adulthood and conceptualized it more as an ongoing reshaping of a coherent worldview and identity depending on the person's life experiences and her interaction with her environment (Lundberg, 1997; Höfer 2000). Schnyder, Büchi, Sensky, and Klaghofer (2000), in their study of severely injured accident victims and patients suffering from rheumatoid arthritis, found SOC to be a relatively stable trait which, however, could be challenged by the experience of traumatic life events such as life-threatening accidents.

Antonovsky found out that people with a high sense of coherence manage life better, are more resistant to any kind of stress, and stay healthier. He related these ideas explicitly to social class and to societal and historical conditions. He stressed the importance of social values in tension or stress management and thought, that the person's role in society has an influence on her position on the continuum. Dressler (1982, 1985) showed that the stress process varies according to class. The perception of stress or the degree of strain resulting from different stresses changes depending on the individual's place on the rank ladder. Antonovsky (1987) established a connection between the development of a strong sense of coherence and the individual's social standing. He suggested that the ability to act and a high number of decision making options was a characteristic of social groups that gave the opportunity for developing a high SOC's. He also thought these social groups to be dominated by individuals who typically had high levels of education and demanding professional positions in which decisions had to be made routinely. This theory got confirmed in a study from Finland (Kaplan 1995) in which SOC-scores increased with increasing income levels. In another epidemiological survey (Lundberg 1997) the probability to have a low SOC was 3.9 times higher in unskilled workers than in higher grade professionals.

The relationship between SOC, quality of life and health has been widely studied and the SOC scale has proven to be highly reliable (Antonovsky, 1993). Sek and Pasikowski (1998) demonstrated a high correlation between SOC and the perceived quality of life at present. They also found out that a high SOC explained the paradox of high subjective quality of life despite unfavorable life conditions (paradox of satisfaction) and that a low

SOC was correlated with low quality of life despite favorable life circumstances ('unjustified' discontent). Sense of coherence is believed to play an important role in maintaining and restoring health (for an overview see: Bengel, Strittmatter, & Wilmann, 1998). Psychologically healthier individuals supposedly see their personal lives as meaningful and coherent (Ryff 1989). The sense of personal coherence, according to Antonovsky (1994), may therefore be a marker of health: individuals who have coherence attempt to maintain coherence when faced with unpredictable and traumatic life events.

Because Antonovsky thought that the sense of coherence is constant over time and not modifiable, there are only few studies which examine whether this sense of coherence can be influenced through psychotherapeutic measures. Sack, Kunsebeck, and Lamprecht (1997) described a significant increase of SOC in the course of an 8 to 12 week inpatient psychosomatic treatment. Besides an overall slight increase, a greater augmentation was measured in two patients who had fallen in love. Love seemed meaningful in promoting "Salutogenesis", as well as the experience of a loving community. Hauser (2001) studied the effectiveness of a structured psychotherapeutic intervention in the treatment of heroin addiction. He demonstrated a mean significant increase of 7.4 points in SOC after a brief intervention that was aimed at helping the subjects to find meaning in their altered state experience.

Social Psychology of Perceived Rank

Personality traits (e.g. altruism) have been found to be related to health outcomes in a female HIV population (Millner 1998) and to modulate rank/endocrine relations in non-human primates (Sapolsky 1999). Conceptions of self influence the individual's perception of social and cultural processes that may subject him or her to stress and ill-health. Positive and negative self-concepts have been studied in their relationship to child and adolescent behavior (O'Dea & Abraham 1999), to body weight (Davison & Birch 2001; Schmidt & Steins 2000), and to other health-related behaviors (Mahoney 2000). Measures of acculturation, the preservation of ethnic values, and independent or interdependent self-construals have been related to the development of depressive symptoms in Korean Americans (Bae 1999) and mental health in East Asian immigrants (Barry 2000).

I covered the social dynamics of marginalization and the biopsychosocial effects of discrimination and oppression through group biases, stereotypes, and community policies and more specifically their influence on health (for review, see Clark, Anderson, & Williams, 1999). On the other hand, the relationship between individual and collective self-esteem, and the role of culturally shared meanings and values in affecting the individuals' well-being, are dynamics and forces we don't fully understand yet. I believe that rank is central to these interactions and at the core of many disease processes. Process Work's differentiated concept of rank (see previous chapter) will help to link socio-cultural variables to psychological and physical well-being. It might also help explain intergroup differences in health outcomes.

The effect of these cultural and collective processes on the individual is very complex and constitutes one central research focus of social psychology. It centers on the notion that the individual self (James' empirical self or 'me') is shaped by social forces of culture and society as well as social microenvironments. It culminates in the idea that a sense of self exists only in response to a social world. Social identity theory (for reviews, see Tajfel, 1978, 1981, 1982, 1984) asserts that through viewing oneself as a member of a social group, and through ingroup favoritism or outgroup devaluation, one maintains and enhances self-esteem. Self-categorization theory (Turner, 1985) proposes that the degree to which the individual self ('I') and the social self ('we') becomes more salient depends on the context or situation. For example, when we take any exam our personal abilities are important. In contrast, when we attend a game of our favorite basketball team our group identification will much likely prevail over our personal identity.

