CHAPTER VI

DISCUSSION

Health can be defined in many ways and the description of health encompasses objective factors, subjective experiences and their somatic, mental, and social dimensions. Both a "pathogenic" approach, that stresses causal factors detrimental to health, and a "salutogenic" theory, that emphasizes health fostering determinants, have their merits. For my research I took a "salutogenic" stance, so that my research questions were aimed at the contexts of health, and coping with adversity and challenges. The general query was about the constituents of health and the role of societal factors in influencing health and creating health disparities. More specifically, I was interested in the part that social standing or rank plays in affecting subjective health. From the field of conflict resolution we know that subjective rank has strong effects on social and group dynamics (Mindell 1995). But to my knowledge rank has never been studied in its relationship to subjective health.

Perceptions of socio-economic status (SES) are important elements in the pathways to ill-health and health disparities. The subjective experience of social standing and rank is complex and intertwined with many other psychological factors. Depression, negative affect, feelings of distrust, control a person has over his or her working and living conditions, and perceptions of social cohesion are some of the factors that have been

linked to individual and collective health outcomes. They are all inter-correlated in their effect on health.

As outlined in preceding chapters past research has demonstrated that low social status is an important predictor for poor health, and that social factors have a major influence on every person's health. The significance of social factors for health is important in all echelons of society. Redelmeier and Singh (2001) found that even Oscar winners live 3.9 years longer than Oscar nominees. The association of social rank with increased health and longevity extends to celebrities and prevails in all segments of society. Further social status has had its meaning for good health throughout history. In studies of skeletal pathologies and grave goods some biological indicators of stress and ill-health in adult life have been associated with social status in Italy as early as 700-300 BC (Robb, Bigazzi, Lazzarini, Scarsini, & Sonego 2001).

Most studies have focused on objective measures of social standing. Wilkinson (1999) and Adler (1999, 2000) determined that the experience of status differences might have a stronger effect on health than objective indicators of social status. They suggested that relative position in social hierarchies, the subjective experience of social status may by itself be a risk or protective factor, and more significant than objective position in society. Adler and colleagues (2000) developed two social standing ladders, one that assesses peoples' standing within society, and a second version of the ladder that determines peoples' standing or rank within social groups such as religious or local communities. This second ladder is supposed to detect individuals who may not have high standing in

terms of income, occupation, or education but may have more rank within their communities. This is the only example I found, that used a widened concept of rank (beyond the conventional measures of social rank) to study the relationship between subjective rank and health outcomes. Besides that, no other study has yet, in my knowledge, used an expanded concept of rank that includes materially and non-materially based dimensions of rank, to analyze the influence of subjective rank on health.

Until now experience of social standing has been shown to have effects on biological processes related to health and is associated with both physical and mental health. Lower ratings on the social ladder were associated with greater waist-to-hip ratio (a measure of body fat distribution related to susceptibility of atherosclerosis and heart disease), and a two and a half to four fold risk to develop an infection after exposure to rhinovirus virus (MacArthur 2001). After controlling for objective SES the ladder was related to basal arousal and sleep latency as well as to chronic stress, pessimism, control over life and passive coping (Adler, Epel, Castellazzo & Ickovics, 2000). In a follow-up of the Whitehall II study, which included the ladder of subjective social standing, subjective status not only showed more of a gradient than objective SES measures, but the effect of occupational grade became non-significant once subjective status was entered. Further, the association of subjective status and physical health remained significant even when depression was controlled for (MacArthur 2001). Two other studies (Goodman, Adler, Kawachi, Frazier, Huang & Colditz, 2001; Piko & Fitzpatrick 2001) demonstrated that among adolescents, social stratification as reflected by subjective social status was associated with health. In the first study subjective social status explained 9.9% of the variance in depressive symptoms and was independently associated with obesity. In this

study community ladder rankings were more strongly associated with health than were society ladder rankings. In the second study SES self-assessment proved to be a stronger predictor of adolescents' psychosocial health than objective SES indicators.