The symbolic interactionist theorists (Cooley, 1902 and Mead, 1934) argued that the self is a social construct and that we develop our sense of who we are from our observation and interpretation of the responses we receive from others. Symbolic interaction assumes that your perceptions of how others view you influence your self-perception. One's sense of who one is gets developed by the interaction of one's natural impulses and how one interprets and internalizes one's interaction with the environment. Our behavior and sense of self is fashioned by our interpretation of the gestures, actions and values of others and what we believe they mean. Our personal history and our experience of society's values shape our interpretation of the world and our behavior. The 'social reality' of a stereotype of black inferiority, for example, gets created if enough people are convinced through

interaction with one another that this is “real,” and then it becomes individual reality as well. Thus the process of conformity to mainstream values is reflected in the outer world but also in our inner world. The social dynamics of the outer world get internalized and are mirrored in the way we relate to and perceive ourselves. From that perspective, a person who is stigmatized, besides suffering from the institutional disadvantages (e.g. reduced access to goods, services and opportunities) tends to internalize the negative images and stereotypes, resulting in low self-esteem, stress, and impaired psychological and physical well-being. The dominant culture’s values about race, gender, sexual orientation, class, age, nationality, health etc. affect our perception of ourselves and others. We all incorporate cultural values, but minority people internalize devaluing collective stereotypes into their own sense of self. To achieve a positive self-image they have to separate their personal identity from the collective minority identity. This tension surely adds to other structural factors like barriers to equal educational opportunities, job discrimination, housing options and unequal access to quality services. On the other side one’s potential strength to surpass devaluing cultural values may influence, depending, as we will see, on one’s construct of self, one’s self-perception in a positive way and add to a strong sense of coherence.

Some studies of African-Americans’ self-esteem, for example, show no difference in comparison to that of Americans from European descent (Porter & Washington, 1979). Equally no differences in self-esteem are shown in studies comparing men and women (Maccoby & Jacklin, 1974), and obese and non-obese people (Friedman & Brownell, 1995). The within group variability in self-esteem depending on other areas of socio-

cultural influence (e.g. gender, age, socio-economic status) may explain this somehow surprising failure to find low self-esteem among the stigmatized. In other words, one area of high rank may compensate the effect of low rank and marginalization in another area. Furthermore attributing negative feedback to prejudice against one's group may actually protect self-esteem (Crocker, 1999). Other studies have shown that the effects of stigma on the self are highly dependent on the situation and context. Perceived controllability over a specific health behavior influences the effect the sequels will have on one's self-esteem (e.g. eating habits in overweight people) (Crocker, 1999). Thus to understand the consequences of membership in a devalued or low-status group, we must not only understand the collective representations or culturally shared values the individuals carry. But we also must understand how individuals or groups learn to deal with and confront oppression, and how through that they might gain personal coping strength. And third we must understand how specific features of the situation influence the relevance of perceived collective values.

From an interactionist perspective, the perception of stress is central in understanding the impact of the stress process. The meanings that individuals attach to the social conditions are what determines if they are a source of distress. Stress is viewed as a complex multidimensional process and it is the individual's perception of the situation that mediates the relationship between social conditions and their outcomes.

The concept of interdependent or dependent self-construals (Markus & Kitayama 1991, 1994) is theoretically distinct from group-derived identity theories. The individual notion

of self in relation to others differs from one individual to another and between groups and cultures. Individuals in different cultures have different concepts of the self, of others, and of the relationship between or interdependence of the two. These culturally shared ideas of the self are pervasive and held in place by main-stream language, cultural or social practices of daily life, by the laws, the media, and by social institutions. They influence, and in many cases determine, the very nature of individual experience. Most white middle-class men with a Western European ethnic background share a concept of self that is bounded, autonomous, and separate from the social context. Many people from other cultures, like the Japanese or other Asian cultures, as well as African and Latin-American cultures and marginalized cultures (e.g. women, gay and lesbians, members of non-dominant ethnic groups, the poor, the sick, and the elderly) share a different view of the self. For them the self is more social, an integral part of the collective, not separate from it. The self becomes whole in relationship to others and is more connected and less differentiated from others. Individuals with independent self-concepts tend to emphasize individualistic aspects of the self (e.g. autonomy, personal achievements) whereas individuals with interdependent self-concepts tend to emphasize collective aspects of the self (e.g. harmonious relationships with ingroup members).

Social psychological conceptions of self and of one's self in society differ strongly. What constitutes a positive view of self depends on one's concept of self and its cultural integration. For individuals and groups who value an independent self, self-esteem will require asserting oneself and confirming one's inner attributes. The motive to maintain a positive view of the self may take a different form, for those with interdependent selves.

Belonging, fitting in, promoting others' goals, and maintaining harmony will be more important for self-esteem and self-concept than self-realization.