The topic of health and rank touches upon individual and collective processes and upon subjective perceptions of social dynamics, as well as objective elements of social status. Hence, the discussion of social inequalities and health mirrors the general debate about health. Both the role of individual and collective determinants and the importance of subjective and objective effects animates current academic controversy. At an individual level distinctions are drawn between associations based on psychological measures and those related to social conditions. Discussed are the role of psychology in contrast to the role of exposures to determined risk factors and hazardous behaviors. Wamala, Lynch, and Kaplan (2001) report that women exposed to cumulative socioeconomic disadvantage in both early life and later life have some four times the risk of developing coronary heart disease, compared to those without disadvantage at either stage of life. A life course perspective is postulated to explain health inequalities as biologically plausible phenomena. Kaplan and colleagues (2001) use the term "early life imprinting" to explain the biological transmission of parental socioeconomic position and the subsequent cognitive abilities of their offspring. The stimulating environment created by educated parents fosters brain development and leads to improved cognitive function in adulthood. In this view health is biologically embedded (via poor diet, housing, stimulating learning environment, etc.) in the fetal/childhood period and/or is biologically transmitted by a previous generation.

Antonovsky's Sense of Coherence (SOC) has been shown to be a strong predictor of health outcomes (Lutgendorf, Vitaliano, Tripp-Reimer, Harvey, & Lubaroff, 1999; Bengtsson-Tops & Hansson 2001; Nilsson, Holmgreen & Westman, 2000; Forbes 2001; Suominen, Helenius, Blomberg, Uutela, & Koskenvuo, 2001; Svartvik, Lidfeldt, Nerbrand, Samsioe, Schersten, & Nilsson 2000; Zhang, Vitaliano, Lutgendorf, Scanlan, & Savage, 2001; Mendel, Bergenius, & Langius, 2001; Freire, Shelham, & Hardy, 2001; George 1999; Adams, Bezner, Drabbs, Zambarano & Steinhardt, 2000; Kivimaki, Feldt, Vahtera, & Nurmi, 2000). SOC postulates a psychological and social transmission of health. In a Canadian study (Wolff & Ratner 1999) stress and traumatic events in childhood were found to be inversely related to SOC, and social support was positively related. Another study (Torsheim, Aaroe & Wold 2001) showed a strong association between SOC and stress in younger adolescents. In this view health is socially embedded (via trauma and stress) in the childhood/adolescent period and is psychologically transmitted by learned patterns and meanings that lead to a weak Sense of Coherence.

The extrapolation of findings from individuals to whole populations is controversial. People with strong social networks, for instance, have mortality half or a third that of people with weak social links (House, Landis & Umberson 1988; Berkman 1995). A study of 38 US states showed that income inequality and mortality was reflected in the degree of distrust people expressed and in the extent of organisational membership and community participation of the population. These three factors were important for the association between income inequality and health within the U.S. (Kawachi, Kennedy, Lochner & Protherow-Smith 1997). Wilkinson (1996) proposed that the level and quality

of social ties or mutual cooperation in a society may explain why some countries have healthier populations than others. Lynch and colleagues (2001) repeated Wilkinson's studies and included data from more countries. They found that income inequality, and characteristics of the psychosocial environment, such as trust, control, and organisational membership did not seem to be key factors in understanding health differences between wealthy OECD countries. In this study psychological ways of defining social capital are not related to average population health. They claim that neither an income inequality nor psychosocial environmental theory of health is universally applicable to understanding why some countries have better population health than others. Rather, levels of health within a country are a product of complex interactions of history, culture, politics, economics, and the status of women and minorities. Navarro and Shi (2001) studying the political context of social inequalities and health found that countries with political traditions more committed to redistributive policies (both economic and social) and full-employment policies, such as those with social democratic governments, were generally more successful in improving health of populations, such as reducing infant mortality. Thus, both horizontal social interactions like social support, social cohesion and community spirit, and vertical social interactions between classes, like policies that reinforce solidarity through redistributive and full-employment policies are influential on a population level. But some authors (Whitehead & Diderichsen 2001) argue that these complex interactions are not adequately described by singular approaches that are extrapolated from findings from studies on individuals.

Most understanding of the link between social conditions and health centers on the influence subjective and objective social circumstances have on health. Health, on the other hand, contributes to one's experience of subjective rank. Ill-health can be associated with stigma and marginalization and affects people's health-related quality of life and subjective well-being. The experience of severe and chronic illness challenges our subjective rank or social standing and may have drastic effects on our life courses. Health is in my opinion definitively one aspect of rank and should therefore be controlled for when studied from a social causation perspective. As far as I know there is no study of social status and health that has addressed this dilemma.

For my study I developed, on the base of Mindells' (1995) broad conceptual definition of subjective rank, a questionnaire assessing peoples' material (social) and non-material (psychological) dimensions of rank. I compared these measures to an index of self-rated health, Antonovsky's SOC, and to objective demographic measures of social status. I surveyed two samples of participants of the Lava Rock Network Seminars (Schwarz 1993) in Yachats, Oregon and Basel, Switzerland.

In the US sample the participants' appreciation of their ethnic identity, religious beliefs, and sexual orientation didn't contribute much to the consistency of the index of subjective rank. This might be related to the fact that in this sample most respondents were white, middle class, heterosexuals, and liberals. In the U.S. sample, measures of subjective rank, SOC, and objective SES were all significantly related to indicators of self-rated health. The highest associations were found for the indices of subjective and

psychological rank, and measures of rank and sense of coherence were all more strongly related to self reported health than the composite measure of objective SES. Subjective rank and psychological rank independently explained 31% of the variance in self-reported health. Subjective rank was not only most strongly associated with self-reported health, but the effects of SOC and objective SES became non-significant once subjective rank was entered in the multiple regression analysis. The association of subjective rank and self-rated health remained significant even when SOC and objective SES were controlled for. The results confirm my hypothesis that high subjective rank is strongly linked to self reported health and more sensitive than SOC and objective SES. These results are consistent with the assumption that low subjective rank is linked to greater stress by either increasing stress directly or increasing the vulnerability to the effect of stress.

In the smaller European sample psychological rank (a sub-category of subjective rank not based on material dimensions) demonstrated the highest association with self-reported health and it was the only index that was more strongly correlated with health than the composite measure of objective SES. Subjective rank, SOC, and objective SES had similar correlations. Measures of social rank were not significantly associated with self-reported health.

Being in a significant relationship improved in the U.S. sample the participants' rank and sense of coherence and had a protective effect on health. It confirmed the fact that emotional and social support are significant predictors of well-being and health (Seeman,

Lusignolo, Albert, & Berkman, 2001). Furthermore, marital status had an additional beneficial effect especially on the participants' appreciation of their social rank. Siegrist (2000) stipulates that social roles, such as the family and marital role, are essential prerequisites for successful personal self-regulation in adult life and the exclusion from these roles triggers a state of social reward deficiency. Above-mentioned results demonstrate the importance of the support from a significant relationship, and, in addition, a clear relationship between marital role and subjective and social rank. Being married is perceived with higher social rank or centrality and contributes to less experiences of stress and thus increased well-being.

As expected, the frequency of doctor visit was associated with self-reported health. But, I was astonished that it only explained 10.1% of the variance in self-reported health. In this sample, the participants' subjective experience of their health didn't translate systematically into a behavior seeking help from a health care provider. This finding calls for further research on subjective health and help seeking behavior. Frequency of doctor visit was further correlated with subjective rank, externalized social rank, psychological rank, and sense of coherence.

The weak association between sexual orientation (if regrouped into two categories: heterosexual and all others) and subjective rank, psychological rank, and SOC – sexual orientation accounted for approximately 4% of the variance in subjective rank, psychological rank and SOC – illustrates that this subgroup with some diversity in sexual orientation, felt socially integrated in regard to their sexual orientation. It reflects a liberal

orientation of this specific subgroup of people that attended the mind-body seminars I used for my study. It might point to a general tendency towards acceptance of some diversity in sexual orientation in the US and the Western world. Berlin's new mayor, for example, openly acknowledged that he was gay and that it was good that way. Mr. Wowereit's appointment is seen as a breakthrough for sexual freedom and tolerance in Germany (Erlanger 2001). His statement *"und das ist gut so"* has become famous and the tag line for many advertisements. The lower mean subjective rank, psychological rank, and sense of coherence of the 21 participants who identified themselves as being mostly heterosexual with occasional homosexual experiences might express a fragile sense of self and identity, their homosexuality being somehow in the closet.