There is some growing evidence that these independent (individualist) and interdependent (collectivist) self-perceptions are not only culture-specific phenomena, but rather that they can coexist in individuals aside from culture (Singelis, Bond, Sharkey, and Lai, 1999). Both views of the self can be separate or jointly present in one individual. The relative importance that we accord to others depending on our self-perception has a wide range of psychological implications. Self-esteem is, for example, related to those different conceptions of self. An interdependent self-esteem might rely less on personal attributes and achievement but more on the worth of harmonious relationships or family and ancestral ties. Our self-perception and values will also influence the emotional impact of one's social status. The experience of exclusion from social bonds because of one's nonconformity by way of inappropriate emotional states or differing sexual orientation may have a greater impact for someone with a predominant interdependent self construal than the experience of limitations because of low socio-economic status. Someone with a dominating independent self concept will probably be more affected by experiences that transgress her individual choices and goals. Much of the research on stress, vulnerability and coping doesn't sufficiently address the complexities of culture as for example one's construct of self. These self-construals will mediate the effects of perceived group status on self-esteem and psychological well-being (e.g. the self-esteem of an individual with an independent self-concept will be less reliant on the outer acceptance of his group than the self-esteem of someone with an interdependent self

concept) and co-shape one's perception of personal rank and power. We might also consider that esteeming the self may be primarily a Western phenomenon, and the concept of self-esteem should perhaps be extended to self-satisfaction, or with another term that reflects the value of interdependent self better.

The self-concept as personal identity delineates a person's implicit definition of his or her own personality and stresses the distinguishing and individual aspects of the self. The concepts of a social self focus on the aspect of a person's self-concept based on group memberships; it is a person's definition of self in terms of some social group membership and its associated values. Positive social identity as a function of group membership may reflect finding one's place in the social world and manifest a meaningful human experience.

Role theories and concepts delineate the strains and incongruities between personal and social expectations (Biddle 1986; Heiss 1981) or focus on the ways in which people manage the incongruity between private and public life and images (Goffman 1959; Shaw & Costanzo 1982). Health and well-being are primarily considered an individual phenomenon. But individuals are embedded in social structures and communities, and face countless social tasks and challenges that arise from their membership in specific social groups. Social integration and marginality reflect one aspect of the quality of one's relationship to society and community. Membership in different social groups is more or less valued and respected by social norms. Some of these values and beliefs are not very integrative and open to individual and group diversity. Thus, social integration can be

ambiguous depending on the values that are attached to it. For some it will be beneficial adding to their lives a sense of belonging, safety and trust. For others it will be associated with assimilation with oppressive values and norms. Nevertheless, I assume that, in general, cultural estrangement and social isolation reflect a strain that has a detrimental effect on an individual's health.

These various theories are useful in understanding how individuals respond to social forces like marginalization and oppression. Exposure to discrimination and oppression is stressful and influences our psychological and physical well-being. The social stress resulting from everyday experience of systematic marginalization and oppression by the dominant culture's beliefs, norms and values is detrimental for our health. The biases and stereotypes held by a dominant group and reinforced by political, social, and economic power result in racism, sexism, ageism, and healthism. People from ethnic and nonethnic minority cultures (e.g. African American, women, older people, people with disabilities, and sexual minorities) experience what Grace (1998) called "mundane extreme environmental stress (M.E.E.S.)," mundane because these micro-aggressions or hassles are common and part of the day-to-day experience; and extreme because they have a harsh impact on the psyche, world view, and health of minority people and their families. They form what Pearlin (1996) called chronic stressors. He differentiated between ambient strains that arise from person-environment interactions, role tensions from interpersonal relationships, and strains that result from ordinary circumstances of daily life. They are significant but affect people differently depending on an individual's access to and use of adaptive resources. One's sense of coherence or psychological and

transpersonal rank, the meaning we assign to problematic circumstances, our coping repertoires, our social support, as well as our individual historic and social conditions may account for the variability of the impact of the stress experience.

From the perspective of social action theory (Merton 1938, Weber 1978) conflicts and pressure result from a mismatch between society's structure of opportunities or constraints, and socially patterned individual aspirations and needs. Historical and sociocultural change occurring at a macro level is translated into stress on the individual, and the individual's response to these stresses can lead ultimately to impaired health and well-being. The biological vulnerability of the individual, in response to external strains, is dependent on her psychosocial environment. In other words, the impact of a particular event will vary depending upon its meaning to the person experiencing it. Since meaning is essentially defined at the subjective level of each individual life, the impact of an event will derive from its overall specific position within the person's life. The study of objective variables of social status will therefore miss important characteristics of the relationship between stress and disease, and new measures of subjective social status need to be considered.

One interesting question is which part of the experience is affecting our resilience or sense of coherence. Is it our subjective experience of our own values or the perceived societal values? Or is it the tension between both value systems? A person with an interdependent notion of self who tries to correspond to social values might experience less stress than a person with a high independent self concept and pride, who will keep

her own values high and experience more tension because of the discrepancy with social values. From a Western individualistic point of view one might think that individual strength and pride will have a beneficial effect on the SOC and, on the other hand, that adaptation and assimilation to devaluating or even racist viewpoints will more often weaken the SOC. Durkheim's (1952) sociological theory differentiated between those aspects of society concerned with regimentation (social regulation) and those concerned with integration (social cohesiveness and supportiveness). Dressler's hypothesis (1985) is that integration has a protective value and that, in contrast, the repressive component associated with regulation is pathogenic. He found that in some black communities greater "support" from the extended kin network was associated with a larger number of mental health symptoms for younger women. The "support" received from the extended family represented not real help, but rather the imposition of controls and burdensome obligations. I assume that the above mentioned concept of varying independent/interdependent dual self-constructs might also help to differentiate the extent of impact social circumstances (like social support) have.

Perceived discrimination is a potential source of stress that affects everyone's psychological and physical well-being, but the more marginal you feel in respect to society the bigger the burden is of added stressors due to unfair treatment. Numerous factors will influence the relationship between exposure to environmental stimuli and health outcome. They do that in shaping our coping resources and in affecting our experience of them as well as in influencing directly the perception of the discriminatory stressors. Constitutional, sociodemographic, psychological, and behavioral factors

participate in establishing and influencing our various dimensions of rank that will constitute, in my point of view, our central asset for coping with outer oppression. This more or less conscious sense of rank and empowerment affects also directly our perception of outer stress or demands. Lazarus and Folkman (1984) suggested that it is both one's evaluation of the seriousness of a specific event and one's coping responses – which are directly influenced by our overall rank – that determine whether a stress response will ensue. That is, our subjective experience of demands, in the context of our social status, is more important than the objective size of the demand. The perception of one's group status and one's self construals participate also in that complex interaction and may play a role in the cultural diversity of stress experience. The whole, partially conscious inner process, which contains the overall experience of these social dynamics is embedded in the field of culturally shared meanings and representations. They constitute forces we are constantly subdued by; we can't avoid them. On the other side the more awareness we have about these dynamics the more we will be able to detach from them and gain personal power.

My conclusion is that rank can be seen from an objective point of view, like degree of education or annual income, and from a subjective perspective. Our experience of distress relies, as we have seen, less on objective criteria than on the subjective feelings the different circumstances create in us. They will always be influenced by our perception of our overall life situation and therefore co-created by many single experiences.

Rank, Stress and Health

I am proposing that the sum of stressors experienced contributes to persistent background stress that characterizes people's daily lives and affects how people respond to new stressors or how quickly adaptation is achieved. Excess chronic stress burden may interfere with health maintenance, affect response to acute stressors, and influence survival and well being.

Let me exemplify my theoretical concepts with a story I heard. A Hispanic female lawyer of lower socio-economic status was hired by an upper class and dominantly white law firm in Washington DC. She was chosen as a member of a minority group (a kind of affirmative action). The mere fact of the context of her work situation made her sick. She couldn't cope with the daily tension of the situation. Because of her education and her pride in her roots, she was able to make the choice to leave the unhealthy situation and got better. Another person with fewer resources or more obligations might end up staying in a similar situation and really become ill, tension turning into stress leading to illness. The same woman told me that she used to be labeled 'crazy' by her family because of her extreme ideas, like wanting to go to law school. Her family of origin, due to lack of pride because of racism and the social context of the time, with less awareness about diversity and minority issues, put a lot of pressure on her. She managed to hold the pressure at bay, and to fight against the disempowering values. I suppose that she escaped with more personal strength and a higher SOC. The fight might have cost her a lot and caused her lot of pain, but the fact that she came out of it successfully gave her personal power. In process-oriented words, she gained psychological (personal) and spiritual (transpersonal)

rank. If she had failed to cope she might have developed low self-esteem, doubts about her abilities to successfully meet the needs and expectations of life and therefore develop low SOC.

I once met two people with similar health problems; they both suffered from an autoimmune disease. One was, from a conventional point of view, a successful young white man, the other a black American single mother. The man had been able to overcome his condition through diet and exercise; the woman was still suffering from a lot of symptoms and was still engaged in risky health behaviors, for example, not following a healthy diet.

I am aware that this comparison may be seen to carry a judgment. Precisely for that reason, I asked myself how her so-called unhealthy behavior was related to her position in society and her everyday experience as a black woman and single parent? How is the context of her life situation connected to her ability to adapt to coping behaviors? Or are the very concepts of a healthy diet and the benefit of exercise, which of course may be beneficial for one's health, not also in themselves representative of a dominant white culture and therefore difficult to follow for a person from a minority group? Besides, we have to consider the question of whether today's behavioral coping concepts constitute the only answer to this very complex matter.