I am not sure if there is any difference between the experience of marginality and the experience of outwardly projected social rank. My index of marginality didn't help in the prediction of self-rated health over and above the effect of externalized social rank. The conceptual definition of marginality needs further research for marginality to be used in studies of rank and self-rated health. The operational definition of the construct of independent/interdependent self also needs further elaboration. The association of my index of interdependent self with some rank indices suggests that further investigation of the association between self constructs and subjective rank/health could be meaningful.

In general, my findings suggest that one's sense of feeling well is related to subjective and objective rank but one's perceived rank dominates the effect on self-reported health. The strong relationship between subjective rank and self-rated health over and above the

effects of objective measures of social status confirms my hypothesis that perceived rank is more sensitive in predicting health than objective measures of social status. In the U.S. sample perceived rank was also more effective in predicting health than Antonovsky's sense of coherence (SOC) scale. This finding could not be replicated in the Swiss sample.

Marginalization and discrimination by sexist, homophobic, and racist structures and policies translate into peoples' experience of rank and have a direct influence on people's health and well-being. My results show that some of the effects can be compensated for by other individual powers and value orientations. The women in my U.S. study, for example, had a realistic view of their social standing and the sexism that affected their external social rank; but nevertheless they were able to report a stronger sense of internal social rank. My results further demonstrate that feelings of being loved and accepted on a community level (through feelings of empowerment and subjective rank) can have an important impact on health. In this view health is socially embedded (via integration and acceptance) over one's life course and is psychologically transmitted by feelings of love and support that lead to a strong subjective rank. Marginalization and discrimination have the opposite effect. They lead to a low sense of rank and contribute to impaired health and well-being. From this perspective one could argue, for example, that the improved health outcome of individuals suffering from AIDS might not only be a result of better treatment and earlier detection, but could be linked to feelings of improved societal integration and acceptance as homosexuals.

The experience of structural violence and oppression as expressed in one's sense of rank explains the negative health impact of social disparities. From studies of the effect of violence on children we know that experienced and witnessed violence affects young children's brain development and can lead to serious behavioral and other health problems and perpetration of violence later in life (Dutton 2000; Shumaker & Prinz 2000; Borowsky, Hogan & Ireland 1997; Wingood, DiClemente, McCree, Harrington & Davies 2001). Furthermore, shaming and humiliation is often found at the roots of violent behavior (Potter-Efron 1999; Dutton, van Ginkel, & Starzomski 1995). Structural violence and oppression that prevent people from developing a sense of rank and empowerment, the marginalization and shaming of individuals and groups affects everybody's health. The marginalization of whole cultures and religious beliefs incites more violence. It might be a cause of today's terrorism (Silver, 1997; Volkan, Julius, & Montville, 1991; Crenshaw, 2000).

Perceptions and their first-person subjective character, and all those aspects of experience that are directly knowable only through introspection are thought not to be analyzable in terms of causal relations and, thus, are often marginalized by the objectifying approach of science. From neuroscience we know that the perception of loud music is influenced by one's appraisal and valuation of the music. Unpleasant, dissonant music is perceived as louder than agreeable music. The detrimental health impact of loud sounds depends also upon the individual's judgment in such a way that unpleasant sounds do more damage to the ear (Marin & Perry 1999; Steinberg 1995). Thus, perceptions are ubiquitous and their

influence is broad. Based on my research I think that subjective rank is central to individual's, community's, and whole nation's health, safeguard and well-being.

First-person or subjective experiences and people's way of presenting and explaining their difficulties do not get enough attention in current health science curricula. The concentration on analysable causal relations holding between objective, physical objects, events, states and processes leave out those aspects of life which are accessible only through our perceptions, intuitions, and feelings. Biomedicine centers on knowledge of the external material world as perceived from a third-person perspective. Psychology, in contrast, is based on knowledge of the internal world. Both approaches have their merit. The one-sided materialistic view of biomedicine that has almost become a philosophy or doctrine marginalizes and disowns peoples' subjective experience. It might be at the root of burnout feelings of many health care providers and of the dissatisfaction with present health care expressed by many patients.