Research (e.g. Anderson & Armstead, 1995) has clearly demonstrated that lower socio-economic-status (SES) correlates with the performance of health damaging behaviors

(increase in smoking, decrease in physical activity, increased consumption of high-fat diets, and decreased knowledge about health). Other studies have shown that blacks with lower SES have a higher risk profile than other groups. Hostility scores were higher for nonwhites (who in the study were predominantly black) compared with whites at most levels of SES. In general blacks with low SES reported more stress in their lives than did whites with low SES. Epidemiological studies have documented an especially high prevalence of smoking among low-income blacks, who are at the greatest risk for lung cancer and heart disease. Finally a recent study found SES to be inversely associated with reactivity to a stressful interview among black women but not among white women.

Despite substantial research that relates objective indicators of socioeconomic status (SES) to health there is limited work on subjective experience of social status and health. Most previous research on subjective status examined determinants of class identification and their association with political attitudes and behaviors (Cantril, 1943; Centers, 1949; Jackman & Jackman, 1973; Kluegel, Singleton & Starnes, 1977). Two more recent studies explored the correlation between subjective class identification and objective class location and socioeconomic factors (Baxter, 1994; Ekehammar, Sidanius, & Nilsson, 1987). Psychological variables related to perceptions of stress and adversity have been discussed to mediate the impact of SES on health (Taylor & Seeman, 1999). Socio-emotional distress, pessimism, and sense of control – for example, some people's experienced imbalance between the demands life makes upon them and the amount of room they have for decision-making and control (job-strain-model) – have been linked to both SES and worse health outcomes (Adler et al., 1999; Cohen, Kaplan, & Salonen,

1999; Taylor & Seeman, 1999). Adler, Epel, Castellazzo, & Ickovics (2000), using a simple drawing of a social ladder on which respondents had to place themselves, showed that their measure of subjective social status was more consistently and strongly related to psychological functioning and health-related factors (self-rated health, heart rate, sleep latency, body fat distribution, and cortisol habituation to repeated stress) than objective indicators of social status. The authors' conclusion was that psychological perceptions of social status may be an independent contributor to the SES-health gradient. In another study Ostrove, Adler, Kuppermann, & Washington (2000) showed that the same simple measure of subjective social status was significantly related to self-rated health among four racial/ethnic groups of pregnant women.

All these studies document a relationship between one's social position and one's ability to live a 'healthful' lifestyle and a difference in nature and experience of SES in blacks and whites. The so-called health damaging behaviors may be perceived as a form of 'host' response to a hostile social environment. The singular behaviors are obviously an individual action, but they may not be an individual choice. One's capacity to modify potentially pathogenic behaviors is directly related to one's position in the social hierarchy. The psychocultural dynamics of status and class seem to have powerful effects. I conclude that experienced racism, sexism, and classism – be they coming from individuals, institutions or from culture – are in general detrimental to health. The inferiority of poor blacks' environmental and residential conditions, which is used to explain the differences, is just a good example of structural racism. However, let's not forget that for those who are oppressed identification with their marginal group may be a

source of strength and power. And, sociocultural power is only one of various possible dimensions of rank.

Specific Dimensions of Rank

In this section I will focus on some specific aspects of rank and health that I haven't covered yet and that I found useful for the operationalization of the concept of rank into a survey instrument measuring health outcomes. While I am concentrating on individual aspects of rank it is important to remember that from a subjective stance many aspects of the experience of rank are interrelated and influenced by each other. The measurement of one variable or dimension will therefore additionally reflect the sum of our lived experience of our social standing.

Self-rated Health

Good health is fragile and a temporary privilege. The way we experience our health is often closely related to how we perceive the quality of our lives and to subjective well-being. For many it is therefore essential to their sense of rank. And, health-related rank is in itself a multi-dimensional concept that encompasses the physical, emotional, and social components associated with an illness or treatment (Revicki, 1989). Researchers disagree about which precise dimensions to include in the concept of health-related quality of life or rank. Torrance (1987) stresses physiological and emotional functioning whereas Kaplan et al (1989) include social functioning (social role and social contacts) into their view of health-related quality of life.

It further has been recognized that various types of illnesses are associated with stigma isolating the individual from others. The association of illness with stigma and the effect of stigma depends on the degree of stigmatization and differs by illnesses. Fife and Wright (2000) demonstrated a derogatory influence of illness stigma on the self of the diseased persons further influencing their health. Farmer (1997) observed that poor perceived health was in itself a stressor that had an immediate and long-term impact on health. Coping with chronic illness is over time a source of distress and favors a cycle of health decline. In this study African Americans were more likely to perceive their health poorly, a finding consistent with the literature (Gibson 1991). This supports my hypothesis that different types of life stress, life events or chronic life strains (M.E.E.S), influence one's perception of one's health. I further think that, in addition to their relation to underlying disease processes, the question on self-rated health will reflect a burden of perceived ill-health that shows a clear social class gradient.

The subjective experience of physical and mental health may differ strongly from the health care professional's perspective. Both perceptions rely on different knowledge and experience. The subjective theories are important because they will influence the individual's behavior. The patient's understanding will influence health and disease long before a physician might have the opportunity to examine her and declare her ill or in good health.