My research has attempted to incorporate subjective factors and my subjective rank scores appear to be at least as significant as Antonovsky's SOC. The questionnaire needs to be tested on larger and more diverse populations to determine its validity for further health research. If my results are replicable the subjective rank construct will add to the existing concepts used to appraise someone's subjective social and community status (Adler, 2000 & MacArthur, 2001).

Limitations

There are various limitations to the present research. Health in itself is contributing to peoples' sense of personal and social powers. It is one aspect of social and psychological rank and will therefore manifest in peoples' appreciation of their rank. The correlation between self-rated health and subjective rank might therefore be overstated. The question is how much of the relationship is influenced by subjective health's intrinsic contribution to rank.

Another noticeable limitation is the restricted range of social status, age, and ethnic background. The participants in both samples all held at least a high school degree and a high percentage held a graduate or professional degree. This restriction may influence and probably underestimates the impact of education on health. It limits my ability to draw conclusions about the relative association of subjective and objective social status with health. A second limitation of this study is that the participants were mostly white women and men. Associations between social status, rank and health may not be the same for all ethnic groups. I also do not know if similar associations would come forth for older and younger people.

Participants of Lava Rock Seminars are further likely to be pre-disposed to linking psychological states to physical health states. This might result in an overstatement of the connection between health and rank. Then, the survey was self administered and unhealthy people might have lacked the energy or motivation to fill out the questionnaire. As a result, the range of self-reported health was constricted. Despite these limitations, I

found significant associations of rank factors with self-rated health. These effects might well be magnified with a more diverse sample.

The operational definition of rank as a conscious or unconscious, social or personal ability or power emerging from areas of socio-cultural influence, personal psychology, and/or spiritual ties is broad. Experience of rank encompasses material SES dimensions as well as other less materially based social elements like community integration and self-esteem. It includes perception of social and community standing as well as other psychological values of coping with life, such as self-knowledge, comfort with strong emotions, and the ability to interrelate with others and solve conflicts. In covering psychosocial resources it corresponds with Antonovsky's SOC, and concepts of subjective social status developed by Adler and colleagues. Rank is therefore difficult to rigorously discriminate from concepts of sense of coherence, subjective health, and psychological well-being. These concepts overlap and it is questionable if it is possible to assign measured effects on one scale to a single entity. For example, rank and sense of coherence overlap both conceptually and empirically. In my study I measured a correlation coefficient of 0.18 (externalized social rank), 0.42 (internalized social rank), 0.65 (subjective rank), and 0.72 (psychological rank) between these subscales of rank and SOC. Psychological rank and subjective rank showed a correlation coefficient of 0.93. Others have shown high correlations between measures of SOC, depression and fear (for an overview see Geyer 2000). Part of the correlation between my subscales of psychological rank and SOC is explainable with similar item formulation (e.g. "mixed up feelings" and "feelings you'd rather not feel" in Antonovsky's questions and "comfort

with strong feelings" in my questionnaire). It is therefore difficult to assume that these three scales measure disparate constructs. In the case of psychological rank and SOC, the degree of correlation is so high that standard procedures for evaluating a subscale's relative importance (e.g., beta weights or bivariate correlations) are failing. In an effort to broaden researchers' options and thereby allow for greater interpretive clarity new statistical methods have been developed for analyzing factor associations in the context of predictor collinearity (Hittner 2000).

Nevertheless, multifaceted personality scales assess multiple related facets or dimensions, and, as such, they are typically made up of correlated subscales. The individual's experience cannot be rigorously separated and the academic discussion of the relative importance of the various dimensions is secondary to the existing link between SOC, rank and health. Our internal experience of rank – as shown with my results – is very relevant for our ability to stay healthy, become resilient, and cope with the challenges of life. Its effect on health is matched by our experience of one's subjective social standing, sense of coherence, depression and fear. Many questions remain to be investigated: for example, how these factors combine and interact and what individual responses need to be taken into account. But the specific questions shouldn't distract us from the important fact that people's internal experiences of the external world have an important influence on health outcomes.

Implications for Further Studies

Further research is needed to explore the importance of rank to psychological, social, and physiological well-being. The ways the concepts of rank and marginality can be converted into research instruments, and the relationship between self constructs and rank, need to be studied more. Questions that showed low correlations in item analyses need to be revised and re-tested in a bigger sample. A qualitative analysis of the valence of the various subdimensions of rank and marginality will help refine the operational definition of these concepts. Then, a future quantitative study would have to aim at a bigger and more diversified sample. I would try to include subjects from different ethnic or national groups, from a broader range of social class, and with a larger scope of health problems. Optimally I would also compare rank with objective measures of health. New advances in biology have contributed to a better understanding of how stress due to adverse social conditions or low rank "gets under the skin" to produce health disparities. Glucocorticoids, the adrenal steroids secreted during stress, while critical for successful adaptation to acute physical stressors, can have a variety of deleterious effects if secreted in excess. It has come to be recognized that glucocorticoid excess can have adverse effects on the nervous system. These effects include disruption of synaptic plasticity, atrophy of dendritic processes, compromising the ability of neurons to survive a variety of coincident challenges (Sapolsky 1999). Stress and glucocorticoid excess leads, furthermore, to various metabolic aberrations (e.g. alteration of lipid metabolism and insulin resistance). These nervous and metabolic changes are supposed to mediate the influence of stress on the body. Concepts of allostatic load (McEwen & Seeman 1999) and vital exhaustion (Appels, Falger, & Schouten 1993) reflect the renewed interest in the

effects of stress. Measures of allostatic load and vital exhaustion would be a perfect addition to a future study.

If we consider health to be an aspect of rank the debate between a social causation approach to health and a social drift or selection theory acquires a new facet. The contribution health has on subjective rank and the relationship between health-related quality of life and rank are therefore topics that request further understanding and research.

I would further implement the above mentioned newer statistical methods (predictor collinearity) for accurate factor associations and comparing two dependent semipartial correlations. Nevertheless, my preliminary results suggest that rank is a promising concept that may broaden the definition and understanding of social status and health. Rank may account for the SES/health gradient that is not confined to poverty and might replace in the future the concept of risk factors (e.g. health behaviors like cigarette smoking). The so called health-damaging behaviors will possibly be considered as concomitant phenomena of rank which, in my view, dominates the distribution of risks and resources.

In addition there is, in my opinion, little knowledge about possible interventions for countering the unfavorable effects of, for example, low SES. Besides structural or political changes, there are no innovative strategies addressing the specific needs of persons with lower SES. Williams (1990) has shown that for people struggling with

chronic economic difficulties, it is more difficult to adopt and maintain healthful lifestyles compared with the more affluent. Further studies and research might want to evaluate if, for example the new skills developed in large group settings by Mindell and his colleagues form an original and effective approach in dealing with these issues.

Final Comments

It is well known that different individuals experience the same stressful life events in very different ways. However, little is known about the factors that increase or decrease an individual's vulnerability to stress and its effects on health. Personality type, individual temperaments, self-esteem, and emotional styles are seen as determining factors for how individuals perceive and cope with stress. Antonovsky, studying a group of individuals who were resilient to intense stress and trauma, proposed a personality trait of a coherent worldview as a coping resource. Objective and subjective social status have well-documented associations with health. I suggest that subjective rank, a person's perception of his or her standing in society, combined with intrinsic non-materially based personal powers, may by itself be a risk or protective factor. From that perspective rank is a social and psychological substrate of resilience. In this sense, risk factors (e.g. health behaviors like cigarette smoking) that have been drawn to explain SES/health relationships can only be considered as concomitant phenomena of the more influential primary factor rank. I further believe that rank rules the distribution of risks and resources and may account for the SES/health gradient that is not confined to poverty.