There is an established link between perceived health and other measures of health status. Various researchers (Idler & Angel, 1990; Idler, 1992; Idler & Benyamini, 1997; Mossey

& Shapiro, 1982) have shown that self-assessments of health predict subsequent mortality, even when controlling for health as assessed by physical exam. In a study analyzing the results of the Manitoba Longitudinal Study on Aging, Mossey and Shapiro (1982) showed that the elderly respondents' self-assessments of health were much better predictors of their future survival than extensive objective data on their health.

Physical appearance

Self-esteem is often mentioned in terms of appearance or body image and cultural stereotypes, racial and ethnic prejudices affect a person's body image and self-esteem. Plus, social pressure for attractiveness differs by age and gender. In a meta-analysis of 222 studies Feingold and Mazella (1998) found that males have a more positive body image than females. They further found that gender differences increased from early to mid-adolescence, then decreased in adulthood. Body shape and physical appearance are relevant in the dynamics of social comparison and influence people's sense of self. Depending on age, gender, and cultural environment they form a distinct aspect of some individual's sense of their social rank.

Sexual Orientation

Heterosexuals have higher social rank than homosexuals. They can express their affection and love openly without having to fear discrimination. In fact heterosexual love is celebrated in mainstream society in a very provocative way for homosexuals. Furthermore homophobia is prevailing and a significant cause of discrimination and marginalization. Nevertheless, sexual orientation data are often missing in population

health reports so that the health concerns of lesbian, gay, and bisexual people are difficult to assess (Sell & Becker 2001). In a rare population-based study of lesbian and bisexual women's health (Diamant, Wold, Spritzer, & Gelberg 2000) lesbians and bisexual women were more likely than heterosexual women to have poor health behaviors and worse access to health care. In a study of older lesbian and bisexual women (Valanis et al. 2000) the lesbian and bisexual women were of higher socioeconomic status than the heterosexuals. However, the lesbian and bisexual women more often used alcohol and cigarettes, exhibited other risk factors for reproductive cancers and cardiovascular disease, and scored lower on measures of mental health and social support. In a study of homeless adolescents (Noell & Ochs 2001) membership in the group of gay, lesbian, bisexual, and "unsure" adolescents was associated with measures of depression, suicidal ideation, and substance abuse. In another study (Gilman et al. 2001) homosexual orientation was related to increased risk for anxiety, mood, and substance use disorders and for suicidal thoughts and plans.

Age

Whereas higher levels of objective social status promote better health and social well-being, the relationship of age to health and well-being is equivocal. Age results in decline in physical health and constriction of social positions and activity (Carstensen 1995; Riley, Kahn, & Foner 1994). Moreover, while some self-conceptions (such as personal control) apparently decline with age (Mirowsky & Ross 1989), other studies find that adults, as they age, feel happier and more satisfied with their lives and report higher levels of some dimensions of psychological well-being (Heidrich & Ryff 1996; Ryff &

Keyes 1995). The ability to age successfully suggests that some facets of social well-being, like psychological well-being, may increase with age.

On the other hand many older people experience more or less subtle discrimination because of their age. Their opinion is less honored in discussions, their life experience not valued in a society, which develops at a constantly faster pace. Besides the burden of less bodily strength they have to confront a hostile environment. The perceived value of age is in my opinion another important factor of rank.

Spirituality, Spiritual and Religious Beliefs

Everybody will outline spirituality differently. I define a spiritual person as someone who can overcome difficult life events without losing her compassion for herself and her fellow humans. I intentionally portray her in a large and open sense. For many meditation practices this sense of loving kindness and compassion is a central aspect. As Arnold Mindell says: “A tough life destroys many people. But for others, it can lead to insight, power and psychological radiance... Racism, sexism, homophobia, religious persecution, childhood abuse and ill health destroy many people. They hurt us all. They are meant to fill their victims with despair, depression, hatred, vengeance, and self-loathing. But there are the few who are transformed by those evils into compassionate human beings” (1995, 60). Surviving difficult life events can lead to centeredness and spiritual power, which is not included in the idea of social rank. I therefore believe it has to be studied separately.

Religious and spiritual beliefs can be a deep source of strength and a cause of persecution and pain. They are intimately related to institutional or communal forms of spirituality. They may also be a source of social support. In everyday life religious beliefs are often used to marginalize people. Anti-Semitism and prejudices against Islam or Christian fundamentalists are still very dominant in many societies and have an important impact on people's life experience. The manner in which we are valued or value ourselves with regard to our religious beliefs will in my opinion influence my overall sense of rank.

Self-knowledge

Self-knowledge is a concept which is difficult to define. Its importance in healing lies at the basis of every attempt to influence health through psychotherapeutic measures. In knowing and valuing more of my inner self I might develop a stronger feeling of coherence and consistency in life. Growing self-knowledge might strengthen one's potential for dealing with difficult life events. People with vast life experience and a broad knowledge of themselves in various situations gain in personal power; their psychological rank is obvious to anybody around them.