Then, a narrow conceptualization of the rank/health and well-being relationship might be flawed too. Some research on self-esteem has demonstrated that the connection between self-esteem and measures of academic performance, social adjustment, and well-being might be overrated (Emler 2001). According to Emler low self-esteem doesn't have to be harmful; "people with low self-esteem seem to do just as well in life as people with high self-esteem. In fact, they may do better, because they often try harder" (208). To blend the notion of self with worth or the notions of rank and power with health is problematic. Although the statement that "the less rank you have, the worse you do and the more rank you have, the better you do" may seem to make much common sense this conflation of rank with value is a product of our culture with its specific sexist and individualistic connotations. Rank is a product of culture and its link with value is critical or at least should be interpreted in a cultural context. High rank, as history and sociology teaches us, can be very dangerous. And low rank can be a value too. Humbleness and modesty are values that many religions propagate often to contrast the material achievements of high social rank. The inclusion of non-materially based dimensions into my conceptual definition of rank is an attempt to correct a too unidimensional understanding of social rank. But its correlation with health remains difficult.

A danger of a salutogenic emphasis is that it overstates health and marginalizes non-health states. The described centrality of health discriminates against ill and disabled people and those whose inner states and experiences are less strong and resilient. Guggenbühl-Craig's (1999) "archetype of the invalid" stresses sickness as a basic phenomenon of life that often defies all healing efforts and will guide us all to our

ultimate destiny. It balances a philosophy of health that hinders us from connecting ourselves with aspects of “life” that are bigger than life itself. A pathogenic approach is one-sided too. It overestimates the importance of objectifiable cause and effect relations. It disavows influences of psychology, dreams, and non-local field effects.

Dualistic and scientistic[1] thinking prevail in medical discourse. The strength of dualistic thinking is that it raises the distinctions and polarities of the many issues. When combined with value-laden thinking, with favoring some states over others, hierarchy is created as well as uneven distribution of power and privileges and the domination of a few over others. Minnich (1990) described this meaning system in which differences are not mere distinctions but characteristics that justify privileging some over others as “hierarchically invidious monism.” In medicine it led to the domination of objectifiable, third-person perspectives and the marginalization of subjectivity.

Scientism dominates in modern universities where academic success often requires formal alliance with the materialistic and reductive perspectives of scientism, and humanities have been elbowed into a marginal status. Different perspectives offer essences of wisdom that remain valuable to all. Philosophy, psychology, phenomenology and other fields of humanities and social sciences dwell in human experience; science focuses on the material domain, and social science sensitizes us to issues of social justice. According to Schrödinger (1983), an integral element in the development of a philosophical or spiritual world view is a sense of wonder, which scientism sadly lacks.

[1] See my definition of scientism in chapter I.

For Schrödinger, the most profound occasion for wonderment is the common features of all experience and the fact that anything is experienced and encountered at all.

For some, conscious states are emergent properties of the physical world, whereas others hold that something called Spirit is fundamental. David Bohm (1980) states that contrary to usual opinion, modern quantum physics approaches closer and closer to the principles of immediate perception. Characteristics of quantum field effects (holism, spontaneity, complementarity, non-locality) are mirrored in immediate consciousness and self-awareness. The philosopher of science Spencer-Brown (1969), the psychologist C.G. Jung (1959), and the physicist and psychologist Arnold Mindell (2000) observe that the lines between psychology and physics blur and new developments at the limits of one become relevant at the limits of the other. William James (1912) suggested that the extremes of objectivity and subjectivity are ultimately based on contrasting attitudes we can take towards a shared primary beingness or 'pure experience.' This dimension of primary experience which he described as of a sheer "thatness" or "suchness" and which physicists have called "undivided wholeness" (Bohm 1980) or the realm of "tendencies" (Heisenberg 1958), comes before the divided world of probabilities in physics, particular views and experiences in psychology, and physical manifestations of the material world. Arnold Mindell (2000) states that: "In the new physics and psychology, the fundamental process is not elementary particles or parts of the personality such as ego or Self, but dreaming" (580). He refers to Richard Feynman's (1961) seminal text on particle physics that stresses that the particles themselves are not the roots of physical reality: "Instead, the true roots are the interactions, invisible relationship processes between particles" (

581). Psychology and physics or consciousness and the material world are two complementary aspects of the same indistinguishable primal stuff and this basic stuff of the universe “is an interactional relationship process between everything involved in observation” (581). Arnold Mindell calls this sentient dimension of experience also the realm of Dreaming. “Dreaming no longer means only dreams, pictures from the night. Dreaming refers to all sentient NCR [Non Consensus Reality] experiences, such as the feelings you have in sleep, your fantasies, intuitions, and unexpected body feelings, as well as partially observed objects that fleetingly catch your attention. These are the pre-material origins of the world” (581).