Behavior and Communication Style

“Privilege, rank, and lack of privilege are encoded in behavior”(Summers, 1994, 124).

Behaviors that distinguish low rank or self-esteem tend to include smiling a lot, listening with pressured attention, hesitating to voice one's opinion, pausing, giving in, and acting shy. Accordingly, those who have more power tend to behave and communicate showing signals of self-assurance and control – like being relaxed, empathic, interrupting the

narrative flow of the discussion partner etc. Thus the way we behave and express ourselves in groups or individual relationships is an expression of our self confidence and overall rank. On the other hand one's communication style is also an individual characteristic or personality trait through which we value ourselves and are valued from others within our specific cultural context. Various behaviors and communication styles are distinctively valued in different cultures. They are a deep expression of one's personality and will have an important impact on our relationships, depending on their appreciation in the group in which we live. Many people feel marginalized because their individual communication style and behavior is less valued in their environment. The collective recognition of our behavior and communication style will strongly influence our ability to express ourselves in smaller or larger groups. Lack of valuation can lead to chronic relationship conflicts and a sense of exclusion from our own community. It will strongly influence our own self-esteem. I therefore think that communication style and behavior are an important constituent of our overall sense of rank and are important variables in the measurement of the relationship between rank and health.

Social Support

The significance of social support for health and well-being is well documented (Cohen & Syme, 1985). I share the opinion that social support phenomena involve objective (actual events and activities) as well as subjective elements. However, again the most powerful correlations are found between psychological distress and perceived or experienced social support (Kessler, 1992). An open question is whether social support has a direct impact on well-being or exerts its influence through buffering the

consequences of stress exposure. The detailed mechanism is irrelevant for the purpose of my study. Turner and Marino (1994) found a close correspondence between the epidemiology of perceived social support and the epidemiology of psychological distress and disorder. They demonstrated that the availability of this important resource is partly a function of conditions of life that vary in relation to one's social status. In comparing perceived social support with other personal and subjective resources, I intend to deepen the understanding of the social contingencies that are relevant to variations in health risk by gender, race and SES.

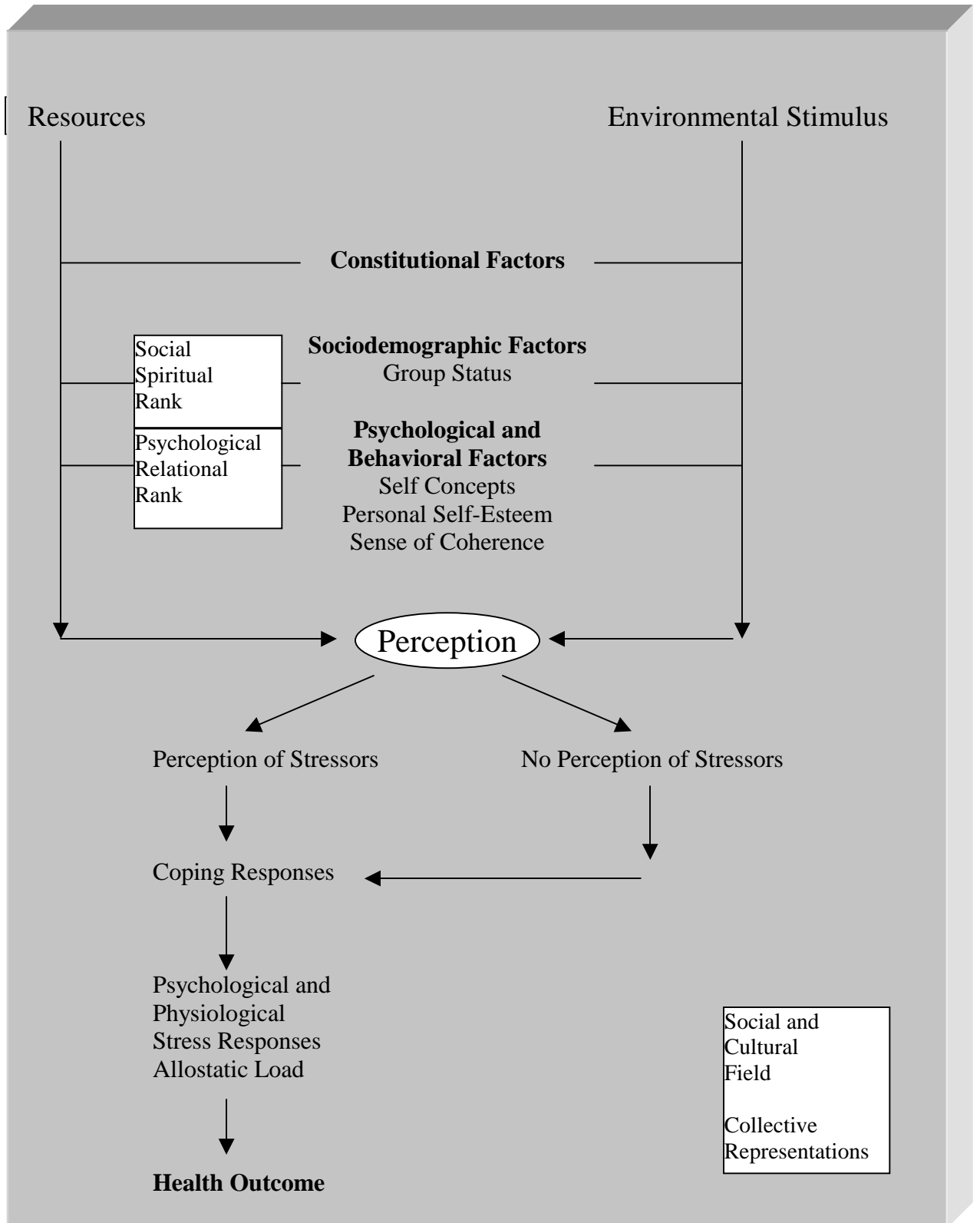
Conclusion

The conclusions are that stress is a condition of human existence and a factor in the expression of disease. Adaptation in the face of potentially stressful challenges involves activation of neural, neuroendocrine and neuroendocrine-immune mechanisms. This has been called as we have seen "allostasis" or "stability through change" and described as an essential component of maintaining homeostasis (McEwen & Seeman, 1999). The process of adaptation to stress over time leads to wearing of the physiological mechanisms (allostatic load) that can accelerate disease processes. The animal studies mentioned earlier show that among the most important stressors are those arising from competitive interactions leading to the formation of dominance hierarchies. As we have seen social ordering in human societies is also associated with gradient of disease, with an increasing frequency of mortality and morbidity as one descends the scale of social status. The cumulative burden of coping with limited resources and negative life events varies depending on genetical, environmental, behavioral, social, psychological, and

spiritual factors. A health model that goes beyond the curative model will approach the questions of health and disease from all the different angles. It will include a differentiated concept of the roles of rank, oppression, and coping resources in shaping one's ability to stay healthy and well.

Everybody experiences life constraints differently. A subjective approach to rank and privileges is therefore a prerequisite for a truly cross-cultural way of dealing with each of our individual culture of experience. It might explain the presumed strong relationship between subjective social status and health. My concept of the biopsychosocial effects of a minority status, which is based upon above mentioned theories, is depicted in Figure 1. Marginalized people are disproportionately exposed to environmental stimuli that may be sources of chronic and acute stress. An infinite number of these stimuli (especially interpersonal) involve racism, sexism, ageism, homophobia and all the many stereotypes that lead to discrimination. For example, more than 50% of African Americans attribute substandard housing, lack of skilled labor and managerial jobs, and lower wages to ethnic discrimination (Sigelman & Welch, 1991). Much research has shown that the psychological and physiological stress responses are more sensitive to the individual's perception of stressfulness than objective demands (Burchfield, 1979; Matheney, Aycock, Pugh, Curlette, & Canella, 1986). There is therefore no a priori way of determining if an environmental stimulus will be perceived as discriminating by an individual (Adams & Dressler, 1988).

Figure 1
 A Contextual Model to Examine the Biopsychosocial Effects of Perceived Rank



My hypothesis is that an individual's response to the social environment and the stresses affecting his or her life is closely related to overall rank and subjective positioning in social hierarchy respectively. His or her subjective experience of cultural, racial and gender background has an effect on their Sense of Coherence or resilience. It also depends on the social values of the majority of the group in which they live. I assume that factors that contribute to one's rank, like communication style, self-knowledge, social support, and other elements of social standing will have an effect on one's subjective experience within one's social groups. Societal world views and values influence the tension individuals experience, if they are not blending in with the majority values or behaviors. They affect the individuals' sense of coherence and the cohesiveness of their everyday experience. A person might come out strengthened if he or she is self confident enough and has enough other resources. Lack of money, for example, may not be experienced as a stressor if one can rely on education to find a good job whenever one chooses to do so. Education and self-esteem may form a kind of safety-net and compensate for the momentary lack of money. In the same way money might help to cope with the tension of lack of education; and higher SES might compensate for some of the tensions from racism and sexism. Ethnicity, SES, age, gender, health status, and sexual orientation are parts of people's General Resistance Resources or General Resistance Deficits. I suppose that the differences of how much rank someone has in the specific areas (social, psychological, transpersonal) and that the diversity in experience of and vulnerability to stigma and marginalization will account, at least partially, for the fact that someone with low social rank can cope with the adversity of his or her status. It might answer the question why some individuals in the lower social class groups come to

develop and maintain a strong sense of control (high personal mastery and low perceived constraint) or strong sense of coherence, despite social and economic adversity. The refined concept of rank will also help explain – besides all other constitutional, environmental, and behavioral contingencies of health – the occurrence of bad health in people with high social status.