If we return to my previous analogy of Asclepius and his rod, the rod might represent the complementary aspect of seemingly opposing approaches, the sentient realm of interconnectedness in which there are no rigid boundaries between things, thoughts, persons, and events. The rod stands for the core from which the manifold themes unfold as polarities and dichotomies. The two intertwined snakes portray the world of particularities which creates tension and diversity and in so doing brings forth consciousness and awareness and awakens us to the complexities of the world and of health.

In the historical and current debate in medicine the rod as the unifying sentient experience has been marginalized. From a dreaming perspective polar mechanistic and vitalistic concepts are the two opposite sides of the same coin. Both views emerge from a deeper level, the fecund field of emptiness or undivided wholeness from which

everything arises. The rod is the root foundation out of which matter and power that gives rise to the matter emerge. Consciousness and matter co-emerge from the same basic stuff.

From this perspective every disease, like epilepsy, is experiential and material. There is no separation between a philosophical or symbolic and a material realm. The distinctions are helpful because they nourish the group process which is necessary for increased consciousness and awareness. But ultimately all factors need to be accepted and included as part of any disease process, the sentient realm of the rod as well as the intertwined snakes who symbolize the world of material manifestations and particular views and experiences. Reality has a material foundation and a non-visible and non-visualizable dimension of pure generative power. Symptoms in their material and subjective expression can be, from that perspective, not only a source of suffering and pain, but an unseen ocean of creative potentialities.

Furthermore everybody's lived experience is complex and multifaceted. It doesn't just abide to an either/or approach nor to a rational and objective truth stance of Western medicine and science nor to a healthy/non-healthy dichotomous division. In our lived experience many perspectives are all true at the same time and the interconnectedness is a basic reality.

My research suggests that subjective experience of rank and social ordering makes a difference for health. The role of objective social status, race, gender, and sexual orientation, in perceptions of rank cannot be underestimated. Lifelong exposure to

discrimination based on rank undermines physical and psychological health. Many experts now conclude that lifetime stress as well as transgenerational stress from experiencing discrimination causes for example release of hormones that weaken the uterus, leading to premature delivery or mortality across generations in African American women (Rothstein 2002). From this perspective power is an absolute dimension of physical, emotional and mental health. Everybody who experiences lower rank knows of its ill making effect. A power imbalance between men and women hampers, for example, womens' ability to negotiate and request safe sex practices and prevent HIV infection in many countries (Dreifus 2001). My results suggest that rank strongly influences what you are doing with your body and your ability to lead a healthy and long life.

Social and especially income inequality has been increasing throughout the industrialized world (Stille 2001). There is further an increasing economical divide between industrialized and developing countries and some of this inequality goes along religious barriers with Islamic countries representing most of the poorest countries. Growing inequality produces a host of social ills (e.g. drug use, teenage pregnancy, crime and lowered life expectancy) and as I have shown ill health in general. It is, in my opinion, also at the center of today's terrorism. Nobody, no group, no society, the world cannot be happy and flourishing with an increasing part of its members getting poorer and more miserable. Thus, equity, equality, and rank consciousness is a crucial prerequisite for the future health of us as individuals, as societies, and as the world as a whole. But my results also endorse the idea that for reducing inequalities in health one might not only aim at attenuating material disparities, but also find new ways of processing social status

comparisons and issues of plurality and diversity at all levels of community. Diversity issues, such as racism, homophobia, classism, and sexism are relevant in every human interaction. To reverse these fundamental injustices requires, in my opinion, not only political and economic consciousness and policy changes, but also an attitude that integrates a sense of wonder and an awareness of the deep interactional relationship processes – of which rank is especially significant – that lie under everything.

I think that every health professional should become aware of the importance of subjective social standing and include a routine assessment of every patient's subjective rank in his or her clinical interview, as he or she would do with any other risk factor. And, education about the internal world of the patient and the influence that rank has on people's perception and experience should become an integral part of every health care curriculum. Consequently medicine would re-associate itself with socio-political issues of rank and privileges and help adjust health disparities